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FINAL EVALUATION: USAID/ETHIOPIA HIGH-RISK CORRIDORS INITIATIVE

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This publication was produced for review by the United States Agency for International Development. It was prepared by Jenny Hunt, Deborah McSmith, Solomon Negash, and Sister Yetimwork Tekle through the Global Health Technical Assistance Project.

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The two evaluation teams observed project activities through slightly different lenses, depending on their roles and expertise. Team A focused more on voluntary counseling and testing services and Team B on palliative and home-based care. Consequently, observations and assessments between the teams may have slightly different perspectives and areas of emphasis.

We thank Dr. Sam Clark from the Ethiopia USAID Mission for his consistent support beginning before our arrival in country and continuing throughout our stay.

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Above all, we wish to acknowledge the exemplary and committed volunteers and appreciative beneficiaries with whom we were privileged to visit during our travel.

ACRONYMS

AAC	Anti-AIDS Club
AB	Abstinence, Be faithful
ABC	Abstinence, Be faithful, and use Condoms
ANC	Antenatal care
APCA	African Palliative Care Association
ART	Antiretroviral therapy
BCC	Behavior change communication
CBO	Community-based organization
COP	Country Operational Plan
CSW	Commercial sex worker
DFID	United Kingdom Department for International Development
EDHS	Ethiopia Demographic and Health Survey
EHNRI	Ethiopia Health and Nutrition Research Institute
FBO	Faith-based organization
F-Framework	Foreign Assistance Framework
FGC	Female genital cutting
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FHI	Family Health International
FP	Family planning
FY	Fiscal year
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home-based care
HBCV	Home-based care volunteer
HCT	HIV counseling and testing
HRCI	High Risk Corridor Initiative
IC	Information center
ICAP	International Center for AIDS Prevention Care and Treatment Programs (Columbia University)
IEC	Information, education, and communication
IGA	Income-generating activity
IOM	International Organization on Migration
ISAPSO	Integration Service for AIDS Prevention and Support Organization
ITN	Insecticide-treated nets
M&E	Monitoring and evaluation
MAC	Millennium AIDS Campaign
MARPs	Most-at-risk populations
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Nongovernmental organization

OI	Opportunistic infection
OVC	Orphans and vulnerable children
PC3	Positive Change: Children, Communities, and Care
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	Provider-initiated counseling and testing
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
QA	Quality assurance
RHAPCO	Regional HIV/AIDS Prevention and Control Office
SC/USA	Save the Children Federation USA
SOP	Standard operating procedure
SOW	Scope of work
STI	Sexually transmitted infection
TA	Technical assistance
UCSD	University of California San Diego
USAID/E	United States Agency for International Development/Ethiopia
VCT	Voluntary counseling and testing
WAD	World AIDS Day
WAR	Women at Risk
WFP	World Food Programme
WHO	World Health Organization
YAK	Youth Action Kit

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APPENDICES

EXECUTIVE SUMMARY

The United States Agency for International Development/Ethiopia (USAID/E) requested that the Global Health Technical Assistance (GH Tech) Project conduct an evaluation of the High Risk Corridor Initiative—HIV/AIDS Prevention for Ethiopia and Djibouti (HRCI) in Ethiopia. The major focus of the end-of-project evaluation was to document the success and impact of HRCI in achieving its three main objectives:

- Strengthen prevention strategies for effective behavior change.
- Strengthen and expand accessibility to and availability of voluntary counseling and testing (VCT) and sexually transmitted infection (STI) services.
- Increase access to care and support services for persons living with HIV/AIDS (PLWHA).

The evaluation team consisted of Jennifer Hunt, a senior expatriate Team Leader with expertise in care and support and palliative care; Deborah McSmith, a senior expatriate VCT specialist; and Kuleni Berhanu, a local evaluation logistics assistant. The core team was assisted by two Government of Ethiopia (GOE) staff, Mr. Solomon Negash from the Oromia Health Bureau and Sister Yetimwork Tekle, an expert on prevention of mother-to-child transmission (PMTCT) from the Federal HIV/AIDS Prevention and Control Office (FHAPCO). The evaluation, conducted June 8–July 2, 2008, assessed program process and impact, documented lessons learned, and made recommendations for follow-on activities.

INTRODUCTION AND BACKGROUND

The HRCI project began in 2001 with the signing of a three-year cooperative agreement by USAID Ethiopia (USAID/E) and Save the Children USA (SC/USA). The HRCI project works in 21 towns along a busy transportation corridor originating in Addis Ababa that has two separate routes to the border with Djibouti. The initial project focus was on HIV prevention strategies for the mobile groups at highest risk of transmission. Implementation did not begin until December 2001 due to a delay in hiring core staff.

Several modifications to the cooperative agreement have affected the project. In August 2002 the prevention program was expanded to encompass the continuum of care from prevention to care and support for PLWHA and orphans and vulnerable children (OVC), as well as livelihood enhancement. The project was fully staffed and implementing the new agreement by April 2003, with completion scheduled for September 30, 2004. A mid-term review conducted in April 2004 (Lemma and Tamiru, 2004) concluded that the project had made considerable progress in putting in place the structures necessary to achieve the expected outcomes. An extension for fiscal year 2005 (FY05) to run through March 2008 incorporated Phase II of the HRCI within program activities funded by the President's Emergency Plan for AIDS Relief (PEPFAR) and continued the work with community and clinic partners, with an expectation that access to health clinics and 25 central medical centers would be expanded.

The project targeted transport workers, commercial sex workers (CSWs), and other vulnerable groups, such as in-school and out-of-school youth who engage in high-risk activities (street youth, unemployed youth, and sexually vulnerable girls) as well as PLWHA and OVC. The project employed information dissemination, active Community Conversations, group discussions, peer education, and interactive drama as implementing strategies. In Country Operating Plan 2007 (COP 07), palliative care was introduced into the HRCI as part of the care and support package, with the intent to incorporate a holistic approach to physical, psychosocial, and spiritual care for PLWHA.

MAJOR FINDINGS FROM THE END-OF-PROJECT EVALUATION

- **Knowledge and practice:** The project has exceeded its objective of increasing preventive knowledge and practice by reaching community members in general as well as targeted groups.
- **VCT:** The project has provided solid support for health facilities-based VCT and provider-initiated counseling and testing (PICT). Partially due to the success of the information, education, and communication (IEC) campaign and increased uptake of VCT services, the project has seen an unprecedented rise in demand for VCT and treatment services that staff in health facilities do not have the capacity to meet, which compromises quality assurance (QA). Other factors, including efforts by the GOE, contributed to the increase in demand for VCT during the 2001–2008 project period.
- **ART:** Many PLWHA access antiretroviral therapy (ART) through VCT and home-based care (HBC) referrals to ART services. PLWHA describe ART as easy to access and freely available.
- **STI:** Referrals to and support from STI clinics were not as integrated as other services.
- **OI:** There has been increased access to treatment for opportunistic infections (OI) at health centers and hospitals for adult and pediatric patients, mainly due to the medicines provided for both by the project.
- **Care and support:** PLWHA reported significant benefits from the care and support provided by the HBC program. There is, however, some concern about volunteer competence in counseling, especially around emotional issues, even though commitment and compassion were always evident. Supervision structures have been put in place by identifying nurse supervisor focal persons at local health facilities. While this has provided some measure of checks and support for volunteer HBC activities, supervision skills varied by site and individual.
- **OVC:** Material support for OVC has been meaningful, with the project providing school uniforms, fees, and supplies; food through a partnership with the World Food Programme (WFP); and additional family support through partnership with the Positive Change: Children, Communities, and Care (PC3) project.
- **Palliative care:** Palliative care is just now emerging as a health specialty in Ethiopia, which has yet to roll out national policies and guidelines. Thus a working understanding of palliative care could not be cascaded downward to implementers. Evaluators concluded that achievement of this component of Objective 3 was an unrealistic expectation given the time available.
- **Food support:** Food support for PLWHA and OVC has been provided by the project in partnership with WFP and is recognized as crucial in helping PLWHA and OVC regain health, respond optimally to ART, and return to productive lifestyles. The evaluation determined that combining treatment with care and support, including food support, has increased quality of life beyond measure.
- **Livelihood security:** The project was able to lay the foundation for sustainable livelihood security for a limited number of PLWHA along the corridor. Despite reaping only small profits, some income-generating activities (IGA) appeared to have already achieved a measure of sustainability. Replicating these activities, however, may require more seed money and more intensive business training.

- **Cross-cutting issues (gender, stigma reduction, and community strengthening):** The project benefited both females and males. More females were beneficiaries because more women are HIV-positive, and the project had a successful focus on CSWs. There was little evidence that gender awareness was raised among HRCI staff, however. Both males and females were recruited as home-based care volunteers (HBCVs).

  Stigma reduction is probably the single most successful outcome of the project, even while recognizing that the project has been working with GOE and nongovernmental organization (NGO) campaigns that also mitigated the stigma for PLWHA. Stigma has been reduced through a combination of awareness campaigns, distribution of prevention materials, broad community representation on HIV/AIDS committees, HBCVs providing care and support to families affected by HIV/AIDS, access to ART enabling PLWHA to reintegrate into normal community life, Community Conversations, and widespread community testing. The integration of PLWHA and HIV-negative people as educators is also considered key. Community strategies focused on capacity-building training for HIV/AIDS committees and other HRCI project implementers. The project is credited with increasing volunteerism along the corridor and for modeling compassionate care in communities previously characterized by HIV/AIDS phobia and discrimination. It has built up community capacity through training in IGA management and entrepreneurship and seed money grants for IGA start-up.

CHALLENGES/WEAKNESSES/LESSONS LEARNED

- Although the project initiated useful monthly experience-sharing meetings for HIV/AIDS committees, HBCVs, and other participants, it did not implement "care for the caregiver" strategies to prevent burn-out; nor was skilled emotional support available for HBC volunteers dealing with the continuing suffering of PLWHA.
- The quality of project training was difficult to assess apart from skills observed in the field and in-depth interviews. Training content seems to adhere to national guidelines, but the experience of trainers tends to vary widely. Formal training evaluation is limited to daily feedback by participants. Counseling, supervision, and HBC skills varied noticeably between sites, which the team considered to be a result of variance in both training and personalities.
- Palliative care has not been effectively implemented due to a lack of cascaded information and training.
- There are gaps in the quantitative data captured by the project, possibly due to changes in staff and leadership over the life of the project.
- CSWs seem to be accessing VCT, but it is not clear if truck drivers and at-risk youth are testing in increased numbers.
- QA for laboratory VCT protocols was difficult to assess because evaluators had no opportunity to interview laboratory workers. Referrals to and use of STI services did not meet project targets; staff believes this may be the result of coding errors due to blending STI with other clinic services and to changes in coding practices. Evaluators did not notice a focus on STI during visits or interviews. This treatment service should not be overshadowed by other elements of the response to HIV.
- Several sites expressed concerns about a shortage of prevention education materials. The resistance of some truck drivers to specific materials is a reminder that if messages are to be effective it is of paramount importance to include stakeholders in the design of materials and strategies. Follow-up with CSWs trained as peer educators was compromised due to their mobility, making it difficult to accurately assess the impact of this strategy.

RECOMMENDATIONS

Immediate Recommendations

- If at all possible, the project should continue until the redesign, tender, and partner selection process of the next project has been completed to ensure a smooth transition and continuation of urgently needed services.
- If this is not possible, a minimum package of support should be defined and continued through the redesign that includes transport stipends and care kit supplies for HBCVs (including nurse supervisors and spiritual counselors), food distribution costs, and IGA support.
- Whether or not the previous recommendations are followed, project staff should work vigorously with all partners over the next three months to plan sustainable exit strategies that address materials replication, support for IGAs from microfinance organizations and local businesses, and support for HBCVs, Information Centers (ICs), and HIV/AIDS committees that are not yet ready to function on their own. Mentoring could perhaps be arranged between stronger sites and those needing support.

Recommendations for Future Planning

1. Explore partnerships with larger private industries in Ethiopia, e.g., in the pharmaceutical industry, to mobilize more resources for responding to HIV.
2. Explore partnerships with businesses along the corridor, e.g. tire manufacturers and spare parts businesses.
3. Expand local partnerships (e.g., with hotels that give food to PLWHA) along the corridor.
4. Build the palliative care knowledge and skills of HBCVs and nurse supervisors by linking with University of California San Diego (UCSD) and I-Tech, which are driving the palliative care agenda in Ethiopia.
5. Add "care for the caregiver" trainings for HBCVs family caregivers, nurse supervisors, and spiritual counselors.
6. Provide regular skilled support for volunteers who make home visits to sick clients.
7. Include at-risk populations in the design of strategies and messages intended to change their risky behaviors.
8. Ask community and religious organizations to fund lower-cost activities, such as coffee ceremonies and Community Conversations, that have proven successful in educating communities about HIV.

I. INTRODUCTION AND BACKGROUND

BACKGROUND

The estimated national prevalence of HIV in adults in Ethiopia in 2008 is 2.2 percent; an estimated 1,037,267 people live with HIV and just under a million children are thought to be orphaned due to AIDS[1]. The prevalence is nine times higher in urban than in rural areas[2]. Populations considered at high risk of transmission and infection are commercial sex workers (CSWs), truck drivers, youth in and out of school (especially street and unemployed youth and sexually vulnerable girls), mobile groups (transport workers and assistants as well as CSWs), influential leaders, employed civil service personnel, and groups affected by HIV and AIDS such as people living with HIV/AIDS (PLWHA) and orphans and vulnerable children (OVC). The predominantly urban epidemic is likely to be concentrated among these groups[3].

USAID/E–PEPFAR's prevention strategy focuses on expanding outreach to most-at-risk populations (MARPs). USAID/E's High Risk Corridor Initiative—HIV/AIDS Prevention for Ethiopia and Djibouti (HRCI) directs its activities primarily to high-risk groups in urban areas and 'hot spots' along the major Addis to Djibouti transport corridor.

In July 2001 USAID/E and Save the Children Federation (SC/USA) signed a cooperative agreement to support the HRCI project. Initially planned as a three-year prevention program (2001–2003) to reach mobile groups at highest risk of HIV transmission, the program was modified in August 2002: The scope was broadened to encompass the continuum from prevention to care and support for PLWHA and OVC and enhancement of their livelihood. The completion date was extended to September 30, 2004. A program extension in FY05 to run through March 2008 incorporated HRCI into PEPFAR-funded activities. It continued to work through community and clinic partners, with an expectation of expanding access to health clinics and 25 central medical centers. The project also continued to target transport workers, CSWs, and other vulnerable groups, such as out-of-school youth who engage in high-risk activities.

As part of the PEPFAR Country Operational Plan (COP) for 2007, palliative care was introduced into HRCI as part of the care and support package. PEPFAR has allocated 15 percent of its budget to palliative care and defines the approach in its adaptation of the World Health Organization (WHO) definition (see Appendix H). The HRCI was asked to participate in the PEPFAR Care and Support Working Group to ensure a standard approach to community-based care and support. Because funding for OVC support was not included in the extension, partnership with the PC3 project, which focuses on OVC, was encouraged. The HRCI project was also asked to incorporate into its work the three cross-cutting themes of gender, stigma, and community strengthening. The end date was extended from March to September 2008.

SIGNIFICANT FINDINGS OF THE MID-TERM REVIEW

Among the recommendations from the mid-term review were to

- Replicate best practices established in certain towns along the corridor in other sites.
- Network more closely with HAPCO, facilities-based voluntary counseling and testing (VCT) centers, and the police.

[1] FHAPCO, 2007
[2] Cassell and Myrick, 2007
[3] Cassell and Myrick, 2007

- Encourage HIV/AIDS committees to focus on their supervisory role and build their capacity by further linkages within communities.
- Reinforce Information Centers (ICs) with up-to-date information, materials, and activities.
- Enhance quality of care and referral systems at VCT sites.
- Extend home-based care (HBC) to psychosocial and material support for chronically ill and bedridden patients.
- Recognize the value added to the project by volunteers.
- Strengthen and expand IGA activities.

PURPOSE, SCOPE, AND METHODOLOGY OF THE EVALUATION

In response to the evaluation scope of work (SOW) provided by USAID/E (Appendix A), the core evaluation team drafted and submitted questions and strategies designed to collect a balance of quantitative and qualitative data about HRCI effectiveness. After useful clarification during two days of briefing and planning with USAID/E colleagues, the team narrowed the focus of the questions.

The evaluation methodology was determined by the team in collaboration with USAID/E; both qualitative and quantitative methods were employed. Formats for in-depth interviews were created for HBCVs, health workers, PLWHA, other stakeholders, and VCT counselors. Focus group discussion guides were drafted for PLWHA, HBCVs, health workers, spiritual counselors, HIV/AIDS committee members, high-risk youth, Youth Action Kit (YAK) members, and CSWs. Specific questions were added for PLWHA, iddir members, and health workers. The evaluation teams used these tools flexibly, depending on numbers, situations, and time constraints. Assessments were carried out at facility and community levels. Data were collected in field notes and processed into themes after the team returned to Addis Ababa. (The evaluation rationale and questions can be found in Appendix C.)

Team A visited Dire Dawa, Assebe Teferi, and Hirna; the team held focus group discussions, interviews, and meetings with a total of 176 HIV/AIDS committee members, partners, PLWHA, VCT counselors, HBCVs, and spiritual leaders. Team B visited Bishoftu, Adama, Wolenchiti, and Awash, holding focus groups, interviews, and meetings with a total of 115 participants. (A comprehensive list of project sites visited and contacts made is contained in Appendix B.)

II. EVALUATION FINDINGS

MAJOR STRATEGIES

Increase HIV Prevention Practices and Demand for Services

The teams observed:

- Well-attended community gatherings, such as coffee ceremonies, with HIV-positive and HIV-negative educators working together
- Large-group and home-to-home education by spiritual leaders
- Development of information, education, and communication (IEC) and behavior change communication (BCC) materials
- Information Centers that broadcast messages; distributed cassette tapes, posters, leaflets, and youth passports; and promoted and distributed condoms to CSWs, out-of-school youth, truck drivers, bars, and hotels
- Anti-AIDS clubs (AACs) for both in-school and out-of-school youth
- A YAK school-based peer education program that educates adolescent/secondary school students in a variety of ways using multiple materials and includes condom education
- Primary and secondary prevention education for PLWHA, families, and neighbors through HBC and social gatherings

Increase Availability of and Access to Prevention and Treatment Services

The teams observed:

- VCT promotion through banners, leaflets, message cards, and billboards
- Health facility VCT, provider-initiated counseling and testing (PICT), and prevention of mother-to-child transmission (PMTCT) counseling
- Mobile VCT in both urban and rural communities
- Training of health providers in VCT and PICT
- Referrals to sexually transmitted infection (STI) services
- Referrals for opportunistic infection (OI) treatment and provision of OI meds to health centers and hospitals

Care and Support Services, Including Food Support

The teams observed:

- Referrals for antiretroviral therapy (ART) by VCT counselors and HBC volunteers
- HBC by volunteers and nurse supervisors
- Spiritual counseling by Muslim, Orthodox Christian, and Protestant spiritual leaders working in teams
- HBCV support for ART adherence

- Formation of PLWHA associations for advocacy and legal support and cooperatives for IGAs
- Trainings for HBCVs, nurse supervisors, spiritual counselors, and family caregivers
- School materials and food support for OVC and follow-up on their progress and stability
- Food support for PLWHA:

  a. Provision of food for PLWHA and OVC in partnership with the World Food Programme

  b. Training for beneficiaries on how to cook high-protein food supplements

  c. Provision of food for individual PLWHA through partnerships with private business owners, hotels, and cafeterias

Livelihood Enhancement

The teams observed:

- Support for and training in establishing PLWHA cooperatives
- Support for and training in establishing IGAs
- Linkages with microfinance organizations to maximize resources for PLWHA
- Individual arrangements with business owners and private citizens to provide employment to PLWHA or resources to assist new IGAs (e.g., shelters for animals)

The project's primary implementing structures are the HIV/AIDS committees, whose membership strategically includes leaders from kebeles, woredas, health bureaus, health centers, hospitals, town administrations, churches and mosques, schools, local NGOs, iddirs and other CBOs, PLWHA, and members of at-risk populations. Each HIV/AIDS committee has four subcommittees: Youth and Prevention, Care and Support, Fundraising, and OVC. The committees are demonstrably effective structures for partnerships, linkages, referrals, community engagement, and transparent record-keeping.

PHASE II OBJECTIVES AND ACHIEVEMENTS

Strategic Objective 1: To Increase HIV/AIDS Prevention Practices and Demand for Services

Information from the HIV/AIDS behavioral surveillance survey suggests that although high-risk groups demonstrated considerable knowledge of HIV prevention methods, they still had misconceptions about safe sex, condom use, and ART and little comprehensive knowledge about HIV/AIDS (Mitike et al., 2005). Misinformation was occasionally evident even among generally well-informed interviewees, but the scope and timing of this evaluation task did not allow for comprehensive questioning of CSWs, truck drivers, and at-risk youth about the degree and accuracy of their knowledge. The evaluation team is therefore unable to determine whether in-depth knowledge of prevention practices has improved since 2005.

There is clear evidence that the following target groups defined in the Phase II work plans have been reached: CSWs, truck drivers and their assistants, and in-school and out-of-school youth. It is not clear how well other mobile populations, such as civil servants and people who sell contraband, have been reached. (Interestingly, members of MARPS who were interviewed defined high-risk populations somewhat differently by including users of alcohol and chat and government employees posted away from their families.

CSWs were successfully targeted through social gatherings, bar and hotel outreach, peer education trainings, ICs (with cassette tape and condom distribution), VCT testing services, and IGA activities. Many CSWs have verifiably been tested.

Truck drivers were reached primarily through ICs with cassette tapes and condoms. It is not clear from project records how many truck drivers have been tested, although VCT sites at health facilities have this information from their Occupation question and it should be possible for representative health centers to provide the data to the project. (Compiling the data would be useful to HAPCO's planning to strengthen VCT outreach to MARPs.)

Out-of-school youth actively use ICs and AACs, but it is not clear from the data available to the team how many have been tested, even though the VCT centers are collecting the data. **In-school youth** have enthusiastically connected with the YAK program, where abstinence is promoted with condom education and support for VCT.

The oral tradition is embedded in Ethiopian coffee ceremonies and Community Conversations. Coffee ceremonies, which offer an environment for discussion and sharing of information and experience, have been cited as especially useful as a forum for transfer of knowledge about HIV. An effective venue for community education and problem-solving, they are held regularly at different venues in all the communities where the project is active, and they reach the community as a whole, including high-risk individuals who live there. PLWHA and HIV-negative educators work in teams to provide primary and secondary education through coffee ceremonies and meetings and dramas at mosques and churches. The success of these oral teaching methods is evidenced by the demand for VCT and condoms and the uptake of testing. It was not evident, however, that the messages disseminated adequately conveyed the risks associated with having multiple or concurrent sex partners. Beyond a strong "Be Faithful" message, specific information about partner reduction was seldom observed.

Besides coffee ceremonies, other helpful learning methods cited were guidance and instruction from HBC volunteers and peer educators and group discussions. Iddir members use their traditional community discussions to inform and be informed about HIV. YAK peer education was considered an effective means to cascade information included in the Youth Passport (see below).

There was evidence that prevention messages and materials reached beyond target groups to residents in rural communities who come to town for testing and treatment after learning the benefits of these from the IEC campaign. In the town of Hirna, information on HIV transmission and prevention was provided to militia during rural training activities and to youth living in rural areas near the town.

There was anecdotal evidence that some older family members are not being reached, perhaps due to prohibitions on open family discussions about HIV in a culture where there are strict social rules relating to age and taboo topics. Elderly family members may also not be sufficiently mobile to attend public educational gatherings.

Peer Education as a Prevention Education Strategy

The Trainer's Manual for Peer Educators Training drafted in 2003 by the Dire Dawa, Afar, Oromia, and Somali regions (RHAPCO/SC/USA) demonstrates effective peer education strategies and was used for all peer educators, including CSWs, IC counselors, and YAKs.

CSW Peer Educators: During Phase II 1,235 CWS peer educators were trained. Recent quarterly project reports describe a gradual decline in high-risk peer education activities, primarily, it seems, because many CSWs are mobile. The number of CSWs actively working as peer educators has also diminished in part because engagement with IGAs leaves little time for

educational activities. Indeed, the most effective prevention strategy for CSWs appears to be IGA activities that include training for new roles and training in personal development, such as that provided by Women at Risk (WAR).

In one focus group discussion, evaluators were told that CSW peer educators were frustrated because although they now had knowledge and education skills, there are no paid positions in which they could use these skills, so they had to continue doing sex work. Project staff has suggested that peer education might work more successfully with home-based sex workers than with those who are mobile.

YAK Student Peer Educators: The YAK program in secondary schools appears to have worked well in terms of training and retaining peer educators. Student peer educators and affiliated teachers had been involved for four years, and students ceased their involvement only upon graduation. This is clearly an effective way to reach students with "Abstinence, Be Faithful" (AB) messages and condom education for those who are sexually active. The YAK approach advocates finding activities like music and sports to occupy time out of school and replace chewing chat and drinking. YAK peer educators have three days of training in how to teach others. They are then asked to train at least 20 more peer educators. The total number of peer educators and youth leaders trained during Phase II was 3,755. There is no breakout of YAK and out-of-school peer educators; nor is it clear whether the latter use similar materials and messages or revise them to reflect the special risks for out-of-school, unemployed, and street youth.

Phase II had no peer education or other trainings for truck drivers.

Prevention Materials for At-Risk Populations

IEC/BCC Materials Produced by the Project in Phase II: The HRCI project drafted and distributed materials in Amharic, and messages were conveyed on opposite sides of billboards in both Amharic and Oromifaa.

Billboards that promote faithfulness for married people, condom use for truck drivers, VCT, and care for OVC:	29
Banners produced and displayed:	22
Leaflets:	52,000
Brochures:	20,000
Youth passports (developed by SC/USA but not by HRCI)	334
Serial drama audiocassettes (22 episodes)	13,242
Addis Ta'em cassette tape	3,000
Copies of *The Essence of Life* (book) (this is a pictorial document about the project)	1,000

Youth: HRCI did not publish any youth prevention materials, but YAK groups, ICs, and AACs identified the Youth Passport developed by another SC/USA project (INSIGHT) and used extensively in the HRCI project as the project's most effective preventive material. By March 2008, 334 copies had been distributed. Materials from other organizations (e.g., Save the Youth Generation) were also distributed.

Truck Drivers: Several series of dramas on audiocassettes depicting truck drivers and CSWs are used to provide HIV information. An evaluation of the Maleda cassette project (Iffa, 2004) reported high receptivity and success. In a focus group discussion, however, four truck drivers felt that the cassette "Addis Ta'em" was discriminatory and stigmatizing. They reported that among truck drivers this tape had led to marital disputes and drivers' children being discriminated

against at school. They asked that the Ethiopia Truck Drivers Association be more actively engaged in HIV prevention campaigns.

The HRCI Maleda cassette serial drama was developed through a pre-project process of determining knowledge, attitudes, and practices (Iffa, 2002). The series was found to be successful, and its benefits extended beyond the target population of truck drivers to other members of the community (Iffa, 2004). It is not clear whether a similar process informed the development of "Addis Ta'em." It is also not clear whether the negative feedback from the small sample in the truck driver focus group represented the opinion of the truck driver population as a whole.

Also distributed, though not published by HRCI, were 85,139 leaflets, 16,334 brochures, 30,893 posters, and 166 magazines.

VCT Materials and Messages: The project used billboards, banners, and message cards to mobilize communities for VCT. Billboard display points were selected in collaboration with HAPCO and other partners; they were usually at the entry and exit points of the main project towns. Several message cards were also published to support VCT outreach.

The effectiveness of preventive messages may be measured by behavior change, but such change also requires financial support, usually through IGA activities. It is also necessary to integrate prevention with a basic package of treatment, care, and support. There are anecdotal reports of an increase in condom use and adherence to all or part of ABC messages by youth, sex workers, and truck drivers. The significant reduction in stigma and discrimination is another measure of the success of the IEC campaign.

AIDS Information Centers and MARPs

The project's HIV/AIDS Information Centers (ICs) are well known in the communities. They seem to have a particularly comfortable working relationship with CSWs, who volunteer at some of them. Truck drivers reported sporadic visits to ICs but also feel well informed from other media sources. The most regular IC visitors are youth aged 18 to 30.

In an attempt to set consistent standards for ICs, the project prepared a Minimum Standards Guideline (SC/USA, 2007): All centers have a uniform appearance, displaying on the walls name, mission and vision, nationally approved posters, town demographic data, list of IC activities, and a weekly schedule of services. ICs keep excellent records of visitors and of information and condoms distributed. However, volunteer HIV knowledge and current information was inconsistent; some volunteers demonstrated excellent information and skills, and others were clearly less informed. For example, in Dukem, evaluators asked youth volunteers about the sexual practices hierarchy of risk for HIV. The volunteers, who considered themselves knowledgeable and well trained, did not know that anal sex carried a higher risk for HIV transmission.

The majority of volunteers at ICs were very young. We were unable to establish whether their youth was a deterrent for older people. More worrying is how able they are to deal with intoxicated and aggressive visitors. The team heard of one young female volunteer who had been raped, leading to a decision to use only young male volunteers at that site.

High-risk youth reached (in and out of school)	Target:	271,048
	Achieved:	318,996
Mobile populations, including truck drivers	Target:	127,136
	Achieved:	150,972
Commercial sex workers	Target:	19,582
	Achieved:	26,712
Condoms distributed	Target:	NA
	Achieved:	1,121,079

Many of the ICs are located on land donated by municipalities, often either on the roadside itself or in an area associated with the corridor, such as learner driver grounds or large bus stops. They are well integrated and visible.

Key Learning for Strategic Objective 1

Evaluators repeatedly heard and witnessed the necessity of blending prevention messages with support that provides alternatives to risky behaviors, particularly for CSWs, at-risk youth, and older OVC and their guardians. A prevention strategy that informs people about how to reduce risky behaviors without supporting sustainable ways to change those behaviors is incomplete and ineffective.

Strategic Objective 2: To Improve Access to and Availability of Prevention and Treatment Services for HIV, AIDS, STIs and Opportunistic Infections

HRCI Support for HIV Counseling and Testing (HCT) Services

The HRCI project has provided solid support for VCT and PICT at 16 health facilities and for VCT outreach campaigns conducted in partnership with HAPCO and health centers in both urban and rural communities. Establishing new VCT sites was never a project mandate for SC/USA, which rather was asked to build testing capacity at health centers and hospitals and in the community through mobile testing. The evaluation team assessing the Bishoftu-Awash sector was unable to access the same range of VCT services as the Dire Dawa team. In Awash, although the project has enhanced VCT, PMTCT, and all treatment services, the health center is unable to offer the services provided elsewhere: there are no laboratory services, and a regular shortage of staff diminishes the availability and quality of care.

Promotion of Mobile VCT Outreach:
There is consensus at all sites that the mobile campaigns have made a big difference in increasing VCT demand and testing. The HRCI project was particularly active in supporting regional health bureaus during the Millennium AIDS Campaign VCT outreach that started in November 2006. In Dire Dawa the first mobile outreach campaign, coordinated by health centers under the auspices of HAPCO, woreda officials, and HRCI, lasted for two months. Regular mobile outreach continues in both urban and rural areas; all health centers in the Dire Dawa region are involved. Along with billboards, banners, leaflets, and message cards, in some locations the HRCI project provided battery cells for microphones, created dramas to attract the community to the test location, and provided testing supplies. The

Clients Tested Through VCT in Phase II	
Target:	132,000
Achieved:	88,162
Testing positive:	1,732 (just above 2%)

project was also an active partner in World AIDS Day celebrations, supporting panel discussions, coffee ceremonies, and candlelight ceremonies.

In the Dire Dawa area, outreach has been effective in increasing demand for testing throughout the geographic area. Both health workers and community members affirmed that large-scale community testing successfully reaches both high-risk populations and the general community. Testing was even done at one prison; according to interviewees, the inmates first tested became promoters for prevention and testing and convinced many more inmates to be tested.

Provision of Testing Supplies: Until recently the HRCI project has filled critical supply gaps for 16 hospitals and health centers along the Corridor, providing alcohol, cotton, syringes, epindorf tubes, biohazard bags, yellow tips, and test tubes. HAPCO is now mandated to provide testing supplies to health centers through the Ethiopia Nutrition Research Institution, which purchases, stocks, and distributes kits. However, some health center managers indicated that HRCI supply support continues.

Training in VCT, PICT, and PMTCT for Health Workers: Besides training VCT counselors, the project has provided PICT training for health workers, PMTCT counseling training for antenatal nurses, and training focused on couples counseling, all of which were a key contribution to health facility partners. The project also provided training and refresher training for health-facility-based VCT counselors (mostly nurses and midwives who provide VCT part-time) and PICT and PMTCT trainings for health providers. A major contribution was to teach health workers how to initiate conversations with patients about HIV testing when that is not the primary purpose for the patient visit.

Project staff selected trainees from each health center; some trainers were project staff but most were from CDC Ethiopia and the MOH, who follow national guidelines and conduct CT training for all NGOs. The Dire Dawa Project Coordination Office has videotapes all its training workshops, but evaluators were unable to assess the quality because they are in Amharic.

Health professionals trained on VCT, PICT in Phase II 323

Increased VCT Utilization at Health Facilities: There are no known static VCT sites separate from health facilities along the high-risk corridor. Several interviewees expressed the belief that health centers are the only appropriate locations for static VCT to ensure immediate referrals to integrated services like ART, STI, or OI treatment; PMTCT; food support; HBC; and PLWHA associations and cooperatives.

Evaluators asked whether members of high-risk groups come to health facilities for testing. VCT counselors emphasized that many CSWs have comfortably done so. VCT entry forms designate occupation, and MARPs are on the list (see Appendix D). Health center VCT records can therefore provide an accurate report of the numbers of CSWs, truck drivers, assistant drivers, and students who have been tested. The form does not have a specific category for out-of-school or unemployed youth, although the latter may be subsumed under "12 = None [i.e., no occupation])." It would be useful for out-of-school or unemployed youth to be a distinct category on any form used by health center VCT services.

Provider-Initiated Counseling and Testing: Recently health centers have begun to integrate PICT into family planning (FP), immunization, outpatient, pediatric outpatient, and antenatal clinics as part of the PMTCT services. This is an exciting expansion of counseling and testing for patients that is working particularly well in Hirna and is now getting underway in Dukem.

When a patient is identified as positive through testing at any clinic, the health worker who gets the positive result will bring the patient to the ART clinic, where the patient will be clinically

staged for eligibility for ART. Patients not yet eligible are placed in the pre-ART registry and monitored so that ART begins when the CD4 count reaches the eligibility threshold.

Two of the health centers visited in the Dire Dawa project region have organized their VCT and PICT areas so that there is a private walkway between test locations and ART services, enabling patients to move to the ART treatment room unseen by other patients. This effective confidentiality measure could be replicated in other health centers.

QA for VCT Counseling: HRCI staff had been providing monthly QA supervision for all project-trained VCT counselors, reviewing VCT records and testing procedures, but as the number of staff has fallen during phase-out, it no longer does so. One QA issue for both health facilities and mobile outreach that was noted in project quarterly reports is the short amount of time spent with clients during pretest counseling, because just one or two VCT counselors must attend to a high number of clients. This was particularly true during the intensified community mobilization undertaken in 2007 as part of the Millennium AIDS Campaign Phase III and World AIDS Day.

Project staff encouraged VCT counselors to invest more time with clients during pretest counseling to better prepare them to cope with test results. In some locations, clinical staff that provide VCT are supported by HAPCO-trained community counselors.[4] At some project-affiliated health centers, these are first-line counselors, with VCT-trained clinical staff providing service in their absence. Appendix E contains field notes that describe how VCT skills were assessed in the evaluation.

QA for Rapid and Confirmatory Tests: Project staff was directly involved in QA for laboratory processes and reliability results, in collaboration with the Oromia Zonal Health Office. Staff reported that in 2006 and 2007 for QA the VCT Officer in the Dire Dawa Project Coordination Office brought experts from Addis Ababa every six months to train laboratory staff on infection prevention during rapid test sticks and phlebotomy.

According to staff, not all HIV laboratories in corridor health facilities are following QA protocols. The Ethiopia Health and Nutrition Research Institute (EHNRI) is drafting a new national standard operating procedure (SOP) for the introduction of two new confirmatory test kits; Unigold will be the final confirmatory test. Training is currently underway for laboratory technicians on correct use of the new kits. Physicians told evaluators that incorrect results will be less likely with the new kits because they are "technically simple."

Referrals from Other HRCI Components to VCT: Referrals to VCT, an integral component of the HRCI Project, are made from ICs, AACs, YAK programs, coffee ceremonies and other social gatherings used for HIV prevention, and HBCVs, who encourage family members of PLWHA to test. Along the high-risk corridor, testing for HIV seems to have become a social norm. Pre-adolescent youth are familiar with the messages that promote testing for children as well as adults and in Hirna asked evaluators how they could be tested.

Referrals from VCT to Treatment Services: Health facilities affiliated with the HRCI project have excellent referral systems for patients who require ART, STI or OI treatment, HBC, and food support, depending on availability and patient eligibility. Patients are also referred as appropriate to HIV/AIDS committees, PLWHA associations, and IGA cooperatives.

As a direct result of the HRCI project, treatment, care, and support referrals are integrated and well-organized through both VCT/PICT services at health facilities and HBCVs. The project has done an outstanding job of linking newly diagnosed patients with needed services and linking

[4] According to the HAPCO team member, 700 community counselors have been trained throughout the country, many of them youth or HIV-positive volunteers, or both.

health facilities with HIV/AIDS Committees, HBC volunteers, PLWHA associations, WFP food support, and other available community support for their newly diagnosed positive clients/patients.

Referrals by IC Volunteers to VCT, STI, and OI Services 7,350

Project staff report that STI services were given more support in Phase I than in Phase II, and acknowledge that the project did not collect accurate data on STI referrals in Phase II. Reportedly, this was due in part to a change in MOH strategy: previously, STI services were provided in separate clinics, so treatment data were kept separately and easily accessed. The MOH stopped running separate clinics both because of the stigma caused by the known association with HIV and because of staff shortages. As a result, STI treatment data are no longer disaggregated, and STI services are reportedly sometimes miscoded. The project can thus track referrals to STI services but not utilization. Staff asserts that a majority of those who are referred do receive treatment.

The project improved access to OI treatment by providing medicines to health centers and hospitals for both adult and pediatric patients; in future the MOH will provide drugs. Some clinic supervisors expressed concern about drug shortages after the project ends.

Key Lessons for Strategic Objective 2

- Raising demand for testing and treatment services increases the need for VCT counselors and ART prescribers.
- Creating demand for and access to ART also creates a demand for food and other care and support services. Planning for all activities must be carefully integrated.

Clients Referred from VCT to Other Services (FY 2008)–

ART:	272
STI:	100
PMTCT:	65
OI:	392

- QA for HIV counseling and testing (HCT)-related laboratory protocols needs to be strengthened by either HAPCO or its partners.

Strategic Objective 3: To Improve the Availability and Quality of Care and Support Services for People Living with HIV and AIDS and Orphans and Vulnerable Children

Care and support within the HRCI project begins with identification of PLWHA. HIV/AIDS committees, VCT counselors, health workers who have initiated PICT, and HBC volunteers may all identify PLWHA and connect them with ART and other care and support services. Palliative care was added to the care and support component by the COP 07 document. The implications of introducing palliative care into the HRCI project need to be assessed in relation to expectations and differences in care and support before and after its inclusion. For that purpose a clear understanding of palliative care—a relative newcomer in health services worldwide—should have been cascaded from USAID/E to SC/USA to health facilities to HIV/AIDS committees to HBC volunteers. Because palliative care in HRCI was primarily intended to be delivered by HBCVs, this section will assess the HBC activities observed before evaluating how or whether palliative care was incorporated into the project.

Roles and Contributions of HBCVs

If HIV/AIDS committees are the primary structure of the project, HBCVs are the project's heart. Care and support subcommittees within HIV/AIDS committees are instrumental in selecting the PLWHA who most need HBC. Volunteers are trained for 21 days, provided 50 birr a month for transportation to patients' homes, and supported in varying degrees by trained nurse supervisors.

Evaluators witnessed astonishing commitment and compassion on the part of these volunteers, many of whom use their meager transport stipend to transport sick patients to health facilities or to buy food for them. Most volunteers visit PLWHA at home three times a week. Their visits in some cases complement the support provided by family caregivers, but often they are the only caregivers. Of interest was the high percentage of male volunteers in both sites. Care for others seemingly cut across this traditionally female-dominated domain.

HBC volunteers articulated for evaluators the many contributions of HBC:

> "HBC reduces congestion of hospital patients, reduces workloads of nurse supervisors, links PLWHA with ART, and increases VCT demand. Before HRCI HBC, many clients were severely ill and didn't know about the disease. HBC education reduces misconceptions and stigma and supports behavior changes."

> "What is different about HRCI is its grassroots approach and HBC. Through HBC we share our humanity. Community awareness started when HBC volunteers went to bedridden patients, then familiarized neighbors through coffee ceremonies. Behavior change started with reduced fear, increased compassion, increased knowledge and understanding, and service to those in need."

Some HBC volunteers reported that they too experienced stigma and discrimination at first, and some PLWHA did not want to be visited because they were afraid of being stigmatized by visits witnessed by their neighbors. However, young unemployed men have been successfully recruited as volunteers; they expressed deep contentment at being able to make a difference to the lives of chronically ill people.

HBC Volunteers and HIV Prevention: Volunteers, health workers, and PLWHA acknowledged the close relationship between HBC and prevention. HBCVs educate family members, neighbors, and the community through social gatherings, and health workers consistently report that HBCVs have influenced uptake of both VCT and ART services.

HBC Volunteers, ART, and ART Adherence: HBC volunteers play a crucial role in linking PLWHA to ART services. They report that many PLWHA did not initially want to visit health clinics, either for fear of stigma or in doubt that ART would make them better. Through building trusting relationships with PLWHA, and often providing transport costs (in some cases literally carrying clients on their backs), they have been directly responsible for the uptake of ART by many eligible PLWHA.

Volunteers support client adherence by knowing which ART is being taken, when, and the dosage; with the client's permission they identify a family member to train in adherence support. As the health of PLWHA has improved on ART, many have also become HBC volunteers, choosing to disclose their status in order to encourage undisclosed PLWHA to connect with ART and other care and support services.

The impact of ART on the lives of PLWHA cannot be underestimated. We heard repeated stories of PLWHA close to death who recovered with treatment and were able to again work and be integrated back into society. HBC volunteers are an integral link between PLWHA and ART services. Due to the success of this aspect of the project, in its final stages many PLWHA are being tested and accessing ART. The implications of ending HBC activities without having a bridging or transition strategy in place are a major concern.

HBC Volunteer Training: All HBCVs and nurse supervisors are trained for 21 days using the MOH HBC training manual. Much of the curriculum is theoretical, though there are opportunities for some practical input, such as demonstration of bed baths. Volunteers are taught the practicalities of how to wash clothes, prepare food, wash the client's body and hair, and clean the

home, along with basic communication skills and symptom management. Module 4, on the concept of care and support, describes emotional and psychological support for such problems as anger, shock, and fear. Trainees are advised to "counsel them, listen to them, be patient with them, and provide them with basic needs or with emotional and psychological support" (MOH, 2001; p. 63). However, the "how-to" of counseling is missing; unless trainers are themselves experienced in counseling, volunteers will not learn the skills they need for this. This explains the limited counseling skills witnessed in some areas of the evaluation.

There is also no palliative care content, and there is minimal understanding that palliative HBC can provide expanded and comprehensive care at home, thus minimizing referrals to overloaded health facilities. It was noted in Bishoftu, Adama, Wolenchiti, and Awash that volunteers rapidly refer to health facilities because their capacity to help families manage patients at home is limited. Palliative HBC also depends on effective pain control and good supportive services from trained health workers at facilities.

HBC Volunteers Trained in Phase II:

Target:	**1,210**
Achieved:	**1,810**

Role of Nurse Supervisors in HBC: Nurse supervisors that are identified by project staff as focal persons to support and supervise HBCVs are paid 50 birr a month and generally make home visits to PLWHA twice a month. Monthly meetings between nurse supervisors and volunteers allow for experience-sharing and informal case management. Nurse supervisors sometimes accompany HBCVs and take ART to clients' homes if they cannot to come to health facilities to pick it up. Both nurse supervisors and volunteers collect medicines at pharmacies for immobilized clients.

Project staff reported that early in the project, when stigma was higher, HBCVs would transport PLWHA to health facilities where clients would be ignored by health workers. Staff recognized the need to train focal persons to ensure that clients would be properly cared for and volunteer efforts would not be in vain. Engaging nurse supervisor focal persons has been useful for both volunteers and clients. However, evaluators witnessed significant discrepancies in the capacity of nurse supervisors to provide emotional support and personal development strategies for volunteers. In the Dire Dawa region, nurse supervisors evidenced deep concern and compassion for clients and great appreciation for volunteers—one who is HIV-positive clearly identified with the feelings and concerns of clients. A nurse supervisor in the Adama area, however, actively discouraged the expression of emotions and advised volunteers to suppress their reactions. Care for the caregivers, particularly emotional support for managing this challenging work, seems to be an area that has not yet been well developed. SC/USA reportedly trains nurse supervisors in supervision skills, but evaluators were unable to review the curriculum.

Project offices facilitate quarterly meetings of nurse supervisors and HBC volunteers to review performance and strengthen linkage between community-based and facility-based services.

Role of Spiritual Counselors in HBC: Adding spiritual support to the HBC package gives comfort to PLWHA and has clearly been life-changing for the spiritual leaders who have assumed an educational and care-giving role. Evaluators met with Muslim, Christian Orthodox, and Protestant counselors ranging in age from remarkably young to elderly; their teamwork is inspiring. Spiritual leaders sometimes visit PLWHA along with HBCVs and nurse supervisors. Most project sites have two or three spiritual counselors who are also engaged as members of HIV/AIDS committees.

Spiritual counselors receive training similar to that for the HIV/AIDS committees; they credit the project with giving them skills to provide religious succor to clients. In some areas spiritual dogma was observed rather than spiritual exploration in relation to chronic illness, the meaning of illness, and the impact on beliefs. This may reflect either different training approaches or the

different capacities of spiritual support volunteers. Training in conflict management for spiritual leaders seems to be common and to be helpful in mediating domestic and community disputes. Where mobile VCT is conducted at church locations, spiritual counselors provide immediate support for people who test positive.

In most project-affiliated communities, churches and mosques fully support HIV/AIDS education for their congregations through public meetings as well as HBC. Stigma and discrimination were reported as much lower among religious congregations. Muslim spiritual counselors reported that previously HIV awareness was low and fear was high in their communities. Project staff helped them initiate monthly social gatherings where people came together and received factual information. After that, they visited homes of Muslim families to educate them about prevention and counsel them on how to support positive family members. In some corridor communities the madrasa schools are providing HIV prevention education to students and families.

In Hirna three spiritual leaders visit sick PLWHA as a close-knit team promulgating the Be Faithful message. They also participate together in HAPCO-initiated Community Conversations and use HIV prevention education to help stop female genital cutting (FGC) and uvula-cutting practices where shared cutting instruments could transmit HIV.

Role of Family Caregivers in HBC: HBC volunteers attempt to identify a primary family member who is willing and able to support the PLWHA. These relatives are given five-day family caregiver training on such topics as HIV/AIDS prevention, how to assess client needs, counseling for positive living and support for ART adherence, making referrals, physical care for sick clients, life-experience sharing, and networking. Identification of a caregiver ensures sustainable care for the patient and lessens dependence on HBCVs.

Nurse supervisors, spiritual leaders, family caregivers, and HIV/AIDS committee members trained to provide HBC to PLWHA in Phase II:

Target:	**2,001**
Achieved:	**3,719**

Palliative Care Components of HBC: National standards in palliative care, which are currently being defined and implemented, have emerged too late to be integrated into this project. Moreover, PEPFAR's expectations for palliative care to contribute to care and support in this project were unclear, from the level of program development down to volunteer activities. HBCV refresher trainings introduced volunteers to basic definitions of palliative care but not to palliative care counseling skills. This explains why HBCVs were able to describe components of palliative care but not demonstrate such skills during home visits.

Key aspects of palliation are pain management, spiritual and psychosocial care, and end-of-life care. Although Ethiopia has drug control policies and guidelines that support appropriate use of analgesics, a lack of palliative care–informed health workers results in misunderstandings about pain control methods and in inadequate pain relief. There are many similar settings around the world where access to analgesics (opioids and other agents) is limited by supply problems, regulatory issues, too few prescribers, inadequate training, habit, or other constraints. Pain relief alone does not constitute a palliative care service; that requires a holistic, multiprofession service that can provide care in the physical, psychosocial, and spiritual domains. Without any one of these, palliative care is compromised. Nor do programs that provide only supportive care, glossing over pain assessment and management, or that fail to deal with more difficult issues like suffering and death provide palliative care. A typology developed by the African Palliative Care Association (APCA) (Appendix J) would be a useful classification guide to assess palliative care services in Ethiopia as they develop.

No volunteers or supervisors interviewed by the Adama evaluation team were equipped to discuss with patients issues of death and dying or provide bereavement counseling beyond basic comfort. Training in emotional counseling generally seemed inadequate.

Because meaningful training in palliative care is absent, health workers and nurse supervisors also are not conversant with its approach. Training, supervision, and direct implementation of care of the seriously sick is therefore often drawn from personal experience rather than sound practice principles. This results in inappropriate care. It may also mean that harmful messages are conveyed, such as, "Stop crying, be strong, forget the deceased person."

Doctors receiving ART training from the International Center for AIDS Prevention, Treatment and Care Programs (ICAP) reported having two hours on the basics of palliative care as a subtopic. Health workers showed no evidence of knowledge about pain assessment and pain management. No levels recognized the palliative care concept of "total pain" and the WHO pain ladder. Palliative care as a term was recognized but often thought of as being the same as HBC, or occasionally as end-of-life care, and many believed it was only delivered in hospitals.

QA for HBCVs, Including Palliative Care: To evaluate QA for HBCVs, the evaluation team observed skills in the field and reviewed training manuals. Observations of several HBCVs, particularly in the Dire Dawa area, showed their compassion, dedication, and empathy for clients, and they gave practical care in the home, including washing clothes, cleaning house, and preparing food. Families and focus groups in some areas were asked about their preferred place of death. The majority responded that hospitals would offer the best facilities. When it was explained that home-based palliative care has the potential to provide a pain-free and emotionally, socially, and spiritually comfortable death with their family present, there was unanimous consent that a home death would be preferable.

Communication skills, such as questioning and probing techniques, were variable among the sites visited. Given the lack of practical training and supervision in counseling skills, this is not surprising; this training component deserves more attention. Nurse supervisors are expected to provide some QA because they visit the same clients being supported by volunteers, but this is not being documented.

Volunteers acknowledged that clients sometimes remained in pain despite being given paracetemol and found this distressing for both the clients and themselves ("I cry when I can do nothing about their pain"). Apart from referring clients to a health facility they did not appear to realize that pain can be controlled in other ways. A doctor in Adama who felt that pain was adequately controlled in his facility confirmed that he had personal fears and concerns about the use of opioids because "they can have an addictive effect."

Project staff in Awash acknowledged that "palliative care was brought in just about a year ago. It is in name only. We have made no change to what we were doing previously." This was confirmed by data collection forms that had not been changed to include palliative care.

Role of Food Support in Care and Support for PLWHA: Along the corridor, many PLWHA who are eligible for or receiving ART cannot afford the food that needs to be taken along with the medicine. In 2004 during the project mid-term review in the Dire Dawa region, a PLWHA who was interviewed told evaluators, "I have no food." As more people were identified as HIV-positive through vigorous testing campaigns, project staff realized the urgent need for nutritional support for ART adherence and in September 2004 developed a partnership with WFP, supported by USAID, to provide food supplements to the neediest patients. WFP agreed because the project met their requirements for integration of prevention, treatment, and care and support services and integration of food support with ART. Distribution is designed to provide food supplements for six months to give patients time to stabilize on ART and link with IGA opportunities.

WFP food distribution was exceptionally well organized. HIV/AIDS committees identified community storage facilities and distribution points and provided security guards. HIV/AIDS committees identify PLWHA on ART who are most needy to receive food support for six months to help stabilize their weight and enhance the benefits of ART. Families taking care of OVC were also able to receive rations for up to three children under 18. HBCVs until recently also received food in lieu of payment for their work. Health centers use a referral form for patients (including PMTCT patients) eligible for WFP food distribution. Patients must bring this form confirming the date of their last clinic visit and receipt of their ART prescription to the distribution site. The distribution program includes WFP-funded training by project staff to teach recipients how to cook the food supplements they receive. While the project's involvement as a crucial partner in the distribution program ends in August 2008, both USAID and WFP have pledged to continue food distribution in the current areas of activity. Since WFP must have an NGO partner to carry it out, it is not clear to evaluators how this will happen.

Reasons for nonadherence to ART are commonly related to lack of food; either PLWHA believe they should stop taking ART if they are unable to eat regular good meals, or they continue taking ART without enough food, suffer physical discomfort and diarrhea, and eventually become too ill to continue. Field visits confirmed that the majority of food program recipients have no future food security after their eligibility ends. This presages a major negative impact on the health of families who have been involved with the project. One doctor suggested that without food support patients will "just give up hope." Unless beneficiaries are linked to IGA projects that can increase their capacity to source food, benefits from this program will erode rapidly. Clearly, providing ART services without food support and income-generation opportunities is not enough. Beneficiaries also need support to put in place alternative food access after their eligibility ends.

At some project sites HIV/AIDS subcommittees have partnered with local hotels and private business owners to provide food daily for a limited number of PLWHA. This practice has sustainability and expansion potential.

Beneficiaries receiving WFP food support in Phase II

PLWHA	**Target:**	**1,809**	**Achieved:**	**1,705**
OVC	**Target:**	**5,747**	**Achieved:**	**5,406**
PMTCT clients	**Target:**	**272**	**Achieved:**	**181**
HBCV:	**Target:**	**291**	**Achieved:**	**180**

Care and Support Services and PLWHA Quality of Life

In focus group and individual conversations, care and support services were identified as the most beneficial aspect of the project. Through HBC families have been taught about HIV/AIDS, basic nursing skills are provided at home, and counseling and spiritual support provide comfort. Beyond the practical care and support components, psychosocial support for positive living has also been generally well implemented, although there were many interpretations of what constituted psychosocial care and volunteers have not been well trained in these skills.

Specific information for those who are HIV-positive about prevention of transmission and nutritional advice was available. PLWHA who took part in positive living training told trainers that until they received training and better understood HIV disease, they had been hiding and waiting for impending death and had no hope for the future. The training seems to have had a profound positive effect on participants, giving them hope and motivation to volunteer in HIV prevention and support activities. Many PLWHA reportedly stopped using chat and alcohol after the training and experienced a significant improvement in quality of life. CSWs demonstrated that

this component has been implemented, with good understanding of prevention strategies, and with further training on nutrition and how to run cafeterias.

The spiritual aspect of psychosocial care has been delegated to spiritual leaders from all major faiths. In Hirna, spiritual leaders use their close working relationship to model the concepts of acceptance and good communication. It appeared that spiritual questioning and exploration in relation to chronic illness, the meaning of illness, and the impact on beliefs is, however, not yet part of services for PLWHA.

How Care and Support Services Benefited Families

> "SAVE changed the situation from family members hating each other to supporting each other."

In 2007 the HRCI OVC activities were transferred to the USAID-funded PC3 project. As far as possible, the two projects integrate to avoid duplication of services. FHI, which trains PC3 HBCVs, has adapted the MOH manual and begun to integrate elements of family-centered palliative care. Volunteers are selected by iddirs and work with national NGOs, such as MEKDIM, to implement activities.

PC3 is not in fact mandated to provide palliative care, so it links with HRCI, which does have that responsibility. The PC3 target population is OVC identified by three criteria (child living with bedridden parent/s, households of PLWHA, OVC who are chronically ill). Project training and services include grief counseling. As a result of the linkages between the projects, care has been provided for the whole family, but it is unclear how much the two collaborate in securing the best counseling for whole families. Site visits in Adama and Awash demonstrated that children's needs and emotions are often ignored in home visits by HRCI volunteers. A family-centered approach was generally absent. There are few child patients registered through HRCI.

However, the HRCI project does provide uniform and school materials support to OVC. HBC volunteers, iddirs, and spiritual leaders also track the OVC in their area and know which local NGOs are supporting them. Many HIV/AIDS committees actively fundraise on behalf of the OVC in their area, and some help with sponsorships and adoptions.

At all evaluation sites PLWHA and HBC volunteers reported that more PLWHA have been able to stay with their families because stigma and discrimination have been reduced. ART has helped many beneficiaries to regain their health and productivity and once more support their families. HBCVs and social gathering education help uninfected family members to protect themselves from risks. Family caregiver training complements support by HBCVs, promotes family caring, and motivates family members to learn their own HIV status.

The formation of PLWHA associations, particularly those working as IGA cooperatives, has benefited families in terms of legal support and income-generation opportunities.

Care and Support from Communities

Evaluators observed several examples of communities taking up responsibility for care and support for OVC and PLWHA:

- Iddirs are expanding their support for OVC beyond funeral costs and arrangements.
- At least two AACs are providing financial and social support for OVC.
- Some IGA cooperatives have made a commitment to care for any orphaned children of members, and PLWHA associations are looking at ways to further support OVC.

Key Lessons for Strategic Objective 3

- Care and support plays a key role in reducing stigma and helping PLWHA to access ART.
- PLWHA identify HBC as one of the most meaningful support services.
- HBCVs are deeply committed but need support and extended training to continue their essential work.

Strategic Objective 4: To Increase the Livelihood Security of People and Children Infected and Affected by HIV/AIDS

How IGAs Improve Livelihoods for PLWHA

The HRCI project has linked PLWHA with local enterprises, such as GASHA Microfinance Share Company and local offices of the Federal Micro and Small Enterprises Development Agency, to maximize IGA training and seed money for PLWHA who want to generate income.

The numbers of PLWHA benefiting from the IGA component of the project are low compared to the total number of people reached by other project activities. Appendix F details the number of PLWHA engaged in IGA activities supported by the project.

The project has taken two different IGA approaches:

- Cooperative ventures, such as CAAP in Adama, where 20 PLWHA run various agricultural activities; CSW collectives that run cafeterias; and groups of PLWHA working together on brick making and animal fattening
- Individual ventures (e.g., owning a Pepsi shop, making injera, fattening sheep)

The WAR program has a comprehensive approach to providing alternative livelihoods for CSWs. Beyond providing income for participants, this program offers numerous behavior change and personal development strategies to ensure the sustainability of alternative lifestyles. This seems to be the best-developed IGA strategy within the project, and because WAR is not dependent on the project there is potential that ex-CSWs will be able to sustain their change of lifestyle.

PLWHA groups working in cooperatives open group bank accounts and generally have basic operating rules or committees and agreements about how finances will be managed. They must be careful to manage the funds transparently, and they even offer small stipends to keep members motivated.

With a few exceptions, IGA cooperatives are not yet in a position to provide dividends to members. PLWHA engaged in IGAs and interviewed in focus group discussions reported profits to date that are barely sufficient to support a family. Expansion of activities depends in some cases on greater investment in start-up resources and in others on finding customers for the new enterprises. There were reports in Bishoftu that offers from the HIV/AIDS committees for IGA

support had been rejected because the seed money of 1,000-2,000 birr was thought to be inadequate to start a successful business.

IGA beneficiaries are selected by HIV/AIDS committees based on established criteria; overall, there seem to be more female than male beneficiaries. However, a local NGO operating a cooperative of PLWHA women running an agricultural venture has a male manager and a male nurse as staff. Of three paid positions two are occupied by males; the 20 women members have yet to receive any dividends.

Are IGA Activities Sustainable and Replicable?

IGA activities visited seem to have the potential to be sustainable despite reaping small profits. PLWHA want to work and support their families, but because so many IGA activities are in start-up or early stages, without additional continuing support their potential for success may not be realized.

One IGA recipient who succeeded in obtaining loans from other organizations was able to expand her Pepsi shop into a thriving grocery store, demonstrating that with sufficient investment an IGA activity can produce solid results. For such success stories to be replicable, larger amounts of seed money are required, together with more intense business training.

A three-day training on micro-finance and record-keeping has been given beneficiaries of IGA initiatives to build their business skills. IGA participants interviewed said that this had been helpful but expressed a desire for more skills training.

Some of the project-affiliated IGA cooperatives have made a commitment to support any children orphaned by their members. Discussions are also underway in some cooperatives about how to integrate OVC older than 15 into skills-building and IGA activities, but no clear plan to do so is yet in place.

At some project sites, local hotels have provided jobs for PLWHA. While this is certainly helpful, it is too soon to assess the replicability of these opportunities.

Key Lessons for Strategic Objective 4

- Access to ART is improving the health of many PLWHA who want to work and support their families.
- IGA activities have the potential to improve income and quality of life for many PLWHA, but many IGAs require continuing technical support and assistance in linking with customers. Much of the potential for self-sufficiency may be lost if support is discontinued.

Strategic Objective 5: Incorporate Cross-cutting Themes of Gender, Stigma Reduction, and Community Strengthening into all Project Activities

Gender: The project has demonstrably benefited both males and females, and probably more females, given that in Ethiopia more women than men are HIV–positive, and the project focused on CSWs. Opportunities to educate project staff on gender issues were not realized.

Stigma Reduction: Stigma reduction is clearly one of the project's shining accomplishments, indeed perhaps its most successful one. Although some credit needs to be given to concurrent anti-AIDS campaigns, HRCI has reduced stigma through the combined efforts of HIV/AIDS committees, peer educators, HBCVs, PLWHA, health facility staff, and spiritual leaders. Integrated strategies that have helped reduce stigma include

- Community education that "normalizes" HIV

- Integration with municipal and civic structures that have responsibility for HIV/AIDS issues in towns along the corridor and provide unified support for PLWHA and OVC
- Client/family education by HBCVs, nurse supervisors, and spiritual counselors
- Distribution of educational materials and condoms
- Peer education for multiple at-risk populations (CSWs, youth, truck drivers)
- Widespread community testing
- Access to ART and the resultant improved health
- Integration of PLWHA and HIV-negative educators.

Community Strengthening: Various project documents reviewed contain indicators for strengthening communities and related M&E. It was apparent that communities had been reinforced on several fronts, including M&E, which has implications for the sustainability of the benefits of the project. Community strengthening strategies have included

- Training:
    1. Capacity-building for HIV/AIDS committees in team building and conflict management
    2. Financial management and leadership training for HIV/AIDS committees and PLWHA associations
    3. Proposal writing for HIV/AIDS committee fundraising subcommittees
    4. Training on IGA management and entrepreneurship for the IGA subcommittees of HIV/AIDS committee and for beneficiaries of IGA ventures.
- Strategic selection of HIV/AIDS committee members to represent a cross-section of community stakeholders, including iddir, kebele, and woreda leaders; health bureau and health facility managers; and religious leaders
- Strategies to increase volunteerism, including some small incentives but primarily focused on reducing stigma and increasing compassion and collective concern
- Development of excellent relationships with partners, and project staff modeling of compassionate care and support.

Community strengthening was evidenced by

- A sense of volunteerism at the community level, and a sense of ownership for responding to the needs of community members affected by HIV/AIDS
- Strong networks of local stakeholders, starting with their membership and participation on HIV/AIDS committees
- Spontaneous community responses beyond project parameters, e.g., an older Pepsi shop owner becoming counselor of choice for PLWHA and referred to as an expert patient by hospital staff; and PLWHA electing to disclose their status during social gatherings and becoming HBCVs to help others to access ART.

Committee members reported that the conflict management skills they learned have been used to resolve committee and community disagreements. Spiritual leaders have found the training beneficial when called upon to mediate family disputes.

Positive Living trainings for PLWHA have greatly increased their sense of hope and collective responsibility for helping educate the community and support fellow PLWHA.

The town of Hirna is considered to be a project Center of Excellence. Appendix G describes how Hirna has emerged remarkably stronger from the HRCI project.

Key Lessons for Strategic Objective 5

- Testing, treatment, and care and support services are benefiting both women and men, and both are actively participating in the community response to HIV and seem to be working well together. Gender issues are expected to be a key topic in the Community Conversations being implemented nationwide.
- The project has achieved outstanding results in reducing stigma.
- Communities have clearly benefited from the project. The formation of HIV/AIDS committees has ensured wide representation and ownership of the HIV response.

Main Challenges/Weaknesses

Quantitative Data: There are unfortunate gaps in data related to accomplishments during Phase II. Also, some data have been compiled in ways that make it difficult to know how many MARPs were reached (e.g., truck drivers have been folded into the larger category of mobile populations reached through prevention activities). Adding to data confusion is the fact that some PEPFAR targets were apparently changed by the second agreement. Quantitative data inserted throughout this report represent the evaluators' best repeated efforts to collect numbers that accurately reflect project accomplishments.

Significantly Lower Referrals to STI Services than Targets, and Lack of Information on Utilization: Project staff explained that since STI services are no longer specifically tracked at health centers, it is difficult to access complete data. Nevertheless, the general impression is that STI were not given as much attention as ART and OI during Phase II.

Limited Data on Access of MARPs to VCT: Evaluators were unable to access the occupation summary data collected by health facility VCT centers. It should be possible to find out from these data how many truck drivers and youth are testing, so it seems useful that HAPCO review the data.

MARPs Not Adequately Included in Design of Prevention Strategies and Materials: Representatives of the Ethiopia Truck Drivers Association[5] who were interviewed have felt sidelined; they expressed a desire to be contacted by the HRCI project and to become actively involved by leading campaigns directed to high-risk members in the corridor. Their organization applied to establish an office for this purpose in Djibouti, but there has been no official sanction.

Highly Mobile Populations: The major challenges are attrition and difficulty in tracking post-training contributions of mobile populations. This is particularly true for CSW peer educators; it is impossible for the project to know how many peers mobile CSW peer educators have trained in HIV prevention. It is equally difficult to document whether truck drivers who are picking up condoms at ICs use them consistently while traveling.

Emotional Support Needs of Volunteers: Care for the caregivers seems to be a project area that is underdeveloped, apart from monthly experience-sharing. Because HBCVs who visit poor and sick clients will inevitably experience emotional stress, regular skilled support for them should be

[5] Ministry of Transport, 5th Floor, Addis Ababa.

part of any future project, especially techniques for volunteers to reduce stress and for nurse supervisors to recognize burn-out and respond appropriately.

Difficulty in Assessing Training QA: Project training seems to adhere to national guidelines in terms of content, but there are unanswered questions about its quality. The skills and experience of trainers vary widely by location and training content. In Dire Dawa all trainings were videotaped; these DVDs are a potential source of QA for evaluators who speak Amharic.

Inability to Assess QA for HCT Laboratory Protocols: Evaluators were unable to visit health facility laboratories.

Shortage of Prevention Education Materials: Several sites expressed concern about their limited ability to replace materials, and materials were evident at one suboffice that could have been distributed to ICs. Helping HIV/AIDS fundraising committees to budget and raise funds for photocopying expenses would be a useful exit strategy.

Non-Implementation of Palliative Care: As already discussed, palliative care was not part of this project. Attempts to reframe and capture data under "basic palliative care" and "components of palliative care" when there is no true palliative care are inappropriate and not in the best interests of clients.

MAJOR ACHIEVEMENTS AND OUTSTANDING ACCOMPLISHMENTS

Major Achievements

The HRCI project has garnered many successes, most obviously

- A firm sense of community ownership
- Dramatically increased awareness of HIV prevention in the general community and among CSWs, truck drivers, and youth in and out of school
- A noticeable increase in uptake of VCT services by both the general community and CSWs
- Increased demand for and comfort with condoms
- Decreased stigma and discrimination, confirmed by those vulnerable to both
- Increased access to ART (linked whenever possible with food support)
- Better health for many PLWHA as a direct result of HBC referrals to ART and subsequent HBC and food support
- Decrease in the number of AIDS deaths
- Material support for OVC, including school supplies, food through the WFP partnership, and additional support through linkages with the PC3 project
- Regular (at least monthly) experience-sharing among HIV/AIDS committee members, VCT counselors and health facility managers, health bureau officials, HBCVs, nurse supervisors, PLWHA, and other volunteers where they can talk forthrightly about experiences, successes, and needs. In these meetings beneficiaries with special needs are identified and the progress of OVC is discussed. These open meetings help to explain why stakeholders are able to provide detailed information about current project activities.
- Remarkably high levels of community solidarity, compassion, and deep concern for PLWHA and at risk groups: Project volunteers understand the value of an integrated approach that

combines prevention, treatment, and care and support and have been very resourceful in linking with partners and sharing information to ensure maximum use of resources.

- Prevention activities that run through all project components. Primary prevention messages and strategies have been developed for youth, truck drivers, and CSWs, and secondary prevention messages for PLWHA and their families.
- Exemplary partnerships with health facilities, town administration offices, and churches and mosques that deserve to be shared as a global best practice: The multiple levels of strategic integration within the project are also outstanding and worthy of replication elsewhere.

Particularly Outstanding Accomplishments

Sustainable Life Changes for CSW Through IGA Activities and Personal Empowerment: CSWs involved with the WAR Ellilta Project have made firm decisions not to re-engage in sex work even though the profits from that work are considerably higher than the income they generate through their café work. One worker told the evaluation team, "If this project doesn't work, I would become a house servant rather than go back to being a CSW."

Strategic Integration of Activities at Multiple Levels: Evaluators witnessed effective integration of program strategies and services, including

- Primary and secondary prevention education through public gatherings, training, and HBC
- Education and stigma reduction through social gatherings and public disclosure of HIV status by PLWHA educators
- HIV-positive and HIV-negative educators
- Religious organizations as spiritual leaders working cooperatively in teams
- Beneficiaries and caregivers as PLWHA become HBC volunteers
- Prevention, treatment, and care and support services woven tightly together
- Project activities with HIV responses being implemented by HAPCO, kebeles, woredas, iddirs, and civil service offices, including Community Conversations
- OVC care and support into PLWHA association activities (e.g., provision for orphaned children of association members)
- Government and private NGO microfinance programs
- Health facilities and the community.

Changes in Social Norms: In Hirna HIV/AIDS committees proudly shared the following changes in social norms that they believe have resulted from the combined efforts of the project's social gathering education, the collaborative work of spiritual counselors, and participation in local Community Conversations[6] now being rolled out nationwide by HAPCO:

- "No testing, no marriage": In Hirna the entire community has agreed that all couples wanting to marry should first undergo HIV testing; religious leaders encourage couples to test as part of premarital counseling. This has reportedly reduced wife inheritance, since some widows or brothers-in-law prefer not to test and therefore do not marry.

[6] Community Conversations is a community mobilization process used globally to facilitate discussions about HIV that allow community members to talk frankly about HIV/AIDS, bypassing traditional age and gender restrictions.

- Reduced FGC and uvula-cutting in children: Two factors have apparently influenced this reported reduction in harmful cutting practices: education about the HIV transmission risk associated with shared cutting instruments, and Community Conversations in which it is explained that these practices are no longer legal.

III. IMPLICATIONS FOR SUSTAINABILITY, AND RECOMMENDATIONS

COMPONENTS THAT MAY BE REPLICABLE IN OTHER CORRIDOR COMMUNITIES

- VCT services are now managed by HAPCO, and the introduction of PICT has strengthened HCT at health facilities.
- There are strong linkages with public sector offices, health offices, NGOs, FBOs, regional HAPCO, kebeles, woredas, and iddirs.
- Some ICs are now supported by town administrations.
- Town administrations have provided land for PLWHA cooperatives and for low-cost housing for PLWHA.
- Local offices of the Federal Micro and Small Enterprises Development Agency are supporting PLWHA cooperatives.
- MOHA is providing private partner support for Pepsi stands.
- The YAK program has been successfully introduced into schools and endorsed by the Ministry of Education.
- Churches and mosques are addressing HIV/AIDS and educating their members.
- Local individual private businesses are providing
  - Food three times a day for a limited number of PLWHA
  - Three days' income for part-time employed PLWHA
  - Other job opportunities
  - Donations to HIV/AIDS committees
  - Support for IGA activities.

Replicable activities to support PLWHA that are not attributable to the project:

- 2 percent national tax allocated for HIV/AIDS
- Bank accounts opened in civil service offices for employees affected by HIV
- 1 birr additional payment on ID cards from kebeles
- Rollout of Community Conversations by HAPCO in many rural communities
- Commitment of government offices to mainstream HIV/AIDS policies

END-OF-PROJECT CONCERNS

Because the project has successfully increased demand for HIV testing along the corridor, many new PLWHA are being identified. Currently, in fact, the increased demand for treatment and care and support services, which was another goal of this project, is outstripping capacity.

HBCVs require some minimal support for transport stipends and HBC kits. Spiritual counselors and nurse supervisors also need monthly transport stipends to be able to visit clients. Without this support, effective HBC activities established by the project are likely to falter.

ART and food must go hand in hand. It is clear that people are less likely to adhere to ART if they do not have enough food. Ethiopia's ART regimens should be taken with food, so continuation of food support is crucial. While USAID and WFP have expressed a commitment to continue distributing food in project sites, there are no obvious NGO partners who can replace SC/USA in supporting food distribution along the corridor.

Many new PLWHA cooperatives and IGAs are not yet ready to succeed without minimal technical and financial support. Their promise for sustainability may thus not be realized.

IMMEDIATE RECOMMENDATIONS

1. The project should be continued.
2. If this is not possible, the team recommends an extension or transition agreement with SC/USA that will continue until follow-up project redesign, tendering, and partner selection have been completed. Even though many project staff members have already left in anticipation of losing their positions, this still seems the best way to continue urgently needed support for HBC, food distribution, and support to IGAs.
3. Alternatively, we recommend that a minimal package of support be deduced from the current project budget, sufficient to support HBC with transport stipends and kit supplies, food distribution costs, and IGA support, and that SC suboffices (rather than project offices) manage the interim funding to ensure that essential project activities do not unravel.
4. Regardless of whether the previous recommendations are followed, we encourage project staff to work closely with all partners, volunteers, and beneficiaries over the next three months to plan sustainability strategies, such as
   - Plans to fund replication of prevention education materials
   - Exploration of linkages to other NGOs for HBC volunteers
   - Agreements for microfinance programs to provide support to fledgling IGAs
   - Negotiations with town administrations to take over support for ICs
   - Expansion of local partnerships with private industry (hotels, cafeterias) for food support and with small businesses to do business with PLWHA IGAs
   - Provision of final facilitation and management skills trainings to HIV/AIDS committees and ICs that are not yet functioning optimally. Mentor relationships should be explored between the best-functioning groups, such as the Hirna HIV/AIDS committee, and weaker groups.

RECOMMENDATIONS FOR FUTURE PLANNING

- Explore partnerships with large private industries in Ethiopia; pharmaceutical industries in particular are potential partners to supply (close to expiry or other) drugs and supplies.
- Explore partnerships with corridor-linked businesses, such as tire manufacturers, vehicle manufacturers, spare parts businesses, and shipping agents. A dynamic corporate approach is recommended.

- Expand local partnerships with private partners (hotels, cafeterias) for food support and with small businesses to contract with IGAs for livelihood support.
- Coordinate with UCSD and I-Tech in Addis Ababa, which are driving the palliative care agenda in Ethiopia. Involvement in national training of health professionals and support for palliative care integration into HBC trainings is crucial if PLWHA and their families are to benefit from palliative care. Adding to the pain control lobby through UCSD will also reap benefits for patients in pain once opioids are more easily accessible through the mainstream health system.
- Continue to build the skills of HBCVs and nurse supervisors with palliative care training that meets emerging national standards.
- Include "care for the caregiver" in training for HBC volunteers, family caregivers, nurse supervisors, and spiritual counselors.
- Provide regular skilled support for volunteers who make home visits to sick clients.
- Include at-risk target populations in project design and implementation to ensure that prevention strategies and messages are appropriate for them.
- Negotiate with community organizations to continue funding for coffee ceremonies and other low-cost social gatherings that have been effective in reaching large numbers of people with prevention education.

The evaluators are grateful to have had the opportunity to witness the community spirit that has grown as a result of the HRCI project. We have witnessed extraordinary levels of compassion and commitment. We have also heard from volunteers and beneficiaries at every site we visited that losing project funding just when VCT and condom demand are high, the need for ART and care and support services is high, and new PLWHA cooperatives are still in need of support will profoundly undermine community morale and momentum. We sincerely hope that USAID will consider the best ways to protect its seven-year investment, and we hope that the significant gains made by this project will not be eroded.

APPENDIX A: SCOPE OF WORK

USAID/Ethiopia President's Emergency Program for AIDS Relief (PEPFAR)
Statement of Work (SOW) for End-of-Project Evaluation
High Risk Corridor Initiative
(Revised 04-6-08)

PROJECT IDENTIFICATION DATA

1. Project Title: Positive Change: High Risk Corridor Initiative
2. Project Number: Cooperative Agreement No. 663-A-00-01-00350-00
3. Project Dates: February 2001–September 2008
4. Project Funding: $6,972,186
5. Implementing Organization: Save the Children, USA
6. Cognizant Technical Officer (CTO): Dr. Omer Ahmed

I. IDENTIFICATION OF THE TASK

The USAID/Ethiopia (USAID/E) PEPFAR office requests technical assistance from the Global Health Technical Assistance Project (GH Tech) to design and implement an independent external end-of-project evaluation of the High Risk Corridor Initiative (HRCI). The HRCI has been implemented in 24 towns in five regions along two main trucking routes: Addis Ababa–Nazereth–Awash–Galafi–Djibouti border and Addis Ababa–Nazereth–Awash–Dire Dawa–Djibouti border. The high-risk corridor includes the Amhara, Afar, Oromiya, Dire Dawa, and Somali Regions.

The program has the overall goal of reducing the transmission and impact of HIV/AIDS, with three main objectives: strengthen prevention strategies for effective behavior change; strengthen and expand accessibility to and availability of voluntary counseling and testing (VCT) and sexually transmitted infection (STI) services; and increase access to care and support services for persons living with HIV/AIDS (PLWHA). This external end-of-project evaluation will determine the success and impact of the HRCI in achieving these three main objectives.

The USAID/E PEPFAR office requests that the in-country components of this evaluation be fielded by o/a July 2, 2008, in order that the findings, conclusions, and recommendations can be used in the planned redesign of future programs for most-at-risk populations (MARPs) along the Addis–Djibouti transport corridors.

II. BACKGROUND

USAID/E Response to HIV/AIDS: From 2004 through 2006, an estimated 288,000 Ethiopians died from HIV/AIDS-related causes. The 2007 Federal estimate[7] of national HIV prevalence is 2.1%: 7.7% in urban areas and much lower in rural areas at 0.9% (FHAPCO, 2007). As of 2007, almost one million (977,000) Ethiopians were estimated to be living with HIV (FHAPCO, 2007).

[7] *Federal HIV/AIDS Prevention and Control Office (FHAPCO), Single Point Estimates of HIV and OVC Indicators, April 5, 2007.*

Recent Antenatal Care (ANC) and Ethiopia Demographic and Health Survey (EDHS) analysis reveal a more concentrated urban HIV epidemic in Ethiopia than previously believed. Representative survey data for Ethiopia imply a predominantly urban epidemic that is likely to be concentrated among higher-risk populations.

Based on the new prevalence information and behavioral data, PEPFAR Ethiopia's prevention strategy prioritizes expansion of outreach activities to MARPs and expanded/new HIV prevention activities for both the general population and high-risk groups in urban areas and along major transportation corridors.

Despite the seriousness of the epidemic, there have nonetheless been some positive trends. EDHS (2000 and 2005) data on behavioral indicators related to abstinence, being faithful, and condom use (ABC) have all shown significant improvement over the recent five-year period. Reported premarital sex among men 15–19 decreased from 8% to 4%, and among men 20–24 decreased from 21% to 13%. Reported premarital sex among women 15–19 decreased from 4.0% to 1.0%, and among women 20–24 decreased from 16% to 3%. Reported condom use at last higher-risk sex increased among men 15–49 from 30% to 52%, and among women 15–49 increased from 13% to 24%.

The U.S. Mission to Ethiopia's HIV/AIDS interagency team, composed of the Department of State, the Department of Defense, the U.S. Centers for Disease Control and Prevention, and the U.S. Agency for International Development (USAID), began integrated HIV/AIDS programming in 2004 under the oversight of the Office of the Global AIDS Coordinator. Peace Corps joined the PEPFAR team in early 2007.

The U.S. Mission collaborates with a number of Ethiopian government agencies: the HIV/AIDS Prevention and Control Office; the Ministry of Health; the Ministry of Finance and Economic Development; the Ministry of Youth and Sports; the Ministry of Women Affairs; the Ministry of Education; and the Ministry of Labor and Social Affairs.

USAID responds to HIV/AIDS as part of PEPFAR in collaboration with the Ethiopian Government and numerous other partners. USAID supports prevention, care, and treatment activities with a combined FY06 program budget of over $122 million.

USAID Integrated Strategic Plan FY 2004–2008 and the 2007 Foreign Assistance Framework: USAID/Ethiopia's HIV/AIDS programs were initiated under the USAID/E Integrated Strategic Plan (ISP) for the period FY 2004 to FY 2008 under the strategic objective (SO) *SO 14: Human Capacity and Social Resiliency Increased* and *SO 14.2: HIV/AIDS prevalence reduced and mitigation of the impact of HIV/AIDS increased*. In 2007, SO14 was incorporated into an alternate Foreign Assistance Framework (F-Framework) for the USAID 2007 Operation Plan.

Activities under the HRCI now fit under the F-Framework Objective, *Investing in People*, Health Program Area, Program Element HIV/AIDS, within the Program Sub-Elements for Condoms and Other Prevention Activities, Counseling and Testing, and Palliative Care: Basic Health Care Support.

III. OVERVIEW OF THE HIGH-RISK CORRIDOR INITIATIVE

USAID/Ethiopia issued a Cooperative Agreement (CA) in July 2001 to Save the Children Federation, USA (SC/USA) to support a program entitled "High Risk Corridor—HIV/AIDS/STDs Prevention for Ethiopia and Djibouti." The High Risk Corridor stretches almost 1,000 kilometers from Addis Ababa to Djibouti City along two main routes. There are 27 communities along these routes, of which 25 are accessible based on security considerations. First planned as a prevention program for three years (2001–2003) to reach mobile groups at highest risk of HIV transmission, the initiative was modified in August 2002 to expand its scope and

become a comprehensive program that encompasses the continuum of care from prevention demand and practices to care and support for PLWHA and OVC.

The goal of the program is to reduce the transmission and impact of HIV/AIDS along the two main corridor routes. More specific objectives include:

- To increase HIV/AIDS prevention practices and demand for services.
- To improve the availability of prevention and treatment services for HIV, AIDS, STIs, and opportunistic infections (OIs).
- To improve the availability and quality of care and support services for people living with HIV and AIDS and orphans and vulnerable children.
- To increase the livelihood security of people and children infected and affected by HIV/AIDS.

The program focuses on several target populations: higher-risk youth (including street youth, commercial sex workers, in and out of school youth, unemployed, sexually vulnerable girls); mobile higher-risk groups (transport workers and assistants and commercial sex workers); influential leaders; employed civil service personnel; and groups affected by HIV and AIDS, PLWHA, and orphans and vulnerable children (OVC).

The HRCI has used a two-pronged approach to achieve its objectives with these target populations:

Prevention Strategies

- HIV/AIDS Information Centers
- Behavior change communications (BCC) material development
- Training peer educators
- Awareness raising with hotel and bar owners
- Curriculum-based information for truck drivers
- Improving access to and capacity of VCT and STI and OI treatment
- Strengthening partnership-defined quality (PDQ) at health facilities along the routes.

Care and Support Strategies

- Home-based care (HBC) for chronic debilitating illnesses
- Psychosocial support and positive living for PLWHA
- Community-based child care centers (CBCCC) for OVC
- Material support for OVC.

The program was initially for a 27-month period, through September 30, 2003, for a total life-of-activity amount of US$1,905,211 of USAID and US$196,000 of SC/USA resources.

The CA has been modified nine times, including:

- Modification #2 (09/04/02) (i) provided $1,068,695 in incremental funding; (ii) amended the program to add a new component for follow-on HIV/AIDS care and support in the corridor; (iii) increased the total estimated life-of-activity amount to US$3,062,186 in USAID and

$757,500 in SC/USA resources; (iv) extended the completion date to September 30, 2004, and

- Modification #5 HRCI Program Extension for FY 2005 incorporated the HRCI within PEPFAR-funded program activities.

The HRCI Program Extension for FY 2005: Given the positive results of the HRCI program, PEPFAR Ethiopia proposed an extension to the HRCI program under Track 2 funding. The proposal was approved in May 2004 as a Track 2 one-year extension, with the understanding that USAID would include plans for further work under its longer-term PEPFAR 5-Year Plan that was prepared in August–September 2004.

The geographical areas in which the HRCI works in Ethiopia were integrated into the PEPFAR program. The HRCI was asked to continue to work through partners at the community and public health clinic level. The communities were expected to get expanded access to the public health clinics, which in turn were to be linked into 25 central medical centers. By March 2005, under the Track 2 extension, the HRCI-supported activities were to contribute to achieving the PEPFAR Year One Targets shown in Table 1 below:

TABLE 1: HRCI TARGETS FOR PEPFAR YEAR ONE	
Prevention Component	
Infections averted (non-PMTCT) – Total PEPFAR*	58,000
HRCI high-risk youth (target population reached)	51,200
HRCI mobile populations (target population reached)	18,500
HRCI sex workers (target population reached)	6,000
HRCI VCT facilities supported	22
Number of lab technicians trained	44
Number of clients reached through VCT	17,000
Care and Support Component	
Palliative care—Total PEPFAR*	32,000
HRCI number of home-based care (HBC) volunteers trained	160
HRCI number of PLWHA receiving HBC	1,000

*Data are to be modeled by PEPFAR. HRCI is not responsible for calculating this target itself but will contribute to achieving it.

The HRCI was to continue to apply its two-pronged approach, described above, complemented by the development of partnership strategies. The HRCI was asked to coordinate closely with other PEPFAR partners to ensure a standard approach to community-based care and support. This coordination was expected to include active participation in the PEPFAR Care and Support Working Group.

There were four significant differences in the program under the FY 2005 HRCI Program Extension:

- **Activities were limited to Ethiopia as of April 2005:** No Ethiopia PEPFAR funding was allocated to the Djibouti Field Office or activities. USAID advised SC/USA to actively seek other support.

- **Funding for OVC support was not included in the extension**. SC/USA received a separate award under PEPFAR Track 1 funding for OVC work in Ethiopia and was encouraged to use the Track 1 resources to continue OVC work along the corridor. There are no Track 2 PEPFAR funds available for OVC under this CA extension.
- Funding for Clinical Quality Improvement in Health Facilities, except for interventions to improve VCT and STI access, quality, and use, was not included. SC/USA was expected to build upon its considerable comparative advantage in community-based mobilization for prevention and care and to establish linkages with other USG-funded partners with more experience in clinical care.
- **Funding was allocated for four specific intervention categories**: Cross-cutting the two primary program components of "Prevention" and "Care & Support," the PEPFAR funding that supported the FY 2005 extension was allocated into four components: **Abstinence** ($400,000); **Voluntary Counseling and Testing** ($255,000); **Other Prevention** ($85,000); and **Care and Support** ($170,000). SC/USA was expected to allocate staff and management time accordingly. As of COP 07 the funding allocation changed as follows: **Abstinence** ($800,000); **Voluntary Counseling and Testing** ($132,000); **Other Prevention** ($800,000); and **Care and Support** ($374,000).

TABLE 2: HRCI ANNUAL TARGETS: FY 2005–FY 2008

	FY 2005	FY 2006	FY 2007	FY 2008
Prevention Component				
High-risk youth reached	25,000	75,000	110,000	160,000
Mobile populations reached	40,000	30,000	45,000	65,000
Sex workers reached	6,000	6,500	7,000	7,500
VCT facilities supported	22	24	25	27
No. of laboratory technicians trained	44	48	50	54
No. of clients tested through VCT	17,000	25,000	40,000	50,000
No. of clients treated for STI	1,700	2,500	4,000	5,000
Care & Support Component				
No. of HBC volunteers trained	160	250	300	500
No. of PLWHA receiving HBC	1,000	2,000	2,500	4,000

The HRCI was strongly encouraged to incorporate three cross-cutting themes into all of its program planning, achievements, and monitoring and evaluation (M&E): Gender, stigma, and community (see page 7 of Modification # 5 for details).

Given the importance of the high-risk corridor, the strong results achieved by the HRCI, and the endorsement by the Office of the Global AIDS Coordinator (OGAC) to integrate the HRCI into the Ethiopia Country Operation Plan (COP) for year 1, USAID/E extended the HRCI through the PEPFAR planning period of FY2008 subject to continued availability of funds and satisfactory performance. Indicative targets for the extension are shown in Table 2 below:

Monitoring, Evaluation, and Reporting: SC/USA is expected to continue to provide comprehensive monitoring, evaluating, and reporting (MER) on achievements and impact throughout the extension period. Specific data required are of two types: (i) those that report on progress toward recipient-proposed milestones and targets under the CA shown in Table 2; and (ii) those that measure PEPFAR HIV/AIDS indicators. All HRCI indicators are required to be disaggregated by gender. Currently, the HRCI reports on the indicators shown below in Attachment 1 in aggregate.

Emerging Program Issues: Based on site visits and other sources over the past two years, four areas of concern have emerged:

- **Need for renewed focus on MARPs at the partner level:** There is a concern that the project needs to increase its numbers in testing for MARPs. There is low utilization of VCT service by high-risk groups like migrant workers, truck drivers, and commercial sex workers (CSWs) as compared to other population groups. There is a need for more focused inventions to increase behavior change among CSWs. For example, a greater emphasis may be warranted on income-generating activities to move women from a life of prostitution. More outreach is needed for VCT service in areas like Awash and Adama at coordination sites for construction workers and for other communities in need. There is a need to develop "blended" approaches of HIV counseling and testing (HCT), particularly HCT at community level.
- Need for tailored materials for information, education, and communication (IEC) as well as for behavior change communication (BCC): Finding IEC/BCC materials that address the needs of specific high- risk groups in Amharic (or other local languages) remains a challenge. There a need to produce and/or reproduce more adequate educational materials addressing OP messages.
- **High turnover in staff:** There is high mobility with subsequent high attrition of CSW peer educators as well as a shortage of HCT counselors and frequent absenteeism. Innovations are needed to keep counselors motivated, such as cross visits and case conferences.
- **Quality assurance for VCT and related services:** There is a need for facility-level assessments to see the gaps and bottlenecks for implementation of HCT. Site visits have revealed a shortage of HCT kits, poor internal quality control by lab technicians, and a lack of appropriate laboratory equipment and materials in some of the laboratories (including refrigerators, centrifuges, tips of micropipette, and test tube holders, needles, and biohazard bags). In some cases there is a failure to maintain universal precaution and infection prevention techniques; there is a lack of training/ refresher training on basic HCT techniques.

IV. PURPOSE OF THE ASSIGNMENT

USAID/E requires a team of three consultants to conduct an end-of-project evaluation of the HRCI Project. GH Tech staff for this evaluation must be limited to GH Tech staff or subcontractors that are **not** currently implementing HIV/AIDS-related programs in Ethiopia. With less than one year remaining in the project, this evaluation will collect information about HRCI implementation, progress, and challenges.

This evaluation will determine the success and impact of the HRCI in achieving the three main objectives: strengthen prevention strategies for effective behavior change; strengthen and expand accessibility to and availability of voluntary counseling and testing (VCT) and sexually transmitted infection (STI) services; and increase access to care and support services for persons living with HIV/AIDS (PLWHA). It will formulate recommendations for follow-on programs. The evaluation will focus on the HRCI program performance period from May 2004 to the present. The evaluation report will be designed to help USAID/E and SC/USA address issues of management, quality of services, and sustainability.

The evaluation will answer the following illustrative questions:

Program Management

- What innovative measures can be taken to improve the administrative linkage between the AIDS Information Centers along the highways with facility- and community-based care and support and treatment services?

Service Delivery

- Develop a definitive summary of service delivery achievements to date for key indicators such as:
  - Number of persons receiving HCT
  - Number of HCT clients testing positive
  - Number of HIV+ persons referred to services
  - Number of HIV+ persons linked to income-generating activities (IGAs).
- How can VCT be further expanded for highest focus on MARPs?
- How can the linkages be improved between the HRCI and care and support services at the facility and community level?

Quality of Care and Services

- What is the status of quality assurance for HCT services and how can HCT service quality be improved?

Capacity Building and Sustainability

- How can HCT counselor attrition be reduced?

Impact

- Acknowledging the problem of attribution, is there evidence that the HRCI has:
  - improved quality of life for PLWHA?
  - improved livelihoods through alternate IGAs for CSWs?
  - reduced risk of HIV transmission among MARPs?

Monitoring and Evaluation

- Is the M&E system able to provide timely high-quality data?

Lessons Learned

- What are effective approaches for expanding the program to additional high-risk corridors?
- How best to introduce "blended" approaches to HCT at the community level?
- Identify lessons learned, successful interventions that merit continuation or replication, better practices, significant products, and tools from the HRCI for possible dissemination and replication.

V. EVALUATION METHODS

The evaluation will be carried out in Ethiopia by a team of three independent, external consultants over a three–four-week period through multiple qualitative and quantitative methods. One or more USAID staff and three or more GOE representatives may join the evaluation team during the team planning meetings and in briefings, site visits, debriefings, and report preparation. The evaluation methodology will be designed by the team in collaboration with USAID/E to include key informant interviews, field observation, facility- and community-level assessments to identify gaps and bottlenecks, and a review of HRCI reports, tools, and materials. Interviews will include the following:

- USAID Mission staff, including the HIV/AIDS Team and staff from the Office of Financial Management (OFM)
- SC/USA and sub-agreement holders
- Government of Ethiopia representatives—the regional HIV/AIDS Prevention and Control Organization (HAPCO), kebele leaders, and Regional Health Bureaus (Ministry of Health), woredas;
- Beneficiaries (MARPs, PLWHA)
- Other PEPFAR partners.

VI. INFORMATION SOURCES

Consultants will be provided the following background documents in preparation for the assignment:

- HRCI Cooperative Agreement, including all major modifications
- HRCI PEPFAR Semi-Annual Report submissions
- HRCI 2005, 2006, and 2007 Annual Reports
- HRCI Quarterly Reports
- HRCI Evaluation Reports
- Rapid Assessment of VCT Services Along the Transport Corridor
- HRCI Internal Guidelines
- HRCI M&E Guidelines
- USAID trip reports summarizing past field visits to HRCI
- GOE Road Map for HIV/AIDS Prevention, Care, and Treatment
- Ethiopia Demographic and Health Survey, 2005
- Federal HIV/AIDS Prevention and Control Office (FHAPCO), Single-Point Estimates of HIV and OVC Indicators, April 5, 2007

VII. TASKS TO BE ACCOMPLISHED

Below is a list of the specific tasks to be accomplished by the consultant team, with an estimated level of effort for each task. (See Attachment 2: Level of Effort Timeline and Attachment 3: Planning Calendar for the exact schedule).

Review background documents, develop evaluation methodology, and complete field visit and interview schedule in consultation with CTO and Evaluation Coordinator (one month prior to departure)	3 days
Travel Day for international consultants	2 days
Team Leader and team members advance planning in country	3 days
Participate in team planning meeting and in-briefing with USAID/E HIV/AIDS technical staff	2 days
Conduct field visits and interviews	7 days
Team analysis and synthesis of site visit findings	2 days
Conduct primary stakeholder interviews in Addis, prepare for debriefings	2 days
Conduct debriefings for USAID and HRCI (separately)	1 day
Draft and submit report to USAID/E in-country	4 days
Travel Day for international consultants	2 days
Finalize report—Team Leader incorporates Mission comments and submits report electronically to CTO	4 days

Total LOE: 32 days of LOE for Team Leader and up to 26 days for team members, including four travel days each for the international consultants. A six-day work week is authorized for work in Ethiopia.

VIII. TEAM COMPOSITION AND PARTICIPATION

USAID/E seeks three consultants: a senior expatriate Team Leader experienced in evaluating USAID HIV/AIDS programs with in-depth knowledge and experience in Care and Support as well as Palliative Care, a senior expatriate VCT Specialist, and a local Evaluation Logistics Assistant. The evaluation may include PEPFAR Ethiopia, Washington-based CDC, and Government of Ethiopia (GOE) participation.

1. The Team Leader will be an international consultant with extensive PEPFAR program implementation and evaluation experience, with a particular focus on Care and Support and Palliative Care. S/he will agree to fulfill his/her responsibilities in over four weeks, spending three weeks in-country, and will play a central role in guiding the evaluation process. The consultant will hold conference calls with core team members and USAID/E representatives before and after the visit to Ethiopia, brief USAID/E on arrival, debrief USAID/E and HRCI on evaluation findings, and produce a draft report to be left with USAID/E prior to departure, followed by a final report for USAID/E.

   The Team Leader will

   - Finalize and negotiate with the client the team work plan for the assignment.
   - Establish assignment roles, responsibilities, and tasks for each team member.
   - Ensure that the logistics arrangements in the field are complete.

- Facilitate the team planning meeting (TPM) or work with a facilitator to set the agenda and other elements of the TPM.
- Take the lead on preparing, coordinating team member input, submitting, revising, and finalizing the assignment report.
- Manage the process of report writing.
- Manage team coordination meetings in the field.
- Coordinate workflow and tasks and ensure that team members are working to schedule.
- Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, payment is made for services, car/driver hire or other travel and transport is arranged, etc.).

2. The VCT Specialist will be an international consultant with extensive implementation and evaluation experience of VCT programs in sub-Saharan Africa. Knowledge of HIV/AIDS programming and PEPFAR is essential. The consultant will be responsible for writing some sections of the report. The consultant will assist the Team Leader in the development of any qualitative instruments to be used during site visits as well as analysis of any data collected.
3. The Evaluation Logistics Assistant will be a local consultant, preferably fluent in Amharic, with demonstrated: ability to be resourceful and to successfully execute complex logistical coordination; ability to multitask, work well in stressful environments, and perform tasks independently with minimal supervision; ability to work collaboratively with a range of professional counterparts at all levels.

The Evaluation Logistics Assistant will be responsible for logistics, coordination and administrative support, and that ensuring all aspects of the evaluation are carried out seamlessly. He/She will assist the Team Leader and the implementing agencies in facilitating meetings, coordinating logistics, and organizing site visits. The Evaluation Logistics Assistant will collect and disseminate background documentation to the evaluation team.

In addition to senior Government of Ethiopia experts from Regional Health Bureaus (RHBs) and the Federal Ministry of Health (FMOH), one or more USAID/E (local) and CDC staff (one international and one local) may join the evaluation team during the site visits. HRCI staff may accompany the team on site visits as appropriate but will not be present during interviews with the HRCI partners, stakeholders, or beneficiaries.

SELECTION CRITERIA FOR EVALUATION TEAM

Senior Team Leader (maximum 100%) distributed as follows:

1. **Education (25%):** An advanced degree (PhD, MA, MS, or MBA) from a reputable accredited institution in any of the social sciences pertinent to work with Care and Support and Palliative Care.
2. **Work Experience (35%): Minimum 10 years** of progressively responsible experience with recognized organizations in the design, implementation, and evaluation of HIV/AIDS programs with demonstrated technical expertise and skills in HIV/AIDS Care and Support and Palliative Care.
3. **Skills and Abilities (40%):** Demonstration of strong analytical, managerial, and writing skills is very critical for the evaluation work. Exceptional leadership in coordinating, assigning the team appropriate responsibilities, communication, and interpersonal skills is

absolutely critical. In addition, the Team Leader must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGOs counterparts. Must be fluent in English and have proven ability to communicate clearly, concisely, and effectively both orally and in writing. Must be able to produce a succinct quality document that gives direction and facilitates improvement for programs for MARPs.

Senior VCT Specialist (maximum 100%) distributed as follows:

1. **Education (25%):** MA, MS, MBA, or BA from a reputable accredited institution in any of the social sciences pertinent to working in HIV/AIDS programs, with special emphasis on VCT.

2. **Work Experience (35%): Minimum 6 years** of progressively responsible experience with recognized organizations in the design, implementation, and evaluation of VCT programs with demonstrated technical expertise and skills in HIV/AIDS in sub-Saharan African countries.

3. **Skills and Abilities (40%):** Demonstration of strong analytical, managerial, and writing skills. Able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. Must be fluent in English and have proven ability to communicate clearly, concisely, and effectively both orally and in writing.

Mid-Level Evaluation Logistics Assistant (maximum 100%) distributed as follows:

1. **Education (25%):** MA, MS, MBA, or BA. Four years of work experience may be substituted for the degree.

2. **Work Experience (35%): Minimum 6 years** of progressively responsible experience within GOE and/or NGO work settings handling complex logistics, such as coordinating business travel and meetings.

3. **Skills and Abilities (40%):** Must have a demonstrated ability to be resourceful and to successfully execute complex logistical coordination; ability to multitask, work well in stressful environments, and perform tasks independently with minimal supervision; ability to work collaboratively with a range of professional counterparts at all levels, including those from host country governmental and nongovernmental organization, U.S. Government agencies, and other donors; capacity for effective time management and flexibility. Must be able to interact effectively with a broad range of internal and external partners, including international organizations, host country government officials, and NGO counterparts. Must be fluent in English and preferably Amharic and have proven ability to communicate clearly, concisely, and effectively, both orally and in writing.

IX. Schedule and Logistics

The in-country phase of the evaluation will be conducted over a period of up to 22 days with a desired start date on or about June 8, 2008. The Evaluation Logistics Assistant, in collaboration with the USAID/E Evaluation Coordinator and SC/USA will arrange all partner meetings, site visits, and debriefings in advance. Meeting space will be provided at USAID/E, but the agency cannot provide access to fax and email. All associated travel and per diem costs for non-USAID staff will be covered by GH Tech under the contract with USAID/E (See Attachment 2: Level of Effort Timeline and Attachment 3: Planning Calendar for the exact schedule).

Time Line

3 days	Review of background reading materials. Develop evaluation methodology and field visit and interview schedule in consultation with the USAID/E CTO and Evaluation Coordinator (one month prior to departure).
2 days	Travel Days en route to Ethiopia.
3 days	Team members in-country for advance planning.
2 days	Team planning meeting; in-briefing with USAID/E.
7 days	Interviews and field visits outside of Addis Ababa.
2 days	Team synthesis and analysis meetings
2 days	Interviews with primary stakeholders in Addis/ prep for debrief
1 day	Debrief USG and HRCI partners (separately)
4 days	Draft and submit report USAID/E
2 days	Travel Day departure from Ethiopia
10 days	USAID/E review of draft report
4 days	Final report completed by Team Leader and delivered to USAID/E
3 weeks	GH Tech prepares final edited evaluation report.

X. Period of Performance

Work is to be carried out over a period of approximately 10 weeks, beginning on or about (o/a) April 25, 2008, with field work completed in June 2008 and final report and close out concluding o/a July/August 2008.

XI. Financial Plan

A budget plan agreement between the USAID/E PEPFAR and GH Tech will be reached and USAID/E will process a MAARD to transfer funding for the evaluation activity into the GH Tech Indefinite Quantity Contract (IQC).

XII. Deliverables

Approximately one month prior to arrival: Team Leader will develop an evaluation methodology and field visit and interview schedule in consultation with the USAID/E CTO and USAID/E Evaluation Coordinator.

Four days after Team Leader arrival: Team meeting and in-briefing with USAID/E. USAID/E HIV/AIDS technical staff to review and comment on evaluation methods.

Prior to departure: Team makes presentation to USG PEPFAR staff and a separate presentation to HRCI partners, and Team Leader submits a draft report in the exact format specified by the USAID/E Evaluation Coordinator (see separate MS Word file for GH Tech Evaluation Report Guidelines) to USAID/E CTO—two hard copies and one electronic copy on CD ROM or flash drive.

After departure: Team Leader submits final unedited content to USAID/E within one week of receiving comments from USAID/E. The report (not including attachments) will be no longer than 30 pages with an Executive Summary, Introduction, Methodology, Findings, Lessons Learned, Conclusions, and Recommendations in English in the exact format specified by the USAID/E Evaluation Coordinator.

Upon final approval of the content by USAID/E, GH Tech will have the report edited and formatted. This process takes approximately 3–4 weeks. The final report will be submitted electronically to USAID/E CTO and Contract Officer.

GH Tech makes the results of its evaluations public on the Development Experience Clearinghouse and on its project web site unless there is a compelling reason (such as procurement sensitivities) to keep the document internal. Therefore, GH Tech will request USAID/E confirmation that it will be acceptable to make this document publicly available. If there are certain restrictions regarding specific parts of the report that should be removed from a public version due to procurement-sensitive information, GH Tech is able to produce a second version suitable for public availability.

HRCI INDICATORS FROM THE HRCI ANNUAL REPORT AS OF 09/2007

I. Prevention: Promotion of Abstinence and/or Being Faithful (AB)

- Total number of individuals reached with community outreach HIV/AIDS prevention programs that promote abstinence and/or being faithful: **67,099**
- Total number of individuals reached with community outreach HIV/AIDS prevention programs that promote abstinence: **45,927**
- Total number of individuals trained to provide HIV/AIDS prevention programs that promote abstinence and/or being faithful: **1,109**

Non-PEPFAR AB Indicators

- Number of IEC materials developed: **1**
- Number of IEC materials distributed: **87,930**
- Number of youth clubs established: **18**
- Number of supportive supervision visits to youth clubs: **No data available (NA)**
- Number of peer educators currently working under the program: **237**
- Number of peer educators that left the program for various reasons:**116**
- Number of trainings conducted: 20
- Percentage of target audience reached: **NA**
- Are there financial incentives to peer educators? **No**
- Did peer educators refer to other HIV/AIDS services? **Yes**

II. Prevention: Behavior Change Beyond Abstinence and/or Being Faithful (OP)

- Number of targeted condom service outlets: **21**
- Number of individuals reached with community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful: **74,865**
- Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful: **266**

Non-PEPFAR OP Indicators

- Number of IEC materials developed: **20**
- Number of IEC materials distributed: **1,560**
- Number of peer educators currently working under the program: **319**

- Number of peer educators that left the program for various reasons: **36**
- Number of trainings conducted: **11**
- Percentage of target audience reached: **103%**
- Are there financial incentives to peer educators? **No**
- Did peer educators refer to other HIV/AIDS services? **Yes**

III. Basic Palliative Care (BPC)

- Number of individuals provided with general HIV-related palliative care (including TB/HIV**): 2,318**
- Number of individuals trained to provide general HIV-related palliative care (including TB/HIV): **662**
- Number of service outlets/ programs providing general HIV-related palliative care (including TB/HIV): **24**
- Number of individuals provided with general HIV-related palliative care (including TB/HIV) by five core areas: clinical care **(2,574),** psychological care **(6,990),** spiritual care **(8,775),** social care **(1,633),** and prevention for HIV-infected persons (**6,444).**

Non-PEPFAR BPC Indicators for BPC

- Number of individuals on Cotrimoxazole prophylaxis: **1,124**
- Number of individuals on food and nutrition support (WFP): **7,671**
- Number of individuals on food and nutrition support (Care & Support): **2,385**

Non-PEPFAR BPC Indicators for Home-Based Care Programs

- Number of household members referred for HIV counseling and testing (HCT): **447**
- Number of individuals screened for TB based on symptoms: **506**
- Number of individuals who received insecticide-treated bed nets (ITN): **619**
- Number of individuals who received safe water treatment: **288**
- Number of individuals who received condoms: **26,588**
- Numbers of individuals counseled on adherence: **6,024**
- Number of HBC programs linked with health centers and hospital: **19**

IV. Counseling and Testing (CT)

- Number of individuals trained in counseling and testing according to national and international standards: **116**
- Number of individuals who received counseling and testing for HIV and received their test results: **30,648**
- Number of registered TB patients who received counseling and testing for HIV and received their test results (a subset of all receiving CT): **NA**

- Number of service outlets providing counseling and testing according to national and international standards: **16**

Non-PEPFAR CT Indicators

- Number of individuals who received provider-initiated counseling and testing (PICT): **2,033**
- Percent HIV-positive among PICT: **9.6%**
- Number of individuals who received outreach HIV counseling and testing: **7,103**
- Percent HIV–positive among outreach HCT: **2.9%**
- Number of sites that sent samples for quality assurance (QA) and received QA report: **4**
- Percent of positive individuals that were referred to other HIV/AIDS services: **100%**
- Number of site supervisions for QA/quality improvement conducted within the quarter: **NA**
- Number of VCT service outlets visited through site supervision: **16**

LEVEL OF EFFORT (LOE) FOR HRCI END-OF-PROJECT EVALUATION TIMELINE			
Activity	**Team Member(s)**	**Total Days**	**Proposed Date(s)**
Mission sends background documents to Evaluation Team Members	Evaluation Coordinator	1 day	April 25
Review of documents; completion of draft work plan, initial determination of site visit approach and schedule and evaluation method	Team Leader, USAID/E in collaboration with implementing partners	3 days (**approx one month prior to team leader arrival in country**)	April 28–30
Team Leader arrives in country			June 8
Team Leader evaluation prep/ pre-evaluation informational interviews with stakeholders	Team Leader and team members	3 days	June 9–11
In-brief USAID/E approval of work plan	Core team	PM: 2 hours	June 11
Team planning meeting in country	Full team (w GOE experts)	2 days	June 12–13
Fieldwork	Four subteams in up to 21 cities in collaboration with SC/USA HRCI	6–7 days	June 14–21
Information analysis and synthesis	Full Team (w GOE Experts)	2 days	June 23–24
Addis Ababa meetings and interviews with key Addis stakeholders Prep for debriefing	Team Leader and team members	2 Days	June 25–26
Oral debriefing of Mission staff	Team Leader and team members	Morning	June 27
Stakeholders presentation	Team Leader and team members	Afternoon	June 27
Completion of draft report	Team Leader and selected team members	4 days	June 28–July 2
Team Leader submits report and departs Addis	Team Leader	1 Day	July 2
HAPN USAID/E review draft report	HAPN and other USAID/Ethiopia staff	10 Days	July 3–16
Team Leader responds to HAPN USAID/E comments	Team Leader	4 Days	July 17–22
GH Tech completes final report editing	GH Tech	3 Weeks	August 12

ATTACHMENT 3: PLANNING CALENDAR FOR HRCI EVALUATION						
Monday	**Tuesday**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sunday**
June 2	June 3	June 4	June 5	June 6	June 7	June 8 Sunday Team Leader arrives
June 9 Team Leader planning in Addis/ Pre-evaluation meetings with stakeholders	June 10 Team Leader planning in Addis/ Pre-evaluation meetings with stakeholders	June 11 Core Team planning in Addis/ Pre-evaluation meetings with stakeholders PM In-briefing with USAID/Ethiopia	June 12 Full team (w GOE experts) planning meeting in Addis	June 13 Full team (w GOE experts) planning meeting in Addis	June 14 Outside of Addis Four teams field work in 21 cities in collaboration with SC/USA	June 15 Sunday Outside of Addis Rest/Travel Day
June 16 Outside of Addis Four teams field work in 21 cities	June 17 Outside of Addis Four teams field work in 21 cities	June 18 Outside of Addis Four teams field work in 21 cities	June 19 Outside of Addis Four teams field work in 21 cities	June 20 Outside of Addis Four teams field work in 21 cities	June 21 Outside of Addis Four teams field work in 21 cities	June 22 Sunday Rest in Addis
June 23 in Addis Full team information and synthesis Team Leader final stakeholder interviews /prep for debriefing	June 24 in Addis Full team information and synthesis Team Leader final stakeholder interviews / prep for debriefing	June 25 in Addis Team Leader and core team final stakeholder interviews/ prep for debriefing	June 26 Team Leader and core team final stakeholder interviews/ prep for debriefing	June 27 AM Core Team Oral Debrief to USAID/Ethiopia PM Core team Oral Debriefing for SC/USA and Stakeholders	June 28 Core Team Draft report/ Team Members depart.	June 29 Sunday Rest
June 30 Team Leader Draft report	July 1 Team Leader Draft report	July 2 Team Leader submits report and departs	July 3	July 4	July 5	July 6 Sunday Rest

APPENDIX B: PERSONS CONTACTED AND INTERVIEWS CONDUCTED

WHOLE TEAM INTERVIEWS IN DUKEM AND ADDIS ABABA TO FIELD-TEST DATA COLLECTION INSTRUMENTS:

Interview with Director of Women At Risk

Interview with Dukem Health Center Director

Interview with Dukem Health Center VCT counselor

Interview with HAPCO official

Attendance at coffee ceremony with several PLWHA, 2 spiritual counselors, HIV/AIDS committee members, nurse supervisor, HBC volunteers

Focus group discussion with AIDS Information Center youth volunteers (counselors and educators) and at-risk youth beneficiaries

Team A:

Dire Dawa

Visit HRCI project office in Dire Dawa, interviews with 3 project staff

Interviews with RHAPCO (Ms. Lem Lem) and RHB Office (Dr. Tigerade)

Interviews with Dire Dawa health center staff: director, nurse supervisor, VCT counselor

Interviews with Dil Chora Hospital; meet with Dr. Abel Malkamu, nurse supervisor?

Focus groups with HIV/AIDS committee, HBC volunteers, PLWHA, spiritual counselors at Kebele 03

Observational home visits with 2 PLWHA and families

Blended focus group with beneficiaries, HBC volunteers, HIV/AIDS committee members at Kebele 04

Observational visit to IGA brick-making activity

Visit to Information Center; informal interview with 5 volunteers

Assebe Teferi

Focus group with 2 YAK teachers and 2 student peer educators

Interviews with Health Bureau and HAPCO officials at Health Office

Observation visit to IGA activity (stationery shop)

Focus groups with HIV/AIDS committee, spiritual counselors, HBC volunteers and nurse supervisor, PLWHA, HAPCO, Health Bureau Manager

Visit to Information Center; informal interview with 5 volunteers

Hirna

Interview with Health Center Manager
Role play QA with VCT counselor and community counselor
Focus group with PLWA

Focus group with HBC volunteers and nurse supervisor

Observational visits with 2 PLWHA and families

Focus group with HIV/AIDS committee

Visit to Information Center; informal interview with 3 volunteers

Observation visit to animal-fattening IGA

Total interviewed by Team A: 176

Team B:

Bishoftu

AIDS Committee and HAPCO: 5

Information Center: 4 volunteers

Mixed focus group: 12 (PLWHA, committee members, volunteers, spiritual leader)

YAK: 1 teacher, 12 youth

Pepsi shop: 1 manager and 1 PLWHA

Pepsi shop: 2 managers

Adama

SC/USA sub-office: 4

AAC: 1 kebele manager, 1 AAC coordinator

Information Center: 1 volunteer

Ellilta café: 1 manager

Iddir group: 11

CAAP (local NGO): 1 manager, 1 nurse

Mixed focus group: 16 (PLWHA, spiritual leader, volunteers, nurse supervisor, AIDS committee members)

Adama Hospital: 1 doctor

PLWHA home visits with volunteers: 3

Wolenchiti

Mayor: 1

AIDS Committee chair: 1

Truck drivers: 4

Ellilta shower block: 1

CWSs: 10, and 1 child

AIDS Committee: 6

Awash

SC/USA sub-office: 3

Volunteer focus group: 4

Information Center: 3

PLWHA home visits: 2

Total Interviewed by Team B: 115

Total people interviewed by both teams: 291

APPENDIX C: EVALUATION RATIONALE AND MATRIX

INITIAL EVALUATION RATIONALE

1. Much of PEPFAR reporting is numbers-driven, yet the evaluation seeks to assess quality of care throughout the project. Questionnaires, focus groups, and other evaluation methods should be primarily qualitative and the process probing, thorough, and personalized to elicit experiential information on quality of project results.

2. Key areas of concern include supervision, referral systems, engagement of key stakeholders, and retention issues. These will form the focus of much of the evaluation. Recommendations from the evaluation will move beyond the numbers and systems and capture real concerns using in-depth interviews and focus group discussions. The review of documents, records, and reports will be the starting base, to which we will add qualitative detail.

3. Although we will have coverage of all the main questions in the SOW, the most important focus will be

    a. exploring quality of care and service delivery in relation to numbers achieved, i.e., getting beneath the numbers
    b. exploring understanding and implementation of palliative care (training, practice, and supervision)
    c. assessing the impact of the program on the main stakeholders, i.e., what real differences can they see, and how sustainable is the change?

EVALUATION QUESTIONS Agreed on by ore Evaluation Team Members and USAID Mission/E Staff
Strategic Objective 1: To increase HIV/AIDS prevention practices and demand for services
IEC/BCC Materials
For which MARPs have materials been developed?
How are messages for targeted populations developed?
How are messages for targeted populations evaluated?
How do we know if these are effective messages?
How well have MARPs been reached with tailored messages?
AIDS Information Centers
Are AIDS Information Centers reaching MARPs?
How were IC locations chosen?
Prevention Trainings
What is the QA status of prevention training content?
What is the QA status of prevention training delivery (for VCT counselor, VCT supervisor, peer educators [teachers, students, truckers, CSWs])?
Volunteer Attrition
How can VCT counselor attrition be reduced?
How can peer educator attrition be reduced?

VCT
What is the QA status for VCT counseling services?
What is the QA status for lab function?
Is mobile VCT reaching MARPs?
Is stand-alone VCT reaching MARPs?
Is facility-based VCT reaching MARPs?
How can VCT be scaled up to reach more MARPs?
How can a 'blended' approach to VCT best be introduced at the community level?
Effectiveness of Prevention Activities
How effectively has the project increased demand for prevention services?
How effectively has the project increased prevention practices?
Are prevention activities effectively reaching the most-at-risk populations (rather than general communities)?
Is there evidence that HRCI has reduced risk of HIV transmission among MARPs? (not looking at incidence, looking only at self-reported behavior change that reduces risk)
Strategic Objective 2: To improve access to and availability of prevention and treatment services for HIV, AIDS, STIs, and OIs
VCT Services
How many VCT sites have been established over the life of the project?
Are VCT services located near MARP hot spots?
How effective are referrals from VCT centers to treatment, care, and support services? How are referrals being documented, tracked?
ART Services
How does the project make HIV-positive people aware of ART services?
Who is being referred to ART services? (Are there pockets of people at project sites not accessing ART services?)
How effectively has the project increased access to ART services?
STI Services
How does the project make people aware of STI services?
Who is being referred to STI services?
How effectively has the project increased access to STI services?
OI Services
How does the project make people aware of OI treatment services?
Who is being referred to OI services?
How effectively has the project increased access to OI services?
Strategic Objective 3: To improve the availability and quality of care and support services for people living with HIV and AIDS and orphans and vulnerable children
Volunteer Attrition
With which volunteers is attrition a problem?
How can volunteer attrition be reduced?

Process for Selecting Beneficiaries
How are people selected to receive support?
What percentage of known PLWHA in project areas are served through the project's care and support component?
Are there pockets of people not receiving support?
Care and Support Training
What is the QA status of care and support training content?
What is the QA status for care and support training (HBC volunteers, nurse supervisors, including the palliative care component of training)?
What is the status of QA for delivery of HBC palliative care by volunteers?
Care and Support for Families Affected by HIV/AIDS
How well were entire families served through the project's OVC component?
What impact has the partnership with WFP for food distribution had on families affected by HIV/AIDS?
Care and Support for PLWHA
What prevention activities for those HIV-positive are taking place?
Is there evidence that HRCI care and support services have improved the quality of life for PLWHA?
Strategic Objective 4: To increase the livelihood security of people and children infected and affected by HIV/AIDS
Income–Generating Activities
Is there evidence that HRCI has improved livelihoods through alternative IGAs for MARPs?
Which MARPs have benefited from IGA?
Are IGA activities sustainable and replicable?
Strategic Objective 5: To incorporate the cross-cutting themes of gender, stigma reduction, and community strengthening into all project activities
How well has the project incorporated gender awareness and gender equity into project activities (for staff, beneficiaries)?
How well has the project reduced stigma and measured stigma reduction?
How well has the project strengthened community ownership and leadership for HIV prevention, treatment, and care and support?
How well has the project worked with government partners and counterparts toward sustainability?

APPENDIX D: OCCUPATION TABLE FROM VCT INTAKE FORM

Excerpted from the HIV/AIDS Prevention in Mobile Populations Along the High-Risk Corridor Project, HRCI HIV Counseling and Testing Record

23. Current Occupation
1 = Unskilled
2 = Skilled
3 = Professional
4 = Sex worker
5 = Military/Police
6 = Truck driver
7 = Assistant
8 = Student
9 = Farmer
10 = Housewife
11 = Daily laborer
12 = None
99 = Other

APPENDIX E: FIELD NOTES FROM QA ROLE-PLAY COUNSELING QA VISIT WITH VCT COUNSELORS

To get an accurate sense of VCT counseling content and counselor skills, one evaluation team participated in a simulated couples counseling session involving high-risk behaviors by both husband and wife and resulting in discordant test results. A nurse supervisor and community counselor team provided counseling in the role play.

The intake and registration process was thorough, with assurance of confidentiality ("all results will remain between you and me") and explanation of the use of anonymous code numbers.

The lead counselor used a manual throughout the session to ensure that he covered all necessary information. He provided an overview of what the session would include and a time frame for receiving test results, clearly explained the window period, asked if the couple would prefer to be counseled separately so that both parties could speak freely, assessed the couple's knowledge of how HIV is transmitted/history of STIs/history of risky sexual behaviors/history of condom use, talked about benefits of condoms including prevention of unintended pregnancies, and offered to demonstrate correct condom use.

After the 'wife' received a positive test result and the couple asked about possible testing for their sick 6-month-old infant, there was a clear explanation of why children are generally not tested before 18 months of age. The couple was informed that alternative testing at three months is available in Addis if the couple wished to confirm the baby's status. Overall, the quality of pre- and post-test counseling was excellent. The only advice that gave the evaluation team concern was the suggestion that a married woman who is doing commercial sex work to feed her children should abstain from sex. While this was clearly the least risky option for herself, her husband, and her sex clients, it seemed an unlikely option for her, and we thought that disclosure to clients and consistent condom use would have been more realistic and practical advice for her.

APPENDIX F: IGA BENEFICIARES AND TYPES OF IGAS

Table 1. HRCI Supported IGAs and Beneficiaries

Activities	FY 2008		Total (2005-2008)		Remark
	Annual Target	Achieved	Target	Achieved	
Social marketing of condom for Information Center volunteers	50	63	50	63	In partnership with DKT Ethiopia (It is implemented at Modjo, Dukem, Awash Arba, Mile, Logia, Hirna, and Dire Dawa town Information Centers)
Engage CSWs in IGA activities (e.g., Sisters Café)	10	10	10	10	In partnership with local NGO called Ellilta in Adama Wolenchiti and Dire Dawa towns
Engage CSWs in IGA activities (e.g., Public Shower)	20	20	20	20	
Engage CSWs in IGA activities (e.g.,Brick production and foundry)	10	10	10	10	
Community Gardening	50	22	50	22	In Afar region, Mille town
Engage PLWHA in IGA activity (e.g. Pepsi Shop)			NA	4	In FY 2005, Bishoftu town
Pepsi Shop Project supported by MOHA Soft Drinks Industry Share Company	50	50	50	50	In partnership with MOHA Soft Drink Industry Share Company [in Ten Towns along the corridor].
Engage PLWHA in IGA activities through Gasha Micro Finance.	100	105	100	105	In partnership with Gasha Micro Finance (in Adama town (e.g. Animal Fattening (73), petty trade (39), Hand craft (3), and Service business(10))
Engage PLWH in IGA activity (e.g., Baking Machine)	NA	43	NA	43	In Afar Logia town
Engage PLWHA in IGA activity (e.g., Ice Making)	NA	16	NA	16	In Afar Dichoto town
Engage PLWHA in IGA activities (e.g., Poultry)	10	10	10	10	In partnership with local NGO called Coalition for Action Against Poverty (CAAP) in Adama town

Engage PLWHA in IGA activities (e.g., Sheep Rearing)	10	10	10	10	
Engage PLWHA in IGA activities (e.g., Building Production and Laundry)	NA	14	NA	14	For PLWHA Association called Millennium 2000 at Dire Dawa town
Engage PLWHA in IGA activities (e.g., Animal Fattening)	NA	21	NA	21	For PLWHA Association called Twelede Begna Yidan at Hirna town
Engage PLWHA in IGA activities (e.g. Stationery, Photocopy, and Tele Center)	NA	200	NA	200	For PLWH cooperative associations called Beza Lewegen at Chiro town.

Total IGA beneficiaries: 598

APPENDIX G: HIRNA, HRCI PROJECT CENTER OF EXCELLENCE

Hirna, An HRCI Project Center of Excellence: In Hirna, the project has developed a close partnership with the health center, until recently supporting VCT through testing supplies, participating in mobile VCT outreach, providing OI adult and pediatric medicines,[8] training several health workers in VCT and PICT, and including health workers as HIV/AIDS committee members and in monthly project experience-sharing sessions. Two health center nurse supervisors have been trained to support HBC volunteers. Through the project, community members are contributing money to the health center that is used to pay care costs for children with HIV. The project has clearly bridged the health center and the community.

The HIV/AIDS committee is proud to have spent nearly six years working in partnership with SC/USA. The four subcommittees work well together and keep careful, transparent records of their activities. Recently the OVC committee has transferred much of its work to Pro Pride, a local NGO partner in the PC3 project. The HIV/AIDS committee also works closely with CARE Ethiopia and Rural Reach Ethiopia to avoid duplication of services and maximize resources.

The **Fundraising** subcommittee works within the project agreement that 10 percent of funds are to be contributed by the community, with the project matching their fundraising with a 90 percent contribution. This committee has raised funds from individual community members, business people, hotels, iddirs, civil servants, project volunteers, and teachers. The two kebeles in the woreda have both added a 1 birr charge to the cost of ID cards and in this way have contributed 800 birr to the subcommittee. The project has trained the subcommittee in proposal writing and also contributed 15,000 birr to the animal-fattening IGA. Health bureaus and city administrators have also contributed seed money for IGA activity start up. Other volunteers have donated a total of 1,136 birr to help form PLWHA associations. Rural Reach Ethiopia contributed 36,400 birr to support an animal-fattening IGA and the project provided another 15,000 birr. The subcommittee has engaged local business and churches to help feed PLWHA and provide wood to build the structure that holds animals being fattened.

The **Care and Support** subcommittee, which originally provided support for 13 people (6 males, 7 females), has grown to support 92 PLWHA (36 males, 56 females). These beneficiaries belong to the PLWHA association and hope that more PLWHA will join.

Youth Outreach: The **Youth and Prevention** subcommittee is comprised of smaller subcommittees: in-school youth, out-of-school youth, and the Information Center. The committee oversees four in-school YAK clubs and three out-of-school AACs. They experience attrition in YAK clubs when members graduate from 10th grade, and in out-of-school clubs when volunteers get jobs. The project provides capacity building for all these youth clubs. Both types of clubs engage in similar activities: drama, poetry, role plays, Q&A sessions, mini-media, and condom promotion.

The most effective strategies to reach out-of-school youth include coffee ceremonies, outreach to government offices like Youth and Sport and Agriculture, and preparation of special social gatherings just for youth. Youth AAC club members conduct education on Saturdays at two local markets and also at sports events. The committee has established a youth center in one rural area and has posted a volunteer there full time to provide education and recreational activities for about 100 youth daily.

[8] This health center reported an increase in the number of PCP cases and has made good use of OI drugs.

Through woreda officials who serve on the HIV/AIDS committee, subcommittee members hear about social events in surrounding rural communities and are able to attend and provide HIV education. They have also done this at rural area militia trainings.

For in-school youth, in addition to the YAK clubs schools allocate time to talk about HIV at the beginning of school days during flag-raising ceremonies and before classes start. The school-based YAK clubs visit one another.

A major challenge they face is difficulty in keeping up with the demand for prevention materials. Apparently they have not budgeted for reproduction costs but have relied on the project to provide materials. Planning for materials reproduction should be part of exit strategy conversations in the remaining three months.

Outreach to CSWs: Q&A sessions are held four to five times a year for CSWs who work at local hotels. Committees have reached up to 80 CSW at a time through these sessions. Committee members told evaluators, "This is an area where we have seen many changes. Many CSWs decided to take VCT. Some have stopped being CSWs. Some got married."

From conversations with CSWs, they believe that more than 90 percent of CSWs are using condoms regularly, based on their twice-weekly visits to the IC to get more condoms and the number of condoms they are taking. "If a man wants to have sex without a condom, the CSWs inform one of us; they refuse. They have close relationships with the IC, and one former CSW is a lead IC volunteer. The health center's VCT counselor, a committee member, says that when CSWs come for counseling and testing they tell him they are using condoms."

Outreach to truck drivers: "We provide fliers to truck drivers. Demand is increasing, and sometimes we have a shortage of materials."

Hirna's **Information Centers** conduct outreach to the four main target groups: CSWs, truck drivers, youth, and mobile populations. The latter group includes people who are selling contraband along the corridor. IC counselors, one of whom is a former CSW, conduct condom promotion and distribution, mini-media, home-based and mobile sex worker outreach, outreach to hotels, truck drivers, youth, and mobile populations.

In the past quarter IC volunteers gave prevention information to 21 CSWs and 70 truck drivers (2 were female). Some local CSWs use the IC as a lending library, borrowing cassette tapes and returning them.

The **key messages** delivered by IC volunteers vary according to the at-risk population.

For truck drivers: Be tested, use condoms, practice abstinence while away from home; they are given condoms and audiotape cassettes. For CSWs: get tested and know your status, and use condoms with every client. Youth messages differ depending on age and life circumstances; for younger students, they promote abstinence and delayed sexual debut; for sexually active youth, they promote being faithful and using condoms.

IC volunteers distributed 5,625 condoms with the following breakdown:

CSWs	4,118
Truck drivers	568
Out-of-school youth	359
In-school youth	249
Mobile people	331
Total	5,625

They distributed the following prevention materials:

Truck drivers:	12 fliers, 15 posters, 25 cassettes
Out-of-school youth:	8 fliers, 19 posters, 17 cassettes
In-school youth:	8 posters, 16 cassettes
Mobile people:	20 fliers

In the past quarter, Youth and Prevention subcommittee activities reached 248 in-school youth (106 female, 142 male); 255 out-of-school youth (76 female, 179 male), and 25 mobile males and provided 20 premarital (10 male, 10 female) VCT referrals.

This is how the HIV/AIDS committee and the subcommittees assess their impact:

1. We have gained significant changes in traditions: all people in this woreda have agreed to premarital counseling and testing, widow inheritance has decreased, and FGC and removal of uvula (done to children with trouble swallowing) is reduced because we have taught people that HIV is transmitted by blood and it is unsafe to use the same cutting instrument for various people.
2. Utilization of condoms has become a norm with no fear. People take them from ICs; there is high usage.
3. Stigma and discrimination are reduced in this woreda.
4. People who were bedridden have come out of their beds and are walking thanks to ART.
5. The number of ART users has increased.
6. Misconceptions in the community have changed; people know the facts about HIV.

To this self-assessment evaluators would add that the town's government offices, business owners, and religious leaders have taken responsibility for HIV, and PLWHA have assumed leadership roles in prevention education and home-based care. Within this community, commitment and love are evident.

The HIV/AIDS committee fully recognizes the irony of their situation in that they have been very successful in raising demand for services and now the project is stopping.

APPENDIX H: WORLD HEALTH ORGANIZATION DEFINITIONS OF PALLIATIVE CARE

WHO DEFINITION OF PALLIATIVE CARE

Palliative care is an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering and the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

Palliative care

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten nor postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient's illness and in their bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated
- Will enhance the quality of life, and will also positively influence the course of illness
- Is applicable early in the course of illness, in conjunction with other therapies that are implemented to prolong life, such as chemotherapy or radiation, and includes those investigations needed to better understand and manage distressing clinical complications.

WHO DEFINITION OF PALLIATIVE CARE FOR CHILDREN

Palliative care for children represents a special, albeit closely related, field to adult palliative care. WHO's definition of palliative care appropriate for children and their families is as follows; the principles apply to other pediatric chronic disorders (WHO, 1998a):

- Palliative care for children is the active total care of the child's body, mind, and spirit and also involves giving support to the family.
- It begins when illness is diagnosed and continues regardless of whether a child receives treatment directed at the disease.
- Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
- It can be provided in tertiary care facilities, in community health centers, and even in children's homes (the child's own home, community home, or other place of care).

APPENDIX I: BACKGROUND TO PALLIATIVE CARE IN ETHIOPIA

Ethiopia is one of 15 focus countries in receipt of funding from PEPFAR. Up to 15 percent of the fund is dedicated to provision of palliative care for people living with HIV/AIDS. In Ethiopia four U.S. university-affiliated organizations—International Center for HIV/AIDS Prevention (ICAP); I-Tech (Washington University); John Hopkins-Technical Support Ethiopian HIV/AIDS Initiative (JHU-TSEHAI); and UCSD-Ethiopia (University of California San Diego)—work at hospital level giving technical support for ART scale up, palliative care, and other HIV-related programs. UCSD employs a focal person for palliative care and a volunteer consultant for palliative care to drive this process. All PEPFAR partners are tasked to support palliative care in their respective geographic territories or sectors, and the role of UCSD and ITECH is to coordinate the efforts of Ethiopian PEPFAR partners.

A WHO situational analysis undertaken in 2004 identified key gaps in relation to palliative care. These included lack of trained health care providers and palliative care trainers, resistant social stigma, and slow behavioral change in acknowledging HIV as a serious health issue. A National Palliative Care Task Force was established to focus the development of palliative care delivery in Ethiopia, chaired by a representative of HAPCO in the Ministry of Health. Under this umbrella a Pain Management Guideline Task Force was created. Guidelines in pain management were developed by I-Tech in collaboration with the Ministry of Health, and the document was launched on December 4, 2007. The guidelines are comprehensive and include pain assessment scales for adults and children, clear guidance on using the WHO analgesic ladder, and tips for using opioids. Appendix 11 refers to the drug formulary for analgesics and specifies: “Morphine remains the most valuable analgesic for severe pain” (p. 58). A training plan for doctors, nurses, and health officers is currently being implemented by HAPCO with the support of UCSD and I-Tech on how to use and implement the guidelines, with a training-of-trainers sensitization component. Distribution of the guidelines is managed by MOH with a quota system for hospitals and health centers.

APPENDIX J: APCA TOOL FOR CLASSICATION OF PALLIATIVE CARE ACTIVITIES

Organizational Capacity Level	Qualifying Criteria for Organizational Capacity Level
Level 1: Not palliative care	1. Relies mainly on community health workers (CHWs) and volunteers 2. Includes basic administrative structures 3. Provides supportive care 4. Does not provide basic OI and/or pain assessment and management services
Level 2:	1. Relies on CHWs, volunteers, and part-time qualified health professionals 2. Includes basic administrative structure and procedures (for example, job descriptions) 3. Provides support and basic clinical services for OI and WHO level 1 pain assessment and management
Level 3:	1. Relies on CHWs, volunteers, and full-time qualified health professionals 2. Includes managerial and administrative structures and procedures (management, technical, and support staff) 3. Relies on a multidisciplinary team approach for service delivery 4. Uses protocols for support and clinical services for OI and pain assessment and management 5. Provides support and clinical services for OI and at least WHO level 2 pain assessment and management 6. Manages a basic referral network for provision of essential palliative care components
Level 4: Center of Excellence	1. All of the above 2. Manages a proactive referral network 3. Provides support and clinical services for OI and WHO level pain assessment and management 4. Provides technical assistance and training to partner organizations 5. Is a recognized palliative care champion

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