USAID/URBAN HEALTH EXTENSION PROGRAM END-OF-PROGRAM REPORT

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END-OF-PROGRAM REPORT
(September 30, 2009 – March 31, 2013)

USAID/Ethiopia Urban Health Extension Program (USAID/UHEP)

Cooperative Agreement No. 663-A-00-09-00428-00

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LIST OF ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CBIA	Community-Based Information for Action
CBO	Community-Based Organization
CHIS	Community Health Information System
CTHO	City/Town Health Office
EPI	Expanded Program of Immunization
ER	Expected Result
FHC	Family Health Card
FP	Family Planning
GoE	Government of Ethiopia
HBHTC	Home-Based HIV Testing and Counseling
HC	Health Center
HDA	Health Development Army
HEP	Health Extension Program
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNRA	Health Need and Risk Assessment
HTC	HIV Testing and Counseling
IEC	Information, Education, and Communication
JSI	John Snow, Inc.
M&E	Monitoring and Evaluation
MARPs	Most-at-Risk Populations
MCP	Multiple and Concurrent Partnerships
MDGs	Millennium Development Goals
MoH	Ministry of Health
MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organization
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
QA	Quality Assurance
QI	Quality Improvement
RHB	Regional Health Bureau
SNNPR	Southern Nations, Nationalities and Peoples' Region
TB	Tuberculosis
ToT	Training of Trainers
UFF	Urban Family Folder
UFHC	Urban Family Health Card
UHE	Urban Health Extension
UHEP	Urban Health Extension Program
USAID	United States Agency for International Development
USAID/ UHEP	United States Agency for International Development-supported Ethiopia Urban Health Extension Program

USAID/UHEP IN NUMBERS

THE ETHIOPIA URBAN HEALTH EXTENSION PROGRAM WITH TECHNICAL SUPPORT OF USAID/UHEP:

- **2,337** nurses have successfully completed a pre-service training to become urban health extension professional nurses (UHE professionals) and provide a range of public health services to the community.
- More than **112,000** most-at-risk populations (MARPs)/vulnerable populations for HIV were 'reached' with individual level evidence-based HIV prevention intervention using the minimum standard of the 'Reach Protocol' developed by the program.
- More than **47,400** MARPs/vulnerable individuals received HIV testing and counseling (HTC) services and heard their test results.
- More than **10,700** eligible adults and children were provided with a 'minimum of one care service' by UHE professionals.
- More than **9,800** MARPs/vulnerable individuals were referred to health and social services by the UHE professional in USAID/UHEP operational cities/towns.
- More than **3,000** UHE professionals have been provided with in-service trainings on various topics.
- **669** UHEP supervisors, city/town health experts and health facility staff were trained on supportive supervision and provided with continuous support.
- More than **120** review meetings were conducted on the urban health extension program to discuss issues, and identify challenges and lessons.

LETTER FROM THE CHIEF OF PARTY

USAID's Urban Health Extension Program (USAID/UHEP), implemented by John Snow, Inc. (JSI), was launched to support the Government of Ethiopia's Urban Health Extension Program (UHEP). USAID/UHEP had the opportunity to partner with the Government of Ethiopia (GoE) to support the implementation of the UHEP at the federal and regional levels, specifically in 19 cities/towns. USAID/UHEP supported pre-service training, deployment, and implementation activities including sensitization of the community and stakeholders, planning, monitoring, and continuous quality improvement. We introduced and adapted tools, strategies, and standard implementation practices.

The UHEP is a new program and an innovative platform for delivering services to urban families. There was very limited experience and research in Ethiopia to guide the delivery of primary care owned and led by the public sector in urban areas. In collaboration with Ministry of Health (MoH) staff and with the extended support of USAID/Ethiopia, USAID/UHEP built a solid foundation with key stakeholders, fostering communication, and creating ownership in order to implement the UHEP.

After three years of implementation, USAID/UHEP operational cities and towns now have the capacity to implement the UHEP and engage communities. They understand how to integrate the UHEP into the health system, and know that it is important to encourage small accomplishments in order to scale-up for system-wide success. In addition, they have identified the challenges in implementation and have strategized with possible solutions to address them. They know the specific support they need and how to utilize the support to strengthen the UHEP. Most importantly, UHE professionals have developed skills and knowledge to identify and provide targeted support to individuals and families.

The success of USAID/UHEP has been possible due to the commitment of the USAID/UHEP team and the support from USAID and the MoH. The mutual understanding between USAID/UHEP and the MoH, Regional Health Bureaus (RHBs), and City/Town Health Offices (CTHOs) has been the

most significant key to success. USAID's close follow-up and support throughout program implementation has been a crucial element to the overall success of USAID/UHEP. Over the course of the Program, USAID/UHEP had the opportunity to share its story with various dignitaries, including former President George W. Bush and his family and USAID Administrator Rajiv Shah.

It is with great pleasure that I invite you to review this report which summarizes our experience supporting and implementing a new government program. The report illustrates the meaningful partnerships which JSI maintained throughout the program implementation. The report also serves to document the step-by-step process of implementing USAID/UHEP objectives so that others who follow after us will learn from our experience.

SAMUEL YALEW, USAID/UHEP CHIEF OF PARTY

I. EXECUTIVE SUMMARY

Ethiopia has one of the fastest urban growth rates in the world. Currently, about 17% of Ethiopia's people live in urban areas. By 2050, estimates suggest that 42% of Ethiopians will live in urban settings.[1] The urbanization process is not without challenges. Inequalities in accessing health services and structural issues such as urban poverty, poor sanitary conditions, overstretched infrastructure, overcrowding, and social exclusion create significant vulnerabilities, particularly for the urban poor. In order to partly address these health challenges, the MoH of Ethiopia designed and implemented the UHEP to improve access to basic health services particularly for the urban poor. The UHEP aims to provide 'household-centered' health promotion, disease prevention, and strong referral and linkages to health facilities. The objective of the UHEP is to improve access to and address equity issues in the delivery of basic health services, and to help mitigate urban health problems. The key strategy for the implementation of the UHEP is to train, deploy, and support Urban Health Extension professional nurses (UHE professionals) to deliver health packages to urban households. To date, more than 4,000 nurses have been deployed as UHE professionals to more than 400 large and small cities and towns across the nation.

With the launch of the USAID/UHEP in 2010, USAID prioritized a focus on health impacts in Ethiopia's urban areas, supporting Ethiopia's move towards the achievement of the United Nations Millennium Development Goals (MDGs). The goal of USAID/UHEP was to support, at scale, the implementation and monitoring of the UHEP as a means of improving access to and demand for health services. Specifically, the program aimed to strengthen the capacity of UHE professionals to identify and reach most-at-risk populations (MARPs)/vulnerable individuals or groups in their

[1]United Nations: 2006. World Urbanization Prospects.

catchment areas and to provide these individuals with public health services that improve their overall health outcomes, including HIV prevention, care, and support services. USAID/UHEP works to ensure that MARPs/vulnerable individuals and groups have access to basic public health information and services while contributing to the overall strategic goals of the US government PEPFAR program in Ethiopia and, specifically, its emphasis on MARPs/vulnerability.

In collaboration with the MoH, USAID/UHEP provided support for the pre-service and in-service trainings, directly contributing to the overall strategy of the UHEP. Technical support focused in areas such as technical capacity building, quality improvement, supportive supervision, and community awareness concerning the UHEP. USAID/UHEP has also worked to strengthen the overall health management and information system (HMIS), including referrals and linkages as well as community participatory planning.

The Program conducted numerous assessments, and as a result developed systems to identify and reach both undocumented urban dwellers and MARPs. Additionally, USAID/UHEP adapted several tools from the rural HEP, such as the family health card (FHC), scaling the tool up in 19 cities and towns in Ethiopia.

USAID conducted a technical evaluation of the UHEP in fiscal year 2012. The evaluation provided critical information to key stakeholders for future consideration, as it assessed the performance of USAID/UHEP, identifying and documenting key challenges and successes in program implementation, and reviewing and analyzing the UHEP from the perspective of key stakeholders. Actions were immediately addressed during a cost extension period from October 2012-March 2013. Innovative activities were included in the workplan and implemented to provide evidence-based support to the UHEP.

Throughout the life of the Program, JSI worked directly with the GoE to achieve results. Over three years, USAID/UHEP strived to assess, understand, and implement activities and then adapt according to challenges and success identified by the UHEP's stakeholders. Considering the nascence of the UHEP, adaptation was critical in order to succeed and foster sustainability. This final report outlines key components of USAID/UHEP and its contributions to the overall health outcomes of urban Ethiopians.

II. BACKGROUND

INTRODUCTION

The population in urban areas in low income countries will grow from 1.9 billion in 2000 to 3.9 billion in 2030.[2] As a result, policy and public health professionals and economists worldwide are developing strategies to address the needs of the changing urban population. In line with the strategy of USAID Forward, USAID/UHEP supported the GoE to design, strengthen, and build local sustainability, foster innovation, and deliver results at a lower cost. The success of the Program reflects the well-established partnership between the GoE, USAID/UHEP, and its partners, as well as the design of the Program which required working directly with the GoE and supporting the overall health system.

ETHIOPIA COUNTRY CONTEXT

Ethiopia has one of the fastest urban growth rates in the world. Ethiopia's urban poverty, defined by poor sanitary conditions, social fragmentation, overstretched infrastructure, pollution, crime, geographic instability, overcrowding, and social exclusion, creates significant vulnerabilities for the urban population and particularly the urban poor. However, there is very limited information on the health status of different sub-population groups, including the urban poor, female-headed households, migrants, and homeless populations. Rapid population growth has placed a great strain on basic service systems and the development of critical infrastructure, which have failed to keep pace with the rapidly growing needs of the population.

[2] United Nations: 2006. World Urbanization Prospects.

Ethiopia's urban infant mortality rate is 59 per 1000 live births, with an under-five mortality rate of 83 per 1000 births.[3] The national adult HIV prevalence rate is around 1.5%, with marked regional variations, and significantly higher urban than rural rates (4.2 vs. 0.8%).[4] While there is much goodwill and momentum towards improving urban health, Ethiopia still faces great challenges (Table 1). The shortage of human resources in the health sector and the low level of community awareness regarding basic health information, existing attitudes and cultural practices, and low access to basic health services challenge the health status of the Ethiopian population. In view of these challenges, the MoH has recognized that the delivery of public health information and services in urban settings is less than optimal and worked to develop and roll out the UHEP, which launched in 2009. The MoH also called for increased multi-sectoral collaboration to address Ethiopia's most pressing urban health challenges.

MOST-AT-RISK POPULATIONS (MARPS) FOR HIV INFECTION IN ETHIOPIA

The GoE has prioritized reaching those most-at-risk, and USAID/Ethiopia's strategy reflects this shared commitment. Although there have been various assessments and small-scale studies on at-risk populations, there is limited epidemiological information on the patterns and population sizes of these groups. There is, however, enough data available to know that throughout Ethiopia, there are highly vulnerable sub-populations. Data from the Ethiopian Strategic Plan for Intensifying the Multi-Sectoral HIV/AIDS Response II and the Federal HIV/AIDS Prevention & Control Office, in collaboration with the World Bank,[5] suggest that those most-at-risk in Ethiopia include female sex workers, uniformed forces, long distance drivers, discordant couples, refugees, and migrant laborers, including cross-border and mobile populations. Other at-risk groups include youth in and out of school (especially girls), day laborers, mobile merchants, individuals who engage in transactional sex, individuals who engage in multiple and concurrent partnerships (MCP), clients of sex workers, and men who have sex with men (MSM). In addition, data from the Ethiopia Demographic and Health Survey[6] indicate that HIV prevalence rates in smaller towns are higher than in larger cities, suggesting that individuals living in these smaller towns are at higher risk of contracting HIV.

While determinant factors that drive the epidemic and sexual and other behaviors among different population groups have not been adequately explored, evidence suggests that low levels of comprehensive knowledge about HIV, low levels of perceived risk and threat of HIV, high prevalence of unprotected sex and MCP, intergenerational and transactional sex, high prevalence of sexually transmitted infections (STIs), alcohol abuse and khat chewing, gender inequality, and poverty are significant and overlapping drivers of the epidemic.

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[3] Central Statistics Agency and Measure DHS, ICF Marco. Ethiopian Demographic and Health Survey Report 2011: Addis Ababa, Ethiopia and Calverton, MD: Central Statistics Agency and Measure DHS, ICF Marco, April 2011.

[4] Ibid.

[5] World Bank and HAPCO: April 2008: HIV/AIDS in Ethiopia: Epidemiological synthesis.

[6] Ethiopia Demographic and Health Survey, 2005.

TABLE 1.
ETHIOPIA 2011 DEMOGRAPHIC AND HEALTH SURVEY DATA AT A GLANCE

	INDICATORS	TOTAL	URBAN	RURAL
1	FERTILITY			
1.1	Total fertility rate (number of children per women)	4.8	2.6	5.5
1.2	Women aged 25-49 who are currently pregnant (%)	12	4	15
1.3	Median age at first birth for women age 25- 49 years (%)	19.2	20.5	19
2	FAMILY PLANNING			
2.1	Current use of any method (%)	29	53	23
2.2	Current use of any modern method (%)	27	50	23
2.3	Currently married women with an unmet need for family planning (%)	25	15	28
3	MATERNAL AND CHILD HEALTH			
	MATERNAL INDICATORS			
3.1	ANC – at least one visit (%)	34	76	26
3.2	Birth assisted by a skilled provider (%)	10	51	4
3.3	Birth delivered in a health facility (%)	10	50	4
3.4	Maternal mortality ratio (per 100,000 live births)	676	★	★
	CHILDHOOD INDICATORS			
3.5	Neonatal mortality (per 1,000 live births)	37	41	43
3.6	Infant mortality (per 1,000 live births)	59	59	76
3.7	Under-five mortality (per 1,000 live births)	88	83	114
4	NUTRITION			
4.1	Children under five years who are stunted (%)	44	32	46
4.2	Children under five years who are wasted (%)	10	6	10
4.3	Children under five years who are underweight (%)	29	16	30
4.4	Children age 6-59 months with any anemia (%)	44	35	45
4.5	Women age 15-49 years with any anemia (%)	17	11	18
5	HIV AND AIDS			
5.1	HIV prevalence for women age 15-49 (%)	1.9	5.2	0.8
5.2	HIV prevalence for men age 15-49 (%)	1	2.9	0.5

★ *Data not available*

THE EVOLUTION OF THE HEALTH EXTENSION PROGRAM

The MoH's nationwide HEP and UHEP are designed to improve access to basic health services by expanding the physical health infrastructure and through the training and deployment of health extension workers (HEWs) in rural areas of the country and UHE professionals in urban areas. The foundation of the HEP and UHEP is based on the idea that providing appropriate preventative, promotive, and basic curative services will lead to the adoption of positive behavior and improved health outcomes. Today, these programs are major pillars of the health service delivery system in Ethiopia. The programs have gained momentum and recognition as critical community health strategies for substantially improving the health outcomes of both rural and urban Ethiopians.

THE URBAN HEALTH EXTENSION PROGRAM

Ethiopia's UHEP was designed as a key national initiative for primary health care service delivery in urban Ethiopia. The organizing principle of the UHEP is the provision of 'household-centered' health promotion, disease prevention, and strong referral and linkages to public sector health facilities. The objective of the UHEP is to improve access to and equity in basic health services and to help mitigate urban challenges such as high HIV prevalence and poor sanitation (among numerous other health and non-health issues). The design of the UHEP stipulates that each health center (HC) serves 40,000 people, with one UHE professional assigned to 500 households. Key to the implementation of the UHEP is the need to improve access to and the quality of public health information and services for the urban population by deploying UHE professionals and expanding and strengthening the health system and infrastructure. The primary difference between the urban and rural programs is that the UHE professionals have a diploma in nursing.

The UHEP focuses on preventive, promotive, and rehabilitative services targeting urban dwellers at households, youth centers and schools, with strong referral linkages to health facilities. The UHE professionals are responsible for delivering 16 packages with a focus on four major health program components:

1. Hygiene and environmental sanitation;
2. Family health care;
3. Prevention and control of communicable and non-communicable diseases; and
4. Injury prevention and control, first aid, and referral and linkage.

THE URBAN HEALTH EXTENSION PROFESSIONAL

The role of the UHE professionals is to provide health information and selected health services, and to refer clients to the HCs as necessary. The UHE professional sits at either the HC or at the *kebele* office, with 16 UHE professionals placed in each HC catchment. One supervisor is tasked with supervising 8–12 UHE professionals, visiting those under her/his supervision on a regular basis. Supervisors are also responsible for holding routine group meetings with supervisees to review performance, share learning, and ensure that UHE professionals are carrying out their activities effectively and professionally.

The major role of the UHE professional is to ensure that all families in the assigned catchment area of 500 households receive basic and actionable health information and skills so that families take charge of their own health. To accomplish this, UHE professionals implement a model family training and graduation method where families first use the skills to improve household practices and health-seeking behavior and then share the practices and benefits with neighbors and other community members. Additionally, UHE professionals provide targeted services such as family planning, home-based HIV counseling and testing, expanded program of immunization (EPI), distribution and utilization of insecticide-treated bed nets, first aid, and referral and linkages. Moreover, UHE professionals are also expected to keep a thorough demographic and health-related database on each household.

The MoH has trained more than 4,000 nurses for the UHEP to date, each of whom receives a three-month pre-service training. The three-month training focuses on the role of the nurses as community health workers with more emphasis on health promotion, disease prevention, community mobilization, and communication and counseling skills. After the training, these nurses have been deployed to more than 400 large and small cities and towns across the nation. The MoH has also provided a three-week training to more than 500 supervisors and deployed them to serve as UHEP supervisors in each city/town.

USAID/ETHIOPIA URBAN HEALTH EXTENSION PROGRAM (USAID/UHEP)

USAID/UHEP was awarded to JSI on September 30, 2009 and extended through March 31, 2013. The goal of the JSI-implemented USAID/UHEP was to support, at scale, the implementation and monitoring of the GoE's UHEP as a means of improving access to and demand for health services. More specifically, the program strengthened the capacity of UHE professionals to identify and reach MARPs/vulnerable individuals or groups in their catchment areas and to provide them with public health services in order to improve their overall health outcomes, including HIV prevention, care, and support services.

EXPECTED RESULTS OF USAID/UHEP

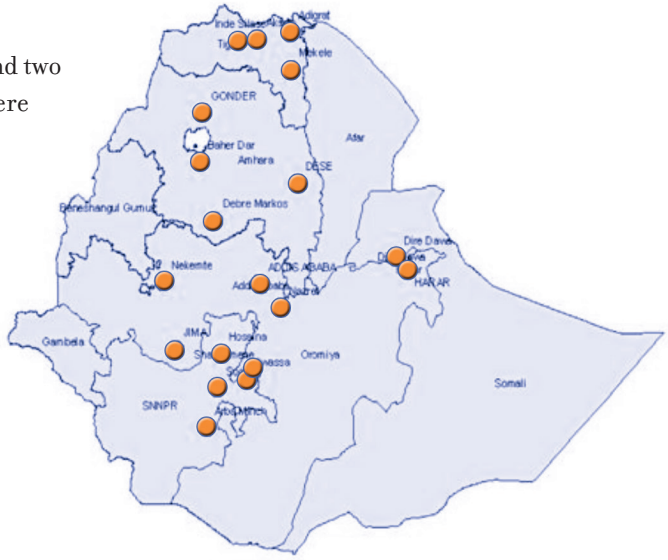
USAID/UHEP's four expected results addressed the accessibility, demand, quality and sustainability of the UHEP, specifically targeting MARPs/vulnerable individuals, to achieve the desired outcomes and contribute to the health of the Ethiopian urban population. USAID/UHEP has set forth four objectives organized as the following Expected Results (ER):

- **Expected Result 1:** Improved access and decreased barriers to public health services for at-risk populations through engagement of households and communities.
- **Expected Result 2:** Increased demand for public health services through active engagement of at-risk populations, households, and communities, using behavior change communication (BCC) for prevention, health promotion, and risk reduction.
- **Expected Result 3:** Improved quality of UHEP service delivery through training and professional development of UHE professionals on public health, including HIV services for at-risk populations.
- **Expected Result 4:** Support an enabling environment to implement a sustainable UHEP, including support for development and implementation of community information systems to support a multi-sectored HIV/AIDS and health program.

GEOGRAPHIC SCOPE OF USAID/UHEP

USAID/UHEP supported implementation activities in five regions and two city administrations, covering 19 cities/ towns. These cities/towns were selected based on population size and HIV prevalence. The GoE, USAID/UHEP, and RHBs worked together to select the specific intervention areas as listed below by region and city/town.

- Amhara Region: *Bahir Dar, Debremarkos, Dessie, Gondar*
- Harari Region: *Harar*
- Oromia Region: *Adama, Jimma, Nekemte, Shashamenie*
- SNNP Region: *Arbaminch, Hawassa, Hossana, Wolayita Sodo*
- Tigray Region: *Adigrat, Axum, Mekele, Shire*
- Dire Dawa Administration: *Dire Dawa*
- Addis Ababa City Administration: *Arada and Yeka Sub Cities*



III. EXPECTED RESULTS & ACHIEVEMENTS

USAID/UHEP made a significant contribution to the UHEP by providing technical support in the areas of capacity development, quality improvement trainings, coaching and mentoring, improved supportive supervision, and establishment and support of the referral system between the community-based health programs and the health facilities. These efforts increased access to public health services, including HIV prevention interventions, specifically for MARPs/vulnerable populations and in the creation of demand for health services. The program worked to develop the capacity of the service delivery system, focusing on implementation in cities/towns. The support of USAID/UHEP has increased the visibility of the UHEP at the policy level and developed critical tools that have been handed over to RHBs and CTHOs for replication. Additionally, USAID/UHEP worked to develop the overall system by improving management and leadership and the responsiveness of public health leaders to identify issues, challenges, and limitations and work to take action to better the overall health service delivery of the UHEP.

USAID/UHEP, in collaboration with its government counterparts and through capacity development and implementation, has reached more than 112,000 MARPs/vulnerable individuals with evidence-based HIV prevention interventions. Of these individuals, more than 47,400 received HTC and heard their test result from UHE professionals, and more than 10,000 eligible adults and children were provided with 'a minimum of one care' service by UHE professionals.

TABLE 2:
USAID/UHEP TARGETS AND ACHIEVEMENTS FOR SELECTED INDICATORS

INDICATOR	TARGET	ACHIEVEMENT	
		NUMBER	%
Number of MARPs/vulnerable individuals and groups reached with individual and or small group level with HIV prevention/intervention that are based on evidence and/or meet the minimum standard.	128,551	112,055	87%
Number of MARPs/vulnerable individuals who received HTC and received their test result by UHE professionals.	48,547	47,469	98%
Number of eligible adults and children provided with 'a minimum of one care' service by UHE professionals.	13,059	10,714	82%
Number of MARPs/vulnerable individuals referred to health and other social services by UHE professionals.	11,308	9,870	87%
Number of cities/towns for which community asset map/ resource map developed.	20	19	95%
Number of UHE professionals who successfully completed a pre-service training.	2,000	2,337	117%
Number of UHEP supervisors who successfully completed the initial training of supervisor for UHEP.	200	152	76%
Number of UHE professionals and their supervisors who successfully completed an in-service training.	4,323	3,007	70%
Number of UHEP supervisors, CTHO experts, and HC experts trained on supportive supervision.	505	669	132%
Number of UHE professionals and their supervisors trained on use of urban family health card for health promotion.	787	823	105%
Number of cities/towns continuously supported in implementing community-based information for action.	2	2	100%

EXPECTED RESULT 1: Improved access and decreased barriers to public health services for at-risk populations through engagement of households and communities.

USAID/UHEP developed the capacity of GoE staff to generate and utilize data for planning, reporting, accountability, and decision making. Functional referral systems and linkages were established by developing referral toolkits (which consist of the directory of services, referral slips, and referral registers). The tools were developed through a consultative process with government counterparts. USAID/UHEP supported the roll-out of these tools, and in its third year conducted an assessment to determine how well the system was functioning and being integrated.

At the onset of the program, USAID/UHEP determined how MARPs would be identified, and what would constitute as 'reaching' them. A 'Reach Protocol' was developed, tested and distributed to UHE professionals, with training and ongoing support, supervision, coaching and mentoring to provide MARPs with evidence-based HIV prevention services. As a result of USAID/UHEP support, UHE professionals in 17 USAID/UHEP operational cities/towns expanded access to HTC services, reaching more than 47,400 individuals with HTC services. Eligible adults and children were provided with care and support services which included screening for tuberculosis (TB), condom promotion and supply, home-based care/palliative care, ongoing counseling, psychological support, and ensuring access to health care services through referrals to health facilities.

BASELINE DATA COLLECTION AND PROCESSING

One of the responsibilities of the UHE professional is to collect, utilize, and manage the demographic and health data of her catchment area. Upon deployment, one of a UHEP professional's first activities is a community-level baseline data collection and mapping exercise of the 500 households in the catchment area, including the identification of households with vulnerable individuals, community 'hotspot' areas, and existing community assets (CBOs, NGOs, and organized community groups) that she can link with to facilitate referrals. USAID/UHEP supported this baseline data collection and technical assistance was provided in reviewing and adapting the data collection tools. Furthermore, data collection formats were printed and provided to the CTHOs.

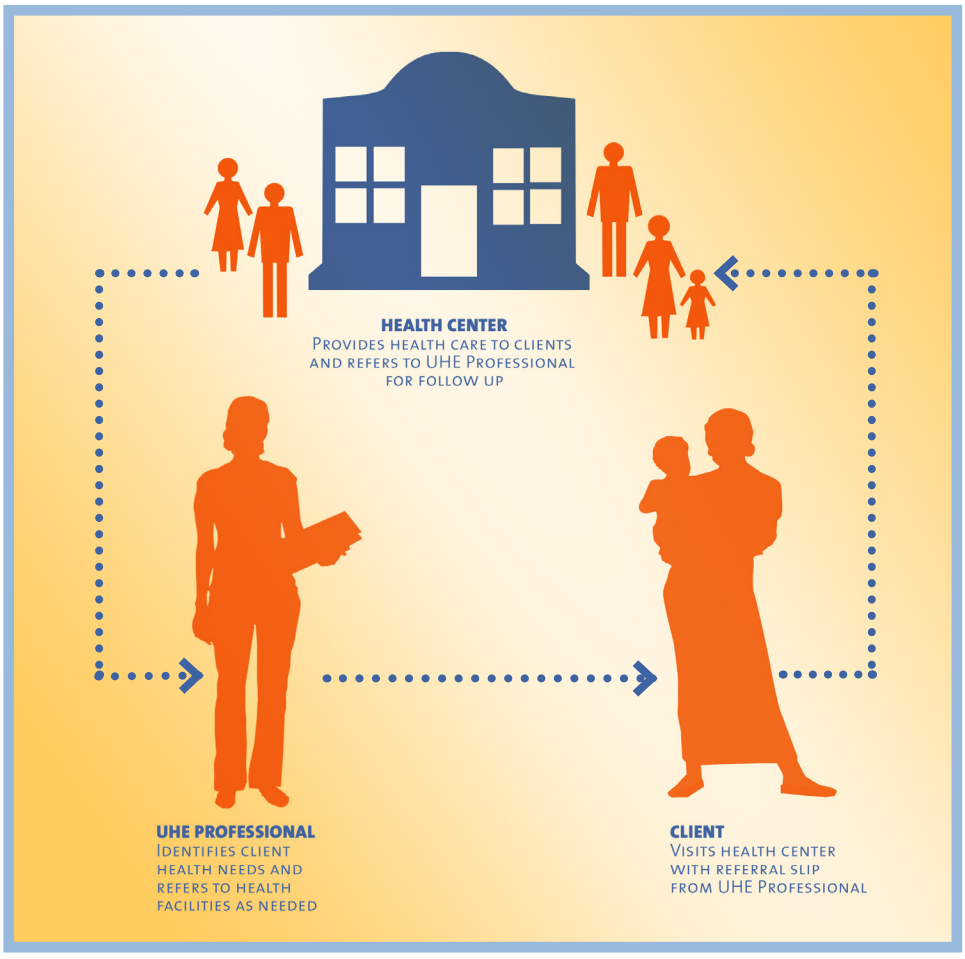
In addition to the UHE professionals, UHEP supervisors and CTHO staff were trained on the baseline data collection tools, and the analysis, interpretation and utilization of the data to enable them to provide technical assistance through supportive supervision, on-site visits, and coaching.

Using the baseline data, UHE professionals identified households with vulnerable individuals and prioritized these households for the provision of basic public health services, including HIV prevention, care, and support services. The data was presented to community groups and was used to facilitate participatory planning sessions with the community to help the community prioritize health problems in their locality, develop community maps of where to best reach MARPs/vulnerable individuals or groups, and develop workplans for the UHE professionals that reflect the needs of the community.

REFERRAL AND LINKAGES

Developing a referral network or strengthening an existing referral system is a multi-step process that involves many stakeholders. Within the UHEP, referrals should be bi-directional: health facilities refer clients to the UHE professionals as well as receive clients being referred from the UHE professionals. However, throughout Ethiopia, referral systems are weak. Prior to USAID/UHEP's work, the necessary referral tools and standardized forms such as client registers and client tracking forms were lacking, compromising the ability to maintain accurate, efficient, and consistent referral systems.

FIGURE 1:
THE THREE PREDOMINATE PLAYERS OF THE REFERRAL SYSTEM IN THE UHEP



In the UHEP referral system there are three predominant players: clients, community health service providers (UHE professionals) and health facilities (Figure 1). The UHE professionals refer clients to health facilities for services either not provided at the household level or to supplement services provided, including but not limited to immunization, family planning (FP), HTC services, anti-retroviral therapy (ART), prevention of mother-to-child transmission of HIV (PMTCT), TB/HIV, and care and support for people living with HIV (PLHIV).

During the life of the Program, USAID/UHEP, in close collaboration with RHBs and CTHOs, designed, produced, disseminated and provided training on referral toolkits. The Program then supported the roll-out of these tools, and in the third year, conducted an assessment to determine how well the system was functioning. Through this assessment, challenges with identifying and following up with defaulters/dropouts of TB treatment, ART, EPI, PMTCT and ANC were identified. To address these challenges, targeted technical support was provided to help CTHOs and HCs.

In Year Three, a rapid review of the functional referral system was conducted to identify the most common referral cases, assess the availability and utilization of all necessary inputs (toolkits) for the functioning of the referral system, and to assess the status of the existing UHEP referral system. The review found the most common reasons for referral were for EPI, antenatal care (ANC), malnutrition, and FP services. These findings indicate that most of the UHE professionals are focusing only on a few cases for referral while postnatal care, PMTCT, TB and non-communicable disease screening, ART, and sexually-transmitted infection cases are very rarely or not at all referred to health facilities. The assessment also found that default tracing is a major challenge for the UHE professionals.

In response, USAID/UHEP provided technical support to CTHOs and HCs to strengthen TB, ART, PMTCT, ANC and EPI defaulters identification from their records and to better use the UHEP to trace and link defaulters to health facilities. The technical support included establishing an active defaulter tracing system in the HCs, developing mechanisms to improve communication between UHE professionals and the HCs, regularly reviewing progress in defaulter tracing, and providing timely feedback on referrals. USAID/UHEP successfully pilot-tested the tracing, identification, and linkage to health facilities to ensure that defaulters return to health facilities and continue to receive treatment and services. Results from this pilot indicated improvements in loss to follow-up (mainly among TB, PMTCT/ANC, ART, and EPI clients).

REACHING MOST-AT-RISK POPULATIONS

Work with MARPs cannot just focus on medical interventions alone, but must first and foremost take into account the vulnerability and risk factors to enable providers to expand their understanding of how individual risk behavior and vulnerability may be influenced by drivers of vulnerability such as gender inequity and stigma/discrimination. This includes empowering those at risk to affect the personal and social circumstances that influence their vulnerability and risk, discourage risky behaviors, and reinforce protective ones by addressing knowledge, attitudes, skills, and beliefs. At the onset of the program, USAID/UHEP had to first determine how most-at-risk individuals would be identified, and what would constitute 'reaching' them. As noted in Box 1, the 'Reach Protocol' was developed, tested and distributed to UHE professionals, with training and on-going support, supervision, coaching and mentoring. Using the 'Reach Protocol,' USAID/UHEP reached over 112,000 MARPs/vulnerable individuals over the period of the program, of whom 84,140 (75%) were female.

BOX 1:
'REACHING' MARPS WITH EVIDENCE-BASED HIV INTERVENTIONS

The 'Reach Protocol' was developed by USAID/UHEP to define steps to 'reaching' MARPs/vulnerable individuals or groups with evidence-based HIV prevention intervention services. Using this protocol, more than 112,000 MARPs/vulnerable individuals or groups were reached by UHE professionals in the 19 USAID/UHEP target cities/towns.

EXPANDING ACCESS TO HIV TESTING AND COUNSELING

The uptake of HTC services has been a major challenge to achieving universal access goals. However, global evidence[7] suggests that a high uptake of HTC can be achieved by delivering HTC at home. The UHEP provides a major opportunity to expand home-based HTC (HBHTC) in urban settings of Ethiopia. However, supportive supervision conducted jointly by USAID/UHEP and RHB staff revealed that the majority of UHE professionals and their supervisors have limited skills to deliver HBHTC as per Ethiopia's established quality standards.

In order to better understand HBHTC in Ethiopia, USAID/UHEP commissioned an independent study to assess the situation of the HBHTC practices conducted by the UHE professionals. The purpose of this assessment was to review the current HTC/HBHTC practices of the UHEP, to identify gaps, and provide recommendations that will assist in program planning, implementation, and monitoring and evaluation (M&E). The assessment explored the current practices of HTC/HBHTC activities in Ethiopia, identified the major gaps, benchmarked the findings with available international and regional standards and desired practices in HBHTC service provision, and put forth recommendations on areas for improvement. The assessment also recommended that Ethiopia should develop an HBHTC policy and strategy to guide the proper planning and implementation of the Program.

[7] Mutaleet al. 2010. Home based voluntary HIV counseling and testing found highly acceptable and to reduce inequalities. BMC Public Health 10:347.

Based on the recommendations of the assessment findings, quality improvement activities were initiated and supported by USAID/UHEP. With technical assistance from Uganda to improve HBHTC activities, USAID/UHEP developed materials, and a training of trainers (ToT) on HBHTC was provided to 20 HTC trainers in Ethiopia drawn from Oromia, Amhara, SNNPR, and Dire Dawa Administration. The training was the first of its kind in Ethiopia, and aimed to build the skills and knowledge of HTC trainers on HBHTC and to transfer HBHTC knowledge and skills to the health system. After the ToT, HBHTC training was provided to UHE professionals in Dire Dawa Administration to pilot test the training materials and to improve the training curriculum before rolling out the training throughout the nation.

Throughout 2012 and into 2013, USAID/UHEP provided technical assistance to the MoH in the finalization of the UHEP HBHTC Operational Manual and HBHTC training materials to ensure the overall direction and guidance regarding the implementation of HBHTC by the UHEP. The manual ensures the standardization of HBHTC services provided by the UHEP throughout the nation. Following the finalization and endorsement of the HBHTC Operational Manual, the MoH formed a working group to develop HBHTC training materials. As part of institutionalizing and scaling up of HBHTC, USAID/UHEP provided technical assistance to the MoH in the development of HBHTC training materials. Both the HBHTC implementation manual and the training materials have been finalized. This standardization will ensure the quality and uniformity of the HBHTC provided by the UHEP throughout the nation.

PROVIDING 'A MINIMUM OF ONE CARE' SERVICE

In USAID/UHEP implementing cities/towns, UHE professionals provided 'a minimum of one care' service to more than 10,700 PLHIV and their families (Box 2). The care and support services provided by UHE professionals are clinical, preventive and supportive, including screening for TB, condom promotion and supply, home-based care/palliative care, on-going counseling and psychological support, and ensuring access to health care services through referrals to health facilities. There has been a steady improvement in the performance of the provision of care and support services every quarter. This was achieved through coaching and mentoring of UHE professionals and their supervisors during supportive supervision visits and monthly meetings.

BOX 2:
'A MINIMUM OF ONE CARE' SERVICE

A 'minimum of one care' service refers to a broad range of services that meet the needs of HIV-infected and affected individuals for clinical, preventive, and supportive services such as condom promotion and supply, home-based care/palliative care, ongoing counseling or psychological support, and client referrals and linkages to health facilities and social services.

EXPECTED RESULT 2: Increase demand for public health services through the active engagement of vulnerable groups, households and communities using BCC for health promotion, disease prevention and risk reduction.

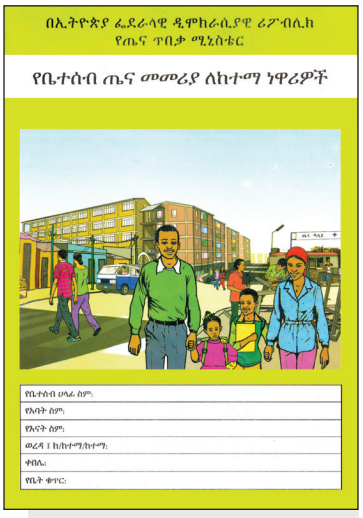
Community mobilization is a capacity building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others. The key tasks in successful community mobilization efforts involve developing an ongoing dialogue between community members, creating an environment in which individuals can empower themselves to address their own and their community's health needs, promoting community members' participation in ways that recognize their impacts, working in partnership with community members in all phases of a program, and creating locally appropriate responses to health needs.

The full participation of the community is required to plan, carry out, and monitor and evaluate the activities of the UHEP in order to improve the health outcomes of the community. In order to create an environment in which individuals and community members participate, USAID/UHEP developed community participatory planning tools and trained the UHE professionals on the tools. The UHE professionals used the tools to meaningfully involve the community in the prioritization of the health problems that the UHEP should focus on. USAID/UHEP has also adopted the rural FHC health communications materials for the urban context. The program provided training and support to the UHE professionals on the use of the FHC. In order to reinforce the message provided by the UHE professionals using the FHC and to enhance the visibility of the program, USAID supported the engagement of the media by providing trainings to the media personnel, providing talking points, and facilitating field visits for journalists.

COMMUNITY MOBILIZATION AND INVOLVEMENT

The UHEP is a relatively new program that requires support from various sectors and community groups. Sensitization workshops, designed to raise awareness of the Program and to ensure buy-in among communities, government sectors, and partners were conducted with representatives from health departments, HCs and hospitals, civil society organizations, local and international NGOs, government sector bureaus, and other stakeholders. USAID/UHEP also utilized different opportunities such as the model family graduation to organize social events and to popularize the Program in the community. USAID/UHEP supported sensitization workshops in all implementing cities/towns. The workshops engaged stakeholders (such as woreda, city/town and *kebele* administration officials and community members) to take action and provide support to further UHEP objectives.

IEC/BCC MATERIAL PRODUCTION: THE URBAN FAMILY HEALTH CARD (UFHC)



Information, education, and communication (IEC) and behavior change communication (BCC) materials are important resources for UHE professionals to promote health behaviors among individuals and families. Given the nascent nature of UHEP, UHE professionals lacked the necessary IEC/BCC and job aids to deliver effective health messages at the household level. The IEC/BCC material that has been widely used in Ethiopia's rural health extension program is the FHC, a material that has also been in use in the UHEP by the UHE professionals to deliver health messages.

In 2011, USAID/UHEP adapted the rural FHC to the urban context and developed an orientation guide for the UHE professionals on its uses. Messages for all packages, namely, family health, hygiene and environmental sanitation, disease prevention and control (HIV and adolescent

health), and injury and accident prevention and control were developed by the MoH in collaboration with health partners in Ethiopia, including USAID/UHEP. The UFHC has been distributed to UHE professionals for use during counseling, health promotion and model family training sessions. Trainings were provided on the UFHC to enable the UHE professionals to effectively use and deliver targeted health messages. The Amharic version of the UFHC was translated into Oromiffa and Tigrigna, two additional local languages. To date, more than 100,000 UFHCs have been printed and distributed across all implementing USAID/UHEP cities/towns. In addition, USAID/UHEP adapted a facilitators' guide for the UFHC that has been used by UHE professionals to train and engage community groups such as the health development army (HDA) in health promotion activities.

USE OF LOCAL MEDIA OUTLETS

Reporters and media personnel have limited access to resources related to the UHEP. With the objective of increasing public knowledge of the UHEP, USAID/UHEP organized orientation sessions for reporters and media personnel from different regions to increase media coverage and foster community sensitization and mobilization. Following the workshop and site visits, various media outlets such as National, Tigray, Amhara, Debub, Dire Dawa, and Harari TV and Debub, Dire Dawa, and Harari FM radio broadcasted topics related to the UHEP. Following the workshop, site visits for the media personal was conducted by these media agencies and journalists.

EXPECTED RESULT 3: Improved quality of UHEP service delivery through training and professional development of UHE professionals on public health, including HIV/AIDS services for vulnerable populations.

USAID/UHEP focused on quality improvement activities, supporting pre-service trainings, and providing in-service trainings to build the capacity of the UHEP staff. USAID/UHEP developed tools such as the supportive supervision facilitator's guide and trained the UHEP management and supervisors on innovative techniques to build the capacities of the UHE professionals. Follow-up was provided by conducting coaching and mentoring after the training to ensure the skills gained from the supportive supervision have been applied appropriately. Additionally, a quality improvement assessment was conducted to identify issues related to defining, measuring and implementing quality improvement activities.

PRE-SERVICE TRAINING

USAID/UHEP supported the pre-service training of 2,337 nurses to become UHE professionals, using the standard curriculum developed by the MoH. To ensure the quality of the training, USAID/UHEP also supported a ToT, which contributed to better standardization of the agenda, proper scheduling, and overall organization and management of the training. To further ensure the quality of pre-service training, supportive supervision to the training sites was conducted by the USAID/UHEP team and RHB staff to identify challenges that need to be addressed and areas for improvement. To facilitate these visits, USAID/UHEP developed a supportive supervision checklist in collaboration with the respective RHBs. The checklist enabled the team to assess the implementation status of the theoretical and practical sessions of the pre-service training and to make timely corrections. The findings demonstrated that facilitators led the sessions according to the standardized curriculum developed by the MoH and the practical sessions also met the standards set by the respective RHBs.

IN-SERVICE TRAINING: HEALTH NEED AND RISK ASSESSMENT (HNRA)

Beginning in the first year of the Program, USAID/UHEP developed a training package on HNRA and rolled out the training to build the skills of UHE professionals and their supervisors to provide health services (particularly HIV prevention, care, and support services) to MARPs/vulnerable individuals or groups. The training built the capacity of UHE professionals to identify and reach MARPs/vulnerable individuals or groups and provide them with targeted public health services, including HIV prevention, care, and support. Further, the training strengthened the skills of UHE professionals to facilitate effective interactions with clients to increase their awareness of health risks, to prevent or minimize such risks, to identify possible actions to change risk behaviors, to implement prevention interventions at different community levels (home, youth centers, and schools), and to access health and social services through effective referrals and linkages.

Once trained, the UHE professionals were visited to identify gaps in applying the skills gained during the training sessions. Supportive supervision was then conducted to identify gaps and develop a tailored refresher training to better equip the UHE professionals to provide quality HIV prevention, care, and support services to MARPs/vulnerable individuals or groups. A total of 1,518 UHE professionals, their supervisors, and experts from CTHOs and HCs attended the HNRA training.

SUPPORTIVE SUPERVISION

One of the key lessons learned from USAID/UHEP implementation was that ongoing capacity building for UHE professionals and their supervisors through continuous follow-up and supportive supervision plays a critical role in program success and in ensuring service quality. In FY2012, USAID/UHEP developed a supportive supervision training manual in consultation with respective RHBs to help provide quality supportive supervision training. The manual is now part of the system and is being used by RHBs to train UHEP supervisors. The manual was launched during a four-day ToT on supportive supervision which included participants from all USAID/UHEP operational regions. The training equipped participants with the necessary skills on supportive supervision to help them cascade the training to UHEP supervisors in all UHEP implementing areas. A total of 619 UHEP supervisors, HC officers, and officers from CTHOs attended the training. In addition to the USAID/UHEP focus cities/towns, using resources from the RHBs and with technical support from USAID/UHEP, the training was cascaded to 81 UHEP supervisors in two sub-cities of Addis Ababa City Administration and six cities/towns of Tigray Region where USAID/UHEP is not operational. This expansion of the training into areas not covered by USAID/UHEP is an example of the expanded effects of the program across Ethiopia.

In collaboration with RHBs, joint supportive supervision visits were conducted over the life of the program to more than 60 cities/towns. The supervision visits were conducted in both USAID/UHEP and non-USAID/UHEP focus cities/towns. The visits focused on experience sharing, the identification of barriers to effective implementation, and seeking solutions together. The visits showed that cities/towns are at different levels of implementing the UHEP. The major findings revealed that there was lack of standardization across sites, difficulty understanding specific roles of implementation by stakeholders, insufficient lines of accountability, and competing priorities within the RHBs, which tend to focus on their rural programs. According to the report, USAID/UHEP-supported cities/towns were found to be in a much better position of implementing the UHEP, as evidenced by data recording and reporting, effective referral, better knowledge of the UHEP by CTHO officials, and better motivation of the UHEP staff.

Based on the lessons drawn from the supportive supervision visits, RHBs have developed action plans to improve the implementation modalities of the UHEP. RHBs shared the supervision findings and their action plans with their respective regional administration councils. It was, for example, recommended by the MoH that other sub-cities in non USAID/UHEP implementing cities within Addis Ababa City Administration learn from the USAID/UHEP supported Yeka Sub-City's implementation experience.

At the city/town level, USAID/UHEP staff embedded at the CTHO played a critical role in providing continuous and consistent supportive supervision, follow-up, coaching, and mentoring. Supportive follow-up visits using the standardized checklist developed by USAID/UHEP are a key mechanism for maintaining the quality of service delivered by UHE professionals. These visits were conducted regularly in all the 19 USAID/UHEP-supported cities/towns by the USAID/UHEP field team. Following the visits, USAID/UHEP continued to make follow-up visits together with UHEP supervisors, and staff of RHBs and CTHOs. The use of standard checklists during the visits facilitated an assessment of the status of each UHE professional's competency. The visits helped create a common understanding of the status of the program, helped to identify gaps, and facilitated the development of joint action plans to improve the performance and quality of service provided to the community.

BOX 3:

QI ASSESSMENT DOMAINS

- Human resources management
- Technical quality standards
- Supportive supervision
- Training and coaching
- Client communications and feedback
- Community involvement
- Service delivery
- Quality assurance
- Planning, M&E
- Referral

ASSESSMENT OF THE QUALITY IMPROVEMENT PROCESS OF THE UHEP

Recognizing that quality is a major issue in the implementation of the UHEP, in FY12 USAID/UHEP conducted a formative assessment to learn more about the implementation of the UHEP. The assessment examined seven domains (Box 3). Some of the key questions addressed in the assessment included:

- What factors enable UHE professionals to perform their tasks confidently and competently?
- To what extent do UHE professionals rely on each other, their supervisors and the HCs to deal with technical and knowledge constraints?
- What knowledge, attitudes and beliefs do community members have about the UHEP and UHE professionals?
- What factors promote or hinder uptake of the services?

The assessment was carried out in four regional cities: Mekelle, Bahir Dar, Adama, and Hawassa.

The key findings of the assessment reported the following:

- **Pre-Service Training and Human Resources:** The pre-service training was provided to the UHE professionals using the nationally-developed curriculum. Deployed UHE professionals have job descriptions; however, performance assessments are rarely communicated to UHE professionals in writing. The recommended ratio of UHEP supervisors to UHE professionals is not observed in all the assessment cities. Additionally, UHE professionals tend to cover more than 500 households, more than the standard set by the MoH implementation manual.

- **Reporting Mechanism for UHE Professionals:** UHE professionals are technically reporting to the HC and are administratively responsible to *kebele* administrations. There is an absence of strong systems to assure that the practice is based on the approved standards.
- **Client-Provider Interactions:** In client-provider interactions, the UHE professionals were observed to be respectful, used a friendly tone of voice, and were attentive. However, the UHE professionals lack some critical client communication skills. They tend to provide too much information to the client instead of encouraging the client to ask questions and/or clarify concerns. Further, they did not have the tools and skills to determine the unique needs of each specific client, and to tailor the services based on the individual's needs.
- **Quality Assurance (QA) and Quality Improvement (QI):** The concept of a quality assurance and improvement component of the assessment tool is new to the UHE professionals, supervisors, and HC staff. There is no established, ongoing system for assessing and improving client services. Although some supervisors attended a brief QI training through the balanced score card process, the training was not enough to help the staff plan, implement, and monitor QI strategies.
- **Referral Network:** The UHEP referral system works in such a way that the UHE professionals refer clients to the primary HCs and in some circumstances to private and NGO-run health facilities. Referral tools such as referral slips and referral directories were provided with trainings on the referral system. However, client satisfaction, which points to the quality of the services, is not formally assessed on a regular basis to take client views and perceptions into overall program planning, implementation, and M&E.

The assessment recommended the development of QA processes and standards, implementation of improvement plans, and regular measurement and monitoring of the quality standards. The assessment findings and recommendations were disseminated in Bahir Dar, Mekelle and Adama cities, followed by participatory planning sessions to develop QI plans.

MODEL UHEP CENTERS

Defining standards is the core dimension of a quality improvement process. As part of defining, measuring, and improving the quality of the UHEP, the Program has established two model UHEP centers to standardize working formats, guidelines, wall charts and office arrangements for the UHE professionals, and to link the UHEP with HCs. As part of supporting the standardization of the UHEP, USAID/UHEP worked with Hawassa and Adama city health offices to establish one model UHEP center in each city. The centers were provided with the required amenities according to the

minimum standards jointly developed with the health offices. The overall objective of the model UHEP centers approach is to establish a quality improvement and standardization process by creating a suitable work environment for both service providers and users as part of a continuous quality improvement process. The centers will serve as UHEP demonstration centers from which lessons and best practices can be drawn and scaled up. They will also showcase uniform amenities and services for the UHEP and motivate UHE professionals to provide quality services, thereby contributing to the standardization process. The guiding principles of the model UHEP centers are scalability, sustainability, technological and local appropriateness, cost-efficiency, and being need-based. USAID/UHEP has developed a model UHEP center user manual and provided orientation on the manual to help the UHE professionals and other UHEP staff, including the CTHOs that manage the centers.

SUPPLIES AND LOGISTICS

USAID/UHEP conducted a rapid assessment on the availability and accessibility of UHEP kits in the Program's focus cities/towns to determine the needs for the kits, and the result of the rapid assessment was shared with RHBs and CTHOs. Based on the identified gaps and in consultation with the MoH and RHBs, UHEP kits containing medical equipment and consumables such as HIV test kits, penile models, fetal stethoscopes, measuring tapes, first aid supplies, and torch lights for examining throats, eyes, and ears were procured and distributed to all UHE professionals working in USAID/UHEP implementing cities/towns. Bicycles and motorbikes were provided to select UHE professionals and their supervisors to address challenges related to mobility.

EXPECTED RESULT 4: Support an enabling environment to implement a sustainable UHEP including support for development and implementation of community information systems.

As a step towards strengthening the HMIS, USAID/UHEP worked closely with RHBs and CTHOs in the development of data recording and reporting formats for the UHEP. USAID/UHEP made a significant contribution to data collection, recording, compilation, and reporting by developing tools, conducting trainings on how to use the tools and providing continuous support. The recording and reporting formats were distributed to UHE professionals along with orientation, and follow-up was conducted through coaching and mentoring. This improved the documentation of the UHEP in all USAID/UHEP implementing cities/towns. The best practices and experiences observed in USAID/UHEP implementation cities/towns were scaled-up by RHBs to non-USAID/UHEP operational towns/cities. USAID/UHEP played a key role in the generation of data and information for planning and decision making, strengthening health systems by working with the MoH, RHBs, CTHOs and partners on the UHEP. In some regions, the evidence from USAID/UHEP-focus cities/towns was used to influence decision makers and officials to support the UHEP implementation by allocating adequate budget for the recruitment of nurses to become UHE professionals.

DATA RECORDING, REPORTING, AND UTILIZATION

Prior to the start of USAID/UHEP, the UHEP was lacking data recording, documentation, and reporting formats and guidelines. To address this challenge, the Program worked with RHBs to develop a data recording and reporting system including the development, printing, and distribution of materials, as well as training on the system. As a result of USAID/UHEP's commitment to training UHE professionals and their supervisors on data recording and reporting, significant improvement in reporting has been seen in all USAID/UHEP cities/towns.

As part of strengthening the data recording, reporting and documentation of the UHEP, the MoH piloted the community-based health information system (CHIS) using the urban family folder (UFF). The UFF is a CHIS package designed for data collection, recording, reporting and documentation. It is a simple recordkeeping and reporting format and procedure that feeds into the community-level health information systems. USAID/UHEP has been supporting the piloting

of CHIS/UFF in Addis Ababa (Woreda 9 of Yeka Sub-City) in collaboration with the MoH and Addis Ababa City Administration Health Bureau. In order to draw lessons from this pilot, and to develop a scale-up strategy for CHIS/UFF, a team of experts from these three entities was formed to conduct a formative evaluation of the implementation of the CHIS/UFF pilot in Addis Ababa.

USING COMMUNITY-BASED INFORMATION FOR ACTION (CBIA)

Community-based information for action (CBIA) is a community-focused approach that facilitates empowerment of communities to take control of their own health by providing timely and accurate health information at the community level. The main aim of CBIA is to support UHE professionals to engage community members (community representatives, volunteers, and HDA members) in their catchment areas to assist with the collection of community data/demographic information (e.g., number of pregnant women and number of children under the age of five in the households). The collected data are then compiled, analyzed and interpreted at the *kebele* level by UHE professionals and a CBIA committee/health committee, and pertinent findings are discussed (and ideally, acted upon) by the health committee.

USAID/UHEP spearheaded the adaption of the CBIA approach from the rural context. This included facilitating experience sharing meetings, developing and adapting tools, and providing training on the tools. A ToT was organized on the concept, approach and implementation steps of CBIA. UHE professionals, UHEP supervisors, CBIA committee/health committee members, and CTHO staff attended the training, which was cascaded to more than 1,900 community groups such as the HDA. The HDA members, who have the responsibility of implementing the government's community-based health activities, were supported by the UHE professionals and CBIA committees. Follow-up meetings helped to assess how the CBIA is being implemented, what information is being gathered, and how the information can be used for action, and to document lessons to improve the tools and processes of implementation.

USAID/UHEP also developed a monitoring system and provided technical support for the implementation of CBIA. UHE professionals implementing CBIA in Debremarkos and Hawassa received technical support from USAID/UHEP on a range of activities including data compilation, facilitating meetings with the HDA and health/CBIA committees, and providing refresher trainings to the HDA on priority technical areas. The CBIA approach was reviewed to understand lessons learned concerning CBIA implementation, document best practices, and identify challenges before scaling-up CBIA to the remaining *kebeles* of the implementing cities/towns.

SUPPORT TO IMPROVE THE LEADERSHIP AND MANAGEMENT OF THE UHEP

Throughout the life of USAID/UHEP, regional review meetings were conducted in all regions with the support of USAID/UHEP. The purpose of the regional meetings was to review the implementation status of the UHEP with reference to the implementation manual, to understand best practices, to identify challenges, and to make recommendations. USAID/UHEP also supported CTHO in conducting 123 sessions of city/town review meetings in all 19 cities/towns. These meetings were vital components of USAID/UHEP's contribution to the development and improvement of the UHEP as they provided an opportunity to discuss the progress of the Program and findings of supportive follow-up visits, and to share best practices and lessons learned, as well as present solutions to challenges encountered in program implementation. The meetings were attended by officials, CTHO staff, UHEP supervisors, UHE professionals, HC staff, and *kebele* administration representatives. Similarly, experience-sharing visits were supported by USAID/UHEP, enabling further on-site learning and experience sharing among cities and towns. These visits offered first-hand experience of replicable practices of high-performing cities, towns and woredas, and presented an opportunity for both the leadership of the UHEP and the UHE professionals to meet their counterparts and learn from each other.

DATA QUALITY ASSURANCE

Data quality control assessments were conducted in all 19 cities/towns using checklists developed by USAID/UHEP. These checklists were designed to assess the consistency, completeness, and accuracy of reporting at the central, regional, city/town and UHE professional level, and to provide immediate feedback to the UHE professionals. The assessment found that the quality of the data being reported by UHE professionals is fairly consistent, complete and accurate, and that there is continuous improvement. USAID/UHEP made efforts to improve the quality of data collected through data quality assessments, mentoring, coaching and on-the-job support at all levels. The major challenge with regards to ensuring the quality of the data is that the newly deployed UHE professionals were not well versed with the indicators and the variables of the data collection tools.

IV. CHALLENGES

As a new government initiative, the UHEP faces a number of challenges. The UHEP has limited experience in planning, implementing, and monitoring a community-based program in an urban setting. This requires a specific set of skills and knowledge base, as well as systems for continuous learning from and adaption of the rural HEP practices. The UHEP's attempt to serve all urban dwellers' diverse health risks, needs, and lifestyles, and the lack of a coordinated, multi-sector approach to implement urban health are other challenges faced.

STANDARDIZATION, QUALITY ASSURANCE AND IMPROVEMENT SYSTEMS

Apart from a single document (The *UHEP Implementation Manual*, developed by the MoH in 2009), the UHEP lacks guidelines, standard operational procedures, and protocols to guide UHEP planning, implementation, and monitoring. The absence of QA and standards resulted in lack of uniformity and fragmentation of approach, strategy, and service delivery as well as insufficiency of benchmarks to monitor progress and quality of service delivery. There is no established and on-going system for assessing and improving client services in the UHEP health packages.

In order to address these challenges, USAID/UHEP supported trainings, supportive supervision, coaching, mentoring, and the development of tools. The immediate quality issues were identified through supportive supervision visits and review meetings, where action plans were developed in coordination with RHBs and CTHOs. Serious issues, such as HTC provided by UHEP practices in Ethiopia, were emphasized and USAID/UHEP worked with the MoH to better understand the situation and prioritize actions.

HUMAN RESOURCES

UHE professional 'burn-out' due to an unclear career path, including lack of continuing education, and both financial and non-financial reward mechanisms poses a major challenge for the UHEP. The shortage of qualified personnel with the appropriate skills to manage, support, and coach the UHE professionals and continued turnover of staff at various levels also presented challenges throughout the life of USAID/UHEP implementation.

USAID/UHEP pursued a number of interventions to address the 'burn-out' issue of the UHE professionals. The program provided a number of trainings in various areas to motivate the UHE professionals and provide them with useful skills. USAID/UHEP worked to provide tools such as the daily data recording and reporting tool, referral directories, and the UFHC. These systematic tools assist the UHE professionals to do their job professionally and contribute to job satisfaction by facilitating smooth interactions with clients. USAID/UHEP also piloted model UHEP centers to systematize standards of the UHEP and to motivate the UHE professionals by providing a motivating working environment.

BUDGETARY CONSTRAINTS

The RHBs and CTHOs have inadequate budgets for implementing the UHEP, and there is a limited number of partners supporting the UHEP across the regions and cities/towns. USAID/UHEP strived to utilize every opportunity to decrease the costs of trainings in order to provide more training coverage to UHEP staff (e.g., cascade trainings) and create awareness of the importance and need to allocate budget to the UHEP. Through organizing regional and city/town review meetings, USAID/UHEP created a platform for discussion and debate among government counterparts. In some instances, the forums resulted in CTHOs and regions allocating budget to recruit more UHE professionals.

ABSENCE OF UHEP DATA RECORDING AND REPORTING SYSTEM LINKED WITH EXISTING HEALTH MANAGEMENT INFORMATION SYSTEMS (HMIS)

The UHEP is not yet fully integrated into the health system and challenges are faced in UHEP data recording and reporting that links the UHEP data with the health system's HMIS. Due to delays in implementing the CHIS which enables data record and reporting for the UHEP, each city/town resorted to using diverse recording and reporting formats. As a result, reporting and utilization of data from UHE professionals is highly challenging, since the UHEP does not have a system linking the data to the existing HMIS in Ethiopia.

As a long-term solution and as part of strengthening the data recording, reporting, and documentation of the UHEP, USAID/UHEP, MoH and Addis Ababa City Administration Health Bureau collaborated to pilot-test the CHIS using the UFF in order to draw lessons from this pilot, and to develop a scale-up strategy for CHIS/UFF. A team of experts was formed to conduct a formative evaluation of the implementation of the CHIS/UFF pilot and the official report from this formative assessment will inform how the UFF should be implemented through the country to improve health information.

LEADERSHIP AND MANAGEMENT OF THE PROGRAM

Although there is considerable commitment by the GoE, this commitment has not yet translated to managerial staff at lower levels of administration. The lack of a clear accountability and lines of responsibility of the UHEP (which is currently shared between the HCs and the local *kebele* administrations) has created confusion in relation to ownership of the UHEP by both parties. Furthermore, the lack of a forum to facilitate collaborative efforts amongst various government and non-government stakeholders has also been a challenge in implementation. The absence of organized information from the UHEP has also posed challenges, as the data and information captured in the urban areas has not been used to inform leadership decisions.

In order to inform the decision-making process at various levels, USAID/UHEP organized town and regional-level review meetings and conducted joint supervision with the RHBs and CTHOs. The findings from these activities were communicated with proper officials and actions were taken.

SUPPLY CHAIN MANAGEMENT SYSTEMS

The UHEP is not well established within the health system of Ethiopia. A logistics system that supports requesting, tracking, and refilling of supplies and consumables is not in place. The lack of supply chain management systems has created a number of challenges for UHE professionals, for example, stock outs of HIV tests. With no mechanism to predict supply and to place refill orders, test kits are often wasted.

In order to address this challenge, USAID/UHEP has worked closely with the CTHO to ensure a working relationship between the health facilities and the UHEP. Many health facilities now provide technical support with logistics and commodities to the UHEP.

ADAPTION AND CUSTOMIZATION OF TOOLS, JOB AIDES, AND PROTOCOL FOR THE URBAN CONTEXT

The UHEP has been expanded to urban areas from the experiences of the rural HEP without a full understanding of the urban context and how the health systems in urban areas work. There are some fundamental differences between urban and rural communities, resulting in urban-specific challenges. There are competing priorities in the urban setting, and as a result, it is difficult to convince urban community members to participate and to 'buy-in' to UHEP activities. Selecting urban communities, adaptation of urban communalities to the expected practices and lack of evidence on how the 'innovation diffusion' theory works in urban areas since urban communities are comprised of independent families will continue to be challenge.

MOBILITY

Mobility is a feature of an urban life style. It has been challenging to the UHE professionals to identity and to provide health services to certain target population on a consistent and continual manner since the target populations move from place to place across towns or in the same town. The mobility affects continuity of services being provided to the clients and this will continue to be a major challenge.

LACK OF EVIDENCE

The GoE's establishment of the UHEP provides an important opportunity to better understand and address Ethiopia's urban health challenges. However, key determinants of health in urban areas are not well studied to guide policy formulation and programmatic and health system responses. The GoE has made commendable steps toward addressing urban health issues through designing and implementing the UHEP. However, the generation and strategic use of information and research on urban health issues is limited.

LACK OF COMPREHENSIVE URBAN HEALTH STRATEGY

The GoE has not yet developed a comprehensive urban health strategy to address the key urban health issues and the determinants of the health of urban population. The lack of a comprehensive strategy challenges the MoH's role in overseeing and providing policy guidance to the whole urban health system, including the private sector that is growing in the urban areas of Ethiopia. To address this challenge, USAID/UHEP (through the Maternal and Child Health Integrated Program) organized experience sharing and a study tour to India for high-level GoE public health officials from the MoH, RHBs, and USAID/UHEP staff. In addition, USAID/UHEP staff were linked with urban health champions by participating in the International Urban Health Conference in Brazil. There, the staff shared experiences from the Brazilian urban health strategy. These experiences will create urban health champions who will provide technical support in the development of policy guidance, system design, and will ensure that Ethiopia has a wealth of advocates for urban health.

V. RECOMMENDATIONS

The following recommendations are based on USAID/UHEP's experiences and lessons learned over the course of program implementation:

UPDATE THE UHEP IMPLEMENTATION MANUAL

The UHEP Implementation Manual, the only document guiding the UHEP's planning, implementation, monitoring and evaluation, needs to be reviewed and revised based on the evolution of the Program, lessons and experiences gained during program implementation. Analyzing the workloads of both UHE professionals and supervisors, developing standard operating procedures, protocols, performance standards, updating job descriptions, and provision of incentive and reward mechanisms would ensure continued commitment and higher performance. Career development plans and opportunities for skill-development should be considered. Additionally, guidelines to enhance the model family training and implementation of UHEP packages in schools and youth centers need to be developed.

DEVELOP/STRENGTHEN SYSTEMS TO BETTER SUPPORT THE UHEP

The government's HMIS, supply chain management system, as well as the M&E systems need to be refined to ensure effective planning, implementation, and M&E and to enable learning and informed decision making at all levels.

STRENGTHEN PARTNERSHIPS

Partnerships for the implementation of the UHEP need to be strengthened: stakeholders from all sectors must be engaged. This includes non-health sector organizations and government offices, community groups, and community leaders as well as the mass communication agencies to increase the understanding, publicity and acceptance of the UHEP by the community.

INVESTIGATE THE SOCIAL DETERMINANTS OF HEALTH IN AN URBAN SETTING

Rigorous research needs to be conducted to generate strategic information to further understand the social determinants of health in an urban population. A better understanding of the health service delivery system and community utilization of services would provide direction on how to target and design interventions in urban areas.

GENERATE STRATEGIC INFORMATION, ESPECIALLY ON VULNERABLE POPULATIONS

It is critical to generate strategic information through rigorous scientific standards, including the size estimation of MARPs and their locations and to broaden the definition of MARPs beyond occupation proxies (such as demographic characteristics and geographic locations) to implement targeted and high impact interventions. Broader understanding of health risks in urban areas will also need to be understood.

SUPPORT THE GOVERNMENT IN THE DEVELOPMENT OF A COMPREHENSIVE URBAN HEALTH STRATEGY

Strategic planning and developming detailed action plans related to urban health is critical, considering the current lack of adequate and systematic considerations of public health responses in largely unplanned and growing Ethiopian cities. The urbanization process has resulted in a wide array of cultural, community, family, migration, and socio-economic challenges that requires adjustments in programming through a comprehensive strategy.

RESPOND WITH AN INTER-SECTORAL APPROACH

Addressing the specific needs of the urban population requires a multi-sectoral response. The MoH will also need to mobilize the multitude of stakeholders and adjust health services to meet the specific needs of urban populations by implementing an urban health approach. The MoH will also need to advocate for a common goal and shared responsibility by coordinating the academia, the private sector, NGOs, and civil society.

STRENGTHEN THE HEALTH SYSTEM TO MEET SPECIAL HEALTH NEEDS OF URBAN POPULATIONS

In order to ensure that the urban health system meets the needs of the urban population, the health systems strengthening approach needs to offer guidance on ways to address urban health issues, particularly those related to health determinants, health promotion, and primary care.

BUILD CAPACITY ON URBAN HEALTH MANAGEMENT AND LEADERSHIP

To address the specific needs of the urban population through comprehensive urban health strategy, the capacity of staff of the health systems at the various levels (MoH, RHBs, zonal health departments and city/town offices) needs to be built. Capacity development will help to ensure that the health system can assume stewardship for promoting urban health and adjust health service delivery for urban populations. Capacity development at the national MoH level will also ensure policy development to effectively design policies and interventions, inform evidence-based decision making, and improve human and financial capacities.

IMPROVE CLIENT COMMUNICATIONS

In any setting, clear communication to clients is important, and needs to take into account diversity such as differences in culture, gender, age, religion, and reading/literacy levels. These diversities are even more pronounced in an urban setting. Ensuring a client-friendly health delivery system that suits the need of each and every client should be planned and implemented. The UHE professionals should be provided with the necessary tools and skills to explore the client as an individual and provide tailored services to the individual in question.

VI. CONCLUSION

USAID/UHEP has made a significant contribution to the UHEP of Ethiopia through capacity building, quality improvement, increasing access to public health services in urban settings, strengthening referral between community and the health facilities, supportive supervision, and creating demand for health services. USAID/UHEP provided support to build the service delivery system, especially in towns, to inform programming for the UHEP. This on-going USAID/UHEP support increased program visibility, helped with the development of tools and systems, improved management and leadership capacities, and increased the responsiveness of the UHEP to arising issues, challenges, and limitations. With the support of USAID/UHEP, the UHEP reached a significant number of MARPs/vulnerable individuals with health and HIV services. USAID/UHEP's contribution has had an impact on the lives of Ethiopians in major cities and towns and contributed to an improvement in public health service delivery in urban areas.


PROF GENDE KORE ZONE
ENDE SHABEL 2003
MONITORING CHART 2004 RUMIAAL
ACTIVITY
ANNUAL PLAN
FIRST QUARTER
SECOND QUARTER
THIRD QUARTER
FOURTH QUARTER
HCT>15
PWC

ANNEXES

ANNEX 1. USAID/UHEP TARGETS AND ACHIEVEMENTS, SEPTEMBER 2009 – MARCH 2013

SN	INDICATOR	TARGET	ACHIEVEMENT	
			NUMBER	%
ER 1. IMPROVED ACCESS AND DECREASED BARRIERS TO PUBLIC HEALTH SERVICES FOR VULNERABLE POPULATIONS THROUGH ENGAGEMENT OF HOUSEHOLDS AND COMMUNITIES.				
1.1	Number of Most at Risk Populations (MARPs)/vulnerable individuals/groups 'reached' with individual and or small group level with HIV prevention/intervention that are based on evidence and or meet the minimum standard.	128,551	112,055	87%
1.2	Number of MARPs/vulnerable individuals who received HTC and received their test result by UHE professionals.	48,547	47,469	98%
1.3	Number of pregnant women who received HTC service and received their test results.	500	384	77%
1.4	Number of eligible adults and children provided with 'a minimum of one care' service by UHE professionals.	13,059	10,714	82%
1.5	Number of Under-5 children screened for nutritional status and referred for supportive services.	500	601	120%
1.6	Number of MARPs/vulnerable individuals referred to health and other social services by UHE professionals.	11,308	9,870	87%
1.7	Number of complete referrals documented for MARPs/ vulnerable individuals.	6,195	3,922	63%
1.8	Number of TB; PMTCT; Vaccination/EPI; and ART defaulters referred from the health facilities to UHEP and 'followed up' by UHE professionals.	500	582	116%
1.9	Number of cities/towns for which community asset map/resource map developed.	20	19	95%
1.10	Number of cities/towns developed referral directories.	20	20	100%
1.11	Number of UHE professionals and UHEP supervisors who develop workplans that include a MARPs/vulnerable focus.	1026	977	95%
ER 2. INCREASED DEMAND FOR PUBLIC HEALTH SERVICES THROUGH ACTIVE ENGAGEMENT OF VULNERABLE GROUPS, HOUSEHOLDS AND COMMUNITIES USING BCC FOR HEALTH PROMOTION, DISEASE PREVENTION AND RISK REDUCTION.				
2.1	Number of community sensitization/orientation and mobilization guide developed/adapted.	1	1	100%
2.2	Number of sensitization sessions/meetings conducted to introduce UHEP to government sectors, NGOs, CBOs and FBOs.	20	20	100%
2.3	Number of health center and hospital staff oriented on UHEP.	600	145	24%

SN	INDICATOR	TARGET	ACHIEVEMENT	
			NUMBER	%
2.4	Number of individuals who are members of community groups such as "Health Developmental Army" who received orientation and guidance to be involved in health promotion activities.	2,620	1,335	51%
2.5	Number of media personnel oriented on UHEP and USAID/UHEP.	142	116	82%
ER 3. IMPROVED QUALITY OF UHEP SERVICE DELIVERY THROUGH TRAINING AND PROFESSIONAL DEVELOPMENT OF UHE PROFESSIONALS ON PUBLIC HEALTH, INCLUDING HIV/AIDS SERVICES FOR VULNERABLE POPULATIONS.				
3.1	Number of UHE professionals who successfully completed a pre-service training.	2,000	2,337	117%
3.2	Number of UHEP supervisors who successfully completed the initial training of supervisor for UHEP.	200	152	76%
3.3	Number of UHE professionals and their supervisors who successfully completed an in-service training.	4,323	3,007	70%
3.4	Number of UHEP supervisors, CTHO experts and HC expert trained on supportive supervision.	505	669	132%
3.5	Number of UHE professionals and their supervisors trained on use of urban family health card for health promotion.	787	823	105%
3.6	Number of supportive follow-up visits conducted to UHE professionals and their supervisors.	3,314	3,763	114%
3.7	Percentage of health centers with functional two-way referral system.	80%	70%	88%
3.8	Number of professionals including UHEP supervisors trained on HBHTC quality assurance.	72	10	14%
3.9	Number of operation manual/guide developed with the support of USAID/UHEP.	2	2	100%
3.10	Number of cities/towns where referral system strengthened and patients referred with referral slip and feedbacks available/documented by UHE professionals.	20	20	100%
ER 4. SUPPORT AN ENABLING ENVIRONMENT TO IMPLEMENT A SUSTAINABLE UHEP INCLUDING SUPPORT FOR DEVELOPMENT AND IMPLEMENTATION OF COMMUNITY INFORMATION SYSTEMS.				
4.1	Number of cities/towns continuously supported in implementing community based information for action.	2	2	100%
4.2	Number of UHE professionals, health committee and community groups such as HDA who received refresher training on CBIA.	1,980	2,219	112%
4.3	Number of checklists completed for the purpose of data quality assessment.	372	480	129%
4.4	Number of review meeting conducted at regional level on UHEP.	10	6	60%
4.5	Number of review meetings sessions conducted at cities/town level on UHEP.	174	123	71%
4.6	Number of UHEP kits provided/supplied to UHE professionals.	897	897	100%
4.7	Number of motorbikes and bikes distributed to UHE professionals and their supervisors.	280	255	91%

ANNEX 2. USAID/UHEP ABSTRACTS PRESENTED AT INTERNATIONAL CONFERENCES

- *Building Community Health Worker Capacity to Identify and Reach Vulnerable Populations with HIV and Other Health Services in Ethiopia.* Poster Presented at the139th American Public Health Association October 29 – Nov 2, 2011.
- *Community based health information system for action: How local community improved health service utilization of health center in Hawassa City.* Poster presented at the19th International AIDS Conference, July 22 – 27, 2012.
- *A referral toolkit to establish and monitor functional referral system between community health program and health facilities in urban setting of Ethiopia: should frontline primary health care adapt it?* Poster presented at the 19th International AIDS Conference, July 22 – 27, 2012.
- *Ethiopia's Urban Health Extension Program: the risk group approach to reach vulnerable populations.* Abstract selected and poster presented at the 10th International Conference on Urban Health, Belo Horizone, Brazil.
- *Improving access to health services for the urban poor in Ethiopia: An innovative strategy.* Abstract selected and poster presented at the 10th International Conference on Urban Health Conference, Belo Horizone, Brazil.

ANNEX 3. OPERATIONAL STUDIES CONDUCTED BY USAID/UHEP

- An assessment on the Current Practice of Home-Based HIV Testing and Counseling (HBHTC) Services provided by UHE Professionals in Ethiopia.
- An assessment of the Quality Improvement Process of the UHEP in Four Major Cities of Ethiopia: Mekelle, Bahir Dar, Adama and Hawassa.

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