# Mid-term Review of the High Risk Corridor Initiative

# Save the Children USA

***Lead Reviewer Teigist Lemma***
***Co-reviewer Michael Tamiru (MD)***

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## Acknowledgement

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Finally the team is honored to have the privilege of taking this assignment. It had an opportunity to study the process and progress that HRCI undergone and learned a great deal from the experiences of the diverse activities of the comprehensive HIV/AIDS prevention program.

# Acronyms

| | |
|---|---|
| ARV | Anti retro-Viral |
| BCC | Behavioral Change and Communication |
| CBCCC | Community Based Child Care Center |
| CDQ | Community Defined Quality |
| CPP | Community Planning Process |
| CHBC | Community Home Based Care |
| CRM | Community Resource Mobilization |
| D.D | Dire Dawa |
| FGA | Family Guidance Association |
| FGD | Focus Group discussion |
| FHI | Family Health International |
| FSW | Female Sex Work/ers |
| HAPCO | HIV/AIDS Prevention and Control Organization |
| HBC | Home Based Care |
| HRCI | High Risk Corridor Initiative |
| IC | Information Center |
| IDI | In Depth Interview |
| IEC | Information Education and Communication |
| IG | Income Generating/ion |
| IOM | International Office of Migration |
| IR | Intermediate Result |
| ISAPSO | Integrated service Aids Prevention & Support Organization |
| OI | Opportunistic Infection |
| OSSA | Organization for Social |
| OVC | Orphaned and Vulnerable Children |
| PLA | Participatory Learning Approach |
| PMC | Population Media Center |

| | |
|---|---|
| PMP | Performance Monitoring Plan |
| PLWHA | People Living With HIV/AIDS |
| QoC | Quality of Care |
| SC | Save the Children |
| SC/USA | Save the Children/United States of America |
| STI | Sexually Transmitted Infection |
| TOR | Terms of Reference |
| VCT | Voluntary Counseling and Testing |

## Executive Summary

The High Risk Corridor Initiative (HRCI) has an overall goal of reducing HIV/AIDS transmission along the major trade route with a distance of about 2000 kilometer from Ethiopia to Djibouti through the Afar NRS and Dire Dawa Administration. The initiative is planned for three years (2001-2003) and the project agreement was signed on July 2001 although the implementation started in December 2001 due to the delay in administrative arrangements. The initiative targets to reach 10,570 female sex workers (FSW); 956 hotels and bars owners; 5000 truckers, mechanics and truckers assistants; 5000 Dockers and port workers through its comprehensive HIV/AIDS prevention program. It also targets those associated with the transport sector, particularly related to transport of relief/food aid commodities. Its comprehensive program is inclusive of a comprehensive prevention, care and support, and impact mitigation of HIV/AIDS.

An Evaluation team was fielded to review the appropriateness of the project planning in relation to the intermediate results set in the planning document and the implementation process. The evaluation focused on assessing the project in terms of its appropriateness (strategies, activities, inputs and intended outcomes); level of collaboration between the different stakeholders and programs; its role in mobilizing the communities and their structures; and the progress made towards achieving the intermediate results

A range of qualitative and quantitative information gathering and methods of analysis were used to compile this report. On-site visits and review of secondary information were also used to acquire adequate insight on the project's performance and effectiveness. Accordingly, the following are the major findings of the evaluation:

### *Major findings*

The project has made remarkable achievements in terms of placing the appropriate and necessary structures to achieve the expected results from the implementation of the project. This was particularly significant given the short period (18 months) of project implementation and limited human resource available to it; both in its coordination offices and partner institutions. The accomplishments of the project realized thus far are indeed exemplary although there are some more challenges that require fine-tuning of the already adopted strategies and initiated activities. Commitment and motivation of project staff at the various levels was a major contributing factor for the extraordinary accomplishment recorded by the project.

**Good Practices**

Among the wide range of achievements made by the project, the following were prominent:

The revision of the project based on its initial experiences enabled an appropriate shift from both planning and strategic point of view. Laying the ground for a comprehensive and integrated HIV/AIDS program along the corridor, setting up of the necessary coordination structures and smooth operation for the implementation of the diverse care,

support and accomplishments registered in the preventive services in the short project implementation period is exemplary.

Linkages established with different sector offices and social organization has helped to create a sense of responsibility among officials of line offices, committee members and the community towards supporting the People Livinb With HIV/AIDS (PLWHA) and Orphan and Vulnerable Children (OVC). Facilitating and/or developing local systems (instituting and/or organizing committees and establishing integrating Voluntary Counseling and Testing -VCT in government managed health providers) for sustaining the initiative make it most appropriate and relevant program. Regarding the targeting, involving the street based FSW in the preventive aspect and street OVCs in the care and support program in some of the sites visited is appropriate.

### IR1 HIV/AIDS Prevention Practice and Demand Creation for Services

In addition to its expected services, the Information Center (IC) has been considered as a referral point for the community not only for VCT services but also for medical information and coordination center for vaccination in Mojo and sexual harassment reporting center in Mille. In addition, it has been serving the residents of the rural areas in the vicinity of the towns the ICs are located.

Users and stakeholders have received very well the cassette serial drama and the recent IEC material published in the different languages. The messages in the drama were easily understood and taken up by listeners and disseminated among the community. In addition, volunteers and counselors of IC are able to initiate socialization forums to reach the communities and disseminate information regarding HIV/AIDS prevention. Although their outreach is limited due to their capacity to finance these events, the initiative is sound outreach strategy.

FSW contacted in every site visited are well aware about the HIV/AIDS prevention and control practices and are effectively using the services of the IC. The inception of the FSW association with 186 paid up members and its sibling (girls' HIV/AIDS clubs with 80 members) in Mille is one of the best out come from the thrust of the project. The Association has developed an effective network with local administration and police to address the sexual harassments that FSWs are currently facing.

### IR2 Access and Availability of Preventive Services

The VCT services have been given high priority by political/administrative officials as all Regional Health and HIV/AIDS Prevention and Control Organization (HAPCO) officials expressed that there is high level of political commitment to VCT as part of the overall prevention and care. Its benefits are well understood. All sites have conducted advocacy/advertisement activities to promote the VCT services. The promotional campaigns that are carried out through various medias have contributed to the increased demand for services.

The availability of VCT services in all the sites is considered as one the strengths of the HRCI project. All visited VCT centers use uniform referral counseling and testing

procedures. They have operational guidelines/manuals, training handbooks and other relevant forms and formats in line with the national execution guideline. This is one of the strong aspects of the programs that place systematic approach and standardized procedure. In addition, the centers have well-trained and motivated human resource who adequately recognize their role in the community. The HRCI program has done a commendable job in building the required institutional capacity at project level.

The referral system adopted in Mojo has great potential of reducing the possible fraud that might arise from overusing the care and support of the committee. (Fraud in over consuming by PLWHA has been identified in Dire Dawa -D.D) VCT services were developed and accompanied by appropriate supportive HIV prevention services for clients tested sero positive. This has contributed to make the community attitudes favorable and their interest in VCT to be high.

**IR3 Accessibility to Care and Support by PLWHA and OVC**

Although the committees have not yet gained from longer period of experience and skill development exercises, their ability to raise the 10% matching fund through various ways provides indication of the potential for furthering the approach for acquiring/ensuring sustainability.

The introduction of an organized community care and support for OVC is very likely to contribute to the development and strengthening of the new and existing mutual support systems. Although mutual support systems are well practiced in many communities, adopting the objective of care and support in the areas of OVC and/or PLWHA has given promising insight to the community.

An Iddir allows part of its plot for the set up of the Community Based Child Care Center (CBCCC) and takes the responsibility of ensuring appropriate care for OVCs (feeding and follow up of children under 6 years of age). The Iddir also fills the gaps created due to late financial transfers. The selection of such local structures for effective and sustainable management is very relevant and appropriate for the success of the initiative.

The Community Home Based Care (CHBC) has offered a range of positive effects in terms of reducing stigma and discrimination as well as in creating a positive reception of the issue of HIV/AIDS among the residents of the visited towns. All contacted community members and PLWHAs are very grateful to CHBCs' commitment in venturing in an activity that is socially not yet accepted.

**Issues seeking more attention**

Despite the remarkable achievements recorded by the project, its effectiveness has been constrained by factors presented below and some may require alteration.

**IR1 HIV/AIDS Prevention Practice and Demand Creation for Services**

The IC staff and volunteers have been attempting to live up to the challenges of huge information gap. The attempts made to fill this gap by collecting publications from

passer-bys, locally produced scripts have not been sufficient and some sites are forced to transmit music to fill their airtime gap. In addition to the translation of the existing IEC materials, the need for variety serial drama and other media such as videocassettes in the Amharic, Oromiffa and Afar languages is high. In the use of locally produced IEC materials, the services of the IC have suffered from low capacity of its staff and volunteers in the design of IEC materials, write up and editing scripts.

Potential users including PLWHA in some sites did not know the services availed by the IC. The outreach service has not been sufficient to adequately inform the residents of the various sites. In addition, the absence of advertisement (posted on the ICs) contributed to inadequate recognition. In addition, the IC services at the main/obligatory truck stops, for example, Galfi, Awash, Dewele, are not efficient to adequately contact TW who could have ample time for counseling.

The IC staff did not feel responsible to network with Anti-HIV/AIDS clubs neither does the Youth and Prevention sub committee while it is vital for sharing information. While it is relevant too promote non-IC based services, all ICs contacted have weak linkages. Although this is an area currently taken up, unavailability of the necessary funding for the IC to participate as well as to coordinate the public events to work with the clubs may partly impair its progress.

Potential adverse effects of recruiting volunteers from Anti Aids Clubs have been observed. The pulling out of active club members in Chlenko (by recruiting them as IC volunteers) had resulted in the disintegration of a school Anti Aids Club. Had there been appropriate linkage developed between the IC and clubs, the program would have benefited from managing attrition of volunteers easily.

The project intends strengthening the link with local community structures and one potential area is linking through the IC. Although there are some attempts in Mille, the IC had played inadequate role in promoting local partnership in most of the sites visited. Its link with local institutions such as *Iddir* and *Mahiber* is not yet adequately attended.

The IC counselors and volunteers are attempting to educate community members adopting un-institutionalized activities such as the coffee ceremony and participation in public events. Expenses involved in these activities are born by the IC staff as it was not budgeted. Its continuity is very doubtful in the face of absence of any other budget allocated for operational costs of the IC.

### IR2 Access and Availability of Preventive Services

Although the heath workers (VTC counselors) in all sites surveyed understood the benefits of VCT and perceive it as a priority service area, health service mangers in Mojo and Mille were reported to have inadequate commitment (provide additional room, poor attention to VCT and STI, and scheduling of service for few days/week in some sites) to integrate and promote VCT as a priority program area and major part of their job. This has repercussion on the commitment of staff in the centers as appropriate administrative arrangement to reduce workload is lacking.

The VCT and IOM have been unable to conduct the quality control of the HIV/AIDS testing in the VCT services and some sites are running short of neck-cylinder (NUNC tubes) because of the accumulated blood samples. In addition, the tubes with the samples were stored in the cooler refrigerator meant for vaccination due to the inadequate procurement preparations made during the setting up of the centers. It was also reported that a sites without electricity supply was provided with refrigerator working with electricity alone.

Against the accepted procedure, some VCT centers have been conducting HIV/AIDS testing without Cappillus test kit. While it is procedurally advised to stop testing in such a situation, the services have continued testing and referring clients to other VCTs after test. In addition to affecting the credibility of the service, the centers have been providing unreliable information to the clients as well as stakeholders.

The HIV/AIDS testing kit has expired early March 2004 and some counselors and lab technicians did not recognize it. Although the staff in IOM expressed the problem with the supplier of the kit, there have not been any arrangements made to either stop the service or deliver the required kits with certain arrangements.

The referral systems in all the sites visited are not uniform and has created antipathy among the PLWHAs and members of the community in the process of acquiring the VCT services. The tendency of relying on the trust among the IC and VCT staff, volunteers and committee members may not be sufficient to create a credibility among the users.

**IR3 Accessibility to Care and Support by PLWHA and OVC**

Recruitment of the committee members upon appointment by their respective institution (due to the tendency to maintain HAPCO's structure) has negatively contributed to the expected outcomes. Except for Mille, all contacted committees had operated sub optimally due to lack of genuine commitment by the committee member. In addition, most committee members represent formal institutions and their transfer and/or attrition has affected the progress of the committees (for example Nazreth, Mille and D.D) and this is very likely to create an operational gap unless corrective measures are taken.

In addition to involving in overlapping responsibilities, all IC counselors and volunteers in Logia and some in Mille are members of the HIV/AIDS prevention committee with an excuse that there are no literate people in the town. On the other hand, members reported that there is a workload. The domination few individuals in the committee activities and blocking of others from the exposure and participation may contribute to reducing the effectiveness of the initiated activities.

The sub committees responsible for the care and support for PLWHA, OVC and fund raising members seem to lack understanding as to how they could discharge their responsibility. Lack of clarity and inadequate skill in the process of project implementation, financial management and supervision, and monitoring has created

uneasiness (and led to unintentional personal friction in the case of Logia) among committee members.

The fund raising committee limits itself with contact to members' institutions and has not yet developed linkage with community to mobilize community resources except in Mille. Members understanding and recognition on the relevance of involving the community rather than the local formal institutions in the fund raising as well as in participating in all the efforts of the HIV/AIDS is not satisfactory.

Members of particularly the youth and prevention sub committee could not think of an activity that doesn't require external funding support with an assumption that funding is imperative. Out of all contacted committees in D.D attempted to link with the HIV/AIDS club and Logia linking with school recently. Lack of direction and technical backing for the Youth and Prevention sub committee in their perceived activities has made them inactive.

# 1. Introduction

## *1.1 Background*

The High Risk Corridor Initiative (HRCI) has an overall goal of reducing HIV/AIDS transmission along the major trade route that has total distance of about 2000 kilometer from Ethiopia to Djibouti through Afar NRS and Dire Dawa Administration. The initiative is planned for three years (2001-2003) and the project agreement was signed on July 2001 although the implementation started in December 2001 due to the delay in adminisstrative arrangements. The initiative targets to reach 10,570 female sex workers (FSW); 956 hotels and bars owners; 5000 truckers, mechanics and truckers assistants; 5000 Dockers and port workers through its comprehensive HIV/AIDS prevention program. It also targets the transport sector, related to the transport of relief/food aid commodities.

The initial project document considered Behavior Change Communication as its major focus. However, the need for broadening the scope of the program to a more comprehensive prevention, care and support, and impact mitigation activities became more evident in the course of the first year of the project implementation. This has necessitated the redefining of the project strategies and activities to offer services that are complementary and inclusive of counseling, establishment of VCT centers, support services such as capacity building, psychosocial support by community members as well as mitigation of the economic problems of PLWHA and OVC.

To inhance complementarity and effectively address the divers and complex components/intermediate results designed in the intiative, SC/USA intended to continue and expand the existing preventin activities along the corridor. This had called for identifying and recruiting capable local NGOs and other implementing partners in the target area. In this connection a local NGO, ISAPSO, and IOM were sub granted to implement the discemination of IEC materials in 21 towns and setting up of the VCT centers in 7 sites.

This arrangement together with the reviaion of the project to include the care and support, and impact mitigation component (approved in August 2002) enabled the initative to involve in community-based activities that has positively contributed to its increased developmental impact. This has been accompanied by positive response from the donor, USAID, to provided the necessary additional funds for undertaking the current care and support, and impact mitigation components.

### 1.2 Overall goal and purpose

The current HRCI program included five major strategic objectives that lead to the following five intermediate results congruent to the national HIV/AIDS policy, national strategic framework and program guidelines for 2001 – 2005. Accordingly, the HRCI targeted the following major intermediate results to be achieved within the project period.

1. Increased HIV/AIDS prevention practices and demand for services;
2. Increased accessibility to and availability of prevention services;
3 Increased accessibility to Care and Support by PLWHA and OVCs;
4. Facilitation of the livelihood security of PLWHA, OVCs, care givers and affected families.
5. Improved Community Defined Quality (CDQ) of services;

### 1.3 Objective of the Mid-term Review

The overall objective of the evaluation is to make a comprehensive assesment of the progress of the HRCI program and to chart the success and operational limitations that contribute to the achievement of the desired intermediate results, and take the necessary alterations to improve the quality of the services established by the proejct during the remaining implementation period and forseable future. It is specifically intended

- To assess the level of achievements per intermediate result, using the HRCI performance monitoring plan (PMP)
- To identify gaps and successes in the implementation of the prevention activities against the original plan
- To assess the level of participation and involvement from the stakeholders per component or intermediate results at the respective project implementation sites along the corridor route
- To assess whether the implementation strategies were carried out as planned and to identify and explain obstacles, if any
- To document best practices and challenges for organizational learning as well as to share with relevant stakeholders including the donor.

A review of the planning documents of the project and progress reports from sub granted partners as well as the three coordination offices was undertaken during the review period. The team has attempted to acquire a good grasp of the goal and objectives of the project, and the operational principles utilized during the implementation process.

The review of the implementation process has included the assessment of targeting, setting up partnership and facilities for HIV/AIDS, linkages with national policies and programs on HIV/AIDS and STI, and other relevant national programs and mobilization of communities. In addition, the progress made particularly in terms of its programmatic directions, outputs and placing the necessary networks with communities since the implementation of the project in 2001 are also assessed. In both national and local contexts, the relevance, effectiveness, appropriateness and sustainability of the project components are also reviewed. The implementation arrangement, financial Management and the monitoring and reporting systems are also included in this report.

In addition, the lessons learnt and reflection on each project component and strategic issues are assessed. This considers the assessment of the systems developed for sustainability (adaptability, replicability and appropriateness) with a particular emphasis on the community-based HIV/AIDS and STIs preventive mechanisms introduced by the initiative. A review of community and stakeholders participation and integration of the project activities and the efforts made to mainstream gender are also conducted.

## *1.4 Mid-term Review method and approach*

Consistent to the objectives and directions stated in the Terms of Reference, the following methodology is adopted to conduct the review and compile the report.

### *1.4.1 Team formation*

The initial plan to include stakeholders in the review team failed due to administrative reasons. Therefore, the review team consited of two professionals and was accompanied by a staff from the coordination offices for the coordination of the review activities. The lead consultant take the responsibility of ensuring that the terms detailed in the TOR are discharged appropriately. The regional HAPCO and Health Bereaus in Oromiya, D.D and Afar are contacted during the review period.

### *1.4.2 Data collection tools*

**Desk review**

The desk review task includes an assessment of available information from the existing planning documents of the project, the memorandum of understanding signed between SC/USA and sub granted partners, progress reports and other relevant documents such as baseline survey and assessments reports. This exercise has helped the team to develop appropriate guides/protocols and checklist and design other data collection tool.

**Data collection tools**

The evaluation benefited from drawing an exhaustive data from the interview using of tape recorder, as interviewers get a chance of concentrating on probing and spacing questions.

An interview guides for both the in-depth interview and focus group discussion that includes list of generic, target and issue/ Intermediate Results (IR) specific questions were developed to make the interview comprehensive and systematic (refer Annex 5). The guides are designed to include the participants and stakeholders outlook and feelings about the project and the various stakeholders, their experience in the project, their knowledge about the project activities, the process, quality of service delivery and outcomes, participants expectations, salient features of the project and their perception on the changes they have made/acquired due to the project. The interviews were conducted with Information Center counselors and volunteers, VCT Counselors, CHBC volunteers, FSWs, PLWHAs, OVCs, truck drivers, youth and committee members.

In-depth interview (IDI): In-depth interview is designed to capture detailed information from clients and stakeholders for the team to exhaustively assess the relevant issues. In addition to the above respondents, the in-depth interviews with key informants from the public sector (Administrative structures, Health Bureaus) and private sector (hotel owners) and community leaders were conducted. The IDI with PLWHA in Chelenko could not be conducted as the PLWHA was not able to discuss due to recognition of her syro positive status recently and the interviewer observed and had a counseling session. The IDI in Logia and Mille is also canceled due to the very small number of PLWHA found to be willing to participate in the interview were all considered.

Focus group discussion (FGD): The objective of the focus group discussion was to adapt and facilitate participatory impact evaluation methods and tap relevant information about the feelings of target groups in terms of accepting the services, systems and strategies introduced/enhanced by the project, assess the commitment of stakeholders and the available potential for sustaining project components. Each group included 6-12 participants and , their transportation costs was covered based on the earlier practice of SC/USA. This discussion provides a social context (group dynamics) and helped the team to capture information from the interactive discussion and/or interpersonal interaction in the group. Due to the availability of limited number of people the FGD with youth in Chelenko, Committee in Mojo & Nazreth were conducted with less than 8 participants.

Structured questionnaire: Structured questionnaire is used to generate basic quantitative and some qualitative data on relevant issues related to knowledge, attitude and practice (KAP) to assess the possible changes in behavior that have been brought by the project in the last couple of years. The questionnaire was administered in the six randomly selected sites for the review. The respondents are selected based on their income status and direct and indirect contact with the services offered by the project. A sample of 50-180 respondents were contacted in each site

**Data management and analysis**

The IDI and FDG are recorded on 60 cassettes and transcribed (refer Annex 7 & Annex 8) and analyzed in conjunction with the results from the data generated by the structured questionnaire.

**Report writing and feedback**

The outline of the report was discussed with the SC/US prior to its adoption. Team members review the draft report before submission to the SC/US. The data from the structured questionnaire is processed and analyzed using SPSS and Excel. The team has reviewed the draft repot before submission to the SC/USA. The draft report is expected to be distributed to all stakeholders and coordination offices before finalization of the report.

# II Processes, Progress, and Achievement

## *2.1 General*

Cognizant of the need for action to reduce the transmission of the HIV/AIDS and STI along the principal routs from Ethiopia to Djibouti, the SC/USA designed the HRCI initially targeting high-risk groups, i.e., the FSW and TW, hotels and bars owners, truckers, mechanics and truckers' assistants, 5000 Dockers and port workers. This project was planned to be implemented in July 2001 right after the signing of the agreement. However, due to administrative reasons, the implementation started in December 2001 The process of setting up the appropriate administrative structure, recruitment of staff, facilitation with line offices, redefining of the project objectives and its approval, recruitment of sub-grantees took nearly half of the project period. The actual implementation of the project components was delayed by about 16 months. The review of this project, thus, has considered this delay and attempted to assess the achievements since October 2002 when the project was at its full scale of implementation.

After the implementation of the project, the composition of the target population identified was found insufficient and/or incomplete for implementing effective preventive as well as care and support measures against the transmission of the virus. With the desire to designing a comprehensive program, the project is revised to include care ands support and impact mitigation components that specifically included the care ans support for PLWHAs and OVCs. The initial focus on TW and FSW was incomplete and/or insufficient to reduce the transmission of the virus as well as mitigate its ill effects in the society/community. This revision was an appropriate shift from both planning and strategic point of view.

In addition, the implementation process has involved in a close follow up of activities and outcomes that called for technical inputs for alteration of the strategies, activities and set-ups at various stages. For example the increase in the number of VCT centers from 7 to 17, designing of complete package for income generation scheme through

revolving fund and school quiz competition are some to mention. Such changes have imposed further challenges that required additional efforts and resources in the process of implementation.

Compared to the plans in the planning document, it may seem that some of the activities planned in the document are over or under attended. The changes made to track the outcomes in the various processes of facilitation and mobilization, nonetheless, was instrumental for improving the effectiveness and appropriateness of the project components. Some examples are to train the VCT counselors as per the agreement with health bureaus and move into fulfilling the facility in order to avail the service by filling the gap created by commitment failure by the government stakeholders.

The establishment of the services currently available in these towns, the diversity and integration of the interventions as well as the attempts made to mobilize the various stakeholders (government, NOGs and community) in 18 months is exemplary accomplishment. The implementation of the project was highly dependent on the strength of the sub granted partners. The selection of sub granted partner in particular ISAPSO and IOM that had some experience in setting up and managing IC and running a mobile VCT respectively was one of the appropriate decisions taken to successfully establish and run the 21 IC and 17 VCTs along the corridor. Facilitating and/or developing local systems integrating and/or establishing the VCT centers in government managed health providers is an appropriate measure while furthering the commitment of the public health providers for continuous supply necessary materials and/or equipments is crucial for the success and sustaining the initiative.

The discussion with officials of local administration offices, Regional HAPCO, Health Bureaus and key informants in Afar and Dire Dawa indicated that the impacts observed from HRCI interventions provided very important lessons for replicating the services in other areas. Although the locally available services are far from being sufficient to meet the existing demand, the project placed effective interventions that have directly impacted on the knowledge of the community on HIV/AIDS (ref Table 1 and Table 2).

Involvement of street based FSW in the preventive aspect and street OVCs in the care and support program is also an appropriate targeting observed in some visited sites. Laying the ground for a comprehensive and integrated HIV/AIDS program along the corridor by addressing the needs of those affected and infected by the HIV/AIDS virus makes the HRCI most appropriate and relevant program. Particularly the care and support for OVC has been very well recognized as confirmed by the survey (refer Table 4 and Table 5).

It is worth to note that most of the services availed by the initiative are new to most the population in all towns that are targeted by the initiative. Although the challenges of ensuring efficiency and monitoring of the initiative to SC is obvious, the effectiveness and appropriateness of the project is well understood and recognized by all stakeholders About 35% and 27.1% of the respondents indicated that the care and support for PLWHAs and OVC respectively are the most beneficial while counseling and IC services are voiced by 14.5 and 12% respectively (refer Table 4). In addition, it is the

belief of the key informants and all stakeholders contacted during the review process that the project has yet to continue to efficiently address the increased local demands and needs due to the HRCI. Out of the total 567 respondents, for instance, 42% have not yet started to use the HRCI services (refer Table 4). The review team also conquers the need for the continuation of the initiative for fine-tuning of the already initiated activities as well as scheduling the smooth transition and/or handing-over of components to strengthened local systems that can ensure the sustainability of the interventions.

The effective systems incepted in the process such as the referral system in Mojo, the inception of the FSW Association in Mille, inclusion of the street based FSW and OVCs in the program offer additional opportunity for SC/USA to further look into its program directions and approaches for more effective results, extension of workable experience and pursue enhancing its role.

The Vice President of the Afar Regional Administration indicated that prevention activities need to involve community health agents, traditional birth attendants, clan and religious leaders. In addition, he indicated that there is a need to strengthen the network with HAPCO and the Wereda Administration that needs to provide full support. A Kebele leader in D.D also indicated that the kebele (where the IC is located) is very committed to provide any support for making the IC as well as the Committee activities more effective. According to the key informants, the public institutions were looking for effective strategy to mobilize communities to fight against HIV/AIDS. The role of CHBC in terms of inspiring people others to commit and support the activities on the issue has played great role in reducing the stigma and discrimination.

## 2.2 Project components/Intermediate Results

### *2.2.1 HIV/ADIS Prevention Practices and Demand creation for services*

Behavioral Change and Communication (BCC) has been central for the realization of this intermediate result. Accordingly, SC/USA designed strategy for BCC (in 2002) to effectively streamline the implementation process. This was accompanied by the development of message and material, availing peer education support system and condom distribution. The arrangements made with the sub-granted partners such as ISAPSO for setting up the IC, FHI for the baseline survey and PMC for designing and production of the cassette serial drama helped the realization of the IR by promoting the desired objective as well as placing the required facilities in the target areas.

ISAPSO has been responsible for the overall supervision and control of the activities of the IC and specifically for the dissemination of information and supply of condom while SC/USA is responsible ensuring the availability of IEC materials, although the initial agreement indicates that IEC will be produced by ISAPSO in consultation with SC/USA. Shortages of IEC materials have been reported as a major challenge in all the IC visited and in the progress reports of the three coordination offices. ISAPSO has been attempting to collect IEC materials from DKT, other programs and its affiliates to fill the gap. Most of the IEC materials distributed were for reference by IC counselors and volunteers.

SC/US is also able to provide recently IEC materials prepared in the three languages. The materials have been effective in informing the population about the services offered by the VCT centers. These materials, however, include information tailored to free VCT services and cannot be used in Nazreth and Dire Dawa where OSSA charges Br. 5 for cost recovery purposes. It is necessary that the future endeavors in the design of IEC materials should undergo exhaustive consultation and information exchange process with the appropriate partners and institutions.

**Service Provision**

The IC has been central for executing the HIV/AIDS prevention and communication. All the ICs visited are currently providing standardized service to the users. ICs are open for an average of 8-11 hours a day (except Saturday open for 4-6 hrs and Sunday is closed) and provide basic counseling, distribute print media and condom and air information through sound mini media to the community and other users.

Counselors and volunteers conduct outreach programs once in a week to educate FSWs, peer educators and communities. Some counselors and volunteers in Mojo and Chelenko have gone to the outskirts of the towns for disseminating information on HIV/AIDS. There are a total of 11 untrained counselors in the corridor and the team has contacted untrained counselors. The average daily intake of ICs ranges from 2-4 persons per day in one-to-one counseling although estimating the number of people contacted through group counseling was difficult. Although they have a clear picture of the goal of the IC, those who did not received the counseling training expressed they did not have the full confidence in their ability to conduct counseling. All counselors and volunteers are well aware about the need for respecting the confidentiality principles, however, against the accepted procedure; however, some ICs receive counter referrals from VCT centers.

The IC staff plays a very important role in the referral systems. For instance they liaison clients with VCT services and CHBC with committee. The setting up of the IC in the target towns and the services offered (group and individual counseling, and, non and IC based services) have been very instrumental in informing the various users on HIV/AIDS prevention as well as the care and support services availed by the project. About 66% of the respondents got information about the HRCI activities through volunteers and informal exchange of neighbors and peers (Table 6).

The IEC materials have circulated well among the communities. However, some indicated that materials containing further information on HIV/AIDS are much needed. The people residing in the vicinity of the towns where the IC and VCTs are located, uses the services effectively. It was reported that, for instance, couples that are ready to get married have used the services of both the IC and VCT in Chelenko and Mojo towns. The IC has played a very crucial role in increasing the demand for the HIV/AIDS prevention services-IC services, VCT counseling and condom- (Table 7).

Users and stakeholders have received very well the cassette serial drama and the recent IEC material published in the different languages. The cassette serial drama has been very influential in terms of arosing interests of users in the issues of HIV/AIDS. The

sound system mini media also uses the currently available serial drama. The demand for more and other varity of serial drama is highly increased. In addition to the translation of the existing IEC materials, the need for other varieties of serial drama and other media such as videocassettes in the Amharic, Oromiffa and Afar languages is very high. The sound system has been very effective particularly in towns where the IC is located at central places. The team is informed that the local community events on HIV/AIDS is been video recorded, for example in Chelenko are available. It might be of interest to review such materials for development and publication of IEC materials in future.

In addition to the very low capacity of staff and volunteers in the design of IEC materials, write up and editing scripts, the IC did not have any other source of audio inputs for its sound mini media. The staff, counselors and volunteers, have been attempting to live up to the challenges of the huge information gap by collecting publications from passer-bys, locally produced scripts (from individuals, anti-AIDS clubs in few cases) and this is very far from being sufficient. Most sites are forced to transmit music to fill their airtime. Users have also expressed the need for more audio and visual electronic inputs to the IC in this regard.

Clients of the IC, community members and almost all FSWs, have been using the condom distribution services very effectively. They also have indicated that the IC service has contributed to bring change and increased use of condom in the community has improved in the last two years. Respondents also indicated this achievement (Table 8).

The IC staff are very committed not only to discharge their responsibility but go beyond to educate community members adopting un-institutionalized activities such as the coffee ceremony, school competition and participation in public events as part of their out reach program. Although the outreach is limited due to the capacity of volunteers and counselors to finance these events, the approach is found effective to adequately inform communities. Expenses involved in these activities are not budgeted and most are conducted at the expense of counselors and volunteers.

Potential users including PLWHA in some sites did not know the services availed by the IC. The outreach service has not been sufficient yet to adequately inform the residents of the various sites. In addition, the absence of advertisement posted on the ICs contributed has contributed to inadequate recognition of IC and dissemination of information. In addition, the IC services at the main/obligatory truck stops, for example Galfi, Awash, Dewele, are not sufficient to adequately address the needs of the TW who have ample time for counseling.

The involvement of the IC staff in educating the community on HIV/AIDS was not limited to fulfilling the information needs alone but the IC served as a center for accessing and/or facilitation point for VCT, harassment issues (Mille) and other medical services such as immunization (Mojo & Nazereth). In addition to inspiring the community by their various activities, the IC can serve as centers of dissemination and coordination points for various developmental activities. Supporting and *strengthening*

*IC in such initiatives would have a multiple benefit in sustaining its services as well as broaden it scope.*

The ICs in Dire Dawa and Mille have networks with the Military in dissemination of information. This is encouraging and need to be strengthened in future. On the other hand, only few ICs have been able to develop contact with Anti AIDS Club in operating in the vicinity. Only ICs in Nazreth, D.D. and Mojo started with very few clubs. Pulling out of active volunteers due to their involvement in the IC had resulted disintegration of an Anti AIDS Club in Chelenko. Although this is an area currently planned taken up, unavailability of the necessary budget for the IC to participate as well as to coordinate their activities along this line and participate in public events to work with the clubs may impair the necessary progress.

The IC staff did not feel responsible to network with these clubs neither does the Youth and Prevention sub committee while it is vital for sharing information and participation in non-IC based services. The linkage with local institutions such as *Iddir* and *Mahiber* is not yet attended and ICs had played inadequate role in promoting local partnership.

Despite the unique and relevant services, problems such as absence of teaching aid models, suggestion box, counselors support group, assessment of clients' information needs are outliving the IC. It was also reported that unclear chain of command with SC/USA has been affecting the working environment of the IC staff.

**Service users**

*Female Sex Workers (FSW)*

The contacted peer educators for FSW and FSWs are all well aware of the HIV/AIDS transmission and prevention mechanisms. Peer educators expressed that they provide education to new entrants particularly those who are brought by middlemen without being informed about the job (sex work). New entrants contacted during the focus group discussion also express that their peers and volunteers inform them about the use and management of condom and the need for prevention of HIV/AIDS. FSWs pass their leisure time by discussing about their partners and HIV/AIDS in addition to what they are informed through various Medias. They also expressed that the cassette serial drama was effective in providing them information on condom management (some have learned from this drama and started using as well as informing others) and deeper understanding of peoples' behaviors from the characters featured in the drama.

The team has understood that almost all FSWs are also effectively using the services offered by the IC (IEC materials, cassette serial drama and condom supply) in the towns visited. Apart from ad-hoc shortages of supply of condom observed during this year, they are provided with adequate condom both at their workplace and IC. Although the level of their understanding on the issue of HIV/AIDS is high, FSWs expressed that those who have regular partner do not use condom consistently (Mojo, Mille, Logia and Chelenko).

FSWs' involvement in other project activities is minimal. They have indicated the need for having a forum for FSWs to get together and discuss on necessary issues regarding HIV/AIDS. Although almost all FSW agree that their job involves in high risk of health and well-being (harassment), their use of the VCT services is very low. Many FSWs' are not empowered enough to follow up their syro status as well as to think of other possible areas of work. In addition, they expressed that they are facing sexual harassments due to their request for the use of condom (and when client is not interested) and only few hotel owners cooperate (if it happens only in the premises of the FSW's work place). The HIV/AIDS committee, neither local administration nor police are yet ready to adequately address this issue. This gap needs to be filled in the remaining project period in order to solve the problems of sexual harassment and the experience of FSWs in Mille could be one promising option for designing intervention in this regard.

The inception of the FSW association with 186 paid up members and its sibling in Mille is one of the best out come from the thrust of the project that effectively address the problems of FSWs. Members contribute Br. 2.00 per month and have regular monthly meetings to discuss their problems and future directions. The association is able to include as well as assist about 80 young girls (in and out of school) to establish HIV/AIDS club. The association has the objective of educating members and new entrants about HIV/AIDS, assisting FSW who contracted HIV/AIDS, discuss problems of FSW and find solutions. The Association has developed an effective network with local administration, police and other institutions such as the Military Administration to address the sexual harassments and STI cases that FSWs currently are facing. It has also designed three projects and submitted to HAPCO and HRCI for funding but has not yet acquired the support. The association has a plan to involve in activities that would help FSWs to do more decent work, involve in community activities and protect their right.

Most contacted FSWs express that a discussion on the launching of the IG has been going on with HRCI since last year. As all are aware about the risks involved in the sex work, most want to start other activities that are more reliable in terms of reducing risks. The tendency of depending on external support, however, is observed to be very high among all contacted FSWs. No one, among contacted, has the intention to start other activity by herself. This is an area that requires revisiting.

*Transport Workers*

Promotion of the HIV/AIDS preventive services among the TW through involving Federal Transport Authority is one of the sound achievements recorded by HRCI. In partnership with ISAPSO, HRCI was able to integrate the HIV/AIDS education in the national driving licensees lessons in A.A. and this is one of the exemplary achievements in the promotion of the HIV/AIDS preventive practices.

The team was able to discuss with truck drivers in Logia and Nazreth towns. One out of 4 drivers contacted in Logia was willing to discuss with the team and he is well informed as well as takes personal actions to protect himself and his partner from contracting HIV/AIDS.

In addition, a representative of a trucking agency in Logia expressed that volunteers in his institutions are attempting to do their best to keep truck workers informed of the necessary precautionary measures they could adopt to protect themselves and the society at large. However, most of the time his office is short of the IEC materials. A continuous supply of IEC materials and condom for the drivers to access it easily in their work place is suggested.

The truck drivers met in Nazreth were not well informed about HIV/AIDS and were keen to discuss about HIV/AIDS. Instead of discussing about the project, the team ended up providing information and answers to questions raised by the drivers. Feeling excluded, the drivers expressed the need for having the IC services in the other routes of the country as well.

### *2.2.2 Access and availability of preventive services*

One of the objectives of SC/US comprehensive HIV/AIDS prevention and control project is to increase the accessibility to and availability of VCT for HIV, treatment of STI and opportunistic infections. The preventive/treatment services are the central elements of the HRCI HIV/AIDS program. According to project plan, the services are considered by SC-US as important sector of the HRCI program with critical advantage for being an entry point for the comprehensive HIV/AIDS prevention and care program.

The responsibilities of planning, implementation and technical support for the VCT and STI centers have been entrusted and sub granted to IOM and OSSA mainly in government health facilities. IOM has been earlier experience of managing mobile VCT/STI services in Dissie and Nazreth, OSSA centers. The SC coordination team in A.A and coordination offices in the field have involved in the co-ordination and implementation of technical capacity building aspects.

IOM signed an agreement with SC/US – HRCI program in September 2002 and started establishing VCT and strengthening STI centers in government health facilities and OSSA (Nazerth) respectively in February 2003 (as securing agreement with Ministry of health took 6 months).

As per the agreement, IOM conducted institutional assessment of health services in all the target areas and identified seven sites (4 sites in afar, and 3 sites in Oromiya) for setting up the VCT and STI services. Subsequently, it provided training to VCT counselors in which both IOM and SC have considered the participation of trainees from sites that are not identified for the VCT set up, based on the request from the local authorities. The understanding among all stakeholders was that HRCI provide training to VCt counselors and the public providers equip and supply the sites not considered by HRCI. Accordingly, IOM set up the seven VCT centers and SC initiated its care and support program in all targeted towns. The failure of the public health providers to set up the VCT centers forced SC and IOM to strategocally consider the setting up of ten additional VCT centers the start the care and support activities in all the targetd towns. HRCI, eventually, was able to increase its VCT sites from 7 to 17.

The scaling up of the VCT services, however, was not accompanied by increasing the supply of the Cappilus kits and other necessary supplies. Thining out of formerly procured resources was indeispensable. On the one hand, the bulk purchase enabled meeting the newly emerged needs of the additional VCT centers as well as efficient utilisation of the already procured supplies. On the other hand, the thining out of kits and other supplies had imposed shortage of same particularly in the face of inadequate preparations made to procure supplies for replenishment early on.

Regarding HRCI's comprehensives, the VCT service is availed in conjunction with capacity building of the public providers for sustainability, HIV education and information through the IC and, care and support services for those who test sero positive; an arrangement that markdly contributed to making the target community attitudes favorable and their interest in the VCT sevices high. The services in the visited sites are carried out based on operational guidelines/manuals, training handbooks, national execution guidelines and other relevant forms and formats. These manuals assists the staff to carry out their duties to the standard and effectively. As a result, there seems to be no significant problem in the implementation of VCT/STI services due to lack of in-house capacity. This is one of the strong aspects of the component as it had placed a systematic and standardized procedure on its day-to-day operation.

All visited project offices have conducted advocacy/advertisement activities to promote the VCT services of the program to the community. Although not coordinated, the promotional campaigns carried out through various media have significantly contributed in increasing the demand for services. In addition, the community in all sites have received education and information on HIV/AIDS, STI and VCT on regular basis. Political/administrative officials have aslo given the services of VCT high priority political amd political commitment by Regional Health and Hapco officials. The respondents of the varuous discussions have highly appreciated the efforts of SC/US in advocating the concept, availing the service and attempts made to mitigate the effectes of HIV/AIDS. It was reported that there was a high demand and clients flow following the promotion conducted. In all areas except Nazareth and cheleko, lack of adequate preparation or absence of a medium-term plan for the service, the supply couldn't meet the demand and counselors reported that a lot of clients were not able to access the service and take appointment as the system is not in palce.

Althugh counselors attempted to guarantee and respect confidentiality in all the sites, briches have been observed in some areas due to revealing oneself for the care and support. Most clients feel more comfortable about attending VCT services if they can give a pseudonym and have anonymous testing. As indicated in the previous section, the VCT centers and/or the whole referal system did not have policy to guarantee confidentiality and avoiding breaches of confidentiality at all stages. In addition, other medical and administrative staff did not receive specific guidance about the role of counseling and confidentiality.The polcy on confidentiality is relevant in terms of promoting acceptability and crediblility of the service.

Although, Heath workers (VTC counselors) in all sites surveyed have understood the benefits of VCT and perceive it as a priority service area, health service mangers were

reported to have inadequate commitment to promote VCT services as a priority and major part of their job. The reluctance of the Mojo Heath Center management to provide additional room for VCT to handle the increasing flow of clients, poor attention given to VCT/STI (functioningfor 2 days per week despite high and growing demand) in Mille and Logia are some examples to site. The VCT sites have mostly well-trained and motivated manpower who felt to have got good recognition and given high value by the community and staff. the HRCI program has done a commendable job in building the required institutional capacity at project level.

Although, there are well-ventilated waiting areas, thre are no separate private space in Dire Dawa health center and separate room in mille and logia. In addition, the absence of signposts in all sites to indicate the VCT rooms has brought challenges for ensuring privacy. In addition, counselors have mentioned work load because of involvement in other departments, lack of adequate counselors support, procurement of test kits for VCT activities have been a major problem.

The overall figures from sentinel surveillance survey in Dire Dawa and VCT reports of other 5 areas evaluated indicate the high HIV sero-prevalence in the community (refer Annex 6 for details). This has brought a high level of understanding among health service managers/planners on the services' effectiveness for targeting and identify appropriate strategies to develop services. The services in all areas were found to be affordable for the majority of people as they get the service free of charge (and provided at low cost in Nazareth, OSSA and Dire Dawa hospital).

The quality of the VCT service was supposed to be crosschecked and samples have been collected and some centers are currently facing shortage of NUNC tubes. Although HIV testing methods have become much more sensitive and specific, evaluations have shown that without rigorous quality control high numbers of false positive and negative results are common. Not only can this be harmful for clients, but it can undermine the credibility of the service. Although supply of the testing tubes are planned by IOM, the quality control need to be taken up as soon as possible. In addition, cappillus test kit was found to have expired as of 8 March 2004 in all the sites surveyed the. According to the guideline the services should have been shut until the test kit is made available but counselors were referring clients to other services and this negatively may contribute to the credibility of the services.

Although Counselors are aware of the special medical needs of people living with HIV or AIDS, absence of free treatment at public health facilities (except in logia) and inadequate availability of drugs for opportunistic infections were reported to be the major challenges.

Assessment of the diagnosis and treatment of STIs by providers revealed that patients with STIs or STI symptoms at all sites are appropriately diagnosed and treated according to national guidelines. This could be the result of provider training in STI case management and the adequacy of the history taking, assessment and treatment of patients reporting to facilities with specific STIs. All providers make satisfactory efforts treat as well as prevent the recurrence of STIs by promoting condom use and

encouraging the treatment of partners to avoid reinfection. However, STI care was not given adequate attention as an entry point for referral for VCT in all the sites visited. This indicates the need to improve the extent to which these aspects of STI service provisions are functioning.

Although STI drugs are due to expire in two months time, all services except Mojo health center have the supply of essential STI drugs and reported no stock-outs lasting longer than one week in the preceding 12 months. Drugs int Mojo health center are kept in the drug store and the store keeper is not always available making drug and other necessary materials availability short. This poses a negative impact on ensuring adequate provision of service difficult

### *2.2.3 Accessibility to care and support by PLWHA and OVC*

This is one of the intermediate results implemented after the approval of the revised project in September 2002. This result is expected to be achieved through

Strengthening of family and home based care, and support networks,

Increased attention to orphan care and

Increased awareness and responsibilities of communities for protection against violence, social and gender discrimination and reduction of stigma for PLWHA.

It is also expected that especial effort are made to link HIV/AIDS committees, task forces and local institutions (Mahiber, Iddir) with public and private sector business.

#### 2.2.3.1 HIV/AIDS Committees

In line with the intension of the projects, Wereda and Kebele HIV AIDS committees that include sub-committees for 1) Prevention 2) Care and Support for PLWHA 3) Community Resource Mobilization and 4) Care for Orphan and Vulnerable Children are established in all the sites visited. The linkages with the health facilities and schools have been arranged through the sub committees for care and support for PLWHA and OVCs respectively.

The program is exemplary in its expansive coverage along the route and particularly the mobilization of the HIV/AIDS committees in all the targeted towns. The team has understood that the need for pooling efforts by all stakeholders to support the project activity is recognized by both the residents and, local and regional officials. According to the discussion with committee members, the workshop organized by SC/USA on "Community Planning Process" has been instrumental in equipping the members of the committee with the appropriate need idnetification and planning skills. The need assessment and the designing of project documents by the trained committee members was one of the best accomplishments accepted and appreciated. Committee members have expressed that they are capable of designing a project document for submission to other funding agencies. In addition, the formation of both the committee and sub

committees along with the capacity building training on planning is found most appropriate and effective.

The committee was organized in line with the national guideline for the establishment of HIV/AIDS committee. This intention limited the office to contact and delegate the Wereda Administration offices to identify and select committee members and members represent their respective institutions (government, religious and community based institutions). Such process had eliminated the chance of ensuring the interest and commitment of the members of the committees. In addition to omiting/excluding the paricipation of the community, the process did not allow assessment of the skill and knowledge of members in project planning, management and monitoring as well. In the initial set up, there were on average 30 members in each committee that made the committee activities cumbersome particularly having the right quorum for making decisions in the face of members' poor commitment. Almost all committees faced serious challenges that require revisiting the constituency in the sites visited during execution of their respective activities. This called for reorganizing of the committees that was conducted since September 2003.

The re-organization of the committees provided opportunities for members to reduce the size of membership to about 20, include relatively committed individuals and try out the effective implementation of the committee owned projects. Although inadequate commitment of members is still a challenge, the commitment of few individuals (about 3-6 members) had enabled the implementation of the care and support to PLWHA and OVC and Community Resource Mobilization since the approval of the fund for their projects by SC/USA in November 2003.

Contacted committee members express committee objective same as project objective submitted to SC and it gives an impression that the committee did not have its own broader goal(s) and vision. In addition, they believe that only those sub committees with funding from the currently approved project can remain active while the youth and prevention and fund raising sub committees, for example, are left inactive in almost all the sites visited. The inclination to stick to the project objective (and not developing committee vision and goal) as well as the miss conception on the role of sub-committees needs to be looked into in the future. If the activities presented in the project are choices and priorities of the communities based on community needs assessment, the committee needs to learn how to address it by going beyond the project with SC/USA. Committees can develop more projects, submitted to other donors and/or look a means of fund raising.

Committee members in Mille, Logia and D.D., indicated that the SC staff both from the coordination offices as well as the coordinatin team in A.A need to spend more time with them for technical support. This will give opportunity for SC to forward the community/committee dynamics and provide transparent information regarding its and HRIC's vision and goals, which is found to be very low among committee members.

Although the HRCI staff exerted their effort to facilitate and organize committees along the whole route in the last 6 months (in a very short period), the process of setting up and

functions of the committee has revealed the absence of timely designing of appropriate guidelines, weak management skill of committee members, lack of close technical backing on the part of SC/US. The absence of procedural guideline has also created a loophole for staff to provide untimely and sometimes conflicting directions that is taken as false promise by committees and communities. Lack of skill managing committee activities and procedure for project implementation and management, and fund raising are the major gaps in the functions of the committees.

Financial procedures, for example, are not clear for any of the committees contacted. The finance department of SC made a visit recently and committees indicate that they did not get any technical support in this regard. For a community structure particularly where skills are scarce are low, it is necessary to adjust modern financial systems to accepted lower levels of record keeping and reporting. Looking for skills may crate marginalizing potential volunteers from being involved and exposed to societal activities as the case is in Logia.

SC has acquired and adopted a guideline from is Mali program and this was sent to the coordination offices to discuss it with the various committees in their areas. The coordination office in Awash was able to provide its feedback while others are planning to do so in the near future. While the team likes to propose the speeding up of the finalization of the guideline, it would like to express that the setting up of the committee was not accompanied by a genuine commitment of the local stakeholders and/or members and in part by pre-defined/piloted guidelines that can effectively direct the efforts of the local communities and network with local systems (Iddir, Mahiber, etc) to contribute to developing a sustainable mechanism for the reduction of the transmission. As the communities are not yet adequately exposed to such systems the need for technical backing is high. The team found measuring the effectiveness of the project in terms of creating and/or developing a sustainable system as premature in such a context.

The care and support as well as the CRM sub committees were able to meet the 10% requirements of mobilizing community resources for their projects. Community resource mobilization is the most relevant in promoting ownership of the care and support for PLWHA and OVC and appropriate intervention for developing a sustainable prevention program. It is observed that only the committee in Mille had involved in real CRM by contacting and soliciting funds from the residents of the town. The CRM in most cases was acquired mainly from government institutions and kebele structures. Committee members need to be appropriately skilled and motivated to move beyond their respective offices and link with their community at large.

All contacted committees had developed a selection criterion for the care and support in discussion with SC/USA. The process involved in the identification, compiling of the family and personal background, acquisition of testimony from the social courts in Kebeles and key informants, and home visits. The review team has not encountered any complaint on the selection process.

The availed care and support package for both PLWHA and OVC are uniform. The contacted PLWHAs indicated that they have been receiving Br. 100 for food, bed sheets;

sanitary materials and detergents, financial coverage for house rent and palliative care supplies from CHBC.

Contacted OVC express their gratefulness to the SC/USA for its assistance and have testified by showing what they have received from the committee and/or HRCI. While the interaction of the street based OVCs in the support program is appreciable, the exclusion of the support for basic needs such as shelter and food for those living in the street made the effort incomplete. With a due regard for the general tendency of communities and/or OVCs towards food relief, the team believes that the project needs to address these special needs of OVCs living in the street. Provision of educational material for contacted street boys under the care and support is encouraging them to attend their classes but does not ensure its continuity. They perform well in schooling and could do much better if they are provided with shelter in which they can study, do their assignments and, if any in the future, entitlement to the support package could be upon fulfilling certain condition such as good school performance.

The community in Nazreth, D.D. and Mille (visited by the team) give high value to the establishment of CBCCC for the care and support to the OVC under age of 6 years. The team has been able to visit and talk to OVCs in the CBCCC in these towns. The sanitation at the CBCCCs are very good, the children are clean and provided with 2-3 meals a day. The team believes that there are issues of OVC's integration with their guardians and communities after CBCCC. According to the current program, a child has to graduate at the age of 6 and when joining the elementary school. All the support package will automatically be changed to schooling support. Although identified/planned by the committee, the variety and quality of the meals provided by the CBCCC need assessment if it is different from the staple diet in the area. The committee needs to be well aware about the potential problem of integrating OVCs into the family norms. It might be relevant to look into the need for having a transition period for a child to normalize the food habits in the family norm.

### 2.2.3.2 Home Based Care Service Provision

CHBC volunteers are working in close contact and under supervision of the HIV/AIDS committees. Their major activities are collecting referrals from the VCT centers, liaison with the committee for approval and provision of palliative and psychosocial support to PLWHA. The selection of HBC volunteers was undertaken based on recommendations of committee, kebele. The criterion includes previous performance, interest in the intervention area and motivation to help people. Although the committee recommends all CHBC volunteers were self initiated and applied voluntarily and clearly understand the objective of the home based care and their expected role in their communities.

Before their involvement in the home based care service all were provided with two weeks training which they feel has adequately equipped them with the necessary skill for providing counseling and palliative care. Some CHBC givers indicated that additional training on on going-counseling and details of HBC would help them to acquire more knowledge and improve the quality of their service.

Most of the CHBC volunteers conduct 4 visits/day and work for an average of three days/week regularly and provide service upon request from communities and individuals. Due to their proximity and the uniqueness of the service they provide, the community gives CHBC volunteers high value. They givers have indicated that they are often called on emergencies and sometimes work for 7 hours per day and for a number of days in week. Although most found the job more difficult than they perceived during the training, all expressed that it is a rewarding job and particularly when observing that PLWHAs are content and recover from their sickness and the value and respect the community and committee give them.

Most CHBC volunteers indicated that the objectives of home based care is to reduce stigma and discrimination against PLWHA. The team has understood from the various discussion with stakeholders and key informants that CHBC volunteers have substantially contributed to increasing awareness of communities on care and support to PLWHA, changing communities attitude towards PLWHA, OVC and HIV/AIDS. Furthermore, almost all indicated their determined move to provide care for the PLWHA have aroused the enthusiasm of many. PLWHAs also noted that the CHBC and its accompanied care and support as the most efficient therapy for revitalizing their social touch/relationships and filling their economic resource gap in the most fraught time of their life.

The volunteers also regard the project as strong in increasing the understanding of the community on issues of HIV/AIDS and concluded that this component of the project is designed and availed based on the needs of the affected and infected. They also noted that service is not limited based on location and time and the process has enabled the full community participation. Apparently, availing HBC is one of the most remarkable input of HRCI in terms of providing an appropriate, relevant and effective service to the needy and by and large to reduce stigma and discrimination. Contentedly, however, they indicated that their ability to cover the costs of health services is extremely low in the face of their high vulnerability to opportunistic infections and repeated illnesses.

The available public heath providers are backing the HBC services and CHBC volunteers refer to the public health providers; however, the existing links/referrals for PLWHAS for specialized care services is inadequate. In addition, patients don't get adequate treatment immediately particularly treatment for opportunisstive infection (OI) and access to medicines/drugs at the public health providers.

One of the challenges of the volunteers is their inability to creating conditions for family to discuss with patients if the PLWHA is resistant. Bringing an open dialogue environment in the family, they believe, is relevant for training family care givers. Based on the interest of PLWHA, volunteers are providing training family care grivers by ensuring confidentiality, and conduct follow ups.

CHBCs in Logia have been providing care and support for any bed ridden patient and there are patients who have not visited the VCT but under the care and support for the last 3-4 months. The patients need to be motivated and to visit the VCT and know their syro status and the committee need to revisit its appoach, in this regard.

The problems created by landlords/homeowners to evacuate PLWHAs have adversely affected the activities of volunteers, as they have to track PLWHA and provide the care and support. However, the general attitude of the community is good and Community based organizations such as Iddir and Mahiber has positive views on volunteers' interventions.

Volunteers and/or the committee receive referrals from the various VCT centers (such as OSSA, FGA, public health providers and other VCTs). Committees are required to conduct close supervision, approve support to PLWHA as fast as possible and network with other institutions to reduce over consumption of the available scarce financial resources by PLWHA. Although Wogen Lewogen and religious organizations in Nazreth, OSSSA and MMM in D.D are involved in home-based care, there is no coordination to standardize and control over consumption of the support and care resources and this requires networking. The networking may also include the assignment of focal persons for referrals in the public service providers.

According to the CHBC volunteers, the areas that need further consideration are training on post mortal/terminal care as communities are currently requesting for the service, timely financial support to PLWHA and adequate and regular supply of HBC materials. In addition, the prediction of shortages of supplies and protective materials for HBC such as aprons, plastic sheets, and shoes, due to the currently increasing demand for care and support of HBC seems to raise concerns of the volunteers and the committee. The currently available resources would not be sufficient to meet the potential demand in the future.

Committees in D.D and coordination offices in Nazreth and Mojo manage the HBC material supply. Differences in the efficiency of replenishing HBC have been observed where the committee shows a bit of delay due to the timely unavailability of the responsible members.

### 2.2.3.3 Users of Care and Support

**PLWHA**

The team contacted PLWHAs most of whom are living with children of age 1-30, some live with syro positive children and have received either diagnostic or referral VCT and HBC counseling and palliative care before they visited the VCT centers (before they discover their syto status). Some are still under on-going counseling by the volunteers, VCT counselors, and other institutions such as OSSA, FGA and Tesfa Goh (in Nazreth, D.D. and Mojo). Few of the contacted PLWHAs visited the VCT by their own inclination/reasoning without referral. Most have expressed that they are motivated to visit VCT due to the care and support component of the HRCI. In addition, participants have received one week training on positive living in D.D, Nazreth, Mojo, Mille and Logia.

The services offered by the VCT and STI centers is reckoned to be of good quality because of the existence of staff that are supportive of PLWHA. Staff provides adequate

time and information during pre and post counseling and give priority for PLWHAs. Mistreatment of specific counselors and use of abusive term by other health workers in facilities of Mojo and D.D, absences of free medical treatments, lack of diagnostic services such as X-ray and bed for inpatient treatments are some of the observed problems of health facilities as identified by PLWHAS.

PLWHAs are well aware about the existence of and STI services, home-based care, care and support for OVCs and IC services.In addition, they appreicated the efficient and regular services and adequate attention given to bed-ridden patients by CHBC volunteers. During their visits, CHBC volunteers share their experience and provide information on positive living. Although home-based care is the most efficient therputic service they received to date, it is inadequate due to insufficient supply of sanitary materials, first aid materials and bed sheets. The service is well recognized as need based and, appropriate, relevant and effective support, however.

The institutional support is believed to have impacted on improving access to VCT services, attitude of communities towards PLWHAs due to education on HIV/AIDS and workshops and acceptance and use of condom in the community. The HRCI project is also strong in securing the means of subsistence for PLWHAs and placing access to home-based palliative care and facilitating support from health care providers. The limitations identified, in this regard, are inadequate commitment by committee members, inadequate support to organize PLWHAs' association, lack of income generation activity, absence of OI management and ARV supply, the need to register PLWHA children for care and support after their termination.

Regarding preventive practices, most PLWHA indicated that they have either abstained from sex or use condom consistently, strictly avoid sharing piercing materials with others/family members. Few inform their status to partners who are syro negative (in D.D) and casual partners who did not want to use condom. Most are interested to be productive and independent of the support they are currently receiving.

Although few of them disclose their status, PLWHAs who have healthy children express that they inform and discuss with their children about the prevention and control of HIV/AIDS. Those who have not disclosed did not have the intension in the near future. On other hand, there are PLWHA who are interested to participate in the project activities particularly in providing public and informal education on HIV/ADIS and few participate at their workplace and in communities with and without disclosing their status. A PLWHA in D.D has recently acquired a support letter from the government to educate the community on HIV/AIDS by traveling to different places.

Apart from Mojo where some Iddirs have stopped penalizing members who are syro positive when they fail to pay the monthly contributions, the support form community organizations is reported to be very minimal. There are private clinics (Mojo and Nazreth) that provide support for PLWHA and some community members in the neighborhood of the PLWHA provide good support. However, PLWHA indicated that they and their children face high degree of stigma and discrimination and stressed the need for reducing self-stigmatization by PLWHA. Some of the other challenges faced by

PLWHA are unaffordable medical services, poor ongoing counseling, and psychosocial and emotional support. All PLWHAs indicated that the economic support is inadequate and irregular (in Nazreth, Mille, Logia).

**OVC**

The OVCs considered for the FGD were older than 8 years of age and are attending their schooling. All contacted OVCs are thankful for the support they received from the committee, SC/USA and their guardians.

The OVCs under the care and support are living with their guardians and some are from single PLWHA. Some are also living in the street without guardian and almost all are living in very poor environment and/or guardians/families. Even though they feel the support is very essential for continuing their schooling (for those living with guardians), they indicated that they need food supplies. Some OVCs (in Mille) have experience of receiving food aid and they tend to look for same support. On the other hand, street boys who are under the support program express that shelter is what they need most. With due regard to the originality of the intervention in the target areas, the team conquers the need for addressing the special needs of OVC such as shelter for those living in the street is very crucial. However, future supports packages need to consider the appropriateness of the current and other supports provided by SC and other institutions.

In spite of their demands, all OVC has received uniform support package that contains education and sanitary materials and uniforms since October 2003. The support they received, according to OVCs in Nazreth, Mojo, Chelenko and Logia, has helped them to feel less discriminated as they used to feel dirty and shameful before the support. In addition, they feel much more integrated in school because of the sanitation as well as good attention given by their teachers. Teachers, they say, have been very helpful in advising us to pursue our education. This change has been attributed to the increased feeling of responsibility of teachers due to the influence of the committee in the locality (example Mille, Logia, Mojo, Chelenko).

As care and support to OVC is fully managed by the committee, in most of the sites visited, an attempt was made to discuss the problems and living situation OVCs usually during the distribution of the support materials. This has not been taken up as a regular activity though. Other than the support package, OVCs indicated that they are concerned about the rape in/around schools and sexual and ethnic harassments (in Afar). They have revealed their insecure feelings and this probably is due to absence of psychosocial support as well as inadequate committee and stakeholders' intervention along this line. The team, for instance, encountered a girl of about 12 years of age who has been harassed by her ankle and forced to leave her grand mothers' house (her guardian). Such issues can be addressed if the committee is able to mobilize the community to act in support of the OVCs under the support program. The OVCs in Mojo requested that it would be helpful for OVCs to get together and discuss problems either among themselves or with committee.

Mille. A shop owner's assistance to OVC in providing them credit whenever they need and counsel on behavior can be taken as exemplary action.

OVCs are knowledgeable about SC/USA-HRCI and particularly about the education (IEC) on HIV/AIDS and condom distribution and, care and support for PLWHA. They have suggested that if grown up OVCs are provided with skill training they would be able to support their families/siblings.

### 2.2.4 Livelihood security for PLWHA and OVC

This intermediate result is planned to be achieved through mobilization of community organizations for the setting up of the income generation schemes, strengthening social safety nets, nutrition interventions and support for accessing health and education services.

As the process of setting up the committee and running the care and support activities have been given priority from the point of view availing the basic comprehensive HIV/AIDS prevention package, activities for this intermediate result has been planned to be taken up gradually and as second stages. To start full implementation of this activity, strong committee and community awareness and commitment to mobilize and manage the resources of the IG is crucial. Currently, SC has prepared the guidelines at the coordination team level (in Addis Ababa). The committees in Mojo has also formed a group (of PLWHAs and OVCs) and secured a plot for the IG, and is in the process of launching it. It is expected that this component will be taken up in the remaining project period.

### 2.2.5. Community defined quality of services (CDQ)

This intermediate result is planned to involve in identification of community and service providers perception of quality of care (QoC) indicators through participatory learning approach (PLA), bringing community and service providers in a forum to prioritize QoC indicators that needs to be improved, specify roles of community and service providers for QoC improvement and introducing a joint monitoring system by community and service providers

This component has only been taken up very recently and training on partnership-defined quality was provided in Mojo. Community members and service providers had a forum to prioritise the indicators and set up the monitoring system. Participants from service providers indicated that the training and setting up the monitoring system is relevant.

HRCI need to continue to provide trainings and definitions of quality indicators need to be taken up in other target areas.

# 3. Project management

## 3.1 Implementation arrangement

The initial project envisages that SC will be fully responsible for the monitoring and evaluation of the results of the program based on the baseline survey that would be conducted on component specific and regular basis throughout the life of the project. The revised project document stipulates that SC will sub grant some of the care and support, and impact mitigation components to one or more demonstrated local NGOs by sub granting. The sub grantees take responsibility for social mobilization, capacity building and advocacy activities.

Significant in the management arrangement is the establishment of the HIV//AIDS committee in line with the HAPCO guideline. The establishment of the committees at Wereda levels has contributed to the successful beginning of the care and support activities, created a sense of ownership and responsibility and strong link between the administration and the beneficiaries/target groups. The reorganization of the committee had been one of the appropriate measures taken to ensure efficiency of the services although it may require additional assessment as committee members are still expressing that there are work load on few members and, lack of commitment, clarity on duties and responsibilities of the committee and sub committees. Although committee would like to have more time with staff, all have reported the consistent close follow-ups made on activities at grassroots level. Considering the huge task entrusted on the coordination offices, remarkable accomplishments have been registered in the visited areas.

## 3.2 Coordination offices

The progress of the project was realized through the establishment of the management and coordination systems at regional levels with three coordination offices in Nazreth, Awash and Dire Dawa. SC/USA recruited technical staffs (three-four technical staff) at the field office that are responsible for providing technical backstopping and follow up of the various activities of the HRCI activities. Their technical support was relevant in streamlining, standardizing, mobilizing and facilitating for creating a good working environment. Their input in ensuring the integration of activities and liaison with partner institutions at higher levels had significantly contributed to the active involvement of the concerned line offices and smooth implementation process.

The coordination offices established provide full assistance in terms of following up the daily activities related to the HIV/AIDS committee, the facilities (the VCT centers, IC) and provide close technical support to the care and support activities of the committees, front-line health workers, service users and community leaders to define and successfully operate referrals and counter referrals for PLWHA. In addition, the coordination office is reponsible to manage the finance and plays a crucial role in providing feedback to the coordination team in A.A.

The coordination offices have set up a regular monthly meeting with stakeholders and contact every 2 weeks. The regular joint meeting is attended the IC staff, VCT

counselors, CHBC and committee representative. This has contributed to strengthen the linkage of the various stakeholders and also of the activities of HRCI. In addition, quarterly reports are discussed at head office level. This has helped the coordination offices to exhaustively address their concerns and find solutions for their operational problems.

Regarding planning of activities, the coordination offices in the field have a problem of maintaining schedules due to the incongruent and frequent visits (often not planned by the coordination office) by the SC staff in A.A. All offices reported that this renders a minimum of 5 days delay (per month) in their planned activities and negatively influenced the quality of their service/job. In addition, inadequate prior in-house preparation on technical issues, for instance on the new procurement procedure, CPP, CDQ had created an apprehension by the staff as they believe that they should have made adequate preparation to address technical issues and back up the local structures (committees). The closing of the dropping center was done without adequate consultation of the coordination offices and such activities hamper the effectiveness at lower levels.

On the other hand, some activities are placed without proper assessment of the local needs. Some cases reported are the setting up of inactive care and support programs in Karamile (no PLWHA reported due to inadequate advocacy), missing of refrigerator in setting up VCTs, providing refrigerator operating by electricity to town without electricity supply. The project is well received by its flexibility, however, it also opens up for more challenges in terms of achieving the desired result in the short project period.

The D.D office reported that it was difficult to facilitate the mobilization and the activities of the committee in the absence of clear strategic direction. The networking with stakeholders and institutions working on HIV/AIDS and in the same area of intervention is very weak. Although institutions such as (HAPCO, OSSA, Health Bureaus, Health providers) have a forum to exchange information and experiences, other stakeholders such as FSWs and Down of Hope are not represented. In addition, the HRCI has no clear guideline to receive and provide support to journalists and network with HIV/AIDS clubs. Changes made to financial and other formats without guidelines coupled with inadequate follow up from the coordination team in A.A needs to be revisited.

In view of the planned income generating activity, the D.D office has a concern that without additional staff, it might be difficult for the office to effectively involve in promoting it. Delay of the financial reports of the committee affects the timely processing of the transfers to the committees. All offices have reported that all activities are executed through voluntary activity and this has largely affected the performance of both the office and HRCI.

In addition, the offices were providing office space and transportation facility to the IC supervisors (ISAPSO staff). According to the field officers, this has been effective support to accomplish their activities in the face of the existing resource limitation. A

field supervisor in D.D, however, indicated that his activity is highly constrained by budget limitations as well as lack of transportation facilities.

## 3.3. Sub-granted partners

### *3.3.1 ISAPSO*

ISAPSO is currently managing the 21 IC in the high-risk corridor. Due to the difficulty for the 2 project officers to monitor 21 sites by shuttling from A.A., ISAPSO recruited 3 field offices stationed at the SC/USA coordination offices to strengthen its supervision. The IC started with 42 trained IC counselors in 2002. Through its information dissemination activities, ISAPSO has been able to include a one hour HIV/AIDS prevention session in the National Drivers Training Manual.

The management in ISAPSO believes that counselors are not capable of producing IEC materials for the consumption of the sound mini media although theywere provided with light training on designing. For the prevailing increasing demand for information, HRCI cannot rely on the IC staff and other sources of information should be identified. The need for increased networking with and establishing HIV/AIDS clubs in the target areas recognized by ISAPSO. Some concerns, however, include the need for more training on management of sound mini media, promoting the involvement of stakeholder from the government, designing IG for the IC as phasing out strategy and clarifying the administrative and operational linkages of IC with SC.

### *3.3.2. Population Meida Center (PMC)*

PMC is sub granted for the preparation of the cassette serial drama for dissemination to raise the awareness of transport workers and FSW to adopt safe sex practices and reduce their vulnerability to and risks of HIV/AIDS. To this effect PMC signed a memorandum of understanding with SC in March 2003. In this agreement, PMC takes the responsibility of conducting rapid assessment and pre testing of the initial two episodes, share the results and keep SC informed of the process as well as the scripts, conduct third party evaluation to examine whether the objective is achieved and finally conduct a workshop to disseminate the findings of the evaluation.

In line with its agreement, PMC has produced rapid assessment and shared the results of the pre testing of the initial two episodes to SC. The scripts were prepared by conducting focus group discussion, reviewing literature and dispatching script plotters to target areas. A post evaluation report was also discussed with SC. One thousand copies of the cassette drama was submitted to SC which SC distributed through ISAPSO-IC and its coordination offices.

The coordination offices distributed the copies of the cassette serial dramas to peer educators, truck companies while ISAPSO also distribute to truck companies. The team could not find clear picture of the distribution methodology and this was also expressed by the PMC managment. In addition, PMC is concerned about the acquisition of the information on the dissemination of the cassette serial drama as it will be used for the dissemination workshop planned for June 2004.

### *3.3.3. International Office of Migration (IOM)*

IOM is an international organization sub granted in September 2002 to undertake the establishment of the VCT centers and strengthening of STI treatment mainly in government health facilities. IOM has earlier experience in running mobile VCT centers and availing STI treatment in Dessie and Nazreth. IOM has taken responsibilities of conducting facility assessment of public health care providers survey in all the targeted towns, training of staff, setting up the VCT centers and strengthening of STI treatment by providing the necessary equipment and supplies, as well as integrate these facilities in the public health service system. Due to the long process involved in placing the appropriate administrative arrangement with Ministry of Health, Regional and Zonal Health Bureaus, the actual implementation of the HRCI did not start until February 2003.

According to the agreement, IOM conducted the facility assessment in all the targeted towns and identified 7 sites for setting up the VCT centers. As discussed in the preceding chapters, IOM in consultation with SC revised the initially allocated budget and established a total of 17 VCt centers along the corridor. In addition, the team has briefly looked the electronic database created by IOM from information generated by the VCT/STI centers. Lack of cooperation in the public health care providers in the provision of space for office and drug store, inadequate integration of the VCT as regular activities of providers, absence of uniform schedule for the commitment of the public health providers/bureaus, inadequate reception of the staff for effective use of the treatment cards for STI management are some of the observed institutional problems. In addition, IOM has considered the delay of procurement of VCT kits and shortage of sample NUNC tubes as issues to be taken up by the office soon

## 4. Financial Management

## 5. Monitoring and Reporting

Project monitoring is undertaken at various stages. The HIV/AIDS committees do the lower level monitoring. Most of the committees have regular monthly meetings to follows up the activities of various sub committees as well as making decisions. The monitoring emphasizes on specific activities, own procedural guidelines and financial utilization report. The coordination office conducts the second lower local level monitoring and this takes detailed account of the achievements of the committee as well as the sub grantee activities such as the IC and VCT. The project monitoring has provided feedback from the target areas and concerned parties and, served as a means of information exchange and track records the actual practices.

Although there is a general satisfaction in the quality of the progress reporting particularly achievement and financial reports, the analytical part seems lacking. The progress reports have not so far provided information on follow-ups of decisions, technical challenges, gaps, overlaps and synergy with other donor activities and collaborations. It is equally possible that the learning and empowerment process of the

community could be documented for further development/refining of approaches such as for development of sustainable community based systems.

# 6. Conclusion and recommendation

## 6.1 Conclusion

The HRCI program has registered remarkable achievements by demonstrating results from the scaling up and adoption of newly introduced approaches and systems for HIV/AIDS prevention and impact mitigation in the country. The achievements registered to date are voluminous considering the 16 months of the actual project implementation period and its limited human as well as financial resources. Developing partnership with those who have the relevant experience, the adoption of a comprehensive strategy by including the care and support as an entry to increase demand for HIV/AIDS preventive services and mobilization of the local structures to support the community based activities are the most exemplary accomplishments.

Among the prominent achievements of the program, the HRCI is able to create and strengthen linkages among the different sector offices and social organization and developing local systems. These efforts have helped to create a sense of responsibility, ownership and leadership commitment on the part of public institutions to the issue of HIV/AIDS. Most of the initiated activities such as the IC, VCT and STI services, care and support, livelihood security and CDQ are showing promising indications for bringing change although the initiative has yet to confirm its replicability as a package in the future.

The set up as well as the management has placed expedient environment to consider emerging local needs in the course of the implementation. This has provided the initiative to be the most appropriate and effective in trying out new strategies and mobilizing stakeholders to achieve the objectives of each of the components. In addition, the implementation of HRCI is backed by dedicated staff and with and very close follow-up system.

From developmental perspective, a number of the initiated activities and their subsequent outcomes have placed further challenges that require either of replication, advocacy, capacity building and fine-tuning interventions for demonstrating efficiency and sustainability. In light of this, the following recommendations are suggested.

## 6.2 Recommendations

**General**

- Defining roles and responsibilities for managing/monitoring of the various facilities of HRCI and partners, and adopting a transparent information exchange system is necessary for strengeting the partnership and enhancing the efficiency of the initiative. Adopting a clear in house chain of command and system for

exhaustive consultaion and information exchange is also necessary for activities directly managed by HRCI.

- The promissing systems developed as a result of the HRCI such as the referal system in Mojo, FSW Association in Mille, inclusion of street based FSWs and OVCs in the program need to be replicated in the target areas to enhance effectiveness.

- HRCI needs to design a strategy for addressing the needs and in support of the sustainability of locally initiated activities such as the FSW association. The areas could be provision of technical and financial & material support, networking with potential donors/institutios, facilitation for capacity building, etc)

- HRCI needs to promote policy dialogue and strengthen networking with HAPCO, line offices of Health and other concerned public institutions for their proactive support (in terms of faciliation, provision of infrastructure and availing other necessary resources) of all the components of the program.

- To reduce the challengs that may escort newly introduced intervetions, HRCI should undergo an appropriate and exhaustive assessments before venture in activities that have not been well reviewd/studied at the planning or implemenation stages.

- Although convening for deadelines are necessary for the program, attenging the quality of the sersvices of HRCI is sufficient condition for the successful accomplishment as well as sustainbility. It is advisable for the management to focus on enhancing the quality of the already initiated activities instead of adopting new areas of intervetion in the ramaining program period.

- An area that has been marginally addressed is the sexual harrasment that FSW are facing partly due to their insistance in asking clients to use condom. Although this has been addressed at personal level, except Mille, HRCI needs to promote colelctinve and organized action by involving stakeholders (HIV/ADIS committee, administration, VCT and STI centers) and the local police administrations to address the issue.

**IR1 HIV/AIDS Prevention Practices and Demand Creation for Services**

- Strengthening the IC in terms of covering its operation cost for short period and creating IG scheme as phasing out strategy for sustaining its former as well as newly initiated activities and providing capacity building on designing of IEC materials and management of sound mini media are very relevant.

- Designing a mechanism for the ICs to be continuously and adequately supplied with an up-to-date HIV/AIDS information, involving stakeholders from the public sector and access already developed cassette dramas and videocassettes for

circulation are very crucial to meet the prevailing high demand. In addition, Assessing the real life experience of the target population and locally produced mini media documents could contribute to the developing new IEC materials.

- Adopting a systematic and continuous assessment of the information needs of clients is necessary to promote the effectiveness of the IC.

- Broaden the scope of ICs by developing an efficient network with anti AIDS clubs and public stakeholders such as administration, health offices, police, etc to use the IC as source of information and coordination point if need be.

- Strengthening of the IC in the main truck stops of Galfi, Awash and Dewele provides opportunity for increasing the effectiveness of the IEC intervention of the

.

**IR2 Access and Availability to Preventive Services**

- Promote dialogue and commitment for the integration of the VCT activities in the management system of the public health providers and for their proactive action in fulfilling the necessary budget and supplies requirements in the future is crucial for its sustainability.

- Taking urgent steps for supplying the VCT and STI centers with the necessary supplies (such as testing kits), conducting the quality control and, to strictly and uniformly follow appropriate technical and referral procedures for referral (such as in the absence Cappilus kit) are crucial to maintain the credibility of the service.

- Other medical and administrative staff needs to have guidance/direction on the role of counseling and confidentiality in the process of VCT as it is relevant for promoting acceptability and credibility.

- Improving attention given to STI care in all the sites is necessary to achieve the objective of increasing the demand and access to VCT services.

- HRCI needs to promote the availability of OI treatment which is highly demanded by PLWHA.

**IR3 Accessibility to Care and Support by PLWHA and OVC**

- Capacity building of the HIV/AIDS committee in managing the care and support, fund raising, financial and administrative management is crucial for their effective services. In addition, strengthening the linkage with communities (by having adequate representation) is imperative for sustainability. Genuine community participation needs to be adequately exercised in all of the activities and target areas.

- The recently circulated TOR for the committee needs to be discussed, reiterated and adopted by all the committees as soon as possible. All the necessary guidelines and procedures (administrative and financial) need to be placed for committees' effectiveness and empowering them to run all activities by their own. It is also necessary to encourage the committees to develop their own vision, mission and goals in the process for enhancing their efficiency and sustainability.

- Encouraging the direct involvement of communities and local social networks such as Iddir and Mahiber in the activities of the committee is vital for effectively managing as well as sustaining the care and support component of HRCI.

- Committee members with an overlapping responsibility need to revisit their roles and give space for other potential volunteers from the community to take part in the initiative.

- For sustaining the voluntarism in HBC requires rewarding volunteers for their free services through promoting dialogue and mobilizing stakeholders for availing opportunities for them and providing them formal certificate for their service.

- It is necessary to adopt a uniform/standard procedure for the provision of HBC to sick/bed-ridden people as an entry to increasing demand for VCT.

- In bigger towns such as Nazreth and Dire Dawa, HBC activities have to be standardized as there are other NGOs working on care and support. HRCI should make special effort to mobilize and assist either HAPCO or any other appropriate institution that could take responsibility of coordinating, streamlining and standardizing the care and support activities. Tolerating the currently observed frauds for instance in Dire Dawa would create a situation that is morally inconsistent to the objective of the program.

- HRCI need to design a mechanism for addressing the special needs and psychosocial support for OVC. Networking with teachers, community members, and religious leaders for psychosocial counseling has shown positive indications and HRCI need to technically support such efforts. The committee needs to be encouraged to set a regular schedule to have a discussion with OVCs.

**IR4 Livelihood Security for PLWHA and OVC**

- The currently initiated activities need to continue being implemented at full scale as the target group have been informed early on and are expecting to start the schemes.

**IR5 Community Defined Quality of Service**

- This intermediate result also has only been started very recently and need to be strengthening in the reaming project period.

## Annex 1

## Tables generated from Mid-term Review Survey

**Table 1. Knowledge about possible ways of transmission (n=557)**

| Ways of transmission | N | % |
|---|---|---|
| Husband/wife to spouse | 556 | 99.8 |
| Unsafe sexual relationship | 421 | 75.6 |
| Pregnant mother to child | 351 | 63.0 |
| Among fiancés | 266 | 47.8 |
| Using unclean blades, needle | 221 | 39.7 |
| From a friend to friend | 179 | 32.1 |
| Mother to child | 100 | 18.0 |
| Low awareness on HIV/AIDS | 53 | 9.52 |
| From neighbors | 52 | 9.34 |
| Sex without condom | 12 | 2.15 |

**Table 2 Knowledge about preventive measures for HIV/AIDS (n=557)**

| Preventive measures | n | % |
|---|---|---|
| Use of condom | 255 | 45.8 |
| Abstain | 230 | 41.3 |
| Avoid using unclean bladed | 50 | 9.0 |
| Change behavior (trusting partner) | 111 | 19.9 |
| Delay sexual contact | 84 | 15.1 |
| Limiting sexual partner | 334 | 60.0 |
| Use VCT (know self status and before marriage) | 37 | 6.6 |
| Avoid unsafe sex | 3 | 0.5 |
| Wait until god protect us | 5 | 0.9 |

**Table 3 Five major diseases and perceived as symptoms of HIV/AIDS by respondents (n=557)**

| Type of diseases and symptoms | 5 Major diseases | Symptoms of HIV | |
|---|---|---|---|
| | | n | (%) |
| Common illness flue/cold | 462 | 38 | 6.8 |
| HIV\AIDS | 279 | - | 0.0 |
| TB and Repeated TB | 243 | 321 | 57.6 |
| Chronic cough | 133 | 376 | 67.5 |
| Herpis | 87 | 18 | 3.2 |
| STI | 27 | - | 0.0 |
| Long lived diarrhea | 1 | 473 | 84.9 |
| Thinness of hair | - | 35 | 6.3 |
| Visible infection | - | 73 | 13.1 |
| Loss of weight | - | 514 | 92.3 |
| Frequent sickness | - | 385 | 69.1 |

**Table 4 Benefits of HRCI as perceived by respondents (n=557)**

| Type of services | n | % |
|---|---|---|
| Care & support to OVC | 197 | 35.4 |
| Care & support for PLWHA | 151 | 27.1 |
| Counseling service | 81 | 14.5 |
| Information and education on HIV/AIDS | 67 | 12.0 |
| VCT services | 37 | 6.6 |
| Distribution of condom | 10 | 1.8 |
| Lack of behavioral change | 1 | 0.2 |
| Other | 10 | 1.8 |

**Table 5 Respondents views on HRCI Strength and weakness by type of intervention**

| **Strength of HRCI project** | | **Weaknesses** | |
|---|---|---|---|
| **Type of interventions** | **n** | **Type of interventions** | **n** |
| Care & support to OVC | 236 | Inadequate IC activity | 131 |
| Information, education & distribution of IEC materials | 224 | Inadequate support for PLWHA | 104 |
| Care & support for PLWHA | 159 | Inadequate support to institutions | 49 |
| Distribution of condom | 45 | Inadequate behavioral change observed | 20 |
| Created demand for condom | 16 | Distribution of condom | 16 |
| HIV\AIDS committee | 11 | Poor ethics | 12 |
| Availability of VCT to rural people | 1 | Unavailability of ARV drugs | 14 |
| | | Inadequate representation of communities | 9 |
| | | No confidentiality | 6 |
| | | No free VCT service | 5 |

**Table 6 Media through which respondents know about HRCI by source of information Among those who know about HRCI (n=472)**

| Source of information | n | % |
|---|---|---|
| Neighbors | 161 | 34.1 |
| Volunteers | 155 | 32.8 |
| Meeting | 135 | 28.0 |
| HIV/AIDS committee, | 20 | 4.2 |
| Other | 1 | 0.2 |

**Table 7 HRCI interventions that has brought change as perceived by respondents & current users of the services(n=542)**

| Types of services | n | % | No. of users |
|---|---|---|---|
| IC information, education services | 125 | 23 | 69 |
| Counseling service | 73 | 13 | - |
| Distribution of condom | 67 | 12 | 1 |
| VCT services | 66 | 12 | - |
| Care & support to OVC | 54 | 10 | 45 |
| Care & support for PLWHA | 25 | 5 | 8 |
| Attending Meetings on HIV/AIDS | | | 18 |

**Table 8 Examples observed changes as a result of HRCI**

| Examples | n | % |
|---|---|---|
| Availability of information & education on HIV/AIDS | 206 | 37.0 |
| Availability of VCT services | 70 | 12.6 |
| Care & support for PLWHA | 88 | 15.8 |
| Care & support to OVC | 80 | 14.4 |
| Education provided by PLWHA | 11 | 2.0 |
| Increased demand and use of condom | 78 | 14.0 |
| Reduction of stigma & discrimination | 17 | 3.1 |
| Use VCT (for personal benefit & before marriage) | 119 | 21.4 |

**Table 9 Reasons for not using the available HIV preventive services (n=557)**

| Reasons of respondents | n | % |
|---|---|---|
| Have dependable marriage (high trust with spouse) | 87 | 15.6 |
| Have only one partner | 69 | 12.4 |
| Believe in God | 59 | 10.6 |
| Have good knowledge to protect myself and my family | 49 | 8.8 |
| Am using condom | 34 | 6.1 |
| Have abstained | 30 | 5.4 |
| Did not want to bother myself | 13 | 2.3 |
| Have limited my partners | 3 | 0.5 |
| Have stopped sharing blades, needles and sharp object that | 6 | 1.1 |
| Did not take injections | 1 | 0.2 |
| Did not believe on the service provided | 1 | 0.2 |

**Table 10. Intended participation of respondents in the Preventive measures at personal, family and community levels**

| Type of intended participation | Personal | | Family | | Community | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Limiting sexual partner | 311 | 55.8 | 61 | 11.0 | 25 | 4.5 |
| Avoid using unclean piercing materials | 210 | 37.7 | 243 | 43.6 | 3 | 0.5 |
| Abstain | 130 | 23.3 | 49 | 8.8 | 15 | 2.7 |
| Use of condom | 104 | 18.7 | 29 | 5.2 | 4 | 0.7 |
| Try to bring change in behavior | 76 | 13.6 | - | - | 337 | 60.5 |
| Use of VCT services | 20 | 3.6 | 8 | 1.4 | 16 | 2.9 |
| Using counseling service | 10 | 1.8 | 3 | 0.5 | 1 | 0.2 |
| Delay sexual contact | 1 | 0.2 | - | - | 30 | 5.4 |
| Support people infected & affected by HIV/AIDS | 1 | 0.2 | 1 | 0.2 | 9 | 1.6 |

**Table 11. Possible action recommended by respondents for the future**

| Type of future actions | n |
|---|---|
| Strengthen IC activities | 85 |
| Coordinate & integrate with community | 73 |
| Work more on change behavior | 51 |
| Continue the existing services | 50 |
| Care & support for PLWHA | 48 |
| Strengthen on going and basic counseling service | 35 |
| Care & support to OVC | 27 |
| SC have its own staff | 14 |
| VCT services | 12 |
| Illegal video shops, chat shop | 6 |
| Provision of ARV drugs | 4 |
| FSW to involve in another job | 3 |
| Payment for service provision | 2 |

**Table 12. Potential threats (valid) as identified by respondents**

| Type of threats | n |
|---|---|
| Illegal video shops, chat shop | 46 |
| Rejection feedback from users | 33 |
| Inadequate community participation | 28 |
| Lack of behavioral change (resistance) | 20 |
| Low awareness on HIV/AIDS | 19 |
| Lack of cooperation from Council/Administration Office | 18 |
| Absence/inadequate of training on HIV | 13 |
| Poverty and dependency syndrome | 8 |
| Inadequate VCT service | 7 |

**Table 13 Knowledge of HRCI activities by type of services offered (n=545)**

| Type of services offered | n | % |
|---|---|---|
| Care & support to OVC | 201 | 36.9 |
| Information and education on HIV/AIDS | 141 | 25.9 |
| Care & support for PLWHA | 136 | 25.0 |
| Distribution of condom | 28 | 5.1 |
| VCT services | 18 | 3.3 |
| Skill training | 15 | 2.8 |
| Support to HIV clubs | 5 | 0.9 |
| Support to people infected & affected by HIV/AIDS | 1 | 0.2 |

**Annex II**

## High Risk Corridor Initiative: Performance Based on PMP

| Strategy/Result | Planned and Achievement of IR | | | | | | | | Achievement-% |
|---|---|---|---|---|---|---|---|---|---|
| | Year I | | Year II | | Year III | | Total | | |
| | Plan | Achiev | Plan | Achiev | Plan | Achiev | Plan | Achiev | |
| **IR 1 Increased demand for HIV/AIDS preventive services** | | | | | | | | | |
| Peer group education | | | | | | | | | |
| – No. of groups organized for FSW & TW | 27 | 20 | 27 | 2 | 27 | | | | |
| – No. of peers trained FSW & TW | 424 | | 424 | | 424 | | | | |
| – No. of sessions/training for FSW peer groups | 27 | | 1 | | Follow ups | | | | |
| – No. of sessions/training for TW peer groups | 2 | | 1 | | | | | | |
| – No. of IC counselors trained | | | | | | | | | |
| – No. of IC volunteers trained | | | | | | | | | |
| Partnerships established for BCC | | | | | | | | | |
| – ISAPSO | | | | | | | | | |
| – PMC | | | | | | | | | |
| – No of oriented hotel, bar & disco owners | 24 | | | | | | | | |
| – No. of orientation & reorientation meetings | 6 | | | | | | | | |
| – No. of materials developed | | | | | | | | | |
| – No. of monitoring visits & reports | | | | | | | | | |
| | | | | | | | | | |
| IC services | | | | | | | | | |
| – No of IC established | 10 | | 11 | | | | | | |
| – No. people counseled | | | | | | | | | |
| – No. of IEC materials distributed | | | | | | | | | |
| – No. of condoms distributed | 63000 | | 126000 | | 63000 | | | | |
| – No. of people referred to VCT & STI services | | | 10000 | | 13000 | | | | |
| – No. of cassette serial drama distributed | | | 500 | | 200 | | | | |
| No. of Hotels & Bar availing condom & IEC materials | 862 | | 862 | | 862 | | | | |

| Strategy/Result | Planned and Achievement of IR | | | | | | | | Total Achie v. % |
|---|---|---|---|---|---|---|---|---|---|
| | Year I | | Year II | | Year III | | Total | | |
| | Plan | Achiev | Plan | Achiev | Plan | Achiev | Plan | Achiev | |
| **IR 2 Increase accessibility to & availability of preventive services** | | | | | | | | | |
| – No of VCT counselors trained | | | 12 | 44 | | | | | |
| – No of health staff trained on HIV testing & OI | | | 20 | 44 | | | | | |
| – No of health staff trained on STI management | | | 20 | 44 | | | | | |
| – Clinic & health post (HP) staff trained on STI management | | | 18 | | | | | | |
| – Clinic & HP staff trained on VCT | | | 8 | 8 | | | | | |
| – Clinic & HP staff trained on OIs | | | 17 | 8 | | | | | |
| – Clinic & HP staff trained on HIV testing | | | 2 | 8 | | | | | |
| – No of VCT centers established | 16 | | 16* | 18 | 4 | 18 | | | |
| – No of STI centers strengthened | 26 | | 26* | 25 | 4 | 25 | | | |
| – No. VCT kits distributed | | | | | | 193*** | | | |
| – No. STI kits distributed | | | | | | 68 | | | |
| – No. VCT & STI with sufficient guideline/protocol | | | 26 | | | | | | |
| **IR 3 Accessibility to care & support by PLWHA & OVC** | | | | | | | | | |
| Services Offered | | | | | | | | | |
| – No. of HBC Volunteers trained | | | 50 | 32 | 70 | 52 | | | |
| – No. of HBC kits distributed | | | 50 | | 70 | 100 | | | |
| – No. of PLWHA received HBC service | | | 660* | | | 456 | 450 | | |
| – No. of HBC protocols availed | | | 26 | | | 84 | | | |
| – No. of PLWHA received positive living training | | | 32 | | | 32 | | | |
| – No. of PLWHA referred to VCT by HBC volunteers | | | 300 | | 200 | | | | |
| – No. of PLWHA received spiritual counseling by religious leaders | | | 660* | | | 496 | | | |
| – No. of PLWHA received to health facilities for OI & other treatment | | | 300 | | 200 | | | | |

N.B * = revised plan, ** = figure after / represent data for TW, *** = includes determine (screening 123, Capillus (confirmatory) 37 and Unigold (tie-breaker) 33

| Strategy/Result | Planned and Achievement of IR | | | | | | | | Achievement-% |
|---|---|---|---|---|---|---|---|---|---|
| | Year I | | Year II | | Year III | | Total | | |
| | Plan | Achiev | Plan | Achiev | Plan | Achiev | Plan | Achiev | |
| **Social mobilization** | | | | | | | | | |
| – No. of committees set up | | | 28 | 24 | | | | | |
| – No of committees/sub com. currently operational | | | 21* | 18 | | | | | |
| – No. of training for committees on CPP | | | 21* | 18 | | | | | |
| – No. of Iddirs & Mahiber trained on care & support | | | 50 | Are represented in CPP | | | | | |
| – No. of action plans developed by committees | | | | | | | | | |
| Amount of matching fund mobilized by committees | | | Br. 200,000 | Br.244, 290 | Br. 100,000 | | | | |
| Amount of fund released by HRCI to committees (Br.) | | | 1,839,231* | 610,762 | | | | | |
| **IR 4 Increase livelihood security of PLWHA , OVC & care givers** | | | | | | | | | |
| – No. of functional CBCCC | | | 5 | 4 | | | | | |
| – No. OVCs in CBCCC | | | 100* | 100 | | | | | |
| – No. OVCs under care & support above age of 6 | | | 1000 (856) | 523 | 500 | | | | |
| – No. of people organized for IG schemes | | | 300 | 20 | 200 | | | | |
| – No. of IG schemes designed | | | 4 | 2 | | | | | |
| **IR 5 Improve community defined quality of service** | | | | | | | | | |
| No. of Participatory Learning Approach conducted | | | 4 | | | | | | |
| No. of joint monitoring system by community and service providers established | | | 1 | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

## Annex 4

## Terms of Reference for the Mid-term Review

### Tasks accomplished by Team Members

| | Activity | Teigist Lemma | Michael Tamiru |
|---|---|---|---|
| Survey | Data collection, verification, analysis | All | - |
| VCT | Transcribing | - | All |
| | Report | - | All |
| IC counselors | Transcribing | Mojo | Naz, Mojo, D.D, Logia, Mille |
| | Report | All | - |
| IC volunteers | Transcribing | Logia, Mille, Chelelnko | Mojo, Mille |
| | Report | All | - |
| CHBC | Transcribing | - | Naz, Mojo, Celenko, D.D., Mille, Logia |
| | Report | All | - |
| PLWHA | Transcribing | D.D, | Naz, Mojo, D.D, Logia |
| | Report | All | - |
| FSW | Transcribing | All | - |
| | Report | All | - |
| Committee | Transcribing | All | - |
| | Report | All | - |
| TW | Report | All | - |
| Youth | Report | Chelenko | D.D |
| OVC | Report | All | - |
| Hotel Owners | Report | - | D.D |
| Bureau of Health | | - | Mojo, D.D |
| HAPCO Off. | | Mojo | D.D |
| Vice President of the Afar Regional Administration | | Discussion | Discussion |
| Kebele Leader D.D | | Discussion | - |
| Hoter Owners D.D | | - | Discussion & report |
| Coor. Off (Naz, Awash & D.D) | | Discussion & report | Discussion |
| BCC & Social Mob | | Discussion | - |
| Care & Support | | Discussion | - |
| ISASO, PMC, IOM | | Discussion & report | Discussion |
| FHI | | Discussion | - |
| USAID | | | |
| CDC | | | |

## Annex V:

***List of persons and institutions contacted***

## I. List of Institutions and people contacted

| Inst. | Contacted persons | Position | Inst. |
|---|---|---|---|
| SC/US | Dr. Wendy Ravado | HVI/AIDS Advisor | SC/USA |
| SC/US | Dr. Mohammed Ali Bhuyan | Program Manager | HRCI Dept. SC/US |
| SC/US | Dr. Zelalem Tesfaye | Medical Coordinator | HRCI Dept. SC/US |
| SC/US | Mr. Mechal Tilahun | BCC Coordinator | HRCI Dept. SC/US |
| SC/US | Mr. Fisseha Tekle | Community Mobilization | HRCI Dept. SC/US |
| SC/US | Sr. Tsehaitu Desta | Head | Coordination Office, Nazreth |
| SC/US | Mr. Tafesse G/Michael | Head | Coordination Office, Awash |
| SC/US | Mr. Luche Tadesse | Head | Coordination Office, D.D |
| Afar | Ato Mohammed Tahir | Vice Rep | Council of the Afar Regional State |
| D.D. | W/o Haymanot Shenkute | Chair person | Kebele 11 Wereda 3 |
| D.D | | Chair Person | Misrak Hiywot Adin HIV/AIDS Club |
| A.A | W/o Beletu Mengistu | Executive Director | ISAOPSO |
| A.A | Ato Alemayehu | Program Coordinator | |
| A.A | Dr. Nigussie Teferera | Country Representative | PMC |
| A.A | Ato Abebaw Ferede | | PMC |
| A.A | Dr. Leul Ayalew | Medical Coordinator | IOM |
| A.A | Ato Abeje | | IOM |
| | Ms. Franchisca | | FHI |
| | | | |
| | | | |
| | | | |
| | | | |

## List of Respondents for FGD OVC

| Name | Gender | Age | Education Grade | Name | Gender | Age | Education Grade |
|---|---|---|---|---|---|---|---|
| **Dire Dawa** | | | | **Chelenko,** | | | |
| Mahlet Terecha | F | 14 | 8 | Henok Tesfaye | M | 13 | 7 |
| Deka Keri | F | 13 | 6 | Yigeremu Haile | M | 13 | 6 |
| Mahlet Abebe | F | 21 | 6 | Hiywot Aseneghe | F | 15 | 7 |
| Bedlu Nigusse | M | 16 | 7 | Fire Hailu | F | 15 | 6 |
| Tamiru Yecime | M | 14 | 7 | Feven Hilu | F | 11 | 5 |
| Ayne Rabi | F | 14 | 8 | Mahelt Gebehu | F | 12 | 5 |
| Michel Hufanta | M | 14 | 7 | Rosa Jafare | M | 12 | 6 |
| Habtamu Itafa | M | 11 | 5 | Hana Weletaw | F | 6 | 1 |
| Matiwos Mesfin | M | 10 | 3 | Abi mamo | M | 7 | 1 |
| | | | | Helen Amare | F | 16 | 9 |
| **Logia** (*To be included*) | | | | **Mille** (*To be included*) | | | |
| | | | | | | | |
| **Nazreth** | | | | **Mojo** | | | |
| Israel Sebsibe | M | 7 | 2 | Shibre Amare | F | 11 | 3 |
| Yonas Hailu | M | 14 | 7 | Woubit gemechu | F | 11 | 4 |
| Ysin Abdla | M | 12 | 3 | Mihret Belda | F | 8 | 1 |
| Atekalay Solomon | M | 10 | 4 | Goshu Tadesse | M | 9 | 2 |
| Yared Zewdu | M | 10 | 2 | Abdul Kasshun | M | 12 | 2 |
| Daniel Fekadu | M | 9 | 1 | Bertukan Legesse | F | 12 | 2 |
| Tigist Begeta | F | 16 | 10 | Ellen takele | F | 12 | 2 |
| Helen Getu | F | 14 | 6 | Hanna Belda | F | 17 | 7 |
| Senatayehu Derje | F | 12 | 6 | Dejene teshome | M | 12 | 5 |
| Bezawit Shegaw | F | 14 | 7 | Messeret Hagos | F | 15 | 8 |
| Toman Dechasa | F | 15 | 7 | Maheder Genene | F | 14 | 8 |
| | | | | | | | |

## List of Respondents for FGD - Peer Educators

| Name | Age | Educ | Name | Age | Educ |
|---|---|---|---|---|---|
| **Dire Dawa (incl non-peer)** | | | **Chelenko** | | |
| Endsare Mamo | 24 | 2 | Haymanot Yonas | 15 | 7 |
| Hebset Haile | 26 | 5 | Tigist Senebe | 18 | 9 |
| Meseret Alemu | 35 | 5 | Meski Ahmed | 20 | Illit |
| Yenenesh Hagose | 18 | 4 | Sosena Endestaw | 18 | 10 |
| Almaz Tadele | 24 | Illit | Yodit Tesfaye | 19 | 9 |
| Tita Hailu | 19 | 10 | Brook Mengistu | 23 | 7 |
| Muna Mohammed | 18 | 10 | | | |
| Aynalem Abebe | 19 | 8 | | | |
| Alfiya Jemal | 18 | 2 | | | |
| Alfiya Aliye | 18 | 3 | | | |
| Elsa Feteno | 17 | 6 | | | |
| Ayele Abate | 30 | 5 | | | |
| **Nazreth** | | | **Mojo** | | |
| Yeshiemebet Mekonnen | 22 | 9 | Embet Shimelis | 21 | Illit |
| Hana Tassew | 20 | 4 | Hana Abebe | 16 | Illit |
| Teje Getaneh | 23 | Illit | Mortha Tadessie | 25 | 7 |
| Mimi Abraham | 23 | 4 | Hiwot Amsalu | 20 | 9 |
| Desta Belachew | 29 | 6 | Abrash Negussie | 28 | 5 |
| Ejigayehu Tadesse | 25 | 8 | Genet Bekele | 20 | 3 |
| Tigist Bezu | 23 | 10 | Elsa Samuel | 24 | 8 |
| Abeba Abera | 23 | 12 | Berhane Tesfaye | 20 | Illit |
| Tebelise K/Mariam | 21 | 6 | Embet Negash | 18 | Illit |
| Selamawit Demeke | 17 | 7 | Mehiret Abrahan | 17 | 9 |
| Abebech Demeksa | 30 | 4 | Genet Tesfaye | 22 | 11 |
| Tigist Gezahenge | 24 | 7 | Feluma Zegeye | 23 | 4 |
| **Logia** (*To be included)* | | | **Mille** (*To be included)* | | |
| | | | | | |

## List of Respondents for Focus Group Discussion PLWHA

| Name | Gender | Age | Educ | Name | Gender | Age | Educ |
|---|---|---|---|---|---|---|---|
| **Dire Dawa** (*To be included)* | | | | **Chelenko** (*To be included)* | | | |
| | | | | | | | |
| | | | | | | | |
| **Logia** (*To be included)* | | | | **Mille** (*To be included)* | | | |
| | | | | | | | |
| **Nazreth** | | | | **Mojo** | | | |
| Fekadu Tsegaye | M | 28 | 3 | Fasika Tebebu | F | 28 | 3 |
| Fekadu Negash | M | 22 | 9 | Tigist Tulu | F | 20 | 10 |
| Alemu Wale | M | 37 | 2 | Welansa Boru | F | 32 | 3 |
| Solomon Assefa | M | 20 | 7 | Fenusie Chechiyibel | F | 30 | Illit |
| Mengistu Fekadu | M | 19 | 2 | Dawit Mamo | M | 29 | 12 |
| Kumneger Mengesha | F | 20 | 5 | Beyenech Alemu | F | 35 | Illit |
| Rahel B/Maiam | F | 22 | 16 | Daniel Mamo | M | 23 | 7 |
| Lokenesh Esheter | F | 43 | Illit | Guluma Zegeye | F | 23 | 4 |
| Addis Girma | F | 18 | 6 | Almaz Tadesse | F | 55 | R&W |
| Gennet Shiferaw | F | 17 | 8 | Meseret Mengistu | F | 35 | Illit |
| | | | | Faitu Jeessa | F | 30 | 4 |
| | | | | | | | |

## List of Respondents for HIV/AIDS and Committee (& sub committees)

| Name | Gender | Age | Educ | Name | Gender | Age | Educ |
|---|---|---|---|---|---|---|---|
| **Dire Dawa** | | | | **Chelenko** | | | |
| **Wereda 2** | | | | Ahmed Sirage | M | 28 | 12 |
| Derge Assfaw | M | 29 | 12+1 | Tena Getu | | 35 | 12+1 |
| Denku Bekel | M | 37 | 12+1 | Geteenesh Shewaye | F | 30 | 12+1 |
| Derege Tsegaye | M | 21 | 12 | Lulu Deribie | M | 30 | 12+1 |
| Kebebush Bruno | F | 62 | 12+2 | Mulugeta Legesse | M | 28 | 10+1 |
| Mohamed Adem | M | 28 | 12+2 | Zenebe Mekonnen | M | 30 | 12+1 |
| Negussie Seyum | M | 60 | 12+2 | Dimisie Assefa | M | 28 | 12+1 |
| Nugusse Zebrga | M | 35 | 12+2 | Tesfa Dubume | | 48 | 12+1 |
| Melaku Tesmema | M | 28 | 12+4 | | | | |
| Mohammed Usman | M | 28 | 12+2 | **Youth & Prevention (Chelenko** | | | |
| **Wereda 3** | | | | Birhanu Dugassa | M | 30 | 12+2 |
| Asrate Sebsibe | M | 25 | 12 | Sintayehu Girma | M | 24 | 12+2 |
| Brelet G/Mariam | M | 43 | 12+2 | **Youth & Prevention (D.D)** | | | |
| Abebe Wolga | M | 36 | 12+1 | Abebe Mekoen | M | 24 | 12 |
| Fekadu Kassahun | M | 32 | 12+1 | Fisum Zeru | F | 21 | 10 |
| Abyote Abra | M | 25 | 102 | Henok Zemdkun | M | 26 | 12 |
| Eshetu Tenkolu | M | 48 | 6 | Mesfin Samuel | M | 20 | 10 |
| Roman Yilma | F | 40 | 8 | Esrael Fresenbet | M | 25 | 12 |
| Genet Bekele | F | 38 | 12+2 | Saada Nasir | F | 22 | 12+2 |
| Yonas Bertu | M | 30 | 12+2 | Meseret Hilue | F | 21 | 122 |
| **Wereda 4** | | | | Fekadu Kassahun | M | 33 | 12+1 |
| Abdurazak Ahmed | M | 37 | 10 | | | | |
| Hirute Beyene | F | 27 | 10 | **D.D Wereda 4 continued** | | | |
| Teshime Desalegn | M | 33 | 12 | Meseret Beza | M | 30 | 12 |
| Kebede Yemane | M | 54 | 9 | Tsegaye Melaku | M | 35 | 12 |
| Abdulwasi Habib | M | 36 | 9 | Eman Adem | F | 180 | 8 |
| Kelemork Mulu | M | 35 | 8 | Alemu kebede | M | 38 | 11 |
| Abulreheman Libto | M | 70 | 8 | Binyame Lemma | M | 23 | 12+1 |
| Tensaye Bekel | F | 38 | 10 | Etafrahu Tsege | F | 38 | 12 |
| Tamerate Bizuneh | M | 38 | 12 | | | | |
| **Nazreth** | | | | **Mojo** | | | |
| Wubayehu Eshete | F | 55 | 12+2 | Tadesse Kassa | M | 56 | 12+2 |
| Tewordros Million | M | 28 | 12+2 | Fidre Demissie | M | 42 | 12+2 |
| Getu | M | | 12+ | Teferra Shetu | M | 40 | 12+2 |
| Tsegayue Assefa | M | | 12+ | Gashaw Mamo | M | 28 | 12+ |
| Abebe Bekele | M | | 12+ | | | | |
| Tefera Engda | M | 46 | 12+2 | | | | |
| **Logia** *(To be included)* | | | | **Mille** *(To be included)* | | | |
| | | | | | | | |

## *Annex 5:*

## *Data Collection Instruments*

### *I. Guide for In-depth Interview*

Introducing self and complement the respondent for agreeing to be interviewed and spend her/his time. Stress that the all the information s/he provides will be kept under strict confidentiality and value and/or appreciate what respondent is working. Ask about herself, her work and livelihood. Tell respondent that the team members want to understand and learn instead of judging what people do.

***Generic questions (applicable to all except VCT and IC volunteers & counselors)***

How are you contacted first to involve in this project? What motivates you to accept the offer and provide service? At which stage of the processes did you participate (in the selection identification of peers, training, etc.)?

Other than being volunteer/peer educator what other services can you offer to the community you live in?

Have you ever been to the IC? If you do, with whom did you go and what do you get in IC (BCC materials, condoms, counseling service, etc.)?

What do you know about the services offered by HBC? What do you know about the OVC care? Can you tell us any of your concerns about HBC and OVC if any?

**Generic questions (applicable to FSW, TW, Youth, PLWHA)**

When and how do you contact the VCT and STI centers? How is the reception? Did you get the service (treatment and drugs) at all times? Is there anything that can be done better?

What do you know about the services offered by HBC? What do you know about the OVC care? Can you tell us any of your concerns about HBC and OVC if any?

Can you tell what you know about HIV/AIDS and STI? How do you come to know about it (through radio, colleagues, health workers, project staff, church/mosque, HRCI, etc.)?

Which institutions in your area are working on HIV/AIDS?

Skip for FSW: What do you know about the condoms supply in the hotels in the town? Are there circumstances that someone is unable to use condom, please explain?

Can you tell us about the practice in condom use in your vicinity? If you think it is low, what are the ways to improve use of condom and make the client accept "100% condom use"

What do you know about HIV/AIDS committees ands sub-committees, care and support for PLWHA, care for OVC? Have you ever participated in community resource mobilization and what was your contribution? If not, what is your reason?

How do you spend you pass time? What is/are the major topics you discuss with your peers when you meet to pass time, get acquainted and some rest?

Can you enumerate other possible activities that might be conducted in that special place and will benefit your peers?

What are the goals that the HRCI project coordinator has set with you? In your opinion, what should we do to help you reach those goals?

Do FSW/TW/Youth/PLWHA have Iddir/Mahber? If yes what is its objective? Can you include HIV/AIDS issues in it? If FSW do not have Iddir/Mahber, can you and your colleagues organize such networks of solidarity along the Northern and Southern trading routes? What can you contribute for the formation?

***Interview with Female Sex Workers***

In your opinion, what are the benefits, and the risks of the sex work? What do you and do not like from sex work and why?

Does your employer encourage you to get services of STI? What about protecting you from sexual harassment? What are you doing to reduce the transmission of HIV/AIDS in your area? What would you like to do in the future in this area?

Do you have adequate supply of condom with you right now? What do you know about the condoms supply in the hotels in the town? If you have a preference, what is your favorite brand? Why do you choose this brand?

If you do not mind, can you show us how to use a condom? How often do you use condom? If there were circumstances that you were unable to use condom, can you tell us about it?

Do you have children of your own? If yes, are they living with you right now? How old are they? Are they in good health? How would you help them become what they want to be?

Thanks again for this confidential interview and for sharing your experiences and possible ideas for strengthening our intervention. We will do our best to take the information to concerned experts for their action. We wish you good luck for everything.

***Interview with Truck Drivers***

Do you have children of your own? If yes, are they living with you right now? How old are they? Are they in good health? How would you help them become what they want to be?

If you had close friend/relative/family member who is interested to become a truck driver, what would you advice him? In your opinion, what are the challenges in being a truck driver and in the context of HIV/AIDS?

Does your employer encourage you to get services of HIV/AIDS and STI? Have you ever visited VCT and IC along the corridor? If yes, for what purpose and/or service did you seek? How did the councilors and volunteers receive you? Did you get what you want from the centers, pleas explain?

Do you have adequate supply of condom along the corridor? Do you travel with supply of condom or buy it wherever and whenever you need it? Think of the towns and hotels along the corridor, what do you know about the condoms supply in the hotels along the corridor? If you have a preference, what is your favorite brand? Why do you choose this brand?

How often do you use condom? If there were circumstances that you were unable to use condom, can you tell us about it?

What are you doing to reduce the transmission of HIV/AIDS in your area? What would you like to do in the future in this area?

Thanks again for this confidential interview and for sharing your experiences and possible ideas for strengthening our intervention. We will do our best to take the information to concerned experts for their action. We wish you good luck for everything.

***Interview with Youth***

Do you have children of your own? If yes, are they living with you right now? How old are they? Are they in good health? How would you help them become what they want to be?

Have you ever visited VCT and IC? If yes, why did you visit VCT and IC? How did the councilors and volunteers receive you? Did you get what you want from the centers, please explain?

Have ever used and/or intend to use condom? If you plan or are currently using condom, from where do you get it? How often do you intend to keep condom with you?

Do you think that there are circumstances that you would be unable to use condom, can you tell us about it?

If you know someone who is HIV positive, what do you think are major challenges that person is facing? In your opinion, what can he do to solve his/her problems? What can other people do to help this person?

What are you doing to reduce the transmission of HIV/AIDS in your area? What would you like to do in the future in this area?

Thanks again for this confidential interview and for sharing your experiences and possible ideas for strengthening our intervention. We will do our best to take the information to concerned experts for their action. We wish you good luck for everything.

*Interview with PLWHA*

Do you have children of your own? If yes, are they living with you right now? How old are they? Are they in good health? What do you advice them to become what they want to be? Do you discuss about HIV/AIDS and STI with you family members?

During your visit to VCT how was the reception of the staff? What kind of service did the councilors and volunteers provide you? Did you get what you want from the centers, please explain?

What is the difference between the service at VCT and health station/clinic? Could you explain about your satisfaction by the services of health station/clinic?

What kinds of protection from transmission do you use at home? Are you using condom? Since when did you start using condom? From where do you get it?

Think all possible ways, do you think that there are circumstances that you would be unable to use condom, can you tell us about it?

What are the major challenges that people living with the virus are facing? In your opinion, what can s/he do to solve these problems? What can other people do to help this person?

What kind of support have you received by people residing in your vicinity? How do you value this support (are you comfortable with it, should it continue same way)?

What are you doing to reduce the transmission of HIV/AIDS in your area? What would you like to do in the future in this area?

Thanks again for this confidential interview and for sharing your experiences and possible ideas for strengthening our intervention. We will do our best to take the information to concerned experts for their action. We wish you good luck for everything.

***IC Counselors (from Michael)***

***IC Volunteers (from Michael)***

## *II. Guide for a focused group discussion with FSW*

Warm up: Make sure that 50% of the participants are female. Fill the brief registration form while participants are arriving. During the meeting, the review team will start by introducing themselves and this will be followed by the introduction of participants of the FGD. Request participants if they allow the recording of the discussion by tapes, set it on and move on to asking the questions below:

*Generic questions*

How are you contacted first to involve in this project? What motivates you to accept the offer and provide service? At which stage of the processes did you participate (in the selection identification of peers, training, etc.)?

Can you briefly explain your responsibility as committee member/peer educator/volunteer? What was your objective to become so? What is your current objective in terms of your active participation in service you are currently offering? Other than being so what services can you offer to the community you live in?

When and how do you contact the VCT and STI centers? Describe your working relationship? Do you think that the centers are well supplied (for treatment and drugs) at all times? Is there anything that can be done better?

Except for FGD of HBC & OVC: What do you know about the services offered by HBC? What do you know about the OVC care? Can you tell us any of your concerns about HBC and OVC if any?

Have you ever been to the IC? How often did you visit IC? If you do, with whom did you go and what do you get in IC (BCC materials, condoms, counseling service, etc.)?

In your opinion, what does volunteer and peer educator mean? What does it require to become a peer educator? What does it require to become a volunteer?

*Discussion with FSW*

In your opinion, what are the benefits, and the risks, of being a sex worker? What are your plans in terms of either continuing your position or changing to another? What would you advice a lady who is a new entrant?

On average, how many one-on-one sessions do you conduct every week? How long does it take?

What do you know about the HRCI project? About Save the Children? Does it bring anything new to the people residing in the area? What do you suggest to sustain the newly introduced schemes? What are the goals that you believe that HRCI has yet to work on?

What is your opinion on the current use of condom practice? What are the ways or means that you suggest to improve the use of condoms among your peers and reach 100% condom use?

Does your employers encourage you to get services of STI? What about protecting you from sexual harassment? What are you doing to reduce the transmission of HIV/AIDS as a group and individually? What would you like to do in the future in this area?

What is the major topic that is discussed when your peers meet, get acquainted and get some rest? Can you enumerate possible activities that might be conducted by your group? And what special place and time do you suggest?

In your opinion, what should we do to help you individually and FSW as a group to reach our common goals?

We would like to thank you very much for your cooperation. You have given us a lot very valid information that will help us to learn about the project and the area. We are confident that you and your peers are able to protect yourselves and to reduce the transmission of HIV AIDS in the area.

***Discussion with Truck Drivers***

Have you participated in training on HIV/AIDS? When and where was it? How do you value the training you participated in (difference from what you earlier know and/or listen to)?

What are the challenges of being a truck driver and particularly at a time where HIV/AIDS and STI have become issues of major concern? If you had close friend/relative/family member who is interested to become a truck driver, what would you advice him?

Does your employer encourage you to get services of HIV/AIDS and STI? Have you ever visited VCT and IC along the corridor? If yes, what was your reason to visit? How did the councilors and volunteers receive you? Did you get what you want from the centers, pleas explain?

Do you travel with supply of condom or buy it wherever and whenever you need it? Do you have adequate supply of condom along the corridor? Think of the towns and hotels along the corridor, what do you know about the condoms supply in the hotels along the corridor? If you have a preference, what is your favorite brand? Why do you choose this brand?

How often do you use condom? If you believe that there were circumstances that you were unable to use condom, can you tell us about it?

What is the major topic that is discussed when you meet your friends and other truck drivers along the corridor? Have you ever-encountered volunteers and/or other people educating on HIV/AIDS in hotels and towns along the corridor? If so, how did you find it?

What are you doing to reduce the transmission of HIV/AIDS in your area? What would you like to do in the future in this area?

Thanks again for this confidential interview and for sharing your experiences and possible ideas for strengthening our intervention. We will do our best to take the information to concerned experts for their action. We wish you good luck for everything.

*Interview with Youth*

How many of you are living with your parents/guardians? If there are more than 3, ask how open and often the family discuss about HIV/AIDS and STI.

How many of you have children of your own? If there are more than 3, ask if they are living with them, their age and health. How would you help them become what they want to be?

Have you ever visited VCT and IC? If yes, why did you visit VCT and IC? How did the councilors and volunteers receive you? Did you get what you want from the centers, please explain? Did your peer comment on your visit, please explain?

Have you ever used and/or intend to use condom? If you plan or are currently using condom, from where do you get it? How often do you intend to keep condom with you?

Do you think that there are circumstances that you would be unable to use condom, can you tell us about it?

Did you know a person living with HIV? If yes, what do you think are major challenges that person is facing? In your opinion, what can he do to solve his/her problems? Who should help this person to solve his/her problem? What other things can be done to help this person?

What are you doing to reduce the transmission of HIV/AIDS in your area? What would you like to do in the future in this area?

Thanks again for this confidential interview and for sharing your experiences and possible ideas for strengthening our intervention. We will do our best to take the information to concerned experts for their action. We wish you good luck for everything.

*Interview with PLWHA*

Do you have children of your own? If yes, are they living with you right now? How old are they? Are they in good health? What do you advice them to become what they want to be? Do you discuss about HIV/AIDS and STI with your children and family members? How are they receiving and treating you?

During your visit to VCT how was the reception of the staff? What kind of service did the councilors and volunteers provide you? Did you get what you want from the centers, please explain?

What is the difference between the service at VCT and health station/clinic? Could you explain about your satisfaction by the services of health station/clinic?

What kinds of protection do you use at home to prevent the transmission of the virus? Are you using condom? Since when did you start using condom? From where do you get it?

Think all possible ways, do you think that there are circumstances that you would be unable to use condom, can you tell us about it?

What are the major challenges that people living with the virus are facing? In your opinion, what can s/he do to solve these problems? What can other people do to help this person?

What kind of support have you received by people residing in your vicinity? What about from social networks? How do you value this support (are you comfortable with it, should it continue same way)?

What are you doing to reduce the transmission of HIV/AIDS in your area? What would you like to do in the future in this area?

Thanks again for this confidential interview and for sharing your experiences and possible ideas for strengthening our intervention. We will do our best to take the information to concerned experts for their action. We wish you good luck for everything.

### *III Facility Assessment Questionnaire for VCT and STI and in depth interview with VCT counselors*

**SECTION I ORGANIZATIONAL PREPERDNESS FOR VCT IMPLEMENTATION**

**Project area Background**

Area _____

Respondent _____

Position _____

HIV sentinel survey figures

- Urban antenatal
- Rural antenatal

Other available sero Prevalence data, please specify

How is VCT seen by the Organization/program management?

Major priority _____ Priority in some settings_____ Not a priority ____

How do you see SC/USA or HRCI role in mitigating HIV/AIDS? Give Examples

Please describe the VCT services in detail

_____

Please describe any obstacles to implementation

_____

Have guidelines for implementing HIV counseling been developed?

Yes _____ In preparation _____ No _____

Is VCT promoted as part of HIV prevention and care services?

Yes _____ In preparation _____ No _____

Is HIV testing a legal requirement under any circumstances?

Pre-marital _____ Migrant workers _____ Other (specify) _____

Is HIV testing frequently performed in:

Pre-operative screening_____Pre-employment_____General antenatal care ____

As part of MTCT intervention _____ Prisons _____ Military recruitment _____

IDU treatment _____ STI clinic _____ TB clinic _____

Are related services available for people living with HIV or AIDS?
Ongoing medical care Yes___ In preparation_____ No____

Ongoing social support Yes___ In preparation_____ No____
Support group for people living with HIV or AIDS
Yes___ In preparation_____ No____
Ongoing counseling support Yes___ In preparation_____ No_____
Liaison with NGOs Yes___ In preparation_____ No_____
Family planning Yes___ In preparation_____ No_____
MTCT interventions Yes___ In preparation_____ No_____
TBPT Yes___ In preparation_____ No_____
ARV interventions Yes___ In preparation_____ No_____
Other preventive therapies Yes___In preparation_____No_____
(please specify)
Are HIV preventive services available?
Condom supplies Yes___ District wide program Yes___ some sites___ No__
Ongoing counseling Yes___ District wide program Yes___ some sites___ No__
Other (please specify) Yes, country-wide program Yes ___, some sites __ No __
Is HIV counseling training courses being run? YES ____ NO ___
If YES, at what level National Provincial ___ District ____ Testing site _____
How many counselors have been trained? _____
What are the backgrounds of the people being trained as counselors?
Nurses ___ Clinical officers _____Social workers ____People living with HIV/AIDS ___
Others (please specify) _____
What training is offered?
Basic counseling training Yes___ In preparation_____No_____
Advanced training Yes___ In preparation_____ No_____
Follow-up supervision Yes___ In preparation_____ No_____

Follow-up assessment of counselors Yes, Regularly _____Yes, some sites___ No___
Number of training courses held _____
How long is the training? _____
Please describe in detail the training offered _____
_____
Are statistical data about the counseling service regularly compiled? Yes _____ No ____
If YES, by whom _____

**SECTION II OPERATIONAL ASPECTS OF VCT SITES ANDSERVICES**

**For VCT site evaluation: logistic considerations and coverage**
**Respondents = VCT managers**
Which services do you offer?
Pre-test counseling ____ Post-test counseling ____ Ongoing counseling _____
HIV testing _____ HIV diagnostic counseling (without testing) _____

If pre- and post-test counseling are undertaken, do carefully defined procedures exist?
Yes ____ No ____

**Please describe these**

Opening hours _____

Are you open at any of the following times?

Early evening (after 17:00) No ____ Yes q (specify how many evenings)
Lunch hour No ___ Yes ____
Weekends No___ Yes ____ (specify Sat. or Sun. or both)

Do you have an appointment system? Yes ____ No ____

If YES, what happens if someone comes without an appointment?

They are asked to make a future appointment Yes ____ No ____
They will always be seen the same day Yes ____ No ____
They will usually be seen the same day Yes____ No ____

**Privacy**

Do you have adequate space to ensure counseling sessions can be private?

Yes, there is adequate space ____ There is some private space, but not enough __
No___ Specify, private office ___ cubicle ____curtained-off area
other (describe) _____

For example, do written policies, checklists, data management systems, etc., exist?

_____

**Waiting area**

Describe the waiting area_____

_____

**Confidentiality**

Does the site have a written policy on confidentiality? Yes ____ No ____

Describe the steps that have been taken to ensure confidentiality _____

_____

Have any of the following staff received specific training about the role of counseling and confidentiality?

Counselors Yes ____ No ____ Laboratory staff Yes ____ No ____
Non-counseling medical staff Yes ____ No ____ Ward attendants Yes ____ No ____
Receptionists Yes ____ No ____ Ancillary staff (e.g. cleaners) Yes ____ No ____
Others (specify) Yes ____ No ____

**Linkages**

Do you receive referrals from any of the following?

CHBC Volunteers Yes ____ Occasionally ___ No ____
Information center Yes ____ Occasionally ___ No ____
FSW Yes ____ Occasionally ___ No ____
HBC volunteers Yes ____ Occasionally ___ No ____
Medical services (e.g. clinics/hospital) Yes ____ Occasionally ___ No ____
Social services Yes ____ Occasionally ___ No ____
Other counseling services Yes ____ Occasionally ___ No ____
NGOs Yes ____ Occasionally ___ No ____
Family planning services Yes ____ Occasionally ___ No ____
MCH services Yes ____ Occasionally ___ No ____

TB/chest clinic Yes ____ Occasionally ___ No ____
STI services Yes ____ Occasionally ___ No ____
Traditional healers Yes ____ Occasionally ___ No ____
Spiritual/religious groups Yes ____ Occasionally ___ No ____
Others (specify) _____

From Where do you receive maximum referrals? _____

---

Do you refer to any of the following?

Medical services (e.g. clinics/hospital) Yes ____ Occasionally ___ No ____
Social services Yes ____ Occasionally ___ No ____
Other counseling services Yes ____ Occasionally ___ No ____
NGOs Yes ____ Occasionally ___ No ____
Family planning services Yes ____ Occasionally ___ No ____
MCH services Yes ____ Occasionally ___ No ____
TB/chest clinic Yes ____ Occasionally ___ No ____
STI services Yes ____ Occasionally ___ No ____
Traditional healers Yes ____ Occasionally ___ No ____
Spiritual/religious groups Yes ____ Occasionally ___ No ____
Others (specify)

Are files kept in a locked filing cabinet, is a system in place to protect confidential Computerized information? Yes ___ No -____
Describe how the referral systems work and any problems and successes

---

Do you feel there are adequate referral services available, particularly for the needs of people who test positive? _____

---

**HIV testing methods**

Where do you carry out HIV tests?

All testing done on site _____
Preliminary tests done on site, confirmations sent to other laboratory _____
All testing carried out in other laboratory _____

What is the time interval between taking blood and results being available? _____

---

Describe the HIV testing schedule employed _____

---

Do you have external quality control for HIV testing? Yes ___ No _____
If YES, describe _____

**Cost and sustainability**

Do you charge for services?

Counseling only No ___ Yes ____ amount_____
Testing No ___ Yes ____ amount_____
Ongoing counseling No ___ Yes ____ amount_____

If YES:

Are there any people who do not pay? Yes ___ No ___ % that do not pay

**Level of service provision and utilization**

In the last 3 months:

How many people have presented at the site? _____
What % of people have had pre-test counseling? _____
What % of people have been tested for HIV? _____
What % of people have returned for their result? _____
What % of people have been given post-test counseling? _____
What % of people have received ongoing counseling? _____
What % of people have been referred to other services? _____

List the services to which most referrals have been made: _____

_____

Describe any problems and successes you have observed in people returning for test results _____

_____

**Outreach counseling (counseling in non-clinical settings)**

Is outreach counseling carried out? Yes ____ No ____

If YES,

How many people, on average, per group? _____

How many outreach sessions in the past 3 months? _____

Where are outreach sessions held? _____

**Advertising and promotion of the VCT service**

Do you advertise or promote your service in any way? Yes ___ No ____

If YES, describe _____

Does HRCI advertise? If yes How _____

**Group counseling**

Is group pre-test counseling carried out? Yes ___ No ____

If YES,

How many people, on average, per group? _____

How many group counseling sessions in the past 3 months? _____

How long, on average is each session? _____

How do you see SC/USA or HRCI role in mitigating HIV/AIDS? Give Examples

_____

**SECTION 3 Counselors' requirements and satisfaction**

**For evaluation of counselor selection, training and support**

**Respondents = counselors**

What is your background?

Nurse _____ Clinical officer _____ Social worker _____

Person living with HIV or AIDS_____Other (specify)

_____

**Selection**

How were you selected to be a counselor?

Proposed by senior colleague _____ Self-motivated (expand) _____

Do you feel that you have been pressurized into doing counseling? (Explain) _____

**Training**

Describe the counseling training have you received? _____

How would you rate your counseling training?

very good ____ good ____ adequate _____ inadequate _____

Give reasons why you decided to train as a counselor, e.g. "concerned about the impact of HIV in the community", "following personal experience" – e.g. have friend, relative with HIV, etc. _____

For example, is counseling something you feel comfortable doing, or do you feel it is a strain, or that you have to do it as part of your job? _____

What were the good things and poor things in your training? _____

Are there any areas in which you feel you need more training? _____

Have you had follow-up or ongoing training? Yes ____ No _____

If YES, describe it. _____

If NO, do you think ongoing training would be a good idea? Yes ____ No _____

If YES, describe how it might, or might not, help _____

**Support and supervision**

How many hours a week do you spend in counseling activities? _____

What proportion of your working life is spent counseling? _____

Do you attend a counselor support group? Yes ____ No _____

If YES, in what way is the group helpful or not helpful? _____

If NO, in what ways do you think you would benefit (or not benefit) from a support group? _____

Do you have support for your counseling from other sources? Yes ___ No ____

If YES, explain whom and how does it help _____

Do you have access to a designated counseling supervisor to provide you with support and technical back up? Yes _____ No _____

If YES, who provides:

Support _____ supervision_____

**How do you feel about your job?**

Do you feel valued or undervalued by clients (explain in what ways)? _____

Do you feel valued or undervalued by other staff (explain in what ways)? ___

Do you feel valued or undervalued by your superiors (explain in what ways)? __

_____

Are you given adequate time in your job to carry out your counseling duties? __

_____

Please indicate how you feel about the following statements

"I feel emotionally drained by my work"

Always ____ often ___ occasionally ___ never ____

"My work is very stressful"

Always ____ often ___ occasionally ___ never ____

"My work is very rewarding"

Always ____ often ___ occasionally ___ never ____

"My work environment is very stressful"

Always ____ often ___ occasionally ___ never ____

"I learn something new in my work every day"

Always ____ often ___ occasionally ___ never ____

"I feel isolated in my work"

Always ____ often ___ occasionally ___ never ____

"I have problems communicating with my colleagues"

Always ____ often ___ occasionally ___ never ____

"I can help my clients"

Always ____ often ___ occasionally ___ never ____

"I have no confidence in my clinical skills"

Always ____ often ___ occasionally ___ never ____

Please elaborate on any of the above statements _____

_____

How many years have you been counseling? _____

How many hours per day do you do counseling? _____

If your daily schedule varies, please give an approximate indication of the number of hours you spend, for each day of the week:

Counseling about HIV-related problems hours _____

Counseling about other issues hours _____

Other work (specify) hours _____

How many days per week do you do counseling? _____

How many clients do you see per day? _____

If your daily schedule varies, please give an approximate indication of the number of clients you see for each day of the week:

Clients with HIV-related problems _____

Clients with other problems _____

How do you see your future in counseling? _____

_____

**HEALTH FACILITY SURVEY**

**INTERVIEW QUESTIONARIE FOR ASSEMENT OF STI SERVICES**

Questionnaire number |__|__|

Date: *day* |__|__| *month* |__|__| *year* |__|__|

Interviewer's code: |___|___|

Name of health care facility:
.....

Facility number |___|___|___|
Health care provider (HCP) code |___|___|
Profession of HCP (nurse = 1; doctor = 2) |___|
Sex of HCP (male = 1; female = 2) |___|
Was this HCP observed managing an STI patient? Y |___| N |___|
1. How many cases of STI did you see at this clinic last **week**? **M** |___|___| **F** |___|___|
2. How many cases of STI do you see at this clinic during an **average month**?
**M** |___|___|___| **F** |___|___|___|
3. When patients report with a complaint of STI, do you routinely ask them questions?
Y |___| N |___|
4. IF YES, do you ask about:
- Present symptoms? Y |___| PROBED Y |___| N |___|
- Onset/duration of symptoms? Y |___| PROBED Y |___| N |___|
- Recent sexual contact? Y |___| PROBED Y |___| N |___|

5. Do you routinely perform a physical examination on your male STI patients?
Y |___| N |___| NA* |___|
7. IF YES, please describe each step of how you would examine a ***male*** STI patient:
A Patient asked to undress so that genitals are fully exposed
Y |___| PROBED Y |___| N |___|
B Patient examined for a urethral/penile discharge Y |___| PROBED Y |___| N |___|

C Genitals examined for lesions after retracting the foreskin
Y |___| PROBED Y |___| N |___|
8. Do you routinely perform a physical examination on your female STI patients?
Y |___| N |___| NA* |___|
9. If YES, please describe each step of how you would examine a female STI patient:
A Patient asked to undress so that genitals are fully exposed
Y |___| PROBED Y |___| N |___|
B Patient asked to lie down Y |___| PROBED Y |___| N |___|
C Patient examined for lesions on vulva and labia Y |___| PROBED Y |___| N |___|
D Patient examined for vaginal discharge Y |___| PROBED Y |___| N |___|
E Speculum examination performed Y |___| PROBED Y |___| N |___|
F Bimanual examination performed Y |___| PROBED Y |___| N |___|
10. Do you have:
- an examination table? Y |___| N |___|
- bivalve vaginal specula? Y |___| N |___|
- an examination light? Y |___| N |___|
- examination gloves? Y |___| N |___|

11. What type of diagnosis do you base your treatment on:
- An aetiologic diagnosis such as gonorrhea or syphilis? Y |___| N |___|
- A syndromic diagnosis such as urethral discharge Y |___| N |___|
  or genital ulcer disease?
- Both Y |___| N |___|

12. Do you have a microscope in this clinic? Y |___| N |___|

13. IF YES, in this clinic, do you perform:
- Wet-mount microscopy to diagnose STIs? Y |___| N |___|
- Gram stains to diagnose STIs? Y |___| N |___|
- VDRL tests? Y |___| N |___|
- Dark field microscopy? Y |___| N |___|

14. Do you send your STI patients (or specimens) to another facility for laboratory investigations? Y |___| N |___|
IF YES, what tests have you requested most often in the **past month**?
1 ..... |___| 2 ..... |___|
3 ..... |___|

15. In your experience, what is the first choice of treatment that you usually prescribe for a patient with:
***A Gonorrhea?*** *Refer to code portion of this section |___|
DRUG name .....
· Quantity: .....
· Dosage: daily |___| bid |___| tid |___| qid |___| other .....
· Route: im |___| oral |___| topical |___|
· Duration of treatment (days): .....
***B Non-gonococcal urethritis?*** *Refer to code portion of this section |___|
DRUG name .....
· Quantity: .....
· Dosage: daily |___| bid |___| tid |___| qid |___| other .....
· Route: im |___| oral |___| topical |___|
· Duration of treatment (days): .....
***C Primary syphilis?*** *Refer to code portion of this section |___|
DRUG name .....
· Quantity: .....
· Dosage: daily |___| bid |___| tid |___| qid |___| other .....
· Route: im |___| oral |___| topical |___|
· Duration of treatment (days): .....

***D Chancroid?*** *Refer to code portion of this section |___|
DRUG name .....
· Quantity: .....
· Dosage: daily |___| bid |___| tid |___| qid |___| other .....
· Route: im |___| oral |___| topical |___|
· Duration of treatment (days): .....

16. In the absence of a definitive diagnosis, what is the first choice of treatment that you usually
prescribe for:
· ***A male patient with a urethral discharge?*** *Refer to code portion of this section |___|
DRUG name .....
· quantity: .....
· dosage: daily |___| bid |___| tid |___| qid |___| other .....
· route: im |___| oral |___| topical |___|
· duration of treatment (days): .....

· ***A male patient with a genital ulcer?*** *Refer to code portion of this section |___|
DRUG name .....
· quantity: .....
· dosage: daily |___| bid |___| tid |___| qid |___| other .....
· route: im |___| oral |___| topical |___|
· duration of treatment (days): .....
· ***A female patient with a genital ulcer?*** *Refer to code portion of this section |___|
DRUG name .....
· quantity: .....
· dosage: daily |___| bid |___| tid |___| qid |___| other .....
· route: im |___| oral |___| topical |___|
· duration of treatment (days): .....

17. Where do your patients usually obtain the drugs you prescribe for them?
    1. At this clinic same day (free) |___|
    2. At this clinic same day (paid) |___|
    3. At the pharmacy/chemist shop |___|
    4. At this clinic and at the pharmacy |___|
    5. Other, SPECIFY: .....

18. Do you have any problem with drug supply? Y |___| N |___|
IF YES, what problem(s)? .....
..... |___|

19. Are there any particular drugs which you feel are essential for the treatment of STIs but to which you have no access? Y |___| N |___|
IF YES, which? .....
..... |___| |___|

20. What type of syringes and needles do you usually use?
Disposable |___|
Reusable |___|
Both |___|

21. Do you give any special education/advice to your STI patients?
a) Do you tell your patients to take all the medications you have prescribed?
Y |___| PROBED Y |___| N |___|
b) Do you advise your patients to use condoms? Y |___| PROBED Y |___| N |___|
c) Do you tell your patients to tell their sexual partner(s) to have treatment? Y |___|
PROBED Y |___| N |___|
IF YES, do you use contact cards or referral slips? (IF YES, ASK TO HAVE ONE)
Y |___| N |___|

22. Do you keep a supply of condoms in this clinic?
Y |___| ASK TO HAVE ONE N |___| SKIP TO Q27
IF THE ANSWER TO QUESTION 22 IS YES:

23. How many condoms are in stock at this clinic today? |___|
Did you verify this number? Y |___| N |___|

24. Was this clinic ever out of stock of condoms in the last 12 months? Y |___| N |___|

25. Do you provide condoms to your STI patients?
    Always |___|
    Sometimes |___|

Never |___|

26. IF ALWAYS OR SOMETIMES:

How many condoms each time? Number |___| |___| |___|

Are the condoms free? Y |___| N |___|

27. Do you provide instructions to your patients on how to use condoms?

Always |___| Sometimes |___| Never |___|

28. Do you follow any specific treatment guidelines in your management of STI patients?

Y |___| N |___|

IF YES, which? ..... |___|

*Refer to code portion of this section

29. Have you received a copy of the STI treatment schedules recommended by the National STI Control Program? Y |___| N |___| NA |___|

30. Do you provide drugs to PREVENT your clients from contracting STIs (do you provide STI prophylaxis)? Y |___| N |___|

31. What is your main qualification

Qualified nurse |___|

Medical practitioner |___|

Other |___|

32. Do you work in **both** public and private clinics? Y |___| N |___|

33. What are the main constraints on your work with STI?

**Drug Supply Checklist**

Questionnaire number |__|__|

Date: |__|__| |__|__| |__|__|

*day month year*

COMPLETE THIS SECTION BEFORE COMPLETING CHECKLIST:

Observer/interviewer code |___|___|

Name of health care facility.....

Facility number |___|___|___|

Position of person interviewed:

01 = Hospital Administrative Officer; 02 = Doctor; 03 = Clinical Officer;

04 = Other_____) |___|

1. When was the last inventory of drugs, equipment or supplies? (MONTH AND YEAR)

MONTH |__|__|

YEAR |__|__|__|__|

2. Who holds requisitions for drugs, equipment and supplies?

FACILITY IN CHARGE |__|

DISTRICT |__|

REGION |__|

OTHER |__|

3. What is done with all supplies that have expired dates?

DISTRIBUTED TO CLIENTS QUICKLY |__|

RETURNED TO SOURCE |__|

THROWN IN GARBAGE HEAP |__|

BURNT OR DESTROYED UNDER SUPERVISION |__|

NOTHING |__|

OTHER |__|

4. Is there a stock record for STI drugs? Y|__| N|__|
5. Are STI drugs stored by expiration date Y|__| N|__|
6. Are STI drugs stored such that they are protected from rain, sun, adverse temperatures, rats, and pests? Y|__| N|__|

STI DRUGS AVAILABLE IN THE FACILITY:

Now I would like to ask you about the medications available to treat STIs in this facility. When we are finished, I will need to see your stock of some of the medications that we discuss.

7. Do you have this____ MEDICATION now?
8. At any time in the last 12 months did this facility run out of MEDICATION?

## *III Issues Included in Structured Questionnaire (Translated from Amharic)*

Date data collected
Data collection site/town
Person who filled the questionnaire

1. Social & economic status of household information

| Marital status | *Age* | # of children | Occupation | Income & status | |
|---|---|---|---|---|---|
| | | | | Status | Income |
| *Unmarried* | | | | | |
| Head of Household | | | | | |
| 1st wife | | | | | |
| 2nd wife | | | | | |
| 3rd wife | | | | | |
| | | | | | |

2. Indicate 5 major diseases in your residential area
3. On which age group are the diseases observed most?
4. Do you think that you have adequate understanding about HIV/AIDS? Yes/No
5. What is the possible ways among people for the HIV/AIDS virus transmission? Data collectors are asked to ask open ended question only
    a. Husband/wife to spouse
    b. From boyfriend/girlfriend to girlfriend/boyfriend
    c. From a friend to friend
    d. From neighbors
    e. Mother to child
    f. Pregnant mother to child
    g. Others _____
6. What other possible ways of HIV/AIDS transmission? Data collectors are asked to ask open ended question only

a. By Providing care to PLWHA
b. By way of direct blood transmission
c. Specify others

7. What are the possible symptoms that an AIDS patient could manifest? Data collectors are asked to ask open ended question only
   a. Loss of weight
   b. Chronic cough
   c. Frequent sickness
   d. Repeated TB
   e. Long lived diarrhea
   f. Others
8. What action would you take if you have a family member has chronic illness? In chronological order.
   a. Keep him/her at home
   b. Auto medication
   c. Use traditional medicine
   d. Consult pharmacies and buy medicine
   e. Visit VCT
   f. Visit health center
   g. Visit hospital
   h. Consult information center
   i. Consult HIV/AIDS committee
   j. Consult CHBC
   k. Other
9. Do you know about the activities undertaken by SC/USA or HRCI? Yes/no
10. If yes, from how did you get the information?
    Meeting, neighbors volunteers HIV/AIDS committee, others specify
11. If you know the activities of HRCI, please indicate
12. do you know about the following activities conducted by HRCI

| Type of service | Yes I know | It is supported by ___ |
|---|---|---|
| Voluntary Counselling and Testing | | |
| Information center | | |
| HIV/AIDS committee | | |
| Community Home Based Care | | |
| Support to Orphaned & Vulnerable Children | | |
| | | |

13. Do you believe that SC/US intervention is beneficial for your community?
14. If yes, what are the benefits?
15. Do you believe the intervention on HIV/AIDS in the last 2 years has brought change in your community?

16. If your answer is yes, please indicate what the changes are and other pertinent info.

| Service that brought a change | Responsible body for the service | Service that you are using |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

17. Give example for the change you indicated above?

18. If you mention that you are not user of the service in no. 17, please indicate your reasons
    a. I have good knowledge to protect myself and my family
    b. I have dependable marriage (high trust with spouse)
    c. I have abstained
    d. I believe in God
    e. I have only one partner
    f. I have limited my partners
    g. I did not want to bother myself
    h. I am using condom
    i. I did not take injections
    j. I have stopped sharing blades, needles and sharp object that may have blood contamination with others
    k. I did not believe on the service provided
    l. Others specify

19. Do you know from your family, work place or neighborhood that has contract HIV or is AIDS patient? Yes/no
20. Do you believe that prevention of the transmission of HIV/AIDS is possible? Yes/no
21. What are the measures that can be taken to prevent the transmission of HIV/AIDS?
22. What efforts are you making to prevent the transmission of HIV/AIDS?
    a. Personal level
    b. Family level
    c. Community level
23. Do you use condom? Yes/no
24. If you are not using condom, please indicate your reasons
    a. It reduces satisfaction
    b. Want to have a child
    c. Not allowed in my religion
    d. Unavailability of condom
    e. Don't have the courage to buy condom from shops

f. Unacceptability of condom by the community
g. My partner did not want to use it
h. I am trustable to my partner

25. With whom are you discussing about HIV/AIDS?
    a. With spouse/boyfriend/girlfriend
    b. With friends
    c. With family members
    d. Other specify

26. If you are not discussion about HIV/AIDS with others, please indicate your reasons
    a. I didn't want to
    b. I feel shame
    c. People did not want to discuss
    d. HIV/AIDS is personal secret
    e. My partner is shy
    f. Other specify

27. Please indicate the following
    a. Strength of HRCI project
    b. Weakness of HRCI project
    c. Possible action for the future

Threat for HRCI project

***Anex 6:***

## ***ASSESSMENT OF VCT/STI SERVICES***

INTRODUCTION/BACKGROUND

One of the objectives of SC/US comprehensive HIV/AIDS prevention and control project is to increase the accessibility to and availability of VCT for HIV, treatment of STI and opportunistic infections. The preventive/treatment services are the central elements of the HRCI HIV/AIDS program. According to project plan, the service are considered by SC-US as important sector of the HRCI program with critical advantage for being an entry point for the comprehensive HIV/AIDS prevention and care program.

The responsibilities for the planning, implementation and technical support of the services of the projects sub component have been entrusted and sub granted to IOM to establish/strength VCT/STI treatment mainly in government health facilities.

However, the actual implementation and co-ordination of VCT/STI services are also executed by the HRCI and sub project offices of the program. The responsible organizational unit in the program office for VCT/STI activities is the medical sector coordinator.

The team conducted interviews with different groups that include regional AIDS Program managers, counseling service coordinators, and NGO coordinators involved in VCT activities, health service managers as well as other policy-makers in associated sectors. In addition interviews with counselors and VCT facility survey was conducted. The interviews were conducted individually and the respondents encouraged elaborating on any of the items, qualifying statements and providing additional comments where appropriate.

Both the interviews and survey was carried out using a cheek list developed (adopted) from the national HIV/AIDS mentoring /evaluation framework and the UNAIDS guideline (Tools for evaluating VCT service). To this effect, the assessment/evaluation of the SC/US HIV/AIDS program in executing the VCT/STI services projects was evaluated from the following point of views and criteria.

1. **Institutional arrangements/organizational perspective**
   - Availability of Institutional arrangements/procedures/ relevant services,
   - Organizational preparedness for and commitment to VCT implementation
   - Available program support, resource availability, training support and supervision)

1. **The operational aspects of VCT/STI sites and services**

*2.1. VCT services implementation*

- SITES (Accessibility and convenience, Privacy and waiting area)
- SERVICES (availability, effectiveness, quality and sustainability of the services)
- The counselors perspective (satisfaction and requirements )

*2.2 STI **services implementation***

- Appropriate diagnosis and treatment of STIs
- Advice to STI patients on prevention and referral to HIV testing services
- Drug supply at STI clinics

## ASSESSMENT/ EVALUATION FINDINGS

## 1. INSTITUTIONAL ARRANGEMENT/ORGANIZATIONAL PERFORMANCE

IOM launched the implementation in February 2003 to establish /strengthen the major components of services namely VCT and STI in government health facilities and OSSA (Nazareth) respectively. The following major activates were conducted

- Institutional assessment of health services was conducted and a total of 7 sites (4 sites in afar, and 3 sites in oromiya) were identified for VCT implementation.
- Additional 10 sites were later included after the requests from regional /Zonal administrations making the total sites to 17 for establish VCT/STI. However, there was no additional budget allocated for these 10 sites selected out of the initial plan.
- The local allocated budget for the program sun component was 163.000 USD at first and reached to 233.000 dollar with a budget increment of 30% (10,000 USD ) while the proportion of sites increased by 60 percent (10 in #) approximately therefore, to accommodate the other sites, certain planned activates like BCC were omitted the budge transferred/ used.

The following are major successes and limitations of the services with regard to the institutional arrangement/organizational performance for the implementation of VCT by HRCI program and sub grantees based on the study findings and observations of the team of Consultants

### Strength and Successes

VCT services were developed and provided in conjunction with support services for those who test sero positive and HIV prevention services. In addition, the existing link between the type and quality of HIV education in the community as well as information centers and offering VCT has contributed to making the target community attitudes favorable and their interest in VCT to be high.

In all the project sites, the VCT/STI service activities of the program are carried out through operational guidelines/manuals, training handbooks, national execution guideline and other relevant forms and formats. Several VCT/STI service implementation procedures and guiding manuals have been put in place that assists the staff to carry out their duties effectively. As a result there seems to be no significant problems in the implementation of VCT/STI services due to lack of in-house capacity. This is one of the strong aspects of the programs VCT/STI system that gives systematic approach and standardized procedure on its day to day operation.

The evaluation conducted has found that the level of priority given to VCT services (in all program areas) by political /administrative officials is high by the fact that the benefits of VCT are well understood as priority big all politicians/administration offices. In

addition, all Regional health and HAPCO officials expressed the existing high level of political commitment to VCT as part of the overall prevention and care.

All visited project offices have conducted advocacy/advertisement activities to promote the VCT services of the program to the community. In addition, the community in all sites has received education and information on regular basis on the benefits of VCT for individuals and their families. It has also to be mentioned that the promotional campaign that are carried out through various media have contributed a lot to increased demand for services and also supported the efforts of the VCT services.,

In general However, All the respondents from the areas assessed appreciated the efforts of SC US HRCI program in mitigating HIV/AIDS and the HRCL performance in advocating the concept, demonstrating the need for the benefits of VCT as well as strengthening the services has been commendable in particular.

*LIMITATIONS/GAPS*

- However, there was no existing policy or system put in place to guarantee confidentiality, to avoid breaches of confidentiality at all stages in the VCT process and for VCT services to be acceptable because Other medical and administrative staff did not receive specific guidance about the role of counseling and confidentiality?

- Although, Heath workers (VTC counselors) in all sites surveyed were found to have understood the benefits of VCT and perceive it as a priority service area, health service mangers in mojo and mille were reported to have inadequate commitment and hence promote VCT as a priority program area and major part of their job.

  The reluctance by the mojo heath center management to provide additional room for VCT to handle the increasing flow of clients but agreed to hand over the available room for an NGO was sited as an example.

- On the other hand, HAPCO officials, clients, HBC providers in affar reported the health center management in Mille and Logia give poor attention to VCT/STI and is not seen as a major priority of the health service. VCT/STI site and service provision in mille that has been functioning 2 days per week despite high and growing demand for services.

- there was lack of systematized and coordinated advocacy effort among stakeholders in order to sensitize, maximize the awareness on the existing preventive service provision and the benefits of VCT/STI services to the Community so as to make people more likely to accept it and for sustained attendance.

## *2. EVALUATION OF OPERATIONAL ASPECTS OF SITES AND SERVICES*

### *2.1. VCT services implementation*

*Prevalence of HIV /coverage/attendance*

The prevalence and service coverage of VCT services established in government health services and OSSA by HRCI program indicates that there is a high HIV sero-prevalence among the community in the program areas studied by the consultant team as shown below.

According to the data from the council Health Bureau HIV focal person there are two sentinel survey sites at the hospital and health center, with different statistical data on HIV prevalence. The figures from the health center show the prevalence to be at 7.7 percent while it is 14.4 percent as per the data from Hospital. The bureau uses the average figure from the two that is 11.1% percent.

HIV sentinel survey figures were available for Dire Dawa council area only. In all other areas studies the other available sero prevalence data is based on the statistical data from VCT services which is presented in the table below.

| VCT site | Total cases | Positive cases | |
|---|---|---|---|
| | | No | % |
| Mojo health center | 670 | 131 | 19.55 |
| Nazreth OSSA (three months) | 873 | 96 | 10.99 |
| Chelenko Health Center | 28 | 5 | 17.86 |
| Mille clinic | 193 | 28 | 14.51 |
| Logia clinic | 231 | 38 | 16.45 |

The following are major successes and limitations of the services with regard the implementation of VCT by HRCI program and sub grantees based on the study findings and observations of the team of Consultants

**Strength and Successes**

The overall figures from sentinel surveillance survey in Dire Dawa and VCT reports of other 5 areas evaluated indicated the high HIV sero-prevalence in the community has brought a high level of understanding on the benefits of VCT among health service managers/planners who revealed the program has been effective in target group identification and selecting more appropriate strategies to develop services for the general population with such high-prevalence in the areas.

The services in all areas were found to be affordable for the majority of people for they get free service free of charge and in Nazareth OSSA and Dire Dawa hospital they are provided at low cost.

The VCT sites have mostly well-trained and motivated manpower who felt to have got good recognition and given high value by the community and staff. the HRCI program has done a commendable job in building the required institutional capacity at project level.

In all settings visited there have been commendable efforts by counselors in guaranteeing and respecting confidentiality and it has been observed that people feel more comfortable about attending VCT services for they can give a pseudonym, and anonymous testing is available.

**Limitations/Gaps**

- Although, there are well-ventilated waiting areas, Counselors stated that absence of separate private space in dire Dawa health center and separate room in mille and logia. In addition, the absence of sign posts in all sites to indicate the VCT rooms has brought challenges for ensuring privacy and for VCT to be carried out correctly and effectively.

- It was reported that there was a high demand and clients flow following the promotion conducted. In all areas except Nazareth and chelenko, lack of adequate preparation or absence a medium-term plan for the service, the supply couldn't cope up with demand and counselors reported that a lot of clients were returned back without appointment for there was no appointment system for to under take VCT at another time

- In addition, the service was scaled down after an initial period in mille (working only 2 days a week) and logia because of other workloads of counselors. These are major challenges to ensure sustainability as confidence will be lost and the community will feel let down after expectations have been raised.

- In all the sites surveyed the cappillus test kit was found to have expired as of march 8, 2004. According to the guideline the services should have been shut until the test kit is made available but counselors were referring clients to other services, which in effect can undermine the credibility of the services.

- The program had a crosschecking system for results that was put in place in all sites when setting up an HIV testing services after which samples have been collected, but no tests samples were taken to cross checked at a reference center for quality control.

- Although HIV testing methods have become much more sensitive and specific, evaluations have shown that without rigorous quality control high numbers of false positive and negative results are common. Not only can this be extremely damaging for individuals, but it can undermine the credibility of the service.

- Although Counselors are aware of the special medical needs of people living with HIV or AIDS, absence of free treatment at public health facilities (except in logia) and inadequate availability of drugs for opportunistic infections was reported to be the major challenge.

- However, the counselors have mentioned work load because of involvement in other departments, lack of adequate counselors support, procurement of test kits for VCT activities have been a major problem.

**2.2**

## STI services implementation

### Strength and Successes

Assessment of the diagnosis and treatment of STIs by providers revealed that patients with STIs or STI symptoms at all sites are appropriately diagnosed and treated according to national guidelines. This reflects the success of provider training in STI case management and the adequacy of the history taking, assessment and treatment of patients reporting to facilities with specific STIs.

All providers make satisfactory efforts not just to treat STIs but also to prevent their recurrence by promoting condom use and by encouraging the treatment of partners to avoid reinfection.

Although STI drugs are due to expire in two months time, all services except mojo health center had current supply of essential STI drugs and reported no stock-outs lasting longer than one week in the preceding 12 months, among all STI patients seeking STI care.

**Limitations/Gaps**

- In all areas STI care was not given adequate attention as an entry point for referral for voluntary counseling and testing (VCT) for HIV. This indicates the need to improve the extent to which these aspects of STI service provisions are functioning.

- Unlike all sites visited, all Drugs at Mojo health center are kept at the drug store and the store keeper not always available making it difficult to ensure adequate supplies of drugs and other necessary materials to facilities. This poses a negative impact on improving drug distribution services and ensuring adequate supply of the essential drugs used for STI syndromic management.

## *Annex 7:*

## *Transcription of the In-depth Interview of service providers*

## *In-depth Interview IC Counselors*

**Dire Dawa**

**Background**

- Both counselors are 12 grade completes,
- One trained as CHBC and the other served as IC volunteer
- Both did not feel pressurized as they are voluntarily initiated and were interested.
- Both haven't received counseling training.
- need more training on counseling are counseling because it further knowledge and is not enough to use own earlier experience only

*Job and satisfaction*

- The IC center works from 8 in the morning to 5 in the afternoon weekdays and is open Saturday morning.
- Counseling is provided for five days/week and Saturday morning. Daily intake is 2-4 persons for four days /week and one working day is allocated for out reach education
- Group & one to one education, print media, mini media to disseminate information are conducted
- Conduct 6-7 home visits to FSW and educate thirty sex workers.
- IC is regularly supervised by SC and ISAPSO
- DKT supports IC in provision of different IEC materials
- There is a reference from the training manual but have no guidelines are available for counseling and on confidentiality.
- Both are satisfied by their work because they believe have contributed to saving many lives
- Counseling is a job that has strain and the major challenge is lack of up-to-date materials and information
- Counselors believe that the aim of IC is to reduce the HIV transmission through bringing behavioral change to practice safe sex among the population

**IC Services in the eyes of stakeholders**

- Any person who comes gets services
- Service regarded as important by ISAPSO and community
- High demand for up to date BCC Materials and different serial drama cassettes

- Both Iddir Leaders and their members are not cooperative to allocate time for conducting HIV/AIDS education
- counseling room space is adequate for ensuring privacy .and is done one to one
- Demand for video cassettes is high
- High demand for condom

*Challenges*

- There are no guidelines available for developing, designing, pre-testing and developing target specific BCC materials. IEC materials are developed from different source and disseminated
- No counselors support group exists but only one experience-sharing meeting was conducted.
- Lack of training on mini media, designing of IEC materials.
- Absence of assessment for the information needs of the clients
- Absence of up to date reading and information materials
- Clients requested for placing a suggestion box for their feedback but could not fulfill this request

**Other programs run by other institutions**

- HIV education in the military camp
- Anti AIDS clubs (we network) in providing HIV education for the military, cooperating in production of IEC materials fro educating the military personnel.

**IC service and its referral to VCT and STI services**

- The service is backed by the health center & the hospital
- Problem of secrecy reported
- Counselors have own records, referral slips kept confidential.
- IC receives self-referred clients and refers clients to the VCT and STI management in the Health Center.

*Challenges*

- Clients are asked to pay at the hospital.
- Clients complain that they are not given adequate time for counseling in the VCT
- Access to VCT at the hospital

**Success of HRCI**

- Raised awareness and brought some attitudinal change among the community on HIV/AIDS
- Created demand for condoms, information and counseling services

***Strengths of the project***

- Regular visits and supervision from SC staff
- Prompt response to care and support for PLWHA

**Limitations of the project**

- Lack of up to date information and IEC materials

**Chelenko**

**Background**

- Grade 10 complete and previously actively involved anti –aids club activities
- Selected based on previous performance and after passing the exam given by ISAPSO.
- NO training received by both counselors
- They felt Have inadequate knowledge and skills about HIV and STDs and counseling. They felt the need for more training about HIV and counseling as this will help provide better education to the community

*Job and satisfaction*

- We provide the IC services to any client coming to us.
- Aim of the IC services is to reduce the transmission of HIV among the community and the stigma against PLWHAs
- Counselors conduct Home visits and provide HIV education for FSW,TW youth and parents, Community education, Condom demonstration and distribution ad Counseling and referral for VCT
- One to one, groups as well as mass communication (mini media) are the media methods used.
- We work from 9 in the morning up to 8 evening on week days and Saturday morning.
- Feel mentally satisfied with job but the job has strain because of shortage of volunteers who work only 2 days per week
- Regular supervision from ISAPSO through reports and support from he health center
- There is regular supervision from our senior staff visits and HIV secretariat.

**IC Services in the eyes of stakeholders**

- Community, CBOs and the government have positive view and give us supportive ideas
- Program management closely follows our work while the community committee supports us.

*Challenges*

- The existing services in chelenko however are inadequate with only 2 volunteers and counselors.
- There are no guidelines available in designing, pre-testing and developing target specific BCC materials.

- no mechanisms for continuously assessing the information needs of clients on HIV issuers
- There is shortage of BCC materials available to provide information and education to needy clients
- There is one room for all IC activities located on the road side and there is too much noise and interruptions to ensure counseling sessions can be private.
- The room is usually affected by flood and don't have adequate space for counseling

**Other programs run by other institutions**

- Except the HC, there are no other relevant programs/services in the area available.

**IC service and its referral to VCT and STI services**

- We refer clients mainly to Health center VCT services and STI management.

**Success of HRCI**

- Increased demand and use of condom
- People have started to discuss HIV freely
- Problems are absence of up to date reading and information materials and inadequacy of the rooms.

***Strengths of the project***

- Improved access to information, condom and VCT
- Regular visits and supervision from SC staff

**Limitations of the project**

- The room inadequate and not conducive
- Condom getting affected by hot room temperature and flooding
- They don't provide us with up to date IEC materials
-

**Logia**

**Background**

- Both Grade 10 complete and were trained as peer educator by ISAPSO before joining the IC.
- selected based on previous performance in ISAPSO and after passing the exam given by ISAPSO.
- Both took the initiation and applied for the position and did receive training on HIV/AIDS counseling for 5 days.

- Training was rated as good in general because we had good theoretical knowledge but the poor thing is that there was no practical demonstration with real people.
- Training did not go as scheduled because of Hot whether and Shortage of time given for topics and some important topics were not covered such as code of ethics in counseling, HBC and report writing and evaluation of problems.
- Both had one day follow up training on improving Counseling and HIV education service provision would like to have more training on mini media management, Communicating with and counseling of partners and edutainment in HIV education and to be able to give adequate information and better skills for counseling difficult cases

*Job and satisfaction*

- We provide the IC services to any client coming to us
- Aim of IC services is to reduce HIV prevalence by bringing behavioral change among the community
- Counselors provide HIV education for FSW, TW youth and parents, Condom demonstration and distribution, Counseling and home visits to sexual abuse case and Preparing mini media materials
- One to one, groups as well as mass communication (mini media) are the media methods used.
- The IC center works from 9 in the morning to 8 in the evening weekdays and is open Saturday morning. We conduct from 3 up to 5 counseling sessions and 2-3 visits per day but a lot number of clients come seeking information and condom.
- Both feel happy doing the job because they have good working environment.
- the job has strain because we are involved in multiple other SC program sectors in the committee besides the IC activities, Very hot whether and lack of transport and Shortage of volunteers

**Views on the IC Services and the stakeholders**

- The kebele provides us with support or else We do not have any regular support nearby.
- There is regular supervision from SC staff and Our office staff
- Both Sc and ISAPSO program management see our works as priority area.
- The town kebele administration also gives due attention to our work
- The good attitude and emphasis given by youth ,FSW and TW and response from elders and Kebele is good

*Challenges*

- have been trained & have no guidelines for counseling and on confidentiality

- no guidelines available in designing, pre-testing and developing target specific BCC materials,
- workload and Lack of basic skills in mini media management
- inadequate skills in developing target specific IEC materials
- There is shortage of BCC materials available to provide information and lack variety. There is one room for all IC activities and have inadequate space.
- there is no mechanism for continuously assessing the information needs of clients on HIV issuers prepare materials based on the frequently asked questions and suggestions from audiences fro BCC activities.
- There is lot of disturbance as the room is connected with the main road
- The IC room is on the main road and a lot of voice to ensure counseling sessions can be private. While conducting counseling there are interruptions and the clients finding it to discuss with us with secrecy sometimes a problem.

**Other programs run by other institutions**

- Besides the health center that gives condom, there are no other available services.
- Only collaboration with kebele but there is no coordination mechanism relevant local actors.

**IC service and its referral to VCT and STI services**

- The clinic backs the counseling.
- We receive self-referred clients and the counseling service refers clients to the clinic for VCT services and STI management. But post test cases come back to The IC.
- Referral links are adequate for there is free medical service, spiritual counseling besides the HBC.

**Success of HRCI**

- People have access to VCT and condom when ever they want
- Reduced cost incurred by people for VCT

***Strengths of the project***

- Increased access to VCT, care and support
- Regular visits and supervision from SC staff
- PLWHA and orphans are getting adequate care

**Limitations of the project**

- Inadequate technical support and training
- Inadequate knowledge on mini media and bcc material production
- Staff at times mistreat volunteers
- Inadequate function of the two sub committees

**Mille**

**Background**

- Both Grade 12 complete and actively involved in school anti –aids activities
- Selected based on my previous performance and after passing the exam given by ISAPSO.
- Received training on HIV/AIDS counseling for 5 days.
- Training was good in providing theoretical knowledge but lacks practical demonstration with real people.
- Counselors received a one day follow up training on improving Counseling and HIV education service provision but would like to have more training on HIV, training on HIV/AIDS testing and on STI so as to be able to give adequate information.
-

*Job and satisfaction*

- The IC center works from 9 in the morning to 8 in the evening weekdays and is open Saturday morning. they conduct from 4 up to 5 counseling sessions and 2-3 visits per day
- The counselors feel happy doing their job because they believe what they do is saving many lives.
- The job has strain and there are challenges in work when observing the challenges of PLWHAs who come here and discus with us.

**IC Services in the eyes of stakeholders**

- Counselors provide the IC services to any client coming.
- Counselors provide HIV education for FSW,TW youth and parents, condom demonstration and distribution, counseling and home visits to sexual abuse case
- Aim of IC services is to reduce HIV prevalence by bringing behavioral change among the community.
- One to one, groups as well as mass communication (mini media) are the media methods used.
- According to counselor observations, the major issues that clients seek for information include the nature HIV virus, the mechanism of ARV drugs and what life prolonging means and its role.
- We get support fro the committee, police and government offices. There is regular supervision from SC staff and Our office staff
- Both Sc and ISAPSO program management see the works as priority area.
- The town administration also gives due attention to IC work.
- The emphasis given and response from eders is good and eder representatives collaborate with us when we request them to arrange and conduct education sessions on their meeting.

- The existing services in mille are inadequate and no alternative sources.
- Clients are requesting for more different cassettes on HIV education and also request us to bring similar video cassettes for clients to rent.
- We have bee trained and have guidelines for counseling and on confidentiality.

*Challenges*

- there are no guidelines available in designing, pre-testing and developing target specific BCC materials, for continuously assessing the information needs of clients on HIV issuers
- There is shortage of up to date reading and BCC materials available to provide information.
- There is one room for all IC activities and don't have adequate space to ensure counseling sessions can be private.
- There is lot of disturbance as the room is connected with the kebele office
- Poor access of referred clients to VCT services

**Other programs run by other institutions**

- Besides the health center that gives condom, the woreda HAPCO office involved in HIV/AIDS there are no other organizations.
- The health center provides us condom when we run out of supply and we work in collaboration with HIV office and the police to refer sexual abuse cases but there is no coordination mechanism relevant local actors.

**IC service and its referral to VCT and STI services**

- We receive self referred clients and the counseling service refers clients to the clinic for VCT services and STI management.
- The clinic backs the counseling but there are problems in that many clients wait longer appointments because VCT is provided 2 days a week
- Many clients complain the we are not given adequate time and care for counseling as well as STI management at VCT site

**Success of HRCI**

- People have access to condom when ever they want
- Good community attitude towards IC activities
- The care and support program has improved community attitude and demand for services

***Strengths of the project***

- Regular visits and supervision from SC staff
- PLWHA and orphans are getting adequate care

**Limitations of the project**

- They don't provide us with up to date IEC materials

- Inability to improve the VCT functions

**Nazareth**

**Background**

- Both Grade 12 complete
- Both actively involved anti –aids activities, as peer educator and volunteer counselor for OSSA
- Took the initiation, applied for the position and selected based on previous performance and after passing the exam given by ISAPSO.
- Both received training on HIV/AIDS counseling.
- Training received was felt well in providing theoretical knowledge and but poor for there was no practical demonstration with real people.
- Counselors had one day follow up training on improving Counseling and HIV education service provision.
- Both would like to have more training have inadequate and up to date information on HIV/AIDS/STIs, on HBC provision

*Working conditions and Job satisfaction*

- The IC center works from 8 in the morning to 5 in the evening weekdays and is open Saturday morning. We conduct from 4 up to 5 counseling sessions and 2-3 visits per day.
- Both feel the job is interesting and are happy doing their jobs. The job has strain and there are challenges in work because of shortage of volunteers and lack of transport.
- There is regular supervision from SC staff and Our office staff(ISAPSO)

**IC Services in the eyes of stakeholders**

- Counselors provide HIV education, condom demonstration and distribution, counseling and home visits to sexual abuse case, Pretest and ongoing counseling.
- Aim of IC is to reduce HIV prevalence among the community by bringing behavioral change FSW,TW, youth and parents.
- One to one, groups as well as mass communication (mini media) are the media methods used for IEC. We have bee trained and have guidelines for counseling and on confidentiality.
- Clients seeking information and condom as well as demanding for more different audio and video cassettes on HIV education is increasing.
- Both Sc and ISAPSO program management see our works as priority area.
- Good emphasis and response given by community and eder representatives encourage counselors and provide moral support.

*Challenges*

- there are no guidelines available in designing, pre-testing and developing target specific BCC materials,
- There are a lot of questions asked by clients and we rely on information of year 2001 and yet we are expected to have adequate knowledge to provide information.
- Shortage of BCC materials.
- Difficulty to ensure counseling sessions are private and confidential because of lack of private counseling space and too much noise and interruptions around the IC.
- Lack of knowledge or mechanism for continuously assessing the information needs of clients on HIV so as to prepare need based materials.

**Other programs run by other institutions**

- Besides FGD that provides condom and education in Kebele 07, there are 23 Anti aids clubs involved in education and condom promotion, and Various religious organizations involved in HBC
- Coordination with the IC exists only with 5 anti aids clubs in outreach education and media activities.

**IC service and its referral to VCT and STI services**

- The counseling service is backed by hospital, FGA, OSSA and bethezata VCT center.
- We receive self referred clients and the counseling service refer clients to the hospital, FGA, OSSA and bethezata VCT center for VCT services and STI management.
- VCT Services at OSSA were advertised as being free of charge by SC and clients are disappointed with us for misinforming them

**Success of HRCI**

**Success**

- People have access to condom when ever they want
- Good community attitude towards IC activities

**Strengths of the project**

- Regular visits and supervision from SC staff
- The SC program initiative is new and participatory and has improved community attitude and demand for services
- Highly integrated services

**Limitations of the project**

- They don't provide us with up to date IEC materials
- The IC is not fully equipped with materials and shortage of volunteers
- Clients ask us why not counselors were not tested
- Poor information exchange in the cost of services at OSSA

- absence of up to date reading and information materials
- Inadequacy of the rooms for counseling.

**Mojo**

**Background**

- One is a 12 grade complete and the other a diploma holder in accounting.
- Both Used to work in HIV clubs in Mojo were actively participating because of personal interest and one mentioned to have committed him self after he lost someone dear in 2000.
- Established contact with SC is since the start of the project and through Sr.Tsehay during assessment with FSW in the town was carried out.
- Counselors believe their active participation is the merit that they were trained as counselor and took over the IC last October.
- Only one counselor is trained who stated to have covered the cost of training personally.
- The training I received for counseling had good result the teachers had good ability, provided the necessary materials but there is no follow up for updating ourselves.
- The training about on the subject of communication with the person who wanted to be counseled is not detailed and sometimes we find it difficult to communicate.
- Refresher training and updating oneself about new findings on HIV and on counseling helps to equip myself with adequate information to communicate with people of all sorts and to have adequate counseling skills.

*Working conditions and Job satisfaction*

- We get people in our office and we go to meeting places, coffee ceremony, idir meetings, religious places, etc.
- We talk to the drivers in the morning and some who take the cassette and return to use.
- THE Goal of IC is the change in behavior of the people. There are students who take condom, people talk openly, drivers, FSW have started not to go without condom. There is behavior change and IC is achieving its goal.
- We do not receive referral but we send to them and no problems observed on confidentiality.
- Start working at 8 and close at 11 Mon-Sat. On average I work more than 48 hours. We are supervised by staff of ISAPSO. They provide us IEC materials.
- The service we are providing is not enough. There is a very high demand for condom. The cassettes circulation has increased now at no. 486.
- The job is difficult because we have to go into the community creating our own venue. We did not have leisure time. The job itself did not give us time. We do conduct education during coffee time.

- We are evaluated by ISAPSO. SC provides us with IEC, T-shirt, condom (ISAPSO) through SC vehicle, we provide to the farmers as the IEC materials did not discriminate groups.

**Other programs run by other institutions**

- There is no other agency that works on HIV except Condom distribution by health centre and Shops.
- We did not have any communication with other agencies.

**IC Services in the eyes of stakeholders**

- The relationship we have with ISAPSO is very good.
- The IC has not yet worked with social networks and plans to start.
- But with SC it is only the vague chain of command and there are a number of people coming and passing orders for counselors. This has a repercussion on our self confidence and planned outreach activities.
- The committee has good work but is not yet integrated with the community. Community is not participating. Many people did not know it.

*Challenges*

- Do not have policy on confidentiality and we use our own professional discipline.
- We have a reference but lack teaching aid (models).
- We did not have tape recorder to be used for mini media and demand for video cassettes is high. ,
- We have to go to the people to educate and have no budget for operational expense and counselors are spending their own money for transport, etc.

**IC service and its referral to VCT and STI services**

- The existing referral system is adequate but we have many people just receive our information and go to VCT.
- Referral system required a separate space counselors who are working at VCT center have other medical responsibility and people may not get them.
- Care and support human resource is very small. Additional personnel are required as more people are expected to come out. Support is also required for PLWHA

**Success of HRCI**

- SC/HRCI is the first to start movement on HIV in Mojo.
- Mojo is a town that is always skipped from developmental interventions and we are happy the IC is working because of SC.

***Strengths of the project***

- SC makes regular contact and we understand its vision
- SC realizes its promises and it has build trust, ,

**Limitations of this project**

- Sc did not introduce itself and has poor linkage with government offices.
- IEC material shortage
- Lack of clear management chain with SC. There are orders given directly from SC which sometimes confuse us. They should communicate with ISAPSO not IC.
- HBC should be handled by itself. The committee is not capable of managing this activity.
- FSW drop in centre is closed and we couldn't have FSW in one place that is also very essential for them to discuss their issues.

## *In-depth Interview with IC Volunteers*

**Dire Dawa**

**Chelenko**

### Background

- Both were group members to institute HIV/AIDS club in the town
- Replace in January colleague club members when they moved out of town for education
- Club was dismantled when two volunteers join IC although there were many members
- One completed high school and one attended up to $10^{th}$ grade
- Know that SC is working on FSW, TW hotels but we go to rural areas, tutorial classes, chat chewing places.

**Volunteer Job and satisfaction in the IC service**

- Aim of IC is to bring behavioral change
- Majority visiting IC are youth, few elders come
- Any person has the right to use the service
- Distribute condom to FSW, TW, hotels and other community members. Hotel owners provide FSW and clients freely.
- Condom supplied in few shops
- Distribute IEC materials in schools (HIV/AIDS club)
- Provide education at Iddir meetings, chat shops, tutorial classes, rural areas
- Inform clients availability of STI services
- There is workload
- Advise hotel owners to supply condom in rooms
- Group counseling is conducted with the youth group in town
- Counsel people to visit VCT and STI free of charge
- Conduct outreach education in hotels and other places in the town two days/week
- Provide education for about 15 minutes during Iddir meetings using existing IEC materials
- Have received guidance and explanation for 3 days from ISAPSO field officer Kebele Administration supports IC activities very positively in settling dispute, calling public meetings

*Challenges*

- IEC materials are in Amharic and are short of supply of Oromiffa IEC materials
- No systematic assessment of information needs of clients
- Shortage of IEC booklets and fliers, cassette serial drama, office supplies and microphone to use mini media in another direction
- Inadequate trained counselor
- IC is not convenient for confidentiality

- Shortage of volunteers, training to recruit new volunteers required
- There is no guideline on confidentiality and CHBC
- There are people who request for unfair demonstration from the society

*Perception on voluntarism and misconceptions*

- Married people have never come and asked for condom. Married need not use condom instead lady should go to take injection for birth control. They need to trust each other.

**VCT and STI service and the referral system**

- Other VCT staff are not cooperative when permanently assigned staff is absent
- Counseling is conducted in one room and blood sample taken in another
- IC staff and VCT counselor keep confidentiality, we trust each other
- Clients wait same room with other patients,
- 3 couples from rural area came and have undergone VCT test for their marriage
- Referral system: IC refer to VCT, results are referred back to IC and IC refer to CHBC, committee approve for care and support
- Challenges
- There is no guideline for confidentiality but the IC councilor has informed us well about it.
- Blood sample is taken and tested by the lab technician in another room
- Closing the door when a client entered counseling room exposes to breaking confidentiality

**Other programs run by other institutions**

- No other institution runs similar program.

**Strengths of the project**

- Communities have accepted and started supporting economically (food, money, etc.) PLWHA
- High demand for condom is created
- Community regards the volunteers activity as relevant and positive
- Elderly people are also getting involved in the discussion now.

**Limitations**

- Inadequate number of volunteers available (one is supporting freely since the last 3 months)

**Logia**

**Background**

- One connected by Ethiopian Red Cross Society to ISAPSO and one competed 9th grade and is voluntarily initiated to serve as volunteer

- One trained by ISAPSO, and both by SC four times (including refreshers)
- One is employee of the Kebele Administration, one serves as ___ in HIV/AIDS committee

***Volunteer Job and satisfaction in the IC service***

- Aim of IC is to bring behavioral change and eliminate HIV/AIDS
- Location of IC is central
- Participated in a training that is satisfactory and necessary for the job
- Distribute condom and counseling to FSW in 2 days/week and TW 2 days/week (outreach)
- Distribute condom, IEC materials and counseling TW
- Training will assist us to be able to answer questions arising from clients
- No work load and are satisfied. We work 1 day/week only (there are 5 volunteers)
- Community and HIV/AIDS committee considers the project very positively
- IC service is adequate to the existing demand as 29 sub districts are covered provided that we get support from health workers
- Provide education for Iddir meetings using existing IEC materials on HIV/AIDS and STI
- Produced IEC materials with support of Hussien
- IC acquires IEC materials adequately from DKT
- Topic covered by the HIV/VIDS education is planned and prepared based on the questions from clients
- Sexual harassment is settled involving Kebele Administration

*Challenges*

- No training and guideline on IEC material production
- IC is not convenient for confidentiality

**VCT and STI service and the referral system**

- Confidentiality is strictly followed up (only CBHC volunteers receive the counter referral from VCT) for those who want it to be confidential. Otherwise there is social event organized for them in collaboration with religious leaders.

**Other programs run by other institutions**

- There is one association working on HIV/AIDS and IC provides condoms and IEC materials

**Strengths of the project**

- Support to the PLWHA
- Close supervision and support to volunteers by SC
- TWs behavior is changing
- Very strong supervision organized by ISAPSO (at least once in a week)
- High demand for condom is created

**Limitations**

- Late arrival of support for PLWHA

**Recommendation**

- HRCI to organize information updating sytem
- Training and experience sharing forums as are necessary

**Mille**

**Volunteers and their working conditions**

**IC Volunteers Background**

- One completed high school and one attended up to 8th grade
- One Served as volunteer in Ethiopian Red Cross Society
- Know that SC is working in Mille when invited for meeting before one year and from its care and support to PLWHA and OVC
- One recruited because she is resident (Independent) FSW
- Both volunteers serve in the committee as a treasurer and a member
- One is trained as volunteer by ISAPSO before SC started work and more 5-6 trainings. One received training of peer educators provided by SC.

*Volunteer Job and satisfaction in the IC service*

- Started by distributing condom to various institutions such as garages, hotels, TW (with ISAPSO) and current service includes the whole community
- Any person has the right to use the service
- Distribute condom to FSW and other community members
- Contact hotel owners during visit and advise on support to FSW during sexual harassment
- Counsel people to visit VCT and STI free of charge
- No workload and are satisfied their contribution to the society
- Meet up to 5 people/day (1-2 hrs/day) on average
- Know target specific (age wise) information to be provided
- Participate in counseling in IC while the counselors are busy
- Address problems of FSW particularly when there is sexual harassments
- Provide education for about 10 minutes during Iddir meetings using existing IEC materials (since last 1 year)
- Developed a network with the community to identify PLWHA or sick due to other health problems and did not have any support

*Challenges*

- Former training included HIV/AIDS and STI but we are given instruction that we only remind people that there is HIV/AIDS. However, we encounter various questions that require more explanation
- Except the discussions held during the training, there is no guideline on confidentiality and CHBC
- In adequate IEC material supply. We get IEC materials from DKT

- Need to learn from experience of people engaged in similar activity and new developments in HIV/AIDS and STI
- One speaker cannot reach all parts of Mille and the other Milles are missing
- Inadequate human resource

***Perception on voluntarism and misconceptions***

- Voluntarism requires great patient, trying to disseminate information in various way and treat people according to their behavior and age
- IC does not include all segment of the population but committee does because it includes representation of every part of the society
- Person who goes to IC should be voluntary, patient, have good behavior and would like to talk to counselors Services of volunteers in the eyes of stakeholders
- Community regards the volunteers activity as relevant and positive
- Attitude of community changed most after SC's intervention on care and support
- Committee need not discuss about the speaker, instead ISAPSO should assess and bring it

**Other programs run by other institutions**

- No other institution runs similar program. SC came after ISAPSO stopped
- There is no coordination effort to work with government offices

**Strengths of the project**

- Brought attitudinal change for example elderly people are also getting involved in the discussion now.
- High demand for condom is created
- Multi media addresses information needs of all categories of people and all residents of Mille have listened to serial cassette drama
- Close follows up of the care and support to PLWHA and OVC by committee

**Nazreth**

**Mojo**

***Volunteers and their working conditions***

**IC Volunteers Background**

- Completed 12th grade and were actively involved in anti –aids activities
- Applied for the position
- Not trained
- Training helps to improve knowledge and skills particularly to better educate the community and counsel

- Provide support to counselors. The job has no strain
- Provide education twice a week mainly in the evenings and holidays, preparing coffee ceremonies and dramas
- Community education is planned on regular basis in consultations with counselors.
- Regular supervision made by senior staff visits and reports.

**Volunteer Job and satisfaction in the IC service**

- Any client has the right to use the service
- Aim of IC is to bring behavioral change among youth, TW, Sex workers and practice safe sex
- Volunteers provide counseling during lunch hours
- Volunteers provide service to clients coming for counseling
- Feed back from clients is systematically collected
- Both SC and ISAPSO program management give priority to our works.
- Demand for print IEC materials is increasing
- Demand for condom and information is increasing
- High demand for serial drama cassettes and video cassette to rent
- Better emphasis and response from elders

*Challenges*

- But there are no guidelines available in designing, pre-testing and developing target specific BCC materials,
- Shortage of BCC materials
- Have no knowledge about mechanisms for continuously assessing the frequently asked information and questions by clients and use it as a basis to prepare education sessions.
- Do not have adequate space to ensure counseling in private.
- The services are inadequate and many youths who came from anti AIDS clubs have been denied access at health center for VCT services are not provided for youth under 18 years of age as per instructions given for counselors.
- Lack of up to date information

**Other Institutions working on HIV/AIDS**

- No other institution work in similar activity

**Strengths**

- Regular visits and supervision from SC staff
- Prompt response when ever we need

**Limitations**

- Provision of up to date IEC materials

## *In-depth Interveiw with HBC Volunteers*

**Dire Dawa**

**HBC Volunteers Background**

- 12 grade complete who has been involved in anti aids club activities
- Interested to work in HBC and voluntary applied to work.
- Rated the training as being very good and doesn't feel there are areas in which he needs more training. However ongoing training will be good for it will help me acquire more knowledge and skills to work better fully independent.

***Volunteer Working conditions and Job satisfaction in the HBC service***

- There are no eligibility criteria; all clients coming for HBC are provided services.
- Volunteers provide education and skill training for Home care givers.
- The aim of HBC is to enable PLWHA get the necessary support and care so that they have longer life engage in productive work.
- Home care activates include counseling, Visits for medical care activities like First aid care, providing referrals and education of Home care givers their families.
- Volunteers work there times per week and conducts 2-3 visits per day.
- The stated feeling towards HBC job as good and comfortable

**Views on HBC Services and stakeholders**

- receive support and supervision for any HBC work for sc/woreda committee regularly.
- The existing view of the community, CBOs positive and our work is also given emphasis by HRCI program.

*Challenges*

- There is no guideline/policy on confidently.
- The supply of HBC materials is inadequate and volunteers have no transport to make frequent visits.
- The existing HBC program under HBC is inadequate.

**Other programs run by other institutions**

- There are other HBC programs like Jerusalem, mission of charity that provide care for PLWHAs but there is no coordination/integration mechanism.

**HBC service and its Linkages and referral to other services**

- The HBC service is backed by the HC but not hospital but the existing links/referrals for PLWAS for specialized care services is inadequate.

- We receive referrals from Health center, the hospital and FGA. We refer to the health center. The problems with referral are the Hospitals doesn't accept our referrals, patients don't get adequate treatment at HC and patients are required to pay at FGA.

**Success of HRCI**

- in prolonging the lives of many PLWHAs, who had no more to eat for long.
- Raised the communities awareness on HBC
- Many families engaged in providing care and supportive environment to PLWHA

***Strengths of the project***

- Participatory approach to involve the community fully.

**Limitations of the project**

- Unavailability of committee members to facilitated fully HBC.
- Absence of a focal person who is a referral contact, follow the work programs and facilitates the HBC and provision of materials
- Inadequate /Regular supply of HBC materials.

**Chelenko**

**HBC Volunteers Background**

- Both 10 grade complete who has been involved in anti aids club activities.
- They were self initiated and voluntary applied to work.
- Both trained on HBC for two weeks on caring for bed ridden patients, how to communicate with patients, families and care givers.
- Both rated the training as being very good and but inadequate
- Both felt ongoing training will be good for it will help them acquire more information on HIV/AIDS knowledge on behavioral change skills.
- Subject areas felt for more training like ongoing counseling, psychological support and behavioral change issues.

***Volunteer Working conditions and Job satisfaction in the HBC service***

- The is no eligibility criteria, all clients coming for HBC get the service
- The aim of HBC is to enable PLWHA get the necessary support and care so that they have live quality of life and become productive.
- Home care activates include Counseling, giving first aid, referrals to HC and education of Home care givers.

- Both volunteers work there times per week and conduct 3-4 visits per day. But provide service any time up on request.
- Stated their feeling towards their job as rewarding seeing the response from PLWHAs and being able to give them money cannot buy.

**Views on HBC Services and stakeholders**

- Support and supervision for the HBC work from sc/woreda committee is inadequate and not regular.
- The existing view of the community, CBOs positive and our work is also given emphasis by HRCI program. But the committee members lack commitment and the commit members are not always available for patients to get registered for HBC.
- The long process of registration that all committee members have to sign to commence HBC for new client is the major challenge.

***Challenges***

- There is no guideline/policy on confidently.
- The existing HBC program under HRCI is inadequate.
- the supply of HBC materials is inadequate and volunteers have no transport to make frequent visits.

**Other programs run by other institutions**

-
- There are no other HBC programs in the area nor there coordination/integration mechanism.

**HBC service and its Linkages and referral to other services**

- The HBC service is backed by the HC. We receive referrals from Health center and We refer to the health center.
- The problem with referral is that Patients don't get adequate treatment and lack of medicine at HC.
- The existing links/referrals for PLWAS for specialized care services are inadequate.

**Project in thc eyes of HBC volunteers**

**Success**

- SC/us has placed significant role empowering the community and prolonging the lives of many PLWHAs through.

***Strengths of the project***

- Providing training to involve in HBC and efforts to involve the community fully.

**Limitations of the project**

- Unavailability of committee members to facilitated fully HBC.
- Inadequate /Regular supply of HBC materials.

## Logia

### HBC Volunteers Background

- Both have been involved as volunteer peer educators before he started working as HBC.
- Both were self initiated and interested to work in HBC and voluntary applied to work and were selected based on recommendations of committee members and their previous performance
- Both trained on HBC for two weeks. The training attitudinal change towards PLWHA acquired skills in approaching sick people and enabled us care for bed ridden patients.

*Volunteer Working conditions and Job satisfaction*

- The is no eligibility criteria, all clients coming for HBC get the service
- Volunteers stated the aim of HBC is to enable PLWHA get the necessary support and care so they become productive.
- Home care activities include Counseling, giving first aid, referrals to HC and education of Home care givers.

- Stated their feeling towards their job as satisfying with regard to caring for sick and helpless people
- Both work any day when requested but regularly conducts 4 visits per day and work three days per week.
- get support from SC and Clinic ( provides materials)

**Views on HBC Services and stakeholders**

- The community attitude is good, CBOs have positive view.
- our work is also given emphasis by HRCI program.
- We have problem working with the compound we share with police department who don't allow us enter any time we want.

*Challenges*

- the supply of HBC materials is inadequate and volunteers have no transport to make frequent visits.
- There is no guideline/policy on confidently.

**Other programs run by other institutions**

- There are no other HBC programs in the area. The existing HBC program under HRCI is adequate for the existing number of PLWHAs.

**HBC service and its Linkages and referral to other services**

- The HBC service is backed by the HC. We receive referrals from IC and we refer to the health center. There are no problems with referral except that Patients don't get adequate treatment and lack of medicine at HC sometimes.

- The existing links/referrals for PLWAS for specialized care services are inadequate.

**Project in the eyes of HBC volunteers**

**Success**

- SC has done well in starting HBC program for the destitute positive people and prolonging the lives of many PLWHAs.

***Strengths of the project***

- Providing training to involve in HBC
- All referred cases have got care and support

**Limitations of the project**

- PLWHA don't get money on time always and they lack adequate food.
- Inadequate /Regular supply of HBC materials.

**Mille**

**HBC Volunteers Background**

- Both grade 12 complete and has been involved as volunteer peer educators before
- voluntary applied to work in HBC and decided to do so for their high interest in the area and motivation to help people.
- were selected based on recommendations of committee members and previous performance.
- Both trained on HBC for two weeks and perceive the training as good.
- Ongoing training is good because it upgrades our skills to provide better care and support and improve the quality of service. No areas for training on HBC but counseling.

***Volunteer Working conditions and Job satisfaction in the HBC service***

- There are no eligibility criteria, We respond to all clients when families request our help.
- The aim of HBC is to create conducive environment for PLWHA and their families.
- Home care activities include regular home visits, Counseling, giving first aid, referrals to HC and education of families on Home based care.
- Both work three times per day and regularly conduct 4 visits per day.
- Stated their feeling towards their job as satisfying with regard to caring for sick and helpless people

**Views on HBC Services and stakeholders**

- get support from SC and Clinic ( provides materials)
- The community attitude is good, CBOs have positive view.
- We get good support from HRCI program.

*Challenges*

- There is no guideline/policy on confidently.
- The supply of HBC materials is inadequate.
- There is shortage of gloves and plastic aprons and volunteers have no transport to make frequent visits.

**Other programs run by other institutions**

- There are no other HBC programs in the area. The existing HBC program under HRCI is inadequate.

**HBC service and its Linkages and referral to other services**

- The HBC service is backed by the clinic. We receive referrals from VCT and we refer to the clinic.
- There are no problems with referral except for lack of medicine at clinic sometimes.
- The existing links/referrals for PLWAS for specialized care services are inadequate.

*Strengths of the project*

- People came to see PLWHA for the first time and brought change in attitude towards them.
- All referred cases have got care and support

**Limitations of the project**

- PLWHA don't get money on time always and they lack adequate food.
- Inadequate /Regular supply of HBC materials like gloves and plastic sheets.

**Nazreth**

**HBC Volunteers Background**

- Both Grade 12 complete.
- One has been involved in anti aids clubs and the other working as HBC volunteer.
- Both self initiated and voluntary applied to work.
- Both trained on HBC for two weeks and felt the training brought attitudinal change towards PLWHA and before we had fears and don't know how to car., acquired skills in approaching and providing care for bed ridden patients.
- Need more training on counseling, caring for dead body.

***Volunteer Working conditions and Job satisfaction***

- The is no eligibility criteria, all clients willing and coming for HBC get the service
- Volunteers counseling, giving first aid, referrals to HC and education of Home care givers and family members.
- The aim of HBC is reduce stigma and discrimination against PLWHA, to convince the community and enable PLWHA get the necessary support and care so they live longer and become productive.
- We work three days per week but also work any day when requested.
- Stated their feeling towards their job as rewarding and satisfactory.
- We get support from HRCI and a HBC supervisor selected among us.

**Views on HBC Services and stakeholders**

- The community attitude is good, CBOs have positive view
- Our work is also given emphasis by HRCI program.
- The major problems is with landlords who rent their houses for PLWHA and stigmatize them

*Challenges*

- There is no guideline/policy on confidently.
- The supply of HBC materials is inadequate at times and volunteers have no transport to make frequent visits.

**Other programs run by other institutions**

- There are other HBC programs as wogen lewogen and other religious organizations the area but don't have contact or coordination. The existing HBC program under HRCI is inadequate.

**HBC service and its Linkages and referral to other services**

- The HBC service is backed by the hospital and HC.
- We receive referrals from OSSA and other VCT and we refer to the health center and hospital.
- The problem with referral is that Patients don't get adequate treatment immediately and lack of medicine at HC sometimes.
- The existing links/referrals for PLWAS for specialized care services are also inadequate.

**Views of HBC volunteers on the Project**

**Success**

- SC/us has placed significant role in prolonging the lives of many destitute PLWHAs.

***Strengths of the project***

- People have raised understanding and acting on caring and supporting
- Many cases have got care and support even at their homes

**Limitations of the project**

- People expect us to care for dead body which we have inadequate skills.
- PLWHA don't get money on time always and they lack adequate food.
- Inadequate /Regular supply of HBC materials.

**Mojo**

**HBC Volunteers Background**

- Previous working as a religion volunteer in providing care support to the sick and poor who took shelter in the churches.
- decided to be trained as HBC volunteer because of personal interest and religious obligation to help the poor and destitute
- Received training on HBC but feels the 15 days training is not equivalent to the current job involved.
- The training covers only general issues only and training is lacked detailed and thoroughly education on the subject.
- Further training will help for providing a better HBC acquiring knowledge on how to care for dead body, which I don't know but do it regularly. The subject areas felt for more training are on counseling and detailed /training on HBC

*Volunteer Working conditions and Job satisfaction in the HBC service*

- There is no eligibility criteria form HBC provision.
- We provide counseling over telephone connection and HBC through home visits.

- Volunteers also involved home visits, Conducting follow up and discussions on the need for care giver at home, assisting the PLWHA select a family member he prefers and Providing education and skill practical sessions on area processing for the caregiver.
- Volunteers work 7 days per week, weekends including Holydays, conduct 12 Home visits per day on average for the past 8 months.
- Volunteers feel happy and satisfied doing the HBC job because of the value that the community gives us and personal believe that it is good in the eyes of god. But there are strains for there are inadequate volunteers.

**Views on HBC Services and stakeholders**

- The community response towards HBC has been improving.
- There is lack of support in Providing gown clothes and Protection materials
- There is lack of regular or support or supervision from the committees.

**Other programs run by other institutions**

- There are no other relevant services in the area.
- But there is coordination in activities only at the death of PLWHAS with the municipality and the orthodox church. We prepare the body to the church provides burial place and the municipality gives vehicle and the labor for preparing the cemetery free of charge
- The existing HBC service is inadequate and there are no others sources for clients to get the service.

*Challenges*

- HBC materials like (gloves, soaps) are inadequate and no regular supervision.
- Lack of transport to mark frequent visits
- Lack of file cabinet to put clients' information.
- There is no guideline developed on confidentiality
- Misconception of the about HBC volunteers. People used to believe that we are employees of HRCI and only recently that they learnt we are volunteers

**HBC service, its Linkages and referral to other services**

- We get referrals from Health Center but have Poor backing from the Health center for HBC services.

**Major successes of HRCI**

- Many PLWHA are revealing themselves and initiated to educate the community

**Strengths of the project**

- The program is need based
- Regular follow up the telephone and paying visits.

**Limitations of the project**

- Inadequate provision of HBC protective materials,

## *Discussion with Wereda HIV/AIDS Committee members& some key informants*

**Dire Dawa Wereda 2**

This committee is re-structured in October 2003 and it has regular committee meetings every month. There are 4 members only who are trained on Community Planning Response (earlier committee). Although the youth committee did not have budget and members participate in educational forums organized by others only. The committee has faced a challenge to raise fund for fulfilling its objectives. The Regional HAPCO banned the public event they organized for fund raising and this has to be investigated more by SC. The counsel has contributed to the project but it is not sufficient.

The support initiated for PLWHA is good and has to continue. The committee does the selection of the PLWHA as well as orphans. PLWHA stigmatise themselves and communities are willing to support them. However, there are also other who stigmatise with good reasons. For example, a street tea vendor refused to serve a PLWHA and when asked she said that "no one will come and buy me if they see him/her using my cups and I have to protect my business to survive". The referral from the hospital however, is not efficient. Absence of health care service from the project is a problem. The referral from the hospital to committee is inadequate. The Kebele is committed to support the clubs.

The budget allocated for the purchase of uniform is half of the current price and SC did not respond to the problem. There are also 3 volunteers trained and not providing service due to absence of funding. The shortage of the fund arises from reallocating the budget to cover 7 Kebeles without any discussion against the initial plan of 3 Kebeles.

The committee expressed that they have observed that clubs are actively participating in public education for communities to increase the awareness of people in the last 2 years.

**Strength of HRCI**

- The support initiated for PLWHA is good and has to continue.
- Inadequate budget release for implementing the project
- SC intervention seems a pilot but has broader coverage and strong effect. It needs to help HAPCO to be active in the area.
- Use of condom and using the services of VCT has increased

***The weaknesses are***

- HAPCO is extremely weak even at national level to utilize money

- Have to support PLWHA and child headed households to be productive and help themselves.
- The VCT in the hospital is very weak. Results of tests are obtained in 2 days and only one counselor is taking the responsibility. The health workers behavior in the hospital is extremely weak. In addition, it charges Br. 6 per test. FGA provides Br. 5 and delivers results in a day and sometimes in an hour.
- Absence of health care service from the project is a problem.
- SC should study why the IG initiated by OSSA for PLWHA failed before venturing in another IG with this project.
- Organizing regular forum for information exchange is very important.

**Dire Dawa Wereda 3**

The committee was formed after attending a workshop, conducting need assessment and designing project document last year. Although the committee started early, is progress was slowed down due to the transfer of the SC senior staff. In addition, the inability of the majority of the committee members to attend meetings and discharge their responsibility, the workload on few members had affected the smooth progress. The establishment of the CBCCC was also a challenge for the committee as there were issues unclear on earlier arrangement with the Iddir that has taken the initiative in taking the lead responsibility for CBCCC.

**Strength of HRCI**

- The provision of support to PLWHA is relevant measure and the administration has made its priority to provide house for PLWHAs.
- Communities have changed outlook on PLWHA because of the CHBC volunteers.
- Providing training to the committee and the necessary funding to start implementing the project

**Weakness of HRCI**

- PLWHAs reveal behavior that they stigmatize themselves and committee didn't have the budget to train them change their behavior.
- Promises made by SC staff are not fulfilled (example is promising the Iddir to receive rent from its plots)

**Dire Dawa Wereda – Chair person of an Anti Aids Club**

The club has financial support with DSW (Germany base Donor) and have a budget of Br. 2000/month. It did not have any contact with IC although it is the first club

initiated in the town. The club distributes 5000-6000 packets of condom every quarter. It has institutional cooperation with Mary Stops for reproductive health treatment and for a person referred from the club (who has to undergo a reproductive health education) is treated free of charge (for the first incidence).

There was a report the club received indicating that young boys rape girls using condom. This, said the chairperson, is an indication that people are attempting to prevent HIV/AIDS even for their illegal act and this shows that the issues is well taken in a way.

On sexual harassments, the police is cooperative and reacts well. There is adequate supply of condom. FSW have developed confidence in using condom and they are able to protect themselves. However, there are women who live with their families and have partners. These are currently at high risk. PLWHAs need to be productive although there are some who might find this difficult due to their addiction chats and others things.

**Dire Dawa Wereda Chairperson of Kebele 15, W/o Haimanot Shenqute**

Small business people, economically poor and many FSW are the dominant inhabitants of the kebele. She has expressed her sincere appreciation for the committed staff the IC. As the IC is located in the compound of the Kebele administration, it has been under the observation of every resident as well as the Kebele office. The IC has been following up strict schedule such as 12:00 a.m – 2:00 p.m. condom distribution, 6:00 .m. – 8:00 p.m. multi media. The IC is very cooperative to work with the Kebele and Wereda Administration and the Kebele is committed to support the IC.

The issue that concerns us is that the PLWHA that are receiving support from the different Weredas over consume the available small funding and this has to be checked. They have also developed dependency and are not satisfied with the CHBC and they need to be aware about the sacrifice the society is making in looking after their healthy living environment.

She concluded by saying that the experiences of SC need to be replicated in all other parts of the town and the country at large.

**Dire Dawa Wereda 4**

Managing OVCs is difficult as they are children they need to be given gifts/have new clothes during holidays. OSSA provides food support and children under our support request this. In addition, there are several harassments that children face by people. The committee has responsibility to sort out all these problems. There is a need for developing uniformity.

Committee members know with whom they liaison with in SC/USA. Initially there was a problem with financial procedures and reporting but SC staff has explained

the acceptable reporting system and have developed formats jointly. Committee uses its member's experiences.

**Strength of project**

- Did not intervene in committee's activities
- Mobilising volunteers and integrating them with our support CHBC
- Close follow up and integration of CHBC service with health providers, administration, HAPCO
- *Supporting the PLWHA and OVC*

**Weakness**

- Inadequate and late response to crucial questions from committee
- The budget allocated for the activities is very low for ex. Budget for writing materials is Br. 50.00 for all sub committees
- Supporting the PLWHA and OVC has raised hopes and need to continue
- Covering transportation costs for urgent meetings and CHBC ex bicycle, supply for drugs for OI, etc
- Committee is ignorant of SC/US overall program on HIV/AIDS its direction for the future, the project agreement they signed with the government
- The follow up of SC is not uniform in all Weredas for instance, Wereda 2 has a problem and seems it lacks support of SC

**Chelenko**

The committee is structured last year after receiving training community planning process. It planned a project document and started operation in October after receiving the fund from SC. Members, however, claimed that most are busy.

The committee planned support to OVC by assessing all parts of the town. The support includes education material, detergents for sanitation and uniforms. The committee members expressed their concern about OVCs that do not have supporters and often do not have breakfast when going to school. Currently, they said, the committee identified more OVCs that require support. There is no psychosocial support provided.

It was initially difficult to identify PLWHA as the community was highly stigmatising the infected. Currently, there are 12 people and supported by the committee. All of these people are not tested positive and are yet attempting to convince them for the VCT testing. There are 4 diseased after being identified. The support includes Br. 150 for food, blanket and sanitation, house rent (a total of Br. 750) for the year. The house rent is Br 40-50. Supporting the PLWHA and confidentiality has created a problem to manage the support. It is very difficult to keep confidentiality for a person who applies for support, as its application needs to

be reviewed by the committee members. This is something that requires different approach. There are PLWHA who started receiving the support for few months and leave the town.

Committee has been closely assessing the existing situations to effectively disseminate information about HIV/AIDS. As long as SC continues to support, the committee can try to raise fund locally with improved proportion (for instance up to 20%).

**Strength**

- All the activities are good
- Project has contributed to increasing awareness and paved the way for the community to change behavior.
- High contribution of the Multi media

**Weakness**

- Support to OVC is incomplete due to absence of support for food
- Support to OVC need to be taken up by a strengthened government system
- Provision of ARV to PLWHA and strengthen the VCT with the necessary facility
- Need to get support for strong monitoring, exchange information and make the monthly meeting learning session
- Weak supervision from SC (did not give time to discuss issues thoroughly)
- There is no documented guideline for directing our activities
- Mobile mini media

**Logia**

The Administration selected the committee members from different groups in the society. SC provided training the elected and formed the committee. Some members who join the committee have been working with SC project before their election to join the committee. Some committee members serve as IC volunteers, CHBC giver, counselors, etc. there has not been any attempt to involve other people to reduce the overlapping responsibility taken by these members.

The fund raising committee was active initially (collected about Br. 320; 190 from members and Br. 110 from budget allocated for tea/coffee for committee meetings to expecting that communities may not be willing as there are other contributions). The collection was made using receipt and official seal of the Kebele Administration. A total of Br. 1100 was collected and others were valued from services.

The OVC committee started its support in September although it planned to start in June. The activities were delayed due to delay in the start of counseling services, house for opening CBCCC. The support to OVCs started in September. Support to PLWHA started by supporting people who are bed ridden even if they did not know

their syro status. Continuous support for identified PLWHA started after counseling and having their result from VCT and currently 18 are identified and 6 more will have yet to check. OVCs are providing with writing materials, detergents and uniforms. Committee members meet OVCs while providing detergents while they are in school; this is also a time that discussion with OVCs is conducted. The committee tried to use the funds allocated for purchase of dictionary, balls, etc as per their needs. A teacher who is member of the committee is also closely following up their situation. They are supported by free health service but very often the public health providers did not have adequate supply of drugs.

There are receipts that are accepted by SC are used for financial transactions. The committee has its own documentation and others are released for liquidation to SC. However, there are some items that the committee could not find receipts (ex. recreation to the committee). There is however a problem for lack of financially acceptable system for paying PLWA|HA because payment is made by delegation ex CBHC.

**Strength**

- The communities have released the existence of PLWHA within the community,
- Every PLWHA was known by all committee members initially and created conflict.
- SC staff attend committee meetings
- Support to PLWHA and OVC
- Services offered by CBHC

**Weakness**

- Absence of guideline on confidentiality and its unattended implications on financial procedures
- Lack of guideline for financial procedure and absence of receipts for small expenses has a potential to create problem
- Late release of budget
- Absence of auditing up to now will allow persistent mistakes to pursue if any
- Overlap of activities by members
- Frequent changes of receipts to used and many new instructions

**Mille**

Before initiating the committee SC was working with FSW peers. Later it provided training on community response process and committee prepared a project to support PLWHA and OVCs. The committee was able to raise Br. 5000 and labour contribution and the fund for the project was approved after 7 months (October 2003). After the completion of the CBCCC and OVCs are provided support, the CHBC volunteers started providing support to PLWHA.

**Strength of the project**

- Fund raising activity involved the whole community
- Establishing the CBCCC and addressing the OVC problems
- The care and support to the PLWHA
- Involving the Iddir and religious leaders to regularly raise the awareness of their members
- All members are committed and attend meetings (at least 15 will attend every meeting).

**Areas that require attention**

- Coverage the costs of drug for PLWHA are highly necessary if we want to make them productive. Costs of health services are also necessary for the OVCs. The drug availability in the government provider is very inadequate.
- The OVC in the elementary school are suffering to find food in the town after school and it would be difficult for them to pursue their education. They can drop out any time they are unable to find their food. It is also necessary to start psychosocial support and work reducing the harassment they are facing.
- There is a threat to the PLWHA support because 1/3 of the current beneficiaries came from other places and it very difficult to deny the support if such people come in Mille.
- Shortage of counselors in the VCT
- Lack support to the FSW Association. The association is expecting/waiting SC to jointly plan on IG.

**Nazreth**

The committee was initially not effective as it comprised large membership (30 people) and with higher responsibilities. Conducting meetings and decisions making was a major challenges. The current committee is organized before six months and it 20 members and has planned to establish contact with religious and social organizations, health centers and workers associations. Its members are well aware about the specific activities such as facilitating access for PLWHAs for food, CHBC, better health care and VCT services. Regarding support for OVC, the committee works in close collaboration with the social court in the Kebele administration for screening and selecting children orphaned due to AIDS. The criteria used for selection of OVCs include income status of diseased parents, availability and income status of guardians, history (in terms of health) of the diseased parents and economic status of a single PLWHA parent. The screening mechanism is subject for gradual revision in the future. Currently there are 25 OVCs who are directly benefiting from school feeding program and 75 from support for education. Few children are from a single PLWHA parent family.

Sixteen volunteers are trained in home-based care and are currently working with the committee. They are provided with the necessary kit and replenishments from SC/US. CHBC volunteers receive Br. 100/month as pocket money for transportation. In addition to providing palliative and psychosocial care, the volunteers are responsible for raising the awareness of the community; referral to VCT, HIV/AIDS committee, and information center.

**Strength of the project**

- Participatory need identification, targeting and transparency regarding budgetary information
- Provision of training and home based care kit for CHBCs
- Strong follow up and commitment of staff
- Support provided for the OVC and PLWHA
- Re-establishing of the committee

*Major weaknesses*

- Lack of flexibility to address changes arising from local salutations. Budget limitations that doesn't correspond to existing needs
- Weak response in correspondences
- Low incentive for a volunteering activity that demand about 12 days of work in a month
- Excluding health service for PLWHAs
- Absence of support to the rural areas

**Mojo**

The committee started operation in May 2003 after members attended a workshop on Community Planning Process. A project with a budget of Br. 131,000 was submitted to SC/USA and Br. 83,300 was approved. The committee is able to support 15 AIDS patients, 35 PLWHA and 20 OVC and 10 old aged who lost their children due to AIDS are supported by this project. The committee has registered 51 PLWHA and has realized that the demand for the support is increasing. The available funding is not sufficient to address the needs of the PLWHA.

OVCs were selected based on a criteria (including testimony from the social court in the Kebele Administration, income of guardian and self investigation) developed by the committee and on site investigation. However, waiver from school payment is made in discussion with schools. The committee has planned to work on psychosocial support for OVC, sexual harassment, stigma and discrimination, linking to as many Iddirs as possible (out of 87 Iddirs in Mojo) for social mobilization, and fund raising. The committee members has faced a problem of workload as only few can fulfil their commitment. In addition, it is planned that PLWHA have to be productive but the committee did not have adequate resources.

The conflicting issues in confidentiality have aroused concerns of the committee. Once a PLWHA requires support and applies for it, the confidentiality is broken

and members cannot get closer to PLWHAs to discuss issues. The committee did not want PLWHA to hide themselves and CHBC did not want to violate the ethics they learned. It provides PLWHA with financial support and rents a house from individuals. However, the house owners express that PLWHA stigmatize themselves, even if community members are willing to support them.

**Strength of the project**

- Initiate and support the project implemented by the committee, its support to the care and support
- SC's close relationship to the committee
- Training and supporting the CHBC and counselors
- Increasing demand, interest and openness of people in HIV/AIDS Issues, for

***The major weaknesses***

- Low formal response to requests made to SC
- Inadequate financial utilization supervision; only got a one supervision made in the last 6 months
- Lack of clarity for effecting payments to PLWHA through 3rd person and absence of ledger for financial recording

## *Annex 8:*

## *Transcription of the In-depth Interview and Focus Group discussion with service users*

### *In-depth Interview FSW*

**Dire Dawa**

**First contact with SC**

- Know Family Guidance Association and use its counseling service,
- Staff in FGA receive clients well and provide education on HIV/AIDS.

**VCT and STI**

Doesn't know the existence of VCT and STI services;

**IC**

- Provided education on HIV/AIDS for 3 days and
- Is a venue for FSWs' regular monthly meeting
- Is important for us because we get various educative information on the appropriate use of condom, its management and learn about free VCT although we have not yet checked with out syro-status.
- Counselors and volunteers in the IC are impressively committed
- Have learned much more about condom here.

**Peer education**

- Educate other people but they did not listen instead they scold us,
- We provide advice to new entrants.

**Clients**

- Some are not interested to use condom
- They negotiate with high payment for not using condom.
- Some force and sexually harass FSWs for not using condom.
- There are also FSWs who are not friendly due to ignorance, carelessness and negligence.
- FSWs are advised to limit their alcoholic intake so as to effectively bargain and protect themselves.

**Employers**

- Some were not cooperative initially because they were selling condom and IC is providing us freely.
- Now we have access from IC and refuse to buy from owners only when short of it.
- There are hotels where employers are not cooperative due to financial interest from clients they request FSWs to accept what is demanded by clients.

- Employers did not receive training.
- Employers would not allow leave, do not help when we are sick

**FSW**

- Those working in small places do not meet people because they are forced to confined themselves in places where they houses and they are not matured and are vulnerable to any kind of sexual harassment.
- Most men going to these places drink hard liquor and this exposes them to sever violations.
- Those living in street are the most exposed to serious violations by clients as they did not have any protection. They are also addicted to certain alcoholic drinks and harmful habits.
- Cannot form network, as FSWs are highly mobile. It is good to have the association but can only be organized by non-FSW because we need to be informed about the places.
- Spend our time by chatting while chewing chat.
- Most of the time we discuss about the time we passed with someone. We did discuss about HIV/AIDS, STI. There are some who has tested –ve and this encourages us.
- I take care for my child, I did not feed him breast this time because I want to reduce his risk of contracting the virus, I use condom with all partners although I have regular partner. I have only made 1½ year since I start FSW activity.
- I use the condom from IC, I have adequate supply except few time (buy from shop).
- There are men who bring condom with them; some ask is the FSW has it.

**Harassment**

- The legal institutions did not cooperate when we are harassed (Kebele).
- It is only the humanitarian people around who can support FSW if it happens in the hotel she is working in.
- It is very likely that the FSW will be chased out after the harassment and returning the money she has been paid.

**Contact with the project and use of condom**

- Did not know about HVI committee,
- I know IC when they came to the place I work and explained to me.
- Did not know about HBC, but listen that there are some and OVC too, PLWHA.
- Have not visited VCT, know about the transmission, STI and transmission mechanisms, did not know inst working on HIV,
- there is a better use of condom now, it no more a shame to buy and/or have it,
- I have never made a mistake of not using condom, there is no single situation that force not using condom,
- Me and colleagues have listen to cassette serial drama.
- FSW is risky job; it is like sacrificing ones' life. Business is not encouraging

- I want to contribute by educating people;

**Goal of SC**

- To eradicate HIV/AIDS, this need peoples' cooperation, unity and openness

***Strength of project***

- counseling, good reception, good educative cassette serial drama,

***Opportunity***

- Have videocassette,
- Facilitate organize, access to credit for moving out from FSW,
-

**Chelenko**

***Chelenko (Mike-cassette is empty)***

**Mojo**

**First contact with SC**

- Know SC from a lady who was distributing condom when I first start this job
- Was ignorant of using condom and the lady distributing condom did not explain
- A lady working in a bar had showed me how to use condom
- Know of HIV/AIDS from people talking around me but now I understand very well because of the lessons I learned from meetings.

**Training/workshop**

- Trained by a bar lady who completed 12$^{th}$ grade
- Have attended a training organized by Sister (HRCI)
- Am able to explain in the public meeting about condom

**VCT and STI services**

- Have never visited the VCT even did not know the new site of the health center. Advised a friend to visit STI service and she has acquired the service. I have provided same advise to her partner too.
- There are papers (fliers) I collected that discuss about STI and HIV/ADIS, I attend meetings
- Have listen to cassette serial drama and took it to my family also to teach them about HIV/AIDS.

**The IC**

- Contact IC for collecting IEC materials, to collect condom for distribution to hotels.
- Attend meetings called by Ashebir
- Understand the difference between the HIV and STI, its transmission, prevention.

- At personal level I have contact with committee members and PLWHA

**Use of condom**

- There are a lot of people using condom even those coming from rural places (farmers). I charge them for condom and they agree to use. There are a lot of farmers who well aware.
- Most drivers bring condom with them it is of different brand and I did not feel comfortable with it, as I did not know it. Currently I am a little bit learning on it. But there is a better condom that is provided by health center.
- I have discussed with my family members bout HIV/AIDS and use of condom.
- FSW should force them to use it. I use various systems to get out if the person is not willing to use condom.
- I have never omitted the use of condom for people I have met since
- I did use condom for all my partners irrespective of their regularity.
- It is difficult to say that every one is using condom consistently.
- Use of condom protects us from other health problems as well.

**Stigma and Discrimination**

- There is stigma and discrimination. People did not understand the situation they are in
- I have a PLWHA friend with whom we discuss about the disease
- PLWHA needs to be supported by the community and this requires educating of the people
- people are supportive if they did not know that someone is not positive and the moment they know, they discriminate

**Role of volunteers, CHBC**

- There is high expectation from CHBC
- I am willing to be trained CHBC and provide support

**Employers**

- some are cooperative to allow FSW to stay in their house during sickness In most cases, FSW are forced to move out and rely on colleagues assistance,
- Employers did not receive training

**FSW**

- I spend too much of my time in the house working for my employer
- Discuss and read about the HIV/AIDS during leisure time with friends.
- Spend time by chatting while chewing chat.
- Discuss about the time we passed with someone and connect discussion with about HIV/AIDS, STI
- FSW is risky job, it is like sacrificing ones' life. It is safe for me to work in Araki house because I am not involved in cash. It is better to work as housekeeper currently.

- I have never made a mistake of not using condom.
- There are clients who bring condom with them; some ask if the FSW has it
- FSW did not have network; they are highly mobile
- We provide advice to new entrants.

**Clients**

- They negotiate with high payment for not using condom.
- Some force and sexually harass FSWs for not using condom.

**Harassment**

- It is only the humanitarian people around who can support FSW if it happens in the hotel she is working in.
- It is very likely that the FSW will be chased out after the harassment and returning the money she has been paid.
- Only protected in places where we work not in other hotels

**Knowledge about other inst working on HIV**

- Know support for OVC, PLWHA from meeting.
- Did not know other agency working on HIV/AIDS and CHBC who provide support

**Due to this project**

- Better use of condom, it no more a shame to buy and/or have it,
- support to PLWHA

***Strength of the project***

- It is strong in its every aspect

***Opportunity***

- To educate the community to cooperate in support of PLWHA
- Organize PLWHA like Tesfa Goh

**Mille**

**First contact with SC**

- Attended a meeting in the IC of FSW and I volunteered to become peer educator
- Peer 1. I am trained in Logia and had helped one colleague to know her syro.
- Peer 2. I am a peer educator, volunteer and committee member.
- Know SC from its support for OVC, PLWHA and others sick people until they know their syro-status.

**Training/workshop**

- Before the SC we organized FSW association by the Secretariat and was working with health center.
- SC came in 1994 and we are attached to it
- Association has established youth clubs for girls in the school and has volunteers who educate on HIV/AIDS
- Association is able to train 80 students up to now
- Association has legal status
- Association has submitted a project to the Secretariat but has not received any support so far. (3 projects submitted at different time)

**VCT and STI services**

- A fiend uses STI counseling and treatment service without payment (free), had also received medicine,
- I haven't gone to VCT but know colleague who have gone and tested
- Results are obtained in 45 minutes
- Service can be found on their schedule Tuesday and Thursday at all times. The other peer educator argued that counselors are not committed, are absent from work and this has created a problem.
- Different persons undertake at counseling and blood sample taking. Confidentiality in this process is violated and I did not agree on this procedure. It is possible to train the lab technician and have both the counseling and testing completed by one person.
- Listen to cassette serial drama.

**The IC**

- Contact IC for collecting IEC materials, to collect condom for distribution to hotels.
- Received training on peer education at Logia
- Understand the difference between the HIV and STI, its transmission, prevention and know this since I was a school student.

**Use of condom**

- I know that married people are not using condom,
- Some drivers also did not want to use condom
- FSW should force them to use it. I use various systems to get out if the person is not willing to use condom.
- I have never omitted the use of condom for people I have met since I join FSW except my first contact.
- I did not use condom for my regular partner.
- It is difficult to say that every one is using condom consistently. As there are military some women tend to have regular partner and inclined to omit condom.
- an STI case was observed on FSW and the Association had meeting with the committee in the Military and the client was asked to get the treatment. This reveals that there are such practices.
- The military and community committees here have contact for education on the use of condom and HIV/ADIS.

**Peer education**

- Out of the initially trained 7 peer educators 6 left and one remained. A month a go SC trained additional peer educators
- Schedule peer education ex. Coffee ceremony where we educate each other how to treat spouses,
- Do not have connection with committee, CHBC unless have FSW who are PLWHA and sick
- Counsel FSW, encourage and advise them to go to VCT
- I work with CHBC without any protective shield. I have to be present provide them moral support
- Educate other people but they did not listen instead they scold us,
- We provide advice to new entrants
- Education to house maids on HIV/AIDS is relevant
- We did not have opportunity to participate in activities other than peer education, as my employer would not allow me

**Clients**

- There are many interested to use condom they even bring different brand of condom particularly drivers. But I believe and rely on Trust Condom.
- They negotiate with high payment for not using condom.
- Some force and sexually harass FSWs for not using condom.
- There are also FSWs who are not friendly due to ignorance, carelessness and negligence.

**Employers**

- Are not cooperative to allow FSW to stay in their house during sickness, FSW are forced to move out and rely on colleagues assistance,
- We even did not have rooms to sleep, we lay down on chairs.
- Employers did not receive training

**FSW**

- Discuss about the HIV/AIDS during leisure time.
- Discuss about our future plan to get out of FSW,
- Have a kind of consensus that SC would help us get out of FSW.
- The objective of the Association is to educate all FSW to prevent HIV/AIDS, I can contribute to the Association by education.
- Spend time by chatting while chewing chat.
- Discuss about the time we passed with someone and connect discussion with about HIV/AIDS, STI
- FSW is risky job, it is like sacrificing ones' life
- I have never made a mistake of not using condom; there is no single situation that force not using condom.
- There are clients who bring condom with them; some ask if the FSW has it.

**Other concerns:**

- House maid because they might be tempted and/or forced to partner with guards and they are not well aware about the HIV/AIDS and use of condom. This makes them highly exposed to the contract the virus.
- Probably taking too much alcohol and falling in love may tempt FSW to not use the condom.

**Harassment**

- It is only the humanitarian people around who can support FSW if it happens in the hotel she is working in.
- It is very likely that the FSW will be chased out after the harassment and returning the money she has been paid.

**Due to this project**

- There is a good support for OVC, PLWHA.
- Reduced stigma and discrimination due to CHBC and education on HIV/AIDS
- The Association of FSW is active
- Better use of condom, it no more a shame to buy and/or have it,

***Strength of the project***

- Education on discrimination, support to OVC,

***Opportunity***

- Support to FSW on IG as promised earlier and reduce the number of FSW
- To educate the community to cooperate in support of PLWHA
- Give more education through CBOs
- Support for the Association – running cost,
- I want to contribute by educating people;

Weakness

- Inadequate support for the committee and all other sub committees (they need not rush to cover all sites in one day). One should not believe in reports.
- Inadequate supervision on the activities already ongoing

## *Focus Group Discussion – FSW*

**Dire Dawa**

**First contact with SC**

- FSW on the street were working with FGA
- Staff of SC (Ephrem) contacted them and called a meeting
- Some met SC staff through a meeting called in our hotels.

**Training/workshop**

- Trained on HIV/AIDs prevention practices such as condom management and use, STI
- Regularly report to IC on our Peer education.
- Are motivated with the expectation of assistance to change occupation
- Skill training was also planned and we have chosen the training we want to receive.

**Peer education**

- We are responsible to educate new entrant on HIV/AIDS and use of condom. We also provide this training to male clients
- Train about contraceptive, the challenges of being street girl, etc
- As peer education we have a plan to leave FSW job, to teach colleagues who are ignorant of HIV/AIDS
- If we have the association our efforts would have been strengthened to support other person
- We provide peer education in group and some passersby join our discussion and explain some of our doubts.

**VCT and STI services**

- We know the existence of VCT and STI only by one agency
- Staff in the health center receive patients good and providing medicine

**The IC**

- IC provide counseling, peer education, education on STI, condom and leaflet distribution,
- The street FSW and those working in the Hotel are called to a meeting separately. It is good for bringing us together.
- I come usually to collect IEC materials and borrow cassette serial drama
- We haven seen and/or used the cassette serial drama from IC.
- We get condom supply regularly and IC was not short of it.

**FSW**

- We explain to new entrants on the use of condom, the disadvantage of being FSW. I can only advise her about condom once she decides to become FSW.

- Spend time by chatting while chewing chat (about 4hrs) and Discuss about the time we passed with someone and connect discussion with about HIV/AIDS, STI
- Cannot say that it is beneficial or not because we are FSW due to lack of other option. The cost is high because we did not have physical ability to withstand harassment.
- We did not want to be recorded otherwise we would like to talk to people learn using our leisure time.
- FSW are willing to cooperate as long as they are FSW (on street or not).
- It is difficult to educate people coming to our hotel because both men and women did not trust us that we are genuinely for educating them (they suspect that we are approaching them for developing our sexual contact)

**Use of condom**

- There are a lot of people using condom
- There are some clients who did not want to use condom
- The current use of condom is not satisfactory. There are a lot of people who did not understand the need for it.
- We use various systems to get out if the person is not willing to use condom.
- I have never omitted the use of condom for people I have met since
- It is difficult to say that every one is using condom consistently you can see to my child, I have given birth.

**Stigma and Discrimination**

- There is stigma and discrimination. People did not understand the situation they are in
- people are supportive if they did not know that someone is not positive and the moment they know, they discriminate

**Employers**

- Did not support if street FSW had a problem in his/her premises
- Some employers advise us to use condom
- Some are not cooperative to allow FSW to stay in their house during sickness. In most cases, FSW are forced to move FSW out and we rely on colleagues assistance,

**Clients**

- They negotiate with high payment for not using condom.
- Some force and sexually harass FSWs for not using condom.

**Harassment**

- If there is a person who forces us to contact without condom we will use all the legal instrument to protect ourselves
- If one has the evidence and can go to higher officials, legal system supports. However, if one just rely on police at the station, it might not be helpful.

- We assist each other if it happens within the premises

**Knowledge about other institutions working on HIV**

- Street FSW were affiliated to Catholic Church before they were contacted by SC
- Most use the services of FGA
- Most know about the support by MMM and OSSA for the very sick and PLWHA
- Know about the CHBC who provide support

**Due to this project**

- The training is very good for us, we have learned a lot
- The IC is very important for information and is also our venue to meet
- Better use of condom, it is no more a shame to buy and/or have it,
- CHBC service is good and think it is sustainable as there will be more people expected

***Opportunity***

- Support FSW by recruiting them in certain activity

**Chelenko**

**First contact with SC**

- Have taken seminar in March for 3 days
- Some of us have learned through the volunteers who conduct house to house visit on Tuesday and Thursday and
- some of us learn through the radio.

**Training/workshop**

- Peer education means to teach colleague.
- Have been trained about HIV/AIDS, condom management and use, female condom, STI.
- Have gained behavioral change because we are peer educators.
- Selections criteria for the trainees was being FSW and work in selected hotels
- Our responsibility is to protect ourselves, to teach those who are ignorant, protect the community by using condom and teaching about condom for those who did not know.
- Our aim after being trained is to change my involvement in FSW but did not access training and credit. We are told that the women affairs office will pay for the training. We have given our names in the training in March but have not heard since then.

**VCT and STI services**

- we know the existence of VCT and STI treatment in Cheleko.
- Staff in the health care provider did not receive us politely. I did not get the service. Staff outlook for FSW is not polite.

- I have advised a client who has a problem of STI and he has got treatment in D.D.

**The IC**

- New entrant was also approached by volunteers and thought about the use of condom
- I come usually to collect IEC materials and the volunteers come to distribute condom.
- We haven't seen and/or used the cassette serial drama from IC.
- We get condom supply regularly and IC was not short of it.
- Know the volunteers and counselors of IC by their name. Misconception that volunteers are employees same as counselors

**FSW**

- We try to advise new entrants not to enter in FSW activity but most did not believe our advice. One new entrant witnessed that she was advised by the hotel owner not to continue working as FSW and use condom.
- Spend time by chatting while chewing chat and Discuss about the time we passed with someone and connect discussion with about HIV/AIDS, STI
- FSW is risky job but did not have other option. There is no benefit one could get from it. It is better to leave the job. There is a lot of sexual harassment and like sacrificing ones' life.
- We are working until the WAO responds to our request. If they don't respond we will go back to our families.
- We cannot leave chewing chat particularly if we remain in this job

**Peer education**

- we advise any person who come to the hotel to entertain on the use of condom, abstinence, limiting partners.
-

**Use of condom**

- There are a lot of people using condom even those coming from rural places (farmers).
- There are some clients who did not want to use condom and some remove it during contact and we are cautious on it. We refuse if client did not want to use condom.
- Have to test if I fall in love to have contact without condom. Otherwise we did not have contact without condom.
- Know of a gentle man who is infidel and requested FSW to contact with condom and the lady refused due to misunderstanding.
- The current use of condom is not satisfactory. There are a lot of people who did not understand the need for it.
- It is advisable if the FSW should manage the wearing of the condom
- We use various systems to get out if the person is not willing to use condom.
- I have never omitted the use of condom for people I have met since
- It is difficult to say that every one is using condom consistently.

**Stigma and Discrimination**

- Staff of the health center discriminate FSWs and did not provide the right service
- There is stigma and discrimination. People did not understand their situation
- A lot of people are not exposing themselves as PLWHA. A lady who is positive had to leave the town because the residents were against her
- FSW who test positive leave the town and move to other places.
- People are supportive if they did not know that someone is not positive and the moment they know, they discriminate

**Employers**

- Did not care whether we use condom or not
- Are not cooperative to allow FSW to stay in their house during sickness. In most cases, FSW are forced to move FSW out and we rely on colleagues assistance,
- Employers charge FSW (Br. 10) to go out of the hotel even if she is not willing well.

**Clients**

- They negotiate with high payment for not using condom.
- Some force and sexually harass FSWs for not using condom.

**Harassment**

- We work in a place where there is no bed. And when we have problem, guards and hotel owner assist the FSW
- We assist each other if it happens within the premises

**Knowledge about other institutions working on HIV**

- Did not know other agency working on HIV/AIDS and CHBC who provide support

**Due to this project**

- The education of through the radio/tape in market days is very good for informing people
- CHBC for palliative care is very important and has brought change in terms of changing people's outlook.
- Better use of condom, it no more a shame to buy and/or have it,

***Strength of the project***

- Education, free condom distribution,

***Opportunity***

- To further strength the condom distribution,

– Support FSW by recruiting them in certain activity

**Logia**

**First contact with SC**

- Volunteers and counselors came to our hotel and informed us about the HIV/AIDS and use of condom
- Peer informed me to use condom and there is condom distribution

**Training/workshop**

- We are interested to work as peer educator to contribute to the reduction of HIV/AIDS transmission and support colleagues
- Quite working in bar and tented my own house to reduce the number of contacts/partners and work as FSW from home after the training
- We have been trained about HIV/AIDS, condom management and use, STI.
- We are motivated with the expectation of assistance that help us to move out of the FSW job. We have been told about this.

**Peer education**

- We are responsible to educate new entrant on HIV/AIDS and use of condom. We also provide this training to male clients
- Know about the uses of condom and teach also for clients who did not know how to use (especially people from the rural sites).
- Community members contact are not quite receptive HIV/AIDS education
- Bar based protect them selves well.
- Ladies living with families are very much exposed to the transmission of HIV/AIDS. They even did not use shades or houses during contact and they do it in darkness.
- Peer education is conducted individually and in-group as found appropriate

**VCT and STI services**

- We know the existence of VCT and STI
- Service is not satisfactory because of weak staff commitment
- Have opportunity to access free medical supply in the health center but is often out of stock

**The IC**

- Volunteers and counselors come to a place I work and they follow up our use of condom and availability in the hotel
- We regularly go to IC to collect condom and distribute to FSW in different hotels in the town once in a week.
- There is no cassette serial drama, IEC material is also short
- We have contact with volunteers; they come every week. We discuss on our problems with clients and the supply of condom, etc.

**FSW**

- Have been well informed by peers at when joining FSW
- The cost of being a FSW out weights its benefit due to the sexual harassments and the risk of contracting HIV/AIDS.
- Want to leave their occupation but need external support that can enable them generate income for their survival
- Have small association/Iddir to support members during sickness and loss of job
- Three new entrants testify that she had received advise from colleagues
- Leisure time is spent by chatting while chewing chat and discuss about the time we passed with clients and relate discussion with HIV/AIDS, STI
- It is better to be employed as housemaid but it is difficult to get used to house keeping after being FSW (independent). Going back to families, saving and try to do own business are possibilities
- We are expecting that SC to support us to come out of FSW. We are told about this early on.
- The IC is short of IEC materials, serial cassette drama.

**Use of condom**

- Higher return from unsafe sex (ex. Without condom) tempts many FSW and are inconsistent in using condom
- Don't use condom with regular partner because it provides a feeling of distant relationship
- Nearly all drivers agree and/or ask for condom use. They also bring different brand of condoms but FSW prefer to use the brand they have access to and can ensure its quality such as Trust Condom.
- Most don't trust condom other than Trust Condom

**Employers**

- Some employers discuss with us the disadvantage of working as FSW and advise us to protect ourselves
- Are not trained
- Some are not cooperative to allow FSW to stay in their house during sickness.

**Clients**

- They negotiate with high payment for not using condom.
- Some force and sexually harass FSWs for not using condom
- Most are getting interested to discuss on HIV/AIDS

**Harassment**

- Some employers cooperate to protect us from harassment
- We can only be protected if we stay in the hotel we work in.
- We assist each other if it happens within the premises

**Changes Due to this project**

- There is high rate of use of condom and is well accepted
- CHBC service is good and had changed our attitude towards PLWHA
- Care to OVC is new for the town

## Mille

**First contact with SC**

- Volunteers and counselors came to every hotel and informed about the training of peer education.
- Were trained by Dr. Zelalem
- We educate FSW in small and big hotels. I saw condom from people distributing it within a week I start work in Mille.

**Training/workshop**

- I am committed to work as peer education to contribute to the reduction of HIV/AIDS transmission, support each other among FSW.
- The first time I saw female condom is on this training.
- We have been trained about HIV/AIDS, condom management and use, STI.
- We are motivated with the expectation of assistance that help us to move out of the FSW job. We have been told about this several times.

**Peer education**

- Educating in Logia it are difficult people violating our rights when providing education by moving from hotel to hotel.
- I am told I will be transferred to Mille (from Logia) but no one informed me about the possibility of working after I arrive here in Mille.
- I still work as peer education on HIV/AIDS and STI to colleague FSW. I am trained as CHBC and want to continue working; I have all the material required for CHBC service.
- New entrant is trained by senior FSW in the hotels
- We are responsible to educate new entrant on HIV/AIDS and use of condom. We also provide this training to male clients
- We provide peer education in-group and some passersby join our discussion and explain some of our doubts.

**VCT and STI services**

- We know the existence of VCT and STI
- A case, absenteeism of the health staff in STI forced a lady to leave this area
- There is free medical supply in the health center
- Have never seen any free STI service in the last 7 months. We get the treatment and buy the medicine outside.

**The IC**

- Volunteers and counselors come to a place I work and they ask me various questions regarding use of condom.
- IC volunteers and counselors did distribute condom but did not educate the use of it. We have provided comment and now they are providing the education
- We regularly go to IC to collect condom and distribute to FSW in different hotels. I bring 1 packet of condom.
- There is no cassette serial drama, IEC material is also short

- We have contact with volunteers, they come every week. We discuss on our problems with people, on the supply of condom, etc.

**FSW**

- We explain to new entrants on the use of condom, working condition (access to food shelter, peak business season, rate of payment, etc.),
- A new entrant testify that she had received the above advise from colleagues
- We do not meet FSW working in other hotels. Within our place of work, we spend time by chatting while chewing chat and discuss about the time we passed with someone and connect discussion with about HIV/AIDS, STI
- There is no benefit of being FSW. The disadvantage is that there is a high degree of human right violations and harassment.
- It is better to be employed as housemaid but it is difficult to get used to house keeping after being FSW. Going back to families, saving and try to do own business are possibilities
- We are expecting that SC to support us to come out of FSW. We are told about this early on.
- There women who are living with their families but doing unsafe sex with residents and drivers in Logia. These did not even use rooms for their contact.
- We are discriminated from supply of IEC materials (such as T-shirt, selection of training, etc). This has to be corrected. There are a lot of promises given but not realized.

**Use of condom**

- There are a lot of people using condom
- There are some clients who did not want to use condom
- 2 out of 3 FSW did not use condom with my regular partner.
- We use various systems to get out if the person is not willing to use condom.
- The current use of condom is not satisfactory. There are a lot of people who did not understand the need for it.
- It is difficult to say that every one is using condom consistently

**Employers**

- Were not cooperative when we start peer education. People because of this had bitten me also. Many times they suggest that we know our status first (+ve or – ve.)
- We discuss about condom use with out employers
- Employers discuss with us the disadvantage of working as FSW and advise us to protect ourselves
- We have good handling by the employer when we are sick (shelter and food is not a problem). Sometimes they send us to private clinic for treatment.
- Some employers advise us to use condom
- Some are not cooperative to allow FSW to stay in their house during sickness.

**Clients**

- They negotiate with high payment for not using condom.

- Some force and sexually harass FSWs for not using condom.

**Harassment**

- Takes first action to protect us from harassment
- We can only be protected if we stay in the hotel we work in.
- We assist each other if it happens within the premises

**Changes Due to this project**

- The training is very good for us, we have learned a lot
- Knowledge about condom by people residing in the rural and urban is much higher now. It is well accepted.
- Better use of condom, it is no more a shame to buy and/or have it,
- CHBC service is good and think Opportunity

**Nazreth**

**First contact with SC**

- Volunteers and counselors came to our hotel and informed us about the us of condom
- During orientation for peer education.

**Training/workshop**

- Trained to get organized and start contribute that eventually can help us to start IG but we did not attempt it.
- Motivated due to the interest of the staff of US for
- Helping us to change our occupation,
- The advices we received to protect us from HIV/AIDS

**Peer education**

- Educating peers the reduction of HIV/AIDS transmission
- Supporting PLWHA peers morally and socially
- We did not know what we can do if go out of this activity. We need others to come and support us
- FSWs' pass time by discussing HIV/AIDS related to sexual harassment during leisure time (coffee ceremony, chat chewing)
- Peer educators reach 8 people/week and spend long time talking once we meet (cannot estimate the time spent)

**VCT and STI services**

- Know the existence of VCT and STI services provided by OSSA
- Did not think to visit VCT but need to change job
- Know that FSW can get VCT service through volunteers
- Did not know that some one can get VCT service directly from the VCT centers
- Couples can go and have VCT service and know that people are using the service

- Are not encouraged/motivated to know syro status because people will stigmatize and discriminate if we are positive and did not have other alternative to survive
- Believe that positive FSW should move out of their job
- Know the details of the support and care provided by CHBC and OVC

**The IC**

- Did not know the existence of IC in Nazreth
- Did not know what the services of volunteers are
- Know SC is providing training
- (Call names of individuals) distribute condom and explain the use of it.

**FSW**

- We explain to new entrants on the use of condom, the inconvenient working condition (access to food shelter, peak business season, rate of payment, etc.)
- Advise a new entrant not to join FSW but find job of house keeping in economically well off family
- There is no benefit of being FSW. The disadvantage is that there is a high degree of human right violations and harassment, high risk of contracting HIV/AIDS.
- Think of moving out of FSW but need support from others
- We are expecting that SC to support us to come out of FSW. If support is available, some of us know what we can/want to do and others need skill training

**Use of condom**

- There are a lot of people using condom
- There are some clients who did not want to use condom
- FSWs' use of condom for regular partner is not consistent

**Employers**

- Have cooperative and friendly employers
- Lack of respect by the communities for us and our children
- Can be told to leave the job any time without prior notice
- Did not appreciate FSW's use of condom
- Did not care for us. They are happy to receive higher money if I generate it by not using condom.
- Some are not cooperative to allow FSW to stay in their house during sickness.
- Did not cooperate when FSW are sexually harassed

**Clients**

- They negotiate with high payment for not using condom.
- Some force and sexually harass FSWs for not using condom.

**Harassment**

- Employers are not willing to protected us from sexual harassment

**Changes Due to this project**

- High demand, availability and use of condom
- SC closely follows up and educate on use of condom

- Open discussion, support among FSW
- Better use of condom, it is no more a shame to buy and/or have it,

Strength

- Very good education on the management and use of condom
- The IEC intervention of the project and, care and support to those who need it

*Weakness*

- Education for the community to respect human rights
- To get support from SC for us to be generate income and move out of FSW
- Extend counseling for people for 100% use of condom
- Lack of initiation on the part of FSW who have been contacted
- Lack of access to credit and services and absence of skill training

**Mojo**

**First contact with SC**

- Volunteers and counselors were coming to our hotel to educate us about the HIV/AIDS and provide us condom
- Peer informed us about it

**Training/workshop**

- Trained on HIV/AIDS, STI and how to educate our peers once. We have questions that needs to be addressed
- Expected that this meeting would also be for education
- We are interested to work as peer educator to contribute to the reduction of HIV/AIDS transmission and support colleagues
- We have been trained about HIV/AIDS, condom management and use, STI.
- Motivated due to condom distribution, the installation of free VCT service in the town and wanted to learn more about HIV/AIDS

**Peer education**

- We are responsible to educate peers and new entrant on HIV/AIDS and use of condom
- One needs to be active, dedicated, open to be peer educator
- Three new entrants testify that she had received advise from colleagues on the HIV/AIDS and the working condition
- Bar based protect them selves well and some FSW in small bars are not well aware about HIV/AIDS
- Peer education is conducted individually and in-group as found appropriate

**Knowledge about services of VCT and STI**

- Know the existence of VCT and STI
- Did not know about the quality of the services offered by VCT and STI
- Know volunteers who provide CHBC, care and support for PLWHA and OVC

- Know the existence and activities of HIV/AIDS committee
- Know a PLWHA and we discuss and morally support him
- Know that IC distributes condom, provides availability of cassette serial drama and IEC material

**The IC**

- Volunteers distribute condom to FSW hotels
- Know that IC volunteers and counselors provide education for TW, FSW, students and communities. It provides cassette serial drama, IEC material.
- Have listened to all parts of the serial cassette drama
- The drama is very interesting and FSW listen to it during working hours. It includes issues about condom, the lady vendor who tried to protect the condom from the spoilage, the driver's, PLWHA behavior and others are very impressive

**FSW**

- Have been well informed by peers at when joining FSW
- Have small association/Iddir to support members during harassment is important and it can help liaise with legal institutions
- Leisure time is spent by chatting while chewing chat and discuss about the time we passed with clients and relate discussion with HIV/AIDS, STI. Spend about 2hrs/day on average
- Economically pays off but exposure to various sexual harassment and contracting of HIV/AIDS is high
- Want to leave their occupation but need external support that can enable them generate income for their survival
- Did not have skill, access to credit and shelter to start our own activity. One started IG for 1 year but could not be successful in sustaining their business activities
- The IC is short of IEC materials, serial cassette drama.

**Use of condom**

- Clients negotiate contact without condom with higher pay
- FSW are taking collective action against people demanding unsafe sex
- There are FSW who use condom with regular partner because it provides a feeling of distant relationship
- Nearly all drivers agree and/or ask for condom use. They also bring different brand of condoms but FSW prefer to use the brand they have access to and can ensure its quality such as Trust Condom.
- Some clients ask for using double condom during contact
- Most don't trust condom other than Trust Condom

**Employers**

- Employers did not encourage us to regularly check STI
- Most are not cooperative during sexual harassment
- Guards also harass in favor of the client if FSW had a contact out of her working area

- Some are not cooperative to allow FSW to stay in their house during sickness.

**Clients**

- They negotiate with high payment for not using condom.
- Some force and sexually harass FSWs for not using condom
- Most are getting interested to discuss on HIV/AIDS

**Harassment**

- Sexual harassment is relatively sever in small bars (Areki, Tela shops)
- Many employers do not cooperate to protect us from harassment
- We can only be protected if we stay in the hotel and colleague are around
- We assist each other if it happens within the premises and neighborhood
- Commitment of legal institutions is very low (police did not act upon harassment reports)
- Clients abuse guards and police
- FSWs' has experienced to counter harassed a client who abused a colleague

**Changes Due to this project**

- There is high rate of use of condom and is well accepted now to talk about it in public and buy from shops
- CHBC service is extremely impressive and it has contributed to behavioral change of the community
- Care to OVC is new for the town

**Strength**

- the education on HIV/AIDS and creating understanding on the need to use; we no more feel shy
- want to provide CHBC if we are trained and contribute to the fight against HIV/AIDS

**Weakness**

- Legal protection from sexual harassment through cooperative measures by the concerned offices
- Educate, encourage employers and communities to participate in taking action on harassment
- Need more supply for New cassette serial drama, video cassettes
- Absence of better quality of condom
- Absence of socialization event for FSWs to get together to discuss their problems

## *Report on In-depth Interview with PLWHA*

**Dire Dawa**

*Contact with SC/USA-HRCI project*

- A volunteer in the vicinity assisted me contact with SC/USA

**Perceived future participation in Community Activities**

- Existing stigma and discrimination does not encourage participation
- Might face worsened stigma and its consequence on their children
- Other PLWHA involved in expulsion by home owners

**Knowledge and Availability of Services and providers**

- Received counseling in a clinic and used its diagnostic referral for VCT
- Had the VCT service in Addis Ababa Arsho
- Used the the VCT service by FGA
- Know existence of IC, support to OVC and benefited from care and support by CHBC and financial support for PLWHA
- MMM provides very good service for the very poor and sick people
- OSSA provides care and support for OVC
- All provide good services but have service charges

**PLWHA Situation, Problems and Needs**

Family History and relation with siblings

- Used to work as FSW for a short time
- Have a daughter aged 16
- Used pharmacy prescribed medicine for STI up to now. FGA charges for STI service

**Spend leisure time:** take rest, chat with daughter after her school.

- Advice daughter on HIV/AIDS and she is participating in HIV/AIDS club in school. She used to advice me to protect myself and knows that I am PLWHA

**Views, satisfaction and expectations on VCT/STI and Medical services**

*VCT/STI SERVICES*

- Good reception by counselors and the services of VCT center
- Used private health provider
- Service is good but it is not free and medicines are expensive

**Major problems**

- Absence of drug supply
- Absence of free medical treatment

• HIV prevention practices and condom use

- Condom is found in every hotel
- Have experienced a client who had tear the tip of the condom before I know my status
- There are HIV positive FSW who are still in the job (hiding themselves)

- Many people did not want to use condom with an excuse that Muslims could not be contracted, reduce satisfaction
- Did not know how to use condom and have abstained from sex since I know my status
- Strictly avoid sharing materials with family members but I am concerned about my daughter as we share a bed and I have infections over my body

**Access to care and support services**

**CHBC services**

- Existing CHBC provision is appreciated the service and their regular visits
- CHBCs give adequate attention given to bed-ridden patients
- The service is inadequate and getting unsatisfactory
- Monthly financial assistance is provided regularly
- Received PLWHA were given bed sheets during distribution
- Received medicines for from CHBC and moral support from volunteers
- Received bed sheet
- While I was seriously sick, a physician advised me to eat 3 times in an hour and how can a poor person like me afford to eat 36 times a day.

**Major challenges faced by PLWHA**

- Stigma and discrimination
- Lack of sufficient food
- Inadequate access to medical services
- Communities are not cooperative for PLWHA to participate in social activities

**Attitudes on existing community /social support,**

- There is a big change in terms of raising the awareness of people on HIV/AIDS, open discussion
- Services of VCT are cheaper now. Earlier one should have pay about Br. 50.00 for a test.
- Support for PLWHA
- HIV/AIDS is attributed to other health and superstitious problems
- PLWHA are not cooperative enough to discuss and support each other. If we are supported individually, we might be productive

***Stigma /discrimination***

- Neighbors discriminate me and my daughter
- Other PLWHA had been thrown out from their rental house by home owners
- It is only the poor who need economic support that are exposed to the discrimination and stigma. PLWHA with adequate income need not disclose themselves in public.

Institutional Responses

*Views on past HIV/AIDS Activities*

- Improved access to VCT services
- Improved community education
- Improved attitudes towards PLWHAs

*Views about HRCI program*

**Strengths**

- Securing means of subsistence for PLWHA
- Access to CHBC services and care

*LIMITATIONS*

- HRCI provides what they have budgeted but it is not sufficient for survival
- Need for free health service PLWHA are prone for opportunistic infections
- Lack of income generation sachems for us to be productive

**Chelenko – no PLWHA found for the interview**

## *Focus Group Discussion with PLWHA*

**Dire Dawa**

**Involvement, Responsibility /Participation on Project**

**Developed Contact with Project after The Following**

- FGA Counselors referred us to SC project
- Referred to SC by counselor from hospital and health center
- HBC volunteers came and contacted us at home while being ill
- Motivated to receive care and support service for being too sick to work, absence of any other household income , highly disturbed and had suicidal intentions and felt the services as appropriate after being counseled

**Responsibility /Participation on Project**

- Two participants received one week training on positive living/ counseling work as peer educators
- Majority are currently involved in HIV education teaching other PLWHA on how to live positively with the virus on our weekly meeting
- Others assist HBC volunteers on our visits providing care for other bed ridden and sharing our experiences

**Perceived Future Participation in Other Community Services**

Majority expressed their future wide intention to

- offer HIV education to our community and reduce stigma
- House to hose visits to give one to one education for friends and nearby residents on HIV in general and how to live with the virus
- involving in HIV education through using Community meetings and schools
- One respondent stated to have recently got a support letter from the government to educate the community traveling in different places

**Knowledge and Availability of Services and Providers**

- Participants were found to be aware about volunteers and peer educators and our services of the existing preventive services such as VCT/STI, medical services, HBC and OVC services which were perceived to be good.
- only two participants are aware of IEC/BCC and preventive Services of IC
- Poor utilization of IC services by PLWHA and community because the services are not well advertised

**PLWHA Situation, Preventive Practices and Condom Use**

***Family History and Relation with Siblings***

- 12 participants have children who live with us with age range of 1-12 who are in good health to which
- regularly advise and educate our children to protect them from HIV infection.
- Two participants live with HIV negative spouses who know our status and get good treatment and care at home.
- All reported to have told our children and family members about our status, engage in discussion about HIV/AIDS/STI issues and stated to be treated well.

**Existing HIV Prevention Practices and Condom Use**

- Majority have abstained from sex while others use condom always
- Two participants live with informed HIV negative partners and use condom always
- We take strict care in avoiding sharing materials with family members and
- We teach our families on how to care for us if we get ill
- A participant informed her HIV status to a health worker who was setting IV treatment without wearing glove who thanked her later
- A participant declined an already arranged marriage by his parents residing in a rural area after the death of his wife who revealed his status and convinced us

**Views, Satisfaction and Expectations on VCT/STI, HBC and Medical Services**

**VCT/STI Services**

- Participants that the reception of counselors and the services at VCT center were appreciated and felt satisfactory to what we expected
- VCT counselors were also reported to be highly supportive, receive and treat us very well when we get ill.

**Medical Services**

- In general, We are dissatisfied by the medical services and face many problems at dil chora hospital in particular
- Poor health workers approach and medical staff stigmatize and often mistreat us
- We are not given priority and often told to come another day when we are ill
- Lack of access for free treatment and should pay even having poverty certificate from the kebele social courts for Card and diagnostic services like X-ray , bed for inpatient treatment , drugs and often told to buy from private pharmacies

- The cost of medical care is highly affecting our life through deepening our poverty through forcing us to sell our properties and even our homes.

**CHBC Services**

- The existing HBC provision by volunteers was reported to be good and providers make regular visits to all clients, give adequate attention for bed ridden patients and visit patients even in hospital
- Some HBC volunteers lack commitment and respond late to requests & emergencies
- The service were currently perceived to have some problems and inadequate for monthly financial assistance comes late and irregular, provision of soap as well as detergents has stopped and only few PLWHA were given bed sheets and money for house rent.

**Attitudes on Existing Community /Social Support,**

- Many felt the community has inadequate awareness and provides poor support to PLWHA
- Only two participants reported to have received good care and treatment from peoples residing in our vicinity and IDDIR members
- The level of stigma and discrimination against us ,our children and family members is felt to have reduced and community attitudes towards us has now improved

**Views on Past HIV/AIDS Activities**

**Successes**

- Access to VCT services has improved
- improved care and support efforts are making others to undertake VCT and know our status.
- People who have been educated on HIV issues have brought positive attitudes towards PLWHAs

**Major Challenges Faced By PLWHA**

- Stigma and discrimination
- Lack of access to sufficient food though we are advised
- Inadequate access to medical services
- Poor ongoing counseling, psychosocial and emotional support

**Views about HRCI Program**

***Strengths***

- Ensured means of subsistence for PLWHA and orphans
- Improved access to HBC services and support of providers
- Training given to us has helped us and others to be able to lead a positive life

***Limitations***

- Lack of commitment from committee members
- Poor efforts of the project with regard to HIV community education
- The need to get further training to empower and enable us educate the community

- Inadequate assistance to organize us and set up an association

Lack of sustainable income generation mechanisms to free us from waiting for monthly aid

**Chelenko**

-

**Logia**

**Involvement, Responsibility /Participation on Project**

**Developed Contact with Project after The Following**

- after HBC volunteers came and contacted us at home while being ill,
- Referred to HBC by counselors
- initiated after being provided with information about the services and absence of any household income

**Responsibility /Participation on Project**

- One received peer educator training on positive living and counseling by SC and currently involved in HIV education through monthly meeting among PLWHAS
- Others visit bed ridden patients to share experience and provide psychological support

**Perceived Future Participation in Other Community Services**

- our future intention as to visit sick patients in our neighborhood community and provide counseling to take VCT

**Knowledge and Availability of Services and Providers**

- Participants were found to be aware of the existing services such as VCT/STI, medical services,-HBC and OVC services and -IEC/BCC and preventive Services which were perceived to be good and adequate
- Participants were also aware about volunteers, peer educators and their services

**PLWHA Situation, Preventive Practices and Condom Use**

***Family History and Relation with Siblings***

- All participants have no children or family members who live with us and live alone

**Existing HIV Prevention Practices and Condom Use**

- Majority have abstained from sex and reported to have no desire currently
- intend to use condom always in future
- We reported to take strict care in avoiding sharing materials with our friends

**Views, Satisfaction and Expectations on VCT/STI, HBC and Medical Services**

**VCT/STI Services**

- -We were received and treated well by counselors at pre test counseling

- -we were being given adequate information and were adequately prepared to hear our results

**Medical Services**

- We are satisfied by the health workers approach and support
- we are given free medical services, priority for service when we are ill and medical staff receive and treat us very well.

**CHBC Services**

- The existing HBC provision by volunteers was reported to be good; providers make regular visits to all clients and give adequate attention.
- Monthly financial assistance comes late and irregular has made our life difficult
- Provision of soap, detergents has stopped

**Attitudes on Existing Community /Social Support,**

we don't have much interaction nor do we get any support from the community

**Views on Past HIV/AIDS Activities**

**Successes**

- HIV activities supported by VCT and HBC services has improved our lives and no one is seen dying without help because of AIDS
- HIV is no more seen as dreadful and discussed in public
- People who have been educated on HIV issues have brought positive attitudes towards PLWHAs

**Major Challenges Faced By PLWHA**

- Lack of sufficient food
- Inadequate financial assistance because high cost of living and house rent
- Poor health to enable us involve in productive activities

**Views about HRCI Program**

*Strengths*

- Ensured means of subsistence for PLWHA which we never imagined
- Strong HBC services and support from committed providers and committee members
- PLWHA have been made free from drug abuse and lead a positive life

*Limitations*

- Inadequate Provision of soap, detergents
- We receive financial assistance very late and it has been 2 months since we got money
- Lack of income generation mechanisms to free us from waiting for monthly aid

**Mille**

## Nazreth

### Involvement, Responsibility /Participation on Project

#### Developed Contact with Project after The Following

- referred by OSSA VCT center after self referral for testing
- After being informed by a neighbor
- Contacted by HBC volunteers
- motivated to involve in HBC service for economic reasons, for getting information on HIV and positive living, for ongoing counseling, treatment and support and to be able to educate the community

#### Responsibility /Participation on Project

- Received training on HIV and positive living, provide education to peers , the community and educate colleagues at work place

#### Perceived Future Participation in Other Community Services

- Providing education to peers about HIV
- protecting partners from getting infected with the virus
- To develop personal career and become productive citizen through skills training
- To be from dependent on monthly aid and get employed

### Knowledge and Availability of Services and Providers

- Only three of the ten participants know the information center services provided by HAPCO but all have not visited the centers
- Majority know volunteers and their activities but have no relation with them
- Only one participant is aware of what peer educator
- PLWHA receive ongoing counseling services from SC program, OSSA and Tesfa goh
- Felt the services and the staff reception is good

### PLWHA Situation, Preventive Practices and Condom Use

#### *Family History and Relation with Siblings*

- Three participants have children with age ranging from 3-16, only one lives with own child who never knows about her status but discusses with her about HIV issues.
- Majority of the respondents do not live with their families and have no good relationship with their families though they reside in the town.
- Those who live with their families never told their status or discuss the issue for they fear of being stigmatized if they inform.

**Existing HIV Prevention Practices and Condom Use**

- Majority reported to Use of condom always during sexual encounter
- Others have abstained from sexual practices
- All participants had no experience or never practiced sex that is unsafe or without condom.

**Views, Satisfaction and Expectations on VCT/STI, HBC and Medical Services**

**VCT/STI Services**

The services were perceived to be satisfactory for

- The reception of the staff was good ; the counselors approach and advise was also appreciated
- Received pre test counseling and the sessions were perceived to be good with adequate time given fro us to get well pre pared for the results,
- Adequate information was given as to their expectation at post testing counseling

**Medical Services**

- The medical services were perceived to be in general good at public health facilities.
- The private medical services given by a medical doctor in town for PLWHA was highly appreciated

CHBC Services

- Received regular visits from HBC providers
- Psychological and emotional support
- Received counseling sessions

**Attitudes on Existing Community /Social Support,**

- One participant gets good treatment and support from land lady.
- Two participants mentioned their friends provide them moral and financial support
- It was reported that CBOs in general never give support to PLWHAs
- IDDIR members often point fingers at positive members

**Views on Past HIV/AIDS Activities**

**Successes**

- Improved level of awareness among the community
- The attitudes of the community towards PLWHA is improving
- Condom acceptance and utilization has been markedly increased among both sexes among both the urban and rural community in the area

**Major Challenges Faced By PLWHA**

- High level of Stigma and discrimination
- Economic problems ( poor financial income)
- Inadequate support and care for PLWHA

**Perceived Solutions**

- The HBC providers should be more committed to provide the services and respond well to all requests and emergency situation
- As to stigma and discrimination, PLWHA should reduce self stigma first for the society
- Improve the provision of medical services to PLWHA

**Views about HRCI Program**

***Strengths***

- improved access to ongoing counseling, care and support services
- The existing care and support to orphans is highly satisfactory
- better HBC services when compared to similar services provided by other NGOS

***Limitations***

- Lack of on time and regular monthly financial aid
- Difficulty to keep confidentiality for people now identify HBC providers by the bag they carry when they make home visits
- Lack of access to ARV drugs

**Mojo**

**Involvement, Responsibility /Participation on Project**

**Contact with Project after The Following**

- Contacted by HBC volunteers
- Received counseling and decided to undergo VCT
- Due to self referral for VCT after the death of a spouse
- Diagnostic referral to VCT
- Motivated by the care and support service as all do not have other household income

**Responsibility /Participation on Project**

- One received peer educator training on positive living and counseling by SC and provides HIV education on community meetings organized by the project and one to one education

**Perceived Future Participation in Other Community Services**

- All participants expressed their intention to participate in public education on HIV/AIDS.
- However, challenges they fear facing worsened stigma and its consequence on their children they daily encounter and getting expelled from their rented houses by owners.

**Knowledge and Availability of Services and Providers**

- Participants are well aware of the existing services such as VCT/STI and medical services, CHBC, support to OVC, IEC/BCC and preventive services.
- These services are considered good although access and inadequate economic support are identified as major problems

**PLWHA Situation, Preventive Practices and Condom Use**

*Family History and Relation with Siblings*

- All participants have children of age 1-30 who live with them
- Two participants have HIV positive children, others have then in good health
- Parents of children with good health regularly advise and educate their children to protect themselves from HIV infection.
- Two participants claim to have informed about their status to their children and engage them discussion about HIV/AIDS/STI and expressed are treated well
- Most of the PLWHA met did not inform their close families

**Existing HIV Prevention Practices and Condom Use**

- Majority have abstained from sex and remaining use condom always
- Strictly avoid sharing materials with family members
- Few inform about their HIV status to their casual partner who did not want to use condom

**Views, Satisfaction and Expectations on VCT/STI, HBC and Medical Services**
**VCT/STI Services**

**Satisfactions**

- Appreciable reception by counselors and the services of VCT center
- VCT councilors were also reported to be highly supportive when PLWHA is ill.
- Expectations fulfilled
- Given adequate time and information at pre test counseling
- Adequately prepared to receive their results

**Problems Observed**

- One of the counselor's approaches and communication during counseling lack ethics as s/he mistreated clients
- Clients going for VCT are usually maltreated by health center staff in the reception due to absence of sign post for the VCT in the health provider and inability of clients to directly go to VCT

**Medical Services**

**Satisfactions**

- Satisfactory approach and support by health workers
- Appropriate priority given to PLWHA when they are ill

**Problems Observed**

- Lack of drug supply
- Absence of free treatment

- Lack of diagnostic services like X-ray (they often are referred to Nazareth)
- Lack of bed for inpatient treatment

**CHBC Services - Satisfactions**

- Existing CHBC provision is appreciated the service and their regular visits
- CHBC providers give adequate attention given to bed-ridden patients

**Problems Observed**

- Monthly financial assistance is provided late and irregularly
- Unavailability of sanitary materials (soap and detergents) supply
- Inadequate first aid materials supply for CHBC givers
- Few PLWHA were given bed sheets during distribution

**Attitudes on Existing Community /Social Support,**

- Some IDDIRs have stooped penalizing PLWHA members when they fail to pay monthly contributions
- Global clinic (private health provider) provides free medical services to PLWHA
- Few community members also treat PLWHA well. (A participant receives good care and treatment from her land lady)
- The level of stigma and discrimination faced by PLWHA and their children and family members was identified to be very high by all participants

Views on Past HIV/AIDS Activities
**Successes**

- Improved access to VCT services
- Improved community education (workshop for the community and bar/hotel owners and workers)
- Improved attitudes towards PLWHAs

**Major Challenges Faced By PLWHA**

- Stigma and discrimination
- Lack of sufficient food
- Inadequate access to medical services
- Poor ongoing counseling, psychosocial and emotional support

**Views about HRCI Program**
***Strengths***

- In Securing means of subsistence for PLWHA

- Access to CHBC services and support of health care providers

***Limitations***

- The need to register our children for care if we die any time
  Lack of income generation sachems for us to be productive