USAID/PEPFAR Ethiopia In-Country Reporting System (IRS)
Reporting Template

Integrated Service on Health and Development Organization (ISHDO)

PROGRAM RESULTS
FOR

FISCAL YEAR 2021, QUARTER 1

(OCTOBER 1 TO DECEMBER 31, 2020)

CONTACT INFO FOR THIS REPORT:

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LIST OF ACRONYMS

APC	Area Program coordinator
ART	Anti-Retroviral Therapy
C/ALHIV	Children and Adolescents living with HIV
CAG	Community ART Refill Groups
CEF	Community Engagement Facilitator
COP	Chief of Party
CWs	Case Workers
FFHPCT	Family Focused HIV Prevention, Care and Treatment
FIDO	Fayyaa Integrated Development Organization
HF	Health Facility
HIV	Human Immune Virus
ICT	Index Case testing
ISHDO	Integrated Service on Health and Development Organization
LIP	Local Implementing Partners
LTFU	Loss to Follow Up
MENA	Mekdim Ethiopia National Association
MMD	Multi Month Dispensing
MOU	Memorandum of Understanding
NTCBCO	Nekempt Charity based community Organization
ODA	Oromia Development Association
OVC	Orphan and Vulnerable Children
PEPFAR	President's Emergency Program for AIDS Relief
PLHA	People Living with HIV AIDS
SNUs	Sub National Units
SSWs	Social Service Workers
TOI	Trainers of Instructors
USAID	United states Agency for International Development
VL	Viral Load
VLS	Viral Load Suppression

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1. Reporting period

From October 1,2020	To December 31,2020

2. Publications/reports

Did your organization support the production of publications, reports, guidelines or assessments during the reporting period?

No/Not Applicable ☒
Yes ☐ If yes, please list below:

Publications/Reports/Assessments/Curriculums

Title	Author	Date

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

3. Technical assistance

Did your organization utilize short-term technical assistance during the reporting period?

No/Not Applicable ☐
Yes ☐ Please list below:

Consultants/TDYers

Name	Arrival	Departure	Organization	Type of Technical assistance provided

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

4. Travel and Visits

Did your organization support international travel during the reporting period?

No/Not Applicable ☐
Yes ☐ Please list below:

International Travel (All international travel to conference, workshops, trainings, HQ or meetings).

Name	Destination	Departure from Ethiopia	Arrival	Host Organization	Purpose of the travel

Have any Monitoring Visit/supervision been made to your program in during the reporting period?

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
COP, HIV service director	Nov 6,2020	Nov 6,2020	Meki	Yes
USAID Activity Manger, APC Adama	Dec 16,2020	Dec 17,2020	Bishoftu	Yes
APC Ambo and HIV officer	Dec 21,2020	Jan 01,2021	Ambo, Burayu, Holeta, AdaBerga, Jeldu & Dendi	Yes
APC Adama, HIV officer	Dec 21,2020	Jan 01,2021	Shashemene, Goba & Bulehora	Yes
M&E specialist	Dec 21,2020	Jan 01,2021	Adama and Bishoftu	Yes
OVC officer	Dec 21,2020	Jan 01,2021	Nekempt Gimbi, Nedjo	Yes

HIV specialist and M&E officer	Dec 21,2020	Jan 01 ,2021	Sebeta, Woliso, Fiche, Kuyu, Sululta & Becho	Yes
OVC C&S specialist HIV officer	Dec 21,2020	Jan 01,2021	ODA Modjo, Bishoftu & Dukem	Yes

5. Activity

Program Area (Tick all which apply)	Activity ID	Activity Title (Please write the title of the activity)
☐ **01-PMTCT**		
☐ **02-HVAB**		
☒ **03-HVOP**	72066320CA00013	Family focused HIV prevention, care and treatment activity in Oromia
☐ **04-HMBL**		
☐ **05-HMIN**		
☐ **07-CIRC**		
☐ **08-HBHC**		
☐ **09-HTXS**		
☐ **10-HVTB**		
☐ **11-HKID**		
☒ **12-HVCT**	72066320CA00013	Family focused HIV prevention, care and treatment activity in Oromia
☐ **13-PDTX**		
☐ **14-PDCS**		
☐ **15-HTXD**		
☐ **16-HLAB**		
☐ **17-HVSI**		
☐ **18-OHSS**		

6. Accomplishments and successes during the reporting period

Project overview

Family focused HIV, prevention, care and treatment activity is a USAID funded activity Implemented by ISHDO and its partners in Oromia region for the period of Oct 2020 to September 2023 with a total budget of USD$ 9,828,785 million.

The main purpose of the activity is to strengthen HIV epidemic control so that 95% of individuals living with HIV know their status, 95% of persons living with HIV initiate antiretroviral therapy and 95 % of clients on antiretroviral therapy achieve viral load suppression by 2030.

This community HIV Care and Treatment activity aims to accelerate and sustain HIV epidemic control in Ethiopia through assisting delivery of high-impact community-based HIV services and support community-based case finding through ICT, tracing of LTFUs, HIV self-testing, provision of referral to HF for care and treatment services and support the establishment of community ART refill groups. The project also implements a high quality OVC program that is aligned with new direction and priorities of PEPFAR OVC programs emphasizing on Comprehensive Case management and Primary Prevention of violence and HIV among 9-14-year girls and boys in line with PEPFAR technical Capacity domains for prime partners.

USAID family focused HIV prevention, care and treatment activity will support the implementation of Community HIV care and treatment services, comprehensive HIV service for OVC and primary prevention for adolescent aged 9-14 in 41 woredas/towns of Oromia National Regional State.

This project is implemented as prime by integrated service on Health and development Organization and 6 sub local implementing partners namely 1) MENA, 2) DUGDA,3) ODA, 4) FIDO, 5) HUNDEE and 6) NTCBCO and ISHDO in selected 41 woredas /towns of Oromia regional state towns and collaboration with major regional stakeholders' bureaus of Health, Education, Women children and youth, labor and social affairs and finance and economic development.

Overview of FY21 first quarter

The first quarter is the startup period for the FFHPCT which involved the engagement of partners development of detail work plan and budget, cascaded to implementing partners in the partners in an orientation and plan development workshop and finalization of agreement with sub partners.

Staffing of the project was another important step for the startup. ISHDO and partners have recruited the necessary staffs required for the project using competitive process and most of the

staffs were on Board and started their activity at the project sites. Program area orientations and technical trainings on ICT, MMD, Comprehensive care were provided virtually by technical partners Project Hope and FHI 360. Technical partners Project Hope also organized in person trainings on Community ART and commcare application's and implementing partners have moved very fast in continuing services started in the previous projects. FHI 360 also organized a number of virtual orientations and trainings to equip partners with necessary knowledge to startup services on comprehensive OVC programming.

Accordingly, ISHDO and partners Identify vulnerable children & families, enrolled over 50,000 eligible children & families into care and assessed, developed care plan and provided need-based services.

In line with HIV testing services. ISHDO and partners have been closely working with target towns health facilities signed MOU and using that collaboration collected line list from facilities for Index cases and started tracking in the community. During this reporting period over 2000 index cases contacts were elicited, traced and 138 HIV positives cases were identified and linked to treatment.

FY2021, first quarter FFHPCTA key achievements

- Elicited **2006** contacts of index cases using line list collected from facilities**.**
- Tested **2005** contacts of Index cases
- Identified **111** HIV positives cases from the contacts identified.
- **181** HIVST kits distributed to beneficiaries
- **18** HIV positives identified through HIVST.
- Identified **677** LTFU cases line listed from Health facilities,
- **324** (48%) were tracked and re-engaged,
- **25** CAG groups having **175** members were established and refilled.
- **52,236** (98%) OVC enrolled into care.
- **28,402** caregivers were enrolled into care.
- **4,189** (117%) children and adolescents living with HIV were enrolled into care.
- **458** adolescent girls were reached on IMpower curriculum.
- **778** adolescents and **680** caregivers were reached through Sinovuyo curricula.

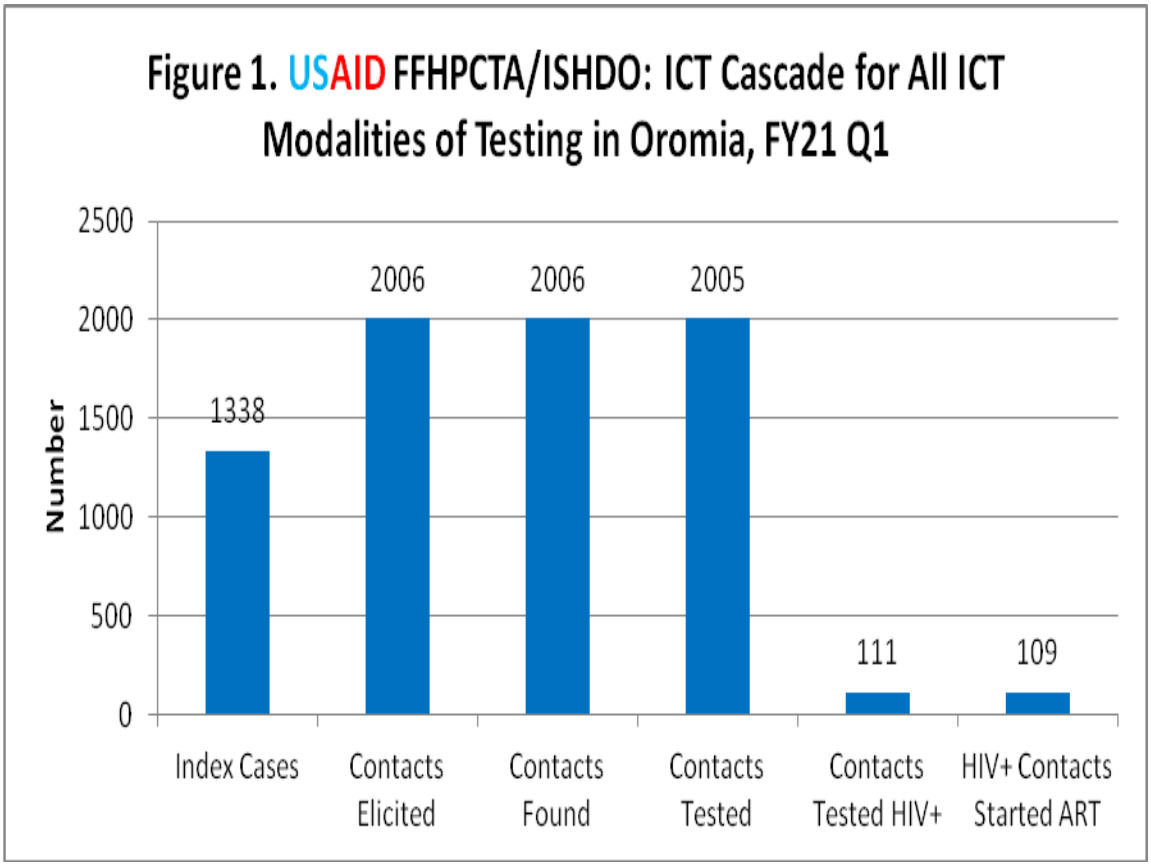
Result 1: Increased access and demand to family-focused HIV services that reduce HIV

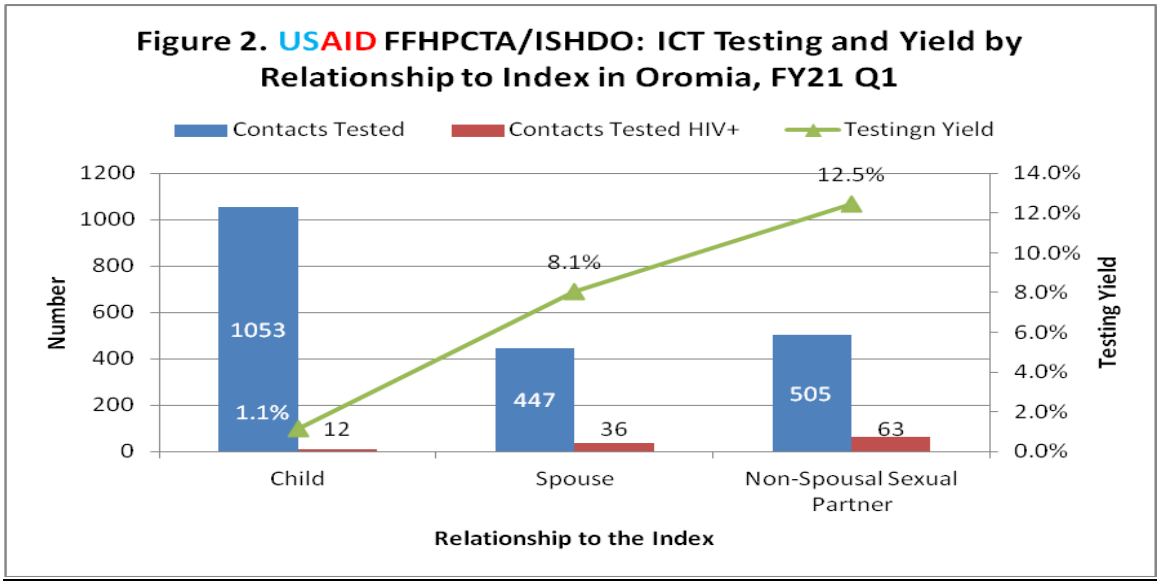
IR 1: HIV testing and counseling in the community

1.1 HIV case finding through ICT

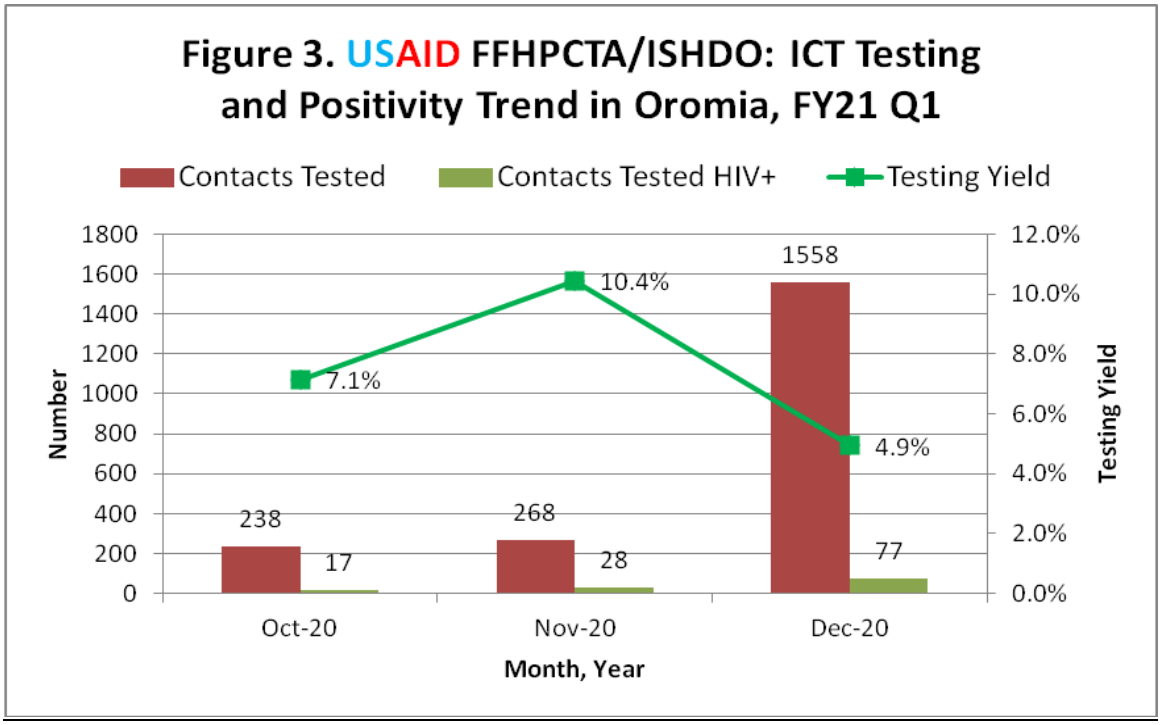
HIV case finding remains the critical gap to treatment cohort growth, given Ethiopia's strong retention. ISHDO and its partners conducted HIV testing service in close collaboration with regional and local health office and health facilities. The collaboration was endorsed using MOU signed on both sides.

HIV testing using health facility-initiated ICT was done for 2005 children and adults. 111 HIV positive cases were identified. The testing cascade is shown in Figure 1 below. Of 1338 index HIV+ cases, 2006 contacts were elicited were tracked and 2005 tested for HIV. An average of 1.5 people was line listed and tested per index case. Community based HIV testing including HIV self-test was 1,049 out of 6,912 target for the quarter. This is 15.2% achievement. 56 HIV positive cases were identified which is 5.2% out of the quarterly target of 1,087.





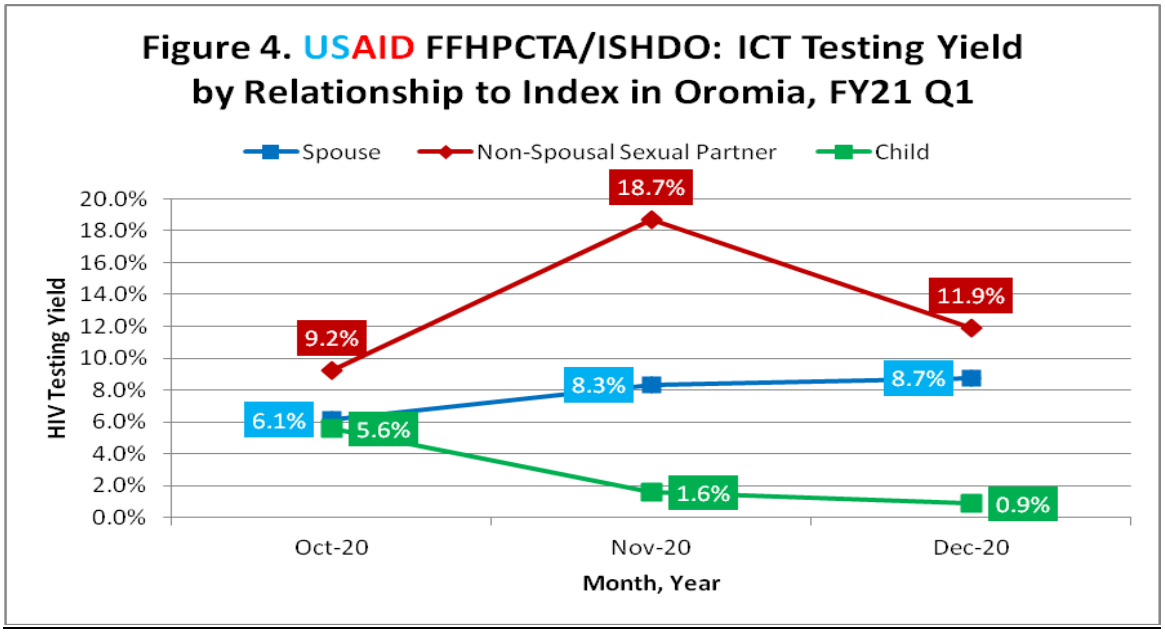
HIV testing yield by the type of relationship to the contact is indicated in Figure 2 above. Of 1053 children tested for HIV, 1.1% were found to have HIV; of 447 spousal partners, 8.1% were found to be HIV positive. The highest yield was for non-spousal sexual partners at 12.6%.



ICT testing trend by month (Figure 3) indicates that testing improved by 6x during December compared to the first two months. This is the result of accelerated case finding activity implemented that involved orientation of all stakeholders including health facilities, town health

office, and community workers including community engagement facilitators, case workers, members of PLHA association. HIV testing yield declined during December 2020 because of increased testing of children who had lower testing yield of 2% as shown in Figure 2 above.

ICT testing yield trend by type of person tested indicates that testing yield is increasing for spousal and non-spousal partners, reaching 8.7% and 18.7% respectively. The use of ICT risk assessment tool that prioritizes testing of cases that were never tested previously is contributing for this improvement. The decining trend of yield with increased testing is because targeted testing for children was not started till end of the quarter. Prioritizing children of HIV+ mothers who were never tested previuosly is already improving HIV testing in some SNUs like Bule Hora where yield as high as 30.8% was observed.



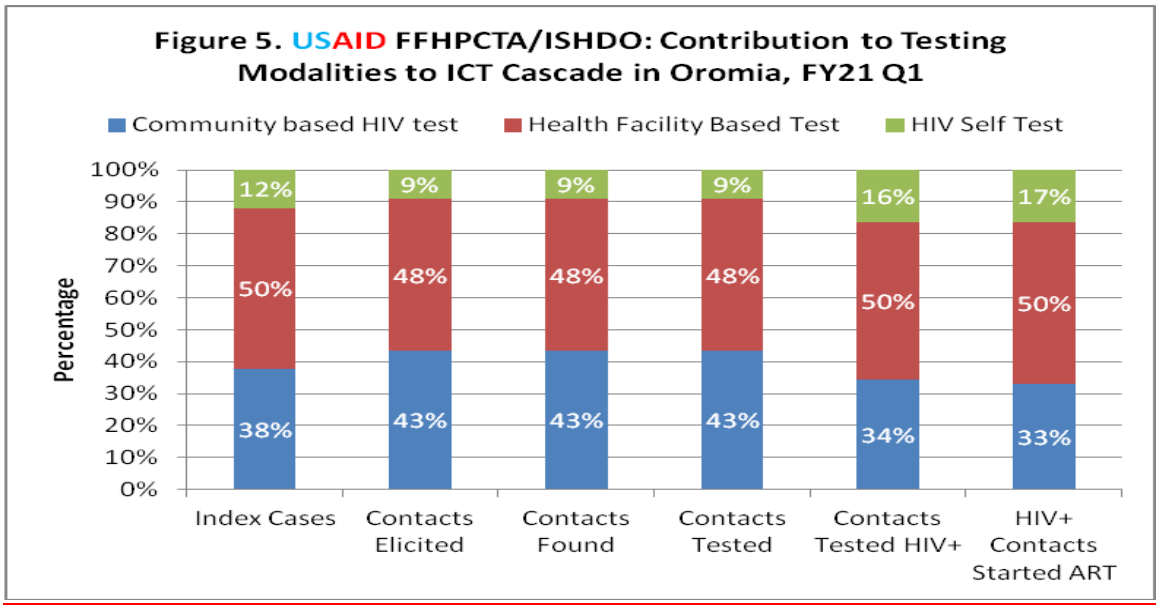
The overall testing volume and yield is low in this quarter which is mostly attributed to late startup of activities and late signing of MOU with facilities due to delayed agreement signing with Oromia health Bureau, limited knowledge and skills of recruited staff on ICT, lack of test kits and related accessories and supplies to do community-based testing.

1.2 HIV case finding through HIV self-testing

HIV self-test has been employed a s an innovative technique for case finding in community-based setting. ISHDO and partners has been using HIVST as one of the modalities for HIV testing in case finding. For the limited skills of frontline workers on HIVST Only 36% (181/498) of

available kits were used during the quarter. And All of the HIV Self-tests reported were assisted tests. The number of cases tested through HIV Self-test was 181 of which 18 were found to be HIV positive which makes HIVST contribution only 16% of positive cases finding during this quarter .All HIV positives cases did confirmatory testing and all confirmatory test was consistent with self-test result 100%. All of the HIV Self-tests reported were assisted tests.

Low level of HIV self-test use was attributed to lack of knowledge of staffs and volunteers on self-test application and lack of confidence to recommend to clients on its use.



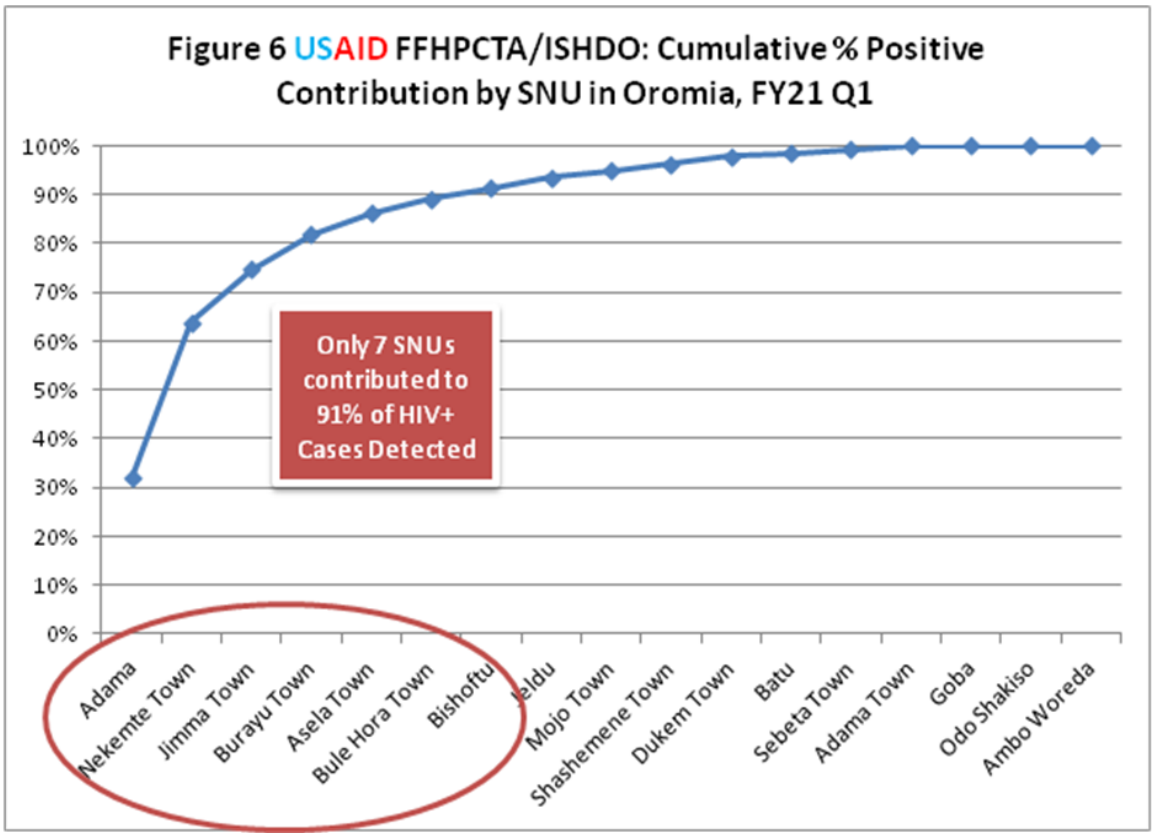
The relative contribution of the different modalities of ICT testing is indicated in Figure 5 above. 43% testing was done through community based testing, 48% through health facility testing, and the remaining 9% through HIV Self test. HIV Positive cases identified were through community-based testing in 34% of cases, while 50% was through facility-based testing and 16% through HIVST.

1.3 Active Linkage to Care and Treatment

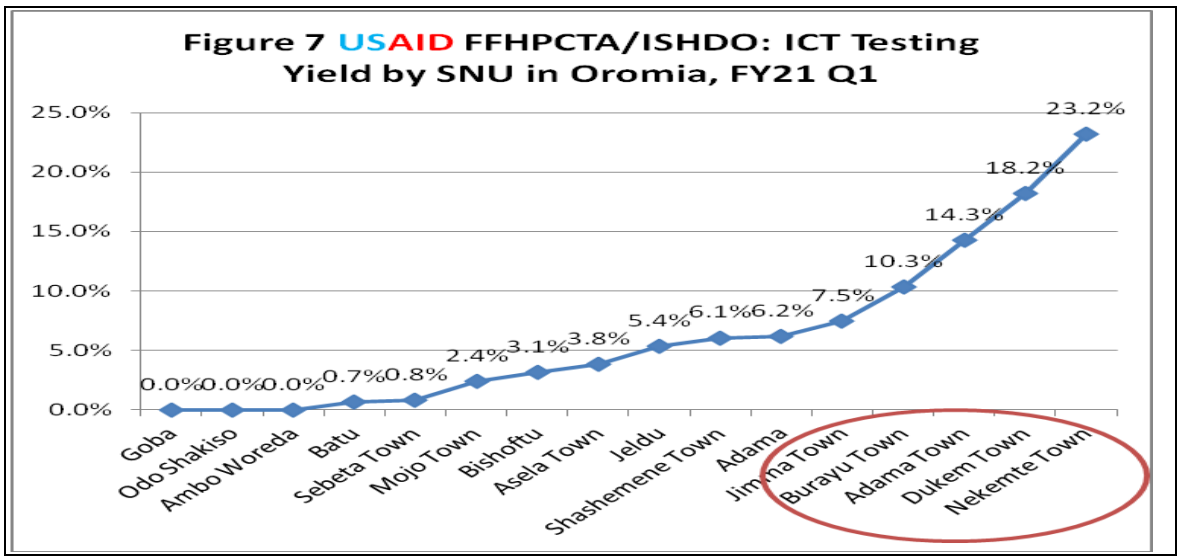
Linkage to treatment for 111 newly diagnosed HIV positive cases was 98.2%. This is shown in Figure 1 with the ICT cascade.

1.4 Geographic and demographic hot- spots identification

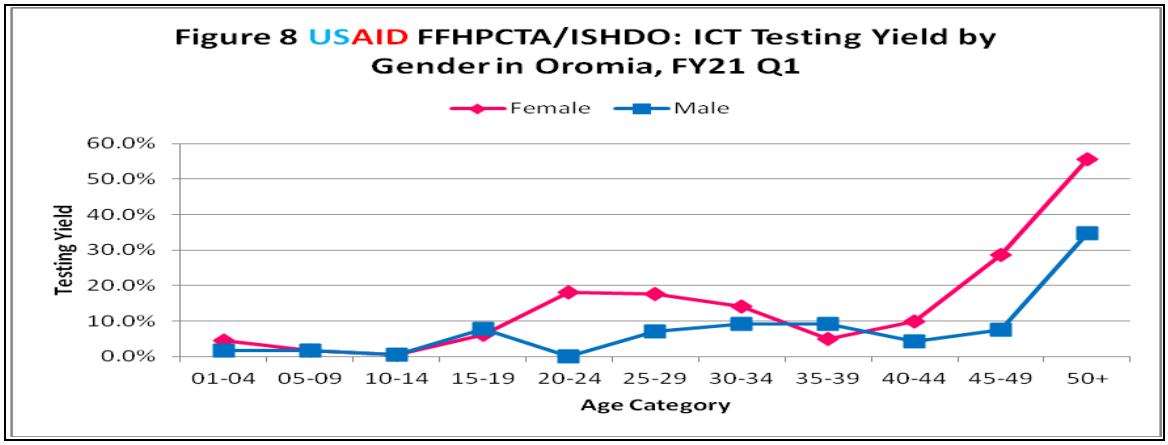
Figure 6 below is a Pareto chart that shows the cumulative proportion of HIV+ cases newly diangosed by SNU. Of the 17 SNUs that reported ICT testing, only 7 accounted for 91% of the cases diagnosed. That is one SNU for each LIP.



On the other hand, ICT testing yield by SNU is mostly consistent but slightly different as there are SNUs with better testing yield that had low volume of testing. Scaling up testing in such sites may improve the absolute number of HIV positive cases identified. (Figure 7)



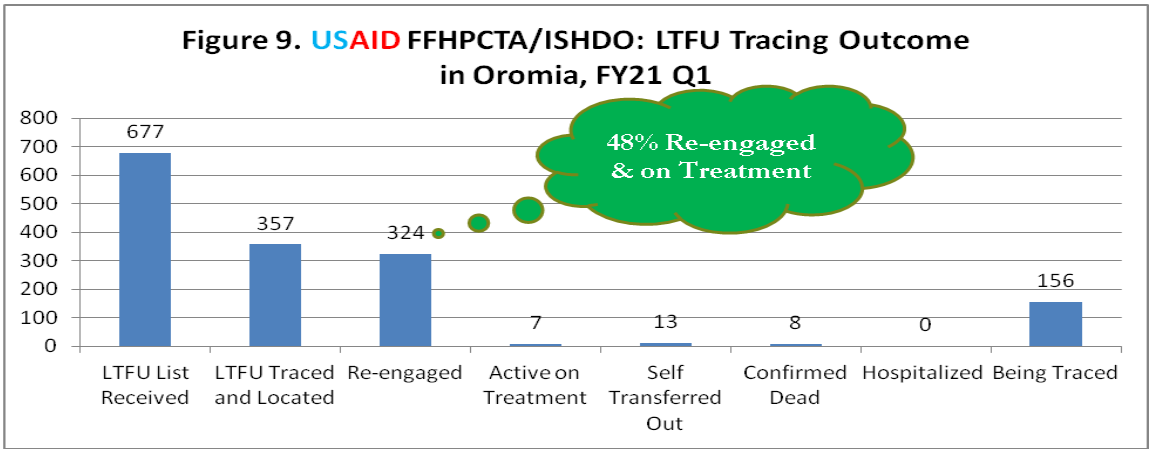
Testing yield by demographic factors is indicated for age and gender in Figure 8. Age and gender differences are seen clearly with women in the age groups 20-29 and 45+ having a higher positivity rate. Men in the age group 50+ were also seen to have high positivity rate. These will be priority areas for FY21 Q2 .



IR 2: Increased adherence and retention on ART through targeted community case management including adherence counseling and support, disclosure, and psychosocial services for PLHIV

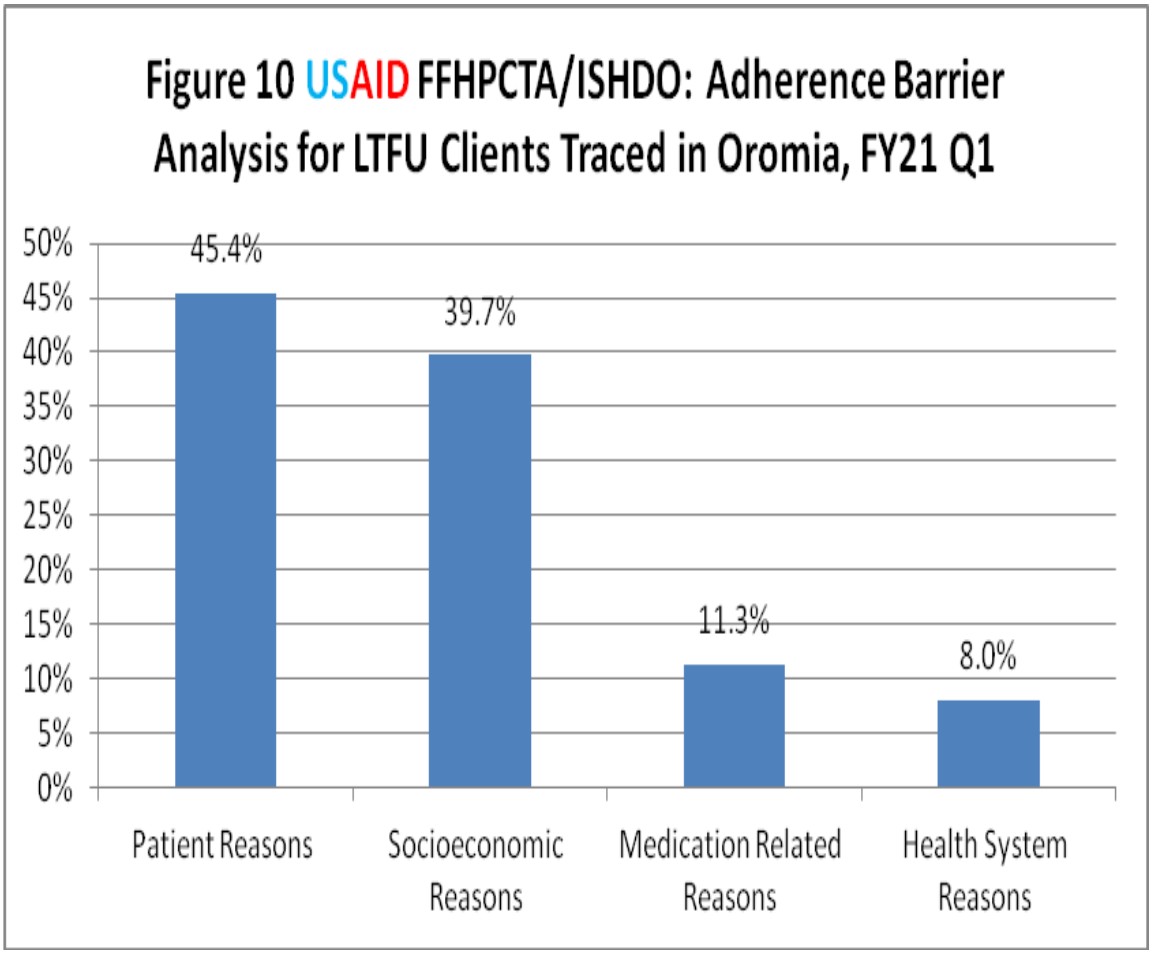
2.1 Ensuring adherence of ART clients

The major activity conducted in this quarter to imrove adherence was tracing of lost to follow-up (LTFU) cases. As shown in Figure 9 below, of 677 LTFU cases line listed, 324 (48%) were re-engaged, while 7 were found to be already on treatment and 13 were self transferred-out cases (3.0%).



2.2 Strengthening bi-directional referral system

For LTFU cases traced and located, adhernece barrier analysis indicates that patient related and socio-economic factors were main reasons for discontinuing treatment (Figure 10) and for that appropriate services were provided for those and other issues through bidirectional referral.



Sub IR 2.1: Implement community-based differentiated care model, including healthcare worker managed groups and adherence peer led groups to improve adherence and retention on ART and achieve viral load suppression.

2.1.1 Implementation of community-based differentiated care model

Community ART groups were established in selected high load ART facilities. Accordingly, 25 CAG groups having 175 members were established and refilled in the quarter. Compared to the target of 229 groups to be established during Q1, the performance was 11%.

IR 1.3 Increased access to high impact community-based services for OVC and prevention of HIV

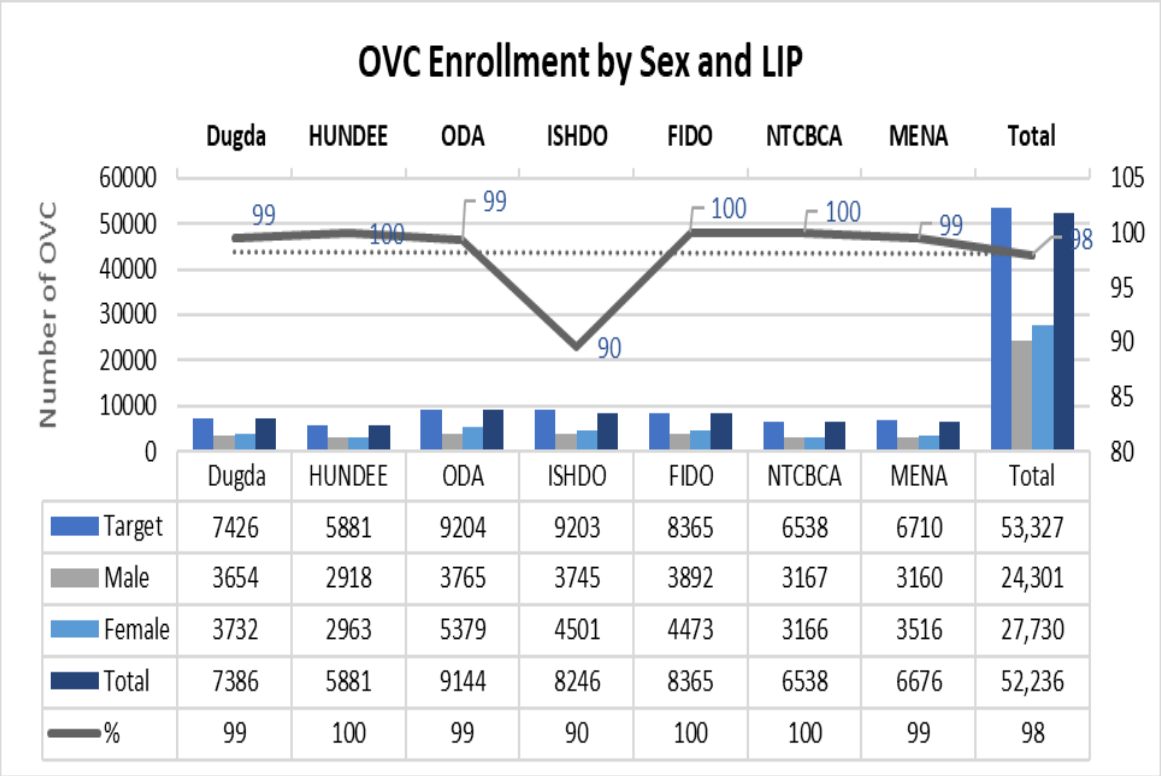
3.1 Implement Comprehensive OVC intervention

3.1.1. Case management and support /OVC and Caregivers Enrollment

As per the designed beneficiary identification strategy, health facilities and community entry points were used for OVC identification. At community level PLHIV associations, HIV support groups and others were used to identify OVC that are HIV infected and at risk for HIV, as per the priority sub-groups of COP20.

As the ratio of COP20 OVC comprehensive services target-to-enrollment shows in figure 11, enrollment resulted in a larger number of OVC in the targeted SNUs. By the end of this reporting period 98% of the total OVC comprehensive services target had been enrolled in to the program.

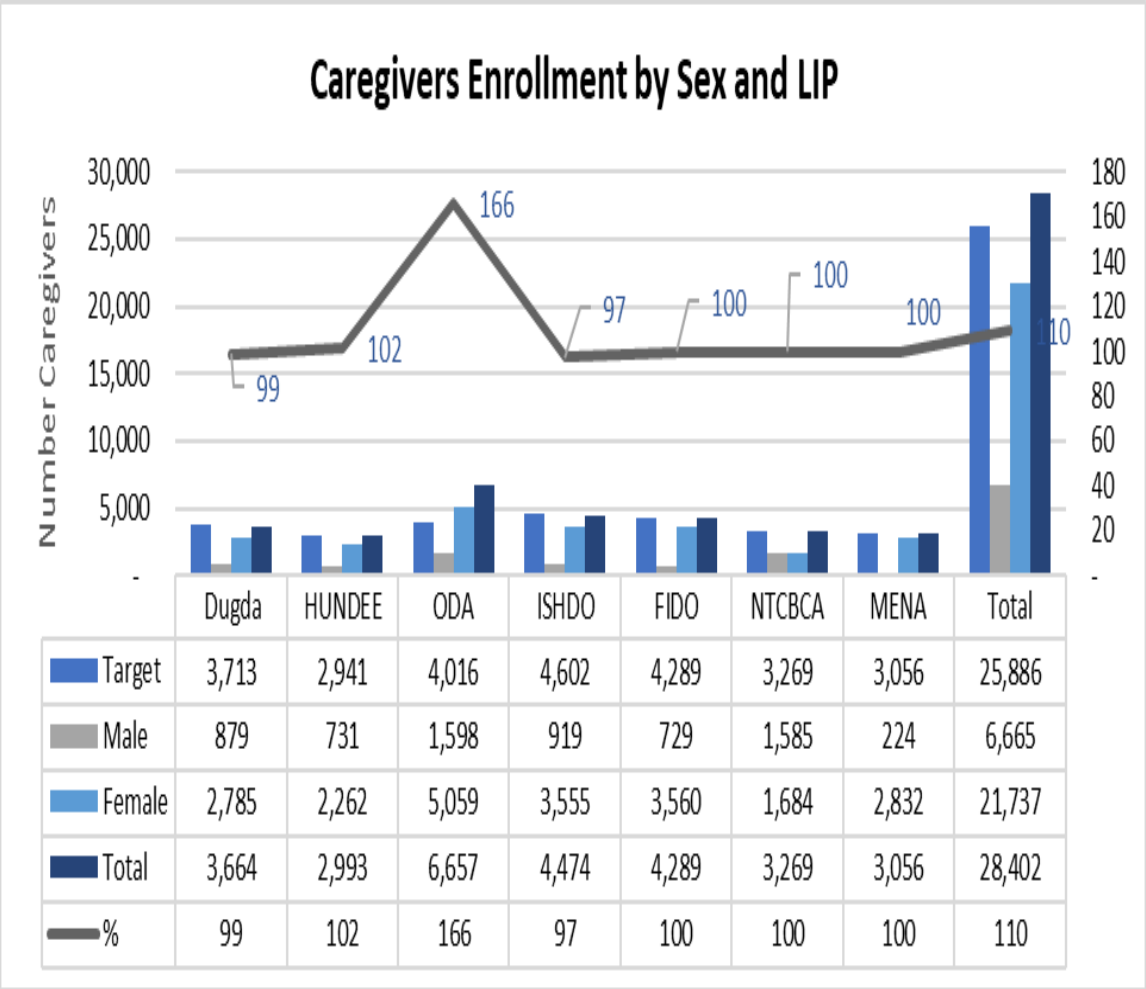
Figure 11: USAID FFHPCTA OVC Enrolled in the Activity



	Dugda	HUNDEE	ODA	ISHDO	FIDO	NTCBCA	MENA	Total
Target	7426	5881	9204	9203	8365	6538	6710	53,327
Male	3654	2918	3765	3745	3892	3167	3160	24,301
Female	3732	2963	5379	4501	4473	3166	3516	27,730
Total	7386	5881	9144	8246	8365	6538	6676	52,236
%	99	100	99	90	100	100	99	98

Additionally, 28,402 caregivers enrolled in the program which accounts 110% of the annual target. The final number of caregivers that are enrolled in the program may vary from the estimated, 17,420 as this number will depend on the number of enrolled OVC and households.

Figure 12: USAID FFHPCTA Caregiver enrollment



	Dugda	HUNDEE	ODA	ISHDO	FIDO	NTCBCA	MENA	Total
Target	3,713	2,941	4,016	4,602	4,289	3,269	3,056	25,886
Male	879	731	1,598	919	729	1,585	224	6,665
Female	2,785	2,262	5,059	3,555	3,560	1,684	2,832	21,737
Total	3,664	2,993	6,657	4,474	4,289	3,269	3,056	28,402
%	99	102	166	97	100	100	100	110

3.1.2 Increase the Enrollment by Priority sub-population groups

In accordance with the COP20 priority interventions for OVC program beneficiaries to improve their retention and VLS the plan was to offer enrollment at least 90% of TX_Curr (<18 years of age) in the 16 SNUs where the OVC program is operating. The plan was to enroll 3,583 C/ALHIV and on average, with a slight variation among SNUs, 117% (4,189) of these children enrolled in the program. The enrollment of C/ALHIV prioritized those with poor VLS and new on treatment. See the graph below.

Figure 13: USAID FFHPCTA Enrollment of C/ALHIV by LIP, 1st Quarter, FY21.

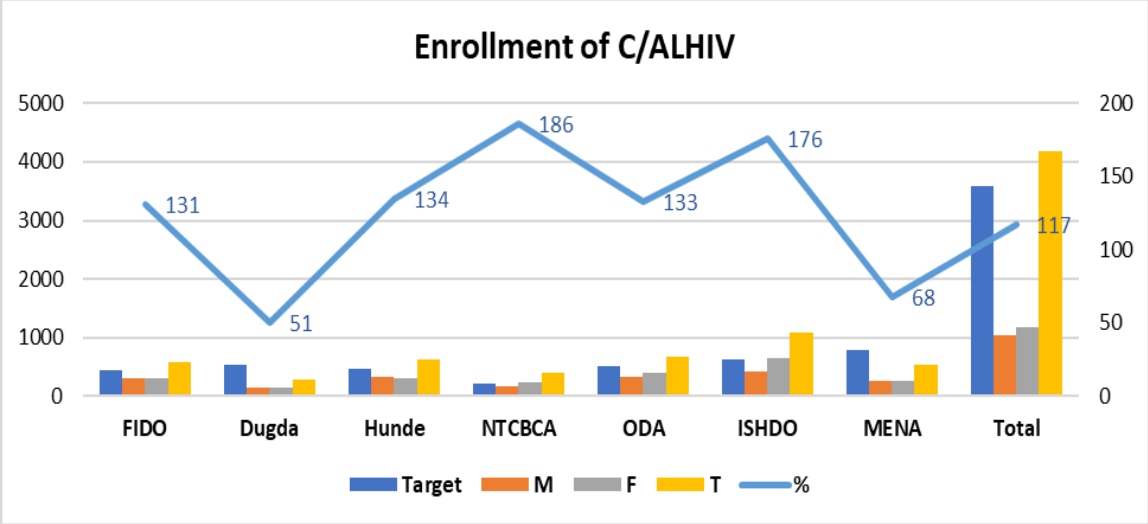


Table 1 below shows performance of OVC enrollment by sub-priorities, for the 7 implementing partners. As can be observed, enrollment almost reaching its target while the performance of other groups has some ways to go to meet the target. In view of this, FFHPCTS is providing coaching and supportive supervision to maximize collaboration with health facilities and clinical partners including the community to identify index cases, among other strategies. Implementing partners have reported some level of difficulty meeting the annual OVC target.

Table 1: USAID FFHPCTA Enrollment by Sub-population in Oromia

LIP Name	Target	HIV+	Children of PLHIV	Children with HIV infected sibling	HIV exposed infants	Sum of CFSWs	Survivors of sexual violence	Children of PBFW aged 10-24 years	Total (Count)	Total (%)
DUGDA	7426	273	4041	771	31	2136	88	46	7386	99
FIDO	8365	591	5277	83	233	1961	145	71	8361	100
HUNDEE	5881	636	2171	951	297	1489	109	229	5882	100
ISHDO	9203	1086	5517	78	154	1202	296	119	8452	92
MENA	6710	525	2187	1731	188	1999	23	23	6676	99
NTCBCA	6538	406	4408	488	166	406	125	540	6539	100
ODA	9205	672	5357	371	129	2284	15	316	9144	99
Grand Total	**53328**	**4189**	**28958**	**4473**	**1198**	**11477**	**801**	**1344**	**52440**	**98**

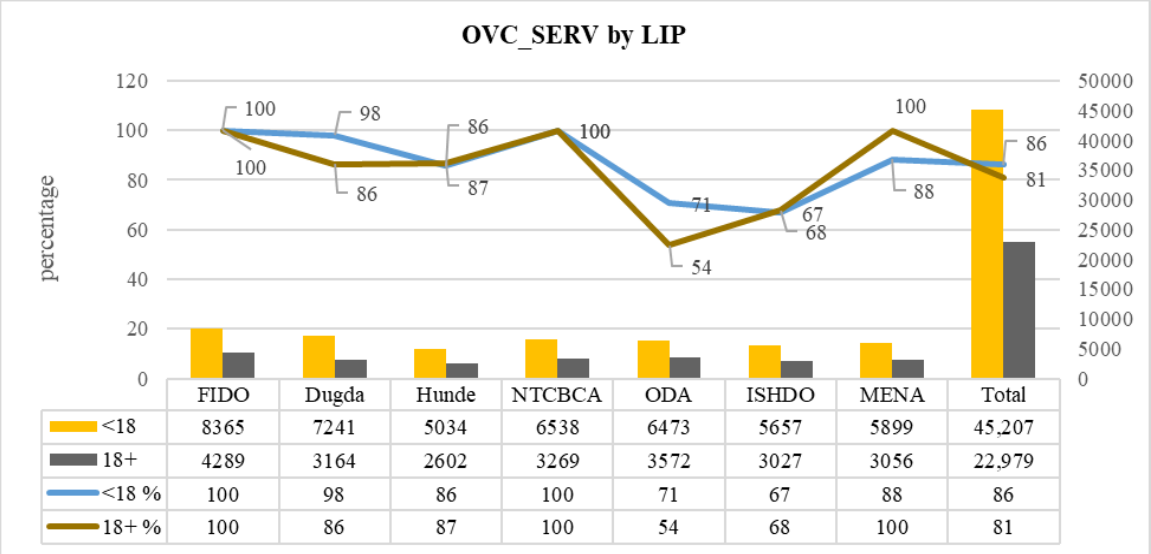
Improved and expanded access to comprehensive services for OVC

Using case management processes and tools, LIP staff working with their community-based workers including CWs and SSWs continued to identify and assess OVC, caregiver and household needs and strengths for new enrolled OVC. Based on assessed needs they provided selected services within the homes and/or referred OVC and their caregivers to other service providers within the system of care.

Consequently, during this reporting quarter, ISHDO and partners reached 45,207 of the OVC (<18) with one or more services based on assessed needs, with 86% achievements against the annual target of 53,328 OVC.

Additionally, 778 (1.5%) 9-14 old's adolescents served by IMpower and Sinovuyo, this is above projection and good performance considering this is the project first quarter of the first year. Therefore, FFHPCT is on track towards achieving FY21 targets. The graph below provides the number of active beneficiaries served during the reporting quarter.

Figure 14: USAID FFHPCTA OVC received one or more services



	FIDO	Dugda	Hunde	NTCBCA	ODA	ISHDO	MENA	Total
<18	8365	7241	5034	6538	6473	5657	5899	45,207
18+	4289	3164	2602	3269	3572	3027	3056	22,979
<18 %	100	98	86	100	71	67	88	86
18+ %	100	86	87	100	54	68	100	81

Additionally, 22,979 caregivers were served that accounts 81% of active caregivers. Overall, 68,186 OVC and caregivers have been served with one or more services based on assessed individual needs utilizing standard case management procedures**.**

OVC_SERV performance varies from Partner-to- partner – FIDO and NTCBCA achieving the most OVC served (100%) followed by Dugda (98%) and MENA(88%). It is worth noting that

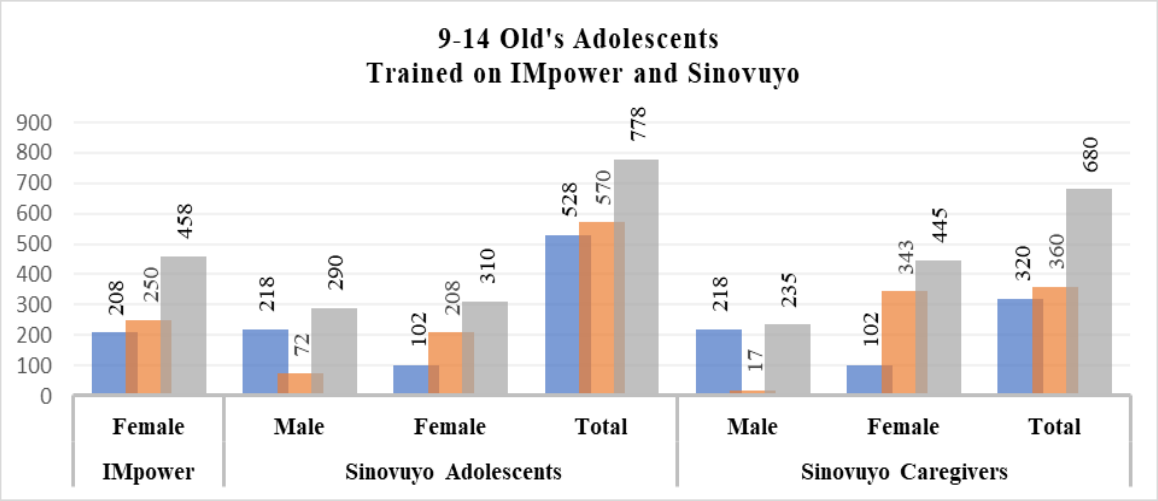
despite the unrest in some parts of oromia, the ISHDO FFHPCTS teams including LIPs staff and their community based workers made a concerted effort to improve servces for OVC enrolled . ISHDO and partners had focused key project activities on the last month of the quarter which were necessary for accerelated service provision including enrollment of C/ALHIV, HIV testing, linkage to ART and VL testing which brought significant progress on the enrollment and service provision.

Sub IR 3.2 Improve primary prevention of sexual violence and HIV training and services for 9-14-year-old girls and boys.

The primary prevention activity focuses on children aged 9-14 years in high burden SNUs. For this age groups the developmental period adolescence entails unique opportunities but also rising exposure to risks including sexual violence particularly for girls and risk for HIV. Social mobilization and interpersonal communication interventions to prevent HIV and violence among 9-14 old adolescents is among COP20 priorities.

ISHDO annual HIV and sexual violence prevention plan is to reach more than 53,328 adolescents. The activity is striving to implement IMpower and Sinovuyo, which are time-limited, curricula based and PEPFAR approved HIV and sexual violence prevention trainings to reach this target population. However, trained candidate TOIs and facilitators of the above curricula were not certified by curriculum developers due to the disruption of the activity to COVID pandemic.

Figure 15: USAID FFHPCTA IMpower and Sinovuyo trainings to 9-14 years old adolescents



ISHDO and partners have a total of 11 certified instructors for IMpower and 46 Trained facilitators for Sinovuyo. Using the trained instructors, a total of 778 Sinovuyo adolescents and 680 caregivers were trained during this reporting period. On the other hand, 458 adolescent girls were trained on IMpower curriculum.

Due to the limited number of trainers and facilitators trained from FHI 360 side, ISHDO and partners couldn't proceed to reach a larger scale of trained beneficiaries.

Result 2: Strengthened utilization of data to monitor service delivery and conduct quality improvement of program services:

2.1.1 Utilizing USAID Unified Data System (UUDS)

ISHDO has been closely working with Project Hope further expand and optimally utilize UUDS for routine program monitoring, case management, and quality improvement. Accordingly, ISHDO has identified focal person from each IPs responsible for the data entry, established location hierarchy of partners and completed all the preparation for smooth data entry into the commcare system. Through the established collaboration ISHDO M&E closely worked with PH to solve challenges faced during day-to-day implementation.

ISHDO has facilitated virtual trainings on UDS and commcare to all IPs to provide basic knowledge of the use of the system and its implementation.

2.1.1.1 Commcare TOT

ISHDO collaborated with PH on the TOT of commcare and trained 5 Staffs from ISHDO and partners to cascade the training to IPs. The training was held in Addis Ababa from Dec 14-18,2020 in Addis Ababa. ISHDO Staffs facilitated some session of the TOT.

ISHDO will cascade training on the commcare for community health workers, volunteers and case managers to understand and operationalize the unified data system including data capture analysis and reporting, optimize utilization of the Commcare system to conduct case management of clients.

2.1.2 Equipping and data management

ISHDO closely worked with PH to find out the specification of tablets /smartphones to be used for commcare data entry for IPs. Based on the specification and support from ISHDO IT experts.

A total of 34 smart phones with a various capacity based on the number of data expected to be entered were purchased, commcare software was set up and distributed to IPs to be used for data capture during their day-to-day encounters with clients.

7. Challenges, Constraints and plans to overcome them reporting period

7.1 Quarterly challenges and Constraints for each program area

Community HIV Care and Treatment

Case finding through ICT

- Low testing volume of community-based testing
- Low HIV positivity for children

Case finding through HIVST

- Low utilization of HIV self-test kits.

Gegraphic identification of Hotspots

- Lack of capacity to conduct recency to identify areas for recent infection

Ensuring adherence of ART clients

- Limited tracing and idnetification of LFTU

Implementation of community-based differentiated care model

- Low uptake on establisment of CAG

Comprehensive OVC programming and Primary prevention

Case management

- Limited enrollment of C/ALHIV by Some IPs due to lack of trained staff .
- Enrollment of non qualifying subpopulation groups as per the COP guidance

Primary prevention

- Delayed startup of training cascade attributed to FHI 360 delayed processes of engaging trainers

Utilizing USAID Unified Data System (UUDS)

- Delayed Commcare datentry on comprehsnive OVC program
- Incomplete variables on commcare for CHCT

7.2 Plans to Overcome challenges

Community HIV Care and Treatment

Case finding on ICT

- Training and on Job coaching to staffs and volunteers
- Ensure enough quantity of testkit for community testing in collaboration with Supply chain and Woreda health offices

Case finding through HIVST

- Provide training to build the CEF and volunteers confident of HIVST use
- Ensure adequate supply of HIVST

Geographic identification of Hotspots

- Provide training to CEF and HV officers in collaboration with EPHI and Oromia heath bureau for CEFs for use of recency testing and identification hotspots to guide our testing

Ensuring adherence of ART clients

- Maximize the engagement of PLHIV association and provide adequate orientation and guidance on the importance of adherence to treatment
- Identify major religious worship places in SNUs and engaged to educate PLHIV about the importance of adherence to treatment

Implementation of community-based differentiated care model

- Intesify the cascade of TOT training to have more trained personnel to manage establishe and support CAG

Comprehisive OVC programming and Primary prevention

Case management

- Provide case management training to staffs and volunteers that will help them to understand the activity and objective

Primary Prevention

- Use other alternatives like Coaching boys into Men (CBIM) PEPFAR approved curriculum to engage and reach more adolescents as an alternative to sinovuyo
- Intensify IMpower training cacade to reach more girls in the upcoming quarter.

Utilizing USAID Unified Data System (UUDS)

- Discussion to solve challnges related to commcare data entry that delayes partners dataentry on comprehesnive data entry

- Discussion held with PH to include age and sex variables on Index cases that are needed for the DATIM, In the mean time the variables were collected using excel based data sheets

8. Data Quality issues during the reporting period

Data Quality issues and how they were addressed during the reporting period

During the reporting period, several data quality issues were observed in the process of case management and CHCT activities. Among the data quality issues observed, the major quality issues are list below

- Incomplete data in submission of Case Management process
- CHCT commcare data system missed sex and age of index client; as a result, MERL and custom indicators were significantly affected
- Inconsistency between HIV testing result and what entered into commcare;
- Blank values in reported services;
- Number of Index case testing and Self-testing varies the data entered into commcare;
- In appropriate sub population categorization;
- Delay in reporting;
- Poor documentation and incompleteness of referrals
- Inappropriate use of data collection forms: Improper use and/or failure to use the appropriate data collection forms by some IPs create inconsistencies in data consolidation and completeness
- Problems of incompleteness, timeliness, accuracy and fully utilization of UDS.
- IPs paper-based case management data is not changed to commcare system and data generated from the data base do not match what IPs reported on summary tables. This makes the report compilation process tedious, time-taking and affects data quality.

What you are doing on a routine basis to ensure that your data is high quality for each program area?

FFHPCTA provided orientation and continuous communication with IPs regarding gaps and errors and sharing recommendations and instructions for improvement.

In addition, technical staff follows up with each IP and provide technical assistance to ensure that the gaps are addressed and records are updated.

The M& E team continued to provide reminders to IPs and ISHDO technical staffs ensure that appropriate data collection forms, including referral forms, are used and completed accurately. The staff continues to monitor progress and to provide assistance during monitoring and supportive supervision visits.

How you planned to address those concerns / improve the quality of your data for each program area

M & E team has prepared and shared data verification tool to avoid/minimize data quality issues during implementation of acceleration plan; conducted data verification via desk review, specifically looking at enrolment and HIV STAT database of the activity. Feedback was provided to IPs on the corrective actions to improve the data quality. FFHPCTA will undertake field visits to supervise, coach and mentor the M &E team on data quality and routine data quality assessment will also be rolled out during this time.

9. Major Activities planned in the next reporting period

Result 1

Community HIV care and treatment

Trainings will be provided for CEFs, case workers, and technical staff:

- Training on ICT, and HIV Self-Test
- Training on Recency Testing
- Training on Case management CHCT only SNUs for care and support
- Training on Differentiated Serice Delivery Models

Targeted testing and LTFU re-engagment .The following activities will be conducted:

- Identification of hot-spots with high testing yield
- Identification of SNUs with high ICT, and LTFU back logs
- Mapping of worship places routinely visited by PLHIV will be identified and religious leaders engaged with adherence support

Coaching and quality improvement for imprpove service delivery Improvement .

- Site visits will focus on low perfoming sites where the following change ideas will be scaled-up to bring about result:
- Effective use of ICT risk assessment tool

- Use of social service workers (SSWs) and case workers to recruit members for health extention (HEW) led community ART refill group (CAG), Peer led CAG (PCAG), and individual community ART refill and delivery (CARD) in OVC households.

Comprehensive OVC programming

- Provide familiarization training to stakeholders on CM, and HIV services coordinated quality care.
- Provide a 4-days training to CCCs on quality care, data quality management and reporting.
- Develop and disseminate VAC and IPV job aids to care givers.
- Support CWs and SSWs to implement ongoing CM activities to OVC and caregivers.
- Provide 5-days CM training to CWs and SSWs to improve case identification, adherence and VLS.
- Train LIPs on Micro Enterprises -Selection, Planning and Management (ME-SPM) & Business Development support (BDS)
- Revise service referral papers that SSWs and CWs use to link OVC and caregivers to services.
- Update service referral SOP and deliver orientation to LIPs.
- Adapt/develop tools and standards to assist the screening of GBV among adolescents and caregivers
- Preventing, recognizing and reporting child abuse (sexual, physical, emotional) using child abuse response protocol

Primary Prevention to 9-14 Adolescents

- Launching Coaching Boys into Men curriculum as a complementary primary prevention intervention.
- Facilitate 2-weeks IMpower preparation workshop
- Train IMpower Instructors who will deliver the training to adolescent girls (9-14 years)

Result 2

- Training on commcare to IPs staff;
- Conduct RDQA
- Follow and support IPs on UDS utilization
- Conduct Monitoring and supportive supervision on different IPs' sites

- Roll out orientations on different CHCT and CM data capturing tools.

10. Environmental compliance

Describe any issues related to environmental compliance (if there are any) During FY21, Quarter 1, FFHPCTA has implemented safety standard for HIV related services through community-based HIV testing to comply with the Ethiopian government and USAID environmental policy. Safety boxes and biohazard bags were used at to collect used lancets, cotton swabs and disposed for incineration at adjacent health facilities.

11. Financial accomplishment

(… in USD)

Life of Activity budget (a)	Obligated to date (b)	Expenditure (Accrual and actual disbursement) to date (c)	Remaining balance (d) = (b) – (c)	Remarks
$9,948,804.00	**$3,316,268.00**	**$368,876.13**	**$2,947,391.87**	

12. Issues requiring the attention of USAID Management

- Constant supply of HIV test kits including HIVST, recency testing kits to ensure continuous community testing by the community partners.
- Ensure commcare and UDS capture all the needed variables on HIV testing (ICT) and other services to avoid parallel data collection by Prime partners

13. Data Sharing with Host Government:

Have you **shared this report** with the host government?

Yes ☒
No ☐

If yes, to which governmental office/s?

- Regional Health Bureau

If No, why not?

[Please put your response here]

Have you made **data reconciliation** with respective regional sectoral office/s?

Yes ☐
No ☒

If yes, to which regional sectoral office/s? Were there any issues that came out from the reconciliation? How these issues were handled/ will be handled?

There is no need for data reconciliation as our sub partners are responsible to do. ISHDO as prime didn't sign agreement with respective signatories. Only MOU are expected to be signed with major stakeholders which is RHB.

If no reconciliation was made, what are the reasons for it?

[Please put your response here]

14. Appendices