

PEPFAR Ethiopia In-Country Reporting System (IRS) Semiannual Program Results

Ethiopia HIV/AIDS Care and Support Project
October 1, 2010 – March 31, 2011

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.

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

*Management Sciences for Health
HIV/AIDS Care and Support Program
(HCSP)*

SEMI-ANNUAL PROGRESS REPORT

SAPR'11

(OCTOBER 2010 – MARCH 2011)

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

AA	Addis Ababa
AB	Abstinence, be faithful
AFB	Acid fast bacilli
AIDS	Acquired immune deficiency syndrome
ANC	Ante-natal care
ANECCA	African Network for Care of Children Affected by HIV/AIDS
ARC	AIDS Resource Center
ART	Anti-retroviral therapy
ARV	Anti-retroviral
BCC	Behavior change communication
BCP	Basic care package
C&S	Care and support
CBO	Community-based organization
CCG	Community core group
CD4	Cluster of differentiation 4 (better known as T cell)
CME	Continuous medical education
CPT	Cotrimoxazole therapy
CTX	Cotrimoxazole
DBS	Dry blood sample
DHS	Demographic and health survey
DNA-PCR	Deoxyribose nucleic acid-polymorphous chain reaction
DOHE	Dawn of Hope Ethiopia
DOTS	Directly observed treatment short-course
DQA	Data quality assurance
DTS	Dried serum sample
EDHS	Ethiopian Demographic and Health Survey
EHNRI	Ethiopian Health and Nutrition Research Institute
EID	Early infant diagnosis
EIFDDA	Ethiopian Interfaith Forum for Development Dialogue and Action
EPI	Expanded program for immunization
EQA	External quality assurance
ESR	Eritrocyte sedimentation rate
F	Female
FFC	Family focused care
FFSDP	Fully functional service delivery point
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FHI	Family Health International
FMOH	Federal Ministry of Health
FP	Family planning
FY	Financial year
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HAPSCO	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
HEI	HIV-exposed infants
HEW	Health extension worker
HgB	Hemoglobin
HIV	Human immune deficiency virus
HIV+	HIV positive
HMIS	Health management information system
IAS	International AIDS Society
IGA	Income generating activity

IP	Infection prevention
IPT	Isoniazid preventive therapy
JPM	Joint pediatrics mentorship
JSI	John Snow International
KOOW	Kebele-oriented outreach worker
L&D	Labor and delivery
LQAS	Lot quality assurance sampling
LTFU	Lost-to-follow-up
M	Male
M&E	Monitoring and evaluation
MDR	Multi-drug resistance
MDT	Multi-disciplinary team
MIS	Management information system
MNCH	Maternal, neonatal and child health
MOH	Ministry of Health
MOU	Memorandum of understanding
MSG	Mother support group
MSH	Management Sciences for Health
NGI	Next generation indicator
NGO	Non-governmental organization
NNPWE	National network of Positive Women Ethiopians
NVP	Nevirapine
OI	Opportunistic infection
OP	Other prevention
OPD	Out-patient department
OR	Operations research
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceuticals fund and supply agency
PITC	Provider initiated testing and counseling
PLHIV	People living with HIV
PMP	Performance monitoring plan
PSI	Population Services International
PwP	Prevention with positives
Q	Quarter
REQAS	Regional external quality assurance
REST	Relief Society of Tigray
RH	Reproductive health
RHB	Regional health bureau
RLTWG	Regional laboratory technical working group
RPR	Rapid plasma regain
SCMS	Supply chain management systems
SI	Strategic information
SNNPR	Southern Nations, Nationalities, and People's Region
SOC	Standard of care
SOP	Standard operating procedure
SPM	Strategic plan management
SPS	Strengthening pharmaceutical systems
STD	Sexually transmitted disease
STTA	Short term technical assistance
T&C	Testing and counseling
TB	Tuberculosis
TB-CAP	Tuberculosis Control Assistance Program
TBL	Tuberculosis and leprosy
THPP	Targeted HIV Prevention Program
TOT	Training of trainers
TWG	Technical working group
USAID	United States Agency for International Development

VCAP	Voluntary community anti-AIDS promoters
VCT	Voluntary counseling and testing
WAD	World AIDS Day
WBC	White blood cells
WHO/AFRO	World Health Organization/ Africa Regional Office

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1. Reporting period

From 1 October 2010	To 31 March 2011
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2. Publications/reports

Did your organization support the production of publications, reports, guidelines or assessments during the reporting period?

No/Not Applicable

Yes If yes, please list below:

Publications/Reports/Assessments/Curriculum

Title	Author	Date
Libona	Dawn of Hope Ethiopia	Monthly issue
Yesetoch Dimtse	NNPWE	Monthly issue

3. Technical assistance

Did your organization utilize short-term technical assistance during the reporting period?

No/Not Applicable

Yes Please list below:

Consultants/TDYers

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Fred Hartman	29 Sept '10	17 Oct '10	MSH	Technical Support by Country Team Leader

4. Travel and Visits

Did your organization support international travel during the reporting period?

No/Not Applicable

Yes Please list below:

International Travel (All international travel to conference, workshops, trainings, HQ or meetings).

Name	Destination	Departure from Ethiopia	Arrival	Host Organization	Purpose of the travel
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Have any Monitoring Visit/supervision been made to your program in during the reporting period?

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
Field visit by Dr. Zeke Emanuel, Senior Global Health Advisor to the White House	27 Oct '10	27 Oct '10	Modjo HC	No
USAID Ethiopia (COTR) monitoring visit	27 Oct '10	27 Oct '10	Kasech HC	No
Inter-agency USG technical assistance team visit: HIV Testing and Couple Counseling	1 Nov '10	9 Nov '10	Bahir Dar HC	Yes
Inter-agency USG technical assistance team visit: Integration of PMTCT and FP with MNCH Services	1 Nov '10	10 Nov '10	Adama HC, Kersa HC, Hawassa HC, Haromaya HC, Saris HC	Yes
USAID Washington field visit by Buck Buckingham	10 Feb '11	10 Feb '11	Yirgache HC	No
USAID-CDC Ethiopia DHS monitoring visit	11 Feb '11	11 Feb '11	Leku HC	No

Inter-agency USAID/CDC technical assistance team visit: PMTCT, Maternal and Neonatal Mortality	10 Mar '11	14 Mar '11	Haromaya HC, Asendab HC, Wukro HC,	Yes
USAID Ethiopia monitoring visit: Prevention (VCT/PITC) services	22 Mar '11	24 Mar '11	Kombolcha HC, Harbu HC, Dessie HC, Hike HC	No

5. Activity

Program Area (Tick all which apply)	Activity ID	Activity Title (Please write the title of the activity)
<input checked="" type="checkbox"/> 01-PMTCT		
<input checked="" type="checkbox"/> 02-HVAB		
<input checked="" type="checkbox"/> 03-HVOP		
<input type="checkbox"/> 04-HMBL		
<input type="checkbox"/> 05-HMIN		
<input type="checkbox"/> 07-CIRC		
<input checked="" type="checkbox"/> 08-HBHC		
<input checked="" type="checkbox"/> 09-HTXS		
<input checked="" type="checkbox"/> 10-HVTB		
<input type="checkbox"/> 11-HKID		
<input checked="" type="checkbox"/> 12-HVCT		
<input checked="" type="checkbox"/> 13-PDTX		
<input checked="" type="checkbox"/> 14-PDCS		
<input type="checkbox"/> 15-HTXD		
<input checked="" type="checkbox"/> 16-HLAB		
<input checked="" type="checkbox"/> 17-HVSI		
<input checked="" type="checkbox"/> 18-OHSS		

01-PMTCT

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 01-PMTCT

During SAPR'11 (Oct 2010 – Mar 2011) the HCSP achieved the following results in the area of PMTCT:

✓ **550 health centers (HCs) are providing PMTCT services (PI.3.D)**

Comment: During SAPR'11, all 550 HCSP supported HCs continued to provide PMTCT services (i.e. 100% of the program's target). These HCs are implementing the national four pronged PMTCT strategy, including (1) static & outreach HIV testing and counseling services, including counseling on AB & OP methods, (2) prevention of unintended pregnancies in HIV positive (HIV+) women (3) prevention of HIV transmission from mother to child through provision of ARV and PMTCT follow-up at the ANC clinic and during L&D (4) enrolling HIV+ mothers and families into comprehensive HIV care and support services including ART at the ART clinic. At all program supported HCs, HCSP promotes PMTCT as an integral part of ANC and therefore continues to strengthen not only PMTCT but the delivery of essential and integrated ANC services in the ANC clinic, L&D services, and HEI identification and treatment at the under 5 and ART clinics.

✓ **191,938 pregnant women were tested for HIV (PI.1.D)**

Comment: During the reporting period, 203,755 pregnant women with unknown HIV status were seen at the ANC clinic and 14,804 at L&D. An additional 1,449 with known HIV+ status were seen at ANC. Among the 203,755 whose HIV status was unknown at entry, 198,350 (97%) were counseled and 191,938 (94%) were tested for HIV (thus, the rate of test acceptance among those who were offered to be tested was 97%).

The continued success in uptake of HIV testing at ANC and L&D is due to HCSP's promotion of PITC, its focus on the quality of counseling and to the fact that HCSP, along with the regional health offices at all levels, has been mobilizing and creating HIV/AIDS awareness among women to access the basic PMTCT/MNCH services. Through the HCSP community based prevention and care support activities, delivered by KOOWS with the involvement of HEWs and CBOs as well as community volunteers, pregnant women are mobilized to utilize available health services.

HCSP exceeded its SAPR'11 target by over 20%, with current data accounting for 122% of HCSP's target of 157,781.

✓ **2,842 (1.5%) of newly tested pregnant women were HIV+ and an additional 1,449 were known HIV+ upon entry at ANC, bringing the total HIV+ women seen during the reporting period to 4,291. (PI.1D - from ANC and L&D)**

Comment: The overall HIV prevalence among pregnant women was 2.2 % for the first 6 months of FY11. This figure is comparable to the national HIV prevalence of 2.1% to 2.3% for the general population (FMOH, FHAPCO: Report on Progress Towards Implementation of the UN Declaration of Commitment on HIV/AIDS, March 2010 and Single point HIV prevalence estimates, MOH, June 2007). The prevalence among newly tested pregnant women, as in previous quarters, continued to decline and is currently 1.3% (see Table 1).

Table 1: HIV prevalence of pregnant women at entry in ANC and L&D

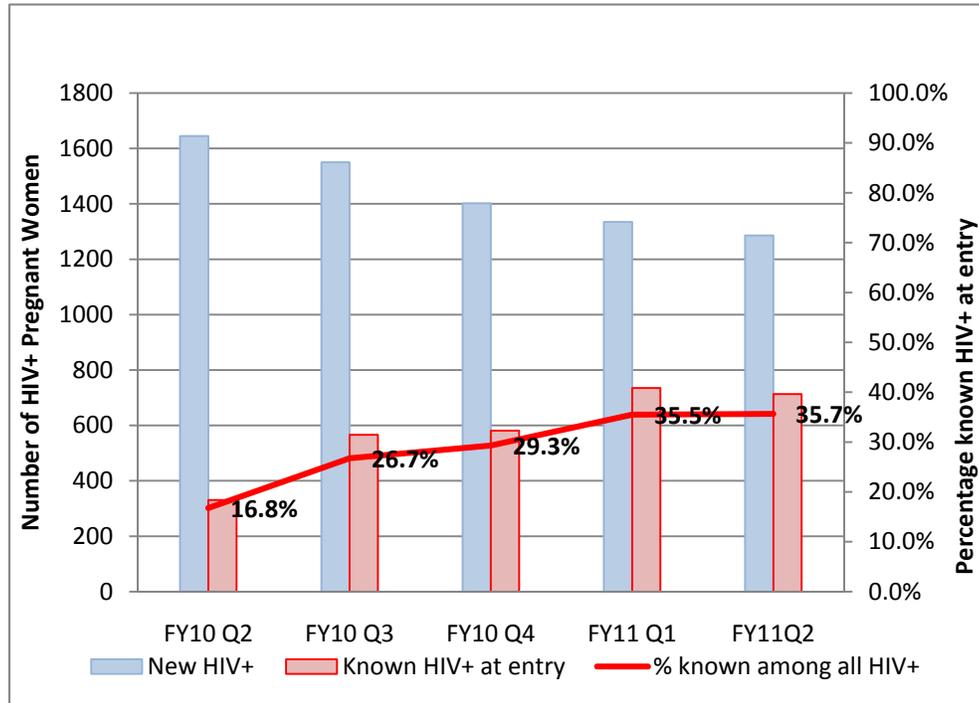
Pregnant women	FY10				FY11	
	Q1	Q2	Q3	Q4	Q1	Q2
HIV prevalence of newly tested	2.4%	2.2%	2.0%	1.7%	1.7%	1.3%
HIV prevalence of all	2.4%	2.5%	2.6%	2.4%	2.5%	1.9%
Amongst HIV+, percent known at entry	no data	15%	24%	28%	32%	36%

At the same time, SAPR'11 data have showed an increase in the number and proportion of pregnant women with a known HIV+ status at entry compared to FY10 (Figure 1). The increase in known HIV+ PW may, in part, be related to successes in HIV testing, in keeping HIV+ women in the health

system when they get pregnant, and to improved knowledge that HIV+ women can have healthy, HIV negative babies so that more HIV+ women decide to become pregnant. Another possibility is that more pregnant women disclose their HIV+ status and therefore are not tested again, as may have been the case before. It is also possible that as the program reaches more HIV+ patients over time, more HIV+ women relative to HIV negative women are coming into HCs for ANC or L&D.

There is the possibility that the increase in known HIV+ PW may indicate an unmet need for FP among HIV+ women, or, as some anecdotal reports suggest, that an increasing number of HIV+ women are intentionally getting pregnant in order to obtain food that is distributed free of charge to pregnant HIV+ women. HCSP has begun a rapid assessment of this situation.

Figure 1: Number and percentage of known HIV+ pregnant women seen at HCSP supported HC, by quarter, January 2010 – March 2011



✓ **2,238 HIV-positive pregnant women received ARV for PMTCT (PI.2.D).**

140 received a single dose Nevirapine prophylaxis (Q1=110; Q2=30)

1,278 received two or three ARVs

820 received ART at the ART clinic

Comment: During SAPR'11, 2,238 HIV+ pregnant women were reported to have received ARV for PMTCT. Among them, 140 took SdNVP, 1,278 received two or three ARVs and 820 were on ART. The FMOH recently directed public health facilities to replace SdNVP with multi-drug prophylactic regimen. This directive is reflected by the quarterly data which show that the number of pregnant women who took SdNVP dropped from 110 in Q1 to 30 in Q2.

In principle, all HIV+ pregnant women should, at some point during their pregnancy, receive some form of ARV, either as treatment based on clinical or immunological evaluation or as prophylaxis, beginning at the 28th week of pregnancy through labor and delivery. As FMOH national guidelines currently recommend starting ARV prophylaxis at the 28th week of pregnancy, HCSP does not expect all HIV+ women seen in the reporting period to be on ARV.

The number of pregnant women who were given ARV for PMTCT was 90% of the HCSP SAPR'11 target. While HCSP relatively achieved its target, the number of HIV+ pregnant women taking ARV

for PMTCT continues to only be 52% of the number of all HIV+ pregnant mothers seen during the reporting period.

To understand the reasons for the above 52% ARV uptake, HCSP conducted a retrospective study of HIV+ PW at a sub-set of 23 HCs. Preliminary findings suggest that reported (27.2%) and actual (33.2%) uptake of ARV prophylaxis is significantly different ($p < 0.01$). The data showed that a significant number (78) of HIV+ pregnant women were already enrolled on ART at a different health facility. Data recording errors also accounted for a small proportion of the difference. In addition, the number of HIV+ pregnant women taking ARV appears to be under-reported because, as per NGI guidelines, the NGI only counts the HIV+ pregnant women newly enrolled on ART. When taking into consideration the number of pregnant women already on ART in the first quarter and adding the newly enrolled ones in subsequent quarters, the total number on ART increased from 66 to 222.

The OR data was similar to the findings of assessments of the standard of care (SOC). During the reporting period, HCSP assessed the SOC at 30 HCs in Amhara and Tigray. At these, the ARV uptake rate was 63% among eligible ANC clients and 84% among women seen at L&D.

In conclusion, both the OR and the SOC results showed an ARV uptake of 64.9% (including those on ART) or 33.2% excluding those on ART. This is significantly better than what is shown by the routine data calculated according to the NGI guidelines. Nevertheless, the data continue to show a number of missed opportunities (35%) among HIV+ pregnant women seen at HCSP supported HCs.

- ✓ **1,533 (54%) of the 2,842 newly tested HIV+ pregnant women were assessed for ART eligibility at HCSP supported HCs** (PI.4.D - data source: ART clinic)

Comment: Our data indicates that among newly tested HIV-positive pregnant women, those assessed for ART eligibility remains low (54%), despite HCSP's great emphasis on follow-up of all HIV + pregnant women both in the HC and at the community level. To improve linkage of pregnant women with family focused comprehensive HIV/ AIDS services, currently health workers are encouraged to escort positive women to the ART clinic and register their Pre/ART number on the ANC/L&D original registers.

- ✓ **1,533 HIV+ pregnant women were newly enrolled into HIV/AIDS care and support in HCSP supported HC** (PI.5.D - data source: ART clinic).

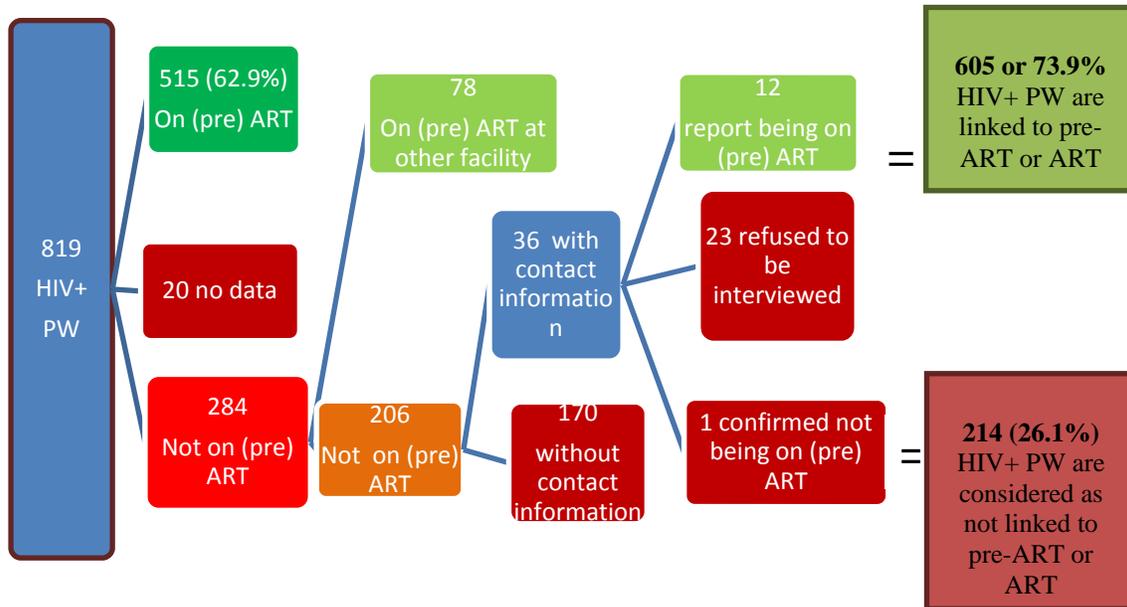
Comment: Since enrolment and clinical assessment of eligibility are done simultaneously at the ART clinic, the figures for enrolment concur with those assessed for ART eligibility. Therefore, the low linkage rate more likely reflects challenges in the referral system between the ANC and ART clinics, or in data recording and reporting.

To fully understand the causes of the low enrollment rates and thus introduce interventions to address the problem, the above mentioned OR study also addressed ANC/PMTCT linkage to ART to identify the causes of the apparent drop-out between testing HIV+ at ANC and enrollment in ART services. Preliminary data from the OR suggest that the true linkage of HIV+ pregnant women to ART is much better (73.9%) than what the program's routinely reported data shows (49%).

Therefore, the apparent low linkage from ANC/PMTCT to ART is, in part, the result of under-reporting. It is also related to the fact that a significant number of HIV+ women seek ANC services at a different health facility than where they are enrolled in HIV/AIDS care and support and several of them end up being tested for HIV as if their status is unknown at ANC entry.

Nevertheless, the OR still suggests that around a quarter of HIV+ pregnant women are not linked to HIV/AIDS care and support services. The difficulty in locating HIV+ pregnant women during the OR who had visited the assessed HCs at least once (170 out of 206 who appeared to be unlinked) and the high numbers who refused to be interviewed (23 out of 36 for whom contact information was available) also suggest that stigma or denial of HIV+ status may lead many women to not access care and support services, and therefore at risk of delivering a HIV+ baby.

Figure 2: Linkage to (pre)ART among HIV+ PW in the selected 23 HCSP supported ART HCs, Ethiopia, 2010 (n=819).



✓ **Additional Achievements:**

Assessment of HC service quality: During the reporting period HCSP used its mentorship check-list, developed in FY10, at all HCs to guide and monitor HCSP mentorship activities, which included strengthening the linkage between ANC/PMTCT and ART clinics.

HCSP assessed SOC at 30 selected HCs in Amhara and Tigray and debriefed with the respective health workers and health decision makers on the results.

This data was subsequently added to recent data collected at the other regions for development of a paper on the spill-over effects of rapid HIV/AIDS services scale-up on the quality of ante-natal care services. In total, 16,034 ANC client records were examined through SOC assessments at 185 HCs, or 34% of the 550. The findings were that a majority of ANC clients were tested for HIV (92%) and had their blood pressure taken (85%). However, only 28% had received urine albumin and hemoglobin tests.

These findings were commented on in the paper as follows: “PEPFAR has been a major contributor to Ethiopia’s rapid scale up of HIV/AIDS services and to its impressive improvements in associated health outcomes. One of these successes is the dramatic increase in the number of pregnant women getting tested for HIV and accessing PMTCT services when needed. However, the singular focus on HIV services and its health outcomes have not resulted in similar outcomes in the quality of other routine health services. In this regard, the GOE’s unwavering focus on service integration will soon benefit from changes in requirements imposed by donors such as the GHI, which will mandate its fund recipients to also set ambitious targets for and report on other maternal, neonatal and child health services and outcomes.”

Mother support groups: To strengthen the PMTCT continuum of care, 133 HCs now have mother support groups (MSGs). In total, HCSP supported HCs have 506 mother mentors who assist newly identified HIV+ mothers at ANC, giving them peer support, providing HIV/AIDS related counseling on positive living, counseling on FP, linking them to HIV/AIDS care and support services, and facilitating the enrollment of exposed infants to HEI programs. During the reporting period, 28 mother mentors were trained and deployed, of whom 10 were for gap filling purposes.

Health worker training: Training on PMTCT, using the revised national training module, was given to 202 health workers during SAPR'11 to build capacity of health centers to provide standard PMTCT services.

PMTCT TWG: During SAPR'11, HCSP experts continued to participate in regional and national TWGs, PMTCT trainings and review and updating of training packages--as a part of continuous technical support to improve national PMTCT services.

Community demand creation for ANC services: Worked closely with the program's sub-contracted national NGOs, especially the National Network of Positive Women Ethiopians (NNPWE), which improved their capacity to stimulate increased demand for ANC services, and thus testing. However, other factors in the community were also important contributors to our increased testing rates, including a national effort led by the First Lady to increase utilization of ANC services.

PMTCT poster: As detailed in the later OP component, under the WAD 2010 description, the program supported the printing of 30,000 copies of a PMTCT poster for national distribution

02- HVAB (HIV prevention through abstinence and be faithful)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 2-HVAB (Sexual Prevention: AB)

During SAPR'11 (Oct '10 - Mar '11) HCSP achieved the following results in the area of AB prevention:

- ✓ **98,900 individuals reached through community outreach that promotes AB messages using NGI modalities (P8.2D).**

Comment: The current achievement for the number of people provided with AB messaging is 78% of HCSP's SAPR'11 target. The moderately below target achievement is likely related to the program's over-estimation of one child between the ages of 10 – 14 per household visited by the program's community outreach volunteers.

For background, AB messages are provided to 10-14 year old members of infected/affected households by the program's kebele-oriented outreach workers (KOOWs) and NGO community volunteers during their regular home visits. The community outreach volunteers have been provided with a reference manual and job aid to help ensure that they present AB messages consistent with the NGI guidelines. The program is careful to avoid double counting across Q1 and Q2 by having the volunteers only report new beneficiaries reached in Q2.

During SAPR'11, the prevention component primarily worked together with the program's Care & Support and NGO strengthening components. Through the concerted effort of the community mobilizers, case managers, KOOWs, community core groups (CCGs) and NGO community outreach workers, a total of 98,900 (M 45,232, F 53,668) youths were reached with AB messages.

- ✓ **Customization and distribution of 261,771 copies of BCC materials and job aids on AB messaging**

Comment: A key support to the facility and community level AB messaging is the distribution to clients and beneficiaries, at facility and community level, of brochures, posters and job aids produced by the program or collected from the FMOH and FHAPCO/ARC.

Thus, during SAPR'11, 161,771 copies of BCC materials that address AB messaging were distributed through the case managers, community mobilizers, KOOWs and other community outreach workers for use by the providers, clients and community volunteer outreach workers. Specifics include:

- 4,000 copies of program's NGI job aid produced and distributed to KOOWs addressing AB
- 155,771 copies of brochures addressing AB collected from ARC

- ✓ **Supportive supervision**

Comment: During SAPR '11, the prevention component jointly carried out supportive supervision at selected HCs and served communities with the care & support component using the program's integrated checklist for prevention and care & support mentorship. Supportive supervision provided technical support, monitored NGI implementation and provision of BCC materials.

Specifically, each regional BCC coordinator, in coordination with the regional care & support coordinator, conducted regional visits to each facility. The regional supportive supervision was conducted in an integrated manner and during the period a total of 187 ART HCs with community outreach workers were supervised in the five regions under HCSP.

- ✓ **Additional achievements:**

Collaboration on World AIDS Day 2010 Commemoration

During the WAD'10 celebration, described in detail in the following OP section, the venue and timing of the celebration provided the opportunity for the collaborators to reach a large population of pilgrims, as the celebration was held during the annual St. Mary Tsion religious festival when an estimated 500,000 pilgrims were in Axum. The program, collaboratively, carry out sensitization and mobilization activities for these pilgrims.

03- HVOP (HIV prevention through other prevention)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 3-HVOP (Sexual Prevention: OP)

During SAPR'11 (Oct '10 - Mar '11) HCSP achieved the following results in the area of OP prevention:

- ✓ **353 persons were provided with post exposure prophylaxis (PEP) during SAPR'11 (P6.ID)**

Comment: During SAPR'11, 353 individuals were provided with PEP. Among them, 185 were for occupational exposure, 100 for exposure by rape and sexual assault and the remaining 68 for other exposures. HCSP achieved 141% of its SAPR '11 target of 250. This over-achievement is probably due to better than expected improvements in documentation and reporting after HCSP developed, distributed and mentored HCs on the use of a PEP registration log book.

During SAPR'11, quality of care of PEP services was assessed in 14 ART HC in Amhara and 13 in Tigray. In Amhara, of the 57 individuals who received care and completed PEP, only 7 (12%) received follow-up HIV testing at 3 months. In Tigray, of the 17 individuals who received care for HIV exposure, 5 completed PEP, of which 3 were tested and counseled at 3 months. For the two regions, all were found non-reactive for HIV.

- ✓ **95,133 people living with HIV/AIDS were reached with a minimum package of prevention with PLHIV (PwP) interventions during this quarter (P7.ID)**

Comment: The current achievement for the number of people provided a minimum package of PLHIV preventions is 190% of the HCSP's SAPR '11 target. The over-achievement is likely a result of the way the target was calculated, which was based on the average per quarter for FY10. It should have been based on the higher average of FY10's first two quarters (79,951), as the first quarter of the NGI annual reporting period counts all visits and subsequent quarters only count new visits. If this calculation had been used, the achievement would have been a still impressive 118%.

To ensure consistency with the NGI guidelines, the program's mentors have oriented health workers in supported HCs on the key messages. In addition, a PwP job aid wall poster has been provided and posted at the various HC clinics. To avoid double counting between a HC's clinics, the program only counts those patients visiting the ART clinic. To avoid double counting between quarters, the program counts, in the first quarter, all pre-ART and ART visits, but only newly enrolled pre-ART patients in Q2.

It is also important to note that the above total achievement for P7.ID only includes facility level interventions. While HCSP does include those supported at community/home-based level, they may visit non-HCSP supported health facilities. To avoid double counting between partners, USAID has instructed HCSP to only report facility level achievement as the total achievement for the NGI.

The achievement for community/home-based intervention was 129,462. As noted in the earlier AB component, the community volunteers have been provided with a reference manual and job aid to help ensure that they present PwP messages consistent with the NGI guidelines. The program is careful to avoid double counting across Q1 and Q2 by having the volunteers only report new beneficiaries reached in Q2.

- ✓ **457,570 individuals reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required (P8.ID)**

Comment: The current achievement for the number of people reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required is 104% of HCSP's SAPR '11 target.

Of note, P8.ID combines both AB results from P8.2.D and OP results. For OP alone, the number of individuals reached was 358,670.

For background, OP results include both home visits and coffee ceremonies. For home visits, OP

messages are provided to ≥15 year old members of infected/affected households by the program's KOOWs and NGO community volunteers during their regular home visits. As with AB, the community volunteers have been provided with a reference manual and job aid to help ensure that they present OP messages consistent with the NGI guidelines. The program is careful to avoid double counting across Q1 and Q2 by having the volunteers only report new beneficiaries reached in Q2.

For coffee ceremonies, the volunteers follow a job aid supported format that schedules four sessions, as follows:

1. Session 1: Social norms that affect sexual behaviors (e.g. sex under the influence of alcohol, cross-generational sex, transactional sex, etc.); stigma and stigma reduction; disclosure, partner testing and referral for testing.
2. Session2: Effective ABC messages (including: abstinence, delay of sexual debut, mutual faithfulness, partner reduction, and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV).
3. Session 3: Messages on: sexual abstinence, delay of sexual debut and secondary abstinence, mutual fidelity, mutual knowledge of HIV status, social and gender norms that promote mutual respect, open communication about sexuality, messages that discourage multiple and/or concurrent partnerships, cross-generational and transactional sex, sexual violence, stigma, and other harmful gender norms and practices.
4. Session 4: ART initiation, ART adherence counseling and support; messages on TB/HIV, STIs, safer sex, etc.; services available at health center: PMTCT, FP, ART, HCT, etc.

The community outreach volunteers conduct the coffee ceremonies in their communities, list the name of clients attending and report those attending the four sessions. They do not list clients that they support during home visits to avoid double counting.

✓ **Customization and distribution of 204,500 copies of BCC materials focused on OP messaging**

Comment: A key support to the facility and community level OP messaging is the distribution to clients and beneficiaries, at facility and community level, of brochures, posters and job aids produced by the program or collected from the FMOH and FHAPCO/ARC.

During SAPR '11, **204,500** copies of OP related BCC materials were distributed for use by service providers, clients, and community outreach volunteers. Accordingly, during SAP '11, working together with the program component teams, the following promotional materials were produced and distributed:

- **200,000** copies of brochures on family focused care for discordance and PwP
- **4,500** copies of a national poster on discordant couples

✓ **15,000 copies of Libona newspaper produced and distributed:**

Comment: During SAPR '11, HCSP continued to support DOHE to print and distribute their Libona newspaper. During this period, HCSP also supported the continued incorporation of the NNPWE's newsletter, Yesetoch Dimtse (The Voice of Women), into Libona. This monthly publication is produced to sensitize and mobilize the general public and PLHIV clients on HIV/AIDS prevention, care and treatment interventions.

During SAPR'11, HCSP supported the printing and distribution of a total of 15,000 copies, which were distributed by DOHE to HCSP supported HCs through the regional HCSP for use by the health providers and community outreach workers. An additional 15,000 are under publication.

✓ **Additional achievements:**

Condoms generally available at all 550 HCSP supported HCs

Comment: Through collaboration and partnership with the PSI-Ethiopia implemented USAID Targeted HIV Prevention Program (THPP) and regional health bureaus (RHBs), the program helped ensure the availability of condoms in HCSP supported HCs. PSI has developed a mechanism to ensure condoms are available through the RHBs and regional HAPCOs. HCSP supports HCs to appropriately receive and make available to their patients the condoms e.g. case managers receive and place condoms in easily accessible, open places in the HC. HCSP also reports to the RHB any shortages at HCs.

In addition to the facility level distribution of condoms, KOOWs and other community outreach workers were actively involved in the distribution of condoms to the community through woreda HAPCOs, HEWs and PLWHIV associations.

Supportive supervision

Comment: During SAPR '11, the prevention component, as reported earlier under the AB component, carried out supportive supervision that also included OP.

Prevention component participation in Technical Working Groups (TWG)

Comment: During SAPR'11, in order to ensure harmonization and integration with the health delivery system, the prevention component participated in TWG activities together with relevant USG partners, mainly C-Change, PATH, PSI and JHPIEGO. The TWGs participated in were chaired and technically monitored by the Medical Service Directorate (MOH) and FHAPCO and included the following:

- Infection Prevention Task Force: Development of guideline, strategy, reference manual and training modules for establishing a standard package for use by all government and partner organizations
- Nutrition TWG: Development of cue cards on exclusive infant breast feeding and nutritional needs of HIV+ lactating mothers for educational use at health center and health post levels
- MARP TWG (for USG funded partners): Collaboration of USG partners working in the MARPs area
- National Communication and MNCH TWG on HIV/AIDS and Malaria Message Harmonization and Integration: Message development and harmonization on HIV/AIDS and malaria with C-Change

Collaboration on World AIDS Day 2010 Commemoration

Comment: Every year, on December 1st, World AIDS Day (WAD) is commemorated with different events and activities under a given theme from UNAIDS. This year's theme, a repeat of last year' was "Universal Access and Human Rights". The national level Ethiopian celebration was colorfully celebrated with different events and activities in the historic city of Axum. Similar events took place in the country's regions.

HCSP was formally requested by FHAPCO to collaborate and support this year's event as it has done in the previous three years. HCSP agreed and supported activities relevant to its mandate at central and regional levels. At national level, HCSP was an active member of the national coordinating committee, chaired by the Director General, and also participated as a member of logistics and resource mobilization task force. In the regions where HCSP operates, the program's regional offices actively participated by providing technical and financial support.

The celebration in Axum was commemorated in the presence of President Girma Woldegiorgis and Ato Abay Woldu, President of the Regional State of Tigray (pictured below).



President Girma Woldegiorgis and invited guests

The President, in his keynote address, reiterated the government's commitment to ensure all citizens have access and equal opportunity to information and services. He acknowledged and commended the role of partners as pivotal and urged them to continue supporting the government efforts.

Remarks by the President and other speakers during the occasion focused on the Government's commitment to universal access to treatment, prevention and care & support and included:

- The need to focus on community intervention by involving HEWs
- Prevention of Mother to Child Transmission (PMTCT)
- The importance of giving priority to Prevention with Positives (PwP) strategy

HCSP's deputy chief of party, prevention team leader and regional health advisor of Tigray participated in the national celebration. HCSP hosted an information booth and its KOOWs presented a coffee ceremony (pictured below).



**Coffee Ceremony Demonstration by Community Mobilizer and KOOWs
World AIDS Day, Axum, 2010**

As noted under the earlier AB section, the venue and timing of the WAD provided the opportunity to reach a large population of pilgrims, as the celebration was held during the annual St. Mary Tsion religious festival with an estimated 500,000 pilgrims in Axum. This allowed the program to collaboratively carry out sensitization and mobilization activities for the pilgrims.

In the regions, HCSP supported such shared, collaborative HIV/AIDS promotional activities as candle light vigils, entertainments and exhibitions, religious ceremonies and other events, involving program community mobilizers, KOOWs, religious leaders, local bands and other social groups. Specific support provided by HCSP for both national and regional celebration included:

- Involvement and participation in WAD TWG with HAPCO at central and regional levels
- Supported the production cost for the printing of 160,525 copies of a brochure on 'Universal Access and Human Rights'
- Supported the production cost for:
 - 30,000 copies of a poster on PMTCT
 - 14,000 copies of a poster on discordance
 - 5,000 copies of a poster on OVC
 - 86 banners for display in main streets, exhibition halls and at the national level celebration main arena
 - 77,380 T-shirts and caps
 - 10,000 ribbons
- Organized coffee ceremony during national celebration to demonstrate a key HCSP strategy to reach individuals with OP messages in accordance with the NGI guidelines

08-HBHC (Home based HIV care and support)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 8-HBHC (Care: Adult Care and Support)

During SAPR'11, HCSP achieved the following results in the area of care and support:

Palliative care - community based (CI.I.D)

- ✓ **469,399 eligible adults and children provided with a minimum of one care service (CI.I.D)**

Comment: The number of infected/affected individuals who received a minimum of one care service through home visits by program community outreach volunteers was 123% of the SAPR'11 target. Over half (57%) were women and 23% were younger than 18 years of age. This distribution reflects HCSP's gender-sensitive, family focused approach as well as the fact that more women are infected and affected by HIV than men. Specifically, the community outreach volunteers track and report on four basic palliative care services, which encompass: 1) the provision of home based care; 2) psychosocial support (screening/assessment/referral); 3) adherence support; and 4) bereavement counseling.

Community care and support

During the reporting period, community outreach activities, led by KOOWs, continued and included the involvement of PLHIV associations, CCGs and HEWs. KOOWs conducted community outreach activities that focused on, among other things, stigma reduction, the value of disclosure, and access to services identified through resource mapping. In addition, KOOWs also conducted home visits for provision of basic palliative care services and training of household members on care as well as mobilizing other household members for increased uptake of services at HCs. The 9 service areas that KOOWs report on include: 1) palliative care; 2) referral for clinical services; 3) referral for food support; 4) referral for IGA support; 5) PWP; 6) OP; 7) AB; 8) traced LTUF for Tb; and 9) traced LTFU for ART.

The KOOWs' most regular formal meeting for reporting is the monthly woreda level meeting, typically held at the HC. In actual practice, KOOWs often visit HCs on a daily or weekly basis. These informal linkages are essential, for example, in reducing LTFU patients. In the reporting period, the monthly meeting continued in the 191 HCs with KOOWs, which were visited by the program staff during quarterly supportive supervision. The program has KOOWs supporting high prevalence HCs (191 out of 350), which contain around 85% of the current ART and enrolled pre-ART patients. There are 6,350 KOOWs based in 1,265 kebeles around these 191 HCs (5 usually peri-urban kebeles per HC). The other HCs do not have HCSP deployed KOOWs. However, HCSP supported NGOs, particularly NNPWE and DOHE, deploy an additional 443 community volunteers to carry out home visits and ensure that people are linked to services. The program is careful to ensure they do not overlap their support to households, and as such, complement the KOOWs by working in non-KOOW supported locales.

To review progress and refocus care and support activities at the community, woreda and HC level, review meetings were conducted for all 191 health center catchments with KOOWs. These review meetings included discussion of the challenges that case managers, KOOWs and CCGs face in supporting PLHIV in their areas. Typically, the review meetings are chaired by woreda HAPCO officers, who continue to show commitment to the program by mobilizing resources in support of KOOWs and facilitating PLHIVs' access to government resources.

Community outreach: During SAPR'11, **228,012** individuals were reached through coffee ceremonies and other community outreach for the reporting period.

Coffee ceremonies continued to be used as the primary vehicle for reaching community members in small group settings. During SAPR'11, 228,012 people were reached through small group (218,834 by KOOWs through coffee ceremonies, 9,178 by NGO community outreach volunteers). The small group sessions focused on promotion of OP and HIV testing, addressing stigma and discrimination, promotion of disclosure and information sharing and promotion of available community and HC

services. KOOWs, through coffee ceremonies, reached the targeted population through small group (25 persons or less) level interventions that met the minimum NGI standard of four sessions. Program Job aids guided these sessions as the volunteers' main reference material. (Earlier OP section provides a more detailed description of coffee ceremonies).

As the KOOWs become accustomed to the NGI implementation modalities, the program is realizing an increase in the number reached through coffee ceremonies. The CCGs and kebele HIV desk officers/HEWs are increasingly assisting the KOOWs in mobilizing the community for attending the 4 sessions required before individuals are counted as reached.

Of the above 9,178 people reached by the NGOs, 7,525 were reached through other small group activities. The NGOs use other small group activities such as testimonial sessions, MSG small groups as well as social mobilization forums in addition to coffee ceremonies. Trained testimonial providers educate the community on HIV/AIDS prevention, care & support, ART, PMTCT and abstinence and faithfulness in schools and other settings. It is an effective approach as testimony providers/volunteers teach their clients by relating each message with their own personal experiences. The testimonial sessions are fine-tuned in accordance with the NGIs. They also provide social mobilization forums which is particularly effective in encouraging VCT.

The establishment of MSGs within the branch offices of NNPWE has become an important part of NNPWE's strategy for PMTCT scale up. A total of 45 MSG groups are established in 9 woredas of Oromia, SNNPR and Amhara regions, with a total membership of 853 women during the reporting period. The women meet periodically for three to four hours to discuss all aspects of PMTCT. Of note, the MSGs are located in urban and per-urban areas where the prevalence of HIV/AIDS is highest.

Among the groups of HIV+ women are those who are pregnant, those who want to become pregnant as well as lactating mothers. The counseling and support they receive from the group encourages them to access all services including FP/RH services. The MSGs help in increasing treatment uptake through counseling about the importance of testing, FP, CD4 count, ART, PMTCT, breastfeeding and pediatric care. They also refer women from HC/associations to VCT and PMTCT. The relationship between NNPWE and HCs has been strengthened by some association members becoming case managers.

Home visits: During SAPR'11, **241,387** infected and affected individuals received at least one palliative care service (228,345 by KOOWs and 13,042 by NGO community outreach volunteers (DOHE and NNPWE).

Home visits continued to be the primary vehicle for identifying and providing palliative care to high-need infected and affected individuals and families, including TB patients. The program's community outreach volunteers typically carry out ongoing home visits to a minimum of 20 households. The households are identified through a variety of sources, including referrals from the HC case managers, community members of the CCGs and local PLHIV associations. As KOOWs are typically themselves HIV+, they also identify households through their own HIV-positive networks. Coffee ceremonies also provide referrals, as people often come up after the ceremonies and ask for assistance.

As noted in the earlier AB section, the community volunteers have been provided with a reference manual and job aid to help ensure that they carry out home visits consistent with program and NGI guidelines. The program is careful to avoid double counting across Q1 and Q2 by having the volunteers only report new beneficiaries reached in Q2.

Results of an operations research (OR) conducted by the program in Oct '10 show that 63% of clients were identified by KOOWs through home visits, 21% through follow-up visits initiated by the HC case managers, 11% through HC case manager referral initiated by an earlier KOOW community to HC referral, and 5% through coffee ceremonies.

In the above mentioned OR, discussions with KOOWs and caregivers indicated a significant decline in the number of bedridden clients. Unfortunately, information on bedridden patients is not included in the KOOWs' reporting format. During this reporting period, HCSP did collect information on bedridden patients from a sample survey of KOOWs and community mobilizers from Addis Ababa and the four operational regions. The sample uncovered a dramatic decrease in bedridden patients, from 20.2% in 2008 (Amhara), to 12.8% in 2009 (Amhara) and 2.4% in 2010 (all regions).

Community Mobilization: The care and support OR indicated that the program's systematic process of engaging communities from the woreda level not only effectively identified community based care and support resources for PLHIV, but also identified community skills and capital as well, resulting in confirmed linkages of PLHIV to food resources, IGA, psycho-social support, preventive care packages, and money for keeping ART appointments, as well as access to government housing. Some communities were found to be innovative in providing food support even in the absence of formal food programs by initiating grain banks during harvest times. Woreda health offices/woreda HAPCO and kebele administrations were found to be active in mobilizing government and other community resources to support KOOWs activities, including coffee ceremonies.

Community Referral and Tracing: During SAPR'11, some key results included:

- ✓ **95,391** individuals referred from community to HC by KOOWs, of which around 423 were referred through NGOs (a non-NGI contract indicator from Result 3)
- ✓ **2,900** individuals were referred by HCs to the community (a non-NGI contract indicator from Result 2)
- ✓ **11,826** individuals were referred for food support from the community
- ✓ **5,967** individuals were referred to or assisted to engage in IGA activities
- ✓ **1,173** TB and **3,153** ART patients brought back to HCs for treatment

Concerning LTFU, the work by KOOWs in both tracing lost patients and adherence counseling is a key feature of maintaining HCSP's relatively low LTFU rates (see Table 2 below). While relatively low compared to reported national levels of between 23% and 28%, the program's LTFU rate has been gradually increasing. Although no study has been conducted to explain the apparent increase, reports from KOOWs during supportive supervision in Addis Ababa and Amhara indicate one possible factor: they are experiencing significant difficulties in tracing LTFU clients where road and housing construction projects have displaced local residents in impoverished urban neighborhoods.

Table 2: Number of HIV+ patients referred from community to HC and LTFU by quarter

	FY10				FY11	
	Q1	Q2	Q3	Q4	Q1	Q2
# of referrals from community to HC	49,259	52,359	33,549	35,032	41,387	95,391
LTFU	9.1%	7.9%	7.8%	8.8%	9.3%	9.9%

- ✓ **Additional achievements:**

Strengthened linkages with GOE HEWs

The GOE is beginning to roll out a community mobilization model of women development teams comprised of women volunteers and women leaders from model households. The GOE's community level primary health care network will be increasingly integrated into this developing community mobilization network. HEW led health services will be coordinated/promoted, under the direct support of the women leaders from "model" households. Separate categories of community volunteers, such as the KOOWs, will likely phase out and they and their work will be assumed by one or more women leaders/volunteers who work with the HEWs and the kebele multidisciplinary

desk. The care and support OR is informative on ways of increasing the effectiveness of community volunteer work and its results will therefore be shared with the regional and woreda health authorities to assist their development of the community primary health care network.

In support of the evolving GOE community level health care network, the program, during SAPR'11, continued to strengthen linkages with the over 2,000 GOE HEWs, their supervisors, woreda women affairs representatives and program oriented woreda HIV focal persons. The woreda health officials continued to chair the monthly and quarterly meeting at health centers and continued to play a key role in coordinating care and support activities at the woreda level. HEWs and other kebele based government officials assisted CCGs and KOOWs in conducting community outreach activities as well as identifying and linking clients to community resources.

A key component of the primary health care network will be an effective bi-directional referral system. The program has already initiated the establishment of a standardized referral system within the HC-community continuum of care for care and support and PWP. FMOH feedback on a first draft submitted to the Ministry is pending.

Operations research (OR)

Comment: As part of the overall HCSP communication strategy, HCSP's care and support team carried out an OR to assess factors that promote community mobilization for increased availability of care and support services for HIV infected and affected people. Using qualitative methods, the OR documented HCSP's experience for the period of 2007-2010. The research targeted government stakeholders at woreda and kebele levels, community mobilizers, case managers, care givers, clients, KOOWs and CCG members. Some key findings from the research include:

1. Early identification of key partners at community level allowed communities to create a common vision and shared understanding of the impact of HIV on their community members. This fostered community ownership and created a foundation for increasing services available to people infected and affected by HIV.
2. Working with dynamic leadership (community, government, civic and faith based leaders) proved instrumental in mobilizing community resources and capital for supporting people living with HIV and their families in non-stigmatizing ways
3. A combination of formal training and 'mentoring' proved important to ensuring that communities and other partners at various levels developed the capacity to plan, implement and monitor program activities.
4. The deployment of community volunteers within supportive facilitated communities increased access to care and support services at HC and community level, decreased burden of care among caregivers and improved health outcomes among clients on ART.
5. Mobilizing communities in a systematic manner for action by applying the community action cycle helped community level organizations (woreda HAPCO, HEWs, PLHIV associations, CCGs) to integrate care and support activities into their regular day to day activities. For example, woreda HAPCO now carry supportive supervision of HCSP's community level interventions during their routine woreda supervision of health and HIV programs. HEWs mobilize communities to attend coffee ceremonies as part of their routine community work. Kebele administrations assist OVC to return to school. In summary, mobilized communities show an institutionalization of case and support, and therefore do not necessarily need a written action plan to carry out such activities.

Care & support mentorship checklist developed

Comment: HCSP has developed and began using a standardized mentorship checklist for care and support and prevention supportive supervision of HCs and supported communities. The checklist serves both as a job aid and a monitoring tool. In this reporting period, supportive supervision was conducted for all the 191 HC with KOOWs deployed in served kebeles. The checklist was used to

identify programmatic gaps and reinforce NGI implementation and reporting requirements. Any gaps identified during supportive supervision were discussed with the associated woreda HAPCO or health office.

Stigma and discrimination reduction manual developed

Comment: As part of the HIV/AIDS technical working group under FHAPCO, HCSP was mandated to lead a subcommittee in the drafting of a national stigma and discrimination reduction manual. The program's training manager participated in a two week writing workshop which resulted in production of a draft manual.

Customization and distribution of care and support materials

- **2,000** copies of the program's NGI training manual were produced and distributed for use by KOOWs and other volunteers
- **5,000** copies of a poster on OVC (earlier reported in the OP section's description of WAD'10)
- **500** copies of poster on standard operating procedures for case manger
- **10,086** copies of booklets on ART adherence collected from ARC
- **14,000** copies of NGI reference manual and job aids for community outreach volunteers

09-HTXS (Adult Treatment)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 9-HTXS

During SAPR'11, HCSP has achieved the following results in the area of adult HIV/AIDS treatment::

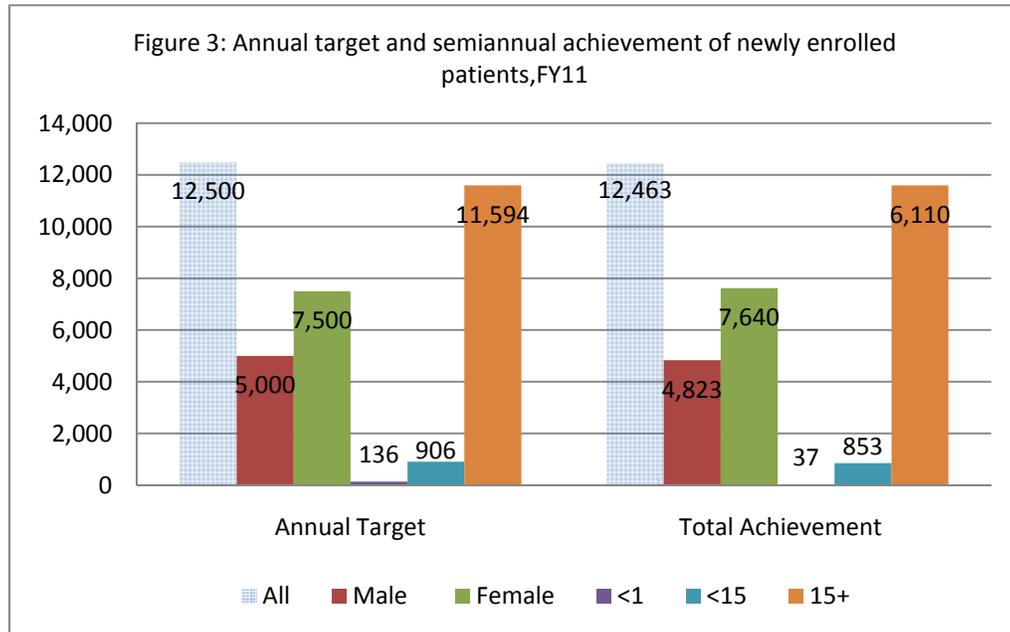
✓ **550 HCSP supported HCs offer comprehensive HIV/AIDS services (T1.5.D)**

Comment: During this reporting period, HCSP continued to work in all 550 HC through mentorship, training and other support. Of the 550 HCSP supported HCs, 394 are now providing ART services. This represents 113% of the HCSP target. The reason why HCSP is supporting more than its target of 350 ART HCs is that the RHBs have transitioned 47 program supported chronic HC sites to ART sites: 24 in Oromia, 16 in SNNPR, and 6 in Tigray and 1 in Addis Ababa. Of note, 3 HCs in Oromia were earlier upgraded to zonal hospitals and transferred to I-CAP upon request of the Oromia RHB. However, the program continued to support the KOOWs, as this was outside I-CAPs program scope. While HCSP does not provide the full package of support to these 47 HCs (e.g. HCSP is not deploying KOOWs, community mobilizers, MSGs, data clerks and case managers), HCSP has initiated mentorship and, at times, ART focal person training for their ART clinics.

✓ **12, 463 new individuals were enrolled on ART from October to March 2011 (T1.1.D)**

Comment: During SAPR'11, 12, 463 new individuals were enrolled to care in 350 ART HCSP supported HCs. Of note, the program has not included a reported 2,467 new individuals enrolled on ART from the RHB upgraded ART HCs noted above. As described above, while the program has mentored these facilities, it was not able to train and deploy data clerks and case managers, and therefore was not able to fully integrate the data into the program's reporting system e.g. does not have disaggregated data etc.

Of those enrolled, 853 were children under the age of 15 years and 11,610 (4,370 male and 7,240 female) were adults 15 years or older. HCSP achieved nearly 100% of its SAPR'11 target 12,463 due to strong HCT activity in all service areas.



✓ **86,005 HIV patients are currently receiving ART (T1.2.D)**

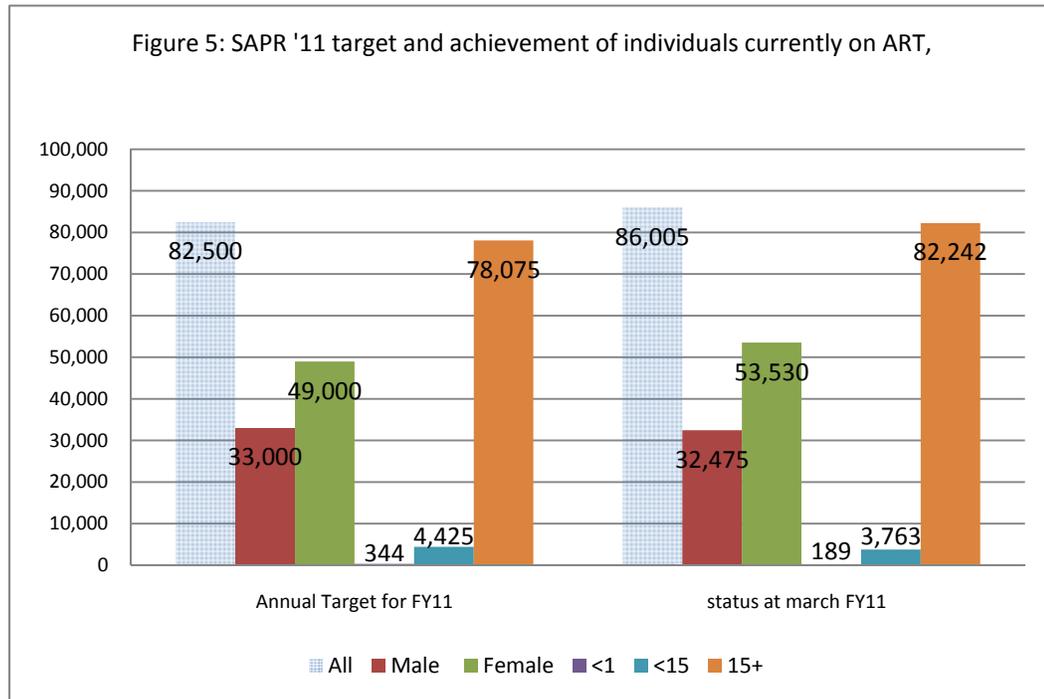
Comment: The number of current patients receiving ART in HCSP supported HCs reached 86,005 or 104% of HCSP's SAPR'11.

The program's good performance included strengthening of the PITC services and referral linkages, an increased number of transfer ins (25,453 individuals) compared to transfer outs (13,313), the emphasis on the importance of regular assessments of patients who are on pre-ART service, restaging and early initiation of ART for those eligible, and technical support to the HCs through clinical mentoring, quarterly catchment area meetings and supportive supervisions.

The number of patients currently receiving ART is very close to the number that ever received ART at HCSP supported HCs and thus suggests a low loss to follow up. As of the end of this reporting period, the LTFU in HCSP supported health centers reached 9.9 % (9,569 individuals).

Some of the reasons for the increasing LTFU rate at HCs include the duration that patients are on ART. The longer patients are on ART, LTFU tends to increase as more time has elapsed, more patients begin feeling good, and more move to other locales. However, the LTFU rate in HCSP supported health centers is still low compared to the national figure of 28% (Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS 2010. FHAPCO, March 2010). Through support of the case managers and KOOWs, 629 individuals restarted treatment during the period.

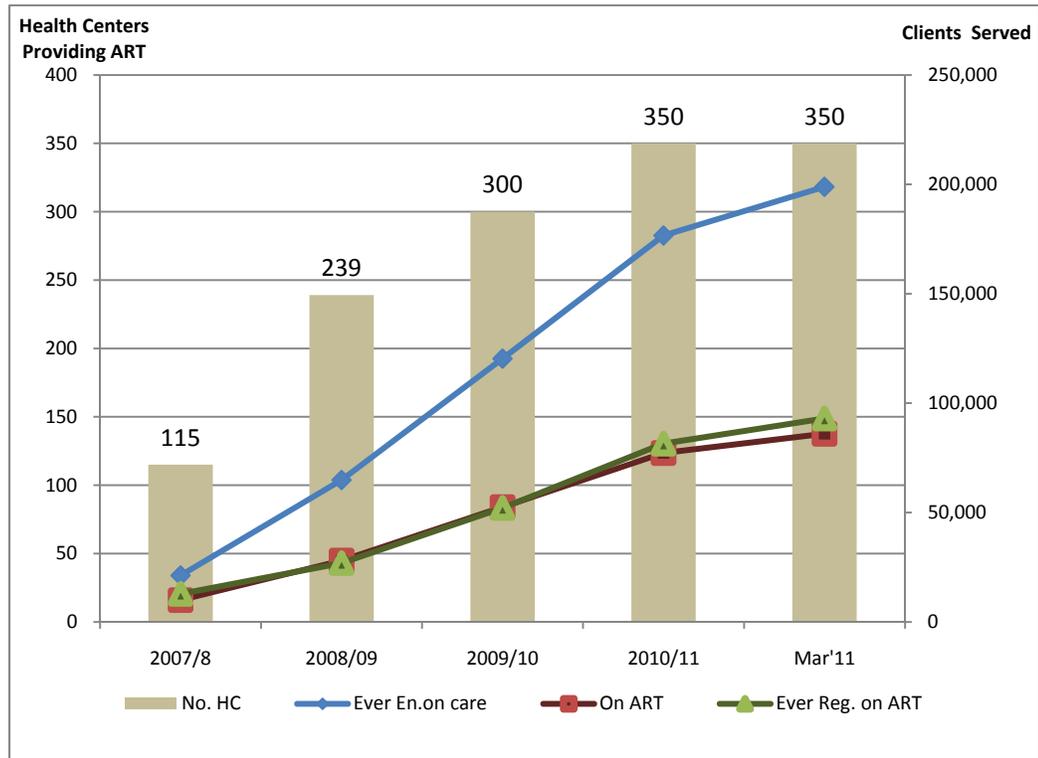
A key factor in the program's relatively low LTFU is certainly the success of decentralization of services to HCs and the linkage with community based services (see the earlier Care & Support section), which brings services closer to where people live, thus greatly reducing access difficulties. Quality of adherence counseling and refresher training for case managers also likely contributed, as do the active tracing of lost patients by KOOWs and other community volunteers.



✓ **93,027 individuals who ever started on ART (T1.4.D)**

Comment: During SAPR'11, the number of individuals who ever started ART at HCSP supported HCs reached 93,027.

Figure 4: HCSP supported HCs providing ART (total = 393) and clients served, 2007-2011



✓ **Additional achievements:**

Measuring the Standards of Care (SoC):

During SAPR'11, the clinical team from the central office assessed SOC for ART treatment and HIV+ patient management at 27 ART HCs, 14 in Amhara and 13 in Tigray.

In Amhara, of 293 newly enrolled clients in October '10, 80% had their CD4 tested within one month of enrollment. Follow-up CD4 counts were performed for 59% of 266 patients who had been on treatment for more than 6 months at the time of assessment. In Tigray, among 136 newly enrolled patients in January, 54% had undergone a CD4 count test within one month of enrollment to HIV/AIDS care. Follow-up CD4 was done for 74% of 247 clients on treatment for more than 6 months at the time of assessment

CD4 machine and serum transport problems continue to be key factors behind the low CD4 testing rates. For example, in Tigray, the low proportion of patients with an initial CD4 test was due to CD4 machine problems at hospitals and in delays of sample transportation payment at health centers resulting in the dissatisfaction and low motivation of laboratory technicians to transport samples.

HCSP also included, as part of the SOC, an assessment of baseline and follow-up hemoglobin for patients on AZT regimens. Though the baseline determination was relatively high (86% Amhara, 100% Tigray), follow up hemoglobin determination tended to be low in patients seen in both regions. In Amhara, 21% of 237 patients had follow-on Hgb determined; In Tigray, 58% of 142 patients had follow up hemoglobin. HC staff explained the low rate as being due to a lack of equipment and shortages of reagents. Another reason was that most facilities only had access to Sahel's method of hemoglobin testing. This method is seen as outdated, time consuming and subjective.

Support to catchment area meetings

In the four regions (Amhara, Oromiya, Tigray and SNNPR), regular quarterly catchment area meetings were conducted where HC heads shared their experiences, addressed common challenges and presented their quarterly achievements in PITC, HCT, ART, PMTCT and HIV/TB through a standardized reporting template developed by HCSP. In this meeting, ART health centers present major quarterly achievements, gaps, solutions to the gaps and ways forward. In AA, monthly meetings are held in major hospital catchment areas. During the Addis meetings, case reviews are conducted.

These meetings are crucial as they present a forum for experience sharing, capacity building, provision of practical solutions for unresolved problems, debriefing on new advances and/or any existing confusions and motivation for health care providers etc. The format that the HCSP developed has triggered a sense of competition among facilities by comparing their performances. This approach motivates health workers to achieve better results and share their experiences.

Desk Top reference to complement the program's pilot CME through video conference

To complement CME video conferencing conducted in the Amhara Region during FY10, the 8 lectures were compiled into a desk top reference booklet. HCSP has printed the reference booklet and has distributed it to the participating HCs

Comprehensive HIV/AIDS health worker training

As a crucial step to preparing the health system to deliver standard comprehensive HIV/AIDS care, including ART at primary health facilities, HCSP has been supporting comprehensive HIV care/ART training of HC providers. Gap filling training during SAPR'11 included 285 health workers trained on comprehensive HIV/ART. To support adherence, counseling on PwP, and link HC with communities, 51 case managers were trained and deployed to fill the gap of those who vacated.

10-HVTB

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 10-HVTB

During SAPR'11, HCSP achieved the following results in the area of HIV/TB::

- ✓ **109,789 HIV+ patients visiting the ART clinic during the period were screened for TB in HIV care and treatment settings (C2.4.D)**
 - Of whom:
 - **2,441 began TB treatment (C2.5.D)**
 - **7,696 were assessed with AFB**
 - **9,362 began IPT (C2.6.D)**

Comment: The number of HIV-positive patients visiting an ART clinic who were screened at least once during this semi-annual period for TB represents 111% of the estimated eligible HIV-positive patients, namely those HIV patients visiting an ART clinic minus the estimated 4% who are already receiving TB treatment: (C2.1.D: $99,564 \times 96\% = 95,581$).

HCSP's number of HIV+ patients screened for TB during the reporting period reflects 229% of the target of 48,000.

As noted in the earlier HVOP section, the over-achievement is likely a result of the way the target was calculated, which was based on the average per quarter for FY10. It should have been based on the higher average of FY10's first two quarters (68,681), as the first quarter of the NGI annual reporting period counts all visits and subsequent quarters only count new visits. If this calculation had been used, the achievement would have been 160%.

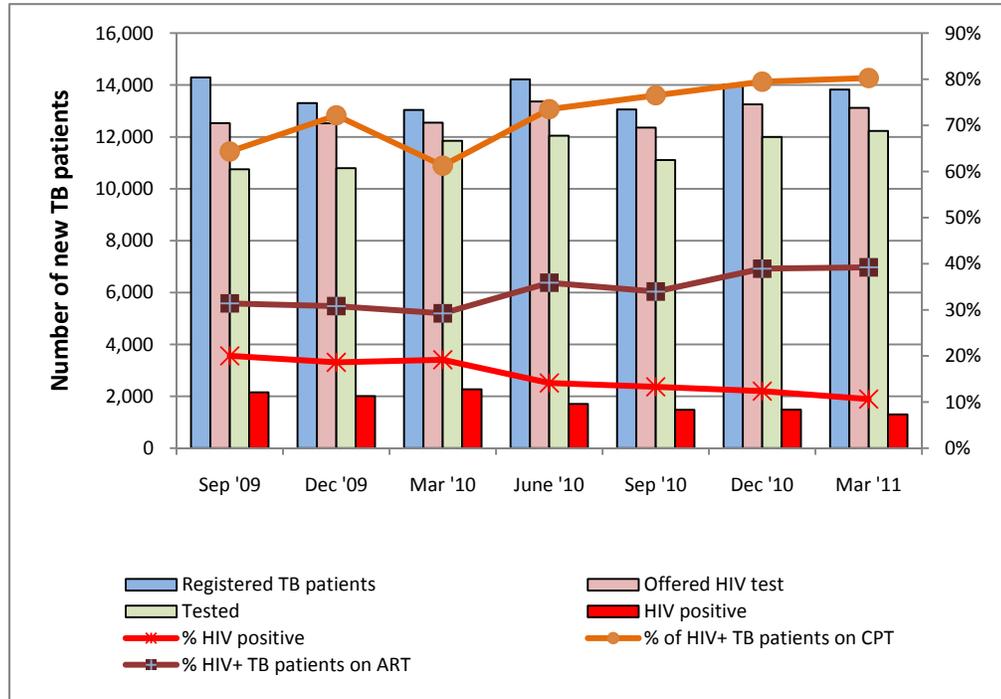
For C2.5.D, HCSP achieved 80% of its SAPR '11 target for number of TB/HIV patients in care and support who started TB treatment.

The number of patients who began IPT continues to be low. Although IPT is supported by national policy, it is not yet fully implemented nationally. There has been considerable resistance to the use of IPT for fear of inducing resistance. Until recently, the Tigray RHB did not endorse the use of IPT. However following a sensitization workshop in the region, all hospitals initiated IPT and HCSP is working closely with the RHB to encourage HC staff to also initiate IPT when indicated.

- ✓ **25,958 TB patients had an HIV test result recorded in the TB register (C3.1.D)**

Comment: During the reporting period, there were a total of 25,958 HIV/TB patients, of whom 1,724 came from the ART clinic. Among the 27,845 TB patients whose HIV status was unknown, 26,376 or 95% were offered to be tested for HIV and 24,233 patients (13,811 male and 12,147 female) or 92% accepted and were tested; 12% tested HIV+, of which 80% were put on CPT.

Figure 6: TB patients with unknown HIV status at entry, who were offered and accepted to be HIV tested, and the proportions among HIV+ TB patients who are put on CPT and ART, by quarter, September 2009 – March 2011



The above table shows a consistent trend of around 35-40% of newly tested HIV+ TB patients being registered on ART. The achievement for SAPR'11 of 39% was consistent with this trend.

During the first quarter of SAPR'11, HCSP initiated a data assessment OR to determine what factors contribute to the low ART enrollment of HIV+ TB patients and if it is real or an artifact of data recording and reporting. The OR was conducted at 12 high patient load health centers, with the following findings:

- 77% of newly identified HIV+ TB patients were put on ART. In contrast, the program's routinely collected data reports 44%.
- 93% of newly enrolled at the ART were put on CPT. In contrast, the program's routinely collected data reports 86%.
- 70% of HIV+ TB patients were enrolled in either ART or Pre-ART, which the program's routine data collection does not include.

The OR concluded that linkage and uptake of ART and CPT for TB/HIV co-infected patients is higher than program's routine data reports. However, for 30%, linkage and uptake cannot be confirmed.

✓ **Additional achievements:**

Mentorship: HCSP continued supporting the GOE's TB/HIV initiative by mentoring 550 HCs and training 50 HC staff on TB/HIV co-management.

Finalization of National Comprehensive TB, TB/HIV and Leprosy Training Manual for Health workers: HCSP has continued to be involved in the finalization of the National Comprehensive TB, TB/HIV and Leprosy Training Manual being developed for health workers under the leadership of FMOH through the national TWG.

Strengthening the national shift in anti-TB therapy from Ethambutol-INH to a Rifampin-INH based regimen: HCSP has continued to provide technical support to both FMOH and RHs for the quantification of anti-TB drugs shifting to an RH based TB regimen.

12-HVCT

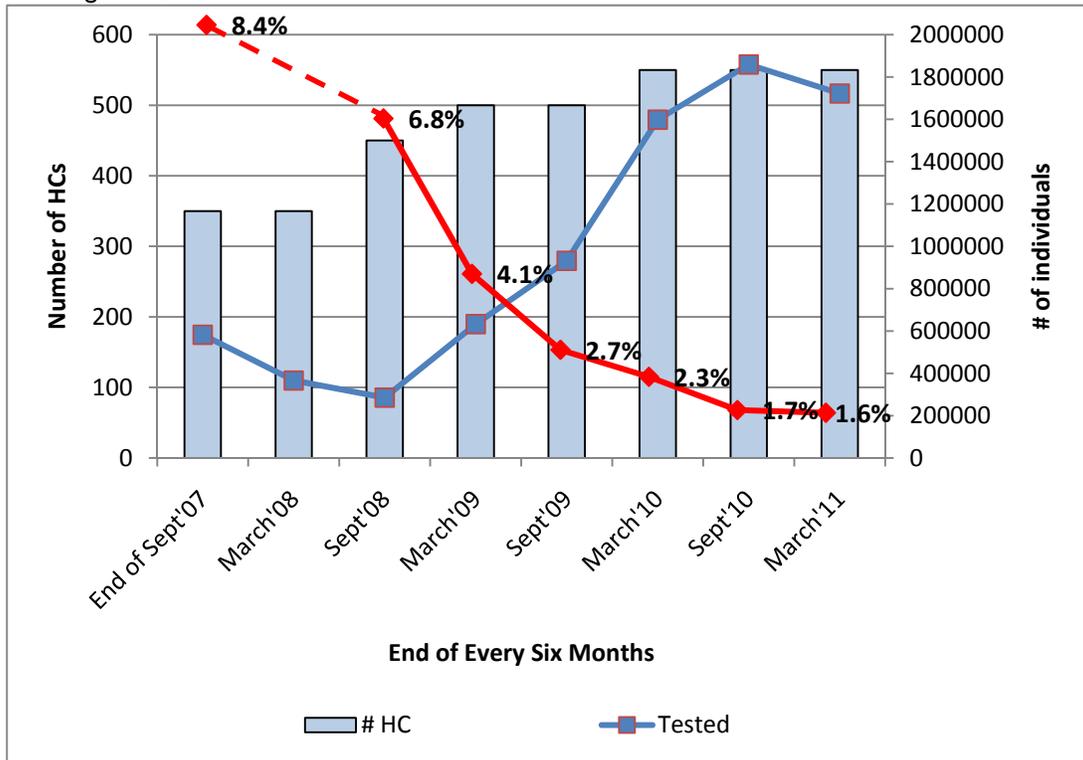
Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 12- HVCT (Counseling and Testing)

During SAPR'11, HCSP achieved the following results in Testing and Counseling:

- ✓ **1,722,036 individuals received Testing and Counseling (T&C) services for HIV and received their test results (P11.1.D)**

Comment: This achievement of **1,722,030** individuals having received T&C for HIV is 128% of the SAPR'11 target and includes 148,007 children <15 and 979,126 women. These results were achieved principally through PITC and VCT in HCSP supported HCs, thus greatly ensuring that all HIV + clients are immediately linked to treatment services. Among those tested, 27,874 or 1.6% were HIV+.

Figure 7: Number of HCSP supported health centers and clients tested for HIV, with percentage testing HIV+, 2007-2011



- ✓ **550 service outlets (HCs) providing counseling and testing according to national or international standards** (Contract deliverable #2 and a non-PEPFAR indicator)

Comment: The program's support to HCs in T&C includes training of health workers, support to VCT centers, monthly on-site mentoring by clinical mentors on the national opt-out approach of PITC, and use of PITC at every unit of the HC, including outpatient, family planning, ANC, labor & delivery, TB and EPI clinics. During this reporting period, HCSP training in this area included gap filling training of the following:

- 50 health workers trained on PITC
- 129 laboratory personnel trained on comprehensive laboratory services, including HIV testing and confirmation of results

✓ **HCT training curriculum review**

Comment: through participation in the national HCT TWG , HCSP continued to be involved in the revision of the HCT training curriculum that aims at unifying all materials on VCT, couple counseling and burn-out management into one training manual, which will reduce the number of days required for training.

✓ **Dissemination of implementation manual and strategic document**

Comment: Through participation in the national HCT TWG, HCSP continued to be involved in the dissemination of the PITC implementation manual, strategic framework for referral and linkage, and HCT guideline documents developed by the TWG.

13-PDTX (Pediatric treatment)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 13-PDTX

During SAPR'11, HCSP achieved the following results in the area of pediatric HIV treatment:

- ✓ **HCSP continued to operate in the following number of ART HCs to support the delivery of pediatric HIV treatment**
 - 350 ART HCs (100% of target) have health workers trained on pediatric care and treatment
 - 346 HCs (99%) have currently enrolled pediatric patients
 - 324 HCs (93%) have pediatric patients currently receiving ART
 - 349 ART HCs (99%) have health workers trained on DBS
 - 346 HCs (99%) have DBS tests available
 - 346 HCs (99%) have HEIs enrolled
 - 346 HCs (99%) are sending DBS to regional labs

Comment: Service expansion and maintenance has continued. HIV DNA PCR testing, using DBS, is taking root in HCSP supported HCs. The program's motto of 'Pediatrics ART wherever there is adult ART' will soon be fulfilled. Early infant diagnosis (EID) using DBS is becoming a reality.

- ✓ **853 children (including 37 infants) with advanced HIV infection were newly enrolled into the ART program by the closure of SAPR'11 (T.1.1.D)**

Comment: The number of children who were newly enrolled in the ART clinic during the quarter constitutes 6.8% (853 out of 12,463) of all newly enrolled patients across all ages. This is an advance towards the national target of 9%.

- ✓ **3,594 is the cumulative number of children ever started on ART (T.1.4.D)**

Comment: The cumulative number of children ever started on ART represents 3.9 % of ever-started across all ages.

- ✓ **4,424 children received a minimum of one clinical care service during the first two quarters of FY 2011 (C.2.1.D)**

Comment: This is 147% achievement of the SAPR'11 target (4,431/3,000)

✓ **3,763 children are currently receiving ART, including 189 infants (T.I.2.D)**

Comment: The number of children currently on ART constitutes 4.3% the total number of patients on ART. This percentage is similar to the national result and has slightly increased compared to previous FYs. The increasing trend is shown in Figures 8 and 9 below. Nevertheless, the current achievement is still below the 9% national target of national. Of note, intensive case finding by ANECCA of HEIs in high prevalence HCs has failed to find the expected # of HIV+ infants, possibly reflecting the increasing effectiveness of PMTCT programs.

Figure 8: Number of HIV+ children under 15 years of age enrolled on pediatric ART at HCSP supported HCs, March 2011

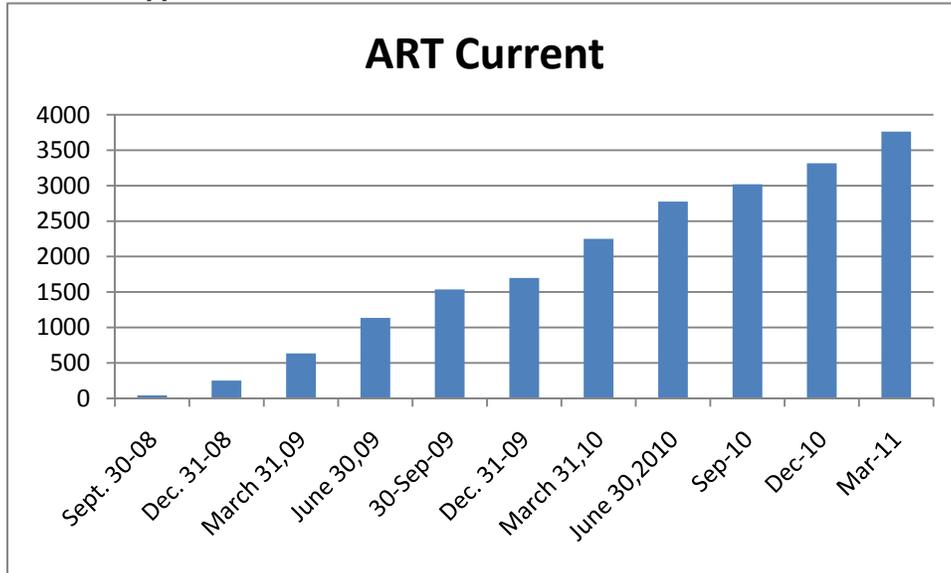
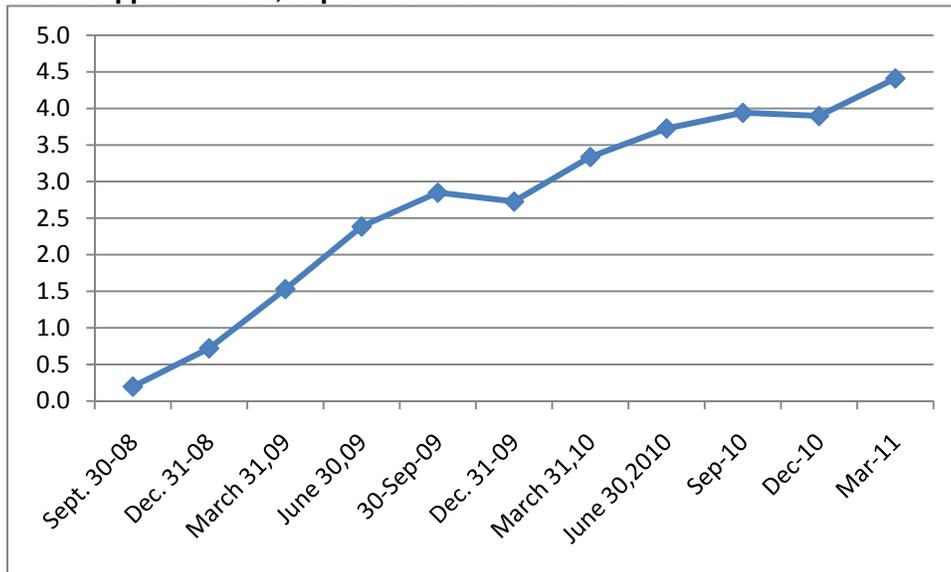


Figure 9: Percentage of pediatric HIV cases on ART among all HIV patients in HCSP-supported HCs, September 2008- March 2011



✓ **Additional achievements:**

Early infant diagnosis/HIV exposed infant program (EID/HEI)

Table 3: Performance of HCSP supported EID/HEI program

Indicator	Status as of March 2011
# HEI ever registered on EID/HEI	30,369
# of HEI currently under follow-up	24,555
# HEI newly enrolled on EID/HEI	3,177
# of all HEI currently enrolled tested with DBS	2,594 (82%)
Of whom within the first 2 months	1,065 (41%)
# of all HEI who received a DBS result during SAPR'11	3,303
Of whom tested HIV +	228 (7%)
# of HEI initiated CPT within 2 months of birth	2,130
# of HEI currently receiving ART	189
# of HEI released from EID/HEI during by mid-year	1,186
# of HEI ever released from EID/HEI	5,814

Comment: Table 3 above shows the current status of the EID/HEI services at the 346 HCSP supported ART HCs that have started EID/HEI. HCSP began focusing on this area in 2009. Hence, with HEI being followed up to 18 months of age, the majority who were ever enrolled are still under follow-up today. As of March 2011, a total of 1,186 infants were confirmed by 18 months of age to be uninfected.

✓ **Assessment of the SOC for pediatrics:** Pediatric and HEI SOC application was conducted on Amhara and Tigray regions during SAPR'11. On spot feed-back was provided to ART focal persons and HC directors. Amhara regional and sub-regional staff was later de-briefed.

14-PDCS (Pediatric care and support)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 14-PDCS

During SAPR'11, the program achieved the following results in the area of pediatric HIV/AIDS care:

- ✓ **3,911 HIV positive children under 15 years of age received cotrimoxazole (CTX) prophylaxis (CPT) (C.2.2.D)**

Comment: The above number represents 176% achievement of the SAPR '11 target.

- ✓ **2,432 infants were virologically tested for HIV within 12 months of birth and, of those, 1,252 received virological testing within two months of age (C.4.1.D)**

Comment: The number of infants tested within 12 months of birth continued to increase compared to previous quarters. The SAPR'11 achievement is 158% higher than the previous two quarter period.

- ✓ **6,809 children received psychological, social or spiritual support (C5.6.D)**

Comment: Psychological, social or spiritual support was provided to 6,809 children by case managers and their network of community partners.

- ✓ **148,007 children under 15 years of age were provided testing and counseling services (P11.ID)**

Comment: This result, at 73%, is moderately below the SAPR'11 target.

16-HLAB (Laboratory Infrastructure)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 16- HLAB (Laboratory Infrastructure)

The HCSP has achieved the following results in Laboratory Infrastructure during SAPR '11:

✓ **550 HCSP supported HCs have the capacity to perform clinical laboratory tests (HI.I.D)**

Comments: During SAPR'11, the program conducted a survey to develop a better understanding of HC staff turnover of laboratory personnel trained in HIV diagnostics. The study specifically assessed the availability of trained laboratory personnel at the program's 550 supported HCs where it had supported the training of 759 laboratory technicians in two waves, between 2008 and 2010.

The assessment uncovered considerable regional variation in the retention of program trained laboratory personnel in general and those trained on comprehensive laboratory services. The average two-year health center turnover rate was around 10%, with specific rates by locale as follows: SNNPR (43%), Tigray (18%), Amhara (11%), Oromia (8%), and Addis Ababa (4%). It is clear that the more remote locales have greater challenges in retaining staff.

The results of the survey were converted into a paper entitled "Availability and Turnover of Laboratory Personnel Trained on HIV Diagnostics at Public Health Centers in Ethiopia", which was then submitted for publication to the Ethiopian Public Health Association. Key conclusions of the paper were:

- Most of the surveyed health centers had the required laboratory staff
- Over half of the laboratory staff were not trained in HIV diagnostic services, clearly indicating an urgent need to train more laboratory technicians in HIV diagnostic services
- Encouraging trained laboratory technicians to teach their untrained colleagues on-the-job would help maintain health center capacity during turnover
- A mechanism to monitor turnover of laboratory personnel should be developed to allow better regional planning for staff recruitment and gap filling training
- An incentive package for "hard to fill" posts would help address the issue of high staff turnover in isolated locales.

✓ **157 individuals trained in the provision of HIV related laboratory activities (Contract Indicator Result 1)**

Comment: Major topics in gap filling training included rapid HIV testing, TB microscopy, malaria microscopy, quality control; DBS sample transportation, inventory management and preventive maintenance

Table 4: Distribution of planned and actual number of people trained in laboratory tasks, gap filling

Region	Target	Accomplishment
Amhara	35	34
Oromia*	34	67 (29 gap- filling)
SNNPR	40	28 (number limited by RHB)
Tigray	28	28
Addis Ababa	13	0

*38 of the lab staff trained in Oromia were for their new ART sites

✓ **25 laboratory personnel at HCs in Addis Ababa were trained in the use of CD4 analyzer machines**

Comment: HCSP supported 25 health centers in Addis Ababa that have semi-automated clinical chemistry machines, 15 provided by the Global Fund and JICA, 7 from the Society of International Missionaries (SIM) and 3 from the GOE. SCMS through PFSA, has agreed to provide the laboratory reagents for the machines.

To initiate testing, laboratory professionals from the 25 health centers required training on their use, which HCSP supported. As such, during SAPR'11, the program trained 25 laboratory personnel (M=15, F=10) on CD4, hematology and clinical chemistry analyzers.

It is expected that all current health centers in Addis Ababa City Administration will soon initiate clinical chemistry testing for ART patients, which will improve patient access to testing services. It is expected that the following improvements will be observed.

- Challenge of sample transportation will be avoided once clinical chemistry tests are performed at HC level;
- Result turnaround time will be dramatically reduced as patients will typically collect their results on the same day of sample collection.
- Sample rejection will be dramatically reduced with unsecured sample transportation eliminated;
- High work load of regional laboratories reduced; and
- HC laboratories can process samples from newly established health centers in Addis Ababa.

The Tigray and Addis Ababa regional HCSP office have initiated a study, with the results to be presented in the form of success story.

✓ **HCSP actively participated in national and regional laboratory TWGs**

Comment: During SAPR'11, in support of the NLTWG, HCSP provided technical and material support to the pilot Regional External Quality Assurance Scheme (REQAS). HCSP material support included provision of laboratory supplies to key labs in Tigray and Addis Ababa. The items delivered to each region included the following:

- 40 slide boxes of 50 slides each
- 40 boxes of filter paper (each box has 100 tissues)
- 40 boxes of microscope lens paper (each box has 100 tissues)
- 40 boxes of applicator stick (each box has 1,000 applicator sticks)

✓ **TOT for laboratory advisors and staff**

Comment: During SAPR'11, program staff participated in the NLTWG, EHNRI and CDC conducted training of trainers (TOT) training that included laboratory advisors of partners (including HCSP advisors), regional laboratory professionals and government university laboratory staff. The training covered 12 essential quality assurance areas: Organization, Information Management, Documentation and Record Keeping, Personnel, Equipment, Assessment (EQA, IQA, internal audit), Occurrence Management, Purchasing & inventory, Process Improvement, Customer Service, Process Control and Facility & Safety. The training helped HCSP regional laboratory advisors to provide technical support to QA at facility laboratories.

In addition, 2 HCSP regional laboratory advisers, from Addis Ababa and Tigray, participated in a 5-day TOT training on laboratory bio-safety. The training, prepared and conducted by EHNRI and CDC Ethiopia, was organized for all laboratory advisors of partners, referral hospital laboratory heads, and regional laboratory professionals. The training enabled HCSP regional laboratory advisors to provide technical support to health facilities in the implementation of bio-safety applications.

✓ **External Quality Assurance**

Comment: EHNRI is developing national guidelines on EQA assessment and monitoring of ART sample collection and transportation. HCSP's regional laboratory advisors from Oromia and Addis Ababa actively participated in two focus group discussions sessions on the draft guidelines.

During SAPR'11, HCSP provided financial, material and technical support to regional laboratories to conduct REQAS at HCSP supported HCs. The REQAS included HIV/AIDS proficiency testing using HIV proficiency panel specimens; collection of malaria and AFB microscopy monitoring slides; and checklist assessment of all laboratory services, including CD4 sample transportation and DBS sample collection and transportation. Immediate feedback was given on site except for the malaria and TB, where the microscope slides had to be analyzed later at the reference laboratory, with subsequent written feedback provided to the HCs. During SAPR'11, 155 HCSP supported HCs were assessed, as follows:

- 25 (100%) in Addis Ababa
- 43 (100% ART sites) in Tigray
- 60 in Amhara
- 27 in Oromia

Major challenges noted in the REQAS reports included inadequate record keeping materials and poor documentation for decision making by HC management. To help address the challenges noted, HCSP supported gap filling provision of record keeping materials.

Of note, the regional labs have not fully met their schedule of carrying out quarterly REQAS and, except for Tigray and Addis Ababa, have not submitted reports on their findings.

✓ **Participation in the regional laboratory technical working groups (RLTWGs)**

Comment: During SAPR'11, HCSP's regional laboratory advisors actively participated in the regions with RLTWGs (Amhara, Tigray and Addis Ababa).

In Tigray, the RLTWG customized its SOPs in accordance with type of laboratory: regional, hospital, and HC laboratories. Tasks were assigned to the RLTWG members and HCSP's regional laboratory advisor led the HC component. Another key issue discussed was the initiation of once-weekly viral load testing by the regional laboratory. However, criteria on accepting requests for testing remain to be developed.

In Amhara, the RLTWG linked eight HCs to the Injibara HC CD4 testing (Injibara HC is one of the HCs that recently received a CD4 testing machine).

In Addis Ababa, major challenges were discussed, including periodic interruption of laboratory supplies to HCs. For example, clinical chemistry reagents were not being supplied on time. The issue was then discussed with SCMS and PFSA and consensus was reached to deliver all laboratory items directly from the PFSA hub to HCs (rather than through the RHB), similar to the distribution of ART medications and DBS kits. This system has resulted in fewer stock outs.

✓ **HCSP strengthened HCs through the provision of SOPs, job aids and other tools**

Comment: During previous FY's, the program had distributed considerable numbers of laboratory reference tools, such as SOPs and other laboratory documents, However, supportive supervision and mentorship visits has noted additional need for such. As a result, during SAPR'11, HCSP regional offices distributed the following to program supported HCs:

- Addis Ababa: SOPs of HIV rapid test, Tb microscopy, malaria, and color print malaria atlas, and HIV laboratory registration book (to 3 health centers);
- Amhara: SOPs and job aids on DBS;
- Tigray: malaria and TB microscopy SOPs (to 25 health centers);
- Oromia: SOPs and job aids (to 10 ART health centers)

✓ **HCSP ensures availability of DBS kits in supported HCs**

Comment: As noted in the earlier pediatric HIV/AIDS treatment section, DBS kits are available in the 346 HCs where EID has been initiated. The total number of DBS testing per supported HCs, by region, during SAPR'11 is shown in the below table:

Table 5: Status of DBS Tested by DNA – PCR by Region

Region	Sample collected	Sample tested	Result	
			Positive	%
Tigray	280	280	15	5.4
Amhara	853	780	54	6.9
Oromia	523	643	52	8.1
SNNPR	396	305	29	9.5
Addis Ababa*	930	930	51	5.5
Total	2,982	2,938	201	6.8

Of note, during SAPR'11, CHAI-Ethiopia/EHNRI requested partners to submit data on DBS sample collection and EID consumables to help quantify the need for such supplies by health facilities in order to curb unanticipated interruptions of services. HCSP submitted the requested data from all HCSP supported regions.

✓ **Coordination with SPS and SCMS for provision of lab supplies**

Comment: During FY10, HCSP submitted a list of laboratory consumables for all 550 HCSP supported HCs to SCMS for inclusion in their regular quantification and supply system. The procurement is now in progress.

During SAPR'11, SCMS informed HCSP about the availability of leftover OI laboratory supplies that could be distributed to HCs experiencing critical shortages. HCSP, in collaboration with the RHBs, then identified the needy HCs, prepared distribution lists and forwarded them to SCMS for distribution. SCMS has already dispatched distribution schedules to PFSA regional hubs for distribution of the supplies to health centers.

In addition, HCSP, during this reporting period, provided key supplies, such as refrigerators, stabilizers, swivel chairs and tables to Gonder HC to facilitate it's initiation of CD4 testing on-site.

Recently, HCSP participated in a national quantification workshop jointly organized by PFSA and SCMS. Topics included: ARVs, OIs, food support, STIs, lab, IP, community home based care (HBH), PMTCT, TB, and malaria. It is anticipated that this will lead to a more consistent supply of lab consumables to program supported HCs..

The above, as well as the earlier noted collaboration with SCMS, under the above RLWTWG discussion, presents examples of HCSP's ongoing collaboration with partners, including SCMS, which is in line with MSH's One MSH Ethiopia principle. Another example is HCSP's collaboration with AIDSTAR, who assisted a program supported HC to construct a placenta pit. Upon request from HCSP, AIDSTAR assessed and facilitated construction of the pit within a day.

✓ **HCSP conducted laboratory mentorship to 138 HC laboratories**

Comment: During SAPR'11, HCSP lab advisors conducted mentorship to 138 HC laboratories as follows: Tigray (45), Addis Ababa (25-of which 12 required revisits), Amhara (10), SNNPR (13), and Oromia (45). During mentorship, short term solutions were developed on-site. . Other problems, once noted, required involvement of higher levels, such as the earlier noted involvement of the Addis Ababa RLWTWG to address interruptions in lab supplies in Addis Ababa due to an inefficient distribution process.

17-HVSI (Strategic Information)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 17- HVSI (Strategic Information)

During SAPR'11, HCSP achieved the following results in the area of SI:

✓ **74 data clerks provided basic training**

Comment: HCSP is committed to strengthening strategic information (data for decision making) and fostering a culture of evidence based decision making at all levels. During this reporting period, HCSP recruited and trained 74 (33M, 41F) data clerks in HCSP supported regions. These were gap filling trainings with a key focus on accurate implementation of the HCSP revised NGI reporting format in combination with GOE formats.

✓ **Data quality assurance (DQA) instituted as a routine part of HCSP's M&E system**

Comment: HCSP monitors the quality and validity of its data in multiple ways, as follows:

Internal consistency checks: Central and regional office staff discuss and review data, both monthly and quarterly, to ensure completeness and consistency. Regional M&E advisors conduct detailed consistency checks of all data submitted by the HCs. Data inconsistencies and incompleteness are verified at source and corrected prior to submission to the central office. At the central office, data are compiled and verified. Incomplete and inconsistent data are discussed with regional M&E staff and corrected where possible.

During SAPR'11, staff from the central M&E team visited program regions to give direct technical assistance to regional M&E staff as well as to monitor data capturing, compilation and reporting at source level. During the visits, feedback was given to the regions as well as required actions for improvement.

HC mentorship focus on data: HCSP HC mentors can spend over 30% of their time mentoring health providers and data clerks on correct recording, reporting and verification of data. In addition, whenever HCSP M&E advisors visit a HC, at least 3 data spot checks are conducted.

SoC: During central office's clinical team's supportive supervision, compliance with the standards of care (SOC) for key clinical areas is monitored using LQAS and other sampling methods of patient registers and follow-up cards and logbooks.. During SAPR'11, the team conducted supportive supervision in Amhara & Tigray.

Special data assessments: HCSP continued verifying data at source for CD4 counts, PMTCT, HEI, and HIV/TB. Assessments, conducted on samples of the total data, examined data validity.

✓ **Additional achievements:**

Supported revision of HMIS indicators

Comment: During SAPR'11, the FMOH has taken the initiative to revise their current HMIS indicators in consultation with their TWGs. HCSP actively participated in the TB and Care and Treatment TWG review meetings. In these meetings, HCSP proposed selected NGI that are not in the current HMIS but which the program is required to report on. Their inclusion is pending feedback provided by the FMOH.

Of note, the FMOH has preliminarily agreed to introduce a new pre-ART register based on WHO's format. This is extremely important as the current register provides no information on pre-ART patients follow-up visits post enrollment. Without this information, tracing of patients who miss their appointments is not possible.

Further required steps will include the revision of data capturing tools and reporting formats, development of revised implementation guidelines to ensure that the new HMIS is implemented according to national standards.

Gap filling printing of HMIS forms

Comment: During SAPR'11, HCSP printed and distributed different types of HMIS and data forms for HC use, including registers, patient intake forms, lab request formats and patients cards. These are essential in ensuring continuous services and are part of HCSP's commitment to assist GOE in M&E activities.

Supported the development CIS

Comment: During SAPR'11, under the coordination of FHAPCO, implementing partners were invited to participate in the development of a community based HIV/AIDS management information system (CIS). HCSP actively participated in this process and assisted FHAPCO in piloting the draft guideline.

Operations research

Comment: During SAPR'11, HCSP focused on data validation and assessment and secondary analysis of program data for OR. Data collection has been completed for most of the OR and HCSP is currently cleaning, entering and analyzing the data for preparation of conference abstracts and papers to the Ethiopian & international public health community. The following areas that OR has been undertaken are as follows:

1. PMTCT: ARV uptake and linkage to ART clinics
2. TB/HIV: linkages between TB and ART clinics
3. Health outcomes at HCSP supported HCs
4. Measured improvements in technical knowledge by the participants of the program's pilot CME
5. Gender mainstreaming
6. Pediatric HIV/AIDS scale up
7. PITC and VCT
8. Community volunteers and their impact on the continuum of care
9. Pregnant factors for HIV+ mothers

Supported data for decisions making

Through participation in catchment area meeting, HCSP staff helped facilitate review and use of data, at zonal level, by participating GOE service delivery and management staff and partners. HCSP also facilitated such data use during GOE review meetings, such as the quarterly FHAPCO review meetings.

18- OHSS (Other Health Systems Strengthening)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 18-(OHSS (Health Systems Strengthening))

During SAPR'11, the HCSP achieved the following results in the area of HSS:

- ✓ **HC mentorship checklist, log book and user manual were developed and distributed to all HCSP mentors for immediate use**

Comment: The national guidelines on HC mentorship published in 2007 identified the need for developing a mentorship checklist and logbook. To date, the FMOH has not yet developed these tools. Because there was a need within HCSP to better standardize the HC mentor's role and monitor their performance, HCSP developed and is now using its own HC mentorship checklist, log book and an instruction guide on how to use them. These mentorship tools also serve as job aids to mentors, documentation of the mentorship visit, and a reference for HCs in between mentorship visits.

- ✓ **Continuous quality improvement through the FFSDP**

Comment: During SAPR'11, the FFSDP quality improvement tool was implemented in all regions and Addis Ababa. It contributed to identifying gaps that collaborating partnership could address. For example, 43 HCs in SNNPR worked jointly with other partners to address FFSDP identified gaps in maintenance of incinerators and the construction of wet and dry waste disposal pits.

One health center MDT member commented: "The FFSDP requires and stimulates collaborative team work, joint and coordinated planning and implementation at service delivery point. The FFSDP gave HC staff, HC heads and woreda/sub city officials the chance to come together and discuss challenges and gaps identified FFSDP surveys and seek solutions together."

During SAPR'11, HCs continued to complete their 1st round reassessment. In SNNPR, 53 HCs completed reassessment, with 44 developing plans of action for the implementation of the next cycle. In Amhara, 81 HCs completed the 1st round reassessment, with 15 in Addis Ababa. HCSP is currently analyzing the data. The program has found that the FFSDP tool provides HCs with an easy to use, standardized guide for more systematic assessment of key components of their service delivery.

During SAPR'11, HCSP also carried out an analysis of the sustainability of health workers trained on the FFSDP. The main objective of the assessment was to map the continued availability of trained health workers for planning gap filling training. The assessment demonstrated considerable variation in the availability of the FFSDP trained health workers, with an average turnover rate was 9.7% and a range of 0 – 18%. As with the earlier noted trained laboratory health workers, the results indicate that gap filling trainings are an ongoing requirement to maintain the function.

Subsequently, HCSP developed a plan and conducted gap filling training on the FFSDP and trained 95 HC staff, 37 in Oromia and 58 in Amhara.

- ✓ **Participation in TWG**

Comment: At the national level, senior technical program staff continued working closely with the FMOH and participated in the various TWGs under their leadership. In addition, the HSS and M&E teams continued actively participating in the national quality management TWG (NQMTWG).

- ✓ **HCSP supported and participated in joint supportive supervision (JSS) to HCs**

Comment: During the reporting period, HCSP provided financial and technical support for joint supportive supervision in SNNPR, Tigray and Amhara, with the program's regional quality improvement officers jointly participating with regional and woreda health staff to oversee performance of planned activities in health facilities.

✓ **HCSP supported 437 Woreda Health Offices to develop HIV/AIDS service plans**

Comment: During SAPR'11, HCSP assisted 437 out of the 463 HCSP supported woreda health offices to develop HIV/AIDS services plans. The purpose of the planning process was to assist woreda health offices to prepare a comprehensive plan to coordinate all HIV/AIDS actors under their jurisdiction and use resources wisely. The regional distribution is shown in the below table:

Table 6: Number of woredas assisted by HCSP in developing and harmonizing of HIV/AIDS plans, by region

Region	Woreda HIV/AIDS Service Plans Harmonization	
	Plan	Achievement
Oromia	180	180
SNNPR	125	125
Tigray	38	38
Amhara	110	84
Addis Ababa	10	10
Total	463	437

Of note, the target for service plans was incorrectly calculated as 550, on the assumption of one HC residing in one woreda. The actual number of woredas that the 550 HCs reside in is 463. As such, the program's result of 437 woredas having service plans represented an actual achievement of 94%

✓ **Gender mainstreaming activities**

Mainstreaming gender in HIV/AIDS programs: Lessons learned from HCSP: HCSP developed a document that summarizes the role of HCSP in mainstreaming gender during scale up of HIV/AIDS services in Ethiopia. The document presents the creative approaches that HCSP employed to incorporate gender in all its activities, strategies it used to reduce gender inequality in accessing quality health care services, as well as highlighting achieved results. The document is currently being printed and will be disseminated at HCSP's end of program review event, scheduled for May 2011.

A Brief Gender Guide to Health Workers: HCSP is close to completing a draft Gender Guide to health workers to guide MDTs and HC staff on the integration of gender issues into HC activities and service delivery. The module addresses such areas as gender based violence, sexual and reproductive health, child health, privacy and confidentiality issues, partner involvement and time spent with clients, and integration of gender considerations into service delivery. The program has also developed a Gender job aid for HC case managers, service providers and administrations as a supplementary tool to the Gender guide. After discussion with USAID, the program will delay finalization of the job aid until the Gender guide is finalized.

Collaboration with FHAPCO: During SAPR'11, FHAPCO requested HCSP to provide focused, short term technical assistance to better integrate gender into their HIV/AIDS activities. This is an excellent opportunity to build the capacity of FHAPCO and institutionalize a gender framework within the overall work of FHAPCO. HCSP is in the process of outlining the nature of the technical assistance and its objectives, and will develop an MOU outlining the expectations of both organizations in April.

Technical Support for Social Mobilization for Safe Motherhood and PMTCT with the National Coalition of Women against HIV/AIDS and the Federation of Women in Ethiopia: HCSP continues to provide technical assistance to the National Coalition of Women against HIV/AIDS to support their campaign to increase attendance at HCs for ANC and PMTCT. HCSP also supported the coalition with TA to write their proposal for Global Fund support to conduct their campaign and prepare the evaluation forms for their ANC BCC campaign. Although the campaign was launched in high prevalence areas, it was recently interrupted due to budget issues as a result of an audit of Global Fund resources.

Women and Faith Initiative under EIFDAA: Funding for EIFDDA has focused on supporting the Women in Faith Initiative (WFI), which was launched In June 2010 under the auspices of the World Conference of Religion and Peace (WCRP), and the African Council of Religious Leaders (ACRL). In recognition of the significant role women play and their potential for mediation and peace building, EIFDAA appointed an oversight committee consisting of women leaders from the various faiths, designed to serve as an advisory board. One task has been to ensure that the concerns of the female network members are relayed to the highest echelons of African religious leadership. HCSP is supporting EIFDDA's WFI to establish its own identity and autonomy within the organization to mobilize resources and implement activities that are gender focused. HCSP, with WFI, has identified the following key areas requiring external TA:

- Organizational development and institutional capacity building
- Development of a WFI strategic plan
- Development of a plan of action/ work plan including ways to mobilize donors and become a sustainable entity
- Organization of a donor and stakeholder meeting to raise awareness and engage in dialogue with WFI
- Support activities in each member church to promote HIV testing, particularly among pregnant women; fostering of discussions between parents and children about AB; support to teenage orphans; reduction of gender based violence, especially around HIV risks; and knowing HIV status through couples counseling

With technical support from HCSP, the WFI has already conducted an assessment of its 14 member religious organizations to determine the type of gender related activities they are currently engaged in and to identify the gaps and opportunities in each. During SAPR '11, EIFDDA hired a consultant who worked with HCSP to launch their strategic framework for identifying gaps in services among the membership.

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

01-PMTCT (Prevention of Mother to Child Transmission)

Challenges and constraints for each program area:

Program area 01-PMTCT

1. Poor documentation, exacerbated by the high number of logbooks and registers at PMTCT/MNCH
2. Difficulties in linkage to ART clinics and documentation of the linkage (exacerbated for HCs without an ART clinic)
3. PMTC clinics do not have strong community tracking systems as ART clinics do for ensuring follow-up
4. Low ANC attendance and delivery at HCs from expected usage based on served population

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

Program area 01-PMTCT

- I. Since the program is at its end stage of implementation, it will offer its experiences, tools and lessons learned to incoming partners during handover, as well as key recommendations:
 - a. Ongoing need for mentorship at HCs to include emphasize on proper documentation
 - b. Importance of facilitating linkages between the HC and the developing woreda primary health care network at kebele level, through the HEWs and their women leaders, to promote pregnant women to attend ANC and to follow up with HIV+ pregnant women who have missed PMTCT appointments.
 - c. Implementation of “one-stop shopping” for ART care of HIV+ PW in ANC clinics.

02-AB (Abstinence and Be Faithful)

Challenges and constraints for each program area

Program area 2-HVAB

- Limited capacity and skill of community outreach volunteers and HC based community mobilizers to implement and properly document AB in accordance with NCI guidelines.

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

Program area 2-HVAB

- I. Since the program is at its end stage of implementation, it will share its list of KOOWs, experiences, recording tools and lessons learned with incoming partners during handover.

03-HVOP (Other Prevention)

Challenges and constraints for each program area

Program area 3-HVOP

- I. Same as with AB above

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

Program area 3-HVOP (Other Prevention)

- I. Same as with AB above

08-HBHC (Adult Care and Support)

Challenges and constraints for each program area

Program area 8-HBHC (Adult Care and Support)

1. Limited oversight over KOOWs activities and reporting due to complexity of NGI reporting and limited staff resources.
2. Bottlenecks in the resupply of home based care.

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

Program area 8-HBHC (Care and Support)

1. Share lists of its KOOWs and roles and responsibilities assumed by woreda HAPCO, KOOWs and CCGs with the incoming partners during handover.
2. Share importance of facilitating linkages between the HC and the developing woreda primary health care network at kebele level, through the HEWs and their women leaders, to promote a continuum of care between facility and community for care and support.

09-HTXS (Adult Treatment)

Challenges and Constraints for each program area

Program area 9-HTXS

1. High turnover of trained HC staffs resulting in continued shortages of skilled service provider staff.
2. Pre ART patients' status is not well known, although participation in the Care and Treatment TWG may have stimulated a new register that allows tracking of follow-up visits to ART clinic
3. Shortage of some ARV and OI drugs and supplies.
4. Absence of nutritional support at HC for impoverished patients, which negatively affects adherence.
5. Repeated non-functioning of CD4 machines in some hospitals, lack of regular public transport for samples and the limited quotas of samples for testing given to HCs by RHBs makes baseline and follow up CD4 difficult.
6. Inadequate lab services for ART patients.

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

Program area 9-HTXS

1. Share current status of trained staff in HCs with incoming partners during handover.
2. Inform incoming partners that the Care and Treatment TWG has reviewed the pre-ART register and has recommended its revision to allow tracking of follow-up visits after enrollment.
3. Inform incoming partners to collaborate with regional SCMS staff, who play a supporting role with RHBs and PFSA.
4. Inform the incoming partners of the supporting role WFP and SCUS' Food by Prescription Project.
5. Inform the incoming partners of the ongoing difficulties with CD4 testing and sample transport and encourage them to:
 - a. Advocate for sub-contracting maintenance of machines to outside private companies
 - b. Work with relevant government agencies on ways to alleviate the problem of payment of sample transport
 - c. Plan for greater numbers of CD4 machines e.g. at zonal hospitals, to support timely access by a larger number of ART HCs to rapid CD4 tests.
 - d. Inform partners of need for improvement, supported by results of standards of care assessments, on access to basic lab services

10-HVTB (TB/HIV)

<p><u>Challenges and constraints for each program area</u> Program area 10</p> <ol style="list-style-type: none">I. Difficulty of diagnosing active TB in HC setting impacts on the number of patients receiving treatment for co-infection
<p><u>Plans to overcome challenges and constraints in each of your program areas</u> Program area 10</p> <ol style="list-style-type: none">I. Share with incoming partners key recommendations for improving diagnosis of active TB at HCs:<ol style="list-style-type: none">a. Emphasize TB screening and referral by ART clinicsb. Provide targeted technical assistance to HC labs to strengthen TB diagnostic capacity, as HC staff are not allowed to initiate treatment based on syndromic assessmentc. Work with EHNRI and the TWG to strengthen a national lab EQA system, which would include an emphasis on TB lab microscopyd. Collaborate with TBCARE and the follow-on HEALTB Projects, whose predecessor supported nearly 200 HCSP supported HCs for improved lab diagnosis.

12-HVCT (Voluntary Counseling and Testing)

<p><u>Challenges and Constraints for each program area</u> Program area 12: HVCT</p> <ol style="list-style-type: none">I. Shortage of test kits and DBS.
<p><u>Plans to overcome challenges and constraints in each of your program areas</u> Program area 12: HVCT</p> <ol style="list-style-type: none">I. Share with incoming partners importance of mentors assessing the stock balance during each HC visit and report to the responsible bodies for timely action

13-PDTX (Pediatric Treatment)

<p><u>Challenges and Constraints for each program area</u> Program area 13: PDTX</p> <ol style="list-style-type: none">I. Front line health workers lack confidence to handle pediatrics HIV cases, especially in low pediatric patient load HCs
<p><u>Plans to overcome challenges and constraints in each of your program areas</u> Program area 13: PDTX</p> <ol style="list-style-type: none">I. Share with incoming partners the importance of:<ol style="list-style-type: none">a. Establishing a mentoring and training partnership with ANECCA to help build the confidence of front line health workers

14-PDCS (Pediatric Care and Support)

<p><u>Quarterly challenges and Constraints for each program area</u> Program area 14: PDCS</p> <ol style="list-style-type: none">1. Poor linkage between home delivered HEIs and HCs, despite ANC identification2. Limited community care and support services available, especially for nutritional support
<p><u>Plans to overcome challenges and constraints in each of your program areas</u> Program area 14: PDCS</p> <ol style="list-style-type: none">I. Share with incoming partners the importance of:<ol style="list-style-type: none">a. Ongoing feedback to SCMS/PFSA on improving supply of pediatric ARVs and DBS kitsb. Promotion of index HIV+ patients to bring their children for testing and linkage with the developing woreda primary health care network at kebele level, through the HEWs and their women leaders, to reach and link home delivered HEIs to health facility servicesc. Collaborate with SCUS's FBP project and WFP nutritional support programs

16-HLab (Laboratory Infrastructure)

Quarterly challenges and Constraints for each program area

Program area 16: HLAB

1. Turnover of lab personnel trained on comprehensive lab services.
2. Inconsistent implementation of REQAS program by regions.
3. Shortages of equipment and supplies.

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

Program area 16: HLAB

1. Share with incoming partners the importance of:
 - a. Ongoing gap filling health worker training on comprehensive lab services
 - b. Support scale up of technical assistance by regional labs, including budget support for REQAs
 - c. Ongoing feedback to EHNRI and SCMS on equipment and logistic needs

17-HVSI (Strategic Information)

Quarterly challenges and Constraints for each program area

Program area 17-HVSI

1. Data compilation through additional logbooks required for some of NGI indicators like CPT, IPT, and TB screening, exacerbates difficulty of data collection. Especially the problem of capturing and compiling TB screened patients as per the NGI's requirement was a real challenge.
2. Lack of clarity on some of the NGI by community health workers, data clerks and coordinators

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

Program area 17-HVSI

1. Share with incoming partners
 - a. Program's PMP, data collection tools and approach to reporting consistent with the NGI guidelines
 - b. Tools and guidelines for collecting community level NGI data

18-OHSS (Health Systems Strengthening)

Quarterly challenges and Constraints for each program area

Program area 18-OHSS

1. Turnover of health workers and woreda staff trained on FFSDP quality improvement tool implementation.

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

Program area 18-OHSS

1. Share with incoming partners the FFSDP quality improvement tool.

7. Data Quality issues during the reporting period

Specific concerns you have with the quality of the data for program areas reported in this report

All Program areas:

1. The program's supported non-ART HCs do not have data clerks, so the program has to rely on staff assigned by the HC to provide the required data. As a result, quality as well as availability of reports depends on the skill and willingness of these staff, which leads to inconsistency.
2. As previously non-ART sites are becoming ART sites, the absence of data clerks and other HCSP supported staff (e.g. case managers) and interventions compromises HCSP's ability to assure the quality of services and data at these new ART sites.
3. Data from community level also continues to have data quality issues. The data is typically collected by volunteers e.g. KOOWS and compiled by community mobilizers at woreda level. The KOOWS are volunteers with a medium level (sometimes basic education). With this background and large volume of information needed from the community level, the data they collect is also not of consistent quality.

What you are doing on a routine basis to ensure that your data is high quality for each program area

1. For HCs, the program collects SI on a monthly basis, which is reviewed by the regional and central office M&E team for consistency. The central office M&E staff also maintains ongoing dialogue with the regions' M&E advisors on data quality. They, in turn, work with the clinical mentors to address concerns during their visits to the non-ART HCs.
2. For new ART sites, the program is carefully limiting the data it will collect to key areas, such as number of newly enrolled and current ART patients.
3. Program has been providing quarterly supportive supervision to community volunteers, with data collection a key area of review.

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

1. The program has carried out a revised community level reporting format and trained its community volunteers on its use.
2. The program developed a checklist to provide clear guidance, including data collection, during quarterly supportive supervision visits at each HC's community program.
3. The program completed and implemented a mentorship checklist to provide stronger, more detailed guidance to the program's mentors during their HC visits, with improved data management a key element.

8. Major Activities planned in the next reporting period

NOTE: For all program areas, HCSP will present an end of project review presentation to PEPFAR/USAID, GOE, partners and other stakeholder on program achievements and lessons learned.

Major activities planned in the next reporting period should high planned activities and solutions to identified constraints.

Program area 01-PMTCT (Prevention of Mother to Child Transmission)

1. Share its experiences, tools and lessons learned with incoming partners during handover, including key recommendations:
 - a. Ongoing need for mentorship at HCs to include emphasize on proper documentation
 - b. Importance of facilitating linkages between the HC and the developing woreda primary health care network at kebele level, through the HEWs and their women leaders, to promote pregnant women to attend ANC and to follow up with HIV+ pregnant women who have missed PMTCT appointments.

Program area 02-HVAB (Abstinence and Be Faithful)

1. Since the program is at its end stage of implementation, it will share its list of KOOWs, experiences, recording tools and lessons learned with incoming partners during handover.

Program area 03-HVOP (Other Prevention)

1. Same as with AB above

Program area 08-HBHC (Adult Care and Support)

1. Share lists of its KOOWs and roles and responsibilities assumed by woreda HAPCO, KOOWs and CCGs with the incoming partners during handover.
2. Share importance of facilitating linkages between the HC and the developing woreda primary health care network at kebele level, through the HEWs and their women leaders, to promote a continuum of care between facility and community for care and support.

Program area 09-HTXS (Adult Treatment)

1. Share current status of trained staff in health centers with incoming partners during handover.
2. Inform incoming partners that the Care and Treatment TWG has reviewed the pre-ART register and has recommended its revision to allow tracking of follow-up visits after enrollment.
3. Inform incoming partners to collaborate with regional SCMS staff, who play a supporting role with RHBs and PFSA.
4. Inform the incoming partners of the supporting role WFP and SCUS' Food by Prescription Project.
5. Inform the incoming partners of the ongoing difficulties with CD4 testing and sample transport and encourage them to:
 - a. advocate for sub-contracting maintenance to outside private companies
 - b. work with relevant government agencies on ways to alleviate the problem of payment of sample transport
6. Inform partners of need for improvement, supported by results of standards of care assessments on lab services accessed

Major activities planned in the next reporting period should high planned activities and solutions to identified constraints (continued)

Program area 10-HVTB (TB/HIV)

- I. Share with incoming partners key recommendations for improving diagnosis of active TB in HC setting:
 - a. Emphasize TB screening and referral by ART clinics
 - b. Provide targeted technical assistance to HC labs to strengthen TB diagnostic capacity, as HC staff are not allowed to initiate treatment based on syndromic assessment
 - c. Work with EHNRI and the TWG to strengthen a national lab EQA system, which would include an emphasis on TB lab microscope
 - d. Collaborate with TBCARE and the follow-on HEALTB Projects, whose predecessor supported nearly 200 HCSP supported HCs for improved lab diagnosis.

Program area 12-HVCT (Voluntary Counseling and Testing)

- I. Share with incoming partners importance of mentors assessing the stock balance during each HC visit and report to the responsible bodies for timely action

Program area 13-PDTX (Pediatric Treatment)

- I. Share with incoming partners the importance of:
 - a. Establishing a mentoring and training partnership with ANECCA to help build the confidence of front line health workers

Program area 14-PDCS (Pediatric Care & Support)

- I. Share with incoming partners the importance of:
 - a. Ongoing feedback to SCMS/PFSA on improving supply of pediatric ARVs and DBS kits
 - b. Promotion of index HIV+ patients to bring their children for testing and linkage with the developing woreda primary health care network at kebele level, through the HEWs and their women leaders, to reach and link home delivered HEIs to health facility services
 - c. Collaborate with SCUS's FBP project and WFP nutritional support programs

Program area 16-HLAB (Laboratory Infrastructure)

- I. Share with incoming partners the importance of:
 - a. Ongoing gap filling health worker training on comprehensive lab services
 - b. Support scale up of technical assistance by regional labs, including budget support for REQAs
 - c. Ongoing feedback to EHNRI and SCMS on equipment and logistic needs

Program area 17-HVSI (Strategic Information)

- I. Share with incoming partners:
 - a. Program's PMP, data collection tools and approach to reporting consistent with the NGI guidelines
 - b. Tools and guidelines for collecting community level NGI data

Program area 18-OHSS (Health Systems Strengthening)

- I. Share with incoming partners the FFSDP quality improvement tool.

9. Environmental compliance

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

HCSP collaborates with AIDSTAR for construction of incinerators, as well as lined pits for disposal of placentas. At HCs that do not have an incinerator, there are disposal pits.

10. Issues requiring the attention of USAID Management

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

All Program Areas

USAID needs to encourage to incoming partners to accept MSH's commitment to assist them during turn over.

11. Data Sharing with Host Government

Have you shared this report with the host government?

Yes

No

If yes, to which governmental office/s?

If No, why not?

HCSP prepares separate reports to each RHB that provides considerably more detailed information that is specific to each region.

12. Appendices

(Include any relevant documents, data etc as appendices)

Appendix I: Country Lead STTA Report (Dr. Fred Hartman)