

Trip Report: Kate Stratten

Ethiopia HIV/AIDS Care and Support Project
July 11 – August 21, 2008

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TRIP REPORT

Project: HIV/AIDS Care and Support Program (HCSP)

Organization: IntraHealth International

Staff member: Kate Stratten, Senior Program Manager

Dates: July 11th – August 21st

Purpose of the Trip

The primary purpose of this STTA under 663-C-00-07-00408-00 HIV/AIDS Care & Support Program was to provide program management support, plus additional tasks, including the following:

- To assist the Prevention Team with finalizing the year 2 work plan and budget and developing a clear plan for meeting year 2 targets and deliverables.
- During the transition period with the Intrahealth Country Director resigning, provide program management support to begin implementing year 2 activities.
- Assess the quality of prevention activities at one of the field sites.
- Assist with the communication strategy workshop.
- Review any contractual issues and provide continued orientation on USAID projects, including maintenance of compliance within USAID rules and regulations.

Travel, M&IE, LOE was cost-shared with the following projects: USAID Preventive Care Package implemented by PSI (Task Order GHH-I-01-07-00062-00), Public Private Sector Partnerships Program (PC4) implemented by Abt Associates (GPO-I-00-04-00007-00; Task Order #807), and ESD/Fistula - field Support Mechanism implemented by Intrahealth International.

A total of 13 days were allocated to HCSP.

Background

My first STTA trip for HSPC was in April 2008. During this trip, the Treatment Team Leader resigned (originally a key position for IntraHealth) and was to be replaced by MSH, however this position is not yet filled. The Regional Clinical Managers titles were changed to Regional Clinical Mentors, a change which many of Regional Clinical Managers were dissatisfied with and resulted in three of them resigning. These positions were also replaced by MSH staff. There had been delays in the implementation of the prevention activities due to confusion regarding the budget for these activities – funds for prevention activities were moved from IntraHealth’s budget to MSH’s and due to some misunderstanding, the Prevention Team Leader didn’t have a budget from which to work.

Since April many improvements and achievements have taken place in both the treatment and prevention program components, however staff retention continues to be difficult for a number of

reasons. IntraHealth is yet to sign a sub-contract with MSH due to ongoing changes with personnel and the budget. To date, IntraHealth has received funds through Letters of Approvals from MSH.

Activities and meetings during my trip

1. Work plan and budget

In response to a technical direction from USAID, which included an increased scope of work but no increase in budget, the Prevention Team was requested by MSH to reduce its budget. The Prevention Team Leader and I had a number of meetings to revise the work plan and the budget. The final version reduced the following personnel and activities:

- BCC consultants reduced from 3 to 2 – the original plan was to have 5 BCC Advisors at national level, including the Treatment Team Leader, to support each of the HCSP Regional BCC Coordinators.
- STTA trips reduced from 3 to 2.
- Infection prevention training reduced from 5 to 4 days.
- Prevention training costs for KWOOS incorporated into the Care and Support budget.
- Number of materials to be developed and printed significantly reduced.
- Audio-visual equipment for clinics taken out of the budget.
- Year three's budget was reduced significantly by decreasing the staff's time from 12 to 6 months and in some cases, taking staff like clinical mentors out completely.

Total budget for IntraHealth International for year two is \$ 1,131,650.

It was also agreed that the training activities will be moved to MSH's budget, as was done in year one, to facilitate the administration and logistics of these activities. The treatment team work plan and budget have been developed by MSH.

2. Attendance of the USAID review meeting

I attended the Regional Clinical Mentors meeting on Saturday July 19th. During this meeting the USAID CTO for HCSP, Dr Abeje, presented findings from a project review USAID recently conducted. Findings included, amongst others, a need for job aides for health care professionals and information leaflets for clients, a need to strengthen the link between clinical and community activities and referrals between the two and stronger linkages between the project partners – currently the project continues to be referred to as MSH's project as opposed to HCSP.

3. Meeting with Prevention Team to discuss quarterly plan

I met with the Prevention Team to discuss the first quarter plan, see appendix B. MSH has instructed us to move ahead with activities despite the year 2 work plan and budget yet to be approved by USAID. The team also needs to send through activities that require VAT approval ahead of time to prevent delays in implementation. An annual work plan was not developed due to the ongoing changes in the work plan and budget. It was also agreed that an internal communication strategy work shop would not take place but rather that the team would refer to HAPCO's National ART, PMTCT and VCT communication strategy which clearly identifies messages for specific audiences. The current IEC assessment which the Prevention Team is carrying out will also identify materials that can be re-printed and the gaps for new materials to be developed.

4. Field visit to SNNPR

From August 6th to the 9th I traveled to Awassa, SNNPR, to visit two HCSP sites with Temesgen Benti, the Prevention/BCC Advisor and Mateus Kabele, the Regional BCC Coordinator. We visited health centers, in Aleta Wondo and Shinshicho as well as the community core groups associated with these centres. We tried to visit a third health center on the way back from Shinshicho, however due to rain and poor roads we were unable to reach it before the end of the day. Two clinical mentors, Yirgalem and Yehualashet, accompanied us during the visits. Observations and findings from this field trip reflect are similar to those of USAID's recent project review.

Aleta Wondo

The visit to the Aleta Wondo health center coincided with a visit from USAID and CDC. We toured the health facility, which offers comprehensive HIV/AIDS services, met the community core group members and visited a church on the outskirts of town. The tour of the health facility revealed that the services are well run, registrars are up to date and that staff that have been trained are still in their positions at the health center. Referrals between this health facility and the local hospital could be strengthened and some ART clients are lost during referrals. The case manager at the facility explained that clients sometimes give false addresses, making it difficult to follow up with them.

The data capture clerk is capturing data manually. The need for a computer for data input was raised by the USAID representative, who also encouraged the clinic to use the same data capturing software as the hospital. The clinic also needs job aides and client materials on ART, PMTCT, VCT, prevention and care and support.

The community core group was represented by 30 men and women, who included KWOOS, religious and community leaders. They told us that the training they received from HCSP has been very useful and went on to tell us of the activities they've accomplished since they've been trained. As a result of the community outreach activities, numbers of people coming for testing has increased, however stigma is still an issue in this community, resulting in some clients that test positive going to another health center or hospital for treatment.

At the community church, 25 people attended the meeting, most of them were religious and community elders who have been trained to do outreach, but are not part of the community core group. During this meeting, the religious elders praised HCSP for the training and information they've received. As a result of the training couples wanting to get married are being tested for HIV. The clinic nurses come to the church to perform the tests. Those that test positive are not allowed to marry and are referred to the clinic for treatment. The religious leaders are encouraging positive people to marry each other. In this case, information and education on prevention for positives is critical. All members at this meeting commented that since the training, stigma and discrimination within the community has decreased, especially now that religious and community elders are speaking more openly about HIV/AIDS and accepting and caring for people living with HIV.

Shinshicho

During the visit to this health facility most of our time was spent with the community core group. I was particularly impressed with the commitment of this group and the measures they've taken to assist PLWHAs and to educate the broader community on prevention and the available HIV/AIDS services. Throughout their outreach work, the importance of HIV testing as a prevention intervention is emphasized and they stress the importance of HIV/AIDS knowledge as a means to reduce stigma and

discrimination. The heads of the Kabeles in this Woreda publicly went for HIV tests to encourage others to do the same. The PLWHA Association's membership in this community has risen from 45 to 75 since the community core group started its HIV/AIDS outreach activities. Religious leaders are now making home visits to give spiritual support to PLWHAs and their families and teach youth at church once a week on HIV prevention. Additionally, this group has raised funds to support people with HIV and support to 50 OVCs with uniforms and school fees.

Through these activities this community has become acutely aware of the consequences and cost of losing community members to AIDS, making their commitment and focus on prevention particularly strong. The cohesion of this group has been strengthened by the loss of the HCSP Case Manager as a result of AIDS and whose wife is a member of the community core group. This community is enormously grateful for HCSP's training and ongoing support but they are struggling to maintain their motivation without incentives.

A tour of the clinic revealed that it is providing comprehensive HIV/AIDS services under difficult conditions. The physical condition of the clinic is appalling. Although it is clean, the roof needs to be replaced, walls painted and new beds and linens are needed. While I was there I also witnessed mothers and children lining up for food aid. MSF was there weighing and treating infants and children and distributing food packages. Most of the wards were full of malnourished children and one of the PMTCT rooms had been given to MSF to store food packages.

5. Meeting with Capacity and HCSP regarding the transition of PMTCT sites

A meeting was held with HCSP and Capacity to discuss the transition of PMTCT sites and mother support groups from Capacity to HCSP. To date Capacity has shared with HSCP all its training materials and support materials and a total of 102 sites have been transitioned. Another 74 sites and 30 mother support groups are ready to be handed over, which Capacity plans to do during August. The transition is formally carried out during a meeting with the relevant Regional Health Bureaus and clinic heads, after which Capacity staff stop supporting the sites and the HCSP Clinical Mentors step in to continue the support and any refresher training required. Capacity has developed a detailed transition plan (see Appendix C), which has been shared with HCSP and USAID.

USAID also expects the mother support groups to be handed over to HCSP with the PMTCT site. Capacity plans to provide HCSP staff with an orientation on the purpose of the mother support groups and how to set up and maintain them. The Mother Support Group Coordinator and the Capacity Program Manager will plan the transition of sites and mother support groups with HCSP's PMTCT Advisor.

Throughout the coming year, Capacity will continue to hand over its new PMTCT sites to HCSP once the service has been well established.

6. Human resources management

This aspect of the project continues to be a challenge. For the past 6 months four IntraHealth staff have been hired on a contract basis pending USAID's approval of these positions. The staff involved are dissatisfied with this situation and have said that they will leave the project if their status on the project isn't resolved soon.

During my trip a team of us interviewed candidates for the newly created BCC Regional Coordinator positions for Addis and Tigray regions. Two women have been selected for the posts and they will be

offered the positions this month. Assuming they accept, their paper work will be processed in time for them to start on October 1st. SNNPR and Oromia Regional BCC Coordinator posts have been filled by the previous Regional BCC and Community Mobilization Managers (Mateus and Melaku). Gizachew, previously an MSH employee has been employed by IntraHealth as the BCC Coordinator for Amhara Region.

IntraHealth continues to recruit a Pediatric/Palliative Care Advisor. The first candidate selected turned down the offer due to the low salary. The other candidate put forward was rejected by USAID due to insufficient experience. Myself and the Capacity Pediatric Advisor, Dr Telahun, interviewed a third candidate who was recommended by Dr Muluken. IntraHealth has offered this person the position, however he's yet to respond.

Two Regional Clinical Mentors, one from Oromia and another from SNNPR, hired by IntraHealth resigned during August and another from Amhara threatened to leave. The two mentors in Oromia are upset after they were issued with a letter from the Regional Health Advisor citing underperformance. Both Clinical Mentors objected to this criticism, especially as they received a positive performance review a month ago. Ato Haile and a representative from IntraHealth will travel to the region to assess the situation. The mentor in SNNPR resigned due to management problems in this regional office. He informed me of his frustrations due to a lack of team work and joint planning and told me that he was considering resigning. MSH plans to address this issue the SNNPR Regional Health Advisor, who they acknowledge is a weak manager and that there are ethnic conflicts within the team in that region.

Recommendations

Prevention activities

The Prevention component is focusing its activities on interpersonal communication and print materials. The training of religious leaders and community elders has been successfully carried out and I believe that targeting parents and teachers will also be an effective group through which to disseminate messages. Print materials in the form of job aides are definitely needed and the prevention team is currently developing 8 job aides in consultation with the Treatment Team. However, the amount of funds spent on print materials and distribution thereof should be reviewed as it may be more cost-effective to reach the broader community through radio. Reference to HAPCO's national communication strategy will provide this type of guidance and I encourage the Prevention Team to study the strategy's recommendations for messages and methods for different audiences.

- During my field trip I observed that the community core groups are focusing mostly on HIV testing and treatment, however PMTCT information and knowledge is weak. This may be due to the fact that not all sites are yet offering PMTCT services, but I encourage the team to ensure that community members know of this important prevention intervention and that they promote ANC and PMTCT services.
- I also encourage the Prevention Team to work closer with the Gender Advisor. Gender is a key social issue driving the HIV epidemic in Ethiopia and community members need to be made aware of this. The mother support groups, which HCSP will inherit from the Capacity Project, are a good opportunity through which to address this issue.

- The Prevention Team needs its activity budget from MSH if it is to plan and monitor activities and expenditure. Last year, lack of knowledge of this budget was a major cause for the delay of implementing prevention activities.

PMTCT and mother support group transitions

This transition process needs to be closely monitored. I suggest that monthly meetings are held with HCSP (Treatment, Prevention and Care and Support) and Capacity to track the handovers and any problems that arise during the transition period. During my field visits I was informed that it's hard for HCSP to provide the same level of support to the clinics that Capacity did because of the number of clinics and services HCSP supports compared to Capacity. For example, concerns have been raised about the supply of PMTCT support materials to clinics, such as clinic cards and registers, and that clinics that have been handed over to HCSP have not received these materials and were reverting to Capacity for such supplies. This is an example of the kind of problems that need to be addressed as transitions take place.

- I strongly recommend that the orientation of the mother support groups is with the Regional Clinical Mentors, the Regional BCC Coordinators and the Regional Social Mobilizers, not just the Clinical Mentors as I believe it is planned. Although the mother support groups meet at the facility and play a role in supporting treatment services, their work in the community as advocates for treatment and prevention is equally important. They also have the potential to be a critical link between the health facility and the community if trained and supported appropriately.

Clinical Mentors

Traveling to two HCSP sites gave me an understanding of the conditions that the clinical mentors are working under, the vast distances covered to reach health centers, and the mentors' work load. It became apparent to me that to ensure quality, regular supportive supervision visits HCSP needs additional clinical mentors.

Human resources management

I've recommended to the Prevention Team Leader that all the BCC Advisors and the Regional BCC Coordinators are called to a meeting for an orientation to the project and their scopes of work. This is particularly important since the Regional Social Mobilization and BCC Coordinator positions have been split into two – staff need to understand their scope of work in relation to the Social Mobilizers, where their jobs are different and where they overlap. The BCC Coordinators also need to know how often they are expected to visit sites for follow up and supportive supervision. They have to have the Regional Advisors support to ensure that vehicles and other resources are available for them to perform their jobs effectively. Other issues such as planning, lines of communication, monitoring, reporting and budgets also need to be addressed.

- It was agreed with the Prevention Team that in future weekly reports will be sent to the Team Leader and BCC Advisor and the Regional Health Advisors will be copied on these e-mails. The Team Leader will send me the summarized weekly report, the quarterly, semi-annual and annual reports so that I'm up to date with activities and can provide assistance as and when is necessary.
- With regard to the community core group members, HCSP needs to develop an incentive scheme or income generating activities if these groups are to maintain their commitment and

motivations. PSI's new Preventive Care Package (PCP) project could be one method of income generation and I encourage HCSP to liaise with the PCP project in this respect.

- Lastly, throughout my trip, I observed that within HCSP there is much emphasis on treatment and facility-based activities. The project was also frequently referred to as MSH as opposed to HCSP by health workers, community members and donors. Whilst I understand that this is the core activity, prevention and care and support are equally important and should be recognized by the clinical team as such. Regional Health Advisors should be encouraged to continually provide staff with the 'big picture' and recognize and encourage the interdependence of the project components. They also need to work on creating an HCSP team which is collectively striving to achieve the same goal and objectives.

Appendices :

Prevention quarterly plan

PMTCT transition plan