

PEPFAR Ethiopia In-Country Reporting System (IRS)

Ethiopia HIV/AIDS Care and Support Project
October 1, 2009 – December 31, 2009

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

1. Reporting Period	1 Oct – 31 Dec 2009
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2. Prime Partner

Name of the Prime Partner	The HIV/AIDS Care and Support Program (HCSP) implemented by Management Sciences for Health (MSH)
Contact Person for this report (Name, Position/title, Telephone, Email)	Bud Crandall, COP Tele 0912 608-164 email: bcrandall@msh.org

3. 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	Down of Hope Ethiopia	Monthly issue

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

4. 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	Monitoring 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	Monitoring by Country Team Leader
Ousmane Faye	10 Dec 09	24 Dec 09	MSH (consultant)	Organizational functional analysis

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

5. 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	MSH USA headquarters	18 Dec 09	19 Dec 09	MSH	Senior Contracts Manager resigned and returned to headquarters to assume a new MSH position.

6. Activity

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

7. Accomplishments and successes during the reporting period (REQUIRED)

PMTCT

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area I-PMTCT (Prevention: PMTCT)

During Q1, the HIV/AIDS Care and Support Program (HCSP) supported 31 new health centers (HCs) to provide PMTCT, reaching a total of 531 (97% of the targeted 550 by end of Q1). Of the 550 HCs, 26 are in Addis, 166 in Amhara, 184 in Oromiya, 125 in SNPPR and 49 in Tigray, The program has completed training of required staff for 17 remaining HCs and they will initiate services by Jan. of Q2. The remaining 2 are new HCs recently established in Addis to help address the city's high patient load.

The program supports opt-out PICT for all pregnant mothers visiting HCs for ANC and labor and delivery. During Q1, 73,326 pregnant mothers visiting supported HCs' ANCs were tested and received their results. This represented 23% of the annual target of 315,562 and indicates that the program is on target to achieve the annual targeted result. Of note, 80 high HIV prevalence woredas with program supported HCs have been selected for community outreach C&T, so the rate of testing pregnant mothers in the coming 3 quarters is expected to increase.

Of the above tested pregnant mothers, 1,725 (2.3%) were found positive. In addition, 1,017 were reported to have received prophylaxis or HAART (12% of the annual target of 8,331). It is possible that a number of women who tested positive during the quarter are not yet eligible for prophylaxis, which is currently provided beginning at 28 weeks. Under-reporting may also be a factor as this is a new target for the program under the PEPFAR New Generation Indicators (NGIs). During Q1, the program sent new reporting formats to its regional offices and supported HCs for capturing the NGIs but they will not be fully utilized until Q2.

It should be noted that while the program achieved the expected number of pregnant mothers tested and all were reported to have been enrolled in care and support, this only resulted in 14% of the FY10 target of 12,623. As the program pretty much met the targeted number of women to be tested and receive their results (23%), with a subsequent 2.3% positivity rate, the FY10 targets for newly enrolled in care and support, as well as those clinical staged, may need to be reviewed for appropriateness.

The program promotes counseling and testing (C&T) that targets mothers and children by implementing a family centered HIV/AIDS care approach at HCs' ART clinics. The approach encourages index patients enrolled in treatment to bring their partner and children for testing. The program also promotes HC outreach in communities served by high load HCs by involving HEWs and their volunteer cadres.

The program supports training for health workers in PMTCT, PICT and couple and family counseling. In Q1, 650 health workers were trained in PMTCT and 1,445 in PICT and family counseling. In addition, for HC outreach C&T, 2,051 HEWS were trained on prevention and community mobilization, who then sensitized 1,719 community volunteers (one per 20-30 households) on mobilization of their community for prevention, C&T and assisting and reporting to their HEWs. Woreda HAPCOs and HEW supervisors were also trained to coordinate such efforts. In addition, the program's kebele-oriented outreach workers (KOOWS), now numbering 6,652 (1,930 trained in Q1) and deployed in 1,265 kebeles (338 added in Q1), also promote C&T to pregnant mothers and teach them on the importance of PMTCT.

The program is also enhancing PMTCT by increasing its mother support groups (MSGs). During Q1, it trained 139 MSG mentors, allowing establishment of MSGs at 44 new HCs, reaching a total of 98 (80% of FY10 target of 122).

In Q1, the program also introduced a standard of care (SOC) tool to assess the quality and completeness of PMTCT services provided to pregnant mothers at the supported HCs (see Appendix 9).

In addition to directly support HC provision of PMTCT services, senior technical staff of the program participated in national and regional PMTCT/SRH technical working groups (TWGs) and participated in nationally planned PMTCT/MSG TOT, joint regional supportive supervisions and catchment area meetings. Senior program staff also played a significant role in the updating and revision of the PMTCT/MNCH and MSG national training manuals to ensure consistency with current recommended standards.

Finally, HCSP assisted the FMOH, as part of Ethiopia's 2009 World AIDS Day (WAD) celebration, to print 3,000 copies of a brochure on PMTCT.

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

The program's prevention team works in partnership with the program's care and support (C&S) team to sensitize and mobilize communities and their members on HIV AB prevention messages. Through the program's trained KOOWs, community mobilizers, HEWs and other trained outreach volunteers, a total of 980,543 people were reached with AB messages during Q1.

A key support to this community level messaging is the prevention team's distribution of FHAPCO/ARC BCC materials that integrate HIV AB prevention messages with C&S and treatment. During Q1, 289,650 copies of 17 kinds of BCC material, developed by FHAPCO/ARC, were distributed, primarily for use by the program's cadres of community volunteers.

During Q1, the program also provided training that included HIV AB prevention messages and intervention strategies. A 3 day training was provided on HIV prevention, as well as C&S and counseling and testing (C&T) to 2,051 HEWs (102% of the target of 2,000). Also participating were woreda HEW supervisors, HIV focal persons and other local government technical staff.

In addition, 35 religious leaders were trained in Q1 on AB (as well as on stigma and discrimination) at the Shenkora holy water site, where thousands of people flock for spiritual holy water bathing and drinking. Religious leaders will teach AB messages during holy water services with the visitors.

The program's prevention team also collaborated with central and regional HAPCOs during the commemoration of the World AIDS Day 2009 celebration, which included technical and financial support as follows;

- Central and regional HCSP staff worked as technical working group members with HAPCO at all levels
- Supported FHAPCO to produce 30,000 and 20,000 copies of posters on PMTCT and Stigma respectively
- Supported production of 160,000 copies of flyers and 70 copies of banners in the regions under HCSP
- Helped organize and participated in the national level celebration held at Hawassa.

OP

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

As with AB, the program prevention team works in a partnership with the program's C&S team to sensitize and mobilize communities and their members on HIV OP messages. Through the programs trained KOOWs, community mobilizers, other outreach volunteers and HEWs, a total of 725,751 people were reached with OP messages during Q1.

A key support to this community level messaging is the prevention team's distribution of FHAPCO/ARC BCC materials that integrate HIV OP prevention messages with C&S and treatment. During Q1, 289,650 copies of 17 kinds of BCC material that included OP messaging, developed by FHAPCO/ARC, were distributed, primarily for use by the program's community volunteers. In addition, a brochure on reproductive health needs of PLHIV and ART adherence was technically cleared by USAID and is undergoing printing.

As with AB, during Q1, the program provided training to community members that included OP messages and intervention strategies. A 3 day training was provided on HIV prevention, as well as on C&S and C&T, to 2,051 HEWs (102% of the target of 2,000). Also participating were woreda HEW supervisors, HIV focal persons and other local government technical staff.

On infection prevention (IP) the prevention team supported a 5 day training for 172 HC heads to increase their knowledge and skill on IP practices (73% of Q1 target of 236). The trained HC heads then carried out on-the-job orientation sessions for 1,674 HC staff on institutionalization of IP practices (78% of Q1 target of 2,203). Following this, 467 HCs established IP committees supervised by their MDT (163% of the quarter target of 287).

Finally, on IP, the program's prevention team was actively involved during Q1 in the development of a strategy and training manual on IP by the Infection Prevention and Patient Safety TWG.

The program's prevention team also collaborated with central and regional HAPCOs during the commemoration of the World AIDS Day 2009 celebration, which included technical and financial support as detailed in the earlier AB section.

On post exposure prophylaxis (PEP) initiatives, during Q1, the program carried out on-site orientation at Addis Ababa HCs to strengthen their previously established PEP committees. However, for Q1, only 27 cases (5% of annual target of 500) were reported by supported HCs. It is likely that PEP cases are currently being under-reported by supported HCs as there is no national reporting format to capture PEP and the target is new to the program under the NGIs. In response, the program has developed and distributed, in Q1, a PEP reporting format to program supported ART HCs and expects reporting to improve in Q2.

Finally, condoms were generally available at all HCs, primarily through collaboration with PSI-Ethiopia. The program has an MOU with PSI-Ethiopia to help ensure promotion of and a regular supply of condoms to program supported HCs. PSI also collaborating with the program's C&S component through training and provision of demonstration tools for use by its community volunteers (KOOWs and community mobilizers).

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)

To ensure continuum of care between selected program supported ART HCs with high HIV patients and their served communities, the program provides technical assistance to selected kebele HIV/AIDS desks and health posts followed by community mobilization and deployment of community volunteers, called kebele-oriented outreach workers (KOOWs). With five deployed per supported kebeles and networked with the nearby ART HC, they provide home based care services, adherence support, community tracing of LTFU cases, ongoing community mobilization against stigma and discrimination and referrals to HC and community services.

In Q1, 338 communities were mobilized using the Save the Children USA (SCUS) community action cycle (CAC) methodology. First, the program carries out capacity building of local government. In Q1, 31 woreda HIV/AIDS prevention and control office experts and 139 kebele HIV/AIDS prevention and control desk workers were trained. At the same time, 49 community mobilizers were trained, who are attached to HCs and serve as a link between the HC and KOOWs.

Next, the trained local government staff and community mobilizers mobilize communities (338 kebeles in Q1), leading to formation of an equal number of community core groups (CCGs) comprised of community leaders and representatives of their kebeles' community based organizations. The CCGs subsequently select KOOWs, who, through weekly meetings with the HC's case managers, serve as a bridge between HCs and served communities. These linkages are instrumental, for example, in reducing LTFU patients.

In Q1, 1,930 KOOWs were selected and trained and deployed to the 338 kebeles. This led to the cumulative total of 6,652 KOOWs (105% of the 3-year cumulative contractual target of 6,350) deployed to a cumulative total of 1,265 kebeles (almost 100% of the 3-year contractual target of 1,270). Of note, 241 of the KOOWs were trained as gap filling (attrition rate for KOOWs has remained around 10% over recent program years).

During Q1, community outreach activities, led by KOOWs, continued, including the involvement of PLWH, CCGs, and mother support groups (earlier noted under PMTCT). Coffee ceremonies continued to be used as the primary vehicle for reaching community members in group settings on prevention, testing, stigma and discrimination as well as available HC services. 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 high-need affected and infected households. In Q1, 103,744 individuals were provided with home based care and other palliative services, 45,259 were referred from the community to HCs for services and 3,058 successfully traced who failed to meet their clinic appointment for HIV care and treatment or TB dots.

At HC level, 65,321 HIV-positive adults and children received a minimum of one palliative care service (44% of the FY10 target of 150,000). Of these, 2,319 were children <15 (26% of FY10 target of 9,000).

In terms of collaboration with USAID partners during Q1, the team participated in 7 meetings of the *Community Responses to HIV/AIDS Implementing Partners* working group focusing on collaboration and minimizing duplication of efforts and, ultimately, minimizing double counting. Some specifics include:

- **PATH:** The program will collaborate with PATH in at least 45 towns. To avoid duplication of efforts in palliative care provision, the program and PATH will share lists of volunteers and clients identified in the respective towns. The program will link the PATH CSOs to established CCGs for assistance and community backing. The program will share job aids for AB and OP messaging for uniform messaging in the overlap areas.
- **Land O'Lakes:** The program overlaps with Land O'Lakes in 9 towns. Land O'Lakes will work with the program to identify beneficiaries to benefit from Land O'Lakes' economic strengthening training component. The collaboration will be formalized through an MOU.
- **TransAction:** The program and the TransAction project overlap in 16 towns under their first phase that runs to May 10. The program will link program supported PLHIV to TransAction's economic strengthening component for training and formation for savings clubs. In addition, the PLHIVs under the program will be assisted to form PWP peer support group.

Care and Support (continued)

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

For community centered C&S, the program also works through NGOs. It sub-contracts with DOHE (Dawn of Hope Ethiopia) and has signed performance based contracts (PBCs) with 4 other NGOs, which renders cash payments for services rendered. They are the National Network of Positive Women Ethiopians (NNPWE), the HIV/AIDS Prevention, Care and Support Organization (HAPCSO), IMPACT Association for Social Services and Development (IMPACT) and the Relief Society of Tigray (REST). These organizations and their branch offices cover all the regions where HCSP operates. The deliverables for these contracts are aligned with HCSP and directly support prevention and C&S to those infected and affected by HIV/AIDS. The NGOs deploy outreach workers who are supported by different cadres of professional staff, including health care and social work professionals. They carry out household visits for HBC; provide individual counseling for PWP; and support youth peer to peer education, mother to mother support groups and coffee ceremonies that address prevention and stigma and discrimination; and refer infected and affected for community and HC services.

During Q1, the program supported 200 of the over 600 NGO outreach workers to receive C&S training. The NGOs provided 5,656 people with palliative care, reached 20,647 with AB messages and another 25,458 with OP messages, counseled 29,944 HIV positive persons on PWP and referred 4,674 people to HCs for services, including 119 children.

In summary, for Q1, the program reached, primarily through its KOOWs and supported NGOs. 797,972 individuals through community mobilization activities.

In addition, during Q1, the program supported a major publication, DOHE's 'Libona', which is the only national newsletter on HIV/AIDS and which reaches an estimated 25,000 people monthly. See Appendix I for an example of the publication.

At HC level, it needs to be noted that cotrimoxazole prophylaxis treatment remained very low, with only 1,438 patients reported receiving such in Q1 (representing 3% of the program's FY10 target of 56,000). Some of this is likely due to under-reporting as the program's SI system is transitioning to capturing the NGLs. However, it is also related to low attention by health workers for CPT coupled with irregular supply of the drug.

Adult Treatment

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

For FY10, the program is expanding the number of HCs providing ART services by 50, to 350. As of Q1, 37 HCs started providing the service, resulting in a total of 337 HCs providing ART (96% of the FY10 target of 350). Of the remaining 13, 11 have trained staff and have finished preparations and will start services by Jan. of Q2, with the 2 newly established HCs in Addis a bit delayed.

At the end of Q1, the number of current patients on ART increased by 5,723 to a total of 58,245. This represents 83% of the end of FY10 PEPFAR target of 70,000, but only 61% of the contractual 3 year target of 95,000. The mid-term evaluation highlighted that the contractual target was not realistic as it was based, during program design, on an inaccurately high assumption of expected infection.

During Q1, regular clinical mentorship of HCs continued to build the capacity of health workers in management of patients. Better diagnostic capacity, quality of service and increased re-evaluation of the pre-ART patients, coupled with increased C&T, contributed to the Q1 achievement. Also, there is evidence that the number of patients tested through the program's family focused approach has increased. Although the program has found that convincing index patients to bring their families for testing is a slow process, a review of 26 HCs in Amhara found that 3,454 of 5,878 registered family members (59%) came for testing, with 35% found positive. For spouses, 61% were found positive.

Most of the new patients in Q1 were either newly tested or from pre-ART rolls, with only a net of 746 from transfers (1,928 transferred in and 1,182 transferred out patients). Taking into account the transfer outs (1,182), the loss of patients during Q1, either due to LTFU or death, was only 469 (7.5%). The project's cumulative LTFU rate is now at 8.1%, which remains around a third of the reported national figure. Reasons given are that HCs are nearer to the community so patients do not have to travel far to collect their drugs. Also, HCs are relatively un-crowded and there may be better adherence counseling and community tracing.

Tracing patients who miss their appointments is relatively easier for HCs as they are nearer to the community. The program approach is to start tracing patients within 7 days of missed appointments, instead of the national standard of 30 days—when a patient is officially labeled LTFU. HC based case managers and community mobilizers and community based KOOWS and other volunteers are used by the program to bring patients back for their treatment. The program has also recently started promoting HCs to use the same mechanism for tracing pre-ART patients who miss their appointments.

As part of insuring the quality of service, the program has introduced measurement of Standards of Care (SoC) using Lots Quality Assurance Sampling (LQAS), allowing mentors and central level advisors to evaluate the quality of care. In this quarter, SoC indicators were assessed in 63 HCs in Amhara and 10 in Addis Ababa. The analysis and the action taken are attached as Appendix 9.

For training of health workers in Q1, a total of 1,049 were trained on adult and pediatric comprehensive ART and PMTCT. Also during Q1, 2,342 community health and para-social workers were trained. These included the KOOWs, MSG mentors, case managers and community mobilizers. Specific to adult treatment, 88 case managers were recruited and trained for deployment to the new ART HCs and gap filling to existing ART HCs.

In the four regions, 46 catchment area meetings were conducted, where the HC heads present their quarterly achievements in PICT, HCT, ART, PMTCT, TB/HIV and share experiences. The woreda, zonal and, in some areas, the regional health bureaus (RHBs) attended the meetings. In Addis Ababa, the RHB has temporarily suspended the meetings until a regional SoP is developed.

During Q1, HCSP senior technical staff also actively participated in the national and regional TWGs. Key issues included: developing new a TOR for the HIV/AIDS Treatment TWG, completing an assessment of mentorship, and review of new additional drugs and their coding system and viral load guidelines.

HIV/TB

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 10-HVTB (HIV/TB)

During Q1, the program increased the number of HCs providing enhanced palliative care, which includes TB treatment, by 27, reaching a current total of 531 (97% of the FY10 target of 550). For the remaining 19 HCs, preparation and staff training was completed in Q1 for 17, with activities to begin in Jan. of Q2. The 2 newly established Addis HCs will be a bit delayed.

HIV patients are to be screened for TB at every visit and every TB patient is to be offered HIV testing at TB clinics. During Q1, Lots Quality Assurance Sampling (LQAS) was used at 23 HCs in Amhara (19 patient cards assessed in each HC), with 78% of HIV/AIDS patients found screened for TB and 88% of TB patients tested for HIV. The LQAS found that 20 of the 23 HCs demonstrated 100% linkage between ART and TB clinics, with the remaining 3 between 75-80%.

In Q1, for all supported HC ART clinics, 34,018 HIV/AIDS patients were screened for TB, with 724 (2%) subsequently diagnosed with active TB. In TB clinics, of the 13,312 patients diagnosed with TB, 10,754 (81%) were tested for HIV, with 2,009 found positive (19%).

Together, 2,733 new HIV+ patients were started on TB treatment. This represents 18% of the PEPFAR annual target of 15,000, which is within range of the expected 25%. However, the cumulative total, after two and a half years, is at 21,084, which is only 30% of the 3-year target of 70,000. The mid-term evaluation noted that the 3-year target was based on inaccurate estimates of co-infection made during the program design stage.

During Q1, the program continued supporting the GOE's TB/HIV initiative by training HC staff on TB/HIV co-management and laboratory personnel on TB microscopic diagnosis, onsite mentorship of HCs and community based screening of TB by KOOWs and trained HEWs.

In Q1, 238 HC staff was trained on TB/HIV, 358 laboratory personnel on TB microscopy (as part of comprehensive basic lab training), and 1,930 KOOWs and 2,051 HEWs on community TB screening and education (as part of comprehensive community mobilization training).

These community based initiatives coupled with an improved diagnostic capacity at HCs are expected to improve the TB detection rate in the future. In addition, as described in the later lab section, the program is involved in development of a national laboratory EQA system under the leadership of the Ethiopian Health and Nutrition Research Institute (EHNRI), which would include hospitals and regional labs providing EQA to HCs that would include TB microscopy.

In Q1, the program also continued to work closely with MSH's TB CAP-Ethiopia project in selected regions and zones to synchronize training and EQAs for TB slide microscopy.

At national and regional level, HCSP actively participated, during Q1, in the TB/HIV TWG. Key issues addressed included TB infection prevention and MDRTB.

Counseling and Testing

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

At the end of Q1, an additional 31 HCs initiated reporting to the program on counseling and testing (C&T), reaching a total of 531 (97% of the FY10 target of 550). In Q1, the program supported the training of 2,008 health workers on HCT.

At the HCs, the program supports provider initiated testing and counseling (PITC) following the national opt-out approach of PITC at every unit of the HC, including outpatient, family planning, ANC, labor & delivery, TB/HIV, and EPI. In the VCT clinic, patients are tested using the opt-in approach.

During Q1, 674,226 individuals received C&T and their results at program supported HCs (42% of the PEPFAR annual target of 1,600,000). Of these, 17,705 (2.6%) were found positive.

The rate of individuals accepting testing under the PITC approach has increased, reaching above 90% in TB and ANC clinics while lower than 50% at outpatient departments (OPDs). Because OPDs are overloaded with patients, the health workers, while trained on PITC, are not able to consistently offer to test everyone.

There is evidence that the number of family members tested through the program's family focused approach is increasing. Families of HIV patients are a high risk group but often do not know their status. HCSP has designed a family focused approach and has earlier trained case managers and VCT counselors on couple and family counseling. Case managers and ART focal persons are providing counseling of their patients visiting the clinic to bring their immediate family for testing. Although such an approach takes time to widely implement because of the sensitive nature of disclosing to the family, there is a positive trend. A review of 26 HCs carried out in Amhara during Q1 found that 3,454 of 5,878 registered family members (59%) came for testing, with 35% found positive. For spouse, 61% were found positive, representing a discordant rate of 39%.

A third program approach targeting C&T is HC community outreach for VCT. Eighty woredas with HCs with high HIV patient loads have been selected and HEWs trained to mobilize the communities for HC outreach VCT. HC staff then conducts weekend VCT outreach in pre-selected community sites.

As noted under prevention, a 3 day training was provided to 2,051 HEWs (102% of the target of 2,000), with woreda HEW supervisors, HIV focal persons and other local government technical staff also participating. The HEWs subsequently sensitized 3,616 community members and volunteers on the outreach VCT campaign. The program was initiated in late Q1. For an example, HC outreach visits in the Tigray region resulted in 16,140 people counseled and tested, with the positives linked to the HCs.

In addition to the HEWs, the program has over 6,652 KOOWs deployed in 1,265 kebeles served by 191 high load HCs. They provide education and encouragement to affected families to be tested as well as community mobilization that promotes C&T, as do the 5 NGO supported by the program during Q1: HAPSCO, DOHE, REST, IMPACT and NNPWE.

Finally, senior technical staff actively participated during Q1 in HCT TWGS at national and regional levels. A key issue addressed was the development and field testing of a training manual for urban HEWs

Pediatric Treatment

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

As noted earlier, by the end of Q1, a total of 337 HCs were providing ART. Also noted earlier was that during Q1, a total of 1,049 health workers were trained on ART, which encompasses a 4 week training, of which 2 weeks is on comprehensive pediatric ART.

So almost all ART HCs have staff trained on pediatric care and treatment. However, only 160 currently have enrolled pediatric patients, as health workers remain fearful of handling pediatric patients and continue to refer to hospitals. With additional refresher trainings and ongoing mentorship, HCs are increasingly initiating pediatric treatment.

Q1 data indicates that the program is relatively on target, with 406 children started on ART (22% of PEPFAR FY10 target of 1,812). The total number of children currently on ART reached 1,730 (49.3% of the PEPFAR cumulative target for the end of FY10). A subset of the above is children <1. In Q1, 60 were started on ART (22% of the FY10 annual and cumulative target of 272).

The above is related to improved linkages with PMTCT, increased PITC of pediatric patients, support for the testing of children at community level by KOOWS, and ongoing clinical mentorship. The joint mentorship by ANNECA and HCSP clinical advisors at central and regional level has helped build the capacity of program mentors and subsequently health center staff, building their confidence to initiate pediatric treatment.

Finally, senior program technical staff, during Q1, actively participated in the national TWG on pediatrics. Key issues addressed included: changing first line drugs for pediatrics consistent with revised WHO standards and DBS.

Laboratory Infrastructure

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

A key initiative during Q1 was the assessment of the HCs that are newly establishing ART services, using the MSH quality assurance methodology, the Fully Functional Service Delivery Point (FFSDP) tool. Prior to service initiation, the HCs were assessed using the FFSDP tool, which included assessment of their laboratories, encompassing such key areas as essential equipment, supplies and reagents and presence of trained personnel.

In terms of training, in Q1, 358 HC lab personnel (73% of the program's annual target of 489) were trained on comprehensive lab services. Major topics covered included rapid HIV testing, TB microscopy, malaria microscopy, quality control, DBS sample transportation, inventory management and preventive maintenance. The remaining staff is scheduled to be trained in Jan.

During Q1, the program also carried out specialist training on CD4 machines. The current practice is for HCs to send blood samples to local hospitals, and at times, regional labs for CD4 testing. However, in Amhara, the RHB has provided machines to two HCs and plans to provide for an additional three. During Q1, the program supported, in collaboration with EHNRI and the RHB, the training of 15 lab personnel (3 per HC) on CD4 as well as on chemistry and hematology analyzers.

In terms of external quality control, HCSP has supported regional laboratories to implement HC EQA. This has proven inconsistent for various factors (limited human resources, funds, and especially limited availability of vehicles for travel). During Q1, 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 the approach with RHBs, who accepted the strategy in principle but raised concerns over the capacity of the hospitals, the modalities of their involvement, the roles of the different actors in the lab areas etc. EHNRI is now planning to convene a national workshop to look into such issues and come up with a workable modality/strategy.

Laboratory Infrastructure (continued)

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

In terms of provision of essential supplies, the program works with MSH's Supply Chain Management System (SCMS) and Strengthening Pharmaceutical Systems (SPS) projects. Earlier, the program partnered with them in assessing and identifying gaps in needed laboratory equipment and supplies. During Q1, the regional lab advisors liaised with the regional distribution hubs of the Government of Ethiopia (GOE) Pharmaceuticals Fund and Supply Agency (PFSA) to ensure lab supplies are being distributed according to schedule to the program supported HCs. The supplies include key consumables such as gram staining reagent, WBC tommma pipette, Sahil-heligh hemoglobinometer, hemocytometer, microscope slide, immersion oil, wooden applicator stick, RPR test kits and pregnancy test kits. The regional lab advisors then encouraged the hubs to distribute to those HCs who have not received scheduled supplies and then followed-up with the HCs to ensure receipt. While the program also procures stop-gap supplies, none were procured during Q1.

In terms of TWGs, regional laboratory technical working groups (RLTWGs) have been established to help strengthen regional laboratories and better coordinate support and inputs to the regional labs from partners. During Q1, the laboratory advisor participated in the regular monthly meetings of the National Laboratory TWG (NLTWG) and the Early Infant Diagnosis TWG (EIDTWG), convened at EHNRI. Issues such as DBS sample transport, accreditation of laboratories, EQA and quality control were discussed during the meetings. An ongoing topic is the WHO/AFRO plan to accredit laboratories in hospitals and HCs.

Strategic Information

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

The program is committed to supporting and implementing the principle of the "Three Ones" in Ethiopia. In line with this, during Q1, the program 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. This training was part of the program's commitment to support the rolling out of the new GOE HMIS.

In addition, in Q1, the program supported the training of 107 data clerks and their deployment to ART HCs. Currently, all ART HCs but the 2 new Addis ones have assigned data clerks, although staff turnover causes a few to be short staffed at times.

In terms of the NGIs, during Q1, the program revised its reporting formats for HCs to capture the NGIs. The revised formats were distributed to the regions and HCs, with full initiation expected during Q2. The program also began revising community level reporting formats in accordance with the NGIs. Revisions of community level reporting also targeted simplification and minimization of double reporting.

As part of HCSP's commitment to strengthen/establish CBMIS at community level in collaboration with other relevant stakeholders, CBMIS was incorporated into the quarter's training of KOOWs and HEWs.

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 quarter's training of new data clerks.

In addition, the program ensured that SI was used during the quarter's catchment area meetings as well as during GOE review meetings, such as the quarterly FHAPCO review meeting, which program SI staff participated in.

The program's M&E and quality management team members participated in PEPFAR workshops on the NGIs and national and regional M&E and SI TWGs, including discussion of the GOE's HMIS roll out.

HSS

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

The program's HSS component emphasizes strengthening the GOE's HCs to provide comprehensive HIV/AIDS care and treatment through a continuum of care that links HC services to served communities.

A key area of HSS is the HC. The FY10 target is to support 550 HCs to provide comprehensive HIV/AIDS care and treatment, of which 350 also provide ART. As of Q1, 531 are reporting such services (97% of FY10 cumulative target), of which 337 are providing ART (96% of FY10 cumulative target).

The program supports the decentralization of ART services from hospitals to health centers and from physician prescribers to mid level health workers e.g. health officers or nurses. To support this decentralization of services, the program supports trainings of these mid level health workers on comprehensive ART training, TB/HIV, PMTCT, PICT, HCT, infection prevention and comprehensive laboratory services. In Q1, for all these areas, 5,015 health workers were trained (50% of FY10 target). Of these, 2,008 were trained in the area of HIV and TB C&T and 1,049 on treatment. In addition, 358 HC lab personnel were trained on comprehensive lab services.

In addition to training, the program provided, during Q1, equipment, furniture and other supplies to the new ART HCs. In addition, 350 computers and their accessories were bought during Q1 and shipped to Ethiopia for distribution to all ART HCs to support the GOE's new HMIS system. In Q2, they will be distributed to the HCs.

All 350 ART HCs (except the two newly established Addis HCs) have trained and deployed data clerks. In addition, in Addis Ababa City Administration, the program supported the training of 406 health workers on the new HMIS upon the request of the city health bureau.

The program follows up in-service training with on-site mentoring carried out by clinical mentors who are supported by regional and central team clinical advisors. The main objective of support is to build the technical capacity of the trained health workers, HC managers and community members. During Q1, 47 clinical mentors carried out ongoing mentoring to the active 531 HCs.

During Q1, the program also focused on strengthening the internal quality assurance of HCs. The program targeted training on the quality assurance FFSDP tool, encompassing 2 HC staff per ART HC (including the HC head) and one woreda health officer who has HC supervisory responsibilities. During Q1, 641 health personnel (60% of 1,077 planned for the quarter) were trained, with the shortfall to be completed in Jan. Around 300 of the targeted 350 ART HCs and woredas now have trained staff on the FFSDP tool and are ready for implementation during Q2. During Q2, the HCs' multi-disciplinary teams (MDTs) will complete the FFSDP tool to analyze quality of services and develop action plans to address areas requiring improvement.

As noted above, a key area of strengthening is the HCs linkages to served communities. A key to this is the HC based case manager, a typically HIV-positive para-professional who provides adherence and psychosocial counseling, directly connects HIV-positive patients to community care and support and oversees community tracing for LTFU in partnership with the KOOWs and HEWS.

In Q1, 88 case managers were trained and deployed. All ART HCs except the 2 newly established HCs in Addis now have case managers, with some HCs with high HIV patient load having an additional one. With Q1's training, a cumulative total of 419 case managers have been trained and deployed (107% of the cumulative 3-year contractual target of 393). The extra numbers of trained involve gap filling of those who have resigned.

HSS (continued)

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

At the community level, the program carries out community mobilization of communities (kebeles) serviced by typically high HIV patient load HCs. In Q1, local government capacity building was followed by mobilization of 338 communities using the SCUS community action cycle (CAC) methodology. Following formation of an equal number of community core groups (CCGs), comprised of community leaders and representatives of community based organizations including PLHIV associations, a total of 1,930 KOOWs were selected by the CCGs and trained and deployed to the 138 communities. With Q1 trainings, a cumulative total of 6,917 KOOWs have been trained and deployed to 1,270 kebeles that are serviced by 191 high load ART HCs.

The KOOWs provide home based care for infected and affected, trace lost to follow-up patients; teach on prevention, stigma and treatment adherence. The KOOWs are typically deployed in town-centered kebeles, where HCs are also typically located. To reach the more rural kebeles served by high HIV patient load ART HCs, the program facilitates HCs to link with rural based health extension workers (HEWs), especially for community level tracing for LTFU. In Q1, 2,051 rural HEWs in 80 high HIV burden woredas were trained by the program on AB, OP and community mobilization for HC outreach VCT. The trained HEWs then oriented recruited volunteers in their respective kebeles to assist in mobilization for prevention and outreach VCT.

For woredas that supervise program supported ART HCs, the program supports their HIV planning. The purpose of the planning process is to assist woredas to prepare a comprehensive plan to coordinate all HIV/AIDS actors in their jurisdiction. In Q1, 321 plans were developed and harmonized with the program (90% of the annual FY10 target of 350).

At the regional level, the program assists the Regional Health Bureaus (RHBs) to prepare supervisory checklists, do joint supportive supervision, carry out data analysis and lead the coordination of partners. In Q1, all the five regions conducted supportive supervisions, with active program involvement.

The program also supports catchment area meetings that bring together all the key HIV/AIDS actors within a zonal catchment area, including hospitals and HCs. During the meeting, the HC heads present their data for review and analysis, which includes the transfer of stable patients to HCs and complicated cases to hospitals. In Q1, 46 catchment area meetings were held in the 4 regions.

At the national level, senior technical program staff worked closely with the FMOH and participated in the various TWGs under their leadership, as described in the earlier sections. Of note, during Q1, the FMOH established a National Quality Management TWG (NQMTWG), with staff from the program's HSS and M&E teams participating in all six meetings.

Finally, as part of the program's strengthening of HC linkages with served communities, the program carries out capacity building of NGOs operating within HC serviced communities. During Q1, the program supported 4 NGOs sub-contracted under performance based contracts (PBCs), which link support to specific, monthly performance results. Ongoing capacity building during Q1 on PBC has significantly increased the NGO's capacity to implement care and support activities, including work planning, data collection and monitoring of impact and has instilled the concept of performance linked to results. For example, in Q1, PBC helped the NGOs comply with new national legislation for CSOs by allowing them to better and more accurately report on their activities and expenditures to the GOE. All were successfully registered during Q1.

8. Challenges and Constraints and plans to overcome them during the reporting period (REQUIRED)

PMTCT

Quarterly challenges and constraints for each program area:

Program area I (PMTCT)

1. HC staffing shortages often result in ANC-PMTCT nurses being assigned to additional HC duties, causing them to be over-stretched.
2. High staff turnover of HC trained PMTCT staff.
3. PMTC clinics do not have strong tracking systems as ART clinics do, for follow-up to ensure continuum of care.
4. Limited facility and community service linkages in non-KOOWs areas.
5. Low ANC attendance and delivery at HCs.

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

Program area I (PMTCT)

1. HC staffing shortages are beyond control of program, although the program continues to carry out gap filling training.
2. For high staff turnover, program continues training to fill gaps.
3. For poor tracking, proposal will be made to the national TWG to design a strategy for improving inter-facility referral and tracking systems.
4. Program has trained HEWs of rural kebeles served by 80 high load HCs to link with the HCs.
5. Program has trained and involved HEWs in both KOOW and non-KOOW supported communities to mobilize mothers, including attendance at ANC.

AB

Quarterly challenges and constraints for each program area

Program area 2-HVAB (Sexual Prevention: AB)

1. Program required to address the new PEPFAR NGLI guidelines on AB prevention.

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

Program area 2-HVAB (Sexual Prevention: AB)

1. During Q1, the C&S, prevention and NGO capacity building teams analyzed the new AB guidelines and developed a strategy for addressing them. In Q2, the strategy will be implemented, including finalization of specific messages; development of training curriculum and training TOTs (community mobilizers, NGO outreach supervisors, HEWs etc); initiation of implementation at community level (by KOOWs, NGO outreach workers, community volunteers) using new approaches (which the NGLI specify); and revision of reporting to capture results.

OP

Quarterly challenges and constraints for each program area

Program area 2-HVOP (Sexual Prevention: OP)

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

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

Program area 2-HVOP (Sexual Prevention: OP)

1. During Q1, the C&S, prevention and NGO capacity building teams analyzed the new OP guidelines and developed a strategy for addressing them. In Q2, the strategy will be implemented, including finalization of specific messages; development of training curriculum and training TOTs (community mobilizers, NGO outreach supervisors, HEWs etc); initiation of implementation at community level (by KOOWs, NGO outreach workers, community volunteers) using new approaches (which the new guidelines specify); and revision of reporting to capture results.
 - a. Prevention team to develop new job aids for HC clinics (PMTCT, TB, ART) on new OP and PWP messaging.

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 NGIs on prevention pose a serious challenge.
2. Insufficient follow-up of community activities due to limited human resources and staff turnover.
3. CPT coverage is very low, partly because of drug shortage.
4. There is no food supply for malnourished patients.

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

Program area 8-HBHC (Care and Support)

1. During Q1, the C&S, prevention and NGO capacity building teams analyzed the new AB guidelines and developed a strategy for addressing them. In Q2, the strategy will be implemented, including finalization of specific messages (which are specifically revised); development of training curriculum and training TOTs (community mobilizers, NGO outreach supervisors, HEWs etc); initiation of implementation at community level (by KOOWs, NGO outreach workers, community volunteers) using new approaches; and revision of reporting to capture results.
2. Regional C&S coordinators mentor the mentors to follow-up on community activities as they visit each HC at least once a month e.g. meet regularly with community mobilizers.
3. Strengthen mentorship to assist HCs to build their clinical capacity to initiate CPT. Inform the FMOH to avail drugs and assist the distribution.
4. Collaborate with the upcoming food by prescription program of SCUS.

Adult Treatment

Quarterly challenges and Constraints for each program area

Program area 9-HTXS (Adult Treatment)

1. Shortage of supplies like OI drugs.
2. Absence of nutritional support at HC for impoverished patients, which negatively affects adherence.
3. Difficulty in collecting PEP data as there is no national guideline.
4. Blood sample transport difficulties, with some hospitals imposing limited quotas on samples to be processed as they are overwhelmed by their own patients.

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

Program area 9-HTXS (Adult Treatment)

1. An ad hoc 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.
2. Collaborate with upcoming food by prescription project of SCUS.
3. A new program reporting format to trace the NGIs that includes PEP was developed and distributed to HCs for Q2 initiation.
4. Rapid lab assessment of HCs and their problems has been started with EHNRI. Based on the findings action will be taken by the responsible body.

HIV/TB

Quarterly challenges and constraints for each program area

Program area 10 (HIV/TB)

1. Although the TB screening rate is improving at the HCs, the current annual rate after Q1 (18%) remains lower than the expected 25%.

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

Program area 10 (HIV/TB)

1. For the above:
 - a. Continue providing targeted technical assistance to the regional labs, HCs and community interventions to strengthen TB screening and diagnostic capacity.
 - b. Continue gap filling training of new staff.
 - c. Continue working with EHNRI and the TWG to initiate 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 was a challenge partly because of distribution problem and partly because of short supply at national level.
2. Outpatient departments at HCs do not routinely offer a test for every visitor because they have many patients in the morning hours.

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 training for all health personnel will be continued.
 - a. Consider PICT corners at HCs where every patient passes through before being seen that offer out-out testing.

Pediatric Treatment

Quarterly challenges and Constraints for each program area

Program area 13: PDTX

1. DBS kits for EID are not distributed to all ART HC.
2. DBS transportation and result notification is a challenging area as the DBS is done only in 5 regional labs. Some require transport of hundreds of KMs.
3. Poor collaboration between HEI and ART unit in many HCs. There is no clear guideline where HEI should be followed, in PMTCT or ART clinics.
4. Trained HC staff's lack of confidence to handle pediatrics cases

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

Program area 13: PDTX

1. Discussions started with EHNRI, CHAI and SCMS to distribute DBS Kits to ensure distribution to all HCs.
2. A prepaid postal courier system is under design by EHNRI and the process will be monitored for effectiveness.
3. HCSP is proposing that prophylaxis and ARVs for pregnant women be provided at ART clinics for a better follow up and stronger linkages for pediatric ART. The agenda will be forwarded to the national TWG.
4. Ongoing mentoring and training to build the confidence of front line health workers in managing pediatrics patients.

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. Program has worked with EHNRI to facilitate their interest in and development of a national EQA, which would include hospitals providing EQA to catchment area HCs.

SI

Quarterly challenges and Constraints for each program area

Program area 17-SI

1. NGIs have revised reporting requirements.
2. Absence of standard recording and reporting formats for umbrella C&S services.
3. Turnover of trained data clerks.
4. Problem of getting reports or incomplete reports, often from non ART HCs as there is no data clerk at these HCs.

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

Program area 17-SI

1. Program has sent out new reporting formats to capture the NGIs.
2. Program is developing formats in lieu of national standards.
3. Program will continue to carry out gap filling trainings, often combining data clerks from different regions.
4. Mentors to continue working with non ART HCs to strengthen their SI systems and reporting.

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.

9. Data Quality issues during the reporting period (REQUIRED)

All Program Areas

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

All Program areas:

1. Data quality 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. During Q2, the program will revise its community level reporting, targeting simplification and minimization of double reporting.
3. During Q1, the program revised its reporting formats for HCs to capture the NGIs. The revised formats were distributed to the program's regional offices and supported HCs, with full initiation of their use expected during Q2. Of note, the program has had to revise its implementation approaches and messaging to meet the NGIs criteria for reporting on prevention.

10. Major Activities planned in the next reporting period (REQUIRED)

PMTCT

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

- Ensure all targeted 550 HCs are providing PMTCT services.
- Continue providing HC health worker gap filling training on PMTCT.
- Ongoing mentorship of HCs for PMTCT.
- Participate in national and regional PMTCT TWG meetings, including advocating for an improved referral tracking system, both inter- and intra-facility.
- Expand HC outreach VCT and ANC promotion through HEWs and community volunteers, targeting woredas served by 80 high HIV patient load HCs.
- Complete establishment of additional 24 HCs with MSG activities.
- Introduce innovative interventions that are envisaged to improve quality of PMTCT services (hospital to health center mentorship, piloting of a take home prophylaxis package),
- Continued collaboration with partners, including the IntraHealth Community PMTCT project.

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. Finalize development of training and messaging materials on the NGIs for AB prevention, followed by TOT training of program regional C&S and BCC coordinators, community mobilizers and NGO's outreach supervisors on the NGI AB prevention guidelines to enable them to cascade training to KOOWs and NGO outreach workers.
2. Development of implementation guidelines and job aids for carrying out AB during home visits.

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. As with AB, finalize development of training and messaging materials on the NGIs for OP and PWP, followed by TOT training of program regional C&S and BCC coordinators, community mobilizers and NGO's outreach supervisors on the NGI OP guidelines to enable them to cascade training to KOOWs and NGO outreach workers.
2. Develop implementation guidelines and job aids for carrying out AB and OP during home visits and OP during coffee ceremonies.
3. Develop implementation guidelines and job aids for carrying out PWP at clinic level.

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. Conduct capacity building training for at least 470 kebele HIV/AIDS desk officers.
2. Conduct 10 bi- annual review meetings in all the regions.
4. Develop implementation guidelines and job aids for carrying out OP during home visits and coffee ceremonies.
3. Conduct refresher training for over 6,000 KOOWs and NGO outreach workers on NCI prevention guidelines and job aids for community outreach and home visits.
4. Conduct linkage meetings in 470 kebeles to further strengthen the community and health centre linkages.
5. Provide TA to NGO's to carry out case studies to document key initiatives.
1. Facilitate the NGOs to intensify efforts to address gender issues in their work, such as targeting increased ANC/PMTCT attendance and prevention of gender based violence.

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. Fully implement the program's HC VCT outreach initiative.
7. Improve follow-up and evaluation of patients who are on treatment for more than a year to capture failing treatments.
8. Pilot hospital-to-HC mentorship and telephone consultation.
9. Start CME through the video conferencing facility of the government

HIV/TB

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

1. Finalize expansion of services to 17 HCs by Jan. of Q2.
2. Continue gap filling training on TB/HIV screening and laboratory testing.
3. Facilitate HCs' MDTs to implement the FFSDP tool and develop action plans to respond to gaps.
4. Continue measuring implementation of SOC through LQAS, which will continue to include TB/HIV.
5. Assist implementation of a national EQA system under EHNRI. A target for Q2 is a national dissemination workshop and training of hospital lab personnel for carrying out EQA for HCs.

HIV/CT

Upcoming activities should highlight planned activities and solutions to identified constraints (write for each program area): Program area 12: HVCT

1. Fully implement the HC outreach VCT initiative.
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. Increase emphasis on pediatric treatment during on-site HC mentorship.
2. Strengthen the PMTCT and PICT services to increase pediatric treatment coverage.
3. Work closely with EHNRI in implementing the curer system of DBS sample transportation.
4. Present the issue of HEI follow-up to the national TWG.

Lab

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

1. Link the 2 ART HCs with CD4 machines with nearby HCs for providing testing services to them.
2. 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.
4. Provide technical and financial support to each of the 5 regional laboratories to facilitate increased consistency of their regional external quality assurance program (REQA).

SI

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

1. HCSP will work with other PEPFAR partners and GOE to help develop a standardized reporting system and forms to capture the information needed for the NGIs.
2. Ongoing support to the regions and HCs to strengthen roll out of the HMIS system.
3. Train and deploy data clerks for gap filling at HCs.
4. 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. Train remaining 196 lab personnel (Amhara and Oromiya).
2. Support the trained staff in 350 ART health centers and woredas for HC MDTs to self-implement the FFSDP, including collection of baseline information and development of plans of action to address identified gaps.

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

- Appendix 1: Libona (publication of DOHE)
- Appendix 2: Trip report from Laura Sider-Jost
- Appendix 3: Trip report from Carla Goncalves
- Appendix 4: Trip report from Fred Hartman
- Appendix 5: Trip report from Diana Silimperi
- Appendix 6: Trip report from Scott Kellerman
- Appendix 7: Trip report from Fred Hartman
- Appendix 8: Trip report from Ousmane Faye
- Appendix 9: SOC LQAS