FHI/IMPACT Ethiopia

Final Evaluation Report

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Executive Summary

In April 2006, a team of 17 experts evaluated the Family Health International/ Implementing HIV/AIDS Prevention and Care Project (FHI/IMPACT). The evaluation focused on VCT, TB-HIV care, facility-based OI and non-ART care and support, home- and community-based care, and support for referral systems and linkages. Members of the team visited field sites in Amhara, Oromia, and Southern Nations, Nationalities and Peoples regions, and Addis Ababa.

The evaluation findings indicate that FHI/IMPACT has achieved its overall objectives of contributing to decreasing HIV prevalence and improving the quality of life of people living with HIV and AIDS by strengthening the continuum of prevention, care, support and treatment.

FHI/IMPACT has achieved results through transparent, collegial, peer-based relations with Ministry of Health (MOH) staff and close relationships with its partner NGOs. FHI technical assistance has led to a rapid and dramatic increase in the number of sites providing VCT services and a rapid uptake in the use of these services. FHI/IMPACT has achieved more than double its President's Emergency Plan for AIDS Relief (PEPFAR) target for people trained to provide clinical TB-HIV services, and nearly double its target for people trained to provide general HIV-related palliative care. Some health centers have established chronic care clinics offering co-located TB-HIV and OI and other non-ART care. Along with the MOH, FHI/IMPACT has provided formats and guidelines for health centers, including registration of patients. FHI/IMPACT has established referral systems between services within the health center, and between the health center and hospital.

FHI/IMPACT has faced challenges in meeting its goals due to shortages and outages of needed supplies and personnel attrition at health centers. The major challenges to providing reliable VCT services include staff attrition and stockouts of test kits. Shortfalls in the number of health centers providing TB-HIV services (84% of target) and of persons receiving TB-HIV services (65% of target) resulted from delays in training that were beyond FHI/IMPACT's control. Similarly, shortfalls in the number of health centers providing general HIV-related palliative care (89% of target) and of persons receiving palliative care (95% of target) arose because FHI/IMPACT could not begin training before the end of 2004. Health centers frequently experience stockouts and shortages of drugs to treat OIs and for OI prophylaxis due to weak logistics and supply management at the national and regional levels. Health centers have not all implemented effective internal referrals and linkages between units. Referrals between TB care and VCT are weakest. As a result of these shortages of supplies and personnel, health centers are not able to provide optimal prevention, care and treatment for HIV/AIDS.

A further hindrance to providing the full continuum of palliative care is the model in use at health centers which is too focused on treating symptomatic infections. There is no provision for assessment and treatment of mental health conditions and for assessment and treatment of pain. Health center staff have little understanding of the need to provide services for "well positive persons" to maintain good health and a productive life, and to include family planning and other preventative services. The only referrals for home- and community-based care (HCBC) appear to be to kebeles for

poverty certification and to certain faith-based and other organizations that provide for those in extreme economic need.

In 14 urban centers, FHI/IMPACT has trained HCBC nurse supervisors employed by partner NGOs, who in turn have trained HCBC volunteers managed by local idirs. The programs have achieved more than double the PEPFAR targets for HCBC support. However, the NGOs require direct financial support for salaries and for basic office equipment and supplies. Idirs have a hugely increased financial burden, and one idir has gone bankrupt as a result of its support to bedridden AIDS patients while others are seriously depleting their mutual funds. HCBC nurses and volunteers commonly spend their own money on provisions for individual clients and families.

The evaluation team has concerns about the appropriateness of the training curriculum and materials on the needs of bedridden HCBC beneficiaries, given the situations in which HCBC nurses work. People who have AIDS often deplete their household resources and lose their means of livelihood before becoming eligible for HCBC. They then remain dependent on HCBC after commencing ART and recovering their physical health. The end-of-life model is an inefficient entry point to ART.

Cross-cutting issues include stigma, which remains a major barrier to people living with HIV/AIDS (PLHA) accessing diagnostic, care and treatment services, and branding of the FHI/IMPACT program. Many people believe that FHI is a donor organization and in the regions personnel believe that they will not function adequately without FHI/IMPACT support. They do not realize that there will be a follow-on PEPFAR/Ethiopia activity.

The evaluation team's principle recommendations for the follow-on activity for treatment, care and support of PLHA at health centers and in the community are outlined here and described in full detail in the report. The follow-on activity should strengthen and expand VCT services, with promotion to high-risk populations as well as the wider community. The follow-on activity should build MOH and HIV/AIDS Prevention and Control Office (HAPCO) capacity to improve health systems and service management at the federal, regional and local levels and to ensure sustainability of the improved health services. It should provide health centers with further support to improve the quality of care for PLHA from diagnosis as HIV positive to end-of-life care and bereavement support. The follow-on activity should provide technical assistance to enhance health worker in-service training in general HIV palliative care, including TB-HIV and OI services, to reinforce the concept of integrated general palliative care services for PLHA and to improve the quality of care provided by health centers for PLHA. The evaluation team recommends a broader definition of palliative care as defined by the World Health Organization (WHO) and reflected in the Office of the Global AIDS Coordinator (OGAC) guidance. Services should encompass a more comprehensive, holistic approach to delivering a continuum of palliative care services, which initiates care at the time of diagnosis and establishes a network of providers – including home-based and facility-based care – in the delivery of a full range of services. Pediatric palliative care services are recommended.

General palliative care in the community must draw on existing community resources rather than create dependency on donor resources. Existing and proposed new cadres of community outreach workers and community-based HCBC volunteers need training in new skills to mobilize communities for development of local care and support mechanisms for PLHA and their families. The training must include skills for mobilizing resources for orphans and vulnerable children drawing on existing social capital. The evaluation also recommends establishing an enhanced tracking system to identify bottlenecks in service provision and places and/or referral linkages where clients and beneficiaries are lost to follow-up. The follow-on activity should support local staff on the use of collected data in order to enhance decision-making and improve services. Finally, the follow-on activity must be branded as PEPFAR/Ethiopia so that all health sector staff and beneficiaries know that the assistance is provided by the American people. The follow-on mechanism must have a clearly-articulated exit strategy with local ownership and institutionalization of innovations and services for sustainability.

In conclusion, services for diagnosis, care and treatment of PLHA in Ethiopia need further technical assistance to integrate service provision in the community, at health centers and at referral hospitals. The optimum service will:

- facilitate access to services needed by PLHA and their families at all levels of health care and at different stages of HIV infection;
- track clients, patients and beneficiaries to coordinate care and treatment at different levels, and identify and follow-up those who fail to attend or default from care and treatment;
- avoid duplication of services and gaps in provision of services; and
- reduce barriers to care and congestion at referral hospitals by appropriately moving services to health centers and into the community and home.

This optimum service can best be achieved through implementation of the network model proposed in *The PEPFAR U.S. Five-Year Global HIV/AIDS Strategy*. The follow-on activity should assist the Government of Ethiopia (GOE) and MOH/HAPCO to build capacity in the community, at health centers, and at the regional level to fully implement the network model. The new cadre of case managers, and new and existing cadres of community-based extension workers and HCBC volunteers, will have key roles in establishing the efficient functioning of the network model for providing enhanced HIV services to PLHA in Ethiopia.

Abbreviations, Acronyms and Ethiopian Terms

ANC	antenatal care
ART	anti-retroviral therapy
ARV	anti-retroviral [drugs]
BCC	behavior change communication
CBO	community-based organization
CDC	communicable disease control
CDC/Ethiopia	Centers for Disease Control/Ethiopia
COP	Country Operating Plan
DOTS	internationally recommended strategy for TB control
ETB	Ethiopian birr — the local currency
FBO	faith-based organization
FGAE	Family Guidance Association of Ethiopia
FHI	Family Health International
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HAPCSO	Hiwot AIDS Prevention Care and Support Organization
HBC	home-based care
HCBC	home- and community-based care
HHS	Health and Human Services
HSDP	Government of Ethiopia Health Sector Development Plan
idir	a community-based, mutual burial association
IMPACT	Implementing HIV/AIDS Prevention and Care Project
kebele	neighborhood
M&E	monitoring and evaluation
MOH	Ministry of Health
MCH	mother and child health
NGO	nongovernmental organization
OGAC	Office of the Global AIDS Coordinator
OHA	[USAID's] Office of HIV and AIDS
OI	Opportunistic Infection
OSSA	Organization for Social Services for AIDS
PASDEP	Government of Ethiopia Plan for Accelerated and Sustainable Development to End Poverty in Ethiopia
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	provider-initiated counseling and testing
PLHA	person(s) living with HIV/AIDS
RHB	Regional Health Bureau
SNNPR	Southern Nations, Nationalities & Peoples Region
TB	tuberculosis
USG	Government of the United States of America
VCT	voluntary counseling and testing [for HIV]
woreda	district

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The evaluation team would like to thank Family Health International/Ethiopia and Family Health International staff in the regions for guidance on scheduling field visits, being our field guides, and making our introductions to various stakeholders. Our gratitude also goes to all the many busy GOE staff at Regional Health Bureaus, Regional HAPCOs, and health centers that spared time to answer our questions. The staff of FHI/IMPACT's "mentoring partners" – HAPCSO, FGAE, OSSA and Medan Acts – are also thanked for taking time to meet with the evaluation team and to organize visits with beneficiaries in their homes. Idir and HCBC volunteers gave their time willingly, and beneficiaries who often lived in highly-disadvantaged circumstances allowed us into their homes and graciously answered our questions. For this, too, we are grateful.

The United States Government (USG)-appointed members of the evaluation team highly appreciate the contributions of the GOE members of the team. Their tremendous experience and insights contributed invaluably to the evaluation and this report.

Lastly, but certainly not least, we are truly grateful to Melissa Jones, PEPFAR/Ethiopia, for her guidance, and to Brenda Moreno, local coordinating consultant, who undertook all the logistics support, coordination and other arrangements for the evaluation team's field visits.

The Evaluation Team

April 26, 2006

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I. METHODOLOGY

A team of 17 persons conducted this evaluation prior to the scheduled closure of the Family Health International/Implementing AIDS Prevention and Care Project (FHI/IMPACT) in September 2006. Members of the team included eight senior Government of Ethiopia (GOE) experts from Regional Health Bureaus (RHBs) and the Ministry of Health (MOH); an expatriate specialist in HIV program assessment, planning and design who served as consultant team leader; two experts from USAID/Ethiopia; one USAID/Washington voluntary counseling and testing (VCT) specialist; one USAID/Kenya expert; one home- and community-care (HCBC) expert from the Office of the Global Aids Coordinator (OGAC); an Addis Ababa University professor/Fulbright Scholar; a CDC/Ethiopia expert; and a local coordinating consultant.

Prior to heading out to the field, team members reviewed project documents provided by PEPFAR/Ethiopia, USAID and FHI/IMPACT. The team leader reviewed relevant interview instruments and prepared two data-recording tools: a "Daily Record Sheet" and a "Field Visit Data Summary Report" to collect qualitative data regarding the achievements and shortfalls in FHI/IMPACT performance against its PEPFAR targets. The team leader also prepared a "Guidance Sheet" to prompt questions for interviewing various stakeholders. (See Annexes 2-4) These tools included data and information collection mechanisms for the five intervention areas to be evaluated: 1) voluntary counseling and testing, 2) TB-HIV care, 3) facility-based OI and non-ART care and support, 4) home- and community- based care, and 5) support for referral systems and linkages.

For the field visit stage of the evaluation, the team divided into five sub-teams that undertook eight days of fieldwork in project areas, including Amhara, Oromia, SNNPR and Addis Ababa. Although sites were initially selected randomly, team members modified the field visit itinerary somewhat to ensure that they used their time efficiently in the field. The team eliminated some very remote sites as well as sites where security concerns existed, however members were careful to include rural sites, including some in remote locations. While FHI/IMPACT works in seven regions and two special administrative areas, the team evaluated sites in four geographic areas where FHI/IMPACT has worked since the project's inception. The primary objective of the field visits was to observe project activities as implemented by FHI/IMPACT at health centers and the HCBC activities of FHI/IMPACT's local partner NGOs. The sub-teams also consulted with regional, zonal, woreda, kebele and idir officials in an effort to determine how the project was addressing critical HIV/AIDS needs in the country (see Annex 5 for list of places visited and persons met). All sub-teams visited at least one hospital providing ART to evaluate referral linkages within the wider health system. Finally, the sub-teams all visited at least two HCBC beneficiaries in their homes to observe, interview, and gain their perspectives of the care and support they are receiving.

All of the sub-teams used common interview guides to ensure consistency in information-gathering and reporting of the qualitative data collected. Upon completion of their fieldwork, the five sub-teams reconvened in Addis to review their findings and recommendations, highlighting the strengths of the project and the challenges confronting it. Finally, the entire team came to consensus on proposed recommendations for the follow-on, PEPFAR/Ethiopia-supported HIV/AIDS project.

Following the fieldwork, a smaller group of team members completed primary stakeholder interviews in Addis Ababa with FHI, USAID and the Global Fund. The writing team then prepared a first draft of the evaluation report based primarily on the field findings and recommendations, but refined and modified based on the additional stakeholder interviews and a review of relevant FHI/IMPACT training materials. The methodology did not gather quantitative data from the field and does not support quantitative analysis of the findings. The evaluation findings are at the output result level for which FHI/IMPACT is accountable under PEPFAR.

II. INTRODUCTION

FHI/IMPACT has been the leading HIV/AIDS technical assistance project in Ethiopia since its inception in September 2001. The goals of the project are to contribute to decreasing HIV prevalence and to improve the quality of life of people living with HIV and AIDS (PLHA) by strengthening the continuum of prevention, care, support and treatment.

To achieve these goals, FHI/IMPACT has built strong partnerships with the MOH and HAPCOs at the national, regional and local levels. The PEPFAR/Ethiopia-funded FHI/IMPACT project works in collaboration with other partners, especially the Global Fund, Intra-Health, Linkages, JHPEIGO, I-Tech and JSI, to avoid duplication of efforts, ensure efforts are comprehensive, and strengthen referral linkages between service providers.

FHI/IMPACT has received substantial PEPFAR/Ethiopia support. Under its cooperative agreement with USAID, FHI/IMPACT has received $20,600,700 in USAID and PEPFAR/Ethiopia funds since 2001. In addition, FHI/IMPACT more recently began receiving financial support from the Netherlands Government.

The environment in which FHI/IMPACT works is challenging. With 77 million people, and an annual population growth rate of 2.7 percent, Ethiopia is the second most populous country in Sub-Saharan Africa. Ethiopia’s rugged topography, very low levels of education and health, low GDP per capita, poor infrastructure, and high levels of animal and human disease all impede economic growth. Eighty-five percent of the population lives in rural areas, compounding the logistical and staffing difficulties of providing health services to the vast majority of the population.

Ethiopia has a generalized HIV/AIDS epidemic with an average prevalence of 4.4%. However, this average masks a wide rural-urban disparity in prevalence, with 12.6% in urban areas and 2.6% in rural areas (all percentages are 2003 figures based on ANC data; updated DHS data are forthcoming). The estimated number of persons living with HIV in 2003 was 1.5 million, of whom 96,000 are children. Furthermore, 537,000 children had been orphaned by AIDS as of 2003.[1]

In response, PEPFAR, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other donors are devoting substantial resources to the fight against HIV/AIDS. Ethiopia is one of 15 PEPFAR focus countries receiving support from the USG and is the largest recipient of grants from the GFATM. In March 2006, PEPFAR/Ethiopia signed a Memorandum of Understanding with the GFATM to jointly commit to provide ARVs to Ethiopia for five years. Under this agreement, the GFATM provides first line ARVs and PEPFAR/Ethiopia provides second line ARVs, as well as both first and second line pediatric ARVs. The GFATM provides drugs for prophylaxis and treatment of tuberculosis and opportunistic infections. Additionally, PEPFAR/Ethiopia funds training and other assistance to build Ethiopian capacity for care and treatment of PLHA.

Momentum in Ethiopia's health sector is significant. The GOE's decentralization effort, initiated in 2000, has moved resources, management, and decision-making authority to the regional and woreda levels, thereby enhancing their participation in health sector development. Within the framework of the Government's Health Sector Development Plan (HSDP), the implementation of the Ministry's Health Extension Package (HEP) is underway and health extension workers (HEWs) are already being deployed to kebeles in the regions. Further developments on the health front include the training and deployment of health officers to health centers and the "logistics plan" for drugs and contraceptives. Finally, and perhaps most importantly, the HIV/AIDS epidemic has been recognized at the highest levels of government, contributing to a new commitment for action including the establishment of HIV/AIDS Prevention and Control Offices (HAPCOs) at the local, regional and national levels as well as a comprehensive National Strategy for prevention, care and treatment of HIV/AIDS.

The environment in which FHI/IMPACT operates has changed radically since the inception of the project. In 2001, there were extremely few VCT sites, HCBC programs were rare, and no facilities provided ART. The activities of FHI/IMPACT have had a major impact in helping PEPFAR/Ethiopia reach its targets for prevention, voluntary counseling and testing, TB-HIV and non-ART/OI care at health centers, and home- and community-based care for PLHA. FHI/IMPACT has also supported the development of referral systems and linkages in the wider network of services for people living with HIV, both at the facility and community levels.

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[1] U.S. Embassy, Ethiopia - Ethiopia Country Profile based on *AIDS in Ethiopia* (5th Edition, 2004), Ministry of Health.

FHI/IMPACT's approach towards achieving these objectives is also in line with PEPFAR/Ethiopia's mission of working in concert with Ethiopian and other partners, within and outside government, to reach specific treatment, care, support and prevention targets. At the same time, through their cooperative agreement with USAID, FHI/IMPACT is supporting USAID's Strategic Objective 14: To Increase Human Capacity and Social Resiliency. Specifically, FHI/IMPACT addresses the Mission's sub-intermediate results: 14.2.1 to reduce risky behaviors; 14.2.3 to increase access to care, treatment and support for PLHA; 14.2.4 to expand access to care and support for OVC; and 14.2.5 to provide a more supportive environment for responding to HIV/AIDS.

The near-term objective of this assessment is to assist PEPFAR/Ethiopia in identifying the project's strengths as well as its shortcomings, and to propose recommendations that may assist in shaping the direction of the new PEPFAR/Ethiopia care and support follow-on activity. A longer-term objective of the review is to stimulate a broader discussion among PEPFAR/Ethiopia, the MOH, donors and others as they consider ways to respond to the challenges inherent in addressing HIV/AIDS in Ethiopia.

This report highlights the findings of the external evaluation of FHI/IMPACT conducted in April 2006. Findings and recommendations are presented by the five intervention areas reviewed by the evaluation. Recommendations for the PEPFAR/Ethiopia follow-on activity that will begin on or around November 2006 are presented in Section IV: Future Directions for Care and Support of PLHA.

III. FINDINGS

Cooperative Agreement Program Interventions

FHI/IMPACT's program approach was originally organized to address intervention areas specified by USAID in the RFA released for IMPACT. With the roll-out of PEPFAR/Ethiopia in 2004, the project has focused its activities on supporting PEPFAR/Ethiopia's Five-Year Plan targets at the health center and community levels.

The PEPFAR/Ethiopia intervention areas reviewed in this evaluation include:

1. Voluntary Counseling and Testing
2. TB-HIV Care
3. OI and non-ART Care and Support
4. Home- and Community-based Care
5. Referral Systems and ART Linkages for PLHA

Evaluation findings are presented by these intervention areas. Discussion for each intervention area includes an overview of PEPFAR/Ethiopia targets, the project's achievements, results from FHI/IMPACT data and reports, and findings from the sub-teams' fieldwork and interviews with key stakeholders. Program constraints and issues – identified as "challenges" – are often systemic in nature and beyond FHI/IMPACT's control. These challenges are cited in order to provide a more complete understanding of the sometimes problematic context in which the project operates.

Overarching observations regarding the FHI/IMPACT project include:

- FHI/IMPACT has introduced updates to training and has begun to reduce the stigma associated with AIDS at the household and community levels. FHI/IMPACT's training and technical assistance have directly resulted in a rapid and extensive increase in the number of sites providing VCT services and a correspondingly rapid uptake in the use of VCT services.

- FHI/IMPACT has achieved results through transparent, collegial, peer-based relations with RHB staff. FHI/IMPACT has collaboratively undertaken assessments, data review and planning with the RHBs. The RHBs greatly appreciate the joint visits to health centers for supportive supervision of trained health center staff, and value FHI/IMPACT's flexibility and responsiveness to RHB problems. Several RHB staff went out of their way to emphasize that they did not think their RHB could function effectively without FHI/IMPACT support.

- Similarly, FHI/IMPACT's close relationship with its partner implementing NGOs ("mentoring NGOs" – HAPCSO, FGAE, OSSA and Medan Acts) is described as supportive and has enabled the NGOs to enhance their response to HIV/AIDS in the communities they serve. However, these organizations also require direct support to pay for staff salaries and such items as basic office equipment and computers. The mentoring NGOs have no readily apparent means of maintaining staffing and activity levels without continued external financial support.

- Staffing levels at health centers limit the capacity to provide HIV/AIDS services. Few health centers outside Addis Ababa have a doctor on-site, and in many rural health centers, health officers are also scarce. Highly-dedicated, yet resource-strained nurses provide the bulk of health center diagnostic and curative services throughout the country. Staff turnover at all levels further strains personnel resources and impacts the level of training and, therefore, services available on-site.

- Referral linkages both within health centers and to-and-from the wider health system are nascent at best. Use of formal internal referral systems within health centers is uneven. FHI/IMPACT has provided a flow-diagram for internal referrals, however most health centers have not yet internalized the procedures and put them into practice. Although health centers are referring patients to the hospital for ART, once the patient has been treated and released there are no feedback mechanisms in place either for follow-on chronic care at the health center or transfer of medical records.

Intervention 1: Voluntary Counseling and Testing

FHI/IMPACT has worked with RHBs in Addis Ababa, Amhara, Oromia and SNNPR to set up and/or strengthen VCT services in health facilities with a focus on training new personnel, ensuring refresher training for those already trained, providing on-site supervision, conducting monitoring and evaluation, and ensuring quality control. FHI/IMPACT's aim is to build the capacity of the RHBs to take on a strong leadership role in VCT program management and quality control. Specific PEPFAR/Ethiopia targets for fiscal years 2004 and 2005 related to FHI/IMPACT and the project's corresponding achievements are detailed in the table below:

Table 1: Voluntary Counseling and Testing

	FY 2004		FY 2005	
	Targets	**Results**	**Target**	**Results**
Individuals trained in counseling and testing	631	1,269	1,170	1,703
Individuals received counseling and testing	125,000	46,843	216,000	288,029
Service outlets providing counseling and testing	228	359	223	469

Targets are based on PEPFAR/Ethiopia COP for 2004 and 2005. Results are as reported by FHI/IMPACT.

VCT service set-up and strengthening in Amhara and SNNPR did not start until the end of 2004 and FHI/IMPACT, therefore, fell short of its target for individuals that received counseling and testing for FY04. After services were established in all four regions, FHI/IMPACT met its PEPFAR/Ethiopia FY05 targets for voluntary counseling and testing, both in terms of individuals trained and persons receiving services. Furthermore, the project far surpassed its targets for setting-up service outlets providing VCT in both FY04 and FY05.

FHI/IMPACT uses the Ethiopian MOH VCT training curriculum and "generic" FHI-produced VCT skills training curriculum and reference guide in its 15-day VCT training program. Approximately 10 training days are devoted to coursework followed by five days of practical on-site training. FHI/IMPACT's own materials fill gaps in such areas as couples and youth counseling. With MOH approval, FHI/IMPACT has also begun using a WHO manual, prepared for Africa, to train on provider-initiated counseling and testing (PICT).

Major Achievements:

FHI/IMPACT, in partnership with the MOH, has taken the lead in providing training and equipment to rapidly and dramatically increase the number of health centers providing VCT. Prior to the project, VCT services were very limited in Ethiopia; at present, this service is now available to a large proportion of the population. By the end of FY05, counseling and testing services had been provided to 288,029 persons as a result of this project, an impressive increase from the 46,843 persons who had received VCT services by the end of FY04. All health centers visited by the evaluation team had VCT services in place, at least one VCT-trained staff member, and at least one room designated for VCT services.

The following comment by Wzo. Amarech Agedew, HIV Prevention and Control Sector Head, SNNPR RHB, echoes sentiments shared by RHBs in all geographic regions evaluated:

> *"The RHB appreciates the training provided by FHI/IMPACT for VCT counselors, as well as the training of trainers. FHI/IMPACT's BCC campaigns have been excellent and well-received. FHI/IMPACT's VCT supervision is strict and feedback is sent directly to the RHB for action and follow-up."*

Specifically, FHI/IMPACT's achievements were noted as follows:

- *Training:* FHI/IMPACT, together with the MOH and RHBs, has trained counselors, trainers and lab technicians, thereby greatly expanding the availability of VCT services in Ethiopia. In general, VCT staff are highly-motivated and committed to providing services to their clients, even when faced with multiple responsibilities and limited resources.

- *Infrastructure*: FHI/IMPACT has provided significant infrastructure support for VCT rooms, including furniture, confidential filing cabinets, and equipment (including refrigerators) for laboratories.

- *Increased VCT uptake and improved service:* With new VCT centers and more trained personnel, uptake of VCT clients has increased rapidly. Most health centers are able to provide VCT services without interruption. Areas where HCBC services are provided have seen particularly high increases in uptake. Due to the availability of care and treatment, and provider-initiated referrals from TB clinics, there is a slight shift towards symptomatic persons also seeking VCT.

  VCT services are provided free at all of the facilities visited by the sub-teams, with the exception of one. All clients can receive their test results on the same day. Some sites are able to process the testing immediately and provide post-test counseling within an hour. Many VCT counselors are interested and able to do HIV testing. As the MOH moves toward approving simpler rapid-test kits that do not require venous blood draws, non-lab technician staff can more easily perform tests and increase the possibility of giving same-hour results.

- *Supervision, Monitoring and Reporting*: FHI/IMPACT in most cases performs quarterly joint supervisory visits with RHB staff and may additionally provide further technical assistance in the first two years of implementation at a given site. Health Center staff regard supportive supervision as extremely beneficial.

  All health centers visited had handmade VCT registration and laboratory log books, pre-printed national client forms, and FHI/IMPACT-provided monthly and quarterly reporting forms. Some sites had wall charts with monthly VCT activity reports.

Major Challenges:

- *Staff attrition and service interruption*: High staff turnover at some health centers is a serious challenge to maintaining services, especially in more rural areas. High attrition leads to service interruption and increased workload for remaining staff. When new staff members are brought in, they often need training before they can begin to provide VCT.

  VCT services may be interrupted if the VCT-designated nurse is pulled away for duty at another clinical service or for outreach activity. Some counselors become overextended or burnt out trying to provide VCT and cover their regular duties as well.

- *Test kit shortages and stockouts*: Lack of and/or expired test kits are causing service interruption in many of the health centers visited, and for as long as three weeks in the case of Shashemene Hospital. Most health centers currently do not have the tie-breaker test (Unigold), and many others have received long expired or at expiry confirmatory tests (Capillus). Some also have stock-outs of the screening test (Determine). Some centers stop testing if even one of the tie-breaker tests is out of stock, while others appropriately decide to continue testing if two tests are available. There also appear to be problems in managing supplies and/or logistical bottlenecks at the regional or national level.

- *Stigma and discrimination* are still deterrents to increasing the uptake of VCT. Despite community mobilization and BCC efforts nationally and regionally, people are still reluctant to learn their HIV status, even with the availability of care and treatment. Self stigma causes clients to seek services in health centers outside their own town or village, causing congestion in some urban areas and under-utilization in rural sites.

- *Quality control*: While all sites appear to retain client blood specimens for quality control testing, it is not clear how regularly these specimens are collected and tested. It is also not clear whether the feedback from the quality control mechanism is provided at the sites.

- *Referrals from VCT inadequate*: Guidance for counselors on how to make referrals for HIV negative or asymptomatic HIV positive clients is not provided systematically. Some counselors are well aware of the services available for referrals, while others are not and do not understand the concept of palliative care for asymptomatic HIV positive persons. Even referrals of symptomatic VCT clients to TB and OI services, or chronic care clinics, can be problematic as the counselor may not have elicited that the client is symptomatic during the counseling, believing that assessment of symptoms is not their responsibility.

- *Referrals to VCT for patients with TB or common OIs are very low*: FHI/IMPACT has rolled out provider-initiated counseling and testing (PICT) training, and the MOH adopted a policy supportive of PICT in September 2005, but this has yet to be implemented in many health centers. Patients presenting with TB or common OIs need a diagnostic HIV test to determine the medical care needed. These patients do not need full VCT with a risk assessment and risk reduction plan. Given the current structure of services, it is not feasible for the TB nurse or the outpatient health officer to provide this lengthy intervention. The current procedure requiring full VCT for sick patients overloads the VCT service and reduces the availability of VCT to self-referred clients. As a result, many TB patients are not being tested for HIV.

- *Condoms*: Although most VCT rooms have condoms for demonstration along with model penises, most health centers do not also stock condoms for distribution to clients in their VCT rooms. Condoms are usually kept in the family planning or MCH clinics, and counselors retrieve some for "clients who need them" or refer clients to the family planning clinic. This approach creates a barrier to easy access. Since self-initiated VCT clients are likely to have some risk for HIV, they should be routinely offered condoms with the option to decline. **All positive clients should leave with some condoms**.

- *Inadequate space and signage:* Clients seeking VCT services in some urban sites with heavy client flow experience long waits or must take a next-day appointment. Some sites, such as the Shashemene Health Center, have just one room for counseling and testing and one health professional doing counseling, testing and laboratory work, greatly limiting the number of clients served in one day. Other sites, in particular Awassa, Woreta, Kolla Diba and Salem health centers, lack adequate waiting areas. Most health centers lack proper signage directing clients to VCT. Several health centers have FHI/IMPACT-provided posters hung outside the VCT room but this practice is not uniform.

- *Waste management*: Health care waste management and infection prevention in the laboratories need improvement in some sites. There were blood-contaminated syringes in general trash containers inside some laboratories and also in the patient waiting area at Salem Health Center in Addis Ababa. Some laboratories also had resheathed needles in their sharps boxes. Supervisory visits can help identify sites in need of attention.

- *Distance*: The distance that many clients must travel to reach their woreda health centers for VCT can be prohibitive. Clients in rural kebeles may have to travel up to four to six hours to reach the health center.

- *Ownership*: Evaluators perceive that some health facility staff members consider the role of FHI/IMPACT in VCT services as indispensable. PEPFAR/Ethiopia should critically review the impact of this tendency on the long-term ownership of the program by the government.

Intervention 2: TB-HIV Care

FHI/IMPACT achieved its FY05 target for individuals trained to provide prophylaxis and/or treatment for TB to HIV positive individuals. These figures include training of HCBC workers to identify potential TB cases and refer clients to a health facility for diagnosis and treatment. The shortfall in the numbers of HIV positive individuals, diagnosed or presumed, receiving clinical prophylaxis and/or treatment and in the number of service outlets providing services to such clients results from a delayed start of the TB-HIV training. TB-HIV targets were not included in the PEPFAR/Ethiopia FY04 COP.

Table 2: TB-HIV Care

	FY 2004		FY 2005	
	Targets	Results	Target	Results
HIV positive (diagnosed or presumed) individuals received clinical prophylaxis and/or treatment	n/a	n/a	25,652	16,757
Individuals trained to provide clinical prophylaxis and/or treatment for TB to HIV positive individuals	n/a	n/a	452	903
Service outlets providing clinical prophylaxis and/or treatment for TB to HIV positive individuals	n/a	n/a	237	198

Targets are based on PEPFAR/Ethiopia COP for 2004 and 2005. Results are as reported by FHI/IMPACT.

FHI/IMPACT began the TB-HIV training program considerably later than its VCT training program due to the need to gain MOH approval of the TB-HIV guidelines and procedures. At most of the health centers, staff have received training as recently as January or March 2006. Although FHI/IMPACT has exceeded its target for individuals trained in TB-HIV, often only one person at the health center has received such training and there are already signs that staff attrition may become a problem.

Some health centers have very recently initiated chronic care services that combine TB and OI care in one clinic. However, many health centers have not yet done so, making meaningful assessment of chronic care services at health centers impossible at this time. Continued training in TB-HIV for additional groups of health center staff will be essential in the follow-on activity to sustain TB-HIV services at health centers. Furthermore, the more recently trained TB-HIV focal persons have not yet received much supportive supervision, which will also be essential in the follow-on activity to ensure quality TB-HIV care.

FHI/IMPACT's TB-HIV training for health professionals draws heavily upon three sources: (i) the WHO Integrated Management of Adult and Adolescent Illness (IMAI) Acute Care module (adapted for Ethiopia in September 2005), which addresses when to suspect TB and HIV infection; (ii) the IMAI Chronic Care Module, which provides guidance on assessing an HIV positive person's tuberculosis status at every health encounter; and (iii) the national TB-HIV guideline.

Tuberculosis and leprosy services in Ethiopia have long been vertically-supported by various organizations, the most notable being Royal Netherlands TB Association (KNCV), German Leprosy and TB Relief Association (GLRA) and the World Health Organization (WHO). Since 2003, the GFATM is the major supporter of Ethiopia's TB control program. As a result, health centers do not have shortages or stock-outs of TB treatment drugs. However, availability of TB prophylaxis medications at health centers is extremely limited. In practice, persons with suspected TB are identified in the outpatient department at health centers and are diagnosed by microscopy of three early morning sputum samples. Chest X-rays are unavailable at health centers. Even when chest X-rays are available from private clinics in urban areas, they are frequently unaffordable for most public sector patients. Tuberculin skin testing is not available at the health center level. Persons found to be sputum-positive are sent to the TB focal person in the health center for initiation of anti-TB drugs. As part of the internationally recommended strategy for TB control (DOTS), TB patients are followed-up daily at the health center during what is referred to locally as the "intensive phase" of treatment. These TB procedures are long established in Ethiopia.

The existence of well-established DOTS programs in health centers creates a solid framework for building the TB-HIV initiative. As well as TB drugs, reagents for TB diagnostics are generally available at health center laboratories. Thus HIV positive persons can receive clinical treatment for TB at all health centers.

Major Achievements:

- *TB-HIV Initiative*: In collaboration with MOH and the RHBs, FHI/IMPACT has undertaken training for the TB-HIV initiative and trained staff are present at some health centers. FHI/IMPACT has provided formats and guidelines that are available at most health centers.

- *TB-HIV committees:* At some health centers (for example Awassa and Salem), a TB-HIV committee has been established. These committees share knowledge of TB-HIV case management from persons who have had training with other personnel at the health center, and provide direction for provider-initiated counseling and testing (PICT) and other TB-HIV initiatives. The committees also provide a potential forum for discussing care and treatment issues, including referrals for VCT. A few health centers have initiated PICT programs.

Major Challenges:

- *Limited VCT referrals of TB patients:* The majority of TB patients are not being referred for VCT. The FHI/IMPACT formats and guidelines are only being implemented in a few health centers. Where implemented, TB registers indicate that more people are being referred to VCT than prior to TB-HIV training, and several registers have records of TB clients who are identified as HIV positive. Staff members have only recently been trained in TB-HIV procedures and have received little if any supportive supervision. It is too early to determine whether the formats and guidelines have been internalized and will be effectively used.

- *Poor rate of referral from VCT to TB screening:* Many VCT clients found to be HIV positive are asymptomatic and unlikely to attend TB or OI (or chronic care) follow-up without additional motivation and support. Most VCT counselors provide only counseling and do not take clinical histories to elicit if the VCT clients have symptoms of OIs or TB. Furthermore, there is no system to track referrals of HIV positive clients to TB or OI services.

- *Limited trained personnel:* Few staff members have received training to date and staff attrition is already evident at some health centers. The service is thus interrupted when no trained staff member is present. There is no TB-HIV committee or plan of action present in many centers.

- *Limited availability of prophylaxis:* TB prophylaxis is not available at many of the health centers visited. In practice, this is not a major problem as most health centers do not have access to x-rays and are thus unable to diagnose sputum-negative tuberculosis. Isoniazid prophylaxis should only be given to HIV positive persons when sputum-negative tuberculosis has been excluded.

Intervention 3: Non-ART Care and Support

In FY04, FHI/IMPACT missed its target for individuals provided with general HIV-related palliative care. Training for OI care strengthening and assistance to ART efforts only started at the end of 2004 and thus clients did not begin receiving FHI/IMPACT-supported services until early 2005. In FY05, FHI/IMPACT attained 95 percent of its target for providing non-ART care and support to 172,700 individuals, reaching 164,283 individuals. FHI/IMPACT surpassed both its FY04 and FY05 targets for individuals trained to provide general HIV-related palliative care.

Table 3: Non-ART Care and Support

	FY 2004		FY 2005	
	Targets	**Results**	**Target**	**Results**
Individuals provided with general HIV-related palliative care	56,580	n/a	172,700	164,283
Individuals trained to provide general HIV-related palliative care	362	415	4,752	8,813
Service outlets providing general HIV-related palliative care	196	158	240	214

Targets are based on PEPFAR/Ethiopia COP for 2004 and 2005. Results are as reported by FHI/IMPACT.

The evaluation team reviewed FHI/IMPACT's OI/ART training materials for nurses, including nurse supervisors working in HCBC programs, along with related modules from the IMAI Ethiopian adaptation guides. The materials are grounded in Ethiopian policy, guidelines and epidemiology, and cover all the major issues and a number of less-common conditions. Materials included simple decision charts and treatment protocols.

Major Achievements:

- *Trained personnel:* Trained personnel are providing diagnosis and treatment for OIs and follow-up of HIV positive patients for non-ART care at many health centers.

- *Chronic care clinics*: Some sites have established chronic care clinics, with technical assistance from FHI/IMPACT, in preparation for providing chronic care for patients on ART. Chronic care clinics offer TB-HIV and OI and other non-ART care in the same clinic. Such chronic care clinics are a major step forward for the provision of non-ART general palliative care in the health center.

- *Formats and guidelines:* FHI/IMPACT, along with the MOH, provided formats and guidelines for health centers, including registration of patients. Self-made registration books for chronic HIV follow-up care are available and in use at some centers (excellent at Shashemene).

- *ART readiness:* Most health centers have some preparations in readiness to follow-up patients on ART. Staff at health centers in Oromia, Amhara, SNNPR and Addis Ababa are trained on ART readiness.

Major Challenges:

- *Limited establishment of chronic care clinics:* Much of the training is relatively recent, implementation of the training is incomplete, and little or no supportive supervision has occurred. Furthermore, the number of OI-trained personnel is inadequate at many health centers and chronic care clinics are not yet established at all health centers. Of those established, not all OI clinics and chronic care clinics provide STI diagnosis and treatment. Instead, patients are referred to STD clinics for diagnosis and treatment of STI symptoms.

- *Model for general palliative care is too medical*: The number of persons registered and receiving chronic HIV follow-up care at health centers is relatively few compared with the number of clients who have tested HIV positive. For example, Salem Health Center in Addis Ababa has only 11 chronic care clients although it has been providing VCT for more than two years. The majority of the chronic care clients are Stage 3 and 4, with only a few Stage 2 and no Stage 1 clients. This situation reflects the prevailing medical model focus on the sick for general palliative care that only addresses diagnosis and treatment, and in some cases prophylaxis, for major opportunistic infections. Services for pain assessment and relief, and general mental health assessment and care, as well as wider services such as family planning are not yet available. Furthermore none of the health service staff interviewed understand the concept of services for asymptomatic or “well” positive people.

- *Stockouts and shortages of OI drugs:* Opportunistic infection drugs are often in short supply or out of stock, including cotrimoxazole, STI and anti-fungal medicines, and others. Patients are given prescriptions, but must then buy medicines on the private market if there is not a "special pharmacy" at the health center as there are stockouts of free medications at the health centers. Many patients go without needed medications due to lack of funds. In some clinics where medications are available, eligible patients are unable to get poverty certificates from their kebele and are therefore unable to access free medication.

Intervention 4: Home- and Community-Based Care for PLHA

FHI/IMPACT has trained home- and community-based nurse supervisors who, in turn, have trained idir-managed volunteers in programs in 14 urban centers. FHI/IMPACT trained HCBC volunteers in the areas of basic hygiene and home nursing, establishing a supportive environment through community education and mobilization, nutrition counseling and support, promotion of safe sexual practices, referrals to medical care services, linkages or provision of other support services (e.g., counseling, prevention, nutrition, income-generating activities, etc.), psychological support for the issues associated with terminal illness.

Table 4: Home- and Community-Based Care

	FY 2004		FY 2005	
	Targets	**Results**	**Target**	**Results**
Ill and bedridden persons provided with HCBC support	11,620	24,075	10,000	22,862
Individuals trained to provide HCBC support	4,340	5,790	no target	7,910

Targets are based on PEPFAR/Ethiopia COP for 2004 and 2005. Results are as reported by FHI/IMPACT.

FHI/IMPACT has surpassed its targets in both FY04 and FY05 for the number of bedridden persons provided with HCBC support, as well as the number of individuals trained to provide such support. In both years the project supported more than double the number of bedridden individuals originally targeted. This achievement is tremendous given the resource-constrained environment in which FHI/IMPACT and its partner NGOs operate, and is a testament to their impressive mobilization of communities.

HCBC services are delivered by volunteers and nurse supervisors in a compassionate, humane manner to beneficiaries and families who often live in extreme poverty andsocial isolation. The volunteers are an enthusiastic cohort, willing to dedicate a large amount of time and often their personal resources to provide HCBC.

It is apparent from home visits that the beneficiaries are grateful for the services and the manner in which they are provided. As attested by one beneficiary:

> *"My mother or father may abandon me. But when the volunteers washed me and treated me as a human that empowered me to improve. Before the volunteers came, only my children cared for me. But from the first day, the volunteers said that I would have some life, and that I would see the fate of my children."*
>
> 34-year-old Jimma woman who has received HCBC for more than one year and been on ART for 11 months

FHI/IMPACT has created a standard training manual to instruct nurse supervisors to train HCBC volunteers. FHI/IMPACT developed the manual to facilitate a TOT process whereby the nurse facilitators learned how to teach HCBC volunteers over a 10-day classroom and 60-day field period. The training is structured in specific modules addressing service areas that are based on didactic and interactive sessions, problem-based learning with case studies, and other adult learning methods. FHI/IMPACT also provided the nurse supervisors and HCBC volunteers with a handbook containing relevant information on care and support, which forms the basis of HCBC volunteer training. Additionally, the HCBC volunteers use the handbook in the community as a reference.

Major Achievements:

- *Nurse supervisors trained:* FHI/IMPACT has trained nurse supervisors in the care and treatment of HIV/AIDS. The training manual includes an introduction to the immunology, natural history, and epidemiology of HIV; diagnosing and managing HIV-related conditions with information on treatment and follow-up; general information on HIV positive women and children; ARV adherence and monitoring activities; and providing supportive care, including end-of-life palliative care. The training manual both underpins the training and provides a general guide for HCBC in resource-poor settings. The training is in two parts: five days are devoted to clinical management and three days to ARV therapy.

- *HCBC volunteers trained:* HCBC volunteers provide home care visits to four or five beneficiaries on a regular basis with nurse supervision and oversight as needed for basic nursing and social support. Volunteers and supervisors meet to review client care. The volunteers each have a home care kit that supports the provision of basic hygiene and nursing activities. The content of HCBC kits is standardized and approved by the MOH (see Annex 8: HCBC Kit Contents). Furthermore, volunteers train family members in PLHA care. Additional supplies are available to the nurse supervisors to address acute and chronic medical problems, including access to additional analgesics and antibiotics.

- *Strong partnership with idirs:* The partner NGOs all worked with idirs as the implementing CBO. Idirs were chosen as implementing partners because these strong, indigenous community and social organizations are present in all communities and have the traditional function of providing burial and bereavement support. Idir members go house-to-house identifying chronically bedridden persons, and idir leaders organize and manage HCBC volunteers. FHI/IMPACT's engagement of idirs has prompted a shift in thinking and action among idir members. Members have decided to help and provide support to people when they are alive and in need, rather than only after death.

  Idir community members are beginning to assume ownership of the program, providing and managing a high number of volunteers, and some collecting an additional 0.25 to 1.00 birr monthly dues per member specifically for funding HCBC activities. Others have accepted HCBC clients who are not members of the idir and who are not all able to pay membership dues. With FHI/IMPACT's technical assistance, the idirs have implemented excellent selection criteria for volunteers, resulting in very low turnover and high continuity of care.

- *Reduction of stigma:* Self-stigma and fear of discrimination create significant barriers for individuals and families in accessing and/or using HIV care services, including HCBC. FHI/IMPACT's HCBC training includes methods for raising community awareness and mobilizing beneficiaries' neighbors through coffee ceremonies. The HCBC volunteers attest that coffee ceremonies are an effective strategy for reducing stigma and discrimination. Further, the appearance of HCBC programs in communities makes evident the benefits of using HIV care services (and, thus, the benefits of knowing one's HIV status) through the improved health conditions of beneficiaries. This outcome may foster an increased awareness of and demand for VCT.

- *Increased availability of OI drugs and better access to services:* HCBC programs are providing cotrimoxazole prophylaxis to their beneficiaries. Some volunteers also purchase other drugs prescribed by the health center or hospital that the beneficiaries cannot afford, if the HCBC center is unable to provide them. Some HCBC nurse supervisors have formed an association to which they contribute regular membership dues. These dues are also used for purchasing drugs and other care that HCBC beneficiaries need and cannot afford.

  Patients receiving HCBC generally receive in a timely manner treatment for OIs and other conditions that arise while they are on ART. Volunteers accompany HCBC beneficiaries to VCT and ART services if there is no available family member to do so. Nurses refer HCBC beneficiaries with notes or in person to chronic care clinics at health centers or hospitals; these referrals allow patients to receive services without waiting and streamline the registration and payment process.

Major Challenges:

- *Insufficient training in some areas:* Training and skill development (as reflected in the TOT manual) for HCBC volunteers do not cover the assessment and management of common HIV-related symptoms experienced by clients with advanced HIV disease. For example, the control of neuropathic and other sources of pain, severe nausea and vomiting, unremitting diarrhea and unintentional weight loss, advanced dermatological conditions, and persistent febrile illness are not covered. To the extent that these conditions are assessed and managed in the home, the nurse supervisor assumes responsibility to a degree, although how this is done is not clear from the nurse training manual. Nurse supervisors interviewed said that they make referrals to health centers or hospitals to fully assess and manage these conditions. In some HCBC programs, idirs request that their HCBC volunteers receive more training on assessing and managing more complex medical and psychological conditions.

- *Nurse training not always suitable for home environment:* Training and skill development for nurse supervisors includes important information on clinical diagnosis and therapeutic remedies as well as the management of common HIV-related symptoms for persons with advanced disease and requiring end-of-life care. However, the training manual provides limited information on specific assessment and management strategies appropriate for the home and how they can be initiated and managed by the HCBC volunteers under the supervision of the nurse. No information is provided regarding protocols for determining conditions or situations that require further consultation and/or referral from HCBC to a health facility. Finally, the manual often refers to diagnostic services often only available in hospital facilities (e.g., FBC, X-ray, and others). Overall, the nurse training manual does not appear to be well-tailored for use in HCBC programs or to the conditions of the Ethiopian health care system.

- *Sustainability:* PEPFAR/Ethiopia, via the FHI/IMPACT project, gives sub-contracts to partner NGOs to run HCBC programs. The NGOs appreciate their collaborative relationships with FHI/IMPACT and voice the need for the continuation of these relationships. It is doubtful whether the partner NGOs could continue their activities without outside donor assistance as there is no clear mechanism for long-term financial sustainability.

  It is interesting to note that in Welliso, Oromia Region, a non-PEPFAR/Ethiopia-supported HCBC program is being planned by the Ethiopian Red Cross, South West Shoa Branch. This HCBC program will sustain itself financially via rental income from a commercial building owned by the Red Cross in the center of Welliso, off-setting the need for continual donor support.

- *Demand for services greatly outstrips supply:* HCBC programs are not available to bedridden persons outside of the program's 14 urban centers. Within these urban centers, the capacity to provide services has generally been reached and idirs are no longer able to take on new patients. The vast majority of HIV positive persons in Ethiopia are receiving no form of HCBC services.

- *Focus on end-of-life rather than comprehensive palliative care:* The HCBC programs implemented by FHI/IMPACT are limited by entry criteria to critically-ill clients that have been bedridden for longer than one month. Based on such criteria, HCBC programs are providing services to persons at end-stage disease. Thus, the program has limited opportunities to affect disease progression or prevent the onset of AIDS-defining conditions (e.g., pneumocystis carinii pneumonia, tuberculosis and toxoplasmosis) for persons in early or moderate stages of immunosuppression. By restricting eligibility for HCBC program/services to critically-ill clients, a relatively small number of clients are receiving intense services, making high demands on a limited number of HCBC workers, and incurring high per-client program expenditures. Consequently, the high demand for costly services among a limited number of clients has created an inefficient and unsustainable approach to delivering HCBC services.

  The requirement for and limited availability of external financing constrains the ability of HCBC programs to expand either their scope or the geographic distribution of their services. Furthermore, the use of an end-of-life model to identify persons in need of ART and treatment for OIs is a very inefficient entry point to ART and prevention treatment. Many persons will die before becoming eligible for HCBC and thus will not access ART or other prevention and treatment services. Those who do access ART have already expended their family resources on care and treatment prior to HCBC, and many have already lost their jobs or other means of livelihood and are thus unable to provide for their families when their physical health recovers on ART.

- *Financial burden for idirs:* The involvement of idirs to manage and organize volunteer activities has resulted in a significant financial burden to these organizations. Idirs provide services to bedridden HCBC beneficiaries without any prior membership payments at a time when the recipients are often unable to contribute even nominal dues. This additional financial burden has resulted in bankrupting at least one idir, and may be seriously depleting the mutual funds of others.

- *Financial and other burdens for volunteers:* Volunteers devote substantial time to their HCBC activities and provide a tremendous service. Most beneficiaries are low-income women with already-heavy family and other responsibilities. The 50 birr stipend that most programs provide does not even cover their basic expenses, such as transport to and from beneficiaries' homes, to and from training meetings, and to and from hospitals and health centers. Volunteers in the Awassa HCBC program noted that they routinely subsidize the expenses of their beneficiaries, such as meals for the patient while waiting all day at the hospital, from their own budgets.

- *Limited pain management and psychosocial support:* GOE policies related to the access and prescription of a wide range of analgesics, particularly level II and III analgesics, outside the hospital setting are creating barriers to appropriate management of pain in HCBC settings. In addition, procedures and protocols for assessing and managing pain with available medications in the HCBC setting are either not established or implemented. This situation is demonstrated by the limited and restrictive use of paracetamol by HCBC volunteers and/or nurses in the home.

  Although the program provides services in basic nursing and other support service areas, there is limited or no availability of other types of services necessary to address pain and suffering on a psychological or spiritual level. The HCBC team is limited to the volunteer and clinical nurse and does not appear to include or collaborate with other types of caregivers such as social workers, religious/spiritual leaders, or mental health counselors within the local community. Based on training manuals, nurses are not trained in areas of HIV-specific mental health assessment and counseling or spiritual support.

- *HCBC services for children lacking:* HCBC services for children affected by AIDS and for HIV positive infants and children are unavailable in HCBC programs. There is no apparent assessment of the vulnerability of children in HCBC beneficiaries' households. HCBC volunteers are not trained in assessment of basic health care issues for HIV positive infants and children. Although nurse supervisors are exposed to HIV pediatric care in training, the level of knowledge and skill is insufficient to assess and manage many of the HIV-related symptoms and conditions of children in beneficiary households. Referrals to pediatric providers and facilities are reportedly limited due to lack of provider capacity.

  Most importantly, HCBC programs do not appear to link or collaborate with MTCT programs for purposes of referral or entry. HCBC providers, both volunteers and nurses, are often unaware of the existence of MTCT programs. HCBC programs need to forge stronger links with OVC programs such as the PC3 project and assure that vulnerable children are gaining access to services.

- *Linkages to other community-based services weak (nutrition, housing, income-generating activities):* Within communities, the HCBC services are limited to general care with home nursing, limited nutritional support, and ad hoc financial support often from the volunteer's or the HCBC nurse supervisor's own pocket. Positive living advice and referral of clients' family members for VCT and tuberculosis care are said to be in place. No spiritual, legal, psychosocial or mental health care is evident.

Many HCBC beneficiaries and their volunteers argue for the changing needs of HCBC beneficiaries on ART. With improvement in their physical health, beneficiaries need nutritional and livelihoods support to "stop the culture of dependency". HCBC beneficiaries have often lost their jobs and depleted their family resources during the period of chronic ill health before they became eligible for HCBC. Clients on ART may dramatically recover physically but then have limited opportunities for sustaining their livelihoods and remain dependent on the HCBC support. As a result, the partner NGOs cannot absorb new clients while continuing to support their existing clients on ART. Linkages to other community HIV services are often missing.

Nutritional support, housing, and income-generating activities are often mentioned as the highest priority among clients, however, a limited number of programs and direct services are available to address these needs. Most bedridden patients are living in extremely substandard housing and even still are unable to pay their rent. Although most kebeles are refraining from collecting rent from bedridden patients, the patients are insecure regarding their shelter since rent waivers are not formalized. Private landlords may not be so sympathetic to HCBC clients. Beneficiaries also note that loneliness is still a challenge for bedridden patients, especially for those with broken family ties.

- *Limited involvement of PLHA:* Although FHI/IMPACT has trained HCBC volunteers in methods for reducing community stigma and discrimination, limited effort is directed at mobilizing PLHA groups or individuals to work collaboratively with the HCBC providers in areas of direct service delivery, community education or advocacy. The local Bahir Dar branch of Mekdim, a national PLHA association, collaborates with the OSSA HCBC program, however their involvement is limited by lack of funds. Other affected people, specifically women's associations and youth clubs, are not engaged or working collaboratively with the HCBC programs.

- *Untapped potential of volunteer "graduates":* The HCBC programs visited "graduate" their HCBC volunteers after 18 months of service. After a transitional period, the volunteers hand over their case loads to new HCBC volunteers and their participation in the program ceases. One ex-volunteer who was met in the Addis Ababa HAPCSO program has become a paid social worker for the HCBC program. However, there appears to be no plan to further train volunteers to deliver a higher level of clinical care and support within HCBC programs, either as a compensated staff member or volunteer. The potential exists to build upon the basic knowledge and skills gained during their initial volunteer period and fill gaps in meeting the demand for HCBC services and for graduated HCBC volunteers to be trained as lay counselors in VCT clinics.

Intervention 5: Referral Networks and Linkages for Persons Living with HIV/AIDS

PEPFAR/Ethiopia targets:

- Links between health facility services and home- and community-based care;
- Positive living support for HIV positive symptomatic and asymptomatic persons through support groups at the community level;
- Referral systems and care networks at the community level, between community and health center, between services within the health center, and between the health center and hospital.

FHI/IMPACT results:

- Referral systems are in place between services within the health center, and between the health center and hospital.
- Referral systems and care networks *for bedridden or previously bedridden persons* exist at the community level, and between the community and health center in areas where HCBC programs are active.

Major Achievements:

- *Internal referral systems introduced at health centers*: All health centers visited had flow diagrams on the walls that indicated, *inter alia*, internal referral from and to VCT, to either OI or chronic care services, and from TB care to VCT; and external referral from the health center to the referral hospital for ART services. In many health centers, the FHI/IMPACT-designed referral system includes referral slips that are completed by the referring health worker. When the referred patient has been seen, the bottom of the referral slip is completed and returned to the referring health worker.

- *Health center referrals to hospitals for ART*: Of the external referral linkages, the referral processes to hospitals for ART and/or CD4 count are the strongest.

- *HCBC referrals to health system*: HCBC programs, where they exist, are referring patients to health centers and hospitals for VCT, TB care, ART and OI treatment. Patients coming from HCBC programs may be treated earlier for infections and other conditions that arise *after* they have commenced ART as compared to others on ART due to increased care-seeking behavior and advocacy by HCBC providers.

Major Challenges:

- *Internal referral system weak at many health centers:* Although referral procedures are in place, there is little evidence that they are being fully used in most health centers visited. Referrals are most commonly seen in the records of the VCT counselor and TB focal person, with slips returned from VCT to TB indicating HIV infection status. The internal health center linkage most often judged to be weak is the OI to TB referral.

- *Limited referral of HIV positive patients from health center to HCBC providers:* Health centers are referring the most destitute clients to kebeles for poverty certificates, and in some areas to faith and other organizations that provide for the poor. However, due to lack of services available and/or little understanding of the needs of HIV positive asymptomatic persons, the vast majority of patients are not being linked to adequate community-based palliative services.

- *Absence of feedback from hospitals to health centers and/or HCBC services:* There are no referral mechanisms back to the health center or HCBC program, nor are records for follow-up care provided for patients that are released from the hospital. Also, for patients referred to the hospital, there is no tracking system to determine if they actually receive hospital services.

  Staff at health centers that are more than 100 kilometers from an ART hospital state frankly that their patients do not attend for ART services when referred. Staff at health centers that are geographically closer to ART hospitals in different regions than their own zonal ART hospital argue for changes in the referral system to permit referrals to the nearest ART hospital.

- *Health center to hospital referral gaps:* TB patients are not generally referred from the health center to the hospital for possible ART. Patients identified as HIV positive via health center tests are not officially referred to hospitals; in many instances VCT is being repeated at the hospital.

- *Patient default and limited tracking:* Follow-up of client referrals is weak. People default between VCT and chronic care, between TB and VCT, and between health center and ART at hospitals. There is little to no tracking of clients' chronic care treatments.

- *Weak networks of HCBC providers:* HCBC provider networks are weak or non-existent, creating the possibility for duplication of efforts and difficulties for patients seeking additional benefits from other organizations that are not covered by their "primary organization". Few if any referrals exist between HCBC programs and other services in the community, including associations of PLHA. Furthermore, HCBC programs are rarely referring children or family members of beneficiaries for VCT, even when they have symptoms of illness.

- *Weak linkages in rural areas:* In rural areas, health centers have poor links with health extension programs for VCT uptake. There are also limited linkages with communities for care and support, primarily due to the lack of adequate programs in rural areas.

Cross-cutting issues for the follow on activity

Shortages of test kits, reagents, test tubes, and drugs for prophylaxis and treatment of OIs are creating avoidable barriers to accessing HIV care and treatment through the public health system. The evaluation team learned that HAPCO, with its Global Fund grant, is to address the strengthening of procurement and logistics at the national level. There is additionally need for strengthening logistics and supply chain management at the regional and woreda levels.

HCBC volunteer "graduates" are an untapped resource in their communities. Staff shortages and attrition of nurses trained as counselors are limiting both current VCT provision and further expansion of VCT services. Providing graduated HCBC volunteers with further training and engaging them as lay counselors would be an effective strategy for expanding VCT services and providing the additional post-test counseling in PICT as the lay counselors are less likely to move elsewhere.

Branding of the FHI/IMPACT program has resulted in many people believing that FHI is a donor organization. Even senior staff at RHBs do not realize that FHI/IMPACT is a PEPFAR/Ethiopia HIV/AIDS project. This confusion has created a climate of anxiety in the regions where personnel believe that they will not function adequately without FHI/IMPACT support, not realizing that there will be a follow-on PEPFAR/Ethiopia activity.

IV. FUTURE DIRECTIONS FOR CARE AND SUPPORT OF PLHA

The following recommendations are focused on providing guidance for the implementation of the follow-on activity for care and support of people living with HIV/AIDS. They build on the achievements of FHI/IMPACT and the lessons learned from the evaluation.

Expansion and Improvement of VCT programs

Promotion of VCT to High-Risk Populations:
Increasing uptake of services at the current stage of the epidemic in Ethiopia requires that VCT be promoted for both the wider communities and for persons at high-risk. Some health facilities have been trying innovative VCT promotion approaches with promising results.

- In general, promote VCT through the active participation and involvement of community outreach workers and community health promoters to integrate VCT promotion in other health campaigns such as immunizations, promotion of breastfeeding, and hygiene and sanitation. Include VCT promotion in community conversations and other community mobilization activities conducted by community outreach workers and woreda/kebele health offices.

- Emphasize the benefits of testing with a goal of getting people to come for testing before they are sick, when they can most benefit from the preventive care package.

- Incorporate mechanisms to extend the hours of VCT services to evenings and weekends to improve access for working clients.

- Provide VCT outreach where at-risk youth congregate, or where other most at-risk persons live or work, to increase uptake by those most in need of care, support and prevention interventions; youth services have to be appealing and "youth friendly".

- Facilitate the formation of PLHA associations that provide examples of living positively to combat stigma and address discrimination in the community. Community outreach workers might do this with additional training and supervision.

Build on the capacity of MOH and HAPCO to improve health systems and service management at the federal, regional and local levels to ensure sustainability of improved health services:

- Provide logistics and supply chain management training for RHBs that will complement the HAPCO/GFATM activities to strengthen logistics and supply chain management at the national level.

- Provide training and supportive supervision for the implementation of new testing algorithms that are developed as the MOH approves a new range of HIV rapid test kits.

- Train VCT sites and woreda and zonal offices on improved data management, collection and analysis so that locally-collected data are used by local health managers and providers to improve services. Such local use of data for decision-making is known to increase the quality of data collection as well as improve the services provided, and can identify the referral linkages and/or service points from where PLHA are frequently lost to follow-up.

Support provider-initiated, diagnostic HIV testing and counseling:
Emphasize provision of abbreviated diagnostic testing and counseling to TB patients and outpatients at health centers who present with signs of opportunistic infections. Utilize lay counselors to provide additional counseling for those who test positive and are in need of additional support.

Improve VCT linkages and referrals:
Assist MOH, HAPCOs (from federal to local levels), RHBs, and zonal and woreda health offices to develop mechanisms for clear linkages and referrals between VCT sites, between community services and ART hospitals, and between care and support services. Provide technical assistance to develop a referral tracking system to follow PLHA and ensure they receive the package of services they need. The introduction of care coordinators should greatly enhance referral tracking. Consider introducing preprinted VCT registration forms similar to those provided for chronic care patients. Standard forms would ensure that all sites collect the same data. Assist MOH and RHBs to improve data collection and analysis at all levels and use data to inform service decisions.

Lay Counselors:
Provide technical assistance for the implementation of the forthcoming MOH policy that will allow health centers to train and employ lay counselors for VCT to expand VCT provision, enhance PICT post-test counseling, and provide some stability in the cadres of counselors to counter the attrition of nurse counselors. Provide technical assistance to the training, deployment and supervision of lay counselors by senior counselors, as this will free up nurses for clinical care. Lay counselors from health centers could also provide VCT outreach at kebele health posts, bringing VCT closer to people's homes.

Follow-on training:
Provide assistance to a regular schedule of MOH/RHB training for VCT counselors and lab technicians to sustain provision of service in the face of high staff turnover/attrition. Support RHB staff to undertake regular supportive supervisory visits to VCT sites and on-site quality assurance supervision to enhance service quality.

Consider providing support for whole-site training programs that address skill development by and sharing between all health workers. This approach should include strengthening referral mechanisms between the different health care services within the health center, and strengthening health center management in areas such as staff deployment and space usage. This approach will also allow for local needs assessment and problem-solving, as well as the development of solutions specific to each health center, rather than a cookie-cutter approach to staff deployment and space utilization.

Increase condom availability at VCT sites:
Promote the best practice of making condoms available in all VCT rooms for easy access. All at-risk and HIV positive clients should be offered condoms.

Signage:
Address such issues as clear signage marking VCT sites. Promote adoption of a standard logo that indicates availability of quality, certified VCT services.

Policy knowledge in the field:
Ensure that health center staff and VCT counselors are aware of changes in MOH policy regarding age of consent for VCT. Many staff members are unaware of changes making it legal to test young people aged 15-18 years who can give their own consent.

Training materials:
Ensure appropriate training materials are available and that the length of training is appropriate for VCT counselors, senior VCT counselors, and lay VCT counselors. The national MOH VCT training curriculum was adapted from USG HHS/CDC materials. However, now that ART is available, HHS/CDC has updated the counseling materials and put more emphasis on discussing care and treatment for HIV positive clients, making referrals for all clients, and making partner referrals for all clients. The updated materials streamline the counseling protocol so that pre-test counseling is much shorter and based on informed consent, while risk reduction counseling takes place post-test based on the individual client's HIV test result.

General Palliative HIV Care at the Health Center

Support enhanced delivery of HIV services at the health center for better quality of care for PLHA from initial diagnosis through end-of-life care, as well as bereavement support for family members.

For sustainability after USG support ceases, expand training of trainers for RHB and HAPCO staff, and assist them to provide a regular program of training in general palliative care for HIV positive persons and their families from diagnosis through to death and bereavement, with continued training in TB-HIV and OI care within the framework of general palliative care. This approach will ensure the needed transformation of health services for PLHA from the end-of-life model to wider HIV palliative care. Specifically:

- broaden health workers' understanding of PLHA needs for care and support in areas wider than the current, more limited, model of diagnosing and treating symptoms by introducing the WHO/OGAC concept of palliative care into the primary training and in-service training for health workers;

- provide technical assistance including training, system analysis, and establishment of procedures and processes for RHBs to strengthen logistics and supply chain management, and secure the supply of test kits, reagents, materials and essential drugs for prophylaxis and treatment at all health centers. This capacity-building should complement the HAPCO/GFATM effort to strengthen supply chain management at the national level and is needed to ensure availability of HIV services at the health center;

- increase the delivery of quality HIV services at the health center by strengthening the integrated chronic care approach such that all clinical services required by PLHA are available on the same day in one clinic. Such an approach will decrease the likelihood that HIV positive persons will default from attending and thus receiving the services needed to maximize their quality of life and enable them to remain productive members of their families and communities;

- continue to strengthen linkages and referrals within the health center, particularly between VCT and TB-HIV/OI services. Promote PICT in the TB clinic and general Outpatient Department and emphasize the need for all HIV positive TB patients to be referred for ART to ensure those who need TB and HIV care receive it promptly, thus reducing the forward transmission of TB and HIV infection. The linkages and provisions of service for persons known to be HIV positive are best met by establishing chronic HIV care clinics that provide integrated care and treatment across the continuum of general palliative care;

- to address the woefully inadequate provisions for HIV infected and affected children, build linkages between PMTCT and general palliative HIV care in the health center and the community to ensure HIV positive mothers and HIV exposed infants are not lost to follow-up, and that they receive appropriate palliative care, including cotrimoxazole prophylaxis for the infant, in the community. The HCBC volunteer then has the critical role of referring the mother and the infant, if needed, for general palliative care at the health center and ART services at the hospital. Another important function of palliative care for the mother and infant should be support for disclosure to the mother's sexual partner so that he, too, is able to access general palliative care and ART when needed;

- establish/enhance the functioning of health center HIV/AIDS chronic care committees that currently exist at only a minority of health centers. Forge links between the health center committee and community HCBC providers to provide a lower cost, and thus sustainable, mechanism for support and supervision of HCBC volunteers. Facilitate health center HIV/AIDS chronic care committees to: (i) regularly review and share with all staff new policy and other guidance received, (ii) review the training and supervision needs of all staff, (iii) address continued service provision when staff are deployed to outreach campaigns, on leave, or resign from service, (iv) review the functioning of referral procedures and the tracking of PLHA through the health system to ensure they receive the package of services that meet their changing needs, and (v) provide guidance and support to HCBC volunteers caring for PLHA in their homes;

- establish community outreach workers to mobilize communities for prevention, diagnosis, and general palliative HIV care at the health center and in the community to both increase demand for VCT, and provide a lower cost and thus sustainable mechanism for support to HCBC than the current high-cost, inefficient model;

- develop the skills of community outreach workers in: (i) mapping community resources and community-based organizations providing services that could benefit PLHA and their families, and (ii) building linkages with and making referrals of PLHA to available community resources and services, and to health centers and ART services, to enhance the quality of HCBC provisions across the full continuum of general palliative care for PLHA; and

- promote the introduction of the treatment helper approach, often called a "buddy" system in the literature and considered a best practice in care for PLHA. Through this approach, PLHA are encouraged to disclose their status to a confidante of their own choice -perhaps a relative or close friend- who agrees to provide personal assistance and support, including accompanying the PLHA to the health center for general palliative HIV care and to ART services, encouraging the PLHA to adhere to treatment, and negotiating access to HCBC services as required. Treatment helpers have been introduced with good results in other PEPFAR country programs.

Enhance the effectiveness of health worker in-service training in general HIV palliative care, including TB-HIV and OI services, to reinforce the concept of integrated general palliative care services for PLHA, as well as improve the quality of care provided by health centers for PLHA, by:

- using on-site and whole-site training at health centers to ensure all health workers receive palliative care training and understand the expanded concept of palliative care and the roles of different cadres in providing such care. Problem- solving on issues related to human and other resource management, as well as patient flows and referrals, should be part of the training;

- creating mechanisms for sharing skills and knowledge across staff at each health center such that staff who receive training from other organizations are able to transfer their new knowledge and skills to their colleagues to maximize effectiveness of training, and ensure continuation of services when staff are on leave or deployed elsewhere;

- supporting RHBs to provide regular post-training coaching and supervision to increase effectiveness of training and enhance quality of service provision at the health center. Consideration should be given to providing incentives such as awards and public recognition for innovation and good services in the provision of care and treatment for PLHA to raise staff morale and reduce attrition;

- introducing the use of job aids such as diagnosis, care and treatment algorithms and checklists that facilitate the provision of the full package of services needed by all PLHA at each health center visit to enhance the quality of general palliative care services for PLHA; and

- providing refresher training to improve application of new knowledge and skills and raise staff moral by providing a venue for staff to present and solve problems and issues they face providing general palliative care and other HIV services at the health center. This will enhance the quality of general palliative care services for PLHA at the health center and address the problem of staff attrition.

General Palliative HIV Care in the Community

Palliative care in the community should encompass a more comprehensive, holistic approach to delivering a continuum of services to clients, which initiates care at the time of diagnosis and establishes a network of providers, including home-based and facility-based care, in the delivery of a full range of services. An important focus of palliative care is the assessment and management of symptoms, including pain, within the home setting. An effort is now needed to address assessment and management of symptoms in the home in Ethiopia; training, service standards and HCBC kits, as established by USG and GOE/MOH policy, should reflect this need. For example, volunteer community health workers and nurse supervisors should be trained in assessing and monitoring pain and common HIV-related symptoms, and have access to a range of analgesics and medications to relieve HIV-related conditions (e.g., foot pain, nausea and vomiting, diarrhea, dermatological conditions) as well as prevent the onset of clinical conditions such as pneumocystis carinii, toxoplasmosis, and tuberculosis. Within HCBC kits, medications should be available for use in the home, based on accepted protocols and procedures. Pain and symptom assessment and management must not be available only through health facility services or providers, and current policies should not intentionally or unintentionally create this situation. Discussion with the Drug Administration and Control Authority may be necessary to determine the extent to which Level II and III analgesics are available in community- based programs, including health centers, and modification of existing policies to assure clients have in-home access to these drugs should be made if necessary. Finally, it is critical to engage the affected community, PLHA, women and others in the delivery of services, thereby increasing community awareness and providing necessary advocacy to change community and government policies.

Based on these and other goals, the following are recommendations to support the development of a more comprehensive, community-based palliative care program in Ethiopia:

Adopt a broader definition of palliative care:
PEPFAR/Ethiopia staff and its implementing partners should adopt a broader definition of palliative care as defined by WHO and reflected in the OGAC guidance (see Annex 6: Field Visit Recommendations). The definition should include: (i) a more comprehensive, holistic approach to delivering a continuum of services to clients, (ii) initiating care at the time of diagnosis, and (iii) establishing a network of providers that includes community-based care, health centers and hospitals in the delivery of a full range of services. In doing so, it may be important to establish consensus with the GOE and existing implementing partners regarding the general definition of HIV/palliative care as described in USG policy guidance, and designate a basic set of services (physical, psychological, social and spiritual) to be provided at the community and facility levels. Existing materials established by normative or expert organizations, such as the WHO IMAI modules, may be useful in this effort.

Update training to address the complete continuum of care:
All community-based providers should be trained in areas of palliative care based on *existing* training manuals, such as those developed by the federal MOH, as well as WHO IMAI modules adopted for Ethiopia, or other manuals produced by other Sub-Saharan African countries. Materials should cover the full scope of delivering essential palliative care services – particularly pain and symptom management – that begins at the time of diagnosis and covers all four dimensions of palliative care: clinical, psychological, social and spiritual. Materials should demonstrate a continual process of assessment and management of the client that begins in the *home* by a trained family member, volunteer community-based provider and/or nurse, and is coordinated with service providers at the facility level.

Service delivery by multi-disciplinary teams:
A multi-disciplinary team that includes a physician/health officer, nurse, community volunteer, caregiver, religious leader, social worker, and counselor as available and needed should deliver palliative care services. Emphasis should be put on building up on existing community systems, service providers and organizations. Palliative care training, as discussed above, should be provided for the entire team in order to support the concept of "team management". It is recommended that training be done as a "whole-site" experience to support this concept.

Expand existing provider capacity:
It may be necessary to expand the existing provider capacity in order to deliver a higher level of palliative care in communities. Suggestions include: (i) retrain volunteer HCBC providers after their 18 months of service within existing programs to provide a higher level of assessment and management in the home and/or community, (ii) train community outreach workers and other related professionals located at health posts to provide higher levels of counseling and support to families, (iii) identify and fund existing local community providers (e.g., OSSA and Red Cross) that are trained in delivering home- and community-based palliative care, and (iv) continue to train nurses and health officers in providing higher levels of clinical and psychological assessment and treatment in the home and at health centers. Finally, the training and involvement of family members in the provision of care and treatment in the home should be a vital component of community-based care initiatives.

Service delivery through a network model:
Palliative care and support services should be delivered through a network model that includes formally-linked service sites including community-based care services, health centers (including the chronic care clinic, TB clinic, and VCT services), and hospital facilities. The network should coordinate services through an established referral process (e.g., referral slips, etc). Referral mechanisms should be strengthened to assure that patients can navigate the network and that essential information is appropriately shared between the sites. This outcome could be accomplished through the use of a "care coordinator" located at the health center level. In addition, links need to be established: (i) between health centers and community-based care programs and local PMTCT and OVC programs, and (ii) between health centers and hospitals and community-based providers for the purpose of providing ARV and HIV specialty services. Hospitals should establish referral and discharge procedures with community-based programs with the referral process facilitated by the "care coordinator".

Engage and mobilize affected communities:
Engagement and mobilization of affected communities, such as PLHA and youth, is essential in reducing stigma and discrimination, and increasing the capacity to deliver services in the community. Affected groups may be trained to provide community-based services, increase awareness and reduce stigma and discrimination, and provide advocacy activities. These groups should work in collaboration with community-based programs and be included as part of the palliative care "team".

Introduce pediatric palliative care services:
Services for HIV positive infants and children are beginning to emerge in Ethiopia. However, these services, to the extent they are available, are predominantly delivered within secondary facilities with limited or no clinical care follow-up available at the community level. In order to understand the opportunities and methods of developing pediatric community-based care programs, the evaluators recommend that a group of clinical and programmatic experts convene to discuss this issue. Specifically, it is recommended that the USG convene a meeting of pediatricians caring for HIV positive infants and children, program staff of pediatric care facilities, organizations representing women as caregivers, and other experts. They would be charged with developing and implementing pediatric programs or care standards in order to *develop a consensus document* on scaling-up community-based pediatric HIV care and support services for infected infants and children. The meeting should include a discussion of: (i) minimum services to be provided in the home and the first level facility; (ii) training pediatric care providers (RNs, Health Officers) for home- and facility-based care; (iii) identifying the unique clinical, psychological, social and spiritual needs of pediatric clients and translating these into care and training strategies; and (iv) the support and resources provided to mothers and other caregivers for the care and support of children in the home and community.

Referral Networks and Linkages for PLHA

The follow-on activity for care and support for persons living with HIV/AIDS should provide additional assistance to strengthening the regional, decentralized, public health system for enhanced efficiency and effectiveness in providing the continuum of HIV prevention, care, support and treatment services through the network model. This approach will ensure optimum quality of services and sustainability when USG support ceases.

Technical assistance to strengthen linkages:
Provide technical assistance to the MOH, HAPCOs, RHBs, and zonal and woreda health offices to develop mechanisms for further strengthening the linking of health centers and hospitals to community-based programs and services. The introduction of case managers/care coordinators will facilitate the establishment of the network model and the efficient movement of PLHA through the services that they need at the different stages in their disease.

To maximize numbers of PLHA accessing diagnosis, care and treatment services as well as to increase secondary prevention of HIV infection, kebele health posts and community outreach workers must be fully integrated into the enhanced public health system delivery of the continuum of HIV prevention, care, treatment and mitigation services in the community and home.

Train community outreach workers and community-based volunteers to expand the provision of general palliative care in the community by drawing on community resources rather than creating dependency on donor resources.

The existing and proposed new cadres of community outreach workers and community-based HCBC volunteers need training to enable them to:

- mobilize indigenous community mechanisms and resources that can organize to provide care and support to PLHA and their families in their homes. Such "social capital" includes post-test clubs, PLHA associations, women's associations, youth clubs, religious leaders willing to minister to PLHA and their families and address spiritual needs, as well as idirs and other community service organizations;

- facilitate access to the preventive care package by persons who have been diagnosed as HIV positive but who do not yet have symptoms that would make them seek further medical care;

- identify those in the community who need health center HIV services, including VCT before they become seriously ill, and promote the benefits of accessing the services, such as having a better and longer life by taking prophylaxis against infection and commencing ART before AIDS-defining conditions develop;

- link PLHA and their families with community services and resources such as local legal advice, support for making wills and laying out provisions for care of children, and production of memory books or boxes, as well as with health center and ART services.

Strengthen efforts to address stigma and discrimination in the community through the involvement and mobilization of PLHA, in- and out-of-school youth, religious leaders and others in the community who can educate and raise awareness, and provide examples of "living positively with HIV," as well as contribute to community-based services for PLHA and their families.

Employment of PLHA as case managers/care coordinators would contribute to addressing stigma by providing roles for PLHA that enhance the visibility of living positively, and of PLHA as valuable members of society. The use of case managers will also strengthen the referral and linkage networks between health centers, ART hospital services and community-based programs, enabling PLHA and their families to gain better access to the full package of services that will meet their changing needs from diagnosis to death and bereavement.

Establish an enhanced tracking system: The follow-on activity should support the establishment of an enhanced tracking system to identity: (i) bottlenecks in service provision, and (ii) places and/or referral linkages where clients and beneficiaries are lost to follow-up. The care coordinators will use the tracking system to review care plans and service utilization by PLHA, and to identify those lost to follow-up to ensure their needs are being met and that they are linked to services at the health center and in the community as their needs change over time.

Cross-Cutting Issues for Care and Support for PLHA

The follow-on activity must be PEPFAR/Ethiopia-branded so that all health sector staff and beneficiaries know that the assistance is provided by the American people.

The managers and implementers of the follow-on activity will need to build strong working relations with the federal MOH, HAPCO and RHBs. This effort will inevitably take some time to establish and will likely set back attainment of PEPFAR/Ethiopia targets during the follow-on mechanism's first year in operation. FY07 targets in the COP should reflect this need for the new activity to establish a foundation of strong working relationships during its start-up phase before becoming fully operational with interventions in support of the Ethiopia PEPFAR strategy, and FY07 COP.

The approach to working with the MOH and RHBs should emphasize transparency, collaboration, responsiveness and mentoring in a manner similar to the approach employed by FHI/IMPACT and preferred by MOH and RHB staff. This approach will maximize the effectiveness of the working relationship in enhancing MOH and RHB capacity and performance as the agencies oversee the decentralized provision of HIV/AIDS services at the health center and in the community. Such an approach will also ensure the potential for supporting region-specific interventions rather than a set of standard interventions that are less well matched to local needs.

To avoid the development of dependency, the follow-on mechanism must have a clearly-articulated exit strategy with local ownership, and ensure institutionalization of innovations and services for sustainability.

V. CONCLUSIONS

The evaluation findings indicate that FHI/IMPACT has achieved its overall objectives of contributing to decreasing HIV prevalence and improving the quality of life of people living with HIV and AIDS by strengthening the continuum of prevention, care, support and treatment.

FHI/IMPACT has largely attained its targets for persons trained and persons receiving services, including achieving dramatic increases in the numbers of sites providing VCT. However, for reasons beyond FHI/IMPACT's control, much of the training in TB-HIV care and OI care was only recently undertaken and trained staff attrition is a widespread problem. In the long-term, it will be far more efficient and effective, in the primary training of health workers to introduce concepts of "living positively with HIV" and general palliative care for PLHA through a continuum of services from diagnosis to end-of-life care and bereavement support, rather than rely on in-service training in these essential areas. In-service training and follow-up supportive supervision can then focus on improving service quality, enhancing staff morale, and reducing attrition.

FHI/IMPACT has achieved excellent working relations with the MOH and HAPCO at national, regional and local levels. While these relations have enabled FHI/IMPACT to make huge contributions to achieving PEPFAR/Ethiopia targets, they have also fostered, to a degree, feelings of dependency by RHB and health center staff. The follow-on activity must address local ownership from the onset and articulate a clear exit strategy in the design.

The current end-of-life model for HCBC creates dependency, is an inefficient entry point to ART services, and depletes PLHA and their families' resources and livelihoods. The focus of the follow-on mechanism should be on promoting the benefits of early access to the preventative package of services to maintain good health. Furthermore, the follow-on activity should mobilize existing social capital for HCBC. The human capacity development approach presented at a USAID–sponsored side event at the Barcelona International AIDS Conference provides one proven approach to facilitating stronger community responses to HIV, including both prevention and care and support responses for PLHA in the community. There are Africa regional resources for human capacity development that the follow-on activity might draw upon to build local capacity rather than create the dependency that the current model for HCBC creates.

Further, all PEPFAR-funded projects should seek to build the capacity of the MOH to provide palliative care within health centers and the community, and not bypass the MOH entirely with an NGO implemented model for HCBC that is quite separate from the public health services as the GOE has overall and accountable responsibility for health in Ethiopia.

Services for diagnosis, care and treatment of PLHA in Ethiopia need further technical assistance to integrate provision of service in the community, at health centers and at referral hospitals. This optimum service can best be achieved through implementation of the network model proposed in *The PEPFAR U.S. Five-Year Global HIV/AIDS Strategy*. The follow-on activity should assist the GOE and MOH/HAPCO to build capacity in the community, at health centers, and at the regional level to fully implement the network model.

The follow-on activity should track beneficiaries to coordinate care and treatment from the household, community and health facilities and to identify and rectify bottlenecks and gaps in service provision and/or referral linkages where patients are lost to follow-up. One objective of the follow-on activity should be to reduce congestion at referral hospitals by appropriately moving provision of services to health centers, the community and home. To the end, the future project should consider introducing care coordinators at health centers to facilitate referrals and linkages and expand training of volunteer outreach workers to provide services in the community, thereby ensuring a continuum of palliative care at all levels of health care and at the different stages of illness.

The FHI/IMPACT project has had substantial success in rapidly enhancing the response to HIV/AIDS in Ethiopia. FHI/IMPACT's activities provide a solid base in terms of human resources and infrastructure at health centers and in the community from which to expand PEPFAR/Ethiopia's care and support initiative.