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## HIV/AIDS Care and Support Program

# USAID's HIV/AIDS Care and Support Program PY2 Semiannual Report July 1, 2008 – December 31, 2008

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## USAID's HIV/AIDS Care and Support Program

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July 1–December 31, 2008

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## About USAID's Ethiopia HIV/AIDS Care and Support Program

The HIV/AIDS Plan developed by the Government of Ethiopia's (GOE) Federal Ministry of Health (FMOH) calls for a nationwide scale-up of HIV/AIDS care and support to health centers and communities within the HIV & AIDS network. In this effort, Ethiopia receives support from the United States Government (USG)/President's Emergency Plan for AIDS Relief (PEPFAR) and the US Agency for International Development (USAID) through the HIV/AIDS Care and Support Program (HCSP). HCSP is implemented by Management Sciences for Health (MSH), and partners Intrahealth (IH), Save the Children/US (SC), EIFFDA, and DOHE. In particular, HCSP works with government and local NGO counterparts at the federal, regional, woreda (district), and community levels, and coordinates with all PEPFAR activities to expand comprehensive HIV & AIDS and tuberculosis (TB) prevention, diagnosis and treatment, and care and support services to 550 health centers and their surrounding communities; of these health centers, 393 will provide the basic HIV/TB services plus symptomatic and palliation care, and 300 will also provide a full range of antiretroviral therapy (ART) services. The services in the community and health centers are linked to hospitals, and as such promote the transition of patients from hospitals to health centers, to community-level care and support services, and back again as needed by individual patients and families. These linkages are key to strengthening Ethiopia's HIV & AIDS network of services in a sustainable fashion.

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## Acronyms and Abbreviations

AB	Abstinence, Being faithful
ABC	Astinance, Being faithful, Condom use
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANNECA	African Network for the Care of Children with HIV/AIDS
ARC	AIDS Resource Center
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CBO	Community-Based Organization
CCG	Community Core Group
CDC	[US] Centers for Disease Control and Prevention
DOHE	Dawn of Hope Ethiopia
DOTS	Directly Observed Treatment Short course
EIFDDA	Ethiopian Inter-Faith Forum for Dialogue, Development, and Action
EMI	Ethiopian Management Institute
FBO	Faith-Based Organization
FFSDP	Fully Functional Service Delivery Point
FHAPCO	Federal HIV/AIDS Prevention and Control Coordinating Office
FHI	Family Health International
FMOH	Federal Ministry of Health
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Coordinating Office
HAPSCO	Hiwot HIV/AIDS Prevention, Care and Support Organization
HBC	Home-Based Care
HC	Health Center
HCSP	HIV/AIDS Care and Support Program
HEW	health extension worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IMAI	Integrated Management of Adolescent and Adult Illness
IPC	Infection Prevention and Communication
IT	Information Technology
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KOOW	Kebele-Oriented Outreach Worker
LDP	Leadership Development Program
LTFU	Lost To Follow-Up
M&E	Monitoring and Evaluation

MEOP	MSH Ethiopia Operations Platform
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NGO	Non- Governmental Organization
NNPWE	National Network of Positive Women
OI	Opportunistic Infection
OP	Other Prevention [methods of HIV prevention]
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PPD	Planning and Programming Department
PEP	Post Exposure Prophylaxis
PEPFAR	[US] President’s Emergency Plan For AIDS Relief
PFSA	Pharmaceutical Fund and Supply Agency
PITC	Provider-Initiated Testing and Counseling
PLWHA	people living with HIV & AIDS
PMP	Performance Monitoring Plan
PMTCT	prevention of Mother-To-Child Transmission
PSLD	Pharmaceutical Supplies and Logistics Department
PY	Program Year
REST	Relief Society of Tigray
RHA	Regional health advisor
RHAPCO	Regional HIV/AIDS Prevention and Control Coordinating Office
RHB	Regional Health Bureau
RFP	Request-For-Proposal
RPM Plus	Rational Pharmaceutical Management Plus Program [MSH]
SC	Save the Children/US
SCMS	Supply Chain Management System
SNNPR	Southern Nations and Nationalities Peoples Region
SOC	Standards of Care
SOW	Scope of work
SPS	Strengthening Pharmaceutical Systems Program [MSH]
STI	Sexually Transmitted Infection
STTA	Short-Term Technical Assistance
TWG	Technical Working Group
TB	Tuberculosis
TIMS	Training Information Management System
TOT	Training Of Trainers
USAID	US Agency for International Development
USG	US Government
VCT	Voluntary Counseling and Testing

WFP	World Food Program
WHO	World Health Organization
WrHO	Woreda Health Office
WHO	World Health Organization

## Executive Summary

Management Sciences for Health (MSH) is pleased to submit to the US Agency for International Development (USAID)/Ethiopia this semiannual report on the progress in the first half of program year 2 (PY 2, July 1, 2008–December 31, 2008) of the USAID/PEPFAR-funded HIV/AIDS Care and Support Program (HCSP). The HIV/AIDS Care and Support Program in Ethiopia is a three-year USAID-supported project, implemented by MSH and its partners Dawn of Hope Ethiopia (DOHE), Ethiopian Inter-Faith Forum for Dialogue, Development, and Action (EIFDDA), Save the Children/US, and IntraHealth. The project began on June 15, 2007, and has since successfully achieved or exceeded most of its first-year targets (see table at the end of this Executive Summary). The first-year results were disseminated in Addis Ababa on July 9, 2008, to all stakeholders, including representatives from the Federal Ministry of Health (FMOH), the Federal HIV/AIDS Prevention and Control Coordinating Office (FHAPCO), the US Embassy in Addis, USAID, the US Centers for Disease Control and Prevention (CDC)-Ethiopia and other PEPFAR (US President’s Emergency Plan for AIDS Relief) and non-PEPFAR partners.

While HCSP focused its PY 1 activities on expanding antiretroviral therapy (ART) services, consistent with the Government of Ethiopia (GOE) programmatic goal of achieving universal access to comprehensive HIV & AIDS services by 2010, PY 2 activities are geared toward strengthening and scaling up comprehensive and integrated HIV & AIDS services in health centers and communities, and thus reflect the FMOH-FHAPCO strategic developments outlined in the Road Map 2007–2008/10 for Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia (the second Road Map).

An emphasis in the second Road Map on *comprehensive* services broadens the focus from HIV & AIDS treatment services to a renewed emphasis on primary and secondary prevention of HIV infection; prevention of mother-to-child transmission (PMTCT) and pediatric HIV & AIDS; prevention, early detection, and management of opportunistic infections (OIs); care and support in the community and household; and palliation. The focus on *integrated* HIV & AIDS services takes HCSP activities into basic health services, including maternal, neonatal, and child health (MNCH), antenatal care (ANC), and outpatient department (OPD), as well as community- and home-based services, and other primary health care (PHC) service delivery and use. This strategy extends into a “whole site” approach at the health center (HC) and promotes holistic management of HC clients. The whole site approach is complemented by an emphasis on community- and home-based care and on linkages through health posts, kebele-oriented outreach workers (KOOWs), case managers, nongovernmental organization (NGO) outreach workers, mothers’ support groups, and other available mechanisms.

During the first half of PY 2, HCSP continued to work toward the four intermediate results specified in the program contract. Progress toward those results is measured by 13 core indicators (see table at the end of this Executive Summary) and support indicators as detailed in the revised Performance Monitoring Plan (PMP) (Annex 1).

In line with the Second Road Map and USAID/Ethiopia's programmatic goals, and the themes of the Millennium AIDS Campaign–Ethiopia (MAC-E) of “Speed-Volume-Quality,” HCSP is on track to achieve or exceed its PY 2 targets through accelerated implementation and focuses on quality, PMTCT, and pediatric HIV & AIDS. Accordingly, in PY 2, HCSP operations have intensified at the regional, Woreda, health center and, particularly, community levels. The result will be twofold: (a) reaching higher numbers of people in need of comprehensive HIV & AIDS and PHC services, and (b) preparing the foundation for “graduating” health centers, in a phased manner, from HCSP technical assistance to sustainable government ownership and management, beginning in PY 3.

## Intermediate Results

Specific achievements during the reporting period toward the four results are outlined below.

**Result 1: Provision of high-quality, integrated HIV & AIDS prevention, care, and treatment services at health centers.** By the end of the reporting period, a cumulative total of 78,271 individuals had been enrolled for HIV care and 32,975 patients had been started on ART at the HCs being supported by HCSP. A cumulative total of 7,555 stable patients on ART have been referred to HCs from hospitals to attend treatment at the HC level. At the end of PY 1, the number of individuals receiving ART services was 22,090, equivalent to 147 percent of the first-year target. With a progressive increase in the number of patients receiving treatment at the health center level, 33,975 patients were receiving ART by the end of December 31, 2008, indicating that 11,885 patients were placed on treatment in just six months. About 61.6 percent of patients on ART are women, and 0.7 percent are children under 14 years of age. The rate of patients lost to follow-up (LTFU) is about 5.4 percent, compared to a national average rate of 25 percent. The low rate of patients LTFU is an important measure of the quality of support provided by the HIV/AIDS Care and Support Program.

HCSP expanded comprehensive HIV and TB counseling and testing services to 500 health centers. The service has been provided through Voluntary Counseling and Testing (VCT) and Provider-Initiated HIV Testing and Counseling (PITC) strategies at the facility and community levels, and has resulted in more than 371,400 clients being served during the reporting period. The program's interventions have supported 500 HCs in expanding care and support services, which are now reaching more than 178,288 individuals infected or affected by HIV. A total of 255 health centers now offer comprehensive ART services.

During the first quarter of PY 2, the main focus areas were (a) prioritizing HCs for new site expansion to meet the PY 2 target and (b) assessing the existing HCs to identify training gaps in different categories. In the second quarter, a number of trainings were given, in a variety of categories. A total of 398 individuals selected from all HIV/AIDS Care and Support Program regions received training on National Comprehensive HIV Care/ART, making a cumulative total of 2,305, which is 91.5 percent of the PY 2 target. Training in counseling and testing was provided for 892 health workers, for a cumulative total of 2421 (97 percent of the target for PY 2). Other trainings, on TB/HIV collaborative activities, PMTCT, comprehensive laboratory services, and dried blood spot (DBS) testing, have also been conducted. The HIV/AIDS Care and Support Program has continued providing technical support to the health centers, including

mentorship, multidisciplinary teams, and catchment area meetings for ART HCs. The treatment team staff is participating in various national and regional meetings, workshops, and technical working groups (TWGs) for the development and/or revision of programs, manuals, and guidelines relating to ART, Post Exposure prophylaxis (PEP), palliation care, TB/HIV, PMTCT, and sexually transmitted infections (STIs). The team also provides technical support to the regions during HC assessments as well as to woreda HIV & AIDS plan harmonization, and conducts joint supportive supervision to ensure quality of services.

**Result 2: Deployment of case managers to support care and strengthen referrals among health centers, hospitals, and community services.** At the end of HCSP PY 1, 232 case managers had been trained and deployed to ART HCs. During the current reporting period, frequent visits and integrated supportive supervision have been conducted to support this new cadre of staff to enable them to properly discharge their roles and responsibilities. At present, the case managers are well integrated into the existing system and play a crucial role in adherence counseling, provision of targeted and personalized care for people living with HIV & AIDS (PLWHA), referral linkages, and tracing of LTFU patients together with community volunteers. In the next quarter, gap-filling training and training of case managers for new site expansions will continue. By the end of PY 2, a cumulative total of 393 case managers will have been trained and deployed in 300 ART HCs. More than one case manager will be deployed in HCs with high patient loads. Selection of health centers for deployment of more than one case manager was made based on caseload; a list of these HCs was sent to the regions for endorsement or modification of the plan by the Regional Health Bureaus (RHBs). In parallel, a total of 217 data clerks were selected, trained, and deployed to ART HCs during PY 1; these staff are playing a critical role in strengthening the national Health Management Information System (HMIS) and strategic information. More data clerks will be trained and deployed in new ART HCs. Of the data clerks deployed to date, the Oromia region already pays salaries for 54 of these staff using Global Fund resources and another 50 are paid through MSH's USAID-supported Rational Pharmaceutical Management (RPM) Plus Program and its successor, the Strengthening Pharmaceutical Systems (SPS) Program.

**Result 3: Deployment of volunteer outreach workers to support family-focused prevention, care, and treatment in communities.** HCSP has expanded the number of kebeles served, from 267 at the end of PY1 to 487 by the end of the current reporting period (61 percent of the target for PY2), with at least five kebele-oriented outreach workers (KOOWs) that are networked with ART sites. A total of 1,100 KOOWs were trained in the second quarter of the current reporting period, bringing the number of trained KOOWs to 2,502 to date. HCSP plans to train and deploy a cumulative total of 4,000 KOOWs in 800 kebele by the end of PY 2.

During the current reporting period, a total of 518 health extension workers (HEWs) and kebele HIV/AIDS desk officers have also been trained on community mobilization, prevention, and care and support strategies to strengthen the work of volunteers at the community level. The 1,402 KOOWs and 85 community mobilizers trained and 270 community core groups formed during PY1 continued to sensitize community members and increase their awareness of HIV & AIDS services available at health centers and in communities. In the current reporting period, a total of 369,989 individuals were mobilized for prevention, care, and treatment through outreach activities—with coffee ceremonies being the main venue for mobilization—and home visits. A further 165,910 individuals were mobilized for VCT. Moreover, 178,288 newly identified

individuals affected and/or infected by HIV & AIDS were provided with care and support services, out of which 78,847 were provided with home-based care. KOOWs, together with case managers stationed at the HC level, traced 20,079 on ART and/or TB DOTS with poor adherence, potential for defaulting and some who had been lost to follow-up and provided them with adherence support in order to minimize subsequent losses.

By strengthening referrals and health networking, nearly 52,622 individuals have been referred to health facilities and community-level care and support organizations for various services. Nonetheless, the mechanism of getting feedback on referrals has been a challenge. Reporting forms have been revised for simplification and to minimize double reporting of individuals provided with care and support services to ensure the quality of data. Regular supportive supervision is being conducted to monitor community-level prevention, care, and support activities.

**Result 4: Implementation of HIV prevention activities using best-practice ABC interventions incorporating stigma, discrimination, and gender concerns.** Prevention is one of the key results of HCSP. Based on best practices and lessons learned from PY 1 implementation, the program is making a concerted effort to scale up best prevention practices. In the current reporting period, various trainings have been conducted for service providers, community elders, religious leaders, and other community outreach volunteers to reinforce the prevention program and promote ABC prevention strategies (Abstinence, Being faithful, Condom use), as well as VCT, ART, and PMTCT services. Customizing of existing behavior change communication (BCC) materials continue in order to address the issues of gender, ART, PMTCT, positive living, TB, and condom provision services.

In this reporting period, more than 980,000 different types of BCC materials with prevention and care and support messages have been adapted, reproduced, and distributed to the regions. These materials will fill gaps in the availability of BCC materials at both the facility and community levels and help create demand for and increase access to services. In addition, new materials to be adapted or developed have been identified, and will be finalized and printed early in the next quarter. Local consultants were recruited to assess existing BCC materials and BCC needs linked to ART at the health center level. The study results revealed that there is a real shortage of BCC materials and that even where they exist they are not properly used. An assessment was also done on the supply and distribution system of condoms that helps in making targeted interventions to insure the regular availability of condoms at both the health facility and community levels. Regular supportive supervision and monitoring of prevention activities are being carried out, in collaboration with other stakeholders.

## **Implementation Modalities**

**Health systems/network strengthening.** Since its inception, HCSP has been committed to strengthening the existing health system and has been implementing a number of innovative interventions in Ethiopia to address existing deficiencies and support HIV & AIDS services at all levels. During this reporting period, a logistics system advisor and a local consultant (health economist) were hired. The logistics advisor works with HCSP as well as the SPS Program, while the local consultant has been seconded to the Federal Ministry of Health (FMOH) to

support the design of performance-based financing (PBF) and its implementation in the public sector. Short-term technical assistance (STTA) was provided by the MSH home office in Cambridge to the FMOH to help finalize the PBF strategy, draft contracts, and develop the costing strategy. Final scopes of work and budgets were finalized, after completion of pre-subcontract audits, with three competitively selected organizations for private sector PBF contracts. The second round of field visits to review progress in implementation of the Fully Functional Service Delivery Point (FFSDP) quality tool in the initial pilot health centers was completed. Preliminary data analysis was conducted and reported to USAID and FHAPCO with STTA from MSH's home office. The FFSDP pilot study results dissemination workshop has been conducted. Selected HCs from the study sites shared their experience regarding the implementation of FFSDP and results obtained in terms of improved quality of services. In collaboration with SCMS, RPM Plus, and other stakeholders, activities to strengthen the logistics and laboratory systems are well under way.

**Mainstreaming gender into all HCSP activities and strengthening NGO capacity.** During this reporting period, HCSP negotiated scopes of work and budgets and has now finalized work plans with the following NGOs, which were selected on a competitive basis: IMPACT, National Network of Positive Women (NNPWE), and the Relief Society of Tigray (REST). HCSP has conducted a pre-award audit of all the organizations with the exception of IMPACT. The recommendations of the audit are currently being implemented by the NGOs. HCSP will send all relevant documents for USAID's concurrence. HCSP is awaiting USAID budget approval to start activities with these NGOs.

The Hiwot HIV/AIDS Prevention, Care and Support Organization (HAPSCO), previously funded by FHI, will now receive funding from HCSP to continue its activities in Addis Ababa. A scope of work (SOW) and a budget are being finalized. HAPSCO will work in all subcities in Addis Ababa.

Dawn of Hope Ethiopia (DOHE) and EIFDDA have also submitted their work plans and budgets, which have been approved. A pre-award audit has been conducted, and DOHE has finalized work on the recommendations that have been made. EIFDDA has developed an SOW with HCSP to train religious leaders and integrate gender as part of their agenda. During this exercise, HCSP and the capacity building team provided extensive technical assistance to the organizations to prepare their SOWs, work plans and budgets. EIFDDA, in collaboration with the HIV/AIDS Care and Support Program, organized an event to commemorate World AIDS Day on December 1, 2008, at the United Nations Conference Center, Economic Commission for Africa (ECA), Addis Ababa, Ethiopia.

**Strategic information and quality management.** Activities include supporting the implementation of the national Health Management Information System (HMIS), ensuring the quality management of HCSP activities (including those being implemented through NGO partners), implementation of Standards-Based Management/Performance Quality Improvement (SBM/PQI tool) and the FFSDP tool, and training and deployment of data clerks to strengthen the strategic information system at the ART HC level.

During this reporting period, the HCSP PY 2 work plan and the Performance Monitoring Plan (PMP), which are the basis for the monitoring and evaluation of the program activities, were developed and submitted to USAID. USAID technical staff reviewed the draft work plan, and their comments were communicated and discussed with HCSP key staff. HCSP incorporated comments and submitted the final version. USAID technically approved the PY 2 work plan in September 2008. But the process of realigning the work plan with some technical areas emphasized under the second Road Map continues and hopefully will be finalized soon. The initial work plan was regionalized in a three-day meeting held in Addis Ababa in July 2008. All regional HCSP staff participated.

Facility- and regional-level reporting forms that capture HIV/AIDS Care and Support Program and PEPFAR data requirements have been developed, pilot-tested, finalized, and implemented in all regions and health facilities supported by HSCP. Training Information Management System (TIMS) forms are regularly sent to JHPIEGO for entry into PEPFAR's database.

The HIV/AIDS Care and Support Program continued its support to HCs, woreda health offices, and RHBs in implementing the national HMIS by printing and distributing registers and forms. HCSP is coordinating and conducting joint supportive supervision visits to help with the implementation of the national HMIS. The HCSP regional monitoring and evaluation (M&E) advisors support RHB, WHO, and HC staff in ensuring a culture of data use for evidence-based decision-making. Data clerks who were trained and deployed to ART HCs in PY 1 continued to support the data management system at the HC level. Preparation is under way to train and deploy more data clerks to the new ART HCs where HCSP will expand in the upcoming quarter.

Active participation continued in both the national technical working group to develop one national quality assurance framework for HIV & AIDS services and the PEPFAR strategic information (SI) technical working group. The PMP has been updated and is being submitted USAID together with the program's PY 2 semiannual report.

**Status of Core Targets or Indicators of the HCSP performance (as of December 31, 2008)**

	<b>Types of Activities</b>	<b>Baseline Performance* (as of June 30, 2007)</b>	<b>PY 1 Target</b>	<b>PY 1 Performance (as of June 30, 2008)</b>	<b>PY 2 Target</b>	<b>Current Performance (as of December 31, 2008)</b>	<b>Remarks</b>
<b>Facilities Assisted</b>							
1	Number of woreda health offices supported with an HIV & AIDS services plan	0	240	251	290	247	Current performance
2	Number of health centers offering comprehensive HIV and TB counseling and testing services	198	450	398	500	500	Cumulative
3	Of which, number of health centers offering enhanced palliation care services	212	267	261	350	500	Cumulative
4	Of which, number of health centers offering antiretroviral therapy	115	240	239	300	255	Cumulative
<b>Individuals Trained</b>							
5	Number of health providers trained in HIV and TB counseling and testing curriculums	467	1,135	1446	2,500	2421	Cumulative
6	Number of health workers trained with IMAI/clinical care and antiretroviral therapy curriculums (including pediatric HIV case finding and care)	402	2,136	1,907	2,520	2305	Cumulative
7	Number of case managers trained and deployed on IMAI/case manager modules	0	267	232	393	232	Cumulative
8	Number of outreach workers trained in community and household HIV prevention, care, and treatment promotion	507	1,335	1402	4,000	2502	Cumulative

	Types of Activities	Baseline Performance* (as of June 30, 2007)	PY 1 Target	PY 1 Performance (as of June 30, 2008)	PY 2 Target	Current Performance (as of December 31, 2008)	Remarks
<b>Kebele and Health Center Performance Standards</b>							
9	Individuals reached with basic palliation care	79,128	120,000	126, 567	220,000	178,288	Current performance
10	Number of HIV-infected clients attending HIV care/treatment services who are receiving treatment for TB	5,266	12,000	6360	34,000	9,702	Cumulative
11	Individuals counseled and tested for HIV who received their results	265,153	260,000	934,275	350,000	371,400	Current performance
12	Individuals receiving antiretroviral therapy (cumulative)	9,994	15,000	22,090	50,000	33,975	Cumulative
13	Number of kebele with deployed outreach workers that are served by a network health center	0	267	267	800	487	Cumulative

\*Baseline figures have not been included in calculation of cumulative totals.

# **1. Narrative Progress Report on General Activities**

## **1.1 HIV/AIDS Care and Support Program PY 1 Annual Progress Review and PY 2 Work Plan Development**

A meeting was organized at the Sheraton Addis Hotel on July 9, 2008, to disseminate the first-year achievements of the HIV/AIDS Care and Support Program. Participants from FMOH and HAPCO led by the State Minister of Health, Dr. Kebede Worku, the US Embassy, USAID, CDC and other PEPFAR and non-PEPFAR partners attended the annual review meeting. Participants appreciated the program's first-year achievements. During the following three days, the HCSP central and regional teams reviewed regional performance and developed the PY 2 work plan. Implementation strategies were also reviewed. Regional teams worked in small groups and developed region specific work plans based on each region's targets.

The first draft of the HIV/AIDS Care and Support Program's work plan for PY 2 was developed and submitted for comments to USAID during the first week of July, 2008. The USAID's technical team reviewed the work plan and forwarded its comments to HCSP for consideration. In addition, a day-long meeting was held at MSH Ethiopia's head office to discuss the comments and the PY 2 proposed activities. The second draft work plan was resubmitted to USAID in August, together with the updated PMP, for final approval. In September 2008, USAID gave official technical approval of PY 2 work plan, with a few comments for technical consideration by MSH. These included the need to review the number of days for mentorship, mentorship frequency, and catchment area meetings. But the realignment of the work plan continued because of the direction given from USAID to strengthen technical areas such as pediatrics HIV care and treatment and PMTCT services. This work plan realignment is in the final stages of completion.

Regional HCSP offices have conducted workshops to harmonize regional HCSP plan with woreda work plans, and so far 247 woredas out of 300 have completed this process. The rest will complete the process in early next quarter.

## **1.2 Collaboration with PEPFAR and Non-PEPFAR Development Partners**

HCSP continued striving to provide comprehensive care and support services at the HC and community levels through leveraging mechanisms with other PEPFAR and non-PEPFAR partners. The following are collaborative activities HCSP has been engaged in during the current reporting period:

- Toward the end of the first quarter of PY 2, HCSP signed an MOU with WFP, which will further strengthen KOOWs' capacity to provide comprehensive services by linking deserving clients to food resources. Under this MOU, WFP will provide training to 245 KOOWS from Addis Ababa on the use of corn soya blend and other foods and follow-up clients on nutritional support. KOOWS will also be able to effectively refer clients from HCSP to local CBOs working with WFP in the provision of food. This partnership will expand to other urban centers where both HCSP and WFP operate, in due course.

- HCSP has also initiated discussions for possible partnership with Land-O-Lakes and the Urban Gardens Project for improved livelihoods and food security among infected and affected households. Land O-Lakes has held several exploratory meetings with HCSP staff and community core groups. If this partnership comes to fruition in the third quarter of PY 2, PLWHA, community core group members, mothers' support groups, and orphans and vulnerable children (OVC) will benefit from dairy farming–related activities.
- Toward the end of the second quarter, HCSP initiated talks with the Development Alternatives International (DAI)/USAID Urban Gardens Project. Ongoing discussions point to the possibility of a fruitful partnership with DAI in linking urban HCSP beneficiaries to the garden project while increasing access to health center services for the urban gardens project beneficiaries.
- HCSP continued to link with Save the Children (USA) programs to provide comprehensive support to OVC. In particular, HCSP is working with the Community Therapeutic Centre (CTC) to provide children under five with nutritional support. This is a critical partnership in pediatric care and support, and as such CTC will provide refresher training to KOOWs in Addis Ababa in the next quarter to equip them with skills for identifying children under five who are in need of nutritional support. Through asset mapping, KOOWs have managed to tap into resources available to Save the Children PC3 Tier III partners—mainly local community-based organizations (CBOs) and faith-based organizations (FBOs) to provide services to OVC. The Supply Chain Management System (SCMS) is procuring home-based care (HBC) kits for KOOWs valued at 5 million US dollars (USD). This will benefit more than 4,000 KOOWs.
- Working with the World Health Organization (WHO) to improve the quality of HIV & AIDS care and treatment at the HC level, particularly on clinical mentorship and case management. A series of joint meetings was conducted, with a focus on discussing and reaching consensus on clinical mentoring tools, basic and refresher training of case managers (adherence supporters), and facility-level implementation of TB/HIV collaborative activities.
- Coordinating with the Clinton HIV/AIDS Initiative (CHAI) to improve access to and quality of pediatrics HIV & AIDS care and treatment at the HC level. CHAI is involved in providing support to pediatrics HIV & AIDS services in the 24 HCSP-supported HCs of Addis Ababa and 25 in the Amhara region. The collaboration includes coordinated mentorship visits to the HCs, and joint regular meetings to review activities of clinical mentorship led by the RHBs.
- African Network for the Care of Children with HIV/AIDS, ANNECA, receiving a grant from USAID, has started preparatory activities to support strengthening of pediatrics HIV & AIDS services at HCSP-supported HCs. For this purpose, a joint field visit was conducted to assess site-level requirements, discussions were held to outline the roles of each partner, and a memorandum of understanding (MOU) was prepared, which was reviewed by all concerned, including USAID/Ethiopia. The MOU has been signed by both parties and the deployment of ANNECA experts to HCSP is pending.

- Pathfinder is undertaking an Integrated Family Health Program at the district level. After a couple of meetings that discussed potential areas of collaboration in districts that are targeted by both programs, identification of districts where the two programs can synergize is just completed. Further steps will be preparation of an MOU by stipulating roles of each partner and implementation.

These collaborative efforts will be consolidated in the second half of PY 2 while new initiatives will continue to be explored.

### **1.3 Results of Activities Related to MSH Ethiopia Operations Platform**

The MSH Ethiopia Operations Platform (MEOP) provides support to the three MSH projects in the country. Support encompasses the areas of finance/accounting, information technology, human resources, communications, and operations (procurement, property management, and fleet management). During this reporting period, MEOP has continued to reassess standard operating procedures to accommodate the contractual requirements of the HIV/AIDS Care and Support Program. During the period, MEOP has supported HIV/AIDS Care and Support Program in the following areas:

*Human Resources:* The human resources unit has been supporting HCSP in meeting recruitment needs, particularly in filling vacant positions as a result of high staff turnover due to mainly low salary scales offered by the HCSP. A number of staff still need USAID approval to be confirmed in employment. Support from USAID in the approval process has been critical to effectively staffing up. The MSH *Human Resources Manual* has been revised in accordance with Ethiopian law and in a way that it accommodates the contractual situation of HCSP.

*Finance/Accounting:* Regional accountants are being trained and deployed. Regional bank accounts have been established. Operating procedures and safeguards are being reinforced to support large disbursements to the regions. Cashiers, who were also recruited, trained, and deployed to each region during the fourth quarter of PY 1, continued providing necessary assistance to regional HCSP offices.

*Information Technology:* In addition to providing routine user support, the IT team established an Internet connection and network in the new building. The team has continued to improve IT services through the upgrading of switches and the integration of the Ethiopia network into MSH's US-based network. A wireless network was also established, and the team has been supporting the regional and subregional offices.

*Operations:* The unit has been providing the full range of procurement support for all HIV/AIDS Care and Support Program needs while also establishing its procurement office. The operations team has been conducting research on fleet management software to support the newly arrived vehicles for HCSP. A full inventory of all assets was conducted in June and July 2008.

## **2. Progress on Achieving Program Results**

### **2.1. Result 1: Provision of Quality Integrated HIV & AIDS Prevention, Care, and Treatment Services at Health Centers**

#### **2.1.1. Staffing of the Treatment Component**

The treatment team has been without a leader since the resignation of the previous team leader in early May 2008. In the interim the team was being led by the program director for technical integration until late September, when the clinical advisor for PMTCT was assigned as acting treatment team leader pending the formal placement of an approved team leader. Of the five other positions available under the treatment team, clinical advisors for IMAI and PMTCT were filled earlier and continued to work actively. The TB/HIV-PITC advisor left in November and has since been replaced. The position of pediatrics HIV and palliation care advisor is still vacant, because individuals selected either did not accept the salary proposed or did not get USAID's approval. Efforts will continue to identify an appropriate person for the post. A new coordinator for case managers joined the team in November, replacing the one who left in September.

The program has deployed 32 clinical mentors to support its ART sites. The attrition rate of clinical mentors has been high, however, with one major reason being the less competitive salary; replacement has been ongoing to quickly fill the vacant positions. In the last two quarters of PY 2, 17 clinical mentors left and were replaced, or individuals were identified, with recruitment for replacement in process. At present, one clinical mentor position is still vacant.

#### **2.1.2. Expansion of ART Services to New HCs**

Expansion to new HCs to achieve the PY 2 target of 300 HCs providing ART services was one major undertaking for this period. To identify expansion sites, HCSP collaborated with the RHBs to carry out assessments at a large number of HCs already providing comprehensive HIV and TB counseling and testing and other palliation care services in four target regions. After the assessments, 61 HCs were selected based on patient volume, HIV prevalence, and regional preferences (26 HCs in Amhara, 20 in Oromia, 10 in the Southern Nations and Nationalities Peoples Region [SNNPR], and 5 in Tigray). Staff at all the new HCs were trained on IMAI, and necessary supplies and equipment were put in place; 13 HCs started providing ART, bringing the total of ART HCs to 255 by the end of December 2008. Throughout PY 2, HCSP will continue to support 500 HCs, 300 of which will be providing comprehensive HIV & AIDS prevention, treatment, care and support services, with the remaining 200 providing counseling and testing and palliation care.

#### **2.1.3 PMTCT Sites Transition from IntraHealth to HCSP**

In PY 1, there was a transition of PMTCT services from the Capacity Project of IntraHealth to HCSP (both are USAID-funded). This initially focused on the transfer of PMTCT services in ART HCs, which was completed by June 2008. The Capacity Project then opened newer PMTCT sites, and FHI transferred all its sites (including non-ART HCs that were providing VCT services) to HCSP. However, as HCSP itself expanded its number of ART sites and worked

to initiate PMTCT services at all non-ART HCs, in accordance with the contract, more and more site overlaps were identified with IntraHealth.

A number of meetings were held between the Capacity Project team at IntraHealth and the HCSP treatment team to identify all the overlapping sites and establish a transition plan for these health centers. A phased approach to the transition process was agreed upon and is being implemented, with the hope that the process will be completed in the upcoming quarter.

#### **2.1.4. Training-Related Activities**

The first quarter of PY 2 mainly focused on selecting new sites for expansion of various services, assessing the training requirements of the sites, and identifying current gaps due to attrition in HCs where trainings were held in PY 1. This process has helped to align the training priorities with the training targets set for the year and resources allocated.

Refresher training for clinical mentors was conducted July 14–19, 2008, at the Global Hotel in Addis Ababa, following the PY 1 annual review meeting. A total of 32 clinical mentors, five regional health advisors (RHAs), and five regional M&E advisors attended the training. The objectives of the training were to give an update on emerging HIV & AIDS developments, introduce the PY 2 work plan, and introduce standard operating procedures (SOPs) for HIV & AIDS services and mentorship activities.

HCSP team leaders presented their respective teams' planned activities for PY 2, emphasizing program integration at the HC and community levels. The integration model presented suggested ways of enhancing technical integration of services at the community and HC levels. The model was extensively discussed, with an emphasis on issues concerning using HEWs and other community health workers, including KOOWs, to deliver various HIV & AIDS services. Updates on management of adult and pediatric patients on ART were given using resource persons from HCSP and FHAPCO. Current issues in HCT, PMTCT, post exposure prophylaxis (PEP), and TB/HIV were also presented and discussed at the refresher training, mainly by HCSP staff. Updates were presented on the national Health Management Information System (HMIS), particularly HIV & AIDS data recording and reporting and data quality management. Regarding the improvement of service quality at the HCs, FFSDP team activities were presented and the outcomes of the intervention in the pilot HCs were discussed. The way forward was established for expansion of the FFSDP tool into more program-supported HCs.

SOPs for the mentorship service were also presented, followed by discussion, particularly about their implementation. In addition, quality indicators for all HIV & AIDS services, including the adherence support and other national tools to be used to improve mentorship quality, were discussed and their implementation agreed upon.

Most of these trainings were conducted in the second quarter of the reporting period. Table 1 summarizes the training activities that were conducted in the reporting period.

**Table 1. Types of Trainings Conducted by HCSP and Individuals Trained per Region**

Training Title	Addis Ababa		Amhara		Oromia		SNNPR		Tigray		Total		
	M	F	M	F	M	F	M	F	M	F	M	F	Grand Total
PMTCT	26	77	68	51	83	117			46	71	223	316	539
Comprehensive HIV Care/Treatment/IMA	42	44	52	28	97	80	36	19			227	171	398
Comprehensive Laboratory Services for HIV & AIDS	63	31	48	7							111	38	149
DBS Testing for Laboratory Technicians					58	22							80
PICT			37	37	62	73			6	11	105	121	126
VCT	53	74									53	74	127
TB/HIV	68	66			23	37					91	103	194

### 2.1.5 Mentorship and Catchment Area Meetings

Clinical mentorship is the major tool used by HCSP to provide practical training and consultation to foster ongoing professional development of service providers at the health center level to yield sustainable high-quality clinical care outcomes. The program deployed 32 clinical mentors that, on average, each provide mentorship support to eight ART providing health centers on a monthly basis. This includes direct support in case management, data handling and use, and case reviews. For example, the mentorship activity in western Oromia has enabled health workers to appropriately manage some drug interactions and opportunistic infection cases, as shown below.

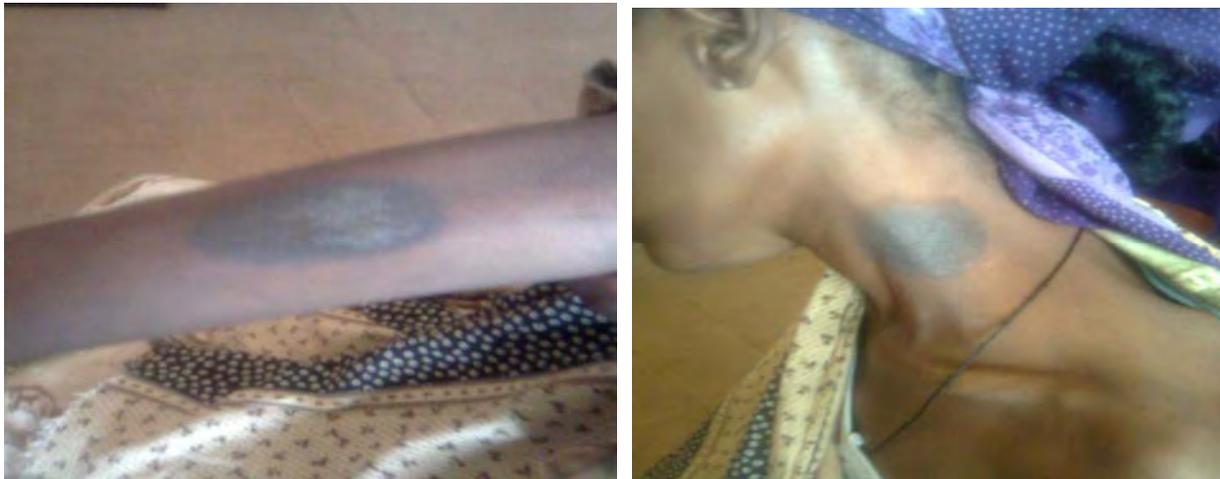


A



B

*Atypical herpetic skin lesion before eruption, Bedelle HC (A) and Typical herpetic skin lesion before eruption, Jimma HC (B)*



*Patient at Genchi having an adverse drug reaction to co-trimoxazole*

A monthly mentorship visit lasts for an average of two days, depending on the client load of the specific health center. Although attrition of the clinical mentors has remained a major challenge for the program (17 mentors left and were replaced over the past six months alone), mentorship support to the health centers has continued throughout the current program year, albeit stretching the capacity of available clinical mentors at times.

Catchment area meetings are used to address issues related to referral linkages among facilities, particularly among the health centers and the nearby hospitals. The managerial challenges of ART services are also presented to local decision-making officials in this forum. The program supports the conduct of these meetings at various sites in its operational regions. However, fund limitations and lack of time for the activity among key players, including the health managers and clinical mentors, have reduced the frequency of these meetings to less than what was desired by the service providers.

## **2.1.6 Comprehensive HIV & AIDS Services Provision**

### **2.1.6.1 Counseling and Testing Services at HCs and in the Community**

HCSP supports HIV & AIDS counseling and testing services in all target regions through various but integrated approaches. Besides the VCT services regularly provided at the health centers, HCSP has supported the integration of PITC services at all service outlets to expand entry points for HCT services, and results have been encouraging. In addition, special occasions such as World AIDS Day and public holidays were used as opportunities for providing mass counseling and testing (C&T) services with the support of the program. A plan has also been established to support HCs in conducting outreach services for C&T.

Through this variety of strategies, the program supported the counseling and testing of 371,400 (M=168,004, F=203,395) individuals during the current reporting period. Of those who were tested and received results in the semiannual period, 16,635 (M=5469, F=11,165) individuals were confirmed to be HIV-positive, making the HIV-positive rate 4.5 percent (M=1.5 percent,

F=3.0 percent) in the five program regions. The HIV-positivity rates among males and females in the target regions are 3.35 percent and 5.5 percent, respectively. All individuals who tested positive have been linked with or referred to health facilities of choice for comprehensive HIV care and treatment services.

### 2.1.6.2. Provision of HIV Care/ART Services at the Health Centers

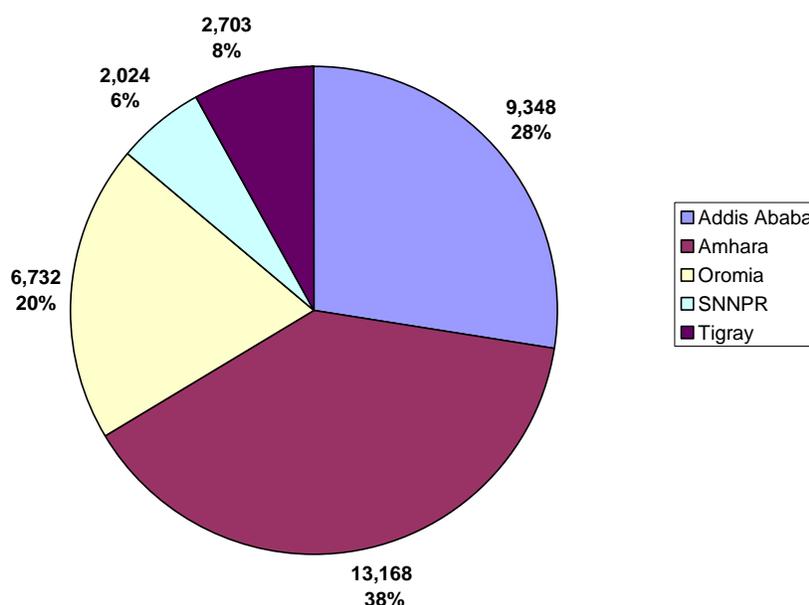
By the end of the reporting period, a cumulative total of 78,271 individuals were enrolled for HIV care, and 32,975 patients were started on ART at the HCs supported by HCSP. A cumulative total of 7,555 stable patients on ART have been released from hospitals to attend treatment at the HC level, and a total of 2,134 patients on ART have been transferred to hospitals for higher-level care or to nearby HCs for follow-up. At the end of HCSP PY 1, the number of individuals receiving ART services was 22,090, which is 147 percent of the first-year target. With a progressive increase in the number of patients receiving treatment at the health center level, 33,975 patients were receiving ART by the end of the current reporting period (December 31, 2008). This indicates that 11,885 patients were put on treatment in just six months' time. About 61.6 percent of patients on ART are women, and 0.7 percent are children under 14 years of age. Table 2 shows sex, age, and pregnancy status, disaggregated by targeted HCSP region, of patients currently on ART.

**Table 2. Regional Distribution of Patients on ART (December 31, 2008)**

Region	Children 0–14 Years	Adults > 14 yrs			Regional Total
		Male	Female (Non-pregnant)	Pregnant Women	
Addis Ababa	144	3237	5778	189	9,348
Amhara	1	4,986	8,143	38	13,168
Oromia	28	2779	3905	20	6,732
SNNPR	1	835	1185	3	2,024
Tigray	62	989	1631	21	2,703
<b>Total</b>	<b>236</b>	<b>12,826</b>	<b>20,642</b>	<b>271</b>	<b>33,975</b>

More than two-thirds of patients currently on ART are from the Addis Ababa City Administration and Amhara regions. Figure 1 shows the regional distribution of patients currently on ART in the five target regions of HCSP.

**Figure 1. Regional distribution of patients currently on ART (December 31, 2008)**



The rate of patients lost to follow-up (LTFU) is one measure of service quality that indicates the appropriateness and fruitfulness of the innovative approaches implemented by HCSP. To strengthen adherence, HCSP is implementing a number of approaches, including delivering services closer to the community (HCs), strengthening adherence counseling (case managers), and using better tracing mechanism (KOOWs and community volunteers). At the end of the reporting period, the LTFU rate at HCSP-supported HCs was 5.4 percent, in contrast to the national average of about 25 percent. At the end of PY 1, the LTFU rate at HCSP-supported HCs was 4 percent. There was an increase in this rate by the end of the current reporting period because, as the number of patients on treatment increases, the chance of losing patients to follow-up also increases. HCSP is striving to keep the rate as low as possible despite service expansion. Table 3 shows the regional distribution of patients lost to follow-up at the health centers.

**Table 3. Regional Distribution of LTFU Patients at the Health Center Level in the Regions Supported by HCSP, December 2008.**

Region	No. Currently on ART	No. LTFU Patients (Lost, Dropped, or Stopped)	% Patients LTFU
Addis Ababa	9,348	957	9.3
Amhara	13,168	550	4.0
Oromia	6,732	200	2.9
SNNPR	2,024	31	1.5
Tigray	2,703	190	6.6
<b>Total</b>	<b>33,975</b>	<b>1,928</b>	<b>5.4</b>

### **2.1.6.3 Provision of Basic Palliation Care Services at the HC and Community Levels**

Providing care and support services at the HC and community levels continues to be one of the major activities of HCSP. Over the past six months alone, a total of 180,985 HIV-infected and affected individuals have been reached with various types of care and support services. In addition to health providers' support at the HC level, this has been achieved through the continuing efforts of case managers, KOOWs, and other volunteers trained and deployed by the program.

While some problems remain in the integration and coordination of these new cadres of health workers, they are progressively showing their effectiveness in the existing system. Both service providers and community health workers have been trained on TB/HIV collaborative activities to strengthen proper screening and diagnosis of patients and to provide proper management (prophylaxis or treatment) and referral of patients, respectively. KOOWs are also following up on TB DOTS and ART LTFU patients, with encouraging results so far. During the reporting period, 20,079 patients (M=9,363, F=10,716) with poor adherence, potential for defaulting and lost to follow-up (either ART or TB DOTS) were traced and provided adherence support or restarted on treatment. Details of KOOWs' performance are described under Result 3 below.

### **2.1.6.4. Provision of PMTCT-Related Services**

Although PMTCT service provision remains poor in Ethiopia, HCSP is working to improve access to and quality of PMTCT services in the HCs supported by the program. In the current reporting period, a total of 55,184 antenatal care (ANC) clients have been registered in the HCs; 39,581 have been tested and received their results. This represents a client acceptance rate of 80.9 percent. Of pregnant women who were tested and received their test results, 1,900 (4.8 percent) tested positive for HIV. Of those testing positive, just 671 (35.3 percent) received complete prophylaxis for HIV, and only 503 (26.5 percent) of the babies born to HIV-positive mothers received prophylaxis. In labor and delivery service outlets, 2,764 pregnant mothers delivered, and 1,549 of them received PMTCT services. Table 4 shows performance of PMTCT services in the last six months.

**Table 4. PMTCT-Related Activities' Performance in Program-Supported Health Centers**

Indicator	Addis Ababa*	Amhara	Oromia	SNNPR	Tigray	Total
Number of new ANC clients whose HIV status is unknown and who visited the ANC during the reporting period	2,432	19,089	12,716	12,846	8,731	55,814
Number of new ANC clients counseled for HIV testing for PMTCT services	2,017	16,600	12,219	10,565	7,516	48,917
Number of ANC clients counseled and tested for HIV who received test results during the reporting period	1,854	13,474	8,799	9,044	6,410	39,581 (70.9%)
Number of ANC clients who tested positive for HIV during the reporting period	222	751	600	140	187	1,900 (4.8%)
Number of pregnant women whose sero status is unknown who delivered at the facility	34	1,789	374	305	292	2,764
Number of pregnant women who received an HIV test in the labor and delivery ward	30	919	358	165	77	1,549
Number of HIV-positive pregnant women provided with a complete course of HIV prophylaxis during the reporting period	54	339	127	59	92	671 (35.3%)
Number of infants born to HIV-positive mothers who received HIV prophylaxis during the reporting period (postpartum infant prophylaxis)	39	264	97	53	50	503 (26.5%)
Number of pregnant women referred for ART during the reporting period	76	417	201	64	158	916

\*Addis Ababa data are for the month of November only.

### 2.1.7. Additional Technical Activities

HCSP participated in technical working groups (TWGs), workshops, and other meetings to review existing policies and standards for ART, clinical mentoring, existing ART and PMTCT programs, guidelines, manuals, and operating procedures. HCSP staff are members of technical working groups for treatment, sexually transmitted infections (STIs), and TB/HIV, all of which meet regularly. The results of the meetings are integrated into HCSP's implementation modalities.

## **2.2. Result 2: Deployment of Case Managers to Support Care and Strengthen Referrals between Health Centers, Hospitals, and Community Services**

At the outset of HCSP, its staff met with PEPFAR partners and HAPCO staff to review HIV & AIDS programs that have deployed case managers. Discussions centered on job descriptions, guidelines, and procedures for case managers. During the reporting period, HCSP participated in a task force composed of various USG partners and led by FHAPCO, for the purpose of harmonization/standardization of nomenclature and salary issues for case managers, who are being hired by various organizations as part of a task-shifting effort to promote client adherence to treatment or care. The task force, after a number of meetings, has come to final decision, which will be implemented across the country: to have two levels of cadres to strengthen adherence. The first level of cadre will be adherence support coordinators, to be based at the facility level. These staff will coordinate and support overall case management activities. The case managers trained and deployed by HCSP belong to this level. The second level, adherence supporters, includes most of the outreach workers. Salaries were also set by considering the salary level of community counselors and health extension workers (HEWs) so as to fit these cadres into the existing system.

A subcontract was awarded to a Deloitte & Touche affiliate, HST, to recruit and hire case managers and data clerks, using salaries and benefit packages that parallel the FMOH structure to facilitate future integration of these cadres into the GOE civil service structure. At present, this system is functioning well. A total of 232 case managers have been trained and deployed to ART HCs and have been well integrated into the system. They are playing a crucial role in adherence counseling, implementation of personalized care plans, linkage of PLWHA with different services at the HC and community levels, referral of patients to the community and hospitals, and tracing LTFU patients in coordination with community-level volunteers (KOOWs). The low rate of LTFU patients at the HC level (5.4 percent) is among the major evidence of effective collaborative efforts of case managers and volunteer community workers. By the end of PY 2, HCSP is expected to train and deploy a cumulative total of 393 case managers at 300 ART HCs. A plan has been established to train additional case managers to deploy at the new ART HCs and in HCs with a larger number of clients, as well as to replace case managers who are lost from the program. In HCs with a large number of clients, more than one case manager may be deployed. The identification of such health centers was made based on caseload and a list was sent to the regions for endorsement or modification of the plan by the RHBs.

In addition to addressing the suboptimal performance of case managers at some HCs as observed during field visits and improving coordination among the management and service providers at the HC level, refresher training is planned for case managers. A training schedule and areas of focus have been outlined and are awaiting finalization of the adherence supporters' training package by FHAPCO, which will determine if any core issues need to be incorporated into the refresher training.

## **2.3. Result 3: Deployment of Volunteer Outreach Workers to Support Family-Focused Prevention, Care, and Treatment in the Community**

### **2.3.1 Overview**

Under Result 3, HCSP is providing technical assistance to selected kebele HIV/AIDS desks and health posts to deploy at least five KOOWs per kebele to support health extension workers providing HIV & AIDS and TB prevention, care, and treatment services in the community. The KOOWs are identified in collaboration with kebele HIV/AIDS desks and community core groups. KOOWs are supported through training, supportive supervision, and payment of travel allowances. To achieve outputs and deliverables under Result 3, the following approaches have been used:

- Community-based, family-focused, and gender-sensitive programming, including strengthening linkages among household-, community-, and health center-based care and support mechanisms.
- Strengthening existing community norms and mechanisms for care and support through capacity building of community core groups, with idirs taking a lead role. This function has extended to strengthening woreda health offices to coordinate care and support services and mobilization of CBO/FBO networks to identify households and individuals in need and provide appropriate services.
- Continuous mapping of kebele assets or resources to support personalized care, including linking treatment with other care and support services at the community level.
- A strong supervision, monitoring, and support plan with active involvement of woreda HAPCO and kebele HIV/AIDS desks.

### **2.3.2 Improving Capacity of at Least 800 CBOs/FBOs/CCGs and Kebele HIV/AIDS Desks to Deliver HIV & AIDS Prevention, Care, Treatment, and Support in the Community**

#### **2.3.2.1 Staffing Status under Result 3**

As per the technical direction HCSP received from USAID, four regional care and support coordinators were hired and deployed, in Amhara, Oromia, Tigray, and SNNPR. This brings the number of persons responsible for the care and support component to five. During the PY 1 implementation period, one regional coordinator was responsible for the coordination of the care and support and prevention components. HCSP believes that the current structure will further strengthen the effectiveness of coordinating activities under the two components. Other positions under Result 3 have been filled and are functioning well.

#### **2.3.2.2 Capacity Building Training of Woreda and Kebele HIV/AIDS Control Offices**

HCSP has realized that the active involvement and ownership of the program by HAPCO officers at both the woreda and kebele levels are critical to the success and sustainability of the program. HCSP conducted two sets of training to strengthen the capacity of woreda HAPCO and kebele HIV/AIDS desks to coordinate and supervise care and support activities at the community level. The community mobilization guide, which follows the Community Action Cycle

framework, and related training materials developed in PY 1 were further revised to take into consideration the roles the woreda HAPCO officers will play in the scale-up and supervision of care and support activities at the woreda level. In this reporting period, a total of 121 (M=108, F=13) woreda officers from the four major regions and Addis Ababa were trained on community mobilization using the Community Action Cycle as a framework. After training of woreda HAPCO officers, HCSP, together with the trained woreda HAPCO officers, identified 533 health extension workers (HEWs) and kebele health and HIV/AIDS desk officers for a similar training in community mobilization training, emphasizing the coordination and supervisory roles of HEWs. In this period, a total of 518 HEWs and kebele HIV/AIDS desk officers were trained, as presented in Table 5.

**Table 5. Regional Distribution of HEWS/Kebele HIV/AIDS Desk Officers Trained**

Region	Number of HEWS/Kebele HIV/AIDS Desk Officers		
	Male	Female	Total
Addis Ababa	9	42	51
Amhara	72	82	154
Oromia	66	88	154
SNNPR	44	49	93
Tigray	1	65	66
<b>Total</b>	<b>192</b>	<b>326</b>	<b>518</b>

The trained officers are members of the community mobilization teams at the woreda and kebele levels. As a result of the training, HCSP is successfully conducting joint planning and monitoring of care and support activities with woreda and kebele HIV/AIDS desk officers. At the end of both trainings, a comprehensive care and support work plan was developed for the implementation of activities that are in line with the HCSP contract.

Both woreda and kebele HAPCOs are taking ownership of the program as envisaged, performing independent monitoring of program activities, as well as providing offices and identification cards/letters for community mobilizers and KOOWs. Program data are fed into the existing system for decision-making, and HCSP activities are considered to be in line with both woreda and kebele care and support plans. To complement the coordination role of both woreda and kebele HIV/AIDS desks as well acting as a link between the program and volunteers, HCSP identified a further 25 community mobilizers and trained them on community mobilization, and on monitoring and coordination of care and support activities. Community mobilizers are also tasked with the formation and capacity building of community core groups. This brings to 110 the number of community mobilizers trained since PY 2.

### **2.3.2.3 Expansion of Kebele and Community Core Groups Networked with ART HCs**

HCSP has planned to expand the number of kebele networked to ART HCs to 800 by the end of PY 2. The prioritization process, in collaboration with regional government bodies, has been completed to select 533 kebele in high-HIV prevalence areas. In this reporting period, HCSP conducted orientation workshops to introduce HCSP activities and advocate for support and buy-

in for the community care and support program in 215 kebele of Addis Ababa, Amhara, and Tigray. Furthermore, a series of meetings was held with representatives of CBO and FBOs in each kebele, culminating in the formation of community core groups chaired by active and influential idirs in each kebele. In this period, 45 community core groups (CCGs) were formulated in Addis, 165 in Amhara, and 5 in Tigray. At least 315 CCGs will be formulated and strengthened in the next quarter. Each community core group is composed of 10 to 15 members who, together with kebele government structures, are tasked with the oversight of care and support activities together with kebele government structures. They oversee the work of KOOWs and provide them with additional support mechanisms to provide care and support services.

#### **2.3.2.4 Formulation/Strengthening Existing Community Core Groups in Each Kebele**

HCSP continued to strengthen existing community norms and mechanisms for care and support through capacity building of community core groups, with idirs taking a lead role. Community mobilizers continued to provide capacity building training to community core groups. The CCGs in all regions continued to mobilize resources for care and support, independent of program support. For example, in Tigray, PLWHA and OVC have benefited from financial, material, and other support from the work of KOOWs. In Axum, at least 52 PLWHA received 1,000 Ethiopian birr (ETB) each for rent and shelter through the combined efforts of CCGs, KOOWs, community mobilizers, and religious leaders. In Sherairio, a homeless TB patient was provided with a tent for shelter, and another had his rent paid for six months. CCGs have managed to link PLWHA to microfinance institutions and in some cases have raised the capital to start an income-generating activity (IGA) benefiting at least 15 households. At least 47 OVC in several woreda in Tigray received educational supplies or uniforms and other materials through KOOWs' and CCGs' efforts, allowing them to continue in school. Potential ART defaulters and those traced and restarted on ART are receiving assistance in adhering through provision of transport money to ART sites, as is the case in Gulele subcity in Addis Ababa. Monthly program review meetings to provide support to KOOWs continued in this biannual period. Kebele HIV/AIDS desks and HEWs are actively involved in the daily activities of KOOWs and are helping them refer PLWHA to appropriate services. Community core groups have also harnessed other community-based structures, such as women's associations, to strengthen the capacity of KOOWs to provide services. For example, in Gulele subcity of Addis Ababa (kebele 13/14), KOOWs, who are all members of the women's association, have managed to reach infected and affected women through the association. Bed-ridden clients have received assistance in accessing medical care through these mechanisms. KOOWs have managed to link clients to resources accessible via the HIV/AIDS desks. For example, several households have been linked to food programs through these efforts.

#### **2.3.2.5. Training of KOOWs and Other Community Volunteers**

During the PY 1 implementation period, a total of 1,402 KOOWs and 85 community mobilizers were trained. In PY 2, HCSP planned to train an additional 2,665 KOOWs selected from 533 kebele. Based on feedback from trainers and the trained KOOWs, the care and support team revised the KOOWs' training materials and came up with simple PowerPoint slides summarizing the training content. These will complement the revised training manual. The team has also started on the development of a pocket guide (based on the training manual), which will be given to KOOWs for easy reference. HCSP provided assistance to selected kebele HIV/AIDS desks and community core groups to identify and recruit 1,100 KOOWs, who were provided with 12 days of training based on the topics stipulated in the contract. (Table 6 shows the regional

distribution of trained KOOWs.) The trained KOOWs were deployed in 220 kebele networked with an ART health center. The trained KOOWs will start providing care and support activities in the next quarter.

**Table 6. Regional Distribution of Trained KOOWs**

Region	Number of New KOOWs Trained		
	Male	Female	Total
Addis Ababa	121	18	139
Amhara	135	170	140
Oromia	261	236	497
SNNPR	73	86	159
Tigray	0	0	0
<b>Total</b>	<b>590</b>	<b>510</b>	<b>1,100</b>

To date, 2,502 have been trained and deployed in 220 kebele. This represents a 62 percent achievement for the PY 2 cumulative target. HCSP is expected to train a cumulative total of 4,067 KOOWs by the end of PY 2.



***KOOWs pledge to serve their community and those infected and affected by HIV***

In the course of the reporting period, HCSP took a quick audit of KOOWs trained in PY 1 to assess whether they are still active. Of 1,402 KOOWs trained in PY 1, 97 KOOWs (6 percent) have either dropped out of the program or were not performing their duties as expected. The main reason cited was lack of motivation related to the meager amount provided as transport

allowance and the lack of refresher training. Moreover, the bottlenecks experienced in the payment of their transport allowances in PY 1 exacerbated the situation. Some KOOWs had upgraded to be case managers and community mobilizers, while some changed residence or obtained employment in formal sectors. The increasing workload, especially in urban areas, was cited as a major contributor to the dropout rate. HCSP has begun addressing some of these issues to prevent an increase in the dropout rate. To minimize delays in the payment of the KOOWs' transport allowance, community mobilizers, under supervision of woreda HAPCO officers, will be responsible for paying the KOOWs' stipend monthly. Plans have already been developed to train replacement KOOWs in the next quarter. Refresher trainings, which cannot be conducted in PY 2 due to budget constraints, have been planned for PY 3. HCSP is still exploring other nonmonetary ways of motivating KOOWs, such as linking them to livelihood activities.

### **2.3.3 Provision of Care and Support Services and Community Mobilization for Prevention, Care, and Treatment**

Based on the skills imparted through training, field practice, and experiences in other care and support work, the 1,402 KOOWs continued to provide the services discussed below.

At the household level, KOOWs provided these services:

- They identified individuals, families, and households infected/affected by HIV & AIDS in the health center catchment kebele. This is being done through home-to-home visits, through the kebele HIV/AIDS desks, health extension workers, community core groups, and through PLWHA and HIV-positive KOOWs' own support networks.
- They provided home-based care and basic palliation services for individuals infected/affected by HIV & AIDS. KOOWs were provided with a home-based care kit, which equips them to provide home-based care and train household members to care for the infected person in their households, with a focus on stigma reduction, infection prevention, treatment literacy, and hygiene and sanitation. As part of HBC, KOOWs assist clients with household chores and arrange for alternate care (e.g., through neighbors and CCGs) for clients who live alone.
- They referred infected/affected family members to appropriate services based on the asset map developed. Typically, KOOWs continued referring family members to services such as VCT, family planning, spiritual and psychosocial support, PMTCT, TB screening, nutrition, and OVC support. The case manager is a critical bridge between community care and support and health center-based clinical services. In this reporting period, concerted efforts were made to ensure that KOOWs work closely with case managers to track referred clients.
- They participated in follow-up of lost clients and provided adherence to TB DOTS and ART regimens and enlisted the support of family members, whom they also provided with basic treatment literacy. KOOWs have been linked to the case managers, who provide them with a list of clients to follow up at the household level.
- At the community level, KOOWs provided services as follows:

- They conducted outreach activities in HIV-related community mobilization for prevention, care, and/or treatment. Through community mobilization, KOOWs encouraged community members to seek and receive comprehensive care and support: ART, PMTCT, VCT, TB, OI, and family planning. They also focused on reduction of stigma through targeting community leaders, FBOs, CBOs, community core groups, and PLWHA in the outreach activities. KOOWs also living with HIV took the lead in these activities to encourage disclosure and reduce stigma. Coffee ceremonies have been the main vehicles for community mobilization activities.
- They strengthened two-way referrals between community-based service providers and health facilities to ensure a continuum of care. KOOWs have been working with a network of identified CBOs/FBOs/idirs, case managers, and community core groups to effectively track persons referred and ensure that they have received the appropriate services.
- They mapped kebele assets to provide an inventory of prevention, treatment and care, and support services to which KOOWs can refer clients as appropriate. Asset maps show all service delivery points in each kebele.

### 2.3.3.1 Outreach Activities in HIV-Related Community Mobilization for Prevention, Care, and/or Treatment

The 1,402 KOOWs and 85 community mobilizers trained during PY 1 and members of the 270 community core groups already formed in PY 2 continued to sensitize community members and increase their awareness of HIV & AIDS services available at both health center and community levels. Coffee ceremonies continued to serve as the main vehicles for mobilizing communities. KOOWs and community core groups have been funding these outreach activities from their own resources. Because of increasing prices, however, KOOWs in Addis Ababa have requested support from the program to continue with similar activities. In this reporting period, 369,989 individuals were reached through community mobilization activities as shown in Table 7.

**Table 7. Regional Distribution of Individuals Reached through Community Mobilizations**

Region	Individuals Reached through Community Mobilizations		
	Male	Female	Total
Addis Ababa	12,719	20,820	33,539
Amhara	22,163	25,613	47,776
Oromia	44,098	48,924	93,022
SNNPR	25,576	30,189	55,765
Tigray	60,493	79,394	139,887
<b>Total</b>	<b>165,049</b>	<b>204,940</b>	<b>369,989</b>



*Coffee ceremony in Gulele subcity in Addis Ababa*

Through these efforts, PLWHA continue to approach KOOWs for care and support (e.g., HBC, referrals, VCT, nutrition support). The community outreach activities continue to be used as vehicles to disseminate both stigma-reduction and prevention messages. Informal discussions with both PLWHA and KOOWs indicate that the community outreach activities have gone a long way in the reduction of stigma. Prior to the onset of HCSP, PLWHA generally did not wish to be visited by any volunteers, as this would “reveal” their status to their neighbors. These days, however, PLWHA actively seek out KOOWs to get services, including assistance with household chores. This openness, according to some KOOWs, is an indication that the level of stigma is declining somewhat.

### **2.3.3.2 Provision of Community-, Home-Based, and Other Care and Support Services to Individuals Infected or Affected by HIV & AIDS**

During this reporting period, KOOWs provided care and support services to 178,288 newly identified HIV-infected and -affected individuals. Identification of these individuals (and households) was carried out through kebele HIV/AIDS desks working directly with HIV-positive-KOOWs’ networks (peer identification), PLWHA associations, CCGs, and KOOWs conducting home-to-home visits for case findings (including TB cases), as well as through outreach activities such as coffee ceremonies. In the process of identifying infected and affected households, KOOWs provided care and support training to household members and offered psychosocial counseling to affected and infected individuals. The distribution of the newly identified infected and affected individuals by region is shown in table 8.

**Table 8. Regional Distribution of Newly Identified Infected and Affected Individuals Provided with Care and Support**

<b>Region</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
Addis Ababa	13,586	23,081	36,667
Amhara	27,841	24,812	52,653
Oromia	15,168	17,389	32,557
SNNPR	7,482	7,498	14,980
Tigray	19,446	21,985	41,431
<b>Total</b>	<b>83,523</b>	<b>94,765</b>	<b>178,288</b>

Of the total number of infected and affected individuals, 78,847 infected individuals were provided with home-based care services. This figure represents those who are bed-ridden and required nursing care and assistance with household chores and its regional distribution is indicated in the Table 9.

**Table 9. Regional Distribution of HIV-infected Individuals Provided with HBC Services**

<b>Region</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
Addis Ababa	7,919	13,397	21,316
Amhara	13,551	12,852	26,403
Oromia	5,105	6,561	11,666
SNNPR	871	1,202	2,073
Tigray	9,227	8,162	17,389
<b>Total</b>	<b>36,673</b>	<b>42,174</b>	<b>78,847</b>



*KOOWs provide HBC to a client in Amhara*

### 2.3.3.3 Referrals of PLWHA, OVC, and Households Impacted by HIV & AIDS within a Network of Existing Community Services, Including an OVC Care and Support System

Working with health centers and other existing CBO networks that provide other care and support services, KOOWs are successfully referring infected and affected individuals for nutritional support, VCT, PMTCT, spiritual and psychosocial support, and in some cases, microfinance. KOOWs make use of the kebele asset maps developed in PY 1 to make appropriate referrals. A total of 52,622 individuals were referred to various services during the course of the reporting period. Table 10 shows regional distribution of individuals referred for various care and support services, disaggregated by gender.

**Table 10. Regional Distribution of Clients Referred for Various Care and Support Services**

Region	Male	Female	Total
Addis Ababa	1,968	3,005	4,973
Amhara	4,357	10,041	14,398
Oromia	5,767	6,299	12,066
SNNPR	623	936	1,559
Tigray	10,495	9,131	19,626
<b>Total</b>	<b>23,210</b>	<b>29,412</b>	<b>52,622</b>

While the KOOWs have been able to document the number of individuals referred for various services, it has been difficult to verify the actual provision of services. HCSP is therefore working to strengthen the referral system to be able to track referrals to and from service providers. The case managers placed at the facility level will play an important role in this regard. A revised referral slip with a tear-off feedback section was distributed to KOOWs.

KOOWs also play an important role in mobilizing communities for VCT. In this reporting period, KOOWs mobilized a total of 165,910 individuals (M=84061, F=81849) for VCT in all HCSP-supported regions.

#### **2.3.3.4 ART and TB DOTS Adherence Support and Tracing of Patients Lost to Follow-Up**

In the reporting period, 20,079 patients on either ART or TB DOTS with poor adherence have been traced and restarted on treatment, and subsequently provided adherence support. Table 11 shows sex-disaggregated regional distribution of traced patients. In PY 1, KOOWs used their own HIV-positive and PLWHA networks to identify patients with poor adherence and provided them with adherence counseling and support. This mechanism was further strengthened in PY 2 through directly linking KOOWs to case managers who have developed a coordinated system of tracing poor adherent and lost to follow-up cases. Typically, case managers meet weekly with KOOWs for update on lost to follow-up cases.

**Table 11. Regional Distribution of Patients with Poor Adherence (for ART or TB DOTS) who were Traced and Given Adherence Support by KOOWs**

<b>Region</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
Addis Ababa	510	732	1242
Amhara	516	711	1,227
Oromia	1,456	1,551	3,007
SNNPR	419	478	897
Tigray	6,462	7,244	13,706
<b>Total</b>	<b>9,363</b>	<b>10,716</b>	<b>20,079</b>

Community core groups have been instrumental in promoting treatment adherence by mobilizing monetary resources to help potential defaulters to keep their appointments. While this is happening in a few cases, transport to health centers is still a challenge. CCGs members in Addis Ababa have indicated that incorporating income-generating activities in the program would alleviate this problem. Supervisory visits conducted in Addis Ababa during the reporting period revealed that, while KOOWs have managed to provide adherence support to clients on ART, food insecurity continues to be a major challenge in the homes. CCGs have also managed to successfully link a few potential defaulters to food-support centers. Where possible, community members, including KOOWs, contribute food from their own homes to assist food-insecure households. It is hoped that both food and livelihood situations will improve through collaboration with the World Food Program (WFP), Land-o-Lakes, and the Urban Gardens Project (see section 2.3.4).

#### **2.3.4 Monitoring and Quality Assurance of Care and Support Activities**

The care and support and monitoring and evaluation (M&E) teams reviewed and modified KOOWs' reporting formats, which were developed in PY 1. This exercise was instituted to make sure the tools are simpler and easy to use. The revised tools will also minimize the problem of

double counting individuals who receive multiple services. It will also be possible to show how many clients are receiving treatment services from the local health centers that are served by the kebele where KOOWs have been deployed to date. This will make it easier to track both clinical and nonclinical services provided to individuals. Currently, there are people on ART who prefer to get treatment at the hospitals for various reasons, including stigma and scarcity of OI drugs at the health centers. This was confirmed through focus group discussions with a group of women on ART in Addis Ababa. It is evident that KOOWs are providing care and support services to the infected and affected households. What is not so obvious, however, is the quality of services provided and the impact on the beneficiaries' quality of life. With this in mind, the care and support team is currently designing simple care and support standards and quality indicators to monitor the quality of services over time. Program personnel continued with monthly supportive supervision of community mobilizers who have weekly contact with the KOOWs. At the kebele level, HIV/AIDS desk and health extension workers meet with the KOOWs biweekly to monitor progress and tackle challenges. Once a month, KOOWs meet with community core groups for reporting and planning of the next month's activities. While there are set times for regular meetings, KOOWs can contact any of the support persons if they need immediate assistance. For example, KOOWs would contact kebele HIV/AIDS desk officers if they come across bed-ridden patients needing immediate medical attention. While every effort was made to effectively monitor program activities, there were some drawbacks. The quarterly peer review meetings that had been scheduled for the first half of PY 2 were not conducted due to budgetary constraints. Findings from HCSP internal midterm review meeting, however, indicated that these meetings were crucial in fostering linkages between health center- and community-based care and support mechanisms. These meetings also served as a platform for sharing experiences and accorded program staff a chance to collect and verify data directly from the KOOWs. A decision was made, therefore, to conduct two meetings in the next reporting period.

## **2.4. Result 4: Implementation of HIV-Prevention Activities Using Best-Practice ABC Interventions Incorporating Stigma, Discrimination, and Gender Concerns**

### **2.4.1 Recruitment and Deployment of Community Mobilization and BCC Professionals**

In the first year of HCSP, one regional coordinator was responsible for the coordination of regional prevention, community mobilization, and care and support activities. Based on the direction given by USAID to HCSP, two regional positions have been created for prevention and another for care and support in each of the regional offices. The previous prevention and community mobilization coordinators working in SNNPR, Oromia, and Amhara have been retained as behavior change coordination (BCC) coordinators. The remaining two posts, in Addis Ababa and Tigray, have been advertised and BCC coordinators for Addis Ababa and Tigray recruited; they started work during the reporting period. Two BCC consultants have been recruited for six months, with possible extensions upon performance evaluation. Based on their performance evaluation, the contract has been extended for an additional three months to ramp up pending activities.

## 2.4.2 Training-Related Activities under the Prevention Component

Training is a tool for enhancing demand for and increasing access to comprehensive HIV & AIDS prevention, care, and treatment services. A number of trainings have been planned and conducted, therefore, under the prevention component on AB (Abstinence, Being faithful) and other prevention (OP) strategies for community elders and religious leaders, school communities, woreda HIV & AIDS desk officers, HEWs and community mobilizers, KOOWs, and infection prevention practices for heads of health centers and other HCs staff. The trainings were conducted with full involvement of RHBs and HAPCO. Resource materials used for the trainings were standardized technical materials from HAPCO and both PEPFAR and non-PEPFAR partners. During the current reporting, trainings were conducted as follows:

- In collaboration with Amhara and Addis Ababa education bureaus and RHAPCOs, 121 individuals (M=106, F=15), from school directors, teachers, parents-teachers associations, and anti-AIDS club student leaders, received training on AB. At the end of the training, trainees developed a rollout plan and mechanisms for follow-up and performance reporting were established.
- In collaboration with HCSP's care and support team and RHB/HAPCO of each region, training of trainers (TOT) was conducted for 130 (M=112, F=18) woreda HIV/AIDS desk officers and community mobilizers, aimed at enhancing the HIV & AIDS prevention strategies and strengthening the Community Action Cycle as well as follow-up of the implementation of the strategies. At the end of the training session, trainees had developed a rollout plan.
- In collaboration with care and support team and RHAPCO, training on HIV prevention strategies was given for 1,283 HEWs, community mobilizers, and KOOWs, focusing on networking referral linkages and other prevention strategies. By the end of PY 2, HCSP is expected to train a total of 3,223 individuals.
- In collaboration with the Oromia health bureau, TOT on infection prevention, referral linkages, interpersonal communication, stigma, and discrimination was given for 92 heads of health centers. The objective of the TOT was to enhance knowledge and skills of the trainees to help establish and institutionalize IP and anti-stigma plans in the ART health centers and roll out the training to health professionals working in the HCs. By the end of PY 2, 500 HCs heads in the target regions are expected to be trained.
- Preparation is under way for the training of 240 community elders and religious leaders to promote comprehensive HIV & AIDS AB strategies. The training will be conducted by EIFDDA as part of its contractual agreement, and the prevention team will collaborate and assist during its implementation.

## 2.4.3 BCC Materials for Adaptation/Development, Production, and Distribution

During the reporting period, regional HCSP offices distributed BCC materials sent from the central level to the health centers under HCSP support and their catchments areas. The materials were disseminated through KOOWs, clinical mentors, community mobilizers, BCC and

community mobilization coordinators, and during supportive supervision. HCSP has distributed more than 22,500 various types of BCC and other promotional materials produced by FHAPCO/ARC, focusing on nutrition and HIV & AIDS/TB to the regions, health facilities, and community under HCSP's support.

Planned and approved BCC materials to be adapted or developed in PY 2 have been identified and assessed for technical compliance and alignment with project contractual issues. The following BCC materials are technically cleared by USAID and the process of reprinting is under way.

- Brochures on PMTCT, ART, and condom promotion
- Leaflet on positive living
- Brochure on PMTCT targeting males
- Brochure on community-level TB screening
- Informational billboard on services offered at the health center level
- Various types of job aids

HCSP has also adapted, reprinted, and distributed BCC materials developed and produced by ARC to the regions HCSP is supporting. Table 12 shows the types and amount of materials reproduced and distributed to regions.

**Table 12. Types and Amount of Reproduced and Distributed BCC Materials**

No.	Topic/Title	No. Copies printed	Regional Distribution					
			Addis Ababa	Amhara	Oromia	Tigray	SNNPR	Others
1	IPC/Counseling Skills	450	51	102	115	51	101	30
2	Advantages of ART	120,000	8,751	32,502	36,515	16,251	25,001	980
3	Positive Living	120,000	8,751	32,502	36,515	16,251	25,001	980
4	Opportunistic Infections	120,000	8,751	32,502	36,515	16,251	25,001	980
5	Community Care Providers	120,000	9,001	33,002	35,115	16,501	26,001	380
6	Stages of HIV	120,000	10,001	30,002	36,015	15,001	25,001	3,980
7	End of Life	120,000	10,001	30,002	36,015	15,001	25,001	3,980
8	CD4 Count	120,000	10,001	30,002	32,015	20,001	20,001	7,980
9	Risky Behaviors	120,000	10,001	32,502	35,515	15,001	25,001	1,980
	<b>Total</b>	<b>960,000</b>	<b>75,309</b>	<b>253,118</b>	<b>284,335</b>	<b>130,309</b>	<b>196,109</b>	<b>21,270</b>

To ensure the appropriate distribution and use of the materials, a guideline on usage, delivery, and follow-up was developed and distributed to all regions. The regions, in turn have distributed the materials to health centers, communities, and relevant partners.

#### 2.4.4 Rollout Performance and Number of Individuals Reached with AB and Beyond AB Messages

During the reporting period, religious leaders, community elders, PLWHA associations, KOOWs, and other community groups mobilized the public on gender, VCT, stigma and discrimination, ABC (abstinence, be faithful, condom use) prevention, and more. The total number of individuals reached with AB and OP messages is shown in Table 13.

**Table 13. Regional Distribution of Individuals Reached with AB and Beyond AB Messages through Rollout Performance Strategy**

Region	No. Reached with AB			No. Reached with OP			No. Reached with AB and OP		
	M	F	Total	M	F	Total	M	F	Total
Addis Ababa	5,864	10,907	16,771	7,373	10,585	17,958	13,237	21,492	34,729
Amhara	122,031	162,545	284,576	134,487	97,806	232,293	256,518	260,351	516,869
Oromia	45,503	46,885	92,388	43,147	28,107	71,254	88,650	74,992	163,642
SNNPR	40,020	33,090	73,110	25,871	29,124	54,995	65,891	62,214	128,105
Tigray	71,814	83,643	155,457	95,158	96,939	192,097	166,972	180,582	347,554
<b>Total</b>	<b>285,232</b>	<b>337,070</b>	<b>622,302</b>	<b>306,036</b>	<b>262,561</b>	<b>568,597</b>	<b>591,268</b>	<b>599,631</b>	<b>1,190,899</b>

#### 2.4.5 2008 World AIDS Day Commemoration Events Supported by HCSP

The HIV/AIDS Care and Support Program commemorated the 2008 World AIDS Day in collaboration with FHAPCO, Regional Health Bureaus, and other partners with the theme “Lead, Empower, Deliver” to support the government’s efforts and commitment to achieve its objective. Campaigns were conducted at the national and regional levels, in the form of candle lighting, mass gatherings, panel discussions, advocacy workshops, a mobilization workshop, VCT campaigns, parades with different prevention messages, a photography exhibit, cultural and religious ceremonies, art and drama shows, and various sport events.

All these World AIDS Day events helped HCSP to reach a large number of people with the campaign messages, encourage leaders for commitment, mobilize the community for HCT, create linkage with facilities, and gain support for orphans. An estimated 1,200,000 individuals were reached with AB and OP messages during these World AIDS Day 2008 events. The events also garnered extensive media coverage, through which we believe the public at large was sensitized.

At the national level, World AIDS Day 2008 was observed under the given theme “Leadership” in Oromia, North Showa Zone, in a town called Fiche, on November 21, 2008. More than 40,000 people from nearby towns and villages attended the World AIDS Day event and participated in various cultural and religious ceremonies. With the financial support of HCSP, a total of 60,000 copies of posters depicting the portrait of the Prime Minister with the key message “Stop AIDS with Committed Leadership” produced in the Amharic and Oromiffa languages were developed and distributed. Two other posters on leadership messages focusing on OVC and community conversation were also printed and distributed on the occasion.

At the regional level, World AIDS Day 2008 was commemorated with a variety of colorful programs in collaboration with National Regional States of Amhara, Oromia, SNNPR, Tigray, and Addis Ababa City Administration, as well as with EIFDDA.

Oromia commemorated the occasion with sensitization of the community using mobile vans, a candle-lighting ceremony in memory of people who died of AIDS, marching bands, cultural shows, public gatherings, a VCT campaign, and sensitization programs at a Kulubi St Gabriel religious event.

In Tigray, World AIDS Day was commemorated in the historic city of Axum in connection with the annual religious celebration of Axum Hidar Tsion Mariam, which more than 100,000 pilgrims attended. HCSP collaborated with the regional HAPCO and Axum town health office with technical and financial support for community mobilization activities, a VCT campaign, and production of leaflets, posters, and banners.

The Amhara Regional State, in collaboration with HCSP, observed World AIDS Day campaign at Bahir Dar town, the regional capital. The major events included a VCT campaign, panel discussion, production and distribution of flyers, a new billboard, a photography exhibit, orphan support, sport events, and an art contest. Overall, more than 120,000 people have been reached with the campaign messages.

HCSP also commemorated World AIDS Day in collaboration with Addis Ababa HAPCO. An advocacy workshop was held at Addis Ababa City Administration cultural hall, where a total of 600 people drawn from various governmental and nongovernmental organizations, media professionals, PLWHA associations, idir leaders, and NGO and FBO representatives were in attendance. A fact sheet depicting the status of HIV & AIDS in Addis Ababa and nationally was produced and distributed to the subcities, kebele, health facilities, partners, CBOs, and FBOs, and banners with leadership messages were developed and displayed in 22 high-traffic streets in all the subcities.

SNNPR celebrated World AIDS Day by organizing an advocacy workshop at Awassa town, where regional, zonal and woreda government officials, leaders of CBOs, partners working on HIV/AIDS Prevention and Control Programs in the region, representatives of PLWHA associations, and sector offices HIV focal persons were in attendance.

EIFDDA, in collaboration with HCSP, commemorated World AIDS Day events by organizing a one-day advocacy and sensitization meeting for high-level religious leaders drawn from the

Ethiopian Orthodox, Ethiopian Catholic, and Evangelical Mekane-Yesus churches as well as the Islamic Supreme Council in Addis Ababa. It was an occasion for religious leaders from all denominations to come together and renew their commitment in the fight against HIV & AIDS. More than 250 participants attended, with all participants pledging their commitment to taking the issue to their respective congregation and followers. They all agreed to address the issues of OVC, care and support ,and rampant stigma and discrimination.



***HIV & AIDS sensitization campaign at Kulubi St. Gabriel Church***

In conclusion, the World AIDS Day 2008 campaign enabled HCSP to convey messages in the fight for HIV & AIDS prevention, care and support programs, mobilizing the community for VCT, support for orphans, identifying challenges and seeking solutions, and enhancing strong leadership and commitment. It has also helped to enhance the commitments of religious leaders in their role in the fight against HIV & AIDS.

HCSP has played a crucial role to help meet these objectives. It is expected that the results of the campaign will yield positive effects in achieving deliverables linked to HIV & AIDS prevention, treatment, and care and support programs.



*A sample of temporary VCT centers in a tent at a public gathering*

A total of 276,895 different types of BCC materials, mainly with leadership messages, were distributed during World AIDS Day 2008 events.

During the VCT campaigns at the Kulubi and Axum annual religious events, a total of 2,750 (M=2080, F=670) individuals were counseled, tested, and received their results and 48 (1.7 percent) individuals were found to be positive for HIV. All HIV-positive individuals identified were linked to care/treatment centers.

#### **2.4.6 Assessment of Existing BCC Materials for Adaptation and Qualitative Study on BCC Needs Linked to ART Services at the Health Center Level**

Local consultants have been hired to conduct a formative study on existing BCC print and electronic materials for timeliness and appropriateness for adaptation or adoption; and to conduct a qualitative study on the BCC needs linked to ART services at the health center level. The main aim of the studies was to make an informed decision on the existing BCC materials either for adaptation/adoption or development for the scale-up of ART and prevention activities. This activity was started in PY 1 and carried over and finalized during the first quarter of PY 2. Findings showed that there is shortage of BCC materials: either they are not available at health facilities or, if available, they are either outdated or not used properly. The other finding was that there is high level of need for BCC materials related to ART services. Based on the findings and recommendations made, HCSP is planning to address the gaps, in collaboration with other stakeholders.

#### **2.4.7 Assessment of the Sources of Condom Supply and Distribution**

HCSP is expected to ensure availability of condoms in the health facilities and other outlets at the community level. Accordingly, a brief assessment was conducted of condom supply, availability, and distribution system at the national, regional, and facility levels. The assessment revealed that, at the national level, FMOH/FHAPCO either purchases condoms or receives donations from partners and then distributes them upon request to the regional health bureaus, which in turn distribute condoms to the health facilities on regular basis. Visits made to RHBs and health centers showed condoms are available and used in all service areas, and a regular replenishment mechanism exists from the RHBs and organizations working in the area of HIV prevention and reproductive health services. HCSP is working with the RHBs to ensure that condoms are supplied and always available in the health centers and are being supplied to the clients in a sustainable manner.

#### **2.4.8 Monitoring and Evaluation of Prevention Activities**

During the reporting period, extensive supportive supervision visits were conducted in the Oromia, Addis Ababa, and Tigray program regions to render technical support on prevention activities at health centers and the communities and find solutions to challenges identified during the visits. Ongoing prevention activities were observed and discussed with relevant technical staff, KOOWS, community mobilizers, and health officials. At the end of each visit, debriefing meetings were held with the technical staff and respective regional officials. Prevention team members regularly participate in the National HIV Advisory Committee on Social Mobilization, the PEPFAR Prevention Partners Retreat, and the PEPFAR Care & Support, Treatment, and Lab Partners Retreat, and they incorporate recommendations coming out of the meetings in daily implementation of prevention activities.

### **3. Implementation Modalities**

#### **3.1 Health Systems/Network Strengthening**

Health Systems/Network Strengthening (HSS) is one of the technical components included in the HCSP to contribute to the rapid scale-up of HIV & AIDS activities via a strengthened ART network. This component addresses strengthening the health systems at the central, regional, woreda, and health center levels through a variety of technical interventions. The major interventions in this component include performance-based financing (PBF), the Fully Functional Service Delivery Point (FFSDP) tool, Management and Leadership (M&L), laboratory services strengthening, and human resources development. In implementing these technical interventions, the health systems strengthening component will focus on building the capacity of the public sector at the national, regional and woreda health offices so that they can better manage and lead the health services at all levels. In addition, the health systems strengthening component has been coordinating four technical working groups working on alleviating shortages and facilitating consistent supply of laboratory supplies in health centers; soliciting sustained solutions to reduce shortages of OI drugs in health facilities; reviewing and strengthening referral system to conform with the existing network model; and developing

sustainability and phase-out plans. The working groups for the laboratory supply and OI drugs are made up of members from SCMS, SPS, and HCSP, and the last two working groups are made up of team leaders and other HCSP staff. Accordingly, the activities mentioned below have been performed during the quarter.

### **3.1.1 Hiring of Appropriate Staff**

A logistics advisor was hired and started work with HCSP as well as SPS as of September 15, 2008. A local consultant (a health economist) was hired and seconded to FMOH to support the design of PBF and its implementation in the public sector.

### **3.1.2 Referral System and Related Services in HCs**

This intervention area has two major activities: review of existing referral system formats and adaptation of revised referral system after approval. During the first quarter, a referral system study proposal was developed. Accordingly, the team started to gather information about the current referral flow at HCSP-supported ART HCs. So far, six health centers in Addis Ababa have been covered. This activity will continue in Addis Ababa and in the other four supported regions.

### **3.1.3 Design of the PBF Process for the Public Sector (FMOH/FHAPCO)**

The design of the PBC process for the public sector was pending during the PY 1 implementation and has started in this reporting period with the FMOH/Planning and Programming Department (PPD). HCSP recruited a local consultant (a health economist) to join the FMOH/PPD to work in the PBF unit. STTA from the MSH Cambridge head office was provided for one month to support the FMOH in finalizing the PBF strategy, drafting contracts, and developing the costing strategy. The local consultant is seconded to the FMOH/PPD for at least one year. The team attended the health sector development program annual review meeting in October 2008, where the FMOH's PBF strategy was unveiled to the regions. The next step is to design and develop the training manual and plan for TOTs during the coming quarter. We will also continue to provide STTA in finalizing the manuals and the contracts.

### **3.1.4 Performance-Based Contracts with the Private Sector**

#### **3.1.4.1 Training**

MSH submitted a request for consent to subcontract with Bethezatha, Inc., on training in logistics coordination to USAID, and is still awaiting approval. The selected contractor assisted in undertaking several trainings to date.

#### **3.1.4.2 Prevention and Care & Support**

Final scopes of work and budgets have been completed with the three organizations selected for award pursuant to the issuance of an RFP for home-based care services. But the final award is pending the finalization of the realignment and approval of the PY 2 work plan. The three NGOs are the following:

1. National Network of Positive Women Ethiopia (NNPWE)

2. Relief Society of Tigray (REST)
3. IMPACT Association for Social Services and Development (IMPACT)

#### **3.1.4.3 Home & Community-Based Care**

A non-competitive RFP for Home & Community-Based Care was sent to Hiwot HIV/AIDS Prevention, Care & Support Organization (HAPSCO) pursuant to a directive from USAID to ensure continuity of PLWHA services previously financed by USAID under FHI. All four requests for consent have been finalized and will be submitted to USAID for approval.

#### **3.1.4.4 Memorandum of Understanding**

HCSP is committed to working in close collaboration with PEPFAR and non-PEPFAR implementing partners to maximize the quality of services being provided to the beneficiaries. MOUs have been the mechanism through which HCSP collaborates with partners, including governmental and nongovernmental organizations. The following MOUs have been processed and signed:

- World Food Program (WFP): HCSP and WFP have signed an MOU whereby the HCSP health network will link with WFP to distribute food for the needy individuals and families.
- William J. Clinton Foundation (WJCF): A draft MOU with the WJCF for collaboration in the Amhara Region has been reviewed and is being finalized. It will be sent to USAID for review and comment.
- The regions and Addis Ababa City Administration: MOUs have been drafted and are being finalized.
- Ethiopian Management Institute (EMI): HCSP has finalized a draft MOU with EMI and is awaiting concurrence from EMI's management. This MOU is for EMI to assist HCSP with the scaling up of leadership training to the regions.

#### **3.1.4.5 Pre-Award Audits**

HCSP usually undertakes pre-award audits of subcontractors and local NGOs and CSOs before awarding subcontracts. The audit firm of Getachew Kassaye & Co. has undertaken the pre-award assessments of the following subcontractors in the last quarter:

- National Network of Positive Women Ethiopia (NNPWE)
- Relief Society of Tigray (REST)
- Dawn of Hope Ethiopia (DOHE)
- Hiwot HIV/AIDS Prevention, Care & Support Organization (HAPSCO)
- Ethiopian Inter-faith Forum for Development Dialogue and Action (EIFDDA)

DOHE and EIFDDA were already approved as subcontractors by USAID and have been issued subcontract agreements. The others (NNPWE, REST, IMPACT, and HAPSCO) will be submitted to USAID to request consent to subcontract.

### 3.1.4.6 Other Activities under the Contracts Unit

The contract unit continues to process the VAT exemptions for reimbursement to USAID. The unit has also started compiling the report which is required annually by USAID to track this expenditure. The unit was involved in preparing MOUs and reviewing budgets for organizations that requested that HCSP provide financial support to their activities to celebrate World AIDS Day in Ethiopia. Training was held on December 9, 2008, for subcontractors Dawn of Hope, EIFDDA, and Getachew Kassaye on USAID contracts rules and regulations. A second session for the new subcontractors is scheduled for January 2008. The contract unit provides support in tracking outstanding advances, invoice approvals, and completion of contract and work plan budgets.

### 3.1.5 Implementation of the Fully Functional Service Delivery Point Tool

During the implementation of PY 1, a pilot test was conducted to adapt the FFSDP tool to the Ethiopian context. As a follow-up, a second round assessment was conducted and reported for the 29 HCs. One health center (Kolfe) in Addis Ababa was under renovation by the sub city administration during the implementation period. A preliminary data analysis of the 29 HCs was prepared for discussion following the completion of the FFSDP second round assessment with STTA from MSH Cambridge. The STTA team has prepared and submitted a trip report. This report was presented to USAID by the STTA and FFSDP team. The FFSDP draft action plans for PY 2 were distributed to the regions for finalization and follow-up implementation.

The FFSDP team accomplished the following activities during the reporting period:

- ***Participated in the national TWG led by FHAPCO to develop a national quality improvement and assurance framework for HIV & AIDS services.*** The TWG holds its regular meetings fortnightly at FHAPCO. During the reporting period the TWG held five meetings and at each, stakeholders presented their progress reports on implementation of quality improvement tools and deliberated on other relevant issues. The FFSDP team has attended all the meetings and contributed its share.
- ***Developed the educational component of FFSDP.*** This is a 36-page document meant for health workers, health service managers at the woreda, zonal, and regional levels, and FFSDP trainers and experts. The document explains the minimum requirements for a health center–level quality standards, specification of materials needed, and strategies for achieving the minimum requirements and other issues. The document will be used in the forthcoming trainings for woreda and zonal health offices and selected health centers from the five regions, as per HCSP PY 2 work plan.
- ***Prepared a guideline for the FFSDP tool.*** This is a user manual for all implementers of FFSDP. It describes every question in the assessment tool and gives guidance about the scoring system. This guideline is also one of the materials to be used for FFSDP scale-up and distributed to the beneficiaries.
- ***Prepared a budget breakdown for FFSDP scale-up.*** The proposed budget breakdown is meant for training of woreda and zonal HIV & AIDS experts from 300 health centers, but revisions will be made based on the revised PY 2 plan.

- **Disseminated FFSDP pilot results.** A national workshop was held at Adama town December 8–13, 2008, to disseminate the results of pilot tests of quality improvement tools implemented by various organizations working in the area of health services quality improvement. The workshop was organized by FHAPCO, with 51 participants from governmental and nongovernmental organizations in attendance. The FFSDP team had poster and oral presentations. Experiences of the best-performing HCs were shared.

### **3.1.6 Management and Leadership Training**

A capacity-building plan for the central, regional, and woreda levels was developed to start implementation during the first quarter of PY 2, with training to be piloted in Tigray. Meanwhile, important sections of the MSH manual *Managers Who Lead* were translated into Amharic. This was to be used to train woreda-level managers.

The Ethiopian Management Institute (EMI) was approached to work on implementation of the Leadership Development Program (LDP) with HCSP, and a draft MOU was prepared and sent to EMI for comment. However, EMI requested HCSP to obtain prior permission from the FMOH before it would agree to participate in program. While HCSP was preparing to carry out EMI's request, HCSP was informed that there was no budget allocated for LDP in PY 2 and at present the entire exercise is halted.

### **3.1.7 Human Resources Development**

A 45 percent staff vacancy rate at the health center level will deter expansion of HIV & AIDS services and improvement in quality of all services. So this component is designed to help the FMOH address staffing issues. One approach indicated in the PY 2 work plan is to introduce some types of incentives to motivate the workforce in the health centers and other echelons in the health system. During the semiannual period, the health systems strengthening team has developed and submitted proposals to HCSP management. In addition, a summary of the recognition guideline was prepared in Amharic and English versions and a recognition certificate prepared and presented for endorsement. A proposal was made for a staff attrition survey, and a questionnaire was developed and produced. The implementation of these approaches awaits budget and work plan realignment.

### **3.1.8 Strengthening Laboratory Services in Targeted Health Centers Providing HIV & AIDS-Related Services**

The recruitment process for seven laboratory services program officers was accomplished during the first quarter of PY 2; however, hiring has been delayed pending the realignment and approval of the PY 2 work plan.

HC laboratory standards have been incorporated into the FFSDP tool, and the laboratories in the 30 pilot-tested HCs have been addressed. Other activities include the finalization and submission of the laboratory needs assessment report, and preparation and submission of the TB CAP APA4 work plan. HCSP took the lead in the revision/adaptation of SOPs for the new algorithm of the

HIV rapid test that has been endorsed by the Ethiopian Health and Nutrition Research Institute (EHNRI).

The MSH Ethiopia Management Team (comprised of country staff of HCSP, SPS, and SCMS) established a laboratory supply technical working group (LS TWG) in early July 2008 to look into the issues of laboratory supply to the health facilities. The health systems strengthening team provided coordination for the working group. The LS TWG created short- and long-term work plans. Based on the work plans, it has been holding regular meetings to address a number of important activities. The following activities have been accomplished by the TWG during the reporting period:

- ***Follow-up of the procurement of laboratory supplies to address current shortages of laboratory supplies at health centers.*** All necessary procurement procedures have been completed and the go-ahead from USAID for delivery of supplies by winning bidders is awaited.
- ***Development and field testing of the comprehensive laboratory assessment tool.*** The assessment tool was revised and finalized after the field test, and will be used to assess health center laboratories. Findings will be used in planning and implementation of the LS TWG long-term work plan, which is aimed at introducing/strengthening a consistent laboratory supply management system.
- ***Visits to the five project areas (Amahara, Oromia, SNNPR, and Tigray regions and Addis Ababa).*** The purpose was to discuss laboratory needs with stakeholders at the regional level to better understand inputs made by the stakeholders in the area of laboratory supply to health facilities. Earlier, the central MSH Ethiopia Management Team had instructed the regional MSH Management Teams to work toward this objective at the regional level. During the visits the LS TWG members met with members of the regional MSH Management Teams, regional health bureaus, regional PFSA hubs, and regional laboratories.

After the visits, the following action points were recommended:

1. Introduce delivery of laboratory supplies to health facilities directly from the regional PFSA hubs.
2. Build capacity of the health centers through training of laboratory personnel at health centers.
3. Introduce and/or strengthen inventory control management at the health facilities.
4. Improve the capacity of regional laboratories, in terms of human resources, institutional capacity, etc., to enable them to support the health center laboratories.
5. Provide technical assistance to support regional and health center laboratory services.

During the reporting period, training on comprehensive laboratory services was conducted in Addis Ababa, and in the Amhara and Tigray regions. So far, a total of 174 laboratory technicians from ART HCs have been trained. Training components include HIV, TB, malaria, DBS specimen collection and transportation, infection prevention, inventory control, and professional ethics. Trainees were assessed in terms of both their theoretical and practical skills at the beginning as well as at the end of the training. During the trainings, more focus was given to practical components to help improve the basic practical skills of the lab personnel. In the Oromia region, 80 lab personnel were trained on DBS. All the trainings have been conducted in collaboration with the treatment teams in the regions.

As a stopgap measure, HCSP has a plan to purchase basic laboratory supplies to ensure regular laboratory service at the facilities. As a result, a list of laboratory supplies that are usually missing and that would affect the service were prepared and forwarded for procurement. HCSP participated in a five-day national TOT program for TB-smear microscopy and external quality assurance held in Hawassa, SNNPR, October 6–10, 2008.

### **3.1.9 Strengthening the Logistics System**

A logistics system advisor was hired and started work as of September 15, 2008. Because there was no logistics advisor until the last two weeks of the first quarter, not much work on logistics was accomplished. However, logistics activities such as addressing the shortage in OI drugs and lab supplies were undertaken in collaboration with RPM Plus/SPS and SCMS, and a TWG was established specifically to deal with OI drug supply. Since its establishment at the end of August 2008, this TWG has managed to mobilize the distribution of OI drugs from FMOH central stores and regional stores directly to sites through negotiation with the responsible department (PSLD) at the FMOH. MSH has supported the regions in transportation and other related expenses. Next, the TWG for OI drugs will be engaged in long-term activities to improve the delivery of OI drugs to sites. The logistics advisor is now a member of the OI drugs TWG.

Members of the OI TWG have actively participated in the preparation and coordination of the national comprehensive quantification of drug needs, which included OI drugs. Furthermore, the group has facilitated the distribution of twenty of the forty-five OI drugs in the pipeline and received during the reporting period. These drugs have been sent out directly to health facilities as agreed with the FMOH. Efforts are also being made to integrate the distribution of OI drugs procured through different partners with the delivery of antiretroviral drugs. The OI TWG has also looked into the reporting system at the facilities on the use of OI drugs. The reporting system was earlier introduced by RPM Plus/SPS. Nevertheless, the group has, during its deliberations, identified the need to strengthen the reporting system. The group has revised the dispensing register for OI drugs, which is ready for printing and will be distributed to health facilities soon.

To identify the strengths and weaknesses of inventory control systems at the health centers, an inventory control assessment tool was developed and applied in three HCs in the Amhara region and four HCs in Addis Ababa. Assessment visits to HCs will continue in Addis Ababa and other regions to identify weaknesses and eventually apply solutions for sustained implementation of an inventory control system.

### **3.1.10 Sustainability and Exit Plan**

The MSH/HCSPP sustainability and exit plan would have a number of important elements, all of which would reinforce one another, to ensure that nationwide delivery of HIV & AIDS services at all levels will continue at the end of the program. In the current reporting period, HCSPP management recently established a technical committee composed of team leaders. Each team member will identify and prioritize activities to be transitioned, develop an exit plan, and start contacting relevant FMOH and RHB units. The exercise is under way, with coordination from the HSS team.

Sustainability and phase out plans have already been prepared for the technical areas of HCSPP. This includes mentorship and case management, community care and support, prevention, data collection and management, the FFSDP tool, laboratory and logistics support, and the recognition and referral systems. Development of the sustainability and phase-out plan is based on the successive implementation approach, which includes (a) assessing and establishing the status of accomplishments to date, (b) filling gaps identified during assessment, (c) open dialogue for handing over program areas at various levels, and (d) finally, beginning the hand-over process.

It is anticipated to start handing over program elements toward the middle of PY 3, while the readiness for the phase-out process will start as of the third quarter of PY 2. Of course, these processes will not deter earlier handing over of program elements that have matured and are ready before the mid-PY 3.

### **3.2 Mainstream Gender into All HCSPP Activities and Develop NGO Capacity**

This unit has been created, given the importance of mainstreaming a gender focus into all HIV/AIDS Care and Support Program activities and the need to build the capacity of NGOs that will be involved in the PBF process. This team is headed by an advisor and an NGO coordinator to implement activities relevant to gender and NGO capacity building and to integrate them into all HIV/AIDS Care and Support Program activities. Gender has been mainstreamed into all HCSPP supported trainings, and into the harmonization of HCSPP and woreda HIV & AIDS prevention, treatment, and care and support plans. To support HCSPP strategies related to women's and children's health, the gender and NGO capacity-building unit has collaborated closely with the contracts unit of the program to develop an RFP and award subcontracts to NGOs doing gender work.

During this reporting period, HCSPP has been negotiating scopes of work and budgets with the following organizations, selected on a competitive basis: IMPACT, National Network of Positive Women (NNPWE), and the Relief Society of Tigray (REST). HCSPP has conducted a pre-award audit of all the organizations except IMPACT. Recommendations of the audit are being implemented by the NGOs. HCSPP will send all relevant documents for USAID concurrence. Once this process is completed, HCSPP will award the PBF contracts, and implementation of agreed-upon activities will begin.

In addition, HAPSCO, previously funded by FHI, will now receive funding from HCSPP to continue its activities in Addis Ababa. HCSPP is now awaiting USAID budget approval to start

activities with these four NGOs. A summary of the sites and the regions they work in and their activities is listed below.

**IMPACT.** The NGO will implement activities in Oromia and SNNPR. Home-based care providers will be trained and deployed. Their catchment areas include large agro-business areas where there is high migration and high employment. IMPACT will also work on peer education strategy to reach adolescents.

**National Network of Positive Women (NNPWE).** The network will implement activities in Oromia, Addis Ababa, and SNNPR. NNPWE is the largest women's umbrella network of PLWHA women's groups. It will provide home-based care, IGA, capacity building, advocacy, testimonials, and advocacy against gender-based violence. NNPWE will also work with HCSP on mother-to-mother support groups (MSGs).

**REST.** The society will implement activities in Tigray, including training of home-based care providers, integrating its activities with existing the CB reproductive health program, and will build capacity of other NGOs. A major focus of REST will include promotion of PMTCT services through ANC referrals.

**HAPSCO.** The group will implement activities in all ten subcities in Addis Ababa. Activities will include home-based care coordinated by nurse supervisors, building the capacity of idirs, social mobilization, IGA training, linkages, and referrals from HCs to hospitals.

Dawn of Hope and EIFDDA have also submitted their work plans and budget, which have been approved. A pre-award audit has been conducted, and DOHE has finalized work on the recommendations made. This has been closely monitored with the contracts unit of HCSP. The program has held discussions with SCMS for procurement of home-based care kits, which will be distributed to DOHE as well as the NGOs that will receive performance-based contracts. The HCSP contracts team has provided training to EIFDDA and DOHE to comply with USAID contract regulations. On-site technical assistance will be provided to DOHE as it implements its activities. It is important to note that, through HCSP's work with NGOs, capacity building is already ongoing, which will help support the sustainability of program areas. EIFDDA has developed a scope of work with HCSP to train religious leaders and integrate gender as part of their agenda. During this exercise, the HCSP capacity building team has provided extensive technical assistance to the organizations in preparing their SOWs, work plans, and budgets.

EIFDDA, in collaboration with the HIV/AIDS Care and Support Program, organized an event to commemorate World AIDS Day, December 1, 2008, at the United Nations Conference Center, Economic Commission for Africa (ECA), Addis Ababa, Ethiopia. The meeting was attended by senior religious leaders, government officials, and invited guests. EIFDDA has been engaged in the fight against HIV & AIDS, addressing related issues and opening dialogue forums for all religious denominations to reflect and discuss their theological perspectives and views. This meeting was part of the 2008 effort to engage religious institutions on the issues of Stigma, Discrimination, and Denial by promoting open theological reflection and discussion.

In line with the global theme for World AIDS Day, EIFDDA focused on “Leadership” concentrating on slogans such as “Lead, Empower and Deliver.” This event was organized to sensitize the public about HIV prevention and to learn more about the commitment of leaders. EIFDDA believes such dialogues are important to control the epidemic, to eliminate social and economic inequalities and injustices that fuel the spread, and to protect human rights.

### **3.3 Strategic Information and Quality Management**

Activities in this modality include supporting the implementation of the national Health Management Information System (HMIS), ensuring the quality management of HIV/AIDS Care and Support Program activities, including those being implemented through PBF, implementation of Standards-Based Management/Performance Quality Improvement (SBM/PQI) tool, the Fully Functional Service Delivery Point, and training and deployment of data clerks to strengthen the strategic information system at the ART HC level.

During the reporting period, particularly during the first quarter of PY 2, the HCSP PY 2 work plan and the Performance Monitoring Plan (PMP), which are the basis for the monitoring and evaluation of the program activities, were developed and submitted to USAID for review. The USAID technical staff reviewed the draft, and their comments were communicated and discussed with HCSP key staff. After incorporating the comments, HCSP submitted the final version and the work plan was technically approved by USAID in September 2008. But the process of realignment of the work plan continues, reassessing the emphasis on some technical areas such as PMTCT, TB/HIV collaborative activities, and pediatrics care and treatment.

The initial draft work plan was regionalized in a three-day meeting held in Addis Ababa in July 2008. All regional HCSP staff participated.

Facility- and regional-level reporting forms that can capture HIV/AIDS Care and Support Program and PEPFAR data requirements have been developed, pilot-tested, finalized, and implemented in all regions and health facilities supported by the program. Training Information Management System (TIMS) forms are regularly sent to JHPIEGO to be entered into PEPFAR’s database. Data entry into the HIV/AIDS Care and Support Program training and PMP databases is well under way.

The HIV/AIDS Care and Support Program is supporting HCs, woreda health offices, and RHBS in implementing the national HMIS by distributing registers and reporting forms to ensure availability at all times. During the reporting period, 250 PMTCT/ L&D registers, 1,000 ANC/PMTCT registers, 10,000 ANC/PMTCT stickers, and 140,000 ANC, L&D, newborn and postnatal care cards were printed and distributed to the regions. HCSP is coordinating and conducting joint supportive supervisions to support the implementation of the national HMIS. The HCSP regional M&E advisors continued supporting RHB, WHO, and HC staff in using data for decision-making. Data clerk coordinators, together with the regional M&E advisors, clinical mentors, and RHAs closely coach and supervise data clerks to strengthen facility-level HMIS and to promote a culture of evidence based decision-making.

HCSP continued participating in the national TWG to develop one national quality assurance framework for HIV & AIDS services. The program also participates in the PEPFAR strategic information (SI) technical working group and the M&E TWG. The PMP has been updated and sent to USAID, together with the program's semiannual report. The team successfully prepared and submitted the HIV/AIDS Care and Support Program annual report and success stories during the reporting period.

## 4. Challenges

HCSP has had difficulty recruiting and retaining qualified technical staff, especially specialized medical staff such as pediatricians and other medical doctors, to carry out mentoring. The market for trained technical staff is highly competitive. The approved salary for many positions is not sufficient to attract and retain qualified staff. We find that after we have trained our new hires, they become much more valuable to the market, and are therefore able to attract significant salary increases elsewhere. Our contract does not allow us the flexibility to adjust the salaries as required to meet the demands of the labor market.

The following are summary of challenges faced by HCSP:

1. **High staff turnover.** The main reason is the noncompetitive salary scale compared with that of other partners. Those higher-paying employers are attracting experienced personnel from HCSP.
2. **Understaffing.** The regional offices are still understaffed and could not provide the required support to the level needed for the rapid expansion of services.
3. **Mentorship quality.** This is a major challenge, owing to the large number of facilities to be mentored by each mentor, aggravated by the high turnover rate for mentors. The SOC tool that was developed by HCSP to measure service quality was not implemented for the same reason.
4. **Approval delays.** Delays in the approval of the plan and budget meant that the program's was unable to bring the required staff on board; some activities, such as support to the NGOs, have not been started.
5. **Salary disparities.** The difference between annual salary increases and cost-of-living increases has created resentment among MSH staff, and experienced personnel are resigning as a consequence.
6. **Budget gaps.** In general, the program needs more financial resources than are currently available because of the large scope of work. This is being addressed through realignment of the work plans and budgets for the coming years.

## Annexes

Annex 1: Updated Performance Monitoring Plan, PY 2 Semiannual (December 31, 2008)

Annex 2: Success stories

Annex 3: Addis Ababa City Administration HCSP PY 2 Semiannual Report

Annex 4: Amhara Region HCSP PY 2 Semiannual Report

Annex 5: Oromia Region HCSP PY 2 Semiannual Report

Annex 6: SNNPR Region HCSP PY 2 Semiannual Report

Annex 7: Tigray Region HCSP PY 2 Semiannual Report

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