

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

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

**FY 2012 ANNUAL REPORT**

**(OCTOBER 1, 2011 TO SEPTEMBER 30, 2012)**

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

AARHB	Addis Ababa Regional Health Bureau
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change and Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
CBO	Community-Based Organization
CMSG	Community Mothers Support Group
CSO	Civil Society Organization
DCCM	Demand Creation Community Mobilization
EIFDDA	Ethiopian Interfaith Development and Dialogue for Action
EOC-DICAC	Ethiopian Orthodox Church Development and Inter Church Aid Commission
FANC	Focused Ante Natal Care
FMOH	Federal Ministry of Health
FP	Family Planning
FSS	Follow-up Supportive Supervision
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HC	Health Center
HCSP	HIV AIDS Care and Support Program
HEP	Health Extension Program
HEW	Health Extension Worker
HF	Health Facility
HMIS	Health Management Information System
HP	Health Post
HRH	Human Resources for Health
ICASA	International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa
IEC	Information, Education, and Communication
IFHP	Integrated Family Health Project
IGA	Income Generating Activities
IRT	Integrated Refresher Training for Health Extension Workers
IYCF	Infant & Young Child Feeding
IYCN	Infant & Young Child Nutrition Project
IOCC	International Orthodox Christian Charities
JSS	Joint Supportive Supervision
MNCH	Maternal, Neonatal and Child Health
MOU	Memorandum of Understanding
M&E	Monitoring and Evaluation
MSG	Mother Support Group
MTR	Mid-term review
NVP	Nevirapine
PATH	Program for Appropriate Technology in Health
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care Unit
PW	Pregnant women

PI	Performance Improvement
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
QoC	Quality of Care
RQCA	Rapid Quality of Care Assessment
RDQA	Rapid Data Quality Audit
RFA	Request for application
RTK	Rapid Test Kits
RHB	Regional Health Bureau
RO	Regional office of CPMTCT project
SCMS	Supply Chain Management Systems
SDO	Service Delivery Officer
SS	Supportive Supervision
TOT	Training of Trainers
TWG	Technical Working Group
VCHW	Volunteer Community Health Worker
VCT	Voluntary Counseling and Testing
WFP	World Food Program
UHEP	Urban Health Extension Program
UHEW	Urban Health Extension Worker
UHPDP	Urban Health Promotion and Disease Prevention
USAID	United States Agency for International Development
WHO	World Health Organization

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### 1. Reporting period

<b>From: October 1, 2011</b>	<b>To: September 30, 2012</b>
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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
Accelerated Plan for Scaling-UP PMTCT in Ethiopia	FMOH	December 4, 2011 to present

**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
Kate Stratten and Loic Hudson	30 Sept,2011	6 Oct, 2011	IntraHealth	Assistance with Yr 3 work planning and sub-recipients' Yr 3 SOW.
Cathy Murphy	March 31, 2012	April 14, 2012	IntraHealth	PQI &SS training material development and field testing
Maryce Ramsey	May 28, 2012	June 8, 2012	IntraHealth	Gender Assessment
Ashley Aakesson	June 16, 2012	June 24, 2012	PATH	TIPS Study - Training
Sara Stratton	July 29, 2012	August 4, 2012	IntraHealth	Assistance with Midyear review and year 4 work planning
Ashley Aakesson	July 18, 2012	August 6, 2012	PATH	TIPS Study - Data collection and analysis

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

Trip reports for Sara Stratton and Ashley Aakesson attached (Annex I).

#### 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
Wondimagegn Tekalign	Tanzania, Dar Es Salaam	September 1, 2012	September 9, 2012	Pathfinder Tanzania	To learn/share experiences with Tanzanian Pathfinder Community level activities

**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
USAID/PEPFAR SI Team	Mar 22, 2012	Mar 22, 2012	-Aynalem HC in Tigray region.	Oral feedback at the site.
USAID/PEPFAR OACG SI Team	Mar 27, 2012	Mar 27, 2012	Legetafo HC in Oromiya region.	Oral feedback at the site.
PMTCT TWG	Mar 13, 2012	Mar 13, 2012	Legetafo HC in Oromiya region.	Oral feedback at the site.
Joint PEPFAR/E PMTCT/OVC/Pediatrics (POP) Site Visit	May 14, 2012	May 18, 2012	Amhara & Oromiya (Kombolcha 05, Buanbuha, Segneo Gebaya and Lode Jimata HCs).	Written feedback, the feedbacks were presented in POP TWG.
The national Technical team (lead by Sr.Yetimwork FMOH)	April 27, 2012	April 20, 2012	Tigray (Hawzen and Megab HCs)	Oral feedback provided
USAID Team	August 8, 2012	August 9, 2012	Addis Ababa [Alembank & Entoto Fana HCs]	Oral and written feedback given.

## 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 checked="" type="checkbox"/> 13-PDTX	663-A-00-09-00429-00	Community PMTCT
<input type="checkbox"/> 14-PDCS		
<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

This progress report documents activities accomplished by the CPMTCT project during FY12 (October 1, 2011 – September 30, 2012). These accomplishments and successes continue to contribute to project's goal of increasing MNCH/PMTCT service uptake and case follow-up and supporting the national Accelerated plan for PMTCT.

### Highlights on expansion

In the third year of the CPMTCT project implementation, the project expanded from 207 to 519 health centers, a major increase by 150%, to provide comprehensive MNCH and PMTCT support. The main reasons for expansion are to support the government's initiative on the Accelerated Plan for PMTCT, to respond to the need of the MNCH/PMTCT services scale-up in remote areas, and to increase MNCH/PMTCT service uptake. This site expansion was done in close collaboration with government counterparts; the RHB recommended sites for expansion and baseline assessments were performed with the involvement of zonal and woreda health office staff. Sites which met the selection criteria, such as adequate staffing, infrastructure, prevalence of HIV and ANC patient load, were selected. The Accelerated Plan for PMTCT scale-up intended to increase PMTCT services in 950 health centers. Of those, 523 health centers are started to date, and the CPMTCT project, through its expansion, contributed to 44% (N=232) toward the government's PMTCT Accelerated Plan. Currently, the CPMTCT project supports one third (N=519/1,557) of the national PMTCT health services. The project does not plan to increase its

number of health facilities in Year 4 as it will focus on strengthening the existing health facilities and implementing Option B+ in selected health centers.

#### Highlights on the MTR findings

The CPMTCT project conducted its mid-term review (MTR) meeting in August 2012. The purpose of the meeting was to review project achievements over its objectives, identify strategies or approaches that contributed to these achievements, solicit and analyze stakeholders' perceptions on the project and areas of improvement as well as prioritize strategies or approaches for the remaining period of the project. The key outcomes of the MTR was to prioritize and to focus interventions in health facilities with HIV prevalence of above 1%; to redefine package of health center support on types of in-service trainings and level of supportive supervision and mentoring to be provided according to health centers' patient load; to further strengthen the strong partnerships with the regional health bureaus and advocacy work conducted by the CPMTCT project; and to optimize the project's performance particularly focusing on the PMTCT cascade. This MTR enabled the CPMTCT team to discuss ways in which to strengthen the collaborative effort of the consortium members, Pathfinder, PATH and IOCC and how to build on each organization's strength for better outcomes.

#### Highlights on successful achievements

During FY2012, the CPMTCT project made significant progress, while expanding its number of sites by 150%, from 207 to 519 health facilities. Meeting the project's testing target at 96%, 90% (N=358,266) of its ANC clients were provided HIV testing services compared to 81% (N=312,443) last year. The prevalence through its supported health centers remains low at 0.5% as in the past years, an encouraging sign on the epidemic in mostly rural areas. One thousand nine hundred sixteen pregnant women were identified HIV+, and 67% (N= 1,282) were put on treatment in CPMTCT supported health facilities. Most importantly, averting the major loss to follow-up, the CPMTCT was able to track 88% (N=1,701) of the HIV+ pregnant women on treatment throughout its supporting health centers or neighboring sites. Thirty-three percent (N=628) of children born to HIV pregnant women were put on treatment, a figure that needs improvement in the coming year. Only 78% (N=494) of the infants were tested for their status within 12 months due to barriers such as non functional transportation and communications systems, which the CPMTCT will work on in the coming year.

The CPMTCT project mother support groups (MSG), implemented through 101 health centers, has made significant contributions in supporting HIV+ pregnant women and lactating women, as 96% (N=521) of HIV+ pregnant women participating in the MSG, delivered at the health facilities, 96% of their children were put on prophylaxis and 88% (N=461) were tested within 12 months. These types of initiatives with such outcomes will be expanded.

Institutional delivery remains low at 10% (N= 41,941), while institutional delivery for HIV+ pregnant mothers is at 33% (N= 641), reflecting the positive outcome of MSG and other supportive interventions the CPMTCT project engages in with HIV+ pregnant women. Another area for improvement remains TB screening at only 70% (N=1,371), the project aims to have 95% screened in Year 4 since it recently equipped all health centers pre-ART record books to register this activity.

Overall, the CPMTCT project was able to accomplish most of its set targets, taking into account the reduced HIV prevalence in the areas it is working in. These positive outcomes are strongly appreciated by the regional health bureaus as this project supports the majority of their MNCH/PMTCT initiatives at health centers and health posts. The intimate collaboration and coordination with the regions enables and facilitates the implementation of this multi-dimension project both at the community and facility following and supporting the government's Accelerated Plan for PMTCT scale-up.

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

#### Support for Public Health Sector and CSO MNCH/PMTCT Policy, Materials and Management Capacity

##### National Level Support:

The Project contributed to a number of important initiatives at the national level, including the followings:

- During this reporting year, the CPMTCT project supported the development of the FMOH "Accelerated Plan for Scaling-up PMTCT in Ethiopia", its national launch and implementation throughout the country. The "Accelerated plan for PMTCT" was presented at the pre-launch session of the ICASA conference by CPMTCT's seconded MNCH/PMTCT advisor to the FMOH.
- As the lead of the PMTCT TWG, the CPMTCT's seconded MNCH/PMTCT advisor and the CPMTCT technical lead also contributed to the revision of the national MNCH/PMTCT training package and guidelines to reflect changes to the ARV protocol (Option A). The MNCH/PMTCT advisor presented the updated PMTCT guidelines during the FHAPCO bi-annual review, and conducted a half day orientation for 30 CPMTCT trainers.
- The project director, technical advisor and regional managers continue to support the FMOH and RHBS by participating in the Accelerated Plan's national and regional steering committees and technical working groups. These staffs lead and participate in various PMTCT TWG subcommittees such as M&E, demand creation and continuous quality improvement.
- As part of the government's policy to adopt Option B+, CPMTCT project staff has participated in several TWG since the project supports one third of the government's PMTCT health centers. The project's seconded MNCH/PMTCT advisor played a key role in leading the PMTCT TWG with activities related to the WHO Option B+ guidelines and CPMTCT project staff has been involved in the development of the Option B+ roll out strategy as well as the revision of the PMTCT training material in line with Option B+.

In preparation of this policy change, the CPMTCT project conducted several consultative meetings with USAID to strategize on the roll-out of Option B+ in its selected health facilities. The project has put together its Option B+ implementation plan in line with the government roll-out plan and is ready to support this initiative.

- As part of the global initiative, and in support of the government's vision to eliminate mother to child transmission by 2015, the CPMTCT project advisor to the FMOH, has also been involved in the development of the three years elimination of MTCT as Ethiopia is among the selected 22 countries in this initiative.
- The CPMTCT technical team continues to participate in the Safe Motherhood, FP, newborn care, M&E, QI, MSG, Nutrition and HIV, continuing professional development and WHO Human Resources for Health (HRH) TWGs. These staffs also contributed to the revision of the MSG training manual and the revision of nutritional care in the context of the HIV guidelines.
- Program and technical team members participated in government led federal and regional level review meetings, PEPFAR partners' meetings and various technical meetings organized by other implementing partners working on MNCH and HIV. In addition, the staff attended two international conferences held in Addis Ababa, Ethiopia, the International Conference on HIV/AIDS and Sexually Transmitted Infections in Africa (ICASA) in December 2011 and the 13<sup>th</sup> World Congress on Public Health in April 2012.
- In FY2012, the CPMTCT project had several posters reflecting its work accepted to national and international health conferences such as ICASA, International AIDS Conference and HAPCO. These include: Cost-Effectiveness of Ethiopia Mother Support Groups in Preventing Vertical Transmission, ICASA Conference, Addis Ababa – Ethiopia, December 4-8, 2011; Strategies for Improved Prevention of Mother-To-Child Transmission (PMTCT) Access in Ethiopia International AIDS Conference, Washington DC – USA, July 22-27, 2012; Effects of Mothers Support Group on PMTCT service uptake and Increasing uptake of prevention of mother to child transmission (PMTCT) of HIV services through performance & quality improvement approach in health centers, FHAPCO Annual Joint Review Meeting, Bahir Dar, Amhara – Ethiopia, September 23-25, 2012.
- Existing Performance Improvement and Quality Assurance (PI and QA) tools used during supportive supervision were revised this year in order to standardize PI and QA approaches with other IntraHealth country programs. A revised PI and QA training package, consisting of a facilitator and reference manual and participant handouts was finalized this year and is now in use by the project staff.
- Job aids and IEC materials such as Focused Ante Natal Care (FANC) posters, Birth Preparedness Cards (BPC), wall charts, danger signs in pregnancy posters, referral cards, partner invitation cards, and appointment cards were printed and distributed to all project supported health centers where such gaps were identified. Moreover, an Infant & Young Child Feeding (IYCF) DVD was produced and 800 copies distributed to project sites, MSG groups, partner organizations and MOH offices. IYCF counseling cards were also translated into Tigrigna and Oromifa and 1,290 cards distributed to the regions. The project also

supported the printing of 4,200 copies of three types of HEW Integrated Refresher Training modules in Tigrigna and delivered them to the FMOH.

- The CPMTCT project collaborated with Handicap International to increase the projects' understanding of disability mainstreaming in HIV/AIDs, and apply that learning when possible within the CPMTCT project. Examples of this collaboration included the following; Two CPMTCT project focal members attended disability awareness training organized by Handicap International; awareness training on disability was given to 92 CPMTCT project staff members with the support from Handicap International staff; awareness training given to 47 health service providers at Alem Bank and Saris health centers in collaboration with Handicap International staffs; and CPMTCT project staff participated in the translation of the English version of TOT Manual on HIV, Sexual and Reproductive Health and Disability in to Amharic. Health centers that participated in these awareness events worked on making their health centers more accessible to all, specially their MNCH/PMTCT services, by changing location of MNCH rooms to be accessible to patients. Major challenges were the resources for changes in infrastructure to increase accessibility.
- In FY2012, the CPMTCT supported 14 CSOs which include 11 PLHIV associations of which 6 are associations of HIV+ women, SNNPR women Federation, DICAC and EIFDDA; these CSOs are located in Amhara (N=2), Tigray (N=2), in Oromiya (N=1), SNNPR (N=3), and in Addis Ababa (N=4). The objective of this support is to assist these CSOs educate their members on major topics of PMTCT including Family Planning, adherence to treatment, Infant and Young Child Feeding (IYCF) including exclusive breast feeding, disclosure, discordance, and most importantly, empower them to play a significant role in increasing demand for services and reduce loss to follow up of HIV+ pregnant women. In order to achieve this, the CSOs in Addis Ababa engaged in DCCM were given trainings on behavior change and community mobilization skills and Small Group discussion facilitation skills. All PLHIV associations were also trained on PMTCT with a focus on adherence to treatment of HIV positive pregnant women; infant feeding in the context of maternal HIV; family planning options and benefits for HIV positive women and need for adherence to treatment by babies born to HIV positive women. Mentoring visits were also done with selected CSOs and bi-annual review meetings conducted with the Women's Federation, and monthly meetings with the volunteers from the four associations in Addis Ababa. Job aids were provided to CSOs in Addis Ababa and the SNNPR Women's Federation. EIFDDA and EOC/DICAC received support through IOCC, which includes training for volunteers from these CSOs on couple counseling and social mobilization skills. Trainings were also provided for program and finance staff on USAID financial compliance policy.
- The CPMTCT project coordinator and religious networks advisor were trained in project management at the Ethiopia Management Institute. Similarly, EOC-DICAC and EIFDDA project officers participated in facilitation skill TOT and project management.

#### Regional Level Support:

- CPMTCT project technical staff from all five regions continues to participate in the Regional Accelerated PMTCT Plan steering committees and TWGs for the scale up of PMTCT services. The CPMTCT regional managers work closely with RHB staff to facilitate the implementation of the Accelerated Plan at the regional level. The CPMTCT project has expanded its

MNCH/PMTCT support to 232 health centers from December 2011 to July 2012, contributing up to 44% of the number PMTCT service expansions (N=523) under the Accelerated PMTCT plan (see Table 1 below).

**Table 1. CPMTCT Site Expansion towards the Accelerated PMTCT Plan**

Regions	Addis Ababa	Amhara	Oromiya	SNNP	Tigray	Total	Total PMTCT sites expanded through Accelerated Plan	% CPMTCT Contribution
Number of sites expanded through CPMTCT support	10	90	70	60	2	232	523*	44%

\*Source: PMTCT TWG Meeting (October 2012)

- In addition, CPMTCT project regional staff ensured the implementation of the revised PMTCT guide in all project supported health centers and participated in EFY 2005 woreda-based planning, and supported World Aids Day events.
- One of the major contributions of the CPMTCT project to the RHB is its staff support and contribution to various technical groups including PMTCT, HIV/TB/STI, RH/MNCH and IPLS. In most cases, the CPMTCT RO serve as leads or secretaries in these meetings, organizing and following up on action items generated in these meetings, and revising regional guidelines. Moreover, the CPMTCT staff participates in regional monthly, quarterly and annual review meetings and provides both technical and financial support. Other meetings supported by the CPMTCT project include the zonal catchment meetings conducted quarterly or semi annually where MNCH and PMTC issues are discussed at greater lengths. Partners Health Forums also occur in selected regions and enable all implementing partners to discuss their progress to date in their respective intervention areas; the CPMTCT project shares its achievements and successes during these events.
- The CPMTCT project secured 45,000 layette newborn kits from UNICEF and distributed them to 393 project supported HCs in selected woredas across the five regions. The purpose of the new born kits is to motivate and encourage women to deliver at a health facility and to reduce hypothermia of the newborn. Newborn corner materials<sup>1</sup> were distributed to 519 health centers in five regions, out of which 196 HC received the full package (Table, two sets of ambu bag, suction apparatus, lamp and heat radiator) while the remaining received only two sets of ambu-bags and suction apparatus. Information on sites receiving the materials were shared with UNICEF, FMOH and SCMS/PFSA.

<sup>1</sup> These materials are neonatal silicone resuscitators, neonatal suction device, salter 914 baby scales, ADC 605 stainless steel infant stethoscopes, and newborn bed with radiant heater.

- The project has developed a PHCU meeting guideline at the request of the woreda health offices and distributed it to the regions.
- Sustainability and transition planning workshops were held with the Regional Health Bureaus (RHB) and stakeholders at all levels. The aim of these workshops is to ensure the sustainability of project interventions through capacity building of regional zonal, woreda, health center staff and community health workers for provision of services to the community. When regional, zonal and Woreda level staff become capacitated, and project sites achieve the required performance level, project staff reduces support over time to these sites. The initial plan was to provide project support on as needed basis for these matured health facilities. However, with the roll-out of Option B+, this approach to transition will be revised as these high performing health centers ready for reduced project support need close follow-up to launch Option B+. Hence, a discussion with the RHB will be held at the beginning of FY2013 in light of the government’s change in policy.
- During this reporting period, the CPMTCT project conducted CM/BC skills training for 225 members of the SNNPR Women’s Federation, to equip them with skills and knowledge of Community Mobilization and Behavior Change in order to carry out activities in 15 woredas of the region. In addition, 48 volunteers from PLHIV associations in Addis Ababa were trained on CM/BC skills.
- Awareness raising workshops on MNCH and PMTCT were organized for members of associations of HIV+ people in Amhara, Tigray, Oromiya, SNNPR and Addis Ababa. A total of 165 participants from 11 associations of HIV+ people attended the two day orientation on PMTCT, family planning for HIV+ people and appropriate infant feeding in the context of maternal HIV.

Expanding MNCH/PMTCT services and strengthening MNCH/PMTCT technical skills

In FY2012, the project expanded from 207 to 519 health centers, a major increase by 150%, to provide comprehensive MNCH and PMTCT support. The main reason for expansion is due to support the government’s initiative of the Accelerated Plan for PMCTC scale-up, to respond to the need for MNCH/PMTCT services in remote areas that were previously supported with outreach activities only, and to increase MNCH/PMTCT uptake of services. This expansion was done in close collaboration with government counterparts; the RHB recommended sites for expansion and baseline assessments were performed with the involvement of zonal and woreda health office staff. Sites which met the selection criteria, such as adequate staffing, infrastructure, prevalence of HIV and ANC patient load, were selected based on these assessment findings.

**Table 2. Regional distribution of CPMTCT supported HCs.**

Description	Addis	Amhara	Oromiya	SNNP	Tigray	Total
Year I	2	12	12	10	12	48
Year II	6	40	38	42	33	159
Year III	14	90	70	61	77	312
<b>Total</b>	<b>22</b>	<b>142</b>	<b>120</b>	<b>113</b>	<b>122</b>	<b>519</b>

All project supported HCs currently provide MNCH/PMTCT services according to the revised PMTCT guidelines, and the project technical staff are mentoring facility level health care providers to ensure the implementation of the revised guidelines.

In FY2012, the project provided MNCH/PMTCT related trainings in all five regions; Addis Ababa, Amhara, Oromiya, SNNP and Tigray as indicated below;

**Table 3: Trainings on MNCH/PMTCT by Region (October 1<sup>st</sup>, 2011 to September 30<sup>th</sup>, 2012)**

Training Title	Addis Ababa	Amhara	Oromiya	SNNP	Tigray	Total	Remark
BC/CM for MNCH/PMTCT	100	104	385	316	91	<b>996</b>	Refresher training for 155 UHEPs in Oromiya; Basic training for 225 volunteers from women federation in SNNP, 48 volunteers from CSOs in Addis, 568 clergies/volunteers of EOC-DICAC/EIFDDA from all regions.
BEmONC	6	20		91	67	<b>184</b>	In-service training for 79 providers from CPMTCT supported HCs, and pre-service training for 105 Hawassa university and Dr. Tewelde Legesse Health Science College graduating midwifery nurses
DBS/CD4 Sample Collection & Transportation	34	95	26	26	49	<b>230</b>	All are laboratory technicians
Expert Patient Training	20	-	-	-	-	<b>20</b>	All are MSG mentor mothers
Infant & young child feeding	20	50	-	-	-	<b>70</b>	20 are MSG mentor mothers in Addis Ababa, and 50 are providers in Amhara
Basic MNCH/PMTCT	85	277	199	188	237	<b>986</b>	In-service training for providers in CPMTCT supported HCs. In addition to the 277 providers trained in Amhara, 245 health providers have received onsite refresher training.
Basic MSG	43	10	8	-	19	<b>80</b>	49 are MSG mentor mothers and 31 are providers (site coordinators)
PQI/SS	21	83	22	44	-	<b>170</b>	160 are providers and 10 are woreda/sub-city officials
Small Group Discussion Facilitation	77	-	-	-	-	<b>77</b>	All are community volunteers from CSOs
<b>Total</b>	<b>400</b>	<b>639</b>	<b>640</b>	<b>671</b>	<b>463</b>	<b>2,813</b>	

As part of the Accelerated Plan for PMTCT, an orientation was provided for zonal, woreda and HC staff in two ways; providing one day onsite training for 29 health workers in Addis Ababa and one day off site training workshop for 226 health workers in SNNP. CPMTCT project staffs in all supported health centers also gave an orientation to health care providers on the revised PMTCT guide during supportive supervision and mentoring visits.

**Table 4: Performance for Key Indicators (Objective 1)**

PMP No.	Ref.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2012)	Annual Target & (% achieved to date)
1.1 – 1		# of CBOs provided with technical assistance for CPMTCT program management	9	14	14	14	14	15 (93%)
1.1 – 2		# of RHBs & woredas provided with TA for CPMTCT mgt						
		RHB	5	5	5	5	5	5 (100%)
		Woredas	177	229	239	244	244	177 (138%)
1.1 – 3		# of RHBs with active sustainability and transition plans	4	4	4	5	5	5 (100%)
1.2 – 1 (H2.3.D)		# of health providers/ supervisors who successfully completed basic or refresher training in integrated MNCH/PMTCT	174	659	75	283	1,191	1,966 (61%)
1.2 – 2 (H2.3.D)		# of midwives who received training on BEmONC	79	18	87	-	184	240 (77%)
1.2 – 3 (H2.3.D)		# of lab technicians trained in CD4/DBS	73	107	0	50	230	576 (40%)
1.3 – 1		# of HCs included in the Pharmaceutical Fund Supply Agency (PFSA) procurement and distribution list	472	472	511	519	519	500 (104%)
1.4 – 1		# of national MNCH/PMTCT guidelines/tools training materials developed or revised with project support	Reported annually: _____					1
1.4 – 2		# of MNCH/PMTCT policies or practices that are consistent with CPMTCT advocacy	Reported annually: _____					1

Note: The original indicator for health providers/ supervisors who completed basic or refresher training in integrated MNCH/PMTCT (N=1,966) included 822 HEW (~50% of target). However, the project is not allowed to train HEW due to a new government policy, which prevents all international NGOs from training the HEW. Hence the project was only able to reach 61% of its target. The figures for laboratory training were also low as there was no sufficient CD4/DBS sample taking materials at the HC, hence the training of health providers were delayed as a result.

### Improvements in supply system management

- To strengthen the project's relationship with PFSA and to prevent stock outs of commodities, an updated list of CPMTCT supported HCs was shared with PFSA staff at the national level. This type of exchange and follow-up also occurred at the regional level, where CPMTCT staff worked closely with PFSA regional counterparts to resolve the on-going supply challenges, such as shortages of RTKs, and CD4/DBS testing. In areas where PFSA does not reach health facilities, project staff distributed ARV prophylaxis and DBS during their JSS and FSS, enabling an immediate distribution of these items. In some sites, the project's service delivery officers (SDOs) support HC to avail supplies by taking from the nearby ART HCs and Hospitals. This collaborative effort has avoided stock-outs of essential supplies and commodities. The project has also trained lab technicians from all five regions on CD4/DBS sample taking and transport thereof.

To address the shortages of basic medical equipment such as microscopes, BP apparatus, Hemoglobino meter, IP materials, laboratory reagents, and RTK, at some of the project sites, the project procured and/or distributed this equipment to health centers. This procurement and/or distribution were done in consultation with USAID, the RHB and implementing partners that have responsibilities of providing these supplies to avoid duplications of purchases. In most cases, the CPMTCT project facilitated the distribution, rather than procuring these items.

The project also supported SCMS in the national quantification of drugs and equipments for all health facilities.

**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.**

## **MNCH/PMTCT RESULTS**

Below are achievements and challenges during this reporting year;

- The CPMTCT project was able to reach 88% (N=394,746) of its annual target for ANC services at least once in project supported HCs and through outreach; and 44% (N=41,941) of its annual target for delivery by skilled health personnel (nurses or midwives).
- A total of 358,266 persons were able to receive testing and counseling services, representing 96% of the project's target. Most importantly, 90% (N= 358,266) of its ANC client did receive this service which is a significant achievement in light of challenges of shortage and interruption of test kits at the health center level. The project has made a great effort to communicate with PFSA and the RHB on a regular basis to address this supply chain management issue.
- As stated above, 358,266 pregnant women and 89,922 male partners were counseled and tested and knew their HIV status. The demand creation activities have been working intensely to increase male involvement in MNCH/PMTCT services through strategies such as hand delivered invitations, organizing couple counseling events and also capturing male partners during delivery for counseling and testing. . Consequently the percentage of male partners of pregnant women counseled and tested increased from 20% in the first quarter to 30% in the fourth quarter. Other interventions such as site expansions, outreaches and communications on supply chain management have heavily contributed towards this achievement.
- Various testing and counseling outlets were used to ensure that clients in different locations received the services. The HIV sero-positivity among MNCH/PMTCT service utilized varied across the service outlets: HCs (0.86%), outreach (0.08%), UHEPs (0.58%), HEWs (0.11%).
- The HIV prevalence rate through the CPMTCT project's supported health centers remains low at 0.5% as in the past years, an encouraging sign on the epidemic in mostly rural areas. However, there is a variation of prevalence rates among health centers, ranging from those with no HIV+ pregnant women to others as high as 9%. One thousand nine hundred sixteen pregnant women were identified HIV+, and 67% (N= 1,282/1,916) were put on treatment in CPMTCT supported health facilities. This figure surpasses the project's annual target that was set at 65% of HIV positive identified (N=2,180/3,354). Moreover, 88% (N=1,701) HIV+ pregnant women received ARV prophylaxis for PMTCT through follow-up either at project supported HCs or other health facilities, as confirmed by our tracking wall chart. This is a significant accomplishment compared to the national figure of 40% (N=8,365)<sup>2</sup> of HIV+

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<sup>2</sup> Source: Multi-sectoral response Monitoring and Evaluation report for EFY2003)

pregnant women on treatment. It is also noted that there is a consistent increase in ARV coverage for HIV+ pregnant women from the first to the fourth quarter: Q1 (51%), Q2 (58%), Q3 (74%) and Q4 (82%). This higher ARV coverage was also made possible because the project made a strategic decision to focus more on HCs than outreach; the outreach services conducted were kept to sites within the project supported HCs catchment areas. Overall, these results derive from cumulative and tremendous efforts of the CPMTCT project's performance improvement and quality assurance strategies, implemented through continuous JSS and FSS visits, use of innovative tools such as the tracking wall chart over the last quarters, and communication with key players in supply chain management.

- Institutional delivery remains low at 10% (N= 41,941); distance linked with lack of transportation, poor treatment of laboring women at health facilities and the absence of pediatric interventions at HC being some of the underlying causes. However, institutional delivery for HIV+ pregnant mothers is at 33% (N= 641), reflecting the positive outcome of the project various interventions: MSG most significantly, counseling and supportive environment at sites, and technical support to sites. The project also realizes that there are areas for improvement and has prioritized community mobilization interventions during its MTR and Year 4.
- Thirty-three percent (N=628) of children born to HIV pregnant women received ARV prophylaxis, a figure that needs improvement in the coming year. Twenty four percent (N=458) HEIs started Cotrimoxizole (CTX) prophylaxis, and 51% (N=322) were tested within two months of birth. Testing of HEI within 12 months has increased from 43% (N=118) in FY2011 to 77% (N=322) in FY2012 (denominator: HIV positive deliveries) reflecting major improvements as a result of setting up functional testing systems that include timely provision of sample test kits and transportation mechanism to laboratory sites. The CPMTCT project advocated that these test kits become available in all PMTCT sites, training of personnel on sites on sample collections, and ensuring that there are no gaps of supplies through regular communications with PFSA and the regions. Major barriers such as receipt of timely results, communications between health facilities and regional testing laboratories remain. The project recognizes these significant bottlenecks among others, and plans to address them in the upcoming year. As a result of various CPMTCT project interventions such as IYCN in the context of HIV, trainings to health care professionals, women living with HIV MSG groups, and DCCM activities at the community level and through HEW, all HEI were breast fed.
- Thirty five percent (N=134) of HIV+ pregnant women have received Cotrimoxazole (CTX) prophylaxis. This low figure is a result of multiple factors: Women who are eligible for CTX are women who are also eligible for ART. These women are referred to ART facilities hence do not receive CTX from CPMTCT supported sites, fee exempted CTX is not available in PMTCT only sites which makes it difficult for providers to avail the CTX to women unless the health center has a strong health care financing system.
- While the ideal is to have all HIV+ pregnant women screened for TB, currently only 72% (N=1371) of the HIV+ pregnant women screened for TB. The CPMTCT project has started to aggressively reinforce technical assistance and to encourage health providers to screen for TB in the second quarter. The project distributed pre-ART registers to all project supported HCs to enable them record their TB screening data. In addition, all the HIV+ women were

assessed for ART eligibility through clinical staging (using WHO clinical staging criteria) or CD4 testing.

**Table 5: Performance for Key MNCH/PMTCT indicators (Objective 2)**

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2012)	Annual Target & (% achieved to date)
2.1 – 1 (P1.1.D)	# of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	71,465	109,648	98,577	78,576	358,266	372,708 (96%)
2.1 – 2 (P1.1.D)	# of HIV+ pregnant women identified in the reporting period	395	520	490	511	1,916	3,354 (57%)
2.1 - 3a (P1.2.D)	# of HIV+ pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission at CPMTCT supported sites	201	299	364	421	1,282	2,180 (59%)
2.1-3b	# (%) the populations of HIV+ pregnant women individually tracked who received antiretroviral from either a CPMTCT-supported health facility or another health facility <i>(Denominator=HIV+ PW ≥ 14 Wks GA in the quarter; Num.= HIV+PW who received ARV)</i>	241 (83%)	519 (79%)	454 (80%)	487 (95%)	1,701 (88%)	2,683 (63%)
2.1 - 4a	# of newborns born to HIV+ mothers who received ARV prophylaxis at CPMTCT supported sites.	134	135	163	196	628	2,180 (29%)
2.1-4b	# (%) of HEI individually tracked who received antiretroviral from either a CPMTCT-supported facility or another facility <i>(Denominator=HEI identified in the quarter &amp; tracked; Num.= HEI who received ARV)</i>	154 (92%)	153 (88%)	163 (95%)	242 (93%)	724 (92%)	2,683 (33%)

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2012)	Annual Target & (% achieved to date)	
2.1 – 5 (C4.2.D)	# of HIV exposed infants who started Cotrimoxizole (CTX) prophylaxis	116	87	118	137	458	2,180 (21%)	
2.1 – 6 (C4.1.D)	# of infants born to HIV+ mothers who received an HIV test within 12 months of birth	110	115	134	135	494	1,380 (38%)	
2.1 – 7	# of new ANC clients	79,741	119,422	108,302	87,281	394,746	447,780 (88%)	
2.1 - 8	# of deliveries by skilled birth attendant	7,700	9,665	11,665	12,911	41,941	95,000 (44%)	
2.1 – 9	# of deliveries for HIV+ women by skilled birth attendant	137	143	166	195	641	2,180 (29%)	
2.1 – 10 (P1.4.D)	# of HIV+ pregnant women assessed for ART eligibility through either clinical staging (using WHO clinical staging criteria) or CD4 testing	395	520	490	511	1,916	3,354 (57%)	
2.1 – 11 (P1.5.D)	# HIV+ pregnant women newly enrolled in care and support services	726	784	727	736	2,973	3,954 (75%)	
2.1 – 12 (P1.6.D)	% of infants by feeding type	# Exclusive breast feeding	100%	100%	100%	100%	100%	90% (111%)
		# Exclusive formula feeding	0%	0%	0%	0%	0%	10% (0%)
		# Mixed feeding	0%	0%	0%	0%	0%	0%
2.1 – 13	# of HIV+ mothers who were counseled on family planning	395	520	490	511	1,916	3,354 (57%)	
2.1 – 14 (C 2.5.D)	# of HIV+ pregnant women who were screened for TB	128	407	408	428	1,371	3,354 (41%)	
2.1- 15 (P11.1.D)	# of male partners of pregnant women who were tested for HIV and received results	14,206	25,879	25,938	23,899	89,922	149,083 (60%)	

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2012)	Annual Target & (% achieved to date)
2.1- 16 (C 2.2.D)	# of HIV+ pregnant women started receiving Cotrimoxazole (CTX) prophylaxis	21	40	28	45	134	671 (20%)
2.2 – 1 (P1.3.D)	# of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site	472	499	514	519	519	500 (104%)
2.3 – 1	# of completed pilot MNCH/ PMTCT service delivery innovations <sup>‡</sup>	-	1	-	-	1	1 (100%)
2.3 – 2	# of MSG site coordinators who received MSG training	4	11	11	5	31	30 (103%)
2.3 – 3	# of MSGs supported	98	103	103	101	101	100 (101%)
2.3 – 4	# of MSG members (current members by end of the quarter)	1,641	1,842	1,981	1,981	1,975	1,300 (152%)

*\* Note that all targets for FY2012 were set using an HIV prevalence rate of 0.9%, while the rate from this report shows a reduced rate of 0.5%. Therefore, all achievements to date vis-à-vis the target will be affected.*

### **Focused Comparative Analysis**

The number of CPMTCT supported HCs increased gradually from 48 in FY2010 to 207 in FY2011 and 519 in FY2012. In order to measure progress over the last year, 126 health centers, which were fully operational and reported data in FY2011 and FY2012 were selected for this focused comparative analysis. The purpose of this comparative analysis is to monitor changes in performances at these project supported health centers using key performance indicators such as ANC coverage, L&D coverage, ARV coverage, percentage of male partner testing (see Figure 1). These health centers cover all five regions and are spread accordingly: 2 from Addis Ababa, 28 from Amhara, 32 from Oromiya, 25 from SNNP and 39 from Tigray.

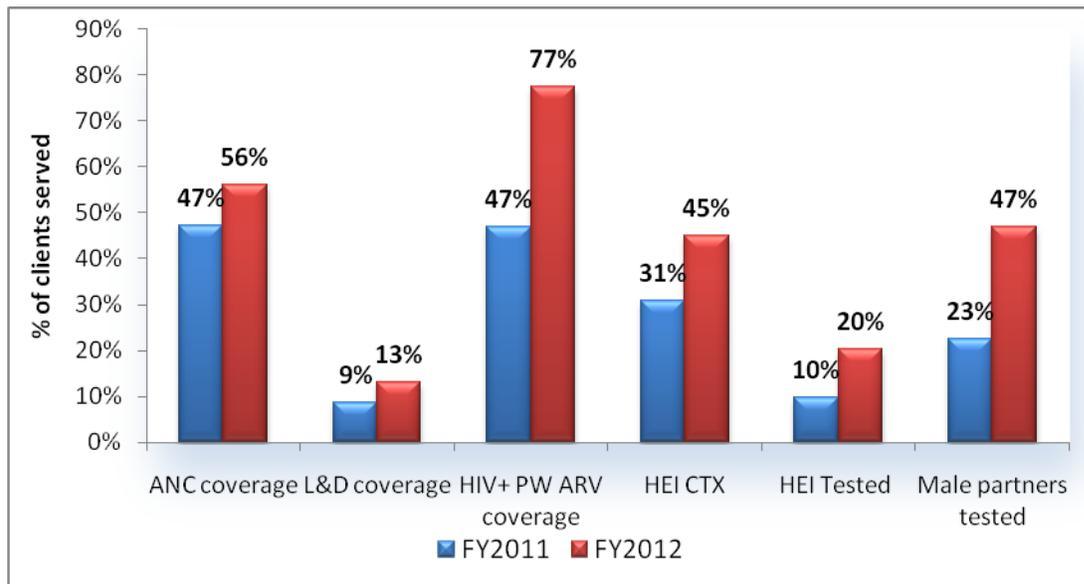


Figure 1. Coverage (in percentage) of key MNCH/PMTCT services in FY2011 and FY2012

Overall, in comparing these key indicators during the two consecutive years, there is a significant progress made. As shown in figure 1, ANC coverage increased from 47% (N=57,157) in FY2011 to 56% (N= 69,591) in FY2012, an increment by 22%. Institutional delivery increased from 9% (N= 10,472) in FY2011 to 13% (N= 16,121) in FY2012 in the intervention areas. An improvement is observed comparing the figures of these two periods resulting in the project supporting health centers with newborn corner supplies, providing BEmONC training and mentoring health care providers working in L&D unit to manage obstetric complications, and also making Mama Kits available to 393 HCs as incentive for PW to deliver at health centers. Institutional delivery remains low and the project will focus in this area in FY2013.

In FY2011, 48% (N= 326) positive pregnant women received ARV prophylaxis compared to 77% (N=601) in FY2012, a significant increase as a result of various factors such as DCCM interventions through its awareness creation, technical support to providers for better counseling and communications with clients, MSG with their support and encouragement for pregnant mothers to receive ARVs and continuous communications with PFSA for ARV supplies. Infant CTX coverage reached 45% (N=349) in FY2012 from 31% (N= 210) in FY2011. Similarly, the percentage of HEI tested for HIV increased from 10% (N= 102) in FY2011 to 20% (N= 208) in FY2012. For increased HEI testing and treatment, the project support HC to have improved access for DBS testing and availing commodities for DBS sample taking played a significant role. Although there is an increase in HEI testing, this result remains low at 20% (N=208) due to external factors such as the sample transportation system and backlogs at central laboratories. Male partner testing increase has been achieved through DCCM activities through HEW and PLHIV supported by the project.

These figures show a significant improvement across all these indicators, particularly, ARV coverage, HEI CTX and HEI testing, reflected through improved quality of services over time. Factors that contributed to these increased figures, as stated above, are improved access to ARV

drugs through continued communications with PFSA and SCMS in order to avoid stock outs at the sites, technical assistance to sites, increased community activities such as MSG, HEW and religious fathers, and use of tracking tools for reduction of loss to follow-up.

### Follow up and Referrals

Successful implementation of PMTCT interventions depends on the follow-up of mother-baby pairs identified during ANC, delivery, and post-delivery. For this reason the project distributed mother-baby pairs tracking wall charts and templates to all health centers and collected data quarterly. The tracking wall chart facilitates monitoring and tracking for women living with HIV and HEI, and serves as a way for health providers to monitor HIV status and to reduce loss to follow-up through improved facility organization and patient tracking.

The following two figures below, Figure 2 and Figure 3, show the number of HIV+ women and HEI traced during follow-up at CPMTCT HCs during FY2012.

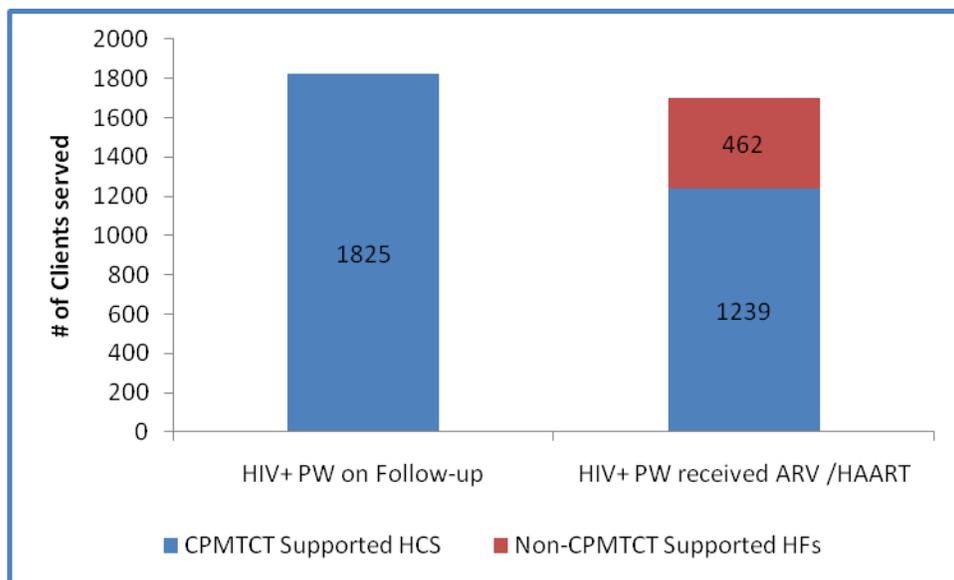


Figure 2. ARV/HAART uptake of eligible HIV+ pregnant women tracked during follow up

As shown in Figure 2, of the 1,825 HIV+ pregnant women on follow-up during the reporting period, 90% (N=1,701) received ARV prophylaxis for PMTCT; 73% (N=1,239) obtained this service at CPMTCT supported HCs and the remaining 27%(N=462) in non- CPMTCT supported health facilities (Health centers and Hospitals). This larger share of ARV coverage reflects the improved capacity of CPMTCT HCs supported staff to provide the service and the availability of ARV drugs.

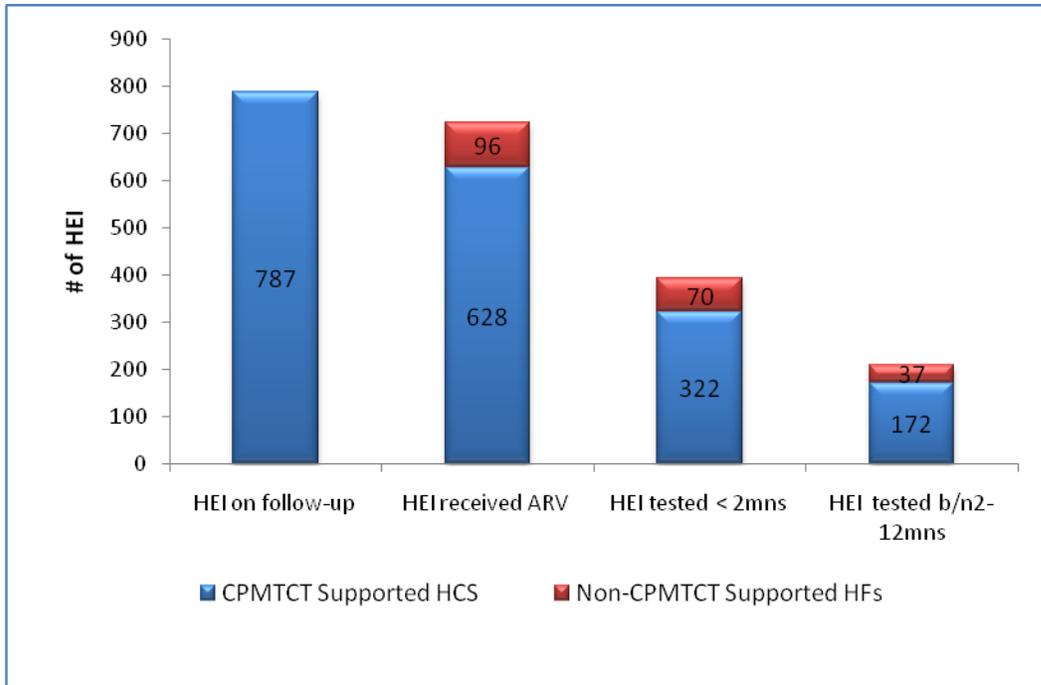


Figure 3. ARV uptake and HIV testing of HEIs traced in follow-up

Out of the 787 infants born to HIV+ pregnant women under follow up during the year, 92% (N=724) received ARV prophylaxis, 50% (N=392) were tested for HIV within two months and 26% (N=209) were tested either virologically between 2 and 12 months, or by serology between 9 and 12 months at CPMTCT supported and Non-CPMTCT supported health centers.

### Outreach services

The CPMTCT project supported health centers to conduct several outreach activities to provide MNCH and PMTCT services in remote areas to extend these essential services to pregnant women and their partners. Regional SDO and DCCM officers support health center staff during these activities by providing them technical and financial supports. As the CPMTCT project matures, these outreach interventions are conducted independently by the health centers as part of their Expanded Program for Immunizations outreaches. In Tigray for example, the HEW, currently conducting HIV testing & counseling services at the health post level, are the ones who will be responsible for such MNCH/PMTCT outreach interventions. In addition to the health center initiated outreach interventions, the CPMTCT project was able to capitalize on its linkages to religious medium to tap into a different target groups. One hundred eighty religious leaders across 36 CPMTCT supported health centers, have been trained in couple counseling, the benefits of male involvement in PMTCT services and community mobilization. Hence, these groups of leaders were able to support outreach activities by linking up with these health centers. In FY2012, a total of 141,993 persons (118,585 pregnant women and 23,408 male partners) were counseled and tested through these outreach interventions, and 95 HIV+ identified were linked and followed up health centers.

## **Mother Support Groups (MSGs)**

During FY2012, the CPMTCT project supported 101 MSG sites in five regions of which 55 are Community MSG and 46 health center based MSG during the fiscal year.

- A total of 1,070 eligible HIV positive member mothers have enrolled in the MSG program in FY2012. Out of these, 65% (N=692) were pregnant women and 35% (N=378) were lactating mothers. Among these member women, 39% (N=419) were enrolled in CMSG and 61% (N=651) HIV positive women were enrolled in facility MSG sites respectively.
- The project has established a strong referral system between MSG clients and different units at health facilities. Almost 96% (517/540) of MSG members delivered at a health facility and of these 99% (537/540) received ARV prophylaxis. Ninety six percent (N=521/540) of infants born to MSG members received ARV prophylaxis and 99% of them received OI prophylaxis. Furthermore, 461 infants were tested for DBS and 321 infants received confirmatory HIV testing. Only 2 turned out to be HIV Sero-Positive. HIV positive test results of infants were seen when the mothers of exposed infants occurred when the women joined the MSG late in their pregnancy or delivered at home.
- Two hundred and fifty seven MSG members are engaged in various income generating activities (IGA) activities. For example, some health centers provided an opportunity for income generating activities by allowing women to establish a cafeteria service in the health center, other health centers provided a piece of land for gardening.
- Seven hundred and fifty one MSG members received food and material support from the world food program (WFP) and other local agencies.
- Eleven MSG sites from three regions graduated 156 MSG members because they completed the required 52 educational sessions and had their infants tested.
- Forty nine mentor mothers and 31 site coordinators received basic MSG training across the project regions, except for SNNP which established new facility based MSG sites and provided gap filling training for existing MSGs. For eight newly established MSG sites in Addis Ababa, the project purchased and distributed basic furniture for their meetings and activities. The project also provided a monthly stipend for mentor mothers and coffee ceremony expenses on an ongoing basis and will continue this support in the coming year. Follow up supportive supervision was conducted monthly, and JSS quarterly, to all community and facility based MSG sites.

Table 6 illustrates, MSG members have very high uptake of MNCH/PMTCT services for themselves and their children.

**Table 6: Performance for key MSG indicators (Objective 2)**

Selected MSG Indicators		Q1	Q2	Q3	Q4	Total to Date (FY 2012)
# newly enrolled in MSG	HIV+ pregnant women	185	180	167	160	692*
	HIV+ non-pregnant women	147	85	81	65	378
# newly enrolled MSG members on pre-ART or ART	Pre-ART	91	105	114	87	397
	ART	116	81	83	94	374
# MSG members who delivered	At HC/hospital	130	124	144	119	517
	At home	8	5	6	4	23
	<i>Total</i>	<i>138</i>	<i>129</i>	<i>150</i>	<i>123</i>	<i>540</i>
# (%) MSG members who delivered and received antiretroviral (ART or ARV prophylaxis)	sdNVP/combined	59	65	79	48	251
	on ART	79	63	70	74	286
	<i>Total</i>	<i>138</i> <i>(100%)</i>	<i>128</i> <i>(99%)</i>	<i>149</i> <i>(99%)</i>	<i>122</i> <i>(99%)</i>	<i>537</i> <i>(99%)</i>
# (%) infants born to MSG members who received ARV prophylaxis	134 <i>(97%)</i>	125 <i>(97%)</i>	145 <i>(97%)</i>	117 <i>(95%)</i>	521 <i>(96%)</i>	
% MSG mothers with babies < 6 months practicing exclusive breast feeding	99%	100%	100%	99%	100%	
% infants of MSG members 45 days to 2 months who started Cotrimoxazole	100%	100%	99%	98%	99%	
# MSG members disclosed status to partners	86	84	92	85	347	
# infants born to MSG mothers who received DBS testing (within 6 months of age)	Positive	3	2	0	1	6
	Negative	121	112	120	102	455
	<i>Total</i>	<i>124</i>	<i>114</i>	<i>120</i>	<i>103</i>	<i>461</i>
# infants born to MSG mothers who received confirmatory HIV testing (within 9 to 18 months)	Positive	0	2	0	0	2
	Negative	51	69	111	88	319
	<i>Total</i>	<i>51</i>	<i>71</i>	<i>111</i>	<i>88</i>	<i>321</i>

\*Taking 1.5% HIV prevalence rate (EDHS 2011) and using actual catchment population of the 101 MSG sites and a pregnancy rate of 2.4% for Addis Ababa, 2.7% for Amhara, 3.5% for Oromiya, SNNP and Tigray regions (Accelerated PMTCT regional plan 2012): 48%(200/417) and 89%(492/553) of the estimated HIV+ pregnant women in CMSG kebeles and facility based MSGs catchment population respectively were newly enrolled. Given that CMSGs are located in towns that are also served by hospital and health center MSGs; 48% represents a substantial number of HIV+ pregnant women.

Overall, the MSG program showed significant results in linking HIV positive pregnant and lactating mothers to various care and support programs inside and out of health facilities. Moreover, MSG members' service adherence to skilled birth attendance, ARV/ART utilization and HEI follow up showed promising changes with major impact in reducing mother to child transmission. In addition, MSG member mothers witnessed their empowerment through participation in community mobilization and engaged in different economic strengthening programs before they graduated from the program, which contribute to their and their babies' wellbeing.

Because of such positive outcomes of MSG, it is recommended to expand this package to other health centers with high numbers of HIV+ pregnant women; however budget limitations have constrained the CPMTCT project to do so.

### Primary Health Care Unit (PHCU)

The project has continued to invest in building the capacity of the primary health care units as a means to improving referral linkages between health posts and health centers, reducing lost to follow up and using data to improve the quality of MNCH/PMTCT services. Capacity building is achieved by the project providing financial and technical support to monthly PHCU meetings at which data is reviewed, in particular the wall chart that tracks HIV + mothers and HIV exposed infants. Project staff have provided guidance and mentoring to health facility managers on how to structure and facilitate PHCU meetings and, as already mentioned, the PHCU meeting guide book has been distributed as a reference for anyone organizing and facilitating a PHCU meeting. The quality and regularity of PHCU meetings varies from region to region. It is encouraging to note that some regions have taken ownership of this process by providing financial support, while relying on the project to strengthen the PHCU's technical support, such as in Amhara and Tigray regions. In addition, the PHCU medium has been extended to include other comprehensive health package discussions, even though focusing on MNCH and PMTCT.

Below is a summary table of PHCU meetings conducted in FY2012

**Table 7: Number of PHCU meetings conducted in FY2012**

Regions	QI	QII	QIII	QIV	Total
Addis Ababa	12	14	14	14	54
Amhara	140	250	265	328	983
Oromiya	9	27	67	36	139
SNNPR	39	21	30	24	114
Tigray	206	267	287	341	1,101
<b>Total</b>	<b>406</b>	<b>579</b>	<b>663</b>	<b>743</b>	<b>2,391</b>

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

In FY2012, the project modified its Demand Creation and Community Mobilization (DCCM) approach from woreda level to Primary Health Care Unit (PHCU) catchment. With this shift DCCM activities have been conducted only in selected catchment areas of the health centers supported by the project. A total of 227 Health Center catchments were selected (Amhara=60, Tigray=42, SNNPR=52, Oromiya=60, and Addis Ababa=13) for intensive DCCM support based on criterion including low ANC uptake at the health center, higher HIV prevalence and large population size of the catchment. Though the project has shifted its strategy from woreda to health center catchment level, some activities such as woreda level review and planning meetings and PHCU meetings were held at the woreda level. For example, bi-annual review meetings were held in woredas where the project supports more than two health centers. These meetings are organized and led by the woreda health office with the technical and financial support of the CPMTCT project.

During the reporting period, successes of DCCM interventions were reflected through the increase in service uptake at ANC; a strengthened referral and linkages system using government structure through HEW; changes in community perceptions through anecdotal information – for example in Tigray, an improved supportive environment at the health centers for pregnant women by setting up community supporting waiting areas providing food and coffee; religious fathers assisting HIV+ pregnant women to disclose to their husband increased knowledge on benefit of institutional delivery (Source: gender assessment). The activities described below aimed at increasing service utilization in ANC, HIV testing during pregnancy, male involvement in PMTCT, health facility delivery and adherence to treatment and exclusive breast feeding.

- The DCCM intervention focused on increasing the skills of HEW in community mobilization, strengthening linkages between community health post and health centers, and creating a supportive environment for HEWs. This was done during the project's DCCM officers' JSS and FSS conducted at the health posts and its catchment areas. Onsite support was given to address gaps identified during these supervision visits and orientation regarding DCCM registration and reporting formats/referral cards. In addition, the PHCU were used as opportunities to address any challenges encountered by HEWs to increase ANC update and PMTCT services.
- The project trained 225 members of the SNNPR Women Federation, to equip them with skills and knowledge of Community Mobilization and Behavior Change in 15 woredas of the region. The trained volunteers were actively engaged in increasing demand for MNCH/PMTCT services. These trained volunteers are attached to health centers where they work closely with HEWs to mobilize pregnant women and their partners to seek services and to eliminate harmful traditional practices that affect health and well being of women and children. This is achieved through house to house visits and small group discussions. In

addition, similar trainings were provided to 48 volunteers from PLHIV associations in Addis Ababa.

- Sensitization and orientation workshops in new expansion sites were conducted to familiarize major DCCM actors with the project's DCCM strategy, reporting formats, job aids and tools for community mobilization. A total of 14 sensitization workshops were conducted at PHCU level. These community level sensitizations aimed at introducing the overall CPMTCT objectives and implementation strategies and to ensure that the community members understand the benefit of ANC, PMTCT, facility delivery and partner involvement/testing for HIV, were conducted around HC catchment areas. These workshops also addressed potential barriers for pregnant women and their partners to seek MNCH/PMTCT services.
- Small group discussion facilitation skills training was given to 77 volunteers from four CSOs in Addis Ababa to equip them with basic knowledge and skill to facilitate SGDs. Discussion guides were developed and shared with the trainees, to support them in doing effective SGDs. Target audience: members of PLHIV content to focus PMTCT.
- Five hundred and four EOC-DICAC/ EIFDDA religious women's group members and religious fathers have received basic social mobilization skill training for PMTCT to reach community members with key CPMTCT messages. These religious groups use different approaches such as house to house, small group discussions and other religious fora to communicate with their audiences on MNCH/PMTCT.
- Key MNCH/PMTCT messages were broadcast to communities in Tigray, Oromiya and Addis Ababa during National VCT week. The messages were prepared in Amharic, Tigrigna and Oromifa languages and addressed knowledge and normative barriers that hinder pregnant women and their partners from accessing services.
- The project has financially and technically supported the development of Integrated Refresher Training (IRT) materials for HEWs.
- The CPMTCT project conducted a gender assessment to identify barriers to male partner testing and health facility delivery and provide recommendations based on identified barriers. The assessment revealed that men and women of the FGD participants have knowledge of both the benefits of facility delivery and the risks of home birth. Many women reported attending ANC but not all deliver in a health center. Some go to private clinics but others still prefer giving birth at home. The primary barriers identified to use of facility-based delivery were lack of transportation, perception of associated expenditure, mistreatment and disrespect and abuse deter pregnant women from seeking those services. The assessment has also come up with the fact that, men and women are aware of the benefits of male partner testing for PMTCT. But this knowledge of the benefits of male partner testing does not translate into actual service utilization. Men in particular have a number of barriers: men prefer to be tested outside ANC; men are testing but not necessarily as part of a couple. Some reported that they do not need to test if their wives have already done so, the idea of testing by proxy (see attached report for details – Annex II). The project will address some of the knowledge and information related barriers to

correct wrong perceptions and misunderstandings regarding partner testing and delivery at facility. Community level DCCM activities will integrate gender issues and gender based violence associated with service seeking in its FY2013 activities.

**Table 8: Performance for Key DCCM for MNCH/PMTCT Indicators (Objective 3)**

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% achieved to date)
3.1 - 1	# 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 ( <i>Small group discussions only</i> )	69,370	81,124	91,083	187,623	429,200	406,862 (105%)
3.1 - 2	# of referrals from community-based and health post workers acted on by clients attending ANC/PMTCT services	6,548	21,479	17,415	7,030	52,472	67,000 (78%)
3.1 - 3	# of IEC/BCC materials distributed at community level	5,960	5,258	3,611	3,966	18,825	12,000 (157%)
3.1 – 4 (H2.2. D)	# of community volunteers trained in PMTCT	140	156	83	628	1,007	1,000 (101%)
3.2 - 1	# of HCs holding PHCU meetings at least quarterly	176	171	293	331	293	500 (66%)
3.3 - 1	# of newborn layette kits distributed	374	163	-	-	537	1,000 (54%)
3.3 - 2	# of HCs received newborn corner supplies∞	196	-	-	304	500	304 (164%)

∞196 have full package of resuscitation equipments (table, radiator heal lamp, ambu bag) vs. 304 has ambu bag and suction)

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

Although all the project objectives contribute to improving the quality of community and facility based MNCH/PMTCT services, this objective specifically concentrates on ways to monitor and ensure that quality MNCH/PMTCT services are sustained and that they are implemented according to Ethiopia's policies and guidelines.

##### Quality improvement support

- This year, the project revised a performance/quality improvement and supportive supervision (PQI and SS) training package. This comprises of a trainer's reference manual, a trainer's guide, and a participant's handbook. To improve the performance and quality of MNCH/PMTCT services at health centers, 170 regional, zonal, woreda MNCH focal persons and health center staffs in all five regions were trained using this PQI/SS training package.
- To monitor the quality of care at health centers, the project has developed a **standard QOC assessment reporting format and performance tracking charts**.

##### Joint and follow up Supportive supervision and mentoring

- The project continued providing technical and financial support for quarterly joint supportive supervision visits at project supported health facilities. This JSS is conducted in collaboration with the CPMTCT project staff and the regional, zonal and woreda level government MNCH/PMTCT focal persons. Findings from supportive supervision were shared with respective offices and we used this opportunity to advocate for issues such as fee exemptions and improved logistics and supplies. In addition to JSS the Service Delivery Officers perform follow-up supervision visits and mentoring in between the JSS visits to monitor the status of the action plans developed during JSS. A similar approach has been applied to the MSG and DCCM sites to improve the quality of these activities.
- To ensure the quality of BEmONC services and to monitor that health workers are implementing what they've learned from the BEmONC trainings, the project has mentored 101 (19%) health center staff for up to three days. During this time they observe deliveries attended by the trained service providers. In addition to mentoring staff in labor and delivery practices, the BEmONC mentors 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. **At the end of the BEmONC mentors' visits, performance action plans are developed with the HC Manager to address any issues related to quality of care.** These plans and mentoring findings are also shared with CPMTCT Service Delivery Officers responsible for providing supervision/mentoring to the sites.
- Technical and financial support was given for integrated supportive supervision that was organized by both national and regional levels.

**Ensured project supporting sites' performance and quality indicators through PHCU, self assessment and performance based review meetings**

- After receiving PQI/SS training, HC managers and health care providers performed self assessments to sustain performance and quality of care. This is a key element of the project's sustainability strategy. To undertake self-assessments and action plans, most HCs used the project's SS checklist whereas others have modified different check lists or developed their own based on their interests and focus areas.
- In addition to the self assessment, PHCU meetings, already mentioned under Objective 1, have been used to improve and to sustain performance indicators and quality of care. In this year the project has conducted 2,391 PHCU meetings.
- To monitor and to share experiences among supporting health facilities, the project has organized performance based review meetings at woreda, zonal and regional levels.

**Table 9: 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)
4.1 – 1	% health facilities meeting the requisite standard of care for PMTCT	To be reported annually: __					80% <sup>μ</sup>
4.1 – 2	% health facilities with acceptable data quality	-	-	75%	-	75%	80%
4.2 – 1	# of GOE employees trained in PMTCT Quality-Performance Improvement (QI/PI) <sup>Ω</sup>	25	123	22	-	170	288 (59%) <sup>Ω</sup>
4.3 – 1	# of service sites receiving joint supportive supervision visits (JSS) regularly	163	371	329	327	450	500 (90%) <sup>α</sup>
4.4 – 1	# of follow-up visits for mentoring PMTCT service providers	158	144	249	230	781	1,457 (54%) <sup>β</sup>
4.4 – 2	# of sites receiving BEmONC mentoring	40	75	101	101	101	116 (87%)

<sup>μ</sup> Postponed to Year 4

<sup>Ω</sup> With PMTCT accelerated plan, a new CQI tool for PMTCT is being developed. Hence, to avoid duplicating efforts, planned CQI trainings were cancelled.

<sup>α</sup> Government officials engaged in other priority activities

<sup>β</sup> Late start of activities in expansion sites

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

### Challenges and Constraints seen during the year for each program area

- In spite of all the effort made to strengthen and improve the supply system, stock outs or lack of RTKs, ARV drugs, lab reagents, IP materials, OI drugs like CTX in many health centers led to delays in establishing new services, interruption of service provision, or incomplete services being offered at HC level.
- The CD4/DBS sample transportation system is not well established in some of the PMTCT sites. As a result the project loses potential clients.
- There is a shortage of basic furniture (table, chair, shelf, etc...) in many of the new sites.
- In Addis Ababa, the new health centers have infrastructure problems such as lack of functional liquid waste disposal systems, laundry and electricity.
- Although there has been a significant improvement in rates of partner testing and skilled birth attendance, coverage is still less than desired, and varies considerably among health centers.
- The new HMIS in Oromiya region is not used across all sites, which creates discrepancy in some indicators.
- A high turnover of trained health center staff continues to be a challenge in all regions.
- A high turnover of Mentor Mothers at CMSG sites. This is particularly evident in Addis Ababa.

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

- The CPMTCT central office and regional offices are working closely with the RHBs, PFSA, SCM and regional laboratories to update the list of PMTCT sites to address the gap in supplies and to ensure a common understanding of the policy pertaining to non-ART PMTCT sites. During the development of the accelerated PMTCT plan, the problems related to supply were emphasized and a clear plan and follow up mechanism developed at regional and national level. Some amount of RTK is also being purchased directly by USAID to temporarily alleviate the problem.. The project SDOs also help CPMTCT supported HC to secure supplies like ARV drugs, RTK and sample collection kits from the nearby ART HCs and hospitals.
- The project is working with key stakeholders to put in place a system for CD4 and DBS sample transportation. Some of the sites are using the Ethiopian postal service to send samples to regional laboratories.
- In an attempt to address the high turnover of trained health workers project staff work closely with woreda health officers and HC managers to ensure that at least 4 staff members per health center are trained in MNCH/PMTCT.

- The project has Intensified DCCM activities and sensitization in HCs with low uptake of services. In addition, findings from the gender assessment will be used to improve SBA and male partner involvement.
- The new CPMTCT supported health centers in Addis Ababa were visited by a team from USAID. We will follow up with the USAID team to find out if they are able to directly support the HCs to resolve the lack of water and electricity.
- In the sustainability and transition plans, most regions have prioritized a cadre of master trainers at the zonal level (or in Tigray, woreda level) with the aim of regularly training up new staff in MNCH/PMTCT. There is also a suggestion from the MOH that off-site training be held at universities, using trained university faculty to teach courses, including MNCH/PMTCT and BEmONC, which might be a possible long term solution to in-service training.

## 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

All indicators required by the project cannot be collected from the HMIS tools at facility level, for example, TB screening, partner testing in labor and delivery, which has an effect on the quality of reporting. The frequent change in HMIS reporting timeline by RHBs, the continued use of old and new HMIS registers, shortages of HMIS registers and forms, some missed data from the facilities due to difference in timeline of PEPFAR reporting and the GOE HMIS reporting calendar, 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 has tried to find innovative ways to capture these indicators through tally sheets and using the remark column of HMIS register, distributing of Pre-ART registers. On top of distribution of registers, regional M&E officers and SDOs are performing regular data quality checks during Joint supportive supervision and data collection. The CO staff also provides quarterly data quality check during supervision.

In addition to the regular data quality checks the project conducted a rapid data quality assessment survey at 40 randomly selected project sites (2 HCs in Addis Ababa, 10 HCs in Amhara, 8 HCs in Oromiya, 10 HCs in SNNP, and 10 HCs in Tigray). The objective of Rapid data quality survey was to assess the quality of MNCH/PMTCT data and strengthen the project's data management and reporting system. From the RDQA survey it was found that seventy five percent (N=30) of the 40 HCs assessed have acceptable data quality (% of HCs with acceptable data accuracy (# reported/# available on register) margin of error <=10%). See Annex III for details.

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

For those indicators not captured by HMIS, health care providers have been advised to record this data on the remarks column of the registers and to use a tally sheet to collect the data regularly.

**9. Major Activities planned in the next reporting period [Quarter I, FY2013]**

- Make the necessary programmatic and operational preparation to implement Option B+ in selected health facilities; this includes orienting and training CPMTCT project staff, revise project implementation plan and communicate with RHB on the project's support of rolling out Option B+. Revise transition approaches vis-à-vis the implementation of Option B+
- Organize annual review meeting and staff retreat.
- Strengthen the linkages between MSG sites for IGA activities in consultation with other partners working on IGA.
- Continue to participate in different TWGs and support the implementation of the accelerated PMTCT plan in supportive supervision, CQI and demand creation
- Provide technical support to zonal catchment and PHCU meetings to resolve supply, training and demand issues.
- Strengthen MNCH/PMTCT services at facility level and intensify outreach services to hard-to-reach areas and relatively high yield sites within the project's HC catchment areas.
- Conduct JSS visits in all HCs supported by the project and FSS visits in all more intensively supervised/mentored HCs. Conduct SS in all MSG and DCCM sites and mentoring to BEmONC sties.
- Expand BEmONC interventions in existing MNCH/PMTC sites
- Support the HEWs/HPs for the HIV testing and counseling services through the strengthening of PHCU in Tigray
- Active follow-up of the materials distributed to HCs like HIV test kits, IP materials, and laboratory reagents, for effective and efficient use for the intended purpose
- Prepare graduation ceremony for graduating mothers who are selected from facility and community based MSG sites (Addis Ababa, Oromiya, Amhara, and SNNP).
- Prepare Basic MSG training for mentor mothers as gap filling for community based MSG sites and for facility based MSG sites new expansion health centers (AA and Amhara).
- Continue demand creation and community mobilization activities
- Print and distribute job aids to volunteers; Procure 10 audio player and distribute it to the remaining high yield catchments area
- Continue audio drama discussion for religious women's group association members in selected health center catchment areas

- Conduct coffee ceremony session at high yield catchments areas
- Conduct monthly review meetings for volunteers at health center catchment areas
- Conduct supportive supervisions to EOC-DICAC and EIFDDA intervention sites
- Revise monthly reporting formats

## 10. Environmental compliance

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

## 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	26,949,223.00	19,738,994.06	7,210,228.94	

## 12. Issues requiring the attention of USAID Management

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

- CDC and USAID implementing partners have plans to expand to new HC in the same geographic areas as the CPMTCT project. While the intention may have been for universities to expand into new primary hospitals and only assume support for old HCSP health centers, in the case of at least one university, their new targets will force them to expand into health centers beyond the old HCSP sites. CPMTCT has agreed with MSH, ICAP and JHU and RHB to maintain existing CPMTCT sites this year and report on the MNCH/PMTCT indicators. M&E staffs from the various partners are meeting to decide which indicators stay with CPMTCT and which with the ART partner (i.e. the TB related and pre-ART indicators). However, given the real reduction in pregnancy rates and the decrease in HIV prevalence and the massive increase in targets for both CDC and USAID partners, all partners will be seeking to expand to new sites unless targets are reduced in line with the new DHS information on fertility rates and HIV prevalence.
- Assistance is needed in resolving water supply and electricity issues in new HCs in Addis Ababa.
- Continued assistance is needed to ensure a common understanding amongst USG and implementing partners that all PMTCT health centers should send DBS and CD4 samples for testing, and thus require sample taking. Clear agreement on whether these materials are collected from ART focal sites as in Tigray, or directly from PFSA, as proposed by others, are essential.

### 13. 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?

After submitting the report to the mission, the report will be shared to FMOH, Urban and Agrarian Health Promotion Disease Prevention Directorate (if required).

### 14. Appendices

Annex I

Ashley Aakesson Trip Report

Sara Stratton Trip Report

Annex II

Gender Assessment Report

Annex III

Rapid Data Quality Assessment (RDQA) Report