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

Ethiopia HIV/AIDS Care and Support Project
October 1, 2009 – September 30, 2010

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

Management Sciences for Health
HIV/AIDS Care and Support Program

PROGRESS REPORT FOR

FY2010

ANNUAL PROGRAM RESULTS (APR)
(OCT 2009 - SEP 2010)

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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
EPI	Expanded program for immunization
EQA	External quality assurance
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	Niverapine
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 reagin
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	To
1 October 2009	30 September 2010

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/Curriculums

Title	Author	Date
Libona	Dawn of Hope Ethiopia	Monthly issue
Yesetoch Dimtse	NNPWE	Monthly issue
IAS'10 Effect of stigma reduction on access to HIV services in Ethiopia	MSH	July 2010
IAS'10 Empowering communities for care and support of PLHIV	MSH	July 2010
IAS'10 improved ART adherence through case management	MSH	July 2010
IAS'10 Measuring the standard of care	MSH	July 2010
IAS'10 HCSP national scale up of HIV/AIDS	MSH	July 2010

If Yes, Please attach an electronic copy of each document as part of your submission.

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
Laura Sider-Jost	21 Sept 09	9 Oct 09	MSH	Communications (for Annual Review)
Carla Goncalves	9 Oct 09	15 Oct 09	MSH	Contracts
Fred Hartman	9 Oct 09	28 Oct 09	MSH	Technical Support by Country Team Leader
Diana Silimperi	9 Nov 09	16 Nov 09	MSH	Monitoring by MSH
Scott Kellerman	9 Nov 09	20 Nov 09	MSH	Prevention
Fred Hartman	3 Dec 09	18 Dec 09	MSH	Technical Support by Country Team Leader
Ousmane Faye	10 Dec 09	24 Dec 09	MSH (consultant)	Organizational functional analysis
Fred Hartman	5 Feb 10	16 Feb 10	MSH	Technical Support by Country Team Leader
Scott Kellerman	15 Jun 10	28 Jun 10	MSH	PMTCT
Fred Hartman	7 Jul 10	25 Jul 10	MSH	Technical Support by Country Team Leader

If Yes, Please attach an electronic copy of the TA report as part of your submission.

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
Judy Webb, Senior Contracts Manager	MSH USA HQ	18 Dec 09	19 Dec 09	MSH	Resigned and returned to headquarters to assume a new MSH position.
John Shin, Senior Finance, Contracts and Compliance Manager	MSH USA HQ	6 Mar 10	15 Mar 10	MSH	Visited MSH headquarters, primarily for acquisition of a business visa for Ethiopia to allow eligibility of a work permit.

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
Dr. John Palen and Ms. Daniele Nyirandutiye, USAID Washington, site visit to established and new ART HCs	28 Oct '09	28 Oct '09	Sebeta and Teji HCs, Oromiya Region	
Tom Staal, USAID Mission Director, site visit	3 Nov '09	3 Nov '09	Modjo HC, Oromiya Region	
Dr. Afework Negash, USAID Ethiopia, site monitoring visit	14 Jan '10	14 Jan '10	Gondar HC, Amhara Region	Yes
Dr. Peter Gichangi, site monitoring visit	11 Feb '10	11 Feb '10	Bole 17 HC, Addis Ababa	
USAID/CDC team, POP site visit	15 Feb '10	19 Feb '10	Bushulo HC, SNNPR Region; Shashemene HC, Yirgalem HC, Oromiya Region	
Dr. Peter Arimi, USAID Washington, pediatric ART site visit	15 Mar '10	19 Mar '10	Bahir Dar HC, Tilily HC, Amhara Region	
Dr. John Palen, USAID Washington, palliative care site visit	8 Jun '10	8 Jun '10	Lideta HC, Addis Ababa	
Dr. Carmela Green-Abata, Dr. Peter Gichangi, joint PEPFAR/USAID site visit	18 Jun '10	18 Jun'10	Woreda 23 HC, Addis Ababa Region	
Dr. Ugochukw Amanyeiw, Jeanne Garcia Davis, USAID Washington, PWP site visit	9 Aug '10	16 Aug '10	Akaki HC, Oromiya Region, Sebeta HC, Addis Ababa, visits to NGOs: DOHE, NNPWE, NEP+	Yes

5. Activity

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

6. Accomplishments and successes during the reporting period

01-PMTCT (Prevention of mother-to-child transmission)

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

During FY10 (Q1-4), the HCSP achieved the following results in the area of PMTCT:

- ✓ **550 health centers (HCs) are providing PMTCT services** (P1.3.D)

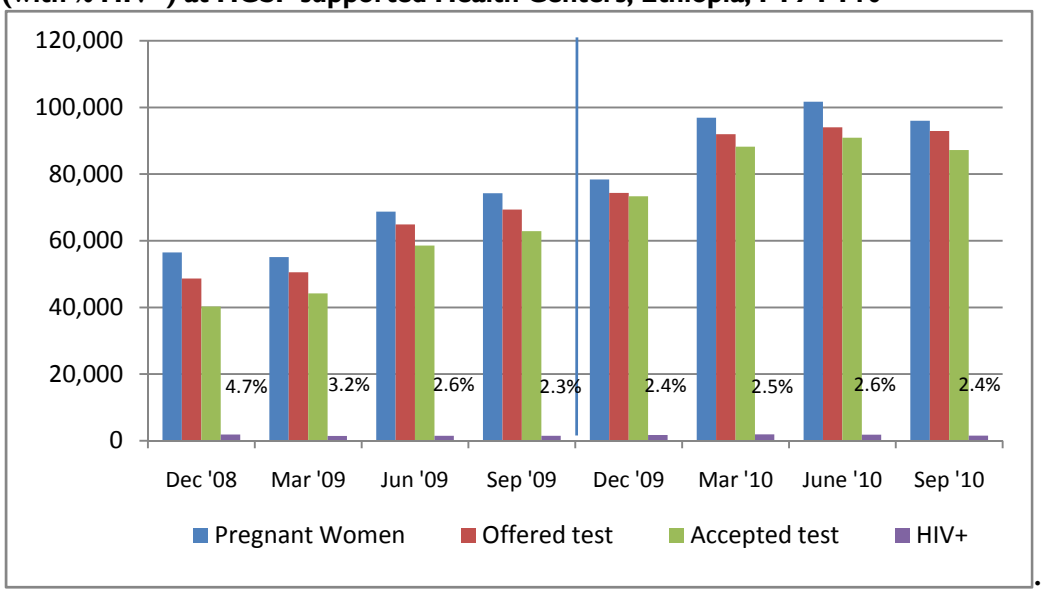
  Comment: During FY10, HCSP covered 550 HC with comprehensive HIV/AIDS service support, and thereby achieved 100% of the program's target. The 550 HC all provide PMTCT services by implementing the national PMTCT strategy which focuses on four prongs: (1) static & outreach HIV testing and counseling services, including counseling on AB & OP methods, (2) screening for and syndromic management of STDs, (3) provision of family planning services, and (4) provision of ARVs for PMTCT purposes, all integrated with care & support for the mother, her child and her family. At these HCs, HCSP emphasizes PMTCT as an integral part of ANC and therefore strengthens not only PMTCT but the delivery of the essential and integrated ANC service package both at ANC consultations and in HC laboratories.

- ✓ **339,687 pregnant women were newly tested for HIV** (P1.1.D)

  Comment: The cumulative number of pregnant women tested for HIV in FY10 is 108% of the target.

  Based on the current fertility rate of 5.4 (EDHS, 2005), Ethiopia's age and sex distribution (USAID Country Health Statistical Report, 2009), and a population coverage of the 550 HCSP supported health centers of around 33 million people (40% of Ethiopia's population), almost 1,500,000 in the HCSP catchment area would have been pregnant in the past year. Consistent with DHS data, 371,022 or 25% these women attended ANC at the 550 HC.

Number of pregnant women, counseled for HIV, tested for HIV, and HIV-positive (with % HIV+) at HCSP supported Health Centers, Ethiopia, FY9-FY10



Number of pregnant women who were offered and accepted to be HIV tested, HCSP, FY10

Indicator	Oct.-Dec. 2009	Jan.-March 2010	April - June 2010	July-Sept. 2010	Total FY10
# pregnant women	76,406	96,912	101,721	95,983	371,022
# pregnant women who were known HIV+ at entry	NA	331	566	581	1,478
# pregnant women with unknown HIV status at entry	76,406	96,581	101,155	95,402	367,544
# offered testing (% of all pregnant women with unknown HIV status at entry)	74,343 (97%)	91,976 (95%)	94,038 (93%)	92,928 (97%)	353,285 (96%)
# accepted testing (% of women who were offered to be tested)	73,326 (99%)	88,206 (96%)	90,917 (97%)	87,238 (94%)	339,687 (96%)
% of all pregnant women with unknown HIV status at entry, who were tested for HIV	96%	91%	90%	91%	92%

As shown in the above figure and table, both the number of pregnant women coming to HCs, the number being tested for HIV and the number accepting to be tested steadily increased since the beginning of HCSP, with the exception of Q4 in FY10 when fewer people may have gone to health centers due to a particularly long rainy season in some regions and because of the agricultural cycle.

The overall increase is likely related to HCSP's success of training and mentoring that emphasizes PITC at and its broad focus on the quality of comprehensive ANC services. In addition, HCSP, along with the regional health offices, has been involved in mobilizing and HIV/AIDS awareness creation among women to access the basic PMTCT/MNCH services through its community based prevention and care support activities delivered by KOOWS, CBOs, NGOs and the involvement of HEW and other community volunteers in mobilizing pregnant women to utilize available health services. Finally, HCSP's coordination and collaboration with other partners has also been an important strategy to reach these targets. In particular, the many efforts to promote mother and child health, including family planning and ANC service use by the Government of Ethiopia (GOE), USAID, the National Coalition of Women against HIV/AIDS (with a grant from the Global Fund), and others, contributed indirectly to the success in PMTCT at the HCSP supported HCs.

As can be seen from the above table, relatively, the proportion of pregnant women being offered to be tested and of those, the proportion accepting to be tested was 96% for FY10. While this result is very encouraging, it also implies that the health system had missed opportunities for 4% of the pregnant women who entered the health system.

- ✓ **6,945 of newly tested pregnant women were HIV–positive and an additional 1,478 were known HIV-positive upon entry at ANC** (P1.1D)

Comment: The total number of HIV positive pregnant women seen at the 550 HCSP supported HCs during FY10 was 8,423. This corresponds to an overall HIV positivity rate of 2.5% among all pregnant women. This finding is consistent with the national rate of 2.3% in the general population (Single point HIV prevalence estimates, MOH, June 2007).

In FY10, the overall proportion of pregnant women who reported to be HIV+ at entry was 18%. However, the proportion increased from 15% in Q2 to 28% in Q4. This big increase may be related to increased knowledge that HIV+ women can have healthy, HIV- 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. Finally, it is possible that as the program reaches more HIV+ patients over time, more HIV+ women relative to HIV- women are coming into HC for ANC or to deliver. Furthermore, the overall 18% may indicate an unmet need for FP.

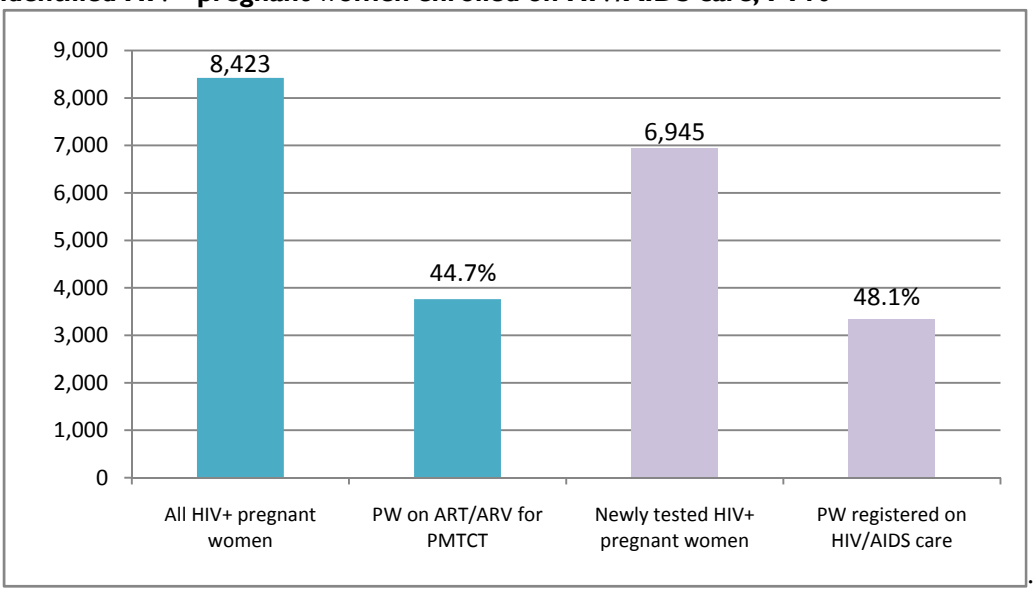
HIV status among Pregnant Women		Oct.-Dec. 2009	Jan.-March 2010	Apr.-June 2010	July-Sept. 2010	Total FY10
Number of Pregnant Women						
Tested for HIV		73,326	88,206	90,917	87,238	339,687
New HIV+		1,725	1,902	1,803	1,515	6,945
Known HIV+ at entry		Unknown	331	566	581	1,478
All HIV+		1,725	2,233	2,369	2,096	8,423
↳ Of whom	% who reported to be HIV+ at entry	Unknown	15%	24%	28%	18%
HIV Prevalence among Pregnant Women						
Among newly tested pregnant women		2.4%	2.5%	2.6%	2.4%	2.5%
Among newly tested and those with known HIV+ status at entry		2.4%	2.5%	2.6%	2.4%	2.5%

✓ **3,762 (44.7%) of the 8,423 HIV+ pregnant women received ARV for PMTCT** (P1.2.D).

→ **510 received a single dose Nevirapine prophylaxis**
1,651 received two or three ARVs
797 received ART at the ART clinic
1,017 women received ARVs for which data is not disaggregated by regimen

Comment: (*Note: From October to December 2009, the program was not able to report on the specific ARV treatments provided (SD NVP, Two ARVs, Three ARVs, ART). In January 2010, HCSP began using revised data collection forms that capture the break-down as required for the NGI and data for Q2 still reflected variable understanding of the NGI definition which led to some HC reporting the uptake of 3 ARVs when, in fact, the drug regimen should have been classified as 2 ARV.)*

Number of HIV+ pregnant women taking ARV for PMTCT and number of newly identified HIV+ pregnant women enrolled on HIV/AIDS care, FY10



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, or beginning the 28th week of pregnancy through labor and delivery. As FMOH national guidelines currently recommend starting ARV prophylaxis in the 28th week of pregnancy, HCSP does not expect all HIV-positive women seen at HC to be on ARV.

According to some recent studies, over 60% of pregnant women who go for ANC enter ANC during their 1st or 2nd trimester, i.e. before the 28th week of gestation (Tura G. Antenatal Care Service Utilization and Associated Factors in Metekel Zone, NW Ethiopia. Ethiop J Health Sci. 10(2), July 2009; EDHS, 2005). In addition, according to the EDHS 2005, among urban women, over 80% of all those who attend ANC are less than 6 months pregnant at the time of their first ANC visit. If these percentages hold true for HIV-positive women today, 60% of HIV-positive women seen at HCSP supported HCs enter ANC before their 28th week of pregnancy. This finding is not very different from HCSP data on a small sub-sample of 275 HIV-positive pregnant women seen at the HCs in the Tigray region during Q2: 145 or 53% of them were less than 28 weeks pregnant at their first ANC visit. In addition, according to current WHO estimates based on clinical or immunological evaluation at the ART clinic, about 20% of all HIV-positive pregnant women are expected to need ART.

% Distribution of HIV-positive pregnant women and those who should receive ARV or ART, by gestational age

	<28 weeks pregnancy	28+ weeks pregnant	Total
HIV positive women	60%	40%	100%
HIV positive women on ART	12% (20% of 60%)	8 % (20% of 40%)	20%
HIV positive women on ARV	0%	32% (all women>28 weeks pregnant who are not on ART)	32%
Total on ARV/T	12%	40%	**52%**

Thus, based on the published literature and WHO estimates, it is reasonable to assume that 60% of HIV-positive women enter ANC during their first or second trimester, and that 20% of HIV+ women will receive ART. Therefore, as shown in the above Table, at any one time when a cross sectional snapshot is taken, the proportion of HIV-positive pregnant women expected to be on ARV or ART will be 52% and this percentage should increase as the time period of observation increases.

HCSP *appears* to perform reasonably well having achieved 76% of its FY10 target. However, the ARV uptake of 44.7% for FY10 continues to be lower than expected in light of national and international guidelines. Although the ARV uptake reported by HCSP supported HC is within range of that noted in many other sub-Saharan African countries, the reasons for this low uptake are not documented. During Q4, HCSP therefore began an assessment of the validity of this data in a sub-set of purposefully selected health centers. Very preliminary results for 5 health centers in Addis Ababa suggest that the low uptake reflects, in part, a documentation gap and underreporting by HCs. Another factor appears to be that a fair number of pregnant women seek ANC services and HIV treatment services at different HC without disclosing this to the HC where they first seek ANC, and are counted as newly tested HIV+. However, these women tend to disclose that they receive treatment in another HC at the time the test results are discussed. These women are not recorded as taking up ARV nor do they get linked to ART since they are already receiving these services elsewhere. Finally, the fear of stigma and discrimination also seems to lead some women to refuse ARV and ART services at the HC where they were diagnosed. HCSP expects to report on the full results in January 2011.

- ✓ **3,342 (48.1%) of newly tested HIV-positive pregnant women (6,945) were assessed for ART eligibility at HCSP supported HC** (P1.4.D - data source: ART clinic)

  Comment: The number of HIV+ pregnant women assessed for ART eligibility in FY10 was 3,342. Although this is a reasonably good achievement, it is a low number compared to the number of newly tested HIV-positive pregnant women (48%). Nevertheless, the FY10 quarterly data show some improvement over the year (Q1=45%; Q2=45%; Q3=52%; Q4= 51%). This reflects an increasing emphasis on follow-up of all HIV + pregnant women both in the HC and in the community. To improve linkage of pregnant women with family focused comprehensive HIV/ AIDS services, currently health workers are escorting positive women to the ART clinic and register their pre/ART number on the ANC/L&D original registers. However, it should be borne in mind that the number of pregnant women assessed for ART eligibility and the number of newly tested HIV+ pregnant women are obtained from two different clinics within the HC. Comparing them as if they were the same is therefore not fully accurate. Nevertheless, this comparison may be used as a proxy for linkage. Therefore, linkage of newly tested HIV+ pregnant women to (pre-) ART services is also included in the above mentioned assessment, the results of which will be available in January 2011 (See comment on P2.1D above and also P1.5D below).

- ✓ **3,342 HIV+ pregnant women were newly enrolled into HIV/AIDS care and support in HCSP supported HC** (P1.5.D - data source: ART clinic).

  Comment: Since enrollment takes place immediately after clinical assessment of a patient's eligibility, the data for this indicator are identical to that for P1.4.D above.

  As noted above, explanations for the relatively low number of HIV-positive women enrolled in care and support include: possibility that the data is wrong due to multiple-counting: some women seek a second (or third) opinion at another health center (hence inflating the denominator); errors in data recording, reporting and analysis; and a high loss-to-follow-up. The stigma associated with testing HIV + and the fear of discrimination may stimulate some women to seek treatment in another location where they are not known (particularly in urban areas), or they may not seek treatment at all, preferring not to divulge their status to spouses and their family. HCSP's previous report (SAPR, FY2010) discussed these possibilities in some detail. To fully understand the causes of the low enrollment rates and thus introduce interventions to address the problem, HCSP is currently assessing this data in a sub-set of health centers (See comment on P2.1D).

Additional Achievements:

- ✓ During FY10, HCSP provided PMTCT training to 1,289 health providers (M 619; F 670).
- ✓ To strengthen PMTCT service and mobilize infected and affected mothers, 114 mother mentors were trained on topics such as PMTCT, tracing lost to follow up, reproductive health needs of mothers living with HIV and reducing stigma and discrimination given by site PMTCT coordinators at the health center level.
- ✓ In order to guide and monitor HCSP mentorship to health centers, and help address the gaps and weaknesses in HIV/AIDS comprehensive service delivery at HCs, HCSP developed a health center mentorship checklist and log book during Q4. These tools will be fully implemented at the beginning of FY11.
- ✓ HCSP continued to use LQAS to measure the Standard of Care (SOC) while conducting routine quarterly assessments of the quality of PMTCT/MNCH services at health centers by regional and central HCSP staff. These assessments always include a thorough debriefing with the respective health workers and the health center head.
- ✓ To strengthen the PMTCT continuum of care, 133 HCs now have mother support groups (MSGs). Together, these MSGs count 506 mother mentors who assist newly identified HIV positive 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.
- ✓ Throughout FY10, HCSP experts regularly participated in regional and national TWGs, PMTCT trainings and review and update of training packages--as a part of continuous technical support to improve national PMTCT services.

  Working closely with the program's sub-contracted national NGOs to strengthen them, especially the National Network of Positive Women Ethiopians (NNPWE), has improved their capacity to stimulate demand for ANC services, and thus testing. However, other efforts, with which HCSP coordinates, in the community are also important contributors to our increased testing rates, including a national campaign to increase utilization of ANC services conducted with a grant from the Global Fund by the National Coalition of Women against HIV/AIDS.

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)

In FY10, HCSP achieved the following results in the area of AB prevention:

- ✓ **94,829 individuals were reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful (P8.2D**).

  Comment: During the third and fourth quarter of FY10, HCSP began measuring the number of individuals reached with various prevention messages following the definition of NGIs. The NGI number reached with primarily AB message for this NGI reflects 75% of the target. This achievement against target almost certainly reflects the challenges associated with a new way of data collection and reporting.

  Previously, under the program's contract indicator under result 4, which uses a different definition, the annual untargeted achievement (Jul 09 – Jun 10) for number of individuals reached through community outreach that promotes abstinence and/or being faithful was 1,907,481.

  In order to transition to the NGIs, HCSP conducted a review of the NGI guidelines and strategy, developed appropriate training materials and job aids, and trained central, regional, woreda, HC, community level and NGO staff on the use of NGIs. These activities and their results included the following:

- ✓ **Customization and Distribution of 322,300 AB message materials and job aids**

  Comment: To support and strengthen the community and facility level HIV prevention, care and treatment services with key AB messages, BCC materials and job aids produced by the program and others collected from FHAPCO/ARC were distributed to the clients and beneficiaries. Thus during the year 322,300 copies of 23 kinds of BCC materials that included AB messages produced by the program and as well collected from FHAPCO/ARC were distributed for use by providers, clients, and program trained community outreach workers. The materials that were distributed for use by providers and program-trained community outreach workers and volunteers included, among others:
    - 8,000 copies of NGI training manuals produced and distributed for use by KOOWs and other volunteers
    - 8,000 copies of NGI job aids produced and distributed to KOOWs
    - 32,000 copies of 4 kinds of job aids each

- ✓ **245 (M 164 F 81) technical staff received TOT on the use of NGIs**

  Comment: Using HCSP developed training modules and supportive job aids, a TOT was given for 245 people, including to HCSP's regional BCC advisors, care & support coordinators, and M&E advisors and to HCSP subcontracted NGO coordinators to enable them undertake TOT for community mobilizers and NGO coordinators to build their capacity to then cascade the NGI training to KOOWs and other community and health workers.

- ✓ **7,539 individuals were given an orientation to NGI and AB messaging**

  Comment: To collect and report on the NGIs, HCSP oriented 7,539 (M 3,079 F 4,460) KOOWs, case managers, woreda HIV desk officers, health extension workers (HEWs) and NGO outreach volunteers. Each individual was supplied with a reference manual, job aids for messaging and reporting formats which help them organize and conduct one to one discussion sessions through provision of minimum package of intervention messages in four consecutive sessions during house to house visits. NGI orientations were given by the community mobilizers in their respective woredas' health centers and were supervised and supported by HCSP's regional and sub-regional prevention and care & support coordinators. All NGI orientations were conducted with the involvement and knowledge of regional health bureaus as well as the woreda health offices. The following table shows the number of people who HCSP oriented to NGI, by region.

Number of people oriented to NGIs

Region	Male	Female	Total
Addis Ababa	127	710	837
Amhara	1,135	1,367	2,502
Oromiya	1,084	1,015	2,099
SNNPR	412	635	1,047
Tigray	321	733	1,054
Total	3,079	4.460	7,539

- ✓ **255 religious leaders were given an orientation to AB messaging**

  Comment: In collaboration with the Ethiopian Interfaith Forum for Development Dialogue and Action (EIFDDA), orientation on AB messaging was provided for 220 religious leaders in the five regions targeting their role in fighting stigma and discrimination, providing spiritual counseling and promoting adherence.. These religious leaders are members of CCGs and thus also involved in tracing LTFU. In addition, the program provided training to 35 religious leaders on AB at the Shenkora holy water site in Amhara region where thousands of people flock for spiritual holy water bathing and drinking who believe the holy water can cure them of HIV. The trained religious leaders teach AB messages during holy water services with the visitors and address the myths and misconceptions around HIV transmission and treatment. The program trains religious leaders using a standard training manual that focuses on:
  - Adhering to mutual faithfulness and moral values during sermons and/or giving spiritual counseling at home and religious settings
  - Exercising their responsibility to reduce stigma and discrimination
  - Teaching and counseling on treatment adherence and dangers of discontinuing while using holy water

Additional achievements:

- ✓ World AIDS DAY (WAD) 2009 Commemoration: HCSP collaborated with the central and regional HAPCOs to commemorate the 2009 World AIDS Day which was celebrated with the theme of "Universal Access and Human Rights". HCSP helped organize and participated in the national level celebration held at Hawassa
- ✓ Central and regional HCSP staff participated as technical working group members with HAPCO at all levels
- ✓ HCSP supported the production of one poster (30,000 copies) promoting PMTCT and one poster addressing stigma and discrimination (20,000 copies)
- ✓ HCSP supported the production of 160,000 flyers and 70 banners on universal access and ART adherence in the five regions where HCSP operates
- ✓ HCSP developed and tested a prevention, care & support mentorship checklist for use by supervisors of community mobilizers and KOOWs
- ✓ Supportive supervision: HCSP provided quarterly supportive supervision in an integrated manner with the care & support team to the project regional staff and HCs they support. With regards to AB, the main purpose of the visits were to;
  - Render technical support
  - Support NGI trainings and cascading activities
  - Orientation and delivery of job aids, BCC materials and formats
  - Test the prevention and care & support mentorship checklist developed by the center

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 this quarter , HCSP achieved the following results in the area of sexual prevention:

- ✓ **371,990 individuals were reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful (P8.1D)**

  Comment: During the third and fourth quarter of FY10, HCSP began measuring the number of individuals reached with various prevention messages following the definition of NGIs. The NGI number reached with primarily OP message for this NGI reflects 84% of the target. This achievement against target almost certainly reflects the challenges associated with a new way of data collection and reporting.

  Previously, under the program's contract indicator under result 4, which uses a different definition, the annual untargeted achievement (Jul 09 – Jun 10) for number of individuals reached with OP messages through community outreach was 1,392,940.

- ✓ **473 persons were provided with post exposure prophylaxis (PEP) (P6.1.D)**

  Comment: The NGI measuring the provision of PEP is a new indicator that HCSP did not monitor in previous years. In FY10, HCSP achieved 95% of the FY10 target of 500. When HCSP began to collect data on PEP, it soon became evident that PEP cases were being under-reported by HCSP supported HCs as there was no national reporting format to capture PEP. To better capture this NGI, HCSP carried out on-site orientation at Addis Ababa HCs to strengthen their previously established PEP committees. Clinical mentors received an orientation to health workers on the principle, concept and guidelines of PEP and during all the IMAI/ART training; PEP is given as one part of the ART training. HCSP also developed and distributed a PEP registration log book to all HCSP supported HC and conducted a focused training and mentorship on the NGI indicators. In Q1, HCSP could not disaggregate this indicator into the three different types of exposure. In addition to the 27 people who received PEP in Q1, 240 (54%) received PEP in FY10 for occupational exposure, 106 (24%) because of exposure by rape or sexual assault and the remaining 100 (22%) for other exposures.

- ✓ **105,948 people living with HIV/AIDS were reached with a minimum package of prevention with PLHIV interventions this quarter** (P7.1D)
  Comment: Prevention with positives (PwP) is a new and required indicator under NGI. PwP is one of the main prevention strategies given due attention for people living with HIV/AIDS. During the reporting period HCSP introduced PwP at facility and community levels through trainings and production of a job aid. The intervention strategy was applied according to the NGI guideline and implementation procedures included house to house visits and/or small group sessions using individual and/or small group intervention messaging packages.

  As with AB, HCSP introduced the OP NGIs to its staff and counterparts in Addis Ababa and the four regions. The operationalizing of these NGIs included the following activities and results:

- ✓ **Customization and distribution of 446,900 copies of BCC materials and job aids on OP messaging**
  Comment: To support and strengthen the community and facility level HIV prevention, care and treatment services with key OP messages, BCC materials and job aids produced by the program and others collected from FHAPCO/ARC, were distributed to the clients and beneficiaries in the project regions. In FY10, 446,900 copies of 26 kinds of BCC materials identified for OP messaging were produced by the program or collected from FHAPCO/ARC for distribution to HC providers, clients, and program trained community outreach workers.

The 446,900 materials include the following:

- 322,300 that also include AB messages
- 100,000 copies of a brochure on RH needs for PLHIV
- 24,600 job aids

✓ **60,000 copies of the Libona newspaper and 11,550 copies of the Yesotoch Dimtse newsletter were distributed**

Comment: 60,000 copies of the Libona newspaper were distributed to all program sites through the regional HCSP offices. This monthly newspaper is produced by Dawn of Hope Ethiopia (DOHE) with the intention to sensitize and mobilize the general public and PLHIV on HIV/AIDS prevention, care and treatment interventions. HCSP continued to collaborate and support the monthly publication of 5,000 copies, which are distributed to HCSP supported health centers for use by the health providers and community outreach workers.

11,550 copies of Yesotoch Dimtse (Voice of Women) were distributed. HCSP supported the publication of this newsletter produced by the NNPWE from Q1 to Q3. The newsletter is distributed to national AIDS Resource Center, member women PLHIV associations and central and regional sector government organizations through the NNPWE distribution outlets.

✓ **Training on the use of NGIs**

Comment: All HCSP staff, KOOWs, case managers, woreda HIV desk officers, HEWs and NGO outreach volunteers trained on AB (together, 10,164 people) were also trained on OP. Each trained individual was supplied with a reference manual, job aid for messaging and reporting formats developed to help them organize and conduct one to one discussion sessions through provision of the minimum package of intervention messages in four consecutive sessions during house to house visits, coffee ceremonies and small group sessions in compliance with the new guideline and implementation procedures. In addition, specific OP training was given to the following:

- **255 health center heads** were trained on Infection Prevention (IP), during five day training. The trainees included 186 men and 69 women. Following the training, the health center heads conducted on site job orientation sessions for 4,066 (M 1,906 F 2,160) health center staff to institutionalize improved IP practices. Finally, 500 health centers established IP committees who are routinely supervised by the multi-disciplinary team (MDT) in each health center. As a result, it is expected that IP practices will be improved and IP materials will be more available. HCSP is planning to conduct a small OR to assess the impact. Results of the OR are expected in February 2011. In addition, the FFSDP 2nd evaluation round will also shed light on IP practices in thee ART HCs.
- **35 religious leaders also trained on OP in Amhara**.

✓ **24 Heads of HCs were trained in IP and PEP**

Comment: Training on Infection Prevention and PEP was conducted for 24 (M 20 F 4) health center heads with the intention to increase their knowledge and skills on IP/PEP practices. In AA and the four regions, IP/PEP practices are institutionalized and routinely monitored/supervised by the MDT in each health center. This brings the year's total number of health center heads trained in IP/PEP to 255, thereby achieving the HCSP target for the year.

Additional achievements:

- ✓ **Condoms were generally available at all 550 HCSP supported HCs**
  Comment: In collaboration with the PSI-Ethiopia implemented USAID Targeted HIV Prevention Program (THPP), HCSP continued to ensure that condoms were available in all health centers.

- ✓ **Participation in TWG**
  Comment: To ensure harmonization and integration with the health delivery system, HCSP continues to be actively involved in the technical working group (TWG) on Infection Prevention and Patient Safety chaired by the Medical Services Directorate. An IP/PS strategy, guideline and standardized training manual was developed by the committee and endorsed by the Ministry of Health. The document is intended as a standard to be adopted by all government and non-government organizations.

- ✓ **Collaboration with USAID partners**
  Comment: HCSP developed and signed MOUs with PSI and Path and also collaborates with C-Change, JSI, Save/US and Intrahealth to coordinate with other PEPFAR funded projects implemented by these agencies.

- ✓ **Collaboration on World AIDS Day 2009 Commemoration**
  Comment: The prevention team collaborated with the central and regional HAPCOs in the commemoration of the 2009 World AIDS Day celebrated under the theme: "Universal Access and Human Rights". The support included technical and financial as detailed in the earlier AB section.

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)

The HIV/AIDS Care and Support Program (HCSP) has achieved the following results as of Q3:

Palliative care (HC centered)

- ✓ **415,203 eligible adults and children provided with a minimum of one care service in Q3** (C1.1.D)

  Comment: The number of infected/affected individuals who received a minimum of one care service represents 109% of the FY10 target. In Q3 and 4, 83,100 were reached through home-to-home visits and 4,336 through NGOs (disaggregation is not available for Q1 and Q2). Almost 60% were women and 33% 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. Of note, this number includes new clients and does not count repeat clients and is thus a conservative estimate of the true number receiving care services.

Community mobilization

- ✓ **1,265 kebeles have deployed outreach workers that are served by a network HC** (Non-NGI contract deliverable #13). This represents 100% of the PY3 target.
- ✓ **6,969 individual outreach workers trained in community and household HIV prevention, care and treatment promotion** (Non-NGI contract deliverable #8) This represents 110% of the PY3 target.
- ✓ **7,537 individual outreach workers, HEWs, case managers and woreda HAPCO officers trained on NGI.**

  Comment: The key components of community mobilization involve the formation of a community core group (CCG) comprised of community leaders and representatives of local community based organizations, including PLHIV associations; the deployment of kebele-oriented outreach workers (KOOWs) to kebeles (5 each); and the deployment of a community mobilizer at each served HC to link the KOOWs to the ART HC. At the end of this reporting period, HCSP achieved the following for both the annual and end of PY3 cumulative targets:
  - Kebeles mobilized, with CCGs formed:
    - Annual: 470 (100% of target)
    - Cumulative: 1,265 (99% of target of 1,270)
  - KOOWs trained and deployed:
    - Annual: 2,345 (99.8% of target of 2,350).
    - Cumulative: 6,969 (110% of target of 6,350)
    - Since the program started paying the KOOWs in advance through the commercial banks, there has been a notable service drop off by trained KOOWs who collect their stipend in advance. HCSP has now initiated post-monthly payments.
  - Community mobilizers trained and deployed
    - Annual: 43 (100% of target)
    - Cumulative: 175 covering 193 HC (100% of target)

Community care and support

During FY10, community outreach activities, led by KOOWs, continued and included the involvement of PLHIV associations, CCGs and HEWs. In total, 1,631,485 people were reached with community outreach services through KOOWs and NGOs. The total figure includes those who have received OP/AB messages, C&S services, and PwP interventions.

Coffee ceremonies continued to be used as the primary vehicle for reaching community members in group settings to promote prevention and testing, address stigma and discrimination and promote available HC services. KOOWs, through coffee ceremonies, reached the targeted population with small group (25 persons or less) level interventions that meet the minimum standard of four sessions. Job aids developed by the program to guide these sessions were the main reference material.

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. KOOWs 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, members of the CCGs and local PLHIV associations. As KOOWs are typically themselves HIV-positive, 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. In this quarter, the KOOWs reached the target population with individual and family level interventions that meet the minimum standards of 4 consecutive visits. During the home visits, KOOWs assessed care and support needs and provided services according to their age groups. In FY10, 415,203 infected and affected individuals received at least one palliative care service.

Of interest is that during Q4, KOOWs have begun to report a reduction in the number of bedridden clients in the catchment areas of the health centers supported by the program. HCSP conducted a focus group discussion with KOOWs during a joint HCSP/SCMS HBC kit quantification exercise. KOOWs revealed that it takes an average of six months for a bedridden client, who has been linked to ART services and community support services, to become ambulatory. The notion of HBC is therefore evolving from nursing care to supporting infected clients and their families to remain healthy and linked to both clinical and community care and support services. An associated challenge is the ability of the program to locate mobile clients as well as link them to initiatives which enhance their livelihoods.

Regular meetings between KOOWs and HC/woredas. The KOOWs' most regular formal meeting 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 at least 191 health centers visited by the program staff during quarterly supportive supervision. At least 7,000 KOOWs, CCG members, case managers, woreda HAPCO officers and HEWs attended the meetings. To review progress and refocus care and support activities at the community level, woreda and zonal level review meetings were conducted for all 191 health centre catchments with KOOWs. These review meetings focus on challenges that case managers, KOOWs and CCGs face in their endeavors to support 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 their access to government resources.

- ✓ **170,199 individuals were referred from community to HC, of whom 165,949 by KOOWs and 4,250 by NGOs** (A non-NGI contract indicator from Result 3).

  Comment: The number of referrals from the community to health centers was similar in Q4 and Q3 but both quarters reported lower numbers than the first 2 quarters of the year. This may be related to the slow transition of KOOWs to the new NGI reporting format and the effect of advance payments on performance experienced in Q2 (see below). In addition, during FY10, KOOWs traced and brought 4,153 TB and ART patients back to the health centers for

treatment. The work by KOOWs in both tracing lost patients and adherence counseling is a key feature of HCSP's relatively low lost-to-follow-up (LTFU) rates (see the table below).

Number of HIV+ patients referred from the community to health centers and lost-to-follow-up rate by quarter, FY10

	Q1	Q2	Q3	Q4	FY10 Total
# of referrals from community to HC	49,259	52,359	33,549	35,032	170,199
LTFU	7.9%	7.8%	8.8%	9.1%	9.1%

Monthly reporting on care and support activities

KOOWS report on the following:

- ✓ **Outreach activities** in HIV related community mobilization for prevention care and or treatment (number of coffee ceremonies and the messages they focus on: prevention, stigma reduction, disclosure).
- ✓ **Mobilized community assets** (number and types of assets identified and types, with evidence on asset maps at kebele level). In the revised reporting formats, it is now possible to identify the number of persons referred to major services like food and IGA through asset mapping.
- ✓ **Provision of community, home based and other care and support services** to HIV/AIDS infected and affected individuals.
- ✓ **Referrals** of PLHIV, OVC and other affected household members within a network of existing community services (case stories on the types of linkages and referrals are reported every now and then and some are documented as success stories).
- ✓ **ART and TB DOTS adherence support and tracing** of lost to follow up of patients. During FY10, HCSP revised its community level reporting formats and no longer considers double counting to be a serious problem. All program supported community volunteers now identify in their reports whether the person supported is a repeat or new person. For the earlier reported referrals, however, KOOWs report the number of linked referrals, not the number of individuals referred. As reported earlier, the KOOWs most regular formal meeting is the monthly woreda level meeting, typically held at the HC. During this meeting, HCSP receives the KOOWs reporting data and had used this to verify payment of their transport stipend. There are indications from all regions that the revised method of payment to an advance method compromised the control and coordination mechanism that has been previously linked to KOOWs performance, reporting and attendance at meetings. By paying a 3 month advance stipend directly to the KOOWs through the commercial bank of Ethiopia, the woreda HAPCO offices in all the regions feel that they no longer have a control mechanism over the KOOWs. There is no incentive for attending monthly meetings or maintaining quality standards of work or reporting. Moreover, non performing KOOWs are being rewarded at the same level as more committed KOOWS. These sentiments are equally shared by community mobilizers and regional program staff. The program is switching to bi-monthly payments for the KOOWs at the instigation of the community mobilizers who verify performance of the KOOWs in their woreda before money is transferred.

Strengthened linkages with GOE HEWs

- ✓ **1,968 HEWs and 448 HEW supervisors, woreda HIV focal persons and women affairs' representatives trained on care and support (C&S) topics.**

  Comment: In addition to KOOWs, HCSP has begun, in collaboration with the RHB and WHO, providing short orientation workshops at the HCs to HEWs to better link them to their area HCs. As the most grass roots government health worker, who are assigned to kebele based health posts, HEWs offer a sustainable link between HCs and community. The HEWs who attended the orientation workshops at the HCs then orient 20-30 voluntary community anti-AIDS promoters (VCAPs) each to assist them in mobilizing community members. The participation of their supervisors and other woreda level people was aimed at strengthening their

capacity to better guide and support the HEWs and their linkage to the area HCs. The current number of HEWs who benefitted from HCSP capacity development in FY10 is 98.4% of the target of 2,000.

Collaboration with PEPFAR partners

PSI Ethiopia: As noted in the earlier OP section above, HCSP has an MOU with the PSI-Ethiopia implemented USAID THPP to help ensure promotion of and a regular supply of condoms to program supported HCs, and which also includes training and provision of demonstration tools for use by HCSP's KOOWs and community mobilizers. The program has also collaborated with the PSI-Ethiopia implemented USAID Basic Care Package (BCP) Project. Working at earlier selected HCs based on prevalence, availability of care and support and number of ART patients, the BCP project subsequently trained ART focal persons to prescribe care packages to appropriate patients, containing point-of-use water protection (WaterGuard), a safe water storage vessel, water purification tablets, soap, ORS, condoms, de-worming tablets and long lasting insecticide treated bed nets--where required. A second distribution of supplies is expected in the following reporting period.

NGO capacity building and partnership

The HIV/AIDS Care and Support Program sub-contracts with EIFFDA, Dawn of Hope (DOH) and in FY10, signed performance-based contracts with four other organizations: National Network of Positive Women Ethiopians (NNPWE), HIV/AIDS Prevention, Care and Support Organization (HAPCSO), IMPACT Association for Social Services and Development, and Relief Society of Tigray (REST). Through their branch offices, these organizations work in all the regions where HCSP operates. The deliverables for the contracts were aligned with HCSP's targets for prevention, care and support to those infected and affected by HIV/AIDS. All sub-contracts and PBCs ran through June 14. After June 14, HCSP renewed or extended the contracts with EIFDDA, DOH and the National Network of Positive Women although technical assistance continued to also to the other NGOs which continue operating with other funds. For instance, HAPCSO operates in all ten sub-cities in Addis Ababa and received funding through FHI.

HCSP's performance based contracting approach includes a strong capacity building component of the recipient organizations. The process involves joint identification of contract objectives and a process whereby the NGOs agree on indicators and outcomes that will be used for monitoring and payment purposes. Performance-based contracting has helped the NGOs develop work plans with TA from HCSP tied to cash payments for services rendered. The NGOs agree to use standardized tools and systems for work plan development and performance monitoring against results and through this, they have strengthened their systems and approaches to plan and monitor their work against results. One objective of HCSP is to make sure that the NGOs are transformed towards a better, more transparent system of accountability. The process of preparing the work plan based on the PBC model has proven very useful to both HCSP and the NGOs to track activities and utilize monitoring formats that HCSP designed for monthly reporting.

In addition, HCSP supported the monthly publication of 5,000 copies of DOHE's 'Libona' which is the only national newsletter on HIV/AIDS and which reaches an estimated 50,000 people monthly; and NNPWE's newsletter, 'Yesetoch Dimtse', which reaches an estimated 19,285 people monthly. See Appendix I for examples of the publications.

Lastly, during FY10, HCSP trained 940 NGO staff including volunteers, volunteer supervisors and project coordinators on the NGIs against which the NGOs began reporting in Q3, using the new reporting formats prepared for them. More than 85% of the trainees are women. Those trained also trained the outreach workers to collect data using the new NGI's.

Contributions of NGO partners to service delivery

HCSP NGOs contributed the following results to HCSP:

- 20,107 people provided with home based palliative care (73% female)
- 16,099 referrals were made from the community to HC for different services including TB, ART, PMTCT and pediatric services (66% female)
- 10 people reached with AB messages in accordance with the NGI guidelines
- 293 people reached with OP messages in accordance with the NGI guidelines
- 46,403 reached with AB messages (not in accordance with the NGI guidelines) (estimated 50% female)
- 34,703 reached with OP messages (not in accordance with NGI guidelines) (estimated 56% female)
- 1,422 patients were traced and followed up, of whom 58% of the LTFU patients were female
- 14,241 patients were provided with ART and TB DOTS adherence support, of whom 70% were female
- 63,151 HIV positive persons counseled on ART, adherence, positive living etc. For the next reporting period, reports will specify PwP in accordance with the NGI (62% female).

Through the partnership with HCSP, DOHE, NNPWE, HAPCSO, IMPACT and REST deployed approximately 858 outreach workers who were supported by different cadres of health care provider's staff in the NGOs. All of them were trained in C&S service delivery. These outreach workers visit households not covered by KOOWs to provide counseling as well as refer individuals who need specific support for different needs. The NGOs selected by HCSP for the PBC were operating in these areas prior to their partnership with HCSP. Therefore, the extensive network of community organizations, such as Idirs, schools and churches they have worked with gives them an understanding of what is available in the community.

The NGO outreach workers conducted house to house visits (around 20 households each) with key responsibilities consistent with those listed above for the KOOWS. Asset mapping which is conducted in each community where KOOWs operate, assures that there is no overlap between KOOWs service areas and NGO service areas. The activities include the provision of adherence counseling and tracing LTFU patients, following up on pregnant mothers, as well as providing home based care and psycho-social support, identifying needs of the infected and affected and referring to HC and community services, and presenting prevention messages. As a result of these NGO activities, individuals are referred for ART, PMTCT, VCT, TB, OI, and family planning at the nearest health centers. The NGOs made a cumulative total of 16,099 referrals to HC. Many were women: 9,080 and 2,348 were referred to HIV counseling and testing and to PMTCT services respectively.

Outside of home visits, the range of services include testimonials, youth peer to peer outreach, community outreach and mobilization through coffee ceremonies, IGA to PLHIV groups, capacity building of peer NGOs and individual peer counseling of PLHIV in sub-offices. HCSP funding and TA enabled accelerated NGO community mobilization by enabling branch offices to work within their catchment areas. Through Idir committees HAPSCO worked in the community and the Kebele HIV/AIDS desk to increase awareness and decrease stigma and discrimination. NNPWE's outreach workers and members of the organizations move within the community providing testimonials in schools, markets, and other venues. The community mobilization by the NGO's has reached 492,290 people in the project areas and a total of 20,107 people were provided with home based palliative care of whom more than 72% were female.

In preparation of PY4, HCSP assisted three NGO's (DOH, EIFDDA, NNPWE) to conduct work planning and issued new contracts, as follows:

DOH

DOH will work with HCSP to support the deliverables of the contract in prevention, care and support and capacity building. Dawn of Hope will continue publishing the monthly newsletter, Libona, which will have a specific theme each month covering the different aspects of HIV/AIDS, prevention, treatment care and support, in consultation with the concerned teams. DOH will carry out prevention activities through publishing articles regularly in 'Libona Magazine', provision of AB and OP messages, and PwP assessment and counseling. DOH will establish referral linkages for HCT, PMTCT, other care and support and HC services as well as to pediatric HIV care. A quarterly monitoring is also planned to intensify best practices and address gaps.

EIFDDA

EIFDDA has been a partner of HCSP since the beginning of the program and has contributed towards the achievement of the goals of the project by training religious leaders in all four regions and Addis Ababa. During the coming year, HCSP's support for EIFDDA will focus on the Women in Faith initiative to maximize the limited resources that EIFDDA will receive from the project and promote gender issues within EIFDDA activities. The Women in Faith initiative has just been launched and building the capacity of this will promote the mitigation of the HIV/AIDS pandemic as well as provide resources to those who are affected by HIV/AIDS such as orphans and vulnerable children. To build this capacity, HCSP proposes to use the resources allocated to EIFDDA to support the development of the strategic plan for the Women in Faith initiative and incorporate it within the work of EIFDDA.

NNPWE

NNPWE will work with HCSP to support the deliverables of the contract in prevention, care and support and capacity building. NNPWE will carry out prevention activities through publishing articles regularly on 'Libona Magazine', provision of testimonials to reach adolescents in schools in AB messages, provision of OP messages and PwP assessment and counseling. In addition, provision of gender sensitive family focused umbrella care to individuals and families affected by HIV/AIDS is also one of the activities planned for PY4. NNPWE will also strengthen and establish 45 MSG support groups as well as provide referrals to HCT, PMTCT, other care and support and HC services, and to pediatric HIV care. A quarterly experience sharing and monitoring is also planned to intensify best practices and address gaps. A final evaluation will also be conducted by the HCSP NGO team to document the strengths, weaknesses and lessons learnt.

09-HTXS (HIV/AIDS Treatment)

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

The HCSP has achieved the following results in the area of adult HIV/AIDS treatment as of Q3:

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

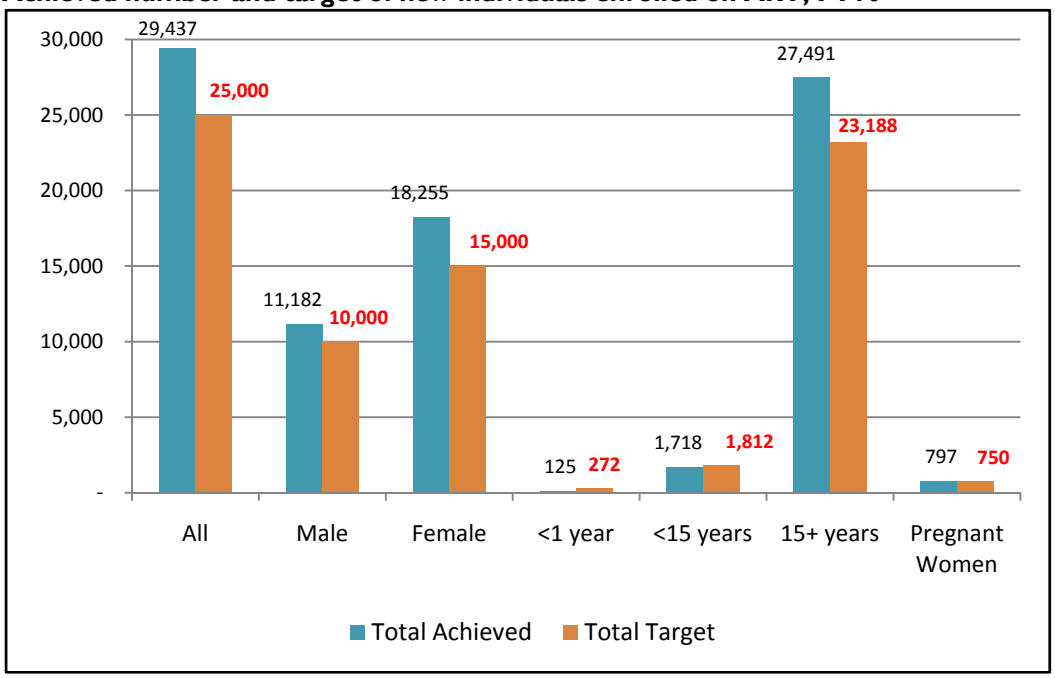
  Comment: During this reporting period, HCSP continued to work in all 550 HC through mentorship, training and other support. Of the 550 HCSP supported government HCs, 350 HCs are now providing ART services. This represents 100% of the HCSP target.

  In addition, in the Oromiya region, discussions between the program and their regional health bureau (RHB) have resulted in the program initiating additional support to their 39 new ART HCs. Of these, 24 were program supported non-ART HCs that have been recently upgraded by the RHB to ART HCs. The remaining 15 new ART HCs were not previously supported by HCSP. The program has initiated an average of 2 mentorship visits per quarter to these new ART HCs, with reduced mentorship to currently supported HCs that have well established HIV/AIDS comprehensive services.

- ✓ **29,461 new individuals were enrolled on ART in FY10** (T1.1.D)
  Comment: The number of new individuals enrolled on ART at HCSP support HC reflects 118% of target. Of those enrolled, 1,718 were children under the age of 15 years and among these, 125 were infants. Of the 27,743 who were 15 years or older, 801 were pregnant women.

  As can be seen from the Figure below, HCSP achieved 118% of its FY10 target for the total number of newly enrolled patients and this over-achievement also held true for new patients above 15 years of age and for males and females separately. HCSP's FY10 results for children under15 years of age and pregnant women were on target (95% and 107% respectively). However, the number of infants newly enrolled on ART is an area of concern, as only 46% of the target was achieved. The low enrollment may be a result of providers' reluctance to treat small babies because of an undue concern of side effects in this age group, as anecdotal evidence suggests. Another possibility is that health providers are not yet sufficiently trained and only recently received focused on-the-job mentorship on pediatric HIV/AIDS management through ANECCA. There may be other reasons, including, for instance, the fact that a majority of Ethiopian women (and therefore possibly also HIV+ women) deliver at home; or that HIV+ women might deliver at another health facility; or, perhaps, there are data recording and reporting errors. Another reason may be that those women who enter care and treatment are having fewer positive babies due to successful uptake of PMTCT which can reduce transmission to as low as 2%. To better understand this finding, HCSP has begun a HC data assessment and expects to report on the results in January 2011.

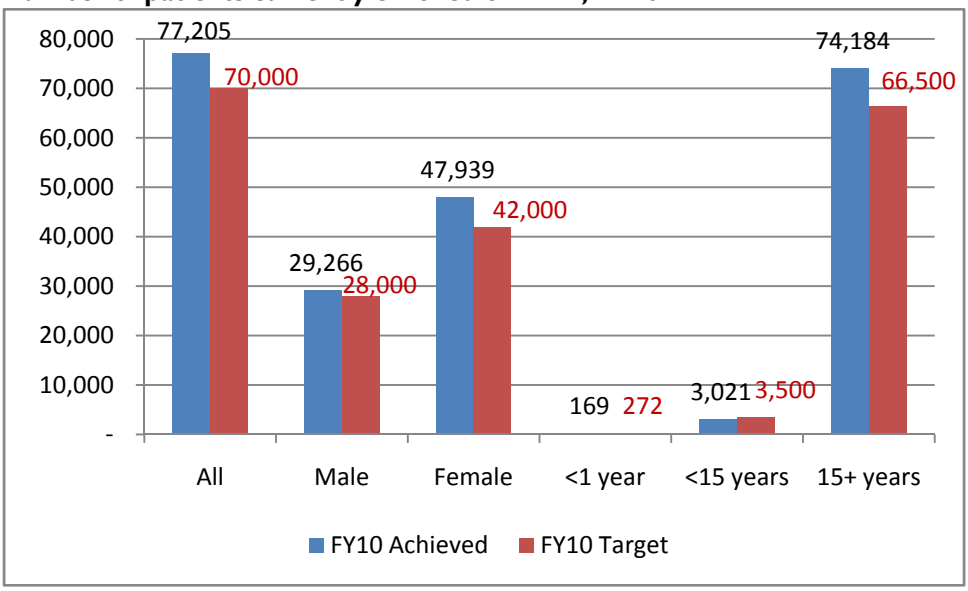
Achieved number and target of new individuals enrolled on ART, FY10



- ✓ **81,506 individuals who ever started on ART** (T1.4.D)
  Comment: The cumulative number of patients who ever started ART represents only those patients who started treatment at HCSP supported HC.

- ✓ **77,205 HIV patients are currently receiving ART through HCSP supported HC** (T1.2.D)
  Comment: The number of current patients receiving ART in FY10 represents 110% of the FY10 target of 70,000 which was based on data from previous years. The program's consistent achievement is likely due to its strengthening of the PITC services and referral linkages, a higher number of transfer-ins compared to transfer-outs, an emphasis on the importance of regular assessments of patients who are on pre-ART service, restaging and early initiation of ART for those eligible, technical support to the health centers through clinical mentoring, quarterly catchment area meetings and supportive supervisions, and continued effective linkages with the community. However, as is the case with newly enrolled patients and shown in the figure below, the number of infants currently on ART is lower than expected (169 which is only 62% of the FY10 target of 272).

Number of patients currently enrolled on ART, FY10

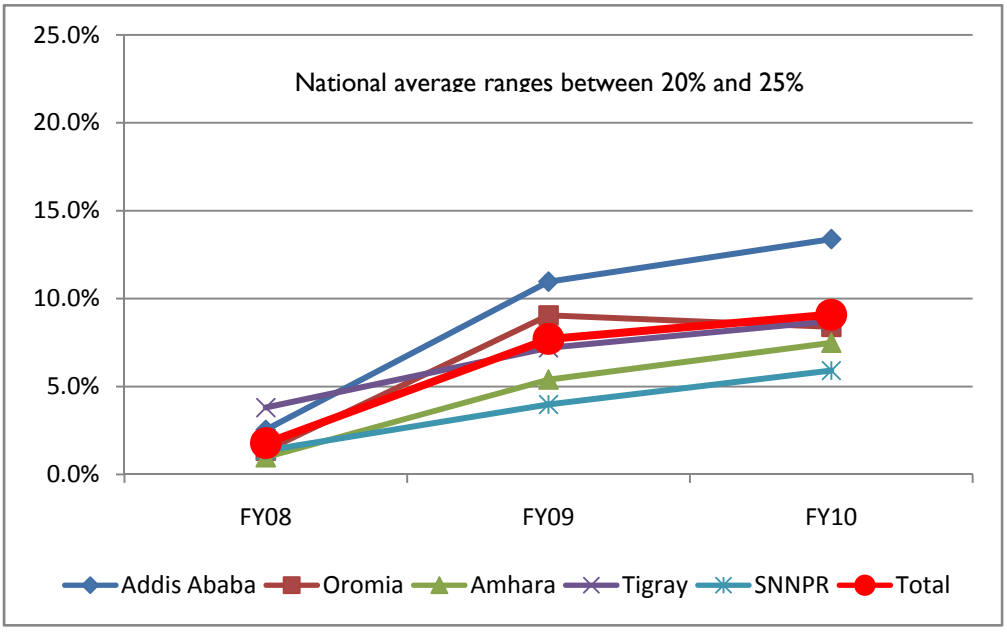


The number of currently enrolled ART patients (T1.2D = 77,205) is very close that the number of patients who were ever enrolled on ART (T1.4D = 81,506) pointing to high adherence and follow-up rates. However, the number ever enrolled refers only to patients who began ART at the HCs while the number who is currently on ART also includes patients who were transferred in from hospitals or other facilities. By the end of FY10, a cumulative total of 22,408 patients had been transferred in; a cumulative total of 10,765 had been transferred out; 7,556 deceased; 128 stopped; and 7,770 were lost. The true LTFU rate must take all this into consideration.

In FY10, the LTFU in HCSP supported HCs was 9.1%. The rate not only increased from Q1 to Q4 but increased compared to the first project year (see figure below). The longer patients are on ART, the higher the LTFU will be simply because more time has elapsed. In addition, as more patients begin feeling healthy, more will stop treatment because they feel better, and more will migrate elsewhere as they have become mobile again. All these factors may explain the increase in LTFU rate compared to the first program year, especially in urban and peri-urban areas. In Addis Ababa, for instance, the LTFU rate was similar to that of other regions in year 1 but rose rapidly to over 13% in FY10. In the months ahead, HCSP will continue to carefully monitor the LTFU rate to assist HCSP in adjusting its interventions, when needed and possible.

Of particular concern is whether the LTFU rate at HCSP supported HCs will continue to increase and eventually stabilize around the LTFU rate seen at hospitals. Currently, HCSP's LTFU rate continues to be well below the national rate which was most recently reported as 28% (Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS 2010. Federal Democratic Republic of Ethiopia, FHAPCO, March 2010). A key factor in the lower than national LTFU rate is certainly the success of decentralization of services to HCs, which brings the service closer to where people live, thus greatly reducing access difficulties. Quality of adherence counseling and refresher training for case managers also likely contributed.

Annual lost-to-follow-up rate at HCSP supported Health Centers, FY08-10



- ✓ **78% of adults and children are known to be alive and on treatment 12 months after initiation of ART (T1.3.D)**
  Comment: The HCSP supported HCs reported 78% survival of ART patients, one year into treatment. FY10 was the first year in which HCSP collected this information. In addition to training providers and data clerks on how to record and report this data, HCSP worked with the FMOH and RHBs to introduce tools for HCs, including a cohort wall chart and book, to capture survival data on the HC's ART patients. Nevertheless, data collection for this new NGI was challenging at several HCs and valid data were only collected from 240 (69%) of the 350 ART HCs. However, all 240 HCs that reported valid data, also reported complete data for the year.

Additional achievements:

- ✓ **Measuring the Standard of Care (SoC)**: During this quarter, as part of a treatment TWG initiative, the program reviewed data on 9,824 patients from the program's 19 highest patient load health centers (9 in AA, 2 in Oromiya and 8 in Amhara). Results were as follows:
  - Pre-ART patients: 95% were clinically staged and 80% had a CD4 test around enrollment
  - ART patients: 82% were clinically staged and 79% had a CD4 test around time of starting ART

- ✓ **Support to catchment area meetings:**
  In the four regions outside AA, regular 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. ART health centers presented major quarterly achievements, gaps, solutions to the gaps and ways forward. This meeting is crucial as it presents 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.

- ✓ **Piloting CME through video conference using Wide Area Network**
  Comment: In collaboration with Regional Capacity Building and RHB, HCSP piloted continuous medical education (CME) in Amhara, using the internet Wide Area Network that the GoE provides to all woredas in the country. This approach to CME through video conferencing is the first of its kind in the nation. The objective of the pilot CME was to build the clinical capacity of health providers to improve the quality of care.

  A total of 251 participants coming from 27 ART health centers near the selected sites participated in 8 CME sessions.

  The CME sessions included interactive mini lectures by power point presentation using standard national curricula for each topic; online questions from the participants; answers from presenters; demonstration to further enable participants to inculcate the theme of the sessions; and practical video shows. During the final (8^{th}) CME regional, zonal, and woreda health office representative attended the video conference, in order to give them a hands on experience, on the use of this technology to deliver health messages and share other health related activities with frontline health workers. The Amhara RHB head described the method as an exciting one, feasible to use, and under-utilized by the health sector. He expressed commitment for future use.

  Each CME session also included a pre- and post-test on the knowledge and understanding of the presented topic before and after the session. At the end of the 8^{th} session a full course evaluation was conducted among the participants. Preliminary results indicate that the CME was effective with trainees having improved their knowledge on comprehensive HIV/AIDS care. HCSP is currently in the process of finalizing the analysis and final results will be available in January 2011.

  Nevertheless, using CME through wide area internet also posed some challenges. For instance, some CME sessions were interrupted by power cuts. Furthermore, the clarity of the pictures and sound need to be improved for effective utilization at scale.

- ✓ **Training**: During FY10, HCSP has supported basic and refresher trainings in comprehensive HIV care/ART, case management, and data management for HCs. A total of 1814 heath workers(contract deliverable #6) were trained on comprehensive HIV/ART. Basic case management service training was provided to 88 case managers and refresher training was provided to 260 case managers in Addis Ababa and the four regions of Tigray, Oromiya and SNNPR. The refresher training for existing adherence case managers aimed at equipping them with up-to-date knowledge and skill on evidence based public health service interventions. Moreover, HCSP oriented the case managers to PEPFAR NGIs using the revised recording and reporting tools. During refresher training, there was also thorough discussion on major barriers of ART adherence and other challenges that case managers face during implementation of service.

Additional achievements:

- ✓ The following activities were carried out during the year:
  - Recording and reporting tools were revised (monthly reporting form, case management registration log book, care plan and family matrix)
  - Draft of case management standardized operation procedure (SOP) was produced
  - All activities conform to PEPFAR NGI, and are reported accordingly by case managers.
  - In Addis Ababa, 5 HCs (Kirkos, Woreda 24, Kazenchis, Bole 17 and Yeka) were visited by central office staff to assess the progress of case management activities in line with the case management tools and to observe any difficulties on performance that limit achievement of intended outcomes. In addition, technical support was given to improve some observed gaps during the visit. In collaboration with RHBs, training on National Comprehensive HIV Care/ART curriculum was given for 29 HC pharmacy technicians in the quarter.

10- HIV/TB (HIV/TB co-infection management)

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

The HCSP achieved the following results in the area of HIV/TB as of Q3:

- ✓ **106,827 HIV-positive patients visiting the ART clinic during the FY were screened for TB in HIV care and treatment settings** (C2.4.D) (*note: documentation records screening at least once, not for each visit*).

  Of whom:
  - 17,316 underwent sputum AFB examination
  - 5,154 began TB treatment (C2.5.D).
    - 2,879 were referred from the ART clinics to TB (i.e. 2.3% of HIV patients who were screened)
    - 2,275 were referred from the TB clinics to ART
  - 19,277 began IPT (C2.6.D)

  Comment: The number of HIV-positive patients visiting a HC ART clinic that were screened at least once for TB (C2.4D) 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=106,827) x 96% = 102,554.

  HCSP is somewhat on target for C2.5.D: the number of HIV-positive patients who started TB treatment is 85% of the target of 6,068. Worldwide data from WHO indicate that 4% of HIV infected patients will develop active TB each year, which is the basis for the calculation of this NGI indicator target, with those referred from the TB clinic added to the 4% of ART patients.

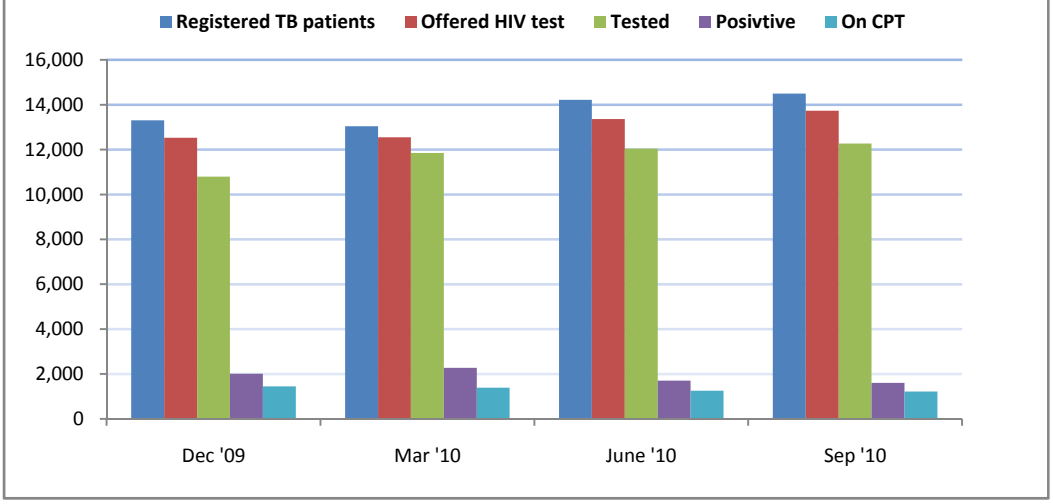
  During the year, the number of patients who received IPT (C2.6D) increased, albeit variably from quarter to quarter (see table below). The overall percentage of those screened but not started on TB treatment who are started on IPT seems low (15.5%) and lower than the national average of 23% of HIV patients on IPT.

ART patients	Q1	Q2	Q3	Q4	FY10 Total
Screened	65,321	14,630	14,065	12,811	106,827
Started TB treatment	1,343	1,177	1,344	1,290	5,154
On IPT	2,422	7,876	4,056	4,923	19,277
% on IPT	7.4%	22.7%	19.6%	14.0%	15.5%

  Although IPT is supported by national policy, it is not yet implemented nationally. Under-reporting is certainly a likely factor because TB screening of HIV+ patients is only effectively captured in individual follow-up patient cards instead of the patient register. In response, HCSP employed a separate screening log for the data clerks to better capture TB screening and related data on daily basis. In AA and the 4 regions, HCSP provided refresher training to data clerks. However, there also continues to be considerable resistance to the use of IPT for fear of inducing resistance, e.g. the Tigray RHB has not yet endorsed the use of IPT.

- ✓ **46,964 TB patients had an HIV test result recorded in the TB register** (C3.1.D)
  Comment: HCSP began collecting information on this NGI in October 2009. During the reporting period, 52,170 or 95% of all registered TB patients were offered to be tested for HIV and 46,964 or 90 % accepted and were tested; 16% tested HIV positive; 70% of them were put on CPT but only 32% were registered on ART (see figure below). As HCSP continues to strengthen the capacity of HCSP supported HCs to routinely test TB patients for HIV, the program initiated a data assessment to determine if and why the low ART enrollment of HIV+ TB patients is real (and the complexities around such) or an artifact of data recording and reporting. The results of this data assessment will be available in January 2011.

Number of TB patients, offered to be HIV tested, accepted to be tested, HIV+ and on CPT, FY10



Additional achievements:

- ✓ **Support to national TB campaign**: HCSP continued supporting the TB campaign to enhance intensified case detection in AA and the four HCSP supported regions. Support to national STOP TB and World TB Day activities intensified this year, as did collaboration with TB-CAP program activities, which currently strengthens TB clinics and laboratory services in 63 HCSP supported ART HCs and 50 HCSP supported non-ART HCs.
- ✓ **Development of national laboratory EQA system**: HCSP has continued to be involved in development of a national laboratory EQA system under the leadership of the Ethiopian Health and Nutrition Research Institute (EHNRI), which includes hospitals and regional labs providing EQA to HCs that include TB microscopy. The pilot involves support to 62 HCSP supported HCs.
- ✓ **Enhancement of TB case detection rate through KOOWs**: HCSP improved TB screening and TB detection rates by enhancing community-based screening of TB by KOOWs and trained HEWs. Referrals of possible TB cases from the community to the HC have increased TB case detection and treatment rates reported above.
- ✓ **Development of national strategic Plan for TBL, TB/HIV and MDR TB:** HCSP has continued to be involved in the development of five year SPM under the leadership of FMOH through the national technical working group (TWG).
- ✓ **Training of health care providers in HIV/TB:** 3,890 health care providers were trained in HIV/TB in this physical year (FY10). This represents a total of 8,616 providers trained in HIV/TB during the life of the HCSP, which is 95% of the target.
- ✓ **Strengthening the shift of anti TB Drug to RH based regimen nationally:** HCSP has continued to provide both technical and logistic support to FMOH and RHBs in quantification of TB drugs shifting to RH based TB regimen in the country.

12-HVCT (HIV voluntary counseling and testing)

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

The HCSP has achieved the following results in Testing and Counseling as of Q3:

- ✓ **3,457,469 individuals who received Testing and Counseling (T&C) services for HIV and received their test results** (P11.1.D)
  Comment**:** HCSP's performance in T&C has been consistently high over its last two years, recently averaging over 2,000,000 annually. Following this, the FY10 target was increased from 1,600,000 to 2,700,000. The achievement is likely a reflection of the GOE's commitment and support for national and partner initiatives promoting T&C. The achieved result of 3,457,469 is 128% of the new PY3 target of 2,700,000 and includes 324,274 (80% of the targeted 405,000) children <15. The number tested and counseled was particularly high for women (1937,809 or 171% of the target). These results were achieved principally through PITC and VCT in health centers, thus ensuring that all HIV + clients are immediately linked to treatment services. 66,965 of all those tested were HIV-positive. The number who tested positive translates into 1.9% prevalence among all those tested at HCSP supported HCs. This rate is consistent with the prevalence among ANC clients and only slightly lower than the current national estimate of 2.1%.

- ✓ **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, 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 FY10, HCSP training in this area reached the following:
  - 2,939 health workers trained on PITC
  - 469 laboratory personal trained on comprehensive laboratory services, including HIV testing and confirmation of results.

  The rate of individuals accepting testing under the PITC approach has increased for ANC and TB clinics to well over 90%. The rate of PITC at outpatient departments (OPDs) is increasing progressively. However, the average rate is lower than 50% at OPDs, likely because they are over-loaded with patients. Health workers, while trained on PITC, are not able to consistently offer testing to every attending patient in the OPD.

  Families of HIV patients are a high risk group but often do not know their status. HCSP has designed a family focused care (FFC) approach and has trained case managers and VCT counselors on couple and family counseling. Case managers and ART focal persons counsel their patients visiting the clinic to bring their immediate family for testing.

- ✓ **Dissemination of implantation manual and strategic document:** Through participation in the HCT technical working group, HCSP was involved in the dissemination of the PITC implementation manual and reprinted the Strategic Framework for Referral and Linkage document developed by the HCT technical working group led by FMOH.

- ✓ **2,380 HEWs, supervisors, Woreda HIV focal persons and women affairs representatives were given an orientation on sensitization and mobilization of community members for HCT outreach service**
  Comment: 1,927 HEW (all female) were oriented on how to sensitize and mobilize community members for HCT outreach services by the catchment health centers. In addition, 453 (M 289 F 164) HEW supervisors, woreda HIV focal persons and women's affairs representatives were trained to guide and support the outreach service. Following training, the HEWs sensitized and mobilized the community members in their catchment areas and as a result a total of 107,706 (M 52,375 F 55,331) were counseled and tested out of which 650 (M 289 F 361) were positive and linked to a health center for comprehensive service.

13-PDTX (Pediatric treatment)

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

By the end of FY10, HCSP achieved the following results in the area of pediatric HIV/AIDS treatment. *(Note: HCSP began collecting pediatric HIV/AIDS data as required by PEPFAR NGIs in October 2009)*

- 350 ART HCs (100%) have health workers trained on pediatric care and treatment
- 350 ART HCs (100%) have health workers trained on pediatric care and treatment
- 341 HCs (97%) have currently enrolled pediatric patients
- 298 HCs (85%) have pediatric patients currently receiving ART
- 349 ART HCs (99%) have health workers trained DBS
- 316 HCs (90%) have DBS tests available
- 319 HCs (91%) have HEIs enrolled
- 350 ART HCs (100%) have health workers trained on pediatric care and treatment
- 245 HCs (69%) are sending DBS to regional labs.
- Among enrolled HEIs, 61% have received a DBS test. Of these:
- 81% have received a result
- 9% tested positive

In terms of progress against FY10 targets:

- ✓ **1,718 children of whom 125 infants with advanced HIV infection were newly enrolled into the ART program** during the year (T.1.1.D). This constitutes 6% of all newly enrolled patients
- ✓ **The cumulative number of children who were ever stated on ART is 2,795** in FY10, compared to 1,067 in FY09 (T.1.4.D)
- ✓ **5,463 children or 91% out of the targeted 6,000 HIV positive under 15 years received a minimum of one clinical care** (C.2.1.D)
- ✓ Among all ART patients in FY10, **3,021 are pediatrics ART cases under the age of 15 years, 169 of whom are under 1 year old** (T.1.2.D) (see figure A below). This constitutes 4% the total number on ART, which is well below the national target of 9 % (see figure B below).

Figure A: Number of HIV+ children under 15 years of age enrolled on pediatric ART at HCSP supported HCs, September 2008 -September 2010

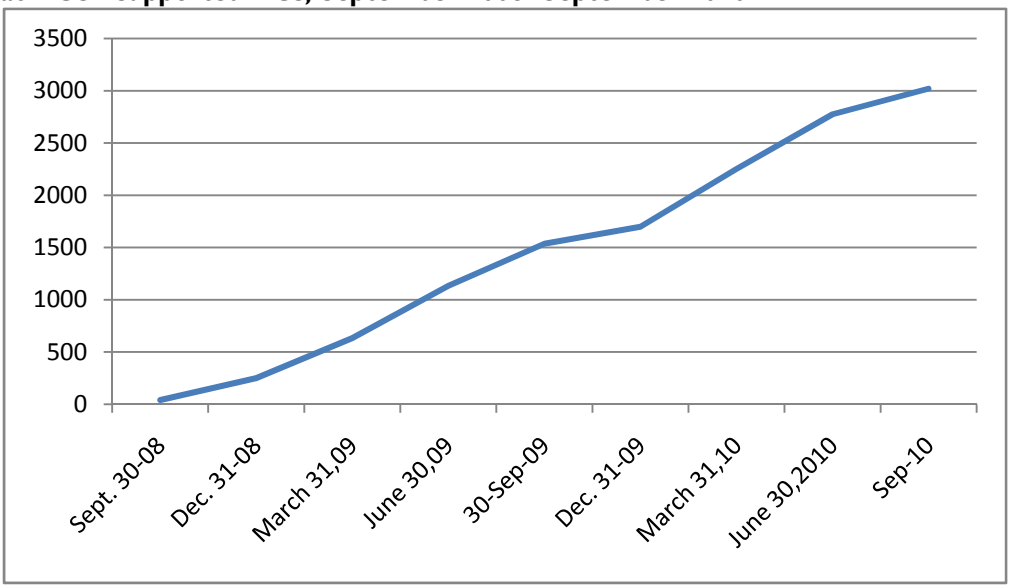
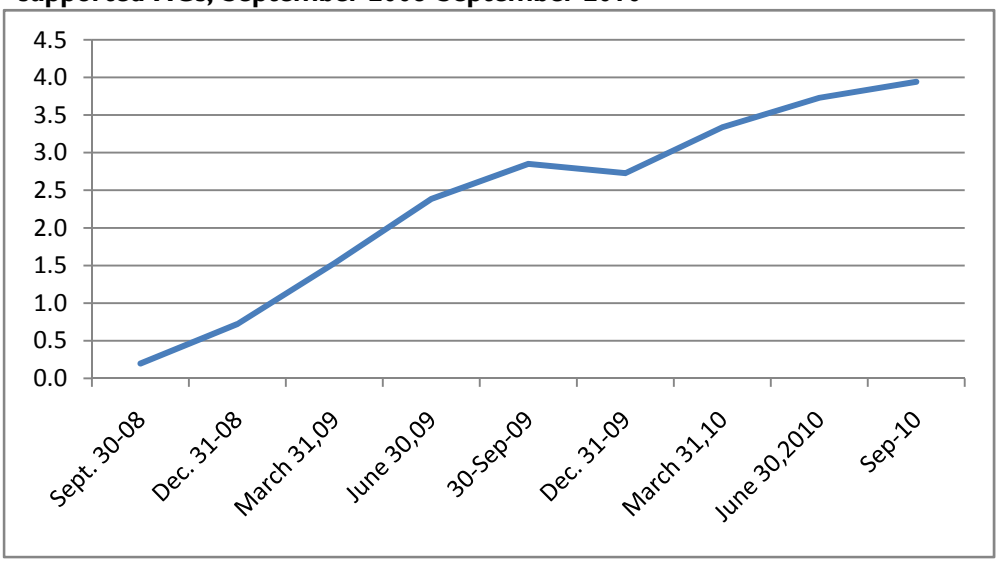


Figure B: Percentage of pediatric HIV cases among all HIV patients in HCSP-supported HCs, September 2008-September 2010



Additional achievements:

- ✓ HCSP participated in the national sub-group on pediatrics ART and other meetings addressing pediatric HIV/AIDS

- ✓ Joint pediatrics mentorship (JPM) and child day activities were conducted at nearly 100 HCs in Addis Ababa, Amhara, Tigray, and SNNPR and Oromia. At these HCs, ANECCA carries out intensive two day mentorship visits during pediatric day arrangements. During these visits, joint pediatrics mentorship (JPM) occurs when HCSP mentors participate, albeit for a limited period of time. This collaboration with ANECCA pediatric mentors, coupled with pediatric day arrangements, was a strategy adopted to accelerate pediatric mentorship and hence pediatric HIV Early Infant Diagnosis (EID).

14-PDCS (Pediatric care and support)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area14-PDCS

By the end of FY10, HCSP achieved the following results in the area of pediatric HIV/AIDS care, and support. (*Note: HCSP began collecting pediatric HIV/AIDS data as required by PEPFAR NGIs in October 2009)*

- ✓ **135,898 children under the age of 18 years (or 119% of the FY10 target) received a minimum of one care package** (C.1.1.D)
- ✓ **5,207 HIV positive children under 15 years of age received cotrimoxazole (CTX) prophylaxis** (CPT) during FY10 (C.2.2.D), 46% of which was achieved in Q4 alone
- ✓ **2,386 infants were tested for HIV**: 1,137 infants received virological testing within two months of age (C.4.1.D), of whom 468 (41%) did so in the last quarter of the year. This is a promising achievement in terms of Early Infant Diagnosis (EID). Another 1,249 infants were tested either virologically or serologically between the ages of two and twelve months to ascertain infection/ exposure status
- ✓ **1,472 infants born to HIV positive mother were put on CTX prophylactic therapy (CPT)** during the year. Among these, 866 (59%) were tested the last quarter alone. (C.4.2.D). This is a reflection of the recently increased attention given to pediatric and especially infant diagnosis and care

Additional achievements:

- ✓ 95,917 children between the ages of 10 and 14 were reached with individual and/or small group preventive intervention. This is a component of pediatrics HIV dealing with prevention of pediatrics/adolescent infections (P.8.1D)
- ✓ 324,274 children under 15 years of age received Testing and Counseling service (P.11.1.D)
- ✓ This is 80 % of the FY10 target
- ✓ 1,867 children under the age of 18 were provided with psychological, social, and spiritual support (C.5.6.D). These are the three out of four components of palliative care. However, the fourth component, pain and other symptom management, is also provided but not reported
- ✓ Focused Pediatrics Palliative Care Training was provided to 80 providers (M=47; F=33) at Bishoftu/Debre Zeit and Adama Nazereth
- ✓ Pediatrics CME through video conference: Using the woreda net video conferencing system, two out of eight sessions were dedicated to pediatric HIV/AIDS care. The first session addressed HIV exposed infants; the second addressed family-centered pediatrics care
- ✓ Integrated supportive supervision and standard of care: clinical advisors from the central team, data clerks and case manager coordinators in Oromiya and SNNPR were involved in examining the degree to which HCs comply with the standards of pediatric HIV/AIDS care. A full report was submitted to the concerned regions and the central HCSP office

  The main components addressed during supportive supervision included the following:
  - Percentage of HEI institutionally delivered and linked to EID program
  - Linkage of PMTCT identified and possibly home delivered HEI linked to EID program
  - Percentage of HEI > 8 weeks with DBS taken
  - DBS turn round time
  - HEI on CPT
  - % of HEI lost to/ dropped from follow up
  - % of HEI on exclusive breast feeding
  - Taking, plotting and interpreting anthropometric measurement (weight, height/length, head circumference and mid-upper arm circumference)
  - Developmental assessments and classifying as appropriate, delayed or regressing
  - Number and percentage of children discharged from HEI program as non-infected

The main components addressed during supportive supvervision for general pediatric care included the following:

- Taking, plotting and interpreting anthropometric measurement as above
- Developmental screening and classification as appropriate, delayed or regressing
- TB screening and IPT initiation
- CPT
- % of children properly on or not on ART as per the national guideline
- Absolute CD4 count or percent on the last 6 months
- HgB determination for those on AZT based regimen

✓ HCSP participated in a workshop for the development of a framework for pediatric HIV communication between 07/07/2010 and 10/07/2010. The work shop was organized by FMoH and AIDS resource center (ARC). A one day workshop to finalize the framework will be organized in the first quarter of FY11.

✓ During Q3, HCSP provided a refresher course on the management of HIV Exposed infants including DBS sample taking conducted in the four regions, courtesy of ANECCA. In addition, a pediatric refresher course was conducted in the regions. These training covered a total of 57 providers (M=27 F=30)`

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 as of Q3:

- ✓ **550 HCSP supported HCs have the capacity to perform clinical laboratory tests** (H1.1.D)
  Comment: A key initiative during FY10 was the assessment of 50 HCs with newly established ART services, using the MSH quality assurance methodology, the Fully Functional Service Delivery Point (FFSDP) tool. The FFSDP includes standards for assessment of the HC laboratories, encompassing such key areas as essential equipment, supplies and reagents and presence of trained personnel. Following the assessment, HCSP trained the laboratory staff (see below) and equipped the laboratories with materials that included micropipettes, ESR racks and stool containers. Starting from the early months of the reporting period, all HCSP supported HCs had a functioning laboratory on site, with trained personnel (i.e. 100% of the FY10 target).

- ✓ **596 individuals trained in the provision of HIV related laboratory activities** (Contract Indicator Result 1)
  Comment: During FY10, HCSP trained 596 lab personnel on comprehensive lab services. Major topics included rapid HIV testing, TB microscopy, malaria microscopy, quality control, DBS sample transportation, inventory management and preventive maintenance.

- ✓ **15 laboratory personnel at 5 HCs were trained in the use of CD4 analyzer machines**
  Comment: HCSP carried out specialist training on CD4 machines at 5 HCs in Amhara. The current practice is for HCs to send blood samples to local hospitals, and at times, regional labs for CD4 testing. In Amhara, the RHB provided CD 4 analyzer machines from EHNRI/CDC to five HCs. HCSP subsequently provided training, in collaboration with EHNRI and the RHB, for 15 laboratory personnel (3 per HC) on ART monitoring including CD4, clinical chemistry and hematology analyzers. HCSP has been assisting the RHB to then link the 5 HC to nearby HCs with the goal of reducing both the burden on hospitals and the turn-around time for receiving results. During the reporting period, three of the five HCs have started running tests. The table below shows the specific number of HCs linked with each HC that received the machines.

Health Centers with CD4 analyzer machines and Linked Health Centers

Health center with machines	Linked Nearby Health centers
Mersa	Girana, Wichale
Wereilu	Jama
Kemise	Bati, Harbu, Woldia, Mekoy, Majete, Shoarobit, Ataye, Senbete
Kombolcha	not yet linked
Kosober	Tilili, Mankusa, Adikidam, dangila, Gijabet, Jawi, Chagni, Denkari

- ✓ **19 HC were supported to manage and use clinical chemistry machines**
  Comment: HCSP supported 19 HCs in Addis that received donations of semi-automated clinical chemistry machines from the Global Fund and JSI. The HCs needed some additional supplies and training for the laboratory professionals in order to initiate tests using the machines. Hence, HCSP provided the training and needed supplies as follows:
  - Basic laboratory ART training was provided on ART machines (CD4, hematology and clinical chemistry analyzers) for 38 laboratory personnel (M=20, F= 18)
  - Start-up laboratory consumables were provided and included: glass test tubes, test tube racks, micropipettes of different volume and micropipette tips, roll thermal papers and other small supplies.

By the end of FY10, the 19 health centers were ready to perform clinical chemistry test for ART patients, thereby increasing the availability of these services. Benefits include:

- Clinical chemistry tests will be performed at health center level, thereby eliminating the need for sample transportation;
- Turnaround time for results will be reduced as patients can collect their results on the same day of sample collection;
- Sample rejection is eliminated, which is a frequent problem when samples are transported by unsecured transportation methods;
- Reduces the work load of regional laboratory; and
- The HC laboratories can process samples from nearby HCs.

✓ **HCSP is an active participant in the National Laboratory Technical Working Group and the National Quality Management Technical Working Group.**
Comment: The NLTWG has been supporting the process of implementing a Regional External Quality Assurance (REQAS) pilot. A consultative meeting was held by EHNRI to develop a common understanding between all partners. National TOT was given for regional laboratories staffs from all regions to enable them to cascade the training and to ensure implementation of REQAS both in health centers and hospitals. HCSP is supporting the pilot by providing laboratory consumables for 100 REQAS piloted health centers. REQAS has now been conducted in 52 HCs in SNNPR and Tigray regions by their regional laboratories during the quarter. HCSP supported the program financially and the program's regional laboratory advisors provided technical support to the regional laboratories and participated in the assessments. A checklist was used by the regional laboratories to assess the HIV and TB laboratory services and immediate feedback was given by assessors for good practices as well as areas needing improvement.

At the national level, senior technical program staff have continued working closely with the FMOH and participated in the various TWGs under their leadership. Also, HCSP's HSS and M&E teams have also continued participating in the national quality management TWG.

✓ **Coordination with SPS and SCMS and provision of lab supplies**
Comment: HCSP continued working with MSH's Supply Chain Management System (SCMS) and Strengthening Pharmaceutical Systems (SPS) programs in assessing and identifying gaps in needed laboratory equipment and supplies. In terms of provision of essential supplies, discussion was initiated with SPS and SCMS to revitalize the internal laboratory technical working group and continue the effort to support health centers with regular supply of OI laboratory diagnostics. Meanwhile, list of laboratory consumables were submitted to SCMS to include them in the regular quantification loop. HCSP participated in the quantification workshop organized by Pharmaceuticals Fund and Supply Agency (PFSA) and SCMS and succeeded to get the lab consumables for the 550 health center laboratories included in the national quantification list. In fact, procurement for six months supply is started. In the future, however, refill of supply will be based on consumption report from the health facilities.

Shortages of HIV and DBS test kits in health centers in the HCSP supported regions and Addis Ababa are resolved through immediate discussions with SCMS staff. Some of the quick measures taken were the following. The implementation of such measures is ensured through regional HCSP advisors and sometimes through the clinical mentors.

- Redistribute test kits from health facilities that have excess to facilities with shortage of kits
- Speed up dispatch of kits from regional hubs

As a sustained routine activity, the regional lab advisors liaised with the regional distribution hubs of the Government of Ethiopia (GOE), PFSA to ensure laboratory supplies were being distributed according to schedule to HCs supported by the Program. The supplies include key consumables such as gram staining reagent, WBC tomma pipette, Sahil-heligh hemoglobinometer, hemocytometer, microscope slides, immersion oil, wooden applicator stick, RPR test kits, HIV test kits and pregnancy test kits. The regional laboratory advisors then supported the hubs to distribute supplies to HCs with appropriate follow-up with the HCs to ensure receipt.

The laboratory supplies that the HCSP had ordered as a stop-gap measure last year were received during the current semi-annual period. The transfer agreement was prepared for the selected HCs and distribution of the supplies to 150 ART HCs is underway.

HCSP also ensured that DBS kits are available in all HCs where EID has already been initiated. The total number of DBS samples tested by DNA-PCR the regions is shown in the table below.

Status of DBS Tested by DNA – PCR by Region

Region	Samples tested
Amhara	707
Tigray	494
SNNPR	234
Oromia	290
Addis Ababa	318
Total	2,043

✓ **Support provided to regional laboratories to conduct External Quality Assurance (EQA)**

Comment: In FY10 HCSP supported all regional laboratories to implement HC EQA. EQA has been implemented to variable degrees in different regions due to limitations in human resources, funds, and availability of vehicles for travel. During the semi-annual review meeting, HCSP management discussed with EHNRI the development of an EQA strategy that would involve hospitals assessing nearby HCs within their catchment area. Joint visits with EHNRI were undertaken to the regions to discuss this approach with RHBs, who accepted the strategy in principle, but raised concerns over the capacity of the hospitals, the modalities of their involvement, and the roles of the different actors in the lab areas. During these visits, regional laboratory technical working groups (RLTWGs) were established to help strengthen regional laboratories and better coordinate support and inputs to the regional laboratories from partners. Currently, RLTWGs are functional in all regions and Addis Ababa, and HCSP regional laboratory advisors are members and active participants.

To strengthen regional laboratories and decide on the involvement of hospitals discussions are underway with EHNRI to implement a pilot regional EQA system (REQAS) for integrated diseases (TB, HIV, and Malaria). For TB and Malaria, HCSP will use known sputum and blood smear samples sent to laboratories for reading and for HIV dried serum samples (DTS). An EQA team of three people was formed that includes the HCSP laboratory advisor, EHNRI's national quality manager and EHNRI's national training manager. A detailed operational plan was developed that identified activities required for the implementation and participation of the pilot REQAS. In HCSP supported regions, a total of 100 HCs (20/region) participated in this pilot phase of REQAS. HCSP has supported the program by providing financial and technical support. The HCSP regional laboratory advisors provided the technical support to the regional laboratory and participated in the assessment program. In principle the regional laboratories plan to conduct REQAS on quarterly bases. However, this target has not been met except in Addis Ababa. Consequently, implementation has been variable as described below.

- **Tigray**: In Tigray pilot regional EQA was conducted for integrated diseases (TB, HIV, malaria) by the regional laboratory. Known sputum and blood smear samples were used to conduct the onsite REQAS. Ranking conducted and immediate feedback given by the assessors to reinforce good practices as well as identify areas which needed improvement. HCSP has supported the program financially. The regional laboratory advisor provided technical support to the regional laboratory and participated in the assessment program. In addition a checklist was developed and used by the regional laboratory to assess the HIV and TB laboratory services and immediate feedback provided.
- **SNNPR**: The SNNPR regional public health laboratory and HCSP conducted regional external quality assessment scheme for HIV testing among selected public health center laboratories. Sites were selected in consultation with the regional public health

laboratory and major criteria employed were proximity of the sites to the main road. The aim of the program was to monitor and assess the performance of each health center laboratory and to identify gaps that need technical assistance to improve the quality of HIV testing in the facilities. The samples used were prepared based on the panel test preparation protocol in collaboration with regional public health laboratory obtained from blood donors who are HIV infected and uninfected blood. Each sample was retested according to the national HIV testing algorism before distribution. Four known HIV negative panel samples of which two were discordant samples and two HIV positive samples were distributed to twenty two (22) participating health center laboratories (Butajira, Hosanna, Durame, Areka, Sodo, Mierab abaya, Lante, Guba,Leku,Yirgalem, Aletawondo, Chuko, Arbaminich, Bodity, Halaba, Wonago, Yirgachefe, Wondogenet, Hawassa, Bushilo, Aletawondo, Humbo). Site and sample code were given to each health facility when distributing the panel tests. All health centers received six known HIV panel samples. Based on their EQA result feedback has been given to health centers that received the EQA HIV panel tests. Out of 22 health centers Mierab Abaya,and Wondogenet, got 4 of 6 the rest of the health centers performed accurately and scored 6 of 6 of the HIV panel tests result which tallied with the regional laboratory performance. Yirgalem, Aletawondo, and Chuko the panel tests were done by VCT staffs and the rest were done by laboratory staff.

- **Addis Ababa**: Addis Ababa regional laboratory had planned to conduct quarterly EQAS and succeeded to perform three during the reporting period. HCSP has supported the program financially as well as provided technical support through its regional lab advisor. EQA assessment was conducted in all 24 health centers. Feedback was provided on the spot except for AFB. AFB slides feedback is provided after the slides are rechecked at regional laboratory. HCSP's HSS central team and the Addis Ababa RHA participated in the process of the EQA implementation in a few HCs. In AA, HCSP and TB-CAP coordination meetings were conducted with the objective to share the findings and discuss the way forward focusing on EQA and training. A list of major activities with a specific time line was then developed to support coordination among TB-CAP & HCSP. The TB sections of the comprehensive laboratory training module, developed by HCSP and used for training, was revised to address the identified gaps by the STTA and other joint EQA activities.

✓ **ART monitoring laboratory referral linkage services strengthened**

Comment: Checklist was developed by EHNRI regional capacity building directorate to assess the ART monitoring laboratory referral linkage service. The objectives of the assessment are to improve laboratory referral linkage for ART monitoring service performance and increase awareness of the goals for improvement and to provide stakeholders with a comprehensive view of laboratory referral linkage services. HCSP has participated in data collection through the regional lab advisors and clinical mentors. The assessment is finalized and health centers have submitted the completed checklist to EHNRI. Once the compilation and analysis is finalized EHNRI will share the information for use for further improvement.

✓ **Participation in Technical Working Groups (TWG)**

Comment: Throughout FY10, HCSP has participated in central and regional laboratory technical working groups. At the national level, monthly progressive NLTWG meetings have been conducted at EHNRI. The major agenda of the meetings has been to develop a process for laboratory accreditation, which is currently in the pilot phase. Around 18 health facilities will be accredited in the first pilot phase, and include regional laboratories and hospitals. Accreditation of HC laboratories will be considered in the next phase. The major accomplishment of the TWG through this process was the finalization of the laboratory accreditation operational plan and customization of WHO/AFRO laboratory assessment checklist. Training to fill the gaps after the assessment in the selected laboratory facilities was provided by EHNRI. As part of the requirement to develop the accreditation process of health facilities, EHNRI, with support from HCSP, formed working groups to develop training modules, human resources, test menus,

laboratory equipment, and laboratory infrastructure standards. HCSP prepared and submitted a draft HC laboratory standardization document to EHNRI. Furthermore, in order to improve sample transportation and reduce the turnaround time, EHNRI has concluded an agreement with the Ethiopian Postal Services Agency to start a pilot study in Addis Ababa. HCSP as one of the active participants in the NLTWG meetings has been participating in all discussions related to the idea that postal service could be one of the feasible modalities for sample transportation. It has also participated in the orientation program organized for health center and hospital lab workers and also agreement signing ceremony.

- ✓ **All 550 HCSP supported HCs have the required SoPs and other management tools for HC laboratories**

  Comment: HCSP developed and distributed SOPs, job aids, quality assurance guidelines, AFB microscopy manuals for TB, SOP for malaria and malaria parasite color plates to all 550 HCs in four regions and Addis Ababa. Technical support was provided by the regional laboratory advisors to selected HCs, but the sheer number of laboratories that need support precludes visiting all the laboratories for direct mentoring. It is now possible that the laboratories can handle samples from nearby health centers (see above). Furthermore, a reporting format has been developed to collect the inventory of the trained laboratory professionals on comprehensive laboratory services at the health centers. The main objectives of the assessment include:

  - Map the continued availability of the trained staff;
  - Ensure continued laboratory plan implementation to provide adequate, timely and quality services at health centers;
  - Facilitate supportive supervision; and
  - Track turnover of trained staff

  Data were obtained from SNNPR, Amhara, Oromia, Tigray and Addis Ababa and showed that 574 out of 654 trained professionals are still in their respective health centers. On average, the turnover rate was 12.2 % notwithstanding the wide variations between the regions.

Region	Number Trained	Number still at post	Balance	Turn-over rate
Tigray	84	74	10	11.9%
Addis Ababa	48	48	0	0%
Oromia	177	151	26	14.7%
SNNPR	124	120	4	3.2%
Amhara	221	181	40	18.1%
Total	654	574	80	12.2%

- ✓ **Partnership with JSI**

  Comment: In FY10, JSI and MSH jointly identified health centers in critical need of infection prevention (IP) materials.. So Far, JSI/STAR One has distributed the IP materials in several health centers including 24 health centers in Addis Ababa, 11 in Tigray, 22 in SNNPR, 25 in Oromia, and 29 in Amhara. The distributed materials are 13 types of IP materials which include heavy duty gloves, face shield helmet, apron, waste bin and others. In addition, a recent report by JSI showed that training on IP was conducted for the HCSP supported 550 health centers. The training covered 7 health workers per HC including all cleaners, one pharmacist and five health extension workers per HC.

- ✓ **HCSP supported to 321 woreda health bureaus with HIV/AIDS services plans**

  Comment: The purpose of the planning process is to assist woredas to prepare a comprehensive plan to coordinate all HIV/AIDS actors in their jurisdiction. During the annual period 321 plans were developed and harmonized with the program (90% of the planned 350). Of note, the plan assumes one HC per woreda. In reality, a number of woredas have two program supported HCs.

17-HVSI (Strategic Information)

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

- ✓ **4 local organizations were provided with TA for SI activities**

  Comment: The 4 national NGOs that receive performance based contracts from HCSP were strengthened in the use of SI as part of on-going monitoring and capacity development of the NGOs. These were the National Network of Positive Women Ethiopians (NNPWE), HIV/AIDS Prevention, Care and Support Organization (HAPCSO), IMPACT Association for Social Services and Development, and the Relief Society of Tigray (REST). During this past year 355(M 72, F 283) individuals for these NGOs were trained on NGIs.

- ✓ **Adoption and integration of PEPFAR NGI into program's SI**

  A major achievement during the FY was the adoption of the PEPFAR NGIs into the program's SI system and PMP. Of note, the NGIs were successfully integrated with HCSP's original contract deliverables and indicators, which the PMP clearly presents. Of note, whenever possible, the contract deliverables and indicators were integrated into a closely aligned NGI.

  The adoption of the NGIs initially involved analysis of their criteria and how they could be integrated into the program's initial set of deliverables and indicators. This was followed by development of a new PMP to report on both sets of data requirements in an integrated manner. As such, the contract deliverables and indicators were reported under the appropriate NGI category.

  Adoption of the NGI also involved a revision of HCSP programming approaches. For example, community based prevention interventions had to be totally revised to be consistent with the new reporting requirements for AB and OP. As will be noted below, re-training of staff at both health center and community level followed on both the revised program approaches and new reporting requirements.

- ✓ **8,280 individuals were trained in strategic information**

  HCSP supported HMIS training of 406 staff from Addis Ababa City Administration, of which 25 were data clerks and the remaining health workers from program supported HCs and the Addis Ababa City Administration Health Bureau. In a similar manner, 107 data clerks were given basic training. This training was a gap filling raining and it was all over the HCSP supported region.

  Besides, 7,539 community health workers were trained on NGIs. Of these 6,227 were KOOWS and the rest were community mobilizers, case managers, HEWs and NGO outreach workers. Moreover, 228 case mangers and community mobilizers were also trained on NGI. This training was given to implement the PEPFAR NGI. The objective was to enhance the community health workers' skill on information capturing and communication. Furthermore, the trainees were well informed on the registration and reporting format introduced by the program.

- ✓ **315 data clerks were provided refresher training**

  HCSP is committed to strengthening strategic information (data for decision making) and fostering a culture of evidence based decision making at all levels. To this end, the program revised and adapted its training manual for data clerks during Q1 and used it for the subsequent training of new data clerks for gap filling.

  In addition, refresher training was given to 315 data clerks from Oromia, Amhara, SNNPR and the Addis Ababa City Administration. The training was aimed at solving common problems with the objective of improving the quality of reports. The training also dealt with the NGI and, specifically, problems encountered in capturing and compiling the information need for PEPFAR report. The training focused on implementation of the HCSP revised reporting formats for NGI reporting. The revised formats were distributed to the regions and HCs during the second half of this reporting period.

- ✓ **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:

  - **Internal consistency checks**: Central office and regional office staff discuss and review data on a monthly basis and every quarter to ensure completeness and consistency. Regional M&E advisors conduct detailed consistency checks of all data that are submitted by the health centers through HCSP mentors and advisors. Inconsistencies and incompleteness is verified at the source and corrected prior to submission of data 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.
  - **HC mentorship**: HCSP HC mentors spend about 50% of their time mentoring providers and data clerks on correct recording and reporting of data. This involves verification of current data. In addition, whenever HCSP advisors visit a health center, at least 3 data spot checks are conducted at the clinics that are visited.
  - **LQAS**: During supportive supervision, compliance with the standard of care (SOC) is monitored using LQAS methods for each clinical area in at least 2 regions per quarter and in all regions once every 6 months. This includes verification of data recording and reporting of 19 randomly selected patient cards in 19 HC per region every 6 months.
  - **Special data assessments**: In FY10, HCSP began verifying data at the source for CD4 counts, PMTCT, HEI, and HIV/TB. The assessments are conducted on samples of the total data, and examine data validity and the underlying reasons for data results produced through HCSP's M&E system.
  - **Training of HCSP staff**: HCSP conducts informal internal trainings and supportive supervision of its M&E staff and other advisors and mentors to ensure uniform understanding and practices around data collection, data quality assurance and data reporting. This takes place at monthly staff meetings and during quarterly and annual work planning. In FY10, HCSP conducted multiple trainings on NGIs and held regional workshops with all its staff.
  - **Data validation**: HCSP is in the process of developing systematic data validation by having, twice a year, M&E advisors of two regions verify data in a third region, under the supervision and support from the HCSP central M&E team.
  - **Operations Research**: HCSP has been conducting small OR studies that supplement the data routinely collected for NGI reporting. The results assist in identifying gaps and strengths and point to areas that warrant special attention and follow-up.

Additional Achievements:

- ✓ HCSP printed and distributed 13 types of HMIS formats to the HCs under the project. Moreover, different type of tools and formats that are essential for program monitoring were duplicated and distributed to HCs.
- ✓ HCSP ensured that SI was used during the catchment area meetings as well as during GOE review meetings, such as the quarterly FHAPCO review meetings, which program SI staff participated in.
- ✓ As part of HCSP's commitment to strengthen/establish community based MIS in collaboration with other relevant stakeholders, community based MIS was incorporated into all training of KOOWs and HEWs (see section on Care & Support).
- ✓ HCSP conducted or initiated a number of data assessment and validation including on the number of patients who had CD4 counts and their ART status, the linkage of HIV + TB patients to ART, the linkage of HIV+ pregnant mothers to ART and their uptake of ARV, HEI performance, the result of community mobilization on care and support, the outcome of CME through virtual platforms, and others.
- ✓ HCSP started an internal review of its current SI system, engaging all staff from both central and all regional offices. The review is being conducted in the form of 2 day workshops with the aim of further standardizing, mainstreaming and simplifying the data flow and improving data quality assurance. The workshops are also used as an opportunity to review and update or refresh HCSP staff's understanding of the NGI.

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)

The HCSP has achieved the following results in HSS as of Q3:

- ✓ **2,600 community health and para-social workers successfully completed a pre-service training program (H2.2D)** (114% of the FY10 target)

  Comment: In FY10, HCSP conducted both basis and gap filling training in all 5 regions. The table below shows the number of providers, by sex, who were given pre-service training in various areas during FY10.

Training Type	Male	Female	% Female	Total
KOOWs gap filling training	145	172	54%	317
Data clerks basic gap filling training	41	66	62%	107
KOOWS	980	950	49%	1930
Community mobilizers	10	9	47%	19
Case managers	44	44	50%	88
Mother mentors	0	139	100%	139
Total	1,220	1,380	53%	2,600

- ✓ **9,958 health workers successfully completed an in-service training program** (H2.3.D) (99% of the FY10 target)

  Comment: The table below shows the number of staff trained in the various areas. All training used the standard government approved manuals and support tools developed by HCSP. HCSP achieved 99% of its FY10 target for this indicator.

Training Type	Male	Female	% Female	Total
ANC/MSG coordination	14	45	76%	59
ART pharmacy	92	94	51%	186
Comprehensive adult & pediatric ART	150	109	42%	259
Comprehensive laboratory services	306	163	35%	469
FFSDP	673	313	32%	986
HEW mobilization	115	1852	86%	1,967
HMIS	*Not available*			406
IP	159	72	31%	231
Pediatric care & treatment	47	33	41%	80
PITC & family counseling	1540	1399	48%	2939
PMTCT	619	670	52%	1289
Refresher case managers	114	188	59%	302
Refresher data clerk	151	164	52%	315
TB-HIV	266	204	43%	470
Total	4,406	5,146	54%	9,958

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

  Comment: In the second half of FY10, HCSP implemented FFSDP in all 350 ART HC and conducted baseline surveys on the HC compliance with the quality standards included in the FFSDP. To date, 222 (63.4%) of the 350 HC have completed their baseline and developed action plans. HCSP is currently in the process of compiling the data for these HCs and results will be presented in January 2011. The distribution of the 222 health centers is shown in the table below. A follow up survey will be conducted during the first half of FY11 to monitor improvements as a result of implementing the action plans.

Distribution of Health centers with FFSDP Survey Result

Region	Number of ART HCs that started FFSDP	Number of HCs with Baseline Results	Percent
Amhara	110	81	74%
Oromia	109	36	36%
SNNPR	64	54	84%
Tigray	43	36	84%
Addis Ababa	24	15	63%
Total	350	222	63%

In addition to the FFSDP, HCSP also provided support to woredas for HIV service plans and training of health workers, provision of small equipment and supplies and support to supervision and catchment area meetings.

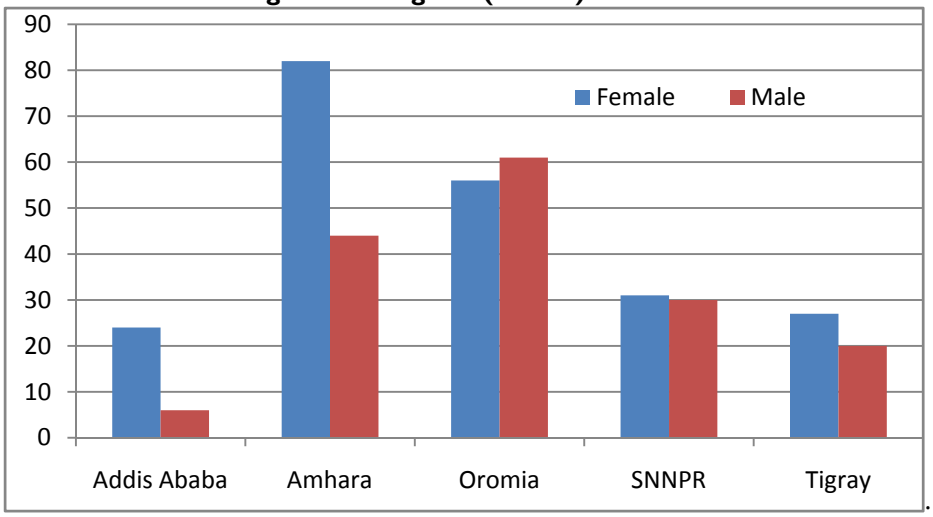
✓ **Gender mainstreaming is fully integrated in HCSP's approach to HSS**

Comment: HCSP's family focused, gender sensitive continuum of care is implemented throughout the program through the following approaches:

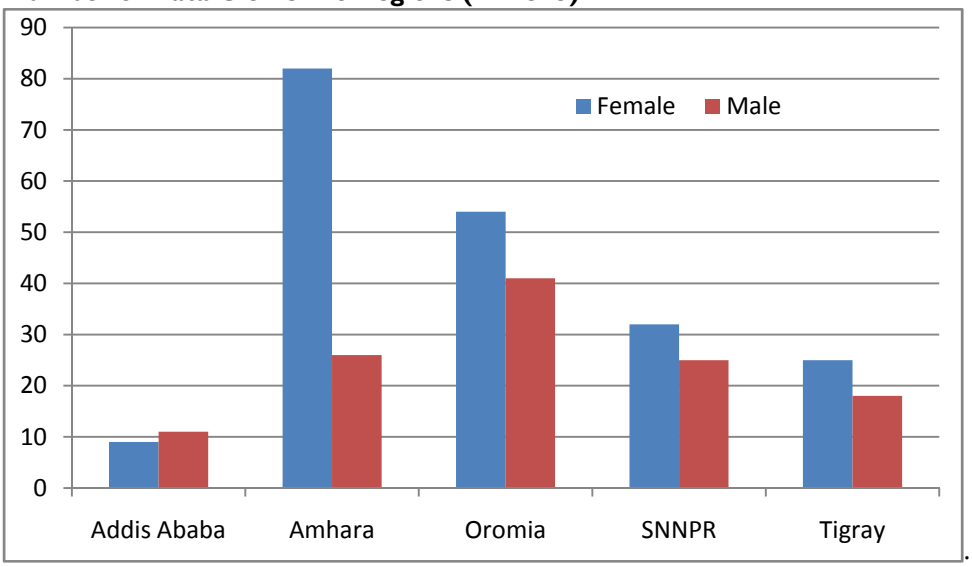
- Use of strategic information disaggregated by sex
- Build on what exists by using all opportunities to identify gender specific needs (e.g. PITC)
- Empower women by hiring, training and engaging them in all activities
- Teach gender literacy not only to communities, health center staff, health providers and managers at all levels, but to HCSP's own staff
- Advocate about gender – it is about men and women alike

The following figures illustrate HCSP's successes in implementing gender sensitive approaches. Of interest is the changing sex ratio of KOOWs over the years of the project. Initially, communities selected more women as KOOWs. However, as their contributions to the community gained them increasing respect, KOOWs gained status in the community, and more men began to be interested in volunteering, with the result that by year 3, the sex ratio had been reversed.

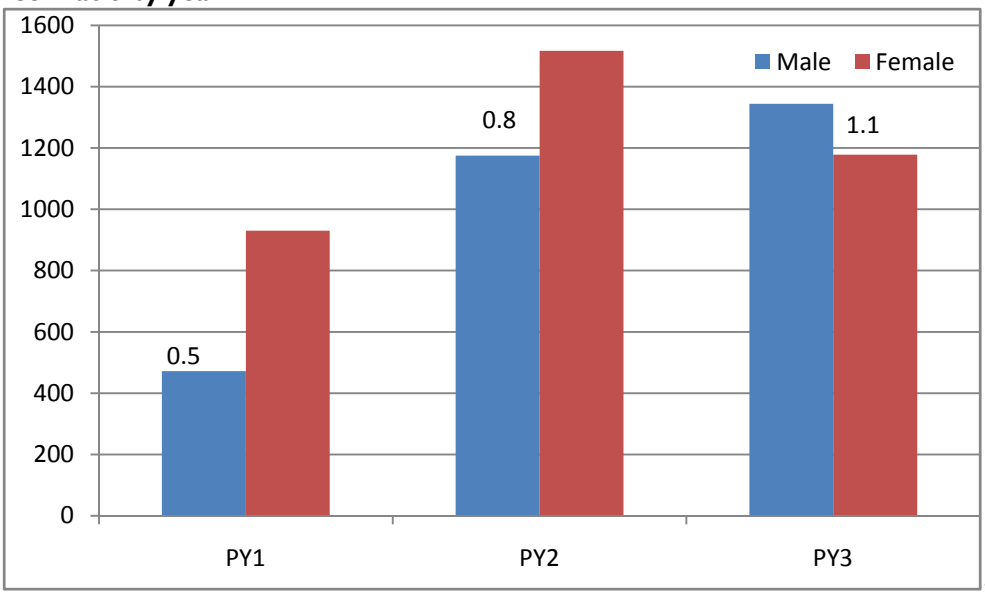
Number of Case Managers in 5 Regions (N=381)



Number of Data Clerks in 5 Regions (N = 323)



Number and male to female sex ratio of Kebele Oriented Outreach Workers with sex ratio by year



Some other key gender related activities in FY10 included the following:

- HCSP presented its gender mainstreaming approach at the PEFPAR partners' meeting in June 2010
- HCSP developed a draft guideline and provider job aid for mainstreaming gender at HCs
- HCSP participated in discussions to establish a technical working group on gender and HIV/AIDS at federal HAPCO
- MSH showcased HCSP's work on gender on its web-site, with a short film about building health systems that featured Ethiopia

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

PMTCT

Quarterly challenges and constraints for each program area:

Program area 1 (PMTCT)

1. Shortage of trained staff is a major problem faced during the reporting period.
2. Poor documentation and reporting which results from number of log books and registries at PMTCT/MNCH
3. Difficulties in linkages and documentation of linkages.
4. Lack of ART at 200 HCs enforcing referrals for CD4 count and ART resulting in higher lost cases during the time of referrals
5. Schedules for sample collection varying with the need of clients. In many health centers sample collection is different from market days when many clients come to town, forcing the clients to repeat their visits to town
6. Shortage of PMTCT drugs
7. Shortage of RTK
8. PMTC clinics do not have strong tracking systems as ART clinics do, for follow-up to ensure continuum of care.
9. Limited facility and community service linkages in non-KOOWs areas.
10. Low ANC attendance and delivery at HCs.

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

Program area 1 (PMTCT)

1. HCSP has planned to coordinate PMTCT training in supported health centers with trainings by partners due to emerging budget constraint.
2. Mentorship activities will continue though less regularly so that HW will provide the necessary comprehensive and complete PMTCT related care.
3. Provide supportive supervision at regional level from central level to assist in maintaining the quality of PMTCT/MNCH care
4. Conduct very basic OR on PMTCT continuum of care particularly the area of linkage between different points of PMTCT/MNCH
5. Discuss with regional health offices, PFSA and SMS to strengthen the supply of test kits and other essential supplies during catchment area meetings and any forums when the opportunity is available.
6. For high staff turnover, program continues training to fill gaps.
7. HCSP will continue emphasizing its community volunteers to prioritize mobilizing mothers to attend ANC.

AB

Quarterly challenges and constraints for each program area

Program area 2-HVAB (Sexual Prevention: AB)

1. Program's transition to the PEPFAR NGI guidelines on AB prevention.
2. Follow up of trained community outreach workers during implementation using NGI intervention strategies and procedures

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

Program area 2-HVAB (Sexual Prevention: AB)

1. Continue provide supportive supervision and on the job training especially to community mobilizers and KOOWs

OP

Quarterly challenges and constraints for each program area

Program area 2-HVOP (Sexual Prevention: OP)

As with AB, program was required to address the NGIs on OP.

1. Follow up of trained community outreach workers during implementation using NGI intervention strategies and procedures;
2. Implementation of facility based PwP intervention

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

Program area 2-HVOP (Sexual Prevention: OP)

1. Supportive supervision will be provided from the center to ensure compliance with the new approach.
2. Facility level PwP intervention will be strengthened through h involvement of clinical mentors and case managers

Care and Support

Quarterly challenges and constraints for each program area

Program area 8-HBHC (Care and Support)

1. As the community care and support component leads implementation of prevention initiatives, the complete understanding of NGIs on prevention pose a serious challenge.
2. Insufficient follow-up of community activities due to limited human resources and staff turnover.
3. Weakened control mechanisms over KOOWs activities and reporting

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

Program area 8-HBHC (Care and Support)

1. Intensify on the job supportive supervision of community mobilizers and KOOWs

Adult Treatment

Program area 9-HTXS (Adult Treatment)

Quarterly challenges and Constraints for each program area

1. High turnover of trained HC staffs that resulted with continuous gap filling training and shortage of man power.
2. Pre ART patients status is not well known
3. Shortage of some ARV drugs
4. Shortage of some OI drugs like antifungal agents and antibiotics
5. Absence of nutritional support at HC for impoverished patients, which negatively affects adherence.
6. Repeated non-functioning of CD4 machines in some hospitals, lack of regular public transports and the limited quotas of sample transport given to HCs by RHB is making baseline and follow up CD4 difficult.

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

Program area 9-HTXS (Adult Treatment)

1. As much as possible to train the new comers and discuss the issue in catchments area meeting.
2. Nationally there should be a standard definition for lost to pre ART follow up.
3. Discuss continually with SCMS colleagues for better logistic provision.
4. An ad hoc regional TWG, composed of HCSP, SPS, SCMS and relevant government partners, established to follow up on the issue of OI drugs and lab supplies, coupled with program distribution of some essential commodities to HCs as a stop-gap measure.
5. Collaborate with food by prescription project of SCUS.
6. Rapid lab assessment of HCs and their problems has been started with RHB. Based on the findings action will be taken by the responsible body
7. Continuous discussion with the relevant government body to alleviate the problem of payment of sample transport

HIV/TB

Quarterly challenges and constraints for each program area

Program area 10 (HIV/TB)

1. Difficulty of diagnosing active TB in health center setting. Hence the number of patients receiving treatment for co-infection remains low.

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

Program area 10 (HIV/TB)

1. Continue emphasizing TB screening and referral by ART clinics
2. Continue collaboration with TBCAP
3. Continue providing targeted technical assistance to the regional labs, HCs and community interventions to strengthen TB diagnostic capacity as HC staff are not allowed to treat patient's based on syndromic assessment.
4. Continue gap filling training of new staff.
5. Continue working with EHNRI and the TWG to strengthen a national lab EQA system, which would include an emphasis on TB lab microscopy.

Counseling and Testing

Quarterly challenges and Constraints for each program area Program area 12: HVCT: 1. Shortage of test kits and DBS.
Plans to overcome challenges and constraints in each of your program areas Program area 12: HVCT 1. Mentors assess the stock balance at each HC and report to the responsible bodies for timely action. The shortage is reported at national and regional levels. 2. Ongoing refresher training for all health personnel will be continued.

Pediatric Treatment

Quarterly challenges and Constraints for each program area Program area 13: PDTX 1. The need to further increase the confidence of front line health workers to handle pediatrics cases 2. Frequent staff turnover and reshuffle at the primary health care units 3. Room shortage 4. Pediatrics drug shortage 5. Shortage of anthropometric and clinical equipment 6. The need to further extend DBS service 7. Poor linkage of home delivered HIV exposed infants despite ANC identification 8. Poor HC linkage with home delivered HEIs
Plans to overcome challenges and constraints in each of your program areas Program area 13: PDTX 1. Continued mentorship via HCSP mentor and joint mentorship with central team advisors to boast the confidence of frontline health workers in handling pediatrics cases. 2. Continue collaboration with ANECCA 3. Availing optimal number of ART trained health worker and advocacy to make on site mentoring of another staff mandatory (On Site Mentorship) before leaving the health center or reshuffled from the ART unit 4. Advocacy for the building of more rooms 5. Following up the anthropometric equipment purchase responsibility vested upon FANTA -2. Draft report available 6. Strengthening and establishing in some areas a postal system for DBS transportation 7. Strengthening health facility and community linkage to reach home delivered HIV exposed infants

Pediatric Care and Support

Quarterly challenges and Constraints for each program area Program area 14: PDCS 1. Trained HC staff's lack of confidence to handle pediatrics cases. 2. Limited community care and support services available, especially for nutritional support. 3. Limited OVC testing,
Plans to overcome challenges and constraints in each of your program areas Program area 14: PDCS 1. Ongoing mentoring and training to build the confidence of front line health workers in managing pediatrics patients. 2. Collaborate with SCUS's FBP project and WFP, as well as continue having mobilized communities' map and access local resources. 3. Continue promotion of index patients to bring their children for testing.

Lab

Quarterly challenges and Constraints for each program area

Program area 16: HLAB

1. Inconsistent EQA program by region.

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

Program area 16: HLAB

1. Continue to provide TA to EHNRI to implement a pilot regional EQA system (REQAS)

SI

Quarterly challenges and Constraints for each program area

Program area 17-SI

2. Manual data compilation for some of NGI indicators like CPT, IPT, and TB screening
3. Unable to find data source for some of the NGI indicators
4. Lack of clarity on some of the NGIs by community health workers, data clerks and coordinators

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

Program area 17-SI

1. No solution to overcome the manual data compilation at HC even though computers are distributed for ART HC, introduction of patients monitoring software is not allowed by FMOH
2. Supporting the staffs involved on NGI through telephone and other communication means

HSS

Quarterly challenges and Constraints for each program area

Program area 18-OHSS

1. Competing schedules for training with HCSP and GOE consistently creates ongoing and unexpected interruptions in training plans.
2. High turnover of trained staff.

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

Program area 18-OHSS

1. Regional leadership maintains ongoing liaison and coordination with the GOE coupled with ongoing rescheduling of trainings.
2. Program carries out ongoing gap filling trainings.

8. 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. Data from non ART HCs often has quality problems. The non ART HCs have no data clerk and the program relies on a staff assigned by the HC to provide the data. So quality as well as availability of reports depends on the skill and willingness of these staff, which leads to inconsistency.
2. Data from community level also often 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.
3. The program has been challenged by meeting new data requirements for the NGIs.

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

For HCs, the program collects SI on a monthly basis, which is reviewed by the 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.

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

1. For HC data, including from non-ART HCs, the program is also finalizing post-reporting data quality assessment tools to assess the level of accuracy of reporting.
2. The program will continue strengthening implementation of its revised community level reporting, including targeting simplification and minimization of double reporting.
3. The program revised its reporting formats for HCs to capture the NGIs. Of note, the program has had to revise its implementation approaches and messaging to meet the NGIs criteria for reporting on prevention.

9. Major Activities planned in the next reporting period

PMTCT

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 1 (PMTCT)

1. Continue providing HC health worker gap filling training on PMTCT.
2. Ongoing mentorship of HCs for PMTCT.
3. Conduct data quality assessments to determine causes for low linkage and ARV uptake

AB

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 2-HVAB (Sexual Prevention: AB)

1. Supportive supervision carried out on compliance with the new approach

OP

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 2-HVOP (Sexual Prevention: OP)

1. Supportive supervision carried out on compliance with the new approach

Care and Support

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area: 08 HBHC

1. Continue support to KOOWs, community mobilizers, HCs, MSGs and NGOs

Adult Treatment

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 9-HTXS (Adult Treatment)

1. Continue training of health workers on national comprehensive HIV care and treatment curriculum.
2. Continue mentorship of HCs and collaboration with RHBs e.g. catchment area meetings, supportive supervision, review meetings.
3. Strengthen utilization of the SOP for clinical mentorship and assess standards of care (SOCs) to improve quality of care.
4. Strengthen pre-ART follow up and enrollment to ART services.
5. Strengthen the family focused approach to increase number of family members tested and enrolled in care and treatment.
6. Support alternate mentorship models in partnership with RHBs

HIV/TB

Major activities planned in the next reporting period should highlight planned activities and solutions to identified constraints: Program area 1 (HIV/TB)

1. Continue gap filling training on TB/HIV screening and laboratory testing.
2. Continue collaboration with TBCAP
3. Continue measuring implementation of SOC through LQAS, which will continue to include TB/HIV.
4. Actively participate in and support a pilot national EQA system under EHNRI.

HIV/CT

Major activities planned in the next reporting period should highlight planned activities and solutions to identified constraints: Program area 12: HVCT

1. Continue expansion of DBS availability and testing.
2. Emphasis placed during on-site mentorship on the use of the family focused care approach, targeting ART focal persons and case managers to better utilize it.

Pediatric Treatment

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 13: PDTX

1. Continue joint pediatrics mentorship between program mentors and ANECCA pediatricians so that the former cascade the pediatrics mentorship to other health centers. This will be coupled with child/pediatrics days
2. Increase ANC/PMTCT linkages with ART clinics and community level HEWs and to trace HEIs
3. Continue strengthening the use of the family matrix
4. Campaigning for pediatrics ART initiation and strengthening at all catchments area meetings and joint support supervisions.
5. Help assure both AZT and d4t based triple and dual formulations are in all ART health centers
6. Strengthen Early Infant Diagnosis (EID)
7. Strengthen through training and on-site mentoring of health workers the PMTCT and PICT services to increase pediatric treatment coverage.
8. Strengthen DBS testing at regional labs through possible placement of data clerks in the facilities.
9. Work closely with EHNRI in implementing the curer system of DBS sample transportation.

Pediatric Care and Support

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 13: PDTX

1. Continue working with ANECCA

Lab

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 16: HLAB

1. Assist EHNRI to implement a pilot regional EQA system (REQAS) for integrated diseases (TB, HIV, and Malaria), including a total of 100 health centers (20/region) participate in the pilot.
2. Link the 2 ART HCs with CD4 machines with nearby HCs for providing testing services to them and liaise with Amhara RHB and partners for delivery of the CD4 machines to the remaining 3 ART HCs with program trained staff.
3. Support training of 150 lab personnel, in collaboration with SCMS, on the logistics management information system used by SCMS.

SI

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 10-SI

1. Ongoing support to the regions and HCs to strengthen roll out of the HMIS system.
2. Training for data clerks for gap filling at HCs.
3. Continued support for integration of SI review into regional review meetings, supportive supervision and catchment area meetings.

HSS

Major activities planned in the next reporting period, should highlight planned activities and solutions to identified constraints: Program area 10-SI

1. Ongoing training of health workers for gap filling at HCs
2. Support the trained staff in ART health centers and woredas for HC MDTs to self-implement the FFSDP, including utilization of collected baseline information for implementing plans of action to address identified gaps.

10. Environmental compliance

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

HCSP did not face any issues related to environmental compliance as the program was not involved in construction or rehabilitation activities.

11. Issues requiring the attention of USAID Management

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

Program area 10-SI

1. The GOE's new HMIS does not capture the information required by the PEPFAR NGIs. Agreement between USAID and GOE could help create greater consistency between the two systems.

12. Data Sharing with Host Government

Have you shared this report with the host government?

Yes ☐
No ☒

If yes, to which governmental office/s?

[Please put your response here

If No, why not?

[Please put your response here]
The program does not share this report in full with the GOE. However, a great deal of the presented information is actually derived from GOE HCs, who also share the information with woreda health offices. During catchment area meetings, the information is further shared with zonal health offices and RHBs. RHBs also review the information during supportive supervision and regional TWGs.

13. Appendices

(Include any relevant documents, data etc as appendices)

Appendix 1: PMTCT STTA Report (Dr. Scott Kellerman)
Appendix 2: Country Lead STTA Report (Dr. Fred Hartman)