



PRIVATE HEALTH SECTOR PROJECT

Monitoring and Evaluation Plan

October 1, 2015 – September 30, 2020

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List of acronyms

| | |
|--------|---|
| ART | Anti Retro Viral Therapy |
| APR | Annual Progress Report |
| AWP | Annual Work plan |
| COPE | Client Oriented Provider Efficient |
| COP | Chief of party |
| DATIM | Data for Accountability Transparency and Impact |
| DCOP | Deputy Chief of Party |
| DQAs | Data Quality Assessment |
| EID | Early Infant Diagnosis |
| EPHI | Ethiopian Public Health Institute |
| FGD | Focus Group Discussion |
| FMHACA | Food, Medicine and Health Care Administration and Control Authority |
| FMOH | Federal Ministry of Health |
| FP | Family Planning |
| GOE | Government of Ethiopia |
| HAPCO | HIV/AIDS Prevention and Control Office |
| HCT | HIV counselling and testing |
| HIV | Human Immunodeficiency Virus |
| HRH | Human Resource for Health |
| HMIS | Health Management Information System |
| HSS | Health system Strengthening |
| JSS | Joint Supportive supervision |
| M&E | Monitoring and Evaluation |
| MDR | Multi Drug Resistance |
| OI | Opportunistic Infections |
| PDSA | Plan Do Study Act |
| PFSA | Pharmaceuticals Fund and Supply Agency |
| PEPFAR | President's Emergency Plan For AIDS Relief |
| PLHI | people living with HIV |
| PMI | president malaria initiative |
| PMTCT | Prevention of Maternal to Child Transmission |
| PPP | public private Mix |

| | |
|-------|--|
| QM/QI | Quality Improvement /Management |
| QIP | Quality Improvement Plan |
| RHB | Regional Health Bureau |
| RNMCH | Reproductive Newborn Maternal child Health |
| SIMS | Site Improvement through Monitoring System |
| STI | Sexually Transmitted Infections |
| SNNP | Sothern, Nation, Nationalities and People |
| SOPs | Standard Operating Procedures |
| TB | Tuberculosis |
| WHO | World Health Organizations |
| USAID | United States Agency for International Development |

Introduction

Private Health sector Project is a new five year (September 2015-September 2020) award with a goal to contribute towards the mitigation of impact of diseases of public health importance. The technical assistance through the associate award will enable the Government of Ethiopia (GOE) and its institutions (FMOH, regional and City Administration Health Bureaus, and FMHACA, Ethiopian Public Health Institutes (EPHI), PFSA and local banks to effectively partner with the private health sector to deliver high impact public health interventions.

This project aims to improve the enabling environment for the engagement of the private health sector, expand access to high quality public health services, and enhance program learning and innovative ventures. The project will also strengthen government oversight including licensing, accreditations and supervision; public private partnership in health; capacity of private health facility associations and private practitioner professional associations; and access to financing for the private health sector.

Under this new award, five regions (Oromia, Amhara, Southern Nations Nationalities and Peoples' (SNNP),Tigray, and Harari) and two City Administrations are supported for program areas funded by PEPFAR and seven regions (Oromia, Amhara, SNNP, Tigray, Gambella, Afar, and Beneshangul–Gumuz) are supported for the program areas funded by PMI and non- PEPFAR USAID funds such as for TB, RMNCH, and FP. HIV related activities will be implemented in scale up and maintenance Woreda as defined by PEPFAR Ethiopia..

Goal and Objectives

The goal of Private Health sector Project is to contribute towards the mitigation of impacts of diseases of public health importance. The project will use a health system strengthening approach to support the delivery of priority primary health care services through the private sector. This award will focus on strengthening capacity system, governance and operations, quality improvement, demand creation, research, improved uses of strategic information and innovation which improves service delivery and uptake.

The private health sector project is designed to achieve the following results:

Project purpose 1: Enabling environment for private sector engagement in health improved: in this project purpose, policy and regulatory environment for the private sector in health will be improved. In addition public private partnership is facilitated.

Project purpose 2: Access to quality services for disease of public health importance increased.

Project purpose 3: The private health care system strengthened

Project Purpose 4 : Program learning and innovative ventures enhances

1) Objectives and Scope of Performance Monitoring and Evaluation Plan

The Monitoring and Evaluation Plan is a guiding document for the design and implementation of a system for measuring the performance of the project and tracking progress towards expected results. This M & E Plan is intended (a) to provide feedback to project managers during project implementation and (b) to provide a comprehensive and coherent information base which can be used to assess its outcomes. In addition, the M & E plan will facilitate the standardization of M&E methodologies and tools across all private health facilities and subcontracting forms and meet the reporting requirements of USAID/PEPFAR. The M&E activities will take place throughout the duration of the project. The activities comprise of carrying out baseline assessments, periodic monitoring of project implementations and evaluation studies. The M&E plan will be reviewed annually, and where necessary improved upon. Any changes to the M&E plan will be discussed with USAID and will only take effect after USAID's approval.

2) Stakeholder/Audience Identification and Analysis for Data Need

A stakeholder/audience is an agency, organization or group of individuals who have a direct or indirect interest in the project, or who affects or is affected positively or negatively by the implementation and outcome of the project. Stakeholder Analysis is an approach for identifying these actors and assessing their respective interest and influence in the system. Influence relates to the power which stakeholders have over a project - to control what decisions are made, facilitate its implementation, or exert influence which affects the project negatively.

Interest relates to stakeholders' interests in the project that converge closely with set objectives, the extent to which a stakeholder is able to persuade or coerce others into making decisions, and following certain courses of action. Certainly, anyone identified with both a strong influence and a strong interest would be considered as one of the key M & E audiences. Accordingly, the following internal and external audiences are identified for the project;

Table I: Private Health sector Project M & E Target Audience Analysis

| Audience | Data needed | Why the data | By When |
|--|--|---|---|
| Internal Audiences | | | |
| Abt Home Office and Private Health sector Project management | <ul style="list-style-type: none"> • Program report • Annual work plan | For management oversight, progress monitoring, and decision making | Monthly (ROV), Quarterly, Biannual & Annual (Program) |
| Program Staff | Physical and financial performance status | To monitor progress and undertake informed and timely management decision | Quarterly Biannual Annual |
| Project M&E/ QM Unit | Facilities' and Supportive Supervision Reports | To analyze data collected for reporting purposes | Quarterly, Biannual and Annual |
| External Audience | | | |
| USAID Ethiopia | <ul style="list-style-type: none"> • Program report • Accrual report • Annual work plan | For follow-up, progress monitoring, to track results and decision making | Quarterly, Semiannual and Annual |
| FMOH | <ul style="list-style-type: none"> • annual report | for follow up of the contribution of the private health facilities | Annual report |
| RHBs | <ul style="list-style-type: none"> • Annual report by regions | For follow up of the contribution of the facilities in the regions | Annual report |

3) Project Results Framework

The performance monitoring plan is organized under the four core result areas of the project:

i) enabling environment improved; ii) access to quality services increased; iii) health care system strengthening; and iv) program learning and innovation enhanced. Each of these broad result areas of the program will be regularly monitored and evaluated to track outputs and outcome that can help measure program effectiveness and efficiency.

For each of the key result areas and outcomes, one or more **indicators** have been identified and targets established, the monitoring of which will reveal the rate of progress. The Framework includes relevant indicators of USAID/PEPFAR as well as other non-PEPFAR program level indicators.

Figure 1: Private Health sector Project Result Framework

Assumptions: 1. Roads and other barriers to access are addressed by the GOE; 2. Political stability; 3. Continued commitment of the host government for PPP; 4. No major changes in the GOE health strategy and/or funding; 5. No major changes in USG funding and strategy; 6. Human capacity stays in country; 7. No major changes with global fund and other donor resources; 8. Partner (s) are expected to come up with innovative ideas

Project Goal: To contribute toward the mitigation of impact of disease of public health importance

Project Purpose 1: Enabling environment for private sector engagement in health improved

Project purpose 2: Access to quality services for disease of public health importance increased the private health sector

Purpose 3: The private health care system strengthened

Project purpose 4: program learning and innovative ventures enhance for the private health sector

Sub-purpose (1.1.): supportive policy and legal framework improved for the private health sector
Sub-Purpose (1.2.): enhanced oversight and implementation of public private partnership in health (PPPH)
Sub-Purpose (1.3.): Capacity of regulatory bodies for enforcement of quality standards strengthened

Sub purpose (2.1.): strategies for demand creation for disease of public health importance from the private health sector established and implemented
 Sub purpose 2.2: increased uptake of service for disease of public health importance from the private health sector
 Sub purpose 2.3 enhanced implementation of quality management strategies and practices with in the private health l facilities
 Sub purpose 2.4: referral linkage and feedback

Sub purpose (3.1.) Capacity of local institutions for the oversight and support of the private health sector enhanced
 Sub purpose (3.2.): the private health sectors access to resources increased
 Sub purpose (3.3.): improved enrollment and practice of accreditation among private health facilities Sub purpose (3.4.): Supply chain management and rational drug use enhanced

Sub purpose (4.1.): evidence based decision making improved in the private health sector
 sub purpose 4.2; implementation of HMIS in the private health sector strengthened
 sub purpose 4.3 ;innovative ventures developed and implemented in the private health sector

- Illustrative outputs**
- enabling policy and legal frameworks amplified
 - prototype public private partnership in health implemented
 - inspection /supervisory capacity of regulatory body improved

- Illustrative outputs**
- strategies for demand creation developed
 - uptake of service for disease of public health sector increased
 - number of key and priority population reached through the private health sector
 - site level services quality management plan developed and implemented
 - improved referrals –linkage and feedback mechanism implemented

- Illustrative outputs**
- proportion of private health facilities and program areas supported by the associate awards transitioned to local entities
 - private health facilities linked to resources
 - private health facilities/services accredited
 - program drug refill system strengthened
 - drug inventory and stock out monitored

- Illustrative outputs**
- monitoring data utilized for program improvement
 - operational research conducted
 - gender analysis conducted
 - forums for dissemination of evidence generated strengthened
 - training and mentoring on HMIS provided
 - data quality maintained
 - period reports produced using HMIS tools
 - innovative ideas developed or adapted
 - innovation piloted and scaled up

Inputs/ process: Sustainable/ feasible in-service training modalities developed; Trainings conducted as per needs assessment; Feasible/ sustainable Mentoring and supervision strategies/ modalities designed; Mentoring conducted; Supportive supervision conducted; need based Technical assistance provided; organizational capacity assessment conducted; financial support (including sub grant for private facility- and professional- associations) provided; formative assessment conducted

4) Indicator Protocols (Performance Indicator Reference Sheets)

The M & E plan presents information on selected indicators in the form of Performance Indicator Reference Sheets. In addition to a precise definition of each indicator (including the unit of measure and how data will be disaggregated) the Performance Indicator Reference Sheet also includes concise information on:

- plan for data collection (methods, sources, frequency, estimated cost, and responsible organization or individuals)
- plan for data analysis, reporting and review (method of analysis, review of data, and reporting)
- discussion on data quality issues (limitations and actions taken to address limitations);
- Information on the performance data table (notes on baseline and targets) and other comments/information as relevant. Please note that Indicator Protocol is prepared for selected few indicators and attached in the annex I).

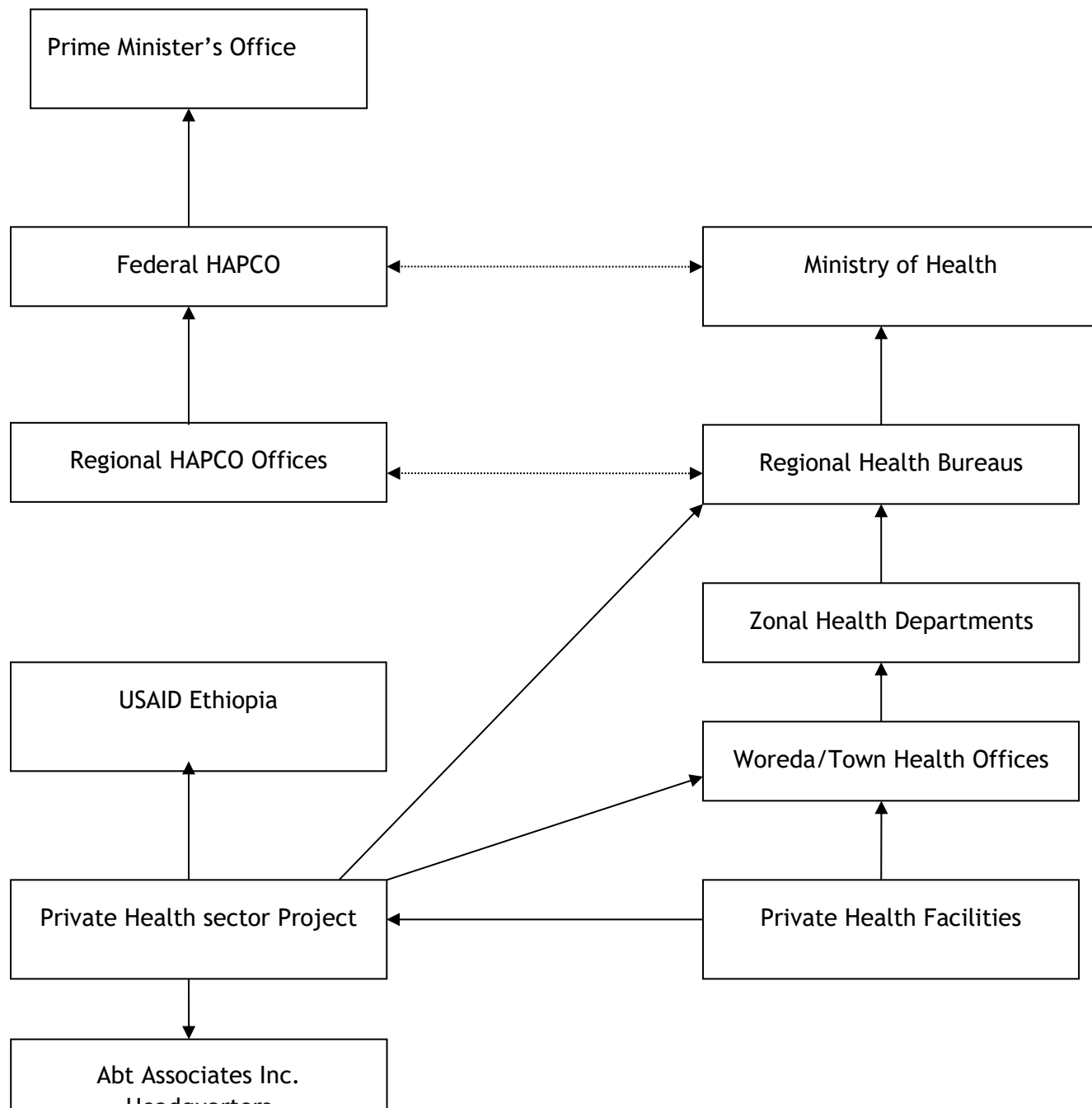
5 Flow of Information

As indicated in the Framework, the M&E indicators are collected from the private health facilities and subcontractors on regular basis. The sources of data for the indicators are supportive supervision reports, patient records, client intake forms, registries, meetings and monthly/quarterly reporting formats. Health providers and data clerks of the private health facilities and Private Health sector Project staff are responsible for routine data collection and reporting activities. Program officers and Monitoring and Evaluation team members of Private Health sector Project support private health facilities to set up and maintain proper and efficient management information systems.

As depicted in the national HMIS, health facilities report to Sub-city Health Offices/Regional Health Bureaus. Private Health sector Project will get copies of regular reports and routine data for further analysis and reporting to USAID, Abt Associates Inc. headquarters and Regional Government. Data recording and reporting system will be based on the national HMIS system. In this project period, Private Health sector Project will engage FMOH, Regional Health Bureaus/ HAPCO, USAID and other stakeholders in monitoring of activities, to ensure better project implementation. Reports will be sent to the stated parties on quarterly basis after being reviewed by the Program Office

Data flow mapping will be carried out every quarter based on the attached flow of reports and using the data quality assessment dimensions mainly (timeliness and completeness of the data) .

Figure 2. Data and Information flow in Private Health sector Project



NB : to determine /find out bottleneck in data flow , staff from the project will check the randomly selected private health facilities report for timeliness and completeness. Data ,aggregation ,usage and bottleneck also assessed in the project regional offices (Addis Ababa, Amhara, Oromya , SNNPR , Tigray ,Dire Dawa and Harari)

6 Data Quality Management

Routine monitoring activities of activities provided by private health facilities is a corner stone for overall program assessment/improvement. Data generated from the facilities with high quality supports to accurately evaluate the effect of implemented program components such as diagnosis, treatment and follow up of TB and HIV patients, malaria diagnosis and treatment and provision of quality health services at the PMTCT and family planning clinics. Quality data are characterized by **completeness, accuracy, validity, reliability** and should be reflective of good clinical practices, e.g., in maintaining **confidentiality**. Collection and review of patient data starts at the health facility level. Data verification will be done for all facilities at least one time per year. Full-fledged DQAs (validity, reliability, completeness etc.) will be carried out for facilities selected based on type of services (ART, PMTCT, TB/HIV) and load of clients once per year .The DQA tool and methods are attached in annex 2.

7 Service /Program Quality Assessment

Quality of health service is becoming a public health concern in many countries including the developing world. Health care providers, public health administrators, funding agencies and beneficiaries of health service are raising quality as a policy and basic right issue. But they define the phrase “Quality of Health Service” differently based on what they value more. Health workers value appropriateness of care; patients give more emphasis for provider-patient interaction and issues of accommodation; funding agents and administrators give more attention to the availability, efficiency and utilization of service components. Considering all these perspectives, the Institute of Medicine of the National Academies (Washington DC, USA) defined it as “the degree to which health services for individuals and populations increase the likelihood of achieving desired health outcomes and are consistent with current professional knowledge.”

Improving quality in health care is achieved by:

- Implementing interventions according to established standards that ensure programs are effective and outcomes are achieved
- Collecting and using reliable data to understand the level of service quality, identify Problems, and make improvements
- Evaluating programs for outcomes and impact.

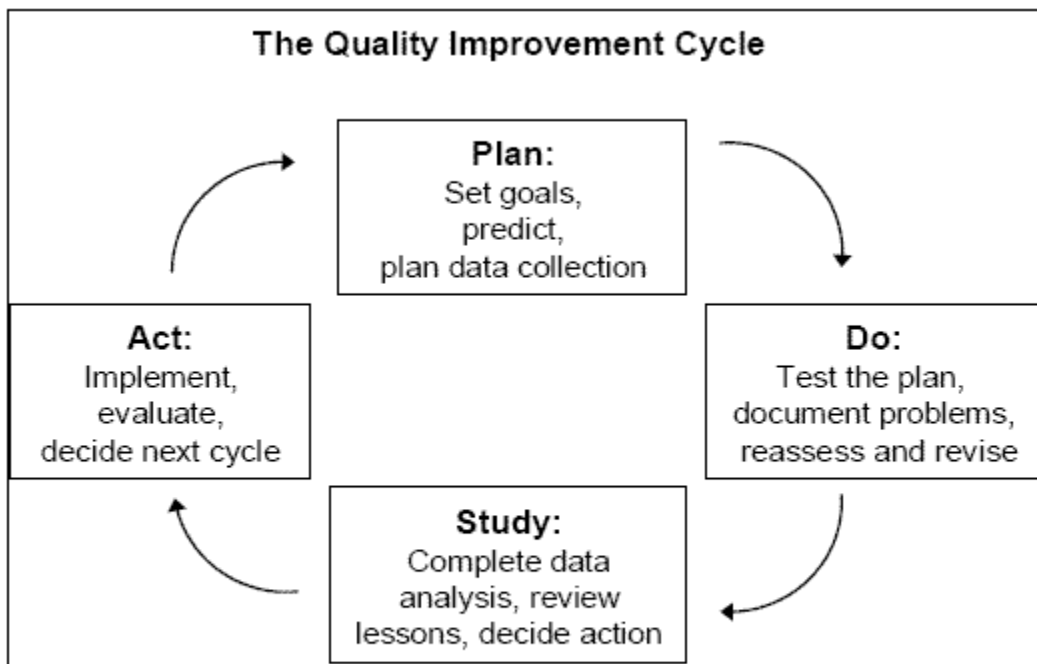
Although there are a few examples of quality improvement in the health service delivery in Ethiopia, such as the implementation of Client Oriented Provider Efficient (COPE), currently there is no comprehensive national system of measuring, improving and reporting on the state of the health service quality in Ethiopia .To determine service and quality improvements in this project, a quality improvement framework will be developed with active involvement of all stakeholders.

Key program areas covered under this QM framework

- HIV Testing and Counseling
- Adult and Pediatric Care, Support, and Treatment
- TB/HIV
- PMTCT
- Laboratory for HIV clinical services
- Family Planning
- Sexually Transmitted Infections
- Malaria
- Strategic information for HIV clinical services, including monitoring, evaluation, and reporting,
- Health Systems Strengthening (HSS), including Human Resources for Health (HRH)
- Supply Chain Management System (SCMS)
- Long term plan in the implementation of the QM framework includes to site and program expansion such as (family planning, RMNCH and malaria services).

The Quality Improvement framework is designed to enable health facilities to implement Quality improved steps which include Identification of quality gap, analyzing the cause, developing change concept and idea , and finally testing the change through the PDSA cycle as depicted in Fig 3. Where appropriate (Ex: facility level is hospital) we will encourage establishment of MDT team. Many of quality improvement issues of our project, however, can be dealt with individual provider level.

Figure 3 : Framework for Quality Improvement, Private Health sector Project



Source: Adapted from Langley G, Nolan K, Nolan T, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. San Francisco: Jossey-Bass Publishers, 1996.

In the next five years the Private Health sector Project efforts to improve the quality of healthcare services will involve the following 3 components:

1) The implementation of a small-scale pilot Quality Improvement (QI) activity. This activities aim to achieve an important results that focus on specific issues with a defined time limit set by the achievement of expected output /outcomes. This will creates a unique opportunity for all involved in the process to learn more about their health care system and use these lessons for replication of improvement. For easy management and quick learning, a pilot QIP is set up on a small scale, involving few facilities. Small-scale pilot improvement projects allow finding out what system changes and interventions lead to quality improvement.

2) The large-scale replication of improvements:

After the first year of implementation, Private Health sector Project will develop a mid -term goal and to replicate the results of a small scale pilot activities (involving more number of facilities) in order to achieve health outcomes of a significant magnitude

3) The institutionalization of improvement processes.

Private Health sector Project will recommend all the process of the quality improvements initiatives at the national level and institutionalize the improvement process.

SIMS assessment as Quality Improvement

The Site Improvement through Monitoring System (SIMS) is a quality assurance methodology used to increase the impact of PEPFAR programs on the HIV epidemic through standardized monitoring of the quality of services at the facility, community, and above-site levels. SIMS uses a set of quality standards against which performance can be assessed and issues identified for improvement through remediation. Providing quality services advances the PEPFAR goal of sustained HIV epidemic control. SIMS visits will be conducted every year to selected private facilities & above site entities on regular basis, and the private health sector project will make sure the development & implementation of quality improvement initiatives based on the SIMS finding & recommendations. .

8 Methodology of Process Monitoring and Performance Evaluation

8.1 Process Monitoring

Process monitoring is an important tool for managers to track project activities and identify problems. Private Health sector Project process and output monitoring cycle will involve structured and informal regular contact (through meetings, reports, site visits, etc.) with health facilities and subcontractors and uses both quantitative and qualitative information, in order to maintain regular communication, monitor progress, identify obstacles to implementation and opportunities for capacity building. The support of Abt Associates Inc. headquarters will be crucial in the course of Monitoring and Supportive Supervision.

Review meetings: Private Health sector Project will arrange a review meeting at the regional level with stakeholders. The meetings are opportunities for private health facilities, subcontracting firms, Regional

Health Bureaus and other relevant government offices to come together, review progress over the period (conduct results analysis), discuss context- specific factors contributing to reports and other problematic issues..

In addition, Private Health sector Project will have a semi-annual internal review meeting to see performances at regular basis and improve reporting and data quality.

Supportive supervision and follow up site visits: Supportive supervision will be carried out every quarter in collaboration with sub-city health offices/regional health bureaus using Smart Phone support. some of the data collected are : human resources , attrition rate in the facilities , capacity building efforts and availability of guidelines and SOPs for services delivery.

Major activities, challenges and possible actions to resolve the challenges will be discussed during the visit. On the spot corrective measures and feedback including action plan are also given on certain problems and constraints. The supportive supervision report produces considerable amount of data which is useful for Private Health sector Project and RHBs for future program implementation. Based on the results and observation of supportive supervision, Private Health sector Project program officers will conduct a follow up visits to fill gaps identified during the joint supervision.

Quarterly Reports – Every three months, Private Health sector Project will compile quarterly activity reports of all programs. These reports will contain PEPFAR level 1 and 2 and Private Health sector Project custom- indicators for each intervention and identify implementation problems and solutions. The reports are collated in order to prepare the quarterly progress report for USAID/PEPFAR and Abt Associates Inc.

8.2 Performance Evaluation

Private Health sector Project will conduct both process and final or end of project evaluation through a detailed analysis of program outcomes or impact. During the project implementation period, summative evaluation will be conducted for HIV care and treatment services (HTC, PMTCT, and ART), TB, STI, FP and Malaria.

Baseline data on the project indicators will be determined from existing sources, such as the predecessor PHSP project M&E data and reports, facility registers, and APR report. Determining baselines on indicators whose data does not exist in available sources will involve separate data collection exercise. Interim process evaluations will be conducted during the project implementation, and will be done through review of existing reports and registers, key informant interviews and secondary analysis of monitoring data. An end line evaluation will be conducted at the end of Year 5 of project implementation. It will involve (private facilities, RHBs, private health facility associations and other relevant stakeholders. Appropriate methodologies will be designed in consultation with USAID Ethiopia

The evaluation reports will be shared with USAID, government and partners. Feedback on opportunities and limitations of the interventions to date will be incorporated into the work plan for the remaining life of the project.

The Private Health sector Project will work with USAID to evaluate project outcomes and impact at the mid and end of the project. The project will collaborate with USAID in the design of the outcome evaluation protocol and in the implementation of the assessment. Findings of the mid-term and final evaluation will be shared with Regional Health Bureaus, USAID; Abt Associates Inc. headquarters, and

other relevant stakeholders. The following evaluations & base line assessments will be done throughout the project span of life:

Base line assessment/ Formative evaluations

Table 2: Evaluation procedure planed by the Private Health sector Project

| Formative Evaluation/baseline survey | | | |
|--|--|---|-------------|
| The Private Health sector Project will conduct the following formative evaluation/assessment as follows | | | |
| no | Plan | Learning question | When |
| 1 | Gap assessments and analysis on private healthcare facilities on the progress of implementation of national standards | How is the national standards implemented | Year 2 |
| 2 | Conduct an assessment of the legal and policy frameworks governing the health sector in Ethiopia | Policy and private health facilities | Year 1 |
| 3 | Conduct a formative research on consumers of private health providers and barriers to use. | Barrier for use at the private facilities | Year 2 |
| 4 | Conduct a formative study to identify the characteristics of the major providers of STI services and explore the prevailing case management practices. | Who is the provider and what is the practice | Year 1 |
| 5 | A Rapid assessment to map the locations of, magnitude of and access to malaria control and prevention intervention by migrant work force | Where are the locations harboring migrant work force ? What is their magnitude ? Where do they access malaria treatment and prevention services ? | Year 1 |
| 6 | A rapid assessment of private facilities currently providing MNCH services in Ethiopia | What is the potential from the private sector | Year 1 |

| | | | |
|----|---|---|--------|
| 7 | Conduct rapid referral assessment to describe referral and linkage situation in the private health facilities | What is referral and linkage practice in private facilities | Year 2 |
| 8 | Establish solid evidence base and advocate for social franchising as a mechanism to increase access to key services | Situation of franchising in Ethiopia | Year 2 |
| 9 | Assessment conducted to identify opportunities of group practices | What opportunities exist for group practice in Ethiopia | Year 2 |
| 10 | Determinant of women health seeking behavior for particular service providers | What is the health seeking behavior determinant | Year 3 |

Mid Term / Process Evaluation

The Private Health sector Project will conduct midterm evaluation at the midpoint of the project life (January 2017)

The general and specific objective of the evaluation will be

- To determine the level of achievements and progress made to date in terms of achieving planned results and performance indicators (as provided in the M&E plan of the project plan).
- To determine the main reasons for exceeding or not meeting expected results? What were the major policy challenges (consider GoE, USAID and PEPFAR policies) and opportunities with respect to achieving program objectives and targets.
- To assess the level of partner monitoring and evaluation process of the output and outcome of the program and the extent to which the results are achieved? How can the monitoring and evaluation (M&E) system be improved
- To determine and assess issues related to any management or staffing issues or challenges during the program and, if so, how have they been identified, communicated, addressed or resolved.
- What are the key lessons learned from the Private Health sector Project , What have been the strengths, weaknesses and best practices with respect to project implementation, M&E, capacity building and the program's relationships with the GoE and other stakeholders
- To determine the level of arrangement and what arrangements have been made to ensure sustainability of the program's results and impacts.

At the end of this mid-term /process evaluation , the following intermediate results will be assessed

- 1) Percentage of improvement in private health sector index score as a measure of enabling environment for the engagement of the private health sector in health.

- 2) Number /percentage of recommendation about policy changes
- 3) Percentage of contribution of the private health sector towards curbing the impact of disease of public health importance'
- 4) Percentage of private health facilities services complaint to established quality standards
- 5) Percentage improvement in the private health care systems (compared to baseline assessment)
- 6) Proportion of national level indicators that capture the contribution of the private health sectors
- 7) Number of higher level decisions made using evidences generated through the support of the associate award

Evaluation questions and Proposed methodology for mid-term evaluation

| no | Evaluation questions | Proposed methodology |
|----|--|-------------------------------------|
| 1 | Program implementation | Project report and plan review |
| | What does the program consists of (activities, events)? | |
| | What delivery methods are used? | |
| | Who actually carries out the program, how well do they do so? | |
| | Who are the beneficiaries, does everyone has equal access? | |
| | What resources and inputs are invested? | |
| | Are the financial and staff resources adequate? | |
| 2 | Program context | |
| | How well the program fits in the local settings (health transformation plan, policy etc.)? | Key informants interview (KII) |
| | What is the socio economic, political contribution of this project (inhibits or contributes to the program success)? | Interview , policy analysis etc. |
| | What are the setting given and what can be changed? | Interview key person , stakeholders |
| | Who else work on similar project? duplication | |
| 3 | Program need | |
| | What needs are appropriately addressed? | FGD, interview |
| | What are current practice ? | Interview |
| | What changes do people see as possible or important | Interview |

Effectiveness Evaluation/Terminal Evaluation

At the end of the project implementation, the project in collaboration with USAID will conduct a terminal evaluation / Effectiveness evaluation. This will be at the middle of January 2020. At this stage the available data (collected each year, secondary data review) and qualitative methods such as most significant change by the project will be determined using composite indicators.

The Objective of the evaluation: to determine if the private health sector project contributed toward **the mitigation of impact of disease of public health importance.**

Specific objectives: are to determine if

- Enabling policy environment for the private health sector engagement improved
- Access to quality services for disease of public health importance increased *in* the private health sector
- The private health care system strengthened
- The program learning and innovative ventures enhanced for the private health sector

Research questions and proposed methodology for terminal evaluation

| No | Program outcome /impact | Methodology |
|----|---|---------------------------|
| 1 | What people do differently as a result of the project? | Interview |
| 2 | Who benefits and how ? | Report , interview |
| 3 | Are the clients satisfied with what they gained from the project? | Interview ,survey |
| 4 | Are the program's accomplishments worth the resource invested? | Analysis ,study |
| 5 | What are the social, economic and environmental impacts (positive or negative) on people, communities, and environment? | Interview |
| 6 | What are the strength and weakness of the project? | Report review , interview |
| 7 | Which activities contribute most and least? | Report review |
| 8 | What if unintended secondary /negative effect of the project? | FGD, interview |
| 9 | How well does the program respond to the initiated need? | Report review |
| 10 | Efficiency of resource utilization? | Financial analysis |

Major base line indicators and trends to be measured at the mid-term and post line evaluation progress

| no | Indicator | Base line | Target | | | | |
|----|-----------|-----------|--------|--------|--------|--------|--------|
| | | | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| | | | | | | | |

| | | | | | | | |
|---|---|-------------|-----------|----------------|----------------|----------------|------------------------|
| 1 | Percentage improvement in private health sector index score as a measure of enabling environment for the engagement of the private health sector in health | na | Base line | 5 % from base | 10 % from base | 15 % from base | 20 % from base |
| 2 | Number /percentage of recommendation about policy changes | na | | | | | |
| 3 | Percentage of contribution of the private health sector towards curbing the impact of disease of public health importance's | 14 % for TB | 20 % | 25% | 30% | 30% | 30% |
| 4 | Percentage of private health facilities services complaint to established quality standards | Na | Base line | 10 % from base | 20 % from base | 30% from base | 100% of the facilities |
| 5 | Number of private health facilities which commenced or improved the quality of existing services for HIV and/or TB as a result of increase access to resources* | Na | 50 | 60 | 80 | 95 | 110 |

9) Data Analysis and Dissemination Plan

The entire Private Health Sector Project a monitoring data from the health facilities and other sources will be collected, processed, compiled and analyzed quarterly and semiannually by the project QM unit. Analysis and evaluation reports will be shared for USAID, RHBs and other relevant stakeholders for planning, and other decision making purpose in review meetings, consensus building, advocacy and referral networking work Private Health Sector Project. The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

The M&E reports will be disseminated to relevant government departments, partners, donors and private health facilities and subcontractors to ensure the project communicates results to the widest possible audience that would benefit from the data.

In addition, annual review meetings will be organized with Regional Health Bureaus, facility managers, focal persons, Sub-City health offices/RHBs, donor and other stakeholders to evaluate the overall performance of Private Health Sector Project. This will help to identify critical challenges and potential solutions to improve service delivery.

10 Working with PHFAs (Private Health facilities associations)

The private health facilities associations are the main stakeholder's and key actors of this project in the sustainability and continuity of the project outcomes. The association will be engaged for the realization of this M&E plan as follows.

- Participated in all HMIS training with the private health sector, participate in basic HMIS and M&E training and start to coordinate and plan similar training in their respective regions
- Participate in the DQAs process (orientation of the DQAs, participate in DQAs and fully take part DQAs in their respective regions)
- Participate in supportive supervision and quality improvement activities (participate in the training, cooperate with RHBs/Town health offices and Woreda town health offices.
- At the end of year five all PHFAs are expected to undertake the DQAs, supportive supervision and reporting using the HMIS registers and forms for their respective regions.

11 Staff in the Private Health sector Project (QM and M&E)

The Private Health sector Project is led by a team of senior experts which includes the COP, DCOP, and Director for program operation, Private Health Sector Development director and M&E /Quality management director¹. The summary of staff in the project with a particular emphasis with M&E is depicted as follows

COP: lead and control the overall program and directly supervise the DCOP and all directors mentioned above

DCOP: assist the COP and lead all the technical component of the program such as clinical director, laboratory service manager, pharmacy manager.

Clinical Director: under the direct supervision of the DCOP, work closely and lead all activities such as malaria program, PPM TB including MDR TB/PPP advisor seconded at the FMOH and comprehensive HIV /STI manager (with ART /PMTCT coordinator and care and support officer).

M&E and Quality Management Director: under the direct supervision of the COP, lead and coordinate the overall M&E activities. The unit is staffed with associate director, M&E officer and CQI officer.

Regional Program Director: under the direct supervision of Director for Program Operation, coordinate and lead the overall regional activities. The regional offices are located in Addis Ababa and, Dire Dawa city administration, Amhara, Oromia, SNNPR, Harari and Tigray regions. The following table shows M&E activities carried out at each level with responsibilities.

Staff in the M&E and capabilities

The staffing level at the M&E and QM unit is organized by the M&E/QM director, associate director for QM and two officers (M&E and CQI officer).

¹ Details organogram of the project is depicted in the annex

M&E and QM Director

- MD and MPH with educational background and more than 18 years of experience and other additional training such as (basic M&E ,project management ,research methodology)
- Has basic knowledge and skills in M&E , indicator development , data collection ,analysis and reporting
- Experience in designing of survey and assessments using qualitative and quantitative methods
- Experience in providing M&E and project management training
- Experience in giving M&E mentoring for health professionals and HMIS training

Associate director for M&E and QM

- MPH with educational background and more than 14 years of experiences
- Has basic knowledge and skills in M&E ,development of data collection tools using electronic methods, data collection and analysis
- Experience in designing of survey and assessments using qualitative and quantitative methods
- Experience in providing M&E and project management training
- Experience in giving M&E mentoring for health professionals and HMIS training

M&E officer

- BSc in statistics with educational background
- Has basic knowledge in doing advanced statistical analysis
- Experiences in conducting DQAs, HMIS mentorship
- Experiences in giving M&E mentorship

CQI officer (Continuous quality Improvement officer)

- Health officer with many years of experience in HMIS and e HMIS
- Has basic knowledge and skills in giving HMIS training for staff
- Experiences in developing and implementing quality improvements activities

Table 3: Summary of M&E activities carried out at each level in the Private Health sector Project

| no | Departments /level | Duties related to M&E | Remarks |
|----|---------------------------|--|---|
| 1 | COP | <ul style="list-style-type: none">• Approves all issues related to M&E and QM , DATIM , all reports , all plan | DATIM approved by COP according to USAID regulation |
| 2 | DCOP | <ul style="list-style-type: none">• Finalize all the narrative reports (clinical services) ,give explanation for under or over achievements of quantitative data | |
| 3 | Clinical service director | <ul style="list-style-type: none">• Analyze all data related to clinical services such as HCT ,PMTCT ,ART ,PPM DOTs, STI , malaria and | |

| | | | |
|---|--|--|--|
| | | <p>FP. Give feedback on under and over Achievements of the data</p> <ul style="list-style-type: none"> • Coordinate the preparation of all the narrative reports for clinical services • Work closely with M&E unit in JSS (tools revision , feedback) | |
| 4 | All program manager (lab ,pharmacy , malaria , ART/PMTCT etc.) | <ul style="list-style-type: none"> • Prepare the narrative reports for their respective program • Participate in the finalization of all tools related to M&E (such as JSS • Analyze all the data collected and write an explanation for under/over achievements. • Link and use the program data for decision g such as mentoring , quality improvements | |
| 5 | Regional program director | <ul style="list-style-type: none"> • Coordinate all the data collection , JSS carried out in the region • Prepare a regional summary and share with regional offices for actions | |
| 6 | Regional offices | <ul style="list-style-type: none"> • Collect facility level data • Conduct facility level JSS • Distribute all the required HMIS tools to the facilities | |
| 7 | M&E and QM unit | <ul style="list-style-type: none"> • Prepare all the data collection tools and distribute to the regions • Coordinate and conduct all trainings related to M&E (such as HMIS, DQAs etc.) • Collate and analyses all the data and prepare the required reports • Coordinate AWP preparation • Conduct DQAs and transfer knowledge to the regional offices • Coordinate , conduct , analyze and disseminate the JSS reports • Receive all feedback and prepare both the narrative and DATIM reports | |

Table 4: List of training required for professionals working in the project

| no | Type of training | Recommended professionals |
|----|--|-----------------------------------|
| 1 | Basic M&E training (03 days) | For all program and M&E staff |
| 2 | Advanced M&E training (05 days) | M&E staff |
| 3 | Basic Project management (03 days | For all program and M&E staff |
| 4 | Statistical package training (SPSS ,SAS ,EPI info | M&E staff |
| 5 | e HMIS | Regional staff and M&E staff |
| 6 | Basic HMIS | Regional program manager /officer |
| 7 | Basic Research methodology | For all program and M&E staff |
| 8 | DQAs assessment | Program staff |

I2 Deliverables Schedule

With this M&E plan, the project will have a deliverables for different program activities and a schedule set to submit to USAID with means of delivery. The major milestones and deliverables includes all the work plan ,all quarterly and semiannual reports, revised and updated M&E plan , midterm and end term evaluations , all assessments and baseline surveys. All those milestones and deliverables will be used as program, service improvements and used as learning points for program sustainability's

Table 5. Deliverables schedule

| Milestone Deliverables | Name of recipient of the deliverable | Date Deliverable is Due <i>(Planned Date)</i> | Actual date it was delivered <i>(this is filled in after delivery has been made)</i> | Means of delivery (Person/method) <i>(this is filled in after delivery has been made)</i> |
|---|---|---|--|---|
| Work plan for FY 16, 17 18,19 & 20 | USAID Ethiopia and Abt Associates Inc. Headquarters | 22 October , of each year for annual | | |
| Report of FY 16-20 quarter report | | 22 January, 22 April, 22 July for each year | | |
| Report of FY 16-20 Annual report | | 22 October for each year for each year | | |
| Revised M & E plan of the project | | 22 October for each year and with ever quarter | | |
| Mid-term evaluation of the project | | June 2017 | | |
| Terminal Evaluation of the project | | Oct 30,2020 | | |
| All base line assessments /program survey | | Oct 30, of each year | | |

Table 6: Private Facilities' Quarterly Reporting Schedule

| # | Report | Report Due Date | Time Periods |
|----------|---------------|------------------------|-------------------------|
| 1 | Quarter 1 | 5 January | 1 October – 31 December |
| 2 | Quarter 2 | 5 April | 1 January – 31 March |
| 3 | Quarter 3 | 5 July | 1 April – 30 June |
| 4 | Quarter 4 | 5 October | 1 July – 30 September |

I3 Cascading the M&E plan

This M&E plan will be cascaded to the project regional offices and the private health facilities in which the project is supporting (Addis Ababa, Amhara, Oromya, SNNPR, Tigray, Dire Dewa and Harari, Benishangul, Gambela, Afar Offices). The major objective of this cascading is to aware and fully engaged all the staff working in the regional offices and private health facilities. It also eases the ways for successful implementation of the planned activities such as baseline assessment and follows up. This M&E plan will have the following outline with maximum of 10 pages.

- Cover page
- Introduction and objective
- Objective of the M&E plan
- Result framework
- HMIS , data flowing , DQAs ,Supportive supervision
- Major base line indicators and bench mark for mid-term and end term evaluation.
- Key /PEPFAR level indicators ,with baseline data and plan for each year

13 List of annexes

Annex I: Indicators Reference Sheets²

CARE_NEW

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|---|
| Indicator Protocol (Reference Sheet) # 1 |
| Name of Indicator: Care New : Number of HIV-positive adults and children newly enrolled in clinical care during the reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count |
| Description |
| Precise definition(s): Newly enrolled in care is defined as HIV positive individuals enrolling in HIV clinical care programs who are registered at the facility and receive at least one of the following at enrollment: clinical assessment (WHO staging)OR CD4 count. In this indicator transfers of existing patients from clinics or health facilities will not count as new enrollees. However current patients at facilities who are newly HIV diagnosed within other clinical programs such as PMTCT or TB should be counted under this indicator |
| Unit of measure: Individuals |
| Disaggregated by: Age and sex such as : <1 Male, <1 Female, 1-4 Male, 1-4 Female, 5-9 Male, 5-9 Female, 10-14 Male,10-14 Female, 15-19 Male, 15-19 Female, 20-24 Male, 20-24 Female, 25-49 Male, 25-49 Female, 50+ Male, 50+ Female |
| Justification/Management Utility: This indicator will allow PRIVATE HEALTH SECTOR PROJECT to: <ul style="list-style-type: none"> • Evaluate coverage of HIV clinical services against need and better plan their programs, • Assess the quality of linkages & referrals between HIV testing and care and treatment programs and identify gaps; when compared with the number testing HIV positive and can be taken as a rough proxy of linkage to care. • Assess the timing of enrollment in care in terms of CD4 count and WHO stage; early enrollment in care should facilitate prompt initiation of ART once eligible, preserve immune function, facilitate appropriate screening and prevention of opportunistic infections, and promote epidemic control |
| Plan for Data Acquisition |
| Data collection method and timing: <p>The data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i></p> <p>The project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, The project will also get copies of regular reports and routine data from health facilities for further analysis. Data recording and reporting system will be based on the national HMIS system, and reports will be sent out to USAID and Abt Head Quarters on quarterly basis.</p> |

² indicators measured in this M&E plan pertain to project supported facilities only

Data source: The sources of data for this indicator are service statistics records, including pre /ART registers, PMTCT filled out by the private service providers as part of the national HMIS, and Data base installed by the project at the private health facilities will be used to capture this data.

Estimated cost of data acquisition: Negligible

Responsible staff and data storage location: Original report collected from the private service providers will be filed at QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.

Data Analysis, Review & Reporting

Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, the project Program Officers carries out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: none

Date of initial DQAs-----

Date of future DQAS -----

Actions taken to address data limitations: none.

Other Notes

Notes on baselines/targets: the baseline target for this indicator is based on the performance of the PHSP in year six which was 913

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 268 | 253 | 606 | 394 | 503 | 567 | | | | |
| Q2 | 268 | 195 | 882 | 570 | 503 | 474 | | | | |
| SAPR | 536 | 448 | 1488 | 964 | 1006 | 1041 | | | | |
| Q3 | 401 | 162 | 1020 | 442 | 503 | 391 | | | | |
| Q4 | 402 | 228 | | 442 | 503 | 378 | | | | |
| APR | 1339 | 838 | 3536 | 1830 | 2012 | 1810 | | | | |

This sheet was last updated on: Nov 30 , 2018

TB_STAT

| |
|--|
| Indicator Protocol (Reference Sheet) # 2 |
| Name of Indicator: TB_STAT : Percentage of registered new and relapsed TB cases with documented HIV status |
| Description |
| Precise definition(s): “TB patients” refers to all types of tuberculosis cases, including Pulmonary (sputum smear positive and smear negative) and extra pulmonary tuberculosis patients diagnosed and treated in private and workplace clinics under the USAID/ private Health sector project. The indicator measures the number of TB patients registered during a given time period who had an HIV test result recorded in the TB register as a percentage of the total number of TB patients registered during the same time period. |
| Unit of measure: Individuals |
| Disaggregated by: age:<1, 1-4, 5-9, 10-14, 15-19, 20+, sex male and female and by HIV status (positive and Negative) |
| Justification/Management Utility: This indicator measures the ability of the TB program to ensure that registered TB cases know their HIV status. This information is crucial to provide registered TB cases who are HIV-positive with important HIV treatment, Prevention and care services to reduce HIV-associated morbidity, mortality, and HIV transmission. If a high proportion of registered TB cases know their HIV status, the routine HIV status data from this population can provide reliable estimates of HIV prevalence among registered TB cases for surveillance purposes |
| Plan for Data Acquisition |
| Data collection method and timing: The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use customized HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> private Health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private Health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis |
| Data source: The sources of data for this indicator are service statistics records, including TB registers filled out by the private service providers as part of the national HMIS, and TB case finding reports compiled by the clinics with support from private health sector project Ethiopia program officers. |
| Estimated cost of data acquisition: Negligible |

Responsible staff and data storage location: Original report collected from the private service providers will be filed at private Health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit and PPM DOTS manager. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.

Data Analysis, Review & Reporting

Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private Health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private Health sector project Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: The indicator is meant to capture the # of new TB patients enrolled during a given time period; clients having HIV test as a percentage of the total # of TB patients registered during the given period.

The national reporting format does not capture those groups of TB patients that were enrolled in the previous quarter, but tested for HIV in the following quarters.

Date of initial DQAs----- Date of future DQAs-----

Actions taken to address data limitations: Feedback will be provided to the RHBs and FMOH so that data will be captured for a group of TB patients registered a year earlier, in a similar way, TB treatment outcome is also reported

Other Notes

Notes on baselines/targets: the baseline target for this indicator is based on the performance of the PHSP in year six which was 87.7%

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 88% | 91.7% | 95 % | 89 % | 95 % | 86 % | 95% | 90% | 95% | |
| Q2 | 88% | 90.6% | 95% | 92 % | 95% | 90 % | 95% | 90% | 95% | |
| SAPR | 88% | 91.1% | 95% | 91 % | 95% | 88 % | 95% | 90% | 95% | |
| Q3 | 88% | 77.5 % | 95% | 91 % | 95 % | 89 % | 95% | 88% | 95% | |
| Q4 | 88% | 80.5% | 95% | 92% | 95% | 90 % | 95% | 93.5% | 95% | |
| APR | 88% | 85.0% | 95% | 92% | 95% | 89 % | 95% | 91% | 95% | |

This sheet last updated on: October , 2019

TB_ART

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|---|
| Indicator Protocol (Reference Sheet) # 3 |
| Name of Indicator: TB_ART : Percentage of HIV-positive new and relapsed registered TB cases on ART during TB treatment |
| Description |
| <ul style="list-style-type: none"> • Precise definition(s): “TB patients” refers to all types of tuberculosis cases, including Pulmonary (sputum smear positive and smear negative) and extra pulmonary tuberculosis patients diagnosed and treated in private and workplace clinics under the USAID/ PRIVATE HEALTH SECTOR PROJECT . The indicator measures the number of TB patients, who are HIV positive and put on ART during TB treatment during the reporting period. • The numerator includes registered new and relapsed TB cases who are HIV-positive that are on ART during TB treatment, including PLHIV who newly initiate ART after TB case registration and those who are already on ART at the time of TB case registration, during the reporting period. • The denominator includes all registered new and relapsed TB cases undergoing TB treatment that tested HIV positive at registration or had documented previously known HIV-positive status (i.e., documented evidence of a previous positive HIV test or enrollment in HIV care), during the reporting period |
| Unit of measure: percentage of individuals |
| Disaggregated by: Age: <1, 1-4, 5-9, 10-14, 15-19, 20+ Sex : male and female and Positivity status : newly tested HIV positive and previously known HIV positive Time of initiation : ART initiation < 8 weeks of start of TB treatment ART initiation > 8 weeks of start of TB treatment |
| Justification/Management Utility: The indicator is intended to measure the ability of programs to ensure registered TB cases initiate ART through program integration or linkage |
| Plan for Data Acquisition |
| Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use customized HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> private Health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private Health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis |
| Data source: The sources of data for this indicator are service statistics records, including TB registers filled out by the private service providers as part of the national HMIS, and TB case finding reports compiled by the clinics with support from private Health sector project program officer. |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at private Health sector project QM unit after thorough review by the Comprehensive HIV care and support |

program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.

Data Analysis, Review & Reporting

Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private Health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private Health sector project Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: ART status is often captured in the quarterly TB case registration report, TB cases that are registered in one quarter but initiate ART the following quarter may not be captured by the TB case registration report. This could result in under-recording of ART initiation if data are not updated to reflect TB cases initiating ART during TB treatment, but in a different quarter from the one in which they are registered.

Date of initial DQAs----- Date of future DQAs -----

Actions taken to address data limitations:

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 71%

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 100% | 81.4% | 100 % | 84 % | 100 % | 91 % | 100 % | 91% | 100 % | |
| Q2 | 100% | 85.55 | 100% | 95 % | 100% | 73 % | 100% | 91% | 100% | |
| SAPR | 100% | 83.7% | 100% | 91 % | 100 % | 80% | 100 % | 91% | 100 % | |
| Q3 | 100% | 85.7% | 100 % | 89 % | 100 % | 81 % | 100 % | 91% | 100 % | |
| Q4 | 100% | 76.4% | 100% | 84% | 100 % | 79 % | 100 % | 93% | 100 % | |
| APR | 100% | 81.0 % | 100% | 86% | 100 % | 80 % | 100 % | 92% | 100 % | |

This sheet was last updated on: October , 2019

TB_IPT

| |
|--|
| Indicator Protocol (Reference Sheet) # 4 |
| Name of Indicator: TB_IPT : Proportion of newly enrolled HIV-positive people started on LTBI treatment during the reporting period |
| Description |
| Precise definition(s): Numerator : Total number of people living with HIV newly enrolled in HIV care who are started on treatment for latent TB infection during the reporting period Denominator : Total number of LTBI treatment eligible HIV positive clients newly enrolled in to HIV care during the reporting period |
| Unit of measure: percentage of individuals |
| Disaggregated by: Age: <1, 1-4, 5-9, 10-14, 15-14, 15+ Sex : Male, Female |
| Justification/Management Utility: this indicator measures the provision of IPT to eligible PLHIV to treat latent TB infection and reduce the significant burden of TB-associated morbidity and mortality among PLHIV, as recommended by the WHO. |
| Plan for Data Acquisition |
| Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> private Health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private Health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis |
| Data source: These data should be captured in pre-ART and ART, PMTCT registers. Programs should modify the register(s) as needed to easily capture this information. |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at private Health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private Health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports. |

In addition, private Health sector project Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: A limitation of this indicator is that less than 100% of PLHIV newly enrolled in HIV clinical care will be expected to start IPT. The health facilities providers may not routinely assess PLHIV eligibility for IPT and the drugs are not readily available

Date of DQAs initial -----

Date of DQAs future -----

Actions taken to address data limitations: continuous program monitoring and if the indicator results shows low levels of IPT provision, or declining trends in IPT provision, will be interpreted as substandard and require work towards program strengthening

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 6.5%

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|---------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 10% | 21.7% | 50 % | 25.2 % | | 34 % | | | | |
| Q2 | 10% | 23.5% | 50 % | 15 % | | 38 % | | | | |
| SAPR | 10% | 22.55 % | 50 % | 15.6% | | 36 % | | | | |
| Q3 | 20% | 40.0% | 50 % | 20 % | | 48 % | | | | |
| Q4 | 20% | | | | | 41 % | | | | |
| APR | 20% | 49 % | 50% | 53% | | 39 % | | | | |

This sheet was last updated on: Nov, 2018

TX-NEW

| |
|---|
| Indicator Protocol (Reference Sheet) # 5 |
| Name of Indicator: TX_new : Number of adults and children newly enrolled on antiretroviral therapy (ART) |
| Description |
| <p>Precise definition: this is the number of adults and children who are newly enrolled in ART in the reporting period, in accordance with the nationally approved treatment protocol. Patients with records who transfer in from another facility, or who temporarily stopped therapy and have started again in the time period should not be counted. NEW is a state defined by an individual's <i>beginning</i> in a program. It is expected that the characteristics of new clients are recorded at the time they newly initiate into a program. This indicator includes newly initiated clients at ART clinic and those newly started ART at PMTCT clinic based on option B+.</p> <p>Note: Patients are counted as pregnant if they were pregnant at initiation of ART. Age represents an individual's age at first initiation of therapy. For example, if a 14 year old child begins ART and then shortly after turns 15, the child will still be counted under NEW in the <15 age category.</p> |
| Unit of measure: number of individuals |
| <p>Disaggregated by: Age/Sex: <1 Male, <1 Female, 1-4 Male, 1-4 Female, 5-9 Male, 5-9 Female, 10-14 Male, 10-14 Female, 15-19 Male, 15-19 Female, 20-24 Male, 20-24 Female, 25-49 Male, 25-49 Female, 50+ Male, 50+ Female</p> <p>Pregnancy status , Breast feeding status</p> |
| <p>Justification/Management Utility: The indicator measures the ongoing scale-up and uptake of ART programs. This measure is critical to monitor along with number of patients currently on ART in relation to the number of PLHA estimated to be eligible for treatment. This will help to assess progress in the programs' response to the epidemic in specific geographic areas and population as well as at the national level. Reporting the number of new patients enrolled on ART is critical to monitoring the HIV services cascade, specifically the successful linkage between HIV diagnosis and initiating ART.</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i></p> <p>private Health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private Health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| Data source: Facility ART/PMTCT registers/databases, tally sheet. |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at private Health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private Health sector project QM unit. Analyzed reports will be shared to USAID and</p> |

other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private Health sector project Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. CURRENT is a state defined by vital/treatment status when *last* seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. On the contrary, NEW and CUMULATIVE are states defined by *beginning* in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program

Date of DQAs initial -----

Date of DQAs future -----

Actions taken to address data limitations: close follow up and update each time

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 837

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 223 | 238 | 795 | 430 | 471 | 524 | | | | |
| Q2 | 224 | 170 | 795 | 554 | 471 | 456 | | | | |
| SAPR | 447 | 408 | 1590 | 984 | 942 | 980 | | | | |
| Q3 | 389 | 181 | 1025 | 461 | 471 | 356 | | | | |
| Q4 | 389 | 432 | 795 | 419 | 471 | 414 | | | | |
| APR | 1,225 | 840 | 3182 | 1863 | 1883 | 1750 | | | | |

This sheet was last updated on: Nov , 2017

TX_CURR

| Indicator Protocol (Reference Sheet) # 6 |
|--|
| Name of Indicator: TX_CURR : Number of adults and children currently receiving antiretroviral therapy (ART) |
| Description |
| <p>Precise definition: The current on -ART count should equal the number of adults and children with HIV infection who ever started ART minus those patients who are not currently on treatment at the end of the reporting period.</p> <p><input type="checkbox"/> Patients on ART who initiated or transferred in during the reporting period should be counted.</p> <p><input type="checkbox"/> Patients that pick up several months of antiretroviral drugs at one visit, which include ART received for the last month of the reporting period, but not be recorded as visits for the last month should be included in the count.</p> <p><input type="checkbox"/> HIV-positive pregnant women who are eligible for and are receiving antiretroviral drugs for their own treatment are included. HIV-positive pregnant women initiating lifelong ART through PMTCT (including Option B+) will be counted under this indicator. These include HIV-infected pregnant women who:</p> <ul style="list-style-type: none"> o Have newly initiated ART during the current pregnancy o Are already on ART at the beginning of the current pregnancy <p>Patients excluded from the Current on ART count are patients who died, stopped treatment, transferred out or are lost to follow-up (patient not seen for 1 to 3 months from last visit).</p> |
| Unit of measure: number of individuals |
| Disaggregated by: Age/Sex: <1 Male, <1 Female, 1-4 Male, 1-4 Female, 5-14 Male, 5-14 Female, 15-19 Male, 15-19 Female, 20+ Male, 20+ Female |
| Justification/Management Utility: This indicator measures the ongoing scale-up and uptake of ART and retention in ART programs as a critical step in the HIV service to cascade and assesses progress towards coverage of ART for all eligible HIV-positive individuals when reviewed against the number of PLHA that are estimated to be eligible for treatment. It allows us to track the response to the epidemic in specific geographic areas and among specific populations as well as at the national level. Provision of Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among those living with HIV, and onward HIV transmission. This indicator uses to measures the 2nd 90 target |
| Plan for Data Acquisition |
| <p>Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i></p> <p>private Health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private Health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| Data source: Facility ART Register/data base, PMTCT register, ARV regimen tally, |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at private Health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private Health sector project QM unit. Analyzed reports will be shared to USAID and |

other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private Health sector project Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: none
 Date of DQAs initial -----
 Date of DQAs future -----

Actions taken to address data limitations: none

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was **4,897**

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 5,120 | 5110 | 7934 | 5999 | | 7836 | | | | |
| Q2 | 5,344 | 5229 | 7934 | 6575 | | 8199 | | | | |
| SAPR | 5,344 | 5229 | 7934 | 6575 | | 8199 | | | | |
| Q3 | 5,687 | 5437 | 7934 | 6977 | | 8400 | | | | |
| Q4 | 6,035 | 5596 | 7934 | 7277 | | 8776 | | | | |
| APR | 6,813 | 5596 | 7934 | 7277 | 8328 | 8776 | | | | |

This sheet was last updated on: Nov ,2017

TX-RET

| Indicator Protocol (Reference Sheet) # 7 |
|---|
| Name of Indicator: TX_RET : Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy |
| Description |
| <p>Precise definition: It is the proportion of individuals who have been retained on antiretroviral therapy (ART).</p> <p>Numerator : Number of adults and children who are still alive and on treatment 12 months after initiating ART</p> <p>Denominator : Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up ((net current cohort))</p> <p>Patients may be included in the numerator (and denominator) if they have missed an appointment or drug pick-up or temporarily stopped treatment during the 12 months since initiating treatment, as long as they are recorded as still being on treatment at month 12.</p> <p>The net current cohort is the number of patients in the start-up group plus any transfers in, minus any transfers out.</p> |
| Unit of measure: percentage of individuals |
| <p>Disaggregated by: Age: 1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50+</p> <p>Sex: Male, Female, pregnant, non-pregnant</p> |
| Justification/Management Utility: This indicator measures the proportion of individuals who have been retained on antiretroviral therapy (ART). High retention is one important measure of program success, specifically in reducing morbidity and mortality, and is a proxy for overall quality of the ART program. Monitoring the program level retention is a critical quality of service indicator at the site, national and PEPFAR program levels as it can highlight barriers to health seeking behaviors and/or gaps in access to and provision of health services. This indicator is also important for long term sustainability of the ART programs |
| Plan for Data Acquisition |
| <p>Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The PRIVATE HEALTH SECTOR PROJECT staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i></p> <p>PRIVATE HEALTH SECTOR PROJECT Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, PRIVATE HEALTH SECTOR PROJECT Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| Data source: Facility ART, PMTCT registers/databases. |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at private Health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private Health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . |

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private Health sector project Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: timely data updates are sometimes lacking

Date of initial DQAs-----

Date of future DQAs -----

Actions taken to address data limitations: try to get all the records updated in consultation with data clerks at the facility level.

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 83.7%

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 90% | 89% | 90 % | 93 % | 90 % | 87 % | | | | |
| Q2 | 90% | 76.7% | 90 % | 96 % | 90 % | 81 % | | | | |
| SAPR | 90% | 85.4% | 90 % | 94 % | 90 % | 84 % | | | | |
| Q3 | 90% | 88 % | 90 % | 97% | 90 % | 79 % | | | | |
| Q4 | 90% | 87 % | 90 % | 84% | 90 % | 90 % | | | | |
| APR | 90% | 85 % | 90 % | 92% | 90 % | 84 % | | | | |

This sheet was last updated on: Nov, 2017

HTC_TST

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|--|
| Indicator Protocol (Reference Sheet) # 8 |
| Name of Indicator: HTC_TST : Number of individuals who received HIV Testing and Counseling (HTC) services for HIV and received their test results |
| Description |
| <p>Precise definition:</p> <ul style="list-style-type: none"> • Total number of individuals (in the given reporting period) who received both HIV testing and counseling including the provision of test results. • Testing and Counseling includes activities in which both HIV counseling and testing are provided for those who seek to know their HIV status (as in traditional VCT) or as indicated in other contexts for PITC (including PMTCT and TB PITC). <p>It is the total number of individuals who received HIV T&C from any service delivery point. Service delivery points could include fixed health care facilities such as, hospitals, private clinics, VCT, ANC, L&D, PMTCT, or TB sites; standalone sites such as free standing sites not associated with medical institutions; and mobile testing such as, HIV T&C services offered in a specific location for a limited period of time, Example: outreach, door-to-door services and workplace testing events. All individuals receiving T&C will be counted in this indicator regardless of where the service is provided. These individuals will include TB patients, pregnant women, and infants.</p> |
| Unit of measure: number of individuals |
| <p>Disaggregated by: Age/Sex disaggregates: <1 Male, <1 Female, 1-4 Male, 1-4 Female, 5-9 Male, 5-9 Female, 10-14 Male, 10-14 Female, 15-19 Male, 15-19 Female, 20-24 Male, 20-24 Female, 25-49 Male, 25-49 Female, 50+ Male, 50+ Female</p> <p>HIV status: Positive</p> <p>Population groups: FCSW, Long distance drivers, Mobile/Daily Laborers, Prisoners, OVC/Children of PLHIV, General population, Other MARPS</p> <p>Service Delivery point:- ANC, TB, VCT, Other PITC --</p> |
| <p>Justification/Management Utility: This indicator is intended to monitor trends in the uptake of HIV T&C services over time, regardless of the type of T&C service delivery method. Data could also be useful for projecting programmatic needs such as test kits and other staffing resources, although individuals are counted</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing:</p> <p>THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use customized HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> private health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| <p>Data source: The sources of data for this indicator are service statistics records, including VCT, PITC, TB, ANC, L & D etc registers, PITC and VCT tally sheets filled out by the private service providers as part of the national HMIS, and HCT reports compiled by the clinics with support from program officers of private health sector project.</p> |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and</p> |

other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private health sector project Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: This indicator is an output measure. It doesn't provide a workload count or provide any specific information about the quality of counseling or the extent to which people are receiving follow up services. The goal is to track the number of individuals who received their test results, however, not all programs are set up to adequately distinguish between those who are tested and those who receive results. This indicator does not track where counseling and testing is taking place. People may go more than once to different outlets during the reporting period.

Actions taken to address data limitations:

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 216,881

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|---------|-------------------------------------|---------|-------------------------------------|---------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 48,246 | 50,270 | 65,000 | 50,153 | | 79,894 | | | | |
| Q2 | 48,246 | 49,441 | 65,000 | 71,342 | | 80,502 | | | | |
| SAPR | 96,492 | 99,711 | 130,000 | 121,495 | | | | | | |
| Q3 | 66,699 | 41,176 | 75,000 | 76,300 | | 81,632 | | | | |
| Q4 | 66,699 | 34,783 | 75,000 | 70,689 | | 74,781 | | | | |
| APR | 229,890 | 175,670 | 290,000 | 268,484 | 319,180 | 315,565 | | | | |

This sheet was last updated on: Nov , 2017

PMTCT_STAT

| |
|---|
| Indicator Protocol (Reference Sheet) # 9 |
| Name of Indicator: PMTCT_STAT : Percentage of pregnant women with known HIV status (includes women who were tested for HIV and received their results) |
| Description |
| Precise definition: Numerator: Number of pregnant women who were tested for HIV and know their results plus number of pregnant women with known HIV status at entry to services. Denominator : Number of new ANC |
| Unit of measure: percentage of individuals |
| Disaggregated by: Age/Sex disaggregates: and Positivity Status : - Known Positive at Entry, Newly Tested Positive |
| Justification/Management Utility: This indicator helps program managers to monitor PMTCT service performance |
| Plan for Data Acquisition |
| Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use customized HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> private health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis |
| Data source: The sources of data for this indicator are service statistics records, including facility ANC/PMTCT registers and program recording tools filled out by the private service providers as part of the national HMIS, compiled by the clinics with support from program officers of private health sector project Ethiopia. |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports. In addition, private health sector project Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care. |
| Data Quality |
| Identified data limitations and significance: There is a risk of double counting with this indicator, as a pregnant woman could be tested multiple times during ANC, L&D, or postpartum. This is particularly true where women get re-tested in different |

facilities, or where they come to the L&D without documentation of their test. While not feasible to avoid double counting entirely, regional and QM team should ensure a data collection and reporting system is in place to minimize it, such as using patient held and facility held ANC records to document that testing took place

Date of initial DQAs-----

Date of future DQAs-----

Actions taken to address data limitations:

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 93 %

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 94% | 89.5% | 95 % | 81.5 % | 95 % | 91 % | | | | |
| Q2 | 94% | 88.0% | 95 % | 90 % | 95 % | 94 % | | | | |
| SAPR | 94% | 88.8% | 95% | 86 % | 95 % | | | | | |
| Q3 | 95% | 67.0 % | 95% | 93. % | 95 % | 97 % | | | | |
| Q4 | 95% | 79.4 % | 95% | 87% | 95 % | 92 % | | | | |
| APR | 95% | 80.3% | 95% | 88% | 95 % | 94.3 % | | | | |

This sheet was last updated on: Nov , 2018

PMTCT_ART

Indicator Protocol (Reference Sheet) # 10

Name of Indicator: PMTCT_ ARV : Percentage of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery

Description

Precise definition:

Percentage of number of pregnant women who tested positive for HIV and received ART to reduce transmission of HIV from mother to child (numerator) to the number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry) (denominator)

Unit of measure: percentage of individuals

Disaggregated by: Age, New on ART, Already on ART

Justification/Management Utility: This indicator measures the provision and coverage of ART for HIV-positive pregnant women. It uses to measures the provision and coverage of antiretroviral treatment, by regimen type, for HIV-positive pregnant women in order to reduce the risk of mother to child transmission of HIV

Plan for Data Acquisition

Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use customized HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report *quarterly*

private health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis

Data source: The sources of data for this indicator are service statistics records, including facility ANC/PMTCT registers and program recording tools filled out by the private service providers as part of the national HMIS, compiled by the clinics with support from program officers of private health sector project Ethiopia.

Estimated cost of data acquisition: Negligible

Responsible staff and data storage location: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.

Data Analysis, Review & Reporting

Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private health sector project Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance:

Date of initial DQAs-----

Date of future DQAs-----

Actions taken to address data limitations:

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 92.6 %

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 100% | 90.2 % | 95 % | 87 % | 100 % | 92 % | | | | |
| Q2 | 100% | 91.7% | 95 % | 88 % | 100 % | 83 % | | | | |

| | | | | | | | | | | |
|------|------|--------|------|------|-------|------|--|--|--|--|
| SAPR | 100% | 90.9% | 95 % | 88 % | 100 % | | | | | |
| Q3 | 100% | 93 % | 95% | 94 % | 100 % | 90 % | | | | |
| Q4 | 100% | 91.1 % | 95% | 86% | 100 % | 80 % | | | | |
| APR | 100% | 91.3 % | 95 % | 89% | 100 % | 86 % | | | | |

This sheet was last updated on: Nov, 2018

PMTCT_EID

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|---|
| Indicator Protocol (Reference Sheet) # 11 |
| Name of Indicator: PMTCT_EID : Percentage of infants born to HIV-positive women who had a virologic HIV test done within 12 months of birth |
| Description |
| <p>Precise definition:</p> <p>Numerator: Number of infants who had a virological HIV test within 12 months of birth during the reporting period.</p> <p>Denominator : Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive women at entry into PMTCT)</p> <p>The number of infants who received an HIV test within 12 months of birth should only be counted once. Only the first test for each HIV exposed infant should be counted in this indicator. Even though there is ongoing exposure of infants to HIV (through breastfeeding), this indicator is only measures early access to testing, and not repeat testing of exposed infants. The numerator should only include the initial test and not any subsequent tests.</p> |
| Unit of measure: percentage of infants |
| <p>Disaggregated by: Testing period and test result</p> <p>Negative: within 2 Months , between 2-12 Months</p> <p>Positive: within 2 Months , between 2-12 Months</p> |
| <p>Justification/Management Utility: This indicator allows the private health facilities to monitor progress in reaching HIV-exposed infants with early infant testing as a critical service that enables early identification of positive infants and reinforces the importance of exclusive breastfeeding and maternal ARVs during the breastfeeding period for those with an initial negative result.</p> <p>This indicator measures the extent to which infants born to HIV-positive women receive virological testing to determine their HIV status within the first 12 months of life. Early diagnosis of infants who acquired HIV during pregnancy, delivery or in the early postpartum period is critical as infants have an increased risk of mortality if they go undiagnosed and untreated</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i></p> <p>private health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| Data source: PMTCT cohort register. |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and</p> |

other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private health sector project Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: risk of double reporting by the private facilities, there is no unique identifier for the infant having virological test. poor data collection system may result in low value for the indicator

Date of initial DQAs-----

Date of future DQAS-----

Actions taken to address data limitations: working closely with the private health facilities referral system and minimize the double counting

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 42%

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 60% | 41.2 % | 60% | 74 % | 60% | 23 % | | | | |
| Q2 | 60% | 81.3 % | 60 % | 33.4 | 60 % | 33 % | | | | |
| SAPR | 60% | 60.6% | 60% | 48.7% | 60% | | | | | |
| Q3 | 60% | 78 % | 60% | 62 % | 60% | 78 % | | | | |
| Q4 | 60% | 60.0 % | 60 % | 67% | 60 % | 35 % | | | | |
| APR | 60% | 60.0% | 60% | 57% | 60% | 29 % | | | | |

This sheet was last updated on: Nov , 2018

PMTCT_FO

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|---|
| Indicator Protocol (Reference Sheet) # 12 |
| Name of Indicator: PMTCT_FO : Final outcomes among HIV exposed infants registered in the birth cohort |
| Description |
| <p>Precise definition:</p> <p>Numerator : Number of HIV-exposed infants with a documented outcome by 18 months of age</p> <p>Denominator : Number of HIV-exposed infants who were born 24 months prior to the reporting period and registered in the birth cohort</p> <p>Number of HIV-exposed infants registered in the birth cohort at any time between 0 and 18 months of age (including transfers-ins)</p> |
| Unit of measure: percentage of infants |
| <p>Disaggregated by:</p> <ul style="list-style-type: none"> by outcome (HIV infected ,uninfected , lost to follow up ,died ,transferred out <p>HIV-infected = Number of HIV-exposed infants identified as HIV-infected at any point during follow-up</p> |
| <p>Justification/Management Utility: This allows for facilities to check all HIV-exposed infants have an outcome assigned to them during the reporting process. the indicator can provide information on the quality of services for HIV exposed infants, the coverage of testing for infant diagnosis, and the progress of the PMTCT services toward elimination of MTCT of HIV by the private health facilities</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i></p> <p>private health sector project Ethiopia staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project Ethiopia will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| Data source: PMTCT cohort register. |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .</p> <p>The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.</p> |

In addition, private health sector project Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: failure to record and report the outcome by health service providers

Date of initial DQAs-----

Date of future DQAs-----

Actions taken to address data limitations: working closely with the private health facilities for better record and follow the infant.

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 22

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 22 | 11 | 19 | 9 | 90% | 36 | | | | |
| Q2 | 22 | 12 | 19 | 9 | 90% | 23 | | | | |
| SAPR | 44 | 23 | 38 | 18 | 90% | 59 | | | | |
| Q3 | 23 | 10 | 26 | 25 | 90% | 12 | | | | |
| Q4 | 23 | 11 | 26 | 13 | 90% | 24 | | | | |
| APR | 90 | 44 | 90 | 56 | 90% | 95 | | | | |

This sheet was last updated on: Nov, 2018

PMTCT_CTX

| |
|---|
| Indicator Protocol (Reference Sheet) # 13 |
| Name of Indicator: PMTCT_CTX : Percentage of infants born to HIV-positive pregnant women who were started on Cotrimoxazole (CTX) prophylaxis within two months of birth |
| Description |
| <p>Precise definition:</p> <p>Numerator: Number of infants born to HIV-positive women who were started on CTX prophylaxis within two months of birth at USG supported sites within the reporting period.</p> <p>Denominator : Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive women at entry)</p> |
| Unit of measure: percentage of infants |
| Disaggregated by: N/A |
| Justification/Management Utility: This allows for private health sector supported facilities to monitor trends in the numbers and proportion of HIV exposed infants who started CTX prophylaxis. Co-trimoxazole prophylaxis is a simple and cost-effective intervention to prevent Pneumocystis Caroni Pneumonia (PCP) among HIV-exposed and -infected infants. Because diagnosing HIV infection among young infants is difficult, all infants born to women living with HIV should receive Co-trimoxazole (CTX) prophylaxis starting at 4–6 weeks after birth and continuing until HIV infection has been excluded and the infant is no longer at risk of acquiring HIV through breastfeeding. |
| Plan for Data Acquisition |
| <p>Data collection method and timing: THE Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i></p> <p>private health sector project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| Data source: PMTCT cohort register. |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project QM unit . Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . |

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private health sector project Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: failure to record and report the outcome by health service providers

Date of initial DQAs-----

Date of future DQAs-----

Actions taken to address data limitations: working closely with the private health facilities for better record and follow the infant.

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 30%

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 60% | 41.2 % | 60 % | 53.2 % | | 86.3 % | | | | |
| Q2 | 60% | 58.3 % | 60 % | 29 % | | 45 % | | | | |
| SAPR | 60% | 49.5% | 75 % | 41 % | | | | | | |
| Q3 | 60% | 90.0 % | 75 % | 65% | | 88 % | | | | |
| Q4 | 60% | 41 % | | 83% | | 76.5% | | | | |
| APR | 60% | 55.0 % | | 55% | | 74 % | | | | |

This sheet was last updated on: Nov, 2018

TB-OUTCOME

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|---|
| Indicator Protocol (Reference Sheet) # 14 |
| Name of Indicator: TB-OUTCOME : TB treatment outcome among registered new and relapsed TB cases who are HIV positive |
| Description |
| <p>Precise definition: Numerator : Aggregated outcomes of TB treatment among registered new and relapsed TB cases who are HIV-positive in the treatment cohort. Denominator : The total number of registered new and relapsed TB cases who are HIV-positive registered in the treatment cohort Outcomes are defined as:</p> <ol style="list-style-type: none"> 1. Cured 2. Treatment completed 3. Treatment failed 4. Died 5. Lost to follow-up 6. Not evaluated <p>The numerator can be generated by counting the outcomes (cured, treatment completed, treatment failed, died, lost to follow up, not evaluated) of TB treatment among documented HIV-positive new and relapsed TB cases in the treatment cohort. The treatment cohort is defined as TB cases registered in the 12 months immediately preceding the start of the reporting period.</p> |
| Unit : number of individuals |
| <p>Disaggregated by: By outcome (see definitions above) and By Age (<1, 1-4, 5-9, 10-14, 15-19, 20+) <input type="checkbox"/> By Sex (male, female)</p> |
| <p>Justification/Management Utility: To reduce the burden of TB among PLHIV and reduce the burden of HIV among registered TB cases, the WHO has recommended a package of TB/HIV collaborative activities (including TB symptom screening for PLHIV, TB diagnostic evaluation for PLHIV who screen positive for TB symptoms, provision of TB treatment for PLHIV diagnosed with active TB disease, provision of IPT to eligible PLHIV in HIV clinical care, provision of HIV testing to registered TB cases, and ART and CPT for registered TB cases who are HIV-positive). This indicator measures the ability of these activities to affect TB treatment outcomes for co-infected patients who enter the TB/HIV service cascade from both the TB and HIV programs, including PLHIV in HIV clinical care who are diagnosed with active TB disease, and registered TB cases who are diagnosed with HIV</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing: The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> private health sector project a staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| Data source: unit TB register |
| Estimated cost of data acquisition: Negligible |

Responsible staff and data storage location: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.

Data Analysis, Review & Reporting

Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private health sector project Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: failure to record and report the outcome by health service providers

Date of initial DQAs-----

Date of future DQAs-----

Actions taken to address data limitations: working closely with the private health facilities for better record and follow the infant.

Other Notes

Notes on baselines/targets: the base line target for this indicator is not available (not recorded in year six of PHSP)

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (TSR) (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|---------|---|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | Na | na | Na | 53/54 | | 59/59 | 90% | 88% | 90% | |
| Q2 | Na | na | | 78/78 | | 61/61 | 90% | 90% | 90% | |
| SAPR | Na | Na | | 61/62 | | 120/120 | 90% | 89% | 90% | |
| Q3 | Na | Na | | | | 182/182 | 90% | 90% | 90% | |
| Q4 | Na | Na | | | | 73/73 | 90% | 86% | 90% | |
| APR | Na | na | | | | 275/275 | 90% | 89% | 90% | |

This sheet was last updated on: October , 2019

TB -NOTIFICATION

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|---|
| Indicator Protocol (Reference Sheet) # 15 |
| Name of Indicator: Number of TB cases reported to NTP by USG assisted non-MOH sector. (PPR) |
| Description |
| <p>Precise definition(s):</p> <ul style="list-style-type: none"> • “TB cases” refers to all types of tuberculosis cases, including Pulmonary (sputum smear positive and smear negative) and extra pulmonary tuberculosis patients diagnosed and treated in private and workplace clinics under the USAID/ private health sector project . • Reported to NTP refers to cases reported by the private and workplace clinics to the Town/Woreda Health Offices, Sub-city Health Departments/Regional Health Bureaus so these figures would be reflected in the National TB Program of the country. • USG assistance refers to funding source in whole or part by the USAID/ private health sector project • Non-MOH/non-Ministry of Health sector refers to private and workplace clinics that are supported under the USAID/ private health sector project . |
| Unit of measure: Individuals |
| Disaggregated by: Sex, region and type of TB |
| Justification/Management Utility: TB is one of the leading causes of morbidity and mortality in resource limited countries, particularly in Ethiopia. Trends over time show progress towards the contribution of the private health sector for the national and international targets. |
| Data Acquisition |
| <p>Data collection method and timing:</p> <p>The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> private health sector project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| Data source: The sources of data for this indicator are service statistics records, including TB registers that are filled out by the private service providers as part of the national HMIS and TB case finding reports. These reports are compiled by the clinics with the support of private health sector project program officers. |
| Estimated cost of data acquisition: Negligible |
| Individual responsible and location of data storage: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the TB/HIV program unit. Data clerks and M & E mentors enter the data into the database; the M & E analysts oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, processed, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders |

for planning purposes, and in support of decision making during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports. Moreover, private health sector project 's Program Officers carry out quarterly supportive supervision using Epi Surveyor software through Smart phones. Data collected using smart phone will be analyzed and feedback provided to private clinics to improve quality of care.

Data Quality Issues

Known data limitations and significance: A limitation of this indicator is that the where about of TB patients that are diagnosed in one facility and transferred out to others could not be traced and their treatment outcome can't be documented.

Date of initial DQAs-----

Date of future DQAs-----

Actions taken or planned to address data limitations: Provide feedback to RHBs and FMOH to look into the current referral system.

Other Notes

Notes on baselines/targets: year six performance is base line and which was 2,565

Other notes:

Performance Indicator Values (October 2009-September 2015)

| Time Period | YEAR 1 (October 15- September 16) | | YEAR 2 (October 16- September 17) | | YEAR 3 (October 17- September 18) | | YEAR 4 (October 18- September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|---|------|---|------|---|------|---|------|-------------------------------------|-----|
| | Plan | Ach | Plan | Ach | plan | Ach | plan | Ach | plan | Ach |
| Q1 | 694 | 468 | 825 | 511 | 795 | 658 | 738 | 509 | 713 | |
| Q2 | 694 | 508 | 825 | 620 | 795 | 726 | 738 | 542 | 713 | |
| SAPR | 1,388 | 976 | 1650 | 1131 | 1590 | 1384 | 1476 | 1052 | 1426 | |
| Q3 | 901 | 542 | 825 | 644 | 795 | 582 | 738 | 492 | 713 | |
| Q4 | 902 | 474 | 825 | 655 | 795 | 566 | 738 | 496 | | |
| APR | 3,191 | 1992 | 3300 | 2430 | 3180 | 2532 | 2952 | 2039 | 2139 | |

This sheet was last updated on: October , 2019

TB_REFERED

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|---|
| Indicator Protocol (Reference Sheet) # 16 |
| Name of Indicator: Number of TB patients referred from diagnosed private facilities (PPR) |
| Description |
| Precise definition(s): <ul style="list-style-type: none"> This number includes the individuals referred to other health facilities for further care and treatment of TB |
| Unit of measure: Individuals |
| Disaggregated by: age , Sex, and type of TB |
| Justification/Management Utility: from private health sector project assisted health facilities a number of cases are diagnosed and because of various reasons referred (such as distance to travel), therefore, this data helps show us the contribution of the private health facilities for TB case detection etc. |
| Data Acquisition |
| Data collection method and timing: The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> private health sector project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, private health sector project will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis |
| Data source: The sources of data for this indicator are service statistics records, including TB registers that are filled out by the private service providers as part of the national HMIS and TB case finding reports. These reports are compiled by the clinics with the support from private health sector project 's program officers. |
| Estimated cost of data acquisition: Negligible |
| Individual responsible and location of data storage: Original report collected from the private service providers will be filed at private health sector project QM unit after thorough review by the TB/HIV program unit. Data clerks and M & E mentors enter the data into the database; the M & E analysts oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, processed, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning purposes, and in support of decision making during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports. Moreover, private health sector project Program Officers carry out quarterly supportive supervision using Epi Surveyor software through Smart phone. Data collected using the smart phone will be analyzed and feedback provided to private clinics to improve quality of care. |
| Data Quality Issues |
| Known data limitations and significance: this data cannot reflect the exact level of efforts exerted for the care and support for TB patient. Date of initial DQAs----- Date of future DQAs----- |

Actions taken or planned to address data limitations: to track the number of individuals who reached the referred facilities and received the actual care for TB management

Other Notes

Notes on baselines/targets: year six performance is base: to track the number of individuals who reached to the referred facilities and ,the base line is 12,671

Other notes:

Performance Indicator Values (October 2009-September 2015)

| Time Period | YEAR 1 (October 15- September 16) | | YEAR 2 (October 16- September 17) | | YEAR 3 (October 17- September 18) | | YEAR 4 (October 18- September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|---|--------|---|-------|---|-------|---|-------|--|-----|
| | plan | Ach | plan | Ach | plan | Ach | plan | Ach | plan | Ach |
| Q1 | 3,432 | 2858 | 4574 | 2839 | 4505 | 3780 | 4512 | 3557 | 4039 | |
| Q2 | 3,433 | 2923 | 4574 | 3247 | 4505 | 3767 | 4512 | 3973 | 4040 | |
| SAPR | 6,865 | 5781 | 9150 | 6086 | 9010 | 7547 | 9024 | 7530 | 8079 | |
| Q3 | 3,936 | 3262 | 4574 | 3988 | 4505 | 4064 | 4512 | 3711 | 4039 | |
| Q4 | 3,936 | 2697 | 4574 | 5269 | 4505 | 3390 | 4512 | 3595 | | |
| APR | 14,737 | 11,740 | 18299 | 15391 | 18020 | 15005 | 18048 | 14936 | 12118 | |

This sheet was last updated on: October , 2019

FP_USERS

| |
|--|
| Indicator Protocol (Reference Sheet) # 17 |
| Name of Indicator: number of clients who received a modern contraceptive methods during the reporting period (Custom) |
| Description |
| Precise definition: Number of people who are currently using any contraceptive method. Modern methods include : pill, implant, IUD, injection, sterilization. |
| Unit of measure: number of individuals |
| Disaggregated by: Type of Clients (new/ continuing clients); type of method (modern long term (IUD, implant)/ modern permanent/, modern short -term (pills, injectable) and by , <i>region</i> |
| Justification/Management Utility: This indicator helps program managers with estimating their client load, method mix profile, and contraceptive ordering needs. Preventing unintended pregnancies in women living with HIV is a critical step towards reducing mother-to-child transmission and is a core component of the international standards for a comprehensive approach to PMTCT. |
| Plan for Data Acquisition |
| Data collection method and timing: The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> The private health sector project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, The private health sector project will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis |
| Data source: The sources of data for this indicator are service statistics records, including facility FP registers and program recording tools filled out by the private service providers as part of the national HMIS, and FP reports compiled by the clinics with support from program officers of The private health sector project . |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at The private health sector project QM unit after thorough review by the FP manager. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by The private health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports. In addition, The private health sector project Program Officers carries out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care. |
| Data Quality |
| Identified data limitations and significance: |

Date of initial DQAs-----

Date of future DQAs-----

Actions taken to address data limitations:

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 32,430

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15- September 16) | | YEAR 2 (October 16- September 17) | | YEAR 3 (October 17- September 18) | | YEAR 4 (October 18- September 19) | | YEAR 5 (October 19- September 20) | |
|-------------|---|--------|---|--------|---|--------|---|--------|---|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 7618 | 6212 | 8859 | 8349 | 9544 | 9566 | 10144 | 10697 | 10144 | |
| Q2 | 7618 | 4864 | 8859 | 8987 | 9544 | 8878 | 10144 | 10186 | 10144 | |
| SAPR | 15,232 | 11,076 | 17719 | 17336 | 19088 | 18444 | 20288 | 20883 | 20288 | |
| Q3 | 8859 | 5543 | 8859 | 8349 | 9544 | 8215 | 10144 | 9757 | 10144 | |
| Q4 | 8859 | 8922 | 8859 | 8033 | 9544 | 11314 | 10145 | 10647 | | |
| APR | 35,437 | 25,541 | 35437 | 34453 | 38176 | 37973 | 40577 | 41287 | 30432 | |

This sheet was last updated on: October , 2019

CYP

| |
|---|
| Indicator Protocol (Reference Sheet) # 18 |
| Name of Indicator: couple Years of protection (CYP) from private health facilities supported by PRIVATE HEALTH SECTOR PROJECT Ethiopia during the reporting period (Custom) |
| Description |
| Precise definition: The estimated protection provided by family planning methods during a one-year period, based upon the volume of all contraceptive methods provided to clients during that period |
| Unit of measure: CYP |
| Disaggregated by: NA |
| Justification/Management Utility: This indicator measures the amount of contraceptive coverage provided to a given population in a given year, which is related to contraceptive prevalence and reduction in unintended pregnancies |
| Plan for Data Acquisition |
| Data collection method and timing: The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> Private health sector project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, Private health sector project staff will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis. |
| Data source: FP log book. |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at Private health sector project staff QM unit after thorough review by the FP program manager /officer t. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by Private health sector project staff QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports. In addition, Private health sector project staff Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care. |
| Data Quality |
| Identified data limitations and significance: none |
| Date of initial DQAs---- |
| Date of future DQAs----- |
| Actions taken to address data limitations: none |
| Other Notes |

Notes on baselines/targets: the baseline target for this indicator is based on the performance of the PHSP in year six which was 14, 842

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 3,479 | 2742 | | 4228 | | 6404 | | 5243 | | |
| Q2 | 3,480 | 2430 | | 4085 | | 6480 | | 8990 | | |
| SAPR | 6,959 | | | 8313 | | 12884 | | 14233 | | |
| Q3 | 4,634 | 2728 | | 4771 | | 5980 | | 9522 | | |
| Q4 | 4,634 | 4762 | | 4773 | | 8788 | | 8922 | | |
| APR | 16,227 | | | 17857 | | 27652 | | 32677 | | |

This sheet was last updated on: October , 2019

MALARAIA-DIAGNOSED

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|--|
| Indicator Protocol (Reference Sheet) # 19 |
| Name of Indicator: Number of Malaria cases diagnosed |
| Description |
| Precise definition: Number of Malaria cases diagnosed through microscopy or RDT or clinically during a reporting period. |
| Unit of measure: number of individuals |
| Disaggregated by: age and sex, diagnosis (clinical or laboratory confirmed) |
| Justification/Management Utility: this shows that contribution of the private health facilities in Malaria case diagnosis and treatment |
| Plan for Data Acquisition |
| Data collection method and timing: The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. Private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> Private health sector project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, Private health sector project staff will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis |
| Data source: Malaria registration book/ Outpatient register, IPD register, Emergency register |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at Private health sector project staff QM unit after thorough review by the Malaria program unit. The data clerks enter the data into the database and the QM focal person for malaria program will oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by Private health sector project staff QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports. In addition, Private health sector project staff Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care. |
| Data Quality |
| Identified data limitations and significance: failure to record and report the outcome by health service providers |
| Date of initial DQAs----- |
| Date of future DQAs---- |
| Actions taken to address data limitations: working closely with the private health facilities for better record and follow the infant. |

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 40,345

Other notes:**Performance Indicator Values (October 2015-September 2020)**

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 12,420 | 9686 | 23460 | 15620 | 15732 | 21812 | 15732 | 18860 | 15732 | |
| Q2 | 12,420 | 7470 | 23460 | 10771 | 15732 | 11103 | 15732 | 13896 | 15732 | |
| SAPR | 24,840 | 17,156 | 46920 | 26391 | 31646 | 32915 | 31646 | 32756 | 31646 | |
| Q3 | 12,420 | 9495 | 23460 | 22602 | 15732 | 14846 | 15732 | 15164 | 15732 | |
| Q4 | 24,189 | 16672 | 23460 | 22550 | 15733 | 17425 | 15733 | 22688 | 15733 | |
| APR | 61,449 | 43323 | 93840 | 71543 | 62929 | 65186 | 62929 | 70608 | 62929 | |

This sheet was last updated on: October , 2019

INSERVICE –TRAINING

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|---|
| Indicator Protocol (Reference Sheet) # 20 |
| Name of Indicator: : number of health care workers who successfully complete an in-service training program |
| Description |
| <p>Precise definition: The number is the sum of health care workers who successfully completed an in-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. In the absence of international or national standards, the minimum requirement will be determined by the PEPFAR country team</p> |
| Unit of measure: number of individuals |
| Disaggregated by: by Cadre, type of training, pediatrics treatment training and all program area |
| <p>Justification/Management Utility: lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health. The data will tell us the number of health care workers who are available to support the mitigation of the HIV/AIDS epidemic each year as a result of full or partial PEPFAR support</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing: Program Officers of Private health sector project staff is responsible for data collection of training activities. As part of the TIMS (Training Information Monitoring System), Participants' Information (group & individual), Course Event Information and Trainer Information Formats (attached) are filled out during each training event. This is collected and checked by Training Program Officer and forwarded to the QM/ME unit</p> <p>Summary report of TIMS is submitted of completion of the training. Training data will also be included in the quarterly reports to USAID and Abt Head Quarters. All raw data will be kept at M & E unit, USAID/ Private health sector project staff</p> |
| Data source: TIMS form. |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Filled TIMS formats are collected by the Training Program Officer, checked for consistency and completeness; will be transferred to the Data clerks for data entry into the TIMS database. All raw data will be kept at M & E unit, USAID/ Private health sector project staff</p> |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from each training event will be collected, compiled and analyzed quarterly and semi-annually by PRIVATE HEALTH SECTOR PROJECT QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project. The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.</p> |
| Data Quality |
| <p>Identified data limitations and significance: none</p> <p>Date of initial DQAs-----</p> <p>Date of future DQAs-----</p> |
| Actions taken to address data limitations: none |
| Other Notes |
| <p>Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 686</p> |
| Other notes: |
| Performance Indicator Values (October 2015-September 2020) |

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 35 | 0 | | 0 | | | | | | |
| Q2 | 446 | 75 | | | | | | | | |
| SAPR | 481 | 75 | | | | | | | | |
| Q3 | 482 | 391 | | | | 221 | | | | |
| Q4 | 93 | 525 | | | | 76 | | | | |
| APR | 1,056 | 991 | | 1580 | | 297 | | | | |

This sheet was last updated on: Nov, 2017

FN-THER

| Indicator Protocol (Reference Sheet) # 21 |
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| Name of Indicator: FN_THER: proportion of clinically undernourished PLHIV who received therapeutic or supplementary food |
| Description |
| <p>Precise definition(s): Numerator : Number of clinically undernourished PLHIV that received therapeutic or supplementary food Denominator : Number of PLHIV that were nutritionally assessed and found to be clinically undernourished</p> |
| Unit of measure: percentage of Individuals |
| Disaggregated by: Age: <1, 1-4, 5-14, 15-17, 18+ Pregnancy status ,post-partum status |
| Justification/Management Utility: The indicator enables the scale and coverage of these services to be tracked and monitors the extent to which these services are reaching those who need them. Provision of therapeutic and supplementary food is generally accompanied by other nutrition services, such as nutrition assessment and counseling, and measuring coverage of therapeutic and supplementary food is a strong indicator of the extent to which the larger package of nutrition care services are reaching PLHI |
| Plan for Data Acquisition |
| <p>Data collection method and timing: The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The Private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i></p> <p>Private health sector project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, Private health sector project staff will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis.</p> |
| Data source: The source of data for this indicator is program and site records that document whether clients have received therapeutic or supplementary food. Each time a client is nutritionally assessed using anthropometric measurement, the measurement is recorded on the client record and/or clinic register indicating whether the client is undernourished. Each time therapeutic or supplementary food is provided to a client, this is also recorded in the clinic register or program records. |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at Private health sector project staff QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by Private health sector project staff QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .</p> <p>The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.</p> <p>In addition, Private health sector project staff Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.</p> |
| Data Quality |
| Identified data limitations and significance: data may not be collected during service delivery or failed to be recorded |

Date of initial DQAs-----

Date of future DQAs-----

Actions taken to address data limitations: mentoring of the data clerks .

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 201/218

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 100 % | Na | | 106 | | 87 | | | | |
| Q2 | 100 % | Na | | 170 | | 47 | | | | |
| SAPR | 100 % | Na | | 276 | | 134 | | | | |
| Q3 | 100 % | Na | | 153 | | 40 | | | | |
| Q4 | 100 % | Na | | 127 | | 89 | | | | |
| APR | 100 % | Na | | 556 | | 263 | | | | |

This sheet was last updated on: Nov, 2017

FN_ASSESS

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|---|
| Indicator Protocol (Reference Sheet) # 22 |
| Name of Indicator: FN_ASSESS proportion of PLHIV who were nutritionally assessed via anthropometric measurement. |
| Description |
| <p>Precise definition(s): Numerator : Number of PLHIV who were nutritionally assessed via anthropometric measurement Denominator : Number of HIV positive adults and children who received care and treatment services during the period (Examples include: clinical assessment/WHO staging,CD4 count, viral load)</p> |
| Unit of measure: percentage of Individuals |
| <p>Disaggregated by: Age: <1, 1-4, 5-14, 15-17, 18+ Pregnancy status ,post-partum status</p> |
| Justification/Management Utility: This data can inform the development of nutrition interventions for HIV care and support services. This indicator is also critical because it is a companion to the indicators that track the number and proportion of PLHIV that are identified as undernourished, as well as the number and proportion of undernourished PLHIV who received therapeutic and supplementary feeding |
| Plan for Data Acquisition |
| <p>Data collection method and timing: The Data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The Private health sector project staff will use HMIS reporting form that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> Private health sector project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, Private health sector project staff will also get copies of regular reports and routine data from health facilities for further analysis .. Data recording and reporting system will be based on the national HMIS system , and reports will be sent out to USAID and Abt Head Quarters on quarterly basis</p> |
| <p>Data source: The source of data for this indicator is program and site records that document whether clients have received therapeutic or supplementary food. Each time a client is nutritionally assessed using anthropometric measurement, the measurement is recorded on the client record and/or clinic register indicating whether the client is undernourished. Each time therapeutic or supplementary food is provided to a client, this is also recorded in the clinic register or program records. Since the indicator includes ART and pre-ART clients, PMTCT clients, and pediatric HIV clients, in some settings information will be drawn from multiple record systems, such as routine health information systems, especially those that target PLHIV. This may require aggregation at the district or national level</p> |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at Private health sector project staff QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by Private health sector project staff QM unit. Analyzed reports will be shared to USAID and other relevant</p> |

stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, Private health sector project staff Ethiopia Program Officers carry out quarterly supportive supervision using Smart phones. Data collected using smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: failure to record it properly

Date of initial DQAs-----

Date of future DQAs-----

Actions taken to address data limitations: mentoring.

Other Notes

Notes on baselines/targets: the base line target for this indicator is based on the performance of the PHSP in year six which was 218

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | 90% | 2% | 100 % | 10 % | | | | | | |
| Q2 | 90% | 3% | | 13% | | | | | | |
| SAPR | 90% | 3 % | | 13% | | | | | | |
| Q3 | 95% | 1.1% | 100% | 15% | | | | | | |
| Q4 | 95% | 13 % | | 23% | | | | | | |
| APR | 95% | 13 % | | 23% | | | | | | |

This sheet was last updated on: Nov, 2017

TB_PREV

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| Indicator Protocol (Reference Sheet) # 23 |
| Name of Indicator: TB_PREV : Proportion of ART patients who completed a standard course of TB preventive therapy within the reporting period |
| Description |
| Precise definition(s): Numerator: - ART patients who have ever completed a standard course or at least 6 months of IPT during the reporting period. Denominator:- ART patients who were newly started on TB preventive therapy, or who were continuing TB preventive therapy from the previous reporting period TB prevention therapy is defined as HIV positive individuals who are newly initiated on ART or already on treatment who initiated TB preventive therapy (IPT) during the previous period/ same period and completed full course of TB preventive treatment within the reporting period. |
| Unit of measure: Individuals |
| Disaggregated by: Age and sex : <15 F, 15+ F, <15 M, 15+ M |
| Justification/Management Utility: This indicator will allow PRIVATE HEALTH SECTOR PROJECT to: <ul style="list-style-type: none"> • Measures the performance of HIV programs in scaling up TB preventive therapy, with the goal of preventing progression to active TB disease among PLHIV and decreasing ongoing TB transmission in this population. • The proportion will inform programs on how well preventive therapy itself is being administered • The denominator will inform programs on the pace of scale-up |
| Plan for Data Acquisition |
| Data collection method and timing: The data to measure performance on this indicator will be obtained from patient registers/records at program facilities. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use reporting format that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> The project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, The project will also get copies of regular reports and routine data from health facilities for further analysis. Data recording and reporting system will be based on the national HMIS system, and reports will be sent out to USAID and Abt Head Quarters on quarterly basis. |
| Data source: The sources of data for this indicator are service statistics records, including pre /ART registers filled out by the private service providers as part of the national HMIS, and Data base installed by the project at the private health facilities will be used to capture this data. |
| Estimated cost of data acquisition: Negligible |
| Responsible staff and data storage location: Original report collected from the private service providers will be filed at QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process. |
| Data Analysis, Review & Reporting |
| Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project . |

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, the project Program Officers carries out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: none

Date of initial DQAs-----

Date of future DQAS -----

Actions taken to address data limitations: none.

Other Notes

Notes : new indicator

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | | | | | | 184 | | | | |
| Q2 | | | | | | 135 | | | | |
| SAPR | | | | | | 319 | | | | |
| Q3 | | | | | | 263 | | | | |
| Q4 | | | | | | 165 | | | | |
| APR | | | | 27% | | 747 | | | | |

This sheet was last updated on: Nov , 2017

Tx_TB

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| Indicator Protocol (Reference Sheet) # 24 |
| Name of Indicator: Tx_TB : |
| Description |
| <p>Precise definition(s): Numerator: - The number of ART patients who were started on TB treatment during the reporting period Denominator:- The number of ART patients who were screened for TB at least once during the reporting period. Treatment TB is defined as HIV positive individuals who were screened for TB and diagnosed with active TB and initiated TB treatment within the reporting period.</p> |
| Unit of measure: Individuals |
| <p>Disaggregated by: Age and sex : <15 F, 15+ F, <15 M, 15+ M Screening result: positive/negative, diagnostic test (Genxpert, smear microscope or other)</p> |
| <p>Justification/Management Utility: This indicator will allow PRIVATE HEALTH SECTOR PROJECT to: This indicator documents the TB screening of ART patients as well as the proportion who were diagnosed and started on TB therapy.</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing: The data to measure performance on this indicator will be obtained from These data should be captured in ART registers as well as additional data collection sources (i.e., facility-based TB screening registers or forms, TB specimen registers, TB microscopy result registers, GeneXpert data collection systems) that may contain relevant information (i.e., TB screening results, TB specimen testing results). The denominator can be generated by counting the number of ART patients who were screened for TB symptoms at least once during the reporting period. This includes newly enrolling patients as well as patients currently on ART. The numerator can be generated by counting the number of those patients who were diagnosed with TB and started on TB therapy during the reporting period. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use reporting format that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report <i>quarterly</i> The project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, The project will also get copies of regular reports and routine data from health facilities for further analysis. Data recording and reporting system will be based on the national HMIS system, and reports will be sent out to USAID and Abt Head Quarters on quarterly basis.</p> |
| <p>Data source: The sources of data for this indicator are service statistics records, including pre /ART registers filled out by the private service providers as part of the national HMIS, laboratory register at facility and Data base installed by the project at the private health facilities will be used to capture this data.</p> |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by QM unit Analyzed reports will be shared to USAID and other relevant stakeholders for</p> |

planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, the project Program Officers carries out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: none

Date of initial DQAs-----

Date of future DQAS -----

Actions taken to address data limitations: none.

Other Notes

Notes on baselines/targets: new indicator

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | | | | | | | | | | |
| Q2 | | | | | | 59 | | | | |
| SAPR | | | | | | 59 | | | | |
| Q3 | | | | | | | | | | |
| Q4 | | | | | | 55 | | | | |
| APR | | | | 1.3% | | 114 | | | | |

This sheet was last updated on: Nov , 2017

Tx_PVLS

| Indicator Protocol (Reference Sheet) # 25 |
|--|
| <p>Name of Indicator: Tx_PVLS: Percentage of ART patients with a viral load result documented in the medical record and/or laboratory information systems (LIS) within the past 12 months with a suppressed viral load (<1000 copies/ml)</p> |
| <p>Description</p> |
| <p>Precise definition(s): Numerator: - Number of adult and pediatric patients on ART with suppressed viral load results (<1,000 copies/ml) documented in the medical records and /or supporting laboratory results within the past 12 months Denominator:- Number of adult and pediatric ART patients with a viral load result documented in the patient medical record and /or laboratory records in the past 12 months.</p> |
| <p>Unit of measure: Individuals</p> |
| <p>Disaggregated by: Age and sex : <1, 1-9, 10-14 M/F, 15-19 M/F, 20-24 M/F, 25-49 M/F and 50+ M/F Indication: routine/targeted, pregnancy/breast feeding,</p> |
| <p>Justification/Management Utility: This indicator will allow PRIVATE HEALTH SECTOR PROJECT to: This indicator monitors the proportion of documented viral load tests from adult and pediatric ART patients with a suppressed result (<1,000 copies/ml), allowing ART programs to monitor individual and overall programmatic response to ART as measured by virologic suppression.</p> <ul style="list-style-type: none"> • Comparison of the denominator for this indicator with the result for TX_CURR can be used to estimate viral load testing coverage |
| <p>Plan for Data Acquisition</p> |
| <p>Data collection method and timing: The data to measure performance on this indicator will be obtained from patient registers/records at program facilities and laboratory registers. Supported facilities will be required to collect client-level data during service delivery and compile M&E report reports on a regular basis. Data will be collected by healthcare providers in program facilities on a daily basis during service delivery. The private Health sector project staff will use reporting format that will be completed by the providers every month and will aggregate the data from the facilities and prepare a progress report quarterly The project staff (regional manager and program officer) will summarize data from hard copy using the smart phone and sent to the server for aggregation, data cleaning and analysis at the same time, The project will also get copies of regular reports and routine data from health facilities for further analysis. Data recording and reporting system will be based on the national HMIS system, and reports will be sent out to USAID and Abt Head Quarters on quarterly basis. NB:- If there is more than one VL test during the last 12 months, report the most recent test</p> |
| <p>Data source: The sources of data for this indicator are service statistics records, including pre /ART registers filled out by the private service providers as part of the national HMIS, and Data base installed by the project at the private health facilities will be used to capture this data.</p> |
| <p>Estimated cost of data acquisition: Negligible</p> |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| <p>Data Analysis, Review & Reporting</p> |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for</p> |

planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, the project Program Officers carries out quarterly supportive supervision using Smart phones. Data collected using the smart phones will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: none

Date of initial DQAs-----

Date of future DQAS -----

Actions taken to address data limitations: none.

Other Notes

Notes on baselines/targets: new indicator

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | | | | | | 90% | | | | |
| Q2 | | | | | | 95.5% | | | | |
| SAPR | | | | | | 90% | | | | |
| Q3 | | | | | | 88% | | | | |
| Q4 | | | | | | 87% | | | | |
| APR | | | | 87% | | 88% | | | | |

This sheet was last updated on: Nov, 2017

LAB_PTCQI (Lab disaggregate)

| |
|--|
| Indicator Protocol (Reference Sheet) # 26 |
| Name of Indicator: LAB_PTCQI: |
| Description |
| <p>Precise definition(s): Number of laboratories and blood centers/banks: A. Engaged in Continuous Quality Improvement (CQI) activities B. Audited and achieved accreditation C. Performing an HIV-related test and participating in and passing Proficiency Testing (PT)</p> |
| Unit of measure: facility/blood bank/center |
| <p>Disaggregated by: a. CQI participation: yes/no, b. CQI status: 1) Not Audited 2) Externally audited but does not meet full accreditation standards, 3) Fully Accredited c. PT:- 1) Perform Test 2) Participate in PT 3) Pass PT <i>participate in and successfully pass Proficiency Testing</i> d. Test performed : HIV Diagnostics, EID, HIV Viral Load, TB Xpert, TB AFB, TB Culture e. PT participation and passing score: 1. Perform Test; 2. <i>Perform Test and participate in PT</i>, 3. <i>Perform Test and passed PT</i>,</p> |
| <p>Justification/Management Utility: This indicator will allow PRIVATE HEALTH SECTOR PROJECT to: Monitor the support for laboratory capacity that will provide access to high quality, rapid, affordable diagnostic tests for care, treatment, prevention, and surveillance for HIV/AIDS. Participation in PT programs can help monitor and improve the quality of HIV-related testing at the testing sites. This indicator will encourage PHSP to implement a PT program if none exists, expand the PT program to cover all HIV testing sites, and will help improve quality of diagnostic and monitoring testing at all sites.</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing: The data to measure performance on this indicator will be obtained from program records and Site level documentation of being audited by an external auditing agency and scores to indicate if quality standards are met and accreditation achieved. Health service providers at the private health facilities and Program Officers of PRIVATE HEALTH SECTOR PROJECT Ethiopia (Lidet Eshetu, Melkie Assefa, Nilie Mustefa, Lakew Huluka, Negash Yehualashet, ,Zeru G/Medhin, Mazengia Ayalew, Amsalu Girma, Alemayehu Mesfin, and Tsegaye Alebel) are responsible for routine data collection and reporting activities. Staff from central laboratory unit (Leulseged Takele and Hulemenaw Delelegn) will take the lead to collect all the relevant data from the filled officer mentioned above.</p> |
| Data source: laboratory registers / registers designed for this specific purposes, program record |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| Data Analysis, Review & Reporting |
| <p>Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .</p> |

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private health sector project Program Officers carry out quarterly supportive supervision using / through Smart phone. Data collected using the smart phone will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: none

Date of initial DQAs-----

Date of future DQAS -----

Actions taken to address data limitations: none.

Other Notes

Notes on baselines/targets: the baseline target for this indicator is based on the performance of the PHSP in year six which was 100%

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | | | | | | | | | | |
| Q2 | | | | | | | | | | |
| SAPR | | | | | | | | | | |
| Q3 | | | | | | | | | | |
| Q4 | | | | | | | | | | |
| APR | | | | | | 151 | | | | |

Out 91 sites involved in HIV PT 78 passing Proficiency Testing and 102/112 pass proficiency test for AFB

This sheet was last updated on: Nov , 2017

LAB_PTCQI (disaggregation HTS/POCT site)

| |
|--|
| Indicator Protocol (Reference Sheet) # 27 |
| Name of Indicator: LAB_PTCQI: |
| Description |
| <p>Precise definition(s):</p> <p>A. Number of HIV Testing Service (HTS) and Point-of-Care Testing (POCT) sites engaged in Continuous Quality Improvement (CQI) activities to achieve national certification.</p> <p>B. Number of HTS and POCT sites which have been audited and achieved certification to quality standards set by recognized national programs.</p> <p>C. Number of HTS and POCT sites performing HIV rapid testing or other POC test and participating in and passing Proficiency Testing (PT).</p> |
| Unit of measure: blood bank/center |
| <p>Disaggregated by: a. CQI participation: yes/no, b. CQI status: 1) Not Audited 2) Externally audited (Level 0-1 achieved a score of (<40%-59%), Level 2-3 achieved a score of (<60%-89%), Level 4 certified > 90%), c. type of test performed :- HIV rapid testing , EID, HIV Viral Load, TB and Proficiency Testing (PT) participation and passing score : 1. Perform Test; 2. <i>Perform Test and participate in PT</i>, 3. <i>Perform Test and passed PT</i>, 4. NA</p> |
| <p>Justification/Management Utility: This indicator will allow PRIVATE HEALTH SECTOR PROJECT to: Monitor the support for laboratory capacity that will provide access to high quality, rapid, affordable diagnostic tests for care, treatment, prevention, and surveillance for HIV/AIDS. Participation in PT programs can help monitor and improve the quality of HIV-related testing at the testing sites. This indicator will encourage PHSP to implement a PT program if none exists, expand the PT program to cover all HIV testing sites, and will help improve quality of diagnostic and monitoring testing at all sites.</p> |
| Plan for Data Acquisition |
| <p>Data collection method and timing: The data to measure performance on this indicator will be obtained from program records and Site level documentation of being audited by an external auditing agency and scores to indicate if quality standards are met and accreditation achieved. Health service providers at the private health facilities and Program Officers of PRIVATE HEALTH SECTOR PROJECT Ethiopia (Lidet Eshetu, Melkie Assefa, Nilie Mustefa, Lakew Huluka, Negash Yehualashet, ,Zeru G/Medhin, Mazengia Ayalew, Amsalu Girma, Alemayehu Mesfin, and Tsegaye Alebel) are responsible for routine data collection and reporting activities.</p> <p>Staff from central laboratory unit (Leulseged Takele and Hulemenaw Delelegn) will take the lead to collect all the relevant data from the filled officer mentioned above.</p> |
| Data source: laboratory registers / registers designed for this specific purposes, program record |
| Estimated cost of data acquisition: Negligible |
| <p>Responsible staff and data storage location: Original report collected from the private service providers will be filed at QM unit after thorough review by the Comprehensive HIV care and support program unit. Data clerks and staff at the private facilities enter the data into the database; staff at the M&E /QM unit oversee and support the entry process.</p> |
| Data Analysis, Review & Reporting |

Data Analysis and reporting: Data from health facilities and other sources will be collected, compiled and analyzed quarterly and semi-annually by private health sector project QM unit. Analyzed reports will be shared to USAID and other relevant stakeholders for planning and decision making purpose during review meetings, consensus building, advocacy and referral networking work Private Health sector Project .

The QM team and program coordinators will take the lead in consolidating the information collected from all sites and prepare analysis reports.

In addition, private health sector project Program Officers carry out quarterly supportive supervision using / through Smart phone. Data collected using the smart phone will be analyzed to give feedback to private clinics to improve quality of care.

Data Quality

Identified data limitations and significance: none

Date of initial DQAs-----

Date of future DQAS -----

Actions taken to address data limitations: none.

Other Notes

Notes on baselines/targets: the baseline target for this indicator is based on the performance of the PHSP in year six which was 203

Other notes:

Performance Indicator Values (October 2015-September 2020)

| Time Period | YEAR 1 (October 15-September 16) | | YEAR 2 (October 16-September 17) | | YEAR 3 (October 17-September 18) | | YEAR 4 (October 18-September 19) | | YEAR 5 (October 19-September 20) | |
|-------------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|-------------------------------------|--------|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Q1 | | | | | | | | | | |
| Q2 | | | | | | | | | | |
| SAPR | | | | | | | | | | |
| Q3 | | | | | | | | | | |
| Q4 | | | | | | | | | | |
| APR | | | | | | | | | | |

This sheet was last updated on: August , 2017

Annex 2: Data collection tools used by the project

| Hospital/Health Center/Clinic/Center Monthly Service Delivery Report Form | | |
|--|---|--------|
| Woreda _____ Name of the health facility _____ Year _____ Month _____ | | |
| Facility ownership: <input type="checkbox"/> Government (FMOH) <input type="checkbox"/> Other Government <input type="checkbox"/> Private for profit <input type="checkbox"/> Private not for profit <input type="checkbox"/> | | |
| Facility type: <input type="checkbox"/> Primary Hospital <input type="checkbox"/> General Hospital <input type="checkbox"/> Comprehensive Specialized Hospital <input type="checkbox"/> Health Center <input type="checkbox"/> | | |
| <input type="checkbox"/> Primary Clinic <input type="checkbox"/> Medium Clinic <input type="checkbox"/> Specialty Clinic <input type="checkbox"/> Type _____ | | |
| HCT <input type="checkbox"/> Specialty Center <input type="checkbox"/> Type _____ | | |
| S.No | Activity | Number |
| CDC | Communicable disease control and prevention | |
| CDC_HIV | HIV/AIDS | |
| CDC_HIV_HCT | Percentage of people living with HIV who know their status | |
| HIV_HCT.1 | Number of individuals who have been tested for HIV and who received their results | |
| HIV_VCT.1 | Clients receiving HIV test results (at VCT) | |
| HIV_VCT.1.1 | < 1 yr : Male | |
| HIV_VCT.1.2 | : Female | |
| HIV_VCT.1.3 | 1-4 yr : Male | |
| HIV_VCT.1.4 | : Female | |
| HIV_VCT.1.5 | 5-9 yr : Male | |
| HIV_VCT.1.6 | : Female | |
| HIV_VCT.1.7 | 10-14 yr : Male | |
| HIV_VCT.1.8 | : Female | |
| HIV_VCT.1.9 | 15-19 yr : Male | |
| HIV_VCT.1.10 | : Female | |
| HIV_VCT.1.11 | 20-24yr : Male | |
| HIV_VCT.1.12 | : Female | |
| HIV_VCT.1.13 | 25-49yr : Male | |
| HIV_VCT.1.14 | : Female | |
| HIV_VCT.1.15 | >= 50 yr : Male | |
| HIV_VCT.1.16 | : Female | |
| HIV_VCT_Pos.1 | Clients testing positive for HIV (at VCT) | |

| | | |
|---------------|--|--|
| VCT_Pos.1.1 | < 1 yr : Male | |
| VCT_Pos.1.2 | : Female | |
| VCT_Pos.1.3 | 1-4 yr : Male | |
| VCT_Pos.1.4 | : Female | |
| VCT_Pos.1.5 | 5-9 yr : Male | |
| VCT_Pos.1.6 | : Female | |
| VCT_Pos.1.7 | 10-14 yr : Male | |
| VCT_Pos.1.8 | : Female | |
| VCT_Pos.1.9 | 15-19 yr : Male | |
| VCT_Pos.1.10 | : Female | |
| VCT_Pos.1.11 | 20-24yr : Male | |
| VCT_Pos.1.12 | : Female | |
| VCT_Pos.1.13 | 25-49yr : Male | |
| VCT_Pos.1.14 | : Female | |
| VCT_Pos.1.15 | >= 50 yr : Male | |
| VCT_Pos.1.16 | : Female | |
| VCT.Add.1 | Clients testing positive linked to HIV care within the facility | |
| VCT.Add.2 | Clients testing positive confirmed linked to HIV care within the facility | |
| VCT.Add.3 | Clients testing positive linked to HIV care outside the facility | |
| VCT.Add.4 | Clients testing positive confirmed linked to HIV care outside the facility | |
| HIV_PITC.1 | Clients receiving HIV test results (at PITC) | |
| HIV_PITC.1.1 | < 1 yr : Male | |
| HIV_PITC.1.2 | : Female | |
| HIV_PITC.1.3 | 1-4 yr : Male | |
| HIV_PITC.1.4 | : Female | |
| HIV_PITC.1.5 | 5-9 yr : Male | |
| HIV_PITC.1.6 | : Female | |
| HIV_PITC.1.7 | 10-14 yr : Male | |
| HIV_PITC.1.8 | : Female | |
| HIV_PITC.1.9 | 15-19 yr : Male | |
| HIV_PITC.1.10 | : Female | |
| HIV_PITC.1.11 | 20-24yr : Male | |

| | | |
|----------------|--|--|
| HIV_PITC.1.12 | : Female | |
| HIV_PITC.1.13 | 25-49yr : Male | |
| HIV_PITC.1.14 | : Female | |
| HIV_PITC.1.15 | >= 50 yr : Male | |
| HIV_PITC.1.16 | : Female | |
| HIV_PITC_Pos.1 | Clients testing positive for HIV (at PITC) | |
| PITC_Pos.1.1 | < 1 yr : Male | |
| PITC_Pos.1.2 | : Female | |
| PITC_Pos.1.3 | 1-4 yr : Male | |
| PITC_Pos.1.4 | : Female | |
| PITC_Pos.1.5 | 5-9 yr : Male | |
| PITC_Pos.1.6 | : Female | |
| PITC_Pos.1.7 | 10-14 yr : Male | |
| PITC_Pos.1.8 | : Female | |
| PITC_Pos.1.9 | 15-19 yr : Male | |
| PITC_Pos.1.10 | : Female | |
| PITC_Pos.1.11 | 20-24yr : Male | |
| PITC_Pos.1.12 | : Female | |
| PITC_Pos.1.13 | 25-49yr : Male | |
| PITC_Pos.1.14 | : Female | |
| PITC_Pos.1.15 | >= 50 yr : Male | |
| PITC_Pos.1.16 | : Female | |
| PITC.Add.1 | Clients testing positive linked to HIV care within the facility | |
| PITC.Add.2 | Clients testing positive confirmed linked to HIV care within the facility | |
| PITC.Add.3 | Clients testing positive linked to HIV care outside the facility | |
| PITC.Add.4 | Clients testing positive confirmed linked to HIV care outside the facility | |
| HIV_HCT_PG | HCT by population group | |
| HIV_HCT_PG.1 | Female commercial Sex workers : Received test result | |
| HIV_HCT_PG.1.1 | :positive | |
| HIV_HCT_PG.2 | Long distance drivers: Received test result | |
| HIV_HCT_PG.2.1 | :positive | |
| HIV_HCT_PG.3 | Mobile/Daily Laborers: Received test result | |
| HIV_HCT_PG.3.1 | :positive | |
| HIV_HCT_PG.4 | OVC :Received test result | |

| | | |
|---------------------|--|--|
| HIV_HCT_PG.4.1 | :positive | |
| HIV_HCT_PG.5 | Children of PLHIV:Received test result | |
| HIV_HCT_PG.5.1 | :positive | |
| HIV_HCT_PG.6 | Prisoners :Received test result | |
| HIV_HCT_PG.6.1 | :positive | |
| HIV_HCT_PG.7 | Partner of PLHIV:Received test result | |
| HIV_HCT_PG.7.1 | :positive | |
| HIV_HCT_PG.8 | Other MARPs:Received test result | |
| HIV_HCT_PG.8.1 | :positive | |
| HIV_HCT_PG.9 | General population: Received test result | |
| HIV_HCT_PG.9.1 | :positive | |
| | Process Indicators | |
| HTC_Process.add.1 | percentage of discordant test result between HIV test 1 and test 2 | |
| HTC_Process.add.1.1 | total number of first test positive during the reporting period | |
| HTC_Process.add.1.2 | total number of second test negative during the reporting period | |
| HTC_Process.add.2 | Number of reporting sites with documented stock out of one or more commodities of HIV Testing, care and treatment. | |
| HTC_Process.add.2.1 | T1 | |
| HTC_Process.add.2.2 | T2 | |
| HTC_Process.add.2.3 | T1 and T2 | |
| HTC_Process.add.2.4 | T1 and T3 | |
| HTC_Process.add.2.5 | T2 and T3 | |
| HTC_Process.add.2.5 | T1, T2 and T3 | |

2) PMTCT Services

| Hospital/Health Center/Clinic/Center Monthly Service Delivery Report Form | | |
|---|---|--------|
| Woreda _____ Name of the health facility _____ Year _____ Month _____ | | |
| Facility ownership: Government (FMOH) <input type="radio"/> Other Government <input type="radio"/> Private for profit <input type="radio"/> Private not for profit <input type="radio"/> | | |
| Facility type: Primary Hospital <input type="radio"/> General Hospital <input type="radio"/> Comprehensive Specialized Hospital <input type="radio"/> Health Center <input type="radio"/> | | |
| Primary Clinic <input type="radio"/> Medium Clinic <input type="radio"/> Specialty Clinic <input type="radio"/> Type _____ | | |
| PMTCT Specialty Center <input type="radio"/> Type _____ | | |
| S.No | Activity | Number |
| C1 | Access to Health Service | |
| C1.1 | Maternal, Neonatal, and Child Health | |
| C1.1.1 | Maternal Health | |
| RMH_ANC_1stV | Antenatal Care coverage –First visit | |
| ANC_1stV_GA.1 | Total Number of pregnant women that received ANC First visit by gestational week | |
| ANC_1stV_GA.1.1 | <16 weeks gestation | |
| ANC_1stV_GA.1.2 | >16 weeks gestation | |
| ANC_1stV_MA.1 | Number of pregnant women that received ANC first visit by maternal | |
| ANC_1stV_MA.1.1 | 10-14 yr | |
| ANC_1stV_MA.1.2 | 15-19 yr | |
| ANC_1stV_MA.1.3 | ≥20 yr | |
| RMH_ANC_4thV | Antenatal care coverage – four visits | |
| ANC_4thV_MA.1 | Total number of pregnant women who made four antenatal care visits dis aggregated by maternal age | |
| ANC_4thV_MA.1.1 | 10-14 yr | |
| ANC_4thV_MA.1.2 | 15-19 yr | |
| ANC_4thV_MA.1.3 | ≥20 yr | |
| | Percentage of pregnant women attending antenatal care clinics tested for syphilis | |
| 1.1.4.1 | Number of pregnant women tested for syphilis | |
| C1.1.1.5 | Proportion of births attended by skilled health personnel | |
| 1.1.5.1 | Number of births attended by skilled health personnel | |
| C1.1.1.7 | Early Postnatal Care Coverage | |
| 1.1.7.1 | Early first postnatal care attendances 0-48 hrs (0-2 days) | |
| 1.1.7.2 | Early first postnatal care attendances 49-72 hrs (2-3 days) | |
| 1.1.7.3 | Early first postnatal care attendances 73hrs-6 days (4- 6 days) | |
| C1.1.1.8 | Caesarean section rate | |
| 1.1.8.1 | Number of women having given birth by caesarean section | |

| | | |
|------------------|---|--|
| C1.1.1.10 | Institutional maternal deaths | |
| 1.1.10.1 | Number of maternal deaths in health facility | |
| C1.1.1.12 | Still birth rate | |
| 1.1.12.1 | Number of still births | |
| 1.1.12.2 | Number of Live births | |
| RMH_PMTCT | PMTCT | |
| RMH_PMTCT_TST | Percentage of pregnant and lactating women who were tested for HIV and who know their results | |
| PMTCT_TST.1 | Number of pregnant women tested and know their result during pregnancy | |
| PMTCT_TST.2 | Number of pregnant women tested and know their result during labour & delivery | |
| PMTCT_TST.3 | Number of women tested and know their result during the postpartum period | |
| PMTCT_TST.4 | Number of women with known HIV positive status attending ANC, delivery and postpartum for new pregnancy linked from Pre and ART | |
| PMTCT_TST.5 | Number of new Positive women during ANC,L&D and Postpartum | |
| PMTCT.add.10 | Number of women tested positive for HIV at ANC : Newly identified | |
| PMTCT.add.11 | Number of women tested positive for HIV at ANC : Known HIV Pos | |
| RMH_PMTCT_ARV | Percentage of HIV-positive pregnant women who received ART to reduce the risk of Women-to child-transmission (MTCT) during pregnancy, L&D and PNC | |
| PMTCT_ARV.1 | Number of HIV positive Pregnant women who received ART to reduce the risk of Women to child transmission during ANC for the first time | |
| PMTCT_ARV.2 | Number of HIV positive Pregnant women who received ART to reduce the risk of Women to child transmission during L&D for the first time | |
| PMTCT_ARV.3 | Number of HIV positive lactating women who received ART to reduce the risk of Women to child transmission during PNC for the first time | |
| PMTCT_ARV.4 | Number of HIV-positive women who get pregnant while on ART and linked to ANC | |
| PMTCT.add.14 | Referred to other facility before starting ARV | |
| PMTCT.add.15 | Waiting (on adherence preparation) | |
| RMH_PMTCT_IPCR | Percentage of infants born to HIV infected women receiving a virological test for HIV within 12 months of birth | |
| PMTCT_IPCR.1 | Total Number of infants within 12 month received virological test | |
| PMTCT_IPCR.1.1 | Number of HIV exposed infants who received a virological HIV test 0-2 months of birth | |
| PMTCT_IPCR.1.1.1 | :Positive | |
| PMTCT_IPCR.1.1.2 | :Negative | |
| PMTCT_IPCR.1.2 | Number of HIV exposed infants who received a virological HIV test 2-12 months of birth | |
| PMTCT_IPCR.1.2.1 | :Positive | |
| PMTCT_IPCR.1.2.2 | :Negative | |

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| RMH_PMTCT_IPCR.add.1 | Number of HIV exposed infants enrolled in follow up care during the month at any age | |
| RMH_PMTCT_IPCR.add.2 | Total number of HIV exposed infants currently on follow up during the reporting period | |
| RMH_PMTCT_ICPT | Percentage of Infants born to HIV-infected women started on co-trimoxazole prophylaxis within two months of birth | |
| PMTCT_ICPT.1 | Number of infants born to HIV positive women started on co-trimoxazole prophylaxis within two months of birth | |
| PMTCT_IARV | Percentage of infants born to HIV-infected women receiving antiretroviral (ARV) prophylaxis for prevention of mother-to-child transmission (PMTCT) | |
| PMTCT_IARV.1 | Number of HIV exposed infants who received ARV prophylaxis For 6 weeks | |
| PMTCT_IARV.2 | Number of HIV exposed infants who received ARV prophylaxis For 12 weeks | |
| RMH_L&D_+ve | Number of HIV positive women who gave birth at health institution | |
| RMH_PMTCT_PRN_TST | Percentage of partners of pregnant, laboring and lactating women tested for HIV | |
| PMTCT_PRN_TST.1 | Total Number of partners of pregnant ,laboring and lactating women tested and know their results | |
| PMTCT_PRN_Pos.1 | Number of partners of pregnant ,laboring and lactating women – whose test result is HIV positive | |
| RMH_PMTCT_IABT | Percentage of HIV exposed infants receiving HIV confirmatory (antibody test) test by 18 months | |
| PMTCT_IABT_Pos.1 | Number of HIV exposed infants receiving HIV confirmatory (antibody test) by 18 months- whose test result is HIV positive | |
| PMTCT_IABT_Neg.1 | Number of HIV exposed infants receiving HIV confirmatory (antibody test) by 18 months- whose test result is HIV negative | |
| PMTCT.add.18 | Number of HIV positive mothers who started using modern FP method after delivery: 15-19 yrs. | |
| PMTCT.add.19 | Number of HIV positive mothers who started using modern FP method after delivery: 20-24 yrs. | |
| PMTCT.add.20 | Number of HIV positive mothers who started using modern FP method after delivery: 25-49 yrs. | |

3) ART Service

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| Woreda _____ Name of the health facility _____ Year _____ Month _____ | | |
| Facility ownership: <input type="checkbox"/> Government (FMOH) <input type="checkbox"/> Other Government <input type="checkbox"/> Private for profit <input type="checkbox"/> Private not for profit <input type="checkbox"/> | | |
| Facility type: <input type="checkbox"/> Primary Hospital <input type="checkbox"/> General Hospital <input type="checkbox"/> Comprehensive Specialized Hospital <input type="checkbox"/> Health Center <input type="checkbox"/> | | |
| Primary Clinic <input type="checkbox"/> Medium Clinic <input type="checkbox"/> Specialty Clinic <input type="checkbox"/> Type _____ | | |
| ART Specialty Center <input type="checkbox"/> Type _____ | | |
| S.No | Activity | Number |
| C1.4 | Prevention and Control of Diseases | |
| C1.4.2 | Communicable diseases | |
| C&T Add 1 | Number of newly enrolled HIV positive adults and children who received clinical Service (clinical WHO staging or CD4 count or viral load) during the reporting period, by age and sex | |
| C&T Add 1.1 | < 1 year: males | |
| C&T Add 1.2 | : females | |
| C&T Add 1.3 | 1-4 years : males | |
| C&T Add 1.4 | : females | |
| C&T Add 1.5 | 5-9 years : males | |
| C&T Add 1.6 | : females | |
| C&T Add 1.7 | 10-14 years : males | |
| C&T Add 1.8 | : females | |
| C&T Add 1.9 | 15-19 years : males | |
| C&T Add 1.10 | : females | |
| C&T Add 1.11 | 20-24years : males | |
| C&T Add 1.12 | : females | |
| C&T Add 1.13 | 25-49years : males | |
| C&T Add 1.14 | : females | |
| C&T Add 1.15 | >= 50 years : males | |
| C&T Add 1.16 | : females | |
| CDC_HIV_RXC.1 | Number of adults and children who are currently on ART by regimen | |
| HIV_RXC.1.1 | Number of adults who are currently on ART by regimen | |
| HIV_RXC.1.1.1 | Adult aged 15-19 | |
| HIV_RXC.1.1.1.1 | first line regimen | |
| HIV_RXC.1.1.1.1.1 | 1c=AZT + 3TC+NVP :male | |
| HIV_RXC.1.1.1.1.2 | :Female | |
| HIV_RXC.1.1.1.1.3 | 1d=AZT+ 3TC+ EFV :male | |
| HIV_RXC.1.1.1.1.4 | :Female | |
| HIV_RXC.1.1.1.1.5 | 1e=TDF + 3TC + EFV :male | |
| HIV_RXC.1.1.1.1.6 | :Female | |
| HIV_RXC.1.1.1.1.7 | 1f=TDF + 3TC+ NVP :male | |

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| HIV_RXC.1.1.1.1.8 | :Female | |
| HIV_RXC.1.1.1.1.9 | 1g=ABC + 3TC + EFV :male | |
| HIV_RXC.1.1.1.1.10 | :Female | |
| HIV_RXC.1.1.1.1.11 | 1h=ABC + 3TC + NVP :male | |
| HIV_RXC.1.1.1.1.12 | :Female | |
| HIV_RXC.1.1.1.1.13 | other firstline regimen:male | |
| HIV_RXC.1.1.1.1.14 | :Female | |
| HIV_RXC.1.1.1.1.2 | second line regimen | |
| HIV_RXC.1.1.1.1.2.1 | 2e= AZT +3TC +LPV/r :male | |
| HIV_RXC.1.1.1.1.2.2 | :Female | |
| HIV_RXC.1.1.1.1.2.3 | 2f =AZT+3TC +ATV/r :male | |
| HIV_RXC.1.1.1.1.2.4 | :Female | |
| HIV_RXC.1.1.1.1.2.5 | 2g=TDF + 3TC+-LPV/r :male | |
| HIV_RXC.1.1.1.1.2.6 | :Female | |
| HIV_RXC.1.1.1.1.2.7 | 2h= TDF + 3TC + ATV/r :male | |
| HIV_RXC.1.1.1.1.2.8 | :Female | |
| HIV_RXC.1.1.1.1.2.9 | 2i= ABC + 3TC+ LPV/r :male | |
| HIV_RXC.1.1.1.1.2.10 | :Female | |
| HIV_RXC.1.1.1.1.2.11 | other secondline: male | |
| HIV_RXC.1.1.1.1.2.12 | :Female | |
| HIV_RXC.1.1.1.1.3 | Third Line regimen | |
| HIV_RXC.1.1.1.1.3.1 | 3a= DRV/r+DTG+AZT/3TC :male | |
| HIV_RXC.1.1.1.1.3.2 | :Female | |
| HIV_RXC.1.1.1.1.3.3 | 3b= DRV/r+DTG + TDF/3TC :male | |
| HIV_RXC.1.1.1.1.3.4 | :Female | |
| HIV_RXC.1.1.1.1.3.5 | Other thirdline: male | |
| HIV_RXC.1.1.1.1.3.6 | :Female | |
| HIV_RXC.1.1.1.1.3.7 | Female : pregnant | |
| HIV_RXC.1.1.2 | Adult aged 20-24 | |
| HIV_RXC.1.1.2.1 | first line regimen | |
| HIV_RXC.1.1.2.1.1 | 1c=AZT + 3TC+NVP :male | |
| HIV_RXC.1.1.2.1.2 | :Female | |
| HIV_RXC.1.1.2.1.3 | 1d=AZT+ 3TC+ EFV :male | |
| HIV_RXC.1.1.2.1.4 | :Female | |
| HIV_RXC.1.1.2.1.5 | 1e=TDF + 3TC + EFV :male | |
| HIV_RXC.1.1.2.1.6 | :Female | |
| HIV_RXC.1.1.2.1.7 | 1f=TDF + 3TC+ NVP :male | |
| HIV_RXC.1.1.2.1.8 | :Female | |
| HIV_RXC.1.1.2.1.9 | 1g=ABC + 3TC + EFV :male | |
| HIV_RXC.1.1.2.1.10 | :Female | |
| HIV_RXC.1.1.2.1.11 | 1h=ABC + 3TC + NVP :male | |

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| HIV_RXC.1.1.2.1.12 | :Female | |
| HIV_RXC.1.1.2.1.13 | other firstline regimen:male | |
| HIV_RXC.1.1.2.1.14 | :Female | |
| HIV_RXC.1.1.2.2 | second line regimen | |
| HIV_RXC.1.1.2.2.1 | 2e= AZT +3TC +LPV/r :male | |
| HIV_RXC.1.1.2.2.2 | :Female | |
| HIV_RXC.1.1.2.2.3 | 2f =AZT+3TC +ATV/r :male | |
| HIV_RXC.1.1.2.2.4 | :Female | |
| HIV_RXC.1.1.2.2.5 | 2g=TDF + 3TC+-LPV/r :male | |
| HIV_RXC.1.1.2.2.6 | :Female | |
| HIV_RXC.1.1.2.2.7 | 2h= TDF + 3TC + ATV/r :male | |
| HIV_RXC.1.1.2.2.8 | :Female | |
| HIV_RXC.1.1.2.2.9 | 2i= ABC + 3TC+ LPV/r :male | |
| HIV_RXC.1.1.2.2.10 | :Female | |
| HIV_RXC.1.1.2.2.11 | other secondline: male | |
| HIV_RXC.1.1.2.2.12 | :Female | |
| HIV_RXC.1.1.2.3 | Third Line regimen | |
| HIV_RXC.1.1.2.3.1 | 3a= DRV/r+DTG+AZT/3TC :male | |
| HIV_RXC.1.1.2.3.2 | :Female | |
| HIV_RXC.1.1.2.3.3 | 3b= DRV/r+DTG + TDF/3TC :male | |
| HIV_RXC.1.1.2.3.4 | :Female | |
| HIV_RXC.1.1.2.3.5 | Other thirdline: male | |
| HIV_RXC.1.1.2.3.6 | :Female | |
| HIV_RXC.1.1.2.3.7 | Female : pregnant | |
| HIV_RXC.1.1.3 | Adult aged 25-49 | |
| HIV_RXC.1.1.3.1 | first line regimen | |
| HIV_RXC.1.1.3.1.1 | 1c=AZT + 3TC+NVP :male | |
| HIV_RXC.1.1.3.1.2 | :Female | |
| HIV_RXC.1.1.3.1.3 | 1d=AZT+ 3TC+ EFV :male | |
| HIV_RXC.1.1.3.1.4 | :Female | |
| HIV_RXC.1.1.3.1.5 | 1e=TDF + 3TC + EFV :male | |
| HIV_RXC.1.1.3.1.6 | :Female | |
| HIV_RXC.1.1.3.1.7 | 1f=TDF + 3TC+ NVP :male | |
| HIV_RXC.1.1.3.1.8 | :Female | |
| HIV_RXC.1.1.3.1.9 | 1g=ABC + 3TC + EFV :male | |
| HIV_RXC.1.1.3.1.10 | :Female | |
| HIV_RXC.1.1.3.1.11 | 1h=ABC + 3TC + NVP :male | |
| HIV_RXC.1.1.3.1.12 | :Female | |
| HIV_RXC.1.1.3.1.13 | other firstline regimen:male | |
| HIV_RXC.1.1.3.1.14 | :Female | |
| HIV_RXC.1.1.3.2 | second line regimen | |

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| HIV_RXC.1.1.3.2.1 | 2e= AZT +3TC +LPV/r :male | |
| HIV_RXC.1.1.3.2.2 | :Female | |
| HIV_RXC.1.1.3.2.3 | 2f =AZT+3TC +ATV/r :male | |
| HIV_RXC.1.1.3.2.4 | :Female | |
| HIV_RXC.1.1.3.2.5 | 2g=TDF + 3TC+-LPV/r :male | |
| HIV_RXC.1.1.3.2.6 | :Female | |
| HIV_RXC.1.1.3.2.7 | 2h= TDF + 3TC + ATV/r :male | |
| HIV_RXC.1.1.3.2.8 | :Female | |
| HIV_RXC.1.1.3.2.9 | 2i= ABC + 3TC+ LPV/r :male | |
| HIV_RXC.1.1.3.2.10 | :Female | |
| HIV_RXC.1.1.3.2.11 | other secondline: male | |
| HIV_RXC.1.1.3.2.12 | :Female | |
| HIV_RXC.1.1.3.3 | Third Line regimen | |
| HIV_RXC.1.1.3.3.1 | 3a= DRV/r+DTG+AZT/3TC :male | |
| HIV_RXC.1.1.3.3.2 | :Female | |
| HIV_RXC.1.1.3.3.3 | 3b= DRV/r+DTG + TDF/3TC :male | |
| HIV_RXC.1.1.3.3.4 | :Female | |
| HIV_RXC.1.1.3.3.5 | Other thirdline: male | |
| HIV_RXC.1.1.3.3.6 | :Female | |
| HIV_RXC.1.1.3.3.7 | Female : pregnant | |
| HIV_RXC.1.1.4 | Adult aged 50+ | |
| HIV_RXC.1.1.4.1 | first line regimen | |
| HIV_RXC.1.1.4.1.1 | 1c=AZT + 3TC+NVP :male | |
| HIV_RXC.1.1.4.1.2 | :Female | |
| HIV_RXC.1.1.4.1.3 | 1d=AZT+ 3TC+ EFV :male | |
| HIV_RXC.1.1.4.1.4 | :Female | |
| HIV_RXC.1.1.4.1.5 | 1e=TDF + 3TC + EFV :male | |
| HIV_RXC.1.1.4.1.6 | :Female | |
| HIV_RXC.1.1.4.1.7 | 1f=TDF + 3TC+ NVP :male | |
| HIV_RXC.1.1.4.1.8 | :Female | |
| HIV_RXC.1.1.4.1.9 | 1g=ABC + 3TC + EFV :male | |
| HIV_RXC.1.1.4.1.10 | :Female | |
| HIV_RXC.1.1.4.1.11 | 1h=ABC + 3TC + NVP :male | |
| HIV_RXC.1.1.4.1.12 | :Female | |
| HIV_RXC.1.1.4.1.13 | other firstline regimen:male | |
| HIV_RXC.1.1.4.1.14 | :Female | |
| HIV_RXC.1.1.4.2 | second line regimen | |
| HIV_RXC.1.1.4.2.1 | 2e= AZT +3TC +LPV/r :male | |
| HIV_RXC.1.1.4.2.2 | :Female | |
| HIV_RXC.1.1.4.2.3 | 2f =AZT+3TC +ATV/r :male | |
| HIV_RXC.1.1.4.2.4 | :Female | |

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| HIV_RXC.1.1.4.2.5 | 2g=TDF + 3TC+-LPV/r :male | |
| HIV_RXC.1.1.4.2.6 | :Female | |
| HIV_RXC.1.1.4.2.7 | 2h= TDF + 3TC + ATV/r :male | |
| HIV_RXC.1.1.4.2.8 | :Female | |
| HIV_RXC.1.1.4.2.9 | 2i= ABC + 3TC+ LPV/r :male | |
| HIV_RXC.1.1.4.2.10 | :Female | |
| HIV_RXC.1.1.4.2.11 | other secondline: male | |
| HIV_RXC.1.1.4.2.12 | :Female | |
| HIV_RXC.1.1.4.3 | Third Line regimen | |
| HIV_RXC.1.1.4.3.1 | 3a= DRV/r+DTG+AZT/3TC :male | |
| HIV_RXC.1.1.4.3.2 | :Female | |
| HIV_RXC.1.1.4.3.3 | 3b= DRV/r+DTG + TDF/3TC :male | |
| HIV_RXC.1.1.4.3.4 | :Female | |
| HIV_RXC.1.1.4.3.5 | Other thirdline: male | |
| HIV_RXC.1.1.4.3.6 | :Female | |
| HIV_RXC.1.2 | Number of children who are currently on ART by regimen type | |
| HIV_RXC.1.2.1 | Children aged <1 yr | |
| HIV_RXC.1.2.1.1 | First line regimen | |
| HIV_RXC.1.2.1.1.1 | 4c=AZT+ 3TC+NVP :male | |
| HIV_RXC.1.2.1.1.2 | : Female | |
| HIV_RXC.1.2.1.1.3 | 4f= AZT +3TC+LPV/r :male | |
| HIV_RXC.1.2.1.1.4 | : Female | |
| HIV_RXC.1.2.1.1.5 | 4g= ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.1.1.6 | : Female | |
| HIV_RXC.1.2.1.1.7 | other first line :male | |
| HIV_RXC.1.2.1.1.8 | : Female | |
| HIV_RXC.1.2.1.2 | Second line regimen | |
| HIV_RXC.1.2.1.2.1 | 5e=ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.1.2.2 | : Female | |
| HIV_RXC.1.2.1.2.3 | 5f=AZT + 3TC + LPV/r :male | |
| HIV_RXC.1.2.1.2.4 | : Female | |
| HIV_RXC.1.2.1.2.5 | 5j=ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.1.2.6 | : Female | |
| HIV_RXC.1.2.1.2.7 | other secondline: male | |
| HIV_RXC.1.2.1.2.8 | : Female | |
| HIV_RXC.1.2.2 | Children aged 1-4 yr | |
| HIV_RXC.1.2.2.1 | First line regimen | |
| HIV_RXC.1.2.2.1.1 | 4c=AZT+ 3TC+NVP :male | |
| HIV_RXC.1.2.2.1.2 | : Female | |
| HIV_RXC.1.2.2.1.3 | 4d=AZT+3TC+EFV :male | |

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| HIV_RXC.1.2.2.1.4 | : Female | |
| HIV_RXC.1.2.2.1.5 | 4f= AZT +3TC+LPV/r :male | |
| HIV_RXC.1.2.2.1.6 | : Female | |
| HIV_RXC.1.2.2.1.7 | 4g= ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.2.1.8 | : Female | |
| HIV_RXC.1.2.2.1.9 | other first line :male | |
| HIV_RXC.1.2.2.1.10 | : Female | |
| HIV_RXC.1.2.2.2 | Second line regimen | |
| HIV_RXC.1.2.2.2.1 | 5e=ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.2.2.2 | : Female | |
| HIV_RXC.1.2.2.2.3 | 5f=AZT + 3TC + LPV/r :male | |
| HIV_RXC.1.2.2.2.4 | : Female | |
| HIV_RXC.1.2.2.2.5 | 5h=ABC + 3TC + EFV :male | |
| HIV_RXC.1.2.2.2.6 | : Female | |
| HIV_RXC.1.2.2.2.7 | 5j=ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.2.2.8 | : Female | |
| HIV_RXC.1.2.2.2.9 | other secondline: male | |
| HIV_RXC.1.2.2.2.10 | : Female | |
| HIV_RXC.1.2.2.3 | Third Line regimen | |
| HIV_RXC.1.2.2.3.1 | 6a=DRV/r+RAL + AZT +3TC :male | |
| HIV_RXC.1.2.2.3.2 | : Female | |
| HIV_RXC.1.2.2.3.3 | 6b=DRV/r+RAL + TDF +3TC :male | |
| HIV_RXC.1.2.2.3.4 | : Female | |
| HIV_RXC.1.2.2.3.5 | Other:male | |
| HIV_RXC.1.2.2.3.6 | : Female | |
| HIV_RXC.1.2.3 | Children aged 5-9 yr | |
| HIV_RXC.1.2.3.1 | First line regimen | |
| HIV_RXC.1.2.3.1.1 | 4c=AZT+ 3TC+NVP :male | |
| HIV_RXC.1.2.3.1.2 | : Female | |
| HIV_RXC.1.2.3.1.3 | 4d=AZT+3TC+EFV :male | |
| HIV_RXC.1.2.3.1.4 | : Female | |
| HIV_RXC.1.2.3.1.5 | 4e= TDF +3TC+EFV :male | |
| HIV_RXC.1.2.3.1.6 | : Female | |
| HIV_RXC.1.2.3.1.7 | 4f= AZT +3TC+LPV/r :male | |
| HIV_RXC.1.2.3.1.8 | : Female | |
| HIV_RXC.1.2.3.1.9 | 4g= ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.3.1.10 | : Female | |
| HIV_RXC.1.2.3.1.11 | other first line :male | |
| HIV_RXC.1.2.3.1.12 | : Female | |
| HIV_RXC.1.2.3.2 | Second line regimen | |
| HIV_RXC.1.2.3.2.1 | 5e=ABC+3TC+LPV/r :male | |

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| HIV_RXC.1.2.3.2.2 | : Female | |
| HIV_RXC.1.2.3.2.3 | 5f=AZT + 3TC + LPV/r :male | |
| HIV_RXC.1.2.3.2.4 | : Female | |
| HIV_RXC.1.2.3.2.5 | 5g=TDF + 3TC + EFV :male | |
| HIV_RXC.1.2.3.2.6 | : Female | |
| HIV_RXC.1.2.3.2.7 | 5h=ABC + 3TC + EFV :male | |
| HIV_RXC.1.2.3.2.8 | : Female | |
| HIV_RXC.1.2.3.2.9 | 5i=TDF+3TC+LPV/r :male | |
| HIV_RXC.1.2.3.2.10 | : Female | |
| HIV_RXC.1.2.3.2.11 | other secondline: male | |
| HIV_RXC.1.2.3.2.12 | : Female | |
| HIV_RXC.1.2.3.3 | Third Line regimen | |
| HIV_RXC.1.2.3.3.1 | 6a=DRV/r+RAL + AZT +3TC :male | |
| HIV_RXC.1.2.3.3.2 | : Female | |
| HIV_RXC.1.2.3.3.3 | 6b=DRV/r+RAL + TDF +3TC :male | |
| HIV_RXC.1.2.3.3.4 | : Female | |
| HIV_RXC.1.2.3.3.5 | Other:male | |
| HIV_RXC.1.2.3.3.6 | : Female | |
| HIV_RXC.1.2.4 | Children aged 10-14 yr | |
| HIV_RXC.1.2.4.1 | First line regimen | |
| HIV_RXC.1.2.4.1.1 | 4c=AZT+ 3TC+NVP :male | |
| HIV_RXC.1.2.4.1.2 | : Female | |
| HIV_RXC.1.2.4.1.3 | 4d=AZT+3TC+EFV :male | |
| HIV_RXC.1.2.4.1.4 | : Female | |
| HIV_RXC.1.2.4.1.5 | 4e= TDF +3TC+EFV :male | |
| HIV_RXC.1.2.4.1.6 | : Female | |
| HIV_RXC.1.2.4.1.7 | 4f= AZT +3TC+LPV/r :male | |
| HIV_RXC.1.2.4.1.8 | : Female | |
| HIV_RXC.1.2.4.1.9 | 4g= ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.4.1.10 | : Female | |
| HIV_RXC.1.2.4.1.11 | other first line :male | |
| HIV_RXC.1.2.4.1.12 | : Female | |
| HIV_RXC.1.2.4.2 | Second line regimen | |
| HIV_RXC.1.2.4.2.1 | 5e=ABC+3TC+LPV/r :male | |
| HIV_RXC.1.2.4.2.2 | : Female | |
| HIV_RXC.1.2.4.2.3 | 5f=AZT + 3TC + LPV/r :male | |
| HIV_RXC.1.2.4.2.4 | : Female | |
| HIV_RXC.1.2.4.2.5 | 5g=TDF + 3TC + EFV :male | |
| HIV_RXC.1.2.4.2.6 | : Female | |
| HIV_RXC.1.2.4.2.7 | 5h=ABC + 3TC + EFV :male | |
| HIV_RXC.1.2.4.2.8 | : Female | |

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| HIV_RXC.1.2.4.2.9 | 5i=TDF+3TC+LPV/r :male | |
| HIV_RXC.1.2.4.2.10 | : Female | |
| HIV_RXC.1.2.4.2.11 | other secondline: male | |
| HIV_RXC.1.2.4.2.12 | : Female | |
| HIV_RXC.1.2.4.3 | Third Line regimen | |
| HIV_RXC.1.2.4.3.1 | 6a=DRV/r+RAL + AZT +3TC :male | |
| HIV_RXC.1.2.4.3.2 | : Female | |
| HIV_RXC.1.2.4.3.3 | 6b=DRV/r+RAL + TDF +3TC :male | |
| HIV_RXC.1.2.4.3.4 | : Female | |
| HIV_RXC.1.2.4.3.5 | 6c=DRV/r+DTG + AZT +3TC :male | |
| HIV_RXC.1.2.4.3.6 | : Female | |
| HIV_RXC.1.2.4.3.7 | 6d=DRV/r+DTG + TDF +3TC :male | |
| HIV_RXC.1.2.4.3.8 | : Female | |
| HIV_RXC.1.2.4.3.9 | Other:male | |
| HIV_RXC.1.2.4.3.10 | : Female | |
| HIV_RXC_LTF | Number of PLHIV who are documented as Lost/lost to follow up during the reporting period | |
| CDC_HIV_RXN | Number of adults and children with HIV infection newly started on ART | |
| HIV_RXN.1 | < 1 yr: male | |
| HIV_RXN.2 | : female | |
| HIV_RXN.3 | 1-4 yr : male | |
| HIV_RXN.4 | : female | |
| HIV_RXN.5 | 5-9 yr : male | |
| HIV_RXN.6 | : female | |
| HIV_RXN.7 | 10-14 yr : male | |
| HIV_RXN.8 | : female | |
| HIV_RXN.9 | 15-19 yr : male | |
| HIV_RXN.10 | : Females Non-pregnant | |
| HIV_RXN.11 | : Female Pregnant | |
| HIV_RXN.12 | 20-24 yr : male | |
| HIV_RXN.13 | : Females Non-pregnant | |
| HIV_RXN.14 | : Female Pregnant | |
| HIV_RXN.15 | 25-49 yr : male | |
| HIV_RXN.16 | : Females Non-pregnant | |
| HIV_RXN.17 | : Female Pregnant | |
| HIV_RXN.18 | >= 50 yr : male | |
| HIV_RXN.19 | : female | |
| HIV_RtR.1 | Number of adults and children who are still on treatment at 12 months after initiating ART | |
| HIV_RtR.1.1 | < 1 year: males | |
| HIV_RtR.1.2 | : females | |

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| HIV_RtR.1.3 | 1-4 years : males | |
| HIV_RtR.1.4 | : females | |
| HIV_RtR.1.5 | 5-9 years : males | |
| HIV_RtR.1.6 | : females | |
| HIV_RtR.1.7 | 10-14 years : males | |
| HIV_RtR.1.8 | : females | |
| HIV_RtR.1.9 | 15-19years : males | |
| HIV_RtR.1.10 | : Females Non-pregnant | |
| HIV_RtR.1.11 | : Female Pregnant | |
| HIV_RtR.1.12 | 20-24years : males | |
| HIV_RtR.1.13 | : Females Non-pregnant | |
| HIV_RtR.1.14 | : Female Pregnant | |
| HIV_RtR.1.15 | 25-49years : males | |
| HIV_RtR.1.16 | : Females Non-pregnant | |
| HIV_RtR.1.17 | : Female Pregnant | |
| HIV_RtR.1.18 | >= 50 years : males | |
| HIV_RtR.1.19 | : females | |
| HIV_NCC | Number of persons on ART in the original cohort including those transferred in, minus those transferred out (net current cohort). | |
| HIV_NCC.1 | 1-4 years : males | |
| HIV_NCC.2 | : females | |
| HIV_NCC.3 | 5-9 years : males | |
| HIV_NCC.4 | : females | |
| HIV_NCC.5 | 10-14 years : males | |
| HIV_NCC.6 | : females | |
| HIV_NCC.7 | 15-19years : males | |
| HIV_NCC.8 | : Females Non-pregnant | |
| HIV_NCC.9 | : Female Pregnant | |
| HIV_NCC.10 | 20-24years : males | |
| HIV_NCC.11 | : Females Non-pregnant | |
| HIV_NCC.12 | : Female Pregnant | |
| HIV_NCC.13 | 25-49years : males | |
| HIV_NCC.14 | : Females Non-pregnant | |
| HIV_NCC.15 | : Female Pregnant | |
| HIV_NCC.16 | >= 50 years : males | |
| HIV_NCC.17 | : females | |
| HIV_UVLC_6M.1 | Total number of adult and paediatric ART patients with an undetectable viral load <1000copies/ml at 6 month | |
| HIV_UVLC_6M.1.1 | < 1 year: males | |
| HIV_UVLC_6M.1.2 | : females | |

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| HIV_UVLC_6M.1.3 | 1-4 years : males | |
| HIV_UVLC_6M.1.4 | : females | |
| HIV_UVLC_6M.1.5 | 5-9 years : males | |
| HIV_UVLC_6M.1.6 | : females | |
| HIV_UVLC_6M.1.7 | 10-14 years : males | |
| HIV_UVLC_6M.1.8 | : females | |
| HIV_UVLC_6M.1.9 | 15-19years : males | |
| HIV_UVLC_6M.1.10 | : Females Non-pregnant | |
| HIV_UVLC_6M.1.11 | : Female Pregnant | |
| HIV_UVLC_6M.1.12 | 20-24years : males | |
| HIV_UVLC_6M.1.13 | : Females Non-pregnant | |
| HIV_UVLC_6M.1.14 | : Female Pregnant | |
| HIV_UVLC_6M.1.15 | 25-49years : males | |
| HIV_UVLC_6M.1.16 | : Females Non-pregnant | |
| HIV_UVLC_6M.1.17 | : Female Pregnant | |
| HIV_UVLC_6M.1.18 | >= 50 years : males | |
| HIV_UVLC_6M.1.19 | : females | |
| HIV_VLC_6M.1 | Number of adults and children who initiated ART in the 6 months prior to the beginning of the reporting period with a viral load count at 6 month visit | |
| HIV_VLC_6M.1.1 | < 1 year: males | |
| HIV_VLC_6M.1.2 | : females | |
| HIV_VLC_6M.1.3 | 1-4 years : males | |
| HIV_VLC_6M.1.4 | : females | |
| HIV_VLC_6M.1.5 | 5-9 years : males | |
| HIV_VLC_6M.1.6 | : females | |
| HIV_VLC_6M.1.7 | 10-14 years : males | |
| HIV_VLC_6M.1.8 | : females | |
| HIV_VLC_6M.1.9 | 15-19years : males | |
| HIV_VLC_6M.1.10 | : Females Non-pregnant | |
| HIV_VLC_6M.1.11 | : Female Pregnant | |
| HIV_VLC_6M.1.12 | 20-24years : males | |
| HIV_VLC_6M.1.13 | : Females Non-pregnant | |
| HIV_VLC_6M.1.14 | : Female Pregnant | |
| HIV_VLC_6M.1.15 | 25-49years : males | |
| HIV_VLC_6M.1.16 | : Females Non-pregnant | |
| HIV_VLC_6M.1.17 | : Female Pregnant | |
| HIV_VLC_6M.1.18 | >= 50 years : males | |
| HIV_VLC_6M.1.19 | : females | |

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| CDC_HIV_SVLC | Percentage of ART clients with a suppressed viral load (<1000 copies/ml) among those with a viral load test in the reporting period | |
| HIV_SVLC.1 | Total number of adult and paediatric ART patients with an undetectable viral load <1000copies/ml in the reporting period | |
| HIV_SVLC.1.1 | < 1 year: males | |
| HIV_SVLC.1.2 | : females | |
| HIV_SVLC.1.3 | 1-4 years : males | |
| HIV_SVLC.1.4 | : females | |
| HIV_SVLC.1.5 | 5-9 years : males | |
| HIV_SVLC.1.6 | : females | |
| HIV_SVLC.1.7 | 10-14 years : males | |
| HIV_SVLC.1.8 | : females | |
| HIV_SVLC.1.9 | 15-19years : males | |
| HIV_SVLC.1.10 | : Females Non-pregnant | |
| HIV_SVLC.1.11 | : Female Pregnant | |
| HIV_SVLC.1.12 | 20-24years : males | |
| HIV_SVLC.1.13 | : Females Non-pregnant | |
| HIV_SVLC.1.14 | : Female Pregnant | |
| HIV_SVLC.1.15 | 25-49years : males | |
| HIV_SVLC.1.16 | : Females Non-pregnant | |
| HIV_SVLC.1.17 | : Female Pregnant | |
| HIV_SVLC.1.18 | >= 50 years : males | |
| HIV_SVLC.1.19 | : females | |
| HIV_VLC.1 | Number of adult and pediatric ART patients with a viral load test in the reporting period | |
| HIV_VLC.1.1 | < 1 year: males | |
| HIV_VLC.1.2 | : females | |
| HIV_VLC.1.3 | 1-4 years : males | |
| HIV_VLC.1.4 | : females | |
| HIV_VLC.1.5 | 5-9 years : males | |
| HIV_VLC.1.6 | : females | |
| HIV_VLC.1.7 | 10-14 years : males | |
| HIV_VLC.1.8 | : females | |
| HIV_VLC.1.9 | 15-19years : males | |
| HIV_VLC.1.10 | : Females Non-pregnant | |
| HIV_VLC.1.11 | : Female Pregnant | |
| HIV_VLC.1.12 | 20-24years : males | |
| HIV_VLC.1.13 | : Females Non-pregnant | |
| HIV_VLC.1.14 | : Female Pregnant | |

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| HIV_VLC.1.15 | 25-49years : males | |
| HIV_VLC.1.16 | : Females Non-pregnant | |
| HIV_VLC.1.17 | : Female Pregnant | |
| HIV_VLC.1.18 | >= 50 years : males | |
| HIV_VLC.1.19 | : females | |
| CDC_HIV_NTR | Proportion of clinically undernourished People Living with HIV (PLHIV) who received therapeutic or supplementary food | |
| HIV_NTR_S4M | Number of PLHIV who were assessed/screened for malnutrition | |
| HIV_NTR_S4M.1 | < 1 year: males | |
| HIV_NTR_S4M.2 | : females | |
| HIV_NTR_S4M.3 | 1-4 years : males | |
| HIV_NTR_S4M.4 | : females | |
| HIV_NTR_S4M.5 | 5-9 years : males | |
| HIV_NTR_S4M.6 | : females | |
| HIV_NTR_S4M.7 | 10-14 years : males | |
| HIV_NTR_S4M.8 | : females | |
| HIV_NTR_S4M.9 | 15-19years : males | |
| HIV_NTR_S4M.10 | : Females Non-pregnant | |
| HIV_NTR_S4M.11 | : Female Pregnant | |
| HIV_NTR_S4M.12 | 20-24years : males | |
| HIV_NTR_S4M.13 | : Females Non-pregnant | |
| HIV_NTR_S4M.14 | : Female Pregnant | |
| HIV_NTR_S4M.15 | 25-49years : males | |
| HIV_NTR_S4M.16 | : Females Non-pregnant | |
| HIV_NTR_S4M.17 | : Female Pregnant | |
| HIV_NTR_S4M.18 | >= 50 years : males | |
| HIV_NTR_S4M.19 | : females | |
| HIV_NTR_S4MU.1 | Number of PLHIV that were nutritionally assessed and found to be clinically undernourished (disaggregated by Age, Sex and Pregnancy) | |
| HIV_NTR_S4MU.1.1 | < 1 year: males | |
| HIV_NTR_S4MU.1.2 | : females | |
| HIV_NTR_S4MU.1.3 | 1-4 years : males | |
| HIV_NTR_S4MU.1.4 | : females | |
| HIV_NTR_S4MU.1.5 | 5-9 years : males | |
| HIV_NTR_S4MU.1.6 | : females | |
| HIV_NTR_S4MU.1.7 | 10-14 years : males | |
| HIV_NTR_S4MU.1.8 | : females | |
| HIV_NTR_S4MU.1.9 | 15-19years : males | |
| HIV_NTR_S4MU.1.10 | : Females Non-pregnant | |

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| HIV_NTR_S4MU.1.11 | : Female Pregnant | |
| HIV_NTR_S4MU.1.12 | 20-24years : males | |
| HIV_NTR_S4MU.1.13 | : Females Non-pregnant | |
| HIV_NTR_S4MU.1.14 | : Female Pregnant | |
| HIV_NTR_S4MU.1.15 | 25-49years : males | |
| HIV_NTR_S4MU.1.16 | : Females Non-pregnant | |
| HIV_NTR_S4MU.1.17 | : Female Pregnant | |
| HIV_NTR_S4MU.1.18 | >= 50 years : males | |
| HIV_NTR_S4MU.1.19 | : females | |
| HIV_NTR_S4MU.2 | Number of PLHIV that were nutritionally assessed and found to be clinically undernourished (disaggregated by Age, Sex and Pregnancy) | |
| HIV_NTR_S4MU.2.1 | Total MAM | |
| HIV_NTR_S4MU.2.2 | Total SAM | |
| HIV_NTR_S4MU_TF.1 | Clinically undernourished PLHIV who received therapeutic or supplementary food dis aggregated by age, sex and pregnant status | |
| HIV_NTR_S4MU_TF.1.1 | < 1 year: males | |
| HIV_NTR_S4MU_TF.1.2 | : females | |
| HIV_NTR_S4MU_TF.1.3 | 1-4 years : males | |
| HIV_NTR_S4MU_TF.1.4 | : females | |
| HIV_NTR_S4MU_TF.1.5 | 5-9 years : males | |
| HIV_NTR_S4MU_TF.1.6 | : females | |
| HIV_NTR_S4MU_TF.1.7 | 10-14 years : males | |
| HIV_NTR_S4MU_TF.1.8 | : females | |
| HIV_NTR_S4MU_TF.1.9 | 15-19years : males | |
| HIV_NTR_S4MU_TF.1.10 | : Females Non-pregnant | |
| HIV_NTR_S4MU_TF.1.11 | : Female Pregnant | |
| HIV_NTR_S4MU_TF.1.12 | 20-24years : males | |

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| HIV_NTR_S4MU_TF.1.13 | : Females Non-pregnant | |
| HIV_NTR_S4MU_TF.1.14 | : Female Pregnant | |
| HIV_NTR_S4MU_TF.1.15 | 25-49years : males | |
| HIV_NTR_S4MU_TF.1.16 | : Females Non-pregnant | |
| HIV_NTR_S4MU_TF.1.17 | : Female Pregnant | |
| HIV_NTR_S4MU_TF.1.18 | >= 50 years : males | |
| HIV_NTR_S4MU_TF.1.19 | : females | |
| HIV_NTR_S4MU_TF.2 | Number of clinically undernourished PLHIV who received therapeutic or supplementary food by nutritional status | |
| HIV_NTR_S4MU_TF.2.1 | Total MAM who received therapeutic or supplementary food | |
| HIV_NTR_S4MU_TF.2.2 | Total SAM who received therapeutic or supplementary food | |
| HIV_PEP | Proportion of persons provided with Post-exposure prophylaxis (PEP) | |
| HIV_PEP.1 | Total number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection | |
| HIV_PEP.1.1 | For occupational risk | |
| HIV_PEP.1.2 | For Non occupational risk | |
| HIV_PE4HIV | Total number of persons exposed for HIV infection and eligible for PEP | |
| HIV_PE4HIV.1 | For occupational risk | |
| HIV_PE4HIV.2 | For Non occupational risk | |
| CDC_HIV_FP | Percentage of PLHIV women using a modern family planning method | |
| HIV_FP_Mtd | Number of PLHIV women aged 15-49 reporting the use of any modern family planning by method | |
| HIV_FP.1_LA | Long Acting | |
| HIV_FP.1_SA | Short Acting | |
| HIV_FP_Age | Number of PLHIV women aged 15-49 reporting the use of any method of modern family planning by Age | |
| HIV_FP_Age.1 | 10- 14 yr | |
| HIV_FP_Age.2 | 15-19 yr | |
| HIV_FP_Age.3 | 20-24 years | |
| HIV_FP_Age.4 | 25-49 years | |

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| CDC_HIV_TBSC | TB Screening for HIV positive Clients | |
| HIV_TBSC.1 | Number of clients who were on ART and screened for TB during the reporting period | |
| HIV_TBSC.1.1 | < 1 yr: male | |
| HIV_TBSC.1.2 | : female | |
| HIV_TBSC.1.3 | 1-4 yr : male | |
| HIV_TBSC.1.4 | : female | |
| HIV_TBSC.1.5 | 5-9 yr : male | |
| HIV_TBSC.1.6 | : female | |
| HIV_TBSC.1.7 | 10-14 yr : male | |
| HIV_TBSC.1.8 | : female | |
| HIV_TBSC.1.9 | 15-19 yr : male | |
| HIV_TBSC.1.10 | : Females Non-pregnant | |
| HIV_TBSC.1.11 | : Female Pregnant | |
| HIV_TBSC.1.12 | 20-24 yr : male | |
| HIV_TBSC.1.13 | : Females Non-pregnant | |
| HIV_TBSC.1.14 | : Female Pregnant | |
| HIV_TBSC.1.15 | 25-49 yr : male | |
| HIV_TBSC.1.16 | : Females Non-pregnant | |
| HIV_TBSC.1.17 | : Female Pregnant | |
| HIV_TBSC.1.18 | >= 50 yr : male | |
| HIV_TBSC.1.19 | : female | |
| HIV_TBSC.1.20 | Number of ART patients who had at least one positive screen during the reporting period | |
| HIV_TBSC.1.21 | Number of ART patients who had a specimen sent for bacteriologic diagnosis of active TB disease | |
| HIV_TBSC.1.22 | Smear Only | |
| HIV_TBSC.1.23 | Gene Xpert MTB / R if Assay | |
| HIV_TBSC.1.24 | Other (No Xpert) | |
| HIV_TBPos.1 | Total Number of HIV positive clients with active TB | |
| HIV_TBPos.1.1 | <15 yr : Male | |
| HIV_TBPos.1.2 | : female | |
| HIV_TBPos.1.3 | >15 yr : Male | |
| HIV_TBPos.1.4 | : female | |
| HIV_TBSC.Add.1 | The number of ART patients who were started on TB treatment during the reporting period | |
| HIV_TBSC.Add.1.1 | <15 yr : Male | |
| HIV_TBSC.Add.1.2 | : female | |
| HIV_TBSC.Add.1.3 | >15 yr : Male | |
| HIV_TBSC.Add.1.4 | : female | |

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| HIV_TBSC.Add.1.5 | The number of patients starting TB treatment who newly started ART during the reporting period | from newly started on ART |
| HIV_TBSC.Add.1.1 | <15 yr : Male | |
| HIV_TBSC.Add.1.2 | : female | |
| HIV_TBSC.Add.1.3 | >15 yr : Male | |
| HIV_TBSC.Add.1.4 | : female | |
| VL.add.1 | VL TAT | |
| VL.add.1.1 | Average turn around time in days that took a viral load result return after days the sample is drawn from patients. | |
| VL.add.1.1 | Number of Viral Load Results Returned to Facility in the Month | |
| VL.add.1.2 | Average turn around time in days that took a viral load result to return after days the sample is drawn from patients. | |

4) Family planning

| Hospital/Health Center/Clinic/Center Monthly Service Delivery Report Form | | |
|---|--|--------|
| Woreda _____ Name of the health facility _____ Year _____ Month _____ | | |
| Facility ownership: Government (FMOH) <input type="checkbox"/> Other Government <input type="checkbox"/> Private for profit <input type="checkbox"/> Private not for profit <input type="checkbox"/> | | |
| Facility type: Primary Hospital <input type="checkbox"/> General Hospital <input type="checkbox"/> Comprehensive Specialized Hospital <input type="checkbox"/> Health Center <input type="checkbox"/> | | |
| Primary Clinic <input type="checkbox"/> Medium Clinic <input type="checkbox"/> Specialty Clinic <input type="checkbox"/> Type _____ | | |
| FP Specialty Center <input type="checkbox"/> Type _____ | | |
| S.No | Activity | Number |
| C1 | Access to Health Service | |
| C1.1 | Maternal, Neonatal, and Child Health | |
| C1.1.1 | Maternal Health | |
| C1.1.1.1 | Contraceptive acceptance rate | |
| 1.1.1.1.1 | Total new and repeat acceptors, disaggregated by age | |
| 1.1.1.1.1.1 | New acceptors by age | |
| 1.1.1.1.1.1.1 | < 15 years | |
| 1.1.1.1.1.1.2 | 15-19 years | |
| 1.1.1.1.1.1.3 | 20 - 24 years | |
| 1.1.1.1.1.1.4 | 25 -49 years | |
| 1.1.1.1.1.2 | Repeat acceptors by age | |
| 1.1.1.1.1.2.1 | < 15 years | |
| 1.1.1.1.1.2.2 | 15-19 years | |
| 1.1.1.1.1.2.3 | 20 - 24 years | |
| 1.1.1.1.1.2.4 | 25 -49 years | |
| 1.1.1.1.2 | Total new and repeat acceptors, disaggregated by method | |
| 1.1.1.1.2.1 | New acceptors, by method | |
| 1.1.1.1.2.1.1 | Oral contraceptives | |
| 1.1.1.1.2.1.2 | Injectables | |
| 1.1.1.1.2.1.3 | Implants | |
| 1.1.1.1.2.1.4 | IUCD | |
| 1.1.1.1.2.1.5 | Others | |
| 1.1.1.1.2.2 | Repeat acceptors, by method | |
| 1.1.1.1.2.2.1 | Oral contraceptives | |
| 1.1.1.1.2.2.2 | Injectables | |
| 1.1.1.1.2.2.3 | Implants | |
| 1.1.1.1.2.2.4 | IUCD | |
| 1.1.1.1.2.2.5 | Others | |
| FP.Add.1 | Number FP acceptors HIV test offered | |
| FP.Add.2 | Number of FP acceptors HIV tested | |
| FP.Add.3 | Number of FP acceptors HIV Positive | |
| FP.Add.4 | # of clients referred for VSC (Voluntary surgical contraception) | |

| | | |
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| FP.Add.4 | # of clients referred for other RH services like CAC/SA, PAC, STI, Infertility, ART, Gynecological treatment etc... | |
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5) TB and TB/HIV

| Hospital/Health Center/Clinic/Center Monthly Service Delivery Report Form | | |
|---|--|--------|
| Woreda _____ Name of the health facility _____ Year _____ Month _____ | | |
| Facility ownership: Government (FMOH) <input type="radio"/> Other Government <input type="radio"/> Private for profit <input type="radio"/> Private not for profit <input type="radio"/> | | |
| Facility type: Primary Hospital <input type="radio"/> General Hospital <input type="radio"/> Comprehensive Specialized Hospital <input type="radio"/> Health Center <input type="radio"/> | | |
| Primary Clinic <input type="radio"/> Medium Clinic <input type="radio"/> Specialty Clinic <input type="radio"/> Type _____ | | |
| TB/HIV <input type="radio"/> Specialty Center <input type="radio"/> Type _____ | | |
| S.No | Activity | Number |
| CDC_TB | Tuberculosis | |
| CDC_TB_CDR | Tuberculosis case detection rate (all forms) | |
| TB_CDR.1 | Number of bacteriologically confirmed New Pulmonary TB cases detected in the quarter | |
| TB_CDR.1.1 | 0-4 years : males | |
| TB_CDR.1.2 | : females | |
| TB_CDR.1.3 | 5-14 years : males | |
| TB_CDR.1.4 | : females | |
| TB_CDR.1.5 | 15-24years : males | |
| TB_CDR.1.6 | : females | |
| TB_CDR.1.7 | 25 -34 years : males | |
| TB_CDR.1.8 | : females | |
| TB_CDR.1.9 | 35 – 44 years: males | |
| TB_CDR.1.10 | : females | |
| TB_CDR.1.11 | 45 – 54 years: males | |
| TB_CDR.1.12 | : females | |
| TB_CDR.1.13 | 55-64 years : males | |
| TB_CDR.1.14 | : females | |
| TB_CDR.1.15 | >=65 years : males | |
| TB_CDR.1.16 | : females | |

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| TB_CDR.2 | Number of clinically diagnosed New pulmonary TB cases detected in the quarter | |
| TB_CDR.2.1 | 0-4 years : Males | |
| TB_CDR.2.2 | : Females | |
| TB_CDR.2.3 | 5-14 years : Males | |
| TB_CDR.2.4 | : Females | |
| TB_CDR.2.5 | 15-24years : males | |
| TB_CDR.2.6 | : females | |
| TB_CDR.2.7 | 25 -34 years : males | |
| TB_CDR.2.8 | : females | |
| TB_CDR.2.9 | 35 – 44 years: males | |
| TB_CDR.2.10 | : females | |
| TB_CDR.2.11 | 45 – 54 years: males | |
| TB_CDR.2.12 | : females | |
| TB_CDR.2.13 | 55-64 years : males | |
| TB_CDR.2.14 | : females | |
| TB_CDR.2.15 | >=65 years : males | |
| TB_CDR.2.16 | : females | |
| TB_CDR.3 | Number of clinically diagnosed and bacteriologically confirmed new EPTB cases detected in the quarter | |
| TB_CDR.3.1 | 0-4 years : Males | |
| TB_CDR.3.2 | : Females | |
| TB_CDR.3.3 | 5-14 years : Males | |
| TB_CDR.3.4 | : Females | |
| TB_CDR.3.5 | 15-24years : males | |
| TB_CDR.3.6 | : females | |
| TB_CDR.3.7 | 25 -34 years : males | |
| TB_CDR.3.8 | : females | |
| TB_CDR.3.9 | 35 – 44 years: males | |
| TB_CDR.3.10 | : females | |
| TB_CDR.3.11 | 45 – 54 years: males | |
| TB_CDR.3.12 | : females | |

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| TB_CDR.3.13 | 55-64 years : males | |
| TB_CDR.3.14 | : females | |
| TB_CDR.3.15 | >=65 years : males | |
| TB_CDR.3.16 | : females | |
| TB_CDR.4 | Number of RELAPSE (bacteriological confirmed and clinically diagnosed) TB cases detected in the quarter | |
| TB_CDR.4.1 | 0-4 years : Males | |
| TB_CDR.4.2 | : Females | |
| TB_CDR.4.3 | 5-14 years : Males | |
| TB_CDR.4.4 | : Females | |
| TB_CDR.4.5 | 15-24 years : males | |
| TB_CDR.4.6 | : females | |
| TB_CDR.4.7 | 25 -34 years : males | |
| TB_CDR.4.8 | : females | |
| TB_CDR.4.9 | 35 – 44 years: males | |
| TB_CDR.4.10 | : females | |
| TB_CDR.4.11 | 45 – 54 years: males | |
| TB_CDR.4.12 | : females | |
| TB_CDR.4.13 | 55-64 years : males | |
| TB_CDR.4.14 | : females | |
| TB_CDR.4.15 | >=65 years : males | |
| TB_CDR.4.16 | : females | |
| CDC_TB_RRXR | Tuberculosis re-treatment rate | |
| TB_RRXR.1 | Number of Bacteriologically confirmed relapse TB cases (BR) | |
| TB_RRXR.1.1 | : male | |
| TB_RRXR.1.2 | : Females | |
| TB_RRXR.2 | Number of Clinically diagnosed relapse TB cases(CR) | |
| TB_RRXR.2.1 | : male | |
| TB_RRXR.2.2 | : Females | |
| TB_RRXR.3 | Number of Treatment after failure TB cases(F) | |
| TB_RRXR.3.1 | : male | |
| TB_RRXR.3.2 | : Females | |

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| TB_RRXR.4 | Number of Treatment after lost to follow-up TB cases (L) | |
| TB_RRXR.4.1 | : male | |
| TB_RRXR.4.2 | : Females | |
| TB_RRXR.5 | Number of Other previously treated (unknown & undocumented treatment outcome) TB cases (O) | |
| TB_RRXR.5.1 | : male | |
| TB_RRXR.5.2 | : Females | |
| CDC_TB_RXO | TB Treatment outcome | |
| TB_RXO_PTB+ | Results for new bacteriologically confirmed PTB cases registered cohort in the same quarter of the previous EFY (PTB+) | |
| TB_RXO_CPTB+ | Total number of new bacteriologically confirmed TB cases enrolled in cohort (PTB+) : | |
| TB_RXO_CPTB+_Co.1 | Treatment completed PTB+ | |
| TB_RXO_CPTB+_Cu.1 | Cured PTB+ | |
| TB_RXO_CPTB+_LTF.1 | Lost to follow up PTB+ | |
| TB_RXO_CPTB+_Dth.1 | Deaths PTB+ | |
| TB_RXO_CPTB+_F.1 | Failure PTB+ | |
| TB_RXO_CPTB+_NE.1 | Not evaluated PTB+ | |
| TB_RXO_CPTB+_DRTB.1 | Moved to MDR TB Register | |
| TB_RXO_PNeg | Results for new clinically diagnosed pulmonary TB cases cohort registered in the same quarter of previous EFY (P/Neg) | |
| TB_TSR_CPNeg | Total number of new clinically confirmed pulmonary TB cases enrolled in the cohort (P/Neg): | |
| TB_RXO_CPneg_Co.1 | Treatment completed P/Neg TB | |
| TB_RXO_CPneg_LTF.1 | Lost to follow up P/Neg TB | |
| TB_RXO_CPneg_Dth.1 | Deaths P/Neg TB | |
| TB_RXO_CPneg_F.1 | Failure P/Neg TB | |
| TB_RXO_CPneg_NE.1 | Not evaluated P/Neg TB | |
| TB_RXO_CPneg_DRTB.1 | Moved to DR TB Register P/Neg TB | |
| TB_RXO_EPTB | Results for clinically diagnosed new clinically diagnosed extra pulmonary TB cases cohort registered in the same quarter of the previous EFY (EPTB) | |
| TB_RXO_CEPTB | Total number of clinically diagnosed and bacteriologically confirmed new EPTB cases enrolled in the cohort (EPTB): | |
| TB_RXO_EPTB_Co.1 | Treatment completed P/Neg TB | |

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| TB_RXO_EPTB_LTF.1 | Lost to follow up EPTB cases | |
| TB_RXO_EPTB_Dth.1 | Deaths EPTB cases | |
| TB_RXO_EPTB_F.1 | Failure EPTB cases | |
| TB_RXO_EPTB_NE.1 | Not evaluated EPTB cases | |
| TB_RXO_DRTB.1 | Moved to DR TB Register EPTB cases | |
| TB.Add. 1 | Results for retreatment TB cases cohort registered in the same quarter of the previous EFY | |
| TB.Add. 1.1 | Total number of retreatment cases enrolled in the cohort: | |
| TB.Add. 1.1.1 | Cured | |
| TB.Add. 1.1.2 | Treatment completed | |
| TB.Add. 1.1.3 | Lost to follow up | |
| TB.Add. 1.1.4 | Deaths | |
| TB.Add. 1.1.5 | Failure | |
| TB.Add. 1.1.6 | Not evaluated | |
| TB.Add. 1.1.7 | Moved to DR TB Register | |
| TB.Add.2 | Results for HIV positive TB cases cohort registered in the same quarter of the previous EFY | |
| TB.Add.2.1 | Total number of HIV positive TB cases enrolled in the cohort | |
| TB.Add.2.1.1 | Cured HIV positive TB cases: <1 yr | |
| TB.Add.2.1.2 | Cured HIV positive TB cases: 1-4 yrs | |
| TB.Add.2.1.3 | Cured HIV positive TB cases: 5-9 yrs | |
| TB.Add.2.1.4 | Cured HIV positive TB cases: 10-14 yrs | |
| TB.Add.2.1.5 | Cured HIV positive TB cases: 15-19 yrs | |
| TB.Add.2.1.6 | Cured HIV positive TB cases: 20+ yrs | |
| TB.Add.2.1.7 | total Cured HIV positive TB cases | |
| TB.Add.2.1.8 | Treatment completed HIV positive TB cases: <1 yr | |
| TB.Add.2.1.9 | Treatment completed HIV positive TB cases: 1-4 yrs | |
| TB.Add.2.1.10 | Treatment completed HIV positive TB cases: 5-9 yrs | |
| TB.Add.2.1.11 | Treatment completed HIV positive TB cases: 10-14 yrs | |
| TB.Add.2.1.12 | Treatment completed HIV positive TB cases: 15-19 yrs | |
| TB.Add.2.1.13 | Treatment completed HIV positive TB cases: 20+ yrs | |
| TB.Add.2.1.14 | Total Treatment completed HIV positive TB cases | |
| TB.Add.2.1.15 | Lost to follow up HIV positive TB cases: <1 yr | |
| TB.Add.2.1.16 | Lost to follow up HIV positive TB cases: 1-4 yrs | |
| TB.Add.2.1.17 | Lost to follow up HIV positive TB cases: 5-9 yrs | |
| TB.Add.2.1.18 | Lost to follow up HIV positive TB cases: 10-14 yrs | |

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| TB.Add.2.1.19 | Lost to follow up HIV positive TB cases: 15-19 yrs | |
| TB.Add.2.1.20 | Lost to follow up HIV positive TB cases: 20+ yrs | |
| TB.Add.2.1.21 | Total Lost to follow up HIV positive TB cases | |
| TB.Add.2.1.22 | Deaths HIV positive TB cases: <1 yr | |
| TB.Add.2.1.23 | Deaths HIV positive TB cases: 1-4 yrs | |
| TB.Add.2.1.24 | Deaths HIV positive TB cases: 5-9 yrs | |
| TB.Add.2.1.25 | Deaths HIV positive TB cases: 10-14 yrs | |
| TB.Add.2.1.26 | Deaths HIV positive TB cases: 15-19 yrs | |
| TB.Add.2.1.27 | Deaths HIV positive TB cases: 20+ yrs | |
| TB.Add.2.1.28 | Total Deaths HIV positive TB cases | |
| TB.Add.2.1.29 | Failure HIV positive TB cases: <1 yr | |
| TB.Add.2.1.30 | Failure HIV positive TB cases: 1-4 yrs | |
| TB.Add.2.1.31 | Failure HIV positive TB cases: 5-9 yrs | |
| TB.Add.2.1.32 | Failure HIV positive TB cases: 10-14 yrs | |
| TB.Add.2.1.33 | Failure HIV positive TB cases: 15-19 yrs | |
| TB.Add.2.1.34 | Failure HIV positive TB cases: 20+ yrs | |
| TB.Add.2.1.35 | Total Failure HIV positive TB cases | |
| TB.Add.2.1.36 | Not evaluated HIV positive TB cases: <1 yr | |
| TB.Add.2.1.37 | Not evaluated HIV positive TB cases: 1-4 yrs | |
| TB.Add.2.1.38 | Not evaluated HIV positive TB cases: 5-9 yrs | |
| TB.Add.2.1.39 | Not evaluated HIV positive TB cases: 10-14 yrs | |
| TB.Add.2.1.40 | Not evaluated HIV positive TB cases: 15-19 yrs | |
| TB.Add.2.1.41 | Not evaluated HIV positive TB cases: 20+ yrs | |
| TB.Add.2.1.42 | Total Not evaluated HIV positive TB cases | |
| TB.Add.2.1.43 | Moved to MDR TB Register HIV positive TB cases: <1 yr | |
| TB.Add.2.1.44 | Moved to MDR TB Register HIV positive TB cases: 1-4 yrs | |
| TB.Add.2.1.45 | Moved to MDR TB Register HIV positive TB cases: 5-9 yrs | |
| TB.Add.2.1.46 | Moved to MDR TB Register HIV positive TB cases: 10-14 yrs | |
| TB.Add.2.1.47 | Moved to MDR TB Register HIV positive TB cases: 15-19 yrs | |
| TB.Add.2.1.48 | Moved to MDR TB Register HIV positive TB cases: 20+ yrs | |
| TB.Add.2.1.49 | Total Moved to MDR TB Register HIV positive TB cases | |
| CDC_TB_HIVSC | HIV screening for TB patients | |
| TB_NRRXTB | Total number of all new and retreatment TB cases enrolled to DOTS in the quarter | |
| TB_HIVSC.1 | Number of TB patients with documented HIV test result including periously known HIV positive in the reporting quarter | |
| TB_HIVSC.1.1 | <15yr : Male | |
| TB_HIVSC.1.2 | : Female | |

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| TB_HIVSC.1.3 | >15: male | |
| TB_HIVSC.1.4 | : Female | |
| TB_HIVSC_Pos | Number of TB patients with HIV positive test result (New and previously known HIV positive) : | |
| TB_HIVSC_Pos.1 | <15yr : Male | |
| TB_HIVSC_Pos.2 | : Female | |
| TB_HIVSC_Pos.3 | >15: male | |
| TB_HIVSC_Pos.4 | : Female | |
| TB_HIVSC.add.3 | Number of TB patients Newly Tested for HIV | Only newly tested |
| TB_HIVSC.add.3.1 | <15yr : Male | |
| TB_HIVSC.add.3.2 | : Female | |
| TB_HIVSC.add.3.3 | >15: male | |
| TB_HIVSC.add.3.4 | : Female | |
| TB_HIVSC.add.3.5 | Number of TB patients Newly Tested positive for HIV | Only newly tested |
| TB_HIVSC.add.3.6 | <15yr : Male | |
| TB_HIVSC.add.3.7 | : Female | |
| TB_HIVSC.add.3.8 | >15: male | |
| TB_HIVSC.add.3.9 | : Female | |
| TB_HIVSC_Neg | Number of TB patients with HIV Negative test result | |
| TB_HIVSC_Neg.1 | <15yr : Male | |

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| TB_HIVSC_Neg.2 | : Female | |
| TB_HIVSC_Neg.3 | >15: male | |
| TB_HIVSC_Neg.4 | : Female | |
| CDC_TB/HIV_ART | Ant-Retroviral Therapy (ART) for HIV positive TB patients | |
| TB/HIV_ART.1. | Total number of HIV positive TB patients registered in the quarter | |
| TB/HIV_ART.1.1 | Total number of previously known HIV positive TB patients who are on ART | |
| TB/HIV_ART.1.1.1 | 0-4 yr: male | |
| TB/HIV_ART.1.1.2 | : Female | |
| TB/HIV_ART.1.1.3 | 5-14 yr : male | |
| TB/HIV_ART.1.1.4 | : Female | |
| TB/HIV_ART.1.1.5 | 25+: male | |
| TB/HIV_ART.1.1.6 | : Female | |
| TB/HIV_ART.1.2 | Total number of newly tested HIV positive TB patients who are on ART | |
| TB/HIV_ART.1.2.1 | 0-4 yr: male | |
| TB/HIV_ART.1.2.2 | : Female | |
| TB/HIV_ART.1.2.3 | 5-14 yr : male | |
| TB/HIV_ART.1.2.4 | : Female | |
| TB/HIV_ART.1.2.5 | 25+: male | |
| TB/HIV_ART.1.2.6 | : Female | |
| CDC_HIV_IPT | INH Preventive therapy (IPT) for newly enrolled HIV positive clients | |
| HIV_IPTE | Total number of IPT eligible HIV positive clients newly enrolled in to HIV care during the reporting period.(exclude patients with active TB or on TB treatment at time of enrollment to HIV care should be excluded from the denominator) | |
| CDC_HIV_IPTE.1 | < 1 yr: male | |
| CDC_HIV_IPTE.2 | : female | |
| CDC_HIV_IPTE.3 | 1-4 yr: male | |
| CDC_HIV_IPTE.4 | : female | |
| CDC_HIV_IPTE.5 | 5-14yr: male | |
| CDC_HIV_IPTE.6 | : female | |

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| CDC_HIV_IPTE.7 | 15+ yr: male | |
| CDC_HIV_IPTE.8 | : Female pregnant | |
| CDC_HIV_IPTE.9 | : Female non pregnant | |
| HIV_IPT.1 | Total Number of newly enrolled clients in HIV care who started IPT during the quarter : | |
| HIV_IPT.1.1 | < 1 yr: male | |
| HIV_IPT.1.2 | : female | |
| HIV_IPT.1.3 | 1-4 yr: male | |
| HIV_IPT.1.4 | : female | |
| HIV_IPT.1.5 | 5-14yr: male | |
| HIV_IPT.1.6 | : female | |
| HIV_IPT.1.7 | 15+ yr: male | |
| HIV_IPT.1.8 | : Female pregnant | |
| HIV_IPT.1.9 | : Female non pregnant | |
| HIV_IPT Add.1 | Number of clients in HIV care who started IPT during the reporting period from previously enrolled clients | |
| HIV_IPT Add.2 | Number of clients currently on IPT during the reporting period | |
| HIV_IPT_CRX.1 | Number of PLHIV who has completed full course of IPT during the reporting period | |
| HIV_IPT_CRX.1.1 | < 1 yr: male | |
| HIV_IPT_CRX.1.2 | : female | |
| HIV_IPT_CRX.1.3 | 1-4 yr: male | |
| HIV_IPT_CRX.1.4 | : female | |
| HIV_IPT_CRX.1.5 | 5-14yr: male | |
| HIV_IPT_CRX.1.6 | : female | |
| HIV_IPT_CRX.1.7 | 15+ yr: male | |
| HIV_IPT_CRX.1.8 | : Female pregnant | |
| HIV_IPT_CRX.1.9 | : Female non pregnant | |
| HIV_IPT_CRX. Add1 | The number of ART patients who were newly started on TB preventive therapy (including those who newly started on TB preventive therapy in this reporting period and those who started in the previous reporting period but had not been reported as they did not fulfilled the minimum requirements for the previous reporting period.). | |

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| HIV_IPT_CRX. Add2 | <15 : male | |
| HIV_IPT_CRX. Add3 | : female | |
| HIV_IPT_CRX. Add4 | >15 : male | |
| HIV_IPT_CRX. Add5 | : female | |
| | RR/MDR TB case Finding | |
| CDC_TB_DST | Proportion of TB patients with DST results | |
| TB_EDST | Number of notified TB cases eligible for drug susceptibility testing according to national policy during the reporting period: | sum |
| TB_EDST.1 | Registration group: New | |
| TB_EDST.2 | :Previously treated including Relapse | |
| TB_EDST.3 | : Unknown treatment History | |
| TB_DSTR.1 | Number of TB cases with drug susceptibility testing result during the reporting period | sum |
| TB_DSTR.1.1 | :New | |
| TB_DSTR.1.2 | :Previously treated including Relapse | |
| TB_DSTR.1.3 | : Unknown treatment History | |
| CDC_TB_DRTB.1 | Number of DR TB cases detected (RR Only, MDR- TB , Pre XDR and XDR TB cases) | sum |
| TB_DRTB.1.1 | Total Number of confirmed RR only TB cases | sum |
| TB_DRTB.1.1.1 | RR only TB cases age <15 yr : Male | |
| TB_DRTB.1.1.2 | : Female | |
| TB_DRTB.1.1.3 | RR only TB cases age: >=15yr : Male | |
| TB_DRTB.1.1.4 | : Female | |
| TB_DRTB.1.2 | Total number of confirmed MDR TB cases | sum |
| TB_DRTB.1.2.1 | MDR TB cases age <15yr : Male | |
| TB_DRTB.1.2.2 | : Female | |
| TB_DRTB.1.2.3 | MDR TB cases age: >=15yr Male | |
| TB_DRTB.1.2.4 | :Female | |
| 4.2.2.12.1.5 | Number of MDR TB confirmed cases linked to MDR treatment center | maintain |
| 4.2.2.12.1.6 | age <15years :Male | |
| 4.2.2.12.1.7 | Females | |
| 4.2.2.12.1.8 | Age >= 15 years :Male | |
| 4.2.2.12.1.9 | Females | |
| Tb.Ref.add | TB Referral | |
| Tb.Ref.add 1 | Number of bacteriologically confirmed New PTB cases detected and referred in the quarter | |
| Tb.Ref.add 1.1 | Female: Under 15 Yrs | |
| Tb.Ref.add 1.2 | Male: Under 15 Yrs | |
| Tb.Ref.add 1.3 | Female: 15+ Yrs | |
| Tb.Ref.add 1.4 | Male: 15+ Yrs | |

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| Tb.Ref.add 2 | Number of clinically diagnosed New P/Negative TB cases detected and referred in the quarter | |
| Tb.Ref.add 2.1 | Female: Under 15 Yrs | |
| Tb.Ref.add 2.2 | Male: Under 15 Yrs | |
| Tb.Ref.add 2.3 | Female: 15+ Yrs | |
| Tb.Ref.add 2.4 | Male: 15+ Yrs | |
| Tb.Ref.add 3 | Number of clinically diagnosed New EPTB cases detected and referred in the quarter | |
| Tb.Ref.add 3.1 | Female: Under 15 Yrs | |
| Tb.Ref.add 3.2 | Male: Under 15 Yrs | |
| Tb.Ref.add 3.3 | Female: 15+ Yrs | |
| Tb.Ref.add 3.4 | Male: 15+ Yrs | |
| Tb.Ref.add 4 | Number of Retreatment cases diagnosed and referred in the quarter | |
| Tb.Ref.add 4.1 | Female: Under 15 Yrs | |
| Tb.Ref.add 4.2 | Male: Under 15 Yrs | |
| Tb.Ref.add 4.3 | Female: 15+ Yrs | |
| Tb.Ref.add 4.4 | Male: 15+ Yrs | |
| Tb.Ref.add 5 | total TB cases referred | |
| CDC_TB_CS | TB Contact Screening Coverage | |
| Add | Number of TB cases enrolled during the quarter for whom contact screening performed | |
| TB_CS_CITB.1 | Total number of contacts with index of TB cases during the reporting period | |
| TB_CS_CITB.1.1 | Contacts of Drug Susceptible TB | |
| TB_CS_CITB.1.2 | Contacts of Drug Resistant TB | |
| TB_CISTB.1 | The number of contacts with index cases screened for TB in the reporting period | |
| TB_CISTB.1.1 | Contacts of Drug Susceptible TB | |
| TB_CISTB.1.2 | Contacts of Drug Resistant TB | |
| Add | Number of total HH/Close contacts diagnosed with TB | |
| CDC_TB_LTBI_IPT | LTBI treatment coverage for under five yr children who are contacts of pulmonary TB cases | |
| LTBI_IPT.1 | Total number of children under 5 contacts with index of drug susceptible pulmonary TB cases during the reporting period | |
| LTBI_IPT.2 | The number of under-five yr contacts with index of pulmonary TB cases screened for TB in the reporting period | |
| LTBI_IPT.3 | The number of under-five yr contacts with index of pulmonary TB cases and screened negative in the reporting period | |
| LTBI_IPT.4 | Total number of under-five yr contact TB screening negative and put on treatment of LTBI treatment (IPT) in the reporting period | |

6) Malaria diagnosis and treatment

| Hospital/Health Center/Clinic/Center Monthly Service Delivery Report Form | | |
|---|--|--------|
| Region _____ Zone _____ Woreda _____ Name of the health facility _____ Year _____ Month _____ | | |
| Facility ownership: Government (FMOH) <input type="radio"/> Other Government <input type="radio"/> Private for profit <input type="radio"/> Private not for profit <input type="radio"/> | | |
| Facility type: Primary Hospital <input type="radio"/> General Hospital <input type="radio"/> Comprehensive Specialized Hospital <input type="radio"/> Health Center <input type="radio"/> | | |
| <input type="radio"/> Primary Clinic <input type="radio"/> Medium Clinic <input type="radio"/> Specialty Clinic <input type="radio"/> Type _____ | | |
| <input type="radio"/> Specialty Center <input type="radio"/> Type _____ | | |
| HMIS_Code | Activity | Number |
| CDC_Mal | Malaria | |
| Malaria.Add.1 | Total number of malaria suspected cases (all fever cases) | |
| Malaria.Add.1.1 | < 5 yr : male | |
| Malaria.Add.1.2 | : female | |
| Malaria.Add.1.3 | 5-14yr : male | |
| Malaria.Add.1.4 | : female | |
| Malaria.Add.1.5 | >=15 yr : male | |
| Malaria.Add.1.6 | : female | |
| Mal_Pos | Malaria positivity rate | |
| Mal_Pos.1 | Number of slides or RDT positive for malaria | Sum |
| Malaria.Add.1.1.1 | Number of slides positive for malaria: PF | |
| Malaria.Add.1.1.2 | Female <15 | |
| Malaria.Add.1.1.3 | Male <15 | |
| Malaria.Add.1.1.4 | Female >15 | |
| Malaria.Add.1.1.5 | Male >15 | |
| Malaria.Add.1.1.6 | Number of slides positive for malaria: PV | |
| Malaria.Add.1.1.7 | Female <15 | |
| Malaria.Add.1.1.8 | Male <15 | |
| Malaria.Add.1.1.9 | Female >15 | |
| Malaria.Add.1.1.10 | Male >15 | |
| Malaria.Add.1.1.11 | Number of slides positive for malaria: Mixed | |
| Malaria.Add.1.1.12 | Female <15 | |
| Malaria.Add.1.1.13 | Male <15 | |
| Malaria.Add.1.1.14 | Female >15 | |
| Malaria.Add.1.1.15 | Male >15 | |

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| Malaria.Add.1.2.1 | Number of RDT positive for malaria: PF | |
| Malaria.Add.1.2.2 | Female <15 | |
| Malaria.Add.1.2.3 | Male <15 | |
| Malaria.Add.1.2.4 | Female >15 | |
| Malaria.Add.1.2.5 | Male >15 | |
| Malaria.Add.1.2.6 | Number of RDT positive for malaria: PV | |
| Malaria.Add.1.2.7 | Female <15 | |
| Malaria.Add.1.2.8 | Male <15 | |
| Malaria.Add.1.2.9 | Female >15 | |
| Malaria.Add.1.2.10 | Male >15 | |
| Malaria.Add.1.2.11 | Number of RDT positive for malaria: Mixed | |
| Malaria.Add.1.2.12 | Female <15 | |
| Malaria.Add.1.2.13 | Male <15 | |
| Malaria.Add.1.2.14 | Female >15 | |
| Malaria.Add.1.2.15 | Male >15 | |
| Mal_DX | Total number of slides or RDT performed for malaria diagnosis | |
| Malaria.Add. | Total number of slides performed for malaria diagnosis | |
| Malaria.Add.1.2 | Total number of RDT performed for malaria diagnosis | |
| Malaria.Add.2 | Number of Malaria cases in the quarter: All Cases | |
| Malaria.Add.2.1 | < 5 yr : male | |
| Malaria.Add.2.2 | : female | |
| Malaria.Add.2.3 | 5-14yr : male | |
| Malaria.Add.2.4 | : female | |
| Malaria.Add.2.5 | >=15 yr : male | |
| Malaria.Add.2.6 | : female | |
| Malaria.Add.2.7 | Pregnant Women | |
| Malaria.Add.19 | Total number of Malaria Cases treated in the facility | |
| Malaria.Add.20 | Number of Malaria Cases treated in the facility: ACT/Coartem+Primaquine | |
| Malaria.Add.21 | Number of Malaria Cases treated in the facility: Chloroquine | |
| Malaria.Add.22 | Number of Malaria Cases treated in the facility: Chloroquine+Primaquine(selected woreda) | |
| Malaria.Add.23 | Number of Malaria Cases treated in the facility: Artemether | |
| Malaria.Add.24 | Number of Malaria Cases treated in the facility: Artesunate | |
| Malaria.Add.25 | Number of Malaria Cases treated in the facility: Quinine | |
| Malaria.Add.26 | Number of Malaria Cases treated in the facility: Referred | |
| Malaria.Add.27 | Number of Malaria Admissions in the quarter | |
| Malaria.Add.28 | Number of Malaria Deaths in the quarter | |

7) STI services

| Hospital/Health Center/Clinic/Center Monthly Service Delivery Report Form | | |
|--|--|--------|
| Woreda _____ Name of the health facility _____ Year _____ Month _____ | | |
| Facility ownership: <input type="checkbox"/> Government (FMOH) <input type="checkbox"/> Other Government <input type="checkbox"/> Private for profit <input type="checkbox"/> Private not for profit <input type="checkbox"/> | | |
| Facility type: <input type="checkbox"/> Primary Hospital <input type="checkbox"/> General Hospital <input type="checkbox"/> Comprehensive Specialized Hospital <input type="checkbox"/> Health Center <input type="checkbox"/> | | |
| <input type="checkbox"/> Primary Clinic <input type="checkbox"/> Medium Clinic <input type="checkbox"/> Specialty Clinic <input type="checkbox"/> Type | | |
| <input type="checkbox"/> Specialty Center <input type="checkbox"/> Type | | |
| S.No | Activity | Number |
| STI Indicators | | |
| STI.Add.1 | # of patients with Urethral discharge Syndrome in the quarter | |
| | 0-4 years | |
| STI.Add.2 | 5-14 years | |
| STI.Add.3 | >=15 years | |
| STI.Add.4 | # of patients with Persistent/Recurrent Urethral discharge Syndrome in the quarter | |
| | 0-4 years | |
| STI.Add.2 | 5-14 years | |
| STI.Add.3 | >=15 years | |
| STI.Add.7 | # of patients with Genital Ulcer Syndrome in the quarter | |
| | 0-4 years: male | |
| | : femlae | |
| STI.Add.2 | 5-14 years : male | |
| | : femlae | |
| STI.Add.3 | >=15 years : male | |
| | : femlae | |
| STI.Add.13 | # of patients with Vaginal Discharge Syndrome in the quarter | |
| | 0-4 years | |
| STI.Add.2 | 5-14 years | |
| STI.Add.3 | >=15 years | |
| STI.Add.16 | # of patients with Lower Abdominal Pain Syndrome in the quarter | |
| | 0-4 years | |
| STI.Add.2 | 5-14 years | |
| STI.Add.3 | >=15 years | |
| STI.Add.19 | # of patients with Scrotal Swelling Syndrome in the quarter | |
| | 0-4 years | |
| STI.Add.2 | 5-14 years | |

| | | |
|------------|--|--|
| STI.Add.3 | >=15 years | |
| STI.Add.22 | # of patients with Inguinal Bubo Syndrome in the quarter | |
| | 0-4 years | |
| STI.Add.2 | 5-14 years | |
| STI.Add.3 | >=15 years | |
| STI.Add.25 | # patients with Neonatal Conjunctivitis Syndrome in the quarter | |
| | 0-4 year ; male | |
| STI.Add.26 | :Female | |
| STI.Add.27 | # of patients with Neonatal Herpes Syndrome in the quarter | |
| | 0-4 year ; male | |
| STI.Add.26 | :Female | |
| STI.Add.38 | # of partners of STI cases identified and treated for STI | |
| STI.Add.29 | Total # of patients diagnosed and treated for STI and offered HIV test in the quarter | |
| STI.Add.30 | Total # of patients diagnosed and treated for STI and tested for HIV in the quarter | |
| STI.Add.31 | Total # of patients diagnosed and treated for STI and tested HIV Positive in the quarter | |
| STI.Add.39 | Total # of HIV positive STI patients successfully linked to HIV care | |
| STI.Add.32 | Total # of HIV patients in HIV care and screened for STI in the quarter: Male | |
| STI.Add.33 | Total # of HIV patients in HIV care and screened for STI in the quarter: Female | |
| STI.Add.34 | Total # of HIV patients in HIV care and diagnosed with STI in the quarter: Male | |
| STI.Add.35 | Total # of HIV patients in HIV care and diagnosed with STI in the quarter: Female | |
| STI.Add.36 | Total # of HIV patients in HIV care and treated for STI in the quarter: Male | |
| STI.Add.37 | Total # of HIV patients in HIV care and treated for STI in the quarter: Female | |

Annex 3: Definition of DQAs and tools used by the project

Accuracy: Also known as validity. Accurate data are considered correct: the data measure what they are intended to measure. Accurate data minimize errors (e.g., recording or interviewer bias, transcription error, sampling error) to a point of being negligible.

Reliability: The data generated by a program's information system are based on protocols and procedures that do not change according to who uses them and when or how often they are used. The data are reliable because they are measured and collected consistently.

Precision: This means that the data have sufficient detail. For example, an indicator requires the number of individuals who received HIV counseling and testing and received their test results, by sex of the individual. An information system lacks precision if it is not designed to record the sex of the individual who received counseling and testing.

Completeness: Completeness means that an information system from which the results are derived is appropriately inclusive: it represents the complete list of eligible persons or units and not just a fraction of the list.

Timeliness: Data are timely when they are up-to-date (current), and when the information is available on time. Timeliness is affected by: (1) the rate at which the program's information system is updated; (2) the rate of change of actual program activities; and (3) when the information is actually used or required.

Integrity: Data have integrity when the system used to generate them is protected from deliberate bias or manipulation for political or personal reasons

Confidentiality: Confidentiality means that clients are assured that their data will be maintained according to national and/or international standards for data. This means that personal data are not disclosed inappropriately, and that data in hard copy and electronic form are treated with appropriate levels of security in locked cabinet and password protected.

DQA tools used by the project

The DQA tools used in this project is adopted from USAID data quality assessment tools and modified to the private health facility context. This focus on two parts data verification (availability and completeness of the source document, recounting reported figures) and system issues (M&E structure, functions and capabilities, data collection, reporting tools and forms , data management process and link with the national system). At the end of each DQA assessment recommendation and feedback will be given to the facility and care providers.

Data Verification and System Assessment Sheet - At Service Delivery Point

Service Delivery Point/Facility Name: _____

Region and Wereda: _____

Date of Review: _____

Name of Reviewer (s): _____

Reporting Period Verified: _____

Instruction: Record "Yes" / "No" / "N/A" and your comments in the remark part. *And also provide a general reviewers comment in;*

Part 1: Data Verifications

A - Documentation Review:

| <i>Review availability and completeness of all indicator source documents (Unit Registers) for the selected reporting period.</i> | | TB | VCT / PITC | ANC | L&D | FP | Pre-ART | ART | Malaria |
|--|---|-----------|-------------------|------------|----------------|-----------|----------------|------------|----------------|
| 1 | Review available source documents for the reporting period being verified. Is there any indication that source documents are missing? | | | | | | | | |
| | <i>If yes</i> , determine how this might have affected reported numbers. | | | | | | | | |
| 2 | Are all available source documents complete (for selected core indicators)** (please refer the selected core indicators)? | | | | | | | | |
| | <i>If no</i> , determine how this might have affected reported numbers. | | | | | | | | |
| 3 | Review the dates on the source documents. Do all dates fall within the reporting period? | | | | | | | | |
| | <i>If no</i> , determine how this might have affected reported numbers. | | | | | | | | |

B) Recounting reported results

- *Recount results from source documents, compare the verified numbers to the site reported numbers & PHSP A/A reported Data base and explain discrepancies (if any)*
- What are the reasons for the discrepancy (if any) observed (i.e., data entry errors, arithmetic errors, missing source documents, other)?

| So | Program indicator | Recount | Reported | ME % (reported/recount)*100 |
|----|--|---------|----------|-----------------------------|
| 1 | # of clients receiving HIV test results (at VCT) | | | |
| 2 | # of clients testing positive for HIV (at VCT) | | | |
| 3 | # of clients receiving HIV test results (at PITC) | | | |
| 4 | # of clients testing positive for HIV (at PITC) | | | |
| 5 | Total # of TB Patients Registered in the quarter | | | |
| 6 | # of bacteriologically confirmed New PTB cases detected in the quarter | | | |
| 7 | # of clinically diagnosed New P/Negative TB cases detected in the quarter | | | |
| 8 | Number of TB cases enrolled to DOTS and who were tested for HIV | | | |
| 9 | Number of TB cases enrolled to DOTS and who were tested HIV positive | | | |

| | | | | |
|----|---|--|--|--|
| 10 | Number of HIV-positive TB patients registered who are on ART | | | |
| 11 | TB Treatment outcome [for those started TB Rx Last Year in the same quarter | | | |
| | New PTB Smear Pos | | | |
| | Cured | | | |
| | Completed | | | |
| | Died | | | |
| | Failure | | | |
| | Defaulted | | | |
| | Transferred Out | | | |
| 12 | Number of pregnant women that received antenatal care at least once in the quarter | | | |
| 13 | Number of births attended by skilled health personnel | | | |
| 14 | Number of pregnant and lactating women who were tested for HIV and who know their results:- | | | |
| 15 | during pregnancy | | | |
| 16 | during lab our & delivery (L&D) | | | |

| | | | | |
|----|---|--|--|--|
| 17 | postpartum period (PNC) | | | |
| 18 | # of women tested positive for HIV at ANC,L/D and PNC | | | |
| 19 | Number of HIV Positive pregnant and lactating women who received ART at ANC+L&D+PNC for the first time based on option B+ | | | |
| 20 | # of HIV exposed infants received HIV test within 2 month | | | |
| 21 | # of HIV exposed infants who received an HIV test between 2 and 12 months, during the reporting period | | | |
| 22 | # of HIV exposed infants receiving HIV confirmatory (antibody test) test by 18 months | | | |
| 23 | # of adults and children with HIV infection <u>newly enrolled in Pre ART</u> care in the quarter | | | |
| 24 | # of adults and children with HIV infection <u>newly started on ART</u> in the quarter | | | |
| 25 | # of adults and children with HIV infection <u>Ever started on ART</u> in the quarter | | | |
| 26 | Total # of <i>Family planning Acceptors</i> (all type) New | | | |
| 27 | Total # of <i>Family planning Acceptors</i> (all type) Repeat | | | |
| 28 | Total # of <i>Family planning Acceptors</i> (all type) Total | | | |

| | | | | |
|----|--|--|--|--|
| 29 | Number of Malaria cases in the quarter: All Cases | | | |
| 30 | Number of Malaria cases treated (Those taking drug in the facility) | | | |
| 31 | Total Number of Malaria suspected cases for whom BF was done in the quarter | | | |
| 32 | Total Number of Malaria suspected cases for whom RDT was done in the quarter | | | |

| Part 2. Systems Assessment | | | | | | | | | |
|--|---|-----------|-------------------|------------|----------------|-----------|----------------|------------|---------------------|
| I - M&E Structure, Functions and Capabilities | | TB | VCT / PITC | ANC | L&D | FP | Pre-ART | ART | Malari a |
| 1 | There are designated staff responsible for reviewing aggregated numbers prior to submission to the next level (e.g., to Town Health Office, Wodera Health Bureau, to regional Health Bureau, to the MoH). | | | | | | | | |
| 2 | The responsibility for recording the delivery of services on source documents is clearly assigned to the relevant staff. | | | | | | | | |
| 3 | All relevant staff have received training on the data management processes and tools. | | | | | | | | |

| II - Data-collection and Reporting Forms and Tools | | TB | VCT / PITC | ANC | L&D | FP | Pre-ART | ART | Malari a |
|---|--|-----------|-------------------|------------|----------------|-----------|----------------|------------|---------------------|
| 4 | Do You have a clear instructions on how to complete the data collection <u>and/or</u> reporting forms/tools. | | | | | | | | |
| 5 | Is the Service Delivery Site used the standard forms/tools (Registers) (HMIS/ MoH format) consistently? | | | | | | | | |

| | | | | | | | | | |
|---------------------------------------|---|------------|--------------|---------------|--|--|--|--|--|
| 6 | Is the Service Delivery Site used the standard reporting forms(MoH format) consistently? | | | | | | | | |
| III- Data Management Processes | | ART | PMTCT | REMARK | | | | | |
| 7 | (for ART sites) , Is the facility have a back-up (by CD, or other storage devices)? | | | | | | | | |
| 8 | ...if yes, frequency of the data back-up (e.g.back-ups are weekly or monthly). | | | | | | | | |
| 9 | (for ART sites) Is the facility maintained confidentiality of relevant personal data ? (Ask/observe) Are Hard copy kept in lockable drawer / lockable room? Is the computer protected with password ? | | | | | | | | |
| 10 | (For ART & PMTCT sites) Is the recording and reporting system avoids double counting people <i>within</i> and <i>across</i> Service Delivery Points (e.g., a person receiving the same service twice in a reporting period, etc) ? | | | | | | | | |
| 11 | (For ART sites) Is the reporting system enables the identification and recording of a "drop out", a person "lost to follow-up" and a person who died ? | | | | | | | | |

| IV - Links with National Reporting System | | TB | VCT / PITC | ANC | L&D | FP | Pre-ART | ART | Malaria |
|--|--|-----------|-------------------|------------|----------------|-----------|----------------|------------|----------------|
| 12 | Is the relevant national forms/tools (HMIS/ MoH format) are used for data-collection? | | | | | | | | |
| 13 | Is the relevant national forms/tools (HMIS/MoH format) are used for reporting ? | | | | | | | | |
| 14 | Is the health Facility reported regularly to Town Health Office? (Please review the copy of the reports) | | | | | | | | |

Part 3: Recommendations for the Service Site

| | | | | |
|----|---|------------------------------------|-----------------------|------------------|
| | <p><i>Based on the findings of the systems' review and data verification at the service site, please describe any challenges to data quality identified and recommended strengthening measures, with an estimate of the length of time the improvement measure could take. These will be discussed with the Program (Regional program officers / mentors).</i></p> | | | |
| | Identified Weaknesses | Description of Action Point | Responsible(s) | Time Line |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |

Annex 4 : Examples of service /program quality assessment tools

| | |
|-------------------|--|
| Outcome indicator | ➤ Proportion of registered TB cases who are HIV-positive who are on ART in the next three months |
| Process indicator | <ul style="list-style-type: none"> ➤ No. of focused mentorship performed in the month ➤ No. of updated presentation conducted by clinical mentors on TB/HIV topic ➤ Proportion of TB cases with missed information who are contacted by telephone for whom information was obtained ➤ No. of targeted HFs with full time trained provider at TB clinic ➤ Proportion of TB patients that refused & received counseling in the month ➤ Proportion of HFs that have planned and archived DQA feedback at TB clinic ➤ Proportion of HFs that have conducted & archived LQAS on TB/HIV indicators ➤ Proportion of targeted HFs that have conducted PRM in the month & discussed TB/HIV performance indicators |
| Problem statement | ➤ Based on the quarter -I report finding in project HFs, from ----Co infected TB/HIV patients,---(---%) were put on ART (facilities contributed for low performance will be identified) |
| Aim | ➤ Increasing proportion of registered TB cases who are HIV-positive who are on ART at project supported health facilities will increase from 81.4% to 100% within three months |

Model of improvement

| AIM | Measurement | Intervention/change idea |
|---|---|--|
| <ul style="list-style-type: none"> ➤ Increasing proportion of registered TB cases who are HIV-positive who are on ART at PRIVATE HEALTH SECTOR PROJECT supported health facilities will increase from --% to 100% within Three months. | <ul style="list-style-type: none"> ➤ No. of focused clinical mentorship performed in the month ➤ No. of updated presentation conducted by clinical mentors on TB/HIV topic ➤ Proportion of TB cases with missed information who are contacted by telephone for whom information was obtained ➤ No. of targeted HFs with assigned full time trained provider at TB clinic ➤ Proportion of TB patients that refused & received counseling in the month ➤ Proportion of HFs that have planned and archived DQA feedback at TB clinic ➤ Proportion of HFs that have conducted & archived monthly LQAS and addressed TB/HIV indicators ➤ Proportion of HFs that have conducted PRM in the month & discussed TB/HIV performance indicators ➤ Proportion of HFs that have conducted & archived monthly LQAS ➤ Proportion of HFs that have conducted PRM in the month | <ul style="list-style-type: none"> ➤ Strengthen mentorship to link patients timely Monitor Proper utilization of intra facility referral feedback ➤ Follow provider to regularly complete the TB register ➤ Maintain assignment of full time trained provider for TB clinic ➤ Intensified Counseling by providers and CM ➤ Strengthening PRM at HFs & discussing TB reports on monthly manner ➤ Conduct regular DQA & LQAS |

Implementation Plan

| S.no. | Activities/ Interventions | Output measure | January | February | March | Responsible person | Specific Activities |
|-------|--|---|---------|----------|-------|---|---|
| 1. | Strengthen mentorship to link patients timely | No. of focused clinical mentorship performed in the month | X | x | x | Regional and central Team | Schedule for mentorship Use checklist for each domain give written feedback on the findings Take place in development of PIP |
| 2. | Monitor Proper utilization of intra facility referral feedback | Avail TB /HIV internal facility referral | X | X | X | Facility management Focal person in TB HIV clinics | Putting intra facility referral forms in TB and HIV clinics Take place in development of PIP |
| 3. | Intensified Counseling by providers and CM | Proportion of TB patients that refused & received counseling in the month | X | X | X | TB/HIV clinic focal person & Case manager | Identify patients who refuse in the last visit Registers the patient in full address to follow Take place in development of PIP |
| 4 | Follow provider to regularly complete the TB register | No. mentorship performed in the month | X | x | x | Regional and central Team | Schedule for mentorship Use checklist for each domain give written feedback on the findings completeness on weekly bases Take place in development of PIP |
| 5 | Assign full time provider for TB clinic | Assigned trained provider | X | | | Facility management | Selecting facility not assigned full time provider and negotiate with facility management |

| | | | | | | | |
|---|--|----------------------|---|---|---|--|---|
| | | | | | | PRIVATE HEALTH SECTOR PROJECT regional & central team | Take place in development of PIP |
| 6 | Strengthening PRM at HFs & discussing TB reports on monthly manner | PRM conducted at HFs | X | x | x | Facility management PRIVATE HEALTH SECTOR PROJECT regional & central team | Collect month data from all department and fill in the monthly report forms Take place in development of PIP |
| 7 | Conduct regular DQA | No. conducted DQA | | x | | PRIVATE HEALTH SECTOR PROJECT Regional and central quality team | Establish Quality team in PRIVATE HEALTH SECTOR PROJECT center Select the facility to conduct DQA Take place in development of PIP |

Annex 5: PEPFAR level 1 and level 2 and custom indicators for the life of the project

| SN | Indicator abbreviation | Indicator Name | Baseline | Year 1 | | Year 2 | | Year 3 | | Year 4 | | Year 5 | |
|----|------------------------|---|----------|---------|-----|-----------------|--------|--------|--------|--------|-----|--------|-----|
| | | | | Plan | Ach | Plan | Ach | Plan | Ach | Plan | Ach | Plan | Ach |
| 1 | CARE_NEW | Care new | 913 | 1,339 | | 3531 | 1830 | 2012 | 1810 | | | | |
| 2 | CARE_CURR | Care current | 5,810 | 7349 | | 8392 | 7277 | | 8776 | | | | |
| 3 | TB_STAT | TB PITC | 87.70% | 88% | 85% | 95% | 92% | 95% | 89% | 90% | 91% | 90% | |
| 4 | TB_ART | TB ART | 71% | 100% | 80% | 100% | 86% | 100% | 80% | 100% | 92% | 100% | |
| 5 | TB_IPT | TB IPT | 6.50% | 20% | | 92%(1236 /1339) | 53% | | 39% | | | | |
| | TB_PREV | TB Prevention | NA | | | | 27% | | 82% | | | | |
| 6 | TX_NEW | New ART | 837 | 1225 | | 3177 | 1863 | 1883 | 1750 | | | | |
| 7 | TX_CURR | Currently on ART | 4,897 | 6,813 | | 7934 | 7277 | 8328 | 8776 | | | | |
| 8 | TX_RET | Treatment retention at 12 Months | 83.70% | 90% | | 90% | 92% | 90% | 84% | | | | |
| 9 | TX_VIRAL | Viral load done within 12 Months | Na | 30% | | 60% | | | | | | | |
| 10 | TX_UNDETECT | Viral Load Undetectable | Na | 100% | | 90% | | | | | | | |
| | Tx_PVLS | Tx PVLS | NA | | | | 87% | 90% | 88% | | | | |
| 11 | HTC_TST | HCT | 216,881 | 229,896 | | 290,000 | 268484 | 319180 | 315565 | | | | |
| 12 | PMTCT_STAT | Percentage of pregnant women Tested for HIV | 93% | 95% | | 97% | 88% | 95% | 94% | | | | |
| 13 | PMTCT_ARV | Percentage of PMTCT ARV | 92.6% | 100% | | 95% | 89% | 100% | 86% | | | | |
| 14 | PMTCT-EID | Percentage of EID PCR test within 12 months | 42% | 60% | | 76%(272/360) | 57% | 60% | 29% | | | | |

| | | | | | | | | | | | | | |
|----|-----------|--------------------------------|-----|-----|--|-----|-----|-----|-----|--|--|--|--|
| 15 | PMTCT_FO | HEI final outcome at 18 months | 22 | 90 | | 90% | 56 | 90% | 95% | | | | |
| 16 | PMTCT_CTX | HEI CPT at 2 months | 30% | 60% | | 76% | 55% | | 74% | | | | |

| SN | Indicator abbreviation | Indicator Name | Baseline | Year 1 | | Year 2 | | Year 3 | | Year 4 | | Year 5 | |
|------|------------------------|--|---------------|--------|-----|--------|------|--------|------|--------|-----|--------|-----|
| | | | | Plan | Ach | Plan | Ach | Plan | Ach | Plan | Ach | Plan | Ach |
| 17 | TB_OUTCOME | TB outcome for HIV Positive TB patients | not available | Na | 87% | 90% | 89% | 90% | 89% | 90% | 89% | 90% | |
| 18 | TB_SCREEN | Percentage of TB screen | 100% | 100% | | 100% | 98% | | 100% | | | | |
| | Tx_Tb | Tx Tb | | | | | 1.3% | | 1.3% | | | | |
| 19 | LAB_CAP | Facilities with capacity to perform clinical laboratory test | 203 | 420 | | 140 | | | | | | | |
| 20 | LAB_ACC | Labs for accreditation | 17 | 18 | | 14 | 10 | | | | | | |
| 21 | LAB_PT | Labs Proficiency testing | | | | 647 | | | | | | | |
| 21.1 | PT for HIV | For HIV participation and Successfully passed (P/S) | | 216 | | 368 | 63 | 235 | 78 | | | | |

| | | | | | | | | | | | | | |
|------|---------------|--|---------|--------|-------|-------|-------|-------|-------|-------|-------|-------|--|
| 21.2 | PT for CD4 | For CD 4 count (participation and successfully passed) | | Na | | | | | | | | | |
| 21.3 | PT for AFB | For AFB microscopy (participation and successfully passed) | | 112 | | 279 | 96 | 277 | 102 | | | | |
| 22 | TB_NOT | TB cases reported to NTP | 2,565 | 3,191 | 1992 | 3300 | 2428 | 3180 | 2532 | 2952 | 2039 | 2139 | |
| 23 | TB_REF | TB referral | 12,671 | 14,737 | 11740 | 18020 | 15391 | 18020 | 15005 | 18048 | 14936 | 12118 | |
| 24 | FP_USER | FP users | 32,430 | 35,437 | 25541 | 35437 | 34453 | 38176 | 37973 | 40577 | 41287 | 30432 | |
| 25 | CYP | CYP | 14,842 | 16,227 | | | 17857 | | 27652 | | 32677 | | |
| 26 | MAL_DIG | Malaria cases diagnosed | 40,345 | 61,449 | 43323 | 93840 | 71543 | 62929 | 65186 | 62929 | 70608 | 62929 | |
| 27 | IN_TRA | in-service training | 686 | 1,056 | | | 1580 | | 297 | | | | |
| 28 | FN_THER | Received supplementary food | 201/218 | | | 100% | 556 | | | | | | |
| 29 | FN_ASSESS | PLHIV assessed for nutrition | 218 | | | 100% | 13% | | | | | | |
| 30 | ANCI_Attendee | | | | | | | 28288 | 40135 | 26174 | 40634 | 29208 | |

| | | | | | | | | | | | | | |
|----|---|--|--|--|--|--|--|-------|-------|-------|-------|-------|--|
| 31 | ANC4_Attende e | | | | | | | | 15960 | 7627 | 18157 | 13242 | |
| 32 | Delivery Attended by Skilled Personnel | | | | | | | 16936 | 20214 | 16936 | 28478 | 21489 | |
| 32 | Early PNC | | | | | | | 5056 | 17291 | 9756 | 25841 | 17889 | |
| 33 | BCG | | | | | | | | 13243 | 16608 | 26807 | 19044 | |
| 33 | Penta_3 | | | | | | | | 8587 | 11724 | 17627 | 11724 | |
| 34 | Measles | | | | | | | | 7938 | 11372 | 16908 | 12450 | |
| 35 | Fully Immunized | | | | | | | | 7938 | 11259 | 16113 | 13749 | |
| 36 | PAB | | | | | | | | 10196 | 11200 | 20321 | 13077 | |

Annex 6: Level of results and corresponding indicators for Private Health sector Project

| Level of result/objective | Result /SO statement | Corresponding Indicator |
|---------------------------|---|--|
| Goal | To contribute towards the mitigation of impact of disease of public health importance | The composite indicators of , the Private Health sector Project contributes the mitigation of impact of disease of public health importance (by Most significant change methods MSC) as yes |
| Project purpose | Project purpose 1) Enabling environment for private sector engagement in health improved | 1) Percentage of improvement in private health sector index score as a measure of enabling environment for the engagement of the private health sector in health. 2) Number /percentage of recommendation about policy changes |
| | Project purpose 2: Access to quality services for disease of public health importance's increased through the private health sector | 1. Percentage of contribution of the private health sector towards curbing the impact of disease of public health importance's 2. Percentage of private health facilities services complaint to established quality standards |
| | Project Purpose 3: The private health care system strengthened | 1 Percentage improvement in the private health care systems (compared to baseline assessment) |
| | Project purpose 4: program learning and innovative ventures enhance for the private health sector | 1 Proportion of national level indicators that capture the contribution of the private health sectors 2 Number of higher level decisions made using evidences generated through the support of the associate award |
| Sub purpose | Sub purpose 1.1: supportive policy and legal framework improved | 1. Number of disseminated report on gap assessment 2. Number of policy dialogue conducted 3. Number of policy advocacy events conducted 4. Number of private providers association representative trained in policy advocacy and dialogue |

| Level of result/objective | Result /SO statement | Corresponding Indicator |
|---------------------------|--|---|
| | Sub purpose 1.2: enhanced oversight and implementation of PPPH | <ol style="list-style-type: none"> 1. Number of PPPH unit implementing staff development plan 2. Number of model /prototype PPHS implemented |
| | Sub purpose 1.3 capacity of regulatory bodies for enforcement of quality standards strengthen | <ol style="list-style-type: none"> 1. Number of supervisory tools /job aids developed /modified 2. Number of sensitization workshop conducted 3. Number of individuals trained to improve supervisory capacity 4. Number of private facilities provided with TA to improve quality standards 5. Number of private facilities provided with TA by private associations to improve quality standards |
| | <i>Sub purpose 2.1 strategies for demand creation of services for disease of public health importance from the private health sector established and implemented</i> | <ol style="list-style-type: none"> 1) Number or percentage of recommendation implemented as per the result of the formative assessment 2) Number of BCC marketing tools developed and disseminated to private providers 3) Proportion of clients visiting private health facilities as a result of communications campaigns |
| | <i>Sub purpose 2.2 increased uptake of services from the private health sector</i> | <ol style="list-style-type: none"> 1) Number of facilities providing major public health services 2) Number of key population reached through comprehensive HIV services Number of clients receiving post GBV 3) Number of male partners accompanying their female partners at least once for PMTCT services 4) Number of clients diagnosed and treated for STI according to the national standards 5) Number of malaria cases confirmed and treated according to the national guideline 6) Percentage of pregnant women received ANC 4 + |

| Level of result/objective | Result /SO statement | Corresponding Indicator |
|---------------------------|----------------------|---|
| | | <ul style="list-style-type: none"> 7 Percentage of women received ObEC from the private facilitie 8 Number of birth delivered in private health facilities 9 Percentage of women ANC 4 + and deliver in health facilities 10 Percentage of women received postnatal care within the first two days of delivery 11 Percentage of newborns delivered in the private health facilities that initiate breast feeding within one hour of birth 12 Percentage of Exclusive Breast Feeding (EBF) until 6 months among those who attended post-natal care in the private health facilities 13 Percentage of children ages 12-23 months attending private health facilities who have received penta Valente vaccination 14 Percentage of children age 12-23 months who had received vaccinations against the six major preventable childhood diseases by one year of age 15 Number of children who received vitamin A supplementation from the private health sector 16 Number of clients attending private health facilities wishing to space or limit birth using modern FP methods 17 Proportion of clients using long acting FP methods 18 Number of male partners engaged in the decision making process of their female partners for utilization of modern FP methods 19 Number of pediatric TB patients diagnosed and treated at the PPM-DOTS site |

| Level of result/objective | Result /SO statement | Corresponding Indicator |
|---------------------------|---|--|
| | Sub purpose 2.3 : enhanced implementation of quality management practices within the private facilities | <ol style="list-style-type: none"> 1 Proportion of private health facilities implementing quality management framework. 2 Number of private facilities engaged in laboratory EQA* 3 Number of audits (including death) conducted (by type of disease) 4 Number of private clinics receiving supportive supervision for standard service packages (TB, HIV/AIDS, malaria, FP/RH services) |
| | Sub purpose 2.4 Referral linkage and feedback mechanism strengthened | <ol style="list-style-type: none"> 1 Number of referral-linkage tools developed to facilitate two-way referrals from and to private health facilities (disaggregated by type). 2 Number of completed referrals from and to private health facilities (disaggregated by type of disease and/or service, age and sex) 3 Percentage of reduction in turnaround time between samples taken in private facilities to results reported to patients |
| | Sub purpose 2.5 : Franchising of high quality provider organization/ service implemented | <ol style="list-style-type: none"> 1. Number of advocacy works conducted on the concept of franchising 2. Number of social franchises identified and piloted 3. Number of successful franchisees as evidenced by scoring at least 85 in the national standards system * |
| | Sub purpose 3.1: Capacity of local institutions for the oversight and support of the private health sector enhanced | <ol style="list-style-type: none"> 1. Proportion of private health facilities and program areas supported by the associate award and transitioned to local entities. 2. Number of private associations with improved organizational systems/tools/processes [Technical, Managerial (planning, HR, leadership, financial) and M&E] 3. Number of private associations with capability to provide in-service training* 4. Number of private associations with capability to provide mentoring services* 5. Number of private associations with capability to provide CPD * |

| Level of result/objective | Result /SO statement | Corresponding Indicator |
|---------------------------|---|---|
| | Sub purpose 3.2: The private health sectors access to resources increased | <ol style="list-style-type: none"> 1. Number of private health facilities effectively linked to resources (disaggregation by sex of the owners and type of facility). 2. Number of private health facilities which commenced or improved the quality of existing services for HIV and/or TB as a result of increase access to resources 3. Number of clients who benefited from services for HIV and TB (disaggregated by type of service) in the private health facilities as a result of increased access to resources*. 4. Number of clients who benefited from services for MNCH, FP, STI and malaria in the private health facilities as a result of increased access to resources |
| | Sub purpose 3.3: Improved enrollment and practice of accreditation among private health facilities | <ol style="list-style-type: none"> 1. Number of self-assessments completed* 2. Number of successful applications/ re-applications submitted* 3. Number of quality improvement activities planned and implemented 4. Number of private health facilities/ services accredited* |
| | Sub purpose 3.4: Supply chain management and rational drug use enhanced | <ol style="list-style-type: none"> 1. Number of individuals trained in logistic management and rational drug use at private facilities 2. Number of drug and therapeutic committees (DTC) established at private hospitals 3. Number of private health facilities with functional clinical pharmacy service 4. Number of private facilities regularly reporting using LMIS (IPLS Percentage of private facilities with > 5% rate of expiry for drugs 5. Percentage of private sector laboratories with testing kits and laboratory reagents with no stock-out in the past 3 months |
| | Sub purpose 4.1: Evidence based decision making improved in the private health sector | <ol style="list-style-type: none"> 1. Number of key research questions to be answered by the project (disaggregated by program area) 2. Number of target audiences reached through evidence dissemination forums (disaggregated by number of sessions) |
| | Sub purpose 4.2: Implementation of HMIS in the private health sector strengthened | <ol style="list-style-type: none"> 1. Number of individuals trained on HMIS (disaggregate by sex and type of training) 2. Number of facilities mentored on HMIS 3. Number of facilities in which data quality assessments performed |

| Level of result/objective | Result /SO statement | Corresponding Indicator |
|---------------------------|---|--|
| | | <ul style="list-style-type: none"> 4. Number of private health facilities producing timely reports using HMIS tools 5. Number of private health facilities experiencing interruption of HMIS tools in the reporting period |
| | Sub purpose 4.3: Innovative ventures developed and implemented in the private health sector | <ul style="list-style-type: none"> 1. Number of innovative ideas/ approaches piloted and evaluated 2. Number of innovative ideas/ approaches widely implemented |

Annex 7: Private Health Sector Project Organogram

