

## **Trip Report: Elke Konings**

---

Ethiopia HIV/AIDS Care and Support Project  
July 13 – August 2, 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

## Trip Report

Submitted to USAID, 31 July 2008

**Elke Konings**

**Addis Ababa, 13 July – 02 August 2008**

Elke Konings, M.Sc., Ph.D.  
Management Sciences for Health/ Center for Health Services  
784 Memorial Drive, Cambridge MA 02139, USA  
[ekonings@msh.org](mailto:ekonings@msh.org)

**1. Scope of Work: Attached in Annex 1**

Destination and Client(s)/ Partner(s)	Addis Ababa
Traveler(s) Name, Role	Elke Konings
Date of travel on Trip	13 July – 02 August 2008
Purpose of trip	FFSDP
Objectives/Activities/ Deliverables	See Annex 1
Background/Context, if appropriate.	See Annex 1

**2. Major Trip Accomplishments:** Should include the major programmatic goals realized, relevant metrics, and stories of impact from the trip.

- FFSDP pilot phase analyzed and report finalized (see attachment 5)
- FFSDP scale up plan detailed (see attachments 1-4)
- Clinical mentors oriented on FFSDP (see attachments 6-8)
- FFSDP tools and manuals revised to be finalized by end August 08
- MSH representation on WHO review panel of IMAI operations manual

**3. Next steps:** Key actions to continue and/or complete work from trip.

Description of task	Responsible staff	Due date
<p><b>Hire / Confirm additional central and regional HCSP staff for FFSDP scale up (=ESSENTIAL &amp; URGENT)</b></p> <p>FFSDP scale-up requires human resources at the health center, woreda and regional levels. Engaging the clinical mentors in the intervention/educational component is key to success. If scale up is to take place at the accelerated rate requested by USAID and FHAPCO, the current number of clinical mentors must urgently be complemented with additional regional staff for which HCSP has been seeking USAID approval. HCSP should seek to obtain approval ASAP and USAID should try to give approval ASAP. Without more staff, HCSP and USAID should adjust the PY02 technical deliverables for Quality of Services.</p>	<p>COP and Head of Health Systems Strengthening Unit</p> <p>USAID</p>	<b>August 08</b>
<p><b>Make resources available for Woreda and HCs (through MOU or PBF) (=ESSENTIAL &amp; URGENT)</b></p> <p>The HCSP project was designed to rapidly expand services through the <i>combined strategy of FFSDP</i> (including specialized TA at health centers and in communities) <i>with PBF</i>. To meet USAID PEPFAR current targets for scale up, the <i>simultaneous</i> implementation of these two strategies is essential. FFSDP action plans require resource support from the woreda/zone. HCSP should seek and engage full USAID and government support and assistance in making the resources available through</p>	COP	<b>August 08</b>

Description of task	Responsible staff	Due date
PBF or MOUs to the woreda and Health Centers (\$5000 per health center). This will further stimulate the woreda to actively engage in FFSDP implementation and ownership		
<p><b>Establish close collaboration, coordination and integrate implementation with USAID's RH/FP project</b> (recently awarded to Pathfinder/JSI)</p> <p>To gain efficiencies in use of regional resources, especially clinical mentors and other regional staff, HCSP should seek close collaboration and coordination with the USAID RH/FP project and consider proposing to them a scenario whereby both programs "merge" the use of human resources at the health center and community level, such that e.g. each clinical mentor (or equivalent) may focus on only 4-5 health centers (instead of 8-10) and cover IMAI/IMNCI including HIV/AIDS/ART and RH/FP (rather than having multiple mentors from different projects assist health centers for different services).</p>	COP	<b>August-October 08</b>
<b>Finalize the FFSDP tool box package</b> including harmonization of tools with other HCSP tools	Yoseph and FFSDP team with virtual STTA from Elke	<b>August 08</b>
<b>Finalize the FFSDP training materials</b>	Yoseph and FFSDP team with virtual STTA from Elke	<b>August 08</b>
<b>Share FFSDP Pilot test results with FHAPCO and disseminate results to regions</b> following USAID approval	Yoseph	<b>August 08</b>
<p><b>Implement detailed FFSDP operational plan for PY02</b></p> <p>See Attachments 1-5</p>	All HCSP at central and in regional offices, with support from Yoseph and FFSDP team, with STTA from Elke	<b>PY02 as indicated</b>

**4. Contacts:** List key individuals contacted during your trip, including the contacts' organization, all contact information, and brief notes on interactions with the person.

Name	Contact info	Home organization	Notes
HCSP Staff	MSH	MSH	
Health Center Staff	HCSP	MoH	
Dr Ashelew	FHAPCO/Ethiopia	FHAPCO	
Dr Abeje	USAID/Ethiopia	USAID	

**5. Description of Relevant Documents / Addendums:** Give the document's file name, a brief description of the document's value to other Ethiopia HCSP and/or MSH staff. Examples could include finalized products and/or formal presentations, TraiNet Participant List, Participant Contact sheet, and Meeting/Workshop Participant Evaluation form are examples of relevant documents.

File name	Description of file	Location of file
Annex 1	USAID approved Scope of Work, Elke Konings, 13 July-2 August 2008, Addis Ababa	
Annex 2	Summary of TDY vis-a-vis SOW	
Attachment 1	FFSDP Team needs and organization, Memo 17 July 08	
2	FFSDP Unit approved by COP 17 July 08	
3	Harmonization of FFSDP tools, Memo, 25 July 08	
4	Challenges and Solutions in FFSDP Scale Up, July 08	
5	Report on FFSDP Pilot Phase, July 08	
6	FFSDP session overview and next steps, clinical mentors meeting, Addis Ababa, 19 July 08,	
7	Clin train AA Julyek 08, clinical mentors meeting, Addis Ababa, 19 July 08	
8	FFSDP Support Systems, clinical mentors meeting, Addis Ababa, 19 July 08	

**Annex 1:**

**USAID approved Scope of Work**

**Elke Konings**

**Addis Ababa**

**13 July – 02 August 2008**

**Ethiopia HCSP**

**Program Activity: FFSDP**

<b>Name of Traveler</b>	Elke Konings
<b>Nationality</b>	EU Citizen
<b>Destination</b>	Addis Ababa, Ethiopia
<b>MSH Ethiopia contact</b>	Bannet Ndyanabangi
<b>Number of days</b>	21
<b>Dates</b>	July 13- August 2
<b>Principal working office</b>	Addis Ababa

**1) Objective:** The primary objectives of this STTA under 663-C-00-07-00408-00 HIV/AIDS Care & Support Program are to assist the HCSP QA team in applying the Fully Functional Service Delivery Point tool, in support of FHAPCO's quality framework for HIV/AIDS services. Elke Konings will help with the pilot phase and scale up of the tool, and with the analysis and publications of the results of the pilot phase, and undertake additional tasks, including the following:

- Anticipate findings that will either confirm the appropriateness of the tool as it is now, or suggest additional improvements for the final tool
- Using the two data points (baseline + follow up) provided by the pilot, analyze in July, and link – in regression analysis – to the outcome quality indicators of the national framework to demonstrate conclusively how the quality improvement and assurance work at health centers are directly improving health outcomes and impact on the HIV/AIDS and related indicators
- Since the FFSDP was entirely adapted to Ethiopia based on Ethiopia's national guidelines, policies, norms and standards, this analysis will be critical to assist FHPACO in its efforts to develop and adopt one national QA/QA approach to scaling up comprehensive HIV/AIDS services
- Remain in communication with USAID, WHO, and the Government of Ethiopia about the notion of “fully functional districts” since HIV/AIDS (especially ART) services must be critically linked into a referral and counter-referral and QA system at the district level all the way into the community. Analyze and discuss the possible opportunity to assist FHAPCO to accelerate the development and implementation of such a national model, which can then serve as a “best practices” example for the rest of Africa
- Pending submission: MSH's justification for multiple STTA for Elke Konings (instead of consolidating multiple STTA trips or using local or regional expertise) and full Scopes of Work (SOW) for previous abbreviated SOW proposed (completed??) for 01/24/08 to 02/09/08, 02/05/2008 to 02/16/2008, 06/06/2008 to 06/20/2008

**2) Outputs/Deliverables:**

The draft trip report should be delivered to the USAID/CTO Dr. Abeje Zegeye prior to departure from Ethiopia. A draft trip report must be submitted to the Chief of Party, Dr. Ndyanabangi. An oral briefing with the Chief of Party is required prior to departure from Ethiopia. A final trip report should be forwarded to Fred Hartman for review, and Heidi Gehret for filing.

**4) Draft activity plan/itinerary:**

Ms. Konings will arrive in Ethiopia on July 13th and depart on August 2nd.

## Annex 2:

### Summary notes for each item in SOW, Elke Konings, HCSP, 13 July- 2 August 2008

- **Anticipate findings that will either confirm the appropriateness of the tool as it is now, or suggest additional improvements for the final tool**
  - a. The report on the first pilot phase of the FFSDP in Ethiopia shows that the FFSDP is
    - Well received by health center staff
    - Able to motivate staff to improve health center performance
    - An educational tool assisting health center staff to work as a team
    - A participative tool that brings about positive change primarily through local actions that do not require external assistance
    - A tool that can at once serve multiple purposes including use as:
      - i. Assessment ART readiness of Health Centers
      - ii. Assessment, monitoring and evaluation of the whole health system
      - iii. Supervision checklist
      - iv. Formative Supervision guide
      - v. Assessment of Quality
      - vi. Improvement of Quality
      - vii. Performance monitoring tool
      - viii. Management tool for establishment and use of QI teams at woreda/zonal and community levels
  - b. The pilot phase experience also highlighted a number of challenges with the FFSDP application. Some of these challenges were immediately addressed while others will require broader inputs and more time. Attached (Attachments 1-4) are the memo's that led to adjustments and, for easy reference, a copy of the Table with challenges and potential solutions from the evaluation report
  - c. As part of the initial feedback and expansion phase, I participated in the training program for HCSP's clinical mentors, held in Addis Ababa from 14 to 19 July, 2008. I used Attachments 6-8 to orient the clinical mentors to the FFSDP and their role in it.
  - d. Support to the FFSDP team was further provided to simplify the FFSDP tool and develop and finalize both the tool and the training materials.
  
- **Using the two data points (baseline + follow up) provided by the pilot, analyze in July, and link – in regression analysis – to the outcome quality indicators of the national framework to demonstrate conclusively how the quality improvement and assurance work at health centers are directly improving health outcomes and impact on the HIV/AIDS and related indicators**

See Attachment 5: the report on the results of the FFSDP pilot phase in Ethiopia.

- **Since the FFSDP was entirely adapted to Ethiopia based on Ethiopia’s national guidelines, policies, norms and standards, this analysis will be critical to assist FHPACO in its efforts to develop and adopt one national QA/QA approach to scaling up comprehensive HIV/AIDS services**

Dissemination of the results of the pilot phase is planned following review and approval by USAID.

- **Remain in communication with USAID, WHO, and the Government of Ethiopia about the notion of “fully functional districts” since HIV/AIDS (especially ART) services must be critically linked into a referral and counter-referral and QA system at the district level all the way into the community. Analyze and discuss the possible opportunity to assist FHAPCO to accelerate the development and implementation of such a national model, which can then serve as a “best practices” example for the rest of Africa**
- a. Before and during my TDY in Ethiopia, communications and discussions with WHO and FHAPCO continued. Following the formal invitation from the WHO/ HIV/SSH IMAI Team mid July 08, I joined the WHO panel of reviewers of the draft Operations Manual for Delivery of HIV Prevention, Care and Treatment at Primary Health Centres in High-Prevalence, Resource-Constrained Settings. This Manual has been under development through a WHO-PEPFAR health centre scale up collaboration since early 2007.
- b. HCSP integrates the IMAI approach in its all its trainings, and is currently anticipating an external evaluation by USAID of its IMAI trainings in September of this year. In this context, I provided recommendations to the HCSP’s COP regarding the preparation for this evaluation.

End of Summary Notes.

Elke Konings

Addis Ababa, 30 July 2008

# Attachment 1

Memo

---

From: Elke Konings  
To: Bannet Ndyanabangi, Hailu Meche, Assaminew Girma  
Cc: Yoseph W/Gebriel, Aberra Kifle  
  
Re: FFSDP Team needs and organization  
  
Date: 17 July 2008

## The Situation:

- Project Year 2 (PY02) of the HCSP has a priority focus on improving quality of services and expanding the FFSDP tool to all health centers in the 5 target regions.
- Consequently, HCSP will have to train regional FFSDP facilitators and support the introduction and application of the FFSDP tool
- The HCSP currently has 2 dedicated technical staff to the FFSDP: one program officer in the Division of Health Systems; one program officer in the M&E Division. A third officer was hired in the M&E Unit but has left the project. In addition to the FFSDP, the two program officers have secondary responsibilities within their own Units.
- During PY01, this arrangement has proven inadequate to fully implement the FFSDP work plan in the required time line. In part, this is related to the internal organization of the FFSDP TA staff (the FFSDP program officers are in different units each with different supervisors). In part, the work load is too large for two people.
- To achieve the FFSDP goals set for end of PY02, the following is therefore necessary:
  - a. The HCSP central FFSDP TA staff must be much better aligned with one another, so they can perform in full compliance with ambitious deadlines
  - b. The central FFSDP TA staff must be increased
  - c. Each region must dedicate TA staff to the FFSDP implementation
  - d. FFSDP training in the regions must be completed in Quarter 1 of PY02
  - e. Operational support must be in place to keep pace with the scale up

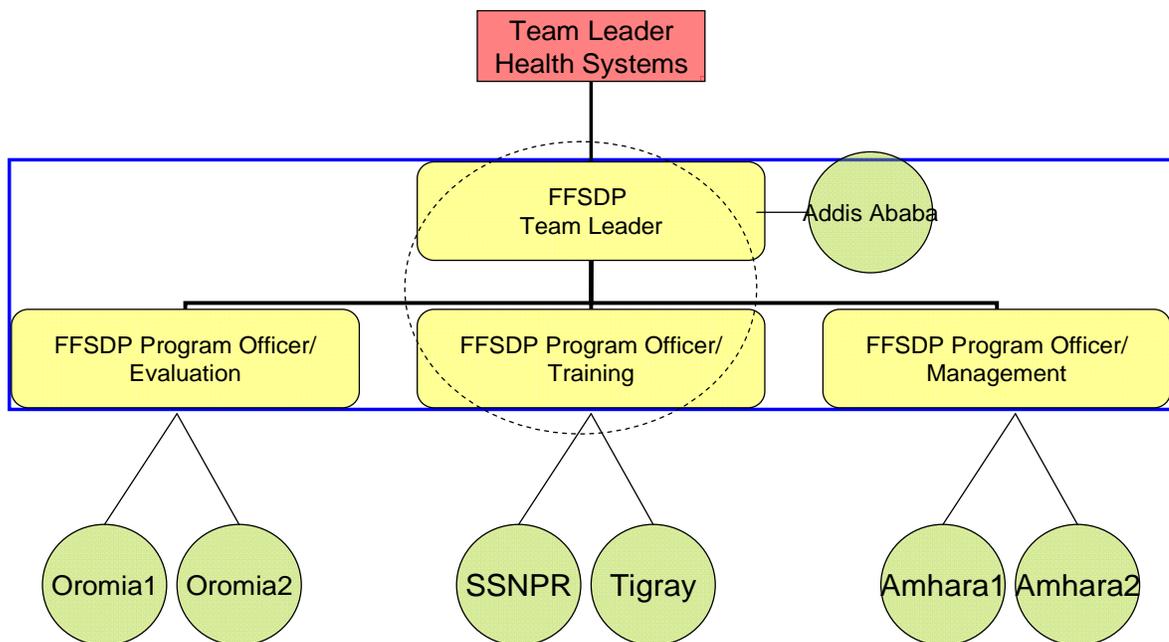
## Recommendations:

1. Consolidate the central FFSDP staff into one FFSDP unit, housed in the Division of Health Systems.

- ❖ *Rationale:* The FFSDP tool is a Quality Improvement (QI) Tool for health services. QI, and by extension FFSDP, is therefore a function of the health system. The HCSP M&E Division is responsible for Quality Assurance (QA) of the overall project, and is thus a project function. While the FFSDP tool application requires some of the same expertise as the M&E Division, its purposes are different. The FFSDP is a project intervention but integral to the health system and services the HCSP supports. The HCSP M&E QA function is somewhat external to the HCSP interventions, ensuring that interventions are conducted in high quality ways to maximize achievement of project results. Therefore, the Division of Health Systems is the appropriate place to house a FFSDP Unit.
  - ❖ *How:* see Organigram
2. Increase the central FFSDP staff to a minimum of three officers, ideally four. Each officer will be fully versed in the FFSDP tool application and uses, and bring special expertise in one of the three main components (evaluation, education/management, training/capacity development). Each FFSDP officer will also be responsible for central oversight and support to one or two regions. They should be supervised and coordinated by a team leader who reports directly to the director of health systems. If only three staff can be dedicated to FFSDP, the team leader should cover one of the three areas of expertise and take on one region.
    - ❖ *Rationale:* PY02 has three main FFSDP activities: 1) train regional facilitators, 2) support implementation of the FFSDP tool and work plans (i.e. educational component) and 3) collect, monitor and analyze the FFSDP progress and impact. This scope of work combined with the geographic coverage in 5 regions requires strong and consistent support from the HCSP central office for each of these three broad activities. As an illustration, the Training alone (first activity mentioned above) of clinical mentors, regional M&E mentors, regional health advisors, and woreda/zonal supervisors in the use of FFSDP in each region in Q1 will require central trainers available for preparing the training (August) and conducting it during at least 5 days in each region (=5 person days x 5 regions = 25 person days) (August & September). In addition, much work that should have been completed by now remains to be done in finalizing the educational part of the FFSDP tool and setting up the data base.
    - ❖ *How:* Given the project's contractual limitations, hiring new staff is not indicated at this time. HCSP should therefore consider which position it can afford to eliminate in favor of a FFSDP position. (e.g. one of the clinical mentors might be moved into a FFSDP program officer role).
  3. Hire data clerks for data entry
    - ❖ *Rationale:* Data clerks are cheap, can be hired by the day, and hiring them frees up a significant amount of time of the FFSDP program officers.
  4. Appoint one FFSDP coordinator/focal point per region.

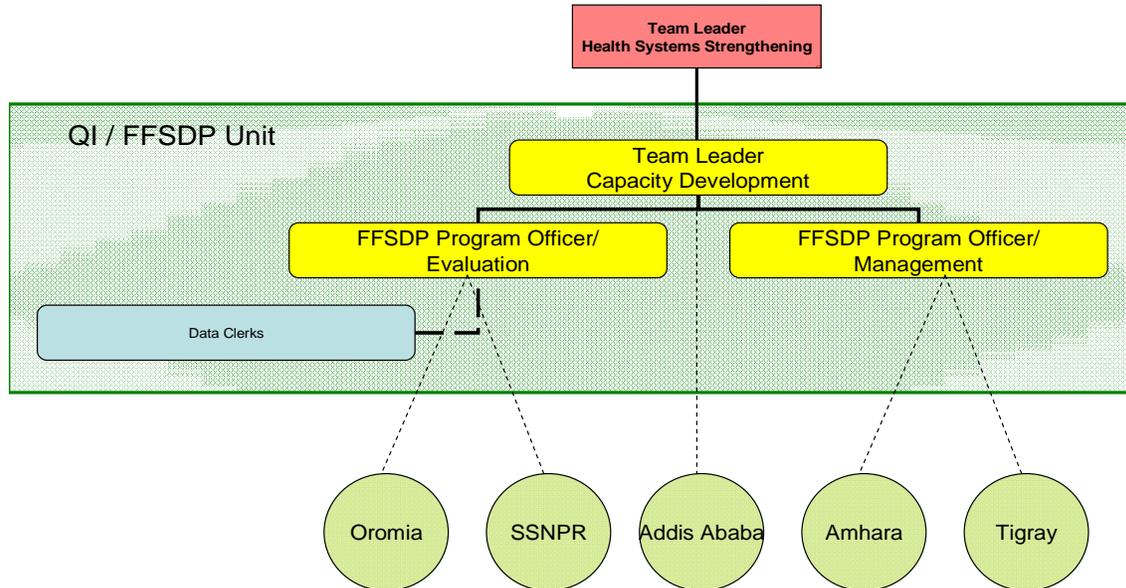
- ❖ *Rationale:* this person is needed to provide support and supervision to the clinical mentors while implementing the FFSDP, and to simplify communications around FFSDP with the central office.
- ❖ *How:* Provided they secure sufficient time for this activity, this role may be assumed by the regional health advisors or delegated to one of the clinical mentors in each region.

**Recommended re-organization of the HCSP FFSDP Team**



## Attachment 2

### HCSP Quality Improvement/FFSDP Unit



17 July 2008, approved by COP

### Roles and Responsibilities: Central Office

#### Team Leader:

- Overall coordination, implementation, and results of HCSP's QI system
- Liaison and coordination with other central functions of the HCSP Health Systems Strengthening Unit
- Supervision of central QI staff and Addis Ababa Regional FFSDP focal point
- FFSDP training and capacity development of HCSP regional staff
- Reports to Team Leader/Health Systems Strengthening

#### Program Officer/Evaluation:

- FFSDP leader for support to Oromia and SSNPR Regions' FFSDP focal points and staff
- FFSDP Master trainer and facilitator
- FFSDP data collection, data base management, data analysis and reporting at project level
- Participation in all FFSDP activities as required
- Reports to QI Team Leader

#### Program Officer/Management:

- FFSDP leader for support to Amhara and Tigray Regions' FFSDP focal points and staff
- FFSDP Master trainer and facilitator
- FFSDP educational component tools and approaches
- Participation in all FFSDP activities as required
- Reports to QI Team Leader

## **Roles & Responsibilities: Regional Office**

### **Regional Health Advisor / Technical Integration Advisor**

- Focal Point for all aspects of FFSDP implementation
- Hosts regional training and follow-up workshops
- Hosts dissemination of results and recognition ceremonies
- Communication and coordination with Central HCSP QI team
- Supervision on M&E advisor and clinical mentors

### **M&E Advisor**

- FFSDP regional data collection, data base management, data analysis and reporting at regional level
- Support to clinical mentors in implementing FFSDP, interpretation and use of data for planning and feedback at health centers
- TA to woreda and health center data clerks for evaluation component of FFSDP

### **Clinical Mentors**

- FFSDP regional implementation
- TA to health centers in implementing work plans
- TA and capacity development of woreda supervisors in FFSDP facilitation
- Coordination and collaboration with other clinical mentors for regional implementation of FFSDP

## Attachment 3

Memo

---

From: Yoseph W/Gebriel on behalf of The HCSP FFSDP Team  
To: Bannet Ndyanabangi, Haile Wubneh, the HCSP Treatment Team  
Cc: Yoseph W/Gebriel, Aberra Kifle, Hailu Meche, Elke Konings  
  
Re: Harmonization of FFSDP and other HCSP tools  
  
Date: 25 July 2008

This memo offers recommendations on the following two questions:

1. How can the Treatment Standards, currently used by the HCSP Treatment Team, be integrated in the FFSDP tool?
2. How can the HCSP Treatment Team assist in implementing the FFSDP?

Background:

- ❖ The FFSDP is the main quality improvement tool of HCSP. It consists of three main components: an evaluation component, a work plan component, an education/intervention component. Each component is implemented at the health center, using a set of tools and documents. These tools and documents (checklists, protocols, management tools) reflect national norms and standards, indicators and guidelines for comprehensive HIV/AIDS service delivery
- ❖ The mandate of the HCSP Treatment Team, as well as other staff, is to strengthen the capacity of health centers and communities to deliver and obtain high quality comprehensive HIV/AIDS services. They do this through technical assistance, training and the use of tailored tools, checklists, protocols, indicators. These tools and documents reflect national norms and standards, indicators and guidelines for comprehensive HIV/AIDS service delivery.
- ❖ Internal to HCSP, the various Teams have developed their own approaches and tools.
- ❖ In order to gain efficiencies, achieve the greatest possible impact, and obtain and report consistent results over time, the various approaches and tools used by HCSP must be harmonized within and through the FFSDP tool.

Recommendations:

**1. How can the Treatment Standards, currently used by the HCSP Treatment Team, be integrated in the FFSDP tool?**

The FFSDP uses 10 standards. Of those, Standard 8 (Adequate Quality of Services) measures the degree to which service providers comply with national treatment and counseling protocols, and the degree to which clients are satisfied with the services.

Recommended Action:

1. Review and compare the questionnaires, checklists and tools of the FFSDP with those used by the Treatment Team in applying the Treatment Standards.
2. Agree on harmonizing the tools so that both FFSDP application and Treatment Team tools are same
3. Ensure weekly coordination at the implementation level, and bi-weekly at HCSP HQ

The central FFSDP Team will take the lead while the heads of each other Team will share all tools and review final package of tools for approval and sign off. Once all tools are harmonized, all HCSP activities will be aligned with the FFSDP approach.

**2. How can the HCSP Treatment Team assist in implementing the FFSDP?**

The FFSDP can only be implemented at scale if all HCSP staff is fully aligned around the FFSDP tool, and the FFSDP tool is fully harmonized with other tools used by the Health Systems Strengthening Team, the Treatment Team, the Prevention Team, the Care & Support Team, and the M&E Team.

Scale up of the FFSDP will require specific assistance from the clinical Mentors, as well as the Regional M&E advisors and the Regional Health and/or Technical Integration Advisors. It will also require diligent coordination between all the mentioned Teams of the HCSP project, so that technical advisors and especially regional staff are fully supported and aligned to implement Quality Improvement through the FFSDP lens.

The attached Table provides an overview of PY02 activities for FFSDP scale up. It also spells out where the treatment Team will assist in the FFSDP implementation.

Next steps:

1. integrate indicators of txt and ffsdp tool
2. integrate /harmonize tools
3. determine frequency of evaluations
4. determine which data will be collected monthly
5. develop detailed SOW for clinical mentors
6. strengthen HC through data clerks to collect data
7. allocate SOW to regional M&E advisors
8. allocate SOW to data clerks

Draft Activity Plan for FFSDP Scale up, PY02

Activity	Who?	When
<b>General FFSDP Preparedness activities at Regional level</b>		
Attend trainings to become FFSDP facilitators in each Region (3-5 days)	<ul style="list-style-type: none"> <li>▪ Clinical Mentors</li> <li>▪ Woreda Supervisors</li> <li>▪ Regional M&amp;E Advisors</li> <li>▪ Regional Health Advisors</li> </ul>	August 2008
Facilitate PBF or MOU with Woredas or directly with HCs for immediate release of Support Funds for HC Improvements	<ul style="list-style-type: none"> <li>▪ Sr.Managers at Central HCSP office</li> </ul>	August 2008
<b>Create Model FFSDP Health Centers</b>		
Select Model FFSDP Health Centers in each Region	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team</li> </ul>	July 2008
Share FFSDP Action plans for model HC with appropriate Clinical Mentors and RHA	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team</li> <li>▪ Clinical Mentors</li> <li>▪ RHA</li> </ul>	July 2008
Conduct intensive TA to model HC to implement Action plans (at least once every 2 weeks)	<ul style="list-style-type: none"> <li>▪ Clinical Mentors</li> </ul>	August 2008 – January 2009
Supervise and review implementation of action plans in model HC	<ul style="list-style-type: none"> <li>▪ RHA</li> </ul>	- Monthly Team meetings with clinical Mentors - Rotated HC visits
Integrate TA into FFSDP action plans at model HC	<ul style="list-style-type: none"> <li>▪ Clinical Mentors</li> <li>▪ RHA</li> <li>▪ Treatment Team leader</li> </ul>	- ongoing
Conduct 6 month follow up evaluation	<ul style="list-style-type: none"> <li>▪ Regional M&amp;E advisor</li> <li>▪ Clinical Mentor</li> </ul>	6 months after Baseline
Analyze & document findings and share lessons learned with other HC, woreda and other stakeholders	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team in collaboration with RHA &amp; Teams</li> </ul>	- every 3 months
<b>Scaling up FFSDP to all Health Centers</b>		
Implement Baseline at new HC	<ul style="list-style-type: none"> <li>▪ Regional M&amp;E advisor</li> <li>▪ Clinical Mentor</li> </ul>	September-December 2008
Share HC action plans with RHA and other LTTA and coordinate support for implementation	<ul style="list-style-type: none"> <li>▪ Clinical Mentor</li> <li>▪ RHA &amp; staff</li> </ul>	- ongoing
Support implementation of action plan at HC through monthly TA	<ul style="list-style-type: none"> <li>▪ Clinical Mentor</li> </ul>	- ongoing

Activity	Who?	When
visits		
Conduct 6 month follow up evaluation	<ul style="list-style-type: none"> <li>▪ Regional M&amp;E advisor</li> <li>▪ Clinical Mentor</li> </ul>	6 months after Baseline
Share BL and follow up data with central FFSDP unit	<ul style="list-style-type: none"> <li>▪ Regional M&amp;E advisors</li> </ul>	7 months after Baseline
<b>Central FFSDP Preparedness and Support Activities</b>		
Produce First Evaluation Report of Pilot Phase	<ul style="list-style-type: none"> <li>▪ Yoseph, Aberra, Elke</li> </ul>	July 08
Share First Evaluation Report with USAID, FHAPCO and disseminate results	<ul style="list-style-type: none"> <li>▪ COP, Sr. HCSP Managers</li> <li>▪ FFSDP Team</li> </ul>	July-August 08
Harmonize FFSDP Tools with other HCSP tools	<ul style="list-style-type: none"> <li>▪ Central HCSP Team with FFSDP team</li> </ul>	July 08
Dedicate more staff to FFSDP and align Central FFSDP Team within Health Systems Strengthening	<ul style="list-style-type: none"> <li>▪ Ato Hailu Meche</li> </ul>	August 2008
Finalize FFSDP tool and manual	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team</li> </ul>	July-August 08
Develop and Produce FFSDP Training materials for regional trainings of FFSDP facilitators	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team</li> </ul>	July-August 08
Conduct trainings in each of the five target regions	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team with support of RHA</li> </ul>	August-September 08
Analyze 3 <sup>rd</sup> evaluation data of FFSDP in model HC and produce report	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team with STTA support from Elke</li> </ul>	October-November 08
Develop FFSDP publication	<ul style="list-style-type: none"> <li>▪ Elke</li> </ul>	November-December 08
Prepare FFSDP presentations at international conference	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team with support from Elke</li> </ul>	January-March 2009
Analyze project wide FFSDP data, Share lessons, provide feedback	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team</li> </ul>	April-June 09
Support to regional Teams to implement FFSDP	<ul style="list-style-type: none"> <li>▪ Central FFSDP Team</li> <li>▪ Central Treatment Team</li> </ul>	- ongoing

## **Attachment 4**

### **Anticipated Challenges and Solutions during FFSDP scale-up (from Report on FFSDP Pilot Phase, Ethiopia July 2008)**

<b>Anticipated Challenges</b>	<b>Possible Solutions</b>	<b>Responsible party</b>	<b>Timing</b>
<b>Within HCSP</b>			
Limited human resources for FFSDP at central level	Obtain approval from USAID to hire staff	MSH and USAID	PY02/Q1
Limited human resources for FFSDP in regions	Obtain approval from USAID to hire staff	MSH and USAID	PY02/Q1
FFSDP evaluation tool is time consuming	Simplify tool and harmonize with other HCSP and MoH/FHAPCO intervention tools	HCSP	PY02/Q1
FFSDP implementation component unable to access planned resources through PBF or MOUs	Ensure through USAID and MoH that HCSP can proceed with MOUs or PBF to public sector	MSH and USAID, MoH	PY02/Q1
Internal coordination of interventions	Continue weekly coordination meetings at central and regional levels	HCSP	On-going
Coordination with other CAs and partners	Intensify coordination with other CAs especially at regional and woreda levels	HSCSP with support from USAID, MoH, and HAPCO	On-going
<b>At the Regional, Woreda and Health Centers</b>			
High expectations	Explain and educate HC staff and regional and woreda authorities about HCSP mandate	HCSP	During FFSDP trainings and implementation
High staff turn-over	Assist regional and woreda managers to limit staff turn over	HCSP	PY02
Commitment and availability of supervisors	Educate regional and woreda authorities about FFSDP and the need for their active participation	HCSP and national health authorities	During FFSDP trainings and implementation
<b>Other</b>			
Global food crisis likely to affect Ethiopia disproportionately	Continue coordination and team work with USAID, FHAPCO, MoH to adjust project objectives and activities as needed	All	On-going

## **Attachment 5**

See HCSP report on FFSDP Pilot Phase

## Attachment 6

Agenda - FFSDP Orientation for Clinical Mentors & Regional Staff  
Addis Ababa, 19 July 2008

Chair/Moderator: Ato Hailu Meche

Presenters:

- Yoseph W/Gebriel, HCSP, MSH Ethiopia
- Aberra Kifle, HCSP, MSH Ethiopia
- Elke Konings, MSH Headquarters, USA

Agenda:

1. Overview of FFSDP Concept and Approach (20 min.)
  - a. PPT presentation (hand-out)
  - b. Q&A
2. Update on FFSDP Activities in Ethiopia (40 min.)
  - a. Adaptation & Pilot Phase
  - b. Results to Date (hand-out)
  - c. Next Steps (refer to PY2 work plan)
  - d. Q&A

Short break (15 min)

3. Your involvement in scaling up the FFSDP (60 min)
    - a. Overview of planned activities and scale up strategy
    - b. Discussion and Q&A
-

## Plan for FFSDP Expansion

### **1. Strengthen FFSDP TA Unit at HCSP central office**

- a. Bring all FFSDP TA under Health Systems Unit
- b. Structure of FFSDP Sub-Unit (hand-out)
- c. Develop detailed quarterly activity plans and operational progress reviews

### **2. Develop FFSDP TA capacity at HCSP regional offices (hand out)**

In each Region:

- a. Orient Regional Health Advisor, M&E advisor, and clinical mentors to FFSDP
- b. Define roles and responsibilities for FFSDP implementation
  - i. RHA: oversight, planning, coordination
  - ii. M&E advisor:
    1. Leads evaluation component of FFSDP, data entry & analysis
    2. Supports Clinical Mentors
  - iii. Clinical Mentor:
    1. Leads work plan and education component of FFSDP
    2. Provides TA and support to Health Centers for implementing work plan
    3. Some may be regional FFSDP focal point/primary liaison with FFSDP staff at central office
- c. Develop Regional FFSDP scale-up activity plans

### **3. Train FFSDP facilitators at regional and woreda/zonal level**

In each Region:

- a. 3 day Training workshop including:
  - i. HCSP RHA, M&E advisor and clinical mentors
  - ii. Woreda/zonal health supervisors and data clerks
- b. Joint baseline activities (clinical mentor + M&E advisor + Woreda supervisor visit first health center)
- c. 1 day Review work shop

- 4. Introduce FFSDP in all health centers**
  - a. With RHA, central FFSDP representative, plan FFSDP baseline and follow-up in all Health Centers
  - b. Conduct FFSDP baseline (= evaluation + work planning)
  - c. Support Health Center in implementing work plan (= education)
  - d. Conduct 6 month and 12 month follow-up at Health Centers (= evaluation + work planning)
  
- 5. Retain a few health centers in each region as “model health center”**
  - a. Link to MOU’s and HC support
  - b. Intensive interventions
  - c. Evaluations at times 0, 3 months, 6 months, 12 months
  
- 6. Roll-up regional FFSDP data, analyze and report on successes**
  
- 7. Feedback to Regions & develop recognition ceremonies**
  
- 8. Celebrate your own achievements along the way!!!**

## **Attachment 7 (ppt presentation on FFSDP)**

## Attachment 8

### Support Systems for The Fully Functional Health Center

