MEETING TARGETS AND MAINTAINING THE EPIDEMIC CONTROL (ECCC) PROJECT

COOPERATIVE AGREEMENT NO. 7200AA19CA00002

SEMI-ANNUAL PROGRESS REPORT

APRIL,2026 TO JUNE 30, 2026

SUBMITTED BY: ORGANIZATION FOR SOCIAL SERVICES HEALTH AND DEVELOPMENT(OSSHD)

UNITED STATES of AMERICA

EpiC Meeting Targets and Maintaining Epidemic Control

ACTIVITY INFORMATION

Project Title	EpiC Project-Ethiopia/OVC
Project Location	Four Zones: eight SNUs; Adwa, Axum, Adigrat, Wukro, Ayder, Semen, Quiha, and Shire Endeselassie.
Funding Agency	PEPFAR/US Department of State (DoS) through FHI 360 as a prime and PSI as a consortium partner
Budget	$69,000
Sub-Partner	Organization for Social Services, Health and Development (OSSHD)
Work plan Health Area Focus	OVC
Target Populations / Prioritized Populations	Orphans and Vulnerable Children (OVC)
Project Goal	Improve HIV prevention and treatment outcomes among vulnerable children and adolescents, and mitigate the impact of HIV on children, households, and communities in Ethiopia
Project Start Date	01 April, 2026
Project End Date	30 June, 2026
Reporting date	01 April, 2026 to June 30 2026

LIST OF ACRONYMS

ART	Antiretroviral Treatment
CG	Caregiver
CALHIV	Children live with HIV
CCC	Community Care Coalition
DoS	U.S. Department of State
EpiC	Meeting Targets and Maintaining Epidemic Control
EID	Early Infant Diagnosis
HEI	HIV Exposed Infants
HIV	Human Immunodeficiency
MMD	Multi-Month Dispensing
MOU	Memorandum of Understanding
NGO	non-governmental organizations
OVC	Orphan and vulnerable children
OSSHD	Organization for Social Services, Health, and Development
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SNU	Sub-national unit
TX_CURR	Current on treatment
VL	Viral load

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EXECUTIVE SUMMARY

Tigray, once a model in the fight against HIV, had a prevalence of 1.4% (Adult 15+ 1.02%,15-24 age group 0.43%). However, this progress was reversed by war and siege, which devastated the health system and disrupted care for people living with HIV. A study conducted by the Health Bureau between May and September 2024, in collaboration with the Tigray Health Institute and Mekelle University, with support from UNFPA, shows the HIV prevalence stands at 3%, more than double the prewar rate, with even higher rates among displaced people (5.5%) and sexual violence survivors (8.6%). Following a stop-work order in January 2025 and a Foreign Assistance Review by the U.S. Department of State (DoS), the EpiC project was authorized on March 5, 2025, to resume limited lifesaving HIV interventions in Ethiopia under a waiver from the DoS Office of Global Health Security and Diplomacy (GHSD).In response, the Meeting Targets and Maintaining Epidemic Control (EpiC) project, funded by PEPFAR and the U.S. Department of State and implemented by FHI 360 in partnership with PSI, supported targeted interventions across eight high HIV burden areas in Tigray. Within this framework, OSSHD implemented OVC intervention focused on restoring critical HIV services, strengthening OVC case management, and improving referral systems since October,2025.

This narrative report outlines OSSHD's activities for April 1– June 30, 2026, in the Tigray region to restart critical services, sustain support for people living with HIV (PLHIV), strengthen OVC case management, and improve the continuum of care through increased access to high-quality, developmentally appropriate, HIV-inclusive case management (CM) to OVC.

The program achieved strong results in reaching and supporting vulnerable children and families. A total of 7072 beneficiaries were served through OVC programs, exceeding the target (110.5%), demonstrating effective identification and enrollment of vulnerable households reflecting strong case management and monitoring systems. Functional bidirectional referral systems were strengthened, establishing effective linkages with service providers and improving access to health, protection, and social services.

The program also strengthened linkages between OVC and clinical HIV services. Among HIV-positive children and adolescents on antiretroviral therapy (ART), 1165(100%) were

successfully enrolled in the OVC comprehensive program after being offered services. Viral load cascade performance among OVC on ART was strong, with 1107 CALHIV (95%) accessing viral load testing, 1107(100%) were tested for viral load, 1082 (97.7%) of them had documented viral load results, and 1047 CALHIV (96.8%) achieved viral suppression, indicating effective adherence support and continuity of care. In addition,3865(95.4%) of the total OVC_TEST_report target were referred for HIV testing and accessed HIV testing services, and 78(96.3%) of the total target tested Positive.

Overall, the project demonstrates that targeted OVC interventions can effectively save lives and mitigate the impact on vulnerable children and families by restoring access to essential services, strengthening household resilience, and improving HIV-related outcomes. Sustained and expanded investment in OVC programming will be critical to protect these gains and ensure long-term well-being for children and adolescents living with HIV in Tigray.

I. Key Results of EPiC/OVC lifesaving Project (April 01-june,30,2026)

A.HIV

Project Goal: Improve HIV prevention and treatment outcomes among vulnerable children and adolescents, and mitigate the impact of HIV on children, households, and communities in Ethiopia

Project Objective: Improve the continuum of care through increased access to high-quality, developmentally appropriate, HIV-inclusive case management (CM) for OVC.

During the reporting period, April 01, 2026, to June 30, 2026, the OVC program achieved significant progress towards its goals. Key activities are listed below:

Table 1: Summary of key achievements

Indicators	Annual Target	Achievement	
		Performance	% Ach't
OVC_SERV	6964	7,072	101.55%
OVC_HIVSTAT	4593	4,643	101.1%
OVC_TEST_REPORT	4050	3865	95.4%
OVC_TST_POS by referral	81	78	96.3%
OVC_ENROL	1160	1165	100.4%
OVC_VL_ELIGIBLE	1096	1107	95.0%
OVC_VL_TESTED by referral	1107	1107	100%
OVC_VLR	1107	1082	97.7%
OVC_VLS	1082	1047	96.8%

N.B: The EPiC/OVC project serves as a critical bridge between the community and clinical care. While the project does not directly conduct HIV or Viral Load testing, it ensures 100% service coverage through a bidirectional referral system. The OVC Program operates as a community-based lead for HIV care by conducting risk assessments and referring children with unknown statuses to clinical partners for testing. Once a child is referred, the program provides intensive follow-up to ensure successful linkage to Antiretroviral Therapy (ART) and delivers a comprehensive package of support services specifically designed for Children and Adolescents Living with HIV (CALHIV). to monitor viral load and clinical progress, the program actively participates in routine joint data reviews, triangulation, and case conferencing with health facilities to ensure all beneficiary and family needs are met.

PEPFAR mandates OVC programs to support CALHIV in achieving viral load suppression (VLS), prioritizing subpopulations of CALHIV at high-risk, including: Newly initiated on treatment, those with high viral loads, and those with a history of discontinuing treatment. Children face the risk of poor adult treatment retention and viral suppression rates.

Based on the PEPFAR COP guidance, the OVC program and clinical partners must collaborate to support the well-being and goals of CALHIV and their families, toward contributing to reducing the pediatric and adolescent treatment gap.

The reportable indicators under the OVC program, as per PEPFAR MER guidance, are those to which the program has made direct, unique contributions.

- **Service Linkage:** Provide (family-centered) differentiated service packages tailored to CALHIV and their households **7072 (4589 OVC and 2375 caregivers), i.e., 110.5% of the annual target.** This includes **1165** children and adolescents living with HIV 0-20 years.

- **Coordinated Collaboration:** Close cooperation between EPiC/OVC and health facilities, HIV clinical partners, at-risk projects, the Global Fund KP project, ART focal persons, case managers, health extension workers, and IDP leaders improved case finding and ensured effective implementation.
- A total of **3,865 (95.4%)** of the targeted individuals at risk of HIV were identified. Those requiring HIV testing were screened and referred to appropriate health services. Of those tested, **78 were newly identified as HIV-positive** and linked to appropriate HIV care and treatment services. A follow-up was conducted to ensure service uptake and continuity of care.
- A mapping of stakeholders and an orientation session were conducted. aimed to strengthen collaboration, clarify roles and responsibilities, provide an overview of the EPIC/OVC lifesaving component, and identify opportunities to enhance service delivery for OVC.
- **95** CALHIV with high viral load and CALHIV with nutritional shortage received family consumption support during the reporting Period.
- A total of ETB 1,486,900 in cash and in-kind support was mobilized and provided to vulnerable children and caregivers during the reporting period.
- Link unsuppressed CALHIV households to food support, & provide Family consumption support, and offer ART home-based adherence counseling (using FHI 360 guides for CALHIV) for those disclosed.
- Linkage to peer group psychosocial support and cover the refreshment cost during the peer-to-peer sessions
- Support children to attend their HF appointments
- Promote VL testing during home visits

- Track CALHIV VL test appointments and provide reminders
- Family-centered OVC case management
- Monthly review meeting was conducted with 174 Community Care Coalition (CCC) members to strengthen the CCC, and OSSHD supported stationery materials for 58 CCCs.
- A case conference meeting with the ART focal, case managers, linkage coordinators, and social service workers was conducted in all 23 health facilities

1. Accomplishments and successes for the EpiC /OVC component Project

1.1. Activity 1: Case management

Needs assessment and case plans: Under the technical leadership of Care and Support Officers and Social Service Workers, case workers conducted standardized household needs assessments in accordance with the approved assessment SOP to systematically identify priority needs of 4653 children and 2419 caregivers, with a focused emphasis on health, HIV care, treatment, and linkage/referral gaps. For each case-managed OVC beneficiary, a comprehensive household case plan was developed in line with the case plan development SOP. Case workers applied a standardized client-level data collection and management system, including quarterly follow-up tools, to routinely track individual progress against established case plan goals. Through regular household engagements, case workers confirmed service uptake following referrals, assessed caregiver and beneficiary satisfaction with services received, documented improvements in household circumstances, and evaluated achievement of case plan objectives, thereby ensuring responsive case management, accountability, and continuous quality improvement across the service delivery continuum.

During the reporting period, the EPiC/OVC lifesaving project program successfully reached 4653(101.3%) OVCs and 2419(102%) caregivers who completed both health facility and community-based identification forms, and received one or more PEPFAR-eligible services during the reporting period. This achievement was made possible through the close collaboration of the EPiC/OVC lifesaving team with HIV clinical partners, ART focal persons, and clinical case managers in health facilities across all OSSHD target SNUs.

Table 2: OVC received one or more PEPFAR OVC eligible services, April 01-june,30,2026

SNU	OVC_ Comprehensive (<18+>18)			OVC-SERV<18 & 18-20y.o			18+ caregivers		
	Target	Per.	% Ach't	Target	Per.	% Ach't	Target	Per.	% Ach't
Adwa	804	815	101.4%	536	545	101.7 %	268	270	100.7 %
Axum	496	498	100%	329	329	100%	167	169	101%
Adigrat	798	822	103%	519	528	102%	279	294	105%
Wukro	243	252	104%	154	159	103%	89	93	104%
Ayder	403	405	100%	266	266	100%	137	139	101%
Semen	2869	2906	101%	1903	1929	101%	966	977	101%
Quiha	470	473	101%	315	317	101%	155	156	101%
Shire Endesellassie	881	901	102%	571	580	102%	310	321	104%
Total	**6964**	**7,072**	**101.6%**	**4,593**	**4,653**	**101.3 %**	**2,371**	**2419**	**102 %**

N.B. The reason for Over Achievement is enrollment of HIV-positive children and their caregivers, and inclusion of newborn OVCs and exposed infants whose families were already enrolled in the program.

During the reporting period (April–June 2026), OSSHD facilitated referral linkages that enabled **4,653 OVCs** and **2,418 caregivers** to receive a comprehensive package of socioeconomic support. Services included cash assistance, economic empowerment interventions, healthcare services, psychosocial support, vocational skills training, food and nutrition support, and other essential services. These supports were provided through partnerships with CCC, PAD Project, Mesfin Industrial Engineering, Kalehiwot Church, Mulu Wengel Church, Abune Aregawi Church, SOS Hermann Gmeiner, Don Bosco, Amen Clinic, Meserete Christos Church, Elshaday Rehabilitation Center, Wengelawuyan Church, Fana Detergent, Amanuel Park, community structures, and other private organizations.

Through these referral linkages, a total of **ETB 1,486,900** in cash and in-kind support was mobilized and provided to vulnerable children and caregivers during the reporting period

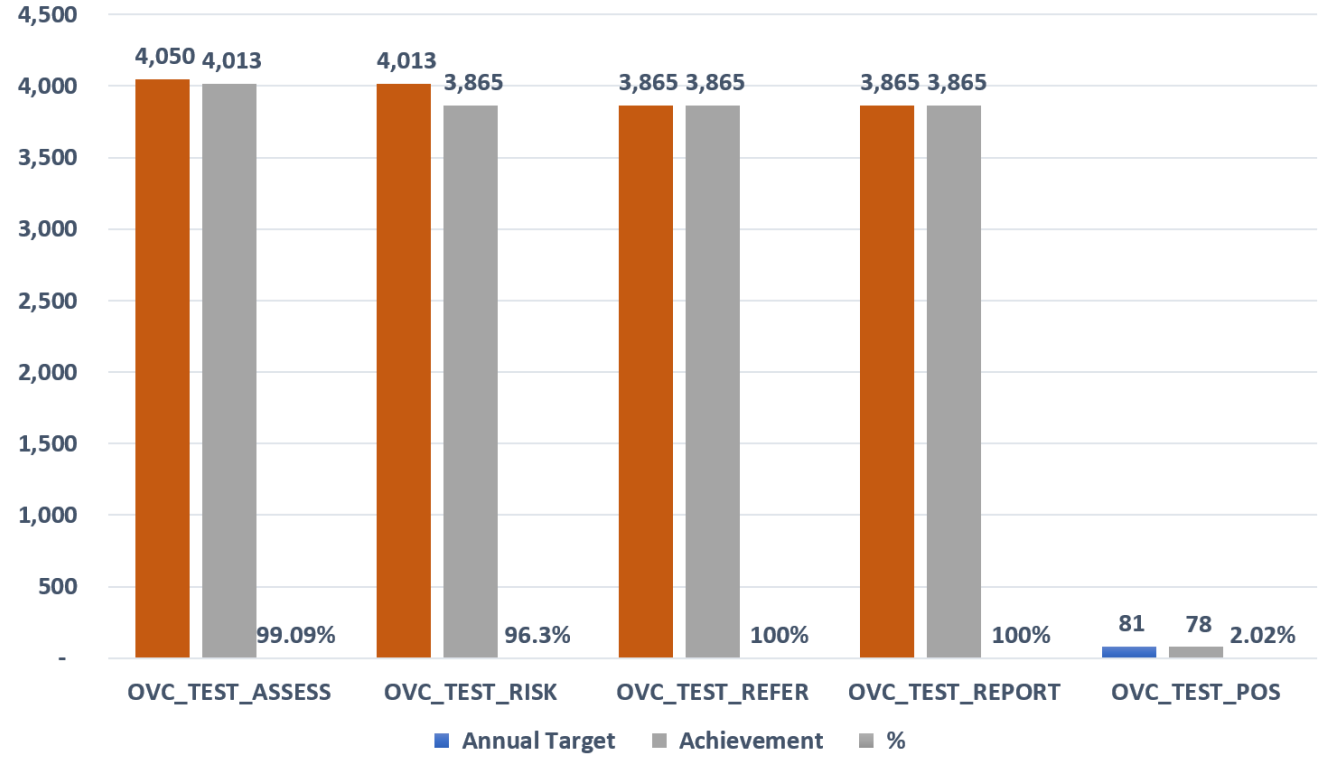
1.2. Activity:2 HIV case finding

Screen OVC with unknown HIV status: starting (Oct 1, 2025, to June 30, 2026) OSSHD, in collaboration with the health facilities, operationalized systematic HIV risk screening for orphans and vulnerable children (OVC) and adolescents with unknown HIV status using FHI 360's standardized HIV risk screening tool. A total of 4013 OVC with unknown HIV status were assessed, of whom 3865 were identified as at risk and referred for HIV testing services (HTS) to health facilities. This represents 95.4% progress toward the annual target of 4050 OVC.

Table 3: Case finding performance per SNU

SNU	OVC with unknown status screened	OVC_TST_ASSESS	OVC_TST_RISK	OVC_TST_REFER	OVC_TST_REPORT	OVC_TST_NEG	OVC_TST_POS	Positivity Rate
Adwa	715	715	697	697	697	679	18	2.6%
Axum	601	601	583	583	583	572	11	1.9%
Adigrat	424	424	406	406	406	403	3	0.7%
Wukro	171	171	153	153	153	147	6	3.9%
Ayder	267	267	249	249	249	242	7	2.8%
Semen	875	875	853	853	853	840	13	1.5%
Quiha	262	262	244	244	244	242	2	0.8%
Shire Endesellassie	698	698	680	680	680	662	18	2.6%
Total	**4013**	**4013**	**3865**	**3865**	**3865**	**3787**	**78**	**2.02%**

Figure 1: HIV testing Cascade



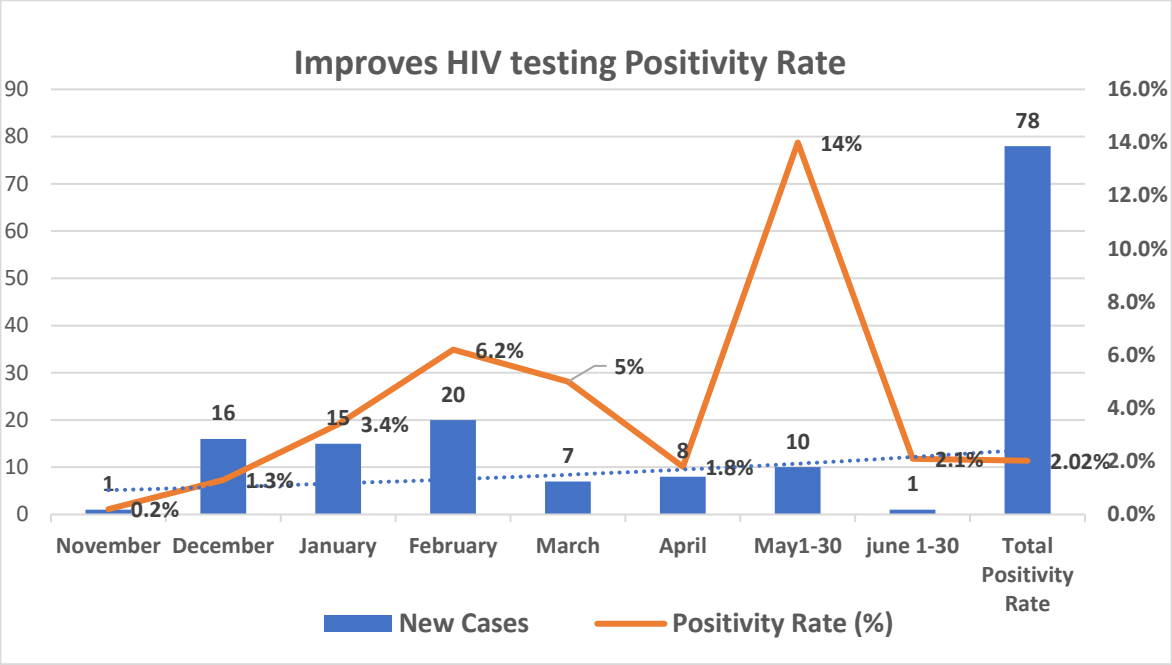
Following referral, linkage coordinators (LCs) and social service workers (SSWs) executed a structured follow-up to ensure the timely completion of HTS and confirm test results. As a result of these efforts, 78 OVC were referred to health facilities for HIV testing and newly identified as HIV-positive, i.e., 96.3%.

In line with PEPFAR COP20 Guidance, OSSHD continues to prioritize closing the pediatric treatment gap by scaling up index testing as a core, high-yield case-finding strategy. This approach is being implemented through tight integration between clinical and OVC platforms, operating as multidisciplinary, results-driven teams

- Systematically assessing all beneficiaries for HIV testing needs using approved HIV risk screening tools
- Assessing caregivers living with HIV who have children for potential OVC program enrollment in supported SNUs
- Prioritizing the highest-risk groups, i.e., biological children of index cases and sexually active adolescents
- Supporting the identification of children of HIV-positive individuals who have not been tested, in close collaboration with clinical teams, and ensuring immediate linkage to treatment for those diagnosed
- Adapting and operationalizing standard operating procedures (SOPs) to strengthen safe, ethical, and effective index testing across OVC and clinical service delivery points.
- Accelerated Reviewing data of children of index cases in high caseload HFs
- Reached 100% of LTFU clients and linked their biological children and siblings to HTS.
- Organizing Situation Room meetings, case conference meetings for updating the progress and sharing experiences and learning within the SNUs.

As a result, the positivity rate continues to improve. The rate increased from 0.2% during November 1–15 to 2.02 % in June 30, 2026.

Figure 2: Improving the positivity rate of HIV among Children/Adolescents <20



1.2.1. Share of Risk Factors for Newly Diagnosed HIV+ Children/Adolescents

Table 4: HIV Testing Positivity for Children/Adolescents by Risk Factor

Risk Factor	Total Tested	#of HIV +ve (new)	Positivity Rate (%)
HIV Exposed Infants (HEI) <2y.o	173	9	5.20%
Biological children of PLHIV with unknown HIV status	1851	32	1.73%
Children experienced sexual violence	3	3	100%
Children of at-risk individuals	579	6	1%
Children in IDP settings	280	4	1.4%
Sexually active adolescents	859	21	2.4%
Children of Difficult-to-Find PLHIV	120	3	2.5%
Total referred &tested	3865	78	2.02%

A total of 3,865 children were referred and tested for HIV, resulting in 78 newly identified HIV-positive cases. Among the priority populations, biological children of PLHIV with unknown HIV status accounted for the largest testing volume, with 1,851 children referred and tested, yielding 32 new HIV-positive cases (positivity rate: 1.73%). Sexually active adolescents were the second-largest group, with 859 referred and tested, identifying 21 new HIV-positive cases (2.4%).

Identify biological children of index cases with unknown HIV status: During the reporting period, OSSHD intensified index testing to identify biological children of HIV-positive parents on ART whose HIV status was unknown, implementing this activity in close collaboration with health facilities and facility-based staff. OVC linkage coordinators (LCs) and social service workers (SSWs), working alongside clinical teams, reached out to 1851 index parents to arrange facility-supported index testing for their biological children (<20 years), to achieve 100% testing coverage and ensure immediate enrollment into the comprehensive OVC program for those diagnosed with HIV. With technical support from EpiC, the program strengthened facility–community integration by collaborating with clinical services and at-risk population partners to identify children of HIV-positive parents who had not previously been tested, facilitate testing, and ensure prompt linkage to treatment. Through these coordinated facility and community platforms, the team identified 32 HIV-positive children who had remained undiagnosed, reinforcing index testing as a high-yield, results-driven strategy for closing persistent pediatric HIV case-finding gaps.

Case finding among adolescent children: A total of 859 adolescent girls and boys were reached through these combined platforms, with active referrals, HIV self-testing, and index testing facilitated in accordance with national HIV testing services (HTS) guidelines. 21 **27%** sexually active adolescents tested positive. This integrated community facility approach resulted in the identification of five newly diagnosed HIV-positive adolescents. In addition, case finding among pregnant, breastfeeding, and parenting adolescent girls and young women under 24 years was intensified during the reporting period through a dual strategy of mobile clinical outreach and structured referrals to health facilities, implemented in close collaboration with facility-based staff. As a result, 3 pregnant and breastfeeding adolescent girls tested positive.

***Support EID among HEIs*:** Social support workers (SSWs) and case workers actively support Early Infant Diagnosis (EID) among HIV-exposed infants (HEIs) by monitoring testing schedules and ensuring mothers have access to HIV testing services (HTS). Mother-baby pairs are followed up through home visits or phone calls when in-person visits are not feasible, with SSWs providing reminders for facility-managed cases and caseworkers for community-managed cases. During the reporting period, i.e., (October 1 -June 30, 2026), 173 HEIs have undergone DNA PCR testing at six weeks, and 9 children tested positive.

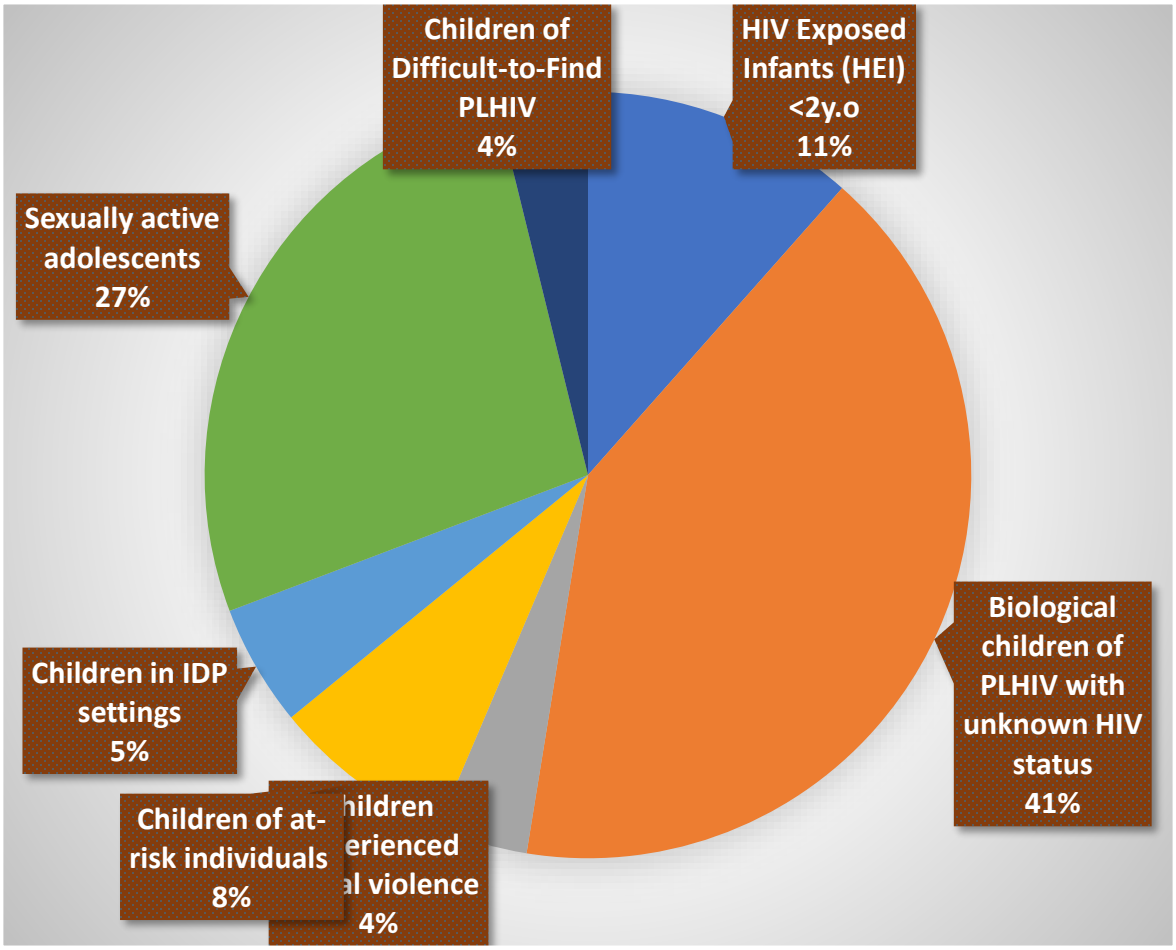
Support HTS among children in Internally Displaced People (IDPs) sites: During the reporting period, OSSHD, in collaboration with IDP site coordinators in all SNUs, tested 280 OVC with unknown HIV status in IDP sites through mobile clinic services and referrals to nearby health facilities. Of these, 4 children were newly identified.

Children experienced sexual violence: during the reporting period, 3 children who experienced sexual violence were referred and tested for HIV, and all three tested HIV positive, resulting in a positivity rate of 100%. Although children who experienced sexual violence had the highest observed positivity rate (100%), this finding was based on only 3 referrals and tests, all of whom tested HIV positive; therefore, this result should be interpreted cautiously due to the small sample size.

Children of at-risk individuals: A total of 579 children of at-risk individuals were referred and tested for HIV. Six children were newly diagnosed with HIV, corresponding to a positivity rate of 1.0%. Although the positivity rate was relatively low, testing this group contributed to the identification of previously undiagnosed HIV infections.

Children of Difficult-to-Find PLHIV: A total of 120 children of difficult-to-locate PLHIV were referred and tested. Three children were newly diagnosed with HIV, yielding a positivity rate of 2.5%. Despite the relatively small number tested, the positivity rate suggests that efforts to trace and test children of difficult-to-locate PLHIV remain an important strategy for identifying undiagnosed HIV infections.

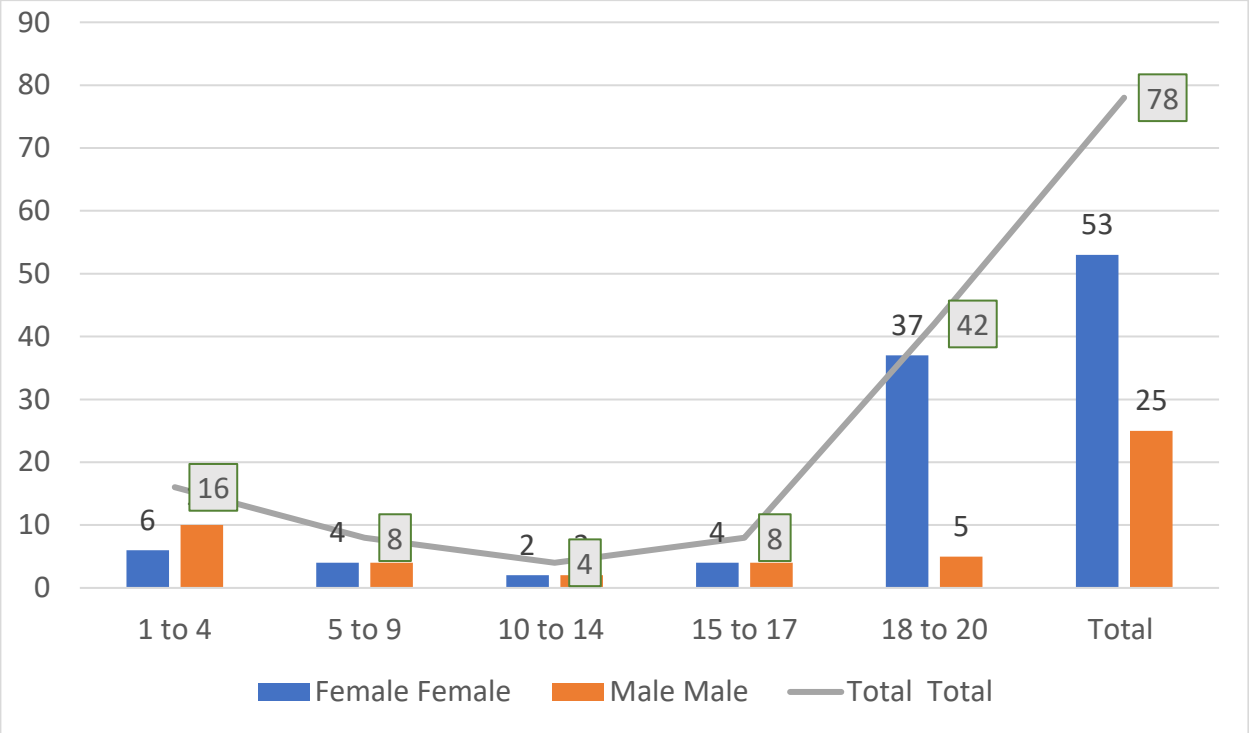
Figure 3: Share of Newly Diagnosed HIV+ Children/Adolescents



A total of 78 new HIV cases were identified, with a significant proportion concentrated among biological children of index cases, who accounted for 41% of all cases. This highlights persistent gaps in index case testing and family-based case finding, suggesting that opportunities to identify and test children within known HIV-positive households are still being missed. Sexually active adolescents represented the second largest group at 27%. Children in internally displaced persons (IDP) settings accounted for 5%, reflecting the increased vulnerability associated with displacement and limited access to health services. Similarly, 8% of cases were among children classified as at-risk individuals, while another 4% were from hard-to-find households of people living with HIV (PLHIV). HIV-exposed infants made up 11% of the cases, suggesting gaps in early infant diagnosis and follow-up within prevention of mother-to-child transmission (PMTCT) programs.

Overall, the data indicate that the highest-risk groups are biological children of index cases and sexually active adolescents, particularly adolescent girls. These findings emphasize the need to strengthen family-based testing strategies, expand adolescent-focused HIV prevention and testing services, and improve integration with sexual and reproductive health programs. Targeted efforts are also required to reach vulnerable populations, such as those in IDP settings and hard-to-reach households, to ensure no groups are left behind in HIV case identification and care.

Figure 4: New HIV case finding through referral by age and sex (October 1-June 30, 2026)



The data consistently shows that there is a high HIV burden among adolescents aged 15–20, accounting for 64.9% of cases, with girls disproportionately affected at 82%, 15.4 % of these are pregnant & breastfeeding. This highlights a disproportionate burden of HIV among adolescent girls. Therefore, strengthening adolescent-focused HIV prevention is imperative, with particular emphasis on the 10–14 age group as a critical window for early intervention to reduce future risk and transmission.

Support uptake of HTS and linkage to ART: During the reporting period,3865 OVC were referred for HIV testing through OSSHD to health facilities, the At-Risk Population Project, and the Global Fund Key Population Project, resulting in 78 newly identified HIV-positive children. OSSHD facilitated the uptake of HIV testing services (HTS) and ensured timely linkage to antiretroviral therapy (ART) by having linkage coordinators and case workers follow up with referred children to confirm completion of testing and enrollment in ART for those testing positive. Children diagnosed through these partner-led testing platforms were escorted or linked to the nearest health facility for same-day initiation of treatment.

1.3. Activity 3: Ensure treatment retention, adherence, and viral load suppression (VLS) for CALHIV

1.3.1. Enroll CALHIV on ART in the OVC program.

OSSHD enrolled 1,165 children and adolescents living with HIV (CALHIV) into the EPiC OVC program, achieving 100.03% of the annual target across eight SNUs and 23 health facilities. During the quarter, CALHIV aged under 20 years who were currently on antiretroviral treatment were enrolled in the EPiC OVC program and received comprehensive services. This performance demonstrates effective linkage of identified HIV-positive children and adolescents to care and support services.

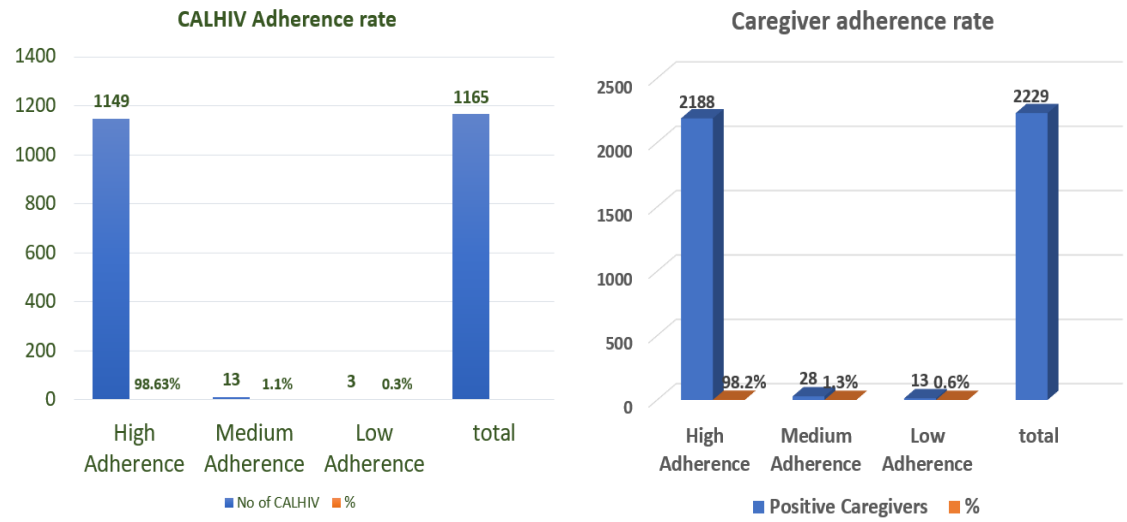
However, during the reporting period, 18 CALHIV exited the OSSHD EPiC OVC program because they relocated outside the OSSHD's operational areas (SNUs).

Table 5: Enrollment of C/ALHIV TX Curr (< 20 years of age) in the OVC program from the target SNUs

Zone	SNUs	#CALHIV target	OVC_ENROLL	Per (%)	CALHIV on ART	Per (%)	Transferred out from outside the OSSHD operating areas
Central Tigray	Adwa	106	98	92%	98	100%	3
Central Tigray	Axum	98	105	107%	105	100%	1
Eastern Tigray	Adigrat	98	114	116%	114	100%	0
Eastern Tigray	Wukro	80	87	109%	87	100%	0
Mekelle Special	Ayder/Mekelle	96	95	99%	95	100%	1
Mekelle Special	Semen/Mekelle	435	371	85%	371	100%	4
Mekelle Special	Quiha	98	78	80%	78	100%	5
Northwestern	Shire Endasilase	151	217	144%	217	100%	4
Total	**OSSHD**	**1,162**	**1,165**	**100.3%**	1,165	100%	**18**

ART adherence monitoring and counseling: OSSHD conducts periodic adherence follow-up every quarter. During the reporting period, health and linkage officers conducted and monitored the adherence of 1165 CALHIV and 2188 caregivers across all the SNUs through the standard adherence monitoring checklist. As a result, 98.63% of OVCs and 98.2 % of caregivers living with HIV demonstrated high adherence. Meanwhile,1.8 % of CALHIV and 1.9% of caregivers showed medium or low adherence. OSSHD provided Home-based adherence counseling, continuous treatment follow-up, and enhanced adherence counseling to the client with low and medium adherence.

Figure 5: Adherence rate of CALHIV and caregivers

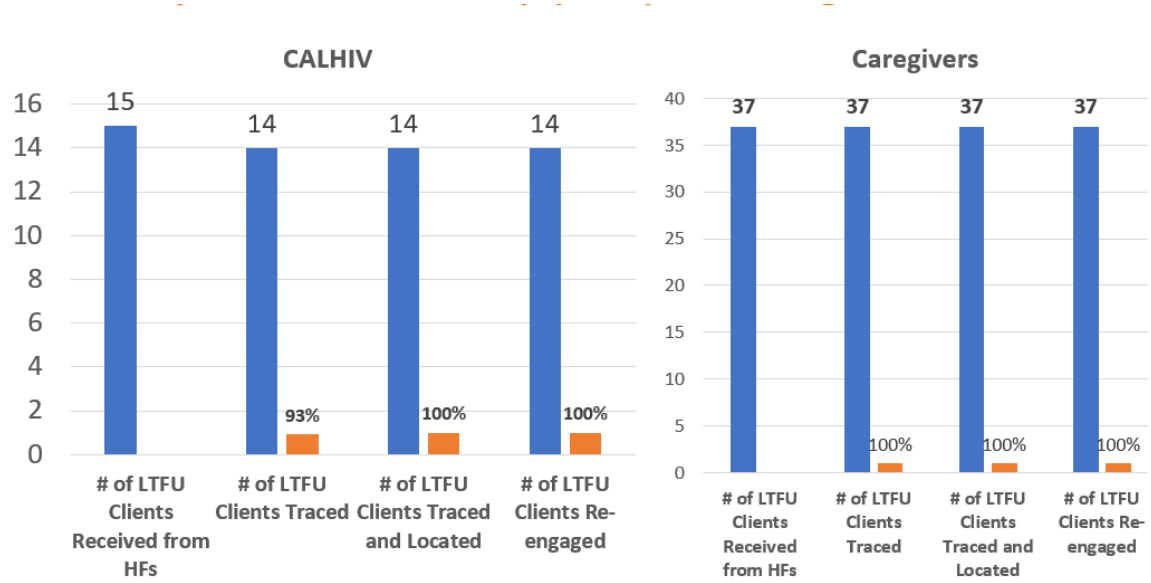


The OVC program provides community-based monitoring visits to CALHIV, utilizing a standardized tool to assess adherence barriers and provide targeted support. As a result, the OVC program identified several factors contributing to medium and low adherence rates, including behavioral barriers to adherence, economic barriers, and cultural beliefs favoring alternative therapies.

To address these challenges, the OSSHD implemented a multi-pronged approach, such as home-based adherence counseling, providing family consumption support, and referral linkage for food and nutrition, and provided age-appropriate adherence counseling, referring cases to health facilities for Enhanced Adherence Counseling (EAC) as needed.

Trace individuals with interruption in treatment: The OSSHD team supported health facilities to trace children, adolescents, and caregivers who experienced interruptions in HIV

treatment using defaulter line lists provided by the facilities. A total of 14 children and adolescents living with HIV (CALHIV) and 37 caregivers living with HIV were identified, traced, and escorted back to their respective health facilities for treatment re-initiation. Tracing activities were extended to internally displaced persons (IDP) camps to ensure coverage of vulnerable populations. In addition to escorting and re-initiating treatment, index case testing was conducted for the children of the treatment defaulter clients, strengthening case finding and continuity of care outcomes.



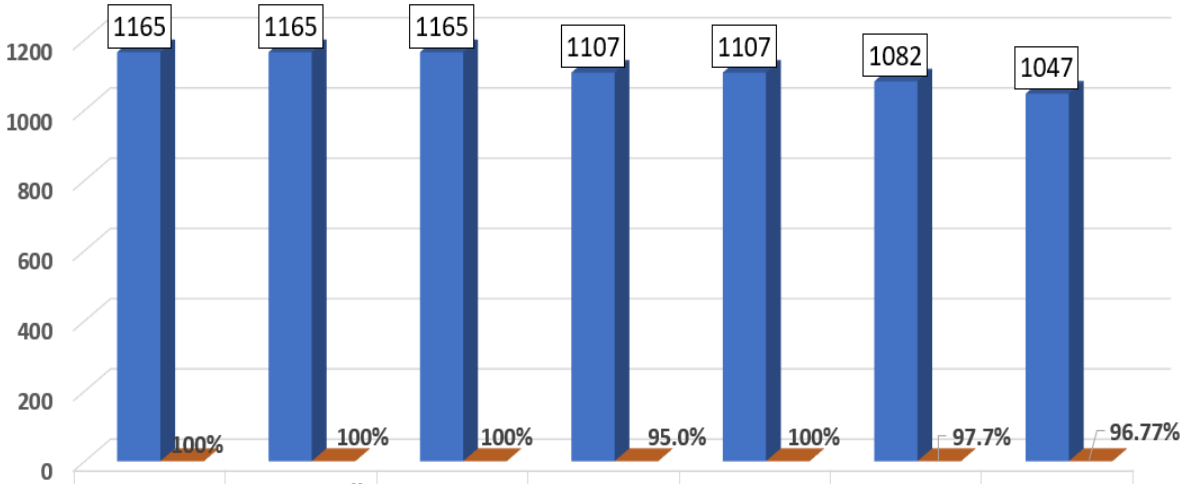
Monitor and support adherence to clinic appointments: A total of 1165 children and adolescents living with HIV (CALHIV) and 2229 caregivers living with HIV were supported by linkage coordinators (LCs) and social service workers (SSWs), in collaboration with health facilities, to monitor and improve adherence to clinic appointments, including ART consultations, ARV refills, and viral load testing. LCs and SSWs maintained appointment tracking systems and provided reminders at least 48 hours in advance through phone calls, text messages, or home visits, with follow-up to verify attendance. Accompaniment to health facilities when caregivers were unable to escort the child, and identification of missed appointments, followed by counseling, referral, and navigation back to health facilities. These interventions strengthened retention in care and continuity of HIV treatment services during the reporting period.

Support referrals for VL testing and tracking of children's VL status: out of 1107 CALHIV, (95%) of the annual target are eligible for viral load testing, and 100% of eligible

CALHIV (1107) were referred for uptake of viral load testing. This demonstrates full compliance with PEPFAR viral load monitoring requirements and effective bidirectional referral with supported health facilities. 1082 (97.7%) CALHIV have documented viral load test results within the previous 12 months, with a viral load suppression rate of 1047(96.77 %)

During the reporting period, 58 CALHIV were not eligible for viral load testing. According to national guidelines, viral load testing is conducted only after a minimum of six months on continuous ART. Therefore, newly diagnosed clients and those who have recently restarted treatment are not yet eligible for viral load testing. OSSHD continued close follow-up and monitoring to ensure timely viral load testing once eligibility and clinical stability were achieved.

Figure 6: Viral load testing Cascade



	TX_curr<20 y.o in fy'26	OVC_Enroll	OVC on ART	OVC_VL_ELIGIBLE	OVC_VLT	OVC_VLR	OVC_VLS
Series1	1165	1165	1165	1107	1107	1082	1047
Series2	100%	100%	100%	95.0%	100%	97.7%	96.77%

Table 6: Viral load testing Coverage cascade by SNU

SNU	OVC_ENROLL	ON ART	OVC_VL_ELIGIBLE	OVC_VL_TESTED	OVC_VLR	OVC_VLS
Adwa	98	84	84	82	79	96.3%
Axum	105	95	95	94	93	98.9%
Adigrat	114	114	114	114	110	96.5%
Wukro	87	82	82	82	80	97.6%
Ayder/Mekele	95	89	89	86	83	96.5%
Semen/Mekele	371	365	365	350	337	96.3%
Quiha	78	75	75	75	71	94.7%
Shire. Endesellassie	217	203	203	199	194	97.5%
Total	1165	1107	1107	1082	1047	96.77%

During the implementation period, viral load suppression improved from 93.1% in the first quarter, i.e., October, to 96.7% through the application of targeted and client-centered strategies. Linkage coordinators, social service workers, and case workers worked closely with health facility case managers to identify children and adolescents living with HIV (CALHIV) who had high viral load results and to assess the underlying causes contributing to poor suppression. Based on these assessments, a range of tailored interventions was implemented for those identified with high viral load.

Barrier identification and analysis were conducted among children and adolescents living with HIV (CALHIV) with high viral load to identify previously missed barriers and correct inaccurate barrier assessments.

Key barriers identified included:

- **Poor adherence to antiretroviral therapy (ART):** 25 of 45 CALHIV (58.1%), making it the most frequently identified barrier.
- **Socioeconomic challenges:** 18 of 45 CALHIV (41.9%), including poor household economic status and financial constraints.

- **Treatment-related barriers:** 17 of 45 CALHIV (39.6%), including pill burden, nausea, and vomiting. These barriers were predominantly reported among children under five years of age, suggesting that treatment tolerability affected adherence.
- **Psychological barriers:** 8 of 45CALHIV (18.6%), including stress, anxiety, depression, other psychological problems, and age-related challenges.
- **Lack of family follow-up and support:** 5 of 43 CALHIV (11.6%).
- **Access-related barriers:** 3 of 45 CALHIV (7.0%), including long distances to health facilities and residence in internally displaced persons (IDP) settings.

Note: Multiple barriers could occur in the same individual; therefore, percentages do not total 100%.

Based on the barrier analysis, a situation room meeting was conducted, and a detailed action plan was designed together with the Linkage coordinators, social service workers, case workers, and the project manager as well. As a result, the following interventions were implemented for the CALHIV with high viral load

These interventions included intensive home-based adherence counseling, complemented by facility-based and enhanced adherence counseling (EAC) for clients requiring closer follow-up. Regular daily treatment monitoring and dose reminders were provided through home-based adherence follow-up visits and phone calls to ensure consistent medication adherence. In addition, clients received counseling on the risks of ART interruption and ongoing adherence education to reinforce treatment importance.

Psychosocial support was strengthened through peer-to-peer support sessions, disclosure-readiness counseling, and mental health and psychosocial support (MHPSS) services. Clients were also linked to trained professionals, including MHPSS-trained nurses and psychiatric outpatient services, where necessary. Caregivers were engaged through parental skills training and counseling, improving their capacity to support adherence and overall well-being.

To address socioeconomic barriers, clients and their families were provided with family consumption support, nutritional assistance, and food support from community and partner organizations. Additionally, cash support and resource mobilization efforts were implemented to reduce financial challenges that could hinder treatment adherence.

Furthermore, strong referral and linkage systems were utilized to connect clients to Comprehensive Care Centers (CCC), health facilities for additional medical support, and social support programs, including life skills training opportunities. These combined interventions ensured a holistic approach, addressing medical, psychosocial, and economic factors contributing to improved viral load suppression outcomes.

Targeted referrals were also made for C/ALHIV with high viral loads to address specific barriers to treatment adherence and overall well-being. Four C/ALHIV were linked to Don Bosco and Kalehiwot Church to receive ongoing food support aimed at improving nutritional status and strengthening adherence to antiretroviral therapy. Two C/ALHIV with high viral loads and a history of substance use were referred to Elshaday Rehabilitation Center for rehabilitation services and vocational skills training to support recovery and socioeconomic reintegration. One C/ALHIV was linked to Yayne Beauty Salon for vocational skills training to improve employability and promote long-term economic self-reliance. Additionally, two C/ALHIV experiencing caregiver-related protection challenges were referred to SOS Hermann Gmeiner to receive care and protection services, ensuring continuity of care and strengthening their overall well-being.

Refer and support ALHIV to participate in HF adolescent psychosocial support (PSS) groups: Children and adolescents living with HIV (CAALHIV) were systematically referred and supported to participate in health facility–based adolescent psychosocial support (PSS) groups as a strategic intervention to drive zero missed clinic appointments, zero missed medications. Zero missed viral load (VL) monitoring. Leveraging evidence that peer-to-peer support groups are a high-impact modality for strengthening treatment continuity, improving ART adherence, mitigating stigma, and achieving viral load suppression (VLS), the project team worked in close collaboration with supported health facilities to operationalize and scale facility-based adolescent support groups where they existed. Through this approach, 852 CALHIV aged 0-20 who were aware of their HIV status were successfully linked to and supported to attend structured peer support group sessions, with the program covering essential transport and refreshment costs to eliminate participation barriers. This intervention reinforced positive health-seeking behaviors, provided safe spaces for peer learning and role

modeling, and strengthened psychosocial resilience, directly contributing to improved retention, adherence, and treatment outcomes among CALHIV.

II. Management and Operations

Partnerships and Stakeholder Coordination

EPiC/OVC program fosters strong partnerships and collaboration at multiple levels to ensure comprehensive care for its OVC families in all SNUs. These collaborations include the Tigray regional health bureau (TRHB), the Tigray disaster and risk management commission (TDRMC), the Tigray bureau of social affairs (TBoSAR), and rehabilitation at the regional, zonal, and woreda levels, CCCs, and nongovernmental organizations that operate in the region. Those with governmental organizations are solidified by Memoranda of Understanding (MoUs) that serve as formal agreements with all health centers and hospitals involved in program implementation. The MoUs range from the regional bureaus, Tigray Regional Health Bureau (TRHB), the Tigray Disaster and Risk Management Commission (TDRMC), the Tigray Bureau of Social Affairs (TBoSAR), and 23 health facilities.

Program Coordination and Review Meetings

During the implementation period, a monthly review meeting was conducted with 174 participants drawn from the 58 Community Care Coalition (CCC) members to assess the progress of the OVC program. The meeting provided a platform to reflect on key achievements, challenges, and lessons learned in delivering comprehensive care and support services, including treatment adherence, psychosocial support, and child protection. Emphasis was placed on strengthening the CCC's role as a community-based coordination structure responsible for monitoring and supporting HIV-sensitive OVC interventions. Participants also discussed ways to improve referral systems, enhance collaboration with health and social service providers, and reinforce community ownership to ensure sustainability. In addition, strategies were explored to facilitate the transition of eligible OVC to vocational training institutions and other service organizations, promoting long-term resilience, self-reliance, and improved quality of life of the OVC.

Supportive Supervision and Data Quality Assurance

OVC team, jointly with Tigray regional health bureau experts, conducted Joint data verification and supportive supervision activities in collaboration with the health facility directors, ART focal points, and case managers of health facilities across eight SNUs: Shire, Axum, Adwa, Adigrat, and Wukro from June 21 to 07 July 2026. The activity aimed to verify the accuracy and completeness of HIV referrals for newly identified HIV-positive clients referred through the EPiC/OVC program, assess the bidirectional referral between the health facility and EPiC/OVC program, identify gaps affecting retention in care and viral suppression, and strengthen referral and feedback mechanisms.

During the visit, the team verified the accuracy and consistency of data for the 78 newly identified HIV-positive clients referred through the EPiC/OVC program by cross-checking positive tracking registers, facility medical records, and the case management files.

During the data verification, the team cross-checked positive tracking registers, ART registers, patient cards, and case management files to validate referrals and confirm successful linkage of clients to HIV care and treatment services. On-site technical support was also provided to strengthen documentation, reporting, referral tracking, and data management practices through engagement with health facility directors, ART focal persons, data clerks, and case managers.

Overall, the team successfully verified referral and linkage data for 78 newly identified HIV-positive clients across the eight SNUs, improved data quality and documentation, and strengthened collaboration between the EPiC/OVC program, the Tigray Regional Health Bureau, and supported health facilities

Table 7: EPiC/OVC program partnerships with health facilities and hospitals.

SNU	#of Hospitals	# of HC	MOU Signed
Adigrat	1	2	3
Adwa	1	1	2
Axum	2	1	3
Ayder/Mekelle	1	1	2
Semen/Mekelle	1	6	7
Quiha	2	-	2
Shire Endasilasie	1	1	2
Wukro	1	1	2
Total	10	13	23

Table 8: Project Key Staff, SSWs and CWs, June 30, 2026

NO	Target SNUs	OVC Project Coordinator	HLCs/ HLOs	OVC Project Officer	M&E Officer	Social Service Workers (SSWs)	Case workers (CWs)	Data Clerks
1	Adwa	1	1	1	1	3	11	1
2	Axum		1	1		2	7	1
3	Adigrat		1	1		3	12	1
4	Wukro		1	1		1	3	1
5	Ayder		1	2		1	6	1
6	Semen		2			6	37	1

7	Quiha		1			2	6	1
8	Shire Endesellassie		1	1		2	10	1
	Total		9	7		20	92	8

2. Lessons Learned from the Implementation

- **Community platforms and health facility bidirectional referrals save lives.** Through the EPIC/OVC projects, 78 orphans and vulnerable children (OVC) identified as being at risk of HIV were referred for HIV testing through community-to-facility referral systems. Those who tested positive were successfully linked to antiretroviral therapy (ART), demonstrating the critical role of integrated community and health facility referral mechanisms in improving timely access to HIV prevention, testing, treatment, and care services.
- Out of the 78 newly identified HIV cases, indicates a high HIV burden among adolescents aged 15–20 years, who account for 64.9% of all cases. Girls are disproportionately affected, representing 82% of these cases. Additionally, 15.4% of the adolescents identified are pregnant or breastfeeding, highlighting the increased vulnerability of adolescent girls and young women to HIV infection. These findings underscore the need to strengthen targeted HIV prevention interventions for adolescents and young women while intensifying primary prevention efforts among early adolescents (10–14 years) to reduce new HIV infections before they reach higher-risk ages.
- OVC programs do contribute to HIV treatment retention, adherence, and VL suppression, and other positive health outcomes for CALHIV
- Family-focused OVC Case Management system has proven effective for finding and linking children to services, especially to HIV treatment and life-saving support
- Community OVC social workforce is effective in identifying and reaching vulnerable and hard-to-reach children and families.

- HIV services are effective with an integrated health and OVC social services workforce model. HIV services are most effective when operating with intentional collaboration and coordination between health and social services
- Socio-economic support-OVC programs address a recognized and unfulfilled need for socio-economic services for households with CALHIV, to improve retention and viral suppression, especially post-conflict recovery
- Regular data triangulation enables early identification of gaps and timely corrective actions.

3. Challenges and Actions taken/required

OVC Program Implementation Challenges	Mitigation Efforts
➢ The short-term nature of the project and the current situation of the region lead to staff turnover	➢ Cover the task by available staff and recruit new staff
➢ Rising fuel prices have increased transportation costs, adversely affecting staff mobility and the implementation of project activities.	➢ Staff maintain a strong commitment and flexibility in implementing activities such as adjusting schedules, combining tasks, or using remote methods to ensure work continues effectively despite challenges.
➢ Reduction of Economic Strengthening activities while families still require economic support to access services	➢ Prioritize the most vulnerable households for limited consumption support. ➢ Link OVC households to community-based social protection interventions (CCCs) and alternative economic support opportunities (NGOs and private donors)

VI. Priority Activities in the Next Three Months (July to September 2026)

- Optimize treatment adherence, enhance viral load monitoring, integrate comprehensive services, and address structural barriers to support all children and adolescents living with HIV (CALHIV) and their positive caregivers in achieving and maintaining good viral load suppression.
- Provide intensive adherence and treatment support through regular home visits, caregiver counseling, and close ART clinic follow-up to address barriers to medication use, while strengthening nutrition and psychosocial support to ensure sustained adherence and achieve viral suppression of 35 CALHIV with high viral load.
- Provide PEPFAR-eligible services for 7072 OVC and their family
- Identification of >15 new HIV cases driven by focused case-finding strategies and prioritization of high-yield risk groups.
- A monthly meeting will be conducted with the Community Care Coalitions (CCC) to strengthen coordination, review service delivery, and enhance support mechanisms for OVC-related interventions.
- Conduct a case conference meeting with the health facility ART focal and case managers.
- Participate in the health facility multi-disciplinary team (MDT) coordination meeting with other partners.
- Provide HIV literacy education to 700 CALHIVs who take medication independently (Focus on ALHIV and/or caregivers who need Enhanced Counselling, e.g., with unsuppressed VL or un-disclosed status for their children, interrupted treatment.
- The peer-to-peer support group will be strengthened, and we have 952 CALHIV aged >12.
- Annual review meeting with the regional health bureau, Health facility ART focal points, directors, CCC, and other stakeholders.

Annex A: Performance Monitoring and Evaluation Matrix

List of indicators	Annual Target	April 01, 2026 – June 30, 2026 Achievements	%	Remarks
Project Goal: Improve HIV prevention and treatment outcomes among vulnerable children and adolescents, and mitigate the impact of HIV on children, households, and communities in Ethiopia				
Project Objective: Improve the continuum of care through increased access to high-quality, developmentally appropriate, HIV-inclusive case management (CM) for OVC.				
	A. Activity Performance Indicators			
	% of case workers with: [case worker database], up-to-date training/credentials, appropriate 92	92	100%	

	caseloads and mix of cases, receiving a supervision visit quarterly				
	% of case workers trained on up-to-date HIV adult and pediatric treatment, and viral load SOPs	92	92	100%	
	# of Community Care Coalitions (CCCs) with functional referral relationships with service providers, and track the completion of referrals	58	58	100%	# of functional CCCs
	B. Key Result Areas Indicators				
Total OVC_SERV (<18+>18 Comp. Active)	Number of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV.	6964	7072	101.51 %	The overachievement is due to the enrollment of CALHIV and newborn OVC in the program
OVC_HIVSTAT (# OVC with reported HIV status)	Percentage of orphans and vulnerable children (0-20 years old) enrolled in the OVC Comprehensive	4,593	4643	101.1%	

	program with HIV status reported to the implementing partner.				
OVC_TST_REPORT	Number of individuals who received HIV Testing Services (HTS) and received their test results	4050	3865	95.4%	
OVC_ENROL (95% TX_CURR <20 y/o)	Percentage of HIV positive children and adolescents on ART at a PEPFAR clinical setting who enroll in the OVC comprehensive program after having been offered enrollment.	1162	1165	101.1%	
OVC_VL_ELIGIBLE	Percentage of HIV-positive OVC on ART, active or graduated, who are served by an OVC comprehensive program, who are eligible for viral load testing.	1096	1107	95%	58 CALHIV are newly diagnosed clients and are not eligible for viral load testing. According to the national guideline, viral load testing is performed after a minimum of

					six months on continuous ART.
OVC_VLR	Percentage of HIV-positive OVC on ART, active or graduated, who are served by an OVC comprehensive program with a known documented viral load test result in the previous 12 months.	1107	1082	97.7%	
OVC_VLS	Percentage of HIV-positive OVC on ART, active or graduated, who are served by an OVC comprehensive program and are virally suppressed (<1000 copies/ml).	1082	1047	96.8%	

Annex B: Photographs from the Joint Data Verification and Supportive Supervision Conducted with the Regional Health Bureau

Annex C: Photographs from the monthly meeting with community care coalitions (CCC)

Annex D: Photographs from the weekly meeting with social service workers, CWS, care and support officers, and health and HIV linkage officers