USAID Funded Family Focused HIV Prevention Care and Treatment Services

OVC_HIV_SERVICE Integration Outcome Assessment Report

September, 2022 - Addis Ababa, Ethiopia

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Contents

LIST OF ACRONYMS

AABoH-	Addis Ababa City Administration Bureau of Health
ART	Anti-retroviral Therapy
CCC	Community Care Coalitions
CDSDM	Community Differential Service Delivery Model
CHCT	Community HIV Care and Treatment Activity
CEF	Community Engagement Facilitators
CRP	Community Resource Persons
ES	Economic Strengthening
GBV	Gender Based Violence
HF	Health Facility
ICT	Index Client Testing
LIP	Local Implementing Partners
MENA	Mekdim Ethiopia National Association
PLHIV	People Living with HIV
QI/QA	Quality Assurance and Improvement
SOP	Standard Operating Procedure
USAID	United States Agency for International Development
VSLA	Village Savings and Loans Associations

EXECUTIVE SUMMARY

Integration of HIV services with the OVC program at the implementation level is a process that involves the coordinated delivery of multiple services to people affected and infected by HIV/AIDS at the same time and is a key priority of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Integration of HIV and OVC services can result in improved health outcomes and increased efficiencies by reducing duplicative services, improving coordination among providers, and maximizing the use of resources. Hince this assessment report is aimed to evaluate current service delivery models, bring to attention opportunities for service integration, and recommend and implement an integration plan. Implementing an integration plan can be a challenge, but it is important to consider the benefits that integration can bring to individuals living and affected with HIV.

HIV & OVC Service Integration Outcome Assessment survey: - USAID Family Focused HIV Prevention, Care and Treatment Service award represents a transition from two unique programs OVC & HIV Care and treatment to one integrated program. To serve families infected or affected with HIV who are newly diagnosed, at high risk of default, or do not achieve viral suppression.

Objective: - to evaluate current service delivery models, assess opportunities for service integration, and recommend and implement an integration plan.

Methods: This study employed qualitative research methods and a participatory process to facilitate the involvement of key staff and frontline workers. Data were collected online through google forms. Survey questions were developed and sent via Google Docs. The data were then downloaded and thematic analysis was employed

Key Findings

Potential benefits of the program integration at the implementation level.

35 responses have been recorded for this Questions

A) Case investigation/HIV testing service for pediatric and adult

Case detection is greatly supported by service integration. In the past, after assessing their risks, we would send them to HF, where they would wait for some time. However, we now have testing services provided by CEFs, who have received training to conduct standard testing at the community level.

One of the best ways for CEF and SSW to connect with stakeholders and get the right message is through integration. For sexual contacts and biological children, community-based Index case testing is being carried out, where SSW & CRP trace, create demand, and CEF are tested.

Every year, an HIV risk assessment is undertaken for the OVC HIV testing cascade through household case management to gather contacts and index them for case identification. To track HIV status unknown project beneficiaries and siblings,

based on the results of the risk assessment, at-risk children are referred to CEF through internal referral for testing in addition to recommending Children to a health institution.

CEF conducts testing at a convenient time and location of the client's choice, which resolved our testing challenge for OVC clients because the majority of them refused to go to a nearby health facility for testing. As a result, our testing is targeted and makes it simple to maintain new clients who have been identified as HIV-positive.

The integration also helped in connecting OVC beneficiaries to both ES and HIV care. It is primarily responsible for the efficacy of the bidirectional referral.

B) Increasing adherence and retention

Our involvement in adherence and retention is increased because of the integration, which also enables us to jointly find a doable strategy. The main strategy used to boost adherence is case management. Providers are well-trained and conversant in the topic during home-to-home visits.

The implementation of adult HIV service case management will address OVC clients' ART adherence and retention status as well as the reverse. CEF and SSW educate people about ART and the advantages of adherence. SSWs use a calendar to keep track of the viral load in OVC and their caregivers. At different and complementary platforms, CEF and SSW both offer ART literacy and the advantages of adherence. SSWs use a calendar to keep track of ART appointments for OVC and their caretakers. For CG and OVC, the program evaluates retention and adherence during a home visit. Integration makes it simpler to spot any hurdles early and create a care plan during the home visit for people with CLHIV and their caregivers. Based on the barrier identified, C-EAC will be facilitated for both the program populations.

Support groups/peer groups are also one of the blessings of the program integration which creates time to discuss adherence. These groups are recruited from OVC &HIV services and our CRPs and volunteers are well-trained and easily discuss during home-to-home visits.

C) addressing IIT -re-engagement (OVC & Adult)

We collaborate closely with OVC caregivers and PLHIV to follow both CALHIV and adult PLHIV in the case of IIT re-engagement. Frontline workers/CWs, CRPs, SSWs, and CEFs carry out lost follow-up tracing and re-engagement for PLHIV and ACLHIV. By reminding them of their appointments, checking their VL, and making sure they didn't miss any doses, CWs and CRPs both play crucial roles in assisting CLHIV and PLHIV patients through the home visit.

The program will address re-engaging to care with CRP and SSW, both of whom are very familiar with communities. Counseling for new cases early initiation...create awareness of what happens if they interrupt their medication and the importance of medication for lifelong.

D) Implementing CDSDM and VSLA for both PLHIV and HIV-positive caregivers

Utilizing various OVC platforms enhances C-DSDM performance. We generate demand for caregivers who are both PLHIV and HIV-positive caregivers of OVC. To establish VSLA, we also use the CDSDM platform.

If a facility has an HVL client, they will connect with their respective SSWs and CEFs to provide C-EAC. The integration also made it easier for clients to join the VSLA group DSDM who are enrolled through both OVC and CHCT case management. We are leveraging VSLA and other OVC program platforms, along with CG from the comprehensive OVC program, to improve our CDSDM performance.

SSW performs an initial assessment of the community for CDSDM. If they accept, they are referring to a health facility or CEFs.

We are also able to form CAG/PCAD by integrating with OVC by using a support group...and it helps us to form a new group.

E) Community C-EAC and Bidirectional Referral Service

In order to provide diverse service alternatives, such as connecting clients with HF, CC & CCCs, Women, Children & Social Affairs & various other associations based on their needs through the service directory, the integration highly played a critical part when it came to bidirectional referral.

Following the completion of the barrier analysis, the clinical component—which was carried out by CEFs—and the social service—which was carried out by social workers—the C-EAC for HVL OVC and adult cases was put into place.

Internal referral services, the creation of a shared service directory, and service mapping all contributed to the bidirectional referral service.

Additionally, it enables us to contact the community in an integrated manner and use resources very effectively.

2. Effectiveness of the program integration in terms of HIV & GBV prevention, in FY21 and FY22.

34 responses recorded

Among the major activities of FFHPCTs are HIV and GBV. Survivors of GBV require both medical and social assistance. We assess all women PLHIV and HIV POSITIVE caregivers, and if a client tests positive for GBV, we refer them to the appropriate stakeholders. The integration makes it simple to meet their needs instantly.

Because of this program, we are able to easily address and provide comprehensive service for highly vulnerable beneficiaries of HIV and GBV activity for both OVC and HIV service program enrolled clients. The identification, CT, and referral of GBV survivors for care and treatment have proven to be highly effective in the prevention of violence and HIV/AIDS. More GVB cases in both OVC and adults are being identified and served as an entry point to detect more HIV new cases. Because of the integration, we can also prevent GBV cases in the future by implementing IMpower and SINOVUYO in the prevention curriculum.

It uses other platforms such as VSLA, support groups, and gender dialog sessions to prevent HIV

and GBV at a low cost. We were able to help clients know their HIV status and manage them accordingly, and create public awareness about GBV in order to prevent or reduce new cases.

All clients who were tested for HIV were screened for intimate partner violence, and those who were enrolled in community care and support activities were routinely assessed and screened for gender-based violence, ensuring service quality as well as service integration.

Finally, another benefit of program integration is case conferencing for GBV. In the presence of all interested parties, a GBV single case is brought up and discussed. After 45 days of the initial meeting, another round will be held until the case is resolved.

3) Effectiveness of the program integration in terms of ES activities in FY21 and FY22.

34 responses recorded

Similar to GBV, the integration of HIV and OVC services allowed the services to recruit clients from both OVC and HIV services for ES services. Because of the program integration, we can easily identify destitute, struggling, and ready-to-grow beneficiaries in order to provide need-based services based on HHEVA findings. Clients from both programs will be assessed and included based on their household vulnerability assessment results, making the program effective in providing services to targeted OVC families and PLHIV clients.

During FY21 and 22, successfully formed and followed up on the VSLA group in both HIV service and OVC integration. Monitoring and evaluating during home visits, as well as a monthly savings performance report

Since the goal of the FFHPCT program is to contribute to HIV epidemic control, and ES is the foundation for health education on ART, achieving 2nd 95 by empowering CALHIV and Adults PLHIV to become resilient is the program's goal. The ES activities (VSLA) platform is used for a variety of community-based HIV and OVC service and demand creation activities.

Beneficiaries recruited from health facilities share their experiences of positive living and adherence, and they may not be as economically vulnerable when compared to others.

4) Benefits of OVC and HIV service integration in terms of efficient resource utilization

28 responses recorded

The two programs OVC and HIV it is distinct and it is also complementary in addressing the same population in terms of achieving the three 95. It is utilized efficiently in terms of strengthening the internal referral system in the same organization instead of different ones and complementing available platforms in both programs for one another. The resource is efficiently used by integrating OVC and HIV services, and CEFs and SSWs are exchanging information about their clients. Clients received comprehensive service that was tailored to their specific needs and was easily addressed despite limited resources. LIPs reduced duplication of effort due to program integration.

We were able to deliver/integrate health services with social services as a result of program integrations, which reduced human resources and

related costs. It creates a resource-effective budget by linking services they want; for example, if there are health-related needs, SSWs will connect clients with CEFs, and if there is a social need, CEFs will connect clients with SSWs.

Both programs can be streamlined, and double efforts will be identified and avoided for the sake of efficiency.

Because integrated programs share human resources, facilities, and infrastructures, they save money on administrative costs.

Many services that were previously referred to HFs or other service-providing areas are now provided in an integrated manner, and beneficiaries are also receiving integrated services. As a result, this directly implies using resources effectively and efficiently.

5) Challenges and learning in human resource management

a) Ensuring keeping confidentiality through the Signed document

b) Build capacity /provide training, mentor-ship, Guidance, and supportive supervision

c) Support in coordination, partnership

28 responses

There are various problems that occur at the grassroots level, but they are addressed by ongoing capacity building through training, mentorship, or guidance.

The presence of different interest groups, particularly TA partners, working separately to achieve their targets and provide training, mentorship, guidance, and supportive supervision is a major challenge to integrating the two programs at the site level. It also focuses only on facility and community coordination and lost community and community collaboration to ensure the sustainability of FFHPCT.

Using the same volunteers for both programs that are not yet integrated with clear direction from the higher level. (Due to the different Volunteer Client ratio) Capacity building should be managed separately by two distinct professionals (CEF/health background Bachler degree and above/ and SSW/social background grade 10 and above). The support and coordination from TA partners have not yet been integrated; instead, it is proceeding as if it were two separate programs.

Every intervention requires specialized training. Budget constraints are an ongoing challenge in delivering basic training. - The guidance is changed on a regular basis, resulting in a complete change of tools. - Because the project requires the participation of multiple stakeholders, coordination requires maximum effort.

Joint supportive supervision needs attention to be integrated. The OVC team, CHCT team, and TA partners each create their own checklists and schedule, causing the implementing sites to spend more time in the field and overstretched. Typically, Specialists and CEFs spent a significant amount of time accommodating supervision.

Preparing standard agreement documents is difficult, but once completed, the terms and conditions will be mandatory, binding all parties to the mandatory implementation of the activities listed, and all benefits and risks will be shared among all parties in accordance with the agreements.

This program is centered on confidentiality. Clients sometimes refuse to sign because they are concerned about the protection of their confidentiality.

6) Impacts of program integration on the OVC budget

23 responses

The respondents in this case have differing viewpoints. When the majority of respondents say No, more of the respondents expressed their thoughts differently Let's go through each idea one by one.

1) No, this has no impact on OVC services because the program is designed to deliver services based on the needs of the HH through a referral system and resource mobilization, so the budget will not be impacted. When we look at human resources, each has its own contribution to the OVC program, and most of the program activities that require budget are in the OVC program, such as prevention, ES, and OVC comprehensive services. Additionally, most of the client's needs should be covered through resource mobilization without compromising service.

   This assists in running coordinated activities with a limited budget. In general, program integration has a tremendous effect on OVC in terms of providing integrated services, ensuring HIV cascade and regular follow-up, effective health service referrals, and improved outcomes.

On the contrary, the majority of the respondents' ideas have been summarized as follows.

2) Despite the importance of program integration, almost all did not follow the 70/30 OVC/HIV cost principle established by USAID. The HIV service consumes the majority of the budget, including costs for training, human resources, and salary payment rates. Health professionals are paid more than social services workers. Furthermore, the human power to beneficiary ratio exceeds the standards for some LIPs, implying
   that the

   OVC/client vs CW ratio, CW vs SSWs ratio, and assigning technical expertise/supervisors are not based on the case management SOP.

7) Degree of satisfaction with the program integration in each of the following areas between FY'21 and FY'22 on a five-point scale ranging from "Very Dissatisfied" to "Very Satisfied"?

7.1 Sharing updated SOPs/Guides

As it is depicted in the figure below(figure1) the team has benefitted or satisfied with the updated SOP sharing among themselves. 38 respondents have rated their level of satisfaction through the shared google form. Accordingly, 42% of the respondents are satisfied and 34% are very satisfied.

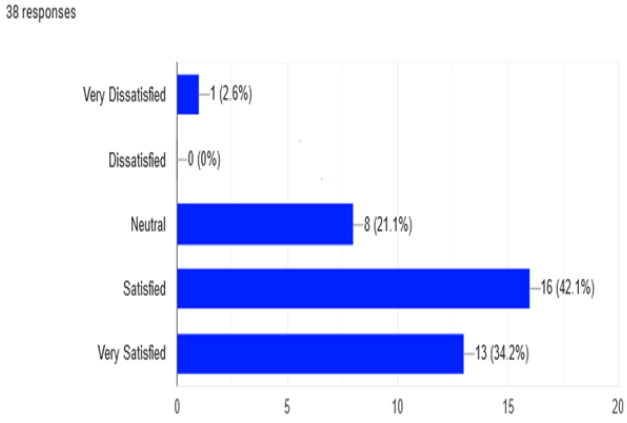


Figure 1Sharing updated SOPs/Guides

7.2 Viral load monitoring and suppression

Here again, depicted in the figure below(figure2) the team has benefitted or been satisfied with the viral load monitoring and suppression. 37 respondents have rated their level of satisfaction through the shared google form.

Accordingly, 54% of the respondents are satisfied and 35% are very satisfied

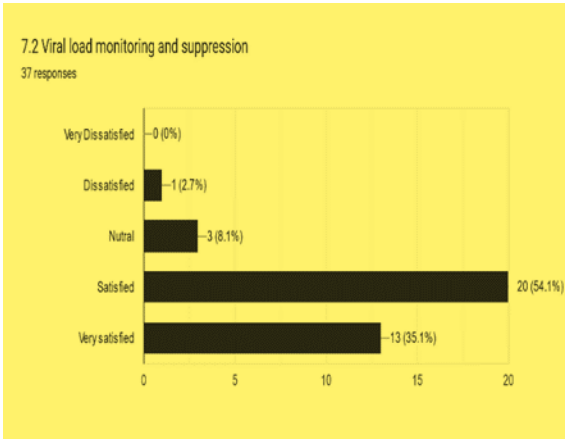


Figure 2 Viral load monitoring and suppression

7.3 HIV Case Identification (ICT and pediatric)

The figure below(figure2) the team has benefitted or is satisfied with the viral load monitoring and suppression. 37 respondents have rated their level of satisfaction through the shared google form.

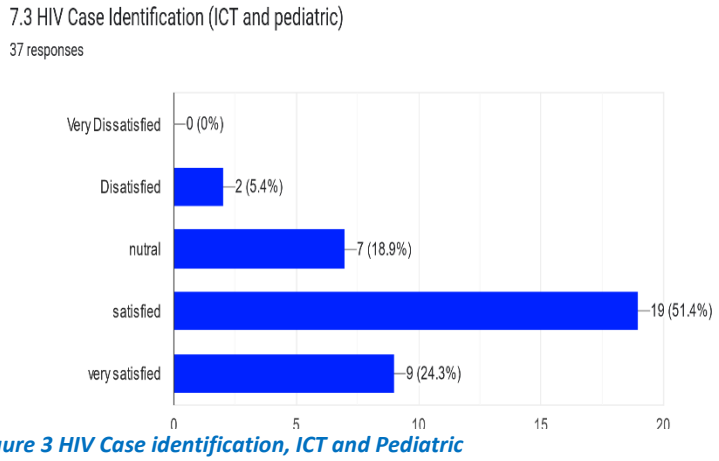


Figure 3 HIV Case identification, ICT and Pediatric

7.4 IIT Tracing and C- EAC adherence support

Here the respondents have requested to react whether they are satisfied with IIT Tracing and C- EAC adherence support. Accordingly, the responses of 37 participants have been summarized in the figure below.

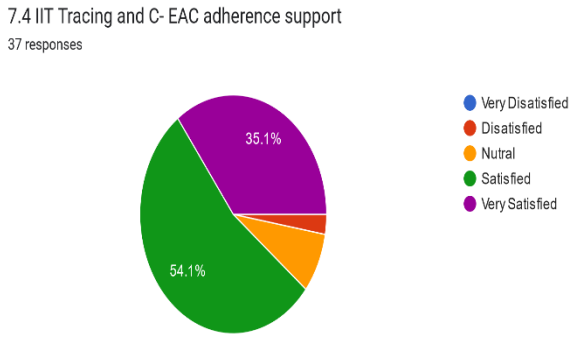


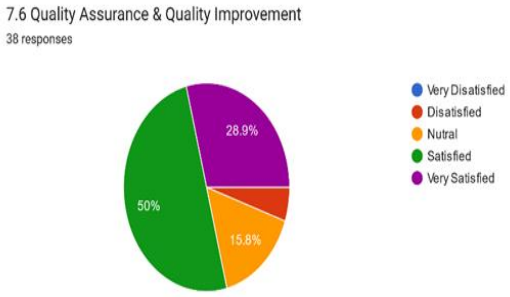
Figure 4 IIT tracing and C-EAC adherence Support

7.5 Bi-directional referral among CEF and SSW or CRP and CW

Here the respondents have requested to react whether they are satisfied with IIT Tracing and C- EAC adherence support. Accordingly, the responses of 37 participants have been summarized in the figure below

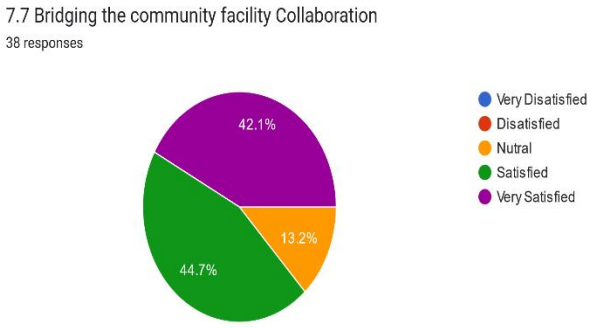
7.6 Quality Assurance & Quality Improvement

Here the respondents have requested to react whether they are satisfied with QI. Accordingly, the responses of 38 participants have been summarized as follows



7.7 Bidirectional and Facility community collaboration

Here the respondents have requested to react to whether they are satisfied with Bidirectional and Facility community collaboration when done in integrated ways. Accordingly, the responses of 38 participants have been summarized as follows



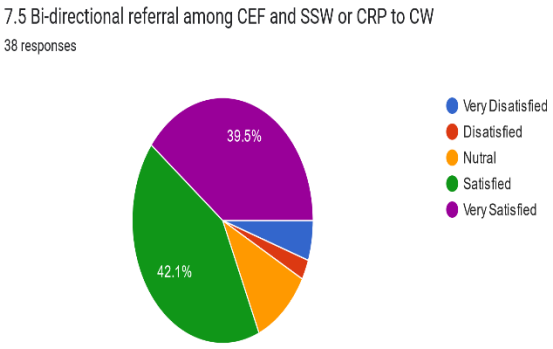


Figure 4 Bidirectional and facility-community collaboration

8) Degree of Challenges and advantages of facility-community participation and partnership in the program integration

8.1 Facilities -Sub Cities-AARHB-HAPCO collaboration

Here the respondents requested to react on whether they are satisfied with the Facilities -Sub Cities-AARHB-HAPCO collaboration. Accordingly, the responses of 38 participants have been summarized as follows

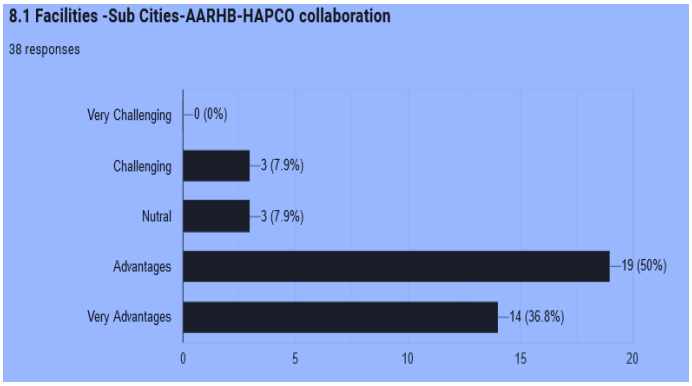


Figure 2Facilities -Sub Cities-AARHB-HAPCO collaboration

8.2 MOU & agreement signing, project launching, and joint planning

Here the respondents requested to react on whether it is challenging to sign agreements with the concerned bodies. Accordingly, the responses of 38 participants have been summarized as follows

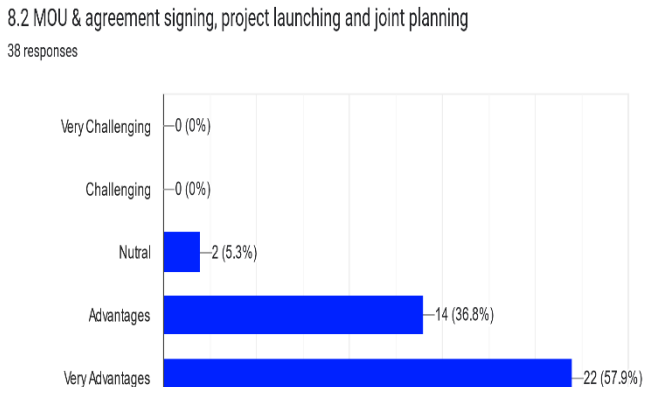
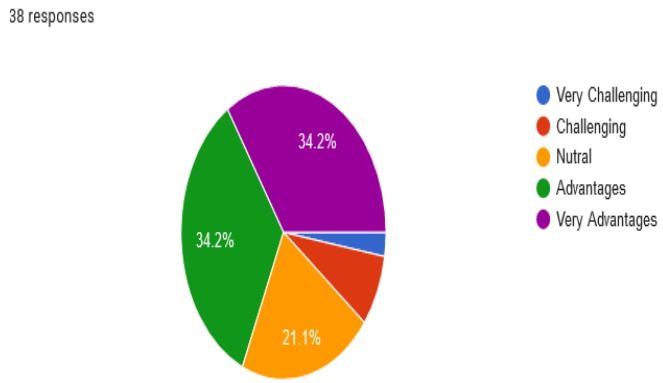


Figure 3 MOU & agreement signing, project launching and joint planning

8.3 Attending and facilitating RM, Catchment area meetings, MDT meetings, OTA (ROTA), QIT meetings, and Case conferencing

Finally, the respondents requested to react attending formal and informal meetings easily and deliver pertinent messages during the session. Accordingly, the responses of 38 participants have been summarized as follows



Recommendation to Action

The team is confident that the new case management system/program management will result in a swift resolution of the case.

In addition, the MENA_FFHPCTs team will develop an action plan to effectively implement the program integrations

Though it is not yet well strengthened (the HR) the same CHW (CEF, SSW, Volunteers) conduct the household visit for different OVC and HIV services such as conducting need assessment, HHVA, and screening. Hence, we recommend finding doable strategies to revise the organogram

To respect the client's rights, all SDPs should have adequate space, and a lockable cabinet and technical experts should sign a confidentiality agreement. The majority of subgrantees' technical experts lack mentorship/coaching skills when conducting supportive supervision.

Favoring continued coaching and mentorship over the formal training for both CEF and SSW

To ensure confidentiality every staff needs to sign confidentiality pledges.

Strong coordination and collaboration with the stakeholders