

## **PY2 First Quarterly Report**

---

Ethiopia HIV/AIDS Care and Support Project  
July 1, 2008 – September 30, 2008

This report was made possible through support provided by the US Agency for International Development, under the terms of Contract No. 663-C-00-07-00408-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

---

HIV/AIDS Care and Support Program (HCSP)  
Management Sciences for Health  
784 Memorial Drive  
Cambridge, MA 02139  
Telephone: (617) 250-9500  
[www.msh.org](http://www.msh.org)



**USAID**  
FROM THE AMERICAN PEOPLE

## HIV/AIDS Care and Support Program

# USAID's HIV/AIDS Care and Support Program PY2 First Quarter Report

July 1, 2008 – September 30, 2008

**October 30, 2008**

This report is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this report are the sole responsibility of Management Sciences for Health and do not necessarily reflect the views of USAID or the United States Government.

---

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

---

**July 1 – September 30, 2008**

The views expressed in this publication do not necessarily reflect the views of the US Agency for International Development or the US Government.

## About the 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. Management Sciences for Health (MSH) and its partners have been awarded a contract by the US President's Emergency Plan for AIDS Relief (PEPFAR) and the US Agency for International Development (USAID) to help the GOE rapidly expand coverage of HIV/AIDS services. The HIV/AIDS Care and Support Program is committed to coordinate with all PEPFAR activities to expand comprehensive HIV/AIDS and tuberculosis (TB) diagnostic and treatment services to 550 health centers; of these health centers, 393 will provide the basic HIV/TB services plus symptomatic and palliative care, and 300 will provide a full range of antiretroviral treatment (ART) services. The ART network will foster a smooth 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.

Ethiopia HIV/AIDS Care and Support Project  
Contract/Coop. Agreement No. [663-C-00-07-00408-00]  
Management Sciences for Health  
784 Memorial Drive  
Cambridge, MA 02139  
Telephone: 617-250-9500  
[www.msh.org](http://www.msh.org)

---

### Recommended citation

*Ethiopia HIV/AIDS Care and Support Program: Quarterly Progress Report, July–September, 2008.* Cambridge MA: Ethiopia HIV/AIDS Care and Support program; Management Sciences for Health, 2008.

USAID's Ethiopia HIV/AIDS Care and Support Program Quarterly Progress Report, July 1 – September 30, 2008

## Table of Contents

About the USAID's Ethiopia HIV/AIDS Care and Support Program.....	3
Acronyms .....	6
Executive Summary .....	9
1. Narrative Progress Report on General Activities.....	14
1.1. HIV/AIDS Care and Support Program PY1 Annual Progress Review and PY2 Work Plan Development.....	14
1.2. Results of Activities Related to MSH Ethiopia Operations Platform, MEOP.....	14
2. Progress on Achieving Program Results.....	15
2.1. Result 1: Provision of Quality Integrated HIV/AIDS Prevention, Care and Treatment Services at Health Centers.....	15
2.1.1. Staffing of the Treatment Component .....	15
2.1.2. Expansion of ART Services to New HCs .....	16
2.1.3. PMTCT Sites Transition from IntraHealth to HIV/AIDS Care and Support Program.....	16
2.1.4. Training-Related Activities.....	16
2.1.5. Comprehensive HIV/AIDS Services Provision .....	17
2.1.6. Additional Technical Activities .....	19
2.2. Result 2: Deployment of Case Managers to Support Care and Strengthen Referrals between Health Centers, Hospitals, and Community Services.....	19
2.3. Result 3: Deployment of Volunteer Outreach Workers to Support Family-focused Prevention, Care and Treatment in Communities.....	20
2.3.1. Summary of Achievements: July 1 - to September 30, 2008 .....	20
2.3.2. General Overview .....	20
2.3.3. Staffing status under Result 3 .....	21
2.3.4. Expansion of Kebeles and CCGs Networked with ART HCs.....	22
2.3.5. Training of KOOWs and other community volunteers.....	22
2.3.6. Provision of care and support services and community mobilization for prevention, care and treatment.....	23
2.3.7. Monitoring and Quality Assurance of Care and Support Activities .....	26
2.4. Result 4: Implementation of HIV-Prevention Activities Utilizing Best-Practice ABC Interventions incorporating Stigma, Discrimination and Gender Concerns.....	27
3.4.1. Recruitment and deployment of BCC professionals.....	27
2.4.2. BCC Materials for Adaptation/Development, Production and Distribution....	27
2.4.3. Assessment of existing BCC materials for adaptation and qualitative study on BCC needs linked to ART services at health center levels.....	28
2.4.4. Assessment of the Sources of Condom Supply and Distribution .....	29
2.4.5. Role out performance and number of individuals reached on AB and beyond AB messages.....	29
2.4.6. BCC Activities by Community Group.....	29
3. Implementation Modalities .....	30
3.1. Health Systems/Network Strengthening .....	30
3.1.1. Hire appropriate staff .....	30
3.1.2. Referral System and related services in HCs .....	30

3.1.3 Design of the PBC process for the public sector (FMOH/FHAPCO) .....	30
3.1.4 Performance Based Contracts (PBC) with the private Sector .....	31
3.1.5 Implementation of Performance Improvement Plan (FFSDP) .....	32
3.1.6 Management and Leadership Training .....	32
3.1.7 Human Resource Development (HRD) .....	32
3.1.8 Strengthening Laboratory Services in Targeted Health Centers Providing HIV/AIDS Related Services .....	33
3.1.9 Strengthening Logistics System.....	33
3.1.10 Sustainability and Exit Plan.....	33
3.2 Mainstream Gender into All HCSP activities and Develop NGO Capacity.....	34
3.3 Strategic Information and Quality Management.....	34
4. Challenges.....	36
5. Annexes.....	37

## Acronyms

AB	Abstinence, Being faithful
ABC	Abstinence, Being faithful, Condom use
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Therapy
BCC	Behavior Change Communication
CAC	Community Action Cycle
CAP	Country Assistance Plan
CBO	Community Based Organization
CCG	Community Core Group
CDC	[US] Centers for Disease Control and Prevention
CSO	Civil Society Organization
DOH	Dawn of Hope
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
FHI	Family Health International
FMOH	Federal Ministry of Health
FP	Family Planning
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
HCT	HIV Counseling and Testing
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRD	Human Resource Development
IEC	Information, Education, and Communication
IMAI	Integrated Management of Adolescent and Adult Illness
IMCI	Integrated Management of Childhood Illness
IT	Information Technology
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KOOW	KebeleOriented Outreach Worker

LDP	Leadership Development Program
LTFU	Lost to Follow Up
M&E	Monitoring and Evaluation
MDT	Multi Disciplinary Team
MEOPS	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]
OVC	Orphans and Vulnerable Children
PBC	Performance Based Contract
PPD	Planning and Programming Department
PEP	Post Exposure Prophylaxis
PEPFAR	[US] President's Emergency Plan For AIDS Relief
PITC	Provider Initiated Testing and Counselling
PLWHA	People Living With HIV/AIDS
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PSI	Population service International
PY	Program Year
REST	Relief Society of Tigray
RH	Reproductive Health
RHB	Regional Health Bureau
RFP	Request For Proposal
RPM	Rational Pharmaceutical Management Plus [Program]
Plus	
SCMS	Supply Chain Management System
SI	Strategic Information
SNNPR	Southern Nations and Nationalities Peoples Region
SOW	Scope of work
SPS	Strengthening Pharmaceutical Systems [Program]
STIs	Sexually Transmitted Infections
STTA	Short Term Technical Assistance
TWGs	Technical Working Groups
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
WAD	World AIDS Day
WFP	World Food Program
WHO	World Health Organization
WJCF	William J Clinton Foundation

## Executive Summary

The HIV/AIDS Care and Support Program in Ethiopia was awarded to Management Sciences for Health (MSH) and its partners on June 15, 2007. Since its award, MSH and its implementing partners have embarked upon implementing the planned activities and the program has successfully achieved its first year targets. The results of the first year achievements have been disseminated in a meeting organized at Sheraton Addis on July 9, 2008. During the meeting, key individuals from FMOH, FHAPCO, US Embassy in Addis, the US Agency for International Development (USAID), CDC-Ethiopia and other PEPFAR and Non PEPFAR partners were in attendance. The program has successfully extended ART service to 239 health centers in 4 regions and Addis Ababa, which represents 99.6% achievement of its first year target. The USAID's HIV/AIDS program has continued supporting the existing activities and service expansion to new sites. Results obtained under four key result areas and other implementation modalities are described in more detail below.

**Result 1: Provision of high-quality, integrated HIV/AIDS prevention, care, and treatment services at health centers.** At the end of the HIV/AIDS Care and Support Program's first year, the number of individuals receiving ART services was 22,090 at 239 HCs and this number has dramatically increased to 28,062 by the end of the current reporting period, and about 61% of patients on ART are women. The rate of patients LTFU is about 1.7%, compared to a national average rate of over 20%. The low rate of patients LTFU is an important measure of the quality of support the HIV/AIDS Care and Support Program is providing.

The HIV/AIDS Care and Support Program expanded comprehensive HIV and TB counseling and testing services to 458 health centers. The service has been provided through voluntary counseling and testing (VCT) and Provider Initiated HIV Testing and Counseling (PITC) strategies at facility and community levels, and has resulted in more than 160,473 clients served during the reporting period. The program's interventions have supported 278 HCs in expanding care and support services that are now reaching more than 95,389 individuals. A total of 242 health centers now offer comprehensive ART services.

Trainings have not been provided for health professionals in this reporting period, because the main focus was in prioritizing HCs for new site expansion to meet the PY2 target and assessment of the existing HCs to identify training gaps in different categories. These activities have been already completed and trainings will commence in the second quarter. However, 1,907 individuals selected from all HIV/AIDS Care and Support Program regions received training on National Comprehensive HIV Care/ART and 1,617 health workers who were trained on HIV and TB counseling and testing curricula at the end of the first year continued providing services in the health facilities. The HIV/AIDS Care and Support Program has continued providing technical support to the health centers, including mentorship, multidisciplinary teams (MDTs) and catchment area meetings for ART HCs. The treatment team staff is participating in different 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), Palliative Care, TB/HIV, Prevention of Mother to Child

Transmission (PMTCT), and Sexually Transmitted Infections (STIs). The team also provides technical support to the regions during HCs assessments, and woreda HIV/AIDS plan harmonization, and conducts joint supportive supervision to ensure the quality of services being delivered.

**Result 2: Deployment of case managers to support care and strengthen referrals among health centers, hospitals, and community services.** At the end of HCSP PY1, 232 case managers have been trained and deployed to ART HCs. During the current reporting period, frequent visits and integrated supportive supervisions have been conducted to support these new health cadres to enable them to properly discharge their roles and responsibilities. At present, the case managers are well integrated into the existing system and they are playing a crucial role in adherence counseling, provision of targeted and personalized cares for 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 PY2 a cumulative total number of 393 case managers will be 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 done based on case load and sent out to the regions for endorsement or modification of the plan by the RHBs. In parallel, a total of 217 data clerks have been selected, trained, and deployed to ART HCs during PY1 and these staff are playing critical role in strengthening the national HMIS and Strategic Information. More data clerks will be trained and deployed in new ART HCs. Of the already deployed data clerks, the Oromia region already pays salaries for 54 data clerks using Global Fund resources and 50 are paid through the RPM Plus/SPS project.

**Result 3: Deployment of volunteer outreach workers to support family-focused prevention, care, and treatment in communities.** The 1,402 KOOWs, 85 community mobilizers who were trained, and 270 community core groups that were formed during PY1 continued to sensitize community members and increase their awareness of HIV/AIDS services available at both health centers and in communities. Both prioritization of new kebeles for care and support services expansion and preparation for KOOWs training are well underway, and training materials for KOOWs are being revised. A total of 177,044 individuals were mobilized for prevention, care and treatment through outreach activities; coffee ceremonies being the leading vehicle for mobilization, and home visits. Moreover, 59,566 newly identified individuals affected and infected by HIV/AIDS were provided with care and support services, out of which 18,096 were provided with home based care. KOOWs, together with case managers at the HC level, traced 4,620 individuals who had been lost to follow up to treatment for ART and TB DOTS, and provided them with adherence support in order to minimize subsequent losses. By strengthening referrals and health networking, nearly 12,000 individuals have been referred to health facilities and community level care and support organizations for various care and support services. Nonetheless, the mechanism of getting feedback on referrals has been a challenge. Reporting forms have been revised for simplification and minimizing 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 utilizing best-practice ABC interventions that also address stigma, discrimination, and gender concerns.**

Prevention is one of the key results of the HCSP. Based on best practices and lessons learned from year one implementation, the program is making a concerted effort to scale up best prevention practices. In PY2, different trainings will be conducted for service providers, community elders, religious leaders and other outreach community volunteers to reinforce the prevention program and promote VCT, ART and PMTCT services.

Customization of existing BCC materials will continue in order to address the issues of gender, ART, PMTCT, positive living, TB and condom provision services.

In this quarter, 9 different types of BCC materials specifically addressing PLWHAs and other vulnerable groups have been adapted, reproduced, and a total of 960,450 copies distributed to the regions. These materials will fill gaps for the shortage of BCC materials at both facility and community levels to help create demand 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 assessments were completed and the study results are being reviewed. Another assessment of roles and responsibilities in ensuring regular supply, distribution and availability of condoms in the ART health centers was also carried out. The results of these assessments will inform and further strengthen implementation of BCC activities supported by the HCSP.

#### **Implementation modalities**

**Health Systems/Network Strengthening:** Since its inception, HCSP is committed to strengthen the existing health system and has been implementing a number of innovative interventions in Ethiopia at all levels to address the existing deficiencies in the system 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 the HCSP as well as the RPM Plus project, while the local consultant is hired and seconded to the Federal Ministry of Health (FMOH) to support the design of Performance Based Contracting (PBC) and its implementation in the public sector. STTA was obtained from the MSH head office in Cambridge to work with the FMOH to finalize the PBC strategy, draft contracts and develop the costing strategy. Final scopes of work and budgets with three organizations competitively selected for private sector PBC awards to provide home based care services were finalized, after completion of pre-subcontract audits. 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 done and reported to USAID and FHAPCO with the assistance of STTA from MSH home office. In collaboration with SCMS and RPM Plus and other stake holders, activities to strengthen the logistics and laboratory systems are well underway.

#### **Mainstreaming Gender into all HCSP activities and Strengthening NGO Capacity**

During this quarter, HCSP has been negotiating scopes of work and budgets with the following organizations selected through the PBC: IMPACT, National Network of Positive Women, NNPWE, and Relief Society of Tigray (REST). HCSP has conducted a USAID's Ethiopia HIV/AIDS Care and Support Program Quarterly Progress Report, July 1 – September 30, 2008

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 concurrence early next quarter. Once this process is completed, HCSP will award the PBCs and implementation of agreed upon activities will start.

HAPSCO, previously funded by FHI, will now receive funding from HCSP to continue its activities in Addis Ababa. A SOW and a budget are being finalized. HAPSCO will work in all sub-cities in Addis Ababa.

DOH, which had concluded its three-month funding and activities, is now working on a new plan for 12 months. A work plan and budget have been agreed upon and a sub-grant will be provided for DOH to continue its activities. EIFDDA has developed a scope of work with HCSP to train religious leaders and integrate gender as part of their agenda. During this exercise, HCSP and the Capacity Building team have provided extensive TA to the organizations to prepare their SOW, work plans and budgets.

**Strategic Information and Quality Management:** Activities in this implementation 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 PBCs), implementation of 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 HCs level.

During this quarter, the HCSP PY2 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 work plan and their comments were communicated and discussed with HCSP key staff. HCSP incorporated their comments and submitted the final version. USAID technically approved the PY2 work plan in September 2008. The initial work plan was regionalized in a meeting held for three days in Addis Ababa in July 2008. All regional HCSP staff participated in this meeting.

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 to be entered 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 supervisions to help the implementation of the "Three Ones." The HCSP regional M&E advisors support RHB, WHO, and HC staff to use data for decision-making.

Active participation in the national TWG to develop one national quality assurance framework for HIV/AIDS services and in the PEPFAR Strategic Information (SI) technical working group continued. The PMP has been updated and is submitted USAID together with the program's quarterly report.

**Table 1. Status of Core Targets or Indicators of the HIV/AIDS Care and Support Program (Updated as of September 30, 2008.)**

Types of Activities	Baseline performance as of June 2007	PY1 target	PY1 Performance (as of 30 June 2008)	Targets for PY2	Current Performance (as of Sept, 2008)	Remark
<b>Facilities Assisted</b>						
Number of woreda health offices supported with an HIV/AIDS services plan	0	240	251	290	202	
Number of health centers offering comprehensive HIV and TB counseling and testing services	198	450	398	500	458	
Of which, number of health centers offering enhanced palliative care services	212	267	261	350	278	
Of which, number of health centers offering antiretroviral therapy	115	240	239	300	242	
<b>Individuals Trained</b>						
Number of health providers trained in HIV and TB counseling and testing curriculums	467	1,135	1446	2,500	1,617	
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	1,907	
Number of case managers trained and deployed on IMAI/case manager modules	0	267	232	393	232	
Number of outreach workers trained in community and household HIV prevention, care, and treatment promotion	507	1,335	1402	4,000	1,402	
<b>Kebele and Health Center Performance Standards</b>						
Individuals reached with basic palliative care	79,128	120,000	126, 567	220,000	144,994	
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease	5266	12,000	+ 6360	34,000	7,848	
Individuals counseled and tested for HIV who received their results	265,153	260,000	934,275	350,000	160,473	
Individuals receiving antiretroviral therapy (cumulative)	9,994	15,000	22,090	50,000	28,062	
Number of kebeles with deployed outreach workers that are served by a network health center	0	267	267	800	267	

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

## **1.1. HIV/AIDS Care and Support Program PY1 Annual Progress Review and PY2 Work Plan Development.**

A meeting was organized at Sheraton Addis 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 achievements of the program's first year. During the following 3 days the HCSP central and regional teams reviewed regional performance and developed the PY2 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 PY2 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 PY2 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 PY2 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.

Regional HCSP offices have already initiated the development and harmonization of Woreda work plans, and so far 202 Woredas out of 300 have completed this process. The rest will complete the process in the second quarter.

## **1.2. Results of Activities Related to MSH Ethiopia Operations Platform, MEOP**

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

*Human Resources:* The human resources unit has been supporting HCSP with the recruitment needs, particularly in filling vacant positions as a result of high staff turn over due to mainly low salary scales offered by the HCSP. A number of staffs 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 to the regions. Regional bank accounts have been established. Operating procedures and safeguards are being reinforced to support large disbursements to the regions. Cashiers were also recruited, trained, and deployed to each region during the fourth quarter of PY1. These staff 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. They have 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 sub-regional 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 the HIV/AIDS Care and Support Program. 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 leader resigned in early May 2008, and the team has been led by the Program Director for Integration. In late September, the Clinical Advisor for PMTCT was assigned Acting Treatment Team Leader, pending the placement of the Team Leader who will be leading the team and coordinating its activities. Of the 5 advisory positions that exist in the treatment team, the clinical advisors for IMAI, TB/HIV and PMTCT were filled earlier and team members continued to work actively throughout the quarter. The Pediatric HIV and Palliative Care Advisor positions are still vacant. Individuals selected for these vacant positions either did not accept the salary proposed or did not get USAID approval. The coordinator for case managers went abroad for further studies at the quarter. Recruitment for a replacement is in progress. Since its inception, the program has hired trained and deployed a total of 32 clinical mentors to support the ongoing clinical mentorship program. However, attrition rate of clinical mentors has been very high due to non-competitive salaries offered by HCSP. A proposal to offer a cost of living adjustment was not approved by the USAID contracts' team. In this quarter 10 clinical mentors left the program and joined other partners who offer more competitive salaries. Six of the mentors have been replaced or recruitment for replacement is in progress; 4 Clinical Mentor positions are still vacant.

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

In addition to providing continued support to the 239 ART HCs currently providing comprehensive HIV/AIDS and TB services in PY1, HCSP has planned to expand services to new HCs to achieve the PY2 target of 300 HCs providing ART services. For this purpose, in collaboration with the RHBs, site assessments have been conducted for among HCs providing comprehensive HIV and TB counseling and testing and other palliative care services in four target regions. As a result, 61 HCs were selected for ART service expansion based on patient volume, HIV prevalence and regional preferences. Accordingly, 26 HCs in Amhara, 20 in Oromia, 10 in SNNPR and 5 in Tigray regions have been selected. A plan is set to train health service providers and initiate ART services in these HCs in the next quarter. By the end of the current reporting period, a total of 242 HCs are providing comprehensive ART services. HIV and TB counseling and testing services and enhanced palliative care services have been expanded to a total of 458 HCs and 278 HCs respectively.

### **2.1.3 PMTCT Sites Transition from IntraHealth to HIV/AIDS Care and Support Program**

During PY1, there was an ongoing transitioning of PMTCT services from the Capacity Project of IntraHealth to HIV/AIDS Care and Support program, both being USAID projects. This initially focused on handing over of the PMTCT services in ART HCs and was completed by June 2008. Since the Capacity Project is expected to open new PMTCT sites, IntraHealth has handed over all its PMTCT sites in non-ART HCs to HCSP. HCSP is expanding ART sites and initiating PMTCT services in all non-ART HCs as expected by the contract. There was a potential challenge of overlapping of sites during the expansion by both programs. A number of meetings were held between the Capacity Project team at IntraHealth and the treatment team of HCSP to identify all the overlapping sites and set a plan for transitioning of these health centers. A phased approach agreed upon for the transitioning process is being implemented. In this quarter, a total of 250 HCs were transitioned and the remaining ones are set for the second and third quarters of this year.

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

The first quarter of PY2 mainly focused on selecting new sites for expansion of various services, assessing the training requirements of the sites and also identifying current gaps due to attrition in HCs where trainings were conducted in PY1. This has helped to align the training priorities with the training targets and resources allocated for the year. Most training activities will be implemented starting early in the second quarter. A few training activities including 94 laboratory personnel were trained on comprehensive laboratory services in Addis Ababa and 68 health providers were trained on PMTCT in the Amhara region.

Clinical Mentorship refresher training for clinical mentors was conducted from July 14-19, 2008 at the Global hotel following the PY1 annual review meeting. A total of 32 clinical mentors, 5 RHAs, and 5 regional M & E Advisors attended the training. The objectives of the training were to give an update on HIV/AIDS, introduce the PY2 work

plan and introduce Standard Operating Procedures (SOPs) for HIV/AIDS services and mentorship activities.

HCSP team leaders presented their respective team's planned activities in PY2, emphasizing program integration at the HC and community levels. The integration model suggested ways of enhancing technical integration of services at the community and HC level. The model was extensively discussed, and issues concerning utilizing HEWs and other community health workers, including KOOWs for the different HIV/AIDS services, were emphasized. Updates on management of adult and pediatric patient on ART were given using resource persons from HCSP and FHAPCO. Current issues on HCT, PMTCT, PEP and TB/HIV were also presented and discussed at the refresher training, mainly by HCSP staff. Current updates on the national HMIS and particularly HIV/AIDS data recording, reporting and data quality management were addressed. Regarding the quality improvement of services at the HCs, FFSDP team activities were presented and the outcomes of the intervention in the pilot HCs were discussed. The way forward for its expansion was set.

Standard Operating Procedures (SOP) for the mentorship service were also presented, followed by discussion, particularly about its implementation. Besides the SOP, standard quality indicators for all HIV/AIDS services, including the adherence support and other national tools to be used to improve the mentorship quality, were discussed and their implementation agreed upon.

## **2.1.5. Comprehensive HIV/AIDS Services Provision**

### **2.1.5.1 Counseling and Testing Services at HCs and Community**

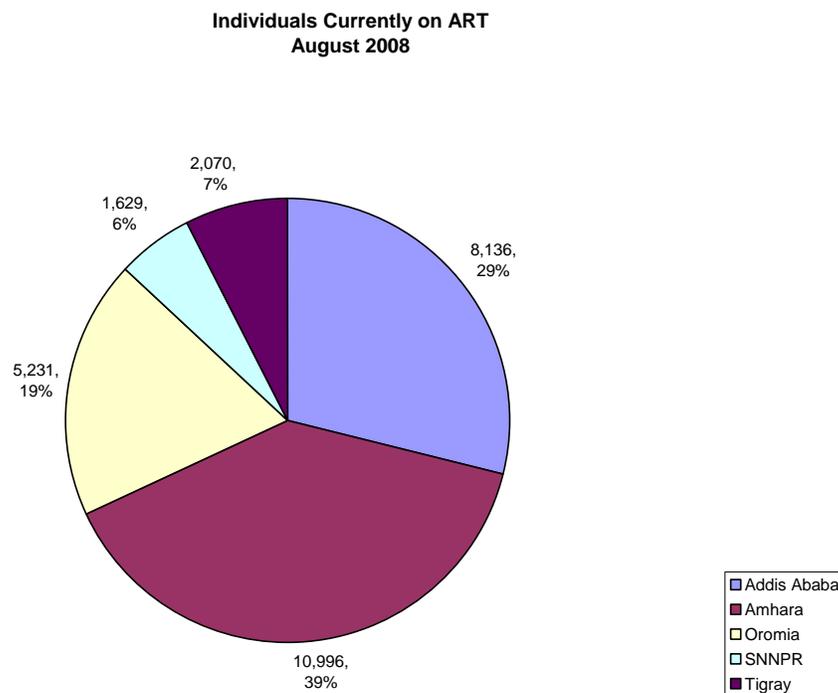
The HIV/AIDS Care and Support Program supports HIV/AIDS counseling and testing services in all target regions through various but integrated approaches. Apart from the VCT services that are regular at the HCs, integrating the PITC service to all service outlets in the HCs has been one major entry point. A plan was set to support HCs to conduct outreach services for HCT to improve access. Through these different strategies, program support has helped 159,155 individuals to get tested and receive their results. All individuals who tested positive have been linked with/referred to health facilities of choice for comprehensive HIV care and treatment services.

### **2.1.5.2. Provision of ART Service at HCs**

At the end of the HIV/AIDS Care and Support Program PY1, the number of individuals receiving ART services was 22,090, which is 147% of the first year target. With a progressive increase in the number of patients receiving treatment at health center level, 28,062 patients are receiving ART at the end of this quarter. More than 61% of patients on ART are women. The Addis Ababa City Administration and Amhara region continued contributing the major part (68%) of patients currently on ART. Based on this data, the HIV/AIDS Care and Support Program is taking targeted measures regarding ART site expansion and identifying communities for community level interventions that include training and deployment of community volunteers, KOOWs. The following pie chart

shows the relative regional distribution of patients currently on ART in the five target regions of the HIV/AIDS Care and Support Program.

Fig1. Pie chart showing regional distribution of patients currently on ART, September, 2008



The rate of patients Lost to Follow Up (LTFU) is one measure of service quality which in the meantime indicates the appropriateness of innovative approaches used by HCSP. Delivering the service closer to the community (HCs), strengthening adherence counseling (case managers), and better tracing mechanism (KOOWs and Community Volunteers) are understandably better tools which HCSP is implementing to ensure adherence. At the end of the current reporting period, the LTFU rate at HCSP supported HCs was at 1.7%, in contrast to the national average which is still more than 20%.

Table 2: Regional distribution of LTFU patients at Health Center level in the regions supported by the HIV/AIDS Care and Support Program, September 2008

Region	No. Currently on ART	No. LTFU Patients	% LTFU
Addis Ababa	8,136	225	2.7
Amhara	10,996	103	0.9
Oromia	5,231	61	1.2
SNNPR	1,629	20	1.2
Tigray	2,070	78	3.6
<b>Total</b>	<b>28,062</b>	<b>487</b>	<b>1.7</b>

#### **2.1.5.3 Provision of Basic Palliative Care Services at HCs and Community**

Providing care and support services at HCs and community levels continues to be one of the major activities of the HIV/AIDS Care and Support Program. A total of 95,389 individuals have been reached with various categories of care and support services during the reporting period. 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 still 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 and very encouraging results have been obtained so far. Details of KOOWs performance is described under result 3 below.

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

The HIV/AIDS Care and Support Program supports comprehensive HIV/AIDS and TB services at HCs and at community level. Although PMTCT services remain poorly addressed area in the country, the HIV/AIDS Care and Support Program is trying to maximize its efforts to improve access and service quality through all the 500 HCs that it is supporting. In the first quarter of PY1, a total of 22,045 antenatal care (ANC) clients have been registered in the ART HCs supported by the HIV/AIDS Care and Support Program. Out of those ANC clients, 17,948 have been counseled and tested; this is 81.4% of the total, and 719 (4.0%) tested positive for HIV. Even though all positive pregnant mothers are expected to get a complete prophylaxis for HIV, only 339 (47.1%) have received the service, and only 40.5% of the babies who are supposed to get the prophylaxis received the services.

#### **2.1.6. Additional Technical Activities**

HCSP participated in TWG, workshops and other meetings to review existing policies and standards for ART, clinical mentoring, existing ART and PMTCT programs, guidelines, manuals, and operating procedures. The HIV/AIDS Care and Support Program staff are now members of technical working groups for treatment, STIs, and TB/HIV which meet regularly. The results of the meetings are integrated into the HIV/AIDS Care and Support Program implementation modalities.

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

HIV/AIDS Care and Support Program staff met with PEPFAR partners and HAPCO staff to review HIV/AIDS programs that have deployed case managers. Discussions centred on guidelines and procedures for case managers and job descriptions. During the current reporting period, HCSP has participated in the task force established from different USG partners being led by FHAPCO for the purpose of harmonization/standardization of USAID's Ethiopia HIV/AIDS Care and Support Program Quarterly Progress Report, July 1 – September 30, 2008

different nomenclature and salary issues for case managers being implemented by different organizations as part of a task shifting principle to promote adherence of clients to treatment or care. The task force, after having a number of meetings, has come up with final decision which will be implemented across the country. The decision made was to have two levels of cadres to strengthen adherence. The first level of cadres would be “Adherence Support Coordinators,” to be based at the facility level. These would coordinate and support overall case management activities. The case managers trained and deployed by HCSP belong to this level. The second level was named as “Adherence Supporters” which include most of the outreach workers. Salaries were also set by considering the salary level of community counselors and HEWs so as to fit them into the existing system.

A sub-contract 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 MOH structure to facilitate future integration of these cadres into the GOE civil service structure. At present, this system is functioning very well. So far, 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 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 HCs level (1.7%) is among the major evidence of effective collaborative efforts of case managers and volunteer community workers. By the end of PY2, HCSP is expected to train and deploy a cumulative total of 393 case managers at 300 ART HCs. In HCs having a large number of clients, more than one case manager may be deployed. The identification of such health centers was done based on case load and sent out to the regions for endorsement or modification of the plan by the RHBs.

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

#### **2.3.1. Summary of Achievements: July 1 - to September 30, 2008**

- 177,044 individuals were mobilized for prevention, care and treatment through outreach activities, coffee ceremonies and home visits
- 59,566 newly identified individuals affected and infected by HIV/AIDS were provided with care and support services
- 4,620 LTFU patients from ART or TB DOTS were traced and provided with adherence support
- 267 Community core groups were provided with technical assistance for HIV related institutional capacity building

#### **2.3.2 General 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 (HEWs) providing HIV/AIDS and TB prevention, care, and treatment

USAID’s Ethiopia HIV/AIDS Care and Support Program Quarterly Progress Report, July 1 – September 30, 2008

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.

KOOWs mobilize family and community members for HIV/AIDS stigma reduction, and counsel and encourage families and community organizations to provide care and support to those with chronic disease. KOOWs also participate in the follow-up of lost clients; facilitate the delivery of elements of the preventive care packages at the kebele level; support adherence promotion to TB, OI and ART; and make referrals to care and support services to community organizations (including those providing OVC services). By continuously mapping Kebele assets, KOOWs support personalized care. In kebeles where the response to providing HIV/AIDS care and support has been limited, KOOWs undertake extensive community mobilization activities through a community mobilization approach known as the community action cycle (CAC). The CAC builds on positive social norms and community mechanisms, linking closely with unique groups such as Idirs. The CAC uses a seven-step approach that culminates in the establishment of core groups of seven to ten individuals each. These groups and the individuals can effectively identify families in need and rapidly link families with resources and services at the kebele level. In addition, KOOWs mobilize networks of CBOs, FBOs, and PLWHA associations to identify individuals and/or households in need of comprehensive HIV/AIDS services. The HIV/AIDS Care and Support Program recruits and trains community mobilizers to coordinate activities at the community level in all the five regions.

To achieve outputs and deliverables under Result 3, the following approaches have been used:

- Community-based, family-focused, and gender-sensitive programming
- Strengthened linkages among households, communities, health centers, and the program
- Community leadership training, support, and involvement in the selection and the work of KOOWs, including strong functional relations with the Regional Governments and strengthening Woreda health offices to coordinate care and support services
- Mobilization of CBO/FBO networks to identify households and individuals in need of services
- Building upon human resources that are already mobilized and trained, for example working with other community volunteers
- Continuous mapping of Kebele assets or resources to support personalized care, including linking treatment with other support activities
- A strong supervision, monitoring, and support plan with active involvement of woreda HIV/AIDS desks
- Linkages to the health system and subsequent follow-up

### **2.3.3. Staffing status under Result 3**

As per the technical direction HCSP received from USAID, four regional care and support coordinators have been hired and deployed in Amhara, Oromia, Tigray and USAID's Ethiopia HIV/AIDS Care and Support Program Quarterly Progress Report, July 1 – September 30, 2008

SNNPR. This brings the number of persons responsible for the care and support component to 5. During the PY1 implementation period, one regional coordinator was responsible for the coordination of the care and support and prevention components. HCSP believes that the current structure would further strengthen the effectiveness of coordinating activities under the two components. Other positions under Result three are full and functioning well.

#### **2.3.4 Expansion of Kebeles and CCGs Networked with ART HCs**

HCSP has planned to expand the number of kebeles networked to ART HCs to 800 by the end of PY2. The prioritization process, in collaboration with regional government bodies, is well underway in order to select kebeles in high yield and high prevalence areas. Community support mechanisms have been further strengthened in the existing 267 Kebeles during this quarter. Community mobilizers continued to provide capacity building training to community core groups. The community core groups in all regions continued to mobilize resources for care and support, independent of project support. Potential ART defaulters and those traced and restarted on ART are being assisted to adhere through provision of transport money to ART sites. Monthly program review meetings to provide support to KOOWs continued in this quarter. Kebele HIV/AIDS desks and HEWs are actively involved in the daily activities of KOOWs and are assisting them to refer PLWHAs to appropriate services. Community core groups have also harnessed other community based structures like Womens' Associations to strengthen the capacity of KOOWs to provide services. For example, in Gulele Sub city 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 their association. Bedridden clients have also been assisted to access medical care through these mechanisms. Through Kebele desk offices, KOOWs have managed to tap into the resources accessible to the HIV/AIDS desks. For example, several households have been linked to food programs through these efforts. Towards the end of the quarter, HCSP signed an MOU with WFP which will further strengthen KOOWs' capacity to provide comprehensive services by linking deserving clients to food resources. In addition, the MOU will see KOOWs in Addis getting additional training. HCSP has also initiated discussions for possible partnership with Land-O-Lakes for improved livelihoods and food security among infected and affected households.

#### **2.3.5 Training of KOOWs and other community volunteers**

During the PY1 implementation period, a total of 1,402 KOOWs and 85 community mobilizers have been trained, and 270 community core groups were already formed and continued to sensitize community members and increase their awareness of HIV/AIDS services available at both Health centre and community.

Based on feedback from trainers and the trained KOOWs, the care and support team revised the KOOWs training materials and came up with simple power point slides summarizing the training content. 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. In addition, the community mobilization guide and related training materials

were 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 woreda level. HCSP is expected to train a cumulative number of 8,000 KOOWs by the end of PY2 and the training will start early in the next quarter.

### 2.3.6 Provision of care and support services and community mobilization for prevention, care and treatment

#### 2.3.6.1 Outreach activities in HIV related community mobilization for prevention, care and/or treatment

The 1,402 KOOWs and 85 community mobilizers trained during the PY1 and members of the 270 community core groups already formed continued to sensitize community members and increase their awareness of HIV/AIDS services available at both Health Center and community. Coffee ceremonies continued to be used as main vehicles for mobilizing communities for the various services available. KOOWs and Community Core groups fund these outreach activities from their own resources. In this quarter, 177 044 individuals were reached through community mobilization activities as shown in table below.

Table 3: Regional distribution of the number of individuals reached through community mobilizations

Region	Number of individuals reached through community mobilizations		
	Male	Female	Total
<b>Addis Ababa</b>	5888	9518	15406
<b>Amhara</b>	18300	14277	32577
<b>Oromia</b>	21,902	24,327	46,229
<b>SNNPR</b>	17279	18308	35587
<b>Tigray</b>	23015	24230	47245
<b>Total</b>	<b>86384</b>	<b>90660</b>	<b>177044</b>

Through these efforts, PLWHA continue to approach KOOWs for care and support (HBC, referrals, VCT, nutrition support etc). The community outreach activities continue to be used as vehicles to disseminate both stigma reduction as well as 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 would not want to be visited by any volunteers as this would “reveal” their status to their neighbors. However, these days, PLWHA actively seek out KOOWs to get services including assistance with household chores. This openness, according to some KOOWs, is an indication that stigma is declining somewhat.

### 2.3.6.2 Provision of community, home based and other care and support services to HIV/AIDS infected and affected individuals

KOOWs continued to provide the following care and support services:

- Identifying infected and affected individuals and screening for those who need services and providing psychosocial support or prevention counseling to the households affected and infected
- ART and /or TB, OI adherence support
- Basic home based care (assisting in housework, bathing of bedridden patients etc.), assisting in accessing medical care
- Tracing of lost to follow-up patients
- Referrals for ART, VCT, PMTCT, FP, Nutritional support, OVC care and support

In this quarter, KOOWs provided care and support services to 59,566 newly identified HIV infected and affected individuals. Identification of individuals and households infected and affected by HIV/AIDS was done through Kebele HIV/AIDS desks working directly with HIV positive KOOWs networks (peer identification), PLWHA associations, home to home visits for case finding including TB cases and through outreach activities like 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 the table below.

Table 4: Regional distribution of newly identified infected and affected individuals and provided with care and support.

Region	Newly identified infected and affected individuals provided with care and support		
	Male	Female	Total
Addis Ababa	3549	5426	8975
Amhara	3183	7151	10334
Oromia	7,273	8,344	15,617
SNNPR	5,605	5525	11,130
Tigray	7318	6192	13510
<b>Total</b>	<b>26928</b>	<b>32638</b>	<b>59 566</b>

Out of the total number of infected and affected individuals, 18,096 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 below.

Table 5: Regional distribution of HIV infected individuals provided with HBC services

Region	Newly identified HIV infected individuals provided with home based care services		
	male	Female	Total
Addis Ababa	1,845	3,311	5,156
Amhara	1,700	2,721	4,421
Oromia	2,214	3,095	5,309
SNNPR	576	852	1,428
Tigray	798	984	1,782
<b>Total</b>	<b>7,133</b>	<b>10,963</b>	<b>18,096</b>

### 2.3.6.3 Referrals of PLWHA, OVC and households impacted by HIV/AIDS within a network of existing community services including OVC care and support system

Working with existing CBO networks which 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 they developed in PY1 to make appropriate referrals. A total of 11,826 individuals were referred to various services during the course of the reporting period. The following table shows sex disaggregated regional distribution of individuals referred for various care and support services.

Table 6: Regional distribution of number of clients referred for various care and support services

Region	Individuals referred for services		
	Male	Female	Total
Addis Ababa	563	1,069	1,632
Amhara	592	1,325	1,917
Oromia	2,794	2,968	5,762
SNNPR	426	628	1,054
Tigray	725	736	1,461
<b>Total</b>	<b>5,100</b>	<b>6,726</b>	<b>11,826</b>

While the KOOWs have been able to document the number of individuals referred for various services, it has been very 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 provider. The case managers placed at the facility level will play an important role in this regard.

#### **2.3.6.4 ART and TB DOTS adherence support and tracing of lost to follow up patients**

In the reporting period 4,620 lost to follow-up patients on either ART or TB DOTS have been traced and re-started on treatments and subsequently provided adherence support. A total number of 4,620 defaulter patients have been traced and the following table shows sex disaggregated regional distribution of traced patients.

Table 7: Regional distribution of patients lost to follow up either for ART/TB DOTS and traced and given adherence support by KOOWs

Region	Number of lost clients traced and supported for ART and TB /DOTS adherence.		
	Male	female	Total
Addis Ababa	263	399	662
Amhara	41	98	139
Oromia	1,019	1,134	2,153
SNNPR	305	314	619
Tigray	514	533	1,047
<b>Total</b>	<b>2,142</b>	<b>2,478</b>	<b>4,620</b>

Community core groups have been instrumental in promoting treatment adherence by mobilizing monetary resources to assist potential defaulters not to miss their appointments. While this is happening in a few cases, transport to health centers is still a challenge. Supervisory visits conducted in Addis Ababa during the course of the reporting period have 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 the food situation will improve through collaboration with the World Food Program (WFP).

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

The care and support and M&E teams reviewed and modified KOOWs reporting formats developed in PY1. 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 of individuals receiving multiple services. It will also be possible to show how many clients are receiving treatment services from the local health centers which are served by the

Kebeles where KOOWs have been deployed. This will make it easier to track both clinical and non clinical services provided to individuals. Currently, there are people on ART who prefer to get treatment at the hospitals because of various reasons, including stigma and lack of OI drugs at the health center. This was confirmed through focus group discussions with a group of women on ART.

It is quite evident that KOOWs are providing care and support services to the infected and affected households. However, what is not so obvious 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 in the process of designing simple care and support standards and quality indicators to monitor 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 bi-weekly 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 bedridden patients who need immediate medical attention urgently.

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

### **3.4.1 Recruitment and deployment of 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 & support in each of the regional offices. The previous prevention and community mobilization coordinators working in SNNPR, Oromiya and Amhara have been retained as BCC Coordinators. The remaining two posts for Addis Ababa and Tigray have been advertised and a BCC coordinator for Addis Ababa was recruited and the process continues for Tigray. Two BCC consultants have been recruited for six months with possible extensions upon performance evaluation.

### **2.4.2 BCC Materials for Adaptation/Development, Production and Distribution**

Planned and approved BCC materials to be adapted or developed in PY2 have been identified and assessed for technical compliance and alignment with project contractual issues. The following BCC materials are technically cleared by USAID and are ready for printing.

- Brochure 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 health center level
- Job Aids

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

Table 8: Types and Amount of Reproduced and Distributed BCC Materials

No.	Topic	No of copies printed	Regional Distribution					
			AA	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 Infection	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

To ensure the appropriate distribution and utilization of the materials, a guideline on usage, delivery and follow up was developed and distributed to all regions. The regions on their part have also distributed the materials to health centers, communities and relevant partners.

#### **2.4.3 Assessment of existing BCC materials for adaptation and qualitative study on BCC needs linked to ART services at health center levels**

Local consultants have been hired to assess existing BCC print and electronic materials for timeliness and appropriateness for adaptation or adoption; and to conduct qualitative study on the BCC needs linked to ART services at health centers 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 has been started in PY1 and carried over to the second year. The consultants have submitted the first draft of the assessment results and the treatment team has

reviewed and forwarded comments for consideration and submitted the final result as per the contractual agreement.

#### 2.4.4 Assessment of the Sources of Condom Supply and Distribution

During the quarter, a detailed survey was conducted on condom supply and distribution mechanisms in Addis Ababa including health facilities. The main objective of the survey was to identify key partners working in the condom importation and supply system. Survey result showed that DKT is the major importer and distributor of condoms in the country, which accounts for 81% of the importation and distribution system. Some other organizations also import and distribute condoms with varying brands but share only a small fraction of the total proportion. PSI has also imported 38 million condoms this year and is planning to distribute the condoms through commercial and PEPFAR partners' networks. Therefore, HCSP is communicating with these groups to create linkages with regional Health Bureaus and HAPCOs to ensure condom supply to the health care facilities through existing systems.

#### 2.4.5 Role out performance and number of individuals reached on AB and beyond AB messages

The following table shows the number of individuals reached with prevention messages through out reach activities.

**Table 9: Number of individuals reached on AB and beyond AB messages through rollout performance strategy**

No	Region	Number reached on AB		Number reached on OP.		Total reached with AB and OP (AB+OP)	
		M	F	M	F	M	F
1	Oromiya	45,503	46,885	43,147	28,107	88,650	74,992
2	Amhara	28,875	92,249	23,504	63,273	52,379	15,5522
3	Tigray	376	376	20,355	24,431	20,731	24,807
4	SNNPR	34,199	27,531	17,361	20,818	51,560	48,349
5	AA	5864	10,907	7,373	10585	13,237	21,492
<b>Total</b>		<b>114,817</b>	<b>177,948</b>	<b>111,740</b>	<b>147,214</b>	<b>226,557</b>	<b>325,162</b>

#### 2.4.6 BCC Activities by Community Group

During PY1, a number of community groups that included religious leaders, community elders, PLWHAs women's associations and school teachers were trained on gender, VCT, stigma and discrimination, ABC prevention and other related issues. During the reporting period these community groups have mobilized, sensitized, counseled the community on gender, VCT, stigma and discrimination ABC prevention and even referred individuals for HIV/AIDS prevention care and support services. During this quarter a total of 102,277 individuals have been sensitized and counseled and 145 individuals have been referred for various HIV prevention, care and support services.

## **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 central, regional, woreda and health center levels through a variety of technical interventions. The major interventions in this component include Performance Based Contracting (PBC), Fully Functional Service Delivery Point (FFSDP) tool, Management and Leadership (M &L), laboratory services strengthening, and human resource development.

In implementing the above technical interventions the health systems strengthening component will focus on building the capacity of the public sector to support the strengthening or capacitating national, regional and woreda health offices so that they can better manage and lead the health services at all levels. Accordingly, the activities mentioned below have been performed during the quarter.

#### **3.1.1 Hire appropriate staff**

A Logistics Advisor was hired and started work with HCSP as well as RPM Plus on September 15, 2008. A local consultant (Health Economist) was hired and seconded to FMOH to support the design of Performance Based Contracting (PBC) and its implementation in the public sector.

#### **3.1.2 Referral System and related services in HCs**

This intervention area has two major activities, which include review of the existing referral system formats and adaptation of the revised referral system after approval. During the 1<sup>st</sup> quarter, a referral system proposal was developed and the study will continue in the next quarter.

#### **3.1.3 Design of the PBC 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 (Health Economist) to join the FMOH/PPD to work in the PBC unit. STTA from the MSH Cambridge head office was provided for one month to support the FMOH in finalizing the PBC 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 PBC strategy was unveiled to the regions. The next step is to design and develop the training manual and plan for TOTs next year. We will also continue to provide STTA in finalizing the manuals and the contracts.

### **3.1.4 Performance Based Contracts (PBC) with the private Sector**

#### **3.1.4.1 Training PBC**

MSH submitted the request for consent to subcontract with Bethzatha Inc. on training logistics coordination to USAID and is awaiting approval. The selected contractor, Bethzatha Inc. has been assisting in undertaking several trainings to date.

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

The last quarter was spent negotiating final scopes of work and budgets with the three organizations selected for award pursuant to RFPs for home based care services. The three NGOs are:

- National Network of Positive Women Ethiopia (NNPWE)
- Relief Society of Tigray (REST)
- IMPACT Association for Social Services and Development (IMPACT)

The awards will be issued early next quarter.

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

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

#### **3.1.4.4 Memoranda of Understanding, MOU**

- HCSP is committed to work in close collaboration with PEPFAR and non-PEPFAR implementing partners to maximize the quality of services being provided to the beneficiaries. MOU have been the mechanism through which HSCP collaborates with partners, governmental and non governmental. 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.
- *The 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.
- *MOUs with the Regions and Addis Ababa* have been drafted and will be finalized in the next quarter.
- *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 sub contractors and local NGOs and CSO before awarding subcontracts. The audit firm of Getachew Kassaye & Co has undertaken the following pre-award assessments 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 will be issued subcontract agreements. The others (NNPWE, REST, IMPACT and HAPSCO) will be submitted to USAID to request consent to subcontract.

### **3.1.5 Implementation of Performance Improvement Plan (FFSDP)**

During the implementation of PY1, a pilot test was conducted to adapt the FFSDP tool to the Ethiopian context. As a follow up of the pilot study, 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. A Preliminary data analysis of the 29 HCs was prepared for discussion following the completion of the FFSDP 2<sup>nd</sup> round assessment with support from STTA. The STTA 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 PY2 were distributed to the regions for finalization of plans and follow up implementation. HCSP has been participating in the national TWG led by FHAPCO to develop a national quality improvement and assurance framework for HIV/AIDS services. There were two meetings during the quarter. At each meeting stakeholders presented their progress reports on ongoing activities related to quality improvement for the participants. In the last meeting it was agreed that both JHPIEGO and HCSP jointly conduct a pilot result dissemination workshop.

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

Capacity building plan for central, regional and woreda levels was developed to start the implementation during the 1<sup>st</sup> quarter. Meanwhile, important sections of “Managers Who Lead” have been translated into Amharic. This will be used to train woreda level managers, subject to availability of funding.

The Ethiopian management Institute (EMI) was approached to work in the implementation of the leadership development program (LDP) with HCSP, a draft MOU was prepared and sent to EMI to provide its comments. However, EMI requested HCSP to obtain prior permission from FMOH before giving its agreement to participate in the leadership development program. This activity has been put on hold until funding issues are resolved.

### **3.1.7 Human Resource Development (HRD)**

A 45-percent staff vacancy rate at the health center levels will deter expansion of HIV/AIDS services and improvement in quality of all services. This component is designed to help the MOH address these issues. One of the approaches indicated in the PY2 work plan is to introduce some types of incentives to motivate the workforce in the health centers and other echelons in the health system. This quarter, a draft recognition guideline was developed and submitted to the HCSP management for review. In addition, a brief summary of the recognition guideline was prepared both in Amharic and English and recognition certificates were also prepared and presented for endorsement. An attrition survey proposal and questionnaire for the survey were developed and made ready. This activity is also on hold pending resolution of funding issues.

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

The recruitment process of seven laboratory services program officers was accomplished during this quarter. HC laboratory standards have been incorporated into FFSDP and the laboratories in the 30 pilot tested HCs have been addressed. In addition, training on comprehensive laboratory services was given for 94 laboratory professionals in Addis Ababa. Other activities include the finalization and submission of the laboratory needs assessment report, and preparation and submission of TBCAP APA4 work plan. HCSP is taking the lead in the revision and adaptation of SOPs for the new algorithm of the HIV rapid test which will soon be finalized.

MSH (HCSP, RPM Plus and SCMS) established a lab supply technical working group (LSTWG) in early July 2008 in response to USAID's comment on the fact that conventional laboratory supplies are often not available at health centers. The established LSTWG was a construct of the staff from the three programs and coordinated by the health systems strengthening team. The LSTWG prepared a short and long term work plan and initially engaged itself in mobilizing the distribution of available lab supplies and the procurement of more supplies and essential equipment for the short term. Supplies have been distributed and the procurement of more supplies initiated. The LSTWG, at present, is prepared to engage into the long term activities that include lab needs comprehensive assessment, training in inventory management and reviewing the existing system.

### **3.1.9 Strengthening Logistics System**

A Logistics System Advisor was hired and started work as of September 15, 2008. As there was no Logistics Advisor until the last two weeks of the 1<sup>st</sup> 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 TWG has been established to deal with OI drug supply. Since its establishment at the end of August 2008, the OI TWG has managed to mobilize the distribution of OI drugs from FMOH central stores and regional stores directly to site through negotiation with the responsible department in the FMOH. MSH has supported the regions in transportation and other related expenses. Next, the OI TWG will be engaged in the long term activities that would improve the delivery of OI drugs to sites. The Logistics Advisor is already a member of the OI drugs TWG.

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

The MSH/HCSP sustainability and exit plan has a number of important elements, all of which reinforce each other, to ensure that nationwide delivery of HIV/AIDS services at all levels will continue at the end of the program. Cognizant of these facts, HCSP management has 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 RHBs units. The exercise is underway and is coordinated by the HSS team.

### **3.2 Mainstream Gender into all HCSP 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 PBC process. This team involves an advisor and NGO coordinator to implement activities regarding gender and NGO capacity-building and to integrate them into all HIV/AIDS Care and Support Program activities. Gender has been mainstreamed into all trainings that are HCSP supported, and into the development of woreda HIV/AIDS plans. In order to support HIV/AIDS Care and Support Program strategies related to women's and children's health, the gender and NGO capacity-building team has collaborated closely with the contracts unit of HIV/AIDS Care and Support Program to develop an RFA and award subcontracts to NGOs doing gender work.

During this quarter, HCSP has been negotiating scopes of work and budgets with the following organizations selected through the PBC: IMPACT, National Network of Positive Women NNPWE, and Relief Society of Tigray (REST). HCSP has conducted a pre-award audit of all the organizations with the exception for IMPACT. Recommendations of the audit are currently being implemented by the NGOs. HCSP will send all relevant documents for USAID concurrence next week. Once this process is completed, HCSP will award the PBCs and implementation of agreed upon activities will start.

HAPSCO, previously funded by FHI, will now receive funding from HCSP to continue its activities in Addis Ababa. A SOW and a budget are being finalized. HAPSCO will work in all sub-cities in Addis Ababa.

DOH, which had completed its three-month funding and activities, will now be working on a plan for 12 months. A work plan and budget have been agreed upon and a sub-grant will be provided for DOH to continue its activities. 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 and Capacity Building team has provided extensive TA to the organizations to prepare their SOW, work plans and budgets.

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

Activities in this implementation 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 PBCs, implementation of 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 HCs level.

During the first quarter of the PY2, the HCSP PY2 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 work plan 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 approved by USAID in September 2008.

The initial draft work plan was regionalized in a meeting held for three days in Addis Ababa in July 2008. In this meeting 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 HCSP is supporting. 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 data bases is well underway.

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 ANC/PMTCT registers, 10,000 ANC/PMTCT stickers and 1,000 ANC/PMTCT appointment and partner invitation cards were printed and distributed to regions. HCSP is coordinating and conducting joint supportive supervisions to help the implementation of the "Three Ones." The HCSP regional M&E advisors continued supporting RHB, WHO, and HC staff to use 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 ensure the 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 quarterly report. The team has 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 some difficulty in 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.

## **5. Annexes**

Annex 1: Updated Performance Monitoring Plan, PY2 First Quarter (September 30, 2008)

**Management Sciences for Health**

784 Memorial Drive  
Cambridge, MA 02139  
Tel: (617) 250-9500  
Fax: (617) 250-9090  
[www.msh.org](http://www.msh.org)