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# IDENTIFYING MOST-AT-RISK POPULATIONS AND HIV/AIDS REFERRAL SERVICES: BASELINE ASSESSMENT FOR MOBILE COUNSELING AND TESTING PROGRAM IN THE OROMIA REGIONAL STATE OF ETHIOPIA

April 2011

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# IDENTIFYING MOST-AT-RISK POPULATIONS AND HIV/AIDS REFERRAL SERVICES: BASELINE ASSESSMENT FOR MOBILE COUNSELING AND TESTING PROGRAM IN THE OROMIA REGIONAL STATE OF ETHIOPIA

## **DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government



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# ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
BCC	Behavior change communication
FGD	Focus group discussion
FSW	Female sex worker
HAPCO	HIV/AIDS Prevention and Control Office
HC	Health Center
HCT	HIV counseling and testing
HIV	Human immunodeficiency virus
KII	Key informant interview
LC	Lower Clinic
MARP	Most-at-risk population
NGO	Nongovernmental organization
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PHSP	Private Health Sector Program
PICT	Provider-initiated counseling and testing
PLHIV	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
RHB	Regional Health Bureau
STI	Sexually transmitted infection
TB	Tuberculosis
USAID	United States Agency for International Development



# DEFINITION OF TERMS

**Areki:** Local drink with an alcohol content of approximately 75 percent.

**Consistent condom use:** Use of condom during all sexual encounters.

**Cross-generational sex:** When a woman age 15-24 has non-marital intercourse with a man who is 10 or more years older than she.

**Female sex worker (FSW):** Females who sell/exchange sex for money/goods at their home, bars, hotels, restaurants, streets, or local brew houses.

**Iddir:** A community-based organization established by residents of the community. Its primary aim is to help members cope with the loss of family members. Also referred to as funeral insurance, *iddirs* provide physical, emotional, and financial support during the burial ceremony. Elders who have the respect of the community are usually elected as leaders.

**Kebele:** The smallest administrative unit of the Ethiopian government (urban and rural), equivalent to a neighborhood association. *Kebeles* are accountable to the *woreda* (district), city, or subcity administration.

**Region:** Ethiopia is divided into nine ethnically-based regional states and two federal city administrations (Addis Ababa and Dire Dawa), each with its own government directly accountable to the Federal Government.

**Risky sex:** Unprotected sex (without a condom) with a non-regular partner.

**Shisha:** Tobacco mixed with molasses and fruit flavors and smoked in a hookah (water pipe).

**Substances:** For the purposes of this study, stimulants other than alcohol. These include *khat* (*Catha edulis*), *shisha*, and *hashish* (marijuana).

**Transactional sex:** The exchange of sex for money or goods.

**Tella:** Locally brewed drink with an alcohol content of 5 to 10 percent.

**Town:** Often the capital of a *woreda* administration with its own local government.

**Warsa:** Marrying a brother's wife when the brother stays away for long time.

**Woreda:** An administrative division of a zone managed by a local government, equivalent to a district. *Woredas* are key political and administrative units with legal recognition and authority, including the delivery of services such as education, health, budget allocation, and management.

**Wuresa:** Wife inheritance.

**Zone:** A subdivision of a region with varying political and legal recognition as well as authority. A zone is divided into *woredas*.



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# EXECUTIVE SUMMARY

In collaboration with the Regional Health Bureau (RHB), the Private Health Sector Program (PHSP)-Ethiopia conducted this HIV counseling and testing (HCT) assessment in seven towns of the Oromia region to inform the design of mobile HCT services. PHSP, led by Abt Associates Inc. and funded by the United States Agency for International Development, is implementing and expanding access to HCT services in Ethiopia through outreach or mobile service delivery approaches.

The seven towns (Muger, Fincha, Gida, Gutin, Kiremu, Jimma Arjo, Bedele) have a number of most-at-risk population groups (MARPs), including in-school and out-of-school youth, female sex workers (FSWs), truckers, daily laborers, migrant plantation workers, and factory employees. This assessment aims to identify the magnitude and concentration of MARPs in these towns and develop recommendations for designing effective mobile HCT services that target the groups.

The assessment utilized both quantitative and qualitative methods. The assessment team conducted interviews with informants and did service mapping in each town. The team also held focus group discussions (FGDs), with FSWs, in-school and out-of-school youths, mobile workers, and adult women. The information solicited from these sources was triangulated to learn MARP knowledge level and attitudes about HIV preventive methods, especially HCT and the use of condoms.

The assessment found that Bedele has the largest number of college students, youths, and FSWs who do not use condoms consistently. All towns have many FSWs, truckers, and migrant daily laborers. These groups have complex sexual networks, with transactional, cross-generational, and extramarital sexual practices. Despite being engaged in risky sexual activities, youths, students (especially those in high school), and informal FSWs (those who operate in local brew houses) do not use condoms consistently. Excessive consumption of alcohol and use of khat as well as misconceptions about condoms were cited as the major barriers to condom use. All but one town has at least one public health institution and all have a nongovernmental organization (NGO) that provide HIV/AIDS-related services particularly targeting people who live with HIV.

The assessment found that the demand for HCT was high in all seven towns. Many FGD participants, particularly youth and FSWs, were not using the HCT services in public health facilities – their reasons for this included poor service quality, fear of stigma and discrimination, and perceived lack of confidentiality. People prefer accessing HCT services through outreach campaigns rather than static HCT service sites. Community members and health offices find the idea of mobile HCT useful. Interviewees emphasized the advantages of collaborating with NGOs and access to services on weekends and at workplaces to ways to better enhance use of HCT services.



# I. INTRODUCTION

According to the single point estimate, the national adult HIV prevalence rate in Ethiopia was estimated to be 2.4 percent in 2010 with a total of 1,216,908 people living with HIV (PLHIV), giving the country one of the largest HIV-infected populations in the world.

Available data and evidence indicate that the epidemic is generalized and heterogeneous, with marked variations across regions. It seems to have stabilized or even declined in most major urban centers but is increasing in small towns. However, there is significant variation in the epidemic by geographic areas and population groups, necessitating a response based on tailored and targeted HIV prevention interventions (HAPCO and the Global HIV AIDS Monitoring and Evaluation Team 2008).

Across the country, urban areas and females are more affected than rural areas and males. Urban HIV prevalence was estimated to be 7.7 percent in 2010, accounting for 62 percent of the total PLHIV in the country, while rural HIV prevalence was 0.9 percent in the same year, accounting for 38 percent of the total PLHIV population in the nation (FHAPCO 2010).

In 2010, the female HIV prevalence rate was estimated to be 2.9 percent while male HIV prevalence was 1.9 percent. In all the regions of the country and in both urban and rural areas, females are more affected than males (FHAPCO March 2010).

There is variation in HIV prevalence among regions by both urban and rural settings. Urban HIV prevalence ranges from 2.4 percent in the Somali Region to 10.8 percent in Afar Region. There is also variation in urban HIV prevalence among large regions (Oromia 6.1 percent, Southern Nations, Nationalities and Peoples 7.2 percent, Amhara 9.9 percent, and Tigray 10.7 percent) (FHAPCO 2010).

The Strategic Plan for Intensifying a Multisectoral HIV and AIDS Response in Ethiopia II (SPM II) (FHAPCO 2009) mentions that most-at-risk population groups (MARPs), such as female sex worker (FSWs), uniformed forces, long-distance drivers, never-married sexually active females, discordant couples, migrant laborers, cross-border population, and in-school youth particularly at tertiary education schools, are increasingly at risk of HIV infection. However, there remains a data gap to accurately measure the recent spread of HIV in these groups and their potential role in further spreading the epidemic to the general population.

Determinant factors that drive the epidemic and sexual behaviors among MARPs and other vulnerable groups have not been adequately explored but limited studies and anecdotal evidence indicate a number of factors that could be driving the epidemic, such as a low level of comprehensive knowledge about HIV/AIDS, a low level of perceived risk to the threat of HIV/AIDS, increased population migration, a high prevalence of unprotected sex in concurrent multiple partnerships, intergenerational and transactional sex, high prevalence of sexually transmitted infections (STIs), alcohol abuse, *khat* chewing, gender inequality and poverty (HAPCO and the Global HIV AIDS Monitoring and Evaluation Team 2008, Vuylsteke and Jana 2001).

As economic expansion accelerates, areas of infrastructure development – large-scale commercial farms, road construction sites, hydroelectric power stations, factories, trade routes, and new industrial zones – are all becoming “hot spots” for HIV transmission and should be targeted when in the design of prevention strategies.

The Private Health Sector Program (PHSP)-Ethiopia is implementing a five-year project targeting MARPs in urban settings and other hot spots. As its name implies, it will implement interventions in the private

health sector with a goal of enabling the Federal Ministry of Health (FMOH) and Regional Health Bureaus (RHBs) to effectively partner with the private health providers in delivering public health services. The project aims at increasing availability and use of HIV prevention information and commodities; increasing access to STI treatment including HCT, treatment, and care for adults and youths involved in transactional sex; and improving networking and capacity building for sustainable HIV prevention programming.

PSHP has been supporting mobile HIV counseling and testing (HCT) in order to reach hard-to-reach MARPs. This rapid mobile HCT assessment is, therefore, aimed at identifying the size and distribution of populations most at risk for HIV disease in seven Oromia towns. Assessment findings will help in designing mobile HCT services that are effectively linked to the ongoing community- and facility-based HIV continuum of care as well as in developing feasible strategies for increasing the demand for and access to mobile HCT services to MARPs in the assessment towns.

## 2. OBJECTIVES

The overall objective of this assessment is to collect and analyze data to develop recommendations for designing effective mobile HCT services targeting MARPs in the seven study towns.

The study's specific objectives are to:

- Identify the MARPs in the study sites in Oromia Regional State and determine their distribution, estimate the number of the target populations, and pinpoint specific localities where target population subgroups reside;
- Identify and document the health facilities and organizations providing HIV/AIDS services in each town, including facility-based services and community care and support services, to establish a referral network for mobile HCT follow-up;
- Identify the behaviors of MARPs, particularly regarding HIV risk behaviors and HCT service use, by collecting information that will be applied to the design and plan for mobile HCT services for each town, including the acceptability of services to target populations and local stakeholders, recommended service hours and locations, and potential partners to assist with implementation.



# 3. METHODOLOGY

## 3.1 STUDY SITES AND PERIOD

Data collection took place from February 27 to March 18, 2011, in seven towns in Oromia Regional State. The towns were selected based on criteria such as having a relatively large population, informal knowledge of traffic load, and a number of migrant/plantation/factory workers. In Oromia, the assessment covers the route that extends from Muger to Fincha and from Kirmu to Bedele. These routes have a relatively high concentration of industries and plantations and a huge concentration of mobile workers attracted by the flourishing of large-scale state farms.

**TABLE I. STUDY SITES IN OROMIA REGION, MARCH-APRIL 2011**

Zones	Name of the Route	Towns	Distance from Addis Ababa (kms)
West Shoa	Addis Ababa to Nekemete	Muger	65
Horoguderu Wollega	Addis Ababa to Shambu	Fincha	285
East Wollega	Addis Ababa to Asosa	Kiramu	478
	Addis Ababa to Asosa	Gida	447
	Addis Ababa to Asosa	Gutin	387
	Addis Ababa to Asosa	Arjo	383
Iluababora	Addis Ababa to Asosa	Bedele	510

## 3.2 STUDY DESIGN

The assessment employed a cross-sectional design that utilized both qualitative and quantitative methods, including key informant interviews (KII), focus group discussions (FGDs), and institutional mapping of MARPs. Twelve in-depth interviews were conducted, two in five towns and one each in Gida and Gutin (two in each of the six towns with representatives from the Woreda Health Offices, HIV/AIDS Prevention and Control Offices (HAPCOs), nongovernmental organizations (NGOs), community- and faith-based organizations, and development associations. Two FGDs were conducted with FSWs (in Bedele and Muger), as well as one with in-school youth and one with out-of-school youth in Jimma Arjo and Gutin respectively. One FGD was conducted with one with a mobile population in Fincha and one with a women's group in Kiremu.

Mapping of available HIV/AIDS-related services and information on MARPs was conducted in each town through a record review and interviews with officials from various sectoral offices including the health office, education office, town administration, and Trade and Industry Office.

## 3.3 SAMPLING AND SAMPLING STRATEGY

Study towns were selected purposively by the RHB in PHSP's implementation priority areas in Oromia. The number of FGDs, and KIIs was based on PHSP's experience with similar baseline assessments conducted under the previous Private Sector Program (PSP) – Ethiopia. KIIs were conducted with all relevant stakeholders and institutions in each town/woreda FGD respondents and FSWs were obtained using a snowball or chain sampling with the help of local organizations, such as the HAPCO, Women's Affairs Office, and Woreda Health Office. Because of the nature of the group, FSWs were identified beginning with a first contact who then helped identify another FSW to join the group and this

continued until the required number of FSWs in each town was reached. Group homogeneity was maintained in the case of FGDs as stipulated by the terms of reference.

### **3.4 DATA COLLECTION, MANAGEMENT, AND ANALYSIS**

The assessment team collected qualitative data using pre-tested and semi-structured KII questionnaires and FGD guides. The questionnaires and guides included questions about the situation of HIV/AIDS in the community, factors that contribute to the spread of HIV/AIDS, identification of the MARPs for HIV, condom use, availability of HIV/AIDS services, and recommendations to improve the services. All of the data collection tools were adapted from PHSP and reviewed by the consulting firm.

Six Seven FGDs, one in each town, were conducted. The FGDs were conducted with youths, adult women, and mobile populations. Twelve KIIs (two each in five towns and one each in Gida and Gutin) were conducted with FSWs, informants from the Woreda Health Offices, HAPCO, NGOs, and community-based and faith-based organizations in all the towns.

Quantitative data were mapped using a structured questionnaire to gather availability of HIV/AIDS services in the towns. This questionnaire facilitated the estimation of the total number of MARPs by subgroup and the availability of health services and implementing partners in the localities.

A three-person data collection team (one team leader and two data collectors), who received a two-day training with a practical session on pretesting of the data collection instrument, was deployed to collect the qualitative and quantitative data. PHSP and Le Monde Health and Development Consultancy (LHD), lead consultants, supervised the overall data collection process.

The qualitative data were transcribed immediately after the interviews. The principal investigator reviewed the transcribed data and did rigorous follow-up with the data collectors for clarification. The final transcription was used to identify and develop categories and themes for data content analysis. Finally, the data were interpreted with selected illustrations using respondents' own words. Microsoft Excel was used to present the quantitative data presented in tables throughout this report.

### **3.5 ETHICAL CONSIDERATIONS**

PHSP and the Oromia RHB agreed to jointly conduct this mobile HCT assessment in the selected towns. To facilitate the study, they sent request letters to the respective towns before implementation began.

Before starting an interview, the data collector explained the objective of the assessment and obtained verbal consent from the participant. The data collectors were trained on the principles of confidentiality. Individual respondent names were not recorded on the questionnaires; the only information recorded was the name of the data collector and contact addresses of organizations implementing HIV/AIDS-related activities in the study towns.

### **3.6 LIMITATIONS OF THE STUDY**

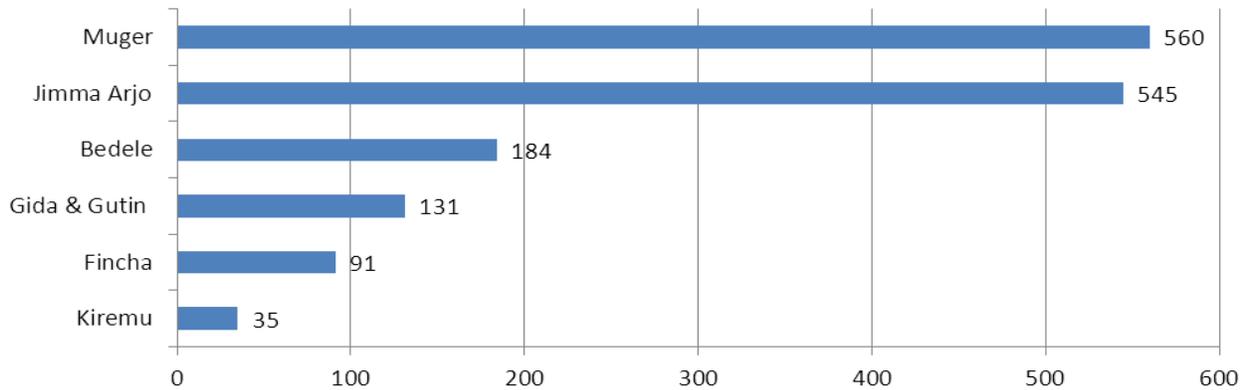
The study towns were selected by PHSP in consultation with the Oromia RHB. The selection criteria focused on HIV prevalence and anecdotal evidence of MARP concentration in these towns. However, the distribution of MARPs may not reflect the true nature of the burden of HIV and its related consequences in the region.

Incomplete data regarding out-of-school youth and uniformed persons limited the generalizability of this assessment. The FGDs and interviews did not include truckers and informal traders, who are key MARPs. Hence, behavioral characteristics of these groups were not included in the study.

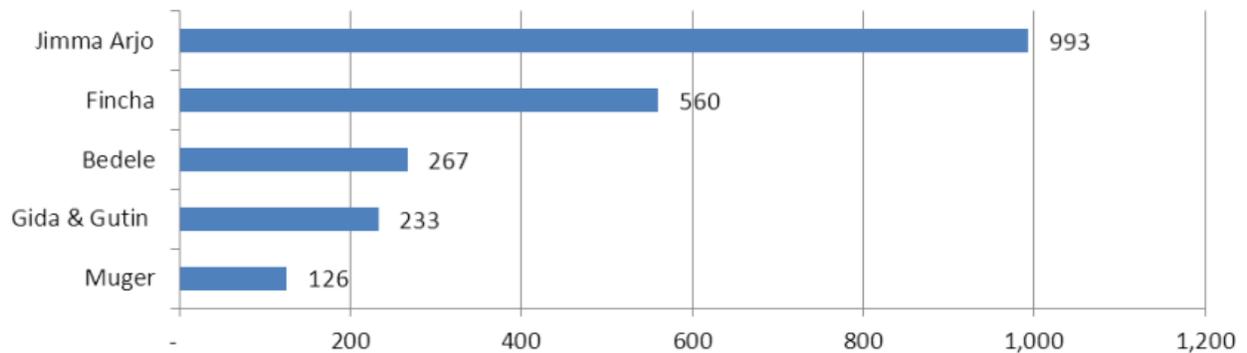
# 4. RESULTS

Seven towns were assessed in Oromia regional state. The results of the assessment for each town are described as follows. The assessment also described distribution of size of selected MARPs in each town below with the four graphs below.

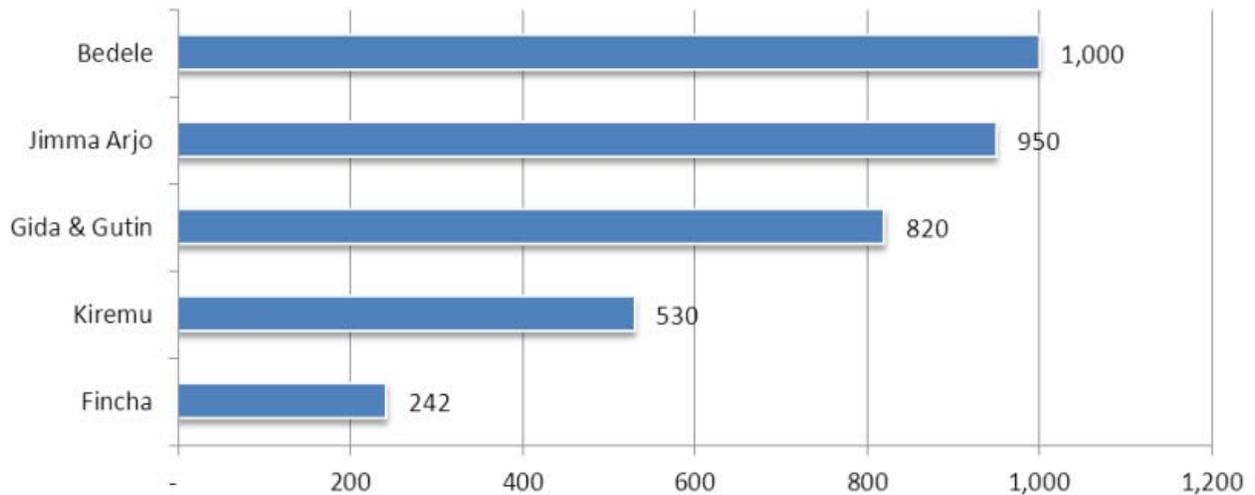
**FIGURE 1: DISTRIBUTION OF SIZE OF FSWS IN SEVEN TOWNS (GIDA AND GUTIN TOWNS TOGETHER) OF OROMIA REGIONAL STATE, MARCH 2010**



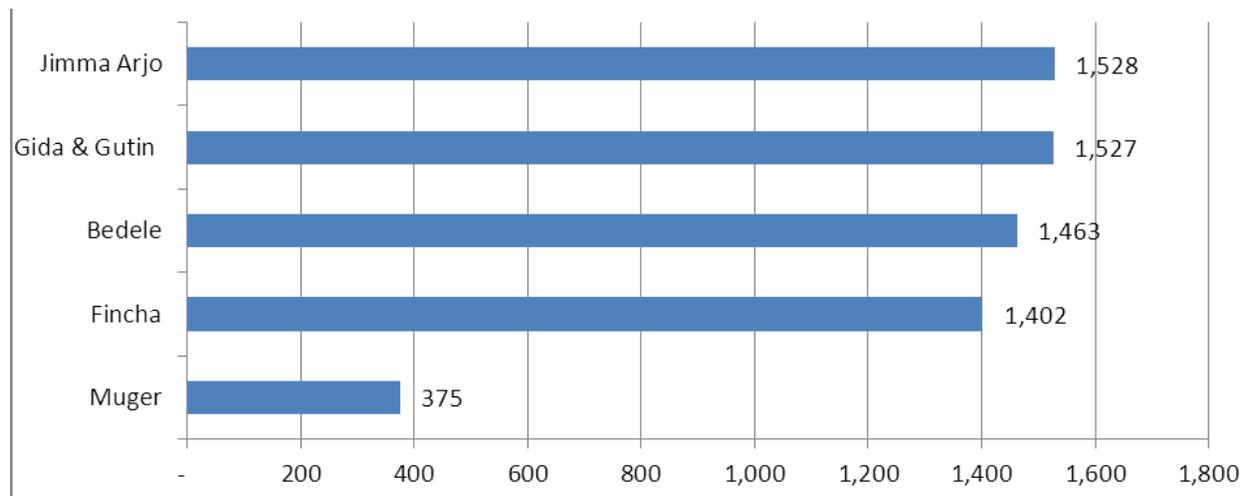
**FIGURE 2: DISTRIBUTION OF SIZE OF CONSTRUCTION WORKERS IN SEVEN TOWNS (GIDA AND GUTIN TOWNS TOGETHER) OF OROMIA REGIONAL STATE, MARCH 2011**



**FIGURE 3: DISTRIBUTION OF SIZE OF DAILY LABORERS IN SEVEN TOWNS (GIDA AND GUTIN TOWNS TOGETHER) OF OROMIA REGIONAL STATE, MARCH 2011**



**FIGURE 4: DISTRIBUTION OF SIZE OF TERTIARY LEVEL STUDENTS IN SEVEN TOWNS (GIDA AND GUTIN TOWNS TOGETHER) OF OROMIA REGIONAL STATE, MARCH 2011**



Among the seven towns, Muger has the highest number of FSWs followed by Arjo and Kiremu has the lowest. Arjo has the highest number of construction workers (993) followed by Fincha. Bedele has the highest number of migrant daily laborers (1000) followed by Gida (820) and both Arjo and Gida the highest number of tertiary level students (1528, 1528) and there are no tertiary level found in Kiremu.

## 4.1 MUGER

### 4.1.1 BACKGROUND

Muger is located in the West Shoa Zone of Oromia Region, 65 kilometers from Addis Ababa. The town has a population of 17,289 (8,731 males and 8,558 females). The total rural woreda population is 117,786 (59,482 males and 58,304 females). Muger Cement Factory is located in Muger. The town has two technical and vocational education and training colleges and four health centers. Tuberculosis (TB) and HIV/AIDS are reported to be major public health problems in the town.

### 4.1.2 MOST-AT-RISK POPULATIONS

According to KII and FGD responses, the factors that contribute to increased transmission of HIV are related to the presence of bars, hotels, and the local drinking houses (*areke* and *tella bets*), where commercial sex is readily available to the cement factory workers and employees of the Ethiopian Electric Power Corporation. These sites also attract and expose youth to transactional sex and subsequent unsafe sexual behavior practices. There are also large numbers of migrant plantation workers, truckers and their assistants, and day laborers, who have disposable cash to pay for sex.

The FGD participants, Woreda Health Office, and HAPCO key informants identified FSWs, mobile workers, day laborers, factory and plantation workers, truck drivers and their assistants, and youth as MARPs in Muger.

**TABLE 2. SIZE OF TARGET POPULATIONS IN MUGER, MARCH-APRIL 2011**

Target Group	Estimated Population		
	Male	Female	Total
Migrant day laborers during peak (harvest) season	170	60	230
Construction workers*	100*	26	126
Uniformed government employees (customs, police, immigration, defense forces, etc.)	779	375	1174
In-school youth (excluding college students)	15,310	13,330	28,640
Out-of-school youth (total)	317	147	464
Out-of-school youth in employment	281	108	389
College students (public)	169	75	144
Informal traders	50	30	80
Truck drivers	650	-	650
Female sex workers	-	560	560
Total	17726	14711	32457

\*Construction workers came for installation of electric power with their female cooks.

#### A. Female Sex Workers

An estimated 560 FSWs (460 permanent and 100 transient) reside in Muger, working in hotels and local drinking houses. Most of them are concentrated in Michi Sefer, Kuas Meda, Chase Sefer, and Libis Gebeya. Long-haul truck drivers and their assistants are the main clients of FSWs in hotels and bars, while farmers who come to town on market days (Sunday), youth affected by substance abuse (khat and alcohol), and Electric Power Company day laborers are the usual clients of the local drinking houses.

**TABLE 3: LOCATIONS WHERE FSW OPERATE IN MUGER, APRIL 2011**

Category	Name and Location
Hotels and bars	Axum Hotel, Kere Kebi
	Tigray Hotel, Chase Sefer
	Shiferaw Negash Hotel, Kuas Meda
	Areki and Tella Houses, Michi Sefer
Streets	Dmich Sefer
	Kere Kebi
	Chase Sefer
	Kuas Meda
Areki and tella bets locations	Libis Gebeya

### B. Truck Drivers

The service mapping and KII responses showed a significant number (650) of truck drivers and their assistants, especially those organized under public transport and the Muger Cement Company truckers, visit FSWs. These groups, especially those who spent the night in the town, are among the high-risk groups.

**TABLE 4: ESTIMATED NUMBER OF TRUCKS ENTERING AND LEAVING MUGER IN ONE DAY, APRIL 2011**

Selected Information	Details
Time	Morning (49)
	Mid day (43)
	Afternoon (36)
	Parking overnight (396)
Overnight parking locations	Inchini 01 kebele
	Muger 01 kebele
Bars, hotels, and restaurants	Axum Hotel, Kere Kebe Eshete Kefalew Hotel Tigray Hotel, Chase Sefer Shiferaw Hotel, Kuas Meda
Truck and bus companies	Muger Cement Trucks MIDROC Truck Company

### C. Youth (in-school and out-of-school)

Muger Town has 11 public schools including colleges. The total primary, secondary and tertiary level school enrollment is 28,884 young people (15,479 males and 13,405 females). The two tertiary public schools have a total of 375 students.

The key informant from HAPCO indicated that youth, including students, are among the most sexually active and high-risk groups in the town. Most of the cement factory workers and truckers with their assistants engage in transactional sex, and particularly target the youth (at school). They prefer to have unprotected sex and believe that young people are less likely to carry the virus.

Most students from rural areas share a rental house. Their sexual partners are truckers and their assistants, as well as fellow-student housemates. According to HAPCO, a significant number of the women visit health facilities seeking safe abortion services. This shows that the students engage in risky sexual behavior and are vulnerable to contracting HIV and other STIs.

## D. Migrant Day Laborers/ Construction Workers/Plantation Workers/Factory Employees

An estimated 230 migrant day laborers live in the town while they work for the electric company; 126 road construction workers employed by the Inchini-Olonkoni Road Construction Project also live there. A key informant said, “These groups of people have limited awareness and are likely to engage in unprotected sex with FSWs, mostly in local drinking houses.”

### 4.1.3 HEALTH FACILITIES, NGOS, AND HIV/AIDS SERVICES

Muger has five government health centers, four lower clinics, and four drug vendors. Three NGOs offer HIV care and support services. World Vision is providing information materials. Birhan Integrated Community Development Organization offers orphans and vulnerable children (OVC) services. These organizations mainly target PLHIV in the town, but there are very limited HIV/AIDS services specifically targeting MARPs.

According to HAPCO in-depth interviews, the town has limited HCT services. The number of people coming for HCT is very high, particularly couples who decide to get tested before marriage. FGD participants said, “There are people who don’t want to come to health center for HCT tests because they don’t want to be considered as patients by the community.” The woreda HAPCO indicated a need for mobile and outreach HCT services to help address this kind of concern. The ideal place for setting up this service would be around the bus stations, according to the HAPCO representative.

**TABLE 5: AVAILABILITY OF HEALTH SERVICES IN MUGER, APRIL 2011**

Name of Facility	Type of Facility	Services Provided					
		HCT	STIs	ART	OI	PMTCT	TB
Inchini HC	Public	√	√	√	√	√	√
Reji HC	Public	√	-	-	-	√	√
Olonkomi HC	Public	√	√	-	-	√	√
Kerkerosa HC	Public	√	√	-	-	√	√
Muger HC	Public	√	√	√	√	√	√
Rhobot LC	Private	-	-	-	-	-	-
Benya LC	Private	-	-	-	-	-	-
Ade’a LC	Private	-	-	-	-	-	-
Amanu’el LC	Private	-	-	-	-	-	-

Note: ART=antiretroviral treatment, OI=opportunistic infection, PMTCT=prevention of mother-to-child infection, HC=health center, LC=lower clinic

### 4.1.4 HIV COUNSELING AND TESTING SERVICES

Few FSWs took part in the FGD. They said they purposely do not disclose their HIV status so that they don’t lose their clients. They suggested that there is a need to improve the HCT services in terms of providing mobile HCT services at night and non-market days, targeting MARPs, mobilizing the target groups to create demand, and increasing awareness regarding service availability. One FSW said, “There are people who don’t want to come to a health center for HCT services because it is assumed that she is ill by the time the person visits the health center.” Therefore, FSWs suggest that the ideal place would be to provide HCT services around the municipality and kebele compounds.

According to HAPCO’s KII, there are limited HCT services in the town. The health facilities provide HCT at schools and during campaigns. The number of people coming for HCT is very high, especially during the marriage/wedding season.

## 4.2 FINCHA

### 4.2.1 BACKGROUND

Fincha is located in Horoguderu Wollega Zone of Oromia Regional State, and is 285 kilometers from Addis Ababa. The town has an estimated population of 8,471 (4,277 males and 4,194 females) and a rural population of 55,339 (27,946 males and 27,393 females). HIV/AIDS and TB infections are reported to be among the major public health problems in Fincha according to the Woreda Health Office representative.

### 4.2.2 MOST AT- RISK POPULATIONS

The presence of the Fincha Sugar Factory, a sugar cane plantation, and the Ethiopian Electric Power Company hydroelectric power construction site has attracted a large number of migrant day laborers. A number of uniformed government employees, college students, and truck drivers pass through the town. These groups constitute most of the town's MARPs, especially the migrant day laborers, uniformed persons, and college students. The town is also frequently visited by middle- and long-haul truck drivers and their assistants. The students, who come from the surrounding rural areas to attend high school and college, live together, usually sharing rented houses. They engage in risky sexual behavior with their fellow students and with other MARP groups.

The findings from the FGD, KIIs, and service mapping show that those factors have contributed to increased transmission of HIV in bars, hotels, and local drink houses, where transactional sex is readily available. The sugar factory and electric company workers, who are migrants and therefore are away from their normal partners, are likely to engage in unprotected transactional sex with FSWs and youth.

In summary, population groups identified as MARPs in Fincha include FSWs, mobile workers, day laborers, factory and plantation workers, truck drivers and their assistants, and youths.

**TABLE 6: SIZE OF TARGET POPULATIONS IN FINCHA, MARCH-APRIL 2011**

Target Group	Estimated Population		
	Male	Female	Total
Migrant daily laborers during peak season (harvest season)	164	78	242
Farm/plantation workers	1,851*	1,932	3,783
Construction workers	534**	26	560
Uniformed government employees (customs, police, immigration, defense forces, etc.)	898	424	1,322
In-school youth (excluding college students)	7,970	7,882	15,852
Out-of-school youth (total)	167	82	249
Out-of-school- in employment	NA	NA	NA
College students (private and public)	480	441	921
Informal traders	3	0	3
Truck drivers	40	0	40
Female sex workers	-	91	91
Total	9722	10956	23063

\*Workers at the Fincha Sugar Factory sugar cane plantation

\*\* Meshe camp's project workers

### A. Female Sex Workers

An estimated 91 permanent FSWs reside in Fincha. They work in hotels and local drinking houses.

FGD and KIIs showed construction workers, truck drivers, and uniformed service persons to be the main clients of FSWs in hotels and bars. The main clients of FSWs working in the local drinking houses are migrant day laborers and truck driver assistants.

**TABLE 7: LOCATIONS IN FINCHA WHERE FSWS OPERATE, MARCH-APRIL 2011**

Category	Name and Location
Hotels and bars	Yodi Hotel, Fincha 01
	Tikur Anbesa Hotel, Fincha 01
	Menagesha Hotel, Fincha 02
	Gemechu Hotel, Fincha 01
	Sisay Hotel, Fincha 02
	Areki and Tella Houses, Gulit
Streets	Dmich Sefer
	Kere Kebi
	Chase Sefer
	Kuas Meda
Areki and tella bet locations	Fincha Kebele 01 and 02

### B. Truck Drivers

Truck drivers and their assistants, especially the Fincha Sugar Factory and other private truck drivers, are among high-risk groups in the town. Truck drivers who spend their nights in the town are clients of FSWs and adolescent girls in the town, according to KIIs.

**TABLE 8: ESTIMATED NUMBER OF TRUCKS ENTERING AND LEAVING FINCHA TOWN IN ONE DAY, MARCH-APRIL 2011**

Selected Information	Details
Time	Morning (6)
	Mid day (5)
	Afternoon (4)
	Parking overnight (8)
Overnight parking locations	Inchini 01 Kebele
	Muger 01 Kebele
Bars, hotels, and restaurants	Yodi Hotel, Kebele 01
	Tolesa Hotel, Kebele 02
	Sisay Hotel, Kebele 02
	Menagesha, Kebele 02
	Aba Geda, Kebele 02
	Tikur Anbesa, Gult Kebele 01
Truck and bus companies	Fincha Sugar Factory transport
	Private truck companies

### C. Migrant Daily Laborers/ Plantation Workers/Factory Employees

As a result of mapping services, there were an estimated 3,783 Fincha plantation workers living in the town working in the Fincha Sugar Factory and a total 560 Nesh Dam construction workers, employed by the electric company. FGD participants and KII results showed that these groups of people have

limited HIV awareness and they engage in unprotected sex with FSWs, mostly at places like local drinking houses, hotels, and bars.

#### **D. Youth (in-school and out-of-school)**

The town has 15,371 primary and secondary school students and 1,402 tertiary-level students enrolled in the two private and 26 public schools. According to KII responses, most of the youth in the town chew khat, smoke cigarettes, and drink alcohol, which can predispose them to high-risk sexual behaviors. Transactional sex is widely practiced at local drink houses, among uniformed personnel, mobile workers, factory employees, and even students.

Most of the FGD participants agreed that the majority of the Fincha sugar cane plantation workers are youths who indulge in risky sexual behaviors with FSWs and female coworkers and also consume alcohol and chew khat. One FGD participant said, “We all are young, unmarried, and spend most of our leisure time drinking and having unsafe sex with FSWs, students, and our colleagues in the camp.”

### **4.2.3 HEALTH FACILITIES, NGOS, FORMAL AND INFORMAL ORGANIZATIONS WORKING ON HIV/AIDS**

There is one PLHIV association and two faith-based organizations providing HIV-related services in Fincha Town. The Hunde Feyine Gudere PLHIV Association provides care and support services. The two faith-based organizations target OVC and PLHIV, providing care, support, and HIV awareness-creation activities.

Fincha has four government and six private health facilities including the Fincha Sugar Factory and three government health centers. There are three lower clinics and three drugstores.

Two of the five health centers provide comprehensive HIV/AIDS clinical services, while the other three health centers provide only TB treatment services. None of the private health facilities provides HIV/AIDS-related services. There are also three local NGOs that provide care and support for PLHIVs and OVC services.

**TABLE 9: AVAILABILITY OF HEALTH SERVICES IN FINCHA, APRIL 2011**

Name of Facility	Type of Facility	Services Provided					
		HCT	STIs	ART	OI	PMTCT	TB
Finchea HC	Public	√	√	√	√	√	√
Homi HC	Public						
Finchea Sugar Factory HC	Public	√	√	√	√	√	√
Mozoria HC	Public	-	-	-	-	-	√
Gebeya Lega HC	Public	-	-	-	-	-	√
Sena LC	Private	-	-	-	-	-	-
Feneti LC	Private	-	-	-	-	-	-
Kubela LC	Private	-	-	-	-	-	-

### **4.2.4 COUNSELING AND TESTING SERVICES**

Respondents reported a huge demand for HCT services in the community. The Woreda Health Office and HAPCO officials welcomed the idea of the mobile HCT approach – according to these key informants, community members prefer to get tested for HIV at facilities far from where they reside as they are not confident that the health providers will keep their test results confidential.

During the FGD, the participants showed keen interest in receiving HCT services, if the government or NGO mobilizes the community in a way that motivates and ensures the availability and accessibility of the HCT services.

To make HIV testing friendly and easily accessible, the FGD participants suggested house-to-house HIV education and testing for the community. A key informant recommended outreach/mobile HCT as the best option to reach the MARPs in the town.

For women at the local drinking houses, bars, and hotels to access the HCT services, mobile HCT services should be set up around the “Tikur Anbessa Hotel.” For farmers and other people, HCT services could be set up on market day (Saturday) and be readily accessible if these were located around Gulit Sefer. The mobile population prefers to have the services at their camp, preferably after 2:00 p.m.

## **4.3 GIDA AND GUTIN**

### **4.3.1 BACKGROUND**

Gida is located in the East Wollega Zone of Oromia Regional State, 447 kilometers from Addis Ababa. The total urban population is 46,314 (25,291 males and 21,023 females). The major public health problems in Gida and Gutin are malaria and HIV. Gida Ayana Woreda has two small towns called Gida and Gutin. Having these small towns (Gida and Gutin) and a main road crossing these two towns the towns are considered as a high-risk corridor for HIV and other STIs, according to the Woreda HAPCO key informant. One FGD with out of school and KII with PLHIV have been conducted based on the Woreda Health officials’ recommendation.

### **4.3.2 MOST AT-RISK POPULATIONS**

As most of in-school youth spend their leisure time chewing khat or smoking shisa, they are prone to engage in unsafe sex practices and contract HIV and other STIs. There are also many unemployed youth in the town that abuse substances (alcohol, khat, etc.) and engage in risky sexual behaviors.

MARPs in the woreda include young boys and girls (both in-school and out-of-school), women working at tella and areki houses, women working in bars and hotels, and long-distance drivers (bus or truck). There is also a large influx of migrant day laborers during the harvest season (July–September), especially in Gutin.

Population groups identified as MARPs in Gida and Gutin are FSWs, migrant day laborers, middle- and long-distance bus drivers and truck drivers and their assistants, and youths.

**TABLE 10. SIZE OF TARGET POPULATIONS IN GIDA AND GUTIN, MARCH-APRIL 2011<sup>1</sup>**

Target Group	Estimated Population		
	Male	Female	Total
Migrant daily laborers during peak season	500	320	820
Farm/plantation workers	281	62	343
Construction workers	225*	108	233
Uniformed government employees (customs, police, immigration, defense forces, etc.)	1,062	549	1,611
In-school youth (excluding college students)	17,459	15,572	33,031
Out-of-school youth (total)	172	128	300
Out-of-school youth in employment	86	99	185
College students (public)	275	191	466
Informal traders	7	-	7
Truck drivers	58	-	58
Female sex workers	-	130	130
Total	19,900	17,159	37,184

\*Construction workers for the electric company substation and private buildings.

### A. Female Sex Workers

An estimated 130 FSWs (65 permanent and 65 transient) reside in Gida and Gutin, working in hotels and local drinking areas. In Gutin, FSWs are concentrated in Gojjam Sefer, Micheal Sefer, and the bus station, and in Gida in Pasta Sefer, Gebeya Sefer, and Addis Sefer.

Long-distance truck drivers and their assistants, day laborers, construction workers, traders, and electric company employees are the main clients of FSWs in hotels and bars; rural farmers who come to the town during market days also patronize FSWs.

**TABLE 11: LOCATIONS IN GIDA AND GUTIN WHERE FSWS OPERATE, MARCH-APRIL, 2011**

Category	Name and location
Hotels and bars	Limuber Hotel, Gebeya Sefer (Gida)
	Oromiaa Hotel, Pasta Sefer (Gida)
	Ayele Hotel, Michael Sefer (Gutin)
	Nekemte Bar, Michael Sefer (Gutin)
	Shewit Hotel, Michael Sefer (Gutin)
	Oromia Hotel, Mazonia
	Menafesha Hotel, Addis Ketema
Streets	Katanga Sefer, Pasta Sefer, Majoria Sefer (Gida)
	Michael Sefer, Nekemte ber, Gojam Sefer , Andode Mewecha (Gutin)
Areki and tella bet locations	Gojam Sefer
	Andode Mewcha
	Katanga Sefer (Gida)
	Michael Sefer, Gojam Sefer (Gutin)

<sup>1</sup> RHB combined numbers for Gida and Gutin because these towns are in the same district.

## B. Truck Drivers

An estimated 58 truck drivers and their assistants, especially those organized under Kenisa Truck and Dedesa Transport companies, are among the high-risk groups in the town, as they spend the night in the town.

**TABLE 12: ESTIMATED NUMBER OF TRUCKS ENTERING AND LEAVING GIDA AND GUTIN IN ONE DAY, MARCH-APRIL, 2011**

Selected Information	Details
Time	Morning (15)
	Mid day (35)
	Afternoon (20)
	Parking overnight (20)
Overnight parking locations	Bank Sefer, bus station (Gida) Michael Sefer, bus station (Gutin)
Bars, hotels, and restaurants	Tesfalem Hotel
	Oromia Hotel
	Gida Hotel, Global Café
	Nekemete ber Hotel
	Shewit Hotel
	Ayele Hotel
Truck and bus companies	Dedesa Truck company
	Kenisa Truck Company

## C. Migrant Daily Laborers/ Plantation Workers

An estimated 820 migrant day laborers live in Gida and Gutin, working mostly in large-scale agricultural enterprises. The migrant agricultural workers peak in during the harvest period, July through September. These laborers have limited awareness about HIV prevention and they are likely to have sex with FSWs, usually after going to the local drinking houses to consume alcohol.

## D. Youth (in-school and out-of-school)

There are 52 schools (47 primary, three secondary, and two tertiary level) with a student enrollment (primary, secondary and tertiary including 1 college) of 33,497 (of which 4,211 are secondary level and 1,527 preparatory and college students).

Because HIV-related stigma and discrimination is common in the town, most youths seem to be little motivated to seek out HCT services. Their level of awareness about HIV/AIDS transmission and prevention appears to be low, also posing a risk for this group. The youth are also vulnerable because they often live in poverty with some pushed into commercial sex work. The majority of their clients are state farm workers who come as migrant workers.

### 4.3.3 HEALTH FACILITIES, NGOS, FORMAL AND INFORMAL ORGANIZATIONS WORKING ON HIV/AIDS

There are three local PLHIV associations targeting PLHIVs. Moreover, the Oromia Development Association (ODA) provides family planning, STI services, and HIV-related services including care and support.

Gida has five government health centers. The town also has 15 private clinics: one medium clinic, 14 lower clinics, two drug vendors, and five drugstores.

**TABLE 13: AVAILABILITY OF HEALTH SERVICES IN GIDA AND GUTIN, MARCH-APRIL 2011**

Name of Facility	Type of Facility	Services Provided					
		HCT	STIs	ART	OI	PMTCT	TB
Gida Ayana Hospital(Gutin)	Public	√	√	√	√	√	√
Gida Ayana HC (Gida)	Public	√	√	√	√	√	√
Gutin HC (Gutin)	Public	√	√	√	√	√	√
Janger HC (Gida)	Public	√	√	-	-	-	√
Gebajimater HC (Gida)	Public	√	√	-	-	-	√
Denbel LC (Gida)	Private	-	-	-	-	-	-
Hawi LC (Gida)	Private	-	-	-	-	-	-
Wabe LC (Gida)	Private	-	-	-	-	-	-
Etiyof Joni LC (Gida)	Private	-	-	-	-	-	-
Mati LC	Private	-	-	-	-	-	-
Mayo LC (Gida)	Private	-	-	-	-	-	-
Gutin LC (Gida)	Private	-	-	-	-	-	-
International LC	Private	-	-	-	-	-	-
Aster LC	Private	-	-	-	-	-	-
Amanu'el LC (Gutin)	Private	-	-	-	-	-	-
Sena LC	Private	-	-	-	-	-	-
Zelalem LC (Gutin)	Private	-	-	-	-	-	-
Mengistu LC (Gutin)	Private	-	-	-	-	-	-
Eba LC	Private	-	-	-	-	-	-
Central MC (Gutin)	Private	-	√	-	-	-	-

### 4.3.4 COUNSELING AND TESTING SERVICES

Women who participated in the FGD said they know that government health facilities offer HCT and ART services, but they feel that the facilities are not convenient as they don't ensure privacy. If people find out their HIV status, it will be difficult to live with the associated stigma in the community. The women prefer to seek services on an outreach basis or from mobile services. The appropriate place would be "Kuas Meda" on Sunday after the usual church program (7:00 a.m.).

The HAPCO officials agreed that the mobile HCT approach is the best option for reaching women in Gida and Gutin. Because they fear stigma and discrimination, women want to get tested by someone whom they don't know. The recommended place is in the compound of municipality on Sunday afternoon.

A woman said, "Health extension workers in rural villages arrange a program for outreach HCT and invite staff from the health center on a regular basis (every three months), but we don't have a special outreach/ mobile program for the most-at-risk populations."

## 4.4 KIREMU

### 4.4.1 BACKGROUND

Kiremu is in the East Wollega Zone of Oromia Regional State, 478 kilometers from Addis Ababa. The total urban and rural population is 9,489 (4,825 males and 4,664 females) and 61,771 (26,988 males and 34,783 females) respectively. The major public health problems in the town are malaria, TB, and HIV.

### 4.4.2 MOST-AT-RISK POPULATIONS

The most common sexual relationships that exist in the town include sex among youth, sex between farmers and FSWs (on market days or overnight), and transgenerational sex. Town residents also practice *warsa* (marrying a brother's wife when the brother stays away for long time). Women who work in tella and areki houses are vulnerable due to the nature of their frequent/ contact with drunk clients, which may expose them to unsafe sex.

Population groups identified as MARPs in Kiremu include FSWs, mobile workers, day laborers, factory and plantation workers, truck drivers and their assistants, and youths.

**TABLE 14: SIZE OF TARGET POPULATIONS IN KIREMU, MARCH-APRIL 2011**

Target Group	Estimated Population		
	Male	Female	Total
Migrant daily laborers during peak season	530	-	530
Farm/plantation workers	500	-	500
Construction workers	30*	-	30
Uniformed government employees (customs, police, immigration, defense forces, etc.)	615	168	783
In-school youth (excluding college students)	8,220	6,790	15,010
Out-of-school youth (unemployed)	75	64	139
Out-of-school youth in employment	461	126	587
Truck drivers	15	0	15
Female sex workers	-	35	35
Displaced population**	1,643	2,117	3,760
Total	12059	9300	21389

\*Who work for electric power installations between Nekemte to Kiremu

\*\*From Wello, having been displaced two years ago, and now they have farmland and have started new lives here.

#### A. Female Sex Workers

An estimated 35 FSWs (15 permanent and 20 transient) reside in Kiremu Town, working in hotels and local drinking areas (areke and tella houses). Most of these FSWs are concentrated in Kiremu 01 and Haro 01 Kebeles.

Truck drivers and their assistants and migrant day laborers are the main clients of FSWs in the hotels and bars. Rural farmers who come to the town on market days are clients of FSWs who operate in local drinking houses.

**TABLE 15: LOCATIONS IN KIREMU WHERE FSWS OPERATE, MARCH-APRIL, 2011**

Category	Name and location
Hotels and bars	Millennium Hotel Kiremu 01 (Center town)
	Redet Hotel Kiremu 01
	Ediget Hotel Kiremu 01 (Wollo Sefer)
	Bogalech Hotel Kiremu 01
	Shiferaw Getahun Hotel Haro 01
Streets	Kiremu 01
	Haro 01
	Begi Tera
	Around the police station
Areki and tella bet locations	Haro 01 and Kiremu 01 (Bege Gebeya)

**B. Truck Drivers**

An estimated 58 truck drivers and their assistants, especially those organized under Abay Zuria Truck Association, Gisla and Dedesa Transport Company, are among the high-risk groups in the town as they spend the night in the town as clients of the FSWS.

**TABLE 16: ESTIMATED NUMBER OF TRUCKS ENTERING AND LEAVING KIREMU IN ONE DAY, MARCH-APRIL 2011**

Selected information	Details
Time	Morning (30)
	Mid day (15)
	Afternoon (15)
	Parking overnight (14)
Overnight parking locations	Kiremu 01
	Haro 01
Bars, hotels, and restaurants	Bogalech Hotel Kiremu 01
	Millinium Hotel Kiremu 01
	Ediget Hotel Kiremu 01
	Shiferaw Getachun Hotel Haro 01
Truck and bus companies	Abay Zuria Truck Association
	Gisila Truck Association
	Dedesa Truck Association

**C. Migrant Daily Laborers/ Plantation Workers/Factory Employees**

An estimated 530 migrant daily laborers working in the construction company for the electric power line expansion from Nekemete to Kiremu live in the town. This group has limited awareness about HIV and is likely to practice unsafe sex with FSWS, whom they meet in local drinking houses.

**D. Youth (in-school and out-of-school)**

There are 25 schools (23 primary and two secondary public schools) in the town with a total student population of 15,010. There are no tertiary level schools in Kiremu.

According to the KII with the Woreda Health Office, an increasing number of young girls migrate to the town for school, better jobs, and reproductive health services like abortion care, which indicates the presence of unsafe sexual practices among students. In addition, it is reported that peer pressure encourages most youths to initiate having sex at an early age.

### 4.4.3 HEALTH FACILITIES, NGOS, AND FORMAL AND INFORMAL ORGANIZATIONS WORKING ON HIV/AIDS

There are no NGOs operating in the town. Kiremu has two health centers and one drugstore. Only one health center provides ART and OI treatment. The HIV/AIDS services are not comprehensive and inadequate according to the Woreda Health Office.

**TABLE 17: AVAILABILITY OF HEALTH SERVICES IN KIREMU, MARCH-APRIL 2011**

Name of Facility	Type of Facility	Services Provided					
		HCT	STIs	ART	OI	PMTCT	TB
Kiremu HC	Public	√	√	√	√	√	√
Kokofe HC	Public	√	√			√	√

### 4.4.4 COUNSELING AND TESTING SERVICES

According to the HAPCO, people prefer to go to private and other outreach/mobile testing centers because they do not trust that the government health centers will keep their HCT services and results confidential. People hesitate to disclose their health status to someone who they know works in a government health institution. Activities such as awareness raising, training of health personnel, provision of test kits, and support for PLHIV need follow-up actions. The key informant at the HAPCO also suggested the need to make public HCT services MARP friendly. Because the only health center is far from the main public residential areas, it is essential to increase HCT services accessibility through outreach and mobile HCT.

Despite the fact that women are highly affected, the services do not address women in particular. A woman said, *“The service is not convenient for women. Even if we sought the service at the health facilities, the health care providers are not cooperative enough to serve us well and our HCT results are not treated as confidential.”*

## 4.5 JIMMA ARJO

### 4.5.1 BACKGROUND

Arjo is located in the East Wollega Zone of Oromia Regional State, 383 kilometers from Addis Ababa. The total estimated urban population residing in the town is 9,702 (4,755 males and 4,947 females). A record review showed that HIV/AIDS, maternal and child illnesses, malaria, and TB are the most common causes of morbidity and mortality in the town.

### 4.5.2 MOST-AT-RISK POPULATIONS

Risky sexual practices are evident in this town, for example, sex among in-school youth, transactional sex in tella and areki drinking houses, and polygamy and *wuresa* (wife inheritance).

Most young girls are targets for the sugar factory workers, and they are prone to have unprotected sex with elderly partners as they can hardly negotiate for safe sex, not really knowing or understanding what this means and entails. Rural girls leave their school to work in the sugar factory as daily laborers. There is also a large number of migrant day laborers who are potential clients of FSWs, having come to the town from nearby rural areas.

Population groups identified as MARPs include FSWs, migrant day laborers, construction workers, truck drivers and their assistants, and youths.

**TABLE 18: SIZE OF TARGET POPULATIONS IN ARJO, MARCH-APRIL 2011**

Target Group	Estimated Population		
	Male	Female	Total
Migrant daily laborers during peak season	600	350	950
Farm/plantation workers	240	150	390
Construction workers	767	266	993
Uniformed government employees (customs, police, immigration, defense forces, etc.)	817	313	1,130
In-school youth (excluding college students)	11,504	10,021	22,525
Out-of-school youth (total)	2,612	1,216	3,828
Out-of-school youth in employment	439	216	655
College students (private and public)	36	20	56
Truck drivers	58	-	58
Female sex workers	0	545	545
Displaced population	963*	815	1,778
Total	17073	13912	32908

\*Came from Selale and Harerge seven years ago in 2003 as part of a resettlement program.

### A. Female Sex Workers

An estimated 545 FSWs (300 permanent and 245 transient) live in Jimma Arjo, working in hotels and local drinking areas (areke and tela houses). Most of these FSWs are concentrated in Genet Sefer, Dedesa Auround Al Abesh Sugar Factory.

Long-haul truck drivers and their assistants, day laborers, construction workers, traders, and electric company employees are the main clients of FSWs in the hotels and bars. Farmers come to the town on market days, and a common practice to have sex with a FSW.

**TABLE 19: LOCATIONS IN JIMMA ARJO WHERE FSWs OPERATE, MARCH-APRIL 2011**

Category	Name and Location
Hotels and bars	Hirko Hotel, in front of the Mosque
	Hera Hotel, in front of the Mosque
Streets	Genet Sefer
	In front of the Mosque
	Michael Sefer
Areki and tella bets locations	Genet Sefer

### B. Truck Drivers

An estimated 58 truck drivers and their assistants, especially those who are organized under Kenisa Truck and Dedesa Transport Companies and who spend the night in the town and patronize FSWs, are among the high-risk groups in the town.

**TABLE 20: ESTIMATED NUMBER OF TRUCKS ENTERING AND LEAVING JIMMA ARJO IN ONE DAY, MARCH-APRIL 2011**

<b>Selected information</b>	<b>Details</b>
Time	Morning (40)
	Mid day (20)
	Afternoon (10)
	Parking overnight (16)
Overnight parking locations	In front of Mosque
Bars, hotels, and restaurants	Hirko Hotel, in front of Mosque
	Biruk Hotel, Near St. Michael church
	Areki and tella houses, Genet Sefer
Truck and bus companies	Waliya Transport Company
	Dedesa Truck Association

### **C. Youth (in-school and out-of-school)**

The town has 39 primary, two secondary and two tertiary-level schools. The total student population is 22,581 of which 3,571 are enrolled in secondary and tertiary level schools.

The key informants said the presence of a new sugar factory makes young girls vulnerable, as they often have unsafe sexual relationships with the factory workers. Some rural young girls withdraw from their education and join the sugar factory to work as day laborers. There is also transactional sex among the youth, and tattooing, warsa, and wuresa practiced in the town, posing risks for HIV transmission.

One of the in-school youth reported, *“HIV-related services at the health center are not addressing the problem of in-school youth because there are HIV-positive students in our school but they didn’t receive any counseling or other care and support services. Even the professionals at the health center are not friendly and don’t provide us with accurate information.”*

### **D. Migrant Daily Laborers/ Plantation Workers/Factory Employees**

An estimated 950 migrant day laborers live in the town working in private construction companies and with the electric company on the electric grid expansion from Fincha to Gida. These groups have limited awareness about HIV transmission and are likely to engage in unsafe sex practices with FSWs, mostly in local drinking houses. Since day laborers are both male and female, they also have sexual relations with each other, which fuels the spread of the virus.

### **4.5.3 HEALTH FACILITIES, NGOS, FORMAL AND INFORMAL ORGANIZATIONS WORKING ON HIV/AIDS**

There is one local NGO, Arjo Mekane Eyesus, that targets PLHIV, providing them care and support. Six *iddirs* in the town also have activities that focus on PLHIV care and support.

Jimma Arjo Town has three health centers, 10 lower clinics, and two drug vendors. There is only one health center that provides all HIV/AIDS-related services including ART, TB, HCT, and chronic care.

**TABLE 21: AVAILABILITY OF HEALTH SERVICES IN JIMMA ARJO, MARCH-APRIL 2011**

Name of Facility	Type of Facility	Services Provided					
		HCT	STIs	ART	OI	PMTCT	TB
Arjo HC	Public	√	√	√	√	√	√
Gambo HC	Public	√	√				√
Wayu wereke HC	Public	-	-	-	-	-	√
Tayech LC	Private	-	-	-	-	-	-
Hundaol LC	Private	-	-	-	-	-	-
Arjentina LC	Private	-	-	-	-	-	-
Meta LC	Private	-	-	-	-	-	-
Gemechis LC	Private	-	-	-	-	-	-
Segni Bontu LC	Private	-	-	-	-	-	-
Hailu LC	Private	-	-	-	-	-	-
Three Brothers LC	Private	-	-	-	-	-	-
Haro Kumba LC	Private	-	-	-	-	-	-
Hunde Gudina LC	Private	-	-	-	-	-	-

#### 4.5.4 COUNSELING AND TESTING SERVICES

Most of the FGD participants, who are not using the services provided at the health center, welcomed the idea of mobile HCT services. The youths suggested mobile/outreach HCT would be preferable if organized in their school compound on Monday to Thursday and after 2:00 p.m.

HAPCO officials said, “We think that even the rural community is requesting outreach/mobile HCT services. People want to get tested at nearby locations especially during an iddir meeting because they don’t want to be seen at health center for HCT services and they don’t want long waiting times, which usually occur at the government health centers.” The HAPCO official suggested that to make HCT friendly and easily accessible, NGOs should work with influential people like the elderly, kebele leaders, and religious leaders in arranging outreach/mobile HCT programs.

## 4.6 BEDELE

### 4.6.1 BACKGROUND

Bedele is located in Iluababora Zone of Oromia Regional State, 510 kilometers from Addis Ababa. The total urban population residing in the town is 26,364 (12,707 males and 13,657 females). The main public health problems in the town are TB, malaria, HIV with OIs, and intestinal parasites.

### 4.6.2 MOST-AT-RISK POPULATIONS

Risk factors for increased transmission of HIV in Bedele, particularly for youth who engage in unsafe transactional sex, are the widespread practice of commercial sex at bars, hotels, and local drinking houses (areke and tella houses) which are frequented by those who work the Bedele Beer factory and the electric power company. There is also a large number of migrant plantation workers and day laborers who have disposable cash to pay for sex.

Population groups identified as MARPs are FSWs, mobile workers, day laborers, factory and plantation workers, truck drivers and their assistants, and youths.

**TABLE 22: SIZE OF TARGET POPULATIONS IN BEDELE, MARCH-APRIL 2011**

Target Group	Estimated Population			Remark
	Male	Female	Total	
Migrant daily laborers during peak season (time of the peak season)	600	400	1,000	
Construction workers	187	80	267	
Uniformed government employees (customs, police, immigration, defense forces, etc.)	163	77	240	
In-school youth (excluding college students)	5,502	5,331	10,833	
Out-of-school youth (total)	170	140	310	
Out-of-school youth in employment	90	70	160	
College students (private and public)	587	475	1,062	
Informal traders	42	5	47	
Truck drivers	10	-	10	
Female sex workers	-	264	264	
Total	7,351	6,842	14,193	

**A. Female Sex Workers**

An estimated 264 FSWs (184 permanent and 80 transient) work in hotels and local drinking areas in Bedele Town. Most of these FSWs are concentrated in Dabo Ber and Doro Manekias.

Long-haul truck drivers and day laborers are the main clients of FSWs in hotels and bars. Rural farmers who come to town during market days (Gebeya), truck driver's assistants, and youths who have become addicted to *khat* and/or alcohol are clients of FSWs who work in the local drinking houses.

**TABLE 23: LOCATIONS IN BEDELE WHERE FSWS OPERATE, MARCH-APRIL 2011**

Category	Name and Location
Hotels and bars	Nager Selam Hotel, Medehani Alem Sefer
	Misrach Hotel, Medehani Alem Sefer
	Tana Hotel, Dabo Ber
	Menahiria Hotel, Dabo Ber
	Ilubabor Bar, Gore Ber
	Saba Hotel, Jimma Ber
	Mola Hotel, Jimma Ber
Streets	Doro Manekia
	Dabo Ber
	Medhanialem Sefer
	Gore Ber
	Jimma Ber
Areki and tella bet locations	Doro Manekia, Dabo Ber

## B. Truck Drivers

A significant number of truck drivers and their assistants, especially those organized under public transport (bus station/*Menehariya*) are among the high-risk groups in the town. Those working around the bus station are young, usually 12–19 years of age, illiterate, substance addicted, and engaging in unsafe sex available at the local areke and tela houses. Truck drivers who spend the night in the town and have sex with FSWs, and the Bajaj drivers who have multiple sexual partnerships, are also among the MARPs.

**TABLE 24: ESTIMATED NUMBER OF TRUCKS ENTERING AND LEAVING BEDELE IN ONE DAY, MARCH-APRIL 2011**

Selected information	Details
Time	Morning (40)
	Mid day (20)
	Afternoon (15)
	Parking overnight (20)
Overnight parking locations	Bedele Beer Factory Dabo Ber Jimma Ber
Bars, hotels, and restaurants	Hagereslam Hotel, Medhanialem Sefer
	Tana Hotel, Dabo Sefer
	Misrach Hotel, Medhanialem Sefer
	Menaharia Hotel, Dabo Sefer
Truck and bus companies	

## C. Migrant Daily Laborers/ Plantation Workers/Factory Employees

An estimated 1,000 migrant day laborers working in the Bedele Beer Factory and the electric power company live in the town. These groups have limited HIV prevention awareness and usually engage in unsafe sex with FSW, mostly in local drinking houses. Because day laborers are both male and female, they also have sexual relations with each other, which fuel the spread of the virus.

## D. Youth (in-school and out-of-school)

There are approximately 310 out-of-school youth and 11,234 students enrolled in 7 primary ( 6 government and 1 private) , two secondary government and 2 tertiary level ( 2 government and 1 private ) schools (3,571 students are in secondary school (2043) and tertiary level including 1 private collage (1528).

Informants noted that the youth are the most vulnerable segment of the population with their inconsistent condom use, evidenced by a high incidence of unintended pregnancies.

### 4.6.3 HEALTH FACILITIES, NGOS, AND FORMAL AND INFORMAL ORGANIZATIONS WORKING ON HIV/AIDS

There are three NGOs, 22 *Iddirs*, and one youth association implementing HIV-related services in the town, particularly HIV prevention education.

Bedele Town has one government hospital, two health centers, and the Bedele Brewery Clinic. The town also has two private medium clinics, three lower clinics, one pharmacy, and five drugstores. The hospital provides comprehensive HIV/AIDS services.

#### **4.6.4 COUNSELING AND TESTING SERVICES**

According to the FGD conducted with FSWs, HCT services that are provided at the health center are not accessible to women working at bars/hotels. These women want to go for services either nearby or close to their bars/hotels where they work. FSWs said the existing services lack privacy and confidentiality does not exist. Information collected from different sources showed that most of the community wants HCT services. However, they are not interested in receiving HCT services at health facility due to the lack of privacy and confidentiality. Interviewees welcomed the idea of mobile HCT services. One of the FGD participants suggested, *“If the HCT services are accessible and ensure confidentiality, I am willing to get tested.”* FSWs suggested that the mobile HCT services be offered close to hotels/bars to attract clients and services should be scheduled preferably on Wednesdays and Fridays. They also suggest using dramas and mass media to mobilize the community.



# 5. DISCUSSION AND CONCLUSION

HCT is the key entry point to prevention, care, treatment, and support services, in which people learn their HIV status, are supported in understanding the implications of the result, and can make informed decisions about their own health.

The demand for HCT services is very high in all the towns where the mobile HCT assessment was conducted. HCT services are being provided, mostly by the public health centers. In Bedele Town, PSHP supported private health facilities in HCT service provision but participation of the private health facilities is limited. The services provided by the government are of limited appeal due to lack of privacy and perceived lack of confidentiality. The key informants reported they are enthusiastic about the mobile HCT approach because it creates an opportunity to fill the gap of unmet need for HCT and to target MARPs.

The increasing number of large – scale state and privately owned farms and factories in the area have attracted large numbers of mobile workers, migrant laborers, truckers, and FSWs.

The assessment found that Jimma Arjo has the highest numbers of MARPs (32,908) and Bedele the lowest (14,193). Jimma Arjo also has the highest number of FSWs and youth population urging the town to focus on HIV prevention interventions.

Places like Fincha have the most plantation workers due to the presence of a sugar factory and a large-scale sugar cane farm that has peak harvest seasons for migrant day laborers and therefore a seasonal influx of sex workers who would benefit from well-timed and targeted services such as mobile HCT.

The practice of wife inheritance is very common in Kiremu; this will require special attention. Towns with high numbers of students and out-of-school youth, such as Muger, Gida, and Jimma Arjo, also need tailored interventions that would address both commercial and transactional sexual practices.

Rural men visit the FSWs who are based in local drinking houses, usually engaging in unsafe sex under the influence of alcohol. These rural workers are among those who have the least access to information and services related to HIV, and they are most at risk to transmit HIV infection to their families and rural communities. They should be reached with education and services such as HCT outreach. Targeting market days and the regular petty markets (gulits) for education and service provision is very important. Events at one marketplace could increase the uptake of key HIV information for many people over time.

The day laborers, migrant workers, and rural men also visit FSWs. These groups have similar characteristics including being less aware of HIV, having less access to services, and being less likely to use condoms.

HIV/AIDS services do not target MARPs in part because they are hard to reach. Most of them are self-employed, and therefore are not available during normal working hours. Innovative local strategies should be devised in collaboration with local partners to reach this group and provide health information and services.

Because of the lack of confidentiality and privacy, and stigma and discrimination, HCT service utilization in most towns is very low. Mobile HCT can improve access through counselors who are not from the

same area. Proper timing and placement of the mobile services and tailoring them to the needs of different MARPs are very important.

## 6. RECOMMENDATION

- Based on the findings from this assessment, displaced, migrant, and mobile populations should have access to user-friendly HCT and HIV care services similar to those provided to other more static populations. Specifically, the following actions are recommended for PHSP's supported mobile HCT services:

### TARGETING MARPS

- Mobile HCT that reaches mobile groups should target specific locations rather than a given population group.
- Mobile HCT services should be given special attention and made available for new migrants who are arriving in unfamiliar surroundings and hence unaware of the risks they face.
- Targeting beneficiaries and mobile HCT site selection should be done in consultation with key stakeholders and implementing partners in each town.
- Services should be appropriate for rural residents and provide regularly scheduled mobile HCT services to increase service uptake.

### COMMUNITY MOBILIZATION

- HIV education together with mobile HCT services should be made available at points of departure and arrival of migrant and mobile populations to mobilize these population groups to seek out these services.
- Develop and use proven effective communication channels identified in the study, including community conversations, Anti-AIDS clubs, peer-to-peer education, audio shows and print materials to mobilize MARPs and vulnerable group for mobile HCT services. Example: use public media and local FM radio to inform local communities about the dates of HCT services in each town. Messages should be expressed in the local language spoken in the town.
- In collaboration with Woreda and Town Health Offices and HAPCO, develop and implement a strategy to complement mobile HCT services with targeted BCC efforts among MARPs to increase condom use, HIV and STI prevention activities, and reduce stigma associated with HCT services at health facilities.

### ACTIVITIES TO IMPLEMENT

- Partnerships should be promoted to facilitate mobile HCT access for hard-to-reach people, bring about policy improvement and help to create a supportive environment for mobile population groups. They should draw upon diversified resources, encouraging stakeholders to make interventions more effective and sustainable.
- Population movement is complex and dynamic. Understanding how it works and how it changes provides a starting point in planning, implementing, and refining mobile HIV/AIDS interventions.
- The issue of stigma during HCT services was frequently mentioned in this assessment, therefore MARPs' and other vulnerable groups' fears and concerns should be addressed in the planning and site selection process, for example:

- Service providers should be from towns other than where the MARP groups reside.
- HCT services should be conveniently available to these groups (in terms of location, days, and times). As identified by FGD and key informants, PHSP should consider scheduling service provision to address different groups of MARPs in each town, e.g., early morning hours (before work time) and lunch times (for day laborers and migrant workers), evenings (for FSWS and truck drivers), market days (for farmers and informal traders), within school compounds in the afternoons (for students)
- Site selection should be done carefully, to maintain privacy of the MARPs.

# ANNEXES



# ANNEX I: LIST OF SCHOOLS IN SIX OROMIA TOWNS, APRIL 2011

## MUGER

### PRIMARY SCHOOLS (1-8 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Primary Governmental schools (11)	Government	13,588	12,071	25,659
Gezaheng Abera*	Private	271	265	536
Total		13,859	12,336	26,195

### SECONDARY SCHOOLS (9-10 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Inchini High school	Gov't	841	514	1355
Muger Community*	Gov't	135	110	245
Reju High School	Gov't	400	314	714
Total		1,376	938	2,314

### TERTIARY/ COLLEGES/VOCATIONAL/PREPARATORY SCHOOLS (NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Inchini preparatory	Gov't	75	56	131
Muger Community*	Gov't	169	75	244
Total		244	131	375

## FINCHA

### PRIMARY SCHOOLS (1-8 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Primary schools in Fincha (23)	Gov't	6171	6498	12669
Horoguduru Primary School	Private	227	79	306
Total		6398	6577	12975

### SECONDARY SCHOOLS (9-10 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Fincha secondary school	Gov't	712	688	1400
Agemsa Secondary school	Gov't	384	285	669
Homi Secondary School	Gov't	186	141	327
Total		1282	1114	2396

### TERTIARY/ COLLEGES/VOCATIONAL/PREPARATORY SCHOOLS (NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Fincha preparatory	Gov't	290	191	481
Horoguduru College	Private	480	441	921
Total		770	632	1402

## KIREMU

### PRIMARY SCHOOLS (1-8 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Primary Schools in Kiremu (23)	Gov't	7202	5923	13125

### SECONDARY SCHOOLS (9-10 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Kiremu Secondary School	Gov't	770	663	1433
Kokofe Secondary School	Gov't	248	204	452
Total		1018	867	1885

### TERTIARY/ COLLEGES/VOCATIONAL/PREPARATORY SCHOOLS (NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
No Tertiary School	0	0	0	0

## GIDA AND GUTIN

### PRIMARY SCHOOLS (1-8 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Primary schools in Gida (47)	Gov't	14,316	13,443	27,759
Total		14,316	13,443	27,759

### SECONDARY SCHOOLS (9-10 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Gida Secondary School	Gov't	1221	1113	2334
Anger Guten Secondary School	Gov't	680	373	1053
Janger Secondary School	Gov't	548	276	824
Total		2449	1762	4211

**TERTIARY/ COLLEGES/VOCATIONAL/PREPARATORY SCHOOLS  
(NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)**

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Gida Ayana TVET	Gov't	275	191	466
Gida Preparatory	"	694	367	1061
Total		969	558	1527

**JIMMA ARJO**

**PRIMARY SCHOOLS (1-8 GRADE; NAME OF SCHOOLS AND  
NUMBER OF STUDENTS BY SEX)**

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Primary schools in Arjo (39)	Gov't	9418	9592	19010

**SECONDARY SCHOOLS (9-10 GRADE; NAME OF SCHOOLS AND  
NUMBER OF STUDENTS BY SEX)**

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Gombo Secondary School	Gov't	192	124	316
Arjo Secondary School	Gov't	979	748	1727
Total		1171	872	2043

**TERTIARY/ COLLEGES/VOCATIONAL/PREPARATORY SCHOOLS  
(NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)**

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Arjo Preparatory	Gov't	337	232	569
Arjo Tech and Vocational	Gov't	578	325	903
Mushken College	Private	36	20	56
Total		951	577	1528

## BEDELE

### PRIMARY SCHOOLS (1-8 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Bedele No. 2	Gov't	211	200	411
Janmeda	Gov't	844	828	1672
Zemlem Kanl	Gov't	693	678	1371
Bedele elementary	Gov't	309	303	612
Fana Acadamy	Private	71	54	125
Ras Tesema	Gov't	607	615	1222
Ula Wellega	Gov't	184	206	390
Total		2848	2830	5678

### SECONDARY SCHOOLS (9-10 GRADE; NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Bedele Secondary School	Gov't	1522	1544	3066
Ingibi Secondary School	Gov't	545	482	1027
Total		2067	2026	4093

### TERTIARY/ COLLEGES/VOCATIONAL/PREPARATORY SCHOOLS (NAME OF SCHOOLS AND NUMBER OF STUDENTS BY SEX)

Name	Ownership (Govt, Private, NGO)	Males	Female	Total
Dabena TVET College	Gov't	407	347	754
Dandi Boru College	Private	180	128	308
Bedele Preparatory	Gov't	259	142	401
Total		846	617	1,463



# ANNEX 2: LIST OF HEALTH FACILITIES IN SIX OROMIA TOWNS, APRIL 2011

## HEALTH FACILITIES: PUBLIC/PRIVATE/NGO

SN	Name of Health Facility	Contact Person	Private / Gov NGO	Office Tele	Mobile	Physical Address	HIV related services					
							HCT	STI	ART	OI	PMTCT	TB
<b>Bedele</b>												
1.1	Bedele Hospital	Kasa Ayele	Gov't	0474451644	0911050983	Bedele	A newly constructed but, will start service after few days					
1.2	Bedele HC	Benya Benti	Govt	0474450112	0917813497	Bedele	√	√	√	√	√	√
1.3	Bedele Brewery Clinic	Ejigu Kumsa	Public	0474450147 ext. 256 0474450148	0913973468	Bedele	√	√	-	-	-	√
1.4	Addis Hiwot HC	Dr. Mesfin Mengistu	Private	0474457122	0911407122	Medehanialem Sefer	√	√	-	-	-	√
1.5	Dr. Feye MC	Dr. Feye Bonsa	Private	0474451499	0911728000	Ababoku Sefer	-	√	-	-	-	-
1.6	Bedele MC	Dr. Gobeze Tefera	Private	-	0911719304	Jimma Ber Sefer	-	√	-	-	-	-
1.7	Robera LC	Tibebu Amenter	Private	0474450181	0917806187	Menahriya Sefer	√	√	√	√	√	√
1.8	Didesa LC	Terfa Jibera	Private		0917805858	Wellegaber Sefer	√	√	-	-	-	√
1.9	Sidisa LC	Alemayew Mekuriya	Private		0917805693	Sidisa Sefer	√	√	-	-	-	√
<b>Fincha</b>												
2.1	Finchea HC	Tarekegn Deslegn	Gov't	0576640047	0913408294	Finchea	√	√	√	√	√	√
2.2	Homi HC	Sileshi Mulugeta	Gov't		0912093155	Homi	-	-	-	-	-	-
2.3	Fincha sugar factory HC	Dr. Sorie Reje	Factory	0576641004	0911768456	Fincha	√	√	√	√	√	√
2.4	Mozoria HC	Dereje Bekana	Gov't		0917078585	Mazoria	-	-	-	-	-	√
2.5	Gebeya Lega HC	Nigusa Belay	Gov't		0917038246	Gebalega	-	-	-	-	-	√

2.6	Sena LC	Befekadu Gebisa	Private		0913755109	Fincha 01	-	-	-	-	-	-
2.7	Feneti LC	Habtamu Abdisa	Private		0911388806	Fincha 02	-	-	-	-	-	-
2.8	Kubela LC	Tigist Bekele	Private		0917805263	Fincha 01	-	-	-	-	-	-

#### Gida and Gutin

3.1	Gida Ayana Hospital	Amen Dinsa	Gov't	0577730581	0917374292	Gida	√	√	√	√	√	√
3.2	Gida Ayana HC	Bayisa Ayana	Gov't	0577730013	0910088644	Gida	√	√	√	√	√	√
3.3	Gutin HC	Merga Hinsermu	Gov't	0576340421	0917851270	Gutin	√	√	√	√	√	√
3.4	Janger HC	Jirenya Fikadu	Gov't		0917839683	Janger	√	√	-	-	-	√
3.5	Gebajimate r HC	Yohanis Nigusa	Gov't		0917045442	Gebajimate	√	√	-	-	-	√
3.6	Denbel LC	Desalegn Temesgen	Private		0917374391	Gida 01	-	-	-	-	-	-
3.7	Hawi LC	Sileshi Akesa	Private		0917854654	Gida 02	-	-	-	-	-	-
3.8	Wabe LC	Lemesa Tessema	Private		0917047823	Gida 01	-	-	-	-	-	-
3.9	Etiyof Joni LC	Regassa Kinate	Private		0917096430	Gida 01	-	-	-	-	-	-
3.10	Mati LC	Jemal Husien	Private		0917819092	Gida 02	-	-	-	-	-	-
3.11	Mayo LC	Daba Gemechu	Private		0917095985	Gida 02	-	-	-	-	-	-
3.12	Gutin LC	Getachew Assefa	Private	0576340154		Gutin02	-	-	-	-	-	-
3.13	International LC	Fozia Mustefa	Private		0913234063	Gutin 02	-	-	-	-	-	-
3.14	Aster LC	Sr. BireTurunesh	Private	0576340025		Gutin 02	-	-	-	-	-	-
3.15	Amanu'el LC	Yared Zemene	Private		0911838630	Gutin 02	-	-	-	-	-	-
3.16	Sena LC	Ato Misa Diriba	Private		0917839979	Gutin 02	-	-	-	-	-	-
3.17	Zelalem LC	Zelalem Benti	Private	0576340197	0911728616	Gutin 02	-	-	-	-	-	-
3.18	Mengistu LC	Menigistu Aniley	Private		0917839108	Gutin 02	-	-	-	-	-	-
3.19	Eba LC	Werkineh Wirtu	Private		0911038494	Estenger Kebele	-	-	-	-	-	-
3.20	Central MC	Gudina Fikadu	Private		0917811123	Gutin 02	-	√	-	-	-	-

#### Jimma Arjo

4.1	Arjo HC	Taye Kaba	Gov't		0917853970	Arjo	√	√	√	√	√	√
4.2	Gambo HC	Getnet Bekele	Gov't		0917838540	Gambo	√	√			-	√
4.3	Wayuwer eke HC	Warke Soresa	Gov't		0917851434	WayuW ereke	-	-	-	-	-	√
4.4	Tayech LC	Tayech Mergiya	Private			GomboKebele	-	-	-	-	-	-
4.5	Hundaol LC	Getachew Hailu	Private		0917093254	Arjo 01	-	-	-	-	-	-

4.6	Arjentina LC	Hirko Wedajo	Private	0576670066		Arjo 01	-	-	-	-	-	-
4.7	Meta LC	Sr.Atsede Tessema	Private		0917470075	Meta Kebele	-	-	-	-	-	-
4.8	Gemechis LC	Tesegaye Tilahun	Private	0576670238		Arjo 01	-	-	-	-	-	-
4.9	SegniBontu LC	Getu Fikadu	Private		0910510082	Hikne Kebele	-	-	-	-	-	-
4.10	Hailu LC	Gebreyes Hunde	Private		0917817245	Arjo 01	-	-	-	-	-	-
4.11	Three Brothers LC	Adunya Diriba	Private		0917140727	Arjo 01	-	-	-	-	-	-
4.12	HaroKumba LC	Tessema Kejela	Private			Kumba Abbo Kebele	-	-	-	-	-	-
4.13	Hunde Gudina LC	Nega Tessema	Private			Hunde Gudina	-	-	-	-	-	-

#### Muger

5.1	Inchini HC	Lidetu Bezabih	Gov't	0112860034	0911390418	Inchini	√	√	√	√	√	√
5.2	Reji HC	Jarso Asmaru	Gov't	-	-	Reji	√	-	-	-	√	√
5.3	Olonkomi HC	Mulugeta Tadese	Gov't	-	-	Olonkomi	√	√	-	-	√	√
5.4	Kerkerosa HC	Fikadu Jebiru	Gov't	-	-	Kerekere s	√	√	-	-	√	√
5.5	Muger HC	Fantahun Ashagere	Gov.	0112379029	0912720317	Muger	√	√	√	√	√	√
5.6	Rhobot LC	Leta Gonfa	Private	-	0911084682	Muger 01	-	-	-	-	-	-
5.7	Benya LC	Bekele Sufa	Private	-	0911618915	Muger01	-	-	-	-	-	-
5.8	Ade'a LC	Birhanu Hailu	Private	-	0911379962	Inchini 01	-	-	-	-	-	-
5.9	Amanu'el LC	H/Mariam Kebede	Private	0112860264	0913084339	Addis Ketema	-	-	-	-	-	-

#### Kiremu

6.1	Kiremu HC	Awake Mekonen	Gov't		0917819216	Kiremu	√	√	√	√	√	√
6.2	Kokofe HC	Shimellis Tefera			0920406996	Kokofe	√	√	-	-	√	√



# ANNEX 3: LIST OF NGOS, COMMUNITY-BASED ORGANIZATIONS AND FAITH- BASED ORGANIZATIONS WITH HIV PROJECTS, APRIL 2011

## MUGER

Name Of NGO	Main HIV/Aids Services (HCT, ART, HBC, STIs, IGA, OVC support, Other)	Main Target Groups	Contact Person And Telephone
World Vision	Care and support and OVC	Orphans	Amsale Genet 011-2-860416/060 0911910730
Adecha Berga PLWHA Association	Care and support	PLWHA	Girma G/Silase 011-2-860086

## FINCHA

Name Of Ngo	Main HIV/Aids Services (HCT, ART, HBC, STIs, IGA, OVC support, Other)	Main Target Groups	Contact Person And Telephone
Hunde Feyine Gudere PLWHA	Care and support	PLWHA	Danyachew Gutema 0910538141

## GIDA AND GUTIN

Name Of Ngo	Main HIV/Aids Services (HCT, ART, HBC, STIs, IGA, OVC support, Other)	Main Target Groups	Contact Person And Telephone
Abdi Bori (PLWHA)	Care and support	PLHIV	Teshay Alemu 0917070522
Dendeti Hojji Gabna (PLWHA)	Care and support	PLHIV	Mamo Gemechu 0910597399
Waluf Hataanuu (PLWHA)	HBC	PLHIV	Tefera Lema 0910102784

## JIMMA ARJO

<b>Name Of Ngo</b>	<b>Main HIV/Aids Services (HCT, ART, HBC, STIs, IGA, OVC support, Other)</b>	<b>Main Target Groups</b>	<b>Contact Person And Telephone</b>
Arjo Mekane Eyesus	Care and Support	PLWHA	Waktola Fufa 0917137371

## BEDELE

<b>Name Of Ngo</b>	<b>Main HIV/Aids Services (HCT, ART, HBC, STIs, IGA, OVC support, Other)</b>	<b>Main Target Groups</b>	<b>Contact Person And Telephone</b>
Feya Inleselle project	Care and support	PLWHA	Tolesa Belete 04744503501
Menshen fur Menschen	Awareness, care and support	PLWHA/Youths	Fasil Wegayew 0474451385
Felege Hiwot PLWHA	Awareness, care and support	PLWHA/Youths	Mitiku Bekele 0910651248

# ANNEX 4: BIBLIOGRAPHY

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