Plan- Ethiopia

Addis Ababa Program Unit

Draft report on the evaluation of HIV/AIDS Program in partnership with M.Joy and ISAPSO funded by NORAD in Addis Ababa

Submitted to: Plan - Ethiopia

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ACRONYMS

1. AAC	Anti AIDS club
2. AIDS	Acquired immune deficiency disease
3. BCC	Behavior change communication
4. CBRHA	Community Based Reproductive Health Agents
5. DHO	District Health Office
6. FBO	Faith Based Organization
7. FGD	Focus group discussion
8. HAPCC	HIV/AIDS Prevention and Control Council (at Kebele level in South; same as KHAC)
9. HAPCO	HIV/AIDS Prevention and Control Office (at Woreda level or South; same as WHAC)
10. HBC	Home based care
11. HIV	Human immunodeficiency virus
12. IEC	Information, education, communication
13. IGA	Income generating activity
14. Kebele	Sub-district, smallest administrative unit in Ethiopia
15. KHC	Kebele Health Committee
16. KHAC	Kebele HIV/AIDS Council (at Kebele level in North, equivalent to HAPCC)
17. M&E	Monitoring and Evaluation
18. MoH	Ministry of Health
19. NGO	Non-governmental organization
20. OSSA	Organization for Social Service for AIDS
21. OVC	Orphans and vulnerable children
22. SSI	Semi structured interview
23. PLWHA	People living with HIV and AIDS
24. PM	Project Manager
25. TOT	Training of Trainers
26. VCT	Voluntary counseling and testing
27. WHAC	Woreda HIV/AIDS Secretariat (at Woreda level in North, equivalent to HAPCO)
28. WHC	Woreda Health Committee

TECHNICAL DEFINITIONS

Community: A community is a group of individuals living in one locality.

Extended family: The social unit, which comprises not only a couple and their children but also other relatives, e.g. uncles, aunts and grand parents. In Ethiopia tradition this may extend to clans.

Family circle: A family which is bounded by parents and their children in the household, or all those who live in one house.

Idir: A traditional social gathering in the form of an association which assist at the time of burial ceremonies.

Kebele: The lowest administrative unit in Ethiopia. In urban areas it is also called an urban dwellers association (UDA) whilst in rural areas it is called a peasant association (PA).

Orphan: A child deprived of father or mother, or both, through death owing to different reasons including HIV/AIDS.

Vulnerable children: Children that are in different circumstances living in the community.

Wereda: An administrative unit (equivalent to a district).

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The cooperation of various groups and partners where the study has been conducted contributed for the success of this assessment. We also appreciate the cooperation of the study subjects and FGD participants in giving valuable information during data collection.

The consultant team.

EXECUTIVE SUMMARY

Introduction: The three-year project started in 2004 funded by NORAD in Addis Ababa In Yeka and Arada sub cities. After conducting baseline study in 2004, Plan Ethiopia with its local partner Mary Joy and ISAPSO has implemented this project in Addis Baba in Yeka and Arada Sub cites for the last three years. The project addresses the human rights, education, health, and stigma challenges posed by HIV/AIDS, among others. It has been expected that this project has already had a tremendous outcomes and /or impact on the lives of youth and children and their communities in the context of HIV/AIDS. The main objective of this assignment is therefore, to precisely understand the outcomes of this project in this operational area and use study results for further programming.

Objectives: The purpose of this assignment is to make a detail assessment on the impact of this project on different components and to forward appropriate strategies in future direction.

Methods: The assessment started with document review. Both quantitative and qualitative methods have been applied. Under this evaluation the same methodology was applied in terms of targets, sample size and sampling procedures like the baseline survey. Hence for the quantitative approach structured questionnaire was applied to interview a total of 300 ever married women, 300 ever married men and another 300 youth. Under the qualitative approach a total of 110 KIIs, 20 case studies and 20 FGDs have been conducted with staff members, partners and beneficiaries. Collected data entered in a computer and analysis performed using SPSS.

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Findings: The major activities performed under the current project are divided in five components including BCC, Home Based care Services, Support for OVCs, Support for PLWHAs and capacity building. Under the first component behavioral change communication (BCC) activities are conducted by strengthening AACs, youth forum, youth association and other targets through mass sensitization, peer education and CC at different levels. This activity has brought a significant change in the reduction of misconception, stigma and increasing demand for VCT and condom use. Among adult respondents during the baseline survey those who believe that a healthy looking person can not have HIV was 19.0%. This has significantly reduced to 14.3 % with a difference of 4.7 % and with an improvement rate of 24.7% when compared with the original indicator. Percent who reported at least one miss conception regarding the possible route of HIV transmission was 13.8% and reduced to 10.3% with a difference of 3.5% and an improvement rate of 26.9%. Percent who reported at least one stigmatizing attitude towards PLWHAs was 55.7% and significantly reduced to 23.9% ($p<0.0001$) with a difference of 31.5% and an improvement rate of 56.9%. Indicators concerning discussion with partner/spouse/opposite sex and family members increased by 25.9% and 17.6% respectively. The difference who are willing for VCT has also increased by 11.0% and the difference on VCT-uptake increased significantly by 18.1%. Those who used condom during casual sex have increased significantly and was also

witnessed by the qualitative respondents. The change observed among the youth has also a similar pattern like that of the adults in all the indicators compared with the baseline survey. Both partners and beneficiaries under KIIs and FGDs have witnessed the above changes for the different indicators.

HBC providers are trained and provided with kits. They participated in assisting PLWHAs, counseling of OVC, referral services and other behavioral change activities. Assistances; like nutrition supplement, medical services and educational materials have been given for 110 OVCs and 68 PLWHAs. In the area of capacity building two VCT centers are built by the project. Training has been given for partners at grass root and for IDIR leaders who were convinced to change their bylaws to assist the community on deployment issues including HIV/AIDS on top of funeral ceremonies

Conclusion: The current assessment has shown as there is an impact brought in the community by the different actives performed and the following relevant points are concluded.

- Most of the activities planned under the five out put areas are successfully completed.
- A significant change is observed in the reduction of misconception and stigma among adults and youth.
- Discussion between partner/spouse/opposite sex and family members, those who are willing for VCT and condom use during causal sex has increased significantly among adults and youth when compared with the baseline survey.
- There is a significant difference in VCT-uptake and condom use
- Significant achievements have been observed under HBC services.
- The critical gaps observed in the area of BCC , home based care, OVCs , PLWHAs , networking and capacity building should get due consideration in future intervention strategies in the project area.

Recommendation: The current project has achieved most of the activities planned. Due to this significant changes have been observed in the area of BCC, care and support. We believe the current project is a good start. We also want to express as much remain to do more work that lead to sustainability by strengthening kebele and sub city capacity, the kebele office and the community at large to take over the work of this project. We also believe that more efforts should be exerted in the future to strengthen the current strategies and to fill the identified critical gaps to mitigate the problem of HIV/AIDS in the project area... Hence, the consultant team has put the following recommendations to be implemented in the next phase of the project activities.

1. The current project started by addressing prevention, service, care and support in an integrated manner is a good start as prevention; services, care and support strengthen each other...
2. To strengthen community mobilization and mainstreaming of sect oral offices, roles of different actors should be clearly identified at the beginning of the project. The role

of different actors in future intervention strategies should focus more on capacity building work to enable the community to take over the problem of OVCs and PLWHAS including the prevention component.

3. AACs both in and out of schools who teach the youth in the school, community and the surrounding should be strengthened and encouraged to recruit more girls as members and leaders in their clubs. Encourage Youth forum to arrange different panel discussion and continue with the mass sensitization through community mobilization, peer education , CC and encourage the education by religious leader, PLWHAs, and elders and community leaders

4. Encourage the current trained HBC providers to participate in counseling, refereeing and other BCC activities. Encourage also PLWHAs to serve as HBC providers. HBC providers should clearly be informed and understand as their responsibly is on volunteer bases to avoid their expectation to be a permanent staff after a certain period of service. Lay out the ground work on how to reward those HBC providers after they completed their assignments. Give additional refresher training for HBC providers to involve them in other RH activities, development programs and follow up ART programs.

5. The support given for OVCs like the nutrition support, educational materials should continue in the next phase of the project. But more focus should be given for CBOs and FBOs to generate sustainable income to accommodate and solve the livelihood of OVCs found at the different kebeles. Encourage guardians or care takers of OVCs to be involved in IGA to be self sustained. Avoid duplication of efforts and the maximum care in selection process. Provide practical skill training for OVCs heading the family and give priority to get job to be a potential bread winners to lead the family.

6. The support given currently for PLWHAs should continue. But more focus should be given on group, sub group and individual IGA to make them self sufficient in the future.

7. The capacity building component of the project can further build schools and encourage IDIRS to participate on income generating process to assist OVCS and PLWHAs for the sustainability of the project.

8. Strengthen the current system of planning, implementing and tighter monitoring among partners and community members.

9. The next phase of the project should focus on capacity building work to enable the community to stand by their own to take the problem by themselves. Hence, the focus of the project in the next phase should be more on rehabilitation activities by encouraging the realization of local resources funds.

10. Introduce succession planning and completing memorial books as additional component

1.0. INTRODUCTION

1.1 Impacts of HIV/AIDS in Ethiopia

Certain sections of the population are more affected than others due to their high level exposure to risky sexual behaviors. Sex workers have often been described as 'core group', a small group in which the infection is endemic and from whom it spreads to the population at large. A large-scale survey on sex workers operating in the main trading roads of Ethiopia in 1988 found HIV prevalence rates ranging between 5.3% -38.1% (average prevalence of 17%). In 1989, HIV prevalence was already 24.7% among sex workers in Addis Ababa. Sex workers are estimated to represent around 7.1% of the sexually active female population of Addis Ababa.

Long distance truck drivers are another group known to be at an increased risk of HIV infection next to sex workers. HIV prevalence of 13%, 17.3%, 40% and 26.7% were documented among truck drivers in 1988, 1989, 1994 and 1995, respectively. Studies conducted between 1993 and 1995 in Gondar town, North West Ethiopia documented prevalence of 25% among soldiers. The same studies found prevalence rates not exceeding 15% among other population groups.

Women tended to become more infected at younger age than men mainly due to their earlier initiation into sexual activity and exposure to elder sexual partners. In particular, young girls in Ethiopia are more vulnerable to HIV than boys because of early age at sexual debut, early marriage, sexual abuse and violence such as rape and abduction.

HIV/AIDS has social and economic impacts in Ethiopia. In 2005 it was estimated 1, 320,000 people were living with HIV/AIDS. Caring for all these patients will constitute a burden on the health care expenditure. AIDS patients occupied hospital beds. This has thus caused the Ministry of Health (MoH) budget on AIDS to increase.

AIDS will Impact the economic development of Ethiopia in a number of ways. The loss of young adults in their most productive years of life will certainly affect overall productivity. Furthermore, AIDS related diseases would cause reduction in savings and investments among the population for reasons of meeting expenses for treatment and funeral. Loss of skilled manpower will lead to increasing loss of management skill and knowledge that will then lead to further loss of productivity.
To the individual the economic impact involves fear of: becoming dependent on other for life; loss of job; loss of saving to cover medical expenses; and, loss of support from others.

All members of rural/ urban families hit by AIDS are likely to be affected. Grandparents have to assume full responsibility for raising the children when the parents die. One of the worst consequences of the epidemic is an increase in the number of orphans. The number of AIDS orphans could increase, according to MoH projection to 1.8 million by 2009. Some

children will lose either their fathers or mothers, and many more will lose both parents to AIDS. Orphans are more likely to become malnourished. Many have fewer opportunities for education if the family cannot afford to finance the child's education or needs the children to work in the home. Many of these children will find themselves in the streets forced to engage in activities harmful to themselves and the society. Their numbers are increasing, and the already strained social system does not appear to cope with them.

The social impact of HIV/AIDS manifests itself on both the individual and group levels. To the individual it consists of bringing a feeling of shame to the family name; being isolated and alienated from previous sexual partners; uncertainty about what would happen to the children left behind; being isolated and alienated from family and friends during hospitalization; a feeling of apprehension for the children being made outcasts; and, fear and loathing of being made the butt of jokes and gossip. To the Family it involves loss of a loved on in the family; loss of a bread winner; loss of family name; possible isolation from community or relatives; broken traditional norms (husband/wife inheritance); broken families (husband/wife abandoned); burden on the elderly (grandparents caring for grandchildren); helpless orphans, widows, and other dependents;

Women are very much affected by AIDS because their ability to protect themselves from HIV infection has been reduced due to various factors. They cannot force their sexual partners to wear a condom. A woman is at risk of getting HIV even when she is faithful to her husband for the latter would often fail to reciprocate this faith. Women take care of the AIDS patient at home without adequate knowledge of the illness or how to protect themselves from the infection. They are also the ones to suffer the economic impact of AIDS. If the husband dies, the mother has to provide the children with food and shelter without even securing herself economically. She might resort to prostitution, thus further endangering her life. The prevalence of HIV infection is highest in the productive years 15-49. For women these are the reproductive years. AIDS also affects babies. About 30-40% of babies born to infected mothers will also be infected with HIV. Most of them will develop AIDS and die within two years. Few will survive and pass away at the age of five. Thus, the combined impact of deaths due to AIDS and fewer births due to smaller reproductive age duration will result in a lower population size and lower productivity than would be the case otherwise.

There has been increasing political commitment and the society as a whole has been mobilized; civil society, faith-based organizations (FBOs) and PLWHA associations have been actively engaged in anti-stigma campaigns, promoting openness, and caring for the sick. Bilateral and multilateral organizations have significantly increased their technical and financial supports with the United States President’s Emergency Plan for AIDS Relief (PEPFAR), Global Fund, and World Bank’s MAP program being the major donors.

These resources have facilitated large-scale social mobilization and expansion of HIV/AIDS prevention, care, support, and treatment services. The health sector response has been strengthened and is now undertaking rapid and mass scale-up of prevention, care, and

treatment services including CT, PMTCT and ART.

1.2. Plan-Ethiopia- Addis Ababa PU

Plan is an international humanitarian, child-centered development organization with out religious, political and government affiliation. Before coming back in 1995; plan was here in Ethiopia for some time during the former Dergue regime. Plan has been operational in Ethiopia since 1995 with its major areas of focus on long term child health Development, basic leering Development, poverty alleviation and sponsorship communication development programmers.

Plan Ethiopia is implementing HIV/AIDS intervention programs to contribute to national efforts being exerted to prevent from and mitigate impacts of HIV/AIDS on children and, youth communities. Plan Ethiopia as a child centered organization, to improve the quality of children's/OVC's life has been implementing HIV/AIDS programs since September 2004 funded by Plan Norway national office in two sub- cities of Addis Ababa, with two local partners, namely Mary Joy Aid through Development working at two kebeles and Integrated Service for AIDS Prevention and Support Organization (ISAPSO) working at three Kebeles. These partners are recruited based on their experiences and profiles related with planning, implementing, and monitoring program with the community, their compliance with Plan's and government requirements to function as community oriented organizations, their experiences on community based HIV/AIDS prevention, care and support programming.

After conducting baseline studies in 2004, Plan Ethiopia with its local partner Mary Joy and ISAPSO, has implemented this project in Addis Ababa for the last three years. The project addresses the human rights, education, health, and stigma challenges posed by HIV/AIDS, among others. It has been expected that this project has already had a tremendous outcomes and /or impact on the lives of youth and children and their communities in the context of HIV/AIDS. The main objective of this assignment is therefore, to precisely understand the outcomes of this project in both operational areas and use study results for further programming. This document presents the findings of Shebedino district

1.3 The two key partner- Marry Joy and ISAPSO

Mary Joy Aid through Development is legal registered independent Non-religious, Non-political, Non-Partisan and Not for- profit Humanitarian Indigenous Non governmental Organization. It has been registered with ministry of Justice in 1995 and has had operational agreement with DPPC in the same year. Renewals have been undertaken in both cases at different times. The genesis of Mary joy is related to major role played by the present executive Director. With the major role played by Zebider Zewdie Mary Joy Aid Through Development came into being in 1994.

Since 1994, Mary Joy has been engaged in different activities benefiting the community both directly and indirectly. Some of its programs that directly benefit the community include the rehabilitation of street children, working children support, educational support for children coming from poor households, non-formal education, tutorial services for the weak children, Savings and Credit Cooperatives to poor mothers with many children, kindergarten construction, orphan support, children and youth recreation center, mother and child health care services are major ones. The programs that indirectly support children include savings and credit program for mothers having too many children to support, clinic-based health care activities, environmental sanitation programs, capacity building and Comprehensive HIV/AIDS prevention, Care and support Program in which Mary Joy is well appreciated.

The total population of the envisaged project area/Yeka sub-city administration/ is estimated to be about 120,000. This project is expected to reach about 21,300 people in 11 kebels of Yeka Sub-City administration both directly and indirectly. The project area is located on the northern part of the city. The train of the area is mostly hilly and cut up by a number of intermittent streams and gully flows. The settlement pattern is characterized by high congestion, but there are some open spaces between residential houses in most Kebeles.

Like any other Sub-City Administration in Addis Ababa, the above-mentioned project site is prone to various urban-related problems, including large family size and poor housing conditions, too many street children and sex-workers with associated social problems, particularly HIV/AIDS and unwanted pregnancies, poor health status of families and environmental sanitation, lack of latrines and garbage disposal facilities, malnourishment on children below five, expanded level of illiteracy and the existence of many women and child headed households are some of the major problems the areas are facing these times.

Integrated Service for AIDS Prevention and Support Organization (ISAPSO), established in October 27, 1997 is an indigenous, non-profit making organization dedicated to curbing the spread of HIV/AIDS/STI's and to mitigate its impact. ISAPSO incorporated reproductive health education and family planning services in 1999 and care and support programs in 2002. Currently, it is assisting 1050 Orphan & Vulnerable Children (OVC) in Addis Ababa, Oromia(Seden Sodo) under the support of funds accessed from various agencies.

The mission of ISAPSO is to initiate, promote, and sustain HIV/AIDS/STIs prevention, care, support and reproductive health education and family planning services to communities and workplaces both at Federal and Regional level. ISAPSO targeted different population groups believed to be at risk of HIV infection due to their age, socioeconomic states, nature of work like transport workers, in and out of school youth, students of higher learning institutions, construction and factory workers, refugees and commercial sex workers, Orphan & Vulnerable Children (OVC) and bed ridden patients. The project area for ISAPSO is Arada Sub-City, which is one of the earliest and largest sub-cities in Addis Ababa. There are very many destitute and vulnerable children, which are exposed to the risks of HIV infection despite the area being a business center.

2.0 OBJECTIVES

2.1 General:

The purpose of this assignment is to make a detail assessment on the impact of this project on stated out comes in the original Project document and critically analyze the gap observed during the project period to suggest future intervention strategies.

2.2 Specific:

The specific objectives of the current assignment are to evaluate the outcomes/results of this project in terms of

- Changes in KABP regarding HIV/AIDS and sexual health among women, youth and adult men in the project areas
- Reducing risky sexual behavior in the study area
- Mitigating and reducing the negative social and economic effects of the epidemic on families and children(both girls and boys)and allowing them to live with dignity
- Addressing the impact of HIV/AIDS on the living conditions of OVC and PLWHA in both operational areas
- Reducing stigma and discrimination attitudes towards PLWHA/OVC among the target population
- Addressing demands for confidential HIV/VCT services
- Improving STI case management at hospital or health center level
- Addressing gender issues in the context of HIV/AIDS
- Providing quality home based care services for OVC and PLWHA and other chronically ill people
- Establishing and supporting psychosocial support groups/association among PLWHA and OVC in the program areas
- Building local capacity and coping strategies and implementing as well as replicating sustainable community based HIV/AIDS prevention, care and support interventions
- Addressing livelihood related Vulnerabilities in rural contact

3.0. SCOPE OF THE SURVEY

a) The consultant/ team is strongly abided by plan's program domains in general, and to the core programs and principles of plan and country strategic plan in particular in undertaking the whole assignment. The consultant team has outlined and justified priority areas that need the immediate attention of Plan Ethiopia, the governments and /or the community in line with Plan's Program Domains /Core programs and principles Country Strategic Plans and Plan's Framework for Sub-Saharan Africa , Child centered Community development Framework and also the relevant government polices and strategies.

b) The consultant team used a variety of data collection techniques to collect relevant data for the study.

c) The consultant team developed methodology for the assessment of impact/outcome of this project on rural lively hoods:

4.0 METHODOLOGY

4.1 General:

The evaluation started with document review including the project proposal, quarter reports and other issues related to the project. It used both quantitative and qualitative methods to see impacts and outcome of the project. Under the quantitative method structured questionnaire similar to that of the Baseline survey with the necessary modification has been applied. For the Qualitative KII and FGD have been applied.

4.2 Document review

The desk review included an assessment of available information from the Existing Planning and proposal of the project document. Other related issues of both at regional and national level the document review has been also included other works conducted in the world, African countries and in Ethiopia to record their Experiences issues related to the current assignment. A check list of Documents was prepared and reviewed exclusively by the consultant team. The main document reviewed includes:

- Project proposal
- Baseline survey
- Annual reports of the project
- Quarter reports of the project
- CPO-II

4.3 The quantitative approach

Under this evaluation the same methodology was applied in terms of targets sample size and sampling procedures. Hence for the quantitative approach structured questionnaire was applied to interview a total of 300 ever married Women, 300 ever married men and another 300 youth. The Total sample size was 900 subjects including 300 ever married women, 300 ever married men and 300 youth. Those kebeles selected during the baseline under NORAD project area were selected under this evaluation...Like the sample size the data collection instruments applied during the baseline survey was used under the current evaluation. (Q1), see annex 1. The Questionnaire for the ever married women and men included:

- Address
- Background characteristics
- Knowledge on HIV modes of transmission and prevention
- Sexual behavior
- Knowledge on misconception
- Knowledge on Stigma and discrimination
- Willingness for VCT
- Opinion on the benefit of the project

The Questionnaire for youth (Q2) included:

- Address
- Background characteristics

- Knowledge on HIV/AIDS
- Sexual behavior
- Knowledge on misconception
- Knowledge on Stigma and discrimination
- Willingness for on VCT
- Opinion on the benefit of the project

4.4 The qualitative approach

Under the qualitative approach key informant in-depth interview (KII) and focus Group discussion was conducted with influential targets.

4.4.1 The Key Informant In-depth Interview (KII)

The target for the key informant in-depth interview can be classified in to three groups:

a) The staff members of Plan-Ethiopia
b) The partners at different levels and
c) The beneficiaries at different levels and groups. In this evaluation, 6 staff members, 36 partners and 64 beneficiaries were interviewed. All in all 106 key informants were interviewed. Case studies were conducted with beneficiaries.

For the key informant in-depth interview three types of open ended in-depth interview were prepared to answer the objective of the assignment focusing on the outputs /outcome of the project...The first key informant in-depth interview (KIIQ1) is prepared (see annex 2) for the staff members mainly focused on their opinion:

- On relevance of the project for the community
- On effectiveness and efficiency of their performance
- Opinion on behavioral change of the community on HIV transmission, stigma and discrimination, care and support , VCT etc
- Their observation on HBC
- Their opinion on the support given for PLWHAs and OVC families
- Lessons learnt and best practices document in the process of the project
- Their opinion on sustainability of the project and
- Others

The main targets among the partners include woreda health office, Health facilities, Woreda HAPCO, OSSA, CBOs, Kebele official; youth club both in and out of school and others. The second key informant in-depth interview (KIIQ2) is prepared (see annex2) for partners and mainly focused on their performance and opinion on the following issues.

- Relevance, effectiveness of the project
- Their performance and contribution for the success of the project objectives and out put
- Their opinion on behavioral change of the community on HIV transmission, stigma and discrimination, care and support , VCT etc
- Issues on HBC
- Their contribution on the support given for OVC, PLWHAs and the youth

- Their opinion on sustainability

The main targets among the beneficiaries include OVC, PLWHA, Adult men and Women, youth and others. The third key informant in-depth interview (KIIQ3) is prepared (see annex 2) for partners and mainly focused on their benefit and opinion on the following issues.

- Address
- Background characteristics
- Relevance, effectiveness of the project
- Benefits obtained by the participants in relation to behavioral change , stigma and discrimination
- Benefits in relation to care and support (OVC, PLWHA answer this)
- Benefits in relation to VCT
- Issues on HBC and
- Opinion on sustainability

4.4.2 The Focus group discussion (FGD)

The target for the focus group discussion are classified in to two groups:

a) The partners at different levels and

c) The beneficiaries at different levels and groups.

In this study, 20 focus group discussions were conducted with partners. The remaining nine were with beneficiaries including youth (boys and girls separately), OVC, PLWHA, Adult women and men.

The focus group discussion was strictly conducted by the consultant team members assisted by the supervisors. During FGD one person moderated and the second person recorded points raised by the participants (6-8 persons) For the FGD discussion points were prepared to answer the objective of the assignment focusing on the outputs /outcome of the project. Concerning partner one FGD was conducted at kebele levels and participants were from health, education, administration, religious leaders, youth association, women association, werda HAPCO.

The discussion points prepared (see annex 3) for partners are listed below.

- Relevance, effectiveness of the project
- Their performance and contribution for the success of the project objectives and out put
- Their opinion on behavioral change of the community on HIV transmission, stigma and discrimination, care and support, VCT etc
- Issues on HBC
- Their contribution on the support given for OVC, PLWHAs and the youth
- Lessons learnt and best practices document in the process of the project
- Their opinion on sustainability

Concerning the beneficiaries FGDs were conducted with

a) OVCs
b) PLWHAs

PRA method that applies SSI and FGD was applied with the adult group (women and men). Issues focused on:

- How gender issues addressed in the project
- Relevance, effectiveness of the project
- Major benefit they got from the project in relation to behavioral change on modes of HIV transmission and prevention , stigma and discrimination, care and support , VCT etc
- Major benefit related to HBC
- Major benefit related to the support given for OVC, PLWHAs and the youth Their opinion on sustainability

Participatory Action Research (PAR) was applied with children mainly OVC to enable children to express their opinion in the form of role play, drawing, and drama , essays poem .After brief explanation for the participants. They were allowed to present their opinion on the project benefit and future intervention strategies using drama. Poem, drawing and others.

Concerning the youth and PLWHAs discussion points include

- Relevance, effectiveness of the project
- Major benefit they got from the project in relation to behavioral change on modes of HIV transmission and prevention, stigma and discrimination, care and support, VCT etc
- Major benefit related to HBC
- Major benefit related to the support given for OVC, PLWHAs and the youth
- Lessons learnt and best practices
- Their opinion on sustainability

4.5 Organizational arrangement:

Interviewers who completed 12th grade were employed temporarily for the collection of the quantitative information. Supervisors with a better educational level and experience were assigned to ensure the quality of the data. The focus group discussions were facilitated by the consultant team. The in-depth interview was conducted by the supervisors and the consultant team members. The team leader for Shebedino district was the team leader with one consultant team member, 4 supervisors, and 30 interviewers. During data collection adequate training both for the supervisors and the interviewers was given theoretically and practically.

4.6 Data, Report and output

The quality of the data to be collected was checked to ensure quality on daily basis. The consultant team was responsible in selecting appropriate method/s for the raw/field data analysis. There was also data clearing activity before processing and analysis.

The data analysis and the assessment report were entirely performed by the consultant. Draft report was submitted Based on the contents of the report for comments for Plan –Ethiopia

5.0 FINDINGS AND DISCUSSION

5.1 Back ground characteristics of the study subjects

5.1.1 Background characteristics of respondents under the quantitative approach

Table 1 presents the background characteristics of respondents among the adult's men and women including the youth. The distribution by sex is at equal proportion (50% each) by design. Concerning the age distribution the majority of the adult men and women are in the 25-34 age groups followed by 35-49. The lowest is recorded in the age group 15-19 as the respondents were selected to be ever married women and men. Concerning education the majority of them are elementary and above as the project area is the capital of the country. Over 50% of the adult respondents are currently in union and the rest are widow and divorced. The majority of the respondents are Orthodox followed by Muslim, protestant and others

Concerning the Youth age distribution it is limited to 15-24 age brackets by design. The majority are in the age interval 20-24. By design equal proportion of boys and girls are considered in the study population of the youth including never married groups. Like the adult population the majority of the youth are Orthodox followers.

Table 1. Back ground characteristics of respondents, Addis Ababa, December, 2007

	Adult		Youth	
	Female =300	**Male =300**	**Female =150**	**Male =150**
Age				
15-19	0.7	0.3	38.0	34.4
20-24	3.3	1.3	62.0	65.6
25-34	37.7	45.3	N/A	NA
35-49	41.7	34.3	NA	NA
50+	16.7	18.7	NA	NA
Educational status				
Illiterate	20.0	4.0	4.3	0.0
Read or write only	18.7	6.7	5.1	0.0
Elementary	24.0	18.0	12.2	6.6
Junior Secondary	16.0	15.3	18.0	16.4
High School+	21.3	56.0	60.4	77.0
Marital status				
Never married	N/A	N/A	100	100
Currently Married	56.3	73.7	N/A	N/A
Divorced	10.7	5..7	N/A	N/A
Widow	15.0	3.7	NA	NA
Others	18.0	17.0	NA	NA
Religion				
Orthodox Christian	85.7	87.0	84.1	88.9
Muslim	2.7	1.0	2.9	1.3
Protestant	7.3	4.0	6.5	5.9
Others	4.3	8.0	6.5	3.9

5.1.2 Respondents under the qualitative approach

Table 2 approach and targets under the qualitative approach

Approach	Targets	Type	NO
FGDs	Partners	1. Kebele Committee members	4
		2. HBC providers	4
		3. IDIRS	4
	Beneficiaries	1. PLWHAs	4
		2. OVCs (PAR)	4
Sub Total FGDS			20 FGDS
KII	Staff members	1. AAPU, Mary Joy , ISAPSO	8
	Partners	1. Kebele Committee members	36
		2. Sub city HAPCO	2
	Beneficiaries	1. PLWHAs.	16
		2. OVCs	16
		3. Guardians	16
		4. Club members	8
		5. CSWs	8
Sub Total KIIs			110
Case studies	Both Partners beneficiaries	misIsellinous (5 at each kebele	20

5.2 Magnitude of the problem and opinion of the community

More significantly, the impact of the HIV/AUDS epidemic is on affected families and particularly children. According to the sixth edition of HIV/AIDS in Ethiopia, a total of 744,100 Ethiopian children are estimated to have been orphaned by AIDS and this number is rising. Despite the efforts to curb HIV/AIDS, the epidemic continues to spread due to poverty, lack of education, and natural and human-made disasters. In general the direct causes for the fast progression of the epidemic are unprotected sex and high frequency of casual partners. In addition to these there are also several underlying factors that contribute to the epidemic such as poverty, ignorance, gender inequality, cultural barriers, war and displacement.

Plan Ethiopia is implementing this project to mitigate the impact of HIV/AIDS on children and youth, and their families and communities with the assistance of NORAD Plan is working in Arada and Yeka Sub-city with ISAPSO and Mary Joy in four kebeles (10, 15/16, 01/02 and 8/15) respectively.

According to the FGD participants, the magnitude of the problem in these four kebeles is significantly higher than others due to several factors. The population living in these kebeles is very poor, with a lot of commercial sex workers. High light of the problem in each kebele is presented below.

Kebele 15/16 found in Arada sub city with a lot of problems related to HIV/AIDS. There are a lot of commercial sex workers. The other kebele found in Arada Sub city under NORAD funded project is kebele 10. This place is very old in its history and found at the center of the city. Famous places like ''Atilet Tera'', ''Doro Menakia'' ''Talian Sefre 'and ''Eri bekentu'' are found in kebele 10 with higher proportion of destitute population. The area is a commercial center with a lot of drinking houses and commercial sex workers. This kebele is visited by many people around the surrounding and from other sub cities which make the situation of HIV transmission at a higher rate with the all possible favorable condition. According to the FGD participants there are 300 PLWHAs and 1000 orphan children. It is expected a lot of others who have not exposed their HIV status. ISAPSO is assisting 50 PLWHAs, 100 OVCs. Abebech Gobena and esmiko assist 400 children. The rest 500 OVCs have not got any assistance so far.

The people in 01/02 are mainly old and 'pensionists'. The rest are poor and their livelihood is based mainly on selling leaves and wood. Most of the women collect leaves from the surrounding forest for sell. In the process rape is common and regularly reported at the police station. Even those who are taking care of children are raping those who live with them especially step fathers are reported regularly. Those who migrate from rural areas are living in this kebele and are the potential source for HIV transmission. Unwanted pregnancy and abortion is common especially among the adolescent group due to rape, abduction and high proportion of youth who migrated from the rural area. Due to this the occurrence of abandoned children documented in this kebele is higher than the other parts of the city.

The other kebele under the intervention of NORAD Project in Yeka Sub city is 08/15 around Shola area. This kebele is formed by merging of the former kebels 07.06,05 and 01. Shola market is found in this kebele, visited by many people from the town and from the rural communities makes the HIV transmission worse than other places. Especially kebele 07 is known by ''Ankorecha'' – illegal house construction to the hill side and awareness of the people living in that kebele is poor, rape is common and this situation is very difficult. In this kebele there is misissconception among PLWHAs. They mainly expose themselves not to stop the transmission of the diseases but only they expose to get the assistance provided by NGO and government.

The FGD participants confirmed that orphan children in the four kebele are with high magnitude in number and severe compared to the rest of the kebeles in the city. As they witnessed the major factors to lose their parents and exposes them to vulnerability is HIV/AIDS. On top of this they have also witnessed that other factors like rape abduction, unwanted pregnancy, poverty, rural urban migration contributed a lot to having a large number of OVC in the four kebeles. In some kebeles like 01/02 orphan children migrate from rural to this kebele to seek assistances from NGOs.

The opinion of the FGD participants in relation to PLWHAs and OVC is quite promising. They have under lined that the current assistance they get from NGOs and GOs is only to solve short term problems. For sustainability and to solve the problem for longer time the community members should clearly take the situation as their own problem. Hence, the coordinators of NGOs and GOs must network themselves to guide the CBOs to generate all possible income to solve the problem of the community by themselves.

5.3 Activities performed and results achieved /outcome under the project

Based on the document review from project proposals and annual reports, information obtained from Key informants the activities performed under the NORAD project in Yeka and Aerada Sub cities can be categorized into five areas including:

- BCC
- Home Based Care
- Assisting PLWHA
- Assisting OVC and
- Capacity Building

5.3.1 Document review

Under The behavioural change communication category increasing awareness of HIV/AIDS and safe sexual practice among the communities are the major exercise performed in both sub-cities by Mary Joy and ISAPSO. According to the document review from AA Plan Program unit the major activities performed under BCC mainly includes peer education using coffee ceremony, strengthening anti Aids clubs and members, teaching the mass communities through religious leaders and other activities.

The home based care providers assist PLWHAs and OVCs by arraging coffee ceremony. In the year 2006, Community Health facilitators and Home based care providers launched coffee ceremonies in various areas where women has less access to information and they discuss issues on HIV/AIDS openly over the ceremony in traditional way. More than 1,050 women are reached to bring about behavioral changes in their sex life.

The objective of supporting OVC's is to reduce risk of exploitation and abuse through knowledge of keeping themselves safe. The skill training provision to elder OVC's also aims for improving their future life and to assist their young brothers and sisters. In 2006, 66 elder OVC's attended 4 months to one year vocational skill training in the process of making youths self supportive. Monthly feeding support is provided for 540 OVC's Clothing, shoes and uniforms are provided for 420 OVC's. School materials are provided for 444 OVC's, as a result the OVC's are attending their education as their basic needs fulfilled. School fee is covered for 136 OVC's who are attending in private school due to lack of public school.

The business management training was organized for a target group of people living with the virus, PLWHA. The training aims at providing skills in making their own business. On the other hand, it will contribute to changing the attitude of the community towards that PLWHA's can work and live with the virus. In line with this, in 2006, waving training was

provided for 11 PLWHA's and started with the production of local costume. Machineries are purchased and financial support is provided as a start up of business. 123 PLWHA's are provided with nutritional, physiological, medical and financial support.

In relation to capacity building, in 2006, two VCT centers that are constructed at Yeka and Arada sub- cities are completed, inaugurated and handed over to the sub cities health bureau. The Plan/Mary-Joy VCT center has providing service immediately with its own medical staffs from its health institution. VCT, PMTCT and CD4 count is fully done in the center. OPD service for 452, diagnostic laboratory service for 21 and health education given for 195.people from December 1st 2006. Whereas the Plan/ISAPSO VCT center had started its service. Other area of capacity building is giving training for health workers, committee members and leaders of CBOs

5.3.2 Observation of partners

To understand activities performed under NORAD project areas in the two sub-cites and in the four kebeles, 12 FGDS have been conducted with Kenbele HIV/AIDS committee members, Home based care providers and Indri leaders (three at each kebele and twelve in the 4 kebeles). On top of this, 36 key informant in-depth interviews have been conducted mainly with Kebele HIV/AIDS committee members to express their observation about their project in their respective kebekles (9 from kebele and 36 from the four kebeles).

According to the partners in kebele 15/16, a tremendous activity has been performed by organizing children and youth who have the capacity and interest in music and foot ball. This group created awareness on HIV/AIDS by entertaining the community. Such approach helped the children and the youth to play a key role in awareness raising and building their capacity in music and football for their future carrier. On top of this encouraging AACs and community conversations has been conducted. Training was given to HBC providers for 21 days and assigned them to give appropriate HBC services for PLWHAs and OVCS. Assistance is provided for OVCs and PLWHAs. Under capacity building A five story building is constructed in the compound of Baeta clinic and space given for VCT services, 60 PLWHA and 70 OVCs have been organized under saving and credit scheme under '' Tiret lwetet association'' and has reached to the capital of 80,800 Birr in two years time. This is one of the best practices observed in this kebele under this project.

In Kebele 10, community awareness has been performed through coffee ceremony. 39 HBC providers got training and are giving service for PLWHAs and OVCs. Uniform and other material assistance is provided for OVCs. They are encouraged to save 10 Birr from

what they got (50 Birr) and are in good position currently. They are able to maintain their house continuously by themselves. The women association gave training on saving and credit for the women group.

The partners in kebele 01.02 witnessed that different activities in the area of reproductive health, environmental health, awareness creation, assisting 120 OVC, school and health facility construction have been conducted by Mary Joy Ethiopia. The participants have also expressed that peer education is going on through the youth association. There are four Local NGOs, Mary Joy, Family Planning, CCF and Hiowot, working on HIV/AIDS in 01/02 kebele. There is no networking arrangement between these four NGOs in the Kebele. Due to this it is always possible to duplicate efforts and to provide Assistance two times for one beneficiary from the different NGOs. The Committee members at the Kebele levels are the administrator (chairman), HIV Desk (secretary), head of health and education sector, NGO, IDIR, Women Association, and youth association. The majority of them have witnessed as they got training from Mary Joy program.

Under Kebele 08/15, by integrating with the youth association awareness rising has been conducted on reproductive health and HIV/AIDS. Training is given for IDIR leaders to teach their members. Peer education is initiated through coffee ceremony. Assisted PLWHAs to get house rent in their kebele by avoiding stigma and discrimination. Assistance provided for PLWJAS and OVCs.

According to the FGD participants from Idir there is an encouraging contribution by cooperating to teach community members at meeting places. Training is given for Idir leaders who discussed for several times to change their bylaws to be involved in the assistance of PLWHAs and OVCS on top of the funeral ceremony. Some Idir leaders who got training from ISAPSO and Mary Joy are in the process of forming networking among the different IDIRS in their respective kebeles to organize themselves for income generation activities and assist PLWHAs and OVCSs. The case study shown in the following box reveal that IDIR should also participate in BCC on top of income generating activities by presenting different cases in their community .

Case 1: IDIR Leader

The first case study is with IDIR leader who is living in Yeka sub city, kebele 01.02 in house numbers 255. He is 11th grade and his occupation is private business. He is 40 years old and one of the executive member the IDIR. . His birth place is in Addis Ababa growing up in the same city. He is the secretary of ''Chefe Tebabari IDIR''

Once up on a time he met a beautiful lady on the street. He said that I introduced my self to her and here response was inviting. Finally we agreed to perform sex and moved to a hotel. At that time I was not having condom in my pocket and could get even one in the hotel. I informed her as I do not have condom with me at that particular time. She replied that you can do it even with out condom. I performed unprotected sex with out using condom. In the process she gets examined for HIV and found to be positive. I have not yet examined my self due to fear and suspect. In the future he will have the courage to get examined to know his HIV status.

As IDIR leader he is selecting OCs for assistance in his kebele and gets satisfied when the affected target are getting the support. He also complain when some families come for assistance with out at least exposing the sick person

From his experience he advises that any individual should not make any mistake at any point for getting pleasure for a second. He advises that all the hotels must put condom at least in each room as one of the necessary material. He promised and dedicated that as IDIR leader to teach the community for behavioral change and also to facilitate the issue of assisting OVCs and PLWHAs by generating income under his kebele.

The FGD participants with HBC providers revealed that their number who got training in each kebele has reduced significantly since some left the job, some died and other left to other places. They have expressed as they have got training for 21 days on the principle of home based care and assisted mainly PLWHAs who were bed ridden. They visit them for three days in a week time. Concerning PLWHAs who were bed ridden they prepare them food, wash their cloth, and clean their houses till they get better to stand by themselves. They bring the assistance like nutrition, money, soap and others regularly from Mary Joy and ISAPSO. They provide them with the necessary counseling and advice to solve their physiological problem. Concerning OVCs, they visit them 3 days a week and provide them advice, follow their education performance, follow assistance they receive from Mary Joy and ISAPSO whether they get according plan and other issues.

Based on the response of the partners some of the major outcomes in both project areas include:

- ❖ PLWHAs get appropriate medical /both opportunistic infection treatment and ART/ and nutrition supplements through the project effort in helping them together with the nearby health facilities .
- ❖ OVCs were provided with different academic materials so that they are capacitated in their school condition to learn more successfully.
- ❖ Home Based care givers were providing the service to bed ridden patients and OVCs
- ❖ Orphans and vulnerable children got counseling services from their psychosocial groups conducted by home based care givers and community elders.
- ❖ Capacity development to health workers (CBRHAs) in order to develop uniform quality of HBC services and to ensure synergy and linkages amongst all HBC service providers.
- ❖ Increased the participation of women by selecting them as HBC providers
- ❖ Effective and efficient referral system implemented as referral linkages.
- ❖ Appropriate nutritional and education material support was accessed for OVC and PLWHAs

In general, according to different respondents the project was very relevant, effective and efficient in the above output areas. It assisted the community to know their status through VCT. Those who know their positive status disclosed themselves and teach the community by explaining their experiences. The partner's of the project appreciated the achievement gained in different issues. They have also mentioned as they were cooperative from their side for the success of the project. They contributed professional support during training, follow up, and participate on VCT in holidays and vacations.

5.4 The intervention from Beneficiaries Perspective

According to the focus group discussions conducted with beneficiary mainly PLWHA and OVCS Home based Care is a service provided by volunteers assigned by NGOs to assist PLWHAs (mainly bed ridden) and OVCs. PLWHAs especially those who are bed ridden are getting assistance 3 days in a week. OVCs also need physiological assistance, recreation, food and medical assistance. The HBC providers is also providing services for orphan children 3 days a week and the assistance include advice, follow up in education and other issues. PLWHAs expressed that the home based care designed in their kebele is very important to get physiological relief, food, medical treatment and shelter. The OVCS have also expressed that the advice given by the HBC providers, food and medical assistance help orphan children to follow their education properly.

Both PLWHAs and OVCs defined quality HBC service as:

- Good physiological support , advice from the HBC providers
- True HBC provider who are volunteer, sincere, interested and clearly understand our problem
- Adequate food provision

- Adequate medical treatment
- Sustainable assistance

Both PLWHAs and OVCs have expressed the service at the beginning of the project was satisfactory in terms of quality and quantity. The situation has decreased from time to time in terms of food provision and other benefits. PLWHAs have complained that after getting better they are replaced by other group by interrupting their support. This leads the situation to a viscous circle where they face the same problem again and gain. Both PLWHAs and OVCs stressed that the project should find means of creating IGA for guardians and PLWHAs who can work after getting better to create a sustainable solution.

The FGD participants expressed that on top of the volunteer HBC provider's parents by avoiding stigma and discrimination, health professionals and religious leaders participation make the service complete. The advice or counseling given by parents, health workers and religious leaders really assist to have a better philological treatment among PLWHAS and OVCs. Hence, these three targets can give this service by program on different intervals arranged by the coordinators of the project. .

In general to improve the HBC service they have suggested that:

- HBC providers needs always refresher training
- Make the service sustainable
- Include parents , health workers and religious leaders regularly on the counseling
- Form groups or association among PLWHAs and OVCS found in each kebele
- Reduce stigma and discrimination significantly

Stigma and discrimination was a serious problem when the project started. This has significantly reduced in many directions. This has been also observed under the quantitative information of this evaluation. PLWHAs, still insist that the program should continue for total eradication of stigma and discrimination by avoiding the misconceptions circulating in the community... For total eradication of stigma and discrimination community conversation and IGA for PLWHAS should be in place. The community members have to see and be convinced that PLWHAs can work for themselves and lead their life. It is only when they observe such situation that a respect and equal treatment can be in place in the community.

Under the participatory action research Orphan children who live with guardians participated in the four kebeles. This group expressed as they were facing insult from school mates at the beginning. This has significantly improved currently and the majority of the students are good for them. They produced drama and essay on the importance of mother love. They have expressed as they are still remembering their mothers and fathers.

Very few of them witnessed as the guardians are not equally treating them like their biological son or daughter. All of them witnessed as they get some food items such as oil sugar, Flour, teaching materials such as exercise book, pen, soap, uniform and other necessary materials from Mary Joy and ISAPSO. They expressed their deepest thank for PLAN Ethiopia. Some of them also expressed as the assistance given for them is shared among family members. They have produced drawings, poem and essays on the importance and love of mother and on the importance of education and assisting OVCs by NGO

Both beneficiaries have suggested seeing the assistance provided for PLWHAs and OVCs from two angles. The first is the temporary assistance provided by the different NGOs in their kebele. The service given by HBC providers, food and medical assistance and others should continue since there are individuals who have no yet exposed themselves and still in their beds. They stressed the focus should be more on the second issue to bring a sustainable and permanent solutions for the problem. For this all actors working in the kebele like NGOs, GOs, CBOs and influential community members should sit down and discusses seriously on how to generate income to be self sufficient to take the problem as their agenda and give a sustainable solutions. They have suggested two alternatives for the permanent solutions. The first is to empower guardians of orphan children and PLWHAs by saving and credit scheme or IGA to solve the issue individually. The second alternative is to organize themselves in groups and involve in group IGA by creating a sustainable income generation activities.

Detailed information was collected from the main beneficiaries of the project especially OVCs and PLWHAs who benefit most from the home based care services. Others like the guardians or care takers of OVC, club members and commercial sex workers. Response of the key informant in-depth interview for five various groups are presented below.

5.4.1 PLWHAS

Key informant in-depth interviews were conducted from 16 PLWHAs (4 at each kebele) on the type of care they received by the intervention. Seven different questions were presented for them and their response is highlighted below.

Type of home based care they received under serious condition:

- HBC providers visit us three days in a week. They clean our house, wash our body, cut our nails and others
- They provided us with the necessary awareness on HIV related issues
- They assisted me during operation
- Using gloves they move the patient from one side to the other and provided good care

- They bring us to our home all the food and other assistance
- They take us to the hospital when we get sick
- They follow us to take our ART drug regularly and properly
- None and No adequate care

Among the 16 respondents only one said none and the other said no care for me. The rest 14 PLWHAs witnessed as they received the different types of care. This is also witnessed by the HBC providers and the FGD participants

Among the 16 respondent 6 have said that the service is adequate, 3 said fair, 4 said that It is not adequate and no comment from the remaining three. Some have expressed the service at the beginning was good but currently reduced; the number of visit by HBC providers should not be limited only to three days. It should be more , if possible daily.

Among the 16 respondents 12 of them said that the service provided for PLWHAS who are in bed driven suggested the following improvent since It lacks the following:

- The number of visit , only for three days is not enough and should be improved
- The counseling part should be improved, more advice should be there to assist themselves and others , especially the community members not to expand the disease
- The finical support is not enough
- Stopping the support after getting better- need serious consideration

PLWHAs respondents have seriously underlined the problem of stopping the assistance with out further IGA or credit and saving scheme mainly in the three kebeles (01/02, 8/15 and 10). It is only in kebele 15/16 under ISAPSO project area where PLWHAs who were bed driven got skill training and provided with IGA after their health status improved. This is a good start for the project and the rest should take the experience from kebele 15/16 on how to replicate the issue in their kebeles based on the resources availability.

Among the 16 respondents 10 of them have started ART and one of them has stopped using the drug which is encouraging and needs further follow up seriously. The rest 6 have no yet started ART.

Case 2: PLWHA

The second case is a lady who is living with the virus. Currently she is living in Yeka sub city kebele 08/15. She is 28 years old and has completed 6th grade. After she came from her country in Addis Ababa she was employed as a maid servant in a house hold where the owner was single in his marital status. One day he raped her and found her self HIV positive when examined. After that even she could not get a chance to get employed since the new clients could not understand her problem. Her situation got worse and tried to live with her friend and became bed ridden

One day when she was discussing the issue with her friend she told her as she got information on the assistance provided by Mary Joy. Their HBC providers found her in her friend house and gave her the necessary assistance. Her health condition improved and stands by herself after receiving the nutritional support including their advice. She witnessed that Mary Joy is her father who saved her life from death.

From her experience she advises all women to take the maximum care when they work as maid servants in different houses. She also advises patients who are chronically ill to get the right assistance on time. They have to know as there is hope for life.

According to PLWHAs some of the gaps observed include:

- There are still some individuals who have not exposed themselves, the potential danger for transmission
- The increased number of beneficiaries compared to the resource available by NGOs is high. This clearly recalls the great involvement of the community to solve the problem in time as the number is expected to rise when those individuals who have not exposed are starting to expose.
- The reduction of assistances from time to time due to high number of beneficiaries
- Delay in release of funds and delay to get assistance on time
- Lack of proper arrangement to get a sustainable solution after PLWHAS gets improved and start to work

5.4.2 OVCs

A total of 16 OVCS were interviewed on the service they got from the project. Among these, 7 of them have lost both mother and father, 3 only father, 3 only mother and the remaining three who are heading the family. They have witnessed as they get 100 Birr every three months, uniform, medical services, educational materials, and nutrition.

Among the 16 OVCs 13 of them have confirmed as they are visited by HBC providers regularly every three days. The rest three complained as they were not visited by HBC providers. Among the 16 OVCs the majority, 14 of them have not faced any form of stigma and discrimination from any side while one respondent said that this was at the beginning but decreased gradually and the other one complained as he still facing stigma and discrimination. Almost all of them confirmed as they get the assistance given through their guardians except one. All of them witnessed as their guardians are treating them equally with their biological children. All OVCs who are heading the family in kebele 15/16 have got skill training. Some of the OVCs have expressed the importance of giving IGA for their guardians to make assistance sustainable.

All have expressed that means of sustaining the current assistance till we finish our education is critical and some expressed as there is a need to assist them even for higher education.

Case 2: Orphan

The third case is an OVC who is living in Arada sub city in Addis Ababa. After completing her education till 10th grade she could not pass the exam for higher education. She still struggled and took the exam for hotel and truism. She passed the exam and that day was her happiest day in her life.

When she remembers the death of her mother and her father that day was the worst for her. She advises that children should have a vision and should not get easily fed up. The struggle should be by tiring alternatives.

5.4.3 Guardians of OVC

Among 16 guardians interviewed from the four kebeles 15 of them witnessed as orphan children are remembering their parents except one who said that she does not remember as she grow up with me stating from infancy. 13 guardians confirmed as the HBC providers are visiting them regularly, 2 said not at all and one said irregularly. All of them expressed as they are giving the assistance they received for the children properly. The guardians stressed as the number of OVCs is increasing it will be hard to solve the problem by waiting for the assistance of GOs and NGOs. They recommended means of generating income individually and through CBOs like IDIRS and others. The community should see the problem as their own, hence local resource mobilization should be enhanced from every direction. They have also expressed in parallel to the awareness creation program on BCC on modes of transmission and prevention of HIV/AIDs the community should be aware on the importance of self sustainability to take the problem of PLWHAs and OVCs. They have also recommended the follow up of HBC providers in advising children on the importance of their education should continue in a more strengthened manner

5.4.4 Club members

Club members were asked on responsibility of members and other related issues on BCC. The respondents have confirmed as they participated in the sensitization of RH and HIV/AIDS using different strategies. The club members confirmed as different behavioral change is observed in kebele 01/02, 15/16 and 10 on modes of transmission, prevention and on stigma reduction while those from 08/15 have complained as they have not participated in the project. About half of the club members confirmed as girls participate in their clubs while the remaining expressed as it is not enough and they face family pressure not to attend as club members. Again club members from the three kebeles witnessed as they got different support in training and material from the project while those from Kebele 08/15 said none. The club members have suggested that future intervention programs must still work with club members to prepare entreating educational materials. It appears that club members from kebele 08/15 are not satisfied and are not working with the project which might need further discussion with them in the future.

Case 4: Club member

The fourth case is a club member who is living in Arada sub city .He was born in August 1972 in Ethiopian Calendar. His religion is Muslim. . He has completed 12th grade, the first 1-6 in Ethiopia Tikdem and the rest in Yekatit comprehensive high school. .

He has always a dream to go to America and always complete the DV form every year where he hasn't succeeded any year. He forces his parents to do some arrangement with a lady who got the DV and his parents paid a lot of money for the arrangement. After all this arrangement when was examined on his HIV status he was found to be positive. That day was his worst day and decided to commit suicide. However, due to efforts of his friend his life was saved and now he serving as a volunteer as a club member. He is always regretting the expense he incurred for his parents .

He advise the youth as they should take the maximum care in the area of HIV if they want to full fill their vision and hope in their future life. He also advises the youth and other community members to think two or three times before incurring cost for any thing they do before ahead.

5.4.5 CSWs

The commercial sex workers confirmed as they use condom for protection. Some of them expressed that the quality of condom is not good. There is a tear in the process. Some also reported as there some clients who refuse to use condom. To solve the problem of tearing, there should be a follow up in the quality control of condom regularly. For the second problem, CSWS should be empowered to say no for clients who refuse to use condom and to design legal protection in this direction. A quarter of the interviewed CSWs witnessed as they are receiving skill training. Still all of them are looking for job in the future. There is a good effort in kebele 15/16 to organize CSWS and work in cafeteria. The others reported that there is an effort of educating CSWS on condom use and there is a free distribution of condom while half of them say there is no effort. The CSWs have expressed their feeling that studied skill training that enable them to have alternative job must be in place in their kebeles.

5.5 Problems observed and solutions attempted

Some of the major problems identified by the respondents in the area of BCC, home based Care, OVCs and capacity building is listed below:

- In the area of behavioral change, some complained as there are groups of youngsters who still resist accepting the awareness program. The CSWS complained as their environment force them not to abstain or to be one to one. Concerning the condom some complained on the quality and on the refusal of their clients to use condom. Some youth clubs are not doing their job as expected and do not use the instrument they got for awareness raising. Some club members and organized groups abuse the assistance given for BCC.
- In the area of HBC providers some forget as they are volunteer for the program and try to see them as a permanent employee. Thy complained in Mary Joy area as they were informed not to continue as HBC providers in the future.
- In the area of OVCs four major problems can be sited. The first is their number is very large to be accommodated with the limited fund available by GOs and NGOs. The second is duplication of efforts by the NGOs working in one kebele. One orphan is changing his/her name and receive assistance from three NGOs when others getting none. The third is the problem selection. Though every care is there to be fair and critical based on set criteria, there are reports where the eligible are selected and getting assistance. The fourth is rural - urban migration. In kebelle like 01/02 and 08/15 who are found near the rural communities some come from the peasant associations to get assistance and to be helped as OVC. There is also rural –urban migration especially in 01.02 and other kebeles who come to the city for the sake of getting assistance.
- In the area of PLWHAs the dependency syndrome is a problem from their side and lack of intensive follow to provide them with the appropriate IGA or saving and credit scheme from the organizers side Some have not also exposed themselves
- The problem with the capacity building of CBOs is at its infancy stage with disorganized manner. There is a good start in giving training of DELTA for Idir members and due to this some IDIRS have changed their by laws to focus on development issue mainly solving the problem of HIV/AIDs rehabilitation program. But the organization of IDIRS even at kebele level is disorganized. Some women IDIRS also complained that some NGOs are only focusing on men IDIR.

The solutions attempted by the project coordinators is discussing the issue in their quarter review meeting and giving solutions by all partners.

5.6 Outcomes/results of this project in terms of KABP, Stigma, VCT, Care and Support

5.6.1 Current KAPB, Stigma and VCT using selected indicators

Table 3 presents Current knowledge using selected indicators among adult and youth respondents. 100% of the respondents have ever heard of HIV/AIDS. Still the majority of the respondents over 93% of them know at least two modes of transmission of HIV. Knowledge on modes of prevention is better compared to transmission. In all cases over 96% at least know two modes of prevention of HIV/AIDS. About 14.3% of the adult respondents believe that a health looking person cannot have HIV/AIDS while the corresponding figure among youth is 12.3%. About 10.3% of the adults reported at least one misconception while the youth reported (7.8%).

Those who reported at least one stigma attitude towards PLWHAs ranges between 23.9% and 26.3%. among adults and the youth respectively. Percent of respondents who discussed about HIV/AIDS with spouse/partner/opposite sexes is 68.2% among adults and 63.3% among the youth. Those who discussed among family members are higher among youth (68.8%) when compared with the adults (63.3%). Percent respondents who tested for HIV are 59.7% among adults and 47.0% among the youth. Those who are willing to uptake HIV-VCT is higher among youth (94.7%) and a beat lower among adults (89.5%).

A higher proportion of the youth who performed casual sex have used condom (74.1%) than adults (69.4%)

Table 3 percent of knowledge, miss conception, stigma, discussion, VCT, and causal sex under the current assessment in Addis Ababa among the adults and the youth, December 2007, Ethiopia.

Variables	Adult	Youth
% Ever heard of HIV/AIDS	100	100
% Who know at least 2 modes of HIV transmission	94.5	98.4
% Who know at least 2 ways of avoiding HIV/AIDS	98.3	99.7
% who believe that a healthy looking person cannot have HIV	14.3	12.3
% who reported at least one misconception regarding the Possible routes of HIV transmission	10.3	7.8
% who reported at least one stigmatizing attitude towards PLWHAs	23.9	26.3
% ever discussed about HIV/AIDS with spouse/partner/opposite sex	68.2	63.3
% ever discussed about HIV/AIDS with members of family	63.3	68.8
% who have taken HIV testing in the past	59.7	47.0
% who are willing to uptake HIV-VCT	89.5	94.7
% who reported condom use in the last casual sex (among those who reported casual sex)	69.4	74.1

Table 4 presents percent of respondents who believe that a healthy looking person cannot have HIV by background characteristics considering age, sex, education and number of sources of information among adults in the project area. This indicator was found to be significantly different by age where the middle group 25-34 was found to be in a better position when compared to the younger and the older group. It forms like a bell shape of normal distribution where the better position is at the middle and the worst in the two extremities. As expected and usually documented else where the educated group is significantly in a better position compared with the illiterate. This clearly shows that encouraging the community to avoid illiteracy assist even the prevention and control of HIV/AIDS. The other interesting finding observed under the current assessment is that those respondents who got information from three sources and above are significantly ($p<0.000001$) better in this indicator. Those with better number of sources of information are by far in a better position. Multi media approach is by far better more than a single media approach. This has to be encouraged in the community to provide community members information from all possible sources in the project area.

Table 4 Percent of respondents who believe that a health looking person can not have HIV by back ground characteristics among adult respondents in Shebedino

Back Ground Variable	**% who believe that a healthy looking person can not have HIV**	**P value**
1. Age		
15-19	33.3	0.10100
20-24	16.7	
25- 34	6.7	
35-49	15.4	
50*	17.4	
2. Sex		
Male	17.1	0.1423
Female	12.5	
3. Education		
Can R &W	12.9	0.745
Illiterate	15.1	
4. No of Source Of information		
One	23.2	0.057
Two	43.8	
Three +	19.9	

5.6.2 Changes in KABP, Stigma and VCT

The changes in KABP regarding HIV/AIDS and sexual behavior among adult and youth is captured from the quantitative information generated in the project area and the qualitative information collected under key informant in-depth interview and FGD participants.

Table 5 compares major indicators between the current result with the baseline survey in the area of information coverage, knowledge on modes of HIV transmission and prevention, misconception, stigmatization, VCT, discussion among partners and families on HIV/AIDS and their sexual behaviors among the adult respondents. Like the baseline survey and as expected all respondents have ever heard of HIV/AIDS. There is a little difference on knowledge of respondents who know two or more modes of transmission and prevention. A significant difference is observed in the area of misconception and stigmatization. For example, during the baseline survey those who believe that a healthy looking person can not have HIV were 19.0%. This has reduced to 14.3 % with a difference of 4.7 % and with an improvement of 24.9% when compared with the original indicator. Concerning other misconception eating together, shaking hand and kissing for greeting were considered both in the baseline survey and in the current study. Percent who reported at least one misconception regarding the possible route of HIV transmission was 13.7% during the baseline survey. This has reduced to 10.3% with a difference of 3.5% and an improvement of 26.9% when compared with the original.

Concerning stigma those variables such as willing to share a meal with HIV infected person, willing to buy a food from a shopkeeper or food seller who had the AIDS virus and willing to care a family member who has HIV or AIDS were included in both the baseline survey and the current assessment. Percent who reported at least one stigmatizing attitude towards PLWHAs was 55.4% during the baseline survey. This has significantly reduced to 23.9% ($p<0.0001$) under the current result with a difference of 31.5% and an improvement of 56.9.0%) when compared with the original indicator. This has been also witnessed by both the key informant in-depth interview and FGD participants under the qualitative approach. The majority witnessed that stigma has decreased significantly in this project area. They have underlined that this is the area where the project brought a significant change among the different output areas. They witnessed that disclosure of many individuals on their HIV status and the participation of PLWHAs in the BCC program and the coordinated mobilization of the community like AACs among the youth, the CBOs and FBOs contributed for this reduction of stigmatization.

Both partners and beneficiaries have expressed the discussion between community members and families have increased during the project period. This is also reflected among the adult respondent result where a difference of 25.9% is recorded with an improvement rate of 61.2% among those who discussed about HIV/AIDS with spouses/partners/opposite sex. And the difference among those who discussed with family members is 17.6% with an improvement rate of 38.5%.

According to the FGD participants and KII the next outstanding change observed due to the current project is the increasing demand of the community members for voluntary counseling and testing. VCT up take has increased from 41.6% to 59.7% with a difference of 18.1% and an improved rate of 43.5%. Similarly those who are willing to test and who used condom during causal sex has significantly increased among the adult group

Table 5. Comparison of KABP, Stigma and VCT indicators regarding HIV/AIDS between the current result and the baseline indicators among adult female (n=300), Addis Ababa, December 2007

Variables	Female		Male		Both	
	Baseline	Current	Base	curr	B	C
% Ever heard of HIV/AIDS	100	100	100	100	100	100
% Who know at least 2 modes of HIV transmission	89.8	93.3	89.8	95.7	88.3	94.5
% Who know at least 2 ways of avoiding HIV/AIDS	97.0	98.3	97.0	98.3	96.8	98.3
% who believe that a healthy looking person cannot have HIV	25.7	11.7	12.2	17.0	19.0	14.3
% who believe that HIV can transmit through eating /drinking tighter	9.6	7.7	9.8	6.3	9.7	7.0
% who believe that HIV can transmit through shaking hands	4.6	3.7	4.1	3.1	4.3	3.4
% Who believe that HIV can transmit through kissing for greeting	7.9	5.3	7.8	4.8	7.9	5.5
% who reported at least one misconception	**14.1**	**9.3**	13.5	11.3	13.8	10.3
% Not willing to share a meal with HIV infected person	16.2	13.3	9.8	4.3	13.0	8.8
% not willing to care a family member who has HIV or AIDS	36.8	14.0	46.6	6.0	41.7	10.0
% not willing to buy a food from a shop keeper or food seller who had the AIDS virus	17.8	22.0	10.1	10.3	14.0	16.2
% who reported at least one stigmatizing attitude towards PLWHAs	52.9	31.0	**57.8**	**17.0**	55.4	23.9
% ever discussed about HIV/AIDS with spouse/partner/opposite sex	61.4	57.7	23.1	78.7	42.3	68.2
% ever discussed about HIV/AIDS with members of family	63.0	61.3	28.4	65.3	45.7	63.3
% who have taken HIV testing in the past	40.3	55.7	42.9	63.7	41.6	59.7
% who are willing to uptake HIV-VCT	77.2	88.3	79.7	90.7	78.5	89.5
% who reported condom use in the last casual sex (among those who reported casual sex)	23.1		33.3		28.1	69.4

Table 6 present the comparison of KABP, stigma and VCT indicators in the project area among the youth. Concerning ever heard information and knowledge on at least two modes of transmission and prevention showed a difference when it is compared with the baseline survey. The difference is not much and not statically significant concerning those who ever heard information on HIV/AIDS. This is mainly attributed to the fact this indicator was in higher percentage even during the baseline survey. A significant difference is observed in the reduction of misconception and stigmatization which was also witnessed by the focus group discussion participants and key informant in-depth interview. Discussion of the youth with partners in general with opposite sexes was at the minimal stage during the baseline survey among the youth. This has improved significantly under the current survey. This can be mainly attributed to the encouragement and the capacity building process conducted for the youth to mix and discuss with opposite sexes. Though discussion with the community and family members was in a better position even during the baseline survey it has also improved significantly under the current assessment. The demand for VCT is also in a better position under the current assessment when compared with the baseline survey which was also witnessed by the qualitative respondents. The other interesting indicator is the change observed among those who used condom during casual sex. This has improved by far when compared with the baseline survey and it has also been witnessed by the FGD participants as the demand for condom use has increased in the project area.

Table 6. Comparison of KABP, Stigma and VCT indicators regarding HIV/AIDS between the current result and the baseline survey among youth (n=300), Addis Ababa, December 2007

Variables	Baseline	Current	Difference	% improved
% Ever heard of HIV/AIDS	100	100	0	0
% Who know at least 2 modes of HIV transmission	96.7	98.4	1.7	
% Who know at least 2 ways of avoiding HIV/AIDS	98.7	99.7	1.0	
% who believe that a healthy looking person cannot have HIV	16.3	12.3	4.0	24.5
% who reported at least one misconception regarding the Possible routes of HIV transmission	11.8	7.8	4.0	33.9
% who reported at least one stigmatizing attitude towards PLWHAs	47.3	26.3	21.0	44.4
% ever discussed about HIV/AIDS with spouse/partner/opposite sex	45.3	63.3	18.0	28.4
% ever discussed about HIV/AIDS with members of family	53.8	68.8	15.0	27.9
% who have taken HIV testing in the past	35.2	47.0	11.8	25.1
% who are willing to uptake HIV-VCT	85.9	94.7	8.8	10.2
% who reported condom use in the last casual sex (among those who reported casual sex)	64.1	74.1	10.0	15.6

5.6.3 Change in Care and Support (HBC, Assistance for OVCs and PLWHAs)

Through the project time a lot of changes have been observed by training HBC providers and provided them with kits. Due to their referral linkage efforts many individuals with HIV/AIDS disclose their HIV status to get the necessary assistance by the project. The HBC providers also participated in the screening of OVCS who are seriously affected in problem to fulfill their livelihood. On top of assisting PLWHAs the HBC providers also participated in giving counseling services for OVCs in their respective kebeles. This is intact a good start as one of the major problem of OVCs is a psychosocial problem on top of fulfilling their minimal lively hood such as shelter, food, health and education. All these services are the out put of the project which changed the service and the home based care component. All these have been confirmed by the qualitative study subjects through the KII and FGDs.

The assistance provided in the form of nutrition supplement, educational facilities for OVCs are a good start to open the way for sustainable community based supports in the future. This assisted the OVCs to continue and follow their education in the project area.

The care and support program changed the attitude of PLWHAs to teach the community by telling their experiences that contributed to the reduction of stigma and the increased demand for VCT in the project area. This has been witnessed by the quantitative information, the KII and FGD participants who are partners and beneficiaries of the project. The assistance given by HBC providers is appreciated by the respondents for PLWHAs who were bed ridden. The key informants witnessed as they saw many individuals who were nearly to die but get better and stand by themselves after they get the assistance of HBC providers. HBC providers also assisted PLWHAs by taking to the appropriate health facilities and by advising them to start ART.

5.7 Organizational experience, dissemination, Lessons learnt, best practices

5.7.1Organizational experience

Sub city Level:

Kebele Level: HIV/AIDS activities at the community level are coordinated by the Kebele level HIV/AIDS committee. The Committee members at the Kebele levels are the admintrator (chairman), HIV Desk (secretary), head of health and education sector, NGO, IDIR, Women Association, and youth association. In most of the kebeles 3 and above NGOs are working in the kebeles. For example in Kebele 01/02 Mary Joy, FAGE, Hiowot and others. Networking of NGOs working at different kebbeles is very crucial that must get due consideration. The net working is very important not to duplicate efforts and to work together for a common goal by uniting tighter. NGOs like Mary Joy and ISAPSO give comprehensive services where there are some NGOS working only on PLWHAS or only on OVCS. This should be clearly documented by the kebele HIV Desk to share the different responsibilities for he NGOs based on their expertise. In a similar manner these NGOs also must unite and pull resources together to capacitate IDRS at kebele level. This has been suggested by the IDIR leaders. They are approached by different NGOs to organize their activity in one kebele which cannot be practical and feasible to organize different groups in one kebele. Instead the NGOS can unite and pool resources to organize on strong organized IDIR at kebele level to ensure sustainability of the assistance of OVCS and PLWHAs in their kebele in a systematic and organized manner.

Partnership issue Mary Joy and ISAPSO/Plan:

In order to examine partnership issue between Plan and the key partners Mary Joy and ISAPSO information is collected from Plan and Marry Joy and ISAPSO staff members on management technical capacity and other related issues. According to the information provided by AA Plan PU Both partners are provided with the necessary manpower and equipments. Both partners prepare quarter reports and this report is presented for all partners found in the Kebeles to discuss the issue to take the corrective measures on time. Both partners submit their financial report on time.

Concerning the planning, yearly operational plan is prepared by the two partners. This will be presented for all partners including community members to incorporate comments of partners. After incorporating comments the operational plan is implemented by all partners concerned based on their responsibility.

5.7.2 Lesson Learnt

According to the opinion of FGD participants and KII respondents some of the lesson learnt from this project includes:

- The community can be changed and start to assisting each other if they see volunteers to assist PLWHAS. In this direction the HBC providers can be seen as an example to nitrate the community members to assist even their family members when they face the problem of HIV/AIDS
- Approaching chronically ill patients in a friendly manner encouraged to expose their status to teach the community and to assist themselves with hope of leading their lives in the future.
- This project showed that PLWHAs can be treated and can lead their life by their own by working together with the people.
- The introduction of ART free of charge initiated PLWEHAs to expose their HIV status and contributed significantly to reduce number of bed ridden patents
- They have stressed that the partnership approach can assist to conduct the intervention effectively. The partners found at district level assisted in mainstreaming the issue of HIV/AIDS with their program which can ensure sustainability. More over, the partners have also learnt that the partnership approach assisted them to avoid unnecessary duplication
- In the process of BCC repeated and multi dimensional strategies must be in place to get a success. Hence, providing the community with different sources of information can assist to bring a better attitudinal change to perform better behavioral change in the community. This was also observed under the quantitative approach where those who got information from three or more sources have reduced miss conception significantly.

- There is also a lesson learnt that the participation of CBOs like idirs and FBOs like religious institutions assisted for better behavioural changes in the reduction of stigma and discrimination, to increase demand for VCT.
- Under the current project there is also a lesson drawn that Assisting PLWHAs encouraged more individuals who live with the virus to disclose their HIV status. This in turn increased the demand for VCT among community members both in the urban and rural areas. and others to take VCT.
- There is also a lesson learnt that the integrated approach of considering prevention, service, care and support has brought the significant change in most of the indicators set under the project. For example the different prevention strategies applied in prevention reduced stigma and discrimination and increased the demand for VCT, condom use and STI services. This in turn encouraged people to disclose their HIV status to create association. PLWHAS again participated to teach the community by sharing their experienced which contributed for prevention.

5.7.3 Best Practices

Some of the best practices of the current project identified by respondents include:

- The existence of the saving and credit scheme to solve the economic problems of women
- The effort to reduce stigma and discrimination through coffee ceremony and community conversation
- The contribution of the volunteer HBC providers in the assistance of PLWHAS who were bed ridden and the psycho-social support given by this target to enable OVCs to continue their education properly
- Establishing close relationship with IDIR, kebele HIV desk and other partners at Kebele level assisted ISAPSO to implement their object smoothly. This is observed in kebele 15/16 where the kebele provided them a discussion hall for all the activities
- Encouraging children to participate on music and sport competition at keel 15/16 is documented as one of the best practices in this project for effective BCC by entertaining the community members and building the capacity of children in their future career.
- The rewarding system established for HBC providers in Kebele 15/16 under ‘’Tiret Lewtet ‘ is one of the best practices observed under this project to be replicated in other kebeles
- The effort started to capacitate IDIRS leaders by giving DELTA training and initiating them to start a systematized income generating scheme is one of the best practices documented under this project which must be pushed forward for its realization in the next phase of the project
- The free VCT services and providing volunteers a card at any occasions is one of the best practices that must continue in the future.
- The initation of memorial fund at kenbele 15/16 is considered as one of the best practices as it leads and encourage the way to local resource utilization

5.7.4 Documentation and dissemination of project activities.

Efforts made on documenting, analysing and disseminations of promising practices for advocacy and scaling up identified by the respondents is promising and presented below.: -

- Educational leaflets, T-shirts and posters were prepared and distributed to the community.
- Experience sharing activities were done within the community.
- Efforts were made to distribute quarterly, six-months, nine-months and annual reports to responsible GOs and NGOs.
- Efforts were made to utilize reports during planning sessions and decisions making.
- General activities of the project were analysed and presented in different workshops to make the intervention conducted as evidence based

5.8 Critical gaps and suggested interventions to fulfill the gaps

5...8.1 Behavioral Change communications

The behavioral communication is the core activity concerning HIV/AIDS in any community to promote the use of condom, to reduce stigma and discrimination and to encourage community members to use voluntary counseling and testing. The current project has brought a significant change especially in reducing stigma and discrimination and promoting the use of VCT up take in the four Kebles of NORD project areas. Some of the critical gaps identified by the FGD participant and key informants under BCC component include:

- Rape and Abduction- In the two project keels 01/02 and 08/15 women livelihood is mainly depending on colleting leaves from the forest and sell in the town. In the process, rape and abduction is reported as a common phenomenon that repeatedly occurs among women residing in the two kebeles. To solve such problems awareness raising and legal protection must be in place.
- Low participation of girls in clubs- The club members and some key informants have stressed that some parents do not allow and send them to involve in anti HIV clubs both in School and out of school areas. Mothers through the coffee ceremony intervention must be aware on the importance of girl's participation under clubs even to protect themselves and to assist others.
- Problems related to CSWs- the FGD participants and the CSWs themselves have expressed the difficult situation of their profession to protect themselves from HIV infection. They have also stressed that the quality of some condoms is not good and clients are not cooperative to use condom. CSWs must be empowered to refuse those clients who force them not to use condom and legal protection in this direction must be in place. More importantly those involved under skill training must be encouraged to change their profession. The training must be studied in such a way to assist them to get a job after graduation
- Attention to Night school students: Most of the night school students are maid servants in different houses. The only place to get this target is during night school events. The FGD

participants have suggested to give due consideration for this target group during the BCC activity.

5.8.2 Home Based Care Services

Home base care services are the core element of the project which contributed significant role in the care and support program of OVCs and PLWHAS. The home based care program in all the four kebeles have brought a significant change especially in assisting PLWHAs who were bed ridden by providing physiological support, medical treatments, assisting in food cooking and providing nutritional support. However, some of the critical gaps identified by the respondents in this area include:

- Misinterpretation of voluntarism: Some of the HBC providers in kebele 01/02 and 08/15 complained as they will be no more continuing their service in the future. This clearly indicates that they are assuming their job as permanent and forgotten that their participation is on volunteer basis.
- Lack of arranging reward for HBC providers: Both key partners at the project areas have witnessed that the effort and the contribution of HBC providers have brought a tremendous significant in the area of care and support both for PLWHAs and OVCs. It has been suggested by the respondents that to give reward by involving these targets on IGA and saving and credit scheme to make them self sufficient in their future lives. A good example of this trial is observed in kebele 15/16 under ISPSO project area where this best practice must be replicated for other project areas.
- Additional refresher training for HBC providers: Currently due to the free distribution of ART it has been reported that the number of bed ridden PLWHAS have decreased significantly. The HBC providers can still assist OVCs by following them with necessary advice to attend their education properly. They can also follow up PLWHAs not to stop the ART drug. In the mean time the HBC providers can also assist in other reproductive health activities in their kebele by providing family planning service and other community based development issues. To use the capacity of HBC providers at the maximum they should be provided with additional refresher training in the future project intervention

5.8.3 OVCS

The support given for OVCs by the project for the limited number of OVCs has contributed a lot to continue their education properly including their psychosocial problems. Some of the problems observed under the OVCs intervention which were reported as critical gaps include:

- The Availability of limited fund : In all the four kebeles it has been reported that there are also other factors such as poverty, unwanted pregnancy and rural-urban migration which lead children to be orphan and vulnerable on top of the HIV/AIDS. Due to this their number is growing from time to time. Though over 2 NGOs on the average are involved in assisting OVCs still there are a lot who have not get the service due to the limited budget they have to provide assistance for all of them. This clearly calls the participation of the community through influential CBOs like IDIR and religious institutions to generate fund from all possible local resources to give assistance for affected children in sustainable manner
- Duplication of efforts: The other critical gaps observed on the OVCs intervention are the duplication of efforts of NGOs. There are some OVCs who receive assistance from two or more

sources when some are deprived of any assistance from any source. It was also reported as some children are coming from the rural areas just to share the assistance of OVCs in the different kebeles. This clearly show that the planning of NGOs working in a certain kebele must be arranged in solving such problem

- Lack of IGA for guardian of OVCs: this has been identified as one of the serious issue that must get due consideration in further intervention programs. Gordian of OVC can not always receive assistances from NGO for longer period of time. They should be empowered to be self sustained individually and in group to generate income in a sustainable manner. The involvement of CBOs like IDIr will play significant role in this direction.

5.8.4 PLWHAs

The current project has contributed in assisting bed ridden chronically ill patients to get better and stand by themselves. In the process the following critical gaps have been identified by the respondents of FGDS and KII,

- Dependency syndrome: Though most of PLWHAs believe that self sufficient is very important for them in their future live still there are also who want to get assistance through out their life time. Some even complained as the assistance provided is decreasing. PLWHAs must understand that the support given for them should be till they get better and able to start to work for their lively hood
- Low efforts to assist PLWHAs to be self sufficient. All the respondents have stressed that PLWHAs must be provided with IGC after they get up from their bed. Though efforts must be in place by themselves to look for job for their livelihood the coordinator of the project must assist and device where and how to get IGA that can fit and go with their condition. Further study must be conducted on the type of skill training to give for them that assist them to work in their life time. Individual and group IGA can be assed and coordinated to put this target to be self sufficient after they get better from their diseases.
- Formation of group: Based on their number and coverage areas, PLWHAs must be advised to form a group at least at Keble level, if not an association. When this happen they can discuss their problem together and can be organized to solve their problem tighter. They should also for a link with other kebeles and with the regional associations like mekedem to share experiences and assistances.
- ART: Based on the KII most of PLWHASs in the four kebeles have started ART . There is also a fear by some respondents that some are stooping ART and looking for holy water. This is a dangerous trend and must be checked by all concerned especially by the HBC providers to avoid drug resistance in the community .
- Encourage those hidden at home to expose: It has been reported as there are still some PLWHS but did not expose themselves. These are the potential targets for HIV transmission. HBC providers with he community members must identify these group and encourage them to report their problem for appropriate counseling , treatment and other services

5.8.5 Capacity building

Under capacity building the project has conducted different training program for partners and mainly CBOs leaders specially IDIR. Those key partners or kebele HIV/AIDS committee members are

applying their training on the implementation of the project. This will also assist them to take over the project during phase out strategies. More importantly the capacity of CBOs like IDOR must be strengthened and empowered to generate the necessary income for OVCs and PLWHAs who are chronically ill and bed ridden. The training given as DELTA for many IDIR leaders has assisted to change their bylaws to include development and HIV/AIDS in their specific areas. Some of the critical gaps identified by respondents include:

- The level of Organizing Idir is at its lowest stage; The FGD participants from the IDIR members themselves have witnessed as they are interested to organize themselves properly and generate income to assist OVCs and PLWHAs. Some IDIRS leaders appreciated the approach of ISAPSO and want to be organized properly. Some have said that here are NGOs who are not cooperating with them. Concerning IDIRS the NGOs working at kebele and sub city level must network themselves and organize at least to form IDIR group at kebele level. This group can network with other kebeles and organize at sub city level. But the ground work at kebele level must be realized. . Some Women group IDIR must also get due consideration to form their group separately or on their own at kebele levels.
- Lack of local resource mobilization: The problem of ensuring sustainability for OVCs and PLWHAs must get due consideration in the next phase of the project. However, experience in using and identifying local resource mobilization is at its infancy stage in both project areas and in other places of the community. This must be studied further to identify local resources and pooled together to use it for generating income by CBOs and by all concerned.
- Lack of job after training. The other critical gaps reported by guardians of OVC, PLWHAs and CSWS is the problem of getting job after skill training. For this two solutions are suggested by the respondents. The first is to study and design the skill training at the beginning that have demand for job. The second solution suggested is that those coordinators in the project areas must discuss with GOs and private sectors how to absorb the individuals who got the skill training.

5.8.6 Miscellaneous

On top of the above project component areas the FGD participants and KII respondents have observed the following critical gaps and suggested future solutions in the following miscellaneous issues.

- Lack of Networking among NGOs working in one kebele: This gap is almost observed in all kebeles of the current project areas. For example, in Kebele 01/02 there are four NGOs working on HIV/AIDs like Mary Joy, FGAE, and Hiowot etc. Due to this there duplication of efforts and mainly observed on the assistance provided for OVCs and IDI. It has been observed when one OVC is getting from three sources when others are getting none. Concerning the trading of IDIRS some leaders got training from different NGOs. To solve such problem, the planning should be excised at kebele level with the HIV Desk who is the secretary of the committee. Their efforts and plan must be filling the gap not working the same issue by all of them. The documentation of the HIV Desk at kebele level should be strong to identify the current on going project and activities that are on board for assistance and encourage the new comer to fill the gap based on their documentation.

- Frequent turn over of partners at kebele and sub city level: This has been reported several times by NGOs working in different kebeles. There are frequent turn over of heads of different sectors who serve as a potential partner of the project. It takes some more time till the new assigned person study the project. For this problem again very effective documentation must be in place at kebele and sub city level. When the former head is getting transfer to other places he/she must leave enough documents for the new comer.
- Missing of succession planning component: Plan has rich experiences on succession planning completing memory book by PLWHAs on their will and property. This assists a lot for Voss to get protection on their parent's property. There are frequent occasions where some guardians or care takers promise to assist Voss for the sake of taking their family property. After they take their property the send them away from their home. To safe guard such in human acts succession planning and encouraging completing memory book by PLWHAs is an important additional component for the project in its future direction.

6. CONCLUSION AND RECOMMENDATION

6.1 Conclusion

In many families, HIV/AIDS affects the breadwinner of the family. Consequently, the family's economic support cripples making them more vulnerable. In addition, affected families need resources for care and support. In the project area, majority of the population lives below the poverty line, struggling to make ends meet and HIV/AIDS further exacerbates the problem. Affected families are in need of economic resources to meet their basic needs. To ultimately end or reduce the problem related to HIV/AIDS adequate prevention, control, care and support program must be in place in both rural and urban communities in Ethiopia. The current project is in response to solve these problems in Addis Ababa in Yak and Arada sub cities. The project focuses on five major components that include BCC, home base care, assisting to OVCs and PLWHAs and capacity building.

The current assessment has shown as there is an impact brought in the community by the different actives performed in the project area. In general, based on the current assessment and by comparing it with the baseline survey the consultant team concludes the following relevant points.

- Most of the activities planned under the five component areas are successfully completed. Under the prevention component a wonderful community mobilization focusing on the youth religious leaders, mothers have been performed by strengthening AACs, youth forums, peer education and community conversation. Under the care and support component training of HBC providers and providing kits, assisting PLWHAs and OVCs with nutrition, medical care and counseling have been performed.
- The successful achievements of the project in the different activities have been reflected in change of knowledge, attitude, practice, and behavior of the adult and the youth in the project area.
- Information coverage is almost 100% among the adults and 99% among the youth. There is a difference (1 to 2%) among those who identified two or more correct methods of transmission and prevention
- A significant change is observed in the reduction of misconception towards the transmission of HIV/AIDS among the adults and the youth.
- Concerning stigma the change is significant with a difference of 31, 5% and 21% among adults and the youth respectively.
- Comparison of the current result with the baseline survey has showed significant increases on the discussion conducted between partners/spouse/opposite sex, family members and willingness for VCT with a difference of 25.9%, 17.6% and 11.0% respectively among adults. In a similar manner the positive difference among the youth (8%, 15.0% and 8.8%) has also showed an increasing trend on discussing issues between partners/spouse/opposite sex, family members and willingness for VCT. As witnessed by KIIs and FGD participants, the change in openly discussing issues among the adults and the youth assisted for community members to tell the true during interview sessions
- The change observed on VCT-uptake is also significant among the youth and adults.

- The critical gaps observed in the area of the five components should get due consideration in future intervention strategies.

6.2 Recommendation

The current project has achieved most of the activities planned. Due to this a significant changes have been observed in the area of BCC, care and support. We believe the current project is a good start. We also want to expressed much remain to do more work that lead to sustainability by strengthening, Sub City capacity, the kebele office and the community at large to take over the work of this project .We also believe that more efforts should be exerted in the future to strengthen the current strategies and to fill the identified critical gaps to mitigate the problem of HIV/AIDS. Hence, the consultant team has put the following recommendations to be implemented in the next phase of the project activities.

1. The current project started by addressing prevention, service, care and support in an integrated manner. This is a good start as prevention; services, care and support strengthen each other. For example efforts conducted under prevention like BCC reduces stigma, misconception and lead the demand for VCT services and condom utilization. This will make alert the service providers to make available services like VCT, condom and STI. The demand for VCT service assists people to know their HIV status and to disclose for the public which calls for care and support activities. The consultant team recommends that such integrated approach should continue to mitigate the problem of HIV/AIDS in the project area. in all directions. To succeed such prevention, services, care and support activity in an integrated manner community mobilization and sectoral mainstreaming plays a significant role in the process of intervention and has to be strengthened in a sustainable manner.

2. To strengthen community mobilization and mainstreaming of sectoral offices, roles of different actors should be clearly identified at the beginning of the project. The role of different actors in future intervention strategies should focus more on capacity building and rehabilitation work to enable the community take over the problem of OVCs and PLWHAS including the prevention component. HIV/AIDS Committees found at different kebeles chaired by the kebele leader and having the HIV Desk as secretary should work more intensively than the first phase of the project by encouraging and strengthening CBOs, FBOs and AACs to participate in income generating activities to generate adequate resource to assist PLWHAS and OVCS in their respective kebeles. The government organizations especially Sub city and kebele HAPCO and NGOs Mary Joy, ISAPSO/ Pan should work in partnership to coordinate the project activities by giving more responsibility for the community. They can provide technical assistance in the form of training on financial management and other issues. Networking of NGOs participating at different kebeles should be considered as a crucial step by coordinators of the program both at kebele and sub city level to avoid unnecessary duplication of efforts. Strict guideline should be put at kebele and sub city level that new NGO joining the kebele should work to fill the gap not to duplicate other NGOs.

3. Community mobilization can play a significant role in the prevention of HIV/AIDS by strengthening and encouraging CBOs, FBOS, etc. AACs both in and out of schools who should to teach the youth in the school community and the surrounding should be strengthened. The AACs both the in and out of school should be encouraged to interact and to share experiences and plan together on how to reach the grass root level . Both the in and out of school AACs should also be encouraged to recruit more girls as a members in their clubs. They should also be given a guidance to encourage girls to take the position of leadership under the club. Encourage Youth forum to arrange different panel discussion for AACs leaders, youth association leaders to discus on HIV/AIDS issue and on the effective implementation of the project among the youth... Strengthen the music and sport competition stated at kebele 15 /16 under IAPSO project areas. Try to give prizes for those who contributed for the project. Empower the women group and place legal protection those who faced the problem of rape and abduction in Kebele 01/02 and 08/15. Empower CSWs to refuse clients that do not use condom in any sexual performance and enforce the legal protection in the process. Initiate school health education for night schools to fill the gaps of housekeepers/ maid servant in different kebeles

5. Continue with the mass sensitization through community mobilization, peer education, CC and encourage the education by religious leader, PLWHAs, elders and community leaders. Encourage the community members to increase their demand on the use of condom during casual sex as observed in the current results. Give attention to encourage the VCT centers established by the two partners to fulfill the demand for VCT. Encourage the community members to get immediate treatment when they face STI by explaining its importance on the reduction of HIV transmission.

6. Encourage the current trained HBC providers to participate in counseling, refereeing and other BCC activities. Encourage also PLWHAs to serve as HBC providers. HBC providers should clearly be informed and understand as their responsibly is on volunteer basis to avoid their expectation to be a permanent staff after a certain period of service. Lay out the ground work on how to reward those HBC providers after they completed their assignments like that of HBC providers under Kebele 15/16 in ISAPSO project area. Give additional refresher training for HBC providers to involve them in other RH activities and development programs on top of assisting OVCs and the few number of PLWAHAs who are bed ridden. Encourage them to follow up the ART process to minimize interruption of ART users in their kebele.

7. The support given for OVCs like the nutrition support, educational materials should continue in the next phase of the project. Bur more focus should be given for CBOs and FBOs to generate sustainable income to accommodate and solve the lively hood of OVCs found at the different kebeles. In parallel, the counseling support given by HBC providers should continue for OVCs since the psychosocial problem that children face is more or less equivalent to the lively hood problem. The duplication of efforts observed in this first phase of the project by different actors should be controlled through networking and proper planning at kebele level. The observed selections of OVCs should be corrected in future interventions. The skill training provided for OVCs that head the family should be studied further to enable them to get jobs after graduation and compete as potential bread winners in the community. Encourage graduations or care

takers of OVC to be involved in IGA and saving and credit scheme to be self sufficient in the future to sustain the program. It might be worthy to think of the micro fiancé section of Plan – Ethiopia to integrate their IGA, and saving and credit scheme for the guardians of OVCs and PLWHAs as suggested by some of the staff members in AA Plan PU and the two key partners

9. The support given currently for PLWHAs should continue. But more focus should be given on group, sub group and individual IGA to make them self sufficient in the future. On top of, the IGA program PLWHAS should get skill training to get employment opportunity under government office and in the private sectors. Hence, the focus of the project in the next phase should be more on enabling PLWHAS to be self sufficient. The skill training should also be given for OVCs who are leading and serving as household heads. After the training give even priority for any job opportunity. The idea of dependency syndrome and the concept of PLWHAs can work should be exercised by motivating them to participate in all possible opportunities that fit for PLWHAs. The HBC providers should encourage those PLWHAs who have not exposed them selves to come out to teach the community and to get the necessary support for them selves. The follow p of HBC providers to minimize the interruption of ART drug by PLWHAs should get a serious attention in future program intervention. The coordinators and key partners at keble levels should encourage PLWHAs to form a group to share their experience and discuss their problem and to link with the association found at sub city or regional level

10. The capacity building component of the project is encouraging for the past three years. The community appreciated the two VCT centers in both project areas and will contribute a lot to full fill the demand of VCT in their kebeles. If possible a similar exercise can be in place in school construction as this has been raised by the FGD participants. More importantly the capacity building training started for IDIR leaders should be pushed further to organize them at kebele level and provide them with the necessary support to generate income to assist OVSCs and PLWHAS by theme lese to ensure sustainability of the program. The capacity building of partners should also continue both in training and material assistance to enable them to take over the project during exit strategy.

11. The managerial , organizational, technical support , monitoring exercise that were practiced by AA plan PU, the two key partners , other stake holders and the community at large should c be encourage and continue in the next phase of the project. The review meeting held among partners quarterly should be exercised in a more strengthen manner starting from planning, implementation and monitoring to ensure for the smooth running of the project both at kebele and sub city level

12. The consultant team believes the project cannot stop at this stage. It is a good initiation, a good start and some remarkable performance and changes have been observed. How ever, we feel that the project is at the beginning stage with encouraging out come. To ensure sustainability and to hand over the project for the community much remain to build the capacity of all actors at different levels especially at the community levels at kebele and sub-kebele stages. Hence, we strongly suggest that the next phase of the project should focus on capacity building work to enable the community to stand by their own to take the problem by themselves. Hence, the focus

of the project in the next phase should be more on rehabilitation activities by encouraging the realization of local resources funds. The memorial fund raising activity started in kebele 15/16 is a good example in this direction that should be shared for other kebeles and also by looking other possible and alternative sources.

13. From the experience and evaluation documents of Plan Shebedino and Bugena has shown that succession planning and completing memory books protects the property of OVCs and their rights in their future life. We believe it will be use full if this exercise is included in the current project as additional component to make the program more comprehensive. Hence it will be good to Encourage all PLWHAS to complete the memory books.

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8. ANNEXES

Annex one Data collection instruments for the quantitative Information

a) Data Collection instrument for ever married women and men (Q1)

Plan Ethiopia
HIV/AIDS and family planning
Questionnaire for femelle
Questionnaire number_____
Instruction: - Only female between age of 15 up to 49 must be included in the study

Program unit_____ Woreda/ sub city_____
Kebele/ _____ House number _____
Place of study_____ 1. Urban_____ 2. Rural_____

No	Information collector's name	Date of information gathering		
		Day 1	Day 2	Day 3
1	Completed			
2	They are not found tin the house			
3	Partially completed			
4	-Time the Questionnaire started - Time the questionnaire ended			

Note of the Supervisor

_____
_____

Name of the supervisor _____.

Signature of the supervisor_____

Part 1. General information

No	Questions	Answer/chooses	Pass
101	Age	In full year_____	
102	What is your religion	1. Orthodox 2. catholic 3. Protestant 4. Muslim 5. others specify _____	
103	Can you read or write	1. yes 2. No →	107
104	Do you take regular education	1. Yes 2. No →	107
105	If yes grade completed		
106	Marital status	1. Married 2. widowed 3. Divorced 4separated 5spouse	
107	age when you first get married	_____	
108	do you work outside of the house to generate income	1. yes 2. no	
109	do you have the following item in your house	Yes No Farming land 1 2 Cattle 1 2 Hoarse/mule 1 2 Donkey 1 2 sheep/got 1 2 radio 1 2 Electricity 1 2 Electric oven 1 2 TV 1 2	
110	Your roof is made up of what?	1. Metal 2. Cement 3. wood and mud 4. Grass 5. other specify	
111	what is the average income of your family		

Part 2 HIV/AIDS

2.1 General knowledge and attitude about HIV/AIDS

No	Questions	Answers/ chooses	Pass
201	Have you ever heard about a disease AIDS?	1. Yes 2. No →	
202	If yes from where or from whom did you heard about AIDS? Do not read choice for them. They can give more than one answer. Try to get additional answer by saying what else and circle all answers provided.	1. Radio/TV 2. Newsletter/books 3. leaf lets/ poster 4. From representative of maternal health workers 5. Health worker 6. church/ Mosque 7. From program organized in the community 8. Market place 9. from friend/family/relative 10. others specify	
203	How is HIV/AIDS transmitted? Do not read choice for them. They can give more than one answer. Try to get additional answer by saying what else and circle all answers provided.	1 sexual intercourse 2 Form a mother to her baby 3. By sharing sharp things 4. By taking infected blood 5. through injured body 6. Do not know 7. Others specify_____	
204	Can a person protect himself for HIV/AIDS	1yes 2. NO ⟶	206
205	If yes how? Do not read choice for them. They can give more than one answer. Try to get additional answer by saying what else and circle all answers provided.	1. Abstinence 2. to be faithful to your partner 3. to use condom 4. to reduce number of sexual partner 5. not to take blood from others 6. not to share sharp things 7. others specify_____	
206	Can a health looking person have HIV/ AIDS?	1. yes 2. no	
207	Can HIV/AIDS be transmitted by eating with HIV patient	1. Yes 2. no	
208	Can HIV be transmitted by shaking hands with HIV patient	1. Yes 2. no	
209	Can HIV/AIDS transmitted by kissing HIV patient for greeting	1. Yes 2. no	
210	For the next 12 months do you think you are at risk of getting HIV	1. Not at risk 2. little risk 3. medium risk 4. High risk 5. Do not know	
211	Are you willing to eat food with HIV patient?	1. Yes 2. No	
212	If any body from your family became AIDS patient do you want to keep it as a	1. Yes 2. no	

	secret		
213	If your relative become sick because of HIV are you willing to help him or to take care of him	1. Yes 2. no	
214	If you know a shop keeper or food seller is AIDS patient will you buy food from that person		
215	Did you discuss about HIV/AIDS with opposite sex(including your partner)within the last 12 months	1. Yes 2. no	
216	Within the last 12 months did you discuss about HIV/AIDS with your family including your children	1. Yes 2. no	
217	Have you every get tasted. Do not tell me your result but did you get tasted	1. Yes 2. no	
218	Do you want to get tasted in order to know your result	1. Yes 2. no	
219			
220	IS there anybody in your community that help HIV patients	1. Yes 2. no	

Part 3 sexual behavior

301	Have you ever had sexual intercourse	1. Yes 2. no	
302	In life time how many sexual partner do you have		
303	With how many people do you have sexual intercourse within the last 12 months		
304	within the last 12 months do you have sexual intercourse with a person who is not your husband	1. Yes 2. no	
305	For how long did you stay in relation ship with this person/ if it is below a month write number of days/		
306	How old is he/she		
307.	Did you use condom the last time you had sexual intercourse	1. Yes 2. no	
308	Did you discuss about HIV/AIDS with this person	1. Yes 2. no	
309.	within the last 12 months was there unusual fluid that come out of you genital		
310	within the last 12 months was there injury or around your genital area	1. Yes 2. no	

b) Data Collection Instrument for the youth (Q2)

Plan Ethiopia

HIV/AIDS study

Questionnaire for youth

Questionnaire number_____

Instruction: - Only single youth's between the ages of 14 up to 24 must be included in the study

Program unit_____ Woreda/ sub city_____

Kebele/ _____ House number _____

Place of study_____ 1. Urban_____ 2. Rural_____

No	Information collector's name	Date of information gathering		
		Day 1	Day 2	Day 3
1	Completed			
2	They are not found tin the house			
3	Partially completed			
4	-Time the Questionnaire started - Time the questionnaire ended			

Note of the supervisor

_____

_____

Name of the supervisor _____.

Signature of the supervisor_____

Part 1. General information

No	Questions	Answer/chooses	Pass
101	Age	In full year_____	
102	What is your religion	6. Orthodox 7. catholic 8. Protestant 9. Muslim 10. others specify _____	
103	Can you read or write	3. yes 4. No →	107
104	Do you take regular education	3. Yes 4. No →	107

105	If yes grade completed		
106	Currently are you learning	1. Yes 2. No	
107	What is your occupation	1. Farmer 2. merchant 3. civil servant 4. Student 5. Not a student but job less 6. Others	

Part 2 HIV/AIDS

2.1 General knowledge and attitude about HIV/AIDS

No	Questions	Answers/ chooses	Pass
201	Have you ever heard about a disease AIDS?	3. Yes 4. No →	
202	If yes from where or from whom did you heard about AIDS? Do not read choose for them. They can give more than one answer. Try to get additional answer by saying what else and circle all answers provided.	11. Radio/TV 12. Newsletter/books 13. leaf lets/ poster 14. From representative of maternal health workers 15. Health worker 16. church/ Mosque 17. From program organized in the community 18. Market place 19. from friend/family/relative 20. others specify	
203	How is HIV/AIDS transmitted? Do not read choose for them. They can give more than one answer. Try to get additional answer by saying what else and circle all answers provided.	1 sexual intercourse 2 Form a mother to her baby 3. By sharing sharp things 4. By taking infected blood 5. through injured body 6. Do not know 7. Others specify_____	
204	Can a person protect himself for HIV/AIDS	1yes 2. NO ⟶	206
205	If yes how? Do not read choose for them. They can give more than one answer. Try to get additional answer by saying what else and circle all answers provided.	8. Abstinence 9. to be faithful to your partner 10. to use condom 11. to reduce number of sexual partner 12. not to take blood from others 13. not to share sharp things 14. others specify_____	
206	Can a health looking person have HIV/ AIDS?	3. yes 4. no	
207	Can HIV/AIDS be transmitted by eating with HIV patient	1. Yes 2. no	
208	Can HIV transmitted by shaking hands with HIV patient	1. Yes 2. no	

209	Can HIV/AIDS transmitted by kissing HIV patient for greeting	1. Yes 2. no	
210	For the next 12 months do you think you are at risk of getting HIV	6. Not at risk 7. little risk 8. medium risk 9. High risk 10. Do not know	
211	Are you willing to eat food with HIV patient?	3. Yes 4. No	
212	If any body from your family became AIDS patient do you want to keep it as a secret	1. Yes 2. no	
213	If your relative become sick because of HIV are you willing to help him or to take care of him	1. Yes 2. no	
214	If you know a shop keeper or food seller is AIDS patient will you buy food from that person		
215	Did you discuss about HIV/AIDS with opposite sex(including your partner)within the last 12 months	1. Yes 2. no	
216	Within the last 12 months did you discuss about HIV/AIDS with your family including your children	1. Yes 2. no	
217	Have you every get tasted. Do not tell me your result but did you get tasted	1. Yes 2. no	
218	Do you want to get tasted in order to know your result	1. Yes 2. no	
219			
220	Are you part of anti-HIV club	1. Yes 2. no	
221	IS there anybody in your community that help HIV patients	1. Yes 2. no	

Part 3 sexual behavior

301	Have you ever had sexual intercourse	1. Yes 2. no	
302	When you start sexual intercourse how old were you?		
303	How old were the person that you had sexual intercourse.		
304	If you remember the first time you had sexual intercourse which of the following describes it. Read all the choose for them.	1. voluntarily 2. I Was pushed 3. I was blackmailed 4. I was forced 5. I was raped	
305	Did you ever receive any money or gift in	1. Yes	

	exchange of sex?	2. no	
306	did anybody force or heart or scare you to have sexual intercourse		
307	In life time how many sexual partner do you have	1.	
308	do you perform sexual intercourse with the last 12 months	1. Yes 2. no	
309	For how long did you stay in relation ship with this person/ if it is below a month write number of days/		
310	How old is he/she		
311.	did you use condom the last time you had sexual intercourse	1. Yes 2. no	
312	did you discuss about HIV/AIDS with this person	1. Yes 2. no	
313.	with how many people do you have sexual intercourse within the last 12 months		
314	did you perform sexual intercourse with a prostitute within the last 12 months	1. Yes 2. no	
315	within the last 12 months whit how many prostitutes do you perform sexual intercourse		
316	did you use condom during the last sexual intercourse you had with a prostitute	1. Yes 2. no	
317	within the last 12 months was there unusual fluid that come out of you genital	1. Yes 2. no	
318	within the last 12 months was there injury or around your genital area	1. Yes 2. no	
319	What are the risk of performing sexual intercourse at an early age before 18 years?	1. More chance of HIV transmission 2. Early pregnancy 3. Unwanted pregnancy 4. Unwanted abortion 5. Others (specify)	

Annex two Data Collection Instrument for the qualitative information – Key informant In-depth Interview (KII)

Name of the supervisor _____.

Signature of the supervisor_____

a) KIIQ1 – Key Informant In-depth Interview for staff members

1. Address
   1.1 Region 1.2 Zone 1.3 District

2. Identification
   2.1 Sex 1) male 2) Female
   2.2 Age _____.
   2.3 Marital status
   2.4 Religion
   2.5 Occupation
   2.6 Educational level

3. Was the project relevant for the community ? What can you say on its effectiveness and efficiency
4. What is your opinion on behavioral change of the community on HIV transmission, stigma and discrimination, care and support , VCT etc
5. What have you observed in relation to home based care (HBC)

6. What did you do in encouraging program communities to establish systems for succession planning for families affected by HIV/AIDS?
7. What did you do in establishing and supporting psychosocial support groups/association among PLWHA and OVC in the program areas
8. What did you perform in Building local capacity and coping strategies and implementing as well as replicating sustainable community based HIV/AIDS prevention, care and support interventions
9. What did you perform in addressing livelihood related **Vulnerabilities** in rural contact
10. What Lessons have you learnt and best practices document in the process of the project
11. What experiences have you gained in implementing projects, like this one, with local partners in terms of organizational arrangement, leadership, financial management, logistics, staffing

12. What efforts have you made documenting, analyzing ,dissemination promising practices for advocacy and scaling up

13. What is your opinion on sustainability of the project

14. Other related issue

b) KIIQ2 – Key Informant In-depth Interview for Partners

Name of the supervisor _____.

Signature of the supervisor_____

1Adress

1.1 Region 1.2 Zone 1.3 District

2 Identification

2.1 Sex 1) male 2) Female

2.2 Age _____.

2.3 Marital status

2.4 Religion

2.5 Occupation

2.6 Educational level

3. Was the project relevant for the community ? what about its, effectiveness and efficiency

4. What did you perform and contributed for the success of the project objectives and out put

5. Do you think the project brought Changes in KABP regarding HIV/AIDS and sexual health among women, youth and adult men in the project areas

6. What is your opinion in Reducing risky sexual behavior in the study area?

7.What role did the project play in Mitigating and reducing the negative social and economic effects of the epidemic on families and children(both girls and boys)and allowing them to live with dignity

8. What was the significant contribution of the project in Addressing the impact of HIV/AIDS on the living conditions of OVC and PLWHA in both operational areas?

9.Did the project play in reducing stigma and discrimination attitudes towards PLWHA/OVC among the target population

10.Has the demand increased for confidential HIV/VCT services

11Did the project contributed in Improving STI case management at hospital or health center level (ask DHO)

12How is gender issues entertained during the project implementation?

13 What was your contraposition and project contribution Providing quality home based care services for OVC and PLWHA and other chronically ill people

15. What are your efforts in documenting, analyzing ,dissemination promising practices for advocacy and scaling up
16. Partnership issue , OSA/PLAN

a. Management

- Are you getting the necessary management support from Plan/OSSA in Dessie, Awassa /AA?
- Do you think the project is properly staffed?
- Do your offices equip with the necessary office materials to run your business effectively?
- Do you plan your work daily, weekly, monthly, quarterly etc? Can you show us samples of your plans? Do you have any problems regarding planning?
- Do you receive the necessary support from government partners? What do you suggest to improve your partnership with theses bodies?
- Any other comment?

B... Technical

- Are you receiving any technical support from Plan/OSSA in Dessie/Awassa/Addis in what ways? At what frequency?
- Explain how your project involves the community and beneficiaries in planning, implementation and monitoring?
- How do you see your project in terms of technical quality, management quality and clients and project office relationships?
- Are you able to document and share your best and promising practices for others? Explain with examples?

c. Reporting

- Can you explain us the reporting procedures in this project?
- Are you able to produce quality reports on time? If not explain your problems? Do you get feedback from Plan on time?
- Are you clear with the reporting format? (for both narrative and financial)
- Do you have any problem in liquidating your expenses at the PU? Do you have any other comments in this regard?

- Are you able to liquidate your expanses as per the agreement OSSA entered with Plan? If not explain?

d. Capacity building

- Does the project build the capacity of the project office and staff properly? Explain how was it?

- Do you have any suggestion regarding capacity building in the future?

c) KIIQ3 – Key Informant In-depth Interview for Beneficiaries

Name of the supervisor _____.

Signature of the supervisor_____

1Adress
1.1 Region 1.2 Zone 1.3 District
2 Identification
2.1 Sex 1) male 2) Female
2.2 Age _____.
2.3 Marital status
2.4 Religion
2.5 Occupation
2.6 Educational level

3. What benefit did you get from the project in information on HIV modes of transmission

4. What benefit did you get from the project concerning care and support

5. What benefit did you get on HBC from the project

6. Do you support the sustainability of the project

7. What should be done to sustain this project ?

8.What do you suggest in the area of BCC, VCT, care and support in your community in the future?

9.Any other related issues

Annex 3 Discussion points for the FGD to be conducted with partners and beneficiaries.

Annex 3 –FGD1 Discussion points with partners. There will be 11 FGDs in one district , one at district level and the rest in the ten PAs/kebeles

5 What are the most important needs of OVC (Orphans and Vulnerable Children) and PLWHA in this community? Who should be responsible for fulfilling these needs in this community? What was the most important contribution of the coalition project in this regard?

6 What are the most common problems that leave children orphaned in this community?
What are the common problems faced by orphans in your community and mentions some of the interventions contributing to alleviate these problems by the project?
- Regarding the provision of food, shelter, health care and education
- Regarding the exposure towards violence, rape, abuse and neglect
- Regarding the right of inheritance (land/house/etc.)

7 What facilities or activities do you suggest to alleviate the HIV/AIDS effects on children/OVC and PLWHA?
- What the community can contribute to this regard?
- How can children/young people participate to this regard?
- In your view how was the contribution of the project?

8 What are communities' views about the effect of HIV/AIDS on the important needs of the children, particularly OVC in the community?
   - Regarding the provision of food, shelter, health care and education
   - Regarding the exposure towards violence, rape, abuse and neglect
   - Regarding the right of inheritance (land/house/etc.)
   - Regarding stigma and marginalization

9 What have you contributed to this project success from your side

10 What are major achievements of the project on the effect of HIV/AIDS on lives of PLWHA in your community?
   - Regarding the provision of food, shelter, health care and
   - Regarding creation economic opportunities and maintaining of their livelihood
   - Regarding stigma and discrimination
   - Regarding the human and legal rights of PLWHA

11 What were the lessons learnt from the current project

12 What were the best practices

13 How do sustain the project

14 What do you think about the prevention and control activities of HIV/AIDS in the community in light of the project suitability?

14.71 What strategies do you suggest to improve the HIV/AIDS prevention and control and impact mitigation activities?

14.72 What do you think about the role of HIV/AIDS committees, NGOs and anti AIDS clubs in your community with regard to provision of care, protection and support for OVC and PLWHA?

14.73 Improving STI case management at hospital or health center level

14.74 How many health workers are trained and start providing services? How is the follow up mechanisms?

15 What are the critical gaps and what do you expect from the project in the future? in
   - Addressing gender issues in the context of HIV/AIDS
   - How is gender issues entertained during project implementation?
   - How girls are participating in preventions and care activities, their role as leaders in clubs and associations ?
   - Do the project track activities in terms of gender? Does the project keep gender segregated data?
   - Providing quality home based care services for OVC and PLWHA and other chronically ill people
   - Encouraging program communities to establish systems for succession planning for families affected by HIV/AIDS
   - How much training conducted on the subject? What were the contributions of these trainings? How is the actual implementation of this component of the project? Bring some case studies on this
   - Establishing and supporting psychosocial support groups/associations among PLWHA and OVC in the program areas?
   - How PLWHA and OVC interact to each other? What venues are being used to share common concerns? How many psychosocial support groups are established and what are the critical achievements of these groups?
   - Building local capacity and coping strategies and implementing as well as replicating sustainable community based HIV/AIDS prevention, care and support interventions
   - Addressing livelihood related **vulnerabilities** in rural context
   - How many households are caring for HIV/AIDS or chronically ill members? How many households care for OVC? How many households are headed by children or women? Qualitatively how was the impact of HIV/AIDS on these households? Are children drop out of school? How is their access to food, health care, economic and psychosocial services affected and what were the project achievements in supporting them? add some case studies as well

16 Any other related issues

Annex 3 –FGD2 Discussion points with beneficiaries.

There will be 9 FGDs with adult men and women, OVC , care taker or guardians of OVC, PLWHA and the youth

PRA method that apply SSI, FGD , wealth ranking will be applied with the adult group (women and men) . Issues will focus on :

a. Wealth ranking
b. How gender issues addressed in the project
c. Relevance, effectiveness of the project
d. Major benefit they got from the project in relation to behavioral change on modes of HIV transmission and prevention , stigma and discrimination, care and support , VCT etc
e. Major benefit related to HBC
f. Major benefit related to the support given for OVC, PLWHAs and the youth Their opinion on sustainability and
g. Others

Participatory Action Research (PAR) will be applied with children mainly OVC to enable children to express their opinion in the form of role ply, drawing , drama ,essays poem .After brief explanation for the participants . They will be allowed to present their opinion on the project benefit and future intervention strategies using drama . poem, drawing and others.

Concerning the youth, care taker or guardians of OVC and PLWHAs discussion points will include

- Relevance, effectiveness of the project
- Major benefit they got from the project in relation to behavioral change on modes of HIV transmission and prevention , stigma and discrimination, care and support , VCT etc
- Major benefit related to HBC
- Major benefit related to the support given for OVC, PLWHAs and the youth
- Lessons learnt and best practices
- Their opinion on sustainability and
- Others