COMMUNITY PREVENTION MOTHER TO CHILD TRANSMISSION OF HIV (CPMTCT) PROJECT END REVIEW

OCTOBER 1, 2009-NOVEMBER 28, 2014

FINAL EVALUATION REPORT

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The Review Team
November 2014

LIST OF ACRONYMS

AARHB	Addis Ababa Regional Health Bureau
ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behavioral Change and Communication
BC/CM	Behavior Change/Community Mobilization
BEMONC	Basic Emergency Obstetric & Newborn Care
CBO	Community-Based Organization
CMSG	Community Mothers Support Group
CPMTCT	Community Prevention of Mother-to-Child Transmission
CSO	Civil Society Organization
DBS	Dried Blood Sample
DCCM	Demand Creation Community Mobilization
EOC-DICAC	Ethiopian Orthodox Church Development and Inter Church Aid Commission
FMOH	Federal Ministry of Health
FP	Family Planning
FSS	Follow up Supportive Supervision
JSS	Joint Supportive Supervision
HAPCO	HIV/AIDS Prevention and Control Office
HC	Health Center
HCT	HIV Testing and Counseling
HDA	Health Development Army
HEW	Health Extension Worker
HMIS	Health Management Information System
IEC	Information, Education, and Communication
IFHP	Integrated Family Health Project
IOCC	International Orthodox Christian Charities
IP	Infection Prevention
LMIS	Logistic Management System
MNCH	Maternal, Neonatal and Child Health
M&E	Monitoring and Evaluation
MSG	Mother Support Group
MTCT	Mother to Child Transmission
PATH	Program for Appropriate Technology in Health
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care Unit
PI	Performance Improvement
PICT	Provider Initiated Counseling and Testing
PIQA	Performance Improvement/Quality Assurance
PQI	Performance Quality Improvement
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission

QI	Quality Improvement
RHB	Regional Health Bureau
SNNPRR	Southern Nations, Nationalities and People Region
SS	Supportive Supervision
TOT	Training of Trainers
TWG	Technical Working Group
VCHW	Volunteer Community Health Worker
VCT	Voluntary Counseling and Testing
UHEP	Urban Health Extension Program
UHEW	Urban Health Extension Worker
WrHO	Woreda Health Office

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EXECUTIVE SUMMARY

This report presents results of the end of project review for the USAID supported Community Prevention of Mother to Child Transmission (CPMTCT) Project. The project was jointly implemented by the prime partner, IntraHealth and sub-partners, Pathfinder International, Program for Appropriate Technology in Health (PATH) and the International Orthodox Christian Charities (IOCC). The project was implemented with close collaboration with the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), Zonal Health Departments (ZHDs), Woreda Health Offices (WrHOs), Health Centers (HC) and local organizations and communities from Addis Ababa, Amhara, Oromia, SNNPR and Tigray regional states. The project period covers five years that runs from October 1st 2009 to November 28, 2014. Starting from the third year of project implementation project activities have been planned and gradually transited to regional health bureaus after detailed discussions and consensus reached.

The three objectives of the review were to: determine the extent to which the CPMTCT project has achieved its goal and objectives, document project processes and implementation and document lessons learned for application in future programming. The review also tried to examine the achievements of the project from the perspective of the four project objectives.

The methods used to review the performance of the project include: review of available project documents and reports and interview of representatives of key project partners at FMOH, RHBs, Zonal Health Departments, City and Sub City Health Offices and Health centers. The review team was composed of three senior public health experts and two research assistants.

Key review findings and recommendations are summarized below:

Result

Capacity building

In assessing the capacity building component of the project, the review team noted that IntraHealth employed different approaches including training, mentoring, joint and follow-up supportive supervision, regular performance reviews and development/review of national strategic documents, manuals, checklists and implementation guidelines, etc. to build the capacity of the implementing partners at different levels.

A total of 20,096 people from five RHBs, 244 WrHOs, 519 HCs and 22 CBOs benefited from the trainings. The capacity building trainings organized by the project include basic and refresher trainings, in service trainings, pre placement trainings and Training of Trainers and cover about 23 different types of topics.

The capacity building support provided to health centers, which mainly focused on building the MNCH/PMTCT technical competence of health staff, enabled the health system to strengthen

the Primary Health Care units to provide, monitor and evaluate quality community MNCH/PMTCT services.

Increase access to MNCH/PMTCT services

IntraHealth has made great strides in supporting the RHBs, ZHD and WrHOs and health centers in improving access to MNCH/PMTCT services. 519 HCs from five regions benefitted from the different types of CB supports and were able to integrate MNCH/PMTCT services both at facility and community levels and about 453 (87.3%) of the HCs implemented Option B+. Establishing functional referral linkages between health facilities and community providers, education and advocacy at the community level, and associated improvement in the level of awareness of the community about the benefits of MNCH/PMTCT were the important elements of the strategy employed by the project to increase access to MNCH/PMTCT services.

Over the five year period covered by the project 1,727,797 new ANC visits were made to HCs supported by the project and 348,543 deliveries were attended by skilled birth attendants, with 94.6% and 103.6% achievement of the project targets respectively. During the same period, 1,393,290 pregnant women were tested for HIV, 4,374 HIV+ pregnant women received ARV prophylaxis to reduce risk of MTCT (63% of the HIV positive pregnant women identified), and about 3,087 deliveries from HIV+ women were attended by skilled birth attendants. The reported marked and progressive rise in service uptake indicates the achievements of the project in increasing access to MNCH/PMTCT services.

Increasing demand for MNCH/PMTCT services through community outreach

The project supported different community level structures and encouraged use of other tested and proven awareness raising and advocacy strategies and approaches like: MSGs and Community MSGs to increase demand for MNCH/PMTCT services. In this regard the project supported the establishment of 230 MSGs with 3,241 members. Apart from the MSGs, the role of PLHIVs, women development army, home visits by HEWs and volunteer community health workers, community conversations, coffee ceremonies, pregnant women conference, religious leaders, PLHIVs and handing of maternal kit/mama kit for women delivering in health facilities, etc. in advocacy, demand creation and identifying and linking HIV positive pregnant women to community and facility level MNCH/PMTCT services was also significant.

Improve the quality of community and facility level MNCH/PMTCT services

It was widely acknowledged that marked improvements have been observed in the quality of MNCH/PMTCT services provided both at health facility and community levels. Interestingly in most areas improvement in the quality of MNCH/PMTCT services both at community and facility levels were measured using different outcome variables like: reduced client waiting time, improvement in ANC and PNC service uptake, increase in institutional birth, increase in the number of pregnant women and their partners who tested for HIV.

The observed improvement in the quality of MNCH/PMTCT services provided both at health facility and community level were widely attributed to many factors including: the different basic and refresher trainings and regular mentoring support, joint and follow up supervisions, the use

of standard operating procedures and algorithms for service delivery, continuous data quality check, use of data for planning, monitoring and evaluation, sharing of experience and best practices, timely identification and filling of skill and supply gaps and creating a functional referral linkages between the community level providers and health centers.

Challenges and Implementation Constraints

Despite observed improvement in the quality and access to integrated MNCH/PMTCT services, the review findings reveled that many challenges were faced in the course of project implementation. These include: shortage and erratic supply of essential equipment, drugs and supplies like HIV testing kits and laboratory reagents, uncertainty related to sustaining the activities of MSGs and CMSGs, repeated policy and guideline change on PMTCT and absence of well-designed and culturally responsive communication materials on how to reach and engage males/partners.

Recommendations

Recognizing the project is scheduled for completion by the end of November 2014, the review team would like to forward the following recommendations which can be used during the follow up by the government counterparts.

Despite notable achievements made by the project, the team didn't come across any best practice documentation. The team is of an opinion that documentation of such experiences would contribute to sustenance of the initiative on the one hand and serves as a reference to guide the scale up of CMPTCT activities on the other hand.

- In view of commonly expressed concerns of the continuity of the regular support in CPMTCT in absence of IntraHealth, the review team strongly recommends a) regional health bureaus roll out the capacity building interventions at different levels to maintain the momentum created b) ensure that the trained mentors are engaged in provision of mentorship and c) health managers and leaders at zonal and regional levels continue to play their leadership role in MNCH/PMTCT and d) communication materials and other related essential program inputs are produced and supplied to the health facilities on regular bases.

- Shortage of supplies like HIV testing kits, DBS testing kits and related logistic was learnt to be one of the challenges faced during the project life. Thus, the team recommends for FMOH/PFSA to take proactive and immediate actions to develop clear road map on how to avail essential PMTCT supplies to health facilities so as to maintain uninterrupted access to services.

- Despite the fact that community PMTCT project started in all focus regions at about the same time, there were evident variations in terms of their current accomplishments. The

team felt that such variations could have been reduced with continuous experience sharing opportunities between regions which could be considered as a forum to gain insights on what and how other regions implement and eventually ensure uniformity in procedures of service provision.

- In as much the role of men in MNCH/PMTCT is recognized, it is recommended to design a well-informed national strategy and tools on how to improve the role of men in maternal health programs in general and that of PMTCT in particular.

1. INTRODUCTION

This report is the result of the end of project review of IntraHealth's five year project, Community Prevention of Mother to Child Transmission of HIV (October 1st 2009 –November 28, 2014). Funding for the project was provided by USAID Ethiopia. IntraHealth, as the prime on this project, was supported by Pathfinder International, Program for Appropriate Technology in Health (PATH) and the International Orthodox Christian Charities (IOCC). The project was implemented in five regions namely Addis Ababa, Amhara, Oromia, South Nations, Nationalities and People (SNNPR) and Tigray. The implementation was carried out in close collaboration with the Federal Ministry of Health (FMOH), Regional Health Bureaus, Zonal and Woreda Health Offices, health centers (HC) and health care providers as well as local organizations and communities.

The project aimed at increasing Maternal, Neonatal and Child Health (MNCH) and Prevention of Mother-to-Child Transmission (PMTCT) service uptake and case follow-up through the provision of PMTCT services at the community level. The four objectives of the project are: (1) To build the capacity of regional heath bureaus, zonal and woreda health offices and community-based organizations to support and manage community-based PMTCT; (2) To increase access to MNCH/PMTCT services through providing facility and community services and improving bi-directional linkages/referrals; (3)To increase demand for MNCH/PMTCT services through community outreach and (4)To improve the quality of community and facility-based MNCH/PMTCT services.

The project implementation strategies have their base on IntraHealth's previous experience on how to implement, sustain and scale up effective PMTCT service in the country through the Capacity*Plus* and Hareg projects. These strategies include creating strong partnerships with those in the health system from the federal to the community level and with other stakeholders including community based organizations to develop, test, refine and rollout a sustainable community PMTCT model that more effectively integrates to maternal health services. The project implementation adopted the MNCH/PMTCT model whose priority elements include increasing access to focused antenatal care (FANC), provider initiated testing and counseling (PITC), essential obstetrics care, linkages to nutrition programs for HIV positive pregnant women, infant feeding counseling and family planning services.

As the CPMTCT project nears its completion, USAID requested IntraHealth Ethiopia to conduct an end of project review. The review was to assess the performance of the project vis-a-vie its goal and objectives and answer key review questions outlined in the Terms of Reference prepared for the review.

2. OBJECTIVES AND REVIEW QUESTIONS

2.1 Objectives

The specific objectives of the review are:

1. To determine the extent to which the project has achieved its goal and objectives
2. To document project processes and implementation
3. To document lessons learned for application in future programming

2.2 Key review questions

The review was carried out to find answers the following key questions:

- How successful was the program in building the capacities of FMOH, RHBs, Zonal and district health offices and health providers in MNCH and PMTCT technical and program management skills?

- Has the CPMTCT project achieved its objectives of demand creation and service access for PMTCT in the five years of the project life?

- What is the role of the project towards integration and coordination of PMTCT and MNCH services over the life course of the program?

- How have persistent problems in the health system affected the service provision and the efforts of the partners to resolve these challenges?

- How did the CPMTCT project contribute to the identification, retention, and referral of HIV positive women and HIV-exposed infants (HEIs)?

- How did the project's strategy, goal and/or objectives change or evolve over the life of the project? Did all activities occur as planned and at an acceptable level of quality and quantity? What factors contributed to the achievement and under- or over-achievement of the goal and/or objectives?

- What are the key lessons learned (both positive and negative) about implementation of the project that can be drawn upon to inform future programming?

3. METHODOLOGY

3.1 Study design and source of data

The end of project review follows institution based cross sectional survey design and utilized both qualitative data quantitative data collection techniques to gather the required information and to document project achievements.

Key informants for the review included officials and key program people from the Federal Ministry of Health, Regional Health Bureaus, Zonal and Woreda Health Offices and Community Based Organizations who benefited from the different components of the project. The documents reviewed included project proposals, annual reports, summery of training reports and the mid-term review report.

3.2 Methods

The methodology of the assessment consists of:

- Review of the project documents including the Project Technical Proposal and annual reports.
- Analysis of IntraHealth Monitoring and Evaluation data.
- Visit to the Federal Ministry of Health, Regional Health Bureaus, Zonal/Sub City/City Health Departments, Woreda Health, selected Health Centers and Community Based Organizations (CBOs) located in five regions namely Addis Ababa, Amhara, Oromia, SNNPR and Tigray.

A total of 37 respondents representing Health Centers, Regional Health Bureaus, Zonal Health Departments, City/Sub City Heath Departments, Woreda Health Offices and Community Based Organizations involved in CPMTCT project intervention were interviewed. The informants were chosen considering the relevant position they hold in their respective organization and their knowledge of CPMTCT project.

The methodology was designed to get both qualitative and quantitative information to document project achievements and to a lesser extent processes and perception of key partners on how the IntraHealth strategy and project inputs and processes contributed to the outputs and impacts observed in the respective regions. Whenever multiple sources of the information were available about a specific issue triangulation of the qualitative and quantitative data was done.

3.3 Review tool and presentation of the review findings

The review tool, a structured in-depth interview guide, attached in Annex 3, was designed to answer eight key review questions outlined in the Terms of Reference. The tool contains a total of 75 indicative questions grouped under 25 themes and four review objectives. In depth interviews with key programs persons from Regional Health Bureaus (RHBs), Zonal Health Departments (ZHDs) and Woreda Health Offices (WrHO), and Community Based Organizations (CBOs) were conducted using local language.

Results of the key informant interviews were thematically summarized and the findings were presented as source documents for analysis and report writing. The findings are grouped under the four major project objectives and presented in such a way that results answer the eight evaluation questions outlined in the Terms of Reference. Where appropriate, very informative and special descriptions forwarded by interviewees were quoted word by word to corroborate the key findings.

For the purpose of this review, the following scales were used and applied in the final report:

- 'Majority/Most' refers to ¾ of participants;
- 'Minority/Few' refers to ¼ of participants

Less than ¼ of participants was considered outlier respondents and more than ¾ was termed 'almost all' or 'all.' The terms "half of the participants", "Some of the participants" and "Many of the participants" were used whenever deemed appropriate.

As part of the data analysis process, the secondary data extracted from the annual reports and IntraHealth monitoring report were used to triangulate the findings obtained from the qualitative data.

3.4 Ethical Considerations

To ensure the willingness of the respondents to participate in the review, each interviewee was briefed about the goal and objectives of the review and verbal consent were obtained before involving them in the discussion. To maintain the privacy of the discussion interviews with each key informant were conducted in a private place where the discussion could not be overheard by a third person, and the confidentiality of information was assured by omitting names and specific addresses of the interviewees from the report.

3.5 Limitations

This review was conducted within a very short period of time and covers only a sample of facilities supported by the project. A total of 16 days were made available for the team to conduct document review, filed visits to 5 regions, 10 zones/city and sub city health departments, 10 Woredas and 10 health centers and CBOs and write the review report. The sites covered by the review were selected on bases of convenience from project supported facilities and as a result it was not possible to compare the views of stakeholders from Health Centers with and without intensive mentoring support "Direct" and less intensive support "Indirect".

4. REVIEW FINDINGS

4.1 General

In all the five regions there are specific departments or units who are mandated to lead and coordinate the HIV/AIDS response activities of all key stakeholders. To facilitate this process, the regions have established platforms such as Regional Health Partner's Consultative Committee with broad participation of key stakeholders from public, NGOs and CBOs (including civil society groups and association of people living with HIV/AIDS) to which IntraHealth is an active member. As such IntraHealth closely works with the RHAPCOs/RHB and provides support in the development of strategies, guidelines and tools, as necessary. It also participates in providing trainings and designing and conducting surveys to generate strategic information useful for planning.

Underscoring the key role IntraHealth played over the last five years in strengthening the health systems in general and MNCH/PMTCT services in particular and its added values, a key informant from Tgrai RHB remarked;

> *"IntraHealth is focused on addressing felt and identified needs and priorities; and supports facilities that serve hard-to-reach populations thus promoting equity. It supports rural health centers to improve their capacity for delivery of MNCH/PMTCT services. It has adapted its design to our local needs and priorities and is our model to engage with other stakeholders."*

IntraHealth followed a consultative approach in planning and implementation of its activities and complemented ongoing capacity development and systems strengthening efforts of the respective regions. Appreciating the consultative approach the organization followed, a zonal health office key informant from SNNPRR noted;

> *"IntraHealth works within the existing system. We jointly plan and implement the activities; and hence the support is aligned to our work plan."*

IntraHealth program inputs ranged from building leadership capacity of program managers to technical and logistics support for health centers; to improving community systems to create demand and increase uptake of MNCH/ PMTCT services. Underscoring the relevance of the inputs to improve facility level service delivery, the head of a health center from Tigray noted;

> *"The logistics and technical support from the organization has enabled us to train our midwives, clinical nurses and health extension workers; and the different guidelines and tools developed have improved our service delivery. We do appreciate the inputs and the mentorship provided by the program officers from IntraHealth who regularly visit us for supervision and training."*

While the above are reflections of the added values from the project as observed by management and technical personnel who had direct roles in the planning and implementation

of AIDS response, the observation from the beneficiaries and members of CBOs is not any different. Reiterating this feeling a key informant from Tesfa Hiwot HIV positive women association stated;

> *"Through the support of IntraHealth and other similar organizations, our members not only directly benefited to live a positive and productive life but are also able to support other mothers to enroll and adhere to their PMTCT schedule, and deliver healthy babies. This was mainly possible through training provided to our members who serve as women support groups."*

Consistent with the views and observations of the program managers, health care providers and IntraHealth program managers believe the project was effective in strengthening MNCH/PMTCT services. Highlighting the key outputs a regional project manager remarked;

> *"As member of different TWGs, IntraHealth supported trainings of program managers, nurse midwives, community health workers and women groups. It organized training of trainers and mentors and supported cascade trainings."*

An important aspect of IntraHealth project implementation was its appreciation of local challenges and needs, and adoption to the specific context of the project regions, With this regard, the project has supported local initiatives as can be noted as observed by an IntraHealth Manager,

> *"There are PHC level meetings but without guide. Thus, the RHB requested support from PHC meeting guide which defines the scope, purpose and process and on how to monitor follow up actions. IntraHealth played key role in this, and this served as a model for a national guideline."*

4.2 Project performance against the four project objectives

The different sections below include review findings grouped under the four project objectives addressing the review questions presented in the Terms of Reference:

4.2.1 Objective 1: Build the capacity of RHBs, Zonal and Woreda health office and health providers in MNCH and PMTCT technical and program management skills

Activities under this objective aimed at strengthening the ability of the responsible people working in the health system (Regional, Zonal and Woreda Health Offices and Health Centers) and the community level partners including CBOs to lead, advocate for, manage and evaluate quality community MNCH/PMTCT services, with the aim of the transferring full responsibility for managing services to local authorities and community organizations.

4.2.1.1 Different approaches employed to build the capacity of managers and health workers at different levels

Overall, data from the field shows that IntraHealth followed different approaches to build the capacity of managers and health workers at different levels. The summary of key approaches employed by the project to build capacity at different levels include:

a) **Training**: Both technical and management/leadership skill trainings for individual service providers and managers were regularly organized. Technical trainings were organized often more than twice a year and additional trainings were organized based on gap identification during regular mentoring and supportive supervision visits and emerging interest at the regional level.

   Five regional health bureaus, 244 WrHOs, 519 HCs and 22 CBOs benefitted from the different trainings provided by the project. A total of 20,096 people from the different levels within and outside the health system including Midwifes, HEWs/UHEWs, community volunteer and others from ZHDs, WrHOs, HCs, CBOs/CSOs, HPs and communities benefited from the trainings. The CB trainings organized by the project included basic and refresher trainings, in service trainings, pre placement trainings and Training of Trainers and cover about five major training topics.

Table 1: Summary of different trainings conducted by region, CPMTCT project, October 1st 2009 – November 28, 2014

Training topics	Addis Ababa	Amhara	Oromia	SNNPR	Tigray	Total
Comprehensive MNCH/PMTCT Training[1]	1505	3045	2028	1618	1947	10,143
Performance Quality Improvement and Supportive Supervision	421	324	349	277	581	1,952
Basic Mother Support Group training	226	189	182	129	172	898
Demand Creation and Community Mobilization	420	1788	1163	1469	1202	6,042
HMIS and Supply Chain Management	99	129	86	174	573	1,061
Total	**2,671**	**5,475**	**3,808**	**3,667**	**4,475**	**20,096**

[1] Note: Comprehensive MNCH/PMTCT Training1 includes basic MNCH/PMTCT, Basic Emergency Obstetric Care, infant and young child feeding and HIV rapid testing, CD4 and dried blood spot HIV testing.

Training was specifically provided for heads of departments/units on leadership (project management and supervision), finance and logistics managers, pharmacy professionals, nurse midwives (basic emergency obstetrics care, maternal and child health, PMTCT, Infant and Young Child Feeding, Dried Blood Sample taking, Logistic Management System (LMIS) and HMIS), and for health extension workers (on PMTCT, Behavioral Change Communication (BCC) and Community Mobilization (CM), Integrated refresher course on clean and safe delivery). Similarly, women support groups and care providers were oriented on preventive practices, benefits of PMTCT, and home-based care. Home-based care coordinators and project officers from CBOs like Amhara NAP+, Tila PLHIV Association and Tigray Tesfa Hiwot HIV positive women association were also trained.

Furthermore, training was provided on continuous quality assurance which is complimentary to an ongoing activity supported by IntraHealth and other partners. At facility-level infection prevention/control committees were established and health care providers and PMTCT mangers were trained on different issues. Such as quality improvement (QI), infection control, counseling, testing and care and support services. The QI training has enabled program focal persons and health managers to use the QI guidelines and tools which are made available by the project.

It was also noted that as part of the sustainability strategy and with the objective of having a critical number of well-trained people at different levels within the health system, the project supported TOT trainings for about 711 health workers. The TOT trainings cover eight different topics including HCT, HMIS, MNCH/PMTCT, MSG, PIQA/SS, and BC/CM for MNCH/PMTCT.

Overall it was noted that the different trainings have contributed to improved coverage and quality of services with a positive outcome in prevention of mother-to-child transmission of HIV and in addressing other MNCH issues. This was evident from the remark of a key informant from a health center in Amhara.

"Last year we had 6 pregnant mothers enrolled to our PMTCT program who delivered babies; by the end of the follow up period none of the newborns was HIV positive."

b) Mentoring: IntraHealth has trained mentors for the regions covered by the project. These mentors are often recruited from Health Centers and the Woreda Health Offices to take over from the project mentors. However, during this review it was noted that most mentors trained from the government health system did not start their mentoring role. Nonetheless, designated IntraHealth staff undertake routine mentoring as noted below by a key informant from a health center in Amhara.

"IntraHealth staff show how to plot and use parto-graph to our midwives and now using a parto-graph for every women admitted to our labor ward for child delivery has become a normal working procedure."

While explaining the potential role of the mentors trained by the project, an RHB official from Oromia said:

"There are 24 trained mentors in our region. These mentors are going to be relieved of their routine responsibilities and do the routine mentoring moving from facility to facility. We have organized logistics that they will soon start their mentoring role."

c) **Joint Supportive Supervision (JSS) and Follow up Supportive Supervisions (FSS):** Supervision is an important capacity building intervention. IntraHealth organizes joint supportive supervision quarterly with a monthly follow up supportive supervisions. All HCs supported by the project benefit from the JSS whereas the project staff conduct FSS visits to more intensively supervised/mentored HCs. During the JSS visits CPMTCT project officers, representative from Zonal Health Department, the Woreda Health Office and the respective facilities visit programs at different levels. It was learned that based on observations and discussions made with frontline service providers both at facility and community level, feedback is solicited and shared with different units in the health centers to take appropriate measures against the identified gaps and problem areas. FSS are also conducted with MSGs and DCCM sites to mentor, support and capacitate MSGs, HEWs and HC staff on community mobilization, documentation, and reporting and referral systems. This often helps to increase service uptake at priority health centers through referrals and community-facility linkage. Explaining his experience in this area a health center head said:

"IntraHealth staff regularly comes to help us with the intervention. He considers himself as part of us. For me this is especially of IntraHealth as compared to other partners who I feel are rather fault finders."

Similarly, underscoring the relevance of supervisory support, a director of a Health Center from Amhara region remarked;

"Regular supervisions have contributed to identify performance gaps and technical and managerial needs, and to seek solutions to address these gaps."

d) **Regular reviews**: Regular meetings are organized to jointly review accomplishments, successes and challenges encountered. These review meetings serve us as forums to share knowledge, skills and best practices. Recognizing the benefits, quarterly, bi-annual and annual review meetings are conducted at different levels. These review forums are organized with the leadership of the respective regional health bureaus and often technically and financially supported by IntraHealth.

The reviews meetings are conducted at different levels of participation. At the regional level, there is a broad participation of stakeholders through the stakeholders committee which serves as a shared forum for government and non-government stakeholders. At zonal and woreda levels the number of stakeholders is far less but regular reviews take place. Similarly, community level reviews take place with the participation of HEWs and women development army volunteers.

It was evident that such reviews conducted on regular bases provided additional insights that helped to improve on routine MNCH/PMTCT interventions both at facility and

community levels. Emphasizing the importance of the review, a head of a health center remarked,

"We meet and review activities with community level steering committee which is tasked with community mobilization."

PMTCT performance data from community level were compiled and reported to health centers where the PMTCT nurse reviews and provides feedback to HEWs. The HC data were then consolidated and forwarded to the RHB and further feedback was given. Areas for improvement were communicated both during supervisory visits and quarterly performance review meetings. On the importance of the practice, a key informant from a health center noted;

"There is a weekly data review session which looks to the report of the HEWs. We provide direct feedback to them at the face-to-face meetings and we also do follow-ups on the actions taken."

e) **Development of manuals, checklists and guidelines**: Different materials including tools, manuals, checklists and guidelines were developed, tested and applied for training, supervision, client referral and service provision. Such materials were found to be in use in all the regions. It was reported that the project has produced and distributed 121,501 copies of different job aids to assist the MNCH/MTCT service provision at the HC and community levels. While explaining the inputs of the different materials provided by the project a key informant from a health center from Amhara region said,

"*All materials delivered by the project were useful. The referral slips and the wall chart were particularly helpful to facilitate the referral linage between the community level providers and the health centers and trace HIV positive women and their children who defaulted from the regular follow up."*

4.2.1.2 Capacity building support at FMOH level

Representative of the Federal Ministry of Health acknowledged the prominent contribution of IntraHealth in building MNCH/PMTCT related capacity at the ministry and other levels. Both as a member of a number of different national TWGs (including National PMTCT, Safe Motherhood, FP, newborn care, M&E, National Quality Initiative, MSG, Nutrition and HIV, continuing professional development and Human Resources for Health (HRH) TWGs and as a TA provider), IntraHealth supported the ministry during the preparation of national strategic documents and guidelines including: Road Map for Accelerating Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia 2012-2015, national PMTCT Guidelines, National PMTCT Accelerated Plan and Implementation Manual, National Accelerated Scale Up Plan for PMTCT Services, Complementary Guidance Note for CQI, The National Strategic Plan for Elimination of Mother to Child Transmission of HIV, National Guidelines for Continuing Professional Development and Maternal Care Quality improvement Self-Assessment Tool for Hospitals 2013.

The training packages developed/revised with a technical input from and with an active participation of IntraHealth staff include: Infant feeding counseling in the context of Maternal HIV Infection for Ethiopia, National Comprehensive PMTCT/MNCH Training package, PMTCT Option B+ Update training package and Basic Emergency Obstetric and Newborn Care (BEmONC) training package, revision of the national PMTCT training materials, preparation of a safe motherhood/PMTCT plan, preparation of continuous Quality Improvement (CQI) supplement guide; option B+ implementation guide, option B+ basic and updated training packages and provision of different trainings including the national MSG TOT, training of master PMTCT trainers, etc.

Acknowledging the inputs of IntraHealth for the national PMTCT program, a key informant from FMOH said,

> *"I would say that IntraHealth is a pioneer in PMTCT program in the country. They did exceptionally good job in supporting the country's health system with the CPMTCT program."*

4.2.1.3 Capacity building on leadership and management skill at RHBs, ZHDs, WrHOs, and health centers

It was also acknowledged that managers and professionals working at different levels in the health system i.e. RHBs, ZHDs, WrHOs and health centers benefitted from the trainings organized by IntraHealth on different issues like leadership and management skill, PQI and supportive supervision, IPLS and HMIS. Interviewees reported that the different trainings they received from IntraHealth on management and leadership skills and on related technical issues helped them to improve the MNCH/PMTCT services provided at the health center and community level.

Some said that the basic trainings they received as well as their participation in the regular joint supportive supervisions and joint review meetings helped them to identify and solve problems, prepare plan for MNCH/PMTCT services for their respective health facilities.

Explaining the benefits of the capacity building component of the project to the health center he leads, the manager of one of the health center from Amhara said,

> *"The basic leadership and management skill training that I received as well as the other related trainings me and my colleagues from the health center received on MNCH/PMTCT, BEmONC, PQI&SS, IPLS and HMIS enabled us to assess our capacity, identify service gaps at our health center, strength the PHC unit, coordinate activities with others within the health system, plan integrated MNCH/PMTCT services, improve the service quality, create a functional referral linkage between the MNCH/PMTCT services provided at the health center and community level."*

On the same note, a key informant from Tigray remarked;

"Training was specifically provided for heads of units on leadership (on project management and supervision), finance and logistics managers. IntraHealth project activities targeted 122 health centers, of which 96% are located in rural areas of the region. Nonetheless, IntraHealth extended support to more facilities where there was need for training and commodities."

On the capacity building support provided to the RHB and others in the health system a key informant from the SNNPRR Health Bureau said,

"At regional level IntraHealth provided leadership skills trainings and training of trainers on: Quality improvement, Demand creation and coordination trainings (how to network our work from RHB to HFs level). They also technically supported us to prepare a transition plan to sustain and expand the project activities after the project period. The RHB and ZHDs and WrHO all benefited from the support."

The use of MNCH/PMTCT data collected both from the health facilities and community level for performance monitoring, program planning and service quality improvement, as well as the regular joint supportive supervision and clinical mentoring for skill gap identification and gap filling and service quality improvements were also the other frequently mentioned benefits of the different capacity building interventions provided in the form of trainings on leadership skills, project management and coordination.

Many also believed that IntraHealth has inculcated irreversible and positive changes in a way managers working at different levels see and manage MNCH/PMTCT services provided at different levels. They attributed these changes mainly on the trainings and mentoring of leadership and management, the use of different planning and quality assessment and quality assurance tools, as well as the integrated and joint monitoring mechanisms introduced by the project.

4.2.1.4 Capacity building on MNCH/PMTCT technical competence

Health professionals from health centers supported by the project have benefitted from the technical trainings conducted on different MNCH/PMTCT topics. It was consistently pointed out that midwives and nurses working in health centers have extensively benefitted from the different technical trainings. Some also pointed out that other health center staff including laboratory technicians and pharmacists have also participated on different technical trainings provided by IntraHealth.

The common trainings conducted by IntraHealth to build the technical competence of providers on MNCH/PMTCT include: basic PMTCT, PMTCT option B+, BEmONC, Infection Prevention (IP), Performance Quality Improvement (PQI) and DBS. There were few cases in SNNPR who mentioned training on long acting family planning (FP) methods. While others mentioned that topics on FP were covered as part of the PMTCT trainings.

Interviewees widely acknowledged that the different trainings provided by the project and the follow up mentoring and technical support provided by the IntraHealth mentors helped to improve the overall technical competence of the health center staff on MNCH/PMTCT. Many also reported that this has greatly contributed to the overall improvement in the quality of MNCH/PMTCT services provided both at the facility and community levels. Explaining the different changes he observed as the result of the trainings and mentoring support provided by IntraHealth, the manager of a health center from Amhara said,

> *"The different trainings we received from IntraHealth helped us to provide integrated MNCH/PMTCT services at our health center. Now, the staff of our health center has better knowledge and skill on MNCH/PMTCT. To mention some, our staff started to take adequate time to counsel each pregnant woman about pregnancy and childbirth. The midwives make sure that all pregnant women know about danger signs related to pregnancy child birth and work with them to prepare birth preparedness plan. After receiving the BEmONC training, all midwives working in our health center started to prepare partograph to follow labor and preparing partograph has become a normal working procedure in our health center. Our staff started to follow strict infection prevention procedures. We also established good referral linkage with the CHWs. All these changes are due to the different trainings and regular mentoring support provided to our health center by IntraHealth."*

BEmONC Training, Tewolde Legesse Health Science College Mekele

Respondents from the different regions also acknowledged that the project supported Woreda Health Offices to strengthen the Primary Health Care (PHC) units (the linkage between health center and health posts). In this regard, it was noted that in the first two years of the project different trainings were provided to HEWs, CHWs and religious volunteers on demand creation, PMTCT, data collection and reporting etc. and this has helped their active involvement in regular planning and review meetings, outreach MNCH/PMTCT service and creating a two way referral linkages between the community level providers and health centers.

It was also noted that in most cases the training support provided to the community level providers was complemented by skill transfer opportunities. In this regard it was learned that every health center staff is allotted a specific cluster in the community where she/he is expected to provide regular technical support to HEWs and provide outreach services like ANC at health posts.

Woreda health officials and health center heads across all regions noted that, as a result of the capacity building interventions supported by IntraHealth at the community level, HEWs started to have more of a role in linking their services at community level with MNCH/PMTCT services provided at health centers. For example, in Amhara and Addis Ababa, it was reported that HEWs started to be directly involved in different MNCH/PMTCT service provided at the health center level. This has given them an opportunity to build their confidence and improve their professional skills. Reiterating the benefits from this the head of a Primary Health Unit remarked

"After training HEWs, facility level deliveries have increased."

4.2.1.5 Capacity building for community based organizations (CBOs)

About 115 people including, leaders, professional staff and volunteer members of 22 regional and woreda level CBOs participated in the different trainings supported by the project. The trainings provided to the CBOs were focused mainly on leadership skills, financial management, monitoring and evaluation, project management, grant/proposal writing, and MSG.

It was widely acknowledged that the different trainings enabled the CBOs to improve their financial management, better manage the IGA activities, prepare grant proposals and mobilize resources. The CBOs who benefited from the different capacity building support were also reported to have started to effectively coordinate their activities with the Woreda Health Offices/HAPCOs, and health centers that are active in community PMTCT. Members of the CBOs and Community MSGs have also started to assist the CHWs in mobilizing the community through health education and advocacy works. This linkage also helped members of the PLHIV associations who are working as community MSGs, case manager and adherence supporters in the health centers participate in identification and referral of the pregnant women for HIV testing, ANC and health facility delivery, directly contributing the observed PMTCT service uptake observed in their receptive areas. They share their experiences to pregnant women during pregnant women conference and coffee ceremonies. Underscoring the relevance of engaging PLHIV associations to improve uptake of PMTCT services, chairperson of PLHIV Women Association from SNNPRR noted,

"Our members do home visits and encourage pregnant mother to attend ANC and deliver in health facilities. We benefit from the trainings and educate others, too."

4.2.2 Objective 2: Increase access to MNCH/PMTCT services through providing facility and community services and improving bi-directional linkages/referrals between PMTCT/MH services at the community, health post, health center and hospital level

Activities under this objectives focuses on increasing the supply and availability of MNCH/PMTCT services at the health center, health post and community level, addresses the importance of improving referral linkages, and introduces innovations to services.

A total of 519 HCs from five regions benefitted from the different types of CB supports provided by the CPMTCT project. All the health centers that are supported by the project are capacitated to integrate MNCH/PMTCT services both at facility and community levels. About 453 (87.3%) of the Health Centers implemented Option B+ and have at least one nurse or midwife who has taken Option B+ training.

IntraHealth has substantially contributed for the improvement in the Antenatal Care, Delivery, Family Planning (FP) and PMTCT services provided in the 519 HCs through training on BEmONC/PMTCT and other relevant issues and through mentoring provided to health care providers working in labor and delivery wards and PMTCT units. The project has also supported 368 HCs with newborn corner materials[2]. This specific support builds the capacity of the HCs to manage common newborn problems like neonatal hypothermia and asphyxiation.

It was reported that in all areas coved by the review, ANC facilities, outpatient visits, and premarital checkups were used to improve HIV counseling and testing uptake through provider initiated counseling and testing (PICT). In some regions like Tigray the follow up of clients and partners of HIV positive pregnant mothers used mobile home-to-home visits, writing invitation letters, making telephone calls, and personal communication with their male partners during delivery. Following delivery, post-natal and newborn care are integrated at facility level. Both mother and neonate are given appointments for follow-up at one visit where services are provided at one ART clinic.

As explained in the previous section as the result of the training of health care providers and improved capacity of facilities, access to MNCH/PMTCT services has witnessed evident positive changes in all the visited health facilities and woredas covered by the project. In this regard, the visited HCs from all the five regions reported a marked and progressive rise in ANC and PNC service uptake and facility delivery. It was also acknowledged that the number of pregnant women who tested for HIV and received test results, the number of HIV positive pregnant women who deliver in health facilities and the number of children born from HIV positive

[2] The newborn materials are neonatal silicone resuscitators, neonatal suction device, salter 914 baby scales, ADC 605 stainless steel infant stethoscopes, and newborn bed with radiant heater.

women and who get prophylaxis have also shown a progressive rise during the course of the project period.

The regular health facility report collected from the HCs supported by the project showed that over the five year period covered by the project 1,724,855 new ANC visits were made and 348,543 deliveries were attended by skilled birth attendants with 94% and 103.6% achievement of the project targets respectively. As shown in figure 1 below, in CPMTCT supported sites the number of new ANC attendants and deliveries attended by skilled birth attendants has also shown a progressive rise during the course of the project period reflecting the improvement in access to essential maternal and child health services.

The report further showed that 1,393,290 pregnant women were tested for HIV (82% of the program target) and out of which 7,855 HIV pregnant women tested positive. During the same period 4,974 HIV+ pregnant women living in CPMTCT supported sites received ARV prophylaxis to reduce risk of mother to child transmission (63% of the HIV positive pregnant women identified), and about 3,087 deliveries from HIV+ women were attended by skilled birth attendant.

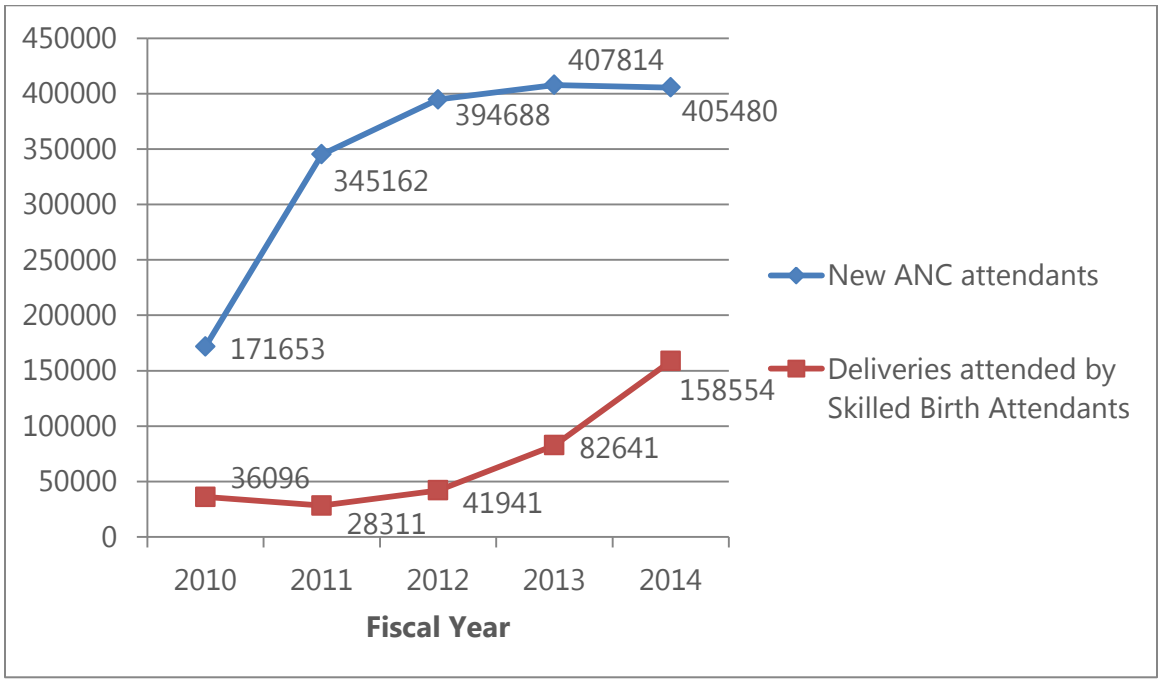

Figure 1: New ANC attendance and deliveries attended by skilled birth attendants in HCs covered by the CPMTCT project, 2010-2014

On the role of the project in increasing access to MNCH/PMTCT services, a regional HIV/AIDS and multi scrotal coordinator remarked;

> *"Through their support, we have now expanded PMTCT services to 89% of the government health facilities and all our health centers have started implementing Option B+".*

The observed improvements in access to MNCH/PMTCT services in areas covered by the CPMTCT project were found to have their bases on multiple factors that include the effort made to provide integrated quality of MNCH/PMTCT services at community and facility level, creating a functional referral linkages between health facilities and community providers, education and advocacy at community level and associated improvement in the level of awareness of the community about the benefits of MNCH/PMTCT.

Some of the measures other than capacity building that have contributed to improvement are in the next section.

4.2.2.1 Integration of services

In all visited health centers the different MNCH/PMTCT services provided are reported to be integrated. It was noted that at the health center level integration of MNCH/PMTCT services starts at the planning stage and extends all the way to recording formats as well as reports. Health professionals working in the MNCH/PMTCT units of the health centers are reportedly involved in program planning, implementation, and joint monitoring and supportive supervision, and this has contributed to the smooth integration of services.

The role of the different trainings and tools used by IntraHealth were widely acknowledged as contributing for the integration of MNCH/PMTCT services both at health centers and community level. These include the CPMTCT project performance and quality monitoring checklist as well as mentoring, logistics and supply support provided.

As noted during the visits to the different health centers, units that provide different MNCH/PMTCT services are situated next to each other and this makes the service integration and information sharing about each client simpler. Moreover, all staff members working on MNCH/PMTCT services received comprehensive trainings on related issues and this has facilitated the different services to be given by any one staff at any moment the client appears in the health center. So, according to the respondents all possible causes that contribute for delay in service provision are avoided and missed opportunities due to provider absence are minimized.

Explaining the integration of the different MNCH/PMTCT services at the health center he leads, the head of a health center in Amhara said.

> *"Woman who directly come to the ANC unit of our health center or referred to the HC by the HEWs would be automatically linked to the different service points such as HCT, PMTCT, ART, delivery, counseling on nutrition and breast feeding etc. Those women who deliver in health facilities or delivered at home and referred to the health centers are also linked to PNC and other relevant services like Family Planning."*

It was also noted that, like the health centers, many health posts also managed to integrate different MNCH/PMTCT service at their level.

4.2.2.2 Creating a functional referral linkage between the community level stakeholders and health facilities

It was noted that in the majority of the cases stakeholders involved in the CPMTCT project did a remarkable job in establishing and strengthening a two way referral linkage between the health centers/health posts and the community level actors i.e. community members organized as health development army, members of PLHIV Associations, CBOs, Community Health Agents, Community MSGs etc.

As a takeoff activity in creating a functional referral linkage between the community level stakeholders and health facilities, IntraHealth trained health extension program (HEP) supervisors and MNCH focal persons as trainers to train Urban HEPs, HEWs and VCHWs in antenatal care ANC/CPMTCT demand creation and referral. Many noted that this activity played an important role in cascading the training to the community level providers and create the desired referral linkage between the community level stakeholders and health facilities. Referral slips/cards produced and supplied by the project also contributed to the smooth implementation of the referral linkage established between the facility and the community level providers.

It was learned that in most cases a recently formulated community structure known as Health Development Army (HDA)[3] is facilitating the role of HEWs in creating a referral linkage between the community level providers and health centers. This was made possible by identifying and referring pregnant women, mothers and children to health facilities for different PMTCT/MNCH service. In the majority of the cases HEWs at the community level refer pregnant women to the health center using a referral slip developed by the project. In regions like Amhara, SNNPR and Tigray, members of local PLHIV associations are involved in referring their members and other pregnant women directly to the health centers for MNCH/PMTCT services.

The role of the HDAs on advocacy and creating referral linkages between communities and health facilities was widely acknowledged in different regions and at different levels, in this regard a key informant from a Health Center in SNNPRR said,

> *"Under the catchment of our health center, there are 124 HDA leaders who have direct reporting linkage with the HEWs. They closely work with the HEWs on awareness creation and advocacy on MNCH/PMTCT issues. The linkage established between the HDAs and HEWs helped us not to miss single pregnant women from our service."*

[3] In recent years the government started to organize mothers living in five adjacent households in a given community to form a neighborhood group known as a development army. Members of the development army are expected to meet frequently to discuss and address several health and development issues including women's employment, environmental sanitation, HIV/AIDS, Family Planning, maternal and child health issue etc. Then six teams of development army (30 mothers) are linked to one HEW.

To facilitate the community facility referral linkage, a women referred by the community level providers will be directly received and assisted by health center staff working in MNCH/PMTCT unit so that the pregnant women gets appropriate service without delay. Feedbacks to referral will be maintained in the box dedicated for this purpose. Supervisors collect the feedback and share the information with HEWs who follow the clients (irrespective of their HIV status) at the community level, while in Addis Ababa HEWs collect the feedback themselves and continue their follow-up. Report on the referral made from the community to the HC showed that about 334,647 such referrals were acted upon with 145% of achievement of the program target.

Moreover, it was noted that in some of the visited health centers, information on each woman referred by CHWs and CBOs to the health centers for different services and the outcome of the referral made to the health facilities are discussed on weekly meetings organized between the health center staff and HEWs and their supervisors.

It was noted that the established community facility referral linkage gives special emphasis to and ensures that the HIV positive pregnant women are linked with and get additional counseling and psychosocial support from MSGs (in health centers where MSGs are active). Members of PLHIV association who work as volunteers and linked with the HEWs also provide the necessary psychosocial support to pregnant women and assist HEWs and MSGs in defaulter tracing.

This practice is also assisted by regular visits made by the HEW to the home of HIV positive pregnant and exposed infants. Health centers also use a tracking/follow up wall chart for early identification and tracking of HIV positive pregnant women and those women with exposed infants who fail to appear to the health center on the date of the appointment.

The routine practice of recording the full home address and phone number of the HIV positive pregnant women and her exposed infant both on the client card and the tracking chart as well as the functional linkage created between the health centers and the health extension workers helped with early detection and tracking of the HIV positive pregnant women and their new born babies who failed to appear to the PMTCT/MNCH units of the health center on the date of appointment. In this regard it was noted that out of the 7,855 pregnant women who were identified as HIV+, 4,974 (68%) were put on ARV in health centers supported by the CPMTCT project). At the same time the tracking mechanism institutionalized by the project helped to track and identify that additional 1,462 HIV positive pregnant women living in non CPMTCT sites were on ARV and this brings the proportion of HIV positive pregnant known to be on ARV from 68% to 82%.

Overall it was noted that the practice of using regular review meetings conducted between IntraHealth mentors, health center staff, Woreda Health Offices, HEWs and their supervisors to check referral uptake data, identify gaps and related causes helped to draw action plans and forward alternative solutions for the problems. This practice was reported as contributing in strengthening the two ways referral linkages established between the health centers and community level providers.

4.2.2.3 Innovations that contribute for increase access to MNCH/PMTCT services

Interventions by IntraHealth has introduced and/or strengthened several innovations that contributed to improved access and quality of service provision at different levels. These innovations are noted at community, facility levels and system levels.

a) Community level

The review team strongly believes that the project uses an innovative approach in using the existing community structure to promote the facility and community level referral linkage in MNCH/PMTCT services and this has contributed its part in increasing access to MNCH/PMTCT services.

At the community level, HEWs were expected to meet expectations laid down in the health extension package. As such, HEWs work closely with community structures (HDA, 1-5 networks, kebele leaders) all of which were introduced by government. At this level the role of community structure to detect cases and inform HEWs was strengthened. It was gathered that in all communities the structures were found to play an important role in identifying pregnant women and bringing this to the attention of HEWs. Regular conferences at the community level were useful in identifying pregnant women for enrolment and ANC follow up.

HEWs refer clients to health facilities using referral cards. The referred client gets appropriate support from the health center and then goes back to the community for closer follow up by HEWs according to feedback provided from the health center. It was learned that the different inputs from the project including the referral cards supplied HEWs and community volunteers, outreach services provided by health center staff, and the pregnant women conference supported by the project contributed to the referral linkages between HEWs and health centers being smooth and strong.

Health providers from health facilities visit communities on a regular basis to provide technical support to HEWs. This is found to be critical requirement from professionals since it is one performance indicator for every professional working at the health center level. This was introduced by the government but was strengthened by IntraHealth through providing guidance so that clients could get proper guidance at the community level. In Tigray, SNNPRR and Amhara it was gathered that regular outreach programs provide services at community level which benefited PMTCT programs. Underscoring the importance of community outreach in increasing demand and access, a key informant from a health center in Tigray noted,

> *"We have the health development army who are organized in a team of five women, these are linked to HEWs and both play important role in mobilizing communities. Through these structures the health center staff provides outreach services to the community."*

b) Facility level

A mother support group (MSG) is a group of five or more HIV positive women who have had a pregnancy and delivery experience while HIV positive. HIV positive women who volunteer to work as MSGs are provided with a formal training conducted following a nationally accepted standard training curriculum. This group is organized and functions at health facilities. Health centers often organize a working site (room) with the necessary IEC/BCC materials within the health center compound where the MSGs perform their function.

The project supported Mother Support Groups (MSGs) as a key strategy to enhance MNCH/PMTCT services uptake through demand creation, creating referral linkage between the community and HCs, counseling and follow-up of HIV+ mothers and mobilizing the target groups to use the available MNCH/MTCT services. During the five year period the project supported 230 MSGs with 3,241 members. It was reported that about 98% of the MSG mothers were on ART and 96% of the pregnant MSG mothers delivered in health facilities. It was further noted that 2,273 of the babies born from the MSG mothers were on ARV, that represents 97% of the members who delivered; and out of them, 1,141 had their confirmatory tests and 1,118 (98%) were found to be free from HIV. This could be cited among the most important achievements of the project related to the use of MSGs in improving the MNCH/MTCT service uptake.

As a normal working procedure, providers at MNCH/PMTCT units refer every woman who tested HIV positive to MSGs for peer support, guidance and counseling. At the health center level, MSGs organize a group discussion and counseling sessions in a form of coffee ceremony and this facilitates the discussion between the positive mothers and MSGs on multiple issues including partner notification, pregnancy, delivery, family planning, ART, infant feeding etc. Whenever necessary MSGs get support from health professionals from the health center to assist with clarifying technical issues to the participants of the discussion. MSGs operating in the health centers often play an important role in linking HIV positive women to essential services like institutional delivery, PMTCT and FP. It was commonly argued that MSG initiative is an important success factor for PMTCT service uptake. In some of the visited health centers in Amhara, Oromia, Tigray and SNNPR, all children born from HIV positive women become free from HIV. It was also acknowledged that with MSGs intervention adherence has improved and demands for services have increased tremendously. Emphasizing the role MSGs play in the program, a key informant from a Health Center in Tigray remarked,

> *"We have established MSG in our health center. They provide peer education and share experience to ANC attendants and encourage mothers to adhere to PMTCT programs. They also do follow-ups in coordination with the nurse midwife."*

The project also supported the establishment of 62 Community MSG (CMSG) sites in the five regions. Alike the MSGs, CMSGs trained and supported by the project were also found playing important role in community mobilization and providing psychosocial support for HIV positive pregnant women and their families. Explaining the role of CMSGs in area where she lives a key informant from SNNPRR said,

"The CMSGs working in Hawassa town are members of our PLHIV association. The CMSGs identify and follow all pregnant mothers, lactating mothers and HIV positive women in their catchment area and link them to the nearby Health Center. The CMSG also works with UHEW's during community mobilization and home visits."

c) System level

It was gathered that such innovations are not sporadic. All were planned so as to sustain as a system to ensure access to services and quality. Case detection by community structures and informing HEWs follows specific procedures. In this regard HEWs use referral slip/card to refer a client to health center and feedback is sent back using the same card which has space for feedback. This is one important system at community level.

Health professional's regular community visit and technical support and service provision is guided by formats that are filled and feedback forms provided to HEWs and to the health center. Based on the feedback, follow ups are planned and cross checked.

At facility level service integration is an important innovation the government has taken. Due to such measure mothers access all services from one window without difficulty. The measure taken in training all family health department staff in some regions made it possible to avail service at any one moment since all are capacitated. Furthermore, the institutionalization of MSG provided an impetus to health facility's endeavor to access and rollout PMTCT services.

4.2.3 Objective 3: Increasing demand for MNCH/PMTCT services through community outreach

The demand creation strategies employed by the project include: production of tailored IEC/BCC materials, training materials and job aids, awareness-raising through mass media and community conversation, creating an enabling environment through involving local community leaders and religious leaders, and interpersonal communication through small group discussion and household visits to promote behavior change (referral and uptake of referral for MNCH/PMTCT services).

The key demand creation and community mobilization message topics developed and disseminated using different channels include benefits of ANC, the danger signs of pregnancy, risks related with home delivery, the importance of SBA and HIV testing. The project performance reports showed that about 1,5million people were reached with DCCM messages and of which 40% were men (108% of target). Similarly, it was noted that about 121,501 print materials including job aids were produced and distributed to HCs, HPs and community providers in sites supported by the CPMTCT project (144% of target).

4.2.3.1 Creating a favorable policy environment for MNCH/PMTCT

IntraHealth is one of the active members of the National Safe Motherhood/PMTCT TWG. The project also complemented the national PMTCT initiative by assigning one full time professional who is seconded to the Family Health Department of FMOH to provide the necessary TA to the national PMTCT initiative.

As a lead agency working on Community PMTCT in the country, the organization used different fora including the regular national TWG meetings, annual review meetings and integrated supportive supervision missions to share best practices and experiences in CPMTCT. The CQI tool developed and used to follow the implementation of CPMTCT activities at health centers supported by the project was adopted and included in the national PMTCT training curriculum. The experience of the CPMTCT project was also used as an essential input during the formulation of National Strategic Plan for the Elimination of Mother to Child Transmission of HIV (2013-2015). Nevertheless, a key informant from Tigray noted that frequent change of PMTCT policies and guidelines without documentation of good practices and bottlenecks poses a challenge for replicating good experiences and lessons in formulation of new strategies and targets.

It was widely acknowledged that at regional, zonal and woreda levels the project used different for a including sensitization workshops for community and religious leaders, annual review meetings and integrated supportive supervision to sensitize community, religious and political leaders on MNCH/PMTCT programs and services. According to the respondents, using this approach helped to promote maternal and child health issues as part of the development agenda for the government at regional, zonal and woreda levels. According to many, this has created a change in thinking and improved the level of commitment of political leaders and decision makers so that they make maternal and child health and MNCH/PMTCT services among their priority agenda. In this regard respondents from the Amhara region reported that plans, achievements and constraints related to access to and utilization of MNCH/PMTCT services are discussed at regular cabinet meetings. Similarly, achievements of program targets are often included among the evaluation criteria used to assess the performance of political leaders at different levels.

According to some of the regional, zonal and woreda level health officials the continuous advocacy work on MNCH/PMTCT done at different levels enhanced the willingness of the respective administrative cabinet to allocate a budget for the MNCH/PMTCT services.

It was also noted that in Addis Ababa, the UHEWs who used to be stationed in the Woreda Health Offices are now stationed in the health centers to work under the technical supervision of staff of the health center. This change in of working arrangement helped to link the PMTCT/MNCH activities carried out at facility and community levels.

4.2.3.2 Education and advocacy and demand creation at community level

The project supported health centers, HEWs and volunteer community health workers to work on sensitization and mobilization of individuals, families and communities on MNCH/PMTCT. In this regard, different communication approaches and community level networks like Women Development Army/ Health Development Army, home visits by HEWs and volunteer community health workers, community conversations, coffee ceremonies, pregnant women conference, religious leaders, PLHIVs, etc. were used to improve the level of awareness and health seeking behavior of the community for MNCH/PMTCT services provided at facility and community levels.

Furthermore, interpersonal communications during facility and home visits, group education sessions including school programs, religious gatherings, and special events such as World AIDS Day and International Women's Day rallies were used to reach the community with different messages. In Tigray, special programs for reaching the youth are organized through youth-friendly monthly programs at kebele level. Moreover, public media outlets such as radio were used to create awareness. With this regard, a key informant from Tigray, commented,

> *"Our office [RHB] has regular radio broadcast on local FM 104.4 where public education on HIV/AIDS, PMTCT, and MNCH are relayed to the general public. This has given us access to wide group of audience and complemented other means of communication."*

Effort made by the project to use religious medium to reach, engage and link different target groups with the community and facility level service providers was found to have encouraging results. In this regard, the project trained 180 religious leaders across 36 CPMTCT supported health centers in couples counseling, on the benefits of male involvement in PMTCT services and community mobilization. These groups of religious leaders trained by the project were able to link with the health centers and support outreach activities. During outreach activities the religious leaders assisted with mobilizing the community members to test for HIV. In some areas religious leaders refer pregnant women to health centers for HIV counseling and testing and PMTCT services. It was noted that in FY2012 alone a total of 141,993 persons (118,585 pregnant women and 23,408 male partners) were counseled and tested through these outreach interventions.

On the role of community volunteers and religious leaders on advocacy and community mobilization for MNCH/PMTCT services a key informant from Hawassa, SNNPRR said,

> *"In Hawassa town, volunteer peer supporters and religious leaders play significant role in referring pregnant women to health facilities. They are given referral cards and often refer clients to Health Centers and the Health Centers send them feedback to their referral."*

On the involvement of religious leaders on education, demand creation and referral, a key informant from Dilla town in SNNPRR said,

> *"There are also two churches in Dilla town working with us on awareness raising and demand creation on MNCH/PMTCT. They refer pregnant women to health centers."*

However, it was revealed that in all regions visited, respondents from most health centers, Woredas and zones reported having shortage of PMTCT related health communication materials. They also noted that, unless a specific plan is put in place they would face shortage of health communication materials like leaflets, brochures and posters for awareness raising, advocacy and demand creation.

In four of the five regions like Amhara, Oromia, SNNPRR and Tigray midwifes from the health centers organize regular outreach visits to the health posts to provide key ANC and PMTCT services. The day of the outreach visit is also used to organize pregnant women conference so that midwives and HEW will get the opportunity to provide counseling to HIV positive women, disseminate information about the service and encourage pregnant women to use different MNCH/PMTCT services.

In all regions visited, the use of members of health development army for advocacy on MNCH/PMTCT was also widely acknowledged. As members of the women development army, women meet on regular bases to discuss topics like ANC, facility delivery, HIV testing, and PMTCT. Most of such discussions that take place at community levels are often supported by HEW in rural areas and UHEWs in some urban localities. In rural communities in Amhara, SNNPR and Tigray, health centers in collaboration with the HEW and members of HDA organize regular pregnant women conference where different topics on MNCH/PMTCT are discussed. This forum is widely used to discuss several important issues with pregnant women, including the importance of preparing a birth preparedness plan, pregnancy related danger signs, benefits of delivering in health facilities, HIV testing, prevention of mother to child transmission, stigma and discrimination, partners' involvement, and misconceptions about facility delivery, etc.

It was also noted that in some areas different mechanisms like community surveys and facility level client satisfaction surveys were used to gather information and assess the perception of beneficiaries about the different MNCH/PMTCT services provided both at community and facility levels. Recommendations collected from mothers and other community members in such surveys were used to make delivery rooms and other services at health centers women friendly and culture sensitive. In Amhara regions Traditional Birth Attendants are invited to supplement the effort made by midwives and HEWs to advocate for and mobilize pregnant women to visit health facilities for ANC, PMTCT and delivery services.

It was acknowledged that MSGs working both at facility and community levels played an important role in encouraging HIV positive women to use health facilities for MNCH/PMTCT services. MSGs who are members of PLHIV associations in Amhara, SNNPR and Tigray were specifically reported to have played a significant role in identifying and linking HIV positive pregnant women with both community and facility level MNCH/PMTCT services.

The other important strategy employed by the project to motivate women to deliver in a facility was layette newborn kits/mama kits which were distributed at no cost to babies of mothers delivering in health facilities. In this regard, the project has distributed 113,000 mama kits as an incentive to pregnant women to deliver in health facilities.

In some health centers it was reported that mothers who deliver in the health center are provided with foods like porridge and coffee and according to the head of one health center,

> *"Both mama kit and provision of porridge and coffee to mothers who deliver in the health facility helped to motivate women to deliver in health center and increased facility delivery."*

It was reported that during the five year period covered by the project a total of 541,264 men were tested for HIV (79% of the target). The number of men partners tested for HIV has increased from 3,301 during the first year of the project to 147,401 in the final year of the project. Despite this notable achievement in men involvement in HIV testing, in some regions like Addis Ababa the overall involvement of men in MNCH/PMTCT services was reported to be low.

In some areas HEWs use different opportunities like CC sessions and community gatherings to disseminate information about the importance of HIV testing and encourage men to visit health facilities with their pregnant women. Nevertheless, several barriers continue to hinder progress in the active involvement of males in the program. These include stigma when the pregnancy is out of wedlock and absence of the male partner due to either military service or other work away from home. Commenting on these challenges a key informant from a health center in Tigray remarked,

> *"We try our best to encourage couples counseling and testing, but it is not easy, especially among 'secret second-wife' because the male partner does not want to be seen with the out-of wedlock pregnant mother due to fear that the legal wife might find-out about the affair."*

When probed what options they may use to address this challenge, the same informant noted,

> *"We encourage the pregnant mother to convince her partner to do testing. The other is to use the time of delivery when the partner is likely to show up to the facility as a neighbor visitor along with others. But, even then, only few are willing to take the test."*

On the effort made to improve male involvement in PMTCT/MNCH the leader of one PLHIV women association from SNNPRR said,

> *"Peer support group members and religious leaders work closely to improve male involvement. They conduct regular community conversation and small group discussion with men and encourage them to be tested for HIV and provide the necessary support to their spouses."*

4.2.4 Objective 4: Improve the quality of community and facility level MNCH/PMTCT services

Almost all interviewees acknowledged that in most areas covered by the project, marked improvements have been observed in the quality of MNCH/PMTCT services provided both at health facility and community levels.

IntraHealth provided support to train healthcare providers (nurses, midwives, laboratory technicians HEWs) on PMTCT, basic emergency obstetrics and neonatal care, and MNCH programs. These capacity building activities were implemented in collaboration with the RHB, Zonal and Woreda Health Offices; and hospitals and health centers in the respective woredas. Similarly, community capacity building activities including orientation and training of women support groups, community volunteers, and the health development army were implemented.

In fact, most respondents attributed an improvement in the quality of services to the different basic and refresher trainings and regular mentoring support provided by the project mentors and related knowledge and skill gained by the health professionals working in health centers, health posts and woreda health office. Sharing of experience and best practices during regular meetings, involvement of key stakeholders in program planning, supportive supervisions and review meetings, etc. are the other important inputs contributed for the improvement in quality of MNCH/PMTCT services at different levels.

The use of standard operating procedures and algorithms for service delivery, continuous data quality checks, use of data for planning, monitoring and evaluation, timely identification and filling of skill and supply gaps and creating functional referral linkages between the community level providers and health centers are the other necessary inputs mentioned by the respondents contributing for the observed improvement in the quality of MNCH/PMTCT both at the health center and community levels.

Woredas health offices and health centers alike mentioned the use of complementary continuous quality improvement guidelines and the CPMTCT project performance and quality monitoring checklist as important inputs for the improvement in quality of MNCH and PMTCT services provided at different levels.

IntraHealth supported regional, zonal, Woreda health offices and health centers with identification and timely filling of supply gaps required for smooth implementation of key MNCH/PMTCT services like HIV testing kits, ARVs and laboratory reagents like KOH. The project also provided health centers with essential materials and inputs like basic infection prevention materials and this has helped the facilities to provide uninterrupted quality MNCH/PMTCT services.

It was also widely acknowledged that IntraHealth was regularly monitoring the supply situation at the health center level through supportive supervision and passing the information for action to key actors like RHB, PFSA, USAID and the FMOH. According to many, this has helped the health centers to quickly alleviate the supply shortage they face and provide uninterrupted and quality PMTCT/MNCH services to the beneficiaries.

Many of the respondents also noted that the regular trainings and mentoring provided to the health center staff and CHWs helped to improve the motivation and commitment of health professionals, HEW, community level and others working at Woreda health offices.

It was noted that most of the health center heads measure improvement in the quality of MNCH/PMTCT services at community and facility levels using different outcome variables like: reduced client waiting time, improvement in ANC and PNC service uptake, increases in facility deliveries, increases in the number of pregnant women and their partners who tested for HIV, zero conversion for children born from HIV positive women, absence of maternal death, and increases in the number of pregnant women referred from the community to the health centers for different PMTCT/MNCH services. While explaining the changes he observed in the quality of the MNCH and PMTCT services at health center and community levels he manages, the medical director of one health center in rural Amhara said,

> *"The trainings, technical as well as material inputs we get from the project helped us to improve the quality of PMTCT/MNCH services provided both at the health center and community levels. The project also helped us to establish a well-functioning PHC unit in our catchment area. We closely work with HEW and representatives of the Woreda Health Office to plan, implement and monitor MNCH/PMTCT services. This helped us to create an effective referral linkage between our health centers and the community level providers. To mention some of our achievements related to MNCH/PMTCT, before getting the support from IntraHealth our HC is used to deliver less than 70 children per year but now (in the last budget year we delivered 263 women which was 67% achievement of the annual target. In the same year, our achievement in ANC visits was 120%. However, our biggest achievement was on HIV testing of the pregnant women. A total of 717 pregnant women were tested for HIV and similarly we tested 394 partners of the pregnant women. This all is because the progressively improved quality of the service."*

On the same note, a key informant interview from Tgray RHB remarked,

> *"As a result of the investment on establishing a system that links the community system to the facility-based public health system, we have achieved good results. The number of facility-based deliveries has increased, and couples testing-albeit still low-have doubled from 17% in 2012/13 to 39% in 2013/2014. IntraHealth, along with support from other stakeholders, made significant contributions to the observed progress."*

4.3 Challenges and implementation constraints

The project has considerably contributed for the observed improvement in quality and access to integrated MNCH/PMTCT services both at facility and community level. Despite this, the review findings have shown that many challenges were faced in the course of project implementation. However, it should be noted that most of the observed challenges and implementation constraints outlined below are not specific to this project and are mostly the reflections of the inherent problems that have persisted in the health system for years.

4.3.1 Shortage of essential materials and supplies

Data from all regions show that supply of HIV test kits, DBS kits, and other reagents like KOH was erratic during the project period. It was also reported that, due to shortage of HIV test kits some health facilities in Addis Ababa have already stopped or are on the verge of stopping to test pregnant women for HIV. Some respondents both from Addis Ababa and other regions also reported that they have very limited stocks of essential program inputs like HIV test kits, DBS kits and other laboratory reagents and they noted that if immediate action is not taken to curb the problems they would stop testing pregnant women and follow children born from HIV positive women.

It should be seriously noted that the supply problem has far reaching implication in sustaining the hard won gains as emphasized by one of the participants from Addis Ababa who said;

> *"Due to lack of reagents and supplies and difficulty to buy these materials from the market, currently we limited our laboratory services to stool and urine test and even that may not sustain beyond four months."*

Another interview from the same regions said,

> *"The shortage of HIV testing kit, DBS kit and other reagents is a serious problem in our sub city and as the result some health centers stopped HIV testing for pregnant women."*

Respondents from Oromia, Addis Ababa and SNNPRR reported that their respective regions have received undisclosed amounts of money from CDC for the PMTCT program. However, they expressed their fear that within the government system use of funds for program activities including procurement of needed supplies remains bureaucratic.

Many also believed that due to inadequate capacity in providing technical and financial assistance conducting key review meetings at various levels would be a difficult task for the RHBs. Some also mentioned that due to other competitive programs they will face difficulties to provide the required level of support and sustain the CMPTCT project activities after the project ends. In this regard a key informant from a Zonal Health Department from Oromia said;

> *"We are responsible not only for maternal health but also for other different health programs. As a result, we may not be able to give as much attention to the PMTCT program in terms of resources, logistical support and capacity building as IntraHealth does. Due to this reason, I doubt that the PMTCT program will be as successful as it was while we were getting support from IntraHealth."*

4.3.2 Staff motivation and retention

Motivation of providers and clients has been an important instrument to the continuous improvement of quality and access to PMTCT/MNCH services. Health professionals were provided with close technical support/mentoring from IntraHealth mentors and provided with different trainings, and clients were provided with baby-mother kits which was found to be one

of the key factors that motivates the mother to deliver in a health facility. Nonetheless, with doubts of continuity of such motivating factors, service quality and ultimately access to MNCH/PMTCT services will be compromised.

Problems related with staff retention at ZHDs, WrHOs and HCs is mentioned as one of the implementation constants faced during the project period. It was noted that in some regions like Addis Ababa, high turnover of staff working at different levels has created information gaps and affects organizational memory about the project activities at different level.

4.3.3 Sustaining the MSG initiative

In as much as MSGs are recognized as success factors for PMTCT service uptake, sustaining MSGs remains a challenge that may jeopardize the hard won gains. During the project period, members of the group were paid a monthly salary to work full time at HCs and communities. Their transportation cost to and from the health facility as well as the cost of coffee ceremony was covered by the project. Now, some RHBs have started to take measures to pay salary to MSGs so that they can retain them in the health system. For example in Addis Ababa the RHB started processing the contract agreement to formally employ the MSGs supported by the project and pay their salaries. It was also reported that in Oromia discussions are underway at the health bureau level on how to cover the salary of MSGs. However, the steps taken to pay MSGs and retain them in the health system are not uniform across the different regions. In some instances, Woreda health offices and HCs do not have the information about the measures the RHBs are taking to keep the MSGs in the health system.

While explaining the possible problems the health center might face in sustaining the activities of MSGs after the project ends, a key informant from a health center from Addis Ababa said,

> *"Sustaining MSG would be a critical challenge for us. We don't know how the RHB will handle their payments. The PMTCT program could continue to succeed without their support."*

On the same issue another respondent from Oromia RHB said,

> *"As the result of the training and skill transfers they received from IntraHealth, the WrHOs, ZHDs and health center can organize supportive supervision, follow the progress, provide feedbacks and ensure sustainability of most of the CPMTCT project activities. The only challenge for our region would be sustaining MSGs, who are assets for the success of PMTCT program in our region. We are not yet certain on how to ensure the MSGs could be paid regularly."*

4.3.4 Male involvement

Male/partner involvement in PMTCT program was always mentioned as one of the gray areas where much has not been done by the project. Lack of a clear advocacy strategy and absence of

well-designed and culturally responsive communication materials on how to reach and engage males/partners are reported as the major factors that contribute for the very low achievement registered so far.

4.3.5 Linkages between community and facility level MNCH/PMTCT services

The review findings reveled that in regions like Amhara, Oromia, SNNPR and Tigray considerable efforts have been made to create a functional linkage between the community and facility level PMTCT/MNCH services. However, it was noted that in Addis Ababa the process of creating a functional referral linkage between community and facility level PMTCT/MNCH services was in a nascent stage. The UHEWs working in some woerdas have not started working closely with members of the women development army and as the result the referral linkage that should have been created between the community and the health centers supported by the CPMTCT project is lacking. The fact that most of the HCs supported by the project in Addis Ababa are fairly new and are in the process of organizing their activities could be one of the major reasons for the observed gap in creating the linkage between community and facility level PMTCT/MNCH services.

5. LESSONS LEARNED AND RECOMMENDATIONS

5.1 Lessons Learned

IntraHealth is considered as a pioneer in PMTCT program implementation in Ethiopia. With its rich experience on PMTCT both in the country and elsewhere, the organization has applied and shared their expertise and experiences in rolling out PMTCT services from hospital to health center and now to the community level. In this currently ending project, the organization has played a pivotal role in capacity building, improving quality and access to Community PMTCT services and demand creation.

After reviewing the implementation of IntraHealth's CPMTCT project in Ethiopia, the review team has concluded the following lessons could be drawn from the different strategies and approaches employed by the project.

5.1.1 Capacity Building

The capacity building support of the organization was found to be clearer at facility level where programmers, providers and data managers were capacitated to be able to plan, manage and provide services at facility as well as community level.

IntraHealth's technical capacity building at the facility level was found to be paramount. Specific trainings, mentoring support and regular integrated refresher courses provided to health professionals as specified in the findings, are recognized to improve the technical capacity and motivation of providers at facility level. Furthermore, capacity to generate, track and use data for programming purposes was found to be strong at the facility level with evident implications on improved planning. This in turn ensured the capacity of institutions to integrate MNCH and PMTCT services at different levels.

The effort made to rollout different trainings to the CHWs and other community level providers through the health center staff, during outreach activities and regular joint supportive supervision helped to strengthen the role of PHC units both in the preventive and curative health care interventions provided at the facility and community levels.

At FMOH level, IntraHealth's technical assistance was found to have strengthened the relationship with the FMOH and has also helped to consolidate the linkage between MNCH and PMTCT activities though refining PMTCT manuals, national PMTCT strategic documents, training curriculum that accommodates continuous quality improvement tools, regular follow up checklists and coordination of hands-on technical support to regions.

Capacity building support has also been extended to CBOs where PLHIV associations like NAP+ in Amhara and Tilla association of positive women in SNNPRR were capacitated through training and technical support in planning, grant writing and resource mobilization, and financial management and coordination with stakeholders. Such support has also enabled such organizations to be linked with health centers and health posts and play a meaningful role in MNCH/PMTCT service provision. The role of such organizations has improved adherence and service linkage at community and facility levels.

As pointed out above, the contribution of IntraHealth for improving systems, procedures and development of manuals, guidelines, checklists and tools relevant for training, supervision, data recording, and referral was paramount. Financial and technical supports to regular integrated supportive supervision and review meetings were found to have clear implication in enabling both individual providers and institution's to provide integrated MNCH/ PMTCT services at different levels.

Although the capacity building interventions by IntraHealth has far reaching implications, it appears that the capacity building interventions at higher echelons (regional and zonal levels) were not as strong. The review team identified that there are considerable number of people at management level at sub city/zonal and woreda levels who did not benefit from the different capacity building trainings provided by the project. From the interviews carried out with such people working at different positions in the health system, it was evident that they do not have adequate information on how some or part of the activities supported by the project are planned to be sustained when the IntraHealth project phases out. High staff turnover and related loss of organizational memory about the program were mentioned as contributing factors for the information gap at different levels within the health system.

The other critical capacity limitation was in the areas of supplies. As highlighted in the findings, IntraHealth's close and hands on support was found to have helped to identify supply gaps and helped the different actors to take actions to resolve the supply gaps without the services being interrupted. Yet, so far neither health center managers nor those in higher level management structures have a clear answer on how supply related problems could be addressed and the essential MNCH/PMTCT services are not interrupted. It is believed that failure to adequately address supply issues could jeopardize the entire initiative especially under circumstances where a clear and well-articulated preparedness plan is not yet in place both at federal and regional levels.

5.1.2 Access to Services

Improved access to MNCH/PMTCT services was found to be an evident case. In some health facilities visited, coverage of ANC, PNC, FP and PMTCT service as well as adherence to ART was excellent. This was found to be an outcome of smooth community – facility linkages that helped improved access to MNCH/PMTCT services both at community and facility levels. In addition to routine guidance and support by HEWs at community level, providers from the facility are deployed to the community on a regular basis to complement the role of HEWs to provide MNCH/PMTCT services at the community level.

Moreover, it could be noted that integrated service provision at the facility level has contributed to improved service access. It was gathered that now in most health centers supported by the project, any pregnant women who visits health centers will get a package of MNCH/PMTCT services at one window. The waiting time for MNCH/PMTCT services has been greatly minimized. Those who come from the community with a referral card from the CHWs get a facilitated service. Feedback sent to HEWs improved follow-up support and minimized the number of HIV positive women and their children who defaulted from PMTCT services. As a routine procedure, HIV positive women who visited the MNCH/PMTCT units of the HCs including those who visited the HCs for postnatal care services receive counseling on family planning and are provided the service in the same unit in the health centers. Support by MSGs to positive mothers improved the latter's motivation to seek more support and remain in the program. The finding attests that now some health facilities are nearly claiming zero transmission from mother to child which is considered a great success for all involved. This has also attracted several more women for the services.

5.1.3 Demand Creation

Demand creation for community PMTCT programs is an integral component of the four objectives of IntraHealth's initiative. Multiple strategies were adapted and employed for demand creation for CPMTCT services. At the community level, Health Extension Workers, Community Volunteers, MSGs/ Community MSGs, political leaders and religious leaders played important roles in demand creation for MNCH/PMTCT through advocacy and community mobilization. The newly introduced community structures (I-5 network, women development army/health

development army), were also found to have started taking promotion of ANC, facility delivery and PMTCT as their responsibilities. Identifying a pregnant woman and linking her with HEWs for facility referral has become the role of members of the neighborhood group (community women network). In certain areas, regular pregnant women conferences are running at community level where discussions are held on the importance of PMTCT in general and ANC, skilled delivery and PNC in particular. In some localities, Traditional Birth Attendants started to work with the HEW and members of the community women network to promote facility delivery.

Mothers are supported to prepare plans for their delivery and identify risk signs related to pregnancy and delivery. This helped most women to reason out why they should deliver in a health facility.

For HIV positive women, the most important facility level demand creation activity along with quality improvement is the engagement of MSGs. This group stays in health center and organizes a traditional coffee ceremony to discuss about the importance of ANC follow up, relevance of institutional delivery and use of ART. The fact that such information sharing and guidance is based on personal experiences, the implication of it in informed decision to adhere to services is critical.

In view of the fact that maternal health issues are becoming the top priority health issues throughout the country, political leaders at woreda, zonal and regional levels started to address maternal health issues including PMTCT in their agenda for discussion at different levels. Similarly, in some regions religious and community leaders started to play an active role in advocating MNCH/PMTCT services. This is said to have played important role in advocating about the service at different levels.

Such ongoing and multifaceted demand creation activities at different level was said to have contributed to an improved level of awareness of the society about MNCH/PMTCT services, increased demand for services, declining stigma and discrimination and improved adherence to services.

5.1.4 Quality improvement

IntraHealth introduced different focused interventions to improve the quality of MNCH/PMTCT services provided both at the facility and community levels. Through training and mentoring efforts were made to build the management and leadership skills of people at different levels in the health system. Knowledge, skills and technical capacities of health professionals working on MNCH/PMTCT have also been built. The use of algorithms, guidelines and quality improvement tools to implement and regularly monitor the different MNCH/PMTCT services as well as the use of data from different sources including data generated from client satisfaction surveys and regular facility reports are the other areas where much has been done to improve the quality of MNCH/PMTCT.

5.2 Recommendations

In reference to the findings of this review and based on available project documents reviewed, the following key recommendations were drawn. These recommendations are believed to help sustain the CPMTCT initiative on one hand and roll out service delivery to more health facilities and community level providers to scale the integrated MNCH/PMTCT service uptake.

- Although this review was limited to few selected health facilities that may have successful experiences to share, there were evident success stories in provision of integrated MNCH and PMTCT services both at facility and community levels. It was gathered that IntraHealth has an established experiences in supporting PMTCT/MNCH service provision at hospital, health center and community levels which appears to be reflected in those health facilities visited. Nonetheless, the team didn't come across any best practice documentation. The team is of an opinion that documentation of such experiences would contribute to sustenance of the initiative on the one hand and serves as a reference to guide the scale up of CMPTCT activities on the other hand.

- Phase out strategies were found to be clear with most of the facilities and zonal and regional level partners. Orientations and discussion forums were organized and facilitated by IntraHealth on sustainability issues at different levels. Yet, it was noted that officials interviewed from some of the zones/sub cities and WrHOs from Addis Ababa and Amhara region are not clear about the plan on how the RHBs, zonal health departments and WrHOs should sustain the MNCH/PMTCT services that used to be supported by the project. The same gap and lack of clarity about the sustainability plan was noted at federal level. The team recommends immediate action to be taken by FMOH to engage regions to rollout plans developed with the support of IntraHealth on how to sustain and expand CPMTCT at different levels. Ensuring the sustainability plan considers the existing capacities and gaps at different levels should also be emphasized

- In view of commonly expressed concerns of sustaining regular support at different levels in the health system in absence of IntraHealth, the review team recommends a) regional health bureaus continue to develop capacity building interventions and roll out at different levels to maintain the momentum created, b) ensure that the trained mentors are actively engaged in the provision of mentorship to providers at facility level, and c) health managers and leaders at zonal and regional levels are further capacitated on MNCH/PMTCT leadership and management.

- Supplies and related logistics was learned to be one of the challenges during the project's life. IntraHealth was used to taking the lead in identifying gaps and mobilizing stakeholders and their resources to take timely action to alleviate supply problems wherever they occurred. In all settings, complaints were flagged where PFSA wasn't prompt in availing supplies to health facilities. Yet, there was no clear strategy and plan at federal as well as regional level on how to avail uninterrupted essential MNCH/PMTCT supplies to health

facilities. Unless addressed robustly and timely, the supply problem will specifically challenge the continuity of PMTCT services at all levels. In Addis Ababa for example, the problem was found to be glaringly serious. Thus, the team recommends that FMOH should take proactive and immediate actions to develop a clear road map on how to avail essential PMTCT supplies to health facilities so as to maintain uninterrupted access to services.

- Despite the fact that CPMTCT has started in all focus regions about the same time, there were evident variations in terms of their current accomplishments. In fact, there are evident variations between health facilities supported by IntraHealth and non-supported facilities across operational regions. Evidences suggest that Addis Ababa, for example, appears to have lagged in several indicators (advocacy, supplies, service coverage, capacity building, etc.). The team felt that such variations could have been reduced with continuous experience sharing opportunities between regions which could be considered as a forum to gain insights on what and how other regions implement and eventually ensure uniformity in procedures of service provision.

- The project has employed multiple demand creation strategies including using community level structures. In as much as such broad range of approaches in tandem has improved demand for services, there were evident gaps. Firstly, print media were found to be produced at central level without due attention to contextual variations at least between regions, and secondly, distribution of such materials were not uniform where some destination could be overlooked, e.g. potential destinations of MNCH/PMTCT messages in Addis Ababa reported did not obtain communication materials for a long time. Thus, the team recommends a) that the production of communication materials should be context specific instead of one size fit all messages that may not bring about desired results, and b) distribution of such message/materials should be uniform where potential destinations are reached with regular supply of communication materials.

- In as much the role of males in MNCH/PMTCT is recognized, accomplishments in this area by way of involving them in the program were not strong. Success in improving maternal health in general and PMTCT service delivery in particular calls for a well-designed strategy to adequately engage males. Thus, it is recommended to design a well-informed national strategy and tools on how to improve the role of men in maternal health programs in general, and that of PMTCT in particular.

- MSG was found to be an important success factor for community PMTCT interventions. During the project period, they were regularly paid and were provided with cost of transportation and coffee ceremonies. Regions have agreed to take over the financial aspects needed to sustain MSGs. However, providing the technical support needed to sustain MSGs still remains a gap. Thus, the team suggests FMOH facilitated discussions where regions could find appropriate strategy both to sustain and scale up the role of MSGs.

ANNEXES

Annex 1: Scope of work

IntraHealth International Ethiopia Program
Community Prevention Mother to child prevention project (CPMTCT)

Terms of reference for project review

I. BACKGROUND

The Community prevention of mother to child transmission (CPMTCT) project is a five year (October 1st 2009 –November 28, 2014) USAID funded project focusing on five regions namely Addis Ababa, Amhara, Oromia, SNNPR, and Tigray. The project has been implemented by IntraHealth International and its partners, Pathfinder International, Program for Appropriate Technology in Health (PATH) and the International Orthodox Christian Charities (IOCC), in close collaboration with the Federal Ministry of Health (FMOH), Regional, Zonal and Woreda Health Offices, health centers (HC) and health care providers as well as local organizations and communities. At USAID's request, IntraHealth Ethiopia plans to conduct a final review of the CPMTCT project.
The project goal is to increase MNCH/PMTCT service uptake and case follow-up through the provision of PMTCT services at the community level.

The four objectives of the project are:
1. To build the capacity of regional heath bureaus, zonal and woreda health offices and community-based organizations, to support and manage community-based PMTCT
2. To increase access to MNCH/PMTCT services through providing facility and community services and improving bi-directional linkages/referrals
3. To increase demand for MNCH/PMTCT services through community outreach
4. To improve the quality of community and facility-based MNCH/PMTCT services

II. OBJECTIVES OF THE REVIEW

The objectives of this final project review are:
1. To determine the extent to which the project has achieved its goal and objectives
2. To document project processes and implementation
3. To document lessons learned for application in future programming

Key questions:
The key questions that this review should respond to are:
- How successful was the program in building the capacities of RHBs, Zonal and district health GOE bureaus and health providers in MNCH and PMTCT technical and program management skills?

- Has the CPMTCT project achieved its objectives of demand creation and service access for PMTCT in the five years of the project life?
- What is the role of the project towards integration and coordination of PMTCT and MNCH services over the life course of the program?
- How have persistent problems in the health system affected the service provision and the efforts of the partners to resolve these challenges?
- How did the CPMTCT project contribute to the identification, retention, and referral of HIV positive women and HIV-exposed infants (HEIs)?
- How did the project's strategy, goal and/or objectives change or evolve over the life of the project? Did all activities occur as planned and at an acceptable level of quality and quantity? What factors contributed to the achievement and under- or over-achievement of the goal and/or objectives?
- What are the key lessons learned (both positive and negative) about implementation of the project that can be drawn upon to inform future programming?

III. METHODOLOGY

The contractor will use qualitative methods to document project achievements and to a lesser extent processes and implementation, stating the extent to which the IntraHealth strategy and project inputs and processes (training, technical assistance, equipment, funding, administrative arrangements) contributed to outputs and impacts observed in the offer and uptake of services. Differences between expected inputs and outputs, as these are described in the project goal and objectives, and actual inputs and outputs, will also be described and explained.

- **Project achievements**
  Questions on outputs and outcomes will focus attention on what the project aimed to achieve and what (intended and unintended) project outputs and outcome swere actually achieved. The status of indicators at the end of the project will be compared to their status at the beginning or during the project.
- **Project inputs, processes and implementation**
  Questions about project inputs, processes and implementation will focus attention on how resources were deployed to meet the goal and objectives of the project.

a) Data sources and collection methods

Qualitative data will be collected during in-depth interviews with project staff, key informants at national, regional, zonal and woreda level and in community-based organizations. Qualitative data will also be collected from existing project documents including progress and annual reports, trip reports, supportive supervision reports and other project documentations, including reports on studies conducted.

b) Sample selections and size

The contractor will conduct in-depth interviews with the key informants in the table below. Given the time and resource constraints, this sample does not aim to be representative of all stakeholders at national, regional, zonal and woreda levels and CBO. Results will however provide some insight on the stakeholders perceptions on project achievements and lessons learned. The identity of the informants to be interviewed will be decided upon in initial meetings with the contractor.

Targets – No more than 40 interviews (targets to TBD by IntraHealth)	**Total number of interviewees**
CPMTCT project staff	1
National level:	1
Regional health bureaus: • Addis Ababa: • Amhara: • Oromia: • SNNPR: • Tigray:	5
Zonal level: Zonal health departments/ Sub City Health Offices	10
Woreda level:	10
Health facility (head of facility only):	10
Community-based organizations:	5
TOTAL	**42**

c) Data analysis plan

The contractor will employ appropriate analysis methods for qualitative data in order to categorize, rank and rate the responses of the interviewees. Very insightful or special (detailed) descriptions by interviewees will be quoted word by word to corroborate findings from other data sources.

IntraHealth will provide quantitative data to the consultant in order for them to be able to triangulate the qualitative and quantitative data in their final report.

IV. MAIN TASKS

Phases	**Activities**	**Timeline**
Preparatory phase	1. Briefing with project staff to clarify expectations and deliverables 2. Planning of the review 3. Formulation of in-depth interview	5 days

	guides and multiplication 4. Preparation of logistics for the collection phase	
Data collection	5. Data collection 6. Management of completed forms	5 days
Data processing and analysis	7. Desk review of project documents 8. Analysis of qualitative data from in-depth interviews	3 days
Report drafting	9. Drafting of the preliminary report 10. Presentation of preliminary results to project staff for feedback 11. Preparation and submission of the final report and PowerPoint presentation	3 days

V. DELIVERABLES

The contractor will submit the following deliverables observing standard IntraHealth branding/marking requirements:

1. Draft in-depth interview guides
2. Draft preliminary report
3. PowerPoint presentation on the findings
4. Final Review Report of not more than 40 pages that shall include detailed methodology, key findings, conclusion and recommendations

In compliance with IntraHealth policy on data management, all documents and materials (hard and electronic copies) should be kept in archives at the IntraHealth Country Office. The contractor should avail these documents / materials to IntraHealth. Before any payment to the contractor is made, these documents/ materials will be checked. These documents and materials include:

- Originals of filled out questionnaires
- Electronic file of qualitative data
- Code manual
- Any other documents or materials that may be required for IntraHealth understanding and replication of results

Annex 2: Review Tool

Region
Zone
Wereda
Name of respondent
Responsibility
How long in this position
Data
Time
Name of interviewer and signature

Objectives	Key Themes	Indicative questions
Objective 1: To build the capacity of regional health bureaus, zonal and woreda health offices and community-based organizations, to support and manage community-based PMTCT	PMTCT leadership skill - Project management - Coordination	1. Type of interventions to build leadership skills? 2. What specific intervention to improve project management skill, coordination skill? 3. Were such interventions regular? Probe how regular? E.g. Annual and quarterly reviews and planning? Who participate? 4. What implication did this has? Explain? 5. How many people benefitted?
	PMTCT/MNCH technical competence - Knowledge - Skill	1. List PMTCT knowledge and skills updated during the project life time at different levels (regional, teaching institution, etc.) 2. What system was developed to update such knowledge and skills? **(HC, WHB)** 3. How was this cascaded to the community? **(HC, WHB)** 4. How many people benefitted from this and at what level?

		5. Was this integrated into government's capacity building plan? Please explain.
	Integrated MNCH/HIV logistic management	1. Participation in PFSA at national level? Consequent implications? **(RHB)** 2. Collaboration with USG PEPFAR program logistic management partners at regional level? Implication? **(RHB)** 3. Capacity building endeavors to staff of RHB and health facility staff on logistics and commodities? No trained, implication? **(RHB)**
	Financial management	1. Types of training provided (probe financial mgt., accounting, managing results, program mgt., grant writing) **(RHB, ZHB)** 2. How frequently has this been organized? 3. Who benefited from such training? Please probe on number.
	Policy change in HEW's involvement in MNCH/PMTCT	1. What specific changes were introduced at HEW's level? (Please list all revisions, changes, etc. by IntraHealth) **(HC,WHB)** 2. What measures were taken to facilitate MNCH/PMTCT service provision other than HEW related policy/strategy changes
	Quality assurance - Targets - Systems/tools	1. What capacity was built targeting RHB and CBOs regarding quality assurance? **(RHB)** 2. What systems and tools were introduced to obtain feedbacks from different levels? **(RHB)** 3. How has such system/tool been applied for improve quality assurance? What was the implication and lessons learnt?
Objective 2: To increase access to MNCH/PMTCT services through providing facility and community services; and improving	Increased number of community level health institutions providing PMTCT/MNCH - Health posts	1. How many health centers and health posts has transitioned to RHB? **(RHB,ZHB,WHB)** 2. What strategy was put in place to minimize

bi-directional linkages/referrals between MNCH/PMTCT services at the community health post, health center and hospital level	- Health centers	staff time away from clients? What lesson was drawn from this? **(RHB,ZHB,WHB, HC)** 3. How do you explain if such strategy has contributed to Lost to Follow up? Please explain. **(WHB, HC)**
	Innovative ways in providing MNCH/PMTCT - Mobile house to house service - Mother support groups - Couple VCT counseling in the community - Use of mobile phones for improved communication - PMTCT connection through pediatric care - Linkage through palliative care	1. How were HEWs engaged for house to house services? What was their role? How were they enabled to do this? What lesson was drawn? **(WHB, HC)** 2. What mechanisms were developed to engage and ensure HIV positive women benefit from the program? Probe for all measures taken? What lessons were drawn? **(WHB, HC)** 3. What communication approaches were introduced? How was this accepted by clients? What improvement needs to be made in the future? **(WHB, HC)** 4. Please tell me what approaches were introduced to identify positive mothers and provide them with services? What lessons were drawn from this? What needs to improve in the future? **(WHB, HC)**
	Collaboration with stakeholders - Coordination modality - Referral linkages between facilities and community service	1. List all stakeholders with whom this project coordinates. **(RHB,ZHB,WHB, HC)** 2. What coordination modality was introduced with such stakeholders? **(RHB,ZHB,WHB, HC)** 3. What referral and feedback mechanism was established? How useful was such mechanism? What needs to improve in the future? **(WHB, HC)**
	Tools for client follow-up and referral	1. Help me understand client follow up

	- Tool for client follow-up - Tool for client referral	mechanism put in place in connection to this project? What was the added value of this? What lesson was drawn? **(HC)** 2. Who do the follow up? What tools are used? Who developed such tools and what needs to improve in the future? **(HC)**
	Integrated MNCH/PMTCT service delivery	1. How do you argue about integration of MNCH/PMTCT to existing stationed and outreach service? Please explain actions taken to integrate the services **(HC)** 2. Please explain if training activities were integrated? How? What tools and modules were developed? **(HC)**
	Role of community in service delivery	1. What interventions were made to ensure community ownership of the initiative? **(WHB, HC,CBO)** 2. Who from the community has what roles to improve MNCH/PMTCT service delivery? **(WHB, HC,CBO)** 3. What internal mechanism was put in place to sustain such role of the community? **(WHB, HC,CBO)**
	Ability of health workers to ensure women's access to services	1. What mechanisms are developed to ensure women always access MNCH/PMTCT services (probe transportation service, preparedness plans)? What lesson was drawn from such an approach? What needs to improve in the future? **(WHB, HC,CBO)**
Objective 3: To increase demand for MNCH/PMTCT services through community outreach	Contribution to improve favorable policy environment for MNCH/PMTCT service	1. What measures were taken to foster a conducive policy for MNCH/PMTCT services (probe advocacy strategies introduced and applied, compilation and sharing of evidences) **(RHB)**

		2. List all stakeholders the project worked with for this purpose? What lesson was drawn from this? What needs to improve in the future? **(RHB)**
	Community awareness on available MNCH/PMTCT services - Interpersonal communication - Community mobilization - Group education	1. Please help me understand measures introduced to improve awareness at community level. What tools were developed (probe for specific ones)? Who benefitted from such measures? What lessons were drawn and what needs to improve in the future? **(WHB, HC,CBO)**
	Strategies to address barriers to MNCH/PMTCT services - Skills of providers - Tools developed	1. What were the major barriers to MNCH/PMTCT service in this setting (woreda/zone/region)? **(ALL)** 2. What measures were taken to address such barriers? (list all tools applied) **(ALL)** 3. What lessons were drawn from such interventions? **(ALL)**
	Community's capacity to manage MNCH/PMTCT problems - Ability for early detection of danger signs - Actions to seek early support	1. What specific interventions were introduced at (household and at community level to detect danger signs and take actions**? (RHB,ZHB,WHB, HC)** 2. Whose capacity was built for this? Why and what was the implication? **(RHB,ZHB,WHB, HC)** 3. Explain how this has contributed to manage MNCH/PMTCT problems? What needs to be improved in the future? **(RHB,ZHB,WHB, HC)**
	Male involvement in MNCH/PMTCT services - To improve access to service	1. What interventions were introduced to improve male involvement? **(RHB,ZHB,WHB, HC)** 2. What was the resultant consequence? **(RHB,ZHB,WHB, HC)**

		3. What lessons were drawn and what needs to improve in the future? **(RHB,ZHB,WHB, HC)**
	Disability grants/incentives to HIV positive women - Implication on service use	1. What interventions were introduced to encourage positive women to use of health facilities? (probe all measures at individual, household and community level) **(WHB, HC,CBO)** 2. What system is put in place to sustain such interventions? **(WHB, HC,CBO)** 3. What lessons were learnt and what needs to improve for the future? **(WHB, HC,CBO)**
Objective 4: Improve the quality of community and facility-based MNCH/PMTCT services	Capacity to provide skilled MNCH/PMTCT services - Community level capacity - Health facility level capacity	1. Please list all capacity building interventions at community and health facility level? **(RHB,ZHB)** 2. What system is put in place to sustain such capacity? Who are beneficiaries of such capacity building interventions? Why?
	PMTCT quality improvement - Number of service managers trained - Number of providers trained	1. Explain quality assurance mechanisms put in place? **(RHB,ZHB,WHB, HC)** 2. What measures were introduced to sustain such interventions? 3. Who benefitted from such interventions and how many (specify numbers) 4. What lesson was drawn and what needs to improve in the future?
	Supportive supervision to providers - System in place (formats) - System in place (regular schedules) - Feedbacks	1. Please explain supportive supervision system put in place (formats, composition of team? Regularity? Feedback?)**(RHB,HC)** 2. What lesson was drawn from such intervention? What needs to improve in the future?
	Mentorship to providers	1. What mentorship system is developed to

		improve provider's skill, performance and commitment? Who developed such system? How many mentors are there in your setting (community/woreda/zone/region/HF) **(ALL)** 2. How many people benefitted from such mentorship program at different levels (community/woreda/zone/region/HF) **(ALL)** 3. What lessons were drawn from such interventions and what needs to improve in the future? **(ALL)**
	Access to quality improvement resources - QI resources - Guidelines	1. What QI tools were developed and put in to use? Please list them all? **(ALL)** 2. What QI guidelines were developed and put in to use? Please list them all? **(ALL)** 3. How has these (too and guideline) been integrated in to government's system 4. What lessons were learnt and what needs to improve?
	Use of data - For quality improvement - For planning	1. How has evidences related to interventions drawn? How frequently? **(ALL)** 2. What is/are the use of such evidences? (For what purpose? Who use?) **(ALL)** 3. What lessons were drawn and what needs to improve in the future? **(ALL)**

Annex 3: List of References

1. Community PMTCT Project, Annual Progress Report for EFY 2010, October 2009 - September 2010. IntraHealth International, Inc.
2. Community PMTCT Project, Annual Progress Report for EFY 2011, October 2010 - September 2011. IntraHealth International, Inc.
3. Community PMTCT Project, Annual Progress Report for EFY 2012, October 2011 - September 2012. IntraHealth International, Inc.
4. Community PMTCT Project, Annual Progress Report for EFY 2013, October 2012 - September 2013. IntraHealth International, Inc.
5. Community Prevention of Mother to Child Transmission (CPMTCT). Technical Application; USAID /Ethiopia RFA No. 663-A-09-019. July 23, 2009. IntraHealth International, Inc.
6. Community PMTCT Project. Midterm Review Report, September 2009 – March 2012.