

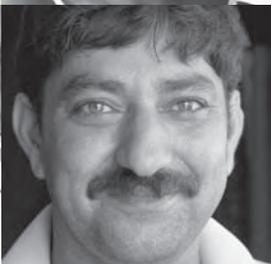
ETHIOPIA FINAL REPORT

September 2001 to September 2006

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT



USAID
FROM THE AMERICAN PEOPLE



Final Report
for the
IMPACT Project
in Ethiopia



September 2001 to September 2006



Ethiopia Final Report

*Submitted to USAID
By Family Health International*

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Family Health International
2101 Wilson Boulevard, Suite 700
Arlington, VA 22201
TEL 703-516-9779
FAX 703-516-9781

In partnership with

**Institute for Tropical Medicine
Management Sciences for Health
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Program for Appropriate Technology in Health
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GLOSSARY OF ACRONYMS

ADA	Agricultural Development Agent
AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
AIDSTECH	AIDS Technical Support Project
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
BOA	Bureau of Agriculture
BoYSC	Bureau of Youth Sport and Culture
BSS	Behavioral Surveillance Survey
CATS	Compassion, Tolerance, and Sensitivity
CBO	Community-Based Organization
CCE	Community Conversation Enhancement
CDC	US Centers for Disease Control and Prevention
CSO	Civil Society Organization
CT	Counseling & Testing
DACA	Drug Administration & Control Authority
DFID	Department for International Development
DOD	US Department of Defense
DOTS	Directly Observed Treatment Short Course
ECR	Expanded and Comprehensive Response
EMSAP	Ethiopia Multi-Sectoral AIDS Project
EPI	Expanded Program on Immunization
ETB	Ethiopian Birr (national unit of currency)
FGAE	Family Guidance Association Ethiopia
FHI	Family Health International
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GDP	Gross Domestic Product
GNI	Gross National Income
GOE	Government of Ethiopia
GSS	Global Spreadsheet
HAPCO	HIV/AIDS Prevention and Control Office
HAPCSO	Hiwot HIV/AIDS Prevention, Care & Support Organization
HB	Health Bureau
HBC	Home-Based Care
HCBC	Home- and Community-Based Care
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HSS	Household Surveillance Survey
IA	Implementing Agency
IGA	Income Generating Activities
IMCI	Integrated Management of Childhood Illness
IMPACT	Implementing AIDS Prevention and Care Project
INGO	International Nongovernmental Organization
ISAPSO	Integrated Services for AIDS Prevention and Support
ISY	In-school youth
IT	Information technology
JSI	John Snow International
LIW	Low-income women
MARPS	Most-at-risk populations

M&E	Monitoring & Evaluation
MOH	Ministry of Health
MOU	Memorandum of Understanding
MOLSA	Ministry of Labor and Social Affairs
MYSC	Ministry of Youth, Sports & Culture
NYNA	National Youth Network Association
NGO	Nongovernmental Organization
NHAPCO	National HIV/AIDS Prevention and Control Office
OI	Opportunistic Infection
OSSA	Organization for Social Services in AIDS
OSY	Out of school youth
OVC	Orphans and Other Vulnerable Children
PEPFAR	US President's Emergency Plan for AIDS Relief
PL	Peer Leader
PLHA	People Living with HIV and AIDS
PLT	Peer Leader Trainer
PMTCT	Prevention of Mother-to-Child Transmission of HIV/AIDS
QA	Quality Assurance
RHB	Regional Health Bureau
SBC	Strategic Behavioral Communication
SIPAA	Support to International Partnership against AIDS in Africa
SNNPR	Southern Nations, Nationalities and Peoples' Region
STI	Sexually transmitted infection
SYGA	Save Your Generation Association-Ethiopia
TA	Technical Assistance
TB	Tuberculosis
TOCAT	Technical and Organizational Capacity Assessment Tool
TOT	Trainers of Trainers
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
USAID	US Agency for International Development
WB	World Bank
WHO	World Health Organization

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EXECUTIVE SUMMARY

FHI executed the Implementing AIDS Prevention and Care (IMPACT) Project in Ethiopia from September 2001 to September 2006. Initiated in the capital Addis Ababa, the program quickly expanded into three other regional states: Amhara, Oromia, and Southern Nations and Nationalities Peoples Region (SNNPR). Project activities sought to decrease HIV prevalence and improve quality of life for people living with HIV and AIDS (PLHA) by strengthening prevention, care, support, and treatment. Under its cooperative agreement with USAID, IMPACT received \$20,600,700 in USAID and PEPFAR/Ethiopia funds.

Country Context

Ethiopia has a young and ethnically diverse population of 77 million. The adult HIV prevalence rate is estimated to be between 1.4 percent (DHS 2005) and 3.5 percent (MOH 2005-ANC data). Tuberculosis (TB) continues to play a major role in Ethiopia's burden of disease, and serves as an important cofactor in the HIV epidemic (TB-HIV co-infection rates range from 25 percent to 47 percent).

Ethiopia is the second most populous country in sub-Saharan Africa, with a current population estimate of 77 million people from 83 ethnic groups and languages. Many of these people reside in relatively remote locations with weak infrastructures. Ethiopia's population will probably continue growing by more than 2 percent annually through 2025. With 45 percent of people living below the poverty line, this expected increase will continue to strain limited resources and likely result in higher levels of poverty.

Chronic and widespread poverty makes it especially difficult for Ethiopians to cope with HIV. Poor people have less access to information, prevention tools, care, support, and treatment. They are also more likely to be involved in transactional sexual behavior.

Among 18- to 24-year-olds in Ethiopia, more women are infected with HIV than men. This is due, in part, to the numerous cultural and gender norms placing women at higher risk of infection. Stigma and discrimination in relation to HIV/AIDS is widespread.

The government of Ethiopia, nongovernmental organizations (NGOs), and civil society partners have been working on HIV/AIDS prevention, care, and support activities for many years. However, during IMPACT/Ethiopia, donor support increased substantially, resulting in significant improvements in the national response to the epidemic. HIV/AIDS prevention and control offices (HAPCOs) have grown rapidly at the local, regional, and national levels. Recently, the government committed to expanding access to antiretroviral therapy (ART) to all with HIV/AIDS. This is a major achievement.

Program Activities and Achievements

Primary IMPACT partners included regional health bureaus and regional HAPCOs (HAPCOs are institutions with the official mandate to coordinate regional responses to HIV/AIDS). Together with FHI, they set out to engage local stakeholders to build an expanded and comprehensive response (ECR) to HIV/AIDS. Local NGOs and community-based organizations (CBOs) also received IMPACT support.

The following were key IMPACT interventions:

Behavior Change Communication (BCC) Interventions

BCC interventions were integral to all IMPACT programs. Initial formative assessments helped partners understand HIV risk perceptions and hopes and fears of vulnerable groups. With a clear understanding of the factors driving high-risk behavior, IMPACT developed BCC strategies with partners in each of the four target regions. IMPACT involved international marketing experts and worked with regional BCC committees to develop a communication campaign theme for each region and materials and products to support behavior change campaigns. Products included posters, radio spots, music videos, pop songs, brochures, and billboards.

Campaigns in each region promoted safer sexual behavior, reduced stigma and discrimination, and promoted counseling and testing. The campaigns reached more than 60 million people. They represented a radical departure from previous anti-AIDS campaigns that caused fearfulness and negatively portrayed people with HIV. The campaign song *Malebabes Iker (Don't hide!)* became a national number one hit. Feedback on TV and radio shows indicate the campaigns raised the level of debate and awareness on HIV/AIDS and enhanced social acceptance and compassion for PLHA. Feedback also showed that at program level the campaigns contributed to a changed vision of how to communicate about HIV/AIDS.

Prevention Programs for Vulnerable Communities

IMPACT supported a range of targeted prevention programs with the following vulnerable communities:

- Regional police forces in SNNPR
- Low-income women in Kirkos Kifle Ketema in Addis Ababa
- Youth in selected *kebeles* in Addis Ababa
- Agricultural development agents in Amhara
- The Addis Ababa taxi drivers program
- National Defense Force Peer Leadership Program

Formative assessments showed that members of these most-at-risk populations (MARPS) are most easily influenced by their peers. The programs trained leaders from each group in initiating discussions on HIV/AIDS and related issues. Through these discussions, correct information on HIV/AIDS was disseminated and used to reduce stigma and encourage safer sexual behavior. The programs reached more than 55,000 individuals from communities taking part in risky behavior. This represents between 50 percent (taxi program) and 100 percent (police, vulnerable youth, low-income women, defense) of target groups in the most developed programs. Results to date show the programs significantly increased basic HIV/AIDS/STI knowledge, encouraged more effective HIV prevention strategies, and reduced discrimination among the various groups. Increased use of counseling and testing and condoms also was reported. This reported increase is documented in feedback received from beneficiaries during regular monitoring and reporting over the course of the project.

Home- and Community-Based Care (HCBC)

Care and support baseline assessments per target region were among the first activities undertaken through IMPACT. The findings of these assessments showed that while a few good examples of home-based care programs existed, their coverage was extremely limited.

IMPACT supported partners in developing an HCBC model for scale up and replication in urban areas throughout Ethiopia. The approach uses local NGOs to monitor community-based organizations (primarily *iddirs*—traditional funeral societies) to manage and support volunteer caregivers.

The model is now operational in 14 cities and towns in IMPACT program areas. Through IMPACT, more than 46,000 chronically ill and bed-ridden patients have received care. More than 250,000 people affected by HIV/AIDS, including family members and neighbors, have been reached. Other community members have been reached with HCBC skills building, provided by more than 11,000 trained volunteers. The approach provides quality care and is rooted in communities to ensure sustainability. It has become the benchmark for HCBC provision throughout the country.

Counseling and Testing (CT)

All government partners identified the expansion of CT as a priority at the beginning of IMPACT. Consequently, IMPACT has supported a major scale-up of CT services by integrating them into government health centers. IMPACT supported regional health bureaus in scaling up and institutionalizing CT provision into the standard package of health services. Under IMPACT, the number of CT sites in the four regions has increased from 157 to 750. Of these, 484 are in public health centers (up from 98 in 2002) that receive IMPACT technical support. Services in the public sector are now free, while those in the private sector are provided at a very low price.

Clinical Care and Treatment

With CT and ART becoming more widely available in Ethiopia, IMPACT supported regional health bureaus in training health center staff to provide opportunistic infection (OI) care and ART, establish chronic care services in 198 health centers, and provide supervision and quality assurance for these services. Referral networks were improved within health centers and between themselves and hospitals and community-based services. IMPACT also supported MOH policy on TB and HIV. More than 1,200 TB and other health center staff in all four regions received cascading training in HIV/AIDS care and treatment. HCBC programs also contributed to TB care at the community level. HCBC nurse/supervisors and volunteers work to detect cases of chronic cough at the community level, making sure patients go to the health center and are screened for TB, and that they adhere to their TB treatment if found to be TB positive. Nurses or volunteers even physically collect TB treatment at the health center if patients are too ill or poor to go. Finally, at the end of IMPACT, FHI supported the MOH and regional health bureaus in initiating the roll out of ART services at health centers.

General Technical Assistance (TA) and Capacity Building

All partners working with IMPACT benefited from ongoing technical assistance to build capacity in areas identified through organizational capacity audits. Support to establish robust monitoring and evaluation systems was a cross-cutting activity.

Lessons Learned and Recommendations

Lessons learned and recommendations are being offered to help the program that will follow IMPACT as well as government and other partners who continue supporting activity implementation in the country.

Key lessons and recommendations are as follows:

General Lessons

- Continue to work closely with health authorities and HAPCOs to improve health systems and HIV/AIDS service provision.
- Recognize and respect the mandate of government partners.
- Help government and civil society partners work together, each managing services for which they have a comparative advantage, and jointly ensuring that the health of people in their constituencies improves.
- Focus on providing all elements of the Expanded and Comprehensive Response (ECR), particularly in rural areas.
- Improve linkages and referrals between all elements in the prevention, care, support, and treatment continuum.
- Support or pilot PLHA tracking or monitoring systems to ensure they and their dependents are not lost from care and support services.
- Support efforts to address staff motivation and high turnover in government health facilities.

BCC and Prevention Programs

- BCC and prevention interventions must be based on formative assessments.
- BCC materials must be updated regularly to keep messages fresh and ensure their ongoing impact.
- Rural populations need new approaches—especially illiterate groups with less media access.
- The effectiveness of peer leadership programs needs further evaluation to inform and consolidate the roll out of programs.
- HIV care and treatment programs should incorporate BCC in efforts to address stigma and adherence. BCC can also be used by care and treatment programs to meet the family planning and childbearing needs of people who are positive, and to promote HIV prevention among HIV-positive people.

Home- and Community-Based Care

- Working with local NGOs, *iddirs*, and volunteers is a very effective strategy—but one that requires appropriate support.
- The range of partners supporting PLHA and OVC should be widened.
- Initially, the entry point for IMPACT’s home- and community-based care services was people who were chronically ill and bedridden at home. Due to efforts of HCBC programs, the health status of people with chronic illnesses—including AIDS—has improved dramatically in communities targeted by the programs. Still, the point of entry to the services should be adapted to include PLHA before they become ill. The HCBC package also needs to be revised so it is more comprehensive and holistic, addressing the changing needs of recovered patients.
- Consider integrating HCBC and OVC care packages into a single family-centered model that meets the needs of all members of the household, including children with HIV and other OVC.
- Poverty and malnutrition are daily challenges faced by HCBC programs. To improve the health status of HCBC clients and their families—and enable those on treatment to take

their treatment effectively—nutritional support and nutrition education must be part of the basic HCBC package. To improve the capacity of communities affected by AIDS to address its impacts, household economic strengthening activities must also be included in the HCBC package.

- Lobby for resources to scale up HCBC programs.
- Integrate sexual and reproductive health and HIV prevention activities into HCBC and OVC programs. This is especially important because, with better care and treatment, PLHA who were previously ill are now becoming mobile and sexually active again.

HIV Counseling and Testing (CT), Clinical Care, and Treatment

- Advocate for increased attention, support, and resources to expand and strengthen OI care.
- Offer continued support to improve commodity management and supply systems.
- Expand health workers' understanding of palliative care beyond the medical aspects.
- Youth and child-friendly CT services need particular attention.
- Consider supporting outreach CT services in rural areas.
- Use lay counselors to counter high health staff turnover.
- CT and other HIV/AIDS training must be integrated into all pre-service training for health staff.
- Site level supervision needs continued support and expansion.
- To enable better access to services, ensure that quality HIV/AIDS care and treatment services are provided at the health center and at lower levels of the health service infrastructure, as well as at the community level.
- Scale up ART services for children at the health center level to enable access and family centered care.
- Develop a nurse-based ART prescription approach to address the reality of health center staffing and a lack of doctors.

General Technical Assistance (TA) and Capacity Building

- Providing holistic support to all implementing agencies and partners is essential to support the scale up in service quality and quantity.
- Data-based program design, monitoring and evaluation, and quality assurance/quality improvement are all essential elements of program implementation. They must be developed and implemented with involvement from program managers and service providers.

PROGRAM STRATEGIES AND ACTIVITIES

Introduction

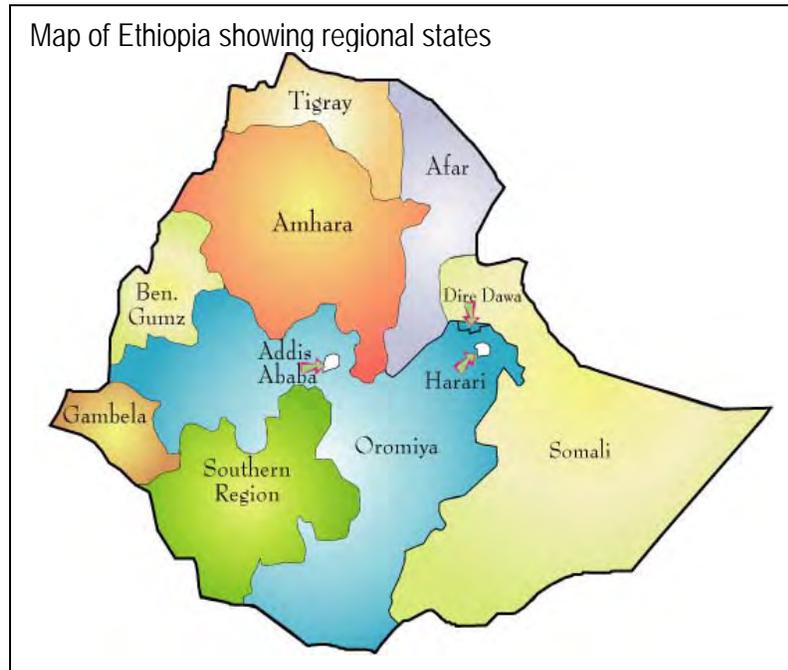
FHI executed the Implementing AIDS Prevention and Care (IMPACT) Project in Ethiopia from September 2001 to September 2006. Initially working in the capital Addis Ababa, the program quickly expanded into three other regional states: Amhara, Oromia, and Southern Nations and Nationalities Peoples Region (SNNPR). Project activities sought to decrease HIV prevalence and improve quality of life for people living with HIV and AIDS (PLHA) by strengthening prevention, care, support, and treatment.

To achieve these goals, IMPACT has built the capacity of key stakeholders, particularly the Ministry of Health (MOH); regional health bureaus; HIV/AIDS prevention and control offices (HAPCOs) at the national, regional, and local levels; and local NGO partners. IMPACT collaborated with other partners, especially the Global Fund, Intra-Health, Linkages, JHPIEGO (an international health organization affiliated with the Johns Hopkins University), I-Tech, and John Snow International (JSI). Partners worked to ensure comprehensive services, avoid duplication, and strengthen referral linkages between service providers.

Under its cooperative agreement with USAID, IMPACT/Ethiopia received \$20,600,700 in USAID and PEPFAR/Ethiopia funds. This report documents the activities and accomplishments of the program. It highlights major achievements, lessons learned, and recommendations for future programming.

Country Context

Ethiopia is one of the poorest countries in the world, ranking 170th of 177 countries in the UN Human Development Index.¹ With an estimated population of 77 million and an annual growth rate of 2.2 percent, it is the second most populous country in sub-Saharan Africa. Because 45 percent of the population lives below the poverty line, this increasing population continues to strain already limited resources and exacerbate poverty levels.



The adult HIV prevalence rate in Ethiopia is estimated to be between 1.4 percent (DHS 2005) and 3.5 percent (MOH 2005-ANC data). TB continues to play a major role in Ethiopia's burden of disease, and serves as an important cofactor in the HIV epidemic (TB-HIV co-infection rates range from 25 percent to 47 percent). While this would indicate a reduction in the reported rate of 7.3 percent in 2001, the lower figure is a result of better measuring techniques and a larger survey sample,

rather than an actual decline in HIV/AIDS cases. Although the urban rate does appear to have leveled off—perhaps because of real behavior change—it remains at the alarmingly high level of 10.5 percent.² The rural HIV/AIDS prevalence rate is still rising, albeit from a much lower level of 1.9 percent in 2005. Around 1.3 million Ethiopians are thought to be living with HIV/AIDS. The majority are female and approximately 135,000 are children. The Ministry of Health estimated that 134,000 adult and child deaths occurred in 2005. Estimates from the same year indicate that the number of children orphaned by AIDS totaled approximately 744,000. FHI estimates that a quarter of urban Ethiopian households may be home to one person living with HIV or AIDS.

Factors Contributing to the Epidemic in Ethiopia

The spread of HIV in Ethiopia and the population's ability to cope with its impacts are negatively affected by many factors. Chronic and widespread poverty is a major underlying factor. Most people (85 percent) live in rural areas. Their livelihoods are based on subsistence agriculture. Much of the country consists of rugged, mountainous terrain and semi-arid lowlands. Uncertain rainfall and poor infrastructure contribute to high levels of poverty and destitution. Education levels are low, with 58 percent of the adult population illiterate and only 36 percent of children enrolled in school.³ In any one year up to 10 percent of the population depends on food

¹ UN Human Development Index Report, UNDP 2005

² AIDS in Ethiopia 6th Report: MoH National HIV/AIDS Prevention and Control Office 2005

³ UNDP *ibid*

aid to meet basic needs. Nearly 47 percent⁴ of children are stunted because of chronic malnutrition.

Destitute people have less access to information, prevention tools, and care, support, and treatment. They are also more likely to be involved in transactional sexual behavior, leaving them at a higher risk for HIV infection. Ethiopia has many migrant populations that are also at high risk of exposure to HIV. These groups include: the rapidly increasing number of rural residents seeking employment in urban areas; military personnel; those displaced by war, drought, and/or environmental degradation; male transport workers; sex workers; seasonal workers; traders; orphans and other vulnerable children; and prisoners.

Among 18- to 24-year-olds in Ethiopia, more women are infected with HIV than men. This is due, in part, to the numerous cultural and gender norms placing women at higher risk of infection. Many Ethiopian women have little power in sexual negotiation with their husbands, and this often leaves them unable to protect themselves from HIV infection. Forty-four percent of women believe that a husband is justified in beating his wife if she refuses to have sex with him.⁵ Approximately 80 percent of women have been circumcised and are therefore more likely to incur physical injury during sexual intercourse. This also increases the risk of transmission. Other issues that render Ethiopian women vulnerable to HIV include rape, abduction, and early marriage.

Women are increasingly bearing the major burden of AIDS and its impact. In most Ethiopian societies, women and girls are expected to care for sick family members.⁶ Because of gender inequalities and women's lower socioeconomic status, they have poorer access to healthcare services and fewer opportunities for education. This is apparent in gender disparities in school enrollment and educational attainment levels, as well as in the country's high maternal mortality ratio of 673 deaths per 100,000 live births.⁷

FHI's own assessments have shown that stigma and discrimination in relation to HIV/AIDS is widespread. Very often, fear of HIV/AIDS-related stigma and discrimination makes people reluctant to change behavior—even if such change would protect them from HIV. It also often makes individuals reluctant to access or provide AIDS care, treatment, and support, even when it exists.

In general, Ethiopians' health services are poor even by African standards. Only 72 percent of the population has access to primary health services.⁸ In recent years, increased donor funding has enabled the Ministry of Health and regional health bureaus to expand the number of health facilities in each region and train more health staff, particularly nurses and health extension agents. However, the health system in Ethiopia remains severely underdeveloped. Public health expenditure, at less than US\$10 per capita,⁹ is among the lowest in the world. HIV/AIDS poses an enormous burden on the country's already frail health infrastructure.

⁴ Ethiopia Demographic and Health Survey: Central Statistics Agency Ethiopia, 2005

⁵ DHS, 2005

⁶ AIDS in Ethiopia, 6th report, MOH, 2005

⁷ DHS, 2005

⁸ i.e., within 10kms of a primary health care facility - Health and health Related Indicators, MOH, 2005

⁹ UNDP *ibid*

The National Response to the Epidemic

The government of Ethiopia, NGOs, and civil society partners have been working on HIV/AIDS prevention, care, and support activities for many years. In 2001, at the start of IMPACT in Ethiopia, major developments were taking place with regard to the national response to HIV/AIDS. Perhaps the most important change was the recognition at the highest levels of government of the existence of the HIV/AIDS epidemic in Ethiopia. During the lifetime of the IMPACT/Ethiopia program, the operating environment for agencies working on HIV/AIDS improved radically. Stronger leadership from the Ministry of Health and a substantial increase in donor support have resulted in definite improvements and a significant expansion in the national response. This includes rapid expansion of HAPCOs at the local and regional levels as well as efforts to implement a comprehensive national strategy for prevention, care, and treatment of HIV/AIDS. Overall, efforts are more coordinated and partners are engaged across all sectors and levels (national, regional, and community).

As this report documents, the activities of FHI/IMPACT have contributed significantly to the national response in the past five years. There has been a remarkable increase in the number and quality of services related to AIDS—in particular CT, prevention, and care and treatment services. In 2001, there were few CT sites, HCBC programs were rare, and no facilities provided ART free of charge. The government's recent commitment to expanding access to ART to all those with HIV/AIDS is a major achievement, fundamentally changing the quality and level of care available.

There is, however, no room for complacency. The epidemic continues and it is clear that the number of persons infected and affected by the disease will rise over the next five years. The Ethiopian government and all agencies working in HIV/AIDS are challenged to expand and scale up efforts in the face of such widespread poverty and limited institutional capacity.

PROGRAM STRATEGIES AND ACTIVITIES

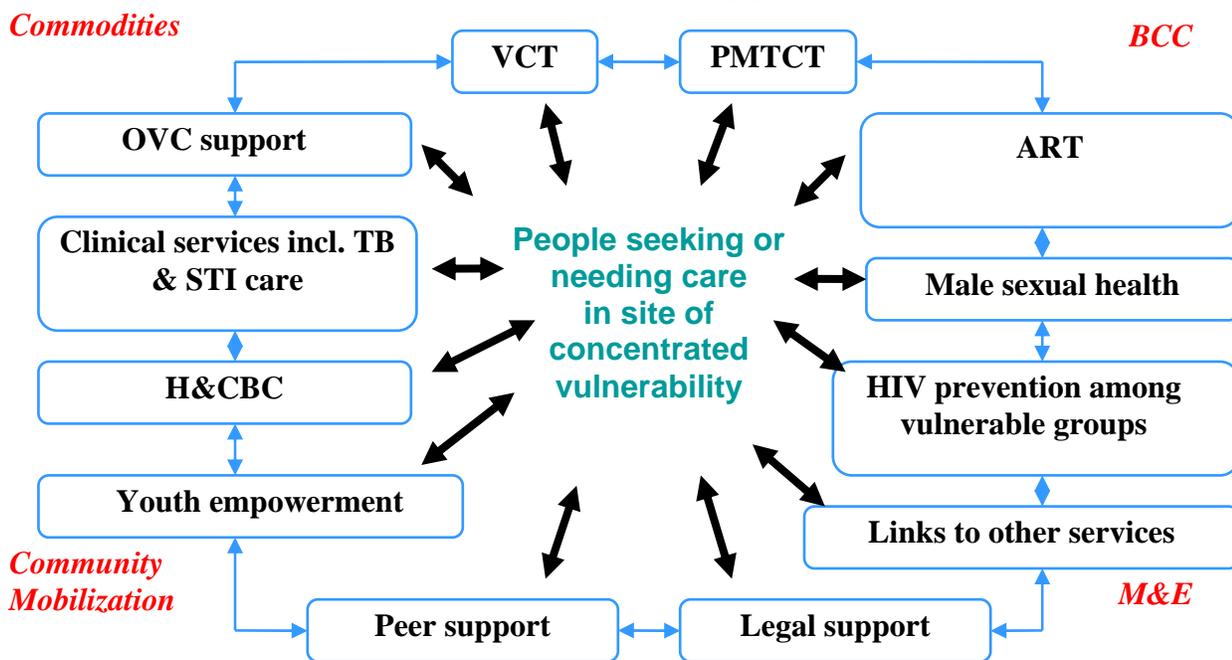
IMPACT encompassed a range of activities that included counseling and testing, home-based care, prevention and behavior change communication initiatives, treatment, and clinical care. All programming was underpinned by core strategies that informed the design and implementation of all interventions. These are outlined below.

Expanded and Comprehensive Response (ECR) Programming

FHI believes a sustainable response to the epidemic can only be achieved if all partners and stakeholders, including beneficiary groups, work together to address the diverse needs of people living with HIV/AIDS, people affected by AIDS, their families, and their communities. FHI has used the expanded and comprehensive response (ECR) framework to obtain buy-in from partners and stakeholders.

The ECR approach recognizes that the multidimensional impacts of HIV and AIDS require similarly diverse responses. Working through existing systems and structures, IMPACT aimed to fill gaps in the continuum of prevention, care, and support, including treatment. By simultaneously intervening at multiple levels—national, regional, and community—and across sectors, IMPACT improved partners’ capacity to implement a multifaceted response. As various elements of the ECR have been built and strengthened, focus has shifted to improving the linkages between services and activities.

The Expanded and Comprehensive Response to HIV/AIDS—a continuum of HIV/AIDS prevention, care, support, and treatment



Effective Behavior Change Communication (BCC)

BCC is a key component of the ECR. BCC can be an activity by itself or an aspect of all other HIV/AIDS programming. An integrated approach is essential because HIV and AIDS are

sensitive, and often taboo, topics. Therefore, peoples’ beliefs and attitudes affect the impact of interventions, from using a condom to caring for a relative with AIDS. As such, BCC is relevant to prevention programs promoting abstinence, being faithful, and condom use (ABCs) as well as care and support activities. In Ethiopia, this has meant tackling stigma and discrimination surrounding HIV and AIDS. Stigma was the greatest barrier preventing people from accessing care and support services such as CT and HCBC.

When IMPACT started in Ethiopia, many government and other agencies focused on providing information and raising awareness of HIV/AIDS. Still, there was little or no evidence of behavior change. Most interventions failed to go beyond awareness-raising to address the factors that motivate peoples’ behavior. This is one of FHI’s key technical competencies. IMPACT sought to demonstrate that, in order to develop effective interventions, organizations seeking to change behavior must understand why people think and behave as they do. IMPACT attempted to do this by conducting “formative assessments” in all project areas. Understanding what “forms” individuals’ beliefs and attitudes enabled FHI to develop more effective behavioral change strategies.

Working through Partners to Address Local Needs and Priorities

As a technical assistance agency, FHI implements all of its programming through partners. At the start of IMPACT, FHI brought together partners in each region to build consensus on major problems and the best ways to solve them.

In implementing IMPACT activities, FHI facilitated joint planning, implementation, supervision, quality assurance, and evaluation. As local capacity increased, FHI deliberately devolved its role to one of program oversight, guidance, and quality improvement. The strategy was founded on the understanding that partners—particularly government—remain responsible and accountable for activities. This necessitates developing relationships based on mutual trust and understanding.

Ongoing Technical Assistance and Organizational Capacity Building

Increasing the capacity of governmental and nongovernmental organizations is key to all FHI programming, and IMPACT/Ethiopia was no exception. So, besides providing one-off activity based support (e.g., TOT training), FHI gave ad hoc assistance to partners monthly, weekly, or even daily if needed.

FHI accepted that partners’ ability to deliver and implement programs could not be built overnight. In Ethiopia, most agencies, including government partners, were extremely new to HIV/AIDS programming and lacked technical skills. Plus, the scale of the response required meant many partners lacked the organizational capacity to manage, supervise, monitor and evaluate their work effectively. IMPACT/Ethiopia ensured capacity assessments were undertaken for all partners. Then, FHI provided support to fill gaps in areas deemed lacking.

Program Activities

IMPACT/Ethiopia activities and support included:

- Assessment and Start-up Activities
- Behavior Change Communication (BCC)
- Prevention Programs for Vulnerable Communities

- Home- and Community-Based Care
- HIV Counseling and Testing (CT), including both provider- and client-initiated CT
- Clinical Care and Treatment
- General Technical Assistance (TA) and Capacity Building
- Monitoring and Evaluation (M&E)
- Quality Assurance/Quality Improvement (QA/QI)

Assessment and Start-up

In the first 18 months of IMPACT, FHI worked hard to build close working relationships with key stakeholders involved in HIV/AIDS service provision and/or coordination in each region. Primary partners included national and regional HAPCOs, the Ministry of Health, and regional health and youth bureaus.

Key start-up activities included **consensus building workshops** and comprehensive **baseline assessments**. In addition, FHI piloted the **expanded and comprehensive response (ECR)** at the district level (known in Ethiopia as a *woreda*) in Addis Ababa.

Program development began in Addis Ababa before anywhere else with two start-up workshops. The first focused on the continuum of care and support while the second focused on BCC strategy development. In the three other regions the two areas were covered by a single workshop. The workshops provided a forum for FHI to introduce itself to the full range of stakeholders involved in HIV/AIDS and explain the scope and mandate of its work.

In the workshops, participants agreed on the definition of the continuum of prevention, care, and support; working in referral networks and BCC; developed a framework for collaboration; and set minimum criteria for services within the continuum. A key issue to emerge from all of the workshops was the lack of sufficient quality data to inform the design of a comprehensive response to AIDS in their regions. Consequently, FHI worked with regional health bureaus, HAPCOs, and youth bureaus to conduct baseline assessments that would complement existing data sources (household surveillance surveys and behavioral surveillance surveys). Initially, in Addis and subsequently elsewhere the following assessments were produced:

- HIV/AIDS Care and Support Service Assessment (both management and coordination level and service provision level; services include TB, STI, clinical care, CT, OVC and socioeconomic support)
- Rapid Assessment of Vulnerable Communities (sex workers, military, truck drivers, migrant workers/mobile populations)
- PLHA Needs Assessment
- Human Capacity Development Assessment
- BCC Formative Assessment

At follow-up meetings in Addis Ababa, Amhara, Oromia, and SNNPR regions, participants discussed the findings of the baseline assessments and prioritized activities and programs to be implemented or strengthened. Their objective was to build the expanded and comprehensive response to AIDS in the regions. Table 1 summarizes the major gaps and priorities identified by workshop participants in the four regions.

Table 1 – Regional Priorities Identified During Consensus Building Workshops

<p>Addis Ababa</p> <ul style="list-style-type: none"> • CT services • HCBC • BCC and prevention with MARPS 	<p>SNNPR</p> <ul style="list-style-type: none"> • BCC /prevention with vulnerable groups—police and migrant workers • Expanding HCBC • Strengthening CT
<p>Oromia</p> <ul style="list-style-type: none"> • CT services • HCBC • Treatment and clinical care through health facilities 	<p>Amhara</p> <ul style="list-style-type: none"> • BCC/prevention in rural areas • CT • Treatment

After completing the Addis Ababa assessments, partners agreed with the Regional AIDS Council Secretariat and health bureau to prioritize an area of concentrated vulnerability to pilot the ECR at the district (or *woreda*) level. They chose *Woreda 5* for the district-based ECR pilot.

After four months, FHI staff realized that the district level was too restrictive in terms of geographical coverage, human capacity, and availability of all components needed for an expanded and comprehensive response. As a result, FHI decided to focus all further ECR programming at the regional and subregional levels.

Behavior Change Communication (BCC) Interventions

BCC was an integral element of IMPACT programming. FHI BCC specialists supported colleagues and partners to ensure all activities incorporated behavior change messages and interventions. They drew on FHI’s extensive experience elsewhere, also referencing baseline research on the behavior of key groups that had been performed at the beginning of IMPACT.

Regional formative assessments, together with several supplementary formative assessments, were carried out for specific target groups (e.g., Addis Ababa taxi drivers and police forces in SNNPR). Formative assessments helped partners know and understand the factors behind certain attitudes and behaviors. They helped the team identify critical messages and develop strategies and interventions that would convey effective messages. Formative assessments provided the basis for the two main BCC interventions under IMPACT: (1) the development of four regional BCC campaigns; and (2) prevention programs for MARPS.



You say you are safe. Is that because you practice. . . Abstinence? Being faithful? Condom use? Still consider VCT. Knowing [your status] is the modern way of living.

(1) Regional BCC Strategy Development

Table 2 below summarizes the steps taken in developing BCC strategies and interventions. This process was used in each IMPACT area, starting with Addis Ababa.

Table 2: Steps in Developing a BCC Campaign

Step 1	Step 2	Step 3	Step 4
<ul style="list-style-type: none"> • Consensus building • Formative assessment carried out • Formative assessment dissemination workshop 	<ul style="list-style-type: none"> • Regional BCC core group formed—members included representatives of RHB, HAPCO, BoYSC, local NGOs, CBOs and youth associations • Key issues, themes and messages identified 	<ul style="list-style-type: none"> • BCC strategy development training for core group members • Development of target group profiles • Design key elements of a campaign 	<ul style="list-style-type: none"> • Material development with marketing consultants • Pre-testing and sharing findings with core group and other stakeholders • Improvement and refinement of materials based on feedback

In each region, the findings of the formative assessments were used to develop profiles of vulnerable groups and understand their specific communication needs. Remarkably, the analysis of formative assessment data led partners in different regions to prioritize the same target groups. The factors driving their behavior and their needs in terms of behavior change were also similar (Table 3 summarizes key findings from the formative assessments).

All formative assessments revealed the existence of widespread discrimination and stigma associated with HIV and AIDS. This inhibited people from accessing care and support services, including CT. Societies were shunning people and families affected by or even suspected of having HIV.

Table 3 – Summary Findings of Formative Assessments

Target Groups	Drivers behind Behavior	Skills and Support Required to Change Behavior
In-school youth	<ul style="list-style-type: none"> • Being highly influenced by peer pressure • Needing humor, romance, entertainment 	<ul style="list-style-type: none"> • Empowerment to handle peer pressure • Encouragement to undergo CT • Relationship with teachers, parents, students
Teachers	<ul style="list-style-type: none"> • Attribution of low value to self/have a strong need to feel a sense of worth • Frustration with their current situation • Pursuing risky behavior as an escape • Needing humor, romance, entertainment 	<ul style="list-style-type: none"> • Encouragement to undergo CT • Relationship with students, parents • Improving self image/image in society
Out-of-school youth (OSY), female sex workers (FSWs), Isuzu truck drivers and taxi drivers	<ul style="list-style-type: none"> • Attribution of low value to self/have a strong need to feel a sense of worth • Frustration with their current situation • Pursuing risky behavior as an escape • Being highly influenced by peer pressure • Needing humor, romance, entertainment 	<ul style="list-style-type: none"> • Empowerment to handle peer pressure and say no (OSY)—negotiation skills (OSY and FSW), condom use skills (focus on FSW) • Being accepted (create a sense of belonging) • Encouragement to undergo CT • Handling peer pressure
Police (in SNNPR)	<ul style="list-style-type: none"> • Pursuing risky behavior as an escape • Being highly influenced by peer pressure • Needing humor, romance, entertainment 	<ul style="list-style-type: none"> • Condom use • Encouragement to undergo CT

Three broad messages/campaigns were adopted for implementation in each region, subject to some variations. These are outlined below:

1. Promotion of Compassion, Tolerance, and Sensitivity (CATS)

Purpose: The campaign sought to establish an environment enabling discussion of HIV/AIDS and sexuality so misconceptions about transmission could be addressed. It also aimed to counter negative perceptions of PLHA, thereby reducing stigma and discrimination.

Approaches used: The campaign was launched in Addis Ababa on World AIDS Day, December 2003. The central element was a music video entitled *Compassion is Modernity*, promoting compassion and sensitivity for people affected by AIDS. Top singers in Ethiopia voluntarily participated in production of the music video, which became an instant hit. The music is supported by a TV clip and a poster showing three faces, one covering his eyes, one covering his ears and one covering his mouth—therefore refusing to see, hear, and talk about HIV/AIDS. Other posters and radio spots were developed for distribution and transmission nationally and in specific regions (see posters that follow and Project Highlight 1).



Examples of BCC Posters produced through IMPACT

2. Promotion of Safer Sexual Behavior

Purpose: The assessments showed a need to encourage safer sexual behavior among target groups. The skills required would vary depending on the context, but centered on addressing peer pressure and negotiation skills. It was important to improve perceptions of risk and improve self-esteem. Addressing these issues is a prerequisite for promoting CT.

Approaches used: Extensive peer leadership and peer education interventions were developed and implemented among a range of vulnerable groups. These activities are described elsewhere in this report under Prevention Programs for Vulnerable Groups and also in the section talking about work with the National Youth Network Association. These targeted interventions were also supported with posters and radio spots.

3. Promotion of CT

Purpose: Since IMPACT supported the scale up of CT services throughout the country, BCC messages were developed to encourage take-up. Even though the capacity of CT services has not reached its full potential, the benefits of testing are undeniable. CT helps prevent the spread of HIV and is also the entry point for care and treatment. A trained and supportive counselor can offer valuable and confidential advice to individuals, whether they test positive or negative. The sooner an individual knows his or her status the sooner that person can start to change behavior and received support.

Approaches used: The theme of the CT campaign was: “Knowing is the new way of living.” In addition to peer education programs, a range of posters (see Project Highlight 1) were developed, along with radio and television messages.

(2) Support for the National Youth Network Association for Improved Sexual and Reproductive Health and HIV/AIDS

In response to a request by USAID/Ethiopia and the Minister for Sports, Youth and Culture, IMPACT supported the ministry in consulting with youth nationwide on issues they face, on the development of a National Youth Charter expressing the youth’s vision of their future, and on a three-year action plan for improved sexual and reproductive health, HIV preventive behavior, and AIDS care and support. Following the consultation, IMPACT/Ethiopia supported the establishment of the National Youth Network Association (NYNA) to lead the implementation of the plan. FHI helped NYNA set up and manage their offices and develop a directory of youth clubs/associations in all regions. FHI also helped them register legally.

With IMPACT/Ethiopia support, NYNA developed a proposal to build youth recreational centers in every region. This was accepted for funding by the World Bank. The NYNA is currently

working with the Ministry of Youth, Sport and Culture to identify sites, construct centers, and build the capacity of youth groups in every region to manage them when constructed. IMPACT also funded the NYNA to enable 100 amateur youth artists in Addis Ababa to draw wall paintings on stigma and discrimination in areas where many people congregate, such as schools, government offices, and on walls lining busy streets.

The NYNA went on to register 3,037 youth clubs around the country, representing about 246,978 youth. Subsequently, the NYNA has been subcontracted by FHI to coordinate technical assistance for youth-led HIV/AIDS programs and to facilitate communication between these groups.

As part of this sub-agreement the NYNA has undertaken the following:

- TOT training for 27 youth leaders from all regions in BCC through peer leadership. These core trainers have cascaded the training down to several hundred other youth from youth associations throughout the target regions.
- In Addis Ababa, the Youth Network has been a strong collaborator in the Addis Ababa CATS and CT promotion campaigns, using messages integrated into their peer education programs.
- Youth associations are active in integrating community capacity enhancement (CCE) through community conversation programs in their ongoing activities. This is a community mobilization technique initiated by UNDP and now promoted nationally by the GOE that encourages communities to discuss sensitive issues such as HIV/AIDS and work together to overcome problems.
- Youth associations have been active in promoting volunteers for the HCBC program in Addis Ababa. A number of these youth have been trained as volunteer caregivers.
- Youth leaders from the Addis Ababa, Amhara, and Oromia youth networks continue to develop and pretest a youth action kit and train representatives of youth groups in these regions in its implementation.

(3) Prevention Programs for Vulnerable Communities

See next section.

Prevention Programs for Vulnerable Communities

In response to concerns raised by partners in the consensus workshops and the finding of formative assessments, IMPACT supported prevention programs for vulnerable groups. While the programs were distinct subprojects by themselves, they all formed part of wider regional BCC strategies. Groups targeted included:

- 1) Regional police forces in SNNPR
- 2) Low-income women in Kirkos Kifle Ketema in Addis Ababa
- 3) Vulnerable youth in selected *kebeles* in Addis Ababa
- 4) Agricultural development agents in Amhara
- 5) The Addis Ababa taxi drivers program
- 6) National Defense Force peer leadership program

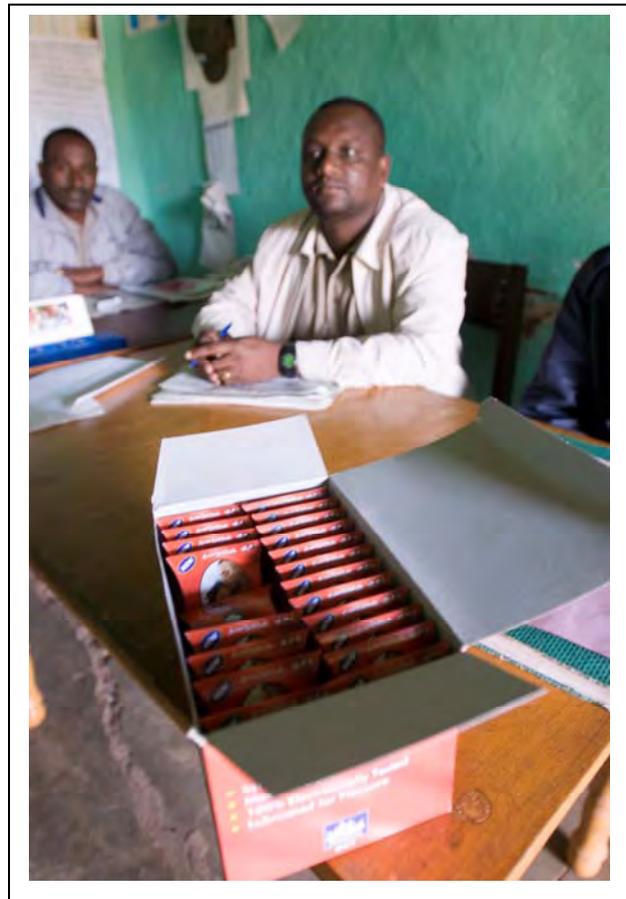
1) SNNPR Police Peer Leadership Program for Improved HIV Preventive Behaviors

The increased impact of AIDS on the police force emerged as a concern of partners in the consultative workshop in SNNPR.

IMPACT/Ethiopia supported the SNNPR Justice Bureau, the SNNPR HAPCO, and representatives of police forces in the region to design and implement a peer leadership intervention. The social coherence and structure of the target group suggested that a peer leadership approach would work best. The project's objective was to increase awareness of basic HIV/AIDS facts, CT, AIDS care and support, ART, condom use, and negotiation skills for safer sex. Peer leaders would initiate conversations on HIV/AIDS and related topics in everyday work situations (e.g., quiet times during the night shift, lunch in the staff canteen). These activities do not require additional time or cost and are actually more effective than formal, organized sessions.

The SNNPR police peer leadership program began in August 2003. Its initial aims were to reduce HIV and STI incidence and decrease stigmatization and discrimination of PLHA. A four-step approach was taken to cascade the training and implementation:

- Step 1:** Twenty core trainers from regional, zonal, and special *woredas* police offices were trained by FHI.
- Step 2:** Core trainers (with FHI support) trained 146 peer leadership trainers at the *woreda* level. They also held advocacy and awareness meetings with police commanders to ensure their buy-in to the program.



The SNNPR Peer Leadership program has expanded condom use in the police force.

- Step 3:** Peer leader trainers (with core trainer and FHI support) trained 432 peer leaders at the *kebele* police station level.
- Step 4:** Peer leaders use their informal social networks to implement behavior change skills with more than 5,000 police peers.

Because of government restructuring in the SNNPR police forces, many police officers were relocated after the program began. This resulted in gaps and oversupply of core trainers, peer leadership trainers, and peer leaders in certain areas. A further round of gap-filling training took place to ensure sufficient peer leaders in each area.

All peer trainers and leaders are volunteers who receive no payment other than per diems for the initial training. Support to the police force continues to ensure full institutionalization of the project. The program is currently being replicated in Oromia Region with funds from another program.

2) *Low-income Women in Kirkos Kifle Ketema in Addis Ababa*

In Addis Ababa, IMPACT/Ethiopia took over support for an HIV prevention program in five *kebeles*¹⁰ of one *woreda* from the international NGO Pathfinder. The project targeted 1,000 low-income women in the Kirkos Kifle Ketema area of the city, which had been identified in the rapid assessment of MARPS as an area of concentrated vulnerability. Many of the women working there work in the sex trade, making them extremely vulnerable to HIV and other infections. The local NGO—ISAPSO¹¹—was retained as the implementing agency. The project received IMPACT support from May 2003 to June 2006.

The project trained 80 low-income women as peer leaders or change agents who set up 40 self-help groups for other low-income women. A group of peer leaders visited Kenya on an experience-sharing visit to see the work of similar programs in Nairobi. The self-help groups worked together to address specific HIV support needs as well as other social, psychological, and economic needs. Activities included:

- Group savings clubs following the rotating loan or “ekub” principle. Initially three literacy centers were opened and 105 low-income women enrolled. When only 35 successfully completed the program, it was changed to a home-based literacy program. Teaching was done by youth from local anti-AIDS clubs. Five-hundred-sixty women enrolled: 281 have successfully completed, and the remaining are continuing. Child care also is provided.
- Eleven low-income women were trained as volunteer caregivers. Later these women were absorbed into the HAPCSO HCBC program.



Former sex workers in the Biruh Tesfa (Bright Future) self-help association have established an *injera* (traditional pancake) making enterprise with training and material support from ISAPSO.

¹⁰ Kebeles are the lowest administrative unit in Ethiopia forming sub-districts of a Woreda (the District level)

¹¹ Integrated Services for AIDS Prevention and Support Organisation

- Peer-counseling training was provided to 25 women, enabling them to provide psychosocial support to peers.
- The program helped these women establish their own *iddirs* (traditional community-based organizations, normally funeral societies) with the mandate to raise funds. These *iddirs* are different from traditional ones because they have incorporated the promotion of peer education and support to members while they are alive.
 - “Biruh Tesfa Sisters Idir” with 118 members
 - “Hibret Amba Idir” with 140 members
 - “Idget Behibret Idir” with 92 members
- The program supported another implementing agency—SYGE¹²—to work with bar/hotel owners, *kebele* authorities, and police to raise awareness of the plight of sex workers and ensure they work in a safer environment (e.g., address gender-based violence, provision of condoms).
- Another implementing agency—the Gemini Trust—received support to train two groups of women in dance and drama. The best women have gone on to form their own dance troupe, giving community performances depicting the problems faced by sex workers.
- To reduce the vulnerability of low-income women’s daughters to HIV/AIDS, three girls clubs with a total of 140 members were established. Over 21 leaders of these clubs were trained in life skills, including negotiation skills and club management.

Through other sources, ISAPSO has also enabled some women to undertake skills training and income-generating activities, such as a weaving cooperative and the establishment of a café/bar.

3) *Vulnerable Youth in Addis Ababa*

Activities in this program emerged out of the initial pilot of the ECR in *Woreda 5*. Given the levels of vulnerability in this *woreda* it was agreed IMPACT/Ethiopia would continue to support prevention programs for vulnerable youth. The activities were implemented through the Mieh for Youth Association and the *Woreda 5* Youth Association.

Initially the associations received help conducting peer group discussions, producing monthly newsletters and other HIV awareness information, and undertaking some mini-media broadcasting.¹³ After a year, FHI undertook a review of the associations and concluded that activities represented an outreach program for youth rather than a peer leadership program, that is, an IEC rather than a wider BCC approach.

Consequently, IMPACT/Ethiopia supported the associations in conducting a supplementary formative assessment of youth in that *woreda*. Using this information, FHI worked with the youth associations to develop a BCC strategy using a peer leadership program as the conduit for appropriate messages. The cascading approach to training was used. So, FHI trained core trainers from the association who in turn trained peer leaders in the community. Peer leaders came from social groups in the target community and were trained using the manual designed for this purpose. They then facilitated discussions among beneficiaries on HIV/AIDS-related issues such as counseling and testing, condom use, and care and support. Through these networks, partners developed key messages to promote counseling and testing. HIV preventive behaviors were introduced and supported by wider IMPACT/Ethiopia BCC materials (see examples in Project Highlight 1).

¹² Save Your Generation Ethiopia

¹³ “Mini media” refers to media broadcast by schools over Public Announcement systems or other manners.

The peer leadership programs continue with Royal Netherlands Government funding support. In addition, both youth associations receive ongoing support and mentoring from FHI.

4) *HIV Prevention for Agricultural Development Agents and the Farming Communities They Reach in Amhara*

The increasing prevalence of HIV in rural areas emerged as a key concern in the Amhara consultation workshop. Consequently, in 2003, the Amhara Agriculture Bureau, Amhara HAPCO, and USAID/Ethiopia requested FHI's help in assessing the HIV risks that agricultural development agents (ADAs) face in their work and their related HIV prevention needs. Also, FHI hoped to determine whether ADAs could play a role in promoting HIV/AIDS behavior change among the farming communities where they work.

In spring 2003, FHI worked with the Agriculture Bureau and HAPCO to design a baseline or formative assessment for ADAs. This assessment was implemented with the agriculture bureau among ADAs in the five training colleges in the region and ADAs in the field. Key findings include the following:

- ADAs are aware of HIV and STIs but they report many misconceptions about means of transmission and prevention methods.
- ADAs observe that AIDS is affecting an important impact on the production capacity of the farmers they know.
- ADAs report that they themselves, as well as the farmers they work with, engage in behaviors that put them at risk of HIV infection.
- Discussion forums and other interpersonal communication activities are the channels of communication used to facilitate HIV programming among ADAs and the farming communities they encounter. ADAs expressed great motivation and interest in being involved in HIV programming, but wanted help getting started.

In April 2004, FHI disseminated the findings of the ADA baseline assessment to the Amhara Bureau of Agriculture (BOA), the health bureau, and the HIV/AIDS prevention and control office staff as well as other stakeholders in the region.

Subsequently, the Amhara BOA and the regional HAPCO worked together to set up a core group to lead the development and implementation of an appropriate BCC strategy. The strategy outlined effective approaches to encourage behavior change in terms of HIV prevention, care, support, and treatment. The approaches focused directly on ADAs, but also indirectly on the farming communities where they work.

With IMPACT's support, a tailored training package for ADAs was developed that would be incorporated into the region's standard ADA training curriculum. Partners agreed to undertake an initial TOT training for 45 regional BOA staff and teachers from regional agricultural colleges. The teachers in the agricultural colleges were identified to train new ADAs still in college.

With 5,000 ADAs already active in the region, it was agreed that it would be best to start small: 900 ADAs in the pilot 20 *woredas*. As the number of TOTs was not sufficient, further TOTs needed to be identified and trained from within the respective pilot *woredas*. To do this, IMPACT agreed to provide technical assistance. Funding was provided by the Global Fund and HAPCO, which used EMSAP funds.

At this stage the project stalled. Although the HAPCO and the BOA agreed with the proposal to expand the number of trainers, they did not immediately receive monies from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) needed for program expansion. HIV/AIDS focal persons and members of the HIV/AIDS Core Group often had little time to help with program implementation because of their many competing priorities. Furthermore the need to accommodate the seasonal work pressures of the ADAs (during planting and harvesting seasons they are all out in the field and unavailable for training) further inhibited flexibility of program startup. However, recently the BOA and the HAPCO have realized that they need to give more focused attention to supporting program implementation. This recognition and the fact that GFATM funds have now been released should ensure acceleration of the ADA HIV/AIDS program implementation.

5) *The Addis Ababa Taxi Program*

The baseline assessment of vulnerable groups and other research data (i.e., BSS-1) showed that the Addis Ababa taxi community was vulnerable to HIV infection and had never been targeted before by any HIV prevention program. In 2002, FHI collaborated with the Addis Ababa HAPCO and the local NGO SYGE to initiate an HIV prevention program among this population. The first activity in the program was a supplementary formative assessment¹⁴ to identify the social networks, movements, and habits of taxi drivers, assistants, and inspectors. It also identified opportunities for and barriers to the implementation of a peer education program.



In the first phase of the program, 20 pilot sites were selected. These represented the largest taxi stations in the capital. As with the SNNPR police and other peer leadership programs, a cascading training approach was adopted. Training took place over six months in 2004. Initially 20 taxi inspectors were trained by FHI as core trainers. They, in turn, trained 97 peer leadership trainers (PLTs). The PLTs subsequently trained 553 peer leaders among taxi drivers, assistants, and inspectors. The formative assessment showed that these 553 peer leaders would interact directly with more than 5,000 taxi workers in Addis Ababa. All peer leaders graduated at a ceremony in the Addis Ababa City Hall in the presence of the city mayor.

In 2005 the project was extended to another 25 sites with 24 additional core trainers, 123 peer leader trainers, and 627 peer leaders trained. The project now covers approximately 12,000 taxi workers representing 43 percent of a total estimated taxi worker population of 28,000.

¹⁴ The initial Addis Ababa Formative Assessment did include taxi drivers. However, more detail was required to fully inform project activities and act as a comprehensive baseline for programming.

Following the training, SYGE supported core trainers, peer leader trainers, and peer leaders to begin working with their peers to promote adoption of HIV preventive behavior and counseling and testing, and to reduce misconceptions about HIV transmission. The Addis Ababa Health Bureau has also agreed to provide free CT services for the taxi program's peer leaders.

The peer leadership program is supported by forum theater performances by SYGE staff at strategic sites throughout the city where taxi community members congregate. The SYGE staff have also received significant training and support through IMPACT/Ethiopia, particularly in BCC message development and monitoring and evaluation. SYGA convenes monthly review meetings with core trainers and ensures that monthly reviews with peer leader trainers also take place. This guarantees problems are addressed immediately. The project continues with funding support from Royal Netherlands Government (see Attachment 4—*Driving HIV Away: Helping Taxi Drivers Protect Themselves and Others*).

6) National Defense Force Peer Leadership Program

IMPACT/Ethiopia supported the implementation of this project from 2001 to 2003. Efforts to support a peer leadership prevention program in the armed forces were started by the Ethiopian Ministry of Defense (MOD) with UNMEE (the UN peacekeeping force for Ethiopia and Eritrea) support prior to the IMPACT program. In response to a request from the MOD for further assistance and with the support of USAID and the CDC, FHI agreed to provide technical assistance to the army through IMPACT/Ethiopia. FHI supported the MOD to design a comprehensive peer leadership program in two cores of the armed forces at the southern and eastern regions of the country. The MOD then developed a proposal for ETB6 million to implement this peer leadership program, which was accepted by the national HAPCO for funding by the World Bank's EMSAP fund.

FHI helped army officials cascade training down to 2,000 peer leaders within the southern and eastern core army divisions during 2002 and 2003. BCC materials were produced for use within the armed forces.

In 2003, with the re-organization of USG support for HIV programs among military personnel, support for the Ethiopian military's peer leadership program was continued by the CDC and DOD, no longer through IMPACT.



Ethiopian soldiers engaged in a condom use communication session.

Home- and Community-Based Care (HCBC)



Huluageresh Tadesse lost her 9-year-old daughter to AIDS and tuberculosis six months ago. Huluageresh is 29 but looks much older. On a recent afternoon, she is so weak she remains practically motionless, curled up under a blanket. A HAPCSO volunteer caregiver visits three times a week, bringing medicine to help her cope with TB, pervasive skin rashes, coughs, and other maladies. The caregiver also brings some basic necessities, like soap and cooking oil. Huluageresh lives with her 5-year-old son who is as energetic as his mother is fatigued. Sometimes Huluageresh's caregiver brings him small books.

The baseline care and support service assessments all examined the coverage and quality of HBC services in the four program areas. The first assessment in Addis Ababa showed that although some excellent models of care existed, their coverage was limited. The assessments also found that the nature of care given varied: some provided food, others money. All varied in terms of the range of health and personal care offered, and there was little integration with health facilities and other service providers. Stigma and discrimination were also major factors inhibiting needy people from accessing services.

In response to these findings, in early 2003 FHI worked with Addis Ababa HAPCO and a number of HCBC providers to develop a community home-based care program profile. This identified *iddirs* as the focus body through which to channel or coordinate HCBC programming. *Iddirs* are community-based organizations that provide funeral support, including mourning and cost support in all communities in Ethiopia. Developing HCBC services through *iddirs* has several key benefits:

- They are existing and strong community structures with large memberships.
- They are locally owned and accountable. As democratic structures, all members vote on all key decisions.
- Every *iddir* is based in the vicinity of its members, facilitating easy access and follow-up of caretakers and beneficiaries.

- As respected bodies, *iddirs*' positive engagement in supporting people with HIV/AIDS helps reduce stigma and discrimination.

In 2003 an HCBC program profile was designed by FHI with the Addis Ababa HAPCO, the Health Bureau, representatives from three local HCBC programs identified through the care and support service baseline assessment, representatives from *iddirs*, and PLHA. After working together to design an HCBC program profile inspired by international experiences of FHI and local lessons learned on how to engage communities and reduce stigma and discrimination, FHI invited the three local NGOs considered to have the best HCBC programs (MMM, CBCIDO, and HAPCSO) to become HCBC mentoring organizations. HAPCSO was selected as the first HCBC implementing agency supported through IMPACT. HAPCSO would fulfill a mentoring role and work with large groups of CBOs in implementing HCBC. In March 2003, IMPACT supported the Addis Ababa HAPCO and the health bureau to convene a meeting with more than 1,500 representatives of *iddirs* from all over the capital. During the meeting it was clear that HIV/AIDS was a major issue for all of them. Following the meeting 20 *iddirs*, distributed throughout the city, were selected to pilot the HCBC program with HAPCSO in Addis Ababa. IMPACT supported the following activities:

- The establishment of 20 HCBC subcommittees in each of the *iddirs*
- Setting criteria for, and selection of, 10 volunteer caregivers by each of the *iddirs*
- HCBC subcommittee member training in M&E, recording systems, and volunteer management
- The recruitment of 10 nurse supervisors by HAPCSO who would each support 20 volunteers
- Establishment of an HCBC resource center with training rooms, stores for medical and other supplies, counseling rooms and offices within the Ras Desta Hospital compound
- Translation and TOT training to nurse supervisors (and a range of other partner staff) on the HCBC curriculum
- Three weeks of training to the first 200 volunteer caregivers—in classroom, hospital, and community settings
- Launch events throughout the city led by *iddirs* to present the program, initiate volunteers, and identify patients in need of support
- Initiation of home- and community-based care activities
- Establishment of referral links and referral systems with healthcare facilities

After eight months of operation it became clear that the demand for HCBC was enormous and the Addis Ababa program was scaled up to a further 40 *iddirs*. This necessitated the recruitment of a further 14 nurse supervisors and 400 additional volunteers. Within one year the Addis program was serving 3,647 chronically ill and bedridden patients. Volunteers are allowed to serve in the community for a maximum of 18 months after which time they “graduate” from the program and a new cohort of volunteers take over. This helps volunteers avoid “burning out” from what can be both physically and psychologically exhausting work. Volunteers receive certificates, T-shirts and an ex-gratia payment of ETB1,000 (approx US\$110) upon graduation. Some scholarships for training grants are also awarded to the best volunteers. Many have gone on to become social workers and train as nurses.

The FHI/IMPACT Home- and Community-Based Care Program

Program goal

To improve the quality of life of people living with HIV/AIDS in Addis Ababa

Objectives of the Home- and Community-Based Care Program

To strengthen home-based care services for PLHA in Addis Ababa and promote an active and wider involvement of communities in HIV/AIDS intervention activities

The **specific objectives** of this program are as follows:

- To enable PLHA, their families, and community groups—including idirs—to provide quality care to PLHA
- To build the capacity of CBOs—including idirs and local NGOs engaged in HBC – to provide quality HCBC services
- To increase the availability of quality HCBC services for chronically ill patients in their homes
- To integrate HCBC in the continuum of HIV/AIDS prevention, care, and support for PLHA, ensuring referrals between services
- To use monitoring and evaluation to inform continuous improvement of HCBC programs

Strategies

1. Collaborative HBC program design
2. Identification of beneficiaries
3. Curriculum development for training of volunteers and family caregivers
4. Home-based care service provision
5. Orphans and other vulnerable children
6. Referrals
7. Incentives for volunteers
8. Involvement of special groups: youth and religious groups
9. The Home-Based Care Center
10. Project management
11. Further strengthening of care for PLHA and their families

Building on the experience in Addis Ababa, the HCBC model was extended under IMPACT support to 13 other major towns in the three other regions. A similar approach was adopted in identifying *iddirs*, volunteers, and capable implementing agencies. The table below indicates the towns selected, implementing agencies used, and the number of *iddirs*, staff, volunteers, and patients covered by the programs at the end of the IMPACT program.

Table 4—Summary of HCBC Programs implemented through IMPACT to Sept. 2006

Region	Towns with HCBC Programs	IA	# Iddirs supported	# Nurse Supervisors	# Volunteer Caregivers	# Patients
Addis Ababa		HAPCSO	60	24	549	20,742
		Wegen Aden	1	1		
Oromia	Adama	FGAE	10	5	394	12,185
	Shashamene	FGAE	10	4		
	Assela	FGAE	5	2		
	Zeway	FGAE	3	1		
	Jimma	OSSA	13	7		
	Nekemt	OSSA	8	4		
Amhara	Bahir Dar	OSSA	12	6	315	7,882
	Gondar	OSSA	13	7		
	Dessie	FGAE	10	5		
	Kombolcha	FGAE	5	2		
SNNPR	Awassa	Kale Hiwot	10	6	227	5,650
	Dilla	Kale Hiwot	7	4		
	Wolaita	Kale Hiwot	7	4		
Totals					1,485	46,459

Additional Support and Activities

During the course of IMPACT, additional activities have been included to the basic HCBC package.

Orphans and Other Vulnerable Children (OVC): As soon as volunteers began working in communities, the desperate plight of the children of chronically ill and bedridden patients became obvious. Initially, IMPACT provided support to implementing agencies for OVC. Some of this was used to cover direct costs such as school uniforms, shoes, or books. Increasingly a referral network approach was adopted with caregivers facilitating access to government exemptions such as free healthcare or school registration fees. In recent years funds for OVC support from PEPFAR/USAID have been channeled through other contracts. In Ethiopia USAID awarded such a contract to Save the Children—US To ensure OVC support in HCBC programs, FHI partnered with Save the Children. These funds are now being used to pilot and scale up care programs for OVC in the IMPACT areas. Often the same implementing agency provides both forms of support—otherwise volunteer caregivers work with their local *iddir* and implementing agency to refer OVC for support from others.

Food relief: More than any other form of support or treatment the lack of sufficient and nutritious food was found to be a key factor undermining the health of PLHA. Under IMPACT FHI staff and program partners have worked with WFP to establish a formal nutritional support program for PLHA and OVC in most of the urban areas covered by IMPACT. Families in the HCBC program are eligible for monthly rations of grain, oil, and fortified cereal mix. The HCBC programs have now also incorporated educational activities to promote balanced nutritional practices within their basic service package. FHI and partners continue lobbying to expand nutritional support through HCBC programs and adapt eligibility criteria as people's health status improves.

ART availability: The introduction and expansion of ART in Ethiopia during IMPACT has radically improved the level of care available to PLHA in HCBC programs. FHI trained HCBC staff in chronic AIDS care, ART follow-up, and adherence support. HCBC staff and volunteer

caregivers help HCBC clients to know their HIV status, access treatment services, and adhere to treatment. It has increased the incentive for chronically ill and bedridden patients to undertake counseling and testing and necessitated greater training on OI/ART among nurse supervisors and caregivers. Consequently in 2005 IMPACT provided TOT trainings on OI/ART and counseling and testing to all nurse supervisors who are responsible for cascading training to volunteer caregivers.

Adherence support programs: As more patients are prescribed ART, volunteers are finding themselves responsible for following up patients' adherence to treatment. The number of drugs and the regularity with which they need to be taken is vital but a habit that some PLHA find very difficult. Many cannot read and do not even own watches. Very close support is provided by volunteers initially. In the longer term a variety of approaches are being implemented to address this. A common approach is establishing PLHA support groups. These meet regularly with volunteers to discuss problems and issues. They also provide an opportunity to follow up on adherence and for members to encourage each other.

Livelihood support: The provision of good HCBC along with ART has resulted in spectacular improvements in the health of many chronically ill and bedridden patients, including PLHA. This decreases their need for intensive HCBC. Indeed, many are now well enough to become caregivers themselves. However, they remain in the HCBC program although their needs change. There is an emerging need among PLHA for sustainable livelihoods to support themselves and their families. This has increased demand for additional livelihood support such as skills training or income-generating activities. The need for livelihood support is challenging the strengthening of networks between various service providers and scale up their programs.

Family planning and other sexual health care support: Clinically well PLHA are also becoming sexually active, with a number becoming pregnant. This necessitates further attention and support in terms of sexual and reproductive health (SRH). It also increases the need for referral to PMTCT services. Under IMPACT, FHI facilitated access to family planning if needed through referral. Comprehensive SRH integration was started in HCBC in September 2006. Guidance on safer sexual behavior to limit the spread of HIV by PLHA is also emerging as another area of care that needs to be incorporated into the current package.

Community conversation as a behavior change strategy: The traditional Ethiopian coffee ceremony has been a popular and effective method for nurses and caregivers to discuss HIV/AIDS issues with the families and neighbors of PLHA. Great progress has been achieved in increasing awareness on HIV/AIDS and reducing stigma and discrimination toward PLHA. Nationally the UNDP is working with HAPCO and other partners to rollout use of the Community Conversation Enhancement (CCE) approach with communities. This more formal technique encourages communities to openly discuss broad issues related to problems brought about by HIV/AIDS and develop consensus on possible responses to address these problems. To enable better linking between different community-level HIV/AIDS communication efforts, FHI has recently incorporated the CCE approach in BCC activities. FHI incorporated the CCE approach into its BCC activities through:

- Analysis of the CCE approach
- Analysis of opportunities for the strengthening BCC activities by including elements of CCE

- Development of a consolidated approach (BCC and community conversation enhancement—CCE)
- Training of prevention and HCBC program partners in the consolidated BCC/CCE approach and related communication techniques
- Support for implementation of BCC/CCE activities in prevention and HCBC programs

FHI is now building the capacity of existing HCBC volunteers, peer leaders, and *iddir* members in combined CCE/BCC strategies to promote HIV/AIDS related behavior change at the community level.

HIV Counseling and Testing (CT)

All partners agreed that the limited number of CT sites was a concern. Both Addis Ababa and Oromia identified the expansion of CT services as their number one priority. Consequently the scale up of CT services in all program regions has been a major activity of the IMPACT program. It has also been one of the most successful activities, expanding the number of CT sites in the four regions from a total in all sectors of 157, at the start of IMPACT, to the current 750. Of these, 484 were developed with IMPACT support at the health center level.

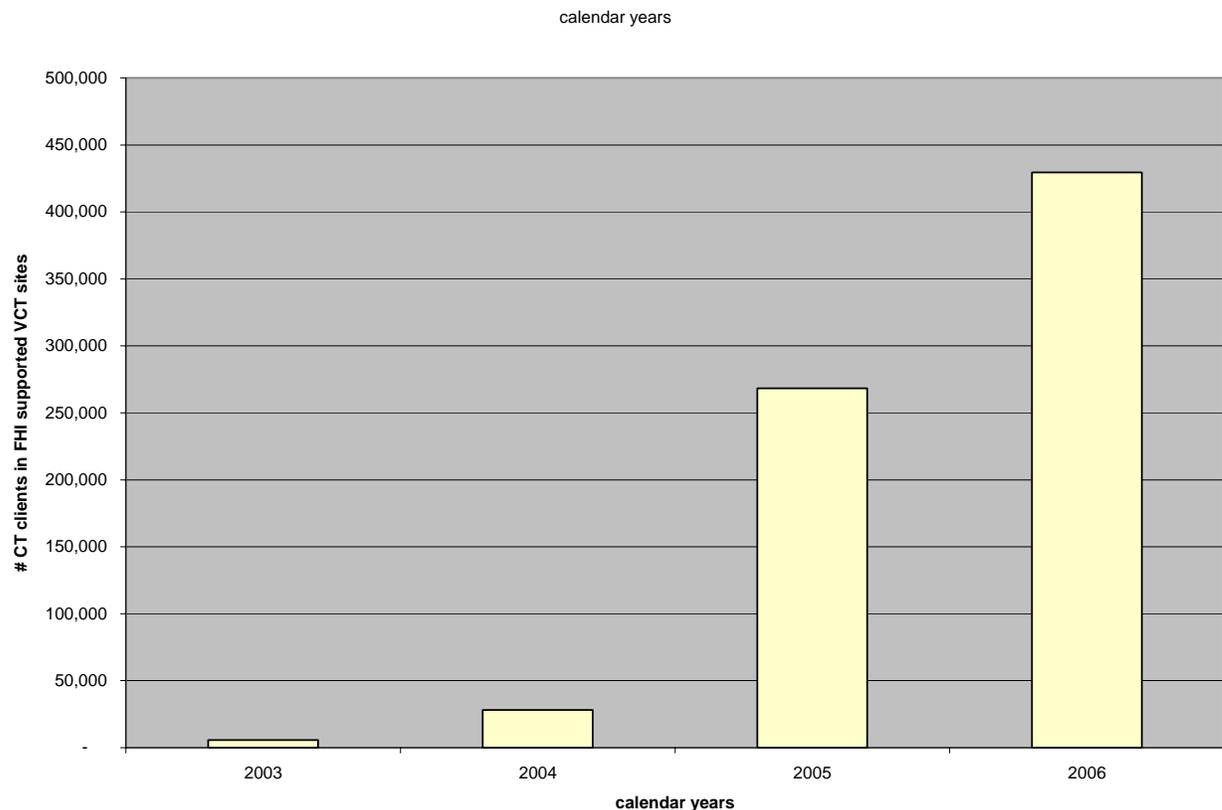


A man being counseled for VCT

The expansion has been achieved through work with the Ministry of Health and regional health bureaus in each region to integrate counseling and testing (CT) services into public health centers. It is now MOH policy for health centers to provide CT as one of their standard services. The strategy to locate CT services in health centers was adopted for a number of reasons. First, health centers ensure relatively wide geographic coverage, even in rural areas. Second, they are multidisciplinary service sites that can be attended by anyone without attracting attention or stigma, unlike standalone CT sites. Third, there are obvious and direct opportunities for referrals and linkages between CT and other health services provided in health centers.

Improving CT is an important entry point into the expanded and comprehensive response (ECR). Building the capacity of regional health bureaus to expand this service was an important step in mainstreaming HIV care and support into the general healthcare system. Throughout the program, FHI staff worked to strengthen existing structures and respect the mandates of the relevant government bodies at each level (i.e., RHBs, zonal and *woreda* health offices and health centers). The direct assistance provided by IMPACT is detailed on the following page.

- Helping RHBs undertake rapid assessments of health centers in all regions to identify the gaps and constraints to scaling up and integrating CT services



- Following the assessment, developing CT expansion plans with RHBs, specifically the HIV/AIDS Prevention and Control teams within the Disease Prevention and Control Departments. Together a schedule was made of all technical assistance required, in terms of training, equipment, supplies, and follow-up support and supervision.
- Providing initial TOT trainings by FHI technical specialists to senior health professionals from federal, regional, and zonal levels as well as from regional universities and teaching hospitals.
- Support in cascading training to health center staff by the trainers. Training falls into two categories: the first in counseling and testing for nurses and other health workers and the second in testing only, for laboratory staff. Trainings take place simultaneously in both areas and are ongoing throughout all regions.
- Where required, IMPACT procured and distributed all furniture and equipment to initiate CT services at the health center level. IMPACT also purchased all supplies, such as test kits and reagents required to ensure services could start immediately following training. Over the lifetime of the program responsibility for the provision of ongoing supplies has been passed to the RHBs, although temporary shortages continue due to weaknesses in the national supply chain management system.
- Following training, FHI staff supported regional and zonal MOH staff to undertake follow-up supervisions of all health centers. These were essential to verify whether CT

services had been initiated and to address teething problems. Following site supervisions FHI staff help the RHBs organize post-supervision review meetings.

- There are also regular review meetings at zonal and regional levels to discuss problems in implementation. IMPACT has provided ongoing technical assistance to RHBs in addressing the management, logistical, and capacity problems related to CT scale-up efforts.
- FHI continues to support the gradual transfer of CT management and supervision skills to the regional, zonal, and *woreda* health staff.

Initially IMPACT support focused on increasing the number of CT services and ensuring services were initiated. Once a significant number of new sites were operational, enhanced attention was given to improving the quality of service provision and strengthening referral systems. As clinical care and treatment also improved (see next section) along with HCBC (in some areas) the value and importance of such referrals has become a priority. Consequently, later program activities focused on the following:

Quality Assurance/Quality Control

IMPACT has been supporting regional health bureaus and regional laboratories to refine their HMIS tools to ensure appropriate and effective data management on CT service delivery and to develop and implement quality assurance systems and tools. These tools include client intake record, peer supervision checklist, counselor reflection form, CT site supervision checklist, laboratory HIV testing supervision checklist, and proficiency assessment of lab technicians. IMPACT also supported the regional laboratories to conduct regular quality control of HIV testing. CT sites are supported to store samples for QC (in Addis Ababa: every third HIV-positive sample and every tenth HIV-negative sample; in the other three regions: all HIV-positive samples and every sixth HIV-negative sample). The regional laboratories collect these samples from all the sites, retest at the regional laboratory to verify the original result, and give feedback to the site. Once a year, IMPACT worked with the regional laboratories to conduct a proficiency assessment of the trained laboratory technicians. The proficiency assessment involves the regional laboratory staff in collaboration with FHI staff directly observing the site lab technician performing HIV testing of five blood samples of which the result is not known to the site lab technician.

FHI further assists each regional health bureau to establish and conduct at least one in-depth technical and operational supervision to all CT sites in their region per year. This in-depth supervision complements the ongoing supervision by zonal supervisors and is conducted with regional health bureau staff, regional laboratory staff, zonal CT supervisors, and FHI staff. The findings of the supervision are shared with counselors, lab technicians, health center heads, wereda health officers, zonal CT supervisors, the regional laboratory head, the regional health bureau head and the regional HAPCO head during the CT supervision review meetings per cluster of health centers. During these review meetings, everyone works together to identify quality assurance and service delivery problems and to take steps to solve the issues identified.

FHI is also a member of the National Counseling and Testing Technical Working Group. This group is examining a number of policy issues including:

- Reviewing and upgrading the National CT Guidelines. These guidelines will incorporate guidance on provider initiated counseling and testing (PICT) as well as CT.

- Development of standardized training manuals on CT, PICT and testing for laboratory technicians.
- Ensuring training is incorporated into the standard preservice curricula for all health professionals. This would avoid the need for and costs of the current ongoing in-service training to health center staff.

Provider-Initiated Counseling and Testing (PICT)

Provider-initiated counseling and testing is requested by a healthcare provider as part of the diagnostic work-up and clinical management for patients who exhibit symptoms that may be attributed to HIV or have an illness associated with HIV. When these symptoms or signs are present, PICT should be offered as standard care. The main purpose of PICT is to identify HIV in sick people so that they can receive comprehensive care within healthcare settings. It is unacceptable for providers to test patients for HIV without their knowledge and consent or without communicating test results to the patient.

To further increase access to CT and to ensure that all people presenting at a health center with HIV/AIDS-related illness can receive OI care and treatment and be considered for ART, IMPACT worked with regional health bureaus to train and support health professionals working in TB, opportunistic infection care services, and in outpatient department services to provide PICT. The PICT training involves three days of classroom training and a one-day practical attachment. Regional health bureaus now require that all health professionals working in these services in health centers are trained in PICT on a routine basis and provide PICT as part of their daily work.

Strengthening Referral Networks

Training to health center staff has incorporated dedicated modules on referral networks. Health center staff are encouraged to consider three levels of referral:

- (1) Within the health center—to other departments (e.g., TB, family planning)
- (2) To referral hospitals—for positive patients who may need full diagnosis for OI/ART
- (3) To other nonmedical services— (e.g., community-based care providers, PLHA support groups, or other government services).

FHI has supported the development of functional referral systems to enable referral between services within a health facility, between different levels of facility-based care, and between community-level HCBC services, community-level multisectoral referral networks, health center services, and hospital-level services. This has included:

- Working with health bureaus, health facility staff, and HCBC program staff to develop practical referral tools, referral cards forms, and procedures
- Working with health bureaus, health facility staff, and HCBC program staff to develop M&E tools to monitor referrals
- Sensitizing health facility and community service staff to use the referral system
- Training health bureaus, health facility, and HCBC program staff to use M&E tools
- Providing mentoring support to ensure the establishment of the M&E system and feedback from monitoring to improve referral systems
- Sensitization of health facility staff to give priority access to health services for beneficiaries of HCBC programs
- Working with health bureaus to ensure authorization to HCBC nurse supervisors and volunteer caregivers to take TB/DOTS and ART treatment from the health facility and provide and monitor directly observed treatment in the home for patients who are bedridden to increase access of services for the poor
- Working with local partners to find solutions to existing barriers for the poor to access services and leading efforts to ensure costs for the poor to access health services are exempted or subsidized

Clinical Care and Treatment

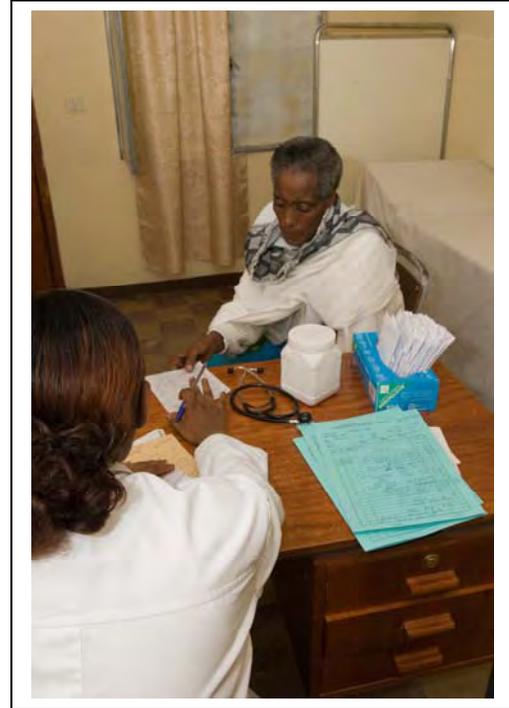
With health services in Ethiopia among the poorest in the world, it was clear the IMPACT/Ethiopia program needed to work with the Ministry of Health if an expanded and comprehensive approach was to work. The expansion and integration of CT sites into public health centers highlighted a clear gap in the clinical care available to people testing positive. Health professionals receive no training on HIV in their standard preservice training. Additionally, at the beginning of the program free ART was not available in Ethiopia. This further undermined the ability of health staff to treat PLHA.

Activities under this IMPACT subcomponent fall into two phases—the first phase covers training and support provided to health staff prior to the introduction of ART and the second phase includes activities implemented after ART was introduced. In all activities the IMPACT program has worked to strengthen existing structures—and where they don't exist to help develop them. All of this has been done through the regional health bureaus in charge of daily management and quality assurance of health services in their regions.

In the first phase FHI worked with the Addis Ababa Regional Health Bureau to provide opportunistic infection care training to health providers working in government hospitals and health centers in the city. This supported the expansion of CT sites, which was a major activity carried out early in the IMPACT program. IMPACT supported further trainings in the other three regions alongside the CT expansion.

By the end of 2003, ART was formally available in Ethiopia, but only through private clinics and at a very limited number of public hospitals. With donor funding from USAID and the GFATM, among others, plans were made to roll out provision through public hospitals and health centers throughout the country. However, the national plan to roll out ART—the National ART Roadmap—was not published until June 2005. With IMPACT funding FHI has helped the MOE and regional health bureaus to plan and prepare for the provision of ART at public health centers and to initiate the first ART services at the health center level. Support includes the following:

- OI/ART site readiness assessments conducted with regional health bureaus in all four regions
- Preparation of Clinical Care Performance Improvement Programs with the MOH and the Drug Control Authority for all public health centers identified for ART rollout (primarily those with CT services and functioning within the referral network of an ART hospital)
- Provision of training of trainers on OI/ART for senior public health staff from the federal MOH, regional health bureaus, and teaching universities in October 2004



Patients at health centers are now able to access a far greater range of clinical treatment.

- Support for the subsequent rollout of training to health center staff from facilities in all four regions by MOH/regional health bureau trainers
- Support to ongoing gap-filling and refresher training in all regions to counter staff turnover
- Provision of material support where lacking to health centers in the form of clinic service furniture, National Guidelines and Protocols, and other reference materials
- Support to regional health bureaus, zonal and *woreda* staff to undertake regular supervision and quality assurance visits to health centers

From the very start of CT service support, when feasibility studies were conducted in health centers to assess whether CT services should and could be established, detailed discussions were held with health center heads and staff on what services a health center could provide to HIV positive CT clients. It was concluded that all health centers could provide basic care for opportunistic infections to HIV-positive clients (diarrhea, TB, other infections). As soon as the CT service was established, FHI worked with the regional health bureaus and health center staff to strengthen internal referral systems within the health center. Then, in 2004, IMPACT worked with the MOH and regional health bureaus to assess the status of national OI treatment guidelines. As a result a tailored training curriculum was developed for the health center level focusing on OI care and on preparing for ART. In October 2004, the first batch of trained trainers learned about chronic AIDS care (which includes OI care and ART). Immediately thereafter, health center staff were trained in chronic care. In December 2004, the first “chronic care units” were established in health centers in Addis Ababa, quickly followed by the other regions. By March 2006, 198 health centers in the four regions had established “chronic care units.” The chronic care units exist to provide dedicated care and follow up for PLHA, incorporating TB and other opportunistic infections.

Chronic care units provide OI care, identify PLHA who are eligible for ART, refer them to ART services for final eligibility screening and treatment, and provide follow-up care related to ART treatment after the patients have been discharged from hospital. A chronic care unit consists of a medical doctor, a health officer and a nurse, or—where there is no medical doctor working in the health center—of a health officer and a nurse or two nurses.

In May 2006, the MOH endorsed nationwide ART decentralization from hospital to the health center level. At that point, the rollout of ART at the health center level proceeded at a rapid pace. FHI provided support for the decentralization of ART services through the following activities:

- Promotion of ART scale-up in a phased manner
- In June 2006, regional health bureaus nationwide short-listed 124 health centers for ART decentralization. To assess the feasibility of providing refill ART services or initiate ART in these health centers, FHI worked with the regional health bureaus to conduct pre-ART assessments in all these sites.
- Training of health center-level healthcare providers in national ART standards and protocols
- Development of Standard Operating Procedures for ART rollout at the health center level for each of the five major regions
- Support for the establishment of ART services
- Clinical mentoring of ART and chronic AIDS care services

- Support for catchment area meetings and regional review meetings involving all actors in the public health structure involved in ART
- M&E and quality assurance supervision

FHI's support has brought about an increased leadership and commitment of the regional health bureaus in the five largest regions where FHI has focused technical assistance in terms of coordinating and leading ART decentralization, and directly facilitated the establishment and functioning of health center level ART services.

ART services are established in health centers that already have functional HIV counseling and testing and OI care services and are part of the referral network of an ART hospital. In mid-October 2006, 80 health centers in Addis Ababa, Amhara, Oromia, and SNNPR were providing pre-ART care services to 4,052 persons and ART services to 1,393 PLHA. This support will continue beyond the IMPACT program with further funding from USAID/PEPFAR.

An integral part of all training to health staff is the emphasis on improving referral networks both within the health center and between the health center and other health facilities – in particular, ART hospitals, which undertake final eligibility screening and initial treatment. Under the health network model strategy, several health centers are linked to an ART hospital and are responsible for initiating new clients on ART and/or providing ART follow-up services to stable patients after their discharge from the hospital.

IMPACT also supported the evolving MOH policy on TB and HIV. Cascading training has been provided to TB and other health center staff in all four regions on HIV/AIDS care and treatment. In Ethiopia it is estimated that between 20 and 50 percent of TB patients are likely to be HIV-positive. The training, therefore, also encourages “provider-initiated counseling and testing” (PICT) for TB patients and vice versa for HIV patients. Again the emphasis is on strengthening patient referral networks within and between healthcare providers.

As clinical services have improved, IMPACT's support has shifted toward strengthening referral networks between different kinds and levels of service providers. For health center staff, this means working with non-healthcare service providers such as local NGOs and CBOs involved in HCBC activities. In 2005, IMPACT supported a pilot program in Bahir Dar, Amhara Region. The regional health bureau and the Amhara HAPCO worked with the local NGO OSSA, local PLHA associations, and youth groups to develop and pilot an adherence support program for PLHA who are on ART. This adherence support program involves health center staff, HCBC program staff, and community volunteers working in the same catchment area to follow up on ART clients attending the health center clinical care units through community level visits. This work overlaps very strongly with adherence support activities that have naturally evolved in the development of IMPACT's HCBC programs.

General Technical Assistance (TA) and Capacity Building

Ongoing capacity building has been an important strategy throughout the implementation of IMPACT. If local counterparts are to effectively design, implement, monitor and evaluate HIV/AIDS interventions programs, they will need the generic supervision and management skills and equipment to do so. All partners were subject to capacity audits to assess their specific needs beyond those directly related to specific interventions. Specific assistance in this category includes:

Monitoring and Evaluation

This was a fundamental element of the IMPACT program. As such, FHI technical specialists provided the following support:

- Helped other FHI staff members, governmental and nongovernmental partners to develop comprehensive, project-level monitoring and evaluation plans and systems
- Provided technical assistance to governmental and nongovernmental partners to analyze and use the qualitative and quantitative data collected
- Supported partners to develop program-level monitoring and evaluation tools, including the design of operational research
- Ensured monitoring and evaluation findings were consistently used to enhance program design and project effectiveness
- Conducted project assessments, evaluations, and design
- Supported the first round of the national BSS

Organizational Development

FHI regularly undertakes organizational capacity assessments of partners to gauge their capacity to implement the technical programs planned. In response to identified capacity gaps, support is provided. As required, this has included capacity building in: financial management; organization management systems and operational procedures; human resource development; external relations; supervision and review systems; and ensuring an appropriate mix of human resources and sufficient support for organization staff and volunteers.

Strengthening Networks and Coalitions

At the community and regional levels, FHI staff have worked with partners to build networks and coalitions to achieve well-coordinated programs that are mutually supportive and effectively work to help clients access services.

Material Capacity Building

IMPACT/Ethiopia has provided a range of supplies and equipment to key partners – specifically local IAs, national and regional HAPCOs, and regional health bureaus. Primarily this is furniture and IT equipment to fill gaps and initialize project activities. Vehicles have been provided to some of the NGO partners involved in HCBC.

IMPLEMENTATION AND MANAGEMENT

The establishment of the FHI office in Addis Ababa was one of the startup activities of the IMPACT program. The expatriate country director was responsible for recruiting a range of technical specialists in each of the subsector areas. As the program expanded beyond Addis Ababa, regional co-coordinators were recruited for Amhara, Oromia, and SNNPR. Additional program offices were established in Bahir Dar, Amhara and Awassa, SNNPR. The Oromia coordinator and other staff were based in the Addis office. An organogram of FHI staff is included as Attachment 2.

Technical specialists in Addis Ababa and each regional office include BCC officers, HCBC officers, counseling and testing officers, treatment officers, and monitoring and evaluation officers. In the Addis Ababa office, the team further includes organizational capacity building officers, OVC and household economic strengthening officers as well as a finance and administration team and management staff. Technical officers all have close working relationships with their respective program partners, specifically regional HAPCO and regional health bureau staff and local NGOs/CBOs. In Ethiopia, the activities of all NGOs must be approved by the government. Therefore, before implementing any IMPACT activities, FHI signed agreements, which set out the scope of activities to be carried out with all regional governments. In addition, for specific IMPACT sub-elements (e.g., CT scale-up), FHI signed a Memorandum of Understanding (MOU) with the relevant government body. This set out the respective roles and responsibilities of each party and the resource contributions required to implement the program.

Nongovernmental organizations implementing IMPACT activities were contracted through sub-agreements. A list of IAs is included under the “List of Implementing Partners,” under Section IV of this report. The subagreement is a detailed document explaining the purpose and objectives of the specific intervention. It contains a detailed log frame for the project outlining the roles and responsibilities of the IA and FHI in the achievement of objectives. Most subagreements are reviewed and renewed annually by FHI and the IA, at which point annual targets and budgets are set.

Implementation Constraints

Stigma and Discrimination

Although the program has done much to overcome stigma and discrimination in the target areas and there are clear signs of reduced stigma at the community level, there is still an important need to continue working to reduce stigma and discrimination. Stigma and discrimination still limit the extent to which people will come forward to access services such as CT or HCBC. It also limits the involvement of community partners in developing their own responses to address the impacts of the AIDS epidemic.

Lack of Appropriate Implementing Partners

Compared to other countries, Ethiopia has a limited number of local NGOs. Outside of Addis, particularly in rural areas, there are limited organizations with the skills, experience, or organizational capacity to implement HIV/AIDS projects. This has been a constraint when identifying suitable partners through which to extend the HCBC program.

Turnover of Government Staff

All government departments and health facilities in particular experience significant staff turnover. As far as possible, staff training and capacity building have been designed to withstand an inherent level of turnover. Still, regular changes in senior staff can be problematic.

Lack of Partner Understanding of the Critical Importance of OI Care

IMPACT worked very hard to draw attention to the need to provide and strengthen OI care services. IMPACT was the first to work with the MOH and regional health bureaus to assess OI care in the country, review existing OI care guidelines, train health professionals in OI care, and support the establishment of chronic care services at the health center level, which focused on OI care. However, it has been difficult to obtain focused attention to OI care. Most government, technical assistance, and donor partners see OI care as solely related to ART. However, most people with AIDS are not eligible for ART. All that many really need is OI care. To improve the quality of life of PLHA, it is critical that more attention and resources are given to ensuring quality OI care throughout the healthcare system.

Stockouts and Shortages of Test Kits, Drugs, and Other Supplies

Lack of and/or expired drugs and test kits cause service interruption in many health centers. This means CT services may be stalled and that patients have to go without important treatments, particularly for OIs. FHI fills gaps where required but sustainable supply of drugs to public health facilities remains problematic.

IMPACT/ETHIOPIA PROGRAM TIMELINE

The table overleaf tracks the implementation of the various elements of the IMPACT/Ethiopia program. The first year of the program was devoted to start-up activities, primarily consultation workshops and undertaking the five baseline assessments in each of the four regions. As the priorities and partners were identified, plans were made for implementation and FHI's technical staff expanded accordingly. The vast majority of activities began in 2003 and have continued to the end of the IMPACT program. Most are continuing with funding from USAID under the PEPFAR program or other donors.

Activity	01	2002				2003				2004				2005				2006			
	Q4	Q1	Q2	Q3																	
Startup and Assessment Activities																					
Addis Ababa consultative workshop	X																				
Addis Ababa baseline assessments		X	X																		
Woreda 5—ECR pilot activities		X	X	X																	
Oromia consultative workshop						X															
SNNPR consultative workshop								X													
Amhara consultative workshop								X													
HIV assessment in resettlement areas									X	X	X	X									
BCC Interventions																					
Addis Ababa BCC Strategy Development			X	X	X	X	X	X													
Amhara BCC Strategy Development							X	X	X	X	X	X	X	X	X						
Oromia BCC Strategy Development							X	X	X	X	X	X	X	X	X						
SNNPR BCC Strategy Development							X	X	X	X	X	X	X	X	X						
Launch & support of Addis CATS campaign									X	X	X	X	X	X	X	X	X	X	X	X	X
Launch & support of Addis CT campaign											X	X	X	X	X	X	X	X	X	X	X
Launch & support of regional BCC campaigns (stigma, CT & self-risk perception)																X	X	X	X	X	X
National Youth consultation and development of action plan			X	X	X																
TA to support National Youth Network						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Prevention Programs																					
Low-income women project							X	X	X	X	X	X	X	X	X	X	X	X	X	X	
SNNPR police peer education program								X	X	X	X	X	X	X	X	X	X	X	X	X	X
Addis vulnerable youth peer education			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Addis taxi driver peer education program						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
National Defense Forces peer leadership program	X	X	X	X	X	X															
HIV/AIDS program support for Agricultural Extension agents in Amhara region												X	X	X	X	X	X	X	X	X	X
Home and Community Based Care																					
HCBC program profile developed						X															
Initial HCBC training and startup activities in Addis Ababa							X														

HCBC program established & supported in Addis								X	X	X	X	X	X	X	X	X	X	X	X	X	X
Activity	01	2002				2003				2004				2005				2006			
	Q4	Q1	Q2	Q3																	
HCBC program established & supported in Oromia											X	X	X	X	X	X	X	X	X	X	X
HCBC program established & supported in Amhara										X	X	X	X	X	X	X	X	X	X	X	X
HCBC program established & supported in SNNPR									X	X	X	X	X	X	X	X	X	X	X	X	X
CT																					
Addis Ababa rapid assessment of health center capacity				X																	
Addis Ababa—Initial TOT on CT					X																
Training and scale-up in Addis Ababa						X	X	X	X	X	X	X									
Oromia rapid assessment of health center capacity							X	X													
Oromia - TOT on CT									X												
Training and scale up in Oromia										X	X	X	X	X	X	X	X	X			
Amhara and SNNPR rapid assessment of health center capacity											X										
Amhara - TOT on CT												X									
SNNPR - TOT on CT												X									
Training and scale up in Amhara and SNNPR													X	X	X	X	X	X	X	X	X
Treatment																					
TA - training to MOH staff on OI prophylaxis and treatment of PLHA						X															
OI/ ART site readiness assessments												X	X								
TOT training on OI/ART													X								
Health center staff training on OI/ART													X	X	X	X	X	X	X	X	X
Gap-filling training, supervision and review														X	X	X	X	X	X	X	X
TB-HIV trainings													X	X	X	X	X	X	X	X	X
Pre-ART assessment																				X	X
ART refresher training																				X	X
Support for establishment of ART services at health center level																					X
Ongoing TA and Partner Capacity Building																					
Training on M&E/Strategic information management		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tailored TA to partners	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

PROGRAM RESULTS AND ACHIEVEMENTS

This section outlines the results and achievements of the various subsectors of the IMPACT/Ethiopia program. The first section summarizes program outputs in terms of resources and other multimedia materials produced. The following sections summarize service outputs and other achievements of each of the IMPACT program subsectors.

Program Outputs

IMPACT/Ethiopia has supported the development and production of a wide range of material outputs and documents. A list of the primary outputs under each of the program subsections is shown in Table 3 below. The list is not exhaustive, as many documents were produced in the implementation of various project activities. Many training documents were tailored and revised according to the specific needs of partners, as were day-to-day monitoring forms, checklists, and other management tools. These are too numerous to mention.

Table 5—IMPACT Program Outputs Produced	
Name of Document/Material	Purpose or Utilization
Assessment and Start-up	
<ul style="list-style-type: none"> • HIV/AIDS Care and Support Service Assessment (x4) • Rapid Assessment of vulnerable groups (x4) • PLHA needs assessment (x4) • Human Capacity Development assessment (x4) • BCC Formative Assessment (x4) 	Baseline reports undertaken in all 4 program areas: Addis Ababa; Oromia; Amhara; SNNPR Used to prioritize and design interventions
Prevention Programs for Vulnerable Groups	
<ul style="list-style-type: none"> • Peer Leadership Strategy Development and Implementation Manual (Military) • Peer Leadership Strategy Development and Implementation Manual (Police—SNNPR) • Report on Final Evaluation of the LIW Project in Kirkos 	Training and support manuals Evaluation
Home and Community Based Care	
<ul style="list-style-type: none"> • Community Home-Based Care Program Profile Manual • Community Home-Based Care Handbook for Caregivers 	Program profile reference Handbook reference for HBC service providers nationally
Counseling and Testing (CT) and Clinical Care and Treatment	
<ul style="list-style-type: none"> • Standard Operating Procedures (SOPs) for Decentralization of ART services to health centers (x 4—Addis Ababa, Amhara, Oromia, SNNPR) • Training materials on basic OI/ART care for health center staff 	Regional guidance for health staff Training materials
Behavior Change Communication (BCC)	
<ul style="list-style-type: none"> • BCC—a TOT Guide (Ethiopia Version) • Final Report on the First National Youth Consultation on HIV/AIDS, Sexual and Reproductive Health in Ethiopia • CATS Campaign Media Kit • CT Campaign Medical Kit • The ANRS CATS and CT Promotion Campaign Media Kit • National Youth Network Directory: directory per region of all youth groups active in sexual, reproductive health, and HIV/AIDS • The Ethiopian National Youth Charter (2002) 	Training material Report on activity Media support materials Directory National charter

Service Outputs and Other Achievements

The primary service outputs of the IMPACT/Ethiopia program are summarized over the following pages under each of the various IMPACT subsectors programs. Quantitative outputs have been comprehensively collected and reported throughout the program. As far as possible the summary indicators shown reflect nationally agreed indicators monitored by National and Regional HAPCOs and regional health bureaus. Wherever possible the baseline situation is also shown to give some indication of the program's impact. After each summary table other program outcomes and achievements are described to give a more qualitative assessment of the program's wider impact.

Behavior Change Communication (BCC) and Prevention Interventions

Table 6—Program Outputs: Prevention Programs and Behavior Change Communication (BCC)		
Indicator	Partner or Region	At the end of IMPACT
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	National Youth Network	23,773
	Woreda 5—Youth Assn.	7,711
	Woreda 5—Mehai Youth Assn.	4,048
	Total	35,532
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	SNNPR Police Project	5,200
	ISAPSO - LIW Project	3,889
	SYGA - Taxi Drivers Project	12,000
	Total	21,089
Number of individuals trained to promote HIV/AIDS prevention programs (BCC Strategy Development + Peer Education)	Addis Ababa	1,040
	Amhara	112
	Oromia	29
	SNNPR	4,494
	Total	5,675
Number of people reached through mass media HIV/AIDS prevention programs	Addis Ababa	3,000,000
	Amhara	18,143,003
	Oromia	25,098,005
	SNNPR	14,085,007
	Total	60,326,015
Number of facilities/programs providing mass media HIV risk avoidance/reduction services	Addis Ababa	25
	Amhara	30
	Oromia	107
	SNNPR	66
	Total	228

Table 7—Multimedia Outputs of IMPACT/Ethiopia Program						
Region		Radio Spots	Billboard Designs	Types of Posters	CT Promotion Brochures	Music Videos
Addis Ababa	CATS	3	3	3	-	1
	CT	4	4	4	1	
Oromia		6	4	4	1	
Amhara		5	3	3	1	
SNNPR		5	3	3	1	
Total		23	17	17	4	1

The figures on the previous page show that more than 60 million people have been reached through IMPACT multimedia campaigns. This represents the majority of the Ethiopian population. It also includes virtually major urban populations and many MARPS. Given that HIV prevalence is greatest in urban areas it was important for campaigns and other prevention activities to focus in these areas.

Following its launch in 2003, the CATS campaign song *Compassion is Modernity* became a number one hit throughout the country and is still on the air. The campaign initiated widespread discussion in the country at all levels (community and media) on how to effectively promote behavior change and reduce stigma, denial, and discrimination. Feedback indicated that the secret behind the success of the music was the positive approach used in addressing sensitive issues. This approach helped to attract the attention and empathy of the audience. Many agree this has encouraged them to reconsider their beliefs and behavior.

One year after launching the Addis Ababa CT promotion campaign, a post-launch assessment of the campaign was carried out in Addis Ababa with youth, taxi drivers, and commercial sex workers. This showed more than 93 percent of them were familiar with the campaign's billboards, songs, or radio spots and judged the messages to be good or very good.¹⁵ Similarly, a review of the Addis Ababa regional health bureau's CT records showed the CT campaign contributed to a significant increase in use (see the "Project Highlights" section later in the report).

Regional Police Forces in SNNPR

The program has significantly increased awareness on basic HIV/AIDS/STI knowledge and HIV prevention strategies among the SNNPR police members. The program reached direct beneficiaries of about 5,000 police members and more than 10,000 indirect beneficiaries.

Low-Income Women (ISAPSO) Project

A recent evaluation of this project found that the project achieved important results, though on a small scale. Sex workers learned to read and write, and the literacy rate among beneficiaries increased from 78 percent to 87 percent. Beneficiaries report increased consistent condom use from 29 percent to 64 percent. Correct knowledge of modes of HIV transmission and prevention methods improved substantially (e.g., correct knowledge of HIV transmission through unprotected sex was 93 to 98 percent; correct knowledge of HIV transmission from HIV-positive mother to child was 60 to 84 percent). More than 60 percent of beneficiaries received HIV counseling and testing services during the program's duration. The percentage of sex worker program beneficiaries who disclosed their HIV status to their partners and/or relatives increased. Sex worker beneficiaries shared that the peer leadership program component helped them feel better about themselves, that they feel empowered to have more control over their lives, and that they have gained a better understanding of HIV/AIDS and ways to negotiate safer sex with partners.

¹⁵ "Good" or "Very Good" meaning that they liked the messages, they recognized that the messages were appropriately designed for the targeted groups, the message dissemination was timely and responded to a need, and the messages effectively addressed the issues related to CT-seeking behavior (hurdles, information, and self-risk perception).

Addis Taxi Program

In the first months of taxi driver peer leadership program implementation, monitoring feedback showed that condom use and CT use had increased. The peer leadership program has gained a sudden and very high acceptance among the large target population of taxi drivers, assistants, and inspectors, with many drivers and assistants coming forward asking to become peer leaders and sharing their testimonies about how the program has given them self-respect, a sense of future, and a desire to be catalysts for positive change among their friends, families, and peers (see Attachment 4).

Youth Peer Leadership Program

The quality and effectiveness of peer education programs with youth groups in Addis Ababa has increased under IMPACT with the development of an improved peer leadership training manual. In addition, organizational support, including training on monitoring and evaluation, has improved the capacity of the pilot youth associations in Addis Ababa to run quality HIV programs. This experience, as well as FHI/IMPACT's other experiences with peer leadership programs, (e.g., with the Addis taxi community) have informed the development of a tailored approach to youth peer leadership programming support through youth associations and anti-AIDS clubs affiliated to the National Youth Network in six regions.

Home- and Community-Based Care

Table 8 - Program Outputs: Home- and Community-Based Care Program		
Indicator	Partner or Region	At end of IMPACT
Number of persons affected by HIV/AIDS including their families who have received HIV/AIDS education and support	Addis Ababa	112,812
	Amhara	42,132
	Oromia	66,008
	SNNPR	30,581
	Total	251,533
Number of individuals reached by community and home-based care programs	Addis Ababa	20,742
	Amhara	7,882
	Oromia	12,185
	SNNPR	5,650
	Total	46,459
Number of HIV-infected individuals receiving palliative home/community-based care	Addis Ababa	18,357
	Amhara	7,143
	Oromia	9,624
	SNNPR	4,841
	Total	39,965
Number of persons trained in providing palliative community and home-based care for HIV-infected individuals	Addis Ababa	2,316
	Amhara	2,738
	Oromia	2,609
	SNNPR	3,895
	Total	11,558
Number of home visits made	Addis Ababa	154,008
	Amhara	176,864
	Oromia	174,066
	SNNPR	93,980
	Total	598,918

IMPACT HCBC activities have directly improved¹⁶ the lives of more than 46,000 chronically ill people, representing a seven-fold increase on the 5,866¹⁷ patients receiving care at the beginning of the program. In addition the HCBC has indirectly benefited over 250,000 people in the households of chronically ill patients. However, more than the numbers of people reached, the quality of care has also significantly improved. Monitoring the number of home visits made was introduced as an indicator of the intensity and quality of care provided by volunteers.¹⁸ The value of the IMPACT model over others lies in the comprehensiveness of the care package provided to all patients. Consequently, the health status of most patients has radically improved and recovery rates are high. In all 14 areas it is estimated that more than 90 percent of the initial patients accepted in the program are no longer bedridden. Although many are reliant on ongoing medication, they are able to live relatively normal lives.

One key achievement, which will probably contribute most to the sustainability of the program, is the development of a community-based model of care that operates through existing structures (i.e., *iddirs*). Their involvement ensures acceptability and respectability of HCBC programs, thereby ensuring sustainability. The majority has now changed their bylaws, extending their mandate to assist those before death. The role of *iddirs* as key stakeholders in all aspects of HIV prevention, care, and support has now been nationally acknowledged. The model also represents a unique partnership between volunteers, community-based organizations (*iddirs*), local NGOs (IAs) and government bodies (*kebele/woreda* offices and health facilities). Strengthening linkages and networks at this level has been a critical element of establishing an ECR.

The level of interest and commitment of volunteers to the program has been overwhelming. In all areas the numbers applying to be volunteers greatly exceeded the positions available. The program has shown the untapped spirit of volunteerism that exists within Ethiopian communities despite such pervasive poverty.

IMPACT has markedly improved the capacity of local NGOs to provide HCBC. All IAs supported through the program have expanded in size, technical, and management capabilities; financial competency; and strategic vision. Before IMPACT, HAPCSO operated with three staff and 20 volunteers in one subdistrict of Addis Ababa. Today it employs 80 staff and works with 66 *iddirs* throughout the city. In a country where there are so few civil society organizations, most with limited capacity, this is a critical achievement (see Project Highlight 3).

The other significant outcome has been the role of the HCBC program in addressing stigma and discrimination. As the case studies and comments in the HCBC “Snapshot” brochure show (see Attachment 3), the program has drastically changed fears and perceptions of HIV. Before the program, sick patients were often shunned by their own families. Parents or siblings would refuse to touch or feed sick patients, so widespread were the shame and misconceptions about HIV and AIDS. A major role of the *iddir* subcommittees, nurse supervisors, and volunteers has been to raise awareness on modes of HIV transmission and address the stigma attached to the

¹⁶ The components of “improved life” include improved health status (from bedridden to up, mobile and able to work again), nutritional status and weight, increased family support, and family members being able to provide care.

¹⁷ Figures taken from baseline Care and Support Service Assessment in all four IMPACT regions.

¹⁸ The number of home visits gives one of several indications of quality of care. If a person is very ill, it is important that the caregiver visits and provides care frequently. This indicator is never used alone to indicate quality, but combined with “types of services provided” and the supervision feedback from the nurses as well as feedback gained through client interviews.

disease. “Often the fact that an outsider was forced to come and look after a family member made families think again” says one *iddir* representative. Because caregivers are from within the community and visit patients several times per week, they have plenty of opportunities for discussion and raising awareness with families and neighbors.

The results of the community-based model have been remarkable. From shunning and ignoring PLHA in their midst, communities are now leading efforts to support them. Many *iddirs* have established local AIDS funds for affected families. In 2005 in the Gondar, Amhara region, the 11 *iddirs* involved in the HCBC program raised ETB 11,500 (approx US\$1,300) for patients in the town. In the past year, the 10 *iddirs* engaged in the HCBC program in Awassa, SNNPR, have raised ETB 17,110 (nearly \$2,000). They have mobilized these funds to cover the emergency needs of HCBC beneficiaries by increasing the monthly contribution fee of *iddir* members and charity events to raise both material and monetary contributions. In addition, they have also mobilized local hotels and restaurants to give food to poor beneficiaries.

Counseling and Testing (CT)

Table 9—Program Outputs: Counseling and Testing (CT) Services			
Indicator	Partner or Region	Baseline Situation in Health Centers	At End of IMPACT in Health Centers
Number of CT service outlets/facilities providing counseling and testing	Addis Ababa	1	25
	Amhara	29	135
	Oromia	9	192
	SNNPR	59	132
	Total	98	484
Number of clients who were pre-test counseled AND tested for HIV at CT centers, and who have received their test result	Addis Ababa	n/a	58,873
	Amhara		222,393
	Oromia		149,636
	SNNPR		104,494
	Total		535,396
Number of staff trained in HIV counseling and testing services (including PICT)	Addis Ababa	38	195
	Amhara	34	430
	Oromia	102	779
	SNNPR	20	338
	Total	194	1,742
Number of lab staff trained in HIV testing	Addis Ababa	n/a	50
	Amhara		210
	Oromia		336
	SNNPR		133
	Total		729

The rapid and dramatic increase in the number of CT sites operational in Ethiopia is a key achievement of the IMPACT/Ethiopia program. The increase in the number of sites, together with effective BCC activities (described elsewhere in this report), have radically increased the number of people being tested in Ethiopia. Prior to IMPACT, an estimated 65,400 people had been tested. By the end of the program this figure had risen to more than 535,000. Furthermore, prior to IMPACT, the limited test facilities that were available were mostly private and rarely free. The integration into government health centers has ensured testing is free and now a standard service in all new health centers.

The other major achievement has been the institutionalization of CT as part of national health service provision. This issue is further explored under Project Highlights later in the report. However, there is clear evidence that regional health bureaus have taken full responsibility for the ongoing provision and improvement of CT services. Addis Ababa is the most advanced in operating the service. FHI no longer support the Addis Ababa regional health bureau in providing CT training to health staff. They have also secured separate funding (with support to develop the proposal) from JICA¹⁹ to purchase all test kits and supplies for CT in the city. All new private health centers must now provide a CT service to receive government approval to

¹⁹ The Government of Japan Development agency

operate. In all regions, FHI's role in supporting training and follow-up supervision has reduced and has even become negligible in Addis Ababa. Once CT/PICT is part of the preservice curriculum for all health professionals, the need for in-service training (one of the most resource-intensive elements of IMPACT support) will further reduce considerably.

Clinical Care and Treatment

Table 10 - Program Outputs: Clinical Care and Treatment		
Indicator	Region	At end of IMPACT
Number of health facilities providing OI/ART (HIV-related palliative care including TB/HIV) service	All regions	198
Number of clients receiving HIV clinical care/provided with HIV related palliative care including TB	All regions	315,803
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease only	All regions	17,814
Number of persons trained in the provision of OI/ART and TB/HIV services	All regions	1,332

In all program regions, IMPACT has trained trainers to cascade training to health center staff and other health professionals in OI/ART. To date, more than 1,200 health staff have been trained in this area. This training continues in all regions along with TB-HIV trainings. IMPACT has produced a comprehensive set of referral slips for use in health centers in all regions to facilitate the referral process within health center departments.

The main impact of these activities is to strengthen interdepartmental linkages within health centers. Until recently this has been a weak link in the chain of the ECR. Trained personnel in many health centers are now providing diagnosis and treatment for OIs and follow-up of HIV-positive patients. These efforts are continuing with funds from other programs.

General Technical Assistance (TA) and Capacity Building

Table 11—Program Outputs: Technical Assistance and Capacity Building		
Indicator	Region	At end of IMPACT
Number of local organizations/service providers given technical assistance for strategic information activities	All regions	524
Number of people trained in strategic information (including M&E, Surveillance, HMIS)	All regions	465
Number of people trained in Management and Leadership	All regions	68
Number of TAs provided	All regions	1341

All IMPACT partners have stressed the value of the general technical assistance they have received during the program. All partners have been supported to establish appropriate M&E systems as part of any intervention. Efforts are made to ensure staff are trained to collect consistent and nationally identified indicators. This ensures individual subprojects can feed into wider strategic information/monitoring systems. All partners feel more confident in being able to collect and use both qualitative and quantitative information to improve program design and implementation.

LESSONS LEARNED AND RECOMMENDATIONS

The IMPACT/Ethiopia program has proved to be an important learning experience for all involved. In implementing such an ambitious program in the socioeconomic context of Ethiopia, challenges and problems were inevitable. However, much has been achieved and the lessons learned must be used to strengthen and enrich continuing HIV programming in Ethiopia and elsewhere. General issues common to all, or several parts of the program, are outlined first. Lessons and recommendations from the respective subsectors follow.

General Program Implementation

Continue to work closely with health authorities and HAPCOs to improve health systems and HIV/AIDS service provision

These are the agencies with primary responsibility for the delivery and coordination of all HIV/AIDS activities and services in Ethiopia. IMPACT projects have built their capacity very successfully through the provision of daily support and technical advice. By developing such close working relationships, the support has been continuous, enabling gaps to be quickly identified and immediately filled. This form of support must be continued.

Recognize and respect the mandate of government partners

It is important INGOs working with governments recognize the relative roles and responsibilities of each partner. Government remains the primary duty-bearer in the delivery of health care in Ethiopia, with HAPCO responsible for HIV/AIDS coordination. In implementing IMPACT, FHI staff have never lost sight of this. Consequently, all interventions respond to needs and priorities identified by government partners, not FHI. As a result, all government agencies in all regions view FHI as one of their most trusted and respected partners.

Help government and civil society partners work together

It is essential to work with both the Ethiopia government and civil society partners, analyzing the problems and needs that arise due to HIV/AIDS and finding opportunities for collaboration—with each managing services for which they have a comparative advantage. Both should jointly ensure that the health of people in their constituencies improves.

Maintain the focus on providing all elements of the expanded and comprehensive response (ECR), particularly in rural areas

IMPACT has supported the creation of significant elements of an ECR that did not previously exist (i.e., CT services, models of HCBC and quality prevention interventions). This means the primary elements of an ECR are now in place in large parts of the country. However, in many areas, particularly rural areas, there are large gaps in services. Future programs now need to work with partners to map gaps in the ECR and develop interventions to fill them on a district by district basis.

Improve linkages and referrals between all elements in the prevention, care, support, and treatment continuum

The last year or so of IMPACT programming has focused increasingly on efforts to create stronger linkages between all aspects of HIV prevention, care, support, and treatment. This should continue to be a vital element of all training and support to and by partners. Specific recommendations are outlined in the following paragraphs.

Support or pilot PLHA tracking or monitoring systems to ensure they and their dependents are not lost from care and support services

Models for tracking PLHA need to be developed. It is not clear who would be best placed to act as the lead agency—health facilities, HAPCOs, *iddirs*, *kebeles*, or combinations of all? Research into possible models is likely to be required.

Support efforts to address staff motivation and high turnover in government health facilities

IMPACT has ensured all training to health staff is given to more staff than necessary and repeated to allow for staff turnover. This has meant ensuring both TOT and standard training sessions are implemented not just once but repeated at regular intervals. For instance, as soon as the first round of OI/ART training to health center staff was complete a second round of “gap-filling” or refresher training was planned almost immediately to train staff filling the positions of staff who had left after the initial training. Besides current efforts to enhance public health personnel’s interest in their work and motivation levels, FHI should work with regional health bureaus to consider other non-monetary incentives that could be introduced to reduce turnover of health center staff.

BCC and Prevention Programs

BCC and prevention interventions must be based on formative assessments

The success of IMPACT BCC interventions is due largely to the baseline formative assessments undertaken at the beginning of the program. Understanding why target groups behave as they do, by undertaking formative assessments, has now become an accepted and integral part of BCC programs nationwide.

Continued funding is required to update BCC materials regularly to keep messages fresh so they have continued impact

IMPACT supported the production of many excellent BCC materials that were much more interesting and attractive than anything produced previously. People’s attention spans are limited and, as with all marketing campaigns, a continual stream of new ideas is required.

New approaches are required for rural populations—especially illiterate groups with less media access

BCC strategies under IMPACT focused primarily on vulnerable groups in urban areas. Further consideration needs to be given to communicating with rural populations with higher illiteracy rates and limited access to radio or television.

It would be good to assess how peer leadership programs could be effectively integrated in other communication programs and possibly scaled up

To date, the only peer leadership program to be evaluated is the ISAPSO low-income women project. This validated the approach but outcome assessments also need to be undertaken of the other peer leadership programs IMPACT has supported to inform the possibility of integrating this approach in other communication programs as well as possible expansion of peer leadership programs around the country.

Home and Community Based Care

Working with local NGOs, *iddirs*, and volunteers is a very effective strategy—but one that requires appropriate support

IMPACT has shown the local NGO/*iddir* model of HCBC to be an excellent approach through which to coordinate and channel assistance to families and individuals infected and affected by HIV/AIDS. However, *iddirs* are facing pressure from other agencies and their own communities to do more, particularly with regard to OVC. *Iddirs* are also composed of volunteers. There has been some evidence of members burning out. Consequently, consideration needs to be given to supporting *iddirs* in working within their capacity and possibly rotating or limiting memberships of key posts and committees. The current practice of limiting volunteers to 18 months of service is a particularly good example.

Iddirs and volunteers have proved to be excellent behavior change agents. They operate at the grassroots level and interact constantly with the community. *Iddir* members are respected, ensuring people at least listen to what they say. *Iddirs* are also democratic decision makers. For instance, the decision to change operating bylaws to enable them to assist PLHA must be taken collectively. This will naturally involve strong debate and discussion at the community level. Through training in the community conversation program, the communication skills of *iddir* and other community members are being strengthened.

Need to widen the range of partners providing support to PLHA and OVC

Support needs to come from beyond *iddirs* which, although widespread, can often be very poor. Efforts to include a wider range of NGOs, the private sector, and other CBOs in providing a stronger and more diverse network of services need to be encouraged in future programs.

The entry point of the current care package focuses on chronically ill and bedridden patients—the entry point needs to be updated to the changed context and the package needs to be more comprehensive and holistic to address the evolving needs of recovered patients

With good care and the expansion of both ART and OI treatment, recovery rates among chronically ill and bedridden patients have been remarkable. As such, their needs have changed. The greatest demand is for support to establish a sustainable livelihood (e.g., skills training or other IGA). Without this, beneficiaries often face destitution, which may precipitate a relapse in their health condition, particularly when they cannot ensure adequate nutrition. The current program is led by nurse supervisors and therefore has a strong health focus. Further training for nurse supervisors and social workers to enable them to assess the wider needs of patients is required. In addition, further medical training on ART and other clinical treatments is required. Overall modifications to the model are being considered as part of a current review.

Enhance the integration of nutritional support in HCBC and OVC programs

Poverty and malnutrition are daily challenges faced in the HCBC programs. To effectively improve the health status of HCBC clients and their families—and enable those on treatment to effectively take their treatment—it is important to include nutritional support and nutrition education in the basic HCBC package.

Consider integrating HCBC and OVC care packages into a single family-centered model that meets the needs of all members of the household, including children with HIV and other OVC

In reviewing the current HCBC model, attention must be given to the integration of parallel support systems for OVC. A family-centered model is recommended. This would avoid the potential for overlap or duplication that exists with two community-based care models. In addition, the recent introduction of pediatric protocols and formulations for ART means children infected with the virus must be supported. Ideally, this should be via a single comprehensive program to avoid duplication.

Lobby for resources to scale up HCBC programs

IMPACT has supported a notable expansion of quality HCBC in Ethiopia. However, they are limited to urban areas and there are many areas—especially rural areas—where no HCBC or similar services exist. Currently many CT services cannot link patients to any HCBC services. A significant increase in funds is required to further scale up HCBC in urban areas, and to adapt the current HCBC experience to ensure feasible provision of care services in less densely populated areas. FHI should undertake a cost-benefit analysis of the service in comparison with other options or models. If the approach can be shown to demonstrate real value for money, this will add strength to efforts to lobby for greater funding to scale up the program.

More attention for developing sustainable livelihoods

As mentioned previously, the combined provision of quality HCBC and ART has resulted in impressive health improvements for PLHA, which enables them to physically return to the workforce. However, lack of skills or available income-generating activities are obstacles to successful self support. The challenge remains for scaling up quality interventions in these areas for current service providers and their clients.

More attention and support of sexual and reproductive health (SRH)

As mentioned earlier in this report, clinically well PLHA often return to sexual activity, with increased needs for referral to PMTCT services, guidance on safe sexual behavior, and other areas related to both prevention and care.

Counseling and Testing (CT), Clinical Care and Treatment

Advocate for increased attention, support, and resources to expand and strengthen OI care services at all levels of healthcare

Most government, technical assistance, and donor partners see OI care as solely related to ART. However, most people with AIDS are not eligible for ART while they all need OI care. To improve the quality of life of PLHA, it is critical that more attention and resources are given to ensuring quality OI care throughout the healthcare system.

Continued support to improve commodity management systems required

Gaps in availability of CT testing kits, OI drugs, and other supplies have proved a problem throughout the IMPACT project. The introduction of ART has further highlighted the weakness of drug management systems in all regions. Gaps in the provision of ART and other treatment can be life threatening for PLHA. FHI is supporting MOH staff at all levels in terms of training on commodity management systems. However, structural problems with the national supply chain management system often represent an even greater bottleneck to ensuring a continuous

supply of HIV test kits, OI and ART drugs, and related laboratory reagents. FHI needs to leverage its good relationships with federal and regional decision makers to help find short-term solutions to these problems and contribute to big picture efforts of the MOH and other partners to ensure sustainable systems are in place.

Expand health workers' understanding of palliative care beyond the medical aspects

In addition to OI and other clinical treatment, people being tested may need a variety of other support. Even if full CT and other clinical training is provided to health workers, further training is required to ensure that nonclinical aspects are addressed. This is true for those who test negative as well as those who test positive, for areas related to home-based care and OVC support, and even family planning and condom supply. Although staff are now being trained to consider linkages and referrals between services, many health staff have limited understanding of support required outside of the health facility. Health workers need to be trained and supported to map out other local service providers and build networks with them. Clearly, in rural areas there are very limited or no services to offer clients. As such, the general recommendation to continue filling gaps in the ECR in all districts applies.

Youth and child-friendly CT and treatment services need particular attention

In Ethiopia, children under 18 need to be accompanied by a parent or guardian to undergo testing. Although legislation is prepared that reduces this to 15, it has yet to be ratified. There are many instances where children (even under 15) need to be tested and an accompanying parent may not be a possible option, or in their best interest. This is particularly true for many OVC. This is a policy issue that FHI should ensure is addressed by the National Testing and Counseling Technical Working group and other advocacy channels. In practical terms, the specific needs of children need to be considered in reviewing CT training curricula and materials. In expanding the scale-up, consideration should be given to establishing specific youth friendly centers with either government or other partners (e.g., FGAE).

Currently ART services for children are only provided at the hospital level in Ethiopia. This is severely limiting the accessibility of ART services for children, particularly because their mothers can often now receive ART services at the health center level, and because hospitals are too far away for most of the population to access easily. To enable effective access to HIV/AIDS treatment for children, adherence to treatment, and family-centered care, it is key that ART services for children at the health center level be established.

Consider supporting outreach CT services in rural areas

Some rural health centers are facing very poor use of CT services. More effort needs to be made to bring CT to target populations where awareness of the service is low. In rural areas, market sites and relief distribution sites would be obvious places where large numbers of people congregate. These should be targeted for outreach CT services.

Lay counselors can be used to counter high health staff turnover

One of the last activities to be funded by IMPACT has been a pilot program to train a group of 23 lay counselors to fill staffing gaps in health centers. It is hoped that locally recruited lay counselors will stay in posts far longer than nurses and other health staff. This could be a particularly effective strategy in rural areas where the turnover of health staff is particularly high, resulting in gaps in CT services.

CT and other HIV/AIDS training must be integrated into all preservice training for health staff

Currently neither courses in CT, OI/ART nor TB-HIV are part of standard preservice training for doctors, nurses, or other health professionals. These should be an essential element of such courses. FHI needs to continue working with the National Counseling and Testing Working Group and other individuals within the MOH to ensure curricula are modified appropriately and offer the technical assistance required.

Continue scaling up health center-level ART services and develop a nurse-based ART prescription approach

To enable better access to services, ensure that quality HIV/AIDS care and treatment services are provided at the health center and at lower levels of the health service infrastructure, as well as at the community level. Also, due to the great lack of medical doctors working at the health center level, it is key to adapt the current ART training curriculum to involve a more nurse-intensive approach to ensure effective service delivery.

Site level supervision needs continued support and expansion

IMPACT support to regional and zonal health officials to undertake regular supervisions of all health centers offering ART has been appreciated by all. It is clear these supervisions, followed by structured supervision review meetings, have been important in improving the quality of service provided. Currently regional and zonal health departments (except Addis Ababa) have no budget provision for such regular reviews. FHI is currently filling the gap and must continue to do so if HIV/AIDS care and treatment is to be truly institutionalized at the health center level. However, FHI must undertake further lobbying and advocacy at federal and regional levels to ensure such levels of supervision and site support are adequately prioritized and resourced.

General Technical Assistance (TA) and Capacity Building

Holistic support to all IAs and partners is essential to support the scale-up in quality and quantity of services

FHI's holistic and day-to-day approach to supporting partners is clearly a key element of successful programming. All future programming must continue to ensure that technical assistance beyond HIV/AIDS is provided. Organizational capacity audits are essential when working with all partners. Donors must be encouraged to see how such comprehensive support is a key part of capacity building.

M&E, Quality Assurance and Quality Improvement are essential components of every program

Data-based program design, M&E, and QA/QI are all essential elements of program implementation and must be developed and implemented with full involvement of program managers and service providers to ensure that data is effectively used to refine program strategies, quality, and coverage.

SUMMARY OF IMPLEMENTING PARTNERS ACTIVITIES

Name of Implementing Agency	Organization Type	Geographic Location	Total Budget US\$	Intervention Support	Period of Implementation under IMPACT
HAPCSO	Local NGO	Addis Ababa	1,075,326	Community Home-Based Care program in Addis Ababa	Sept 2003–June 2006
Wegen Aden Association Ethiopia		Addis Ababa	84,403	Focus for vision	Feb.2003–June 2006
Organization for Social Services for AIDS/OSSA	Local NGO	Bahir Dar and Gondor in Amhara Jimma and Nekemt, Oromia	776,779	HCBC Program delivery	Oct. 2004–June 2006
Family Guidance Association Ethiopia/FGAE	Local NGO	Dessie and Kombolcha, Amhara Adam, Assela, Shashamene and Zwai, Oromia	674,143	H& CBC PROJECT IN DESSIE/KOMBOLCHA	Oct. 2004–June 2006
Ethiopian Kale Hiwot Church	FBO	Oromia	627,277	H&CBC Project in Adama, Assela, Shashemane and Ziway	Oct. 2004–June 2006
Beza Lehiwot Association Ethiopia		Awssa, Soddo and Dilla, SNNPR	40,005	H&CBC project in	Sept. 2004–June 2006
Save Your Generation Ethiopia/SYGE	Local NGO	Addis Ababa	321,570	Bar/Establishment & Taxi Station Project	Jan. 2004–June 2006
Mhei for Youth Association	Youth Association	Addis Ababa	46,332	Mhei for youth peer education program	Feb. 2005–June 2006
Addis Ketema Youth Association	Youth Association	Addis Ababa	51,581	Peer education and counseling, wereda 5 youth association	Feb. 2003–June 2006
Ethiopian Youth Network	NGO	National	112,803	Mobilizing Ethiopian Youth for HIV/AIDS Prevention, Care and Support	Aug. 2004–June 2006
Integrated Services for AIDS Prevention and Support Organization/ISAPSO	Local NGO	Addis Ababa	186,733	HIV/AIDS prevention among Low-income Women	May 2003–June 2006
Ethiopian Gemini Trust	Local NGO	Addis Ababa	40,894	Adugna LIW Project	Nov. 2003–Sept. 2005
International Rescue Committee/IRC	International NGO	Sherkole, Gambella	50,000	Counseling and Testing for Sudanese Refugees in the Sherkole Refugee Camp	Oct.2004–Apr. 2005

PROJECT HIGHLIGHTS

(1) Being Positive about Changing Behavior

When 28-year-old Tigist discovered she was HIV-positive three years ago, her family refused to accept she was ill. “My parents locked me in the kitchen and excluded me from family life. When people came to the house they said I had moved to another city or acted as if they didn’t know me.” As Dawit, a taxi driver in Addis Ababa, admits, “I didn’t even like to say its name, I thought catching HIV would be like living in darkness.”

These comments illustrate the shame and fear associated with HIV and AIDS in Ethiopia. At one time, the topic was unmentionable. “However, with an estimated 1.3 million people living with HIV, it was a subject that desperately needed to be talked about,” says Francesca Stuer, the country director of Family Health International (FHI), an American NGO working on HIV/AIDS in Ethiopia.

“The main mode of HIV transmission in Ethiopia is heterosexual sex with multiple partners. Ethiopian society is conservative and staunchly religious—therefore, people find it difficult to discuss sexual health or behavior issues frankly or openly,” explains Stuer.

Research shows stigma and discrimination are major barriers to addressing HIV/AIDS that can actually increase the spread of the disease. Fear of being identified with HIV prevents people from learning their status. Without knowing their status people cannot adopt appropriate behavior to prevent infecting either oneself or others. It also means that people who have HIV and AIDS hide their status and do not seek care, support, or treatment. This means they get sicker quicker and are more likely to die sooner.

The problem was that public information campaigns on HIV/AIDS actually made things worse. “Initially, campaigns used fear of HIV to encourage safer sexual behavior,” says Stuer. “Typically TV and radio messages were simple directives based on fear of contracting HIV. A sick and dying person, shunned by family and friends, was often the image used to encourage abstinence or condom use. There was no effort to elicit sympathy or empathy for people with HIV. Posters or billboards used images of skulls and crossbones saying, “Use a condom or catch AIDS,” or “Catch AIDS and destroy your life.”



Although such campaigns were meant to be hard hitting, government authorities were dismayed to find that they did little to change behavior. Infection rates continued to rise. Clearly a fresh approach was required.

In 2001, FHI began working in Ethiopia, bringing a wealth of experience in HIV behavior change communication programs from around the world. With funds from the US government, FHI worked closely with key government partners such as the HIV/AIDS Prevention and Control Offices (HAPCOs) and the Ministry of Health to develop an alternative approach.

Working in Addis Ababa and the three most populous regional states of Ethiopia, FHI worked with regional authorities to develop tailor-made Behavior Change Communication (BCC)

strategies. “What made these strategies different,” explains Stuer, “is that they went beyond information and awareness to address Ethiopians’ beliefs and attitudes, which dictate how they behave. Only by understanding what makes people behave the way they do can you start to formulate messages that they will listen to and acknowledge.”

Consequently, FHI supported government partners to undertake “formative assessments” in each region. This is a technique used by social scientists to gain an understanding of what drives people’s behavior through discussing people’s hopes, fears, and dreams in life. The assessments involved a series of focus group discussions and key informant interviews with MARPS such as youth, truck and taxi drivers, and female sex workers.

“This process gave us lots of information from which to develop much more effective campaign messages” says Stuer. “For instance, we found many people had low perceptions of their own risk of contracting HIV. One reason was because they believed their partners would never be unfaithful. As a result, many refused to use condoms or consider being tested, even when they themselves were not always faithful.” Discrimination against people with AIDS also emerged as widespread, as did misconceptions about condom use and testing. “The lubricant in condoms spreads HIV” was a comment made by several in the focus group discussions.

The formative assessments helped to identify the important messages; the next step was to convey messages effectively and creatively. To do this, FHI worked in partnership with an international marketing company as well as BCC committee members in each region. The combination of creative experience and local knowledge resulted in a dramatically different approach to communicating HIV/AIDS messages.

“One of the most important aspects in developing a new approach to BCC in Ethiopia was to ensure all messages were positive,” stresses Stuer. “We wanted campaigns to be engaging and fun. It was important people realize that HIV can affect anyone so we must work together to avoid spreading HIV and support those affected. There is nothing to be ashamed about. That involves quite a radical shift for most Ethiopians.”



Probably the most successful and well-known product of the BCC work was the popular song *Malabebe Yikir* or *Compassion is Modernity*. The song’s lyrics (see page 67) encourage everyone to show compassionate for people with HIV. In true Live Aid style, some of Ethiopia’s most famous musicians and singers agreed to record the song and accompanying video free of charge. FHI asked the national radio station to play it a minimum of two times. The rest, as they say, is history. The song became an immediate number one hit and is still heard in buses, bars, and on radios all over the country. What was more important was the level of discussion and debate it generated. As Dawit, driving his taxi in Addis Ababa, explains, “When the song first came on the radio everyone in my taxi would start talking about it. Lots of people were angry

that people were singing such lively songs about HIV and AIDS. Some people argued that it would just encourage young people to have sex and spread the disease.”

The popularity of the song has sparked radio phone-ins and other public debates throughout the country. Entire radio and TV programs have been produced purely to discuss the song’s impact. “It does not matter if some people are annoyed by the message or tone of the song,” says Stuer. “The most important thing is that the silence on HIV/AIDS has been broken.”



The challenge now is to keep the debate going. Another element of the regional BCC strategies is the use of peer education programs. These target key members of vulnerable groups such as youth, police, or military personnel, to discuss and disseminate appropriate information about HIV/AIDS to their peers. These peer leaders initiate and lead debates with friends and colleagues on issues such as sexual behavior, condom use, and the value of counseling and testing.

FHI’s support has dramatically improved the quality and effectiveness of other public awareness campaigns. With the help of marketing experts, regional BCC committees also produced a range of new posters, billboards, and TV and radio messages for each region. These are much more positive than previous campaigns using provocative and bold statements or storylines to capture the attention of target groups. For example, in challenging the issue of faithfulness, a poster was designed showing a man eyeing up another woman even while hugging his girlfriend. Another applied the “See no evil, hear no evil, speak no evil” proverb to HIV using the traditional cherubs common in Ethiopian church art instead of monkeys. Another poster used the critical role of religion in Ethiopian society to prick people’s consciences. It showed an orthodox priest and imam with young people with a caption saying, “God does not discriminate. Why do we?”

The combined efforts of the BCC interventions supported by FHI have transformed levels of awareness and debate about HIV in Ethiopia. As Tigist admits, “I thought my life had ended when I found I had HIV. Through the work of FHI-supported volunteers and community committees, I am now getting medical treatment and my family now supports me. Having my family and neighbors treat me normally means I can live and smile again.”

Compassion is Modernity/Malabebes Yikir (Lyrics)

The good and bad times
 we shared together
 Because we are neighbors
 Any knock at your door
 can be heard in my house
 Don't do unto others
 Things you wouldn't want
 To be done unto you

***Denial is the danger, to stigmatize a threat
 Life is so graceful, so charming and dear
 A priceless wealth which we should handle with care***

Know and pass it on
 that the mishaps of others are our own too
 Better let others know, than conceal and die
 To know is to change, face the truth be open
 To be worried for others and to love is modern

Denial is the danger

Let the chapter be closed
 Talk the fact dare the act
 Face the truth let it out
 To know is to change,
 be bold and daring, be open to challenge
 No one is eternal,
 live life each day

Denial is the danger

(2) Testing Times - Helping Government Scale Up Testing Services in Ethiopia

“When I was younger I did some very silly things,” says Bekele, a daily laborer based in Filaket, a small town in northern Ethiopia. “Then, when people started talking a lot about HIV and AIDS and some of my friends got very sick, I started to get worried that maybe I was infected. I thought about going for a test to check but the only place was a private clinic in Bahir Dar, which is over 100km from here and would have cost 250 Birr (about US\$30).” Bekele’s plight was faced by many in Ethiopia who, following increased public awareness campaigns, were concerned about their HIV status.

Ethiopian authorities were also concerned. Ethiopia’s health service is one of the poorest in Africa, with public health expenditure less than US\$10 per head. The HIV/AIDS epidemic could very easily overwhelm such an already fragile service. In recent years, over a billion US dollars from donors such as the Global Fund and the US government, has been allocated for HIV/AIDS in Ethiopia. The challenge for the Ethiopian authorities was to use such large amounts of money quickly and effectively to scale up HIV/AIDS interventions. “It is important that in building our capacity to respond to HIV we also strengthen the health system in general,” explains Dr. Endale Engida, Deputy Head of Amhara Regional Health Bureau. “We wanted to scale up HIV testing facilities. We recognized that until people are tested it is very difficult to identify and plan for other services and treatment. We had ambitious plans but we needed help to implement them.”



Help was at hand in the form of the US NGO Family Health International (FHI). In 2001, FHI was allocated US government funding to provide technical assistance to government and civil society partners in scaling up HIV/AIDS programming in Ethiopia. “At that time, there were just over 150 testing sites to serve a population of over 77 million,” explains Francesca Stuer, FHI’s Director in Ethiopia. “The majority of these were located in main cities and very few were free. As a result, the majority of the population had no access to testing facilities.”

FHI began working in partnership with the government’s HIV/AIDS Prevention and Control Offices (HAPCO) and Health Bureaus in four of the country’s main states—Addis Ababa, Amhara, Oromia, and South Nations and Nationalities Regional state (SNNPR), which together account for 85 percent of the country’s population. “Following initial consultation in each state, the need to expand CT was identified as a priority by all,” says Stuer. “It therefore became a central element of our work in Ethiopia.”

With FHI’s help, there has been a dramatic increase in the number of testing facilities over the last five years. Counseling and testing, or CT as it is commonly known, is now freely available in 483 government health centers in the four target regions. There has also been a large rise in the number of people being tested. In the Amhara region alone, 136,000 people were tested in 2005, a 400 percent increase over the year before. The figures continue to rise annually. Bekele, in rural Amhara, has made good use of the new service in his local clinic. “I have now been tested twice and thank God I was negative both times. The counseling has also made me rethink the way I used to behave. I am now much more careful.”

While the expansion of CT sites is a remarkable achievement, the government's decision to institutionalize the service into the national health systems is also important. "The decision to include CT in the minimum service package offered by health centers has dramatically increased availability and accessibility," says Stuer. "By locating CT within health centers, its provision is normalized and referral between health services is facilitated. This has become increasingly important in the last year as the government has rolled out antiretroviral treatment (ART) throughout the country."

So how was CT institutionalized and scaled up so impressively in such a short amount of time?

"One of the main reasons was that scaling up CT service provision was initiated and implemented by health authorities themselves," explains Stuer. "FHI does not have the capacity or the mandate to run CT services. Therefore, we never ran into the problem faced by many NGOs that start up services and then attempt to hand them over to government partners." Instead, the decision to scale up CT, through its integration into health centers, was made by government authorities at both federal and regional levels. "We believe that our support is much more effective when we help a partner, in this case the regional health bureaus (RHBs), to achieve their priorities rather than impose our own," says Stuer. This meant that institutionalizing CT into health systems was the government's objective from day one. No pilot NGO programs were necessary to convince health bureaus of the value of the approach.

Once the objective is agreed upon, the next stage is to implement it. Again, FHI takes a different approach to many other NGOs. "FHI provides extensive technical assistance, but that does not mean we implemented the program. We always respect the fact that in Ethiopia, primary responsibility for the delivery of health services, including CT, lies with the government," says Stuer. In practical terms, this means the assessment of health centers' capacity and the implementation plans for initializing services were all done by regional health bureau staff themselves. Dr. Taye of the Oromia Regional Health Bureau explains, "FHI staff were with us throughout the planning stage, and their help in undertaking the assessment and compiling implementation plans was very valuable."

In implementing a new service, all regions faced large gaps in planning for CT. Regional health bureaus submitted requests for test kits, reagents, and other supplies through Ministry of Health procurement channels. To ensure CT services were initiated as soon as possible, FHI supported the purchase of some supplies and equipment to catalyze the startup of services. "We provided an initial three-month supply of test kits so that services could start as soon as staff returned from training. It is important all elements of the service were provided at the same time so the momentum was not lost," says Dr. Aida Girma, CT team leader for FHI. "We also purchased furniture for counseling rooms and some fridges, but we did not want authorities to become dependent on us." The strategy has worked extremely well in some places. Test kits and other supplies for Addis Ababa CT services are now provided by JICA (the Japanese government's development agency) following the submission of a proposal by the regional health bureaus. Elsewhere regional health bureaus are accessing Global Fund support.

Training large numbers of health staff is another major activity in scaling up CT. This is something done by many NGOs, but again, FHI takes a slightly different approach. "Many NGOs run training courses and say that capacity has been built. We wanted to go beyond that and ensure each region had a comprehensive CT training system in place," says Dr. Girma. This meant FHI worked with each region to develop local CT training curricula and materials, based on national protocols. Large numbers of health professionals drawn from the regional health bureaus, zonal offices, and medical colleges and universities were then trained as CT trainers. "As soon as this pool of trainers completed training, we got them to put their skills into practice

by training health center staff immediately with FHI supervision and support,” explains Dr. Girma. As a result, all four regions now run their own CT training courses with minimal assistance from FHI. Repeated training is essential to fill gaps, given the level of staff turnover in most health centers. Regions are now allocating a budget for such training or submitting proposals to donors where they have insufficient resources.

Material support and training were the key activities involved in initializing CT services. However, institutionalization is about creating sustainable and quality service. This is often the greatest challenge for resource constrained government departments. “FHI believed a strong quality assurance system was essential if CT was to be successfully expanded,” says Dr. Girma. “There were two aspects to FHI’s support; first, we needed to ensure they had the tools and experience required to effectively monitor quality. Second, we needed to convince all partners of the need for and value of regular supervision and review.”

FHI supported all regions to develop a comprehensive range of monitoring forms and checklists that captured information about the quality of the new CT services. “There is already an abundance of paperwork in Ethiopia health centers,” says Dr. Girma. “The challenge was to ensure people were not only completing forms correctly, but also analyzing the information and using it to inform decision making.” This was a challenge and FHI had to work closely with all regions to transfer these skills. Consequently, post-training supervision visits to all health centers were undertaken in each region. These involved a wide pool of health professionals who undertook supervisions alongside FHI technical specialists. Following the monitoring visits, health center staff and supervisors from *woreda*, zonal, and regional levels were called to discuss findings at review meetings using the data collected.

Often just the fact that health centers were being visited regularly by supervisors was a motivation to staff delivering CT. “It was important these review meetings were action-orientated,” says Dr. Aida. Poor performing health centers are named while those where staff had used their initiative to overcome constraints are held up as best practices. It was a harsh approach but effective. Services have improved. This has made everyone realize the value of regular monitoring in maintaining quality services. “In the first supervision in Oromia Region, FHI had to provide all eight vehicles needed for the supervision activity. By the third supervision FHI was only asked to provide one.”

FHI is fortunate in that it had ongoing and flexible funding from the US government that enabled them to work at the pace of its partners. Some regions, such as Addis Ababa, are almost fully independent of FHI’s support; they are even writing their own proposals to other donors to provide supplies of testing kits and reagents. Large regions covering vast rural areas, where health centers suffer serious staff turnover, usually need more support for longer. “We appreciate institutionalization is a process and not a one-off activity. Therefore, we need to accept that it takes time,” says Francesca Stuer. “Ultimately what is important is that although we both share the same objective, responsibility for the delivery of quantity and quality of CT services has always remained firmly with the government.”

(3) Scaling Up Home-Based Care—A Case Study in Rapid Growth

Rahel Zelalim lives in a one-room shack in Addis Ababa. Her husband died from AIDS two years ago, leaving her to bring up their three small children. Unfortunately, she also has AIDS. At one point, her condition had deteriorated such that she could no longer work. “I could hardly leave my bed and didn’t know how my family would survive. When Workenesh started to coming to look after me she literally saved all our lives.”

Workenesh is a community volunteer in a home-based care program supported by the local nongovernmental organization HAPCSO (Hiwot HIV/AIDS Prevention, Care and Support Organization).

“Workenesh is like an angel,” says Rahel. “When I was very sick she would wash me and the children. She brought food and cooked us meals. She was only meant to come three times a week but we saw her nearly every day.” Most important, Workenesh was able to link Rahel to health care through the nurses employed by HAPCSO. When earlier this year antiretroviral therapy (ART) became available in Ethiopia, Rahel was encouraged to undertake an HIV test so she could be referred for treatment.

“The drugs have changed my life. I am able to walk and live again. But it is Workenesh who showed me how—when I first got the drugs she came twice every day to make sure I was taking them at the right time. Then she bought me a watch and showed me how to tell the time so I wouldn’t forget. She still counts my pills to check I have taken the right amount.”

Such inspiring stories of dedicated volunteerism are now common as this model for home-based care has been expanded to 14 towns and cities throughout Ethiopia. Support to expand the program has been provided by Family Health International (FHI), a US-based technical assistance agency funded by the US government. As Francesca Stuer, their Ethiopia director, explains, “The grassroots nature of the approach is a key to its success. Care at this level cannot and should not be provided by external organizations, and government agencies just do not have the resources. Even HAPCSO does not implement the care by itself but works with *iddirs*. These are community-run burial societies of which virtually all Ethiopians are members.” Traditionally *iddirs* cover burial expenses and provide initial support to dependants. The impact of HIV has put huge pressure on their resources as increasing numbers of young adults die. Under HAPCSO’s program *iddir* committees identify and manage volunteers from the community to care for the sick.



Although organizations such as *iddirs* can offer high quality and personal support, they are by their nature small-scale and locally based. This is a problem because HIV is a widespread problem that requires large scale solutions. “Ethiopia has very few large local NGOs with the capacity to implement care programs on the scale required,” says Stuer. “What we liked about the current model is the partnership between the local NGO who mentors several local *iddirs* and many volunteers who provide the actual day-to-day care. This means HAPCSO staff can concentrate on technical training and supervision.”

However, before the program, HAPCSO themselves were also tiny. When FHI identified them as part of a survey of home and community-based care services in Addis Ababa, they employed just three staff supporting three *iddirs* and 20 volunteers.

Nevertheless, FHI saw the potential for scaling up and replicating their work in urban communities throughout the country. In less than five years, HAPCSO itself has grown dramatically. It now employs more than 80 staff and works with 66 *iddirs* in all 10 districts of Addis Ababa. Together they have identified and trained more than 2,300 volunteers to provide care and support to over 20,000 chronically ill and bedridden people in Addis Ababa alone. “Their growth is remarkable as many local organizations struggle when they try to expand so quickly,” notes Ato Dereje Seyoum, head of the government’s HIV/AIDS Prevention and Control Office in Addis Ababa. “With so much funding now available for HIV programs there is lots of pressure on local organizations to scale up their activities, but even with more money, many cannot.”

For donors and international NGOs desperately trying to expand local capacity to the AIDS epidemic, the success of HAPCSO represents an interesting case study. How has such growth been achieved?

Sister Tibebe Maco, nurse and executive director of HAPSO, offers her explanation. “There were two key factors: first, the support from FHI has been invaluable and very different to that which is normally provided by other funders and technical assistance agencies. Second, we were implementing an approach that had huge acceptance from all partners—everyone wanted to help us succeed in expanding the model.”

FHI’s support is certainly critical. FHI is by far HAPCSO’s largest donor with a grant of more than US\$1,000,000. Indeed, HAPCSO’s ability to manage and spend such a large amount of money is by itself impressive. “Although FHI is a specialist technical assistance agency in HIV/AIDS, we ensure our support to partners is much more holistic,” says Konjit Berhan, FHI’s capacity building officer. “Local organizations are usually run by dedicated individuals with certain core skills. Sr. Tibebe is a typical example. She is a nurse who developed an excellent home-based care package for the chronically sick. However, she had no experience in financial management, strategic planning, or staff recruitment. When any organization starts operating beyond a certain size these skills become essential or it starts to flounder.”

Recognizing this, FHI undertakes organizational capacity audits of all local partners before entering into grant agreements. These audits examine all aspects of the organization’s management systems and procedures to identify any gaps and factor them in for support. HAPCSO has found this invaluable as Sr. Tibebe explains, “FHI put me on management and leadership training as I felt so unconfident running such a large organization. They understand the need to fund us beyond project activities, like funding accountants to effectively manage much larger grants.”

While FHI repeats capacity audits during the project agreement period it always works closely with local partners throughout the program. “FHI is not like other funders who may meet us quarterly and want to see a report on project activities and expenditures. Most partners don’t worry about our wider systems and structures. FHI staff members are in our offices every week and talk to our staff daily. They know our day-to-day problems and help us to solve them in very practical ways. When nurses complained they had no job descriptions, FHI helped managers to write them as well as help develop a personnel manual for the whole organization.

The second, and equally critical, factor in the successful expansion of HAPCSO is the buy-in from all parties in expanding its home and community-based care model. “Although the model was based on HAPCSO’s original project, scaling it up required the collaboration and cooperation of many partners,” says Stuer. Government agencies such as the Addis Ababa Health Bureau and HIV/AIDS prevention and control offices knew they could not address the problem without the support of communities. Therefore, FHI supported a meeting between them and representatives of more than 1,500 *iddirs* in Addis Ababa to discuss an appropriate response. *Iddirs* were more aware than anyone of the impact of HIV in their communities, and although keen to respond, felt they lacked the technical skills and support required.

The wider NGO and donor community were also keen to harness the good will and generosity of communities but were aware of the need for a consistent approach. “At that time there were many ad hoc home-based care programs and the range and quality of care provided varied,” explains Stuer. “Everyone was keen to identify a good model that would set the standard for scale-up and replication. Therefore everyone has worked together to develop a strategy to scale up the NGO/*iddir* model.”

Sixty-six willing and suitable *iddirs* were selected from each district of the city, which in turn identified appropriate volunteers. The health authorities donated a building in a major hospital as a resource center for HAPCSO, from which volunteers and additional nurses are trained and supervised. Further funding from donors has also been secured to provide home-based care kit materials and supplies. The overall success of the program has depended on HAPCSO who employ the nurse supervisors and social workers who provide technical and management support to the *iddirs* and volunteers.



Caregiver training run by HAPCSO

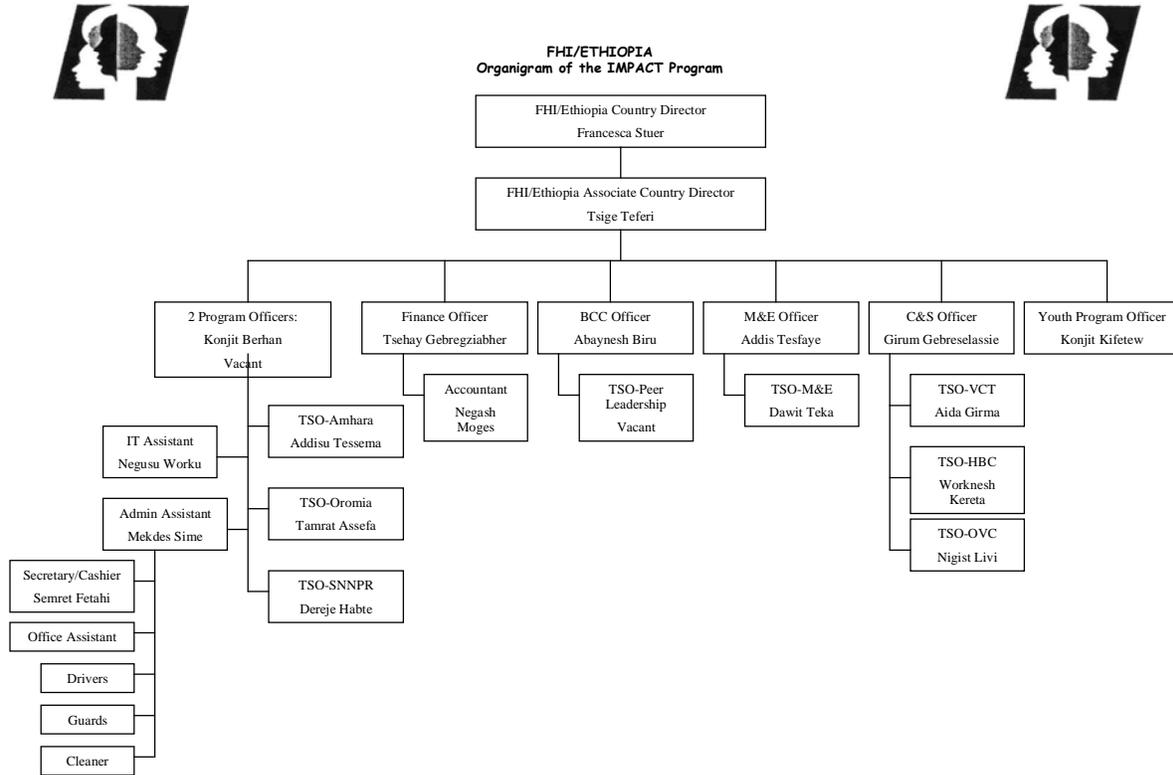
The program has clearly shown spectacular results in a short space of time. However, significant challenges remain. “Building the capacity of HAPCSO is only the beginning; building that of *iddirs* will take much more time but is essential if the program is to be sustainable,” says Stuer. Furthermore, as ART improves the health status of people with AIDS like Rahel (mentioned at the beginning of this story), their needs change. “Well and HIV-positive people no longer need the intensive level of care provided by volunteers. They do, however, need skills and jobs to make a living. Unfortunately, these are not something even the most committed volunteers can provide,” continues Stuer. “The need for new strategies as new problems and challenges emerge is also an area where local organizations struggle. One of the greatest achievements of the current program is the strong sense of shared responsibility, which means all parties work together to address such challenges.”

ATTACHMENT 1 – FINANCIAL SUMMARY

Breakdown of funds obligated under IMPACT by financial year

Financial Year	Type of Funds	Amount US\$
2001	IMPACT Field Support funds	1,420,000
2001	CDC funds channeled through IMPACT:	500,000
2003	IMPACT Field Support funds	3,160,000
2004	IMPACT Field Support funds	4,500,000
	PEPFAR Track 1.5 funds	5,750,000
	PEPFAR supplemental modification #62	168,700
2005	PEPFAR COP 05 funds	5,102,000
	Total	\$20,600,700

ATTACHMENT 2 – FHI ETHIOPIA ORGANIZATIONAL CHART



ATTACHMENT 3 – SNAPSHOT: DRIVING HIV AWAY

DRIVING HIV AWAY:

HELPING TAXI DRIVERS PROTECT
THEMSELVES AND OTHERS

Steve Taravella

SNAPSHOTS FROM THE FIELD



SNAPSHOTS FROM THE FIELD

DRIVING HIV AWAY: HELPING TAXI DRIVERS PROTECT THEMSELVES AND OTHERS

Steve Taravella



Family Health International
Institute for HIV/AIDS
2101 Wilson Boulevard, Suite 700
Arlington, VA 22201 USA
Tel: 1-703-516-9779
Fax: 1-703-516-9781
www.fhi.org

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Cover photo: At gathering places like this central Addis Ababa taxi station, FHI/IMPACT and SYGA are educating taxi drivers, assistants and inspectors to protect themselves and their families from HIV.

Semere is a handsome, 24-year-old Ethiopian. He has a girlfriend but occasionally has sex with other women. He says he mostly uses condoms, but does not want to be seen buying them. He has chosen not to learn his HIV status.

He is also a taxi driver in Addis Ababa, which makes him a prime audience for a new program introduced by the Implementing AIDS Prevention and Care Project (IMPACT), which is managed by Family Health International (FHI). Working with local partner Save Your Generation-Ethiopia (SYGA) and the Addis Ababa HIV/AIDS Prevention and Control Office, IMPACT aims to bring messages of HIV prevention and behavior change to the 28,000 men who work as taxi drivers, taxi assistants or taxi inspectors in the city. Their blue-and-white mini-buses, a familiar site on the streets of Addis Ababa, are a major form of transportation in this city of about five million.

Most taxi drivers are young, unmarried men who have received little education and little information about HIV. They are further vulnerable to infection because they travel throughout the city during their work, encounter many different people, receive money—and sometimes find themselves pursued by women who hope the drivers will spend money on them.

The primary goal of the program, which is funded by the Office of the Global AIDS Coordinator through the U.S. Agency for International Development (USAID), is to educate drivers about HIV so they can better protect themselves and their families. “There must be a behavior change in this community. People are dying,” says Mekete Game, a taxi inspector. The program uses the “ABC Strategy” to prevent new infections. This strategy helps each taxi driver assess his own risk and adopt the preventive behavior that is most appropriate for his circumstances. Some single drivers choose to **Abstain** from sex before marriage, while others choose to **Be faithful** to one partner. Those who are sexually active with more than one partner are encouraged to use **Condoms** correctly and consistently. The behavior change is approached through peer education, augmented by drama presentations at taxi stations where drivers gather and by condom distribution. The condoms are provided by DKT-Ethiopia, the Addis Ababa Health Bureau and local HIV/AIDS Prevention and Control Desks.

A secondary goal of the program is to help drivers like Semere become more comfortable discussing HIV with passengers; in this regard, drivers can function as community educators, transforming a passenger experience into an opportunity to improve community health.

Evidence suggests a great need for targeting taxi drivers with such activities. For a 2003 formative assessment on behavior change communication, FHI and the Addis Ababa HIV/AIDS Secretariat conducted focus groups with male taxi drivers ages 21 to 30 in Merkato, Addis Ketema (Awtobus Terra) and Arada. Though most were single, “none of the taxi drivers felt that they were at risk for HIV infection,” the assessment found. Yet they generally were afraid of dying from AIDS. “I do not even like to say its name,” one taxi driver said. Another driver likened HIV infection to “living in the darkness.”

“All of them considered that contracting HIV was a point of no return in life,” the assessment found. Some felt HIV-positive persons should be isolated from others. Some believed HIV was present in the lubricant on condoms. A few believed condoms were “an instrument for white

people to eliminate black people.” Some taxi drivers were dissuaded from using condoms by the local attitude that those who buy or carry condoms are promiscuous.

Semere, a former mechanic who has been driving taxis for five years, recently talked to a visitor about HIV in the taxi community. Sitting in his vehicle, parked in a crowded taxi station on a rainy afternoon, Semere spoke in Amharic about his life as a taxi driver and the ways in which his livelihood affects his sexual health.

As a permanent, salaried driver, he earns 300 birr (about US\$40) per month from the owner of the mini-bus he drives. Semere and his assistant, whose primary job is to collect fares, each take home an additional 20 birr daily from fares (about US\$2.25). For this money, Semere starts his day at 6 a.m. and works until 9 p.m., with only one day off work each month. His aging vehicle, with its dusty interior and well-worn seats, can accommodate 11 passengers and a driver.

Because his is a good income in Addis Ababa, Semere is often approached by young women and frequently has sex with them. Though most taxi drivers are “careless,” not using condoms, he says he does use condoms. He knows where to buy them, at 25 cents for three, but so great is the stigma associated with sexual activity that he does not want to be seen purchasing them. In this close-knit community, he fears the shop-keeper will tell Semere’s family or neighbors that he is having sex with many women, possibly even sex workers. So Semere sends young boys, and sometimes his younger assistant driver, to buy them for him.

Because he does not want to become seriously involved with these young women, if one should return to see him a second time, as sometimes happens, he might “deliver her” to another driver for sexual activity, or simply drop her at a hotel—but not before using his cell phone to alert a fellow driver of her location and availability for sex.

The drivers are also vulnerable because many of them use *khat*, a stimulant they chew in the afternoons. When mixed with alcohol, *khat* increases their vulnerability, outreach workers say.

Semere, who stopped using *khat* three years ago, believes he has escaped HIV infection. He is concerned about HIV, but not because of his casual sexual encounters. He is concerned he may contract HIV from his regular girlfriend, whose photo he proudly pulls from his wallet. She is living for a month in a nearby Arab country, where she has found work. He fears she may have sex with other men while there.

Addis Ababa’s taxi drivers and assistants—virtually all of whom are men—are more likely to consider information from their fellow drivers than from public health educators; Semere says he is most likely to respond to HIV information if he receives it from other drivers because they also make up his social network. Based upon this understanding, FHI/MPACT and SYGA have so far prepared 20 of the city’s taxi inspectors to become core trainers. The inspectors, who function as

dispatchers and schedule coordinators but who also drive vehicles, train a small number of drivers to be peer leaders. These 20 men, in turn, have trained 100 peer leadership trainers, who have now trained 553 peer leaders to work with their peers and, ultimately, to educate the city's fleet of drivers about using the ABC Strategy to reduce infections.

None are paid for this work, and turning taxi drivers into educators is not easy. "No driver enjoys such chat [about HIV/AIDS]. Rather, they prefer to talk about Manchester

United and Arsenal football clubs in England," one focus group participant said. Another said, "We talk about the traffic charge, not about such sexual issues." Semere says he and his driver buddies do talk about their sexual activity, but just the who and where—rarely what and never anything about the specter of HIV.

But focus group participants said advertisements posted on their vehicles, radio messages broadcast in their vehicles, and pamphlets placed at taxi stations are effective ways to improve taxi drivers' HIV knowledge.

As is street theatre.

At large taxi stations, drivers stop their work and climb atop the roofs of their vehicles to watch the mobile dramas, produced by SYGA Performed by volunteers, the dramas are participatory, allowing the taxi drivers to help determine how stories end. Semere says a recent skit "reinforced that I should keep myself safe and have safe sexual behavior. At the top of the list, even though I have casual sex and I have condoms, is to be faithful to my partner."

A recent interview with three core trainers reveals these efforts—peer training, condom education and street theatre—are making important inroads. "Before the training, we never discussed HIV with colleagues. Now, people come to me with all sorts of questions on HIV/AIDS, and they use the information," says taxi inspector Samuel Birhane.



The program helps taxi drivers become comfortable discussing HIV with their passengers.

Access to credible information is so valued that even before inspector Nega Zafu had completed his training, other drivers were approaching him with questions. One, for instance, sought advice about symptoms he suspected might indicate a sexually transmitted disease. When Nega finished his training, he cautiously brought up condoms with a fellow driver. Doing so opened up a conversation about proper condom use, expiration dates and other helpful details, he says.

Similar changes have occurred with passenger interaction, too. If Samuel sees a billboard or sign about HIV, or hears a radio spot about AIDS, he might seize it as an opportunity to initiate a discussion. Moreover, if he overhears a conversation among passengers about AIDS, he now might offer a comment about condoms. Drivers would never have facilitated discussion about HIV before this program, he said.

Partly that is because of widespread HIV denial and stigma, strong obstacles IMPACT and SYGA must address. Semere, for instance, at first claims to know no one with AIDS, but when pressed, acknowledges that when his own brother died two years ago, the family did not know the exact cause.

“If a taxi driver is found to be HIV-positive, he will be rejected by the society,” one said. Focus group participants described the discrimination itself as “another AIDS.”

One ramification of this stigma is a reluctance to seek HIV testing and counseling services. FHI, with USAID funding, supports 25 public-sector testing and counseling sites that have served more than 40,000 people throughout Addis Ababa in the past year. The sites use rapid testing technology. Some charge 10 birr for a test, but provide it free to those who cannot pay. Most focus group participants did not know counseling and testing services exist. Some drivers who were aware of such services resisted them, saying VCT would not be practical unless the testing was compulsory. Some had been required to take an HIV test by a job or visa application. One participant said, “I will only visit VCT if I get a chance to go to America.”

Time is another obstacle to testing. Semere must work each day, so leaving work for any reason is difficult. An hour spent at a counseling and testing service is an hour without income. To address this difficulty, the Addis Ababa Health Bureau now keeps some public-sector VCT services open later in the evenings and on Saturdays. Yet even Semere appreciates the irony in his life: He has not been tested, but his mini-bus sports a bumper sticker that promotes VCT.

ATTACHMENT 4 – SNAPSHOT: HCBC TRANSFORMING LIVES IN ETHIOPIA

HOME- AND COMMUNITY-BASED CARE:

TRANSFORMING LIVES IN ETHIOPIA

Steve Taravella

SNAPSHOTS FROM THE FIELD



SNAPSHOTS FROM THE FIELD

HOME- AND COMMUNITY-BASED CARE:

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Arlington, VA 22201 USA
Tel: 1-703-516-9779
Fax: 1-703-516-9781
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Cover photo: Andarge Zemene is better able to manage his illness with help from FHI's home- and community-based care program. Photos by Steve Taravella/FHI.

A Andarge Zemene has a strong voice and bright eyes, but his body is failing him. He coughs violently from tuberculosis, remains prostrate because he is too weak to stand, and has lost so much weight from HIV that his skeletal frame feels to him “like a dead body.”

For the past nine months, Andarge, 35, has lived in a one-room shack in an Addis Ababa slum with five strangers, a family that took him in because they believed God would favor them for doing so. He sleeps in a corner of the room—actually, lies here most of the time—grateful for this tiny piece of cold floor covered in dirty plastic. It’s worse at night, when he must compete for floor space with day laborers who pay the shack’s owner 50 cents a night for shelter. During the day, he misses company, so he sometimes asks the little girl who lives there to invite other children to come play beside him.

Andarge likely could benefit from antiretrovirals, but their cost is high in Ethiopia and, since his only family is a father who lives far away, “nobody can support me for the medicine. I have a problem just getting food.”

But for Andarge, a former Ethiopian soldier and beer factory worker, life could be much harder. For one thing, the people he lives with understand his needs: The head of this family is himself HIV-positive. Most importantly, Andarge receives home- and community-based care services developed by Family Health International, a U.S.-based nongovernmental organization, and the local NGO Hiwot HIV/AIDS Prevention, Care and Support Organization (HAPCSO).

During a recent visit, a caregiver from this program brought Andarge flour and sugar. The caregiver washed his body, shaved his head to free him of lice, prepared him a meal, and gave him the blue sheets and heavy green blanket that now keep him warm. Previously, he slept directly on the shack’s cold floor. Without help from the FHI/HAPCSO program, “I would have died immediately,” he said.

The impact of this home-based care program—which is funded by the U.S. Agency for International Development (USAID)—is evident far beyond the shack where Andarge sleeps. The program has reached more than 3,100 people since it began operating in September 2003, including 1,500 orphans and vulnerable children. Within a few minutes’ drive, one can find HAPCSO staff and volunteers helping other HIV-positive Ethiopians, such as:

- **Dejene Mohammed**, who has lost his wife, a son and a daughter to HIV. Not to mention toes and fingers to leprosy. On a recent day, Dejene was visited by Sister Yewagnesh, a HAPCSO nurse who came to change the dressing on his left leg. The dressing is not for HIV-related sores, but for burns he experienced when hot tea fell on him. The wounds are large and raw and must be treated tenderly. Sister Yewagnesh is careful as she removes dead skin and covers the wound with sterile gauze to prevent infection. Dejene lives here with one of his surviving children, and clearly his family has come to depend upon Yewagnesh. While his adult daughter, crouching on the floor, prepares coffee for

Yewagnesh, his adult son tells a visitor that HAPCSO “does a lot. Even if we had a job, we could not do much.”

- **Huluageresh Tadesse**, who lost her nine-year-old daughter to AIDS and tuberculosis six months ago. Huluageresh is 29 but looks much older. On a recent afternoon, she is so weak she remains practically motionless, curled up under a blanket. A HAPCSO volunteer caregiver visits three times a week, bringing medicine to help her cope with TB, pervasive skin rashes, coughs and other maladies. The caregiver also brings some basic necessities, like soap and cooking oil. Huluageresh lives with her five-year-old son, who is as energetic as his mother is fatigued. Sometimes Huluageresh’s caregiver brings him small books.

This home-based care program is a compelling lesson in collaboration among a donor (USAID), a global implementing agency (FHI), a local implementing agency (HAPCSO), the local government (the Addis Ababa Health Bureau and the Addis Ababa HIV/AIDS Prevention and Control Office) and community institutions that at first did not see a clear role for themselves in this kind of service (*idirs*, traditional Ethiopian burial societies). In a city with an HIV prevalence rate of about 15 percent, their challenge was great. But with careful planning and a spirit of cooperation among partners, more than 900 people have so far been trained to help meet critical health needs for residents who otherwise might suffer alone. This network can serve as a useful model for agencies elsewhere.

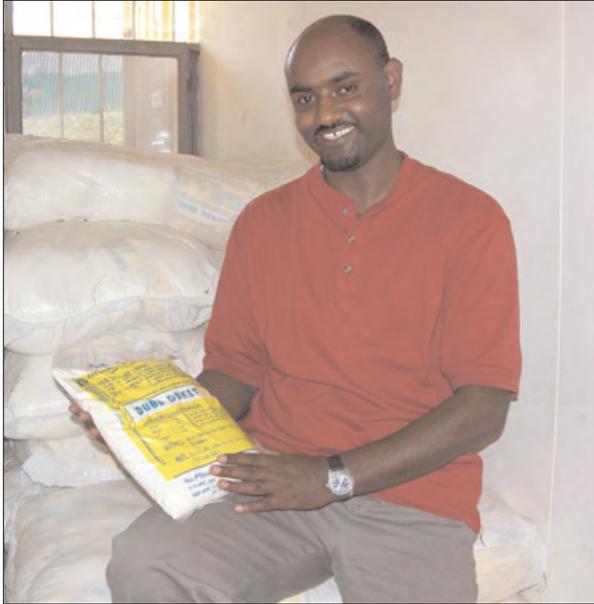
Encountering an increasing need among people who had little access to health care—and no means to reach it if they did—FHI began designing a home-and community-based care project in March 2003 with USAID support.

“Working together, we have created something meaningful. The network is building the community’s capacity to help individuals and families affected by AIDS and poverty. It’s improving quality of life, and helping transform the health system itself,” says Francesca Stuer, FHI’s country director for Ethiopia.

FINDING THE CAREGIVERS

For the volunteer caregivers who are central to this effort, the project turned to *idirs*, the traditional burial societies that help families when a death occurs and during the mourning period that follows.

Funeral services are an important part of Ethiopian culture, so *idirs* are a valued part of society here. Most Ethiopians pay a monthly membership fee to belong to an *idir*, and some might belong to several. They are formed around common characteristics, such as neighborhood, ethnic identity, workplace or religious affiliation. Each one typically represents several hundred households, and payments (typically 5-10 birr/month) are collected at a fixed date and place. With swelling numbers of HIV deaths threatening to bankrupt some *idirs* and cause others to increase



Program Coordinator Ephrem Fikre with some of the wheat flour that is provided twice monthly to poor, HIV-positive clients struggling to meet basic nutritional needs.

Photo: Francesca Stuer

their fees, FHI contacted idir leadership committees to assess their interest in care and support activities for people with HIV.

Engaging idirs did not take much persuasion, explains Worknesh Kereta, FHI's team leader for home- and community-based care. Idir leaders have long operated with a strong sense of community service and leaders hold their positions at no pay. In June 2003, FHI drew 1,500 idir representatives to a one-day HIV sensitization workshop, where the importance of caring for the chronically ill, not just those with HIV, was stressed. The presence of local elected government officials (the meeting was opened by the city's mayor) increased the idirs' comfort level.

After hearing presentations on the nature of home-based care, the prevalence of HIV in Addis Ababa, and the need for care and support

services, participants were divided into small groups by geographic district to discuss particular issues. The idirs showed great interest in supporting people with HIV—but FHI knew the project should begin with only a few of the most engaged before scaling up to idir institutions as a whole. From each of 10 *Kifle Ketemas* (sub-cities), two idirs were selected, based on specific criteria:

- They had to represent more than 350 people.
- They had to serve a densely-populated area with high HIV prevalence.
- They had to already be active, such as by having begun support services on their own.
- They had to serve people who don't already receive HBC services from other agencies.

The 20 idirs that stepped forward received a second, more intense, day-long training. Here, they agreed on criteria for identifying caregivers (must be age 18-45 and educated through at least grade 8), and established HBC organizing committees. Each committee would have five members per idir, two of whom must be women. Caregivers, who are not paid, are required to report to their idir's weekly HBC committee meeting. HBC committee members later received two additional days of training specifically on management. This training covered monitoring and evaluation, volunteer coordination, and records systems. To help them grasp the impact their work could have, FHI bused committee members about 250 kilometers out of Addis Ababa to observe an idir that had initiated care and support activities on its own. Seeing first-hand how these services could be delivered through the idir structure caused some idirs to regret not having stepped forward earlier, Worknesh says.

The HBC program has unexpectedly prompted a huge cultural change among the idirs, which began to see they need not wait until a member dies to offer help. In the past year, many idirs have changed their bylaws to permit involvement in care and support activities. Instead of reserving funds for a member's survivor, many idirs have begun making the money available to the ill member while alive, helping him or her with food, medicine or other needs.

TRAINING THE CAREGIVERS

To select the local NGO that would manage the home- and community based care program, FHI conducted several assessments of local care and support services. Selecting a skilled NGO was important because this group would take on a mentoring role to build idirs' capacity in these activities. FHI quickly identified HAPCSO as an ideal candidate. HAPCSO already had experience caring for PLHA and, although it operated in a limited geographic area, it was working "at ground-zero level," says Worknesh. "They worked very tight, close to the community, and that was important. Their capacity was limited, but they were doing an excellent job." The agreement with HAPCSO became official in September 2003 with a US\$340,000 contract for an initial 13.5 months.

Once HAPCSO and the idir societies were on board, the project began to hire nurses and train them in HBC delivery, simultaneously preparing many of them to instruct others. FHI helped build HAPCSO's capacity by incorporating Ministry of Health training materials into these activities and augmenting them with Amharic translations of new training modules on monitoring and evaluation and on caring for orphans and vulnerable children. The training was provided in three areas, delivered in sequence over three weeks:

- Theoretical—what HBC is and why it's important
- Demonstration in the classroom—some basic nursing skills, such as how to use gloves.
- Observing and delivering care to the critically ill at hospitals and in other HBC programs—bathing a patient, for instance

The Regional Health Bureau donated space at Ras Desta Hospital, where much of the HBC training now takes place. Here, FHI and HAPCSO have created a valuable link between government-run and community-based services. The project opened a home- and community-based care center in May 2004 that today boasts a large training/conference room, a medical supply center, counseling rooms, offices and a small library. Supplies for the HBC "kits" used by caregivers are funded by the Development Cooperation Ireland.

In the conference room, caregivers are taught how to provide nursing care, prepare meals, cleanse clients and help them with various tasks. All training is conducted in Amharic, the local working language, and is of such a high quality that the center receives requests for it from people unaffiliated with HAPCSO or FHI. Where possible, it honors these requests. The Global Fund has asked HAPCSO to train approximately 500 people from the Fund's NGO partners; HAPCSO plans to do so and the Fund will cover training costs. When a Coca-Cola factory asked

for help, a HAPCSO nurse supervisor arranged for volunteer caregivers to present an educational drama for factory workers. The 2,000 birr, or about US\$240, that the factory donated after the performance was distributed in small amounts to about 130 HBC beneficiaries.

In the first two quarters of operation, caregivers assisted 679 patients, mostly of whom are HIV-positive. Of those, 178 have died, reflecting the poverty, poor nutrition and late diagnosis of so many. As with Andarge, each patient typically receives a caregiver visit three times a week. The caregiver provides basic nursing care, offers psychosocial support, and facilitates referral links to other services in the community. Caregivers are also likely to wash clothes, clean house and prepare food. “Caregivers are everything to these people. They’re really filling a gap,” says Worknesh.

The nutritional crisis here is so severe that caregivers sometimes can do little else but bring food, often at their own expense. “For care and support to be complete, it must address all their needs. You can’t separate their economic situation. When you go into a household to give care and you find there’s nothing to eat, treatment is not enough,” says Ephrem Fikre, HAPCSO’s program coordinator. The program supports income-generating activities for women and orphans, and tries to provide some food to help meet basic nutritional needs.



Yeshiemebet Kassa manages the supplies that make up the “home-based care kits” for the project’s volunteer caregivers.

HAPCSO and the idirs have been especially effective at drawing men into care-giving, traditionally a female role here. Men were made a priority in volunteer recruitment (as were people with HIV and older orphans), and now make up about 40 percent of the caregivers. “Everyone here is affected by HIV. The magnitude is so great and the suffering felt so keenly” that it extends beyond gender roles, says Alemu Tadesse, HAPCSO’s HBC nurse supervisor.

Because of the difficulty in keeping caregivers engaged in such emotionally and physically challenging work, HAPCSO has developed incentives. Caregivers are reimbursed for some minimal transportation costs, such as to attend HAPCSO review meetings. They receive a certificate for their commitment. Those who excel as caregivers for at least 18 months are sponsored in skill-training classes, where they may learn hairdressing, electronics, auto mechanics or teaching skills. (For this, HAPCSO pays an average of 2,500 birr each, or US\$300). And, in a region with high unemployment, they are considered for job opportunities on HAPCSO’s paid staff, as community social workers, for instance.

HAPCSO's role in this HBC program has made it a major stakeholder in HIV activities, and earned it recognition by the government and other NGOs. Indeed, the agency's work has not just improved lives and enabled the community to better care for those who are ill. Indirectly it has helped reshape the local health system. "The biggest thing we have done is not providing care or (running) the training program. It's that we made this agenda the agenda of the city government and the local community," says former HBC Project Coordinator Hailu Taye, a nurse and economist. For its outstanding efforts, FHI presented HAPCSO with an Access Award during the International AIDS Conference in Bangkok in July 2004.

These activities take place amidst stigma so pervasive that, even as HIV infections spread, "HIV" is sometimes not said aloud. In fact, a guide produced by the project was carefully titled the *Manual to Provide Home-Based Care for Chronically Ill Patients*. The stigma is evident in personal ways, too. Ephrem recalls a young woman who lost her husband to AIDS. So fearful was she of neighbors learning of her HIV infection that she kept herself isolated, practically confined to bed, for six years. Finally, in February 2004, when she was 25, HAPCSO caregivers reached her. To determine what services she could most benefit from, they asked her to take an HIV test. The result was negative. The woman had been free of HIV all along, but her fear of stigma caused her to forfeit years of her life. "Had it not been for the health care service we provide, the woman would not have known her status. The stigma attached to HIV is so great that people hide themselves, not even talking to others. Many die without getting any support," he says.

This case illustrates a unique aspect of the program: using atypical ways of finding those who need help. This woman was discovered by volunteer caregivers who go home-to-home trying to identify potential clients. In other cases, HAPCSO uses "coffee ceremonies" to spread word of its services. These are traditional events where discussions—part informative, part social—are held among neighbors who gather outdoors, perhaps under a big tree. The speakers might bring coffee, sugar or corn to those who attend. Usually 20-30 people from five or six households participate, but sometimes coffee ceremonies are organized in the home of someone with AIDS, and family members and neighbors congregate to share in the ceremony. As HIV has cut a greater swath through Ethiopian society, the coffee ceremonies' focus on AIDS has grown, too, explains Alemu.

