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# USAID/ETHIOPIA EXTERNAL MID-TERM EVALUATION OF THE HIV/AIDS CARE AND SUPPORT PROGRAM (HCSP)

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## ACRONYMS

| | |
|---|---|
| ABC | Abstinence, be faithful, and (correct and consistent use of) condoms |
| ANC | Antenatal care |
| ART | Antiretroviral therapy |
| ARV | Accelerated retrovirals |
| BCC | Behavior change communication |
| BPR | Business process re-engineering |
| CA | City Administration (FDRE administrative level-Addis Ababa) |
| CBO | Community-based organization |
| CC | Community counselor |
| CCG | Community core group |
| CDC | Centers for Disease Control and Prevention |
| CM | Case manager |
| CMob | Community mobilizer |
| COP | Country operation plan |
| DBS | Dry blood spot |
| DC | Data clerk |
| DHS | Demographic and health survey |
| DOTS | Directly observed treatment, short-course |
| FBO | Faith-based organization |
| FDRE | Federal Democratic Republic of Ethiopia |
| FHAPCO | Federal HIV/AIDS Prevention and Control Office |
| FHI | Family Health International, Inc. |
| FPHIA | Family planning and health-integrated activity volunteers |
| GH Tech | Global Health Technical Assistance Project |
| GOE | Government of Ethiopia |
| HAPCO | HIV/AIDS Prevention and Control Office |
| HAPN | USAID's Health, AIDS, Population and Nutrition Office |
| HBC | Home-based care |
| HC | Woreda or district-level health center |
| HCSP | HIV/AIDS care and support program |
| HCW | Health care worker |
| HEW | Health extension worker |
| HMIS | Health management information system |
| IGA | Income-generating activity |
| IMAI | Integrated management of adolescent and adult illness |
| IP | Infection prevention |
| KOOW | Kebele-oriented outreach worker |
| LTFU | Lost to follow-up |

| | |
|---|---|
| M&E | Monitoring and evaluation |
| MOH | Ministry of Health |
| MSG | Mother's support group |
| MSH | Management Sciences for Health, Inc. |
| OI | Opportunistic infection |
| OP | Other prevention |
| OPD | Outpatient department |
| OVC | Orphans and vulnerable children |
| PAHA | People affected by HIV/AIDS |
| PBC | Performance-based contracting |
| PEP | Post-exposure prophylaxis |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PICT | Provider-initiated counseling and testing |
| PLWHA | People living with HIV/AIDS |
| PMP | Performance monitoring plan |
| PMTCT | Prevention of maternal-to-child transmission |
| PwP | Protection with positives |
| PY | Project year |
| RB | Regional bureau (Government of Ethiopia administrative structure) |
| RH/FP | Reproductive health and family planning |
| SAVUS | Save the Children USA |
| SCMS | Supply chain management system |
| TB/HIV | Integrated tuberculosis and HIV therapy |
| TO | Transferred out |
| TPM | Team planning meeting |
| TWG | Technical working group |
| USAID | U.S. Agency for International Development |
| VCT | Voluntary testing and counseling |
| WFP | World Food Program |

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## APPENDICES

# EXECUTIVE SUMMARY

In its fight against an HIV/AIDS epidemic, the Federal Democratic Republic of Ethiopia (FDRE) and its partners have created a multi-sectoral HIV strategy and a more limited 2005–2008/2010 road map to guide policy and program implementation. "Off-loading" of clients and "task-shifting" are key elements of the government's plan to make HIV/AIDS prevention, treatment, care, and support accessible to all by 2020. "Off-loading" means that provision of ART treatment services is increasingly decentralized from often overcrowded regional and zonal-level hospitals to district-level health centers (HCs). Clients who have been "transferred out" (TO) can then be monitored closer to their homes, significantly reducing their transaction costs. "Task-shifting" involves training and authorizing nurses and health officers at district-level HCs to enroll clients eligible for treatment and to treat them without a physician's supervision. Task-shifting takes place within the HC, so additional staff are not needed to implement the ART treatment program or the rest of the continuum of care. Both of these innovations are part of the health network model, which presumes referral and counter-referral to and from facilities at each level, and reaches from the region down to the community-level health post's HIV desk.

USAID/Ethiopia's HIV/AIDS Care and Support Program (HCSP) is implemented by a consortium led by Management Sciences for Health, Inc., (MSH) that includes IntraHealth International, Inc., and Save the Children USA (SAVUS) as its main technical assistance subcontractors. This follows a project implemented by Family Health International, Inc. In June 2007 USAID/Ethiopia awarded the MSH Consortium a three-year contract with two optional years. Like the predecessor project that closed in July 2007, HCSP emphasizes decentralization of ART treatment from hospitals to the district HC level. Unlike the earlier project, however, HCSP includes the entire continuum of HIV/AIDS prevention, treatment, care, and support. Thus it builds on and scales up prior treatment interventions at a base number of HCs in four regions and one city administration of Ethiopia, targeting a total of 300 HCs with the full continuum of care and integrated HIV/TB testing and treatment. While the evaluation team was in the field, 50 additional HC sites were selected to complete this scale-up. There are a further 250 HCs where ART treatment is *not* supported, but where prevention, care, and support are.

To "assess the achievements of the program goals and results with the ultimate objective of providing recommendations to USAID for further improvement and direction for the remaining base contract period and optional years," the Mission's HAPN Office and its HIV/AIDS Team commissioned the GH Tech Project to conduct an external mid-term evaluation of HCSP. The "core" team of three expatriates worked in Ethiopia during July and August 2009, at the end of HCSP's Project Year 2. They were joined by three representatives of the FDRE Ministry of Health; together, these six experts formed the "expanded" evaluation team. To cover a representative sampling of nearly 10% of all HCs supported by HCSP during two weeks of field visits, the six team members were divided into three sub-teams of one expatriate and one FDRE representative each. Each sub-team visited 8–11 HCs and at least one hospital. A team planning meeting (TPM) was held prior to the field work, and a synthesis meeting was held on return of the team to Addis Ababa, at which all team members shared their findings and reached a consensus on conclusions and recommendations.

The conclusion of the evaluation team is that HCSP is a successful project that is crucial in supporting the FDRE Government's policy and plans to combat the HIV/AIDS epidemic and to make ART treatment, prevention, care, and support more accessible to people living with HIV/AIDS (PLWHA), people affected by HIV/AIDS (PAHA), and other at-risk individuals. This conclusion is shared by both the FDRE officials who participated on the expanded team and those

interviewed at the Federal, regional, and district levels. The evaluation team found that, with few exceptions, each of the four project results is being achieved, as are the relevant targets and benchmarks. However, as noted in the team's scope of work, the contract targets for integrated tuberculosis and HIV therapy are unrealistic given constraints that have been recognized and documented since the original contract was written.[1] Furthermore, the ART treatment target for Project Year 3 is nearly twice as high as the number of persons, including pregnant women, who had tested positive in the project-supported HC catchment areas by the end of PY2, which indicates that this target should be lowered as well.

## CONCLUSIONS BY RESULT

### Result 1: Provision of quality integrated HIV/AIDS prevention, care, and treatment services at health centers

- Decentralization and task-shifting are bringing the continuum of prevention, care, treatment, and support closer to clients, who are, on the whole, taking advantage of this change.
- Prevalence rates, as demonstrated by records of those testing positive at HCSP-supported HCs, are sometimes insufficient to ensure that initiation and enrollment of clients on ART at these HCs is cost-efficient.
- VCT and PMTCT are meeting needs and targets, even though PMTCT has been emphasized more recently than other elements of the continuum of care as required under Contract Modification Five.
- HCSP's continuing mentorship program is effective in ensuring quality of care, treatment, and support, despite constant staff turnover at the district facility level as well as at the FDRE regional health bureau level.
- Catchment-area meetings that involve all partners working on HIV/AIDS in a particular region are becoming more common (HCSP often takes the lead in scheduling and preparing reports), which can improve communication and networking among these partners, including those funded by other members of the U.S. Government's PEPFAR Team.
- ART drug supply is largely adequate, while opportunistic infection (OI) drug, test kit, and reagent supply, which follows a separate distribution system, is often faulty. This is currently being addressed by the FDRE Ministry of Health (MOH).
- Transporting blood samples to hospitals where CD4 machines are located can be problematic, and getting results back is often a lengthy process. Patient loads at almost all individual HCs do not warrant procurement of CD4 machines. However, because machines currently used at hospitals are breaking down, it would be desirable to explore a networked model wherein HCs with the highest patient load have their own machines and serve the HCs nearest them.
- Pediatric HIV/AIDS care is mostly non-existent because HC providers typically lack experience in testing newborns for HIV, which means that few infants are tested, while those providers who are trained in the use of DBS kits often leave the HCs. Linking HIV and TB testing of infants to the Expanded Program on Immunisation (EPI) at HCs might increase use of existing skills among HC staff.

[1] A TB team visited Ethiopia toward the end of the evaluation team's time in the field. There was no opportunity for the two teams to meet, but the evaluation team anticipates that the TB team will contribute to resolution of the target issue.

### Result 2: Deployment of case managers to support care and strengthen referrals between health centers, hospitals, and community services

- Personalized care and support are enhanced by the facility-community linkage model, which uses case managers (CMs) who are located at the treatment facility, but who move with community mobilizers and community-based outreach workers to follow up with clients either on treatment or receiving home-based care (HBC) and other support.
- This model is implemented differently by region and district, depending on the capacity of the district health office and other district-level administrative structures, as well as the presence of community-based organizations (CBOs) and associations.
- Where this model is most successful, CMs support clients as well as provide outreach, often going into the community rather than remaining at the facility, which reinforces the family-focused approach.
- In some cases CMs are prevented by transportation and communication problems from accompanying sick clients to hospitals on referral, and from following up with them once they are there.
- The two-way referral system is being incorrectly implemented, in part because PEPFAR reporting incentives militate against recording the number of clients off-loaded from the hospital to the HC.
- A key area for rethinking HCSP's role is the provision of nutritional support for OVC, other PAHA, PLWHA on ART treatment, and PLWHA receiving palliative care.
- CDC and other international partners are reportedly providing nutritional support and cash incentives for clients who come to the hospitals where these partners are working. This, too, militates against permanent off-loading of transfer-out clients from the hospital to the HC.

### Result 3: Deployment of volunteer outreach workers to support family-focused prevention, care, and treatment in communities

- Kebele-oriented outreach workers (KOOWs) have been trained and are active at most HCSP-supported HCs. These volunteers are extremely devoted, active, and often innovative in providing care and support, as well as in tracing clients lost to follow-up (LTFU). With little or no revenue, and a nominal transportation stipend, KOOWs accomplish the many tasks for which they are trained, including community mobilization; counseling for VCT; mobilization for ANC and PMTCT; promoting family planning and exclusive breast feeding; performing asset mapping; teaching family-focused prevention, care, and support; HBC; and working with community-based organizations (CBOs). The KOOWs also provide material support to the neediest community members using their transportation stipends and money from their—often limited— personal incomes. Many KOOWs are PLWHA, and like members of mother's support groups (MSGs), they seek to create income-generating opportunities for themselves and those they support, including OVC.
- Support to assist KOOWs in registering as CBOs in order to raise funds to initiate income-generating activities for themselves and their community-based clients would be cost-effective and help sustain the KOOWs after HCSP ends.
- Formation of such CBOs would further link the NGO capacity-building theme with the outreach component, strengthening both. This should be done in a gender-sensitive way that avoids labeling that would lead to stigma and discrimination.

- HCSP should explore different ways to use KOOWs and community mobilizers, which should include training and deploying KOOWs in several rural kebeles adjacent to urban kebeles where KOOWs are already present and active—a recommendation made during many field visits.
- KOOWs should visit their counterparts in other regions in order to observe and share best practices, which could then be written up and disseminated through the "success story" publications and fact sheets produced by HCSP.
- The facility-community linkage model is among the most successful elements of HCSP, and is recognized as such by clients, HC facility-based staff, district-level health office staff, and outreach workers themselves.
- The project-supported CMs and CMobs who move from facility to community on an as-needed basis are regarded by the clients, CBOs, and community and district officials with whom they work as valuable in communicating the needs of clients and prospective clients to facility-based staff and local decisionmakers, and in community mobilization.
- KOOWs and other community-based volunteers are considered responsible for the low rates of clients "lost to follow-up" from ART treatment at HCSP-supported HCs, compared to such rates at non-HCSP-supported HCs. These volunteers are the main source of palliative care and support in HC catchment areas.

### Result 4: Implementation of HIV prevention activities using best practice "abstinence, be faithful, and condom" (ABC) interventions that incorporate stigma, discrimination, and gender concerns

- Prevention has been one of the two least well-staffed HCSP teams (along with Gender and NGO Capacity-Building), although this is about to change. Under the recently approved staffing pattern revisions, HCSP will now have staff at the regional level, with shared responsibility for prevention, outreach, care, and support.
- Timely preparation and distribution of prevention materials and job aids may be constrained by contractual and non-contractual factors. Prevention messages produced by HCSP must be based on those already existing. Content must be approved by USAID in English prior to printing, after which the local-language version must be approved for use in the region in question. Only then can the material/job aid be produced.
- Training for use of prevention materials is done by other HCSP staff—usually care and support staff—and the Prevention Team has had little opportunity yet to follow up directly at the field level, to observe how materials are being used, and to consider what additional materials may be required.

## IMPLEMENTATION OF THE HCSP CROSSCUTTING THEMES

Gender sensitivity is not evident in the field at the HC level. Gender issues in Ethiopia are complex, and gender-based violence is a topic that has recently been addressed by a variety of NGOs. Where there is evidence of gender sensitivity, it is equated with awareness of "women's issues." The Gender and NGO Capacity-Building Team has been short-staffed, which has probably contributed to the apparent lack of gender awareness/sensitivity in the field at HCSP-supported sites.

- HCSP has revisited the staffing issue and is advertising for an additional Gender Coordinator. HCSP should also revisit the meaning of engendering all aspects and components of the

program at all levels, by considering the roles of men, particularly mobile men with disposable income, and the power relationships between men and women. While women—with their children—constitute the majority of HC clients, mobile men constitute a reservoir for HIV and are often reluctant to come to HCs or other facilities for testing, enrollment, or treatment. This is also true for mobile women, but both groups are among those most at risk.

- NGO capacity-building has had a delayed start for a number of reasons, but it is now catching up. Local and regional associations are being mobilized by HCSP, and linkages are being made between income-generating activities (IGAs) and potential associations of KOOWs and MSGs.

## EMERGING AREAS OF IMPLEMENTATION CONCERN AND OUTSTANDING ISSUES

On the whole, the evaluation team concluded that what had been seen as emerging areas of implementation concern have already been, or are being, addressed by HCSP management and staff. However, there remain several outstanding issues that require new or further attention from USAID/HAPN and its FDRE MOH counterparts, HCSP management and staff, and "One-MSH/Ethiopia" management, as detailed below.

- HCSP's contract requires the project to link itself with existing programs and partners providing nutritional support and/or humanitarian assistance within the HC catchment areas. This is one of the jobs of CMs and KOOWs. However, in almost all areas visited, neither the World Food Program (WFP) nor any other significant NGO/faith-based organization (FBO) is present and providing such support. This is true despite the efforts of the FDRE's Agency for Disaster Prevention and Preparedness, various U.N. agencies supporting emergency relief, and the persisting problems of localized drought, malnutrition, and undernutrition in Ethiopia.

- Similarly, HCSP is supposed to link with existing programs that provide support to OVC. Again, such programs are conspicuously absent in the HCSP-supported HC catchment areas. The evaluation team could find no linkage between Save the Children USA's subcontract staff under HCSP and their staff under the USAID-supported flagship OVC project.

- Donor and government interviewees repeatedly expressed hope that the USAID-funded Food by Prescription Project would soon be able to help deal with the growing problem of malnutrition and undernutrition of PLWHA, PAHA, and OVC. However, Food by Prescription is a focused and targeted program that cannot solve this wide-ranging problem.

Based on these conclusions and outstanding issues, the evaluation team makes the following recommendations for each responsible party:

### USAID/U.S. Government's PEPFAR Team, together with FDRE counterparts, should:

- Increase interagency coordination regarding agency and partner salary scales, partners who "buy away" staff from other partners, program content, and client incentives, including hospital "off-loading" targets and transfer-outs to HCs. Such coordination should include cross-monitoring and evaluation of all partners, or assessing their specific collaboration, and could perhaps be done by the PEPFAR Coordinator at post.

- Focus on the problem of malnutrition and undernutrition of ART patients and those receiving care and support, via a family-based approach.

- Clarify and revise OVC support programs and Food by Prescription to ensure coverage where HCSP is working.
- Continue participating in technical working groups (TWGs) and other forums with FDRE Government and other donor/partner actors in order to harmonize programs and activities at the Federal, regional, and district levels.
- Review district-level ART treatment accessibility targets (and plans to upgrade HCs to primary hospitals) in terms of present and projected HIV/AIDS incidence and prevalence levels.
- Review current HC staffing targets with donors and other partners in terms of business process re-engineering (BPR), turnover, and pre-training and in-service training strategies.
- Continue to design and pilot the HMIS while observing and including partners' best practices in monitoring. This should include palliative care.
- Expand the number of KOOWs, placing some in rural kebeles adjacent to urban ones.
- Increase the number of kebeles with outreach workers.

### HCSP management and staff should:

- Clarify and harmonize the roles and responsibilities of each member of MSH/IntraHealth/Save the Children Consortium at the institutional, implementation, and M&E levels.
- When staff are dispersed to sub-regions, address disparities among Prevention, Gender, and NGO Capacity-Building and other teams' staffs in order better to achieve targets/results.
- Improve staff salaries and working conditions within the context of Contract Modifications Five and Six to increase staff retention for all consortium members.
- Rethink "integration" as the best way to incorporate gender sensitivity, family focus, and other "crosscutting" themes. This approach is excellent in an ideal situation, but given the reality of hierarchical structures in Ethiopia, it is very difficult to apply.
- Consider whether clinical mentors' should relinquish their monitoring/training responsibilities for non-clinical activities, given the decentralization and addition of HCSP staff.
- Develop internal guidance on communications to and from USAID and other partners in order to decrease the perceived management burden on USAID staff and harmonize messages delivered from HCSP.
- Revise SAVUS's subcontract to reduce the frequency of reporting so that CMs, community mobilizers, and KOOWs will not be reporting more frequently than professional cadres.
- Explore methods of providing access to computers and appropriate software for HCSP-supported data clerks and CMs for reporting and data analysis.
- Consider increasing the transportation stipend for KOOWs.
- Consider the cost-effectiveness of providing KOOWs with mobile phone cards so they can communicate readily with each other and with CMobs and CMs, instead of visiting the HC unnecessarily.

### "One MSH/Ethiopia"

Because substantial effort and resources are being devoted to establishing a single management platform for all five MSH projects in Ethiopia, MSH should:

- Consider the implications of this policy for HCSP subcontractors.
- Review the varying effects of this policy on HCSP implementation (as HCSP is the only contract among five projects).
- Where possible, transfer authority and responsibility from MSH/Cambridge to MSH/Ethiopia.

# I. CONTEXT AND METHODOLOGY

## CONTEXT

The objective of the HIV/AIDS Care and Support Program (HCSP) is to decrease HIV prevalence, and to improve the quality of life of people living with the HIV virus by strengthening the continuum of care, treatment, and support, including antiretroviral therapy (ART). The program aims to achieve this by providing services both at district health centers (HCs), and at the community and family levels, through a series of innovative facility-community linkages and home-based palliative care (HBC).

In June 2007 USAID/Ethiopia contracted with Management Sciences for Health, Inc., (MSH) to implement this three-year project. This contract has two optional years, which would end in FY 2012, and a total ceiling amount of $46 million. The contract requires MSH to overlap with and take over activities and commodities from Family Health International, Inc., (FHI) which had initiated ART treatment in a number of district-level (woreda) HCs in selected regions of Ethiopia under a predecessor project. Both projects were designed to support the FDRE's "off-loading" of clients from hospitals to HCs for ART delivery, HIV/AIDS prevention, chronic care, and support under the broader decentralization policy implemented from CY 2003 on. The HCSP project and contract also support the government's policy of "task-shifting" from hospital-based staff to HC-based staff, and among HC-based staff—a key element of the government's public health strategy, and specifically its HIV/AIDS care and treatment strategy. Physicians are not present at HCs; rather, treatment is initiated and provided by nurses and health officers.

HCSP is the Mission's largest project in terms of dollar amount and geographical coverage in the PEPFAR portfolio. It is regarded as a flagship program and is highly visible to the FDRE Government as a source of support for its multi-sectoral HIV/AIDS strategy and program.

MSH had initiated and scaled up decentralized ART treatment delivery to 300 HCs by the end of Project Year 2, and during the mid-term evaluation period was selecting another 50 for scale-up of ART treatment by the end of Project Year 3.[2] This would achieve the overall project objective of initiating or enhancing the more extensive continuum of HIV/AIDS prevention, chronic care, counseling, testing, and palliative care and support at the community level at 550 HCs. This emphasis on supporting the entire HIV/AIDS continuum of care makes MSH/HCSP considerably different from the earlier FHI program. Furthermore, the addition of task-shifting to the existing decentralized HIV/AIDS approach of the FDRE Government, and the requirement to scale up to cover a total of 550 HC sites over the three-year base period, including integrated HIV/TB care and support, make current HCSP activities both more intensive and extensive than those carried out under the earlier project.

[2] As will be seen in the Conclusions and Next Steps sections, the evaluation team suggests that operations research be designed and carried out to see whether, in fact, the prevalence rate justifies provision of ART treatment at another 50 district-level sites. Current FDRE plans are to turn some existing HCs into primary hospitals, and some existing health posts into HCs. However, analysis is required in order to determine if the anticipated patient loads for HIV treatment are accurate.

## EVALUATION SCOPE OF WORK (SOW), FIELD VISIT SAMPLE, AND METHODOLOGY

**Scope of Work:** USAID/Ethiopia's Health, AIDS, Population and Nutrition Office (HAPN) and its HIV/AIDS Team commissioned an external, mid-term evaluation of HCSP "to assess the achievements of the program goals and results with the ultimate objective of providing recommendations to USAID for further improvement and direction for the remaining base contract period and optional years" (see Appendix A).

The final SOW raises six areas of emerging implementation concern, and then examines program management, accomplishments, and results, posing several "key evaluation questions" regarding M&E and reporting and success in reaching various targets, including success in outreach and implementing various crosscutting themes. The SOW also solicits recommendations on whether HCSP should be extended to one or both optional years, and if so, what activities the team suggests for that period.

In its debriefing sessions with USAID/Ethiopia Mission staff, the evaluation team mentioned several broader contextual issues that arose in answering these questions and in discussing the results and targets achieved by HCSP to date. In turn, some USAID/Ethiopia staff raised points that are outside the SOW, but that would have been interesting to pursue had the team had more time and access to more data. This report follows an outline based on the final SOW.

**Field Visit Sample:** USAID selected a sample of sites for field visits. In all, 29 HCs were visited by the three teams. This was described at the in-briefing as a "purposive" sample.[3] All sample sites were originally from the group of those that had received support from the predecessor FHI project in ART treatment, infrastructure, and the like. At the request of the head of the Oromia Regional HIV/AIDS Prevention and Control Office (HAPCO), four of these sites in Oromia were changed in order to include other nearby sites that had been supported for ART and the continuum of care and support by HCSP only. At the evaluation team's request, CDC agreed to allow visits to several hospitals so that the two-way referral system for individuals undergoing HIV treatment could be assessed. The team visited a total of four hospitals—two zonal-level ones in SNNPR and Oromia Regions, and two regional reference hospitals, one in Addis Ababa, and one in Oromia.

**Methodology:** The external evaluation core team members—a monitoring and evaluation (M&E) and behavior change communication (BCC) specialist, a care and treatment specialist, and a palliative care and support specialist—met and conducted a three-day team planning meeting (TPM) in Addis Ababa at the beginning of the assignment. Together they developed a set of common key informant and focus group discussion guides, covering each type of service provider as well as outreach workers, HC administrative/financial staff, and all the newly deployed staff supported by HCSP (see Appendix C). To ensure comparability of data, the main interview guides were translated into Amharic. USAID decided that the core and expanded evaluation teams would be divided into three sub-teams. Each sub-team traveled separately up and down the country, visiting an average of 10 HCs in at least three regions each (see Appendix D).

[3] Additional sites had initially been selected in order to cover 10% of the HCSP HIV treatment-supported sites in four regions and one city administration.

HCSP HQ staff traveled with each sub-team, and each sub-team met region-based HCSP staff in the field, who were of great assistance in checking interpreters' translations, providing supplementary information, and photographing the various wall charts showing what each HC had accomplished in key project and other areas. This was especially true for visits by Teams 2 and 3. Team 1, while also accompanied to the field by HCSP staff, was composed of two Ethiopians, so interpretation was not required and observations were unassisted.

All sub-teams met with regional health bureaus, woreda health office officials, HC directors and clinical staff, community counselors, lab techs, pharmacy techs, data clerks, community core groups, case managers, community mobilizers, KOOWs, and mother's support group members. In Wolkite (SNNPR Region) Team 3 also met a recently arrived Peace Corps volunteer who had been working with the mother's support groups, the case manager, and the KOOWs.

# II. FINDINGS

## EVALUATION SCOPE AND QUESTIONS

### Program Management

- Under HCSP, MSH, IntraHealth, and Save the Children USA collaborate to support HQ and field personnel. The combined MSH/Ethiopia management platform for all projects works to support each equally, yet interdisciplinary communications appear to be somewhat difficult, although joint staff meetings are held at the regional office level.
- Hiring and retaining staff at HQ and regional office levels—especially mentors, but also fixed staff—remains a challenge, although steps have been taken now that Contract Modifications Five and Six have made them possible.
- Modifications Five and Six have not mitigated what was described as the "training machine" phenomenon—HC staff, particularly mentors, often go through a "revolving door" shortly after training.
- Recent salary and contractual regulations and revisions (Modifications Five and Six) may help recruitment and retention.
- Incoming vehicles, computers, and communications equipment for HCSP/MSH regional offices and supported HCs may encourage retention as well as efficiency and cost-effectiveness, depending on how these materials are distributed and maintained.

### Program Accomplishments and Results

In all 29 HCs visited, HCSP is supporting comprehensive HIV/AIDS prevention, care, and treatment services as per the stated objectives of the program. This has contributed significantly to achieving the stated goals of the Addis Ababa City Administration and Oromia regional plans with regard to HIV/AIDS prevention, care, and treatment, and to those of Amhara, Tigray, and SNNPR. This finding was confirmed through discussions by the entire mid-term evaluation team with FDRE Government Federal MOH, regional bureau, and woreda health and administrative officials. In all regions visited, the HCSP annual plans are harmonized with the regional bureau/regional HAPCO annual plans, and the frequency of catchment-area meetings has increased overall, often with HCSP in the lead.

Result 1: Provision of comprehensive, quality integrated HIV/AIDS prevention, care, and treatment services at health centers

#### Voluntary Counseling and Testing

All HCSP-participating health centers in Addis Ababa, Amhara, Tigray, Oromia, and SNNPR provide counseling and testing services, and the overall rate of C&T through VCT and PICT has increased. Counseling is primarily done by trained community counselors, and in some cases is supported by trained nurses. An encouraging practice observed by the evaluation team is that provider-initiated testing is now conducted in almost all of the HCs visited. The test is administered by health workers, and providers have been trained in PICT. Although the rate of testing has increased since the introduction of PICT to all health centers providing ART, some clients may not have been tested because of the unavailability of trained staff and shortages of equipment, such as capillary tubes. For example, it was explained during the field visit to Bole health center that a gap exists in PICT training for Bole's outpatient department (OPD) staff. Since the health center has no OPD personnel trained in PICT, currently testing is being done by

the laboratory staff. VCT has generally gained widespread acceptance in the communities visited. Pre-marriage testing is common. Challenges include timely provision and distribution of test kits, and adequate staffing at facilities seeing over 20 VCT clients per day.

Persons testing HIV positive at an HC are generally referred to their local HC for staging and treatment, if required. If ill with advanced disease, individuals are referred to hospitals, with Level 1 services being provided at 500 HCSP-supported service outlets.

The FDRE Government estimated that there were a total of 1,037,267 HIV positive persons nationwide as of June 30, 2009. The target number of public health facilities performing VCT by 2008–2009 is 572 (Multi-Sectoral Plan 2007–2010). The national Ethiopian target of 5,650,216 persons tested (2008–2009) with 820 total public and private facilities would require 28.7 tests per facility per day, both public and private. This level of activity would require additional community counselor recruitment, hiring, training, and space allocation. The 500 HCSP-supported sites currently average 3.1 tests per day as of the second quarter of PY2.

### Integrated TB/HIV Screening and Testing

The *HCSP Project Year 2 Report* indicates that all 500 HCs are providing HIV and TB counseling and testing, with 300 providing TB treatment. However, sites treating TB/HIV co-infections average 32 clients per year, or only a few per month. The project's *2009 Semi-Annual Report* highlights some of the issues that HCSP is addressing:

> *TB/HIV training as part of the training of health care workers in comprehensive HIV care, treatment, and prevention; supportive supervision and mentoring of TB/HIV collaborative activities in the supported health centers; assistance to woredas and the health centers' proper recording and reporting system; and standardizing training materials in TB/HIV implementation guidelines and treatment manuals. HCSP is working in collaboration with RHBs to strengthen health centers to improve detection of HIV in TB patients at health centers level, through training of TB care providers in Provider-Initiated Testing and Counseling (PITC), strengthening of internal referral systems between TB, CT and HIV treatment services, mentoring and supportive supervision of collaborative activities. Strengthening of laboratory capacity for early detection of TB is an ongoing process as a package of the over all laboratory capacities and system strengthening. During the current reporting period 280 laboratory professionals were trained on comprehensive laboratory services, including TB microscopy. Community level referral system of suspected patients for having TB and adherence support for TB treatment at community level are well underway through Kebele Oriented Outreach Workers (KOOWs) and so far a good number of defaulters of DOTS have been traced and referred back to HCs. HCSP is providing necessary technical assistance for HCs staff on TB/HIV collaborative activities through regular clinical mentorship program. To further strengthen the mentorship program a ten days long comprehensive refresher training was given for clinical mentors (SAPR09).*

### Palliative Care

Most daily services at the HCs and at the community level include provision of palliative care to clients not requiring ARV. For PY2, 220,000 clients were targeted to receive palliative care, although out of 371,400 tested, only 7,800 (2.1%) would be expected to be HIV positive. This includes CD4 monitoring, OI prevention, TB screening and treatment, and other non-ARV-based support activities. Rapid staff turnover is the most likely challenge. In terms of performance monitoring plan (PMP) reporting, according to the HCSP M&E team leader, most clients receiving palliative care are not HIV positive (palliative care by the project's definition includes both PLWHA and PAHA).

## ARV Treatment Services

The 300 HCSP-supported HC sites that are providing ART treatment services (with 286 reporting) administered ART to 45,612 clients by the end of PY2. This is already 91% of the target of 50,000 for the end of PY3. Overall, major HC challenges are understaffing and overcrowding. Some regional health bureaus requested additional ARV sites in light of the numbers above. There were also uniform requests for additional staff and additional training and mentoring (see Appendix J, Tables 2 and 6).

Of ART clients nationwide, 98.7% are on first-line therapy, with only 1.3% on second-line therapy. Health center sites account for 30% of the patients on ARV nationally; however, HCs only account for 22% of those who have started ARV. This suggests that there has been an influx of HIV positive cases into HCs, and that decentralization of HIV care and treatment from hospitals to HCs is working. The national target is 10%. The above figure represents 8% of patients transferred in from hospitals to HCs. Nine national HC sites (none HCSP-supported) reported more patients on ARV than had ever enrolled. HC sites stated that there was patient overload in both HIV and non-HIV patient services. Some stated that they were seeing over 200 patients per day (75–100 for HIV services) (see Appendix J, Table 2).

Contrary to recommendations in the *Guidelines for Implementation of the Antiretroviral Therapy Programme in Ethiopia*, most facilities visited reported that they continue to have ARV clients visit monthly, even when stable, rather than bimonthly. This may account for significantly worse congestion at HCs where the patient load is high. The most populated site (in Addis Ababa), which has 1,733 patients on ART, would only require 43 visits per day by active patients if the *Guidelines* were followed. Ten ARV sites reported zero patients on treatment (see Appendix J, Graph 1).

Staff turnover at the HCs with ARV programs was uniformly described by local management and staff as a significant challenge. Apparently, after new staff are trained in HIV treatment, they move on to better-paying or better-located jobs.

To build the human capacity that is key to attaining quality comprehensive HIV/AIDS prevention, care, and treatment at health centers, HCSP—in collaboration with other partners—has been training medical doctors, health officers, nurses, and pharmacy and laboratory personnel. Training has also been provided to health care providers in PICT, TB/HIV, and PMTCT. Such training is critical to realizing the goal of task-shifting from overcrowded and understaffed hospitals with few medical doctors, to health centers with higher numbers of mid-level health personnel such as health officers and nurses, and to initiating ART services at some of these centers. HCSP-led training continues to be important in filling the human resource gaps that arise from the high attrition of health workers and ensuring that HCs continue to provide HIV/AIDS care and support services.

Even though training has been provided in all disciplines, high staff attrition (for personal reasons) and reshuffling of health workers (due to the current government-led BPR program) have reduced the number of available trained health workers in the HCSP-supported HCs. On the other hand, the apparently high proportion of newly assigned health workers to the various HCs has increased the demand for training. For example, during a visit to a health center in Addis Ababa, staff stated that out of the currently available five health care workers trained in providing ART, two had already been transferred to a sub-city health office in Kolfe-Keranio. As a result, it seems unlikely that the training needs of HCs will be satisfied any time soon. This is in addition to the need for refresher courses mentioned by most health workers interviewed, although the perceived need for refresher training may be linked to low levels of clients for ARV treatment at some HCs (similar to the lack of clients for pediatric HIV treatment). Staff and HCSP informants often say this leads to a lack of confidence, as well as to forgetting what has been learned.

### Mentoring Program

Clinical mentoring is one of the innovative aspects of HCSP, adopted from earlier WHO and integrated management of adolescent and adult illness (IMAI)-funded activities. WHO initially trained physicians as clinical mentors who could move from one HC to another, sharing expertise based on experience and higher-level pre-service training with health workers at the HCs, especially those newly trained in ART treatment. Some other partners have also trained clinical mentors, but this has been viewed by some as unsustainable. Oromia Region asked WHO to train some of its own staff as mentors, who were then funded and deployed by the regional bureau itself. This model is now to be followed by Amhara Region and Tigray. Some hospitals have provided staff on a part-time basis to mentor staff at HCs. Because of the extremely high rate of turnover, HCSP has trained, deployed, and managed more clinical mentors than are now at post. As a result, at least one mentor interviewed in Tigray was supposed to cover as many as 14 HCs on a rotation, staying two days at each.

During field visits and discussions with mentors and mentees, it became apparent that the HCSP mentors' position descriptions cover mentorship of *all* HCSP-supported activities at the HC level and beyond, through the facility-community outreach program. Comments on the mentoring program were uniformly positive, and HC staff generally requested increased mentoring time. The availability of mentors has contributed to the successful decentralization of quality ART treatment services to HCs. However, questions of selection, remuneration, and sustainability remain, and some observers say that a clearer distinction must be made between clinical mentoring and supportive supervision. When the evaluation team met with WHO/Ethiopia, several alternative models were proposed, one of which would recruit private-sector physicians on a part-time basis, rather than attempting to recruit full-time mentors to the public sector who will almost certainly move on quickly. Whichever approach succeeds, the overall objective is to make the mentorship program nationally owned and sustainable.

### ARV Drugs/OI Drugs

Sites generally reported their supply of ARV drugs to be sufficient. When shortfalls arise, mentors go to neighboring HCs and bring the drugs to where they are needed; these are later replaced. Many stated that stock-outs of OI drugs and lab reagents are a challenge. Some questioned the appropriateness of reagents recently received. Some OI drugs were routinely out of stock, e.g., cotrim, isoniazid, and anti-fungals.

Due to every-other-day electrical outages, cold chain maintenance was unrealistic for drugs requiring refrigeration, although they are transferred to cold chests on the evening before the day when there is to be no power. Most sites had two pharmacies, one ARV, and one general—a result of the existing Federal-level guidelines. Drugs for HIV therapy are stocked and dispensed separately from other drugs "so that the pharmacist/dispenser can provide confidential counseling on how the drugs are to be taken before giving them to the client."

### ARV Laboratory Services

Most HC sites have two laboratories—one for ARV services in the HIV clinic and one for all other HC lab services, including TB & STIs. Labs often had multiple laboratory personnel to accommodate this arrangement, but occasionally a single lab tech would staff both laboratories. ARV laboratories were primarily used for phlebotomy for CD4 tests, hematology, and chemistry specimens, which were then packaged for transport to a higher-level laboratory for performance. The ARV laboratories might thus more accurately be called "blood-drawing stations."

Many sites reported challenges in transporting CD4, hematology, and chemistry specimens to hospitals for analysis, e.g., methods of transportation, costs, long turnaround, etc. Most labs requested onsite CD4 testing, as well as hematology and chemistry, but were unaware of the infrastructure, training, and maintenance requirements of this machinery. The testing volume of a

few sites visited requires CD4 automation, but the problems mentioned first must be solved. Problems observed and reported at HCs in Amhara, Tigray, and SNNPR include the following:

- Shortage of infection prevention materials such as gloves (Shewarobit, Mersa)
- Shortage of slides, which are therefore used repeatedly (Shewarobit)
- Damaged and non-functional hematocrit machine (Shewarobit)
- Lack of CD4 machines (Shewarobit, Bati, Dessie, Mohoni, Korem, Almata, Haik, Freweni)
- Damaged water sink (Shewarobit, Dessie, Korem)
- Shortage of rooms for different services (Shewarobit, Dessie)
- Difficulty in controlling quality of HIV counseling and testing in VCT room, and PICT in all departments, because all staff use the rapid test (Bati)
- Shortage of laboratory agents (Mersa, Dessie, Korem)
- Although a CD4 machine is available, it is not being used because there is no one to train lab technicians and provide reagents (Mersa)[4]
- Shortage of office furniture (Mersa)
- Shortage of trained staff (Dessie)
- Lack of hematology machine (Dessie, Korem)
- Service interruptions caused by electric power interruption, which means that clients must be rescheduled and often cannot return for a new appointment (all health centers except Bati)
- Lack of generator (all health centers except Bati)

Laboratories have internal and external quality control mechanisms. Internally they perform according to the procedures in which technicians have been trained, and the labs check results by taking samples of negative and positive results. Other methods include using refrigerators and checking for reagents with expired dates. External quality control is usually conducted by regional laboratory departments for all HCs.

### PMTCT

By the end of PY2, as a Contract Modification Five-initiated subset of Contract Deliverable 11 (Number of pregnant women [of] ANC clients receiving HIV tests at the service outlets including the Labor and Delivery ward and community outreach (subset of individuals counseled and tested)), HCSP had achieved a total of 183,291 women tested (73% of the end of PY3 target of 250,000). Of this number, 5,863 (3.2%) tested positive. PMTCT services have been initiated at most of the sites visited. Training is up to date, and practice is generally in accordance with the Guidelines. Pregnant women usually receive a two-drug ARV regimen after 28 weeks, occasionally single-dose nevirapine or a full three-drug ARV "cocktail."

HCSP has improved PMTCT services (see Appendix J, Table 1, which was reproduced from the *HCSP Project Year 2 Third Quarter M&E Report* and shows PMTCT target achievement). All

[4] Where there is no CD4 machine at the HC, samples must be transferred to the hospital. For instance, at Mychew hospital there is a quota for the HC of samples in two weeks. At both Korem and Mohoni, there is a quota of 15 samples per week; if the number of samples exceeds 15, excess samples will be poured out or rejected.

ANC clients and mothers with unknown HIV status who go to a facility for delivery have a chance to be counseled and tested. Those who test HIV positive are linked to chronic care, and this has resulted in fewer missed opportunities in health centers.

However, there is no opportunity for mothers who deliver at private health facilities, or for the majority who deliver at home, to benefit from PMTCT services. This concern was echoed by the head of the Addis Ababa HAPCO during the evaluation team's visit. HCSP should use its community and household-level initiatives to provide comprehensive care and support services to these women. This would be a good first step toward providing PMTCT and ANC services to women who deliver at home and who may not choose to come to the ANC service even one time, let alone the four times recommended before delivery. Putting in place a scaled-up system of this kind would also allow staff to provide expectant mothers with prophylaxis for themselves during delivery, and for their newborns.

Part of the new HCSP strategy will involve training 80 health extension workers (HEWs) who will target mothers and children for counseling and testing and home-based mobilization for behavior change. HEWs are precluded by FDRE regulations from drawing blood, so they will not be able to conduct home-based testing. Nonetheless, this pilot may serve as a precursor to an eventual operations research activity that could determine whether home-based testing would work in the Ethiopian context.

### Pediatric HIV/AIDS Care

Most HC sites are not providing ARV treatment to infants or children because of low demand and providers' lack of experience or confidence. As of PY2 Q2, 236 infants and children were receiving ART through HCSP-supported HCs. Recent oral communication reveals that this is now about 1,000 (out of 300 HCs). Even at a large HC in SNNPR with a pediatrician as medical director, it was admitted that HIV positive infants and children are referred to local or zonal hospitals due to low experience with pediatric ARV. Many HCs had a total of 0–20 pediatric HIV patients registered. As of the end of PY2, for a Contract Modification Five-initiated subset of Contract Deliverable 12 (*Number of HIV positive infants and children receiving ART (Subset of clients on ART))*, HCSP had achieved a total of 950 (33% of the PY3-end target of 2,880).

At most sites visited, staff stated that they have no access to DBS kits for infants/children although they had been trained in the methodology. Also, the supply of pediatric OI and ARV drugs is reported as irregular.

### STI Prevention and Treatment

Although STI prevention and treatment is officially part of the HC plan at all participating sites, few sites had adequately trained staff, formal prevention programs, or proper reporting. STI drugs were often unavailable. This may change when OI drug forecasting and provision are linked to the system now in place for ART drugs within the MOH. Under the current HCSP contract, training of health workers in STI treatment is not a contractual target included in any deliverable, nor does it appear in the approved budget. Apparently, no PEPFAR partners are conducting such training, and STI is not part of PEPFAR's current reporting in Ethiopia. Complicating this is the fact that no separate STI clinic in the HCs currently exists; STI patients are treated at the OPD. However, HCSP staff are participating in the STI technical working group, in which WHO takes an active role and which addresses the challenges of STI prevention and treatment.

## Result 2: Deployment of case managers to personalize care and strengthen referrals between health centers, hospitals, and community services

### Personalizing Care

The model for case managers (CMs) who have been deployed at 300 HCSP-supported HCs and provide ART treatment or drug supply to enrolled patients is as follows: The CM (in some

instances more than one, depending on the number of patients at the facility and community levels) is to be the critical link between the facility and HIV positive persons in the communities in the catchment area. S/he is charged with providing psychosocial support and follow-up to those who have tested positive for HIV, whether they are in the pre-enrollment stage, enrolled in ARV therapy, or receiving palliative home-based or community-based care and support.

As the Gender Team Leader at HCSP HQ put it, this is the person who is there to provide support to the women clients who receive the majority of all services, to hear their views, complaints, and concerns about the way they are treated at the HC, as well as about related issues such as the situation of family members (nutritional status especially, as it may affect adherence), gender-based violence, emergency deliveries, and the like. The CMs are also responsible for strengthening referrals both within the facility and from the facility to the community (through outreach workers) or from the facility to a higher-level one, such as the zonal hospital.

CMs are selected on the basis of several criteria, one of which is that they must have at least a tenth-grade education. A number of CMs are HIV positive and have disclosed their status. By their own accounts and those of their clients, this helps these CMs to understand the concerns and problems of others living with the virus (particularly those who are of the same sex as the CM). Reciprocally, their PLWHA clients and PAHA neighbors or relatives are more likely to confide in the CM than in the clinical staff at the HC, which means that it is usually the CM who can convince them to come for testing or treatment to begin with, and to return after an initial visit. CMs who are not seropositive, or who are but who do not disclose their serostatus, may not be perceived by clients as particularly sympathetic or sensitive to their concerns or problems; even among CMs encountered during the field visits, there appeared to be considerable variation in terms of application of the model and of the ability of individual CMs to gain and maintain clients' confidence.

Some of the most effective and dynamic CMs encountered were those who do not just stay at the HC and wait for clients to come to them, or even those who send community mobilizers and KOOWs out with lists of clients lost to follow-up (LTFU). Rather, these CMs frequently go out into the community to encourage persons bringing relatives to be tested themselves or to bring their partners for counseling; to identify OVC and other PAHA; to organize charitable feeding of PLWHA and PAHA by local hotels and other merchants; and to seek contributions of used clothing and other material support for these needy social groups.

The behavior and success of CMs varies with locality, region, training, aptitude, and length of service. Those who have been written up as "success stories" in HCSP bulletins and fact sheets tend to be those who are obviously caring, dynamic, and willing to expend time and resources beyond the minimum required by attending the HC during operating hours. It is these CMs who have found a way to integrate themselves, the CMobs, and the KOOWs into the regular life of the HC.

One of the successes of CMs and the other individuals involved in forging the facility-community link is perceived to be their ability to trace clients who have been LTFU. This label is given to both those who are "pre-enrolled" and who have failed to keep one or more of the three appointments required before they can be enrolled in treatment, and to those already on treatment who do not return for their monthly follow-up visits. Many factors in the system lead to perceived or actual lack of adherence. Some of these have been discussed above, under the various subheadings under Result 1. In general, the transaction costs to many clients remain quite high if they attempt to follow the various pre-enrollment and post-enrollment rules of the system. This is true despite the fact that HCs providing treatment are located closer to the clients than are the hospitals where clients previously had to go.

Off-loading has worked, as noted above. However, all informants note that there is slippage—under the law, clients can go to the hospital at any time and cannot be turned away, even if already enrolled in treatment at a HC or a private facility or with a private practitioner. Some hospitals, including those supported by CDC through some "university partners," are said to provide incentives to enrollment and adherence, including nutritional support, cash, and transport costs, according to HC staff informants and FDRE Government team members.

### Stigma and Discrimination

A recent USAID-funded study of perceived stigma and discrimination among health care providers toward persons with HIV/AIDS, carried out by Miz-Hazab Research Center Addis Ababa, and IntraHealth International Ethiopia, reveals that stigma and discrimination are rife at both the hospital and HC levels (USAID/IntraHealth, n.d.). In addition, fears of stigma and discrimination within the community and at the facility level are said to cause clients to visit hospitals or health centers not in their immediate locality because clients can remain more anonymous. Also, the population of individuals who are HIV positive, or suspect that they may be, is typically highly mobile. Mobile men with disposable income (truck drivers and their assistants, taxi and bus drivers, and business travelers), as well as both male and female tourists, construction workers, commercial sex workers, day laborers, transhumant cattle keepers, merchants, traders, uniformed persons, students, pilgrims, and people going to and from markets, and from one roadside town to another—all use the main transport corridors along which the HCSP-supported HCs are located This is the area of highest fixed-population density and of highest mobility in Ethiopia.

All of these factors separately or in combination can lead to someone being lost to follow-up. Although confidentiality remains an ideal expressed in documents and by health system officials, the latter freely admit that the system at HCs as currently practiced militates against confidentiality as soon as a client tests positive for HIV. This is because that client—a youth, man, or woman—is immediately "taken by the person who has done the test and given the results and post-test counseling to the ART treatment professionals." In the smaller HCs, these two professionals or the professional and para-professional community counselor (CC) who pass the client on may be using the same room as the treatment professional. Even at larger HCs where there is office and treatment space for all, anyone can see that the client who has tested positive is being brought to the professional in charge of pre-enrollment and enrollment for treatment.

To date, both sequential numbering of case files within the HC, and the use of national enrollment numbers that follow those enrolled wherever they go for treatment or to fill their ARV prescriptions, are only used as monitoring mechanisms. They are not used instead of client names to protect confidentiality as they are in other countries. The CM, depending on how closely s/he follows the training content and the manual provided by HCSP, usually provides both the names and addresses in writing of clients LTFU to CMobs and KOOWs, who then go to their respective communities and neighborhoods to try to trace the missing clients and convince them to return to the HC. Although frequently defaulters are found to have provided false names and addresses, the outreach workers are quite successful in tracing them. HCSP "success stories" and other documents indicate that while the average default rate is much lower in catchment areas where CMs, CMobs, and KOOWs are most active (4.6%), it has failed to decrease significantly in areas where there are no HCSP-supported health centers.

As is discussed below under Result 3, this delegation to CMobs and KOOWs of the responsibility of tracing clients LTFU is not what was anticipated in the original project model. The model depends on the qualities of the CM as s/he interacts with individual clients. The CM is supposed to manage the process personally and be responsible for referrals within the HC and to external sites and facilities, including referral back to the community. In many sites visited in Amhara, SNNPR, and Tigray, the CMs had, in fact, been integrated into the facility at least physically,

either sharing a room with the data clerk or being provided with a room to share with the CMobs and/or the KOOWs. All those encountered wore white "doctor coats." Almost all had badges provided by the Woreda Health Office. Where KOOWs are the most active, CMs are also integrated into the local administrative structure, although at a certain remove. This is likely to ensure sustainability when HCSP ends.

However, CMs and associated outreach workers have a completely separate reporting system, which is only used for HCSP/USAID PEPFAR purposes. CMs, like data clerks and community mobilizers, are paid by the project. Their job descriptions may have been shared with and approved by the local administration and/or the HC directors, but they actually report to HCSP. Their reports are collected by the mentors or outreach staff from the regional MSH Offices. The same is true of the reports prepared weekly by the KOOWs.

These are some of the aspects of the case manager model as it was designed, and as it is implemented in the regions and city administration that are included in the HCSP intervention area. There is considerable variability and diversity, as in all project aspects, since the decentralization policy in public health generally (and HIV/AIDS specifically) requires customizing services and approaches to the local culture and the circumstances that distinguish these administrative divisions. Yet some standards and guidelines might be observed with more consistency. Among these, for example, is the recent introduction of an additional column in the intake form for CMs, with instructions in the related manual. The CM is supposed to ascertain by whom the client wishes to be followed up. Is it by the CM, the CMob, the KOOW, or another available individual or entity? The client can, at least theoretically, decline to be followed up at all. No evaluation sub-team appears to have heard of this practice during the field visits.

### Clients' Perception of Services

In 18 of 29 HCs visited, the team had the opportunity to talk to a minimum of two and a maximum of five clients currently on ART. The idea was to elicit information on the quality of services the clients are receiving, and on the interaction between themselves and service providers. The team discovered that all clients were highly satisfied with all services received, particularly with their ART-related services, and they reported being highly appreciative of their interaction with their health care providers, who treat them with courtesy and professionalism. In some cases, clients reported that their providers go beyond expectations and support them in a very personal way. For example, a client from Adullala HC (Oromia) stated that the ART focal person (a nurse) paid the client's laboratory expenses out of the nurse's own pocket when the client informed the nurse that the client was unable to cover the cost. In this case, the laboratory fee was for a test which was not directly related to ART services.

Almost all clients expressed their appreciation to the Government of Ethiopia and its donor partners for making the free provision of ART services possible. In an event observed at Holeta and Tulu Bollo health centers, some clients were even weeping—largely what they themselves said were "tears of happiness"—and remembering those who have passed away without seeing what is possible today thanks to ART treatment.

However, clients who met with the evaluation team have shared some concerns. Most clients requested food and nutrition support. The team met clients who commented on the urgent need for food support in order for them to adhere to the treatment. At an HC in Mojo the team met a mother on ART with twins who is advised not to breastfeed, but who has no other alternative. The issue of food support has also been repeatedly mentioned by KOOWs and case managers as one of the reasons why some clients discontinue treatment. (HCSP recommends exclusive breast feeding.) Some clients also mentioned that it is beyond their means to pay for some medicines that are not listed among the OI drugs and lab fees related to HIV. Because most clients on treatment eventually consider themselves strong enough to go back to work, they also mentioned

the need to reintegrate them into the job market or create employment opportunities through IGAs.

### Result 3: Deployment of outreach workers to support family-focused prevention, care, and treatment in communities

Kebele-oriented outreach workers (KOOWs) have been trained and are active at most HCSP-supported HCs. These volunteers are extremely devoted, active, and often innovative in providing care and support, as well as in tracing clients lost to follow-up at the facility. With little or no revenue, and a nominal transportation stipend, they accomplish the many tasks for which they are trained, including community mobilization; counseling for VCT; mobilization for ANC and PMTCT; recommending exclusive breast feeding, health education, and family planning; asset mapping; teaching family-focused prevention, care, and support; home-based palliative care, and working with community-based organizations. KOOWs also provide material support to the most needy community members, using their transportation stipend and money from their personal—and often limited—incomes. Many KOOWs are PLWHA, and like members of the mother's support groups, a number are female heads of household who seek to create income-generating opportunities for themselves and those they support, including OVC.

These outreach workers are seen as responsible for the low rates of clients lost to follow-up from ART treatment at HCSP-supported HCs, compared to such rates at non-HCSP-supported HCs. At the end of the PY2 reporting period, the LTFU rate at program-supported HCs was 7.1%, in contrast to the national average of 23% (*PMP Report*, April 2009). KOOWs are the main source of palliative care and support in HC catchment areas. It is difficult to convey how sincere and motivated were the majority of KOOWs encountered by the external evaluation sub-teams (see Appendix E for quotes from some of them).

A number of KOOWs, CMobs, and CMs noted that it is difficult to complete the project reporting forms. In fact, the reporting burden is unevenly distributed among data clerks, CMs, CMobs, and KOOWs. KOOWs in some areas report more than once a week to the CMob and the CM at the facility. Others report weekly, which is in line with the SAVUS subcontract requirements. Yet KOOWs often walk relatively long distances to the HC even though they could phone in results if they had access to mobile phone credits—almost all have access to a mobile phone they can borrow. While some KOOWs are high school graduates, and some older men are retired from government or other jobs, the majority is less educated, and has difficulty completing the complicated reporting forms. If they had inexpensive calculators, this would help them avoid double counting. If purchased in bulk, such calculators would not be a major expense to the project. Similarly, CMs complete complicated reports that summarize all data provided by KOOWs monthly. Even where there is a data clerk and a computer at the HC, the CM does not have computer access. Some clerks on a personal, voluntary basis help CMs to automate their reports. Most, however, appear not to do so. As both cadres are paid by HCSP in most instances, this could easily be changed.

### Result 4: Implementation of HIV prevention activities utilizing best practice "abstinence, be faithful, and condom" (ABC) interventions incorporating stigma, discrimination, and gender concerns

Rather than acting as a stand-alone initiative, prevention is integrated into every component of HCSP. Of the program's 13 contract deliverables, none therefore presents a specific target for prevention. Of the program's four results, one does target behavior change communication, but this is only one component of HCSP's prevention work. Specific to BCC, the *HCSP Project Year 2 Annual Report* states the following:

> *A number of trainings have been planned and conducted under the prevention component on AB (abstinence, being faithful) and other prevention (OP) strategies for community*

*elders and religious leaders, school communities, woreda HIV/AIDS desk officers, HEWs, community mobilizers and KOOWs. Training on infection prevention practices for heads of HCs and other HC staff was planned and conducted. All trainings were conducted with full involvement of RHBs and HAPCO. The available and standardized training materials were used for the trainings.*

The Prevention Team has been under-staffed, under-funded, and perhaps also constrained by the contractual requirement that HCSP may not develop any new prevention or other materials, but rather must adapt existing ones. HCSP prevention staff must first clear any message/job aid in an English-language version with USAID. Once clearance has been granted, staff must have the Ethiopian-language version approved by the regional bureau(s) in which each language group is represented. These factors limit the timely development of high-quality materials and training of staff in their use. At the time of the evaluation, the Prevention Team had to rely on other HCSP/SAVUS outreach staff to train in their stead. This will change with decentralization and addition of staff to the regional HCSP offices.

Despite these constraints, the outputs examined by the evaluation team were of excellent quality—both the IEC materials at the facilities, and those for distribution in the community. Job aids were posted and in use in all the HCs visited. In addition, teaching cassettes, logbooks, success stories, fact sheets, newspapers, and other outreach and prevention materials have been distributed and are in use.

Appendix J, Table 4, lists the number of individuals reached with AB and AB+ messages during Project Year 2.

The roles of CMs at the health-center level, and of KOOWs at the community and family levels, were also found to be helpful in disseminating prevention messages. The KOOWs use the traditional coffee ceremony as a channel to initiate conversation with community members on HIV/AIDS, prevention, care, treatment, and support. These activities are effective in helping to reach communities with prevention messages.

HCSP has provided training to CMs, KOOWs, some community core groups, and CMobs to strengthen prevention-related activities. For prevention activities at the community level to become even more effective, it is important to support coffee ceremonies organized by volunteers. At the facility level, for instance, additional training on infection prevention seems essential. As explained by regional care and support officers of MSH, the high staff turnover of those trained in infection prevention (IP) has left most facilities without any trained personnel in this area. For example, it was explained that of the 24 health care workers in Addis Ababa trained by HCSP on infection prevention, only four remain. As a result, the program trainers explained that they must conduct similar trainings in IP one more time (see Appendix J, Table 5).

The evaluation team had discussions with HC staff and MSH regional and national offices in order to determine what HCSP has achieved with regard to preventing HIV transmission. This is equally important since there is an impression, at least among some, that a greater emphasis on treatment and adherence seems to be diverting HCSP's attention from prevention. However, health center staff emphasize that regular health education sessions are usually conducted in the mornings for all who are visiting the HC that day, regardless of the particular concern that brought them there. Some health centers, such as Woreda 23 in Addis Ababa, reported that health education is being provided by other partners, such as national organizations of PLWHA.

Event sponsorship of various types, distribution of HIV/AIDS educational materials, and training of community and religious leaders are included under the prevention category. National HIV/AIDS Day was celebrated in Fitche city and TB Day was celebrated in Jimma. HCSP

supported these events as part of its community sensitization and dissemination of information on HIV/AIDS facts and activities.

The need to focus on prevention was frequently mentioned in the field as an important aspect of the overall task of comprehensive HIV/AIDS care and support services. As explained by the head of the Addis Ababa HAPCO, activities such as VCT, ART, and PMTCT all need to be linked to prevention. Emphasis should also be placed on secondary prevention, using those who test HIV positive. So far, HCSP seems to be focusing more on training and service delivery for treatment and adherence for this group, as the head of the Addis Ababa HAPCO stated. However, Prevention with Positives (PwP) should also be an area for focus in future collaborations of the regional bureaus and HCSP, according to most regional bureau officials interviewed.

While the quality and quantity of existing materials and job aids is excellent, and they are clearly being used at facilities and by KOOWs in community outreach, the materials' variety is probably insufficient to match the range of topics that KOOWs are expected to cover. In at least some areas visited, KOOWs were apparently being instructed to conform to the 16-module approach mandated for HEWs. This is obviously too many messages to be delivered by single or even pairs of KOOWs, who are also supposed to be working on community mobilization, HBC, forming facility-community linkages through intensive emphasis on tracing LTFU and other defaulters, individually and collectively helping those most in need—including the sick and OVCs—to find food, shelter, and clothing (as well as a little cash), and trying to set up IGA projects.

Peace Corps volunteers could more effectively be used as partners in spreading prevention messages, providing condoms, and explaining their correct and consistent use, as well as helping KOOWs, PLWHA associations, women's and youth associations, and local champions to be innovative in spreading prevention messages of all types, as well as in forming associations and seeking IGA resources. The example of PCV Erica in Wolkite is an excellent one.

A key area for prevention is condom distribution, as is indicated in the phrasing of Result 4. Condom distribution seems more clearly evident in Addis Ababa and Oromia than in the other regions visited. The team visiting sites there found condoms available in baskets and in plain sight. Other teams either never saw condoms, or had to ask where they were. KOOWs said that they talked about and distributed condoms. Some HCs reported that they had experienced or were experiencing condom stock-outs. Yet all those interviewed indicated that they believed correct and consistent condom use was a serious problem in their respective catchment areas. Commercial sex is one of the main vectors for HIV transmission in the areas visited. While female commercial sex workers are said to appreciate and frequently request additional female condoms, the consistent condom use by mobile men seems conspicuous by its absence, at least according to those interviewed at all levels. For example, some male KOOWs who are members of discordant couples are very proud that their wives have recently borne children who are HIV free. Similarly, other male KOOWs explained that they are abstinent, even though they and their partners have been married for many years (e.g., "We live as brother and sister."). By their own account, they are not using condoms, at least not most of the time, either at home or outside the home.

Post-exposure prophylaxis appears not to have been raised with any sub-team. Yet PEP is usually one of the main topics service providers seek, and when they have accurate training and access to PEP methods, this tends significantly to reduce their discrimination against HIV positive clients, at least in other PEPFAR countries.

## FINDINGS BY CROSSCUTTING THEME

### NGO Capacity-Building

This set of activities, especially the activity designed to provide technical assistance to NGOs and to the Ethiopian private sector in the MSH "trademark" area of performance-based contracting (PBC), has been delayed. One way in which the project may increase sustainability of community core groups, KOOWs, and income-generating activities is to assist groups of KOOWs to form associations (one has already been formed, and other groups indicated they would like to take similar steps). The main motivation expressed by these groups was to be able as associations to apply for funding to enhance IGA activities for PLWHA, PAHA, and other needy groups (both women's groups and mixed groups). This was also perceived as a way to get more nutritional assistance to those who need it, especially OVC, and malnourished people in the community generally, including those on ART treatment.

### Gender Sensitivity

Under the HCSP contract, several crosscutting themes are to be integrated into the vertical components and together lead to enhanced achievement of results. There are no separate targets or intermediate results for these themes as the contract or PMP now stands. While this is a good way to integrate themes such as gender sensitivity, there are no clear milestones, targets, or activities that can be monitored or evaluated to judge whether they are being integrated effectively. Examination of prevention and other materials, and the fact that in the PMP most data are disaggregated by sex, indicate that some effort is being made to count beneficiaries by sex, if not to determine the differential impact of the various project elements on these beneficiaries. Similarly, there appears to be no attention given to age. The usual emphasis on service accessibility to youth, and prevention education specifically oriented to youth, seems to be lacking in this project, perhaps because this was a major focus of the IMAI Project.

During field visits to 29 HCSP-assisted centers, there was scarcely any mention of gender, of engendering service delivery, or even of outreach and HBC or other palliative care and support. However, discussions with case managers, CMobs, KOOWs, and mentor mothers who are either or both PLWHA and female heads of household did reveal that gender issues are important in outreach and community mobilization and at both the community and facility levels.

Discussions with the HCSP Team Leader for Gender and NGO Capacity-Building at HQ revealed that while IntraHealth and Save the Children, responsible respectively for prevention and for outreach and palliative care and support activities, are as active as their resources will allow in implementing both of these crosscutting themes, the treatment team (also staffed by IntraHealth) is perceived as the least amenable and active in this area. It is the treatment team that has the most staff at HCSP HQ, at the regional level through fixed staff and mobile mentors, and USAID or Global Fund-funded staff at the HC level (not necessarily directly supported by HCSP).

Although HCs are supposed to be dedicated to both preventive and curative treatment, preventive treatment (except for vaccination campaigns) seems largely to be lacking. On the other hand, women make up the largest segment of the patient load at any center, and are especially encouraged to participate in HIV/AIDS-related counseling and testing, ANC/PMTCT, and outreach for obvious policy and evidential reasons. This is true despite the fact that many nurses

and health officers are men; women still predominate as nurses (although this is changing).[5] Yet, as observed by the evaluation team and stressed by the HCSP Gender and NGO Capacity-Building Team Leader, it is women, and not men, who accompany other women and their children to the health center. Women clients together with other women are those who wait, who complain of poor reception by HC staff, who say that HC facilities are not user-friendly, and who often opt to go elsewhere—either to a hospital or to a more distant health center—for fear of stigma and discrimination, especially if they think they may be HIV positive.

Mobile men are a significant pool for HIV transmission, but there are no prevention programs under HCSP specifically oriented toward these men. This could be changed relatively easily, since almost all towns where HCSP-supported HCs are located are on major transport routes where there are many drivers' restaurants and hotels which could be used as sites for prevention messaging, condom distribution, and referrals to local VCT services, as is done by other projects in the region. Case managers already visit hotels and restaurants to solicit food contributions for PLWHA and PAHA, for which they are awarded certificates, so this step might not require additional visits.

Case managers and community mobilizers seem to be more or less evenly divided among the sexes, with a slight preponderance of women among KOOWs. These staff and volunteers indicated at all sites visited that expectations at the community level are that women will provide counseling and HBC to other women, while men will do the same for men. In some instances, they may go in same-sex pairs, while in others, they may pair up as a team of one man and one woman, but will separate when they carry out their planned tasks within the kebele. Membership in community core groups by sex is less clear from the field visits, since most of those members who attended discussions with evaluation team members were men, but they may not have been representative of the CCGs as a whole.

### Family-Focused Approach

One of the most innovative aspects of HCSP is the attempt to involve all family members of HIV positive clients in VCT, treatment, and/or palliative care and support as appropriate. KOOWs are taught how to use a "family matrix," which encourages them to report on their activities with various family members of those who have tested positive, or who are clearly living with the virus. On the other hand, unless the KOOW is able to convince the (often male) partners of those who are HIV positive to come with them to the HC, there seems to be no outreach available to encourage them to come, or to bring their older children with them.[6] The extent to which the family-focused approach is being followed, and the differential impact it makes when it is, should be more closely assessed by HCSP.

### Stigma, Discrimination, and Confidentiality

Opinions expressed by different informants on these sticky issues varied widely. Most Federal MOH staff, regional bureau HAPCO staff, HC clinical staff and directors, HCSP staff, and Ethiopian evaluation team members indicated that confidentiality is greatly lacking among

[6] A health officer has a B.S. in public health and deals with both preventive and curative aspects of health care (50% in each). Health officers typically run health centers, providing leadership and health care. Diploma nurses and B.S. nurses are both registered nurses. Degree holders have in-depth training compared to those with diplomas. These nurses are clinical nurses. In terms of gender distribution it can be said that nursing is female-dominated while health officers are usually male, although this trend is changing. For instance, at the Adullala HC the team met with three female health officers, and in Modjo at least two of them were females.

[7] This is important because if a couple separates, it is the father who has the legal right to take children over the age of three to live with him. Children under the age of three may be allowed to stay with their mother. Widowers are legally responsible for their children.

service providers at all levels, and that they regard this as an artifact of the decentralization of CT and treatment services to the woreda level. The two most often repeated statements made by all informants were: "The clients all know each other" and "Once the client who has tested positive is taken by the counselor or clinician who administered the test to the ART treatment person, there is no chance for confidentiality."

Most service providers interviewed maintained that stigma and discrimination have been significantly reduced since PICT and VCT have become so prevalent that they are "virtually routine." However, case managers, community mobilizers, KOOWs, and HCSP outreach staff indicate that stigma and discrimination continue to be critical to whether PLWHA and PAHA are willing to come to their closest health centers, return for the three mandatory pre-ART counseling sessions, and adhere to their ART regimen once they are enrolled. Furthermore, Ethiopia is one of the many countries in which gender-based violence remains an issue, both within and without the domestic context. Thus, even though couples counseling and prevention with positives are included under HCSP components, both are apparently negatively affected by stigma and discrimination against those who are positive and either reveal their status to others, or those merely suspected of being positive. Both women and men are often loath to reveal their positive serostatus to their partners for fear of gender-based violence, rejection, or divorce.

Some HCSP staff and regional bureau HAPCO staff commented that the major source of stigma and discrimination in Ethiopia—as elsewhere—is among service providers themselves. This is substantiated by the results of a recent study on perceived stigmatization and discrimination by health care providers toward persons with HIV/AIDS (USAID/IntraHealth, n.d.). While personnel have received some training on stigma and discrimination, further training should be provided, given staff turnover and reports of staff burnout.

# III. EMERGING IMPLEMENTATION AREAS OF CONCERN

## LACK OF CAPACITY AT REGIONAL, DISTRICT, AND FACILITY LEVELS

Regional capacity to support, prepare, and supervise health centers, and to provide mentoring roles, is severely constrained by pervasive deficiencies in both Federal and regional health management teams. Their inability to provide supervision or mentoring to HCs has resulted in HCSP carrying out the mentoring and supervision alone rather than as a joint activity, as planned.

## HIGH STAFF TURNOVER/WEAK AND UNDERSTAFFED HCSP REGIONAL OFFICES

In Ethiopia there is a chronic shortage of qualified health providers, who move continuously to better opportunities, resulting in high attrition of government and project health workers at woreda health offices and health centers. Retention of staff within MSH and its sub-grantees is also an issue due to a competitive local market for salaries and benefits. However, as a result of Contract Modifications Five and Six, HCSP is now able to increase some salaries and is putting in place a staff increase and decentralization policy at the regional and sub-regional levels (see Appendix H).

## INCOMPLETE AND POOR DATA REPORTING QUALITY ON CARE AND SUPPORT ACTIVITIES BECAUSE THE NATIONAL HMIS FAILS TO CAPTURE PALLIATIVE CARE/CARE AND SUPPORT SERVICE DATA

### Monitoring, Evaluation, and Reporting

The evaluation team found that delayed reporting is less frequent for HCSP-assisted HCs than for other HCs. Data management has become increasingly proficient, but a lack of computers and software makes reporting difficult and inefficient. Staff must rely on manual systems, while mentors and other HCSP regional and HQ staff must take reports, registers, logbooks, and other reporting formats back and forth from regional offices to HCs.

Uniform reporting formats are being developed by Tulane University technical assistance for the national HMIS. However, neither these formats nor the software that all partners are supposed to use have been put in place. The result is that individual implementing partners such as HCSP must provide their own formats, as well as basic software, so that they can report on PEPFAR and USAID Assistance Objective indicators.

As mentioned elsewhere in this report, KOOWs and CMs report more frequently than do other staff. In fact, for KOOWs, SAVUS is following the terms of its subcontract. Such frequency of reporting—once a week or more—is onerous, especially for those with a more limited education. It is more likely that they will double count than not, and some of them stated that they had difficulty with the monthly reporting formats.

Data utilization is unclear at the facility level—reporting only goes upward. Feedback or feedthrough to or within the facility, and to the community, except through the highest of the three tiers of management committees, appears to be functioning. HCSP staff pointed out that catchment-area meetings at the regional level serve as forums for such feedback/feedthrough, but they, too, are more hierarchical than horizontal, with the result that "instructions" come back down from these meetings, rather than information to which the recipients have an opportunity to respond consensually.

Some data being reported at the local level are suspect and need review. For example, one rural HC is reporting an overall HIV seroprevalence rate of 24% for 2008 (with a 2.1% rate in pregnant women) (see Appendix J, Table 7).

### FACILITY TARGETS

The TB/HIV co-management facility targets stated in the initial contract were over-ambitious because the assumptions for TB and TB/HIV prevalence were over–estimated and the weak national TB program was not fully apparent. During the March 2009 contract modification, review of the weak national TB program and laboratory support resulted in TB/HIV achievable targets.

### THE NEW BUSINESS PROCESS RE-ENGINEERING AT THE MINISTRY OF HEALTH

Application of the HAPCO/MOH business process re-engineering strategy at the regional and Federal levels has resulted in less staff support and assistance to HCSP. BPR encourages both sudden movement of staff from one position to another (often not in the same district or region), as well as downsizing, which means that vacant positions are not filled. How the FDRE Government decides to allocate human resources between and among regional and district health offices and health centers is not clear to the external evaluation team. Since this process has political as well as administrative/managerial content, it may not be completely transparent.

### PARTNERSHIP AND COLLABORATION

HCSP and the other four MSH-implemented projects are now co-managed for finance, contracting, and other administrative aspects, and through joint staff meetings at the regional office level for improved collaboration. HCSP participates in TWGs, PEPFAR groups, and other HIV/AIDS forums. Collaboration at the facility and community levels appears good, but the multiplicity of partners and of volunteer/community groups makes this difficult to manage.

Lack of OVC and nutritional support partners at the facility and community levels is a great source of concern, and may militate against care, treatment, and support success.

# IV. CONCLUSIONS

## RESULTS

### Result 1: Provision of quality integrated HIV/AIDS prevention, care, and treatment services at health centers

It is clear that the decentralization of HIV/AIDS services to health centers has been successful in increasing "on-ART" patient load at health centers by about 8% over forecasts. Much of this off-loading has been accompanied by increasing needs for staff, training, supplies, equipment, and ancillary services, including TB testing, CD4 testing, transportation, data processing, and other requirements.

The pyramid approach to distribution of Levels 1, 2, and 3 services originally conceived (Section C, page 4, of the original contract, and Appendix J, Graph 2) was difficult to institute for numerous reasons. The current distribution of 550 Level 1, 400 Level 2, and 300 Level 3 ARV sites has resulted in too few VCT and PMTCT testing sites (Level 1), and too many Level 3 ARV sites, which consequently lack enough space, infrastructure, staffing, training, equipment and supplies for highly complex ARV treatment. A redistribution of Level, 1, 2, and 3 sites is recommended to accommodate the needs of the local populations as determined by HCSP and FDRE data. Client flows and capacities should be determined from these data, and then staffing, equipping, and other needs may be met. This should be preceded by an operational research study to determine cost/benefit, and then perhaps initiated in the 50 new HC sites recently assigned by the FDRE. From such investigation, it may also be determined what redistribution of Levels 1, 2, or 3 sites might be required.

### Result 2: Deployment of case managers to support care and strengthen referrals between health centers, hospitals, and community services

Personalized care and support are enhanced in the facility-community linkage model, which uses case managers who are located at the facility but who move with community mobilizers and community-based outreach workers to follow up with clients on treatment who are receiving home-based care and other support.

This model is implemented differently by region and district, depending on the capacity of the district health office and other district-level administrative structures, as well as the presence of community-based organizations and associations.

In some cases CMs are constrained by transportation and communication problems from accompanying sick clients to hospitals on referral, and following up with them once there. Where the model is most successful, CMs are supportive of clients, do not behave in the hierarchical and aloof manner characteristic of many service providers, and are integrated into the life of the HC as well as that of the community.

Key areas for improvement are nutritional support for OVC, other PAHA, and PLWHA on ART treatment and receiving palliative care. HCSP is supposed to link itself with available resources for such nutritional support in the HC catchment areas, but in most instances such resources do not exist, especially in pre-drought and drought circumstances. This appears to include the USAID-funded OVC support intervention also implemented by SAVUS.

According to multiple government, hospital, HC, and HCSP staff, CDC and some international partners are providing nutritional support and cash incentives for clients to come to the hospitals where they are working. This militates against permanent off-loading of "transfer out" clients from the hospital to the HCs.

### Result 3: Deployment of outreach workers to support family-focused prevention, care, and treatment in communities

Kebele-oriented outreach workers (KOOWs) have been trained and are active at most HCSP-supported HCs. These volunteers are extremely devoted, active, and often innovative in providing care and support, as well as in tracing clients lost to follow up at the facility. With little or no revenue, and a miniscule transportation stipend, they accomplish the many tasks for which they are trained, including community mobilization; counseling for VCT; mobilization for ANC and PMTCT; promotion of exclusive breast feeding, health education, and family planning; asset mapping; teaching family-focused prevention, care, and support; HBC, and working with CBOs. KOOWs also provide material support to the most needy community members using their transportation stipend and money from their personal—and often limited—incomes. Many KOOWs are PLWHA, and like members of the mother's support groups, they seek to create income-generating opportunities for themselves and those they support, including OVC.

Additional support to assist KOOWs to register as associations in order to raise funds to initiate income-generating activities for themselves and their community-based clients would be cost-effective and help sustain the KOOWs after HCSP ends. Formation of such associations would also link the NGO capacity-building theme with the outreach component, strengthening both. This should be done in a gender-sensitive way and avoid any labeling that would lead to stigma and discrimination.

### Result 4: Implementation of HIV prevention activities utilizing best practice "abstinence, be faithful, and condom" (ABC) interventions incorporating stigma, discrimination, and gender concerns

At HCSP HQ and the HCs visited, the evaluation team found that prevention materials and job aids were of high quality, widely distributed, and in use. This was true despite the fact that the Prevention Team has been one of two least well-staffed HCSP teams—together with Gender and NGO Capacity-Building—although this is about to change. Under the recently approved staffing pattern revisions, HCSP will now have staff at the regional level, with shared responsibility for prevention, outreach, care, and support.

Timely preparation and distribution of prevention materials and job aids is constrained by both contractual and non-contractual factors. Prevention messages must be based on existing ones; their content must be approved by USAID in English prior to printing; and the local-language version must be approved for use in the region in question. Only then can the material or job aid be produced.

Training in the use of prevention materials is conducted by other HCSP staff—usually care and support staff from a different subcontractor—and the Prevention Team has had little opportunity yet to follow up and to see how materials are being used, and what additional materials may be required.

## CROSSCUTTING THEMES

Among crosscutting themes, gender sensitivity and NGO capacity-building are the least institutionalized, due to staffing shortages within HCSP, the inherent complexity of these themes, and the fact that they are meant to be integrated into vertical program components. This requires the team leader first to educate the other team leaders and their respective staffs about gender sensitivity. She must succeed through persuasion, whereas leaders of vertical teams have both responsibility and authority. HCSP has revisited the staffing issue and is advertising for an additional gender coordinator. HCSP should also revisit the meaning of engendering all aspects and components of the program at all levels. This does not mean simply taking women's multiple roles into account. It also means taking into account the roles of men in and outside the

household, especially the roles of mobile men with disposable income and the power relationships between men and women.

The facility-community linkage model is among the most successful elements of HCSP, and is widely recognized as such by clients, HC facility-based staff, district-level health office staff, and outreach workers themselves. The project-supported CMs and CMobs, who move from the facility to the community as necessary, are seen by clients, CBOs, and the community and district officials with whom they work as valuable in communicating the needs of clients and prospective clients to facility-based staff and local decisionmakers, and in community mobilization.

KOOWs, community-based volunteers who receive a nominal monthly stipend for transportation, are considered responsible for the low rates of clients lost to follow-up from ART treatment at HCSP-supported HCs, compared to such rates at non-HCSP-supported HCs. KOOWs are the main source of palliative care and support in HC catchment areas.

## EMERGING AREAS OF IMPLEMENTATION CONCERN

On the whole, the evaluation team concluded that the emerging areas of implementation concern have already been or are being addressed by HCSP management and staff. However, some of these areas, such as the government's BPR, are beyond the project's purview and may be included under outstanding issues that require new or additional attention by USAID/HAPN, HCSP management and staff, the FDRE at Federal, regional, and district levels, and "One-MSH/Ethiopia" management.

HCSP's contract calls for the project to link itself with existing programs and partners providing nutritional support and/or humanitarian assistance within the HC catchment areas. This is one of the jobs of CMs and KOOWs. However, in almost all areas visited, neither the World Food Program (WFP) nor any other significant NGO/FBO is present and providing such support, despite the efforts of the FDRE's Agency for Disaster Prevention and Preparedness, various U.N. agencies supporting emergency relief, and the persisting problems of localized drought, malnutrition, and undernutrition in Ethiopia.

Similarly, HCSP is supposed to link with existing programs that provide support to OVC. Again, these are conspicuous by their absence in the HC catchment areas. There appears to be no linkage between SAVUS's subcontract staff under HCSP, and their staff under the USAID-supported flagship OVC project.

The global PEPFAR program requires frequent and often complex reporting by its implementing partners. Like other partners, HCSP must report quarterly against PEPFAR indicators and USAID Assistance Objectives. In addition, HCSP-funded data clerks at HCs provide reports to the national HMIS, which has not yet been fully designed and is not operational.

The FDRE and its major international partners, including PEPFAR and the Global Fund, are pursuing a policy and strategy for making the continuum of HIV/AIDS care, treatment, and support accessible to all by 2020. While a laudable objective, even at present this is not cost-efficient. Closer adherence to the national guidelines by reducing the periodicity of required follow-up visits for those in treatment would improve cost-efficiency significantly.

### The New Business Process Re-engineering at the Ministry of Health

BPR increases staff turnover at all FDRE levels, causing additional in-service training as well as supervision burdens on HCSP and other partners. Because it involves downsizing, a number of vacancies remain once staff leave.

### Planning and Targets

HCSP staff at all levels report against targets. However, despite all this reporting, the underlying targets for HIV/TB and for ART treatment are not realistic. According to documents reviewed by the evaluation team, and statements from the contractor, this has been recognized by USAID, but the HIV/TB targets have not been changed. For ART treatment, despite the fact that HCSP staff are well-aware that the PY3 target is unreachable and inaccurate given the data cited above, the target has not been changed.

## PROGRAM MANAGEMENT

HCSP contributes to development of regional health bureau comprehensive HIV/AIDS services plans, and, together with other partners, participates in zonal catchment area meetings, which are becoming more regular. In several regions HCSP appears to be leading the way toward improvement, and prepares meeting reports.

## PROGRAM ACCOMPLISHMENTS AND RESULTS

### Target and Result Attainment

HCSP is on track to meet intermediate-results benchmarks and targets in core activities as modified in contract amendments.

### Scale-Up in Optional Years

HCSP scale-up or expansion of *all* current activities in optional years may not be cost-effective. A cost-effectiveness analysis should be conducted before the end of PY3, based in part on the results of the recommended operations research, in order to determine which activities in how many centers should be replicated, and in what combination.

Addition of OVC and nutritional support for existing and new sites is crucial.

### Adherence

Many aspects of adherence are beyond the purview of HCSP.

### Referrals

The two-way referral system between HCs and zonal or reference hospitals is broken. It is not a sustainable system. Hospitals are ranked on the numbers of patients they retain, rather than on the number they off-load. HCs are ranked on the basis of how many clients they retain, but must also demonstrate that they refer those who are sickest out again to the hospitals. Clients/patients can and do make their own decisions to a great extent and also "shop around" for services. The tracking system is poorly developed and relies primarily on outreach workers, members of community groups, and case managers, where these are available at HCSP-supported HCs.

### Lost to Follow-Up, Drop Outs, Transferred-Out

KOOWs bear the primary burden for tracing clients LTFU. They use persuasion to convince clients to return to the HC, often disclosing their own positive status to do so and often providing clients with physical and material as well as psychosocial support. While admirable, some are unable to convince clients to respond, especially male partners of HIV positive women.

### Outreach

As discussed in the findings section and in recommendations, the outreach system has been successful, but it can be improved, and should be sustained by the FDRE Government. Many

government officials at the district and regional bureau levels agreed that this was a significant innovation and that they would support it.

### Home-Based Care

The activity reported as most rewarding by KOOWs is HBC. While many facility staff state that HBC is scarcely needed any more, thanks to high levels of ART acceptance and adherence, this viewpoint is not reflected in interviews with CMs, KOOWs, CCG members, and some district health office staff.

### Transport

When asked why clients fail to return for appointments or why they do not appear in the first place, KOOWs, HC staff, and clients cite the issue of transportation, particularly for those who live in rural woredas or kebeles, who in some instances must walk for eight hours to reach the HC. Such clients cannot return weekly for the three counseling appointments required during pre-enrollment and often are unable to come monthly to have drugs dispensed as is required by HC staff (although this is not in conformity with the current *Guidelines*). The team did not encounter any HCs where more than a month's supply of ART drugs was dispensed at one visit.

### Communications

This is one of the biggest problems for the HCs supported by the project, particularly for clients, but also for CMs, KOOWs, data clerks, lab techs, and pharmacy staff, among others. Wherever possible, HCSP should consider using mobile phones by extending credit for their use, as well as ensuring that fixed phones are in good working order at facilities.

### Branding

HCSP is doing a good job of branding. However, during the evaluation the team noticed many signboards and labels on HC furniture left over from the predecessor project, showing both USAID and FHI logos. MSH was told that it cannot have an HCSP-specific logo and therefore must use the project title or its acronym on signage and in other branding. This is not "catchy" and probably has no meaning for the average Ethiopian. This may also be one reason why most people in the field refer to the project as "MSH." Job aids and prevention messaging materials all have "USAID" prominently displayed on them, but also include logos for WHO, UNAIDS, and whatever organization originally prepared the aid or the material adapted by HCSP. While perhaps appropriate, this may also be confusing. During the evaluation, MSH discussed with USAID/Ethiopia the relative merits of branded signage and the need for security. The result is that HCSP and MSH may now install new signs at its regional offices.

# V. RECOMMENDATIONS

## OVERALL RECOMMENDATIONS FOR CURRENT HCSP BASE AND OPTIONAL YEARS

### General Recommendation

Based on its findings and conclusions, the external mid-term evaluation team's overall recommendation is that HCSP be continued, and that the optional years be funded. However, this recommendation depends on the assumption that the mid-course corrections suggested under the specific recommendation headings below will be implemented by the Mission, the FDRE Government, and the contractor.

The findings and conclusions sections of this report show clearly that HCSP is meeting or has met its original contracted targets, and is likely to achieve its four results, with certain caveats. Some of these caveats are definitely outside the purview of MSH, USAID, or even the FDRE Government. These include, but may not be limited to, the low seroprevalence rate in Ethiopia and the pattern of population distribution. Both of these favor relatively low patient loads at most HCSP-assisted woreda health centers, even in urban and peri-urban areas with the highest prevalence rates (see Http://www.census.gov/ipc/hiv/ethiopia08.pdf). The exception is Addis Ababa City Administration, where the prevalence rate, current population density, and in-migration are highest, and are likely to remain so.

Other caveats relate to the underlying assumptions on which some of these targets were based—such as the integrated HIV/TB targets and perhaps the PMTCT targets included in Contract Modification Five. Mission documentation shows that the former assumptions were invalid and that the targets should be revised, although they were not revised in Modification Five or Six. Other Mission-provided documentation and discussions with key informants suggest that the PMTCT targets may not be met by the end of the third base year—the data on the number of women who have ever tested positive, and on the number of pregnant women, imply that the PMTCT targets may be unrealistically high. On the other hand, PMP reporting through June 2009 indicates that PMTCT targets are in fact likely to be achieved (see Http://www.census.gov/ipc/hiv/ethiopia08.pdf).

The ART treatment targets as currently stated in the contract are not achievable. As noted by the evaluation team's care and treatment specialist, the number of persons likely to be eligible for treatment by the end of PY3—given data on the prevalence rate, how many individuals have tested positive to date, and extrapolating to the population covered by the HCs offering treatment in the country as a whole—is roughly half of the third-year target of 95,000 persons on treatment at project-supported HCs.

## RECOMMENDATIONS BY RESULT

### Result 1: Provision of quality integrated HIV/AIDS prevention, care, and treatment services at health centers

- HCSP should continue to scale up to the targeted 550 HCs by the end of Project Year 3, although the final 50 should not necessarily all provide treatment. During the two additional optional years if funded, focus should be on strengthening the capacity of these centers to deliver high-quality, cost-effective services, including, but not exclusively, ART treatment.

- Emphasis on ANC and PMTCT should continue through Project Year 3 and beyond. Additional emphasis during the next two years should be on piloting ways in which pre- and post-delivery prophylaxis can be extended to the majority of pregnant women who may have attended ANC and PTMTC programs, but who deliver at home.
- The type of "waiting space" provided at some zonal hospitals for pregnant women at risk of complications during delivery should be piloted at larger health centers where many women are registered in ANC/PTMTC programs. These pilots should be carefully monitored, using a baseline for maternal mortality during at-risk deliveries.
- Additional attempts should be made at HCSP-supported HCs to attract HIV positive women to return for well-baby clinics, and to provide additional counseling on infant and young child feeding, in order to supplement what may be provided by KOOWs and other volunteers at the community level.
- Operations research should be conducted, as described below, to determine how to make ART treatment more cost-efficient at smaller HCs with low patient loads.
- HCSP should revisit the reporting requirements and modalities for various service providers at HCSP-supported HCs. Waiting for software to be developed for the national HMIS, while simultaneously providing computers and related equipment to the HCs, sets a bad precedent and frustrates data clerks and others funded by the project.

**Result 2: Deployment of case managers to personalize care and strengthen referrals between health centers, hospitals, and community services**

- Training to provide high-quality integrated HIV/AIDS prevention, care, and treatment services should be intensified, since there is both high worker attrition and a high number of newly employed workers.
- Trainings should include health care providers and program coordinators at the regional, zonal, and woreda levels so that their capacity to coordinate, supervise, and mentor can be developed.
- Based on the results of proposed operations research and a cost-benefit analysis, HCSP should be expanded to uncovered and new health centers in order to increase accessibility.
- Clinical mentoring at all HCs should be rationalized, and existing models of training and retaining mentors should be examined. Mentorship is linked to improved quality of service provision at HCs, but it should not be confused with supportive supervision.
- Adherence to ART and external referral linkages should be improved.

**Result 3: Deployment of outreach workers to support family-focused prevention, care, and treatment in communities**

- Assist KOOWs to register as associations in order to raise funds for income-generating activities for themselves and their community-based clients. This would be cost-effective and help sustain the KOOWs after HCSP ends.
- Experiment with different ways of using KOOWs and community mobilizers, such as training and deploying KOOWs in rural kebeles that are adjacent to urban kebeles where KOOWs are already present and active (a recommendation made during many field visits).

- KOOWs should visit KOOWs in other regions in order to observe and share best practices, which could then be written up and disseminated through the "success story" publications and fact sheets produced by HCSP.
- Reporting forms for KOOWs (and thus for CMs) should be simplified, and KOOWs should not be required to report weekly or semi-monthly. The SAVUS subcontract should be amended to this effect.

### Result 4: Implementation of HIV prevention activities utilizing best practice "abstinence, be faithful, and condom" (ABC) interventions incorporating stigma, discrimination, and gender concerns

- On a systematic basis and with purposive monitoring, HCSP regional staff should pilot various numbers and types of messaging, using a variety of approaches that include, but are not restricted to, community conversations, coffee and tea ceremonies, and presentations at meetings of traditional CBOs. Polling of target audiences could help determine how the audience perceives the messages under different approaches.
- HCSP should continue to monitor and evaluate the effectiveness of its prevention messaging by subject, source, audience, and format. This should include assessing the differential impact of videos, tapes, print materials, and face-to-face information, education, and communication (IE&C) on men, women, and youth.
- The results of this M&E should inform the ways in which prevention messages are delivered in Project Years 4 and 5, in order to yield maximum impact.
- Experiences in kebeles with event-centered messaging and peer educators should be assessed, and best practices should be extended through publications and observation visits of KOOW groups from one area to another. In fact, all HCSP-supported HC staff should have such opportunities to visit other HCs and other regions.

## RECOMMENDATIONS BY CROSSCUTTING THEME

### Facility-Community Linkage Model

- HCSP should revisit the implementation of this model, and stress the community part of the facility-community linkage through the CMs as well as through the CMobs, CCGs, and KOOWs.
- To the extent possible, the transportation stipend for KOOWs should be increased in line with inflation, the range of their activities, and the distances they actually travel.
- HCSP should connect KOOWs and MSGs with resources such as PVCs who can help these groups apply for micro-credit for IGAs.
- HCSP must ensure that the resulting IGA groups are *not* labeled as "PLWHA groups" unless they seek such identification. They should be classified simply as groups of people—in the case of KOOWs, both men and women—who seek to improve their income and quality of life through self-initiated and collaboratively funded activities. The apparently natural linkage between them and *idir* or *equub* should be further explored from the IGA standpoint.

## RECOMMENDATIONS FOR OPERATIONS RESEARCH

### Prevention, ART Resupply, Care, and Support

1. Despite the advanced state of selection and start-up for the additional 50 health centers for PY3, the evaluation team proposes that HCSP create a pilot program at two centers of the 50 where the full spectrum of preventive and curative HIV/AIDS treatment has not yet been initiated. Under the program these centers would be restricted to providing preventive services and ART resupply for clients already initiated/enrolled elsewhere who have national registration numbers and CD4 counts (although the latter may be unnecessary since these clients have been enrolled whether or not they have CD4 counts). These centers would receive reduced ARV initiation and enrollment mentoring, if any. However, their two-way referral systems with "off-loading hospital" would have to be strengthened and closely monitored.

2. The team further proposes that HCSP compare the above two centers in the two regions with least overall patient load, with two other centers in the same regions/neighboring woredas where ART initiation/enrollment is included, and the usual HCSP spectrum of "continuum of care" is provided, including across the board mentoring, etc.

This comparison should be made during the final base year of the project and should receive close monitoring every month, and reporting every quarter to USAID, the woreda health offices, and regional bureaus. Outcomes should be carefully reviewed every six months at catchment-area meetings and by relevant TWGs.

### VCT and Community Counseling by HEWs

1. HCSP should train two community counselors as currently described—40 days pre-service or perhaps fewer—but should include training in home-based VCT, emphasizing confidentiality. This could be combined with referrals by KOOWs of those receiving HBC; for example, by using the family-based approach of testing partners and children.
   2) HCSP should train KOOWs to refer appropriate family members and PLWHA receiving palliative care and HBC to these counselors, who would be community-based in the same kebeles.

2. These measures would then be compared with HCs of similar patient loads that have HC-based community counselors and KOOWs working in the same spectrum of community mobilization, prevention messaging, HBC, and, if necessary, tracing clients LTFU. Monitoring would be as follows: monitor every month; report every month or quarter; assess every six months until the end of PY3; but report and discuss at semi-annual catchment-area meetings with off-loading hospitals, woreda health offices, regional HAPCO bureaus, and MOH. Recommendations should be made to all parties and to both the Federal HIV/AIDS Prevention and Control Office and the Federal Ministry of Health at the end of the project year. If better clinical and non-clinical results and greater cost-effectiveness have been demonstrated, and if approved by FMOH, FHAPCO, and regional HAPCO/MOH bureaus, these new measures can be implemented in optional years on a broader basis.

# VI. NEXT STEPS

## NEXT STEPS FOR EACH RESPONSIBLE PARTY

### USAID/U.S. Government PEPFAR team, together with FDRE counterparts should:

- Increase interagency coordination regarding agency and partner salary scales, partners "buying away" staff from other partners, program content, and client incentives, including hospital off-loading targets and transfer-outs to HCs. This coordination should include cross-monitoring and evaluation of all partners, or assessing their specific collaboration, and could perhaps be done by the PEPFAR Coordinator at post.
- Focus on the problem of malnutrition and undernutrition of ART patients and those receiving care and support, via family-based approach.
- Clarify and revise OVC support programs and Food by Prescription to ensure coverage where HCSP is working.
- Continue participation in TWGs and other forums with FDRE Government and other donor/partner actors to harmonize programs and activities at the Federal, regional, and district levels.
- Review district-level ART treatment accessibility targets (and plans to upgrade HCs to primary hospitals) in terms of present and projected HIV/AIDS incidence and prevalence levels.
- Review current HC staffing targets with other donors and development partners in terms of BPR, turnover, and pre-service and in-service training strategies.
- Continue the design and piloting of the HMIS, while observing and including partners' best practices in monitoring, including palliative care.
- Sustain and expand the number of community outreach workers at the kebele level.
- Increase the number of kebeles with outreach workers.

### HCSP management and staff should:

- Clarify and harmonize the roles and responsibilities of each member of the MSH/IntraHealth/Save the Children consortium at the institutional, implementation, and M&E levels.
- Correct disparities among Prevention, Gender, and NGO Capacity-Building and other teams' staffs while staff are being decentralized to sub-regions, in order to improve achievement of targets/results.
- Harmonize and enhance staff salaries and working conditions within the context of Modifications Five and Six in order to increase staff retention for all consortium members.
- Rethink "integration" as the best way to incorporate gender sensitivity, family focus, and other crosscutting themes. While excellent in an ideal situation, this is very difficult to achieve given the reality of hierarchical structures in Ethiopia.

- Consider whether clinical mentors should relinquish their monitoring/training responsibilities for non-clinical activities, given the decentralization and addition of HCSP staff.
- Develop internal guidance on communications to and from USAID and other partners to decrease the management burden and harmonize messages delivered from HCSP.
- Revise SAVUS's subcontract to reduce the frequency of reporting so that CMs, mobilizers, and KOOWs will not be reporting more frequently than professional cadres.
- Explore various means of providing access to computers and software for HCSP-supported data clerks and CMs for reporting and data analysis.
- Consider increasing the transportation stipend granted to KOOWs.
- Consider the cost-effectiveness of providing KOOWs with mobile phone cards so that they can communicate readily with each other, and with mobilizers and CMs, instead of visiting the HC unnecessarily.

### "One MSH/Ethiopia"

Because substantial effort and resources are being devoted to establishing a single management platform for all five MSH projects in Ethiopia, MSH should:

- Consider the implications of this policy for subcontractors under HCSP.
- Review the differential impact of this policy on HCSP implementation, as HCSP is the only contract among five projects.
- Where possible, decentralize authority and responsibility from MSH/Cambridge to MSH/Ethiopia.

# APPENDIX A: SCOPE OF WORK

**USAID/Ethiopia President's Emergency Program for AIDS Relief (PEPFAR)**
**Statement of Work for Mid-term Evaluation**
**HIV/AIDS Care and Support Program (HCSP)**
**(Revised June 2009)**
**PROJECT IDENTIFICATION DATA**

1. Project Title: HIV/AIDS Care and Support Program (HCSP)
2. Project Number: Contract No. 663-C-00-07-00408-03
3. Project Dates: June 15, 2007–June 14, 2010
4. Project Funding: $28,677,047
5. Implementing Organization: Management Sciences for Health (MSH)
6. Contracting Office Technical Representative (COTR): Dr. Abeje Zegeye

## I. IDENTIFICATION OF THE TASK

The USAID/Ethiopia (USAID/E) PEPFAR office requests technical assistance from the Global Health Technical Assistance Project (GH Tech) to design and implement an independent mid-term-project evaluation of the HIV/AIDS Care and Support Program (HCSP**)**. The HCSP has been implemented in four (4) regions and one city administration of the country, which includes: Amhara, Roomier, Southern Nations and Nationalities (SNNP), Tigray, and Addis Ababa city administrations. The HCSP has the overall goal to support the Federal Democratic Republic of Ethiopia (FDRE) to provide HIV/AIDS prevention, care, and treatment services at Health Centers (HCs), in the community and households, with the objective of decreasing HIV prevalence and improving the quality of life for People Living with HIV/AIDS (PLWHA) by strengthening the continuum of prevention, care, treatment, and support including antiretroviral therapy (ART). This external mid-term project evaluation will evaluate the achievements of the project goals and results and provide recommendations to USAID for further improvement and direction for the remaining base contract period of three years and optional years.

The USAID/E PEPFAR office requests that the in-country components of this evaluation be fielded on or about June/July 2009 in order that the findings, conclusions, and recommendations can not only assist the USAID/Ethiopia mission to evaluate the scale-up of ART and palliative care services and HCSP's contribution in expanding and providing quality HIV/AIDS care/support and treatment services at both health center and community levels, but also look at the effectiveness of the project implementation up to date and make recommendations for key program activity elements for the optional years of the contract.

## II. BACKGROUND

**USAID/E Response to HIV/AIDS:** From 2004 through 2006, an estimated 288,000 Ethiopians died from HIV/AIDS-related causes. The 2009 Federal estimate[7] of national HIV prevalence is 2.3%; 7.7% in urban areas and much lower in rural areas at 0.9% (FHAPCO, 2007[8]). As of 2009, more than one million (1,116,216) persons are estimated to be living with HIV and about 336,160

[7] Federal HIV/AIDS Prevention and Control Office (FHAPCO). *Single Point Estimates of HIV and OVC Indicators.* April 5, 2007.

people living with HIV/AIDS (PLWHA) are in need of ART (FHAPCO, 2008). About 175,612 PLWHA have started ART (FHAPCO, December 9, 2008). In Ethiopia most of the ART sites are hospitals, some of which are already overburdened by clients on ART and requiring chronic care. Therefore, to off-load these already overburdened hospitals and increase the geographic coverage of ART services, there is a need to decentralize the ART and care and support services to the health center and community levels.

Recent sentinel surveillance of antenatal care (ANC) data, and 2005 Ethiopia Demographic and Health Survey (EDHS) analysis, reveal a more concentrated urban HIV epidemic in Ethiopia than was previously believed. Representative survey data for Ethiopia suggest a predominately urban epidemic that is likely concentrated among high-risk populations. Based on the new prevalence information and behavioral data, USAID/PEPFAR Ethiopia's prevention, care, and treatment strategy prioritizes expansion of integrated packages of ART and palliative care and support services in urban and peri-urban areas at facility and community levels.

The U.S. Mission to Ethiopia's HIV/AIDS interagency team, which is composed of the Department of State, the Department of Defense, the U.S. Centers for Disease Control and Prevention (CDC), and the U.S. Agency for International Development (USAID), began integrated HIV/AIDS programming in 2004 under the oversight of the Office of the Global AIDS Coordinator. Peace Corps joined the PEPFAR team in early 2007. The U.S. Mission collaborates with a number of Ethiopian Government agencies—the HIV/AIDS Prevention and Control Office (HAPCO); the Ministry of Health (MoH); the Ministry of Finance and Economic Development; the Ministry of Youth and Sports; the Ministry of Women's Affairs; the Ministry of Education; and the Ministry of Labor and Social Affairs.

**USAID Integrated Strategic Plan FY 2004–2008 and the 2007 Foreign Assistance Framework:** USAID/Ethiopia's HIV/AIDS programs were initiated under the USAID/E Integrated Strategic Plan (ISP) for the period FY 2004–FY 2008 under the Mission Strategic Objectives (SO) 14 ***(Human capacity and social resiliency increased)*** and 14.2 ***(HIV/AIDS prevalence reduced and mitigation of the impact of HIV/AIDS increased)***. In 2007 SO 14 was incorporated into the Foreign Assistance Framework (F-Framework) for the USAID 2007 Operation Plan. The activities under the HCSP now fit under the F-Framework Priority Objective, ***Investing in People***, health program area, program element HIV/AIDS, within the program sub-elements treatment and care services including condoms and other prevention activities, TB/HIV co-management activities, counseling and testing, palliative care, basic health care support, and treatment services. USAID responds to the Ethiopian HIV/AIDS epidemic as part of PEPFAR in collaboration with the Ethiopian Government and numerous other partners. USAID supports prevention, care, and treatment activities with a combined FY 2007 program budget of over $213 million.

## III. OVERVIEW OF THE HIV/AIDS CARE AND SUPPORT PROGRAM (HCSP)

USAID Ethiopia issued a contract in June 2007 to Management Sciences for Health (MSH) to support a project entitled "Ethiopia HIV/AIDS Services at Health Centers and in the Community." **The HCSP Program is a three (3)-year base period contract with two (2) one-year option periods** through June 20, 2010, with a total life-of-activity amount of US$28,677,047 for the base three years with a total of US$46,621,578 including the optional years of USAID resources.

The HCSP project activities overlap and link HIV/AIDS prevention, care, support, and treatment activities to a previous project implemented by Family Health International (FHI), which ended in July 2007. The HCSP project was planned as a comprehensive and integrated service-strengthening intervention linked to prevention, care, support, ARV drugs, ART, and laboratory

services. HCSP focuses on supporting health centers that provide ART, HIV/AIDS care, and palliative care services. In addition, the project focuses on decentralizing comprehensive and integrated HIV/AIDS services to HCs and linking community and facility-based HIV/AIDS activities using case managers for personalized care, and kebele-oriented outreach workers (KOOWs) to support family focused prevention, care, and treatment in the community. In decentralizing the services to the HCs and linking to the community and household levels, a total of 255 health centers providing ART services, and 500 health centers implementing palliative care, have benefited from this program since June 2007. The scaling-up and decentralization of HIV prevention, care, and treatment is also designed to improve and strengthen referrals between hospitals, health centers, and community services, adherence to ART treatment, and co-management of HIV and tuberculosis. In addition, the HCSP program is intended to improve maternal health services through the expansion of an integrated approach to prevention of mother-to-child transmission of HIV (PMTCT) with IntraHealth International. To implement these activities, MSH is working with other key USAID/Ethiopia care and support partners, including the World Food Program (WFP), WHO/IMAI, and other orphans and vulnerable children (OVC) partners.

The HCSP contract was modified in March 2009 to expand and strengthen its scope of services in the provision of comprehensive PMTCT services and to initiate and scale up pediatric HIV/AIDS care, treatment, and support services.

The objective of the program is to decrease HIV prevalence and improve the quality of life for PLWHA by strengthening the continuum of prevention, care, treatment, and support, including ART, by expanding comprehensive HIV/AIDS services. HCSP is providing technical assistance to ensure the provision of quality integrated HIV/AIDS prevention, care, and treatment services at health centers, and build upon the previous FHI activities in this area. HCSP is working to ensure that high-quality HIV counseling and testing services, as well as TB diagnosis, referral, and treatment services, are available at *all* health centers it supports. HCSP is also providing additional technical assistance to Government of Ethiopia (GOE)-identified health centers to enhance asymptomatic and symptomatic palliative care. Of those GOE-identified health centers selected for enhanced palliative care and technical assistance, HCSP is also providing a smaller subset of GOE-identified health centers with additional technical assistance to enable them to initiate and maintain treatment services (i.e., ART). HCSP is also training health workers at the health center level to build their capacity to ensure delivery of decentralized ART services, including chronic disease management, within the national ART network throughout the country and to train and deploy case managers and KOOWs to link facility and community-based services. The specific results expected during the base contract period include:

**Result 1:** Provision of quality integrated HIV/AIDS prevention, care, and treatment services at health centers.

**Result 2:** Deployment of case managers to personalize care and strengthen referrals between health centers, hospitals, and community services.

**Result 3:** Deployment of outreach workers to support family-focused prevention, care, and treatment in communities.

**Result 4:** Implementation of HIV prevention activities using best practice “abstinence, be faithful, and condom” (ABC) interventions that incorporate stigma, discrimination, and gender concerns.

The HCSP project has used a tiered approach to achieve its objectives at health centers (Tiers One, Two, and Three). In this tiered approach MHC/HCSP will provide high-quality HIV

counseling and testing and TB DOTS (directly observed treatment, short-course) in 550 HCs, of which 400 HCs and 350 HCs will provide enhanced palliative care and ART services respectively (see the supporting document for services packages in each tier).

## IV. EXISTING PERFORMANCE OF HCSP

The HCSP has been implemented in four (4) regions and one city administration of the Ethiopia, including Amhara, Oromia, Southern Nations and Nationalities (SNNP), Tigray, and Addis Ababa City Administration. As of December 31, 2008, the USAID/PEPFAR-funded HCSP activities in Ethiopia had scaled up comprehensive HIV/AIDS services to 500 health centers, of which 255 HCs are providing ART services. About 33,975 and 176,288 individuals were receiving ART and basic palliative care respectively as of December 31, 2008. During this period 232 case managers and 2,502 KOOWs were trained and deployed (for detail accomplishments, see the supporting document). HCSP was asked to continue to work through partners including at the Federal level and regionally at the health center and community levels. The country, regions, zones, and woredas were expected to gain expanded access to the decentralized ART health centers' services in line with the Ethiopian HIV strategy for universal access and roadmap targets, which, in turn, were to be linked into the Health Network Model and hospitals providing ART services.

The HCSP is expected to continue to expand comprehensive HIV/AIDS service provision supporting decentralized ART services; training and deployment of case managers and KOOWs, and implementation of preventive services, complemented by the development of partnership strategies; and coordinate closely with other PEPFAR partners to ensure a standard approach to health center and community-based care, support, and treatment. This coordination is also expected to include active participation in the PEPFAR and national care and support and treatment technical working groups (TWG) and catchment-area meetings.

As outlined above, given the important mission of the HCSP, the results achieved by the HCSP, and the endorsement by the Office of the Global AIDS Coordinator (OGAC) to integrate the HCSP into the Ethiopia Country Operation Plan (COP) for Years Two and Three, and with the contractual obligation USAID/E modified and extended the HCSP through the PEPFAR planning period of FY 2009, subject to continued availability of funds and satisfactory performance. The emphasis areas for this modification are further to decentralize HIV/AIDS services, ensure that clinicians are trained using relevant technical curricula, and ensure service quality through clinical mentoring and supervision. Additional technical expertise will be procured from the contractor, which is needed to provide periodic supportive supervision and refresher trainings (see supporting documents for detailed activities of the modification).

**Monitoring, Evaluation, and Reporting:** MSH is expected to continue to provide a performance monitoring plan (PMP) on achievements, results, and/or outcomes throughout the contract period. There are two specific data required: i) those that report on progress toward contract deliverables and expected targets under the contract agreement; and ii) those that measure the PEPFAR HIV/AIDS indicators and indicators for assessing performance of activities accomplished to attain the deliverables. All HCSP indicators are required to be disaggregated by gender, age, and pregnancy status.

**Emerging Implementing Challenges to Consider:** Based on site visits and other sources over the past two years of HCSP activity implementation, six areas of concern have emerged in the Ethiopian operating environment:

- **Lack of capacity at regional, woreda, and facility levels**
  Regional capacity to support, prepare, and supervise health centers and to provide mentoring

roles is severely constrained by pervasive deficiencies at both the Federal and regional health management team levels. Their inability to provide supervision or mentoring to HCs has resulted in HCSP carrying out the mentoring and supervision rather than as a joint activity, as was planned.

- **High staff turnover/weak and understaffed HCSP regional offices**
  There is a chronic shortage of qualified health providers in Ethiopia. Qualified health providers move continuously to better opportunities with a subsequent high attrition of government and project health workers at woreda health offices and health centers. Retention of staff within MSH and its subgrantees is also an issue, due to a competitive local market for salaries and benefits.

- **Incomplete and poor data reporting quality on care and support activities** because the national Health Management Information System (HMIS) fails to capture palliative care/care and support service data for community-level activities.

- **Facility targets**
  Achieving TB/HIV co-management facility targets is constrained in the initial contract as the assumptions for TB and TB/HIV prevalence were over-estimated and the weak national TB program was not fully appreciated, leading to ambitious contract target indicators. During the March 2009 contract modification, review of the weak national TB program and laboratory support suggested a review of TB/HIV achievable targets (see above table).

- **The new business process re-engineering at the Ministry of Health**
  The effects of the HAPCO/MOH business process re-engineering process at the regional and Federal levels have resulted in less support and assistance to HCSP.

- **Lengthy and slow VAT reimbursement approval process**
  The Government of Ethiopia has initiated new and lengthy procedures for VAT reimbursement, which has delayed the reimbursement process.

## V. PURPOSE OF THE ASSIGNMENT

The main purpose of this evaluation is to focus on assessing the effectiveness of the MSH/HCSP program at facility and community-based service levels, identify implementation gaps/challenges, and propose key recommendations to improve the achievements and areas to focus during the optional years. To achieve these objectives, USAID/E requires a team of three independent consultants to conduct a mid-term project evaluation of the HCSP Project. GH Tech staff for this evaluation must be limited to GH Tech staff or subcontractors who are **not** currently implementing HIV/AIDS-related programs in Ethiopia.

This evaluation will collect information about the effectiveness of HCSP implementation, in providing quality and comprehensive HIV/AIDS services, establishing linkages of HCs with hospitals and community services, progress updates, and challenges. This evaluation will assess the contribution of HCSP's family-focused care model to improving the quality of HIV/AIDS care/support and treatment services at the health center and community levels. It will also assess the process used by MSH/HCSP to provide and scale up comprehensive and integrated HIV/AIDS service interventions at the health center level, using a tiered approach, and at the community level through the use of KOOWs.

The evaluation will determine the success, results, and/or outcomes of the HCSP in achieving the following key main objectives as specified in the project result areas: strengthen decentralized ART services at health center and community-based services; strengthen and expand accessibility to and availability of ART services; and increase access to care/support and treatment services for

persons living with HIV/AIDS (PLWHA). The evaluation team will formulate recommendations for strengthening, scale-up, and areas to be improved beyond the three-year base period. The evaluation will focus on the HCSP program performance period from June 2007 to the present. The evaluation report will be designed to help USAID/E and MSH address issues of management, scale-up, and quality of services in HCSP-implemented regions and facilities.

## VI. EVALUATION SCOPE AND QUESTIONS

This external mid-term project evaluation will evaluate deliverables toward the achievements of the HCSP project goals and results and provide recommendations to USAID for further improvement and direction for the remaining base contract period and optional years. This evaluation will include, but is not limited to, the following questions:

### Program Management

- What is the contribution of HCSP assistance in developing woreda health office comprehensive HIV/AIDS service plans?
- How effectively has MSH/HCSP coordinated, managed, and linked facility and community-based services?
- What is the contribution of KOOWs and case managers in improving family-focused prevention, care, and treatment and personalized care services respectively?

### Program Accomplishments and Results

- Is there evidence that utilization of the case manager and KOOW approach has:
  - Introduced and improved the quality of decentralized ART services and chronic disease management at the health center level?
  - Improved the quality of chronic disease management within the ART network by linking facility and community-based services?
  - If not, why not? What suggestions does the team have for improving integrated service delivery using these cadres in personalized care and the family-focused approach?
- Is there evidence that MSH/HCSP-assisted facilities are providing comprehensive HIV/AIDS services (specifically, voluntary counseling and testing, ART, laboratory, PMTCT, TB, TB/HIV, pediatric care and support, STI prevention, and treatment and prevention with positives (PWP)]) in health centers?

### Monitoring and Evaluation (M&E)

- What M&E system did MSH/HCSP use to monitor the progress and trend of their achievements?
- Is the performance monitoring plan (PMP) developed and used to provide timely and high-quality data? If not, why not? What suggestions does the team have for improving the M&E system?

### Lessons Learned

- What are the promising lessons and approaches for expanding the comprehensive family-focused HIV/AIDS care and support services in HCSP to additional health centers?

- How is HCSP's personalized and family-focused care approach between health centers and the community levels best introduced?
- What are the lessons learned from successful interventions that merit continuation or replication, better practices, and significant products and tools from the HCSP for possible dissemination and replication?

## VII. EVALUATION METHODS

The evaluation will be carried out in Ethiopia by a team of three independent, external consultants over a four or five-week period through multiple qualitative (including focus group discussions (FGD)) and quantitative methods. One or more USAID staff and up to three GOE representatives may join the evaluation team during the core team planning meetings, in briefings, site visits, debriefings, and report preparation. GH Tech will be responsible for covering the GOE travel costs based on estimates provided by USAID/Ethiopia. If feasible, USAID staff will be available for the full period of performance so that they are active and full participants in the entire assignment. Given other commitments on the part of GOE participants, it is unlikely that they will be available for the entire duration of the evaluation. About 27 health centers will be selected for this evaluation from the HCSP-assisted ART facilities in purposive sampling and client load on ART program. The evaluation methodology and checklist will be designed by the team in collaboration with USAID/E to include key informant interviews, FGDs, field observation, facility and community-level assessments, and a review of HCSP reports.

Interviews will include the following (NB: the following list is not comprehensive, only illustrative):

- USAID Mission staff, including the HIV/AIDS Team and staff from the Office of Financial Management (OFM), Acquisition and Assistance Office (AAM)
- World Health Organization (WHO)
- Management Science for Health, HIV/AIDS Care and Support Project (HCSP) central and regional offices and subpartners (IntraHealth and Save the Children USA among others)
- Government of Ethiopia representatives—Regional HIV/AIDS Prevention and Control Organization (HAPCO), and regional health bureaus (Ministry of Health), woredas (health offices and/or HAPCO)
- Beneficiaries (health center staff, PLWHA)
- Other PEPFAR implementing partners (WFP, Abt Associates, MSH/SCMS)

## VIII. INFORMATION SOURCES

Reviewers will be provided the following background documents in preparation for the assignment.

- HCSP contract agreement, including modification documents
- HCSP *2007 Annual Report* and *2008 Semi-Annual Report*
- HCSP Quarterly Reports
- WHO/IMAI evaluation report

- USAID trip reports summarizing past field visits to HCSP sites
- GOE *Road Map for HIV/AIDS Prevention, Care and Treatment*
- GOE Universal Access target documents
- *Ethiopia Demographic and Health Survey 2005*
- Federal HIV/AIDS Prevention and Control Office (FHAPCO), *Single Point Estimates of HIV and People Needing ART Therapy*, April 5, 2007
- HAPCO/WHO PMTCT assessment review, February 2009.

## IX. TASKS TO BE ACCOMPLISHED

Below is a list of the specific tasks to be accomplished by the evaluation team, with an estimated level of effort for each task (see Attachment 2, planning calendar, for the exact schedule).

| | |
|---|---|
| Background document review | 3 days |
| International travel days for international consultants | 2 days |
| Team planning meeting in-country (develop evaluation methodology and complete field visit and interview schedule in consultation with COTR and evaluation coordinator (one month prior to departure) and in brief with USAID/E HIV/AIDS technical staff | 3 days |
| Meetings and interviews with key stakeholders in Addis (including MSH/HCSP overall presentation) | 2 days |
| Conduct field visits and interviews (three teams in five regions), including quick snapshot presentations by regional MSH offices | 12 days |
| Full team synthesis/analysis of findings and draft report; prepare for debriefings | 7 days |
| Conduct debriefings for USAID/E and MSH (separately) | 1 day |
| Finalize and submit draft report to USAID/E in-country | 2 days |
| Travel day for international consultants | 2 days |
| Finalize report—team leader incorporates Mission comments (TL: 5; TM: 3) | 5/3 days |

Total level of effort (LOE)—39 days of LOE for team leader and up to 37 days for team members, including four travel days each for the international consultants. A six-day work week is authorized for work in Ethiopia.

## X. TEAM COMPOSITION, PARTICIPATION, AND SELECTION CRITERIA

USAID/E seeks three international consultants and one local logistics assistant:

1. A senior expatriate team leader experienced in evaluating USAID HIV/AIDS programs, with in-depth knowledge and experience in decentralizing care/support and treatment services at the primary health care (PHC) level.

2. A senior expatriate care and treatment specialist team member
3. A senior expatriate community-based HIV/AIDS care and support specialist team member
4. A local evaluation logistics assistant

The core evaluation team will consist of three expatriate team members and three Ethiopian members from regional health bureaus/HAPCO. In addition, one or more USAID/E staff will serve as members of the evaluation team. The evaluation team may include PEPFAR Ethiopia and Washington-based participation (NB: It is assumed that USAID staff will cover their own travel and per diem costs.) During the field portion of the evaluation, five days will include the entire core team's visits to selected HCs and surrounding communities covering all of the HCSP geographic regions of implementation. HCSP staff may accompany the team on site visits as appropriate but will not be present during interviews with the stakeholders and beneficiaries. For the remaining seven days of field visits, the core team will be divided into three teams of two core members each.

1. **The senior team leader** will be an international consultant with extensive PEPFAR program implementation and evaluation experience, with particular focus on decentralizing care and support, treatment, and palliative care services at PHCUs. S/he will agree to fulfill his/her responsibilities in eight weeks, spending six weeks in-country, and will play a central role in guiding the evaluation process. The consultant will hold conference calls with core team members and USAID/E representatives before and after the visit to Ethiopia, in-brief USAID/E on arrival, debrief USAID/E and MSH on evaluation findings, and produce a draft report to be left with USAID/E prior to departure, followed by a final report for USAID/E.

The team leader will:

- Finalize and negotiate with the client the team work plan for the assignment.
- Establish assignment roles, responsibilities, and tasks for each team member.
- Ensure that the logistics arrangements in the field are complete.
- Facilitate the team planning meeting or work with a facilitator to set the agenda and other elements of the TPM.
- Take the lead on preparing, coordinating team member input, submitting, revising, and finalizing the assignment report.
- Manage the process of report writing.
- Manage team coordination meetings in the field.
- Coordinate workflow and tasks and ensure that team members are working to schedule.
- Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, payment is made for services, car/driver hire or other travel and transport is arranged, etc.).

### Selection Criteria for Senior Team Leader

(Maximum 100%) distributed as follows:

- **Education: (25%)** An advanced degree (MD, RN, MPH, PhD, MA, MS, or MBA) from a reputable accredited institution in medicine, public health, or any of the social sciences pertinent to work with care and support and palliative care.

- **Work Experience: (35%) Minimum 10 years** of progressively responsible experience with recognized organization(s) in the design, implementation, and evaluation of HIV/AIDS programs with demonstrated technical expertise and skills in HIV/AIDS care/support, treatment, and palliative care.

- **Skills and Abilities: (40%)** Demonstration of strong analytical, managerial, and writing skills is very critical for the evaluation work. Exceptional leadership in coordinating; assigning team members with appropriate responsibilities; communication; and interpersonal skills are absolutely critical. In addition, the team leader must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGOs counterparts. The senior team leader must be fluent in English and have proven abilities to communicate clearly, concisely, and effectively, both orally and in writing. The senior team leader must be able to produce a succinct quality document that directs and improves HCSP programs in the country.

2. **The Care and Treatment Specialist:** This team member will be an international consultant with extensive implementation and evaluation experience of care and treatment services at the PHC level. Knowledge of HIV/AIDS programming and PEPFAR is essential. The specialist will be responsible for writing sections of the report to be determined during the TPM in consultation with the team leader. The specialist will assist the team leader in the development of any qualitative and quantitative instruments and checklists to be used during site visits as well as the analysis of any data collected.

### Selection Criteria for Care and Treatment Specialist Team Member

(Maximum 100%) distributed as follows:

- **Education: (25%)** MD, RN, MPH, Ph.D., MA, MS, MBA, or BA from a reputable accredited institution in medicine, public health, or any of the social sciences pertinent to working in HIV/AIDS programs, with special emphasis on care and treatment services at the PHC level.

- **Work Experience: (35%) Minimum 6 years** of progressively responsible experience with recognized organization(s) in the design, implementation, and evaluation of decentralized ART programs, with demonstrated technical expertise and skills in HIV/AIDS in sub-Saharan African countries.

- **Skills and Abilities: (40%)** Demonstration of strong analytical, managerial, and writing skills. The specialist must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. The specialist must be fluent in English and have proven abilities to communicate clearly, concisely, and effectively, both orally and in writing.

3. **The Community-Based HIV/AIDS Care and Support Specialist** team member will be an international consultant with extensive implementation and evaluation experience of community-based care and support services. Knowledge of HIV/AIDS programming and PEPFAR is essential. The specialist will be responsible for writing sections of the report to be determined during the TPM in consultation with the team leader. The specialist will assist the team leader in the development of any qualitative and quantitative instruments to be used during site visits, as well as the analysis of any data collected.

### Selection Criteria for Community-Based HIV/AIDS Care and Support Specialist

(Maximum 100%) distributed as follows:

- **Education: (25%)** MD, RN, MPH, Ph.D., MA, MS, MBA, or BA from a reputable accredited institution in medicine, public health, or any of the social sciences pertinent to working in HIV/AIDS programs, with special emphasis on decentralizing ART program and linking community and facility-based HIV/AIDS prevention, care, and treatment services using volunteers and community support groups.

- **Work Experience: (35%) Minimum 6 years** of progressively responsible experience with recognized organization(s) in the design, implementation, and evaluation of ART programs at the PHC level, with demonstrated technical expertise and skills in HIV/AIDS in sub-Saharan African countries.

- **Skills and Abilities: (40%)** Demonstration of strong analytical, managerial, and writing skills. The specialist must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. The specialist must be fluent in English and have proven abilities to communicate clearly, concisely, and effectively, both orally and in writing.

4. **The Evaluation Logistics Assistant** will be a local consultant, preferably fluent in Amharic, with a demonstrated ability to be resourceful and execute complex logistical coordination successfully; multi-task; work well in stressful environments; perform tasks independently with minimal supervision; and work collaboratively with a range of professional counterparts at all levels.

The assistant will be responsible for logistics, coordination, administrative support, and ensuring all aspects of the evaluation are carried out seamlessly. He/She will assist the team leader and the implementing agencies in facilitating meetings, coordinating logistics,, and organizing site visits. The assistant will collect and disseminate background documents to the evaluation team.

### Selection Criteria for Mid-Level Evaluation Logistics Assistant

(Maximum 100%) distributed as follows:

- **Education: (25%)** MA, MS, MBA, or BA. Four years of work experience may be substituted for the degree.

- **Work Experience: (35%) Minimum 6 years** of progressively responsible experience within GOE and/or NGO work settings handling complex logistics, such as coordinating business travel and meetings.

- **Skills and Abilities: (40%)** The assistant must have a demonstrated ability to be resourceful and successfully execute complex logistical coordination; multi-task; work well in stressful environments; perform tasks independently with minimal supervision; work collaboratively with a range of professional counterparts at all levels (including those from host country governmental and non-governmental organizations, U.S. Government agencies and other donors); and manage time effectively. The assistant must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. The assistant must be fluent in English and preferably Amharic, and have proven abilities to communicate clearly, concisely, and effectively, both orally and in writing.

## XI. SCHEDULE AND LOGISTICS

The in-country phase of the evaluation will be conducted over a period of up to 27 days with a desired start date on or about June 15, 2009. The Evaluation Logistics Assistant, in collaboration with the USAID/E Evaluation Coordinator and MSH, will arrange all of the partner meetings, site visits, and debriefings in advance. All associated travel and per diem costs for non-USAID staff will be covered by GH Tech under the contract with USAID/E (see Attachment 2, planning calendar, for the exact schedule).

## XII. Period of PERFORMANCE

Work is to be carried out over a period of approximately fourteen weeks, beginning on or about June 10, 2009, with field work completed on or about July 16, 2009, and final report and close-out concluding in August 2009.

## XIII. Financial Plan

A budget plan agreement between the USAID/E PEPFAR and GH Tech will be reached, and USAID/E will process a modified acquisition and assistance request document to transfer funding for the evaluation activity into the GH Tech Indefinite Quantity Contract.

## XIV. DELIVERABLES

**Finalized no later than in-country TPM:** Team Leader will develop an assessment methodology, and field visit and interview schedule, in consultation with the USAID/E Contracting Officer's Technical Representative, USAID/E Evaluation Coordinator, and MSH.

**Within three days after Team Leader arrival in country:** Team planning meeting and in-briefing with USAID/E. USAID/E HIV/AIDS technical staff to review and comment on evaluation methods.

**Prior to departure:** Team makes a presentation to USAID/E and a separate presentation to MSH and its partners. Team Leader will submit a draft report to USAID/E Evaluation Coordinator—two hard copies and one electronic copy on CD ROM or flash drive. The report will be appropriately edited/formatted after the final draft is approved by the mission (see separate MS Word file for GH Tech Evaluation Report Guidelines).

**After departure:** Team leader submits final unedited content to USAID/E within one week of receiving comments from USAID/E. The report (not including attachments) will be no longer than 30 pages with an executive summary, introduction, methodology, findings, lessons learned, conclusions, and recommendations in English in the exact format specified by the USAID/E Evaluation Coordinator.

Upon final approval of the content by USAID/E, GH Tech will have the report edited and formatted. This process takes approximately three–four weeks. The final report will be submitted electronically to the USAID/E Evaluation Coordinator and Contract Officer.

GH Tech makes the results of its evaluations public on the Development Experience Clearinghouse and on its project website unless there is a compelling reason (such as procurement sensitivities) to keep the document internal. Therefore, GH Tech will request USAID/E confirmation that it will be acceptable to make this document publicly available. If there are certain restrictions regarding specific parts of the report that should be removed from a public version due to procurement-sensitive information, GH Tech may produce a second version suitable for public availability.

# APPENDIX B: LIST OF PERSONS CONTACTED

| NAME | POSITION |
|---|---|
| **USAID/Ethiopia** | |
| Abeje Zegeye | Acting Team Leader, HIV/AIDS Team |
| Sophie Brewer | HIV/AIDS Team M&E Advisor |
| James Browder | Treatment Advisor |
| Dawit Abraham | SI Advisor |
| Nancy Estes | Acting Director |
| Garoma Kera | |
| Henok Amenu, A&M Office | |
| Peter Gichangi | Prevention Advisor |
| Chinyere Omeogu | PMTCT/MCH Advisor |
| Meri Sinnitt | HAPN Office Chief |
| Zemenu Adane | |
| **MSH Addis Ababa and Field Offices** | |
| Dr. Negussu Mekonnen | MSH Country Representative |
| Ms. Hany Abdallah, MSH/SCMS | |
| Ms. Gail Amara, MSH Operations Director<br>Mr. Bud Crandall, HCSP COP<br>Ato Haile Wubneh, HCSP DCOP<br>Dr. Muluken Melese, Program Integration Director<br>Ms. Tigisti Mehreteab, Executive Assistant<br>Ato Atnafu Getachew, PTMTC Advisor<br>Ms. Seble Hailu, Training Manager<br>Dr. Belkis Wolde Georgis, Gender and NGP Capacity-Building Advisor<br>Ato Tefero Fotsopm Advisor IMAI<br>Atu Hailu Meche, Strengthening Health Systems Advisor<br>Dr. Asaminew Girma, M&E and Quality Management Advisor<br>Dr. Berhanemeskel Assefa, HIV/TB<br>De. Afework Negash, MSH HQ<br>Dr. Mebrahtu Abraha, Tigray PMTCT Advisor, Acting Program Integration Advisor, Mentor<br>Ato Gabre Mekonnen, Tigray Outreach and Care and Support Advisor<br>Dr. Tsegaza-Ab, Tigray Senior Mentor, Treatment Specialist<br>Ato Berhanu, Amhara Outreach, Care and Support Advisor<br>Ato Kassa Truneh, Amhara Regional Office | AA Regional Advisor |

| NAME | POSITION |
|---|---|
| Dr. Asfaw Ayaleu, Mentor<br>Ato Negatu Mereke | |
| Dr. Minassie Beyene | Oromia Regional Advisor |
| Solomon Yimam | Care & support) |
| **Other Donors**: | |
| Dr. Gideon Cohen, World Food Program/Ethiopia | |
| Dr. Akram Eltom, World Health Organization | |
| Dr. Seblewongel Abate, World Health Organization | |
| **FDRE Senior Officials**: | |
| Dr. Betru Tekle, FHAPCO<br>Ato Meskele Lera, FHAPCO<br>Ato Getachew Teshome, Addis Ababa Regional Health Bureau<br>Dr. Achamyeleh Alebachew, A.A HAPCO<br>Dr. Gudeta Tibesso, Ethiopia Health and Nutrition Research Institute (EHNRI)<br>Ato Shalo Daba, Dr. Kassa Hailu, Dr. Zenebech Yadete—Oromia Regional Health Bureau<br>Ato Samuel, Tigray Regional Health Bureau<br>Ato Yohannes, Tigray Regional Health Bureau<br>Ato Wondemagen Tadesse, Head, South Wollo Dept. of Health | |
| **Kolfe Health Center (Kolfe-Keranyo sub-city)** | |
| Ephrem Mergia | Prevention (AA) |
| Melaku Muleta | BCC Coordinator, Oromia |
| Ato Yared Kejela | HO, Outgoing Health Center Head |
| Ato Ebsa Feyisa | ART Focal Person |
| S/r Nigist G/Wahd | PMTCT and ANC |
| Ato Genene Deyou | TB |
| Ato Eshetu Demeke | ART Data Clerk |
| Misrak Abraham | ART Case Manager |
| Wondimu Daniel | PMTCT, Delivery |
| Yayehyrad Derese | Pharmacy |
| Elsabet Mezgebu | VCT |
| Takele Dagnachew | Laboratory |
| Mariah Mohammed | KOOW |
| Syntayehu Endale | KOOW |
| Kelemua Demisse | KOOW |
| Amsale Yegilete | KOOW |
| Amsale Adugna | KOOW |

| NAME | POSITION |
|---|---|
| Abebech Maru | KOOW |
| Enatnesh Fissiha | KOOW |
| Workinesh Assefa | KOOW |
| Zenebech Alemayehu | KOOW |
| Loulseged Alemayehu | KOOW |
| **Tekle Hymanot Health Center** | |
| Dr. Zemzem Mohamed | Health Center Head |
| Getachew Assefa | Disease Prevention & Control Coordinator |
| Elisabet Tesfaye | VCT Counselor |
| Abiy Getahun | ART Pharmacy |
| Shiwangizaw Getahun | Laboratory Head |
| S/r Genet Miruse | PMTCT |
| Shewaleme Gebru | ART |
| Kassahun Geletu | ART Data Clerk |
| Endale Abebe | OPD |
| Amelework Sory | ART |
| Wubishet Astateke | TB |
| Aster Gizaw | EPI |
| Tariku Teka | OPD |
| Syntayehu Tadesse | IMICI |
| **Bole Health Center** | |
| Dr. Zelalem Demeke | Health Center Head |
| Merachew Afework | Laboratory |
| S/r ----- Mesgina | MCH, PMTCT |
| Workye Molla | Pharmacy |
| Teklu Lema | HO |
| Lemlem Asnake | Data Clerk |
| Tigist kebede | Counselor |
| S/r Abebech Haile | MCH Head |
| **Woreda 19 Health Center (Nefas Silk-Lafto sub-city)** | |
| S/r ---- Tesfaye | Health Center Head |
| Kelemua Bizuayehu | ART Data Clerk |
| Mezmure Wondimu | ART |
| Martha Seyoum | ART Pharmacy Data Clerk |
| Solomon Emiru | Pharmacy-ART |
| S/r Martha Mitiku | IMMCT Nurse |
| Ato Amsale Mekonen | Chief Lab Tech |

| NAME | POSITION |
|---|---|
| S/r Tegegu Bekele | PMTCT |
| Mulugeta Kidan | ART Nurse |
| Resfahun Tilahun | ART Case Manager |
| Zuriash Yilma | ART Case Manager |
| Asnakech Tsadiku | KOOW |
| Aynalem Ayenachew | KOOW |
| Frew Melesse | KOOW |
| Mekdes Mesfin | KOOW |
| Muluwork Sherefa | KOOW |
| Selamawit Wogi | KOOW |
| Anteneh Teshome | KOOW |
| Rahel Assefa | KOOW |
| **Woreda 23 Health Center** | |
| Ato Yoseph | Health Center Head |
| Eyerusalem Sebane | KOOW |
| Lemelem Bekele | KOOW |
| Senait Tufa | KOOW |
| Bizunesh Mekuria | KOOW |
| Shimeles Abegaz | KOOW |
| **Holeta Health Center** | |
| Ato Meseret Bekele | Health Center Head |
| Kirubel Tesfaye | Data Clerk |
| Tarike Alemayehu | Case Manager |
| Yeshi Mekonen | ART Nurse |
| Gashaw Amenu | TB/Leprosy Nurse |
| Gezahegn Adefris | Lab Tech |
| Boja Mammo | Counselor |
| Alemnesh Gelana | Midwife Nurse, ANC,PMTCT |
| Keria Shefa | KOOW |
| Behailu Byene | KOOW |
| Alemnesh Dida | KOOW |
| Zinash Bekele | KOOW |
| Birtukan Hunde | KOOW |
| Demoze Kebede | KOOW |
| Sara Aklilu | KOOW |
| Kuri Gemeda | KOOW |
| Efrem Girma | KOOW |

| NAME | POSITION |
|---|---|
| Dejene Alemu | Community Core Group (CCG) Member |
| Kebede Sime | Community Core Group (CCG) Member |
| Kassahun Moges | Community Core Group (CCG) Member |
| Zerihun Gebeyehu | Community Core Group (CCG) Member |
| Tesfaye Hailu | City Forum Secretary |
| Gedefa Tento | Iddir Chairperson |
| Kebebew Tadesse | Community Mobilizer |
| **Sendafa Health Center** | |
| Alemework Taye | ART Focal Person |
| Alemnesh Lema | Data Clerk |
| Kumeshi Abdissa | MCH |
| Tamene Goshu | Lab Tech |
| Atrie Fekadu | Health Center Head |
| S/r Wossene Bizuayehu | Woreda Health Bureau Head |
| Shimelis Eshetu | Case Manager |
| Chala Shumi | Counselor |
| Fikadu Dinku | TB/HIV Focal Person |
| Mulugeta Teshome | Pharmacist |
| Zewdu Desalegn | KOOW |
| Getye Getnet | KOOW |
| Mindaye Taddesse | KOOW |
| Daniel Girma | KOOW |
| Senait Alemu | KOOW |
| Syntayehu Gizaw | KOOW |
| Netsanet Dereje | KOOW |
| **Modjo Health Center** | |
| Rev. Zelalem Demisse | KOOW |
| Derebe Meshesha | KOOW |
| Aynalem Anbessu | KOOW |
| Aberash Tesfaye | KOOW |
| Getenesh Tamene | KOOW |
| Tesfaye Taddesse | Community Mobilizer |
| Ato Haji Rabo Feyissa | Modjo City Health Bureau Head |
| **Tulu Bolo Health Center** | |
| S/r Tsion Hailu | PMTCT Focal Person |

| NAME | POSITION |
|---|---|
| Rediet Dadi | Data Clerk |
| Iwanaa Nigissa | HIV/AIDS Prevention Expert |
| Dejene Bogale | OPD Nurse |
| Tsehay Gelalcha | VCT Community Counselor |
| Gemechu Tulu | Lab Tech |
| Fanose Gadisa | Care and Support |
| Elizabeth Negash | Pharmacy Tech |
| Mentewab Leul | ART Clinic |
| Retta Fayyisa | Woreda Health Bureau Head |
| Beferdu Teka | CCG |
| Hailu Jimale | CCG |
| Belete Kebede | Community Mobilizer |
| Dejene Hailu | KOOW |
| Gizachew chuko | KOOW |
| Aregash Bekele | KOOW |
| Abyot Mammo | KOOW |
| Birke Wolkeba | KOOW |
| Worku Terecha | KOOW |
| Wondimale Kebede | KOOW |
| **Adulala Health Center** | |
| Tsion Benti | Under 5 Care |
| Selam Aloma | TB/HIV |
| Gezu Fayissa | CM |
| Yirgalem Firisa | ART |
| Tesfa Ketema | Community Counselor |
| Tayech Mekonnen | Lab Tech |
| Genet Girma | MLT |
| **Adama Hospital** | |
| Dr. Dagim Assefa | Medical Director |
| Tibika Moges | HO, ART Clinic |
| **Zewditu Memorial Hospital** | |
| Dr. Aster Shewa Amare | Disease Prevention & Control Sub-process Owner |
| Haile Mariam Wolde Medhane Alem | HC Director |
| Birtucan | HCSP PICT/TB Advisor |
| Natnael Eshetu | Interpreter/Driver |
| Tesfaye Mamberu | Interpreter |
| Atete | Case Manager |

| NAME | POSITION |
|---|---|
| Betnean Said | HO |
| Kadis (absent) | HC Director |
| Ameraworq | Case Manager |
| Zineretu Said | Data Clerk |
| Wondemagen Tadesse | S. Wello Dept. of Health |
| Dr. Asfaw Ayaletu | Mentor |
| Tilahun Lota | HC Director |
| Goitum | Interpreter |
| Amare Fentaw | HC Director |
| Mogus | Com. Mobilizer |
| Ababa | Case Manager |
| | Mentor |
| Turemay | HC Director |
| Hagos | Lab Tech |
| Fisseha | Pharmacist |
| Sister Tsehai | PMTCT |
| Nurse Hayetum | HIV/AIDS Treatment |
| Ashenagi | Woreda HO |
| Alemnesh Zerai | Woreda HO |
| Mohammed | HC Director |
| Tadesse Belayneh | HC Director |
| Saru Hassein | HC Director |
| Berhanu Negussi | HC Director |
| Aberu | Community Mobilizer |
| Alemat | Case Manager |
| Nasser | HC Director |
| Samuel Darejje | Hospital CO |
| Nurati | Hospital Medical Director |
| Tigist Belayneh | Case Manager |
| Berhane Haile Kristos | KOOW |
| Gennet Zemeda | Community Mobilizer |
| Demissie | KOOW |
| Teffad Admasu | KOOW |

| NO. | DATE/NAME | POSITION | DEPARTMENT |
|---|---|---|---|
| **SN** | **10-July-09** | **Gonder HC** | **Amhara** |
| 1 | Sr. Tiruye Nega | PMTCT Counselor | ANC |
| 2 | Ato Yalew Cassie | ART Pharmacy | Pharmacy |
| 3 | Ato Dagnew Uri/Matzshan | TB | TB Clinic |
| 4 | Ato Ketema Nizusie | Administrator | |
| 5 | Shashe Zewda | HO | ART |
| 6 | s/r Zewditu Begashaw | Nurse | OPD |
| 7 | s/r Kassanesh Bryhan | Nurse | Under 5 Clinic |
| 8 | Ato Massa Yenealem | Community Counselor | VCT |
| 9 | Abeba Glyhonnes | Nurse | F/P |
| 10 | Eyeros Eyayu | Data Clerk | ART Clinic |
| 11 | Zariash Aiemu | Community Counselor | VCT |
| 12 | Endaik Adane | Laboratory Technician | Laboratory |
| 13 | Atoene Shmihret | HO | OPD |
| 14 | Szahmaz Jemma | Nurse | ART |
| 15 | Mulu Ahi | HO | OPD |
| 16 | Mossa Mammo | Data Clerk | ART Pharmacy |
| 17 | s/r Niaste Tsegaye | Adherence Nurse | ART |
| 18 | Abiy Tesfaue | Head | |
| | **13-July-09** | **Durbete HC** | **Amhara** |
| 1 | Hedija Dawad | Midwife | MCH |
| 2 | Firrie Jemal | Midwife | MCH |
| 3 | Enortreosh Asneaiczw | Community Counselor | VCT |
| 4 | Shirshi Kindi | Health Officer | ART |
| 5 | Tiozist Alemoye | Data Clerk | ART |
| 6 | Dessalegne Dametie | Nurse | OPD |
| 7 | Tarekegn Arabie | ART Druggist | Pharmacy |
| 8 | Getachew Mengistu | Head of HC/Lab Tech | |
| | **13-July-09** | **Dangila HC** | **Amhara** |
| 1 | Mulusew Abemneh | Laboratory Technician | Medical Laboratory |
| 2 | Seidu Bilul | Data Clerk | Computer Science |
| 3 | Enanu Worditnu | H/A | Counselor |

| NO. | DATE/NAME | POSITION | DEPARTMENT |
|---|---|---|---|
| 4 | Sizyigartoh Tessema | Midwife | PMTCT |
| 5 | Tigabitu Asmore | Pharmacy | Pharmacy |
| 6 | Beoau Alemu | Lab Tech | Laboratory |
| 7 | Gherenet Shimekaw | Health Officer | OPN, ART, TIS |
| 8 | s/r Yesle Kossa | n/s | ART Clinic |
| | **14-July-09** | **Deten HC** | **Amhara** |
| 1 | Hafiza Mussa | Pharmacist | Pharmacy |
| 2 | Berehane Meshesha | PICMT, Adherence Nurse, Prescriber | Nursing |
| 3 | Tibetau Abebe | HO | OPD |
| 4 | Addis Adegen | Midwife | MCH |
| 5 | Ambeo, Gegmet | Community Counselor | Counselor |
| 6 | Alehesn Amare | Lab Technician | Laboratory |
| 7 | Rentanun Meiku | Data Clerk | ART |
| | **6-July-09** | **Kofele HC** | |
| 1 | Abdo Dule Jerjera | Community Counselor | VCT |
| 2 | Klendimagen Fisseha | Druggist | Pharmacy |
| 3 | Faziya Mussen | Data Clerk | ART |
| 4 | Gizachew Abdissa | BSCMN | ART/PMTCT |
| 5 | Chaito Nebo | Lab Technician | Lab |
| 6 | Deketo Kediro | BSCN | ART/TB/HIV |
| | **17-July-09** | **Awasa HC** | **SNNPR** |
| 1 | Aynolen Churoicka | Delivery | PICT |
| 2 | Eltnesh Naushe | ANC | PMTCT |
| 3 | Sitria Jemal | Lab | Laboratory |
| 4 | Hiwot Darsene | ART Clinic | ART |
| 5 | Rui Sharw | TB/HIV | TB |
| 6 | Tozelele Teha | Counselor | |
| 7 | Asaninew Mengwew | Data Clerk | ART |
| | **17-July-09** | **Bushulo HC** | **SNNPR** |
| 1 | Margarita Joseph | C. Nurse | G/W |
| 2 | Eden Getacher | HO | OPD |
| 3 | Tigist Tesfaye | Data Clerk | ART |

| NO. | DATE/NAME | POSITION | DEPARTMENT |
|---|---|---|---|
| 4 | Enida Dor Taderse | Lab Tech | Lab |
| 5 | Agar Abraham | Nurse | MCH |
| 6 | Chali Gudina | Druggist | Pharmacy |
| 7 | Almaz Kebede | Nurse | Counseling |
| | **20-July-09** | **Adola HC** | **SNNPR** |
| 1 | Tariku Kabayp | AHC | VCT |
| 2 | Zenith Seltani | Pharmacist | ART |
| 3 | Henon Walde | Health Officer | OPD |
| 4 | Mewuded Husen | Data Clerk | ART |
| 5 | Chullo Siba | Nurse | ART Clinic |
| 6 | Abiyo Wako | Program Coordinator | ART Clinic |
| 7 | Sr Tigisa Zewdie | Nurse | TB |
| 8 | Sr Hana Wako | Nurse | TB |
| 9 | Adameah Gemede | Lab technician | Lab |
| 10 | Hailu Kebese | Officer | Zonal Clinical Mentor |
| 11 | Wogene Dugera | CMV | Coordinator |
| 12 | Mesere Adafre | CMV | Case Management |
| | **31-July-09** | **MSH De-briefing** | **Addis Ababa** |
| 1 | Gebremedhim K. Marian | Prevention Team Leader | |
| 2 | Tigishi Mehreteab | Executive Assistant | |
| 3 | Judy Webb | Senior Contracts Manager | |
| 4 | Atrayu Getachew | PMTCT Advisor | |
| 5 | Seble Haiw | Training Manager | |
| 6 | Teferi F. Tsion | Clinical Advisor IMAI | |
| 7 | Hailu Mecke | Senior Health Systems Advisor | |
| 8 | Muluken Melese | Program Integr Director | |
| 9 | Haile Wubneh | Dep COP | |
| 10 | Asamingw Girma | M&E Advisor | |
| 11 | Belkiswolde Giorgis | Gender & NGO Capacity-Bldg | |
| 12 | Bud Crandall | COP | |

# APPENDIX C:KEY INFORMANT INTERVIEW AND FOCUS GROUP DISCUSSION GUIDES

## DRAFT HCSP MID-TERM EVALUATION DATA COLLECTION DOCUMENTS

### No. 1: Basic Checklist for HCSP-Assisted Tier 1 Health Centers

**Tier 1.** The Contractor shall support the delivery of high-quality HIV counseling and testing and TB DOTS services in 550 GOE health centers. Specifically, at all health centers supported under the contract, the Contractor shall provide technical assistance and ensure the provision of services to support implementation of the following:

HIV voluntary counseling and testing (VCT) by medical and non-medical counselors, and provider-initiated counseling and testing (PICT) services for adults and children;

- Quality assurance of counselor performance including in-service performance improvement;

### Screening for active TB;

Outreach services to target most-at-risk populations in surrounding areas; with national guidelines:

Laboratory services including full blood count, acid-fast bacilli microscopy, stool for ova and parasites, malaria; smear, pregnancy test and serology for HIV;

- Routine quality assurance and quality control of laboratory services mechanisms;
- Support groups, non-monetary incentives, and/or other activities for health providers to avoid burnout and address performance improvement;
- Strengthen referrals and linkages to PMTCT services and routine follow-up of mothers and children, including support groups; and
- Provide referrals to RH/FP services.

Post-exposure prophylaxis referral to ART delivery sites including hospitals and health centers; Secondary prevention services for persons living with HIV/AIDS, including correct and consistent condom use and referrals for family planning (prevention for positives);

Provision of basic care (at a minimum, cotrimoxazole prophylaxis [CTX] for HIV and TB clients) in accordance.

### Result 2: Deployment of case managers to support care and strengthen referrals between health centers, hospitals and community services

- To support clinical and community-oriented care initiatives, the Contractor will train and deploy case managers charged with strengthening referral and follow-up systems, and with supporting prevention, care, and treatment services.
- The Contractor shall provide technical assistance to regional health bureaus and zonal and woreda health offices to deploy case managers at all 393 health centers providing enhanced palliative care and ART.

- The Contractor shall support the cost of the case managers' training, deployment, supportive supervision, and salary (expected to be approximately one step below health extension workers at 375 to 400 Ethiopian birr per month) during the life of the contract.
- Following diagnosis of HIV and upon consent, clients will be introduced to the resident case manager. Case managers shall support the completion of referrals within health centers, to and from hospitals for specialized care, and to and from community and faith-based organizations.
- To the extent available, the Contractor shall collaborate with U.S. Government partners at the hospital level in the utilization of innovative communication approaches to enhance referral between facilities. Case managers will be trained in:
  - counseling skills to support those recently diagnosed—asymptomatic and symptomatic— about positive living, prevention, and disclosure
  - infection prevention, family referral for counseling, testing, and care, referral of exposed children for testing and pediatric care
  - HIV prevention of mother to child transmission, including ANC and assisted delivery promotion, ART, and family planning services
  - IMAI training Module 4: Care, ART Aide with emphasis on:
    - Basic counseling and communication skills
    - AFASS counseling on infant feeding, including exclusive breast feeding
    - Adherence monitoring for TB, opportunistic infections (OIs), and ART
    - Utilizing referral systems within health centers, to and from hospitals for specialized care, and to and from community and faith-based organizations
- Establishment and maintenance of coordinated care plans including the Preventive Care Package (see Annex 11, Section 1, "Palliative Care")
- Early identification of orphans and vulnerable children (OVC) for services (although OVC service provision case managers should try to identify and refer OVC to appropriate services (including pediatrics) well before their parent(s) becomes seriously ill or dies)
- Mapping of kebele assets
- Referral for family planning

Case managers shall also increase client awareness of GOE waiver systems for education,housing, and health care.

### Result 3: Deployment of volunteer outreach workers to support family-focused prevention, care, and treatment in communities

USAID expects that the vast majority of HIV prevention and care will take place in communities and households. Upwards of 90% of care is currently provided by families or community members at the household level. Limited asymptomatic care currently takes place in communities.

The Contractor shall provide technical assistance to selected kebele HIV/AIDS desks and health posts to deploy, at a minimum, five volunteer outreach workers to support health extension workers providing HIV/AIDS and TB prevention, care, and treatment services in the community. The Contractor may ask kebele HIV/AIDS desks, in collaboration with health extension workers, to identify the volunteer outreach workers.

The Contractor shall support the training, deployment, supportive supervision, and travel stipend of volunteer outreach workers. Volunteer outreach worker areas should extend beyond official kebele boundaries to reach those in need of services in surrounding areas.

Outreach workers shall:

- mobilize family and community members for HIV/AIDS stigma reduction;
- counsel and encourage families and community organizations to provide care and support for chronic disease;
- participate in follow-up of lost clients;
- facilitate delivery of elements of the Preventive Care Package at the kebele level;
- support adherence promotion to B. 01 and ART; and
- make referrals to care and support services from community organizations, including those that
- provide OVC services.
- Trained outreach workers shall continuously map kebele assets to support personalized care.

In kebeles where the response to providing HIV/AIDS care and support has been limited, the outreach workers, with the Contractor's support, will:

- undertake extensive social mobilization activities.
- The outreach workers shall work in close collaboration with existing community health promoter volunteers and reproductive health agents where they exist in the same community.

In order to carry out these responsibilities, the Contractor will provide technical assistance and basic training to the volunteer outreach workers in the following areas:

- Basic counseling skills
- IMAI training, including secondary prevention and information on how to counsel and encourage family members to provide care and support
- Adherence promotion for TB, OIs, and ART
- Adherence to coordinated care plans including the Preventive Care Package (see Annex 11, Section 1, “Palliative Care”)
- Utilization of referral networks
- Early identification and referral of vulnerable children for OVC services
- Mapping of kebele assets
- Referrals for reproductive health/family planning

### Case Manager (projected one per health center within the ART Health Outreach Volunteer (projected five per kebele)

GOE and PEPFAR activities throughout Ethiopia are based on an ART Health Network model, defined as a hospital providing ART that is linked with three health centers. In 2006 approximately 89 hospitals, 267 health centers, and 200 selected health posts will be included in the ART Health Network. An additional 183 health centers outside the ART Health Network provide counseling, testing, and TB/HIV services. PEPFAR/Ethiopia anticipates that the ART Health Network will expand to include 128 hospitals and 550 health centers by September 2008.

The health system is not limited to facility-based services—equally important is the community and its assets. In Ethiopia social norms and community mechanisms exist to support families affected by shocks such as illness, death, or loss of property. These traditions serve as a social contract between communities and households and are invaluable

assets. The Contractor will give priority to collaborating with existing or potential kebele members and civil society organizations, including traditional Ethiopian burial societies *(idire),* to respond to HIV/AIDS needs in the community.

### Result 4: Implementation of HIV prevention activities utilizing best practice ABC interventions incorporating stigma, discrimination, and gender concerns

- The Contractor shall expand coverage of epidemiologically appropriate, best-practice HIV prevention interventions that apply the "ABC" approach to preventing sexual transmission across different settings. The "abstinence, be faithful, and condom" elements of HIV prevention programming in Ethiopia are appropriate and should be adequately incorporated.
- The Contractor will scale up family-oriented community mobilization and individual behavior-change activities based on previous PEPFAR investments and will use intergenerational and interpersonal communications. Specific themes should touch on coercive, transactional, or cross-generational sex in communities. Limited utilization of targeted mass media is appropriate.
- The Contractor will support the introduction and scaling-up of approaches that include HIV secondary
- prevention counseling to individuals living with HIV/AIDS, termed Prevention for Positives.
- The Contractor shall utilize case managers and volunteer outreach workers noted above to partially implement and monitor prevention activities.
- The Contractor shall support a meaningful expansion of the involvement of persons living with
- HIV/AIDS and families affected by IIIVAIDS in prevention programming. USAID expects that community-based groups of people living with HIV/AIDS can provide mutual support to confront stigma and discrimination, and dispense community-level services to those requiring counseling and basic care and support.
- The Contractor shall provide technical assistance to health care providers and administrators, case managers, outreach workers, and community leaders to integrate activities to reduce stigma and discrimination at all health centers, woreda health offices, and kebele HIV/AIDS desks and in selected communities where outreach workers are deployed.

- The Contractor shall provide technical assistance in addressing gender concerns across all aspects of HIV programming. USAID envisions this to include implementing HIV prevention activities that address girls' and young women's vulnerability, expanding access and uptake to couples counseling, and family-focused initiatives for care.

- Given the plethora of prevention materials available both in English and local languages in Ethiopia, the Contractor shall adapt existing behavior change communication (BCC) materials and customize them as necessary for various regions, local languages, and cultures. The Contractor shall not develop any new materials without USAID approval. All prevention materials shall follow U.S. Government guidance issued by OGAC.

USAID has supported several successful ongoing activities targeting most at-risk populations of HIV infection, including activities targeting taxi drivers in Addis Ababa and the regional SNNPR police force.

- The Contractor shall plan to maintain these activities throughout the duration of the contract, utilizing similar prevention approaches that may include peer leadership activities.

The program will not provide family planning services, but will provide referrals to existing family planning/reproductive health services funded by USAID and other sources.

### Family-Focused and Gender-Sensitive

Pregnant women and children remain critical groups to integrate into prevention, care, and treatment services. Current activities are not adequately integrating these women and children into HIV/AIDS clinical services. All technical approaches should account for better integration.

Family members in Ethiopian communities play the most significant role in caring for persons living with HIV/AIDS. Most households have very limited ability to withstand shocks given high poverty levels throughout the country and therefore face considerable difficulties in providing HIV-related care. Furthermore, families are the primary source of all health-related behaviors, including HIV prevention. However, to date most prevention activities do not utilize intergenerational social networks or family involvement. Family involvement is most likely to occur when prevention, care, and treatment interventions are targeted to the family unit.

Key messages are reinforced through a variety of means, including social and cultural networks, religious and other leaders, and personal relationships, including those with parents, grandparents, and peers.

- The Contractor should consider the power dynamics and social influences in society to strengthen results by involving respected and influential individuals such as village elders, religious leaders, traditional healers, and birth attendants. Their engagement is critical to making HIV/AIDS a topic of community discussion.

Throughout Ethiopia the burden of care falls disproportionally on females, regardless of age. Women are expected to care for sick members of the household, and young girls are much more likely than their brothers to be withdrawn from school for care-giving. The consequences for most HIV-positive women, AIDS widows, and their children are severe:  women, and frequently their children, are ”branded” by society, demeaned, and cast out. They correctly fear rejection, including violence and abandonment, if they are perceived as bringing the virus into the household. Property and inheritance rights for widows and children are frequently disregarded.

### Assets-Based

The approach to implementation shall be assets-based, building on the capacities and resources found within individuals and communities throughout Ethiopia. Communities commit to their own development when they are approached though their competencies and strengths, rather than focusing on their needs and problems. Despite the perception that Ethiopia has few resources and requires massive infusions of donor assistance, its people have many talents and skills. There are numerous formal and informal associations such as *idirs* that have demonstrated they can contribute to care and support for those infected and affected by HIV/AIDS. The Contractor, via the trained community outreach workers, shall use mapping to mobilize the assets of: individuals; religious, cultural, and other organizations; local institutions such as schools and credit groups; and private medical providers. The Contractor shall identify under-utilized physical assets, such as vacant space, and utilize such areas if available and authorized by the local government or the GOE.

### Regionalization and Operation Zone

The GOE has shown strong commitment to the "Three Ones" at the country level: one action framework, one coordinating authority, and one monitoring and evaluation system. In terms of one agreed-upon HIV/AIDS action framework, current HIV/AIDS programming is guided by the Strategic Framework for the National Response to HIV/AIDS in Ethiopia. The six thematic areas of the current Strategic Framework include capacity-building, social mobilization and community empowerment, integration with health and family planning programs, leadership and mainstreaming, coordination and networking, and special target groups.

Ethiopia receives significant funding from the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM). A Memorandum of Understanding has been signed between the GOE and the U.S. Government for PEPFAR and GFATM funds, particularly in the areas of integration, funding, cost-sharing, and roles. As described in the GOE and the U.S. Government's Plan of Action, GFATM resources include elements of the Preventive Care Package (e.g., of drugs including cotrimoxazole and infection prevention commodities), renovation of health centers, ARV first-line drugs, and test kits. The Contractor's activities will be aligned with this MOU.

### Discussion points with case managers

1. How did you end up as a case manager?
2. Had you participated in any training before deployment?
3. What was the training all about? Could you please list some of the topics covered in that training?
4. Have you participated in any refresher courses since then? Which topics were included in the refresher courses?
5. How many cases have you attended just this past week? Last month? And since you became a case manager?
6. Tell us about the process. How do you meet clients?
   - What is your first task once you meet a client?
   - What support do you provide, in general, to clients?
     - Probe: Support & completion of referrals within HCs, to-and-from hospitals for specialized care, to-and-from community and FBOs, OVC referrals, FP referrals.
7. Are there any major challenges that you, as a case manager, encounter in the process of doing your work?
8. What do you suggest/recommend to address these challenges?
9. How do you make reporting? Daily, monthly, etc.? To whom are you reporting?
10. Could you please show us some of your reporting formats, referral slips that you are using?

## HCSP Mid-Term Evaluation Tools

### Key Informant Interview Guide
### HAPCO/FMOH/FHAPCO Officials, RBO Officials

**Date:**
**Interviewer:**
Name of interviewee, organizational affiliation, and position in organization

1. Intro by interviewer: Introductions of self and team.
2. Team's understanding of the purpose of the mid-term evaluation.
3. Does this accord with interviewee's appreciation of the purpose?
4. What are the interviewee's expectations of the evaluation:
   - for his/her organization/institution?
   - for the future implementation of the HCSP project?
   - for the National Multisectoral HIV/AIDS Plan?
   - for decentralization of HIV/AIDS prevention, treatment, care, and support?
   - other?
5. Team's anticipation of the role of FDRE team member(s) from informant's organization.
6. Informant's appreciation of role of informant's organization team member(s).
7. Team's suggested methodology and implementing approach.
8. Suggestions of interviewee for changes/improvements.
9. Interviewee's assessment of major challenges and achievements to be explored by team.

## HCSP Mid-Term Evaluation Interview Guide for HCSP Regional Offices

Date:_____ Region/Location:_____

Interviewee (s):_____

Interviewer (s):_____

1. What is the primary role of your office?
2. How long has this office existed?
3. How long have you been in this position, and what other staff are there in this office? How long have they been here?
4. Are you directly linked with or co-located with the regional bureau?
5. What technical assistance do you provide at each level (RB, HC, woreda office, community, other)?
6. What are your interactions with other programs/projects?
7. What are your major successes in terms of HCSP results and targets?
8. What are your major challenges?
9. What suggestions do you have for improvement now, in the medium term, and for a possible extension through 2013?

**Health Center HIV/AIDS Team Members**

| Question # | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| • Head of the health center | X | X | X | X | X | X | | | | | | | | | |
| • Health center administrator | X | X | X | X | X | X | | | | | | | | | |
| • Physician (where available) | X | X | X | X | X | X | X | | | | | | | | |
| • Nurses (HIV care/ART, TB clinic, PMTCT, etc.) | X | X | X | X | X | X | | X | | | | | | | |
| • Laboratory personnel | X | X | X | X | X | X | | | X | X | | | | | |
| • Pharmacy personnel | X | X | X | X | X | | | | | | X | X | | | |
| • Counselors | X | X | X | X | X | | | | | | | | X | | |
| • Data clerks | X | X | X | X | X | | | | | | | | | X | X |

### Questions

1. Please describe your current position, and your involvement with HCSP.
2. Please describe your understanding of the role of MSH, HCSP, and USAID in the function and operation of your program and facility.
3. Please tell us some of the challenges encountered in your daily routine, and how you think we might help them.
4. Please tell us some of the successes you find in the HCSP program.
5. Please provide some examples of where you believe HCSP is not succeeding in its goals.
6. Please describe the referral system with your various partners, in particular hospitals, community health workers, and those involved in HCSP and the care of PLWHAs.
7. Please describe your understanding of the clinical mentoring program and its relationship to MSH/HCSP. Please tell us how you feel the program is doing, and please mention some successes and challenges.
8. Please describe your area of nursing, and the challenges and successes as they relate to the HCSP program.
9. Please describe your facility's use of laboratory monitoring in the care and treatment of PLWHAs, including your strengths and weaknesses, and your plans to improve.
10. Please address your facility's VCT and PICT programs and your role in them. Please address strengths and weaknesses of the programs.
11. Please describe the pharmacy program at this institution, and how well it is succeeding at its objectives.
12. Please describe your relationship with SCMS and the strengths and weaknesses of the relationship.
13. Please describe your role in the care and support of PLWHAs, and how you and HCSP are working toward your goals. Please describe the strengths and weaknesses in your program.
14. Please describe your HIV data collection, recording, and transmission system, with its strengths and weaknesses.
15. Please describe the data collection process for persons in care and support, and NOT on ARV.

**HCSP Mid-Term Evaluation Interview Guide for Health Center Administrative/Financial Staff**

Date:_____ Health Center:_____

Interviewer:_____

1. Do you work full-time or part-time? If part-time, how many days a week?
2. How long have you been in this position?
3. What was your prior job? Where was it?
4. How is your budgeting done?
5. Does your center get money from: HCSP yes/no; regional bureau yes/no; Federal government yes/no; city gov't yes/no; other projects yes/no. If yes, which ones? (List)
6. For which service areas do you lack funds or have funding shortfalls?
7. How often? Of what duration?
8. What is your financial reporting system?
9. What is your procurement system—for drugs, lab supplies, office materials, equipment, other?
10. What improvements would you suggest for the HCSP support to your HC?
11. Other comments?

### Discussion Points with Outreach Workers

1. How did you become a volunteer to this program? Were you a WHO community worker before? Did you work through another project or organization as a health volunteer?

2. Did you participate in any training before deployment?

3. Could you please tell us a little more about the training, topics covered, any refresher courses you took part in since then?

4. Could you please walk us through your typical day as a volunteer?

   - Your major involvements (probe)

     - Community mobilization for stigma reduction
     - Counsel and encourage families, community organizations
     - Tracing clients lost to follow-up
     - Prevention messaging
     - Home-based care

5. Which geographic areas do you cover? Are you currently providing or previously provided your services beyond your kebele border?

6. How is the community reception of your work?

7. How do you link/collaborate with case managers?

8. How do you collaborate/link with HEWs and the local HIV/AIDS desk?

9. Are you satisfied and happy with your work? If yes, from which aspects of your work are you drawing your utmost satisfaction?

10. Aspects which you are not happy about/dissatisfied? What do you suggest for improvement?

11. How do you make reporting? Daily, monthly, etc.? To whom are you reporting? Could you please show us some of your reporting formats and referral slips that you are using?

12. In your reporting, do you use names of people in your register or house numbers? How do you identify them?

# APPENDIX D: FIELD VISIT ITINERARIES

## ETHIOPIA HCSP MID-TERM EVALUATION: JULY 3–31, 2009

| | |
|---|---|
| Thursday, July 2 | Alice Morton and Steven Brasch arrive in Addis at 8:45pm on KLM Flt# KL0545 |
| | *Airport pick up by Sheraton Airport Shuttle* |
| Friday, July 3 | 9:00am–9:30 am: Alice Morton, Steven Brasch, and Daniel Sahleyesus Telake (hereinafter referred to as the core team) meet with Dinsry and go over the itinerary at Sheraton Hotel-Business Center. |
| | 9:30am–5:00pm: Core team—Team planning meeting at the Sheraton Hotel-Business Center. |
| Saturday, July 4 | 9:00am–5:00pm: Core Team—Team planning meeting at the Sheraton Hotel-Business Center. |
| Monday, July 6 | 9:00–10:00am: Core team in-briefing at USAID—E |
| | Hotel pick up at 8:10am by Medir Travel [9] (need to arrive at USAID @ 8:45am to allow for security check) |
| | 10:30am–12pm: Core team in briefing with MSH and sub-partners (Nelia Matinhure, SAVUS, Dr. Atnafu Getahun and Ato Gebreh Medhin, from Intrahealth). Meeting place: MSH (Bole area, before you get to Lalibela hotel) |
| | 1:30pm–5pm: Core team—–team planning at the Sheraton Hotel Business Center. |
| Tuesday, July 7 | Meeting with stakeholders at their respective offices |
| | 8:30am–9:30am: Meeting with Dr. Gideon Cohen at WFP (next to Hilton Hotel). Hotel pick up at 8:00am. |
| | 10:00am–11:00am: Meeting with WHO, Dr. Akram Eltom, and Dr. Seblewongel Abate. (UN compound-ECA building) Need to arrive at WHO @ 9:50am to allow for security check. |
| | 11:30am–12:30pm: (Rescheduled for Wed., July 8) Meeting with SCMS/MSH. |
| | 12:30pm–1:30pm: Lunch break |
| | 1:30pm–3:00pm: TPM |
| | 3:30pm–4:30pm: Meeting with Dr. Betru Tekle and/or Ato Meskele Lera (FHAPCO). Dembel building 9th floor. |
| | 5:00pm–6:00pm: Meeting with Dr. Yibeltal Assefa, Federal Ministry of Health (FMOH), Dembel Building, 5th floor. |
| Wednesday, July 8 | Meeting with stakeholders at their respective offices. |
| | 7:30am–8:00am: Pick Ato Refissa from home (Bole Rwanda). |

[9] All transportation, unless stated otherwise, is provided by Medir Travel.

| | |
|---|---|
| | 8:00am–8:30am: Drive to Addis Ababa RHB. Hotel pick-up at 8:00am. |
| | 8:30am–9:30am: Meeting with Ato Getachew Teshome) |
| | Addis Ababa Regional Health Bureau (near Urale church around Axum Building). |
| | 10:30am–11:30am: Meeting with Dr. Achamyeleh Alebachew, A.A HAPCO. (Right next to Ministry of Defense after passing Ambassador Theater on your way to Churchill road. The office is on the 6th floor.) |
| | 11:30am–1:30pm: Lunch break. |
| | 2:00pm–3:00pm: Meeting with Dr. Gudeta Tibesso from EHNRI (Gulele area-in Pasteur Institute compound, CDC building). |
| | 4:00pm–5:00pm: Meeting with Oromia Regional Health Bureau: Ato Shalo Daba, Dr. Kassa Hailu, Dr. Zenebech Yadete (Next to A.A Regional Health Bureau, around Urale Church). |
| | 5:30pm–6:30pm: Meeting with SCMS/MSH. Dr. Negussu Mekonnen, SPS, and Hany Abdallah, SCMS. (MSH office – Bole area, before you get to Lalibela hotel.) |
| | 6:30pm–7:15pm: Drop off at Hotel and home. |
| Thursday, July 9 | Teams depart for respective site visits (see Annexes A, B, and C). Teams will be accompanied by MSH staff. |
| Thursday, July 23 | 9:00am–5:00pm: Team information and synthesis meeting at Jupiter International Hotel-Cazanchise. The core team will be joined by GOE reps. |
| | Team members will be picked up from hotel/home (30 minutes drive from Beer Garden Inn). |
| Friday, July 24 | 9:00am–5:00pm: Team information and synthesis meeting at Jupiter International Hotel-Cazanchise. The core team will be joined by GOE reps. |
| | Team members will be picked up from hotel/home. |
| Saturday, July 25 | 7:00am–8:10am: Ato Gojam flies back to Bahir Dar (take a shuttle to the airport). |
| | 9:00am–5pm: Team information and synthesis meeting at hotel (only core team). |
| Mon, 27–Thur, 30 | 9:00am–5pm: Team information and synthesis meeting at hotel (only core team). |
| Friday, July 31 | 10:30am–12:00pm: Debriefing with USAID. |
| | 1:30pm–3:00pm: Debriefing with MSH and sub-partners at MSH office in Bole. |

## FIELD VISIT SCHEDULE—ALL THREE SUB-TEAMS

| DATE | TEAM 1 | | | TEAM 2 | | | TEAM 3 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Visit | Type | Region | Visit | Type | Region | Visit | Type | Region |
| 7/9/2009 | Kolfe | HC | AA | Amhara | RHB | Amhara | Shoarobit | HC | Amhara |
| 7/9/2009 | T/haimanot | HC | AA | Amhara | HAPCO | Amhara | | | |
| 7/9/2009 | | | | Adet | HC | Amhara | | | |
| 7/10/2009 | Bole | HC | AA | Gondar Univ. | Hosp. | Amhara | Bati | HC | Amhara |
| 7/10/2009 | Woreda 19 | HC | AA | Gonder | HC | Amhara | | | |
| 7/13/2009 | Woreda 23 | HC | AA | Durbeti | HC | Amhara | Dessie | HC | Amhara |
| 7/13/2009 | | | | Dangla | HC | Amhara | Hayk | HC | Amhara |
| 7/14/2009 | Adama | HC | Oromia | Dejen | HC | Amhara | Mersa | HC | Amhara |
| 7/14/2009 | Adama | Hosp | Oromia | | | | Alamata | HC | Tigray |
| 7/15/2009 | Mojo | HC | Oromia | | | | Korem | HC | Tigray |
| 7/15/2009 | | | | | | | Mohoni | HC | Tigray |
| 7/16/2009 | Holeta | HC | Oromia | Kofele | HC | Oromia | Tigray | RHB | Tigray |
| 7/16/2009 | | | | | | | Tigray | HAPCO | Tigray |
| 7/17/2009 | Sendafa | HC | Oromia | SNNP | RHB | SNNP | Freweini | HC | Tigray |
| 7/17/2009 | | | | SNNP | HAPCO | SNNP | | | |
| 7/17/2009 | | | | Awassa | HC | SNNP | | | |
| 7/17/2009 | | | | Bushulo | HC | SNNP | | | |
| 7/20/2009 | Tulu Bollo | HC | Oromia | Adola | HC | Oromia | Welkita | HC | SNNP |

| DATE | TEAM 1 | | | TEAM 2 | | | TEAM 3 | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Visit** | **Type** | **Region** | **Visit** | **Type** | **Region** | **Visit** | **Type** | **Region** |
| 7/21/2009 | | | | Sakiso | no | Oromia | Worabe | HC | SNNP |
| 7/21/2009 | | | | | | | Butajira | Hosp | SNNP |
| 7/22/2009 | Zewditu | Hosp. | AA | | | | | | |
| | **Health Centers** | **10** | | **Health Centers** | **9** | | **Health Centers** | **11** | |
| | **RHB** | **0** | | **RHB** | **2** | | **RHB** | **1** | |
| | **HAPCO** | **0** | | **HAPCO** | **2** | | **HAPCO** | **1** | |
| | **Hosp.** | **2** | | **Hosp.** | **1** | | **Hosp.** | **1** | |

# APPENDIX E: COMMENTS FROM KOOWS

*"My happiest moments are when I see my patients walking."*

*"The patients I am following up live in the poorest section of our kebele. From time to time I visit them at their homes. When I reach their homes and find that their doors are locked, that is when I am the happiest person around. Because locked doors tell me that my clients are functioning and have gone out for work. It feels good." (A male KOOW in his 70s)*

In Modjo town a KOOW said that: The happiest day as KOOW was seeing her pregnant client safely deliver a child not infected with the virus. The woman agreed to attend PMTCT sessions in close collaboration with the mother-to-mother support group.

In Tulu Bollo, a town 80 kms west of Addis Ababa, a female KOOW (approximately in her 30s) who is also in leadership position in the town's only association for PLWHA said the following during the field visit: *"Usually I am happy when I am able to provide my support to those who need my help. Among the days I felt most happy was the day I prepared the dead body of one of our members. Her family and neighbors were not willing to prepare the body because they were afraid of HIV transmission due to the stigma. When I and my colleagues arrived at her home the body was about to get [deformed]. Thanks to the HCSP I had the training on how to prepare a dead body and had the required kits such as gloves. I was able to prepare the body for burial, and I also tried to educate the community to avoid stigma and discrimination. I am so happy that I was able to do that.*

Similar stories also told by KOOWs from Woreda 19 (Nefas Silk- Lafto HC). Here are excerpts:

*"Sometimes, during our coffee ceremonies or walking through our catchment area, we ask people if there is someone they know who has been bedridden or sick for long and spending much time at home. Once I was informed that a family was locking their sick child, probably in his 20s, at home and was not willing to seek medical help because of the stigma. At the same time they were not also providing him proper care on their own. They did not want anyone to hear that their boy is sick, and they kept him in a room locked up. Once I got the information, I shared it with kebele officials and got their support for intervention. We went to the house and broke into the room where the sick child was kept by force. There we found a young person, seriously sick, with bedsores and wounds all over his body. It was a sad situation. With the help of others I cleaned him, and took him where he can receive medical care for the opportunistic infections he had been suffering from. Then after, I provided him with psychological support and encouraged him to get tested. He started ART and in a few months' time he was able to walk and function again. Since then, he has been trained, with the help of another charity organization, in photography and videography and now makes a living out of that. Very recently I hosted a wedding party for my daughter and that young boy whom I had found was the camera/video man for that event. That was the happiest day of my life. To make it more interesting he gave me his service for free [laughing]." (A female KOOW, approximately in her late 40s)*

Another KOOW (male approximately in his 50s) from Woreda 23 HC in Addis Ababa expressed his mixed emotions as follows:

*"My happiest day as a KOOW was when I succeeded in helping an HIV positive girl who was sleeping on the street in getting her own place. I mobilized some community members and was able to pay a few months of her rent. We were also supporting her in whatever ways we could. On the other hand, the day I really feel sad is today [the day we had this interview at the HC]. For the last few days I worked hard to convince the same girl to come to the HC and start medication. Finally, she seemed convinced and I accompanied her this morning to this health center. Once in the facility she refused to listen to the advice of health workers and would not start taking her medication. I felt that my efforts were fruitless."*

# APPENDIX F: HCSP PMP REPORT PY2 Q3, APRIL 2009—EXECUTIVE SUMMARY

## EXECUTIVE SUMMARY

Management Sciences for Health (MSH) is pleased to submit to the United States Agency for International Development (USAID)/Ethiopia this quarterly report on the progress in the third quarter of Program Year Two (PY2, January 1–March 31, 2009) of the USAID/PEPFAR-funded HIV/AIDS Care and Support Program. The HIV/AIDS Care and Support Program in Ethiopia is a three-year program, implemented by MSH and its partners Dawn of Hope Ethiopia (DOHE), Ethiopian Inter-Faith Forum for Dialogue, Development, and Action (EIFDDA), Save the Children (USA), and IntraHealth. The program began on June 15, 2007, and has since successfully achieved or exceeded most of its first-year targets and will achieve almost of its targets for PY2 (see the table at the end of this executive summary). The first-year results were disseminated in Addis Ababa on July 9, 2008, to all stakeholders, including representatives from the Federal Ministry of Health (FMOH), the Federal HIV/AIDS Prevention and Control Office (FHAPCO), the U.S. Embassy in Addis Ababa, USAID, the U.S. Centers for Disease Control and Prevention–Ethiopia, and other PEPFAR and non-PEPFAR partners, and we are starting to plan for a similar annual review in July 2009.

Although the HIV/AIDS Care and Support Program focused its PY1 activities on expanding antiretroviral therapy (ART) services, consistent with the Government of Ethiopia's (GOE) programmatic goal of achieving universal access to comprehensive HIV/AIDS services by 2010, PY2 activities are geared toward strengthening and scaling up comprehensive and integrated HIV/AIDS services in HCs and communities, and thus reflect the FMOH-FHAPCO strategic developments outlined in the *Road Map 2007–2008/10 for Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia* (the second road map).

During the current reporting period, the HIV/AIDS Care and Support Program continued to work toward the four intermediate results specified in the program contract. Progress toward those results is measured by 16 core indicators realigned with the approved PY2 work plan (see table at the end of this executive summary) and other indicators as detailed in the revised Performance Monitoring Plan (PMP) (Annex 1).

The HIV/AIDS Care and Support Program is on track to achieve or exceed its PY2 targets through accelerated implementation and focuses on quality, prevention of mother-to-child transmission (PMTCT), and pediatric HIV/AIDS. Accordingly, in PY2, HIV/AIDS Care and Support Program operations have intensified at the regional, woreda, HC, and, particularly, community levels. The result will be twofold: (a) reaching higher numbers of people in need of comprehensive HIV/AIDS and primary health care services, and (b) preparing the foundation for "graduating" HCs, in a phased manner, from HIV/AIDS Care and Support Program technical assistance to sustainable government ownership and management, beginning in PY3.

## INTERMEDIATE RESULTS

Specific achievements during the reporting period toward the four results are outlined below.

### Result 1: Provision of high-quality, integrated HIV/AIDS prevention, care, and treatment services at HCs

By the end of the reporting period the following core results had been achieved:

- A cumulative total of 90,012 individuals have been enrolled for HIV care.
- A cumulative total of 9,736 stable patients on ART have been transferred into HCs from hospitals to attend treatment at the HC level.
- As of the end of March 2009, 39,421 patients (more than 60% of whom are female) are currently receiving ART, indicating a 16% incremental increase in just three months. Pediatric patients on ART constituted just 1% of the total.
- The rate of patients lost to follow-up (LTFU) is about 7.1%, compared to a national average rate of 20% to 25%.
- Comprehensive HIV and TB counseling and testing, and care and support services, have been expanded to 500 HCs and comprehensive ART services to 300 HCs.
- More than 407,680 individuals have been counseled and tested and have received results in the quarter making a cumulative total of 779,080 in PY2 through voluntary counseling and testing (VCT) and provider-initiated testing and counseling (PICT) strategies at the facility and community levels.
- More than a cumulative total of 218, 962 individuals infected or affected by HIV have been reached with care and support services.
- A cumulative total of 122,294 pregnant women among prenatal care clients have had HIV counseling and testing for PMTCT services.
- A total of 420 health workers received training in PY2 on National Comprehensive HIV Care/ART, making a cumulative total of 2,407 (96% of the PY2 target).
- One hundred and ninety-six health workers were trained in HIV/TB counseling and testing, making a cumulative total of 2,617 (105% of the PY2 target).
- Other trainings (e.g., on TB/HIV collaborative activities, PMTCT, comprehensive laboratory services, and dried blood spot [DBS] testing) have also been conducted.
- The HIV/AIDS Care and Support Program continues to provide technical support to the HCs, including mentorship, multidisciplinary teams, and catchment-area meetings for ART HCs and supportive supervisions.

### Result 2: Deployment of case managers to support care and strengthen referrals among HCs, hospitals, and community services

By the end of the reporting period the following core results had been achieved:

- A total of 232 case managers continue working at ART HCs.
- Frequent visits and integrated supportive supervision have been conducted to support this new cadre of staff to enable them to properly discharge their roles and responsibilities; the

case managers were found to have integrated successfully into the existing system and are playing a crucial role in adherence counseling, provision of targeted and personalized care for people living with HIV/AIDS (PLWHA), referral linkages, and tracing of LTFU patients together with community volunteers.

- Refresher trainings have been given for existing case managers in all regions, and best practices were shared during the trainings.
- In the next quarter, gap-filling training and training of case managers for new expansion sites will continue, and by the end of PY2, a cumulative total of 393 case managers will have been trained and deployed in 300 ART HCs.
- More than one case manager will be deployed in HCs that have high patient loads, and this deployment will happen with the concurrence of the regional health bureaus (RHBs).

### Result 3: Deployment of volunteer outreach workers to support family-focused prevention, care, and treatment in communities

By the end of the1 reporting period the following core results had been achieved:

- The number of kebeles deployed with at least five trained kebele-oriented outreach workers (KOOWs) and networked with ART HCs has expanded to 314 in the quarter, making a cumulative total of 801 (more than 100% of the PY2 target).
- In total, 1,527 KOOWs were trained in the quarter, making a cumulative total of 4,019 KOOWs trained and deployed so far (101% of PY2 target).
- Sixty-nine health extension workers (HEWs) have been trained in community mobilization, prevention, and care and support strategies to strengthen the work of volunteers at the community level, which makes a cumulative total of 587 HEWs and kebele HIV/AIDS desk officers trained so far.
- In the current reporting period, 220,794 individuals were mobilized for prevention, care, and treatment through outreach activities—with coffee ceremonies being the main venue for mobilization—and home visits.
- About 29,000 newly identified individuals affected or infected by HIV/AIDS were provided with home-based care (HBC).
- KOOWs, together with case managers stationed at the HC level, traced 2,954 individuals who had been LTFU for ART, TB DOTS, or both, and provided them with adherence support to minimize subsequent losses.
- By strengthening referrals and health networking, nearly 22,495 individuals have been referred to health facilities and to community-level care and support organizations for various services, but the mechanism of getting feedback on referrals continued to be a challenge.

### Result 4: Implementation of HIV-prevention activities using best-practice ABC interventions incorporating stigma, discrimination, and gender concerns

By the end of the reporting period the following core results had been achieved:

- Various trainings have been conducted for service providers, community elders, religious leaders, and other community outreach volunteers to reinforce the prevention program and

promote ABC (abstinence, being faithful, condom use) prevention strategies, as well as VCT, ART, and PMTCT services.

- Customizing of existing behavior change communication (BCC) materials continues in order to address the issues of gender, ART, PMTCT, positive living, TB, and condom provision services.
- Various types of BCC materials with prevention, care, and support messages and job aids have been adapted, reproduced, and distributed to the regions. These materials will fill gaps in the availability of BCC materials at both the facility and community levels and will help create demand for and increase access to services.
- Regular supportive supervision and monitoring of prevention activities are being carried out, in collaboration with other stakeholders.

## IMPLEMENTATION MODALITIES

### Health Systems and Network Strengthening

By the end of the reporting period the following implementation modalities had been achieved:

- Recruitment of regional fully functional service delivery point (FFSDP) and laboratory service program officers is underway.
- Training on comprehensive laboratory services was conducted in two program regions (Amhara and Tigray), and 81 laboratory technicians were trained. The training covered HIV, TB, malaria diagnosis, and sample transfers. The training has also included orientation on logistics management of laboratory supplies.
- The work of technical working groups (TWGs) on opportunistic infection (OI) medicines and laboratory supplies continued to improve the system of ensuring sustainable supplies. TWGs are composed of the HIV/AIDS Care and Support Program, Supply Chain Management System (SCMS) Program, Strengthening Pharmaceutical Systems (SPS) Program, and other governmental and non-governmental partners.
- Implementation of the Leadership Development Program (LDP) was initiated by MSH's Leadership Management and Sustainability Program, and two regions (Oromia and Amhara) were selected as project areas.
- The draft FMOH performance-based contract (PBC) manual was revised.
- A modification was issued to HST Consulting to exercise the option year of its subcontract and increase its obligated funds.
- EIFDDA and DOHE signed subcontracts and began their scopes of work (SOWs).
- A request for consent to subcontract with new NGOs was submitted to USAID.

### Mainstreaming gender into all HIV/AIDS Care and Support Program activities and strengthening NGO capacity

By the end of the reporting period the following implementation modalities had been achieved:

- The HIV/AIDS Care and Support Program negotiated SOWs and budgets and has finalized work plans with the following NGOs, which were selected on a competitive basis: IMPACT, National Network of Positive Women, and the Relief Society of Tigray.

- The HIV/AIDS Care and Support Program has conducted a pre-award audit of all the organizations with the exception of IMPACT. The recommendations of the audit are currently being implemented by the NGOs.
- Activities for issuing the award to the selected NGOs started after USAID's budget approval for the PY2 work plan.
- An SOW and a budget are being finalized for the Hiwot HIV/AIDS Prevention, Care and Support Organization (HAPCSO), and it will work in all sub-cities in Addis Ababa. HAPCSO was previously funded by FHI.
- EIFDDA and DOHE signed subcontracts and began their SOW development.

### Strategic Information and Quality Management

By the end of the reporting period the following implementation modalities had been achieved:

- The process of realigning the work plan with some technical areas emphasized under the second road map and the developments of the corresponding realigned PMP have been finalized. USAID's approval is being awaited early next quarter.
- Training information management system forms are regularly being sent to JHPIEGO for entry into PEPFAR's database.
- The HIV/AIDS Care and Support Program continued its support to HCs, woreda health offices, and RHBs in implementing the national health management information system (HMIS), including printing and distributing registers and forms at times of shortages.
- The HIV/AIDS Care and Support Program is coordinating and conducting joint supportive supervision visits in line with supporting the implementation of the "Three Ones."
- The HIV/AIDS Care and Support Program regional monitoring and evaluation (M&E) advisors continued supporting RHB, woreda health office, and HC staff in ensuring a culture of data use for evidence-based decision-making.
- Data clerks who were trained and deployed to ART HCs in PY1 continued to support the data management system at the HC level. Refresher training has been given for existing data clerks.
- Basic training for data clerks for new expansion of ART HCs was provided in Oromia and Southern Nations and Nationalities Peoples Region (SNNPR), and 43 data clerks were trained in the quarter. Training will continue in the rest of the regions in the upcoming quarter.
- The HIV/AIDS Care and Support Program's semi-annual and PEPFAR's first quarter reports were produced and submitted on time. The PMP has been updated and submitted to USAID together with the program's PY2 semiannual report.
- Active participation continued in the PEPFAR Strategic Information TWG and regular FHAPCO quarterly review meetings.

**STATUS OF CORE TARGETS OR INDICATORS OF THE HIV/AIDS CARE AND SUPPORT PROGRAM PERFORMANCE (AS OF MARCH 31, 2008)**

| No. | Types of Activities | Baseline Performance (as of June 30, 2007) | PY1 Target | PY1 Performance (as of June 30, 2008) | PY2 Target | Current Performance (as of March 31, 2008) | Remarks |
|---|---|---|---|---|---|---|---|
| **Facilities Assisted** | | | | | | | |
| 1 | Number of woreda health offices supported with an HIV/AIDS services plan | 0 | 240 | 251 | 290 | 295 | Current performance |
| 2 | Number of HCs offering comprehensive HIV and TB counseling and testing services | 198 | 450 | 398 | 500 | 500 | Cumulative |
| 3 | Of which, number of HCs offering enhanced palliation care services | 198 | 267 | 261 | 350 | 500 | Cumulative |
| 4 | Of which, number of HCs offering ART | 115 | 240 | 239 | 300 | 300 | Cumulative |
| **Individuals Trained** | | | | | | | |
| 5 | Number of health providers trained in HIV and TB counseling and testing curriculums | 467* | 1,135 | 1,446 | 2,500 | 2,617 | Cumulative |
| 6 | Number of health workers trained with Integrated Management of Adolescent and Adult Illness (IMAI) clinical care and ART curricula (including pediatric HIV case finding and care) | 402* | 2,136 | 1,907 | 2,520 | 2,407 | Cumulative |
| 7 | Number of case managers trained and deployed on IMAI case manager modules | 0 | 267 | 232 | 393 | 232 | Cumulative (additional CM trng. In 3rd qrtr.) |
| 8 | Number of outreach workers trained in community and household HIV prevention, care, and treatment promotion | 507* | 1,335 | 1,402 | 4,000 | 4,019 | Cumulative |
| **Kebele and HC Performance Standards** | | | | | | | |
| 9 | Individuals reached with basic palliative care (care and support) | 79,128* | 120,000 | 126,567 | 220,000 | 218,962 | Current performance |

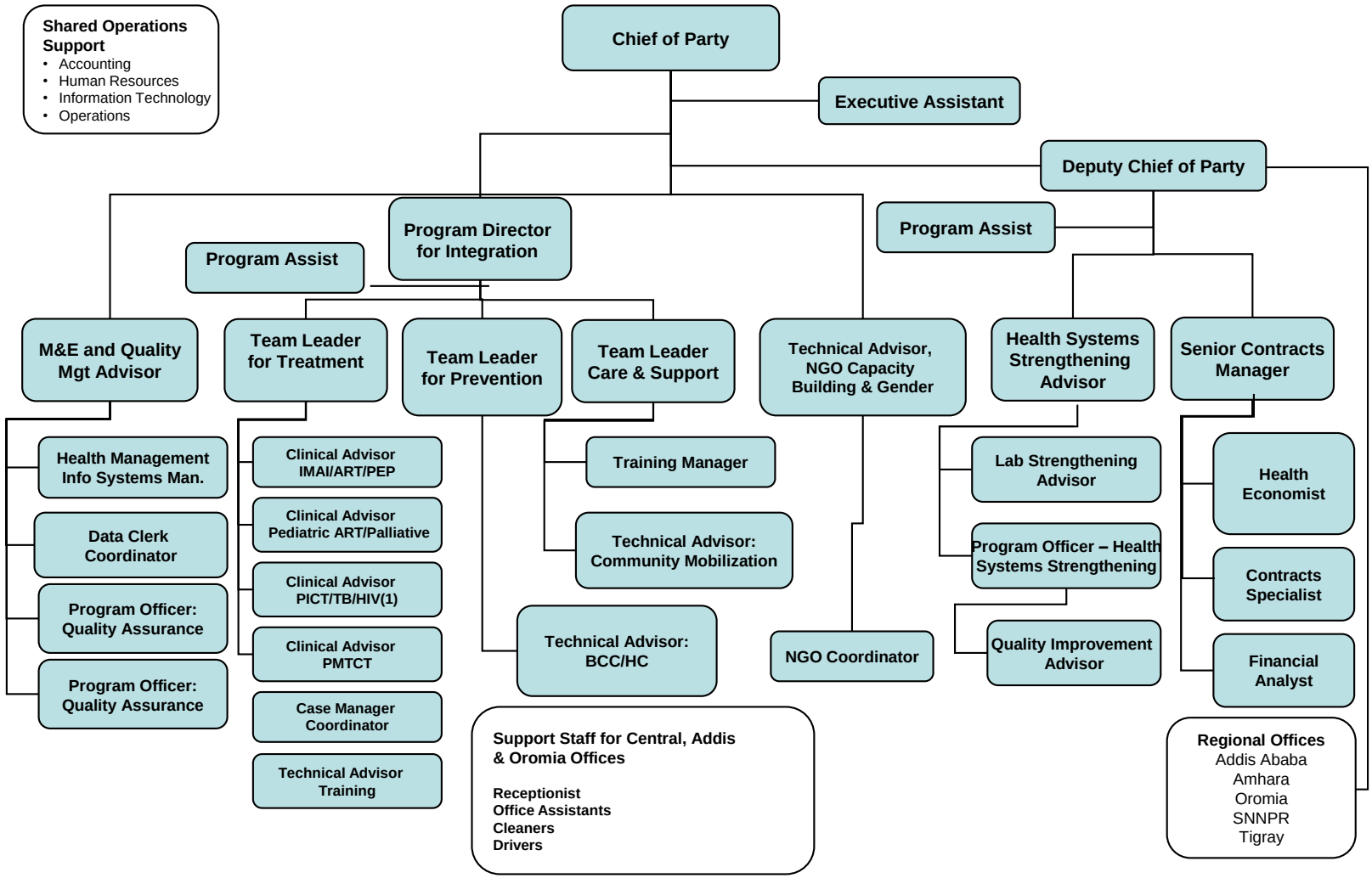
| No. | Types of Activities | Baseline Performance (as of June 30, 2007) | PY1 Target | PY1 Performance (as of June 30, 2008) | PY2 Target | Current Performance (as of March 31, 2008) | Remarks |
|---|---|---|---|---|---|---|---|
| 10** | *Number of pregnant women among prenatal care clients receiving HIV tests at the service outlets including the labor and delivery ward and community outreach* | Not applicable | Not applicable | Not applicable | 250,000 (To end of PY3) | 122,294 | Current performance |
| 11** | *Number of infants and children receiving HIV pediatric care (subset of the basic palliative care)* | Not applicable | Not applicable | Not applicable | 5,760 (To end of PY3) | 2,617 | Current performance |
| 12** | *Number of HIV positive infants and children receiving ART (subset of clients on ART)* | Not applicable | Not applicable | Not applicable | 2,880 (To end of PY3) | 428 | Current performance |
| 13 | Number of HIV-infected clients attending HIV care and treatment services who are receiving treatment for TB | 5,266* | 12,000 | 6,360 | 34,000 | 12,007 | Cumulative |
| 14 | Individuals counseled and tested for HIV who received their results | 265,153* | 260,000 | 934,275 | 350,000 | 779,080 | Current performance |
| 15 | Individuals receiving ART (cumulative) | 9,994 | 15,000 | 22,090 | 50,000 | 39,421 | Cumulative |
| 16 | Number of kebeles with deployed outreach workers that are served by a network HC | 0 | 267 | 267 | 800 | 801 | Cumulative |

* Baseline figures for these indicators have not been included in the calculation of cumulative totals.

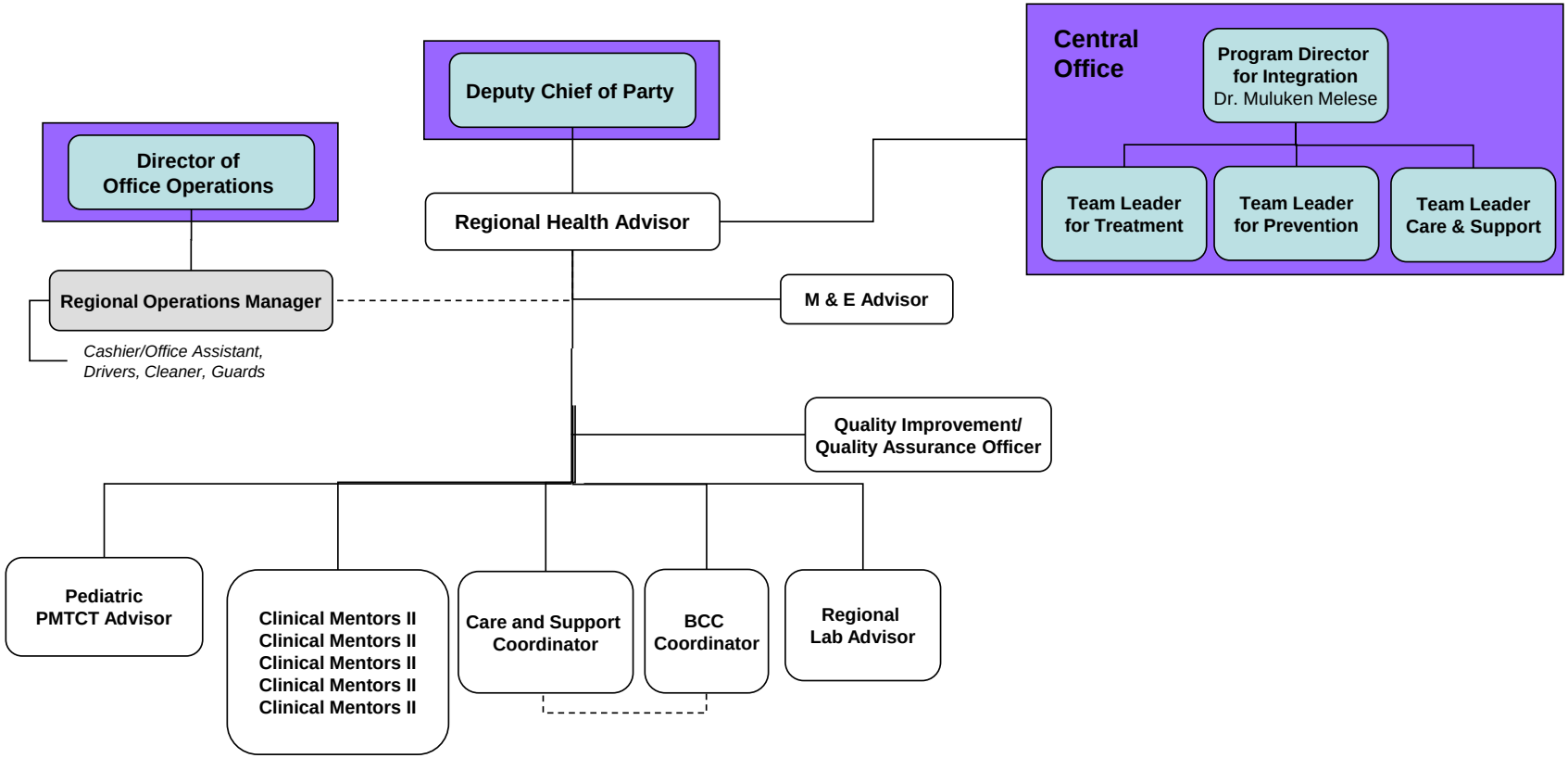
** These are new indicators included in the list of core indicators after the realignment of the work plan for PY2 and 3.

## APPENDIX G: HCSP ORGANOGRAMS

### HIV/AIDS Care and Support Program Organogram — Central Office



# HIV/AIDS Care and Support Program Organogram — Tigray Region

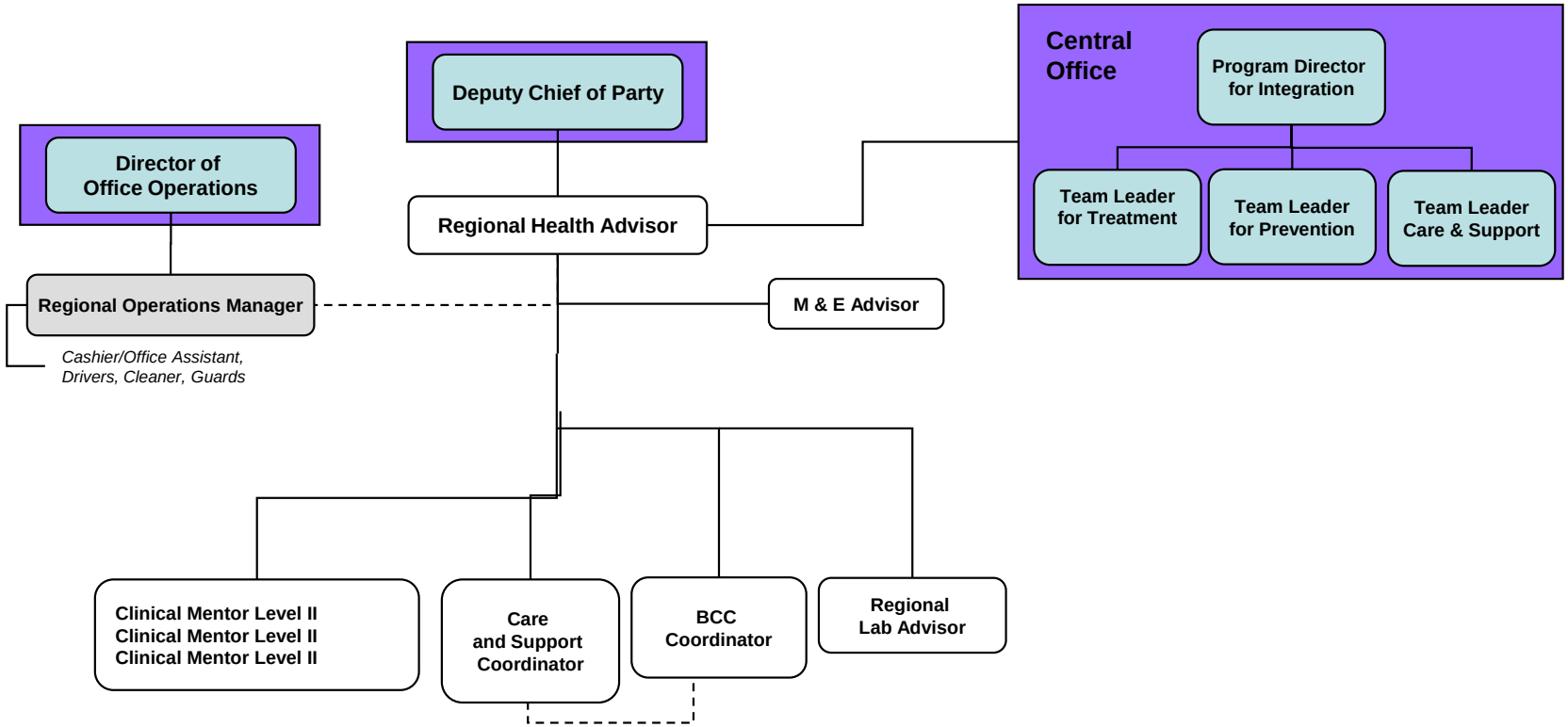



*1- Approved Position*

*2- Revised Title*

*3- New Requested Position*

# HIV/AIDS Care and Support Program Organogram — Addis Ababa Region



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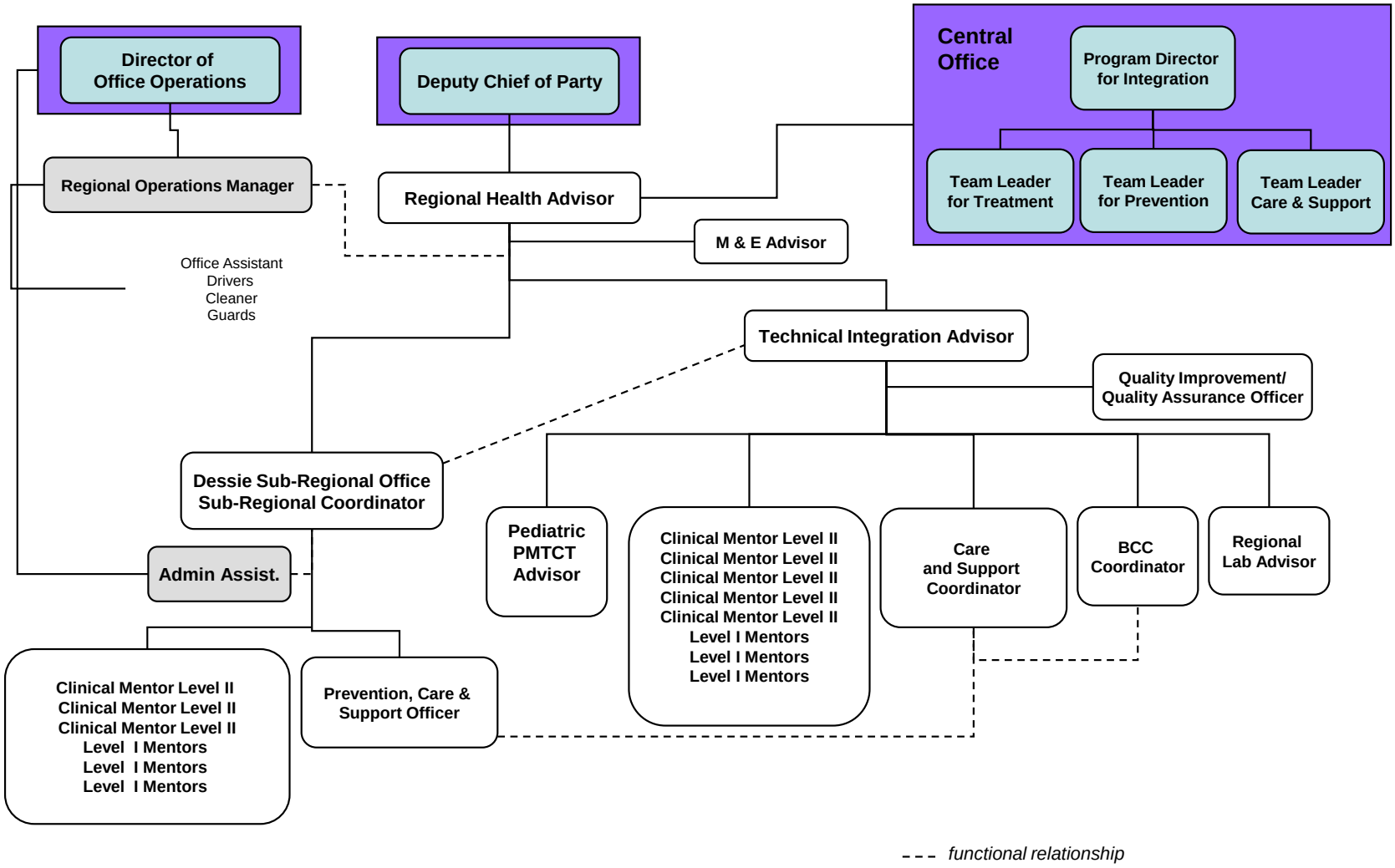
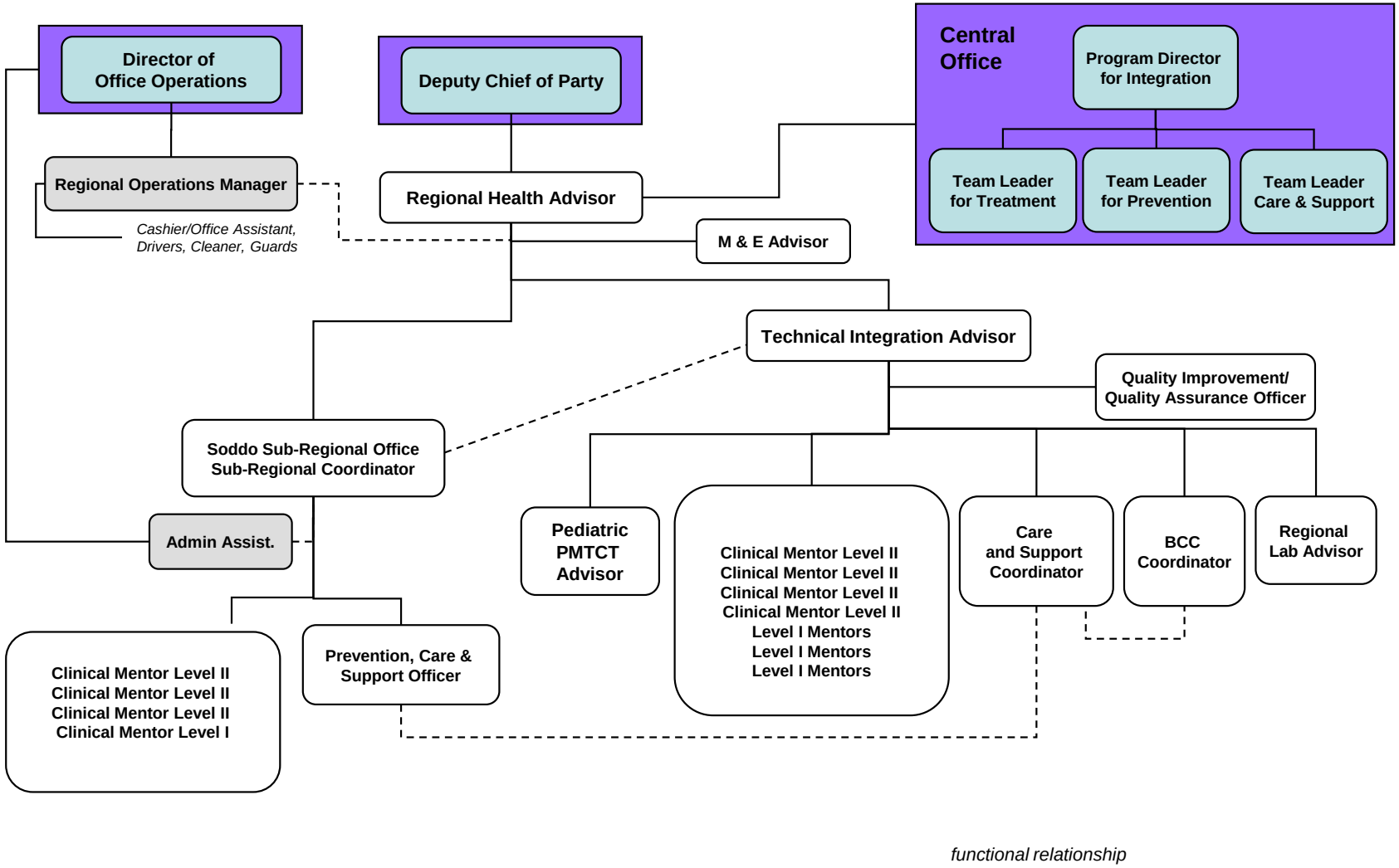
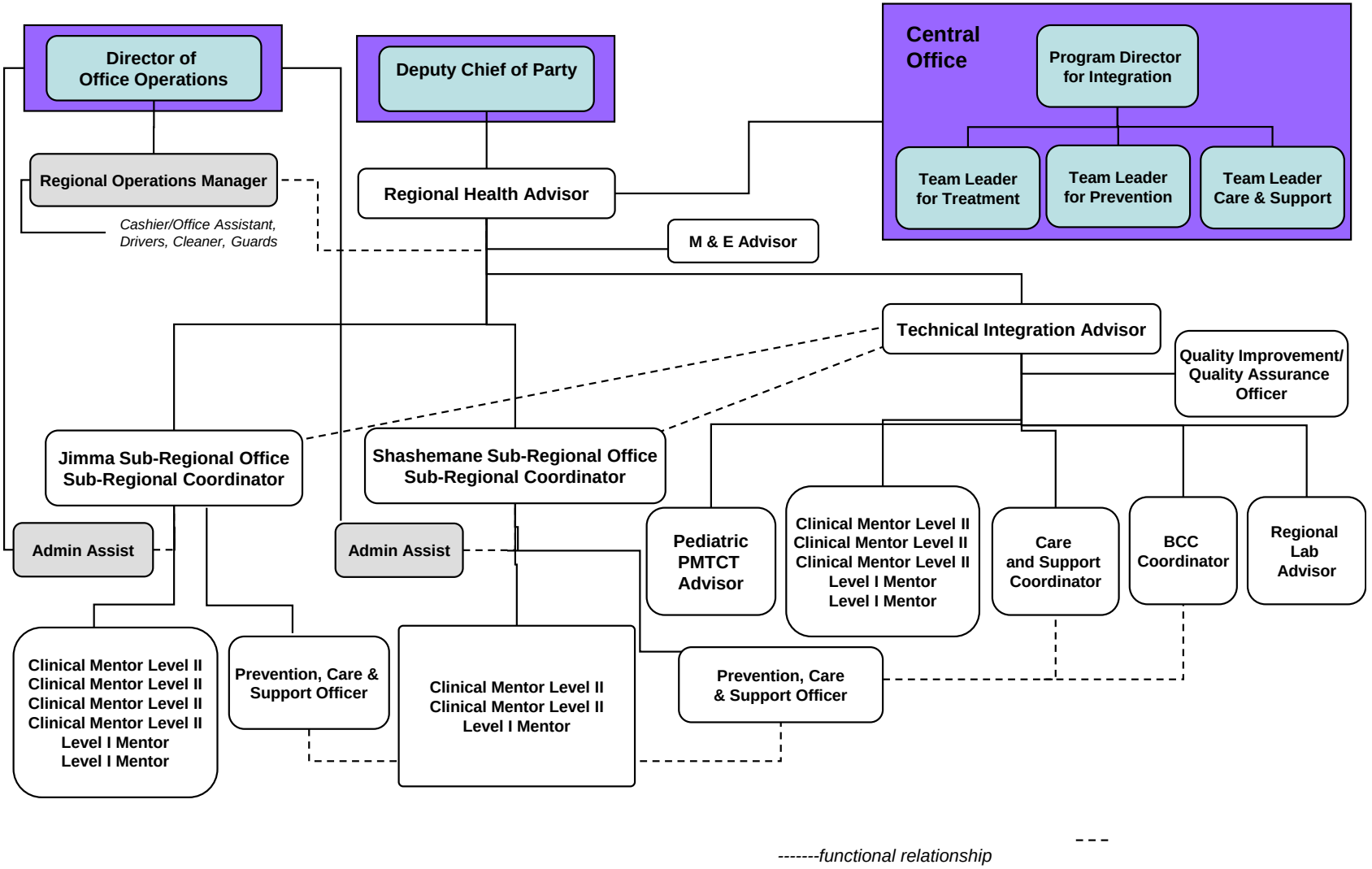
# HIV/AIDS Care and Support Program Organogram — Amhara Region



# HIV/AIDS Care and Support Program Organogram — SNNP Region



# HIV/AIDS Care and Support Program Organogram — Oromia Region



# APPENDIX H: REFERENCES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# APPENDIX I: FIGURES AND TABLES

### TABLE 1. PMTCT-RELATED ACTIVITIES' PERFORMANCE IN PROGRAM-SUPPORTED HCS

| Indicator | Addis Ababa | Amhara | Oromia | SNNPR | Tigray | Total |
|---|---|---|---|---|---|---|
| Number of new prenatal care clients whose HIV status is unknown and who visited the prenatal care facility during the reporting period | 6,577 | 10,702 | 19,926 | 12,929 | 8,009 | **58,143** |
| Number of new prenatal care clients counseled for HIV testing for PMTCT services | 5,638 | 10,323 | 19,006 | 10,774 | 7,652 | **53,393** |
| Number of prenatal care clients counseled and tested for HIV who received test results during the reporting period | 5,903 | 8,935 | 16,334 | 8,820 | 6,930 | **46,932** (81%) |
| Number of prenatal care clients who tested positive for HIV during the reporting period | 413 | 322 | 419 | 122 | 216 | **1,492** (3.2%) |
| Number of pregnant women of unknown serostatus who delivered at the facility | 202 | 1,048 | 944 | 157 | 160 | **2,511** |
| Number of pregnant women who received an HIV test in the labor and delivery ward | 56 | 514 | 944 | 65 | 39 | **1,618** |
| Number of HIV positive pregnant women provided with a complete course of HIV prophylaxis during the reporting period | 161 | 216 | 137 | 40 | 57 | **611** (41%) |
| Number of infants born to HIV positive mothers who received HIV prophylaxis during the reporting period (postpartum infant prophylaxis) | 129 | 152 | 92 | 47 | 25 | **445** (30%) |
| Number of pregnant women referred for ART during the reporting period | 252 | 255 | 238 | 25 | 84 | **854** |

Source: HCSP PMP Report PY2 Q 3.

**TABLE 2A. REGIONAL DISTRIBUTION OF PATIENTS ON ART (MARCH 31, 2009)**

| Region | Children 0–14 Years | Adults > 14 yrs | | | Regional Total |
|---|---|---|---|---|---|
| | | Male | Female (non-pregnant) | Pregnant Women | |
| Addis Ababa | 196 | 3,672 | 6,407 | 100 | 10,375 |
| Amhara | 34 | 5,667 | 9,104 | 55 | 14,860 |
| Oromia | 117 | 3,405 | 4,865 | 56 | 8,443 |
| SNNPR | 5 | 1,049 | 1,426 | 14 | 2,494 |
| Tigray | 76 | 1,214 | 1,941 | 18 | 3,249 |
| **Total** | **428** | **15,007** | **23,743** | **243** | **39,421** |

Source: HCSP PMP Report PY2 Q 3.

## TABLE 2B. FDRE MONTHLY UPDATE MARCH 9, 2009, CONDENSED BY REGION

| MONTHLY HIV CARE AND ART UPDATE<br>UPDATE AS OF END OF YEKATITI,2001 (MARCH 9, 2009) | | | | | | |
|---|---|---|---|---|---|---|
| **Age Category** | **HIV Care** | | **ART** | | | |
| | New persons enrolled during month | Cumulative ever enrolled at end of month | New persons started during month | Cumulative ever started at end of month | | |
| Infants <18 months | 72 | 2,663 | 40 | 784 | | |
| Children 19–59 months | 209 | 6,953 | 79 | 2,863 | | |
| Children 5–14 years | 431 | 12,349 | 174 | 6,078 | | |
| Non-pregnant females >14 years | 4,025 | 176,912 | 2,205 | 96,937 | | |
| Pregnant females | 339 | 9,266 | 106 | 2,349 | | |
| Males >14 years | 2,810 | 131,385 | 1,624 | 80,104 | | |
| Unspecified | | 107 | | 152 | | |
| **National Total** | **7,886** | **339,635** | **4,228** | **189,267** | | |
| | | | 56% of adults enrolled started on ART | | | |
| **Persons on ART** | | | **Pediatric Regimens** | | | |
| Children on 1st line regimen | 7,716 | | 3a | | | |
| Adults on 1st line regimen | 129,156 | | 3b | | | |
| Total on 1st line regimen | 136,872 | | 3c | | | |
| | | | 3d | | | |
| Children on 2nd line regimen | 84 | | d4T-3TC-NVP | 2,838 | | |
| Adults on 2nd line regimen | 1,693 | | d4T-3TC-EFV | 934 | | |
| Total on 2nd line regimen | 1,777 | | AZT-3TC-NVP | 2,640 | | |
| Unspecified regimen | 845 | | AZT-3TC-EFV | 1,304 | | |
| | | | Other Unspecified | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Total currently on ART Adult Regimens** | **139,494** | | **Total** | **Peds 7,716** | | |
| d4t(30)-3TC-NVP | 56,661 | | ABC-ddI-LPV/R | 88 | | |
| d4t(40)-3TC-NVP | 1,588 | | ABC-ddI-NFV | 14 | | |
| d4t(30)-3TC-EFV | 28,162 | | | | | |
| d4t(40)-3TC-EFV | 634 | | | | | |
| AZT-3TC-NVP | 24,342 | | Other Unspecified | 1,591 | | |
| AZT-3TC-EFV | 17,769 | | Total | **1,693** | | |
| Other Unspecified | | | | | | |
| **Total** | **129,156** | | | | | |
| **Percent on 1st line Reporting Facilities** | **98.70%** | | **Percent on 2nd line** | **1.28%** | | |
| Number of treatment sites opened in the month | | | | | | |
| Number of treatment sites operational | | | 441 | | | |
| Number of reporting treatment sites | | | 436 | | | |
| **Monthly update released on Sept 17, 2001 (June 24, 2009)** | | | | | | |

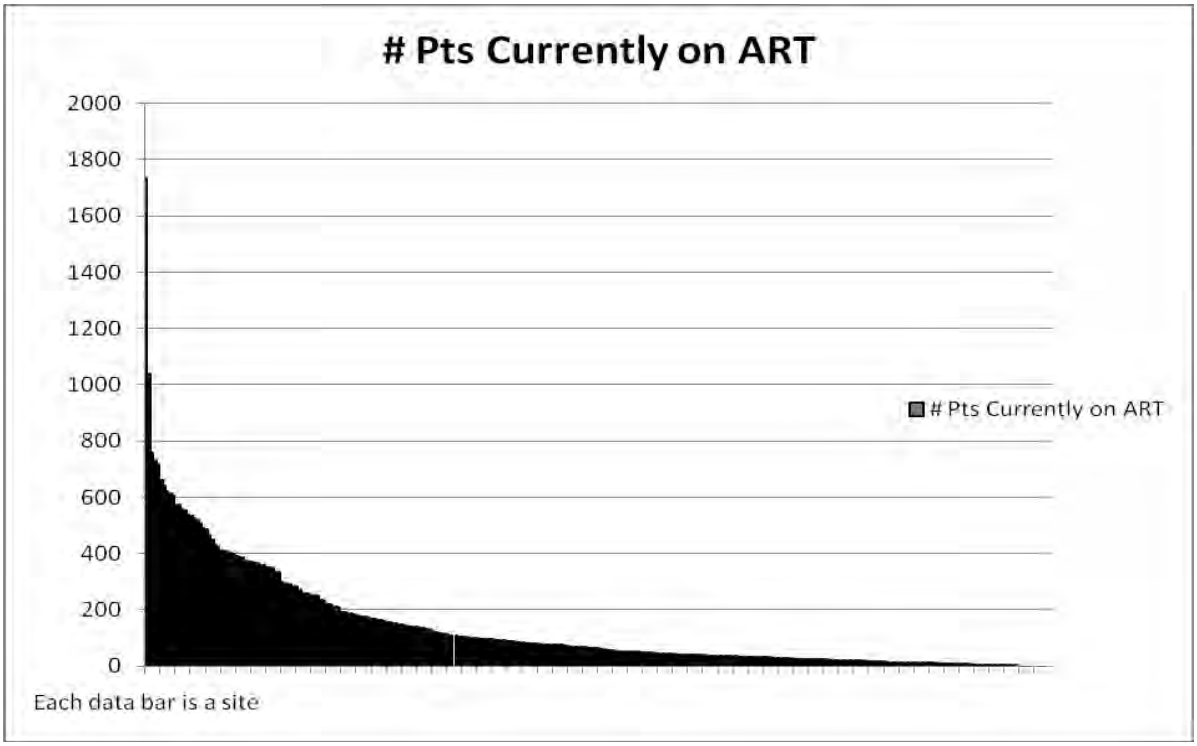
**ANNEX 1. ART MONTHLY UPTAKE BY SITE AS OF END OF YEKATIT 30, 2001 (MARCH 9, 2009)**

| GOE | Ever Enrolled | | Ever Started ART | | Total Currently on ART | Sites reported during the month | %Report Status | On ART HCs | HC% of Total |
|---|---|---|---|---|---|---|---|---|---|
| **Amhara** | 86,520 | | 50,076 | | 38,067 | 73 | 92% | 15,445 | 41% |
| **Oromia** | 78,295 | | 37,706 | | 28,210 | 74 | 66% | 8,043 | 29% |
| **SNNPR** | 28,929 | | 14,489 | | 10,878 | 74 | 78% | 2,645 | 24% |
| **Tigray** | 29,459 | | 16,293 | | 11,914 | 49 | 92% | 3,235 | 27% |
| **Harari** | 4,175 | | 2,275 | | 1,791 | 0 | 0% | 0 | 0% |
| **DD** | 5,466 | | 2,974 | | 2,196 | 0 | 0% | | 0% |
| **Gambella** | 2,077 | | 1,043 | | 707 | | | 197 | 28% |
| **Afar** | 2,855 | | 1,878 | | 1,457 | 6 | 100% | 591 | 41% |
| **Benishangul** | 2,621 | | 1,390 | | 1,015 | 0 | 0% | 176 | 17% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Somali** | 1,122 | | 768 | | 455 | 0 | | 0 | 0% |
| **Addis Ababa** | 76,703 | | 44,414 | | 33,363 | 35 | | 11,246 | 34% |
| | | | | | | | | 41,578 | |
| **Paying Hospitals** | | | | | | | | | |
| Private Hospital | **9,528** | | **8,077** | | **4,773** | **12** | **71%** | | |
| **Report Status (Percentage from the total reporting sites)** | | | | | | | | | |
| **(Public & Private)** | **86,231** | | **52,491** | | **38,136** | | **96%** | | |
| | | | | | | | | 0 | |
| **Uniformed Forces** | | | | | | | | | |
| **Total UF** | **11,885** | | **7,884** | | **4,668** | **20** | **95%** | | |
| **National Total** | **339,635** | | **189,267** | | **139,494** | **343** | | **0** | |

| **National-Level ART Sites Reported During the Month (%)** | | | **78%** |
|---|---|---|---|
| **Categories** | **# of Operational ART Sites** | **# of sites reported during the month** | **%** |
| **# of treatment site operational** | **441** | **343** | **78%** |
| **# Reporting sites** | **436** | **343** | **79%** |
| **Total Hospitals** | **130** | **117** | **90%** |
| Public Hospitals | **94** | **92** | **98%** |
| Private Hospitals | **17** | **13** | **76%** |
| Military Hospitals | **19** | **12** | **63%** |
| **Health Centers** | **308** | **172** | **56%** |
| NGO Clinics | **3** | **3** | **100%** |

**GRAPH 1: POINTS CURRENTLY ON ART**




Msc

**GRAPH 2 PYRAMID EVALUATION**

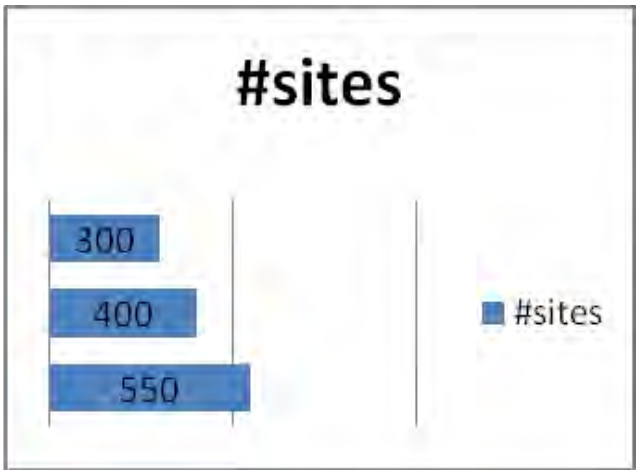


**TABLE 3. REGIONAL DISTRIBUTION OF LTFU PATIENTS AT THE HC LEVEL IN THE REGIONS SUPPORTED BY THE HIV/AIDS CARE AND SUPPORT PROGRAM, MARCH 2009.**

| REGION | NO. CURRENTLY ON ART | NO. LTFU PATIENTS (LOST, DROPPED, OR STOPPED) | PERCENTAGE OF PATIENTS LTFU |
|---|---|---|---|
| Addis Ababa | 10,375 | 1,118 | 9.7 |
| Amhara | 14,860 | 847 | 5.4 |
| Oromia | 8,443 | 663 | 7.3 |
| SNNPR | 2,494 | 82 | 3.2 |
| Tigray | 3,249 | 306 | 8.6 |
| **Total** | **39,421** | **3,016** | **7.1** |

Source: Ibid

**TABLE 4. REGIONAL DISTRIBUTION OF INDIVIDUALS REACHED WITH "ABSTINENCE AND BE FAITHFUL" (AB) MESSAGES AND BEYOND AB MESSAGES THROUGH ROLLOUT PERFORMANCE STRATEGY**

| Region | No. Reached with AB | | | No. Reached with Other Prevention (OP) | | | No. Reached with AB and OP | | |
|---|---|---|---|---|---|---|---|---|---|
| | M | F | Total | M | F | Total | M | F | Total |
| Addis Ababa | 6,244 | 8,981 | 15,225 | 5,272 | 6,767 | 12,039 | 11,516 | 15,748 | 27,264 |
| Amhara | 110,737 | 165,365 | 276,102 | 153,021 | 118,698 | 271,719 | 263,758 | 284,063 | 547,821 |
| Oromia | 31,421 | 36,150 | 67,571 | 32,028 | 36,706 | 68,734 | 63,449 | 72,856 | 136,305 |
| SNNPR | 15,675 | 13,708 | 29,383 | 7,798 | 3,220 | 11,018 | 23,473 | 16,928 | 40,401 |
| Tigray | 10,234 | 11,573 | 21,807 | 9,220 | 11,380 | 20,600 | 19,454 | 22,953 | 42,407 |
| **Total** | **174,311** | **235,777** | **410,088** | **207,339** | **176,771** | **384,110** | **381,650** | **412,548** | **794,198** |

Source: HCSP PMP Report PY2 Q 3.

**TABLE 5. TYPES OF TRAININGS CONDUCTED BY THE HIV/AIDS CARE AND SUPPORT PROGRAM, AND INDIVIDUALS TRAINED PER REGION**

| Training Title | Addis Ababa | | Amhara | | Oromia | | SNNPR | | Tigray | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | Grand Total |
| PMTCT | | | 33 | 18 | 95 | 35 | | | | | 128 | 53 | **181** |
| Comprehensive HIV care, treatment, and IMAI | | | 23 | 16 | | | | | | | 23 | 16 | **39** |
| Comprehensive laboratory services for HIV & AIDS | | | 59 | 24 | | | | | 41 | 8 | 70 | 32 | **102** |
| PICT | | | 49 | 42 | 53 | 31 | | | 16 | 5 | 118 | 78 | **196** |
| VCT | | | | | | | | | | | | | |
| TB/HIV | | | 51 | 32 | | | | | | | 51 | 32 | **83** |

Source: HCSP PMP Report PY3 Q 3.

## TABLE 6. CLIENTS PER SITE PER REGION WITH SUMMARIES

| Team 1 | | | Ever Enrolled | Ever Started ART | Currently on ART | Ever Enrolled | Ever Started ART | Currently on ART | Ever Enrolled | Ever Started ART | Currently on ART | Ever Enrolled | Ever Started ART | Currently on ART | Ever Enrolled | Ever Started ART | Currentl y on ART |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Visit** | **Type** | **Region** | **Amhara** | | | **Oromia** | | | **SNNP** | | | **Tigray** | | | **AA** | | |
| Kolfe | HC | AA | | | | | | | | | | | | | 1,605 | 627 | 660 |
| T/haimanot | HC | AA | | | | | | | | | | | | | 1,537 | 673 | 643 |
| Bole | HC | AA | | | | | | | | | | | | | 2,169 | 1054 | 1041 |
| Woreda 19 | HC | AA | | | | | | | | | | | | | 1,613 | 689 | 755 |
| Woreda 23 | HC | AA | | | | | | | | | | | | | 502 | 188 | 193 |
| Adulala | HC | Oromia | | | | 66 | 24 | 25 | | | | | | | | | |
| Adama | Hosp | Oromia | | | | | | | | | | | | | | | |
| Mojo | HC | Oromia | | | | 1,298 | 543 | 527 | | | | | | | | | |
| Holeta | HC | Oromia | | | | 1,353 | 597 | 532 | | | | | | | | | |
| Sendafa | HC | Oromia | | | | 247 | 124 | 102 | | | | | | | | | |
| Tulu Bollo | HC | Oromia | | | | 179 | 49 | 116 | | | | | | | | | |
| **Team 2** | | | | | | | | | | | | | | | | | |
| **Visit** | **Type** | **Region** | | | | | | | | | | | | | | | |
| Amhara | RHB | Amhara | | | | | | | | | | | | | | | |
| Amhara | HAPCO | Amhara | | | | | | | | | | | | | | | |
| Adet | HC | Amhara | 706 | 291 | 272 | | | | | | | | | | | | |
| Gondar Univ | Hosp | Amhara | | | | | | | | | | | | | | | |
| Gonder | HC | Amhara | 2,046 | 937 | 727 | | | | | | | | | | | | |
| Durbeti | HC | Amhara | 519 | 217 | 176 | | | | | | | | | | | | |
| Dangla | HC | Amhara | 744 | 323 | 333 | | | | | | | | | | | | |
| Dejen | HC | Amhara | 239 | 74 | 115 | | | | | | | | | | | | |
| Kofele | HC | Oromia | | | | 152 | 57 | 34 | | | | | | | | | |
| SNNP | RHB | | | | | | | | | | | | | | | | |
| SNNP | HAPCO | SNNP | | | | | | | | | | | | | | | |
| Awassa | HC | SNNP | | | | | | | 313 | 77 | 95 | | | | | | |
| Bushulo | HC | SNNP | | | | | | | 416 | 156 | 125 | | | | | | |
| Adola | HC | Oromia | | | | 617 | 257 | 173 | | | | | | | | | |
| Sakiso | no | Oromia | | | | 435 | 120 | 167 | | | | | | | | | |
| **Team 3** | | | | | | | | | | | | | | | | | |
| **Visit** | **Type** | **Region** | | | | | | | | | | | | | | | |
| Shoarobit | HC | Amhara | 795 | 456 | 390 | | | | | | | | | | | | |
| Bati | HC | Amhara | 686 | 311 | 258 | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dese | HC | Amhara | 1,600 | 813 | 622 | | | | | | | | | | | | |
| Hayk | HC | Amhara | 1,198 | 638 | 573 | | | | | | | | | | | | |
| Mersa | HC | Amhara | 1,288 | 639 | 717 | | | | | | | | | | | | |
| Alamata | HC | Tigray | | | | | | | | | | 486 | 198 | 149 | | | |
| Korem | HC | Tigray | | | | | | | | | | 374 | 143 | 141 | | | |
| Mohoni | HC | Tigray | | | | | | | | | | 891 | 391 | 346 | | | |
| Tigray | RHB | Tigray | | | | | | | | | | | | | | | |
| Tigray | HAPCO | Tigray | | | | | | | | | | | | | | | |
| Freweini | HC | Tigray | | | | | | | | | | 216 | 97 | 118 | | | |
| Welkita | HC | SNNP | | | | | | | 283 | 99 | 105 | | | | | | |
| Worabe | HC | SNNP | | | | | | | 187 | 79 | 94 | | | | | | |
| Butajira | Hosp | SNNP | | | | | | | 28 | 3 | 51 | | | | | | |
| Total clients | | 43% | 9,821 | 4,699 | 4,183 | 4,347 | 1,771 | 1,676 | 1,227 | 414 | 470 | 1,967 | 829 | 754 | 7,426 | 3,231 | 3,292 |
| #HCs | 32 | | 10 | 10 | 10 | 8 | 8 | 8 | 5 | 5 | 5 | 4 | 4 | 4 | 5 | 5 | 5 |
| Clients/HC | | | 982 | 470 | 418 | 543 | 221 | 210 | 245 | 83 | 94 | 492 | 207 | 189 | 1,485 | 646 | 658 |
| Current/2mo | | | | | 209 | | | 105 | | | 47 | | | 94 | | | 329 |
| **Current/day** | | | | | **10** | | | **5** | | | **2** | | | **5** | | | **16** |
| | | | | | | | | | | | | | | | | | |
| **Regional Totals** | | 44% | 86,520 | 50,076 | 38,067 | 78,295 | 37,706 | 28,210 | 28,929 | 14,489 | 10,878 | 29,459 | 16,293 | 11,914 | 76,703 | 44,414 | 33,363 |
| **Total # HCs** | | | 62 | 62 | 62 | 82 | 82 | 82 | 79 | 79 | 79 | 41 | 41 | 41 | 27 | 27 | 27 |
| **Regional Total/HC** | | | **1,395** | **808** | **614** | **955** | **460** | **344** | **366** | **183** | **138** | **719** | **397** | **291** | **2,841** | **1,645** | **1,236** |
| Current/2mo | | | | | 307 | | | 172 | | | 69 | | | 145 | | | 618 |
| **Current/day** | | | | | **15** | | | **9** | | | **3** | | | **7** | | | **31** |
| | **Amhara** | **Oromia** | **SNNP** | **Tigray** | **AA** | **Total All HCSP Regions** | | | | | | | | | | | |
| **Current/day** | **10** | **5** | **2** | **5** | **16** | **24,788** | **10,944** | **10,375** | **on rx** | | | | | | | | |
| | | | | | | **32** | **32** | **32** | | | | | | | | | |
| | | | | | | **775** | **342** | **324** | **pts/day all sites** | | | | | | | | |

**TABLE 7. HIV SEROPREVALENCE RATES AT BUSHOLO HC (SNNP) PER ANNUAL REPORT**

| BUSHULO HC | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **2003** | **2004** | **2005** | **2006** | **2007** | **2008** | **2008** | |
| **Screened** | 667 | 714 | 801 | 1,043 | 1,075 | 1,386 | 428 | Preg |
| **POS** | 271 | 252 | 280 | 375 | 317 | 330 | 9 | Preg |
| **Neg** | 396 | 462 | 521 | 668 | 758 | 1,056 | | |
| **%POS** | 41% | 35% | 35% | 36% | 29% | 24% | 2.1% | Preg |

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