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Centro Volontari Marchigiani (CVM)

Facilitated:

HIV/AIDS CONTROL

AND PREVENTION PROGRAMME

WEST GOJJAM & BAHIR DAR LIYU ZONES,

AMHARA REGION,

ETHIOPIA.

COMPARATIVE IMPACT ASSESSMENT

CCRDA

15 June to 15 July 2000

Final Report

Christian Relief & Development Association
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P.O.Box 5674

External Evaluation Team:
Dr. Gemmetchu Megersa
Ms M. Verhallen.

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TABLE OF CONTENTS

	List of Acronyms and Abbreviations	3
1.	Acknowledgements	4
2.	Executive Summary	5
3.	Introduction	8
4.	Country and Regional Information	11
5.	HIV/AIDS Situation Information	13
6.	Assessment Findings	16
6.1.	Evolution of the Programme	17
6.2.	Changes at Community Level	19
6.3.	Programme Implementation	29
6.4.	Programme organization and Management	38
6.5.	External environment	42
6.6.	Integrated approach	44
6.7.	Sustainability	45
6.8.	Unmet needs / additional activities / unintended effects	46
6.9.	Conclusions	48
7.	Recommendations	50
8.	Monitoring and Evaluation Tool	57
9.	Possible Strategies for support to Orphans	63

Separate Report: community Level Comparative Study of Intervention and non-intervention Areas, Dr. Gemetchu Megersa Anthropologist University of Addis Ababa.

Annexes

I Terms of Reference
II. Assessment Team composition
III. Itinerary
IV. Persons and groups met
V. Documents consulted
VI. Map of Amhara Region
VII. Profile of the Zones, towns and Kebelles included in the assessment
VIII. Organizational Chart and description of ANRS HIV/AIDS Control and Prevention Co-ordinating and Technical Committees
IX. List of discussions points per level
X. The Questionnaire for Individual Interviews in Urban setting
XI. The Questionnaire for Individual Interviews in Rural setting
XII. The Compilation of the Responses;
XIII. Overview of the observations at instutional level
XIV. Programme outputs:- - Distribution of IEC Materials
- Training Coverage
XV. Overview Six year budget use per activity
XVI. Health Status en Health Care Information
XVII. Main Features of the Federal and ANRS Multi-Sectoral HIV/AIDS Strategic Plans
XVIII. Logical Framework with Monitoring and Evaluation Indicators

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	-	Acquired Immuno-deficiency Syndrome
AAC	-	Anti AIDS Club
ANRS	-	Amhara National Regional State
C/C	-	Counsellors/Communicators
CDPP	-	Commission for Disaster Prevention and Preparedness (Regional)
CDC	-	Communicable Disease Control
CSW	-	Commercial Sex Worker
CVM	-	Centro Volontari Marchigiani
DAC	-	Department of AIDS Control
DAS	-	Development Agents (of the Ministry of Agriculture)
DALY	-	Disability Adjusted Life Year
DLY's	-	Discounted Life Years
DPPC	-	Disaster Prevention and Preparedness Commission (National)
ENARP	-	Ethio – Netherlands AIDS Research Project
EOC	-	Ethiopian Orthodox Church
FGAE	-	Family Guidance Association of Ethiopia
GNP	-	Gross National Product
HCP	-	Health Care Personnel
HIV	-	Human Immuno-deficiency Virus
IC	-	Islamic Council
IEC	-	Information, Education and Communication
KAB	-	Knowledge, Attitude and Behaviour
MC	-	Management Committee
M&E	-	Monitoring and Evaluation
MOA	-	Ministry of Agriculture
MOE	-	Ministry of Education
MOH	-	Ministry of Health
MOLSA	-	Ministry of Labour and social Affairs
NGO	-	Non-Governmental Organisation
OSSA	-	Organisation for social Services for AIDS
PLHA	-	Patients Living with HIV/AIDS
PHCU	-	Primary Health Care Unit
PWA	-	Person with AIDS
RCC		Regional Co-ordinating Committee
RDPPB	-	Regional Disaster Prevention and Preparedness Bureau
RHB	-	Regional Health Bureau
RTC		Regional Technical Committee
STD	-	Sexually Transmitted Disease
SCU-UK	-	Save the Children - United Kingdom
TB	-	Tuberculosis
TOR	-	Terms of Reference
TOT	-	Training of Trainers
VCT	-	Voluntary Counselling and Testing
WA	-	Women's Affairs
WAD	-	World AIDS Day
WCC		Wordea Co-ordinating Committee
WMT		Woreda Technical Committee
ZHD	-	Zonal Health Department
ZCC		Zonal Co-ordinating Committee
ZTC		Zonal Technical Committee

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1. ACKNOWLEDGEMENTS

This evaluation would not have been possible without the great co-operation of a large number of persons.
The consultants first of all would like to thank all the persons, volunteers and groups, of the visited communities, for taking the time to answer all the questions and taking part in the group discussions. They provided a wealth of information that allowed us to assess the achievements and learn important lessons for the future adjustment of the programme.
Next our gratitude goes towards the students, without their assistance it would not have been possible to gather and compile so much information in such a limited time.
Mrs Yeshi greatly facilitated the group discussions and the in-depth interviews. Her insight into the specific issues pertaining to the position of women enabled us to reach better understanding.
The members of the Co-ordinating Committees and Technical Committees that we encountered, assisted us enormously with their information, their views and experiences as well as their support for all the evaluation activities.
A sincere thank you also goes to all the officials who so willing took time to provide the required information and explanations, but also shared their concerns with us.

The CVM teams of Bahir Dar and Addis Ababa provided invaluable support through their explanations and frank discussions as well as by ensuring that most of the visits and meetings could take place in spite of the bad weather and the full schedules of the administration. Thank you very much.
We would also like to thank especially Mrs. Marian Lambert, of the CVM Italy office. Her historical perspective, in depth knowledge of the country, the health and social sector evolution and of the issues at stake in the fight against HIV/AIDS made an important difference.

To all those that cannot be mentioned here: a sincere thank you.

The writer of the report would like to express her gratitude towards her colleague evaluator, Dr. Gemetchu and the Regional Bureau of Health representatives, Dr. Wendemagegn and Dr. Tesfaye. Their knowledge and insights as well as the, sometimes heated, debates contributed to the better understanding and to a clearer discernment of the essential issues and conclusions. Working and laughing together has enriched me.

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2. EXECUTIVE SUMMARY

The West Gojjam and Bahir Dar HIV/AIDS Control and Prevention Programme for a population of around 1.9 million, in the Amhara Region, started in 1994 after a period of research and dialogue by Centro Volontari Marchigiani (CVM) with national and regional parties. Together a multi-sectoral programme was developed to enhance zonal efforts and implementation started in 1994. The first phase ran from 1993 to 1995, the second from 1996 to 1999 extended to the end of 2000. CVM deliberately opted for the role of facilitating organization to enable the local partners to take the lead role.

The long term goal of the programme is to achieve a decline in the number of HIV infected people in West Gojjam. The intermediate objectives were related to improving capacity, promoting the integrated approach; fostering behaviour change and promoting care and solidarity for patients and their families. The main activities: training; production and distribution of IEC materials; support to health structures; facilitating patient care; income generating activities and research.

OBJECTIVES AND IMPLEMENTATION OF THE COMPARATIVE IMPACT ASSESSMENT

CVM, the local partners and the funding agencies aimed to assess whether the programme is having an impact on controlling the spread of HIV/AIDS and to extract lessons for the future. As base line data did not exist, a comparison with non intervention areas was chosen to study the impact. It was realised that it would hardly be possible to assess impact by comparing infection rates as statistical data would not be available and the implementation period might be too short for behaviour change to become measurable. In strict terms the assessment thus mainly concentrated on assessing progress towards the intended impact and outcomes, and assessing which internal or external actions can increase the possibilities to achieve the impact foreseen in a sustainable way. In addition the assessment team was requested to propose a Monitoring and Evaluation Tool for the future and assess possibilities to support care of orphans in the communities.

The Assessment team consisted of two external consultants facilitated by the Regional Bureau of Health and local partners. CVM staff assisted as resource persons. An array of methods was used to collect information at community and institutional level.

SUMMARY OF THE FINDINGS

This HIV/AIDS prevention and control programme is well known and well appreciated in the intervention zones and beyond. The important achievements realised in the intervention areas:

- Knowledge about, understanding of and attitudes towards HIV/AIDS prevention and care have improved at individual, urban and rural community level;
- Participation of community members and vulnerable group members in activities is rapidly increasing, certainly in the urban settings;
- Within all the sectors and institutions, especially in the main religious institutions, knowledge, awareness, capacity to deal with the issues, and involvement in activities have been raised;
- The multi-sectoral and integrated approach are on the way and the experiences gained assist others to install similar co-operation forms;
- The programme has contributed at regional and national level to an increased awareness and understanding of the problem, the issues involved and the practice of prevention and control.

Particular strong points are:

- The significant level of concerted action and collaboration installed;
- The development and distribution of a wide range of IEC material reaching far beyond the intervention areas;
- Training at all levels and of all different partners and support to the health structures.

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Change of behaviour towards prevention of transmission, is not yet assessable. The implementation period in part accounts for this. More importantly experiences and findings indicate that, in the existing socio-economic and cultural setting, improved knowledge and awareness alone can hardly lead to behavioural change. They need to be supported by additional measures. First the level of social mobilization has to rise significantly. Secondly alternatives, for present behaviour, have to become accessible, feasible and lead to comparable benefits. For the latter the widespread poverty forms a near insurmountable obstacle.
The intended improvements of care and solidarity for patients, within the health care system and within the communities, have been partially achieved.

The main external factors hampering the programme implementation and results are:
- The low priority attached to HIV/AIDS control by administrative and political leaders;
- The shortages in infrastructure and resources, certainly in the health and social sector, due to the poor socio-economic situation;
- These shortages and present policies mean counselling and testing are hardly accessible to the majority of the population and counsellors are quite restricted in their possibilities to assist individuals and communities.

Weaknesses within the programme itself are:
- Insufficient sense of ownership of the HIV/AIDS problems and of the programme at the level of the main public actors;
- The organizational set-up and mandates, allocated to the committees, are not conducive for timely decisions on matters beyond daily practice;
- Discontinuity of staff in all sectors and levels decreases the effects of capacity building efforts and hampers progress.

Progress towards the goal and major outcome of the programme is significant. The facilitating role of CVM and the approach of the programme have forged inter-sectoral co-operation. The lessons allow to greatly improve future action and co-operation as well as assist other actors and programmes. The technical and financial resources used are modest but sustainability is still far away due to the socio-economic situation and the extent of the problem.

RECOMMENDATIONS

All available data indicate that the HIV/AIDS epidemic is still rapidly spreading in Ethiopia. This will also count for the Amhara National Regional State. New impetus is being given to the fight now that National and Regional Strategic Plans have been formulated and are being funded by international partners. However the extent and the consequences of the epidemic urge for rapid translation into intensified action as there is no time to wait behaviour change has to be hastened. To improve effectiveness the main recommendations pertain to priorities for the fight against HIV/AIDS, programme and implementation issues and CVM's facilitating role and contributions:

HIV/AIDS Prevention and Control:
- To actually turn the tide, the front line workers need to obtain public support from all leaders and authorities to break the silence. The latter have to actively partake in mobilizing society, in public and in private, in professional and individual behaviour.
- Next the fight against HIV/AIDS has to actively be given the highest priority so that attention, time and available resources really become geared to implementing intensive and comprehensive action, now.
- To succeed, the multi-sectoral strategy is indispensable but it has to be undertaken with clear and undivided directorship, preferably by specifically assigned bodies (bureau, department and office) composed of experts of the most relevant sectors.
- The HMIS system and planning and evaluation approaches should be adapted and strengthened to facilitate inter-sectoral problem identification, analysis and development of solutions.
- A climate of 'learning together by doing' would greatly facilitate collaboration.

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- To increase access to counselling and testing, policies and procedures should be adapted to the realities of the health care system. This would greatly facilitate behavioural change, increase case detection and increase access to care for the PLWA.
- Strategies and laws need to be developed and implemented to improve protection of women and girls. Strategies and interventions are required to enable the most vulnerable groups to earn an adequate income so that risky behaviour can be decreased.

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- The role of facilitating organization is suited to the multi-sectoral approach. On the basis of local commitment clear formal agreements should define the specific roles, division of tasks, responsibilities and contributions well, certainly when the facilitator is also accountable to external parties.
- Goal and objectives should be set more realistically in relation to the local situation and capacities. For a facilitating organization, outcome and output objectives are more in reach. The quality and, to a certain extent, the quantity of the CVM staff should be increased and their coaching capacities strengthened.
- Phasing out of the West Gojjam and Liyu Zone now, is too early. Behaviour change still needs to be realised and this requires different methods / inputs while, at present, local capacity, commitment and resources are not yet sufficient to take over.
- The plan, to extend to six more zones, should be implemented gradually on the basis of clear and practical indications of commitment from the side of the zonal and woreda administration and sector authorities.
- The advocacy role should be deliberately elaborated as it can contribute to concerted and consistent action by all actors and strengthen the positive and caring approach.

Proposal for the Monitoring and Evaluation Tool

The Federal and ANRS Regional Health and HIV/AIDS Strategic Plans allowed to develop a complete M&E framework for the next extended phase of the CVM facilitated programme. The challenges however, to actually measuring impact and outcome in the future, will lie in the speed in which the national and regional systems are developed and capacity to implement them is strengthened.

Orphans

The extent of the orphan problem is already huge and all indications point towards rapid increase due to the combined effects of poverty and HIV/AIDS mortality. The cultural tradition fosters care by the extended family and the governmental approach stimulates this. However very few experiences, related to this scale, are available to build upon and local resources are sorely lacking. Advocacy, further research and piloting of strategies form the mainstays for future action of CVM.

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3. INTRODUCTION

The Italian NGO Centro Volontari Marchigiani (CVM) has been active in community development in Ethiopia for at least two decades. The main area of activity, up to 1991, was community water provision and the main development partner was the local catholic church.
After the end of the civil war in 1991 the programme officers, aware of the impending HIV/AIDS crisis, investigated the possibility to develop an appropriate programme in an area where the need was high. The needs and feasibility assessment indicated that an integrated approach would be needed as well as an approach that involved all the concerned governmental and non governmental parties and institutions. This implied that the role of CVM would have to be that of facilitator rather than direct organiser and executioner of the programme activities.
West Gojjam Zone (population +/- 1.9 million) in the Amhara Region, was chosen as intervention area. At that time Bahir Dar had the highest number of HIV positive persons, outside of Addis Ababa. The then present Zonal health and hospital teams were very aware of the problem and eager to try and tackle the issues. Also no other organization was as yet active on HIV/AIDS in this zone. At that time Bahir Dar town was the capital of the West Gojjam zone. About two years ago it became a special zone because of its size (population of +/- 112.000), role as regional capital and the particular characteristics / problems of the urban setting.
In collaboration with the parties concerned a programme was developed and implementation started in 1994. The first programme phase ran from 1993 to 1995 and the second phase from 1996 to 1999, extended to 2000.

The long term goal of the HIV/AIDS control and prevention programme is to achieve a decline in the number of HIV infected people in West Gojjam. Chapter 6.1 presents the details of the strategy, objectives and activities.

For the second phase a group of European donor agencies (Memisa, later Cordaid, SCIAFF and Trocaire) allocated a budget of 7.961.171 Birr. Of which 5.573.407 Birr was used at the end of 1999.

During this implementing period a first external evaluation was done in 1997. The second external evaluation was foreseen at the end of the second phase.

THE COMPARATIVE IMPACT ASSESSMENT

CVM, the local implementing partners and the funding agencies wanted to know if the programme is having an impact on the spread of HIV/AIDS in the two zones and which lessons can be drawn for the future. As little to no base line data existed it was felt that a comparison with non intervention areas could allow to determine whether an actual impact had been achieved. During the preparatory discussions it was realised however that, as the objective was 'to achieve a decline in the number of HIV/AIDS infected persons' the impact sought was whether less people had become infected. Two important obstacles to such an impact assessment were apparent:

- as no structural surveillance has yet been installed in Ethiopia statistical proof would be hard to come by;
- as changing sexual behaviour is the main way to ensure a decline of transmission and, as experience learns that more than six years are needed to install behavioural changes, it might prove too early to assess impact with respect to the programme goal.

It was therefore understood that in strict terms the assessment would mainly concentrate on assessing progress towards the intended impact and outcomes.

The detailed Terms of References can be found in annex 1. They can be summarised as:

- ✓ are knowledge, attitude and behaviour of the general public, specific high risk groups, health care personnel and authorities changing towards preventing the transmission of HIV/AIDS and ensuring adequate care of PLWA'S;

CCRDA

- ✓ are these changes related to the programme organization, inputs and outputs;
- ✓ which internal or external actions can increase the possibilities to achieve the impact foreseen in a sustainable way.

In view of developments two sub-assignments were added:
- propose a Monitoring and Evaluation tool for the next phase of the programme;
- assess possible strategies to support care for orphans in the communities.

The Assessment team consisted of two external consultants: Dr. Gemetchu Megerssa, an Anthropologist and team leader Ms. Marieke. Verhallen, a Public Health Consultant from the Netherlands. The external team was assisted by: the Regional Bureau of Health in the person of Dr. Wendemagegn Kegne, head of the health programme department and Dr. Tesfay Ayalew, a Public Health expert from the Regional Bureau of Health. Mrs. Marian Lambert, of CVM head office in Italy and staff of the programme office in Bahir Dar actively participated in the activities as resource persons and facilitators. In view of facilitating discussions with women Mrs. Yeshi, a social anthropologist from Bahir Dar university, was added to the team. Ten graduating students from the Bahir Dar Teachers Training College assisted the team for the individual interviews at community level. Irish Aid requested that one of their Public Health officers, Dr. Melaku Samuel, attend the assessment as observer.

The Assessment took place from June 15 to July 15, 2000.
For the field work the team was divided in to two parts: a group that concentrated on the community level and a group that worked at the institutional level. For all, the starting point was document study, an extensive briefing session with the CVM staff and group discussions to ensure consensus on the TOR, finalise the questionnaires and determine the main points of discussion at institutional level.

An array of data collection methods were used of which the main ones were:
- At community level: interviews of individuals using questionnaires with open and closed questions, in depth individual interviews and group discussions;
- At institutional level: semi-structured interviews and discussions with various committees, groups of workers and individuals at Woreda, Zonal, Regional and National level as well as site visits.

Limitations:

It was never the intention to do a scientific research but we did want to gather sound indications.
The time reserved for the assessment proved too limited in comparison to the extent and complexity of the programme itself and the scope and depth of the field work thus required. Some of the foreseen meetings could thus not be fitted into the time available per site and returning for verification of some points or to catch up with parties that were not available was not possible. Communication and planning difficulties meant that the number of parties met in the non intervention zones and woreda's was significantly less than in the intervention area's.
A second set of obstacles was formed by the difficulties experienced in trying to combine elements of fundamental anthropological descriptive research, needed for the Knowledge, Attitude and Behaviour (KAB) assessment, with the more action oriented evaluative methods, needed to assess the organizational questions and public health aspects. Amongst others this meant that during the group session the questionnaires were extended to include all the areas of concern to the local team and thus it became too lengthy. Translating the questionnaires into Amharic and the answers to English also added to the obstacles. Field testing the interviewers and the questionnaire could not be done due too shortage of time. Compiling and exploiting the gathered answers then became quite difficult.
We realise that the combination of factors compromise the validity of the outcomes of the individual interviews. However when the outcomes are taken as indications of the changes occurring amongst

CCRDA

the rural and urban populations they can assist in reviewing progress and learning lessons for the future. This possibility is enhanced by the data and reactions collected simultaneously by the other means: concurring information allows for more definite conclusions.

Attribution

In view of the numerous influences on a given population it is very difficult to attribute specific changes with certainty to a specific set of interventions. Apart from the IEC materials developed by the programme many of the entry points and methods coincide with interventions for other purposes, also information about HIV/AIDS reaches the same population through other sources. This means that directly attributing the outcomes to the programme interventions might not be evident. In this case however there are no other organizations working specifically on HIV/AIDS in the nine woredas of West Gojjam meaning that the programme actors / activities did constitute the main sources of information.
What certainly is unique is the inter-sectoral approach and the integration of activities and interventions. The important question therefore is whether evidence can be found that this approach improves the possibilities to achieve the intended results.

Format of the Report:

The team leader wrote the overall final report. She endeavoured to present the objective results of the consultants research. As such the report cannot reflect all the opinions of every member of the team.
Dr. Gemetchu wrote a separate report of the findings of the anthropological teams findings at community level.
After this introduction chapter 4 presents the country and regional background to the programme. In chapter 5 the HIV/AIDS situation in the country and the Amhara National Regional State is sketched. Chapter 6 presents the findings of the assessment in several sub-chapters, ending with an overview of the main conclusions. The findings at community level of the anthropological team are summarised in sub-chapter 6.2.
In chapter 7 the recommendations are given and in chapter 8 the proposal for the Monitoring and Evaluation Tool. In chapter 9 the findings and ideas with regard to the care for orphans are explained.
The annexes provide the full terms of reference, details of the assessment activities, the questionnaires used and the compilation of the answers, an overview of the observations at institutional level, details of programme outputs and budget overview, a more detailed picture of the health status and health sector information. Lastly the logical framework of the new programme with the monitoring and evaluation indicators and approach.

CCRDA

4. COUNTRY AND REGIONAL INFORMATION

4.1. COUNTRY INFORMATION

Ethiopia has an area of about one million square kilometres and a population of approximately 60 million, of which more than 51 million (85%) live in rural area's. Since 1994 Ethiopia is a Federal Democratic Republic composed of 9 National Regional States and 2 Administrative councils (Addis Ababa en Dire Dawa), which in turn are further divided into Zones (62 in total) and Woredas (523). There are also 2 zones (one of which is Bahir Dar) and 7 Woredas which are classified as special because of specific characteristics.[1]

A combination of rapid population growth, poor economic performance and low educational levels has constrained Ethiopia's socio-economic development and impacted on the health status in particular:

- The 1994 census indicates that the population growth rate should now be estimated at 2.9% per year (WHO: 2.7%).
- The economy is dominated by agriculture: 85% of the population depends on it for their livelihood and it accounts for 70% of the country's export earnings. Since 1991 structure reforms and measures to improve the country's economic situation are being undertaken. The inflation rate budget deficit have been reduced. However the country still ranks among the poorest countries of the world. In 1996 the GNP per capita was estimated as 110 USD.
- Though improved, the level of school enrolment is still very low: national average primary (1-12 grade) and the secondary school enrolment stand respectively at 23.7% and 8.1%. A high proportion of the population is illiterate.

The health status of the population of Ethiopia can be ranked amongst the most disfavoured of the developing countries (annex XVI present detailed information).

Some national average key indicators are[2]:

Crude birth rate: 28.3
Infant mortality rate: 110 – 128
Child mortality rate: 171
Total fertility rate: 4.3
Life expectancy at birth: 50.7
Maternal mortality rate: 500 – 700

The underlying causes of the poor health status are widespread poverty, low education levels (especially among women), inadequate access to clean water and sanitation facilities and poor access to health services (overall health service coverage is calculated at 48.5%.[3] and utilization at 10%[4])

The quality of health services is comprised by inadequate and poorly maintained infrastructure, scarcity of personnel and unavailability of pharmaceuticals and supplies.

The present Health Sector Development Plan aims to improve the health status of the population by extending the health care delivery system to enable it to provide (a) comprehensive and integrated primary health care services, at community level by first line health facilities, and (b) appropriate first referral and other hospital services. Important strategies are decentralization, community involvement and participation and partnerships with other providers and actors.

4.2. AMHARA NATIONAL REGIONAL STATE

The Amhara National Regional State (ANRS) is the second largest of the 9 National Regional States. It is located in the North West part of the country and has a surface of 170752 km^2 (16% of the country) It borders on Tigray to the north, Oromia in the south, Benshanngul in the west and

[1] Sources of information: MoH Programme Action Plan for the Development of the Health Sector; WHO World Health Report 2000.
[2] 1994 Population & Housing Census of Ethiopia
[3] MoH Health and Health Related Indicators, January 1998.
[4] Policy on Human Resource Development Study'

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Afar in the east. The north eastern part of the region is mainly high land (above 1500 mtr.) and the north western part is low land. Subsistence agriculture forms the backbone of the economy. It is endangered by frequent droughts and environmental deterioration[5].
The region counts 11 administrative zones which are divided into 105 districts (Woredas) and 3051 Kebelles. The latter forming the smallest administrative unit at community level.
The main ethnic group is Amhara and the language of the region is Amharic. However there are a large number minor ethnic groups and over 70 different languages are spoken. The Orthodox Christian religion is main religion (80%) though Islam, Catholic and Protestant are also represented.
Key population indicators are:

- Population 1994 census: nearly 15 million (25% of the population of the country);
- Rural / urban distribution: 90.4% lives in rural areas and 9.6% in urban and sub-urban areas; and male / female distribution: 50.2% male and 49.8% are female;
- Mean annual population growth rate: 3.17% (2.23 rural areas / 4.11 urban areas);
- Total fertility rate: 7.5. per 1000 women;
- Life expectancy at birth at 53 years;
- Mean density: 86.49 inhabitants per km^2;
- Average household size is around 4;
- Dependency ratio: 110 dependants per 100 persons in the 15-64 year's age groups (WHO: 1999 national ratio 96);
- Primary school enrolment: 28% / secondary school enrolment: 6%. The urban / rural and male / female variations are important: rural and female participation figuring at the bottom of the scales (exact statistics not available).

The health status of the population of the ANRS largely coincides with the national averages (see 4.1. and annex XVI). The estimates for maternal mortality are higher: 500 to 1000 per 100.000 live births.
The health service coverage and utilization statistics are comparable to the national figures.
A Regional Health Policy and Development Plan has just been elaborated.

Regional State Organization

In 1994 Regional States were recognised and given political and administrative powers for the regional affairs. The Regional Government consists of the administrative Executive Council and the Technical, or line, bureaux. Thus the Regional State took up the responsibilities for the health care of the region as well as for the other sectors. Since then the decentralization has been taken a step further with the handing down of responsibilities to the Zonal Councils and Technical Departments. The next step will be to enable the District (Woredas) Councils and Health Offices to take on the responsibilities for their health care organization and implementation.
At regional level the sector technical or line Bureaux are: Health; Education; Agriculture; Culture; Tourism & Information; Labour and Social Affairs; Justice; and Women's Affairs. At Zonal level the same sectors have a department except Justice. At Woreda level their are technical offices for health, education, agriculture and women's affairs.
In line with the decentralization the role of the Regional sector bureaux is evolving to policy development and technical advice to the departments at zonal level and the offices at woreda level. At present all these levels are in transition.
The lowest administrative level is the Kebelle: the Kebelle Council ensures the administration of a group of communities (town quarters or villages). At this level the staff of institutions bring in the sector technical knowledge.

Visited Zones

West Gojjam is the intervention Zone. It is located around (largest part to the south) of the capital Bahir Dar. Formerly this town was part of the zone but since two years it has been made a special

[5] Health Sector Five Year Plan ANRS

CCRDA

zone: Bahir Dar Liyu Zone because of the specific urban characteristics. The zone counts +/- 1.96 million and Bahir Dar town 112.000 people.
The non intervention zone South Gondar lies to the north east and East Gojjam Zone lies to the south east of West Gojjam Their populations are respectively 1.87 and 1.83 million.
The three zones are quite similar in many respects, though South Gondar is most drought prone and the environmental degradation is most advanced.

Three of the Zones visited have a hospital in the Zonal Capital. These serve as referral centre for the Woreda's (districts). HIV testing and counselling services both for blood transfusions as for diagnostic purposes are to be available here. Most Woredas (population of +/- 200.000) have a Health Centre as first referral health facility . At present these health centres provide outpatient curative services, static and mobile preventive services and they are active in health promotion in their catchment area. Laboratory services are rudimentary and do not yet include HIV testing. Inpatient services are limited. The Woreda Jabitehnan does have a hospital at Finot Selam.
The Felege Hiwot Hospital at Bahir Dar is a Regional Hospital that also serves as the Zonal Hospital for West Gojjam and the Liyu Special Zone (the town of Bahir Dar).
Health service coverage and utilization in the zones South Gondar, West Gojjam and East Gojjam Zone reflect the Regional average.

5. HIV/AIDS SITUATION INFORMATION

5.1. NATIONAL LEVEL

5.1.1. Facts and Figures

The first cases of AIDS were reported in 1986 in Ethiopia. In 1993 the prevalence among adults was 3.2%. At present the prevalence rates among adults are estimated at:[6]

- Addis Ababa: 16.8%;
- Other urban areas: 13.4%;
- Rural areas: 5.0%.

A number of documents mention an overall prevalence rate of 20% among the adult population.
Based on the available data different conservative calculation methods show that by mid 2000 between 2.4 and 2.94 million Ethiopians will be infected with HIV (between 2.4 to 2.67 million adults and 220.000 to 270.000 children). Other calculations suggest that the number of infected persons might rise to 3.2 million by the end of the year 2000 and to 4.7 million by 2014. The number of deaths per year will then reach 525.000 with the AIDS epidemic versus 230.000 without AIDS. These figures indicate that the impact of the HIV/AIDS epidemic is staggering (World Bank Document, July 2000).

The age group most affected is the adult group of 20 - 49 years (90% of the reported cases) As in other African countries, the economically most productive. The majority of the infections result from heterosexual transmission. The two most important risk factors involved are having sexual contact with multiple partners and having a sexually transmittable disease. Blood contact by other means (needle sharing, traditional practices, blood transfusions etc.) also contributes to the spread of the disease (2 to 5% of infections).
The underlying determinants of the risk behaviour are partly cultural and traditional (a.o. young marriages, traditional practices involving skin piercing with sharp instruments, barriers to condom use, gender inequality). But largely they are linked to poverty (f.i. alcoholism, migratory labour, sex work as income generating activity for women, low level of education and lack of infrastructure and capacity in all sectors).

[6] MoH Diseases Prevention and Control Department: Estimating national HIV prevalence using sentinel surveillance data, draft June 2000.

CORDA

The male to female ratio is 0.97:1 since most infections are acquired through sexual contact. Available data suggest that females are infected earlier, often in the 15 - 19 age group, due to earlier sexual activity and the fact the they often have older partners (marriage at young age).
The age group 5 - 14 is least affected thus representing the "Window of Hope" for the country.

At national level the number of orphans is estimated at 700.000. The percentage of this number directly related to HIV/AIDS is not known. Also it is understood that this number does not entirely reflect the actual situation as in the extended family tradition of the population one parent children or children without parents are firstly taken on by members of the extended family and thus not considered as orphans.

5.1.2. Evolution of Prevention and Control Policy and Action

At the first signs of the HIV/AIDS epidemic emerging in the country a national Task Force was established later succeeded by the establishment of the Department of AIDS Control in the Ministry of Health and the launching of a national programme to prevent and control HIV/AIDS (1987). The first sero-surveys were undertaken then to map the extent of the epidemic in the country. Two medium-term plans were designed and implemented between 1985 and 1996.
In the beginning of the 1990'ties major social and political changes affected the efforts in positive as well as negative sense. The changes included: devolution of political power to the Regional States and the creation of a federal government; economic liberalization and growth of the private and non-governmental sector. These developments offered a potentially conducive environment and the Regional States started control programmes assisted by NGO's, religious institutions, private and international organizations.
However the same changes also meant that the national Department of AIDS Control could no longer assure it's role of focal point / directing force to gather all the information, analyse and disseminate it, develop advanced policies and strategies etc. Research, sero-surveillance, monitoring and evaluation came to a virtual halt. At the level of the Regions limited financial and human resources meant that continuity and systematic further development of the activities as well as surveillance and reporting were hampered.
Weaknesses of the first two prevention and control plans were (World Bank document):

- insufficient involvement of the main stakeholders in planning and implementation, especially at community level;
- insufficient co-ordination and integration across the sectors and among the service providers;
- lack of priority within government, society in general, and in the international community;
- limited number and scale of effective programmes and providers.

Realising that the epidemic was worsening and having an impact on life expectancy and on the federal government's efforts to reduce poverty the Ministry of Health started a process to revise the HIV/AIDS Policy in consultation with the main national stakeholders. The resulting National HIV/AIDS Policy was ratified in August 1998. At the same time a situation analysis was undertaken in all the regional states which then served as basis for regional HIV/AIDS multi-sectoral planning process. In this process the Ministry and the Regional Bureau's of Health involved the major Religious Organizations and NGO's. At federal level the sectors and NGO umbrella organizations then elaborated their strategies to facilitate implementation.
The general objective of the National Policy and Multi-sectoral Strategic Plan[7] *is* 'Providing an enabling environment for the prevention and control of HIV/AIDS in the country'. The main features of the plan can be found in annex XVII.

To further mobilise the nation in the fight against HIV/AIDS the President of the Federal Government installed the National AIDS Prevention Council in April 2000. This Council is composed of members of the government, non governmental organizations and civil society and it

[7] Federal Policy document.

CCRDA

will meet three times a year. The Council will oversee the implementation of the Strategic Plan, examine and approve annual plans and budgets and monitor plan performance and impact. The Board of Advisors will meet monthly to oversee progress and through its Executive Secretariat co-ordinate and facilitate implementation of the activities.

During the Assessment exercise deliberations between the Federal Government and its international partners regarding the funding of the plan were in full swing. Since then it has become known that the World Bank has allocated a soft loan of USD 59.7 million in September 2000 for the 2000-2004 Multi-sectoral HIV/AIDS Strategic Plan.

5.2. AMHARA REGIONAL STATE

5.2.1. Facts and figures

As at national level, up to date detailed statistics regarding the actual situation of the HIV/AIDS epidemic and its consequences in the ANRS are not available. Some indications can be derived from the following[8]:

- A recent (Aug.'99 to Oct. '99) sentinel survey among ante-natal care attendees in a health centre in Bahir Dar showed an HIV prevalence of 20.8% in the age group 15-39 (in the 1992/93 survey the rate was 13.0%). In the group of HIV positive women the age group 15-19 is most affected with a rate of 30.2%!
- The cumulative mortality since 1986 due to AIDS in the ANRS stand at 11.613;
- In the past year the Regional Bureau of Education reported 536 suspected AIDS deaths among its teaching staff (the Zone East Gojjam reports 51 suspected deaths among its teachers). One urban secondary school has noted that, of its staff of 85 teachers, 15 bachelor degree holders died suspected of AIDS related illnesses over a four year period;
- Over the year 1998/99 the Regional Bureau of Health reported 1060 new AIDS cases (665 male and 395 female) and during the first nine months of 99/2000: 653 new cases were reported (283 males and 370 females). In both years the highest number of cases are reported in the age groups 20-24 / 25-29 / 30-34;
- The 98/99 BOH report shows that of the 3111 blood donors screened 265 persons were positive (237 males and 28 females). In the first 9 months of 99/00 these figures were respectively 2227 and 208 (192 males and 16 females);
- The counsellor at the Felege Hiwot hospital saw 302 persons for voluntary pre-test counselling in the first six months of 2000. Of these 164 persons were found positive. Of the total group 155 persons were self referrals i.e. they presented themselves for voluntary testing. The other were advised to be tested by hospital or health centre staff;
- The ANRS Region has not yet undertaken a census of the orphan population. The West Gojjam and Bahir Dar Liyu Zone have, at a first attempt, registered 4971 orphans/street children of which 4000 in the town of Bahir Dar alone. The latter probably are not all full orphans and they do not all come from the town itself. Next to the town the Woreda of Jabitehnan (capital Finot Selam) counts the most orphans (608).

The Regional Bureau of Health bases its action plans and resource assessments on the prevalence rates as calculated at national level: overall 7%, rural areas 5%, urban areas overall 12%, with the age group 15-45 at 21%. For the West Gojjam these rates would imply: 70.000 infected persons and in Bahir Dar town: 13.000. The RBOH suspects that these might represent underestimates for the region. The relatively high population density in certain area's, the fact that the main north-south thoroughfare crosses through the region, the high number of migratory labourers and the additional poverty problems in the drought prone area's will contribute to an increase of the infection rates.

[8] National documents and information from interviewees.

5.2.2. Evolution of Prevention and Control Policy and Action

The Bureau of Health of ANRS was assigned the responsibility to organize and ensure implementation of the regional prevention and control activities in 1994. The programme of activities is based on the second National Prevention and Control Plan.
The responsibility for the daily activities falls under the regional department of Communicable Diseases. This organizational embedding is replicated at Zonal and Woreda level. The funds for activities come from the general health care budget allocated by federal and regional government. A limited amount of outside funding was secured by the RBOH mainly for testing and protective material. (In comparison: Malaria Control and TB Control are executed by separate departments, offices and officers and have separate budget allocations from the National Programmes).

At the start, the few other actors, in the fight against HIV/AIDS, are local or international non governmental organization: Family Guidance Association of Ethiopia FGAE), Organisation for Social Services for AIDS (OSSA); USAID / AIDSCAP and Centro Volontari Marghigiani (CVM). The majority execute a specific programme and a certain concentration on the town of Bahir Dar can be noted. AIDSCAP has since terminated its activities. Co-ordination of the NGO interventions was mainly realised by the Department of Disaster Prevention and Preparedness Commission (DPPC) and their own forum: Focus Site Intervention Team (FSIT).

During the years 1997 and 1998 the awareness of the extent of HIV/AIDS epidemic grew at Regional State level amongst others due to the reports of West Gojjam and CVM. On request of the State Governor, CVM sponsored a three day Regional Conference in 1998. One of the main outcomes of the conference was the determination to ensure that Prevention and Control of HIV/AIDS becomes the affair of all the sectors. To install this multi-sectoral strategy a two-tier organizational set-up was decided upon (annex VIII), inspired by the experiences of the West Gojjam Zone and CVM with the Management Committees. At each level (Region, Zone, Woreda and Kebele) a Co-ordinating Committee and Technical Committee is to be installed composed of the main sectors, women's and professional associations, traditional associations, the religious institutions, the NGO' active in HIV/AIDS prevention and the private sector. Since then CVM is member of the Zonal CC and TC for West Gojjam and member of the Regional CC and TC.

The 1998 ANRS Health Sector Plan contains the Bureau of Health's plans for the fight against HIV/AIDS. Building on this, the National Policy and based on a situation analysis a Regional Multi-Sectoral Strategic Plan was developed which is incorporated in the Federal Multi-Sectoral Strategic Plan. Annex XVII presents the main features.

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6. ASSESSMENT FINDINGS

In this chapter the main findings of the Comparative Impact Assessment exercise are presented. In line with the goal the Impact to be sought would be whether the number of new persons infected is decreasing. As expected proof for this intended impact could not be found:

- Baseline data to compare the situation at the start with the situation after the interventions are not available;
- HMIS data and systematic surveillance data are not yet readily available / collected;
- The intervention period is too short to be able to show the intended impact. Experiences in many fields show that a longer period than six years is needed to achieve change of behaviour and for the change to show in a decline of the number of infected persons.

Unfortunately the data that are available at national level, though far from complete and systematic, in fact show that the number of HIV/AIDS infected people is rising at an alarming rate. (see chapter 5)

For the Assessment of the West Gojjam and Bahir Dar programme we therefor concentrated on assessing the progress towards the behaviour outcome intended by the majority of the interventions. The assessment therefore contained two parts:

A. At community level: assessing whether changes are taking place in the Knowledge, Attitudes and Behaviour of the population in view of preventing infection. By comparing the population in the intervention area's with similar populations in non-intervention area's we wanted to establish whether, if changes are occurring, these can be attributed to the programme interventions and which factors are of influence.
As decreasing stigmatization is an important prerequisite to changing behaviour, especially for the care of persons and families affected, it is one of the specific objectives of the programme. The assessment at community level also wanted to establish if changes are taking place in this respect.

B. At institutional level (management, sectors, institutions, civil society actors): assessing which progress is being made towards achieving the results intended and which factors are of influence for the effective implementation of the programme in view of enabling the population to prevent infection and care for the persons affected.

The evolution of the programme and the activities carried out are amply described in the six month and annual reports. The first sub-chapter therefor only summarises the main aspects of the origin and the fundamental philosophy of the programme and highlights important developments. The findings of the Community Level Comparative Assessment Study are described in detail in a separate report of the Anthropologist, Dr. Gemetchu. The main conclusions of the Community report are presented in sub-chapter 2 as reference for the findings at the other levels. The subsequent subchapters present the findings at institutional level with respect to programme implementation, programme organization and management, the external environment, the integrated approach, sustainability, unmet needs and unintended results to end with the conclusions.

6.1. General Evolution of the Programme

In the course of 1991 the CVM management, together with many others, became aware of the extent of the HIV/AIDS epidemic in Ethiopia. A number of sero-prevalence studies among specific target groups (f.e. among soldiers) confirmed the fears. Various persons and officials, among which the Ministry of Health, inspired and assisted CVM to start a needs and feasibility study to establish whether CVM could become active in the fight against the disease.
The West Gojjam Zone in the Amahara National Regional State was selected as intervention zone because:

- HIV/AIDS prevalence was highest outside of Addis Ababa;
- no NGO's were active in HIV/AIDS control in the area;
- the hospital and Zonal Health department staff were very concerned and interested in developing activities;
- in view of CVM's existing programmes the intervention area could not be too far from Addis Ababa.

Based on the assessment, own experiences in the other programmes and advise from staff members of the WHO Global Programme for AIDS, CVM decided that the approach had to be an integrated one:

- all sectors, institutions, civil society organizations and churches had to be actively involved;
- the programme components and activities had to be complimentary to the activities of the other actors and to each other.

These principles meant that CVM opted for the role for facilitator: enabling the local parties at Zonal, Woreda and Kebelle level to carry out the prevention and control activities planned by the Region and the Zone.

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In 1994 the West Gojjam Zonal Health Department (ZHD) and CVM commenced the first programme with the approval and co-operation of the Regional Health Bureau and the National Department of AIDS in Addis Ababa. To organize, manage and implement the programme management committees were set up at Zonal and Woreda level. Representatives of the main sectors concerned (health and education) and the EOC are the members under the chairmanship of the ZHD. The CVM team in Bahir Dar is kept small and its main tasks are mobilization, facilitation and co-ordination.

Next to the planned activities two researches are undertaken:
- Young People on AIDS, by researchers of the University of Edinburgh, 1994;
- Coming to terms with an Epidemic, Christopher Cruise of the University of Edinburgh, 1995.

The outcomes showed a need to adapt the contents of training activities and to address more specific groups The main adaptations installed are a shift from using training activities of other organizations to developing, organizing and providing own courses, increasing and diversifying training also for programme and implementing staff. Progress is reported regularly to all concerned through the minutes of the Management Committees and six month and annual reports.

Based on the experiences of this first phase and the research outcomes the next phase of the programme was formulated in 1995 to start in 1996.

The long term goal of the HIV/AIDS control and prevention programme remained:
TO ACHIEVE A DECLINE IN THE NUMBER OF HIV INFECTED PEOPLE IN WEST GOJJAM.

The intermediate objectives to be achieved, for the 1996 to 1999/2000 period, were:
i. Improve the capacity of Local Government and Institutions in the prevention of HIV/AIDS;
ii. Promote an integrated approach to the problem;
iii. Foster behavioural change;
iv. Promote care and solidarity for HIV/AIDS patients and their respective families.

The following results were to be achieved within the project period:
1) Organise effective management of the programme and promote co-operation with the concerned personnel from Ministry Offices and Institutions in the Zones;
2) Strengthen the operational capacity of the Zonal Health Department at various levels to prevent the spread of HIV and to cope with AIDS patients;
3) Encourage communities and local institutions to provide support for terminally ill PLWA's and their families;
4) Train counsellors and communicators to ensure the availability in all Health structures, Schools and 15% of the E.O.C. parishes;
5) In every Woreda 50% of the population will be aware of HIV/AIDS, modes of transmission and prevention;
6) Uphold positive local traditions and values, functional to the prevention of HIV/AIDS.

The main activities undertaken to achieve the results:
1. Training;
2. IEC;
3. Support to Health Structures;
4. Patient Care;
5. Income Generating Activities;
6. Research.

In the beginning of the new period the management committees are further completed (Labour and Social Affairs, Agriculture and Islamic Council) and a division of tasks between the levels is elaborated: the Zonal Management Committee concentrates on overall management of the programme while the Woreda Committees ensure the implementation of the activities. Management Committees are also started at Kebelle level.
The CVM Bahir Dar team remains small: it consists of one co-ordinator and support staff in the office and two field communicators-educators stationed in Woreda capitals (Finote Selam and Yilmana Densa). When needed the Addis Ababa office or the Italian office provide expert assistance.

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A first evaluation is undertaken in 1997 by Dr. Mengistu Merit of UNAIDS, and Professor Gebre Medin of the Addis Ababa University. The team concluded that in all intended area's progress could be perceived and stressed the achievements in installing inter-sectoral collaboration and participation of so many actors from official and grassroots level. The overall approach and basic philosophy are seen as key elements and exemplary for others. However in order to be able to achieve the planned results and to ensure that people change their behaviour they urge that implementation be intensified. The major constraints are the limited capacity of the CVM team making it difficult to use the existing structures more optimally as well as hampering full participation of all actors in the development of IEC material and other activities. The serious problems the health facilities experience in providing testing and care due to lack of motivation and capacity among the staff. Also it is noted that the lack of monitoring indicators make it difficult to establish actual progress.

Implementation of the recommendations is started. The office is strengthened with an IEC officer and a nurse / women promotion officer. However soon after the appointment of the latter the previous co-ordinator has to be discharged and a replacement could only be found in May of 2000.

A number of changes and major events occur 1998.
Bahir Dar town becomes a special zone: Bahir Dar Liyu Zone.
The Regional State Council, with the support of CVM, called a Regional Conference in view of developing a Regional Strategy for the Prevention and Control of HIV/AIDS. The experiences of the West Gojjam Zone served as inspiration for the strategy development and for the revision of the organization of the activities. In an endeavour to ensure that the fight against the epidemic becomes the affair of all the sectors a two tier organizational model is chosen for the Region, Zones and Woredas whole region (5.2.2. and annex VIII). At Kebelle level one Committee with a similar composition is appointed.
The main responsibilities of the Co-ordinating Committee (CC) are policy setting, establishing the Technical Committee, approval of plans, supporting and advising Zonal (respectively Woreda and Kebelle) CC, seeking resources, monitoring progress and reporting to the Regional Executive Committee and Council (respectively Zonal, Woreda and Kebelle).
The Technical Committee (TC) mainly ensures the elaboration of action plans, the monitoring of the correct implementation of activities and standards, support and advice to the lower levels, research of resource support and reporting to the co-ordinating committee. The Regional Technical Committee (RTC) has the overall responsibility of developing manuals and standards that are to be approved by the Regional Co-ordinating Committee.
The leading line sector is Health, realised through the chairmanship of the TC and secretary to the CC at each level. The connection to the Administration System is to effectuated through the chairmanship of the CC (a representative of the Executive Committee of the concerned level).

CVM now is member of the Zonal CC and TC for West Gojjam and Bahir Dar CC / TC as well as member of the Regional CC and TC.

6.2. CHANGES AT COMMUNITY LEVEL

The specific objective foreseen here is: Foster behavioural change.
The results to be achieved are:

- Encourage communities and local institutions to provide support for terminally ill PLWA's and their families;
- In every Woreda 50% of the population will be aware of HIV/AIDS, modes of transmission and prevention;
- Uphold positive local traditions and values, functional to the prevention of HIV/AIDS.

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The selection of activities is largely determined by the underlying assumption, that increasing knowledge and understanding about the causes, risks and prevention methods, will lead to change of attitude and then to a behaviour that ensures protection of one self from the disease. A positive approach in the messages themselves, and in the ways of conveying them, together with actively involving communities was chosen to facilitate the transition of behaviour. They also aimed at better acceptance of PLWA: break through the stigma and foster care.

The main activities are geared to spreading the knowledge to the general public and to vulnerable groups: orientation seminars, training of intermediaries (trainers, teachers, priests, health staff, development agents, community communicators-counsellors, organising and training Anti-AIDS clubs), production of IEC material etc. From the annexes XIII it can be concluded that 697 female and 1992 male intermediaries have been trained, 74,799 female and 116,669 male community members attended orientation workshops and a large number of different IEC materials have been produced and distributed in impressive quantities. New approaches to reach specific groups have been started as well: youth centres, women groups (including organization of informal sex workers) Anti AIDS clubs in different settings.

6.2.1. Conclusions from the Community Assessment:

The Anthropological Comparative Assessment team collected data through individual questionnaires (800 persons interviewed: per site 100 persons from among the rural community and 100 from the urban community) and through in depth interviews with individuals and groups discussions in the Woreda capital (an average of 25 persons from different social groups of the community). The conclusions of the combined findings are (see separate report):

Knowledge

a. Individual responses:
The factual knowledge concerning HIV/AIDS transmission and prevention of individuals is lowest in the non intervention site of Hamusit rural followed by Hamusit urban. As far as could be established very few interventions have taken place here. (School Anti Aids Club only one mentioned)
According to initial information little to no activities had taken place in Dejen. However knowledge both in the rural and the urban population was, to a large degree, comparable to that of the populations in the in intervention sites. A revisit learnt that the MoH / Woreda Health Office and OSSA had in the past three years trained intermediaries (counsellor-communicators, bar workers and Anti AIDS Club animators). Apparently this information had been lost due to change of staff. The nature of the town (important stop over location for trans-national transport) also means exposure to information but also the number of infected persons is higher.

Reviewing questions indicating higher level of detailed information (symptoms, whether health looking persons can be infected, actions that do not transmit the virus) the intervention sites score slightly better than Dejen and much better than Hamusit. A comparison between the two intervention sites Finot Selam and Durabete the former nearly always scores better.
In all rural populations knowledge is lower than in urban populations.

In none of the areas specific traditional practices are indicated as mode of transmission. Sharing sharp instruments comes closest and is best recognised in intervention sites with Dejen following close behind, and in all urban respondents scoring it more often.

Faithfulness is mentioned most often as prevention method, with very little differences between non intervention and intervention sites, all urban sites scoring very high. The actual use of condoms figures low in all rural sites, while from answers to other questions it can be derived that knowledge is present. In urban sites recognition of condoms, as mode of prevention, is high with the non intervention site Dejen scoring highest. But in these sites less than 40% of the respondents

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acknowledge using them (comparison question regarding modes of prevention with questions regarding knowledge and use of condoms).

Urban people obtain their information mainly from the modern media, family, friends and health workers. Rural male respondents mention radio, family and friends as main sources of information. Females mainly get their information from family, friends and health workers. IEC materials are very little known in the rural areas.
Health workers and priests are mentioned more frequently as sources of information in the intervention sites and Dejen, with the church scoring significantly higher in the intervention area and, of those, in the rural areas. The counsellor-communicators are rarely mentioned spontaneously, as source of information, in the intervention sites. This is most probably because they are seldom known as such and most of them hold other positions in the community which are more prominent and recognised (priests, health workers, committee members, employees).

b. Group responses:
An important conclusion of the community assessment team pertains to the fact that there is a significant gap between knowing the facts and really understanding them. This difference became apparent during the group discussions and the in-depth interviews. Actual understanding of the details of the modes of transmission and prevention as well as the implications of issues such as healthy looking persons possibly being infected was nearly 100% in the intervention groups and quite low in the non intervention groups. In the former the responses and questions posed in return were markedly more analytical. The consequences of the specific town characteristics (stop over for buses, presence of military training camp, higher presence of persons with money to spend on sexual favours) is also much better understood in Finote Selam than in Dejen.
In comparison most participants in Hamusit hardly used the name of the disease or gave it other names (f.i. serious malaria or TB). They also had great difficulties in relating to the concept of the HIV virus as cause for AIDS.

In all groups respondents mentioned that knowing persons with HIV/AIDS and / or knowing persons who died with the symptoms has enhanced their understanding of the disease and its dangers. The participants of the groups in the intervention sites mentioned this much more frequently and spontaneously, naming the disease and expressing compassion. In the non intervention sites mainly the symptoms are cited and fear dominated perceptions.
In the cultural setting exposure to a problem / experience plays a mayor role in acquiring knowledge (Dr. Gemechu). Reflecting on the differences between the intervention and non intervention areas it could be argued that the process of understanding and coming to terms with the consequences follows the opposite route: exposure is similar in all sites therefore the information and education, provided in the intervention sites, enables persons to understand what they observe.

In the intervention groups the use of condoms to prevent transmission is promoted for those who cannot live with one partner alone. In comparison in Dejen the educated participants and women, mostly, female sex workers, also take this view point but the, mostly uneducated, male participants (the majority) vehemently protested the very mentioning of condoms. Their main argument being that suggesting condom use as an option amounts to telling youngsters to go ahead with extra-marital sex.

As no group discussions were held in the rural sites a comparison of the actual understanding of the facts is not possible.

Attitude

Of the three factors attitude is most difficult to define and to measure. The formal dictionary defines it as the way the person thinks and feels about a subject, especially when this shows in the way the

CERDA

person behaves. Changes in attitude therefore have to be derived from the way persons understand, talk and express feelings towards HIV/AIDS and indications of action.
In these terms the difference in attitude is significant: the population of the intervention area's has a higher awareness and expresses a higher level of understanding of all the issues at stake and the consequences for the community (urban population highest). This conclusion is based on the differences found during the group discussions and the individual in depth interviews (see also comparison factual knowledge versus understanding in former paragraph). In the intervention areas the questions and issues raised, reactions presented and alternatives debated went much deeper / further than in the non intervention areas. The difference is largest with Hamusit. The difference with Dejen is less but still significant.

Main proof of a change in attitudes is found in the higher level of involvement of community members in activities in the intervention areas. The intense involvement of the Kebelle Committees in these areas versus the hostility from this side in the non intervention areas is quite illustrative (in the latter Kebelle officials refused collaboration with the assessment team and one even obstructed the group meeting). This higher level of involvement is apparent in the reports and was confirmed in the groups discussions certainly at urban level. New indications are surfacing: groups are initiating new activities like trying to tackle the orphan problem (Durabete registering orphans and seeking relatives).
In the non intervention sites actual community action is near absent. The absence of a programme is probably an important reason. However the overall feeling of fear and that it is 'something that overcomes us and has to be endured' is very strong and definitely contributes as underlying cause as well.

In the rural areas, the answers to the individual questions indicate that awareness of - and involvement in - prevention activities do not reach the same levels as in the urban areas.

The fact that, the majority of the individual interviewees at all sites claim to be willing to have HIV testing done, does indicate that personal awareness of the risks is rising (79% in Finot Selam, 72% in Dejen, 52% in Durabete and 43% in Hamusit). This outcome is quite remarkable as it is in contrast to health care staff perceptions, that willingness to be tested, is very low, certainly among persons suspected. Further investigation would seem warranted.

With respect to stigmatization the responses to the individual questions are difficult to interpret: a majority is not willing to share a meal with an infected person but on the other hand the majority also expresses willingness to care for family members and accepts that persons infected continue to work.
It is more in the stories and examples given, during the group discussions and other meetings, that signs of changes are emerging: in the intervention areas burials of suspected HIV/AIDS patients are no longer obstructed, bishops and priests now openly talk about the disease, etc.

Behaviour

a. Sexual Behaviour:
Evidence of behaviour change in terms of increased use of condoms and / or decrease of commercial sex could hardly be found in any of the areas visited.
Condoms are relatively well available in shops and at locations where 'formal' commercial sex (hotels and licensed bars) is assumed to take place. Belief that they can protect is limited (somewhat higher in urban intervention areas). Of the urban respondents between 22 and 50% know that condoms can protect, but of those less than 40% indicate that they use them.
The majority of the respondents claim to practice faithfulness to partner or abstinence. The visibly active formal and informal commercial sex activities do not confirm these practices.

CCRDA

b. Care for PLWA and their family:

This proves to be a difficult aspect to assess. Cultural tradition places the responsibility for ill family members with the family. Most individual respondents answer that they will take care of family members and even friends. In how far this answer reflects social correctness or real practice could not be determined (see also former page). Individual responses indicate around 20% of the rural and 30% of the urban intervention population is aware of chronically ill persons being taken care of (the rural non intervention area of Hamusit reports 32% and Dejen only 7%). Awareness of chronically ill persons *not* taken care of is slightly lower in rural areas with Dejen only reporting 2%. In urban areas Finot Selam reports 39% and the others around 30%. In the group sessions, in comparison, in the intervention areas significantly fewer examples of PLWA being abandoned were cited.

In the small towns there are people living in cemeteries, in Bahir Dar the number of PLWA living in the streets seems to be rising. All hospitals report that patients, diagnosed as positive, or fearing to be positive, often do not want to go home. Whether they really do not have a family, as they indicate, is very difficult to determine. To establish whether there is a difference between intervention and non intervention areas in this respect a comparison of provenance of patients would be required and this could not be done in the given time.

The number of orphans is perceived to be rising. The main indication is the rise in the number of street children. As traditionally children, of whom the parents have died, are taken care of by the relatives (extended family) this rise shows that these families can not cope. Whether this is because of fear of infection or because of lack of means could not be determined, in this short study, as it is also very linked to social obligations but even more to the socio-economic situation. The fact that the orphan problem is starting to be taken up in Durbete and Finote Selam does indicate growing concern and care.

That the stigmatization is not yet disappearing, in the intervention zones, can be concluded from the fact that the majority of persons diagnosed with HIV do not want to be put in contact with a counsellor in their community. As they are known in the community frequent contact with them seems to be tantamount to confirming your status. Counsellors who are not known, as such, can assist PLWA when they avoid official contact with the programme implementing team. Most PLWA which are willing to assist in education activities do not want to do that in their own communities.

Factors of influence

When exploring why people are not adapting their behaviour, to their knowledge and understanding of the risks, the following factors appear of importance:

a. Alternatives for present behaviour:

An overriding factor influencing behavioural change across the board is the wide spread poverty. It determines present behaviour and greatly hampers the possibilities to change behaviour towards protection as well as possibilities to obtain or provide care for PLWA and their families.

Bar workers, who evidently are well aware of the danger their work entails, when asked why they continue or why they do not insist on condom use, reply that they have no choice if they want to survive and take care of their children. These women have no training and no means to find other jobs to ensure their income.

Alcohol use is rampant because of poverty and men indicate that it in turn makes them forget their determination to protect themselves.

Youth want to experiment and advice from adults is not readily accepted. On top of this they desperately seek to improve their chances in life by ensuring that they get their education or a job. The result is that, for instance in Finot Selam, the highest number of new STD cases, in the past year, was found among the secondary school students (girls can earn quite some money here from the many soldiers, and others, willing to pay for sexual favours). Unemployed school leavers have nothing to do thus the combination of wanting to experiment, wanting to earn some income and alcohol use ends in risking infection.

CCRDA

Thus the all pervading poverty is often the root cause of the rapid spread of HIV/AIDS as well as the main obstacle to stopping it: the vicious circle.

b. Social mobilization and pressure:

The majority of the population belongs to the Ethiopian Orthodox Church. The general teachings of the church with respect to marriage, extramarital sex and punishments of God are important for the public. The general gist of these messages does not seem conducive to HIV/AIDS education and prevention. The teachings might certainly influence the answers persons give to questions regarding their behaviour as well as the behaviour itself (the former being comparable to giving socially acceptable answers in other cultural settings).

The EOC representatives in the intervention areas show however that social mobilization from the side of the church is of great influence. They are very actively involved in education. Their approach is positive and their messages have been adapted in such a way that they do not obstruct the messages from other actors. In these areas they are reported most as source of information, teaching and action, certainly in the rural areas. Whereas in the non intervention areas the priests way of talking about the subject is still markedly traditional and cloaked and they are much less cited as source of teaching.

To be effective however, social mobilization and pressure has to come from all sides. At present very few of the principle actors are active. A large number of respondents question the urgency as they do not see or feel that the authorities are treating the epidemic as a huge and urgent problem. The demand, for action from the side of the authorities, is most prominent in the intervention sites but also surfacing in the non intervention sites (women in general and sex workers, in particular, ask government to provide alternatives for income generation).

Evident risky behaviour of persons in authority (peer examples) are often perceived, by the general public, as confirmation that it is not such a big problem.

c. Relations between rural and urban populations:

The findings show that the rural population lag behind in knowledge and awareness and that messages mainly reach them through personal contacts. The difference between intervention and non intervention areas show that the strategy of communicators is having effect but requires a lot of time.

Contacts between urban and rural populations mainly take place through market activities. During the assessment it transpired that women, who have left their village and are trying to survive in the towns by selling tea and local spirits, often have to resort to sex work to complete their income. Males from their villages are their main clients and thus they constitute the main source of infection for the women in the villages. This informal sex network has, till now, not been well recognised as an important contributing factor for the spread to the rural populations. These women are not included in the condom distribution programmes.

d. The position of women

The responses confirm the assumption that women have less access to information. This counts for urban as well as rural women. The underlying causes are the cultural and traditional position of the women and the low rate of female school enrolment (see general information). This complex of factors means that the possibilities for women to protect themselves are very limited. Abstinence is difficult for women and girls outside marriage as often their only option for income generating is sex trade. For married women protection through faithfulness to one's partner has to be practised by both and, certainly rural husbands, seem not to adhere to their obligation (it should also be noted that cultural practice allows extramarital sex when one's wife is pregnant). With respect to condom use: those that need to practice sex for income are not in the position to ensure that their customers use the condom, while wives have little access to condoms and depend on the willingness of their husband.

CCRDA

6.2.2. Review of the Interventions

This review combines findings of community assessment team with those of the 'institutional' assessment team during discussions with groups of implementers. The perspective chosen is: which lessons can be drawn from the experiences and results to improve effectiveness in the future.

IEC

The IEC material produced and distributed is widely available in both the intervention and the non intervention areas. In many sites this was the only material to be found. The demand for material is very high and the programme management is experiencing difficulties in answering the demand. Production at lower levels is being encouraged and supported.
In the individual interviews these materials do not figure prominently as sources of information, certainly not in the rural areas. To a certain extent this may be caused by the way the questions were phrased. The high level of illiteracy, certainly in rural areas, is probably the main reason. The third reason is that, in most instances, the IEC materials are used in combination with oral explanations.
The means used to reach the illiterate are weekly radio broadcasts at national and regional level. These broadcasts are widely listened to and figure high on the list of sources of information.
The absence of behaviour change suggests that further adapting the materials to the specific target groups is needed but more importantly that the different approaches and means to reach the illiterate and rural population need to be intensified and new ones should be developed.

Anti AIDS Clubs

Anti Aids Clubs (AAC's) were firstly started in schools and later also encouraged in other settings. (119 in school, 87 out of school and 16 others). Their members are active in their own setting and among the general public. Their activities include organising their target group, developing and staging drama's and songs. They are recognised at community level as bearer of educational messages (more in the discussions than in the individual responses). The emphasis put on them and the high expectations officials seem to have with respect to their impact does seem exaggerated. In the non intervention zones officials gave the impression that once installed the AAC's would 'do the trick' of ensuring the education in school.
The fact that, in the past year, the Finot Selam high school students had the highest incidence of STD's, as well as the numerous stories of the difficulties girls have in defending themselves from unwanted sex with fellow students, indicate that behaviour of students is not yet really changing.
Time was too short to meet the AAC's extensively. Based on the views officials have, looking at the training the members receive and at the wide range of public they are to address, one has to wonder if sufficient attention is given to the specific determinants of youth behaviour. As we understand some adaptations are being tried. The more broader approach of 'Life Skills Training' has started but up to now mostly as one of the topics in a training course. However such skill-training requires separate and mostly practice oriented courses combined with supportive follow-up. Personal and group defence strategy training still needs to be developed.

Youth Centres

Two centres, of the five, were visited: Finote Selam, which is operational since more than a year, and Durabete which is on the verge of starting. The aim of these centres is to provide other recreation facilities to the youth and reach them through peers with educational messages in order to prevent experimenting with sexual behaviour. The youth animators have received training in educating youth and the general public as well as managing their centre. The general public is reached through outreach activities. IEC material is readily available in the centres. Drama, songs and quizzes are the main other means of presenting the messages. Access to the games is based on income generating. Though a sound approach in view of sustainability and continuity, two risks

CORDA

are inherent. Firstly that certain groups of youth will hardly have access as they probably have no way of paying. Secondly that too much attention of the animators goes towards income generating and thus limiting the educational efforts.
From the discussions we were also left with the impression that the animators lack a clear focus for their activities. As these centres are located in the towns, where school enrolment is generally much higher, the potential number of students, which could benefit from their activities, possibly surpasses their capacity. On the other hand, considering the high percentage of out of school youth, which is hardly reached by other interventions, this would constitute an important target group for the Youth Centres. To reach them however the animators would have to be able to travel for outreach activities. Further reflection does seem needed.

Trained Intermediaries

As shown earlier a very large number and variety of intermediaries have been trained to inform and educate the community members. In the discussions with community representatives, implementers and officials it is widely recognised that they have contributed most to increasing knowledge, raising awareness and willingness to engage in community activities. Certainly the role of the EOC priests and the Development Agents in reaching the rural populations are perceived as significant.
Unfortunately this conclusion is difficult to substantiate from the individual reactions. The way the questions were phrased and the fact that the questions were different for rural and urban population are probably the cause. Also most intermediaries have other functions in the communities which are more easily recognised and named by the population.
The individual intermediaries spoken find their training very helpful but they also feel the need for further training as issues become more clear or new issues emerge. Some additional training's have already been undertaken.
Many have noted the lack of change in behaviour but they have not yet drawn the conclusion that other kinds of interventions are needed to assist persons to make the transition. Undoubtedly this need for other interventions to enable people to change their behaviour, towards prevention of infection and in breaking the stigma, poses the most important challenge for the future training efforts as well as for the activities of the intermediaries.

The general perception of the integrated approach seems to be 'bringing the same messages at the same time'. Though this is not what the programme intended and what is required, in itself this is no mean feat when we consider the situation at the beginning of the programme, the large number of sectors, institutions and levels involved now and the overall absence of comparable experiences in the country.
Community leaders comment on the high turn over of staff in the line sectors as the main hindrance to acting together.

The positive approach

CVM has invested a lot of thought, lobbying and effort in establishing a positive approach. Though not directly in the terms of reference they wanted some feed back on whether this approach is coming across and has an influence. Unfortunately this can not really be measured by the methods used. The general impression of the community assessment team was that in the intervention communities the negative and hostile feelings / reactions towards the subject and towards PLWA's are significantly less. Concern and compassion are formulated. The sense of inadequacy and inability to do something about the HIV/AIDS threat is lifting here and is visible in the important number of persons involved in community activities. Without a doubt the positive approach has contributed to this development as the general information, available to the non intervention communities, is still often quite negative and fear inspiring of tone.

CCRDA

Income generating activities:

The intended plan, to assist PLWA with IGA, has proven very difficult to implement. To date around 65 persons have been assisted (9% of the budget foreseen spent). Very few of the persons assisted have succeeded in continuing a business. The reasons are manifold: inability to manage business, late entrance so that illness and even death occur before results can be achieved, urgent needs of the family, the very modest amount foreseen per person (500 to 1000 Birr), the limited options to generate income available, etc. The success rate is slightly higher in Finot Selam. Two factors may be of influence: better possibilities to follow the person and his family and less influence of other programmes (in Bahir Dar OSSA provides financial assistance for subsistence).
The major reason why so few PLWA come into the programme is the fact that the nurses and counsellors do not and / or can not refer the patients. The underlying problems are related to all the issues surrounding HIV testing, of which willingness of the persons to be tested, willingness of health staff to refer patients for testing, but most of all, the capacity to counsel and test are crucial. At community level stigmatization is an important factor: PLWA's do not want to be associated with known community counsellors in fear of being exposed as positive.

In order to achieve the intended result this component has to be revised. Research will be needed to develop more different IGA options and to devise family or group approaches. Another approach might be to get employers involved in assisting PLWA. The IGA component could also be developed to assist women to gain their income in other ways then commercial sex and to enable families to take care of the orphans and the ill. This research should also look at what can be a realistic role, for such a programme and a facilitating organization as CVM, in IGA. The overall level of poverty means that the potential number of applicants, of each possible target group, is huge and thus the level of activities and the budget required could be enormous. Maybe a more example / pilot oriented strategy and approach is more realistic.

Research

In the second phase of the programme the 'Survey of KAB on AIDS and Ethnographic Study of West Gojjam Zone' was executed in 1997. The report only became available when important changes were taking place at regional level and the CVM team underwent serious changes.
The main conclusions were used to adapt training contents and target groups (f.i. training of the DA's increased and community counsellor training improved). With respect to the advise to develop alternative IEC materials for the illiterate, the programme concentrated on the radio broadcasts and intensifying the activities of the communicators. Pictionary material has not yet been developed.
Involving the community social institutions (f.i. Mehaber and Idir) more for transmitting information as well as for the care of the ill proves to be quite difficult. They are represented in the Kebelle committees but as they were initiated for other social purposes and depend on contributions from the community members it is very difficult for them to take on new activities / services. The problem of stigmatization complicates their involvement in care for the ill. A first Mehaber of PLWA's has been established in Bahir Dahr.

It is surprising that this study did not establish the informal commercial sex link between urban and rural communities.

6.2.3. Conclusions

Based on the individual interviews:
The populations in the non intervention areas did not represent the expected zero situation allowing for a complete outcome comparison. This is not surprising considering the state of the epidemic in the country: exposure to infected and dying persons, mass media messages, etc.
The rural and urban populations of Hamusit have experienced the least interventions. Knowledge on HIV/ADS is significantly lower than in the intervention areas. In and around Dejen individual factual knowledge is comparable to the intervention sites. This is related to interventions that have

CCRDA

for the families of victims cannot really be assessed either. The symptoms that are found (the rise in people and children living in the streets) very probably have other, mainly economic, causes as well. In consequence, if care for these groups is really absent, this might indicate that other interventions than information and education are needed: moral support and material assistance to provide the care needed. (home based care strategies).
The first initiatives towards orphan care may also indicate that fear is decreasing.

Whether positive local traditions and values, functional to the prevention of HIV/AIDS are being upheld could not be assessed. The traditions have not been clearly defined and the nature of the study combined with the time constraint, did not allow to go into the required depth.
On the other hand knowledge and awareness of the danger of sharing sharp instruments is present, and as behaviour change is much easier to achieve here, it is likely that changes are taking place.

The different components need to be adapted, intensified and diversified. The IGA component needs to be completely revised.

6.3. PROGRAMME IMPLEMENTATION

The objectives and results foreseen at the level of the communities and individuals were to be achieved by the programme implementers. In addition to these the following specific objective and results need to be reviewed here.

- Promote an integrated approach;
- Strengthen the operational capacity of the Zonal Technical Committee Health Department at various levels to prevent the spread of HIV and to cope with AIDS patients;
- Train counsellors and communicators to ensure the availability in all Health structures, Schools and 15% of the E.O.C. parishes.

The main inputs were facilitation, training and support to the health structures.

Implementation is ensured by the following actors:

- the Technical Committees at Zonal and Woreda level;
- the individual sector departments and offices;
- the institutions, associations and religious bodies.

In this subchapter we review the achievements compared to the non interventions areas as well as the achievements and constraints, at the various levels, with respect to the objectives planned and the improvements required for the future. The health sector is singled out because of its importance in the fight against HIV/AIDS and the care for patients and because of the attention it was given in the programme inputs. The findings of the 'institutional' assessment team are discussed per subject. Annex XIII presents an overview of the main observations of the teams visits.

6.3.1. Achievements

The intervention zones and woredas are far ahead of the non intervention zones and woredas in all aspects. The first achievement is undoubtedly the model for the integrated collaboration, developed by the West Gojjam Zone and Woredas by starting with the Management Committees. The aim was to involve all the main sectors, associations and institutions that are concerned with and can act towards the HIV/AIDS problems. The positive experiences with this model inspired the present region wide organizational set up of Co-ordinating and Technical Committees at all levels.

Technical Committees at Zonal and Woreda level in the intervention areas combine much more actors which have a much higher level of involvement and commitment to implement the activities. The number, intensity and scope of the activities is much higher as well. This is mainly due to the longer period that they have been organized and active and the experience thus gained. The access to outside resources and other inputs through CVM has also made an essential difference.

CORDA

The changes achieved, in the intervention areas, at the level of the communities in terms of improved knowledge and awareness as well as active involvement of various community groups are the results of the combined implementers under the directorship of, the former Management, now Technical Committees. Their operational capacity has greatly benefited from the large number of training activities (annex XIV). On top of these management courses for implementers were organized in 1997.

The members of the TC's in the intervention areas are aware that behaviour is not yet changing and their awareness of the consequences of the epidemic are much advanced.

Appreciation for the activities of the programme is high in the intervention area's and even in the non intervention areas. Next to the integrated approach other components of the programme prove to serve as models and / or are used in the non intervention areas (f.i. Anti AIDS Clubs and IEC materials).

6.3.2. Technical Committees

According to the regional plan: the role of the Technical Committees (TC) is to ensure the elaboration of action plans, the monitoring of the correct implementation of activities and standards, support and advice to the lower levels, research of resource support and reporting to the co-ordinating committee.
The Health Sector has been assigned as lead agent in the organizational set up. To ensure this role the Head of, respectively, the Zonal Health Department and the Woreda Health Office are secretary to their CC and chairman of their TC. The Head of the Communicable Disease Control department or office is the secretary of the TC.

Constraints

The TC's in the non intervention areas are aware that they are not yet achieving actual results. In the intervention areas the TC's are aware that they are not as effective as they would need and want to be and they recognise emerging issues which need action.
The most important are:
- overall progress is too slow;
- behaviour change is not yet taking place;
- patient referral, care and counselling at the hospital and community level are insufficient;
- the number of orphans is rising.

The assessment at community level showed that reaching the rural areas lags behind as well.

All TC's report a number of problems that hamper their effectiveness. The differences between the intervention and non intervention areas are as such not large. The main constraints are:

a. Internal problems:
- lack of commitment and active involvement of all the sectors;
- irregular meetings with often long periods in between;
- lack of continuity of members;
- multitude of responsibilities of all members of the committee;
- absence of clear mandates / authorities to ensure adherence to plans;
- absence of resources to support and supervise the lower levels.

b. External problems:
- the low priority attached to the HIV/AIDS control issues by the higher authorities;
- lack of moral, technical and financial support from higher levels;
- lack of manuals and standards and monitoring and evaluation guidelines;
- lack of capacity and infrastructure in the sectors.

The heads of the health departments and offices feel these obstacles most urgently as they are lead agent. But in their turn they have to combine HIV/AIDS control responsibilities with many

CCRDA

others and they lack the capacity, mandates and resources to improve effectiveness. The comparison is often drawn with the Malaria Control Programme which has an own department or office, assigned officers (f.ex. in Finot Selam the Malaria office counts four staff members) and an assigned budget.

The assessment team found that, though the TC members, in the intervention areas, are highly aware of the problem issues, they have not yet been able to develop approaches or action plans to tackle them and propose alternatives to the CC's. The above mentioned obstacles are of influence but analysing their way of working additional problems become apparent:

- Systematic problem identification and analysis:

The governmental sectors are used to quarterly and annual evaluations. The monitoring and evaluation instruments and activities concentrate on verifying progress to quantitative targets set during the planning meetings. This present system has been devised for normal sector services and activities. However the nature of the HIV/AIDS epidemic, the rapid spread and interventions needed are quite different from preceding problems and thus require other approaches. The existing information collection and the instruments do not facilitate problem identification and analysis. Also problems that come to light through other means are not tabled and analysed together.

- Combining specific sectoral expertise

The main instruments for inter-sectoral collaboration used, at the moment, are planning together the activities each sector can undertake, synchronizng them and ensuring that the message content and transmission approaches are congruent. Developing new actions to address problems using the specific expertise of each sector or institution has not yet been tried.

Combined with the lack of mandates and capacity of the TC as well as the individual members the result is that the problems, that are recognised, remain on the table and are not acted upon.

6.3.3. Health Sector

The Health Sector is most affected by the epidemic. Both case finding and all aspects of patient care belong to its domain.
The inputs obtained through the programme are significant and range from blood bank equipment, protective material, medicines, training of counsellors and managers etc.

Zonal Health Department / Woreda Health Office

At their respective level ZHD and Woreda HO are the technical co-ordinating and support structures to enable the health facilities to ensure adequate care. HIV/AIDS Control mainly falls under the Communicable Disease Control department. This department is thus responsible for the fight against all the major infectious diseases except TB and Malaria control which have separate offices / officers and budgets.
All the problems of the Health System (see annex XVI) are felt acutely at this level and lie at the root of the constraints these departments experience in their efforts to tackle the HIV/AIDS epidemic. The concerned officers, themselves, perceive the lack of an HIV/AIDS department with specific authorities, assigned experts and own budget as the key constraint.
As said above, these constraints also hamper their abilities to be the lead agency of the TC and CC's.

A very significant difference between non intervention and intervention areas is that the staff of the Health Department and Offices in West Gojjam and Bahir Dar do not feel alone in facing the problems. The programme orientation, organization and budget did enable them to realise a more clear lead in the committees and activities.

CCRDA

Health Facilities

a. Testing

The policy of the federal government is that all testing is voluntary and has to be preceded and followed up by counselling. Diagnostic testing should be done by an Elisa test. HIV spot checks are to be used for safe blood transfusions.

All hospitals visited experience serious difficulties related to testing patients for HIV/AIDS. The obstacles at their own level are:

- lack of (operational) Elisa equipment and HIV spot testing sets;
- lack of laboratory technicians;
- lack of counsellors;
- reluctance of the patients.

For the population access to testing is very difficult: only the hospitals in the large towns have testing equipment. At the moment of the assessment only the regional laboratory in Bahir Dar could perform diagnostic tests.

Reporting on the number of tests carried out has greatly improved in the two hospitals of West Gojjam during the last two years. Compared to the number of suspected cases in the region the number of patients tested is however very low (FH hospital reports around 300 tests in 1999 and F/S hospital around 60!). In both cases the majority is found positive. The number of self referrals has slightly increased, in FH, but self referrals are practically non existent in F/S. The latter is mainly caused by the fact that F/S has to send the patient or the sample to FH hospital or the regional laboratory.

Counsellors, Health Department staff, and hospital staff all point to the important reluctance of patients to be tested. The answers to the individual questionnaires are in stark contrast with this observation: high percentages of both rural and urban respondents indicate their willingness to be tested. Enabling persons to know their sero-status proves to be an effective way of facilitating behaviour change, in other countries. It seems very worthwhile to investigate whether this willingness really exists and, if it does, to ensure wider availability of voluntary testing sites.

b. Counselling

Among the counsellors, trained through the programme, a large number were for the health facilities. Compared to the non intervention zones the hospitals in the intervention zones have more counsellors: FH now has 4 counsellors (2 male and 2 female) of which one is fulltime / FS hospital has three, all part-time, while Debre Tabor hospital has only two part-time and Debre Markos has none at the moment. However compared to the potential number of suspected HIV/AIDS patients (inpatients and outpatients) the number of counsellors and their availability seems very inadequate. The lower level units in the intervention zones / woredas do have staff trained in counselling but as they have no testing facilities their counselling is restricted to pre-test counselling and more general counselling.

The programme has invested much in training in counselling, however that increased capacity, in the health facilities, is not yet leading to a comparable number of persons counselled, judging from available data. The reasons are:

- Throughout the programme turn over in counsellors in the health facilities has been important. The most frequent reasons are: trained persons leaving due to assignment to other responsibilities or units. But the emotional stress of counselling combined with having to divide one's attention between numerous responsibilities is also very often mentioned as cause of stopping counselling.
- Co-operation of colleagues, by referring patients, is another problematic issue. Reviewing the differences between Finot Selam and Felege Hiwot during the last year the effect of improved staff motivation and mobilization becomes apparent: FH the number of tests has increased from around 200 per year to 300 in 9 months / FS hospital had hardly any test

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done in the last 9 months. The rise in FH hospital coincides with a revival of the counselling services. Without a doubt the absence of an Elisa machine at FS is a cause, but it does not explain all.

- The most important obstacle however is that testing and counselling are inter-linked in the governmental policy. On the one hand this means that when patients are not willing to be tested further counselling cannot be envisaged. On the other hand when people are willing to be tested but testing can not be done, or is too far away for the patient, further counselling can not be undertaken either. In both cases opportunities to prevent the spread of the disease and to assist patients have to be left unused.

When considering the realities of the country and the health care system a review of the testing and counselling policy and procedures to ensure easier access to the people is a challenge that needs to be addressed urgently in order to improve effective control of the spread.

c. Patient Care and Referral System

The numbers of persons admitted in the medical wards, suspected of HIV/AIDS, are comparable in all zones/hospitals (up to 70%). All hospitals report reluctance of patients, that are diagnosed positive, or suspect themselves to be positive, to return home. The overriding cause is most probably the stigma attached to the disease. It might also be connected to the lack of care at lower levels in the health care system (f.i. health centres only have beds for emergencies).

Referral of counselled PLWA to community counsellors patients is hampered from two sides:

- the referral system between health units and to other sectors is not functioning well;
- PLWA are very reluctant to be referred to their community counsellor for fear of exposure.

It is expected that of the patients with TB 50 to 70% are HIV positive. Care and treatment of TB is improving in the region as the new National Programme is being implemented. However the supply of medicines is not yet continuous and defaulter tracing is still to be installed.

Availability of medicines for other opportunistic infections varies a lot in all areas. In 1997/98 there was an absolute shortage of these medicines. Under the programme medicines were purchased for the West Gojjam Zone. Effective use, to ensure adequate patient care, proved quite difficult as staff changes disturbed the consensus concerning the essential package and the existing ZHD drug management system made targeted use and accounting difficult.

Compared to the non intervention zones the hospitals in West Gojjam and Bahir Dar do not lack protective material.

The community assessment showed that care for the chronically ill is a cultural tradition. Comparing the expected number of infected persons with the number of persons reaching the health care system, it can be concluded that most patients do not reach the health care system. They are cared for at home by family and or relatives.

Training of home carers or community members by health staff in view of supporting home care has not yet been undertaken in any of the areas. Staff shortages and financial restrictions form the main obstacles.

d. Health Care Staff

ZHD and Woreda HO are very much involved in HIV/AIDS control activities in all areas. The level of involvement is significantly higher in the intervention areas.

Further health staff involvement in the non intervention areas could not be assessed. In the intervention areas:

- Hospital staff are involved in training activities but not in support to the lower level units. The latter is not foreseen in the health care system;
- Staff of the lower level health facilities are active in IEC in their outreach area and active members of their Kebelle Co-ordinating Committees.

According to a number of interviewees staff motivation varies a lot but certainly needs to be improved. The reasons are both linked to the overall problems of the health system (understaffing

CCRDA

and low salaries) but also to the huge emotional implications of the disease for the patient and the system.

The obstacle cited most often in respect to improving effectiveness and continuity of care and prevention activities is the high level of turn over and attrition of health care staff at all levels (f.i. 6 different hospital directors in 2 years). Training of new personnel can not keep up to maintain capacity and quality.

An issue that struck the assessment team was that, there is an important pool of health care workers that are seldom mentioned in any of the areas: Community Health Agents (CHA's) and Traditional Births Attendants (TBA's). In view of their position and role in the communities it would seem that they represent a great potential to reach the rural populations and to ensure care of patients. When raising this option, it was pointed out that further training and adding activities to their packages quickly raises expectations and even demands for a salary, certainly when an NGO is involved. As this endangers their agreed community services plans have been abandoned.

e. Safe blood transfusions:

Both the hospitals in the intervention zones have been provided with complete blood bank equipment. No such equipment is in place yet in the non intervention hospitals. In view of ensuring safe blood transfusions these inputs have not yet had significant impact. The reasons are:

- the number of laboratory technicians is very low in the region and their continuity in the hospitals is low. The policy describes that also HIV spot checks have to be executed by laboratory technicians;
- availability of HIV/AIDS spot checks is not continuous;
- a system of voluntary donors could not yet be developed: the population is not very willing to donate blood for non-family members and the responsible agency, the Red Cross, lacks technical capacity and sense of urgency to develop and implement strategies.

A policy to decrease the number of blood transfusions has been developed. It could not be established whether this policy is applied in the hospitals. At present the blood needed for transfusions mainly comes from relatives or it is bought. The latter gives rise to concern.
For elective surgery auto blood transfusions is being practised in FH hospital.
The health centres, at district level, do not dispose of HIV spot checks and need to refer all patients needing blood transfusions to the hospitals.

The complex of problems surrounding blood transfusions only became apparent gradually. The lack of the equipment seemed the main problem at the time, but solving the other issues now proves more crucial towards achieving the aim. Careful analysis of the issues and roles of the various parties will be needed to determine the next step for the programme and CVM.

6.3.4. Other Sectors and Institutions

Due to time constraints the individual sectors could not be met in the non intervention areas. The relative recent start of their inter-sectoral organization and activities makes a comparison with the intervention sectors difficult and unfair. The findings at the community level speak for them selves. In the West Gojjam CVM programme the main sectors have been involved from the beginning. A few others have come in later either because their involvement was required, they became interested or because the regional organization set up prescribes their involvement. It would go to far to review them all here.

CCRDA

Community communicators - counsellors

As such the group of community communicators – counsellors is not a separate sector. We single them out as a group here as they have an important potential which does not come out in the assessment at community level or at institutional level.
In total 1764 communicators – counsellors were trained separately but in addition per sector or institution a large number of additional counsellors were also trained. Counsellors Team building courses and meetings were introduced to strengthen mutual support and improve effectiveness.
The approach was adopted to train for the combined function of communicator - counsellors at community level. The reason for this choice was to facilitate access for counselling for community members as contacts would be less conspicuous.
Whether this is having the required results could not be established. These cadres are not spontaneously mentioned, by the individual respondents, as sources of general or specific information (f.i. condom use). The majority of the sector and institution representatives do recognise them as communicators but much less as counsellors. Earlier we pointed out the difficulties hospital counsellors have in referring patients to their community counsellor both for follow up as for IGA. A structural collaboration between health facility and community counsellors has not yet been installed.

Undoubtedly their skills are put to use in their IEC activities as well as in their contacts with individuals. However to enable them to be more effective further investigation is required to establish what the present obstacles are and how they can be solved.

Education

Zonal Education Departments, Woreda Education Offices and the school teachers as well as teachers associations are very active in the programme. The means used to reach pupils are curricular as well as extra curricular activities. An important number of teachers is also involved in the Anti AIDS clubs. At Kebelle level the teachers represent Education in the CC's.
In general there is a high level of participation, with some schools doing better than others.
Teachers often participate or even initiate other community activities and provide individual support to families and orphans.
In view of co-ordinating efforts, ensuring continuity and improving impact the turn over and attrition rate of staff at ZED and WEO and the schools form an essential obstacle.

The general population recognise that teachers are often not the best peers as their behaviour contradicts their teachings (see the high number of teachers dying suspected of HIV/AIDS chapter 5). An obstacle here is the federal policy to place teachers in schools outside their area of origin. The Regional Education Bureau, aware of the consequences of this policy, is trying out a new approach of placing teachers in their own communities. The first results look promising.

Teachers are aware that changing the behaviour of pupils require additional methods and activities, certainly for adolescents. Things they mention are: negotiation and self defence skills for girls, peer examples for boys, etc. Their own lack of staff and extra skills hamper development of new activities.

An important group of youth can not be reached through the education system: the out of school youth. The largest group here are those that do not attend school (f.i. Finot Selam Department of Education calculated that of the 50,120 children that should attend elementary school only 48% do attend, of the secondary school age group of 21,500 only 10% attend. In Debre Tabor the rough calculations for elementary school enrolment only reached 10%!)
The Anti AIDS Clubs and Youth Centres try to reach this group and for school leavers AAC's have been started (87). This group of youth is, however, very large and findings of the community assessment indicate that it is hardly reached while their behaviour makes them highly vulnerable. A more targeted approach and wider scope of activities does seem required.

CCRDA

Labour and Social Affairs

This sector has a department at Zonal level but not at Woreda level. At the latter the Social Affairs Commission of the Woreda Council endeavours to ensure the sector involvement. As the concerned council member has many other responsibilities effective contributions are hardly feasible. At Kebelle level the Social Affairs Council member covers this sector together with many others. As such the sector does not really reach to grassroots level like health, education and agriculture.
At Zonal level the activities of the sector are largely restricted by lack of capacity and budget.

Agriculture

Zonal Agriculture Department and Woreda Office together with their 4000 Development Agents (DA's) reach down to the farmers associations. In reaching the rural communities they play a crucial role, according to the authorities interviewed. Nearly all DA's have received orientation to the subject and 268 have received training in communication and counselling.
The community assessment shows that they are not spontaneously mentioned as sources of information. In view of the lower level of knowledge and awareness at the level of rural population and as the best way to reach them is by verbal messages the potential of the DA's should be used optimally.

Also Agriculture experiences important staff turnovers and the suspicion that the death rate due to HIV/AIDS is high among DA's is quite general.

Women's Affairs

This sector only has a Bureau at Regional level. At the lower level representatives of the Women Associations are member of the TC and the association members are actively engaged in activities to reach their sisters. The representatives, met in the intervention areas, were very much concerned and they are quite instrumental in forming groups according to specific needs/settings (tea sellers, bar workers) and in reaching rural women. Their capacity is limited as all have other responsibilities. On top of this the lack of knowledge and skills to address the gender issues is strongly felt particularly with respect to increasing the abilities of rural women to protect themselves.

Ethiopian Orthodox Church

The EOC has been very actively involved from early on. Compared to the non intervention areas the priests in the intervention areas have underwent an enormous change in understanding of, compassion for and commitment to action with respect to HIV/AIDS. The commitment and instructions from the highest authority, the Patriarch, is of crucial importance. The EOC representatives are members of the TC's and CC's at each level.
Compared to all the sectors the church has the widest network of workers which reaches to the most remote and isolated rural communities. The community assessment confirms their contribution as they are the second most important source of information.
As around 90% of the population adheres to the Orthodox Church and religion of the church plays an important role in daily life the importance of the role of the church in the fight against HIV/AIDS can not be overestimated. In West Gojjam the EOC authorities have found solutions to deal with the ethical issues (condom use) that avoid contradictions between the partners in the programme.

Assessing the counselling capacity of the priests could not be done in the context of the assessment. The aim was to train counsellors for 15% of the parishes. The data show that 449 priests have been trained separately but a number also attended counsellors course for other sectors.
Compared to all the other sectors the church has a high level of continuity as it has less problems of staff discontinuity.

CORDA

The Church Authorities express serious concerns that the government does not talk more openly and forcefully about HIV/AIDS and has such limited number of specific activities.

Islamic Council

The Islamic Council has underwent a re-organization thus has to restart it participation in the programme. As most Muslims live in Bahir Dar and other towns their scope is limited. A total of 104 communicators – counsellors were trained already.

OSSA

The Organisation for Social Services for AIDS has an own externally funded programme, mainly in Bahir Dar. Its main areas are prevention through training of counsellors and support to PLWA by home counselling and subsistence financial / material support. It has started to organize PLWA's. Collaboration with the other partners takes place through the TC of Lyu Zone.
Slight differences in approach gives rise to some misunderstandings between the counsellors trained through the CVM facilitated programme. The different approach in social support to patients (IGA versus subsistence support) leads to 'shopping' of PLWA's and complicate IGA implementation. Solutions to these differences are needed and are being sought.

6.3.5. Conclusions

The operational capacity of the West Gojjam and Bahirs Dar TC's, sectors, institutions and partners has increased through the programme. This is evident from the comparison with the non intervention areas and from the achievements realised.

With respect to achieving the ultimate goal and the objectives of the programme the operational capacity and effectiveness is not yet sufficient. Next to the shortcomings found at community level, areas needing improvement are:

- inter-sectoral problem identification and development of solutions to existing and new problems;
- reaching groups requiring other approaches;
- maintaining and adapting skills;
- coverage and utilization of available services;
- continuity and quality of activities and services;
- testing, counselling and patient care;
- referring patients within the health system and between the sectors.

The external constraints are the lack of infrastructure and lack of resources of which the lack of human resources is the most crucial for qualitative and quantitative capacity. These problems are most acutely felt in the health sector as it is called to increase its effectiveness on all fronts at the same time (patient care, prevention and support to other sectors).
For many implementers the lack of policy guidance, technical and material support from higher levels, specifically for HIV/AIDS control, is a key issue.

The Internal constraints are linked firstly to the novelty of the inter-sectoral and integrated approach: experience still has to be gained. But more importantly: the present structure of the Technical and Co-ordinating Committees and the installed division of tasks means that not one level or sector perceives HIV/AIDS as their responsibility, or in other words "owns" the problem. This is compounded by the fact that none of the sectors has staff assigned to HIV/AIDS control. Though the Health sector has been assigned as lead agent, it has no authority to ensure implementation by other sectors. The end result is that the programme implementation does not have a clear directorship and the sectors miss internal direction and priority setting.

CCRDA

Counselling and testing can be powerful means to ensure behaviour change of persons and improve care. If the present policy and guidelines could be adapted to the realties of the country the counsellors and carers could be much more effective.

6.4. PROGRAMME ORGANIZATION AND MANAGEMENT

The key issue here is the ability of the programme organization and management to ensure effective implementation and co-operation with the concerned personnel from Sector offices and Institutions in the Zones.
The main actors at this level are:

- The Zonal and Woreda Co-ordinating Committees;
- The Zonal and Woreda Sector departments and offices;
- Institution Authorities;
- CVM.

The visits learnt that the Co-ordinating Committees are only just starting in the non intervention. As such a comparison with the intervention zone with respect to effectiveness in organization and management could not be done.
For the intervention areas the separation of the implementation responsibilities from the policy and management responsibilities by the introduction of two committees is relatively new. The original Management Committees combined the two sets of responsibilities. The new committees still have to get used to the new roles. In this perspective the present assessment mainly pertains to the previous set up. Therefore the observations focus on the lessons that the experiences provide for future improvement of effectiveness.

6.4.1. Achievements

As with the TC's the discussions with the CC's, in the intervention areas, covered many more issues and each issue in much more detail. Training of committee members was an important activity in the programme and as such the effects come through. It must be said that in the intervention areas there is a significant overlap between members of the CC's and TC's.
The achievements at the level of the communities and the co-operation installed can be attributed to the programme organization and its inputs. No similar structure existed beforehand and little to no other specific inputs were available till now. As said earlier: the CVM facilitated programme forged new approaches and ways to implement such a wide range of activities with a wide range of actors.

6.4.2. CVM's role and position

Before we look at the constraints concerning the effective organization and management of the programme we have to consider the special role and position of CVM.
CVM opted for the role of facilitating organization from the beginning. The reason for this choice was that the magnitude and characteristics of the HIV/AIDS epidemic required new approaches and the local actors needed to be enabled to carry out the prevention and control activities planned together. This role implies that the organization is not in control of all the actors, elements and factors that are of importance for successful implementation of a programme.

The programme was developed in co-operation with the West Gojjam Zonal Health Department and the DAC at the time. The package of support measures was tailored to the then prevailing policy, and in the expectation that the national plan would be implemented at the same time. CVM's main functions were to facilitate the development and implementation of plans, facilitate capacity building, liaising and lobbying. On the other hand, as applicant of external funds, it was also responsible for accounting to the external donors. This dual role is far from easy, certainly as no precedents exist in Ethiopia.

CCRDA

Early on, the structure of the management committees at Zonal and Woreda was developed to actively involve all the partners and facilitate management of the programme. CVM's own team was kept small in line with the facilitation policy.
This management set up proved to be feasible and appropriate to a certain extent. The limitations showed when solutions to obstacles could not be determined by the management team. Slow action from higher-decision making level combined with capacity and time constraints of implementing staff meant that the management committees and CVM could not maintain the time schedules. More importantly problems persisted (see f.i. halt in improving blood transfusion safety / need to stop supply of drugs for opportunistic infections) and the intended results could not be achieved.

During the discussions with the TC's, CC's and individual sectors it emerged that hardly any of the partners see the programme as their own. Spontaneously everyone calls it the CVM programme. Trying to analyse why the programme is not really owned by the local partners the following are aspects of influence:

- the role of facilitator is new to most actors, NGO's traditionally carry out their own programmes;
- all direct financial resources come from outside through CVM (the considerable inputs of local personnel for the communication and training activities is not recognised as own contribution);
- the problem of HIV/AIDS is not "owned" by any one sector nor by any one department: the management system in combination with the existing system of separation of responsibilities between line / technical bodies and the administrative council committees seems to result in problems "being left in the middle".

For CVM the obstacles were:

- it was not used to the role either, certainly when its accounting responsibilities became endangered it was difficult to maintain the role clearly;
- changes of staff and shortage of staff complicated correct adherence to the role, but it also obstructed progress.

To enable local partners to benefit fully of a facilitating organization and for the organization to be able to really facilitate:

- the commitment to the programme has to come from both sides;
- the division of tasks and practical contributions of each party and should be clearly agreed and described in an agreement;
- responsibilities have to be assigned within the local parties so that actual management decisions can be taken on time.

6.4.3. Constraints

Many of the shortcomings at the implementation level are known to the TC and CC members and CVM but their abilities to affect them are too limited to effectively improve them. The restrictions stem to a large extent from the external and internal obstacles identified under the implementation level (6.3.). A review from management perspective clarifies the influence of a number of these obstacles and shows up some additional constraints.
Key functions of management are planning, steering and correcting. These in turn need clear policy formulation and priority setting; availability of information, analysing skills and capacity and authority to install measures and enforce adherence.

- *Policy Guidelines and Priority Setting:*

The programme started on the basis of the National Policy set in the beginning of 1990. Between 1994 and 1998 federal and regional policy on HIV/AIDS control were not adapted.

CCRDA

The dichotomy between the sense of urgency felt on the ground by the managers and implementers and the absence of priority given to policy development and action from higher level mainly hampered the management in motivating sector office holders and institutions to become involved and take on new responsibilities on top of already heavy work loads. Planning, steering and correcting were complicated by the combination of these factors.

As inter- or multi-sectoral co-operation is new, policy guidelines are not available for this either. This in it self was less of a hindrance at implementation level once willingness to collaborate increased on the ground. Combined with the low priority perceived from regional level it did hamper management as continuity of meetings and the implementation of decisions from line and administrative bodies could not be ensured (f.i. ensuring continuity of staff /adapting job descriptions).

Management information system

There is no comprehensive guideline for information collection and analysis regarding HIV/AIDS in place yet. The Health information System has not yet integrated all the data required to follow the epidemic of HIV/AIDS and it still needs to be adapted to the decentralization. Compilation of data and reporting are very much delayed.
The programme organization and management did set up an information system to gather information on the inputs and outputs of the programme (number of persons reached / trained etc). However for data on outcomes and impact it depends on the existing regional and sector data and reports. Absence and / or late access to this kind of management information obstructs all management functions.

To be able to measure progress and effectively steer programmes like this baseline data are needed. The deficiencies of the health information system combined with the relative newness of the HIV/AIDS epidemic meant that they were / are not available. Subsequently it proved very difficult to develop clear indicators that could be monitored to facilitate steering and correcting. With hindsight one has to conclude that some of the research efforts should have been used to obtain the necessary baseline data and develop appropriate indicators.

Problem identification and analysis

Many of the implementers and managers recognise that behaviour change is not taking place, that new issues are emerging which need new actions and that certain actions are not resulting in the required improvements. However steps to tackle these subjects are not yet in evidence in the CC's and TC's. A start is on the way in Durabete with the registering of - and seeking relatives for orphans.
Reviewing the planning and evaluation traditions it strikes that at all levels workers are used to plan on the basis of performance of the previous year and not on the basis of the problems identified or known. Consequently evaluation looks at the difference between the targets set and those achieved. (f.i. the staff of a health centre set their target for STD treatment at +/- 400 as the year before they had treated 285 while the national incidence rate would set the probable number of new cases at 1000!!). In analogy the TC's and CC's evaluate progress towards the quantitative targets set and teams are judged according to this success rate. Both the evaluation instruments and procedures do not stimulate the identification and analysis of problems.
As the HIV/AIDS control issues are new and the inter-sectoral approach is new, endeavours to improve effectiveness need to concentrate on improving the skills and procedures to ensure adequate problem identification and analysis at all levels using the specific expertise of all the sectors. A comprehensive HIV/AIDS information system is indispensable for this.

CCRDA

Clear Mandates and lines of Authority

The most essential issue in an inter-sectoral organizational set up, probably is the assignment of clear mandates and lines of authority.
In the former management committees but also in the new set up no clear mandates and authorities have been assigned. The management committees and CVM experienced the consequences when the action required went beyond daily implementation: enforcing adherence to plans and decisions (see external implementation constraints). Both sides expected the other to be able to exert influence but neither had the necessary authority. Without this authority effective correcting of the programme could not be realised and thus the results planned could not be fully achieved.

The observation, at implementation level, that the present structure does not facilitate a sense of ownership of the HIV/AIDS problem, certainly also counts for the co-ordinating / management level. Except for Health, none of the sectors has assigned officers for HIV/AIDS. All heads of departments / offices, of the involved sectors, and the council committee members are already heavily taxed with duties and responsibilities. As they have numerous targets to answer to, selection of priorities has to be in line with regional priorities. HIV/AIDS was, up to recently, not yet one of them. In the Health Sector the assigned officer has to divide his/her attention between the numerous other communicable diseases. For implementation Health is the lead agent but it has no powers to shoulder this responsibility. As in other sectors turnover of heads of departments and offices as well as experts is a complicating factor here also.

A comparison of the descriptions of responsibilities of the CC's and TC's learns that the assignment of overall authority as well as management authority is not yet included.

- CC's at each level have to ensure policy setting, establish the TC, approve plans, support and advise the lower level CC's, seek resources, monitor progress and report to the respective Executive Committee and Council.
- The TC's are to prepare plans, monitor implementation and support and advise the lower levels. (see extensive description in 6.3.2.)

The fight against HIV/AIDS needs the involvement of all the sectors, but also the certainty that the actions required and agreed are implemented. A simple co-ordinating structure will not suffice. Clear authorities and terms of references within each sector and between the sectors is indispensable. The CC's, or another body, will also need to be assigned the authority to override individual sector or institutional mandates to enable it to ensure that policies and plans are adhered to.
Ideally an HIV/AIDS Bureau / department or office should be installed, composed of experts from all sectors, and with the necessary authorities and terms of reference to ensure optimal implementation at all levels and in all sectors.

6.4.4. Conclusions

Next to the obstacles to implementation the constraints at the level of the organization and management of the programme also obstructed the attainment of the intended results.
The inter-sectoral co-operation, in view of tackling such large issues as HIV/AIDS control, cannot succeed with only a co-ordinating structure. It needs clear directorship with adequate mandates and term of reference to ensure adherence of all partners.

CERDA

6.5. EXTERNAL ENVIRONMENT

6.5.1. Factors influencing the programme

Country Context

The National Department of AIDS Control (DAC) was involved in the needs and feasibility study for the programme. The advisory support from DAC enabled the Zonal Health Department and CVM to elaborate the programme in line with the national programme. Follow up advice and logistical support greatly facilitated the start up.

The Regionalization of 1994 meant that the main responsibilities for regional state affairs were transferred to the Regional Authorities. The regional administration and line bureaux had to undergo important changes to adapt to the new responsibilities. For the HIV/AIDS Control activities the effects were significant: expert staff and funds for activities did not move down with the responsibilities and the Region had not yet defined an own programme. Thus central leadership and commitment were not in evidence and expertise not readily available.
The lack of clear leadership and commitment from the highest level combined with the lack of specifically allocated funds for prevention activities meant that at lower level commitment and willingness to undertake action was more difficult to mobilize.

The gradual implementation of the decentralization means that responsibilities are continuously in transition this complicates the administrative and technical steering and integration of the programme. The fact that administration and technical mandates are quite strictly divided between the councils and the technical / line offices adds to the complications and often causes important delays. The frequent changes of officers is an important factor hampering factor as well.

Amhara Regional State

At present a start has been made to strengthen expertise at Regional Health Bureau (RBOH) amongst others by employment of HIV/AIDS experts. The main responsibility for the technical steering of HIV/AIDS remains under the Communicable Disease Control Department / Offices. Their budget does not allow for supervision support visits to the lower levels.

The RCC and RTC are installed since one year and still have to become operational. Due to the end of the fiscal year activities only a restricted RCC could be met very briefly, mainly to present a summary of the findings during the assessment. The RTC could not be met.
The TC counts around 20 members (2 members per sector, Family Guidance Association, CVM, OSSA, Save the Children UK, EOC and Islamic Council). It met once in the last nine months.

The individual sector bureau heads could be met during the assessment. The sectors most directly involved and / or affected are very aware of all the issues at stake. Some sectors are not yet very aware of the magnitude of the problem and its consequences (f.i. Agriculture and Justice). This is partly due to changes of staff but also because their involvement in the Committees is low and / or the demand for their involvement is low (f.i. Justice could play an important role, it does not yet recognise that role and other sectors are not yet requesting its specific inputs).

Many of the persons met, realise that the level of commitment and involvement of regional authorities is limited and seriously hamper support to the lower levels. The practical consequences they indicate are:

- the high priority given to other issues than to HIV/AIDS;
- the number and standard of the experts and other staff is still far from the capacity required;
- absence of a clear agenda and of clear mandates / authority for the regional level as, in line with decentralization, Zones and Woredas are responsible for their own plans and budgets;

CORDA

- the separation of technical and administrative responsibilities, combined with the former point, means that the line bureaux have little authority towards the lower levels to ensure adherence to policies and plans;
- there is no budget allocation for the HIV/AIDS: the sectors have to ensure their activities from their regular budgets and cover the activities of the RCC and RTC.

6.5.2. Regional and National Recognition

CVM and the West Gojjam HIV/AIDS Management Team played an important role in raising awareness of the extent of the problem at Regional Council level. The 1998 Regional Conference was sponsored and co-organized by CVM. The experience in the West Gojjam Zone inspired the organizational model chosen by the Regional Council. CVM is now a recognised partner in the Region expressed by full membership of the Regional and Zonal Co-ordinating and Technical Committees and the attribution of a role in the strategic plan. CVM is also requested to extend its involvement to six new zones. A programme based on the same principles as the West Gojjam and Bahir Dar programme has been elaborated.
The ANRS Multi-Sectoral Strategic Plan does not mention this new extended programme but does mention new activities for CVM (undertake blood donor recruitment). The budget does not contain an allocation for CVM or mention the budget that is foreseen for the new programme. The reason is that the plan and budget were still being elaborated at the time.

At National level the DAC has always followed the developments in this programme and when possible provided advice and support. It does not figure in the national data mostly because the data collection system has been disrupted by the regionalization.
The Christian Relief and Development Association (CRDA), the main NGO co-ordinating body is very well acquainted with the programme through field visits and reports. The programme is often presented as a model for other NGO's.

CRDA

6.5.3. Future Perspectives

During the assessment mission it became apparent that at national and regional level the fight against HIV/AIDS was gaining new momentum. The National AIDS Prevention Council has been installed. Important deliberations were on the way to obtain funding for the three year Federal and Regional Multi-sectoral HIV/AIDS Strategic Plan. In the mean time it has become known that the World Bank has allocated a soft loan of 59 million USD for these plans. However set against the extent of the HIV/AIDS disaster in the country the amount is quite modest and the loan aspect gives rise to concern for the future generations.

6.5.4. Conclusion

The West Gojjam and Bahir Dar HIV/AIDS programme adheres to and fits in the national HIV/AIDS Policy. It has contributed at various levels to an improved understanding of the extent of the problem, the issues involved and the practice of prevention and control.

The programme management and implementation certainly felt the obstacles related to the socio-economic situation and lack of infrastructure. But more importantly it missed the assistance in policy and priority setting from the regional level. The latter in turn missed guidance from national level.
In the light of the obstacles related to the external environment the achievements of the programme are remarkable and impressive.

The future promises important positive changes but the practical hurdles to translate them into effective programme implementation are still important as well. The crucial change required, first of all, is increased political commitment and involvement of administrative authorities at all level.

6.6. INTEGRATED APPROACH

In principle an integrated multi-sectoral strategy for HIV/AIDS prevention and control consists of two components:

1. Installing collaboration between all sectors and partners that are affected by a specific (set of) problem(s). The aim is to use the expertise of each to ensure full problem identification, analysis and the elaboration of solutions that address all aspects and that are appropriate and feasible;
2. Developing and implementing a set of interventions that in combination and in a continuum ensure that the entire range of problems is addressed (in the case of HIV/AIDS from prevention to care of patients and mitigation of the consequences at family and community level).

In general the development of an integrated approach evolves through three stages:

a. Synchronizing activities and ensuring that messages are consist and congruent;
b. Pooling expertise to improve each others messages and activities;
c. Developing and implementing interventions together using each others expertise and capacity;

Judging from all the discussions the integrated approach is perceived, at present, as combining the plans of each sector and bringing the same messages at the same time (phase a). In most intervention areas messages and activities are being improved with the expertise of the combined group (phase b).

In comparison with the situation at the start of the programme and with non intervention areas progress is apparent in the consistency and range of activities carried out as well as in the increased awareness of the issues at stake in the TC's and community groups. The example of Dejen (non intervention area with isolated interventions resulting practically only in increased individual knowledge) provides an indication of the added value of the approach. The achieved level of awareness and the level of participation of community members in various activities can only be achieved through concerted action.

Considering the achievements we have to remember that no experience existed with this integrated and multi-sectoral approach before. The number of sectors. levels and institutions involved is vast and their orginal starting points were very varied, to say the least. International reports show that establishing multi-sectoral collaboration is easier said than done (UNAIDS report 1999). Therefore the level of co-operation that has been achieved here is no mean feat and provides important lessons for others. Many external interviewees confirmed this.

In comparison to what was planned and to the level of comprehensive integrated strategy required to obtain an impact, the following factors hampered further evolution:

- the restrictions of the existing infrastructure and capacity in the sectors;
- the low level of urgency and priority given to the epidemic;
- discontinuity in staff involved;.
- inexperience to solve problems that surpass their own sector;
- lack of tradition, experiences and skills in problem identification and analysis as well as in inter-sectoral problem solving;
- lack of standards and guidelines for activities and procedures.

A programme such as this can not address all these factors. The developments at national and regional level promise a higher priority for the fight against HIV/AIDS and the multi - sectoral approach. The Sector Directors need to seek solutions to ensure continuity of staff so that stable teams can develop the approach.

The development of skills and capacity in problem identification, analysis and solution development would be an important contribution. As these can not all be learnt in a class room setting, intensive coaching of the TC's will be of great assistance.

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The development of the HIV/AIDS Information System for monitoring and evaluation as well as the development of standards and guidelines should be undertaken at the same time to facilitate the processes in the TC's and avoid that every team needs to invent the wheel. They can then concentrate on the issues and aspects specific for their own communities and target groups.

The team building efforts which have already been initiated should be strengthened to develop the necessary sense of common purpose and of continuum of care.

6.7. SUSTAINABILITY

The definition used as basis for the assessment of the sustainability is: the capacity of local implementing agencies to continue a programme with minimal to no outside support in financial and technical terms (A. Stefanini in: Sustainability the role of NGO's, WHO Bulletin, vol. 15, 1995). The implementing agencies here are the Co-ordinating and Technical Committee of the West Gojjam and Bahir Dar Zones together with the individual sectors and institutions.
A number of factors are crucial for sustainability. In earlier subchapters we have reviewed factors such as commitment and adherence to local policies and priorities. Here we will focus on cost effectiveness and availability of local resources.

6.7.1. Cost effectiveness

Overall the financial input of the programme is very modest: over the six year period 0,40 USD per capita was spent in the intervention zones. The overhead costs amount to 12.5%: while the percentage foreseen was 9%.
For a grand total of 1,900,689 IEC materials were distributed for the sum of 1,970966.87 Birr (1 USD = 8 Birr: 246,370 USD) was spent i.e. around one Birr per leaflet. This budget line is over overspent by 150%. This was mainly caused by the request from Regional authorities to distribute IEC materials at regional level as of 1998.
A total of 198,716 persons received training or orientation: expenditures 1,542,667 Birr this amounts to 7.75 Birr (+/- 1 USD) per person (a very rough figure as the differences between the kind of training's and workshops is very large, of the total around 180,000 persons attended one day orientation workshops and around 18.000 persons attended training workshops). Also this budget line has been largely overspent (100%). The major component of the costs for training is the per diems that are required both for teaching staff as for employed trainees (ranging from 20 to 50 Birr per day).
Hardly any comparable programme exists to allow comparisons to measure the cost effectiveness. Reviewing the results achieved with the IEC materials and training in terms of change in knowledge and awareness of the target population as well as mobilizing the sectors and institutions, strengthening their capacity and actively involving community members and volunteers the budget was used as effectively as possible.
A review of the other budget lines is much more difficult as the expenditures can hardly be compared to a measurable result and some of the investments (f.i. blood bank) are not yet fully operational.

The significant over and under expenditures of various budget lines do indicate that there is room for improvement of effectiveness in planning and implementation.

6.7.2. Availability of local Resources

Nearly all the financial resources for the activities, carried out under the programme, came from outside through CVM. Technical support came to some extent from outside of the country (CVM head office staff, researchers and some trainers) but mostly from within the country (trainers, advisors). The main aim of the training activities was and is to build local / internal capacity at all levels of programme management and implementation to ensure future sustainability.

CCRDA

During the implementing period the line sectors had no specific budget for HIV/AIDS prevention and control. They had to finance their contributions from the regular sector budget. As such these contributions are important but cannot be quantified at this point for two reasons:

a. The intention of the programme was to facilitate and compliment the local plan. The budget only shows the additional resources foreseen for this purpose. The local contributions were not quantified in advance.
b. The main local contributions consisted of time of staff who belong to the staff establishment of the line sector and the time of volunteers.

It was thought that the absence of a budget from national and regional level for HIV/AIDS was in line with the basket funding principle (when an NGO funds line activities in a zone the budget foreseen for that zone is divided among zones without outside support). However the non intervention zones did not have a special budget for HIV/AIDS prevention and control either.

All respondents asked, expressed serious doubts that the programme could continue if CVM phases out its contributions and if no other budget becomes available. The technical capacity, at the various levels, is now available so basic information and education can continue. But without additional funding there would be no possibility to:

- Produce and distribute standard IEC material let alone develop new material to stimulate behaviour change;
- Ensure further training and refresher courses in view of maintaining capacity, training new people and developing new skills;
- Develop responses to overriding issues or new issues, which do not fit into the regular sector budget.

In other words the local financial capacity to sustain the programme and work towards an actual impact is not available. Stopping the outside support would in fact mean that the programme will become ineffective or grind to a halt.

As all indications point to a continuous rapid spread of the HIV/AIDS epidemic and as the necessary changes of behaviour need different support interventions the contrary is required: increased support to ensure that the tide can be turned.

6.7.3. Future

Ethiopia is one of the poorest countries in Africa. The investments required to halt the spread of HIV/AIDS and mitigate the consequences surpass the national possibilities. The developments at national level (see chapter 5 and 6.6) promise more international assistance. If these funds actually become available also for the region, CVM might be able to review its contributions to the West Gojjam and Bahir Dar Zones.

6.8. UNMET NEEDS / ADDITIONAL ACTIVITIES / UNINTENDED EFFECTS

In respect to this question it is important to remember that West Gojjam programme was formulated as support to the Zonal efforts and CVM's aim was to facilitate. This means that it never was the intention to cover all aspects of the fight against HIV/AIDS and cover all the needs. No unintended effects could be established.
Therefor the following observations concentrate more on the issues that have been left underdeveloped by the sectors and target groups that prove to need adapted strategies.

CCRDA

6.8.1. Target Groups

Out of School Youth

The school enrolment rate in the rural area's is very low. Whether HIV/AIDS information actually reaches the youth, who never attend school, is seriously questioned. The present interventions of the programme are geared towards school youth, school leavers and the general public. Written materials will not be accessible to them and they may not feel addressed by messages which are tailored for adults.

Women

The community assessment showed that the rural women are particularly at risk as they may practise faithfulness, but their husbands have an increased risk due to their commercial sex contacts in town.
Women that have left their rural family and try to survive in town enter into the informal commercial sex net work. The network has not yet been included in the condom distribution system and they are hardly reached through the existing IEC activities (the latter is done in the intervention areas).
A more comprehensive approach to address the gender inequalities and enable women to protect themselves by exerting protective behaviour from their husbands or clients is needed for all groups of women.

6.8.2. Underdeveloped Services

STD and TB care

In all areas STD care is an integrated service of outpatient services. Some units have specific clinics but the feeling is that these are not very successful. Among the population the stigma attached to STD's is comparable to that attached to HIV/AIDS. Compared to the suspected incidence in the region the number of cases found is quite low.
The West Gojjam and Bahir Dar programme did not contain a component for STD's care. At the time of its conception AIDSCAP was active in this field and the MoH was envisaging a separate programme.
In the intervention areas information about the availability of medicines to treat STD's is contradictory: the health institutions report adequate supplies while other respondents report shortages. In view of HIV/AIDS prevention active case finding is needed. The present policies and capacities in the health facilities are the main obstacles to active case finding. The lack of access to health facilities, the long waiting times at the facilities, the stigma attached to STD's and the rapid increase of private drug sellers mean that self medication is becoming wide spread. The risk of increased resistance to antibiotics is a reality.

To a certain extent the same applies for TB care. Though the national programme is being expanded with considerable speed access to the health facilities and to X-ray's for diagnosis is difficult. Active case finding and defaulter tracing are not yet practice in the health units.

Voluntary testing

At present testing is only available in the large towns which have a hospital. Access for population outside of the towns is practically nil. The respondents in the individual interviews indicate a high willingness to be tested. Making testing and counselling available closer to the people could have an enormous positive effect on changing behaviour towards protection of one self and others as well as facilitate support to PLWA.

SCRDA

Support for Home Based Care

The low number of patients admitted and the cultural tradition to care for ill family members, indicate that many patients are being taken care of at home. Whether the number of patients wanting to stay in hospital, living in the cemeteries and in the streets of Bahir Dar are indications of the stigma or of failing coping capacity of the families is not known. Sure is that the number of terminally ill will still rise further and that the hospitals are already failing to cope.
To lift the burden off the hospitals and ensure that families can cope a system of support for home care should be developed together with community organizations and volunteers.

6.9. CONCLUSIONS

The CVM facilitated West Gojjam and Bahir Dar HIV/AIDS prevention and control programme is well known and well appreciated in the intervention zones as well as outside.
Without a doubt much has been achieved in the intervention areas through the programme's approach and interventions:

- Knowledge about, understanding of and attitudes towards HIV/AIDS have improved both at individual as at urban and rural community level;
- A number of specifically vulnerable groups have access to - and participate in specific interventions;
- Participation of community members and vulnerable group members in activities is rapidly increasing, certainly in the urban settings;
- Knowledge, awareness and capacity to deal with the issues has been raised within the sectors and the institutions;
- The main religious institution, the EOC, has become a fully active partner in the programme;
- An important start has been made with the multi-sectoral approach and the lessons being learned assist others to install similar co-operation forms;
- An important start to an integrated strategy of interventions has been piloted which provides a basis for further elaboration to improve effectiveness and address the consequences and emerging issues;
- Last but far from least: the experiences gained together with other actions of the programme implementers and managers have resulted in increasing awareness at regional level and the installation of a multi-sectoral HIV/AIDS organizational structure;
- The programme adheres to and fits in the national HIV/AIDS Policy. It has contributed at various levels to an improved understanding of the extent of the problem, the issues involved and the practice of prevention and control.

Particular strong points are:

- The level of concerted action and collaboration installed;
- The development and distribution of a wide range of IEC material, reaching far beyond the intervention areas;
- Training at all levels and of all different partners;
- Support to the health structures.

The goal: a decline in the number of HIV/AIDS infected persons can not be measured because of lack of data. The major outcome intended to reach that goal: change of behaviour towards prevention of transmission is not yet evident. Considering the time required to achieve behaviour change, which in turn can have an impact on the rate of transmission, one has to conclude that the goal was set optimistically.
More importantly the experiences gained and the findings of the assessment show that, in the existing socio-economic and cultural setting, the assumption, that improved knowledge and awareness will lead to behavioural change, might be incorrect or incomplete. Though essential prerequisites, to achieve the transition, more is needed:

- the sense of urgency to change has to become overriding and

CCRDA

- alternatives, to present behaviours, have to be accessible, feasible and lead to similar benefits.

For the latter, the widespread poverty forms a near insurmountable obstacle.

The intended results towards improved care and solidarity for patients within the health care system and within the communities has only been achieved partially.

The main factors hampering the programme are:

- The low priority attached to HIV/AIDS control by administrative and political leaders: a crucial obstacle to mobilizing staff, population and resources;
- The shortages in infrastructure and resources, certainly in the health and social sector, due to the poor socio-economic situation, greatly hinder coverage and effectiveness as well as sustainability;
- These shortages in combination with present policies mean that counselling and testing are hardly accessible to the majority of the population and counsellors are quite restricted in their possibilities to assist individuals and communities.

Weaknesses within the programme are:

- Insufficient sense of ownership of the HIV/AIDS problems and of the programme at the level of the public actors;
- The organizational set up does not allow timely solutions for obstacles that require decisions beyond the mandates of the members of the committees;
- Discontinuity of staff at all levels and within all sectors decreases the effects of capacity building efforts and hampers progress.

In conclusion: Progress towards the goal and major outcome of the programme is significant. The facilitating role of CVM and the approach of the programme have forged inter-sectoral co-operation. The lessons allow to greatly improve future action and co-operation as well as assist other actors and programmes. The technical and financial resources used are modest but sustainability is still far away due to the socio-economic situation and the extent of the problem.

However all available data indicate that the HIV/AIDS epidemic is still rapidly spreading in Ethiopia. There are little indications that this would be different in the Amhara National Regional State. In view of the extent and the consequences of the epidemic a much higher level of intensive and comprehensive action is urgently needed. There is no time to wait, there is even no time to allow behaviour change to follow it's natural course.

To ensure behavioural change the public awareness of the urgency to change has to be increased rapidly: all leaders and authorities have to assist in social mobilization.
Next to this people must be enabled to develop alternative means to gain an income.

To succeed concerted action the multi-sectoral strategy is indispensable but it has to be undertaken with clear and undivided directorship. Complementarity of actors, strategies and activities require common goals, clear stewardship and a high level of commitment.

Policies and procedures need to be adapted to the realities of the country. Particularly testing and counselling policies should be made available closer to the population to ensure that population wanting and needing testing can have access. The potential effect on changing behaviour and ensuring care are too important.

CCRDA

7. RECOMMENDATIONS

The following recommendations are based on the assessment findings and aim at improving effectiveness so that the intended impact can be achieved more rapidly. They are presented in three parts: recommendations concerning overall HIV/AIDS Prevention and Control priorities, programme organization and implementation; recommendations for CVM and last, but not least, suggestions for specific programme components.
As it is an multi-sectoral programme it is hoped that all partners will benefit from the recommendations.

7.1. HIV/AIDS PREVENTION AND CONTROL

7.1.1. The wall of silence urgently needs to be breached for good and the entire society needs to be mobilized from all sides. Particularly leaders and higher authorities have to provide public backing to the efforts of front line workers.
It is hoped that the renewed attention at National and Regional level and the Strategic Plans will urge National and Regional authorities to start conveying to the public, in words and deeds, the seriousness of the epidemic and the urgency to act.

7.1.2. Next to this the fight against HIV/AIDS has to actually be given the highest priority so that attention, time and the available resources really become geared to intensive and comprehensive action at all levels as soon as possible.

7.1.3. As the HIV/AIDS is a national social problem, that concerns and affects all sectors, institutions and organizations, the multi-sectoral and integrated approach should be maintained and strengthened. The developments at federal and regional level are promising but to succeed, the commitments will need to be translated into daily practice immediately. The experience gained within this programme provides valuable lessons to build upon.

7.1.4. To ensure the success of the co-operation and integrated approach a clear lead agent with the appropriate mandates and terms of references needs to be appointed so that directorship is assured and transparent. Ideally a separate Regional HIV/AIDS Bureau, composed of experts of the main sectors involved, combined with similar Zonal Departments should be set up to lead and support all sectors and actors at the various levels.

Alternatively the sectors should at least appoint officers specifically for the HIV/AIDS programme and assign them the necessary responsibilities and time to ensure sector participation, guide the lower levels and liaise with the other sectors. These same focal persons should be the constant members in the TC's. Measures to ensure continuity in staff involvement need to be set in place.

7.1.5. To improve involvement of all sectors and ensure access to all skills it should be considered to extend the CC's and TC's with the sectors that hitherto have not been included according to their role at the respective level (Justice / Police / Military).
To improve responsiveness to the needs of communities it could be considered to include community representatives at each level as well as strengthen the horizontal links (Woreda representatives in Zonal Committees, etc.)

7.1.6. An adapted HIV/AIDS Information System needs to be put in place to ensure monitoring and evaluation, including a system of reporting that allows all partners to dispose of the necessary information to steer and correct their implementation in a timely fashion. For certain aspects baseline studies have to be carried out.

7.1.7. Together with the information system the quarterly and annual planning and evaluation approach should be adapted to foster and facilitate inter-sectoral problem identification, analysis and development of solutions. The system of planning and evaluation should also include ways to

CORDA

ensure 'learning by doing' as so many issues around HIV/AIDS and inter-sectoral co-operation need to be developed along the way.

7.1.8. Guidelines and standards need to be developed to facilitate implementation and improve quality of services.

7.1.9. Adapting the testing and counselling procedures to the realities in the country and the health care system seems warranted. It would greatly increase case detection, enable persons to adapt their behaviour to their sero-status and increase access to care for the PLWA.

7.1.10. Strategies to address the issues of gender inequality, which obstruct the possibilities of women to protect themselves, need to be developed and supported by the highest authorities to strengthen social pressure towards changes of behaviour. The policies to protect women and girls will have to be underscored by appropriate legislation.

7.1.11. Strategies and interventions need to be developed in collaboration with all sectors to enable the most vulnerable groups to earn an adequate income and / or fulfil their potential so risk behaviour can be decreased.

7.2. CVM

7.2.1. The role of facilitating organization is suited to the inter-sectoral / multi-sectoral approach. However it is complicated and far from easy as the three aspects are relatively new (working with facilitating organizations, the multi-sectoral approach and the HIV/AIDS epidemic) and final control lies elsewhere. It would be helpful to define the specific roles very clearly and ensure local agreement and commitment to these beforehand. The agreements should also define the division of tasks, responsibilities and contributions well.
If the role of facilitator is combined with accounting responsibilities towards external funding agencies, the management responsibilities of the local partners need to be assigned clearly to ensure decisions can be taken timely.

7.2.2. For future programmes, where CVM wants to take the facilitation role, the goal and objectives should be set more realistically in relation to the local commitments and capacities. Impact goals and objectives might be beyond the scope of a facilitating organization, outcome and output objectives are more in reach.

In cases where innovation is required, through pilot experiences, it might be considered to take up a more direct responsibility as implementor to ensure that the lessons to be learnt can be distilled clearly.

7.2.3. Though the influence of the positive and caring approach could not yet be established, or rather, is not yet specifically recognised by the population, all the possible consequences of the epidemic indicate that it is the right way forward and thus it should be enhanced (other experts are arriving at the same choice: Prof, Alan Whiteside said in a radio interview: 'we have to enable communities and societies to care for each other: create caring communities and societies').
As facilitating organization CVM can play an important role in enabling all partners to keep this approach in focus and strengthen willingness and capabilities to cope with HIV/AIDS all round. In particular fostering care for : the youth by helping them to adopt safe behaviour from the start; for women and girls; for patients and families and for orphans (see separate chapter).

7.2.4. To increase the effectiveness of the facilitating role the quality and to, a certain extent, the quantity of the staff should be increased (see Finot Selam: close follow up does make a difference). The realities of the implementing agencies (sectors / institutions) require a certain comparability in seniority and expertise.

CORDA

In line with the facilitating approach and the philosophy of caring communities the main roles of the CVM staff should be that of stimulators and coaches. In turn head office can assist the regional team in strengthening these skills by coaching them.
In view of enhancing inter-sectoral problem solving, the team will need to increase their own skills in this first.

7.2.5. Phasing out of the West Gojjam and Liyu Zone now, does seem too early:
- behaviour change still needs to be realised and proves to need different strategies, methods and inputs. The present integration in these two zones allows to develop these strategies and methods further in a continuos way and thus enable these zones to advance together. At the same time it provides testing ground for new interventions to gain practical experience and adapt according to experience gained;
- the present involvement and commitment of the sectors and institutions does not seem sufficient to take over without back-up support. The responsibility towards the communities suggests a need to continue until continuation is definitely assured.
- when the federal and regional plans obtain funding the handing over could be possible in the coming two years. This will provide the time to implement the phase out gradually in co-operation with all partners on the basis of actual capacity and commitment. Clear agreements and a time frame will have to be elaborated and implemented, including a system to monitor and correct progress, to ensure that the phasing out actually takes place.

7.2.6. The new regional Multi Sectoral HIV/AIDS Strategic Plan does recognise CVM as partner, but the assigned role does seem to limit CVM to a role of provider. In line with CVM's philosophy and in view of strengthening the integrated approach, further negotiation does seem warranted. Certainly when the request to take on six new zones is taken in consideration.

7.2.7. With respect to the request of the Regional Authorities to extend the programme to six more zones and the plan that has been elaborated this far: As there are indications that the commitment to the HIV/AIDS problems still needs to grow in some zones and some sectors;
- it would be advisable to implement the plan very gradually;
- on the basis of clear and practical indications of commitment from the side of the zonal and / or woreda administration and sector authorities.

It should be considered to develop a contract approach in which the Woreda and / or Zone commits itself to certain duties and resource contributions. A financial contribution seems to be necessary to strengthen the sense of common ownership. The TC and CC should also elaborate a first plan of action that can serve as start of the discussions.

7.2.8. There are indications that the World Bank HIV/AIDS programme intends to make funds available to the regions as well as to community initiatives and NGO's;
- CVM should foster access for community organizations by assisting them in investigating the feasibility of their plans, elaboration and presentation of proposals, implementation and accounting;
- CVM should adapt its use of funds to the new possibilities: i.e. prioritise the neglected areas and activities in view of strengthening the coping capacities of the communities.

7.2.9. The evolution of the epidemic in the region as well as the findings, of the community assessment, show that the vulnerable groups should be defined more clearly and the interventions and messages better tailored to their specific situation. (8-10 years; adolescents; out of school youth; jobless school leavers; girls; the informal sex workers; rural women and couples, etc).
CVM can play a role in developing more refined messages and materials.

CCRDA

7.3. PROGRAMME COMPONENTS

7.3.1. IEC

Messages and methods need to be adapted as well as diversified to enhance awareness and underscore other efforts to change behaviour.
An important new thrust should be undertaken to reach the people who can not read mainly in the rural areas. (audio and visual means like tapes, picture stories, songs)
The plans to decentralize the production of printed IEC materials should be studied in view of sustainability (development and printing costs often decrease as the number printed increases).
In interventions for the youth, reproductive health issues should become integrated.

7.3.2. Anti Aids Clubs

The approaches and skills training to foster behavioural change should be strengthened (f.i. practical life skills training). The members need to be better equipped for their roles as peer educators. These youngsters can then also assist in reaching the out of school youth.
Training the members as counsellors could enable them to undertake individual education of school mates with high risk behaviour (preventative counselling).
The gender issues need to be addressed in the schools as well. In addition girls need skills to defend themselves. The members and teachers should be encouraged to create school traditions of caring and defending one and other.
The relations and co-operation between the AAC"s and the Youth Centres should be fostered.

7.3.3. Youth Centres

The animators should be given a much clearer focus and target groups: mainly the out of school youth and the jobless school leavers. Their training in IEC methods and individual education / counselling can then be adapted to reaching these specific groups. Practical training in life skills and TOT capabilities should also be included.

7.3.4. Training

To foster behaviour changes towards prevention and caring the objectives, methods and contents can be taken steps further now: more practice oriented, more on the job coaching and follow up, to further develop skills.

A new area in view of improving the effectiveness of inter-sectoral co-operation is the training in the full cycle of problem solving. All levels could benefit from these training courses: from community to CC's. When committees can be trained together the training itself can enhance their co-operation.

Training in psycho-social support should be increased to improve the counselling skills and stan preventative counselling (providing moral support to the ill and their family members / counselling persons with respect to their behaviour and how they can change it more than focussing on the possible presence of the disease, etc.)

Training in home based care for community volunteers could be tried to investigate a feasibl approach.

Refresher courses and training new comers in the basic skills will have to continue to keep u capacity. (see turn over and drop outs).

Finally to improve continuity of the use of the capacity developed as well as improve the quality o training the following procedures should be installed:

CCRDA

- specification of selection criteria for candidates from institutions and sectors, including minimal assurance that the person will and can put the new skills to use for the benefit of the zone / woreda;
- this can be enhanced by drawing up a bondage contract between institution / sector and the candidate for a period consistent with the duration of the course;
- follow-up supervision should be installed to strengthen motivation and capabilities of trainees (the demand is significant);
- monitoring of the number of persons trained per course and the number of persons continuing to use their skills after specified periods should be installed;
- and together with some periodical post training evaluations the quality and appropriateness of the training's can be kept up to date.

7.3.5. Voluntary Counselling and Testing

Voluntary Counselling and Testing (VCT): there seems to be a demand when we look at the individual respondents. Access to VCT proves to be an effective way to intensify awareness and improve preventive behaviour. It can also contribute to decreasing fear and stigmatization.
It would seem worthwhile to investigate together with authorities whether CVM could play a role here. The present drawback is the policy stipulation that diagnostic testing can only be done by Elisa. However there are indications at national level that this is under reconsideration. CVM could, f.i., consider to apply for / offer to take part in or execute trials for HIV spot / rapid test use in VCT. The suggestion to start such services in the Youth Centres does not seem a good idea as this could restrict the access of exactly those youth groups they should be reaching.

7.3.6. Patient Care

Care for HIV/AIDS (suspected) patients, within the formal health care system, is largely influenced by all the constraints the health care system in Ethiopia is experiencing. In turn the epidemic poses enormous additional strains on the system. If the expected HIV/AIDS funds and those for the health plan become available, for the region, important progress may be achieved. Adequate care for the PLWA is of great importance in the fight against the spread of the disease. If additional resources are to strengthen the fight then care for PLWA will have to be given a much higher priority in all the plans and efforts.

The role of a facilitating organization is to assist and complement, in various ways, the execution of local plans: strengthening of capacity, providing missing 'nuts and bolts', etc. In view of the existing constraints of the health system, the possibilities to have an effect on the system are minimal.

The crucial issue in patient care is testing and counselling. As argued, the present combination of the testing and counselling policy, the lack of infrastructure and resources mean that access, for patients, to testing and counselling is minimal. The potential for facilitating improved access is large if the future national and regional strategy can be adapted (see 7.1.9).

A key area, where CVM can contribute significantly, is building / strengthening capacity by informal / on the job training. However, to have a lasting effect, the local administrative and implementing partners will have to be committed to giving the trained staff the scope to use their new skills to the benefit of the target population and determine ways and means to ensure continuity (keep trained staff in place and motivated).
Another area is assisting in developing manuals and guidelines. Here again local commitment and participation are crucial.

Where CVM could provide most support is in facilitating improved care at community and family level. The cultural tradition to care for family members is very valuable and can be reinforced. The health facility and community counsellors will be key actors here. On the basis of the findings, strategies and further training can be developed to improve their contributions to patient and family

CCRDA

care as well as prevention through individual education (preventative counselling). Strengthening communication and co-operation between health facility based counsellors and community counsellors, for instance by installing regular meetings and / or starting associations of counsellors, can enable them to find solutions to the referral obstacles together.

Investigating possible approaches to provide moral and practical support to family carers through community volunteers (CHA's, TBA's and / or others), could be a significant contribution. Together with the priests and community counsellors the perspective of a more holistic approach might be piloted. The obstacles of the health care system pose significant challenges and certainly mean that a complete home care programme is out of reach (f.i. medical / medicines support will not be feasible given the resource and infrastructure constraints). However, from the perspective of care for the chronically / terminally ill and his/her family, possibilities may lie in training community volunteers to counsel and assist family carers in general physical care and moral support; enlisting support for the family from the community etc. In the same line, community counsellors and priests could be trained to counsel the sick person and his family to enable them to come to terms with illness and possible death.

7.3.7. Support to Health Structures

The considerations presented under 7.3.6. also apply here. The main role a facilitating organization can play here is providing missing parts to ensure complete functioning. The needs will depend on the funding of the Regional Strategy Plan. In view of the experiences in the past, it is advisable to explore the demands carefully to ensure that an investment or effort can actually be put to use i.e. that all the other needs, to ensure effective use, have been adequately addressed. Further refining of agreements should aim at ensuring that partners actually realise their responsibilities to ensure adequate use of the inputs (f.i. to strengthen commitment of local partners, clauses pertaining to consequences of non compliance could be added).

An improved referral system to - and from - health facilities is a prerequisite to improving the continuum of care for patients. However it is the question whether a facilitating organization can play a part in getting it off the ground. In all health systems this is a notoriously difficult area. In Ethiopia more so as the entire health system needs to be further developed and is undergoing rapid changes in view of decentralization.

7.3.8. Income Generating Activities

These activities have not been successful until now. More research is required to develop an approach that can effectively assist the PLWA and their families and be managed well.

IGA has an important potential in facilitating behaviour change if the vulnerable groups could have access to it (f.i. sex workers, girls, unemployed youth). This will require different strategies and it will have to be coupled with skills training.
Other groups of possible beneficiaries, such as relatives or community groups caring for orphans and / or patients, need to be considered as well.

The overall poverty situation entails that the needs are enormous and can not be dealt with by one organization, least of all a facilitating organization. A feasible role would be developing and piloting innovative approaches.
The present experiences, both within CVM as in the direct surroundings are too limited to develop new avenues. Technical expert support should be sought both to develop feasible IG strategies and activities, as ways to ensure adequate management of the funds and loans. The key question 'which role can a facilitating organization actually play in IGA' will have to be an integral part of the research and the proposals.

CCRDA

7.3.9. Research

The essential objective of research, in this phase, is to ensure that the policy and decision makers (Regional Co-ordinating Committee) have full information to improve appropriateness of the plans and actions as well as effectiveness of implementing actors.
A facilitating organization, such as CVM, can play a significant role in instigating and executing research. However if the programme is to benefit from the research findings, the decision making parties have to be involved in the design and methods as well as commit themselves to using the findings.
Specific areas for research are:

- Base line KAB and epidemiological data which can form the basis for future monitoring and evaluation of outcome and impact;
- Feasible options to improve availability and access to Voluntary Counselling and Testing;
- Alternative testing methods (cost effectiveness / sensitivity - reliability; applicability at lower level facility by on the job trained / skilled personnel);
- IGA: feasible strategies and activities, management of loans and funds as well as feasible role for the facilitating organisation;
- Socio-economic and socio-cultural barriers to behaviour change, in f.i. two different target groups, to improve tailoring of approaches and interventions;
- Legislative barriers to protection of vulnerable groups and feasible solutions.

7.3.10. Advocacy

The role was not described as such in the previous programme. Without a doubt it was undertaken as the results show.
In the coming phase advocacy definitely has a place as issues and their implications become clearer and consistent action from many different actors is required. A facilitating organization such as CVM has a unique position to enact the role of advocate for the most vulnerable and for those areas that might get lost between the existing system restrictions and the multitude of responsibilities. Important agenda points are:

- the holistic approach and caring attitudes;
- the rights and quality of life of PLWA;
- the position and rights of women and girls;
- attention for and assistance to orphans;
- improving continuity and quality;

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8. MONITORING AND EVALUATION TOOL

The Assessment team was requested to propose a Monitoring and Evaluation Tool for the future of the existing programme and an eventual extension to new Zones in the ANRS.
CVM's main strategy is to facilitate and support the implementation of the Regional Multi-Sectoral HIV/AIDS Prevention and Control programme. In turn the Regional programme is part of the National Strategic Plan.
In the logic of adequate monitoring and evaluation of the HIV/AIDS epidemic and the effects of the prevention, control and care interventions a M&E system needs to be coherent and consistent from grassroots to national level. A programme sponsored with CVM's assistance has to enter into - and contribute to the M&E system at each level (Region / Zone / Woreda and Kebelle).
The basic strategy of CVM means the effectiveness of its programmes, to a large extent, can only be determined by monitoring and evaluating the impact and outcome of the Zonal and Regional programmes. The CVM M&E activities will therefor also depend on the M&E system at the various levels.

The chapters 4 and 5 show that the Health information System needs to developed a new, and that the Monitoring and Evaluation Plan for the Federal Multi-Sectoral HIV/AIDS Strategic Plan will be further determined during the first year of implementation.
In view of the necessary integration and complimentarity of the M&E systems the proposal for the programme has to take the existing Indicators for Health and for HIV/AIDS into consideration. As the new indicators still need to be developed, we looked at other M&E guidelines. UNAIDS is working on a M&E guideline and stimulates comparability between countries. Therefor we have also used the draft of the UNAIDS manual to develop this proposal.

8.1. HEALTH INFORMATION SYSTEM

In the context of the Federal Health Policy and the Action Plan for the Health Sector Development the Health Information System will need to be developed.
At national level the main indicators that are calculated at this moment are:

Impact:
- Life expectancy;
- Population growth rate;
- Maternal mortality
- Infant mortality rate.

Outcome:
- PHC coverage;
- Contraceptive coverage;
- Immunization coverage.

The data collection methods and instruments are to be devised. An inventory at the level of the hospitals and health centres showed that the staff fill in around 9 forms for the monthly, quarterly, six month and annual reports. The majority of the information gathered concerns output. HIV/AIDS figures on the communicable diseases, laboratory and health education forms.

In the ANRS Five Year Health Sector Development Plan indicators are set out per programme component and the plan contains a strategy to develop an integrated Health Management Information System that answers to the aims of decentralized and participatory management of health problems.

8.2. NATIONAL AND REGIONAL HIV/AIDS M&E GUIDELINES

The Federal Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2000-2004 sets the frame work for monitoring and evaluation. The Federal and Regional Multi-Sectoral Committees will be responsible for these components.

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8.2.1. National Monitoring and Evaluation framework

Monitoring

The aim here is to determine whether implementation is undertaken according to plan. Based on annual work plans the progress towards the targets, the activities and time schedules are to be monitored. Each level will use the annual review of the performance to prepare the next annual plan. The array of checklist and reporting instruments are to developed during the first year. The frequency of reporting will be:

- Zonal departments to report monthly to Regional Bureaux;
- Regional Bureaux to report quarterly to Federal Ministry;
- Federal Ministries to report to the implementing organizations bi-annually.

The Ministry of Health has been assigned the responsibility to compile and disseminate the annual report as well as provide feedback to all parties during the Health Sector Development Plan meetings and the Technical HIV/AIDS Steering Committee meetings.

Evaluation

The aim is to determine the effectiveness of the interventions at mid term and at the end of the plan period. As baseline the Priority Preventive Indicator survey, which was executed in 1993, will be repeated at the beginning of the programme in the same regions (Addis Ababa, Oromiya, Amhara and Dire Dawa). This survey will then be repeated in 2002. The Strategic Plan also foresees HIV and STD sentinel surveys.

The following indicators have been set:

I. Outcome indicators:
- Declining trends of HIV/STD;
- Proportion of pregnant women aged 15-24 testing sero-positive for HIV;
- Proportion of Pregnant women testing sero-positive for syphilis;
- Proportion of men aged 15-49 reporting urethritis in past 12 months.

II. Output indicators
- Condom prevalence rate;
- Proportion of clients satisfied with STD services;
- Proportion of STD clients managed according to National Guidelines;
- Proportion of adults aged 15-49 years with accurate knowledge on HIV/AIDS prevention;
- Proportion of adults aged 15-49 years with right attitude towards PLWA;
- Proportion of adults aged 15-49 years practising non-risky sexual behaviours.

III. Process indicators
- Proportion of health workers treating STD clients according to National Guidelines;
- Proportion of trained institution-based counsellors actually providing counselling services;
- Proportion of planned activities actually implemented.

IV. Input indicators
- Proportion budget actually secured;
- Proportion of planned guidelines/manuals actually distributed;
- Proportion of TOT's actually conducted.

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8.2.2. Amahara Regional State Indicators

The ANRS Health Sector Development Plan contains the indicators for the monitoring and evaluation of the programme component 'Prevention and Control of HIV/STD's'. Next to what has already been said about the development of the health information and management system (9.1.) the ANRS Multi-Sectoral HIV/AIDS Strategic Plan foresees the setting up of sentinel survey sites. The indicators set out are:

I. Impact indicators:
- Reduction rate of discrimination and stigmatization of HIV patients by the population
- Percentage of risk age group to cite at least two acceptable ways of prevention action;
- Reported STD incidence reduction rate in men (15-49).

II. Operational indicators:
- Number and proportion of facilities managing HIV and STD cases with quality of care in accordance with the guidelines;
- Proportion of informal health care providers using safe medical equipment with appropriate care;
- Number and proportion of cases properly managed;
- Number of people citing at least two acceptable ways of protection from HIV infection (age group 15-49);
- Number and proportion of people reporting condom use with none regular partners;
- Number of patients screened;
- Number of health workers providing quality of care with safe use of medical supplies.

8.3. PROPOSAL

The Regional Authorities have requested CVM to extend its support to a further six Zones of the Region and in consensus a programme has been developed. This programme is to facilitate the implementation of the ANRS Multi-Sectoral HIV/AIDS Strategic Plan 2000-2004 (see chapter 5).

8.3.1. Programme Summary:

Overall Objective
Improve the health status of the people in the Amhara National Regional State.

Development Objective
Reduce the number of HIV new infections and number of people contracting AIDS by bringing about behavioural change in the Amhara National Regional State as a whole and the 4 new focus Zones in particular.

Results
Overall, 6 Results are foreseen to achieve the project objective. The results and activities are contained in the Project Planning Matrix (PPM) that serves as a basic planning document. Additional 3 Results are envisaged for West Gojjam and Bahir Dar Zones where CVM has been operational for the last 5 years.
The Results are as follows for Regional Intervention and the four new Focal Zones:
1. *Co-ordination*: AIDS prevention committees will be set up and strengthened throughout the Region and are expected to function regularly and carry out their duties and responsibilities as per directives.
2. *IEC*: At least 90% of the eligible (5 years and above) people (12.5 million people) living in the Amhara Region are aware of the modes of HIV/AIDS transmission and prevention.
3. *Advocacy*: Concerned Government offices, institutions and Civil Society Organisations will address the needs of vulnerable groups and promote care for PLWA's in Amhara Regional National State.

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4. *Capacity Building:* The capacity and the involvement of Government Departments, Religious Institutions and Civil Society Organisations to prevent HIV/AIDS will be enhanced.
5. *Data collection:* Sociological and epidemiological data will be available to guide interventions on HIV/AIDS in the Region.

Additional three Results for West Gojjam and Bahir Dar Zones where activities have been carried out previously

6. *IEC*: 100% of the eligible population (2 million persons) in West Gojan and Bahir Dar Zones receive relevant information on problems and experiences as a result of HIV/AIDS.
7. *Advocacy:* Concerned Government offices, institutions and Civil Society Organizations will actively be involved in the needs of vulnerable groups and promote care for PLWAs in West Gojjam and Bahir Dar Zones.
8. *Capacity Building:* The capacity and involvement of Government and Social Institutions in Testing, Referral, Counselling and Care for the vulnerable individuals and groups (Orphans, PLWAs, etc.) is enhanced.

Overall:

9. *Management / Back-up services*: The established project office will have sufficient capacity to ensure proper implementation and sustainability of the programme.
10. *Review, Monitoring and Evaluation*

8.3.2. Indicators

As argued in the beginning of this chapter, the Impact, Outcome and part of the Output Indicators for the CVM programme have to be the same as those for the Regional Programme.
Another part of the Output Indicators and the Input Indicators are determined by the programme itself and thus are to be followed and measured mainly at programme level.

In the annex (XVIII)) the logical frame work has been filled in. Here we will reflect the main issues and aspects.

Health Status Indicators
- Life expectancy
- Maternal mortality
- Infant mortality
- Mortality Communicable diseases

Context Indicator:
- Accepting attitudes towards HIV infected persons
- Employers not discriminating against those with HIV

Programme Impact Indicators:
- HIV prevalence among pregnant women
- Syphilis prevalence among pregnant women
- HIV prevalence among blood donors

Outcome Indicators
- Condom use at last risky sex
- Condom use by clients at last commercial sex
- Women leaving sex trade for other income generating activity
- Women negotiating safer sex with husbands
- Median age at first sex
- Condom use by youth at last premarital sex
- Median age of girls at marriage
- Population requesting HIV tests and receiving results
- Pregnant women counselled and tested for HIV
- Orphans being cared for in the community

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Output Indicators

- Knowledge of HIV prevention
- Number of incorrect beliefs about AIDS
- Comprehensive knowledge about HIV/AIDS
- Quality of post HIV test counselling
- Number of target groups contributing to IEC productions

Process Indicators:

- Percentage of Committees meeting at least 4 times/year, implementing an annual plan / reviewing progress and adapting activities to improve outcome and impact
- Percentage of Zonal, Wordea and Kebelle multi-sectoral plans carried out and addressing emerging issues and obstacles effectively
- Number of measures installed to protect women, sex workers , youth, PLWA and orphans
- Number of resolutions / conclusions of committees and specific groups carried
- Number of TOT's, counsellors, animators remaining active after one, two and three years.
- Availability of data to guide interventions and evaluate progress, outcome and impact (according the indicators selected)
- The programme is carried out according to plan, internal obstacles are solved before they affect progress, external obstacles are taken up with other partners as soon as possible
- Activity and financial reports are produced in time to assist planning and evaluation.

Input Indicators

As these depend on the details of the activities planned we refer to the annex. XVIII.

8.3.3. Methods to measure

In view of the different kind of indicators and the interdependence on the overall programme an array of methods is required:

- the basic Health Information System;
- KAB surveys for general population and for specific groups: to enable comparisons standard formats / questionnaires should be developed and tested;
- Repeated Sentinel surveys for specific groups and for general public;
- Observational studies.

The basic principle to measure progress is the availability of baseline data. Therefor before starting in a new zone the available data should be collected and baseline KAB surveys executed.

8.3.4. Data collection

HMIS data collection should be continuous. Process, input and the output data specific for the programme should also be collected continuously. These data together form the basis for monitoring progress and emerging obstacles.
KAB surveys, sentinel survey and, observational studies mainly aim at assessing outcome and impact: these data are necessary for evaluation.

8.3.5. Analysing and Reporting

For monitoring changes in the epidemic: HIV testing data, STD data and counselling data are critical and should be reviewed and reported monthly. Activity / input data and the most critical output and process data should be analysed and reported quarterly. Reports should be made available in the two following weeks to ensure that corrective measure can be implemented in the new quarter.

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All data that is collected continuously is analysed and reported annually. The report should be available one month later so that the planning of the year can be based on the findings.

The surveys needed to evaluate outcome and impact should be repeated at mid term so that the analysis can assist in correcting the second half of the implementing period. The same surveys at the end of the programme period will serve to evaluate overall achievement and form the basis for the planning of the next phase.

8.3.6. Responsibilities

HMIS data collection is the responsibility of the Zonal Health Department and the Regional Health Bureau. As CVM is partner in the Regional programme and has to be able to realise its specific tasks as well it has to have full access to the information required for adequate monitoring and steering.
A number of the inputs and outputs are specific to the programme and as the data can be collected directly by CVM it has the main responsibility for analysing and reporting. However these data will also be of importance for the Zonal and Regional actors so reports will need distributed and discussed.
With respect to the surveys tasks can be divided. In view of continuity, comparability and maximizing experience it is best to entrust the specific surveys (baseline and follow up surveys / specific subject and group surveys) to the same actor.

8.3.7. Alternative Monitoring and Evaluation Strategies:

Two important assumptions underlie the above proposal: that the national and regional HMIS and HIV/AIDS M&E system will be developed in the coming months, as stated, and that the capacity to implement it will be strengthened soon afterwards.
In case developments are slow alternatives will need to be considered for the information that needs to be collected on an ongoing basis with respect to assessing effects of the programme. measuring. As argued earlier the possibilities to assess impact and outcome will then be quite limited.
To a large extent monitoring inputs, outputs and process lie in the hands of the programme management and can thus be executed as proposed above.

Based on the present information collection and capacities, two feasible strategies could be further elaborated if required:

I. Completing / Strengthening Woreda HIV/AIDS Information System

- Based on a limited selection of outcome indicators, the information collection system at Woreda level (Woreda health office, health institutions and other sector offices, etc) is assessed in detail;
- Forms and methods are developed to complete the information gathering;
- Training of the key actors is provided and follow up supervision undertaken.

- For the elements that can be monitored at community level a simple system is developed and community members trained.

- The surveys, envisaged in the proposal, remain the same and, if the assessment indicates the need, surveys are added for key issues.

II. Intermittent Assessment

Next to the surveys foreseen, baseline and follow-up surveys are planned for key outcome indicators.

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9. POSSIBLE STRATEGIES FOR SUPPORT TO ORPHANS

9.1. DEFINITION OF ORPHAN

Traditionally children of whom both parents have died are taken on by the extended family and not considered orphans. The general public therefor defines an orphan as a child without parents and without relatives. Officials and social care providers tend to define orphans as children without mother or father or without both parents.
When people are asked how one knows whether there are more orphans the rise in number of street children is given as reference. On the other hands most interviewees recognise that this group also contains children that have run away from home either because of problems with parents or relatives or because the parents/relatives are too poor to care for them.

9.2. EXTENT OF PROBLEM

At national level the estimates indicate that the country counts 700.000 orphans. As, during the last decade, Ethiopia has experienced a number of emergencies resulting in death of parents it is not known which percentage of these orphans are directly related to the HIV/AIDS epidemic. It is also not known whether this number really reflects the actual situation.
In the West Gojjam and Bahir Dar Zone first attempts to gain more insight into the situation yielded a count of 4971 orphans in a population of around 2.1 million. The majority of these children are found in the town of Bahir Dar: 4000. It is suspected that a large proportion of these children come from outside of the town and zone and that about 50% of these children are orphans in the strict term.
The Bahir Dar Liyu Zone Bureau of Labour And Social Affairs has, in the past year officially registered 1223 orphans of which 250 are between 0-5 years, compared to 234 in the ten preceding years.
In all towns visited, street children are seen trying to survive by petty trading and begging. The number of girls seems to be increasing more rapidly than boys. Officials in Bahir Dar are quite concerned as incidences of abuse (mainly rape) are definitely on the rise.

In view of the fact that the transmission of HIV is hetero-sexual, and that mothers are mostly infected by their husbands, the expectation is that the number of orphans due to HIV/AIDS will rise sharply as the mortality rate increases. The average household size being 4, a minimum calculation would indicate that per couple, dying of HIV/AIDS, at least two children become orphan: i.e. country wide the number will rise with around 3 million in the coming 4 to 8 years (3 million adults infected and an average life time between infection and death is 8.5 years in Africa according to UNAIDS).

All interviewees stress that the orphan issue can not be seen in isolation from the overall poverty and the large number of female headed households.

9.3. FAMILY AND COMMUNITY COPING MECHANISMS

In first instance the care of children who loose their mother or both parents are taken care of by relatives of the mother or the father, depending on the ethnic group.
The drastic increase in the number of orphans officially registered by the Bahir Dar Zonal Social Affairs Department and the apparent rise in the number of street children indicate that the traditional coping mechanisms of the extended families are over stretched. General public, teachers and women groups in the intervention Woreda's confirm an increase of the number of children not being taken care of. Examples of other families or individuals taking on orphaned children are not many, examples of adequate care are less and stories of abuse are surfacing. Two teachers and several women explained how their attempts to take on non family orphans were thwarted by lack of sufficient income.
It should be noted that many interviewees mention that most extended families already cater for children without parents as there are many causes of deaths, specifically amongst women.

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As far as we could establish there are no community organizations involved in care of orphaned children. There are community associations / groups set up to assist one and other with emergencies like funerals, illness and hospital admission. (Idir, Mehaber).

During the discussions at various levels it was apparent that awareness, that the problem will increase as the epidemic spreads, is present in the interventions area's.
Groups and individuals, both in the rural as in the urban setting, confirm the traditional view that the first responsibility to care for orphans lies with the relatives. The government and the church are seen as the main next responsible parties. Existing community organizations, like Idirs and Mehabers are rarely (more in the urban setting) seen as possible actors in the care of orphans.
Taking the combination of responses into account one has to conclude that awareness that the extended family may not be able to cope, when the number continues to rise, is not yet very high and views on alternatives are not yet developing.

9.4. Governmental Approach

Care for orphans traditionally belongs to the domain of the Ministry of Labour and Social Affairs. At Regional State level it is represented by a Bureau and at Zonal level by a department. The Woreda and Kebelle levels do not have a public line structure but the Social Affairs Committee of the Administrative Council oversees the implementation of the policies.

A policy exists that facilitates adoption of orphaned children aged between 0-5 both by families from within the country or by families from Europe or America. The negative experiences with orphanages gained in the 1980'ties have lead to a recent Government decision not to allow construction of new orphanages. New policies, that are being developed, will focus on family and community care.
At each level the lack of human and financial resources are reported as most important obstacles to support of individuals as well as to developing new approaches. All existing activities in orphan care are funded externally. The line bureaux and departments do facilitate NGO initiatives.

In the context of Ethiopia's recognition of the International Convention on the Rights of Children a number of legal issues pertaining to children are being revised. Children do now have a right to inherit property. By contrast women do not yet have that right, thus female headed households are often at a disadvantage and dependent on the position taken by the relatives of the deceased husband

A review of the Federal Multi-Sectoral HIV/AIDS Strategic Plan, the World Bank Programme and the Regional Plan show that a rise in the number of orphans is expected as consequence of the epidemic but the number of support components foreseen are very few.

As far as could be established no minimal package of support has yet been determined.

9.5. Present Care Initiatives in the Region

The Regional Bureau of Labour and Social Affairs together with the Zonal department and the EOC have obtained funding from UNICEF for a support programme for street children in Bahir Dar town. The EOC is the implementing agency. Exact details of the programme could not be obtained during the mission. From the explanations it can be derived that the main support area's are: material assistance to attend elementary school, reunification with parents or relatives where possible, access to basic health care, skills training for income generating (petty trade). The programme can take on 200 new children from the recognised street children. At the moment 400 hundred children receive support. The programme has been allocated for three years. Some queries and constraints are surfacing: how long will an individual child will be supported, material support in cases of reunification is very limited and children do not stay; self-reliance for livelihood is the aim of the

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skills training but this means children leave school too soon; the alternatives for self-reliance are very limited: the local market will not accommodate so many petty traders and shoe shiners!
One Kebelle Council in Bahir Dar town has recently rented a house for the street children in their community and are trying to assist them in their livelihood and education.

The international NGO, SOS Villages, is building a new orphanage in Bahir Dar town. The permission for the construction had been given before the governments decision to halt the development of orphanages.

The EOC parish in Finot Selam has taken around 20 orphaned boys ranging from 5 to 14 in. They receive shelter, food and religious education. The parish does not receive any outside support for this and thus can only provide the bare minimum.
In the past the parish had funds to support orphans for their daily subsistence and schooling through DICAD and World Vision. The reasons why the programme had stopped could not be established.

NB. Time did not allow to look extensively into experiences elsewhere in the country. CRDA has held a first workshop to sensitize member organizations and inventorize experiences. As far as we understood no clear lessons are available as yet.

9.6. Conclusions

To a certain extent the orphan problem is not new to the society in Ethiopia. It is to be expected that the number of orphans will rise rapidly due to the HIV/AIDS epidemic. There are definitely signs that the traditional family coping mechanisms are already stretched and, to an extent, failing. In view of the long term consequences for the society support solutions have to be found.

Awareness of the orphan problem is increasing as well as the awareness that the number of orphans will increase rapidly with the number of deaths due to HIV/AIDS. That the extended families will not be able to continue to cope on their own is not yet widely recognised.

At governmental level policies and strategies to ensure adequate care of orphans are being elaborated but they are not yet available. A structured response is not yet foreseen.

There is an important reluctance at many levels to envisage support initiatives because of the potential extent of the problem and the intricate relations with overall poverty. Experiences gained during famine situations have shown that it is next to impossible to ensure that assistance, meant for specific children, really reaches them. In many area's poverty is so wide spread that each intervention has unintended pull effects. Also the concerns regarding the difficulties to prevent abuse, both of the children themselves as of assistance, combined with the lack of local expertise and capacity complicate the development of plans.

Practical experiences in the country are too few to provide sufficient indications of best practices. International experiences do give some indications that community organizations can be partners in programmes to assist extended families to care for children of deceased relatives. Three conditions appear to be essential:

- the family should be considered as a whole;
- the institution or authority that assists the community groups has to be capable and has to set clear criteria;
- procedures have to be transparent for all concerned and follow up should be very regular.

The existing views on enabling street children to become self-reliant for their livelihood, though understandable, entail risks for the future of this generation as well as for the spread of the epidemic. International literature already indicates that orphans who continue to live in abject poverty form the next wave of HIV infected persons.

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9.7. RECOMMENDATIONS

The main aim in orphan care should be to enable the communities and families to care for their orphans so that they can grow up and develop their potential in a "near" family environment. All support activities should therefore concentrate on strengthening community and family capacity. Individual subsistence support should only be seen as last resort temporary solution.

In line with the philosophy of CVM the following recommendations are mainly geared towards better understanding of the issues and facilitating the local authorities, institutions and civil society partners to address the problem more adequately:

I. Sensitising and advocacy efforts will have to be intensified to increase the awareness for the plight of the orphans and to mobilize local initiatives and support as much as possible.

II. Further research is needed to determine why children leave home and start living in the street. This should give indications of the underlying causes for the failure of existing coping mechanisms as well as give more information on what is needed to ensure that reunification can be undertaken successfully.

III. It would also be of assistance to understand more clearly why people do not recognise the community and its own organizations as possible actors in the care of these children. In turn this knowledge can assist in adapting the advocacy efforts and in elaborating community approaches.

IV. A multi-sectoral team of CVM and regional representatives should visit a number of good example projects in the neighbouring countries to gain more insight in the elements that determine success and the lessons which have been learnt there.

V. CVM could facilitate a process of consensus building amongst the local parties to determine:
   - the basic criteria that need to be set for adequate care of orphans and the issues that need to be monitored to ensure that they are adhered to;
   - the minimum package of support that will enable families to ensure that the orphans can develop their potential as far as possible.

VI. CVM could undertake two pilot community support projects in communities where awareness is already high and where community representatives, church representatives and Kebelle authorities are willing to work together to find solutions. These projects should serve as learning sites for further programme development and for other parties. A social worker with adequate experience should be employed to ensure maximum success of the projects, a structured learning process and training of care providers from the various levels.

VII. Research is needed into feasible income generating activities for female headed households and extended families so that they can take care of (potential) orphans themselves. This research should also investigate how and with which parties an IGA programme for this group can be implemented.

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C.V.M. Facilitated HIV/AIDS Prevention and Control Programme In West Gojjam

Community Level Comparative Study Of Intervention and Non-intervention Areas

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July 23/ 2000

Addis Ababa

TABLE OF CONTENT

		Page
1.1	Back Ground	3
1.2	Objectives of the Programme	3
1.3	Methodology	4
2.1	Hamusit- (A Non Intervention site)	5
2.2	Dur-Bete (Intervention Site)	5
2.3	Finote-Selam: (Intervention Site)	6
2.4	Dejen: (A None Intervention Site)	6
3.1	Knowledge Attitude and Behaviour on HIV/AIDS	7
3.2	Background to the Survey Findings	7
3.4	Knowledge and Information on HIV/AIDS	10
4.1	Results of the focused Group Discussion	14
4.2	Knowledge Attitude and behavioural change in the Non Intervention sites (Hamusit and Dejen)	15
4.3	Focused Discussion Group in Hamusit Town A Non Intervention Site	16
4.4	Focused Group Discussion in Durbetee	18
5.1	Knowledge, Attitude and Behaviour on HIV/AIDS	19
5.2	Results of focused group discussion in Dejen town	21
5.3	Focused Discussion Group in Finote-Selam	23
6.1	Conclusion and Recommendation	25

CCRDA

Back Ground

1.1

The Amhara Regional States is one of the regional states established under the Federal Democratic Republic of Ethiopia. It consists of a total area of 179,602 square K/ meters of land. More than 14 million people live in this region. The region is divided into eleven zones that further divides in to 105 waredas. The regional capital Bahir-Dar has a population of 120, 000.

West Gojam is one of the administrative zones in the Amhara regional state. It has an area of 17,288 square K/meters of land. The zone has an estimated population of 1,779,723. Bahir-Dar the capital of the regional state is located in West Gojam zone.

According to the 1994 population senses 13 million out of the 14 million population of the region live in the rural area. Thus the mainstay of the population of the region in general is subsistence agriculture. Land degradation erratic rain fall and high population pressure with the attendant shortage of land are serious constraints. West Gojam shares the same general characteristics. Almost 90% of the population live in the rural area. There are 237 schools, two Hospitals, five Health Centres, 48 rural government clinics and 513 health workers. The population is predominantly followers of the Orthodox Church. There are 1,164 Orthodox churches and monasteries, 223 church schools and 52,956 priests and deacons. The towns are mostly found on the Addis Ababa Gonder Highway and are centres of great social, economic, and political interactions.

CVM has been active in West Gojam and /Bahir Dar special zone, with the conviction of HIV/AIDS prevention and control program, with the following Intermediate Objectives:

1.2 Objectives of the Programme

- Improve the capacity of local government and Institution in the prevention and control of HIV/AIDS.

- The promotion of an integrated approach to enhance the ability of the community, the family and the individuals to address and cope in reaction to HIV/AIDS.

- To foster behavioural change in the individual by bringing change in the community, in the family and thereby in the individual through the integrated approach.

- To break the stigmatisation and alienation of HIV/AIDS patients by educating the public through the training it provides to individuals recruited from the different sectors and institutions of the society at different levels.

Thus the purpose of the present project is to assess the outcome of C.V.M facilitated program in terms of the capacity building of local government and other institutions in the prevention and control of HIV/AIDS.

- To assess the impact of the program at the community, family and individual level in addressing the problem and cooping with HIV/AIDS.

- The extent to which the program has achieved the integrated approach it has set out to promote.

- To measure knowledge attitude and behavioural changes that the program has generated in the intervention areas as compared to selected woredas out side the program area.

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- To identify and assess measures taken by the people, especially the youth, in protecting themselves against HIV/AIDS.
- To assess the degree of care and solidarity with HIV/AIDS patients and families in the programme area.
- To identify and assess the nature of traditional mechanisms functioning for PLWAS.

1.3 Methodology

To assess the outcome of the objectives of the program a brief anthropological fieldwork is conducted in both Intervention and non Intervention areas. A comparative approach is employed to isolate the difference as the net outcome of the program. To achieve this aim four sites were selected, two sites from the intervention area (Dur-Bete and Finote-Selam) and another two from outside the intervention areas (Hammusit and Dejen). Each site included a brief survey of the towns and a survey of a peasant association around the town. (See the map attached for the locations of the assessment sites). The assessment sites were selected with the aim of understanding the situation with respect to the objectives stated earlier from both rural and urban settings.

Various data collection method including the review of CVM annual reports and other related documents were made. Focused discussion groups were also held at the different sites. Discussions with members of different social groups considered knowledgeable on the matter were consulted. Two types of questioners (one for the urban and another for the rural) were also prepared and information collected from an equal number of both male and female. Group discussions were held at each site with wide ranging groups from the different sectors of the society, such as, health personnel, religious leaders, teachers, students, house wives, commercial sex workers and other members of society's grass root associations. In terms of the questions 200 respondents are recorded at each site, (100 rural and another 100 urban). The questions consisted of semi-structured questions to survey and measure the degree of knowledge, attitude and behavioural changes at the different sites and levels. The survey was carried out between the 21st of June 2000 and July 2nd 2000.

A social anthropologist, a woman from Bahir Dar University, Department of Pedagogy and two experts in public health were recruited to oversee the data collection and other information from the four sites. An extensive orientation was conducted to create a common view and understanding of the project.

The group assigned to assess the community level impact of the program was interested in the social institutions, whether formal or informal, traditional or modern, in terms of their role in providing support in times of crises such as the HIV/ AIDS epidemic. The group also gave special attention to traditional and religious beliefs and practices regarding sexual behaviour in particular and health in general. The role of the trained councellors from the different sectors of society and institutions as well as the extent to which their activities are integrated. Relations among the family members with special reference to marriage and divorce is examined to see the impact on family break down and its consequent contribution to the spread of HIV/AIDS. Issues of premarital sex and early marriage and their contribution to the spread of HIV/AIDS were assessed. The extent to which the program has impacted on such institutions was examined. The relation between travelling and multi-partner sexual relations, as well as, prostitution and HIV/AIDS and the impact of the program on such activities were looked into. Finally the impact of the program on the subsistence economy in general and the situation of orphans and the causes for the death of the partners were investigated. In short the community level assessment was geared towards measuring the impact of the program on knowledge attitude and behaviour of people particularly in relation to HIV/AIDS control and prevention.

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Back ground to the sites

2.1 Hamusit- (A Non Intervention site)

Hamusit is a small rural town, located on the Bahir Dar Gondar highway. It is a small town surrounded by vast peasant communities engaged in subsistence agricultural activities. The town is located approx. at 30 K/meters to the north of Bahir Dar. It is administered under Derra Woreda, one of the woredas of south Gonder Administrative zone. The population of the town of Hamusit is estimated to be about 8000. The large majority of the residents are from Amhara ethnic group. Orthodox Christianity is the dominant religion with very few Moslems.

There is a government school of a junior secondary level, with student's population of about 1500. There is one government health station with a health officer. Although Hamusit town has piped water service, water is fetched from the public taps. The town has no municipality. There are only a few hotels facing the Bahir Dar Gonder highway from both sides. The majority of the people, particularly the women in the town earn their living by brewing local alcohol and beverages that they mostly to sell to the surrounding peasants on market days. Although most peasants come to town on the big market day which is on Saturdays, coming to town by the peasants for marketing on a small scale is there every day.

The entire town of Hamusit makes up one Kebellie. The Kebellie is divided in to two by the high-way, each forming a Katanna (villages). The villages are further divided in to four sub villages on each side of the road.

The people in Hamusit have a much-limited accesses to mass media. The number of families owning radio is extremely limited. There are no cinema halls or any kind of centre to communicate an idea to the public, except gatherings occasionally organised by the Kebellie for political rallies. There are no newspapers and no magazines available to read.

In Hamusit it can be concluded with certainty that the great majority of the women in the town, whether in the bar or outside the bar, whether full time or part time, are sex workers giving service to the surrounding male farmers. The very low class local beverage selling women are either divorced, widowed, or are girls who have run away from the family in the rural area for one reason or another. Since the money they earn by selling such local beverages are next to nothing, they obviously engage in prostitution with the farmers and residents of the towns and other travellers.

2.2 Dur-Bete (Intervention Site)

Dur-Bete is the administrative town of Achefer woreda. Similar to Hamusit the town of Dur-Bete is surrounded by the sea of peasant communities. Durbete is located about 60 K/meters south of Bahir-Dar between Bahir-Dar and Dangila towns. The town is built on both sides of the Bahir-Dar Addis Ababa road. The climate of Dur-bete is relatively different from that of Hamusit there is more rain and the vegetation cover is also relatively abundant.

The population in Durbete consists of Amhara ethnic group and they all follow Orthodox religion . The surrounding rural population engages in mixed farming. Agriculture is the mainstay in the area including both crop and livestock production. There is also trade in both agricultural products and petite agricultural and non agricultural products. Just like Hamusit the town of Dur-bete has a piped water supply and the greater majority of the dwellers of the town get their water from the public taps. This is basically because the water supply authority charges more than 500 Birr if a family

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wanted a pipeline to be installed. This is what the greater majority of the residents cannot afford. Thus, one can observe up to 30 women lining up, with huge clay containers, waiting for their turn, at public taps.

2.3 Finote-Selam: (Intervention Site)

The town of Finote-Selam, like most towns in this region, is located on the Addis Ababa Gonder-highway. Unlike Hamusit and Dur-Bete Finote-Selam is a much larger town. Under the military government it served as an Awraja administrative town. Finote-Selam has a population of about 19,000 people. Like all towns in Ethiopia the economy of this town consists of several thousand women who live on brewing local beverages and alcoholic local drinks, as well as, small retail businesses. There are few hundred government employees, and Finote-Selam also serves the surrounding farming community as a woreda administrative centre, and a market centre, to buy the few necessities and sell agricultural products.

Due to its convenient location almost mid-way between Addis Ababa and Bahir-Dar, Finote- Selam also serves as stoppage point for, truck drives and travellers. Thus there are also many hotels and bars selling food and factory processed alcohol and beverages. Many truck drivers and travellers stay at Finote -Selam over night.

The majority of the residents 94% are followers of the Orthodox Church while the remaining 6% or so are followers of the Islamic faith and other, Christian denominations.

2.4 Dejen: (A None Intervention Site)

Dejen is another woreda town outside the Intervention area. The town is located on the last escarpment leading to the Blue Nile Gorge, marking the boundary between the former Showa region and Gojam. Although, it shares all the general characteristics with Finote-Selam, it is a much smaller town interms size and activities.

Like Hamusit and Dur-Bete, the town of Dejen is built on and follows both sides of the highway from Addis Ababa. Almost all the houses immediate to and facing the main road are bars, hotels and retail shops. As one moves away from the main road the quality of the houses deteriorates. In such places are sold locally brewed beverages and alcohol. The consumers of such products are usually peasant farmers who live surrounding the town. The peasant farmers come to the town at least once a week.

The town has a relatively well organised health centre and an elementary and a high school. The entire town consists of two Kebellie, each laying on both sides of the road. Like all the other towns the water supply system is piped, the great majority of the town residents fetch water at the public taps.

The peasant farming community surrounding the town may be classified into two depending on proximity from the town. The first category are those immediately next to the town who are farmers that were relocated from their original homestead (by the military government) and are resettled in very big village groups. Some of these villages have protected water supply taps in a place central to the settlement. As one goes further away from the town the organisations of the rural community then becomes more of the traditional village type. In this type of settlement extended families with kinship ties form the basis of the community. Houses are not built next to one another as it is in the first category. Some times a large family consisting of three to four generation may live together forming a village of its own.

CCRDA

3.1 Knowledge Attitude and Behaviour on HIV/AIDS

3.2 Background to the Survey Findings

A survey on knowledge, attitude and behaviour was carried out in four sites. Two of the sites (Dur-Bete and Finote -Selam) were Intervention sites, while the other two sites (Hamusit and Dejen) are non Intervention sites. 200 respondents participated in each site. The 200 respondents were divided in to two equal half's. 100 respondents from the rural and the other hundred from the urban centre. In all the centres an equal number of male and female respondents participated. 50 of the respondents in Hamusit town were women and the other 50 were men. The same holds true for the rural. The inclusion of equal number of male and female in the survey has allowed to assess the variation in knowledge, attitude and behaviour on HIV/AIDS between the sexes.

With respect to the age of the respondents the greater majority of them were between the age 15 and 45. This is the category most active in terms of sexual behaviour. The table giving the age of respondents by the different sites is presented below.

Table 1

Distribution of Respondents by Age and sites

	Non intervention		Intervention		Intervention		Non intervention	
Age of respondents	**Hamusit**		**Durbete**		**Finot Selam**		**Dejen**	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Under 10	0	0	2	0	0	0	0	0
10 to 17	13	6	17	13	7	20	7	13
18 to 45	60	63	57	76	67	69	72	75
46 to 70	27	28	23	11	25	10	21	12
70 and above	0	3	0	0	1	0	0	0
Total	100	100	99	100	100	99	100	100

With regards to age of the respondents only 2 were under ten. This occrued in Dur-bete rural. 96 respondents were between the ages 10 and 17. The highest concentration of the respondents came from the ages between 18 and 45. Out of the 800 or so respondents 539 respondents were from this age category. There were also a significant number of respondents (160) between the ages 46 and 70. Ages seventy and above were only 4 respondents, 3 in Hamusit town and one in rural Finote Selam.

By far the largest (over 93%) of the respondents in all the four sites are followers of the Ethiopian Orthodox Church. The number of followers of other religious including Islam are insignificant.

Table 2

Distribution of Respondents by Marital Status and Sites

	Non intervention		Intervention		Intervention		Non intervention	
Marital status	**Hamusit**		**Durbete**		**Finote Selam**		**Dejen**	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Single	15	17	3	29	5	50	9	45
Married	60	62	86	59	82	36	80	33
Divorced	22	14	5	8	8	8	9	15
Widowed	3	6	5	5	5	5	2	7
Total	100	99	99	101	100	99	100	100

CORDA

As Table 2 clearly depicts most of the respondents are married. With the exception of Hamusit , the rural constitutes the greatest majority of the category married. Single respondents are relatively fewer in the rural, with the lowest in Durbete (3) and highest in Hamusit (15). The urban singles are also lowest in Hamusit and highest in Finote selam. There is the highest rate of divorce in Hamusit rural (22 respondents). The other rural sites are all less than 10. The numbers of widowers are insignificant. The urban showing slightly higher number. It is also clear that the number of this later category is evenly distributed in all the four sites.

Table 3
Age at first marriage by sex of Respondents

	Non intervention		Intervention		Intervention		non intervention									
	Hamusit Rural		**Hamusit Urban**		**Durabete Rual**		**Durabete Urban**		**Finote Selam Rural**		**Finot Selam Urban**		**Dejen Rural**		**Dejen Urban**	
Age at first marriage	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Below 10	1	5		6	0	10	0	4	4	17	0	5	0	17	0	11
10 to 15	5	29	4	19	10	39	0	18	3	31	1	19	10	24	4	13
16 to 20	14	6	12	2	27	5	11	12	34	1	5	8	31	2	21	8
Above 20	24	0	25	0	8	0	22	6	9	0	12	3	5	0	9	0

The age at first marriage, for the greater part, is dependent on sex. Table three clearly shows the fact that women marry much earlier than men. 17 respondents both in Dejen and Finote Selam rural admitted that they were under ten years old when they were married. No man was married under 10 in Dejen rural while the figure for Finote Selam male is only four. The majority of the girls are married before they are 15 years of age. As the table clearly shows the number of girls marring after 15 years is insignificant while the number of boys marring after 15 increases. The number of women marring after 20 years of age is almost non existent.

Majority of both male and female respondents claimed to have been married only once. The number of respondents that have been married two times is significant, while more respondents claimed they have been married three or more times. The data, however indicates to the fact that they have been married three or more times. The data, however indicates that frequency of times of marriage are evenly distributed for both men and women in all the four sites. Out of the 800 or so respondents 340 have married more than once. This clearly indicates to the fact that divorce and remarriage is common in this area, regardless of the Christian belief they may profess. The majority of the respondents claim not to have regular sexual partner and only small number admited having regular sexual partner.

Table 4
Distribution of Respondents by number of times married.

	Non intervention		Intervention		Intervention		Non intervention									
	Hamusit rural		**Hamusit Urban**		**Durabete Rural**		**Durabete Urban**			**Finot Selam Rural**		**Finote Selam Urban**		**Dejen rural**		**Dejen Urban**	
Number of times married	M	F	M	F	M	F	M	F	%	M	F	M	F	M	F	M	F
Once	27	29	21	23	21	20	20	21	41	15	6	6	19	11	11	15	13
Two times	8	4	13	13	21	15	7	17	24	12	9	3	10	17	13	7	9
Three times & more	10	8	6	11	3	13	4	2	6	19	34	2	10	18	20	1	1
Total	45	41	40	47	45	48	31	40	71	46	49	11	39	46	44	23	23

GCRDA

By far, more than half, of the rural population is illiterate. In the urban the literacy rate is slightly higher. In Hamusit 77, in Durbete 72, in Finote Selam 69 and in Dejen 54 respondents are illiterate, without any form of knowledge to read and write. Only 12 in Hamusit rural, 15 in Durbete, 9 in Finote selam and 15 in Dejen rural claimed to have 6 years of schooling. There is only 1 grade 8 level among the respondents of Hamusit rural, one in Durbete, 4 in Finote Selam, and 8 in Dejen rural respondents. There are no grade 12 level educated respondents both in Hamusit and Durbete rural. There are only 2 in Finote Selam and 7 in Dejen rural. Religious oriented literacy are not also as significant as one would imagine. Only 5 in rural Hamusit 3 in rural Durbete, 2 in Finote Selam, and 1 in Dejen.

Table 5
Distribution of Respondents by Educational Status and Sites

	Non intervention		Intervention		Intervention		Non intervention	
	Hamusit		**Durbete**		**Finot Selam**		**Dejen**	
Education	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Illiterate	77	45	72	19	69	12	54	15
6 the grade	12	15	15	21	9	10	15	17
8 the grade	1	10	1	21	4	12	8	15
12 the grade	0	17	0	31	2	58	7	51
Religious	5	5	3	1	2	0	1	1
Others	5	8	9	1	15	7	15	1
Total	100	100	100	94	101	99	100	100

As it is clear from Table 5, there is a significant difference between Hamusit town and Durbete town. In Hamusit town there are 15 respondents with grade 6 educational level, as opposed to 21 in Durbete town. There are 10 grade 8 in Hamusit town and 21 grade 8 in Durbete. 17 grade 12 respondents in Hamusit town and 31 in Durbete. These differences are, of course, partly the reflection of the difference that Hamusit is not a woreda administrative town while Durbate is. There are always more educated persons in administrative towns than there are in non-administrative towns.

Table 6
Distribution of Respondents by Occupation and sites

	Non intervention		Intervention		Intervention		Non intervention	
	Hamusit		**Durbete**		**Finot Selam**		**Dejen**	
Occupation	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Farm	65	4	71	5	92	0	88	0
House wife	11	13	17	20	0	13	0	6
Professional	0	8	0	19	0	8	0	9
Not working	2	9	3	4	0	5	0	6
Others	22	56	4	51	8	73	12	79
Total	100	90	95	99	100	99	100	100

Data on the occupational status show that 65% of the respondents from Hamusit rural 71 % from Durbate, 92% of Finote Selam and 88% of Dejen rural are farmers (peasants). Only 11 respondents in Hamusit rural, 17 in Durbete and none in both Finote Selam and Dejen are housewives. There is no one respondent claiming to be professional in all the four rural sites. The number of the unemployed are insignificant for all the rural sites. They're only two respondents in rural Hamusit and 3 in rural Durbete.

CCRDA

There are few respondents, that claimed to be farmers, while residing in the town. These included 4 respondents in Hamusit and five in Durbete. Such a category does not exist for Finote Selam and Dejen. There are relatively more housewies respondents in the town than there are in the rural area, 13 in Hamusit town, 20 in Durbete. 13 in Finote Selam and 6 in Dejen town. The number of professionals is also concentrated in the towns with Durbete having the highest number of respondent (19). The data or " not working" and others could be put together and considered as the unemployed. This category together make by far the highest proportion of the respondents in the towns 65 for Hamusit town, 55 for Durbete 78 for Finote Selam and 85 for Dejen Town.

3.4 Knowledge and Information on HIV/AIDS

Information on knowledge, attitude and behaviour were asked on HIV/AIDS in simple language. Knowledge in this culture however should be distinguished from knowledge in western view that ultimately derives from Greece. In the Greece sense knowledge is an intellectual apprehension of reality distinguished from the sensible and the intellectual appetites. The term of knowledge from the western perspective is judgement, an affirmation of the truth perceived. In the Horn of Africa in general and Ethiopia in particular, the word we translate know or knowledge expresses a more complex group of psychic activities. In short however to know in this culture is to experience, experience developed in to acceptance or possession of knowledge. I will come back to this issue latter. For now let us continue with the presentation of the data, on knowledge of HIV/AIDS.

Table 7A
Distribution of Respondents by first source of information on HIV/AIDS and site

Non Intervention Intervention Intervention Non intervention

	Hamusit		Durbete		Finot selam		Dejen	
Source of information	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Television		19		32		40		37
Radio		40		42		48		47
Books & nespaper		15		36		37		40
AIDS information material		12		24		39		28
family	2	7	0	14	1	21	1	18
Friends	14	17	14	14	5	30	14	27
Religious Leaders		21		32		35		31
Political leaders		5		10		14		17
Teachers		4		14		31		36
Health workers	14	29	22	33	28	40	16	42
Others	21	4	19	5	22	3	22	1

CCRDA

Table 7B
Distribution of female respondents by first source of information on HIV/AIDS and site.

	Non Intervention		Intervention		Intervention		Non intervention	
	Hamusit		**Durbete**		**Finot selam**		**Dejen**	
information	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
		10		17		20		27
		29		35		39		42
nespaper		5		15		24		25
nformation		2		9		17		22
	13	24	5	31	16	26	8	33
	11	23	10	27	11	30	18	37
Leaders		16		26		20		28
leaders		5		9		11		16
		9		12		20		25
workers	4	12	12	20	16	39	16	31
	35	4	23	0	25	0	21	1

Radio seems to play the most important role in terms of giving information on HIV/AIDS. In Hamusit town 29 respondents 35 respondents in Durbete, 39 in Finote Selam and 42 respondents in Dejen town gave radio as their first source of information T.V also has a role in the towns. The role of T.V as a source of information on HIV/AIDS is the lowest in Hamusit town (10 respondents) and highest in Dejen town (27 respondents). In short books and news papers, AIDS information materials, family friends, religious leaders, teachers, health workers and the like serve as sources of information with varying degree in the urban centres.

Sources of information for the rural communities are extremely limited, families and friends appear to be the chief source. The role of health workers have also been significant in Finote Selam and Dejen. In both these sites 16 respondents in each rural sites claimed to get their information from health workers. For the majority of the rural community information regarding HIV/AIDS comes from out side what we normally consider to be source of information. In responding to the options given, such as, Television, radio, books and news papers, Information materials on AIDS, religious leaders, political leaders, teachers, health workers and others, by far the greatest majority claimed to get their information from sources other than all these lists of sources. Both sources of information and access to information seems to be equal among both male and female. Comparing table 7A and 7B confirms this fact. It also seems that women discuss about HIV/AIDS in the family more than men do. Only one male respondents in Hamusit rural admitted discussing HIV/AIDS with family members. The number of female respondents on the same question at the same site is 13.

CCRDA

Table 9
Distribution of Respondents regarding knowledge of Transmission of HIV/AIDS
Rural

	Non intervention			Intervention			Intervention			Non intervention		
	Hamusit Rural			**Durbete Rural**			**Finote Selam rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Blood contact	6	5	11	34	11	45	32	33	65	21	24	45
Casual contact	10	10	20	10	13	23	5	6	11	10	6	16
Sexual intercourse	29	23	52	48	28	76	46	40	86	43	38	81
Mother to child	2	0	2	0	0	0	0	1	1	0	1	1
God's order/punishment	0	0	0	0	1	43	0	0	0	0	0	0
Others	3	5	8	1	5	2	0	0	0	2	3	5
I don't know	18	21	39	1	16	42	4	6	10	3	6	9

Urban

	Non intervention			Intervention			Intervention			Non intervention		
	Hamusit Urban			**Durbete Urban**			**Finote Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Blood contact	28	17	45	43	47	90	43	41	84	43	41	84
Casual contact	6	13	19	2	4	6	3	5	8	5	10	15
Sexual intercourse	40	30	70	42	44	86	46	44	90	51	47	98
Mother to child	2	0	2	5	0	5	6	0	6	0	0	0
God's order/punishment	0	0	0	0	0	0	0	0	0	4	0	4
Others	10	4	14	2	0	2	0	1	1	0	1	1
I don't know	6	12	18	1	5	6	1	3	4	2	4	6

For the question" how does a person contract HIV/AIDS?" the majority of the male respondents mentioned sexual intercourse, 52 in rural Hamusit, 76 in Durbete, 86 in Finote Selam and 81 in Dejen rural. In rural Hamusit, Durbete, Finote Selam and Dejen the number of female respondents are much higher than their male counter parts. 70 female respondents referred to sexual intercourse as the chief cause of contracting HIV/AIDS in rural Hamusit, 86 in Durbete, 90 in Finote Selam and 98 in Dejen rural. This is significantly higher than the male respondents. The number of respondents, who answer " do not know" are slightly higher among male respondents than female.

CCRDA

Table 10
Distribution of Respondents regarding HIV/AIDS prevention

Rural

	Non intervention			Intervention			Intervention			Non intervention		
	Hamusit Rural			**Durbete Rural**			**Finote Selam rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
stinence	9	8	17	15	15	30	10	15	25	20	24	44
ithfullness	26	18	44	19	9	28	28	18	46	26	17	43
e condoms	1	0	1	1	1	2	3	3	6	5	3	8
oid sharing p instruments	4	2	6	18	3	21	27	18	45	11	18	29
d illegal ctions/traditional ctices	1	1	2	2	1	3	1	0	1	1	0	1
t going to town	3	5	8	2	7	9	12	4	16	8	7	15
hers	20	12	32	4	10	14	5	15	20	6	3	9
n't know	11	17	28	2	23	25	5	5	10	2	4	6

Urban

	Non intervention			Intervention			Intervention			Non intervention		
	Hamusit Urban			**Durbete Urban**			**Finote Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
stinence	3	3	6	11	10	21	12	9	21	9	14	23
thfulness	44	34	78	40	31	71	49	30	79	47	32	79
e condoms	11	9	20	13	9	22	19	17	36	26	24	50
oid sharing p instruments	16	6	22	18	15	33	23	13	36	18	25	43
d illegal ctions/traditional ctices	2	0	2	6	9	15	1	0	1	1	0	1
hers	7	10	17	8	7	15	6	4	10	1	6	7
n't know	4	11	15	2	2	4	1	3	4	1	1	2

A significant majority in all the rural sights felt that HIV/AIDS is prevented by being faithful to one partner. 44 respondents in Hamusit rural, 28 in Durbete 46 in Finote Selam and 43 in Dejen rural responded. Condom use is not common in all the rural sites. Only one male and one female respondents in Hamusit rural, a male and a female in Durbete, 3 male and three female in Finote Selam and 5 male and 3 female in Dejen responded that condom use can prevent HIV/AIDS. This of course, may be attributed to the activities of the Orthodox church, as they preach faithfulness to one partner as the only option and are opposed to condom use. The number of respondents who answered "don't know" is also significant in Hamusit and Durbete as opposed to Finote Selam and Dejen.

CCRDA

Table 11
Distribution of Respondents on knowledge and use of condoms

Rural

	Non intervention			Intervention			Intervention			Non intervention		
	Hamusit Rural			Durbete Rural			Finot Selam Rural			Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Heard of:												
Yes	18	14	32	42	20	62	40	29	69	40	20	60
No	31	37	68	13	30	43	10	21	31	11	30	41
Use of												
Yes	0	0	0	2	0	2	0	0	0	0	0	0
No	25	41	66	36	44	80	39	40	79	41	39	80
Sometimes												

Urban

	Non intervention			Intervention			Intervention			Non intervention		
	Hamusit Rural			Durbete Rural			Finot Selam Rural			Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Heard of:												
Yes	24	15	39	23	14	37	39	39	78	49	36	85
No	20	20	40	9	21	30	3	8	11	0	13	13
Use of												
Yes	3	0	3	6	2	8	9	5	14	9	11	20
No	47	45	92	43	50	93	41	42	83	45	38	83
Sometimes												

Response to the same question in the urban is significant and evenly distributed. In Hamusit town 44 male and 34 female (78) respondents felt that faithfulness to one partner is the option. In Durbete 40 male and 31 female (71), in Finote Selam 49 male and 30 female (79) and in Dejen 47 male and 32 female (79) respondents answered that faithfulness to one partner would prevent HIV/AIDS. Their view on the use of condom is significantly different from the views of the rural respondents. 11 male and 9 female (20) in Hamusit town, 13 male and 9 female in Durbete (22), 19 male and 17 female (36) in Finote Selam and 26 Male 24 female (50) in Dejen town gave the use of condom as an option in preventing HIV/AIDS. The number of respondents who answered "don't know" is also significantly low than the rural response.

CRDA

4.1 Results of the focused Group Discussion

Perhaps the difference between Intervention areas and the non-intervention areas comes out clearly in the qualitative aspect of the assessment rather than in the quantitative. The assessment group has conducted focused discussion groups in both the intervention and non-intervention woredas. In all the sites the groups consisted of members of both the formal and informal institutions. In all the sites, teachers, health workers, house wives, both part time and full time sex workers, anti AIDS clubs organised in schools, religious leaders and male and female representatives of the different urban dwellers associations at their various levels were invited to participate.

The major objectives of such discussion groups were:

- To see the level of knowledge people have regarding HIV/AIDS

- To assess the attitude that has developed (if any) in response to the intervention made by the program in the intervention areas and how this differed from the non intervention areas.
- Finally the group also tried to assess the extent to which this has impacted on the behavioural changes in the community, in the family and in the individual.

4.2 Knowledge Attitude and behavioural change in the Non Intervention sites (Hamusit and Dejen)

As mentioned earlier the concepts knowledge, attitude and behaviour should be understood with in the framework of the culture in question. Thus knowledge in this preliterate and traditional society has very little to do with judgement or an affirmation of the truth perceived. In the patterns of this traditional thought system, the term which we translate "know" and/or "knowledge" refer to a more complex group of psychic activities. All of these groups of activities work together to make the separation between knowledge and experience impossible. Thus in this culture to know is to experience. Attitude is perhaps relatively simpler to capture. It refers to feelings such as respect, familiarity, affection or hostility, rights or obligations by which people feel bound and which will manifest themselves in certain patterns of behaviour.

It is with this view of knowledge, attitude and behaviour that the team conducted the focused discussions at the different sites. The detailed objectives of the focused discussion group were:

- To see how much awareness there is regarding HIV/AIDS among the general public and how much people have understood the HIV/AIDS problem.
- To assess what coping mechanism (if any) people have adopted in living with the problem.
- To assess if there are changes in the knowledge people have, to see the direction of development in attitudinal change and to what extent this had impacted on behaviour change.
- What measures people are taking (particularly the youth) in protecting themselves against HIV/AIDS.
- To see the level and impact of HIV/AIDS education in schools and outside schools.
- To see the level of Anti AIDS club activities both in schools and at youth centres.
- To see the level of organisation at community level, to fight the AIDS epidemic, and the level of participation in such organisations.
- To assess the source and level of support to families affected by HIV/AIDS.
- To investigate if there are AIDS patients the family cannot care for.
- To assess the condition of orphans and the problems involved in taking care of them.
- To discuss and assess future plans to prevent and control HIV/AIDS.

CCRDA

4.3 Focused Discussion Group in Hamusit Town A Non Intervention Site.

To assess the level of knowledge, attitude and behaviour of the local people in relation to HIV/AIDS a focused discussion group was carried out in Hamusit. The participants were drawn from the different social classes, formal and informal institutions. The focused group discussion in Hamusit included teachers, Anti AIDS club members organised in the school, the health officer, sex workers of the known bars, house wives, merchants, and the like. The assessment team requested Hamusit Kebellie Officials to help organise the discussion group and themselves participate in it. To the disappointment of the assessment team the Hamusit Kbellie officials were not interested in it at all. One of the participant, who came to the group discussion and claimed to have worked with the Kebellie for over five years reported to the group that he had never heard the Kebellie discussing any issue relating to HIV/AIDS in all the time he had worked with the Kebellie.

All the members of the discussion group admitted the fact that they have heard of the disease HIV/AIDS. Some claimed to even know of persons, who have died and/or are dying of it. Some of the participants claimed that many people confuse HIV/AIDS with T.B and malaria. Others tried to explain the difference between T.B and HIV/AIDS by referring to their experience. They claimed that a person who gets ill with T.B will recover after 60 injections. According to them if a person does not recover after the sixty injections then they conclude that the man is an HIV/AIDS patient.

All the participants knew about HIV/AIDS including some of its (causes), symptoms and prevention mechanisms. They also said that they have heard the fact that there is no medicine to prevent or cure AIDS. The local name for the disease are many. There are those who called it " *Amenmin*". There are also others who called it *" Dedeb"* meaning stupid.

The groups were asked to rank the most prevalent diseases in Hamusit and its surrounding areas. They unanimously agreed on T.B and malaria as the most prevalent and HIV/AIDS is associated with both. Almost every participant knew some one who died of HIV/AIDS. All of them talked of what the disease does to the hair and to the body of the person. Others talked of the fact that the husband and the wife die following one another when the disease is HIV/AIDS. Except the teachers, the students and the medical officer, most of the ordinary participants could not relate to the concept of the HIV virus as the cause of AIDS.

Thus as stated earlier knowledge in this preliterate society is inseparable from experience. In Hamusit ordinary people have come to know the existence of a strange disease called AIDS mainly because they have seen, and through seeing experienced what it does to the person. It seemed that every one was dead scared of the name AIDS.

When the group discussed issues of the prevention mechanism, most of the participants suggested faith- fullness to one partner. There were also those who talked about avoiding illegal injectors. Others talked about selecting partners carefully. In the discussion there was some consensus that the disease is not transmitted with shaking hands sharing food, or the like with the person with AIDS.

In the discussion there was a general tendency to view, prostitutes, travellers (especially drivers), solders from the Dergue time and the unemployed in the town to be the high risk groups. Regarding the use of condom, every participant seemed to have the knowledge regarding the protection they provide. But no body wanted to present the use of condom as the first option. This of course seems to emanate from their Orthodox Cristian religious back ground.

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In line with the use of condoms some members of the assessment team also randomly visited some of the shops selling condoms to estimate the rate at which condoms are being sold and used. Shop keepers admitted that condoms are the least sold item in the shop. They told the team that it is usually very young children who buy condoms to make them into balloons and play with it.

Some in-depth interview were also conducted with individuals both in the town and some farmers who came to town from the rural peasant community. The rural community tends to associate HIV/AIDS with the town dwellers and therefore believe it is town disease. It also seems that the rural community gets information about the disease from unauthorised sources, such as, rumours. They tend to believe that if they did not have sex with those commercial sex workers in the bars they are safe. They do not seem to understand the fact that those part time sex workers selling local beverages are just as risky as the former.

Discussion was also held with women both in the focused discussion group and with individual women in Hamusit town. Obviously all the women who participated in the focused discussion group knew about HIV/AIDS. They however showed mixed feelings regarding the cause of HIV/AIDS. A significant number of them persisted on the idea that the disease is a curse from God due to our disobedience. Almost all of them knew the different forms of the transmission of HIV/AIDS. They were not as conversant in knowing those forms of contacts that did not transmit HIV/AIDS. They were hesitant when told touching the body of patient, kissing and sharing food did not transmit AIDS.

They all believed in the fact that condom prevented both pregnancy and HIV/AIDS. Women in the town, the team interviewed, were more positive about the use of condoms than men.

One very serious problem regarding the use of condom the team observed is the fact that the health centre distributes condoms only to bars and hotels that sell factory-processed alcohol and beverages. The local beverage and alcohol selling groups, who are obviously part time sex workers are totally ignored in the distribution programme.

Thus to summarise the findings of the team from the focused group discussion and individual interviews in Hamusit one can conclude the following.

- It is clear that people have become aware of the existence of strange disease called AIDS. It also seems that it is their first time to hear there can be a disease with out a cure. One can clearly observe a degree of panic.

- As far as coping with the crisis of AIDS is concerned, people do not seem to be aware of the magnitude yet. Besides they blame T.B and Malaria instead of the AIDS epidemic. T B and malaria is giving cover for AIDS. But this cover is losing its function, as people now have began to observe, husbands and wives dying following one another. Thus people can no longer explain the phenomena, since what is happening is outside the experience they have of T.B and malaria.

- The epidemic did not reach a breaking point in terms of the number of orphans such that the kinship system and the extended family system cannot deal with it.

- Hamusit is not at all, ready to measure the change in the knowledge people have, leave alone, to measure changes in attitude and behaviour. The simple example is to refer the attitude and behaviour of the Kebellie leaders. These leaders refused to help organise the focused dissension

CCRDA

group and also refused to participate in it themselves. This is surely an indicator that they did not yet take the matter seriously, which I believe is also a reflection of their level of awareness/knowledge.

- In Hamusit it is difficult to say whether people have worked out a collective response to the problem. There is no body concerned regarding HIV/AIDS prevention and control. It is only through the limited activity of the Hamusit Junior High School that an Anti AIDS club has been active. The school complained that the Kebellie association leaders do not co-operate in mobilising the dwellers to attened the few programmes organised by the school to educate the public on HIV/AIDS.

- There is practically nothing co-ordinated, being done, at the community level. The little effort that exists around the school and health centre are bare minimum and there is nothing like a youth centre.

- The only source of support to the families of HIV/AIDS patients are the immediate family.

- The extent of orphan problem is not clear yet (at least in Hamusit). The individuals interviewed and participants of the focused group discussion admitted that the number of orphans is increasing. It does not appear that the society at large and the different institutions at the community level in particular has any future plans to deal with the problem.

- It is obvious and clear from the survey findings that the information women have on HIV/AIDS is not very much less than that of men. Having information about HIV/AIDS, however, is not enough. The fact that women are physiologically and anatomically at a disadvantage regarding transmission of HIV/AIDS is not yet clearly known. In addition women are also exposed to more harmful traditional practices such as ear piercing, tattooing, circumcision, and the like. Consequently, there is a need for more attention to be given to the education of women. This education should be a kind that will encourage open discussion between husbands and wives regarding sexual life.

4.4 Focused Group Discussion in Durbetee.

A focused group discussion was conducted in Durbete following the same procedure as in Hamusit. There was a marked difference between the two sites.

Unlike Hamusit Durbete has already organised a unit for the prevention and control of HIV/AIDS. The unit has an office for HIV/AIDS control within the Kebellie structure. The assessment team had no difficulties in organising the Focus Group Discussion. The HIV / AIDS unit had taped the Kebellie structure, all the way down to the household level for its communication.

The entire Durbete town is divided into four areas. Area A, B, C and area D. In each area the Kebellie has three development committees. Thus there was no difficulty in recruiting participants from the different levels of the Kebellie. The HIV/AIDS unit in the Kebellie also facilitated the assessment team's contacts with both governmental and non-governmental institutions to provide the assessment team with all information required. The HIV/AIDS unit also made sure that all the relevant institutions sent participants for the focused group discussion.

In Durbete, whether or not the general public knew of the existence of HIV/AIDS was not an issue. C.V.M. has already trained 60 (sixty) counsellors and communicators activity operating in the

CCRDA

wareda. Thus, unlike in Hamusit, the assessment team could begin the discussion with the AIDS problematic.

The group began its discussion by explaining the AIDS epidemic as the most pressing problem of the woreda. They also made reference to the fact that the Kebellie has already registered 90 orphans. The cause of the death of the parents, of course, may not all be attributable to AIDS. But such a number of orphans in such a small town is a new phenomena. Other participants also made references to orphans not registered with the Kebellie, who live with relatives. Still others indicated, to the fact that, the orphan problem is also becoming common in the rural area.

The assessment team asked the group to explain the type of measures that are taken or that are being taken to cope with the problem. The discussion group explained that a woreda co-ordinating committee, to prevent and control the spread of HIV/AIDS had been established. This committee in collaboration with C.V.M has accomplished the following activities.

- 47 rural extension workers were trained as educators on HIV/AIDS in addition to their agricultural work.
- Organised a workshop for two rounds to train 573 participants from the farming community. It is hoped that these trainees will in turn train others in the rural area.
- An awareness creation workshop was also organised in two other small towns of the wareda, namely, Kunzila and another small town. 276 sex workers participated.
- The woreda committee had also organised a consultation meeting, of one day, for the already trained councellors and communicators.
- Educational leaflets on HIV/AIDS has been distributed through all the available channels.
- Finally it is also claimed that a team composed of medical personnels, trained councillors and educators carried out a campaign in the surrounding peasant associations of the woreda . The team passed on information regarding the mechanism of transmission of HIV/AIDS and what people should do to protect themselves and so on.

CCRDA

5.1 Knowledge, Attitude and Behaviour on HIV/AIDS:

Durbete Woreda:

It also came out clear from the focused group discussion that the general public is much better informed regarding HIV/AIDS in Durbete than in Hamusit. Members of the focused group discussions, specially the women who are sex workers, were asking if the government could come up with an alternative way of life, for those women, who are now forced into becoming prostitutes. This is surly an indicator that the sex workers in Durbete have realised that the chief mechanism in the transmission of the virus is sexual contact.

In terms of information and knowledge on HIV/AIDS almost 100% of the participants of the focused group discussion understood details. Asked if it is possible to tell whether a person has HIV/AIDS by looking at the appearance of an individual, almost every one answered no. They explained that a person may appear perfectly health, even when he/she maybe carrying the disease.

When asked, what one should do to protect oneself against the disease they presented (offered) different possibilities in the following order of priority.

- Abstinence
- Faith fullness to one partner.
- The use of condoms.

They thus, recounted to the assessment group that the use of condom is not the first priority (option).

The assessment team also tried to find out what source of information the community utilises for their present level of knowledge. From their answer it is easy to conclude that there are different sources at work. The major sources were: radio program on HIV/AIDS, the Ethiopian orthodox church, schools, health workers, Anti- AIDS Clubs, family, friends and leaflets occasionally distributed as their sources of information.

Despite all these the focused group discussion brought out some limitations in terms of translating the knowledge into attitudinal and behavioural change. The following were some of the problems the participants raised:

- The first problem was the irresponsible behaviour of the youth. The discussion group made reference to the fact that there are simply to many young people in the town, who do not have any form of employment. The pass time of such unemployed youth, they say, is in and around bars and in places were local alcoholic beverages are sold. Under the influence of alcohol and the feeling of hopelessness with their condition of unemployment they care less about their life and future.

- Farther more, some participants pointed out, the fact that, there are some individuals among these young people, who will openly deny the existence of the disease AIDS even when they see some of their friends are dying from it.

- A participant who is also a Hotel owner in the town of Durbete argued that there can be no way to control the disease unless the government found an alternative way of life for the woman who constantly migrate from the rural to the town. Such woman will continue to increase the number of women sex workers. Such women, she claimed, are unprotected because of their rural back ground, and are used and abused by men.

- This same woman (Hotel owner) also made a mockery of condom use. In her Hotel, she claimed, condoms are provided at the bedside. She said she kept checking, whether the customers have used the condom, 'when they left the room', she reported that, condoms are seldom used. She made reference particularly to men that brought girls (students) and used them in her Hotel.

- The focused discussion group also raised the link between the urban and the rural in terms of sexual behaviour. They reported that, despite the rural peoples perception that HIV/AIDS is a town disease, it is a common practice for the rural male to come to market every week. Many of these man will end up sleeping with a women and go away the next day. The report emphasised the fact that some even remain in town for two to three days before they go back home.

CCRDA

- The participants admitted the fact that the awareness about HIV/AIDS have impacted more on the behaviour of the married couples. References were made to the fact that men go home early and do not frequent drinking places in the evenings as they used to do before.

- In terms of the HIV/AIDS person; the participants refereed to government employees, such as teachers, agricultural extension workers and the like, who all happen to be young. To emphasise this point a participant remarked: now a days anywhere I go to funerals I don't see sons burning their fathers, I see father burying their sons.

In short despite the significant knowledge and information around people do not feel that this has impacted or resulted in attitudinal and behavioural changes in a significant way particularly among the young. Thus, one can conclude about knowledge, attitude and behaviour regarding HIV/AIDS in Durbete to be as follows:

- That there is a much higher awareness/ knowledge of HIV/AIDS problem, compared to Hammusit.

- That there is a degree of co-ordinated effort and more activities going on to consciences the public against HIV/AIDS, than there is in Hamusit.

- That the availability of knowledge did not translate in to attitudinal and behaviour changes in Durbete and even more so in Hamusit.

- That there is no mechanism at the community level yet to support families that are affected with HIV/AIDS. This is true for Hamusit as it is for Durbete.

- We know of 90 orphans in Durbete town registered with the Kebellie. This indicates that there is some follow up in Durbete as opposed to the situation in Hamusit.

- The fact that in Durbete both the co-ordinating committee and the technical committee has some action plan to continue with the dissemination of knowledge regarding HIV/AIDS and nothing of the sort exists in Hamusit.

Thus, by way of concluding this observation one clearly see's that there is a marked difference between Hamusit (A Non Intervention site) and Durbete (An Intervention site).

5.2 Results of focused group discussion in Dejen town.

Located on the last escarpment leading down in to the Blue Nile gorge, Dejen is another wareda town outside the intervention area.

The assessment team arrived in Dejen town in the morning of 30th June 2000. The survey students were deployed to gather the survey data. Other members of the assessment team continued with an in depth interview with individual members of the community, while the rest of the team began to deal with the Kebellie leaders of Dejen town, to organise the focused group discussion, to take place on the 2nd of July 2000. The survey work and the in depth interview had given the assessment team the chance to place the discussion in the context of the Dejen town.

Dejen Kebellie officials were not at-ease with activities of the assessment team. They kept feeling that the team was there to evaluate their performance regarding HIV/AIDS. Thus they tried to stop

CCRDA

the meeting of the focused group discussion from taking place. Lucky enough the team realised the intention of the Kebellie and was able to overcame the problem.

The Dejen focused group discussion took place in the afternoon of the 2nd of July 2000. The focused group discussion consisted of members of the different government institutions in the town. This included teachers, health workers, and at least one Kebellie official. There were also invited individuals from the informal sectors. The later included housewives, part time and full time sex workers, shopkeepers, priests from the Orthodox Church and few Moslems from the town.

The discussion was conducted in three phases. The first phase of the discussion was meant to measure the degree of awareness and/or knowledge that exists among the general public. Participants who came from Dejen high school explained that the school have organised an Anti HIV/AIDS club and mentioned the fact that the school teaches the students to be aware of HIV/AIDS every morning after the flag raising ceremony. It was also mentioned that the Anti HIV/AIDS club stages dramas and poetry reading programmes. Thus the speaker claimed that there is awareness among the youth.

One of the participants said that there are many persons in the town, who have died of AIDS, and still more are in their deathbed. Hence argued that every body knows about HIV/AIDS. According to this speaker there is now a demonstrative evidence as we can see people dying from this disease.

Most of the participants claimed radio and T.V to be their chief source of information on HIV/AIDS. The participants were asked about the cause of the disease AIDS. Most of them replied that the disease is caused by sexual intercourse. With the exception of the educated, most of the participants did not seem to understand about the virus HIV. The participants seemed to have general information about HIV/AIDS. They also have knowledge regarding infected syringes, blood transfusion and the like to be the cause of transmission. These are of course general information they pick from radio, T.V and the discussions they have with friends.

As far as their knowledge goes regarding the prevention mechanism, most participants referred to faithfulness to one partner, avoiding illegal injections, and the like. The issue of the use of condoms ended up in a heated debate between the male and the female participants.

The educated participants and the female is who were mostly sex workers argued condom use to be an option for those who can't live with one partner alone, due to their way of life. The uneducated male participants, who also constituted the majority of the focused group discussion protested with the very idea of the mention of condom. In their view putting condoms as an option is like telling the young people that they do sex, as they like as far as they use condom.

The Kebellie leader that participated did not at all like the debate. Consequently he did every thing in his power to make the discussion short.

When the assessment team refused to make the discussion short, as the Kebellie leader wanted them to do, the Kebellie leader walked out of the meeting in protest, joined by those male participants opposed to the use of condom.

There is a similarity between the behaviour of the Kebellie in Dejen and that of the Kebellie in Hamusit. In both cases, their behaviour indicates to their low-level awareness of the magnitude of the problem of HIV/AIDS.

CCRDA

Thus to summarise the situation in Dejen in terms of knowledge, attitude and behaviour regarding HIV/AIDS prevention and control programme the following may be concluded:

- The awareness of the general public regarding HIV/AIDS is quite general and has a long way to go to impact on attitude and behaviour.

- That there is no unified cooping mechanism in place at the community level to deal with the problem.

- The attitudinal change still seems to be at the level of fear about HIV/AIDS and this did not change (translate) to changes in the sexual behaviour.

- That there is no unified measure being taken at the community level. It seems that each social class and individuals are responding to the problem as it occurs to them depending on the little information they have regarding HIV/AIDS.

- The schools seem to be relatively better in terms of information they give to the students. Up to now it seems that students are getting lessons on HIV/AIDS in school as part of other subjects they study. It does not seem that they have yet understood the magnitude of the HIV/AIDS problem. But with the current situation of HIV/AIDS in Dejen, in which they can see many people die, young people have taken the use of condom as the only option.

- The Anti AIDS club activity in Dejen is limited to the school and its impact is difficult to measure as it started only this year. That there is no organised body at all to fight HIV/AIDS at community level.

- Families affected by HIV/AIDS do not get support from anywhere, except from the immediate family members.

5.3 Focused Discussion Group in Finote-Selam

The focussed group discussion held in Finote-Selam depicts a qualitative difference between intervention and non-intervention areas in general and difference between Finot-Selam and Dejen in particular.

The assessment team presented the focussed group discussion with the same theme as presented at other sites. The purpose as it was in other sites was to measure the level of awareness and /or knowledge regarding HIV/AIDS. It was also meant to see, how much this awareness has impacted on attitudinal and behavioral change.

The assessment team posed a very general question regarding the problem of HIV/AIDS for the participants to discuss. Their responses were analytical.

An older person among the participants responded. He began by explaining the fact that the town of Finote-Selam is located on the Addis Ababa Gonder/Gaint highway. Thus he claimed, there are an average of ten public buses that stay over night in this town every day. He argued, all these to have consequence for social and sexual transaction in the town of Finote- Selam.

The same person continued to speak: In addition to the buses, there is also a military training camp at a place called Bir- Shalako, in the vicinity of Finote - Selam. This site he mentioned, has

CCRDA

been a military camp at the time of the Dergue and has continued to be today. This too, he said, had and still has an impact on the town in terms of HIV/AIDS. He also made reference to the amount of money the solider can afford to pay to persuade sex workers to go to bed with them.

Other participants made reference to the fact that there are unprofessional injectors in the area, who use the same needle and syringe on different individuals. The participants argued that this practice has also contributed to the spread of HIV/AIDS.

Another women mentioned the fact that she knew some friends who used to argue that HIV/AIDS did not exist. Today, she explained that these friends do not exist any longer because they died of AIDS.

The participants also explained the relationship between the spread of HIV/AIDS and the custom of alcohol consumption. Mention was also made of the fact that farmers come from the rural area to the town both for alcohol and sex. Thus concluded that the rural area is just as much affected by HIV/AIDS.

One of the, sex workers, who participated in the discussion strongly argued that men try to find other excuses, such as mosquito bite and the like, when they very well know that the main form of the transmission of HIV/AIDS is sexual intercourse. She blamed some men who want to have sex with sex workers without using a condom.

Another participant made reference to the fact that HIV/AIDS kills both parents and expressed his worry that soon the country is going to be full of orphans.

He farther made reference to the fact that, Kebellie keeps recording the number of orphans, in the town and expressed that the situation is already beyond what Kebellie can cope with.

Regarding activities to control and prevent HIV/AIDS the participants explained that education is being given by the church, schools, by health officers, by agricultural workers, by the radio and T.V and by leaflets. A mention was also made of the committee established at the wareda level for the same purpose.

In short, the knowledge that the general public has, in Finote Selam, is significantly different from none intervention area such as Hamusit and Dejen.

AIDS patient, families cannot care for, at the present, are not significant in number. Therefore the problem is not as obvious as the problem of orphans. The problem of children whose parents have both died is now real and participants of the focused group discussion have expressed their worry.

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6.1 Conclusion and Recommendation

In a country like Ethiopia where the real risk of catching HIV/AIDS is clouded by cultural and traditional attitudes that have to do with the role of men and women and their financial status, fighting HIV/AIDS has no alternative except educating the public.

CVM as a program has implemented an awareness creation project over the last few years. This program and its activities were limited to West Gojam and Bar Dar Lieu zones. From this point of view it can be said that West Gojam is relatively privileged. Even if attitude and behavioural changes did not show a significant difference it is obvious that knowledge regarding mechanisms of transmission of HIV/AIDS is greater in the CVM intervention area as compared to the non-intervention sites.

When there is no cure to a disease prevention is the only option. It is obvious that prevention is cheaper in terms of HIV/AIDS since the price paid is in life. In such a situation, public education should be highlighted and applied as widely and as consistently as possible.

The real tragedy concerns the innocent victims. These are persons who are infected and continue to be infected due to their lack of knowledge regarding mechanisms of transmission of HIV/AIDS. Worst of all of this tragedy is about those children who are infected while they are still in their mother's womb and those children who are left without mother and father due to HIV/AIDS. This problem is becoming a reality on a large scale.

As the impact analysis at the community level has depicted it is possible to make a difference through a co-ordinated effort in public education in the fight against HIV/AIDS. Public education is not an option but the only approach that may minimise the cost of HIV/AIDS epidemic.

Campaign of public education however should be set in the context of general framework of action. In this line CVM has facilitated the creation of HIV/AIDS prevention and control program with both co-ordinating and technical committees established at the regional, zonal, and Wereda levels. In the intervention weredas the committees have been active with varying degrees of success. Although there are still works that need to be done in terms of; the integrated approach; the effort and the approach appear to be in the right direction.

If the program is to succeed farther there is a need to develop a comprehensive strategy in fighting the epidemic. This perhaps will require:

1. A strategy for infection control and a surveillance system.
2. A need to carry out an in depth research in to the culture surrounding sexual behaviour in the region.
3. A need for the development of health and other services for persons with HIV infection.
4. A strategy should also be worked out to cope with the emerging problem of orphaned children.

Of course, central to all these is the public education. In the specific situation of the Amhara Region the only hope to contain the spread of HIV/AIDS is by influencing individual behaviour and life style.

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Centro Volontari Marchigiani (CVM)
Facilitated:
HIV/AIDS Control and Prevention Programme
West Gojjam and Bahir Dar LiYu Zones,
Amhara Region, Ethiopia.

Comparative Impact Assessment
15 June to 15 July 2000

Annexes to Final Report

ANNEXES

I TERMS OF REFERENCE
II. ASSESSMENT TEAM COMPOSITION
III. ITINERARY
IV. PERSONS AND GROUPS MET
V. DOCUMENTS CONSULTED
VI. MAP OF AMHARA REGION
VII. PROFILE OF THE ZONES, TOWNS AND KEBELLES INCLUDED IN THE ASSESSMENT
VIII. ORGANIZATIONAL CHART AND DESCRIPTION OF ANRS HIV/AIDS CONTROL AND PREVENTION CO-ORDINATING AND TECHNICAL COMMITTEES
IX. LIST OF DISCUSSIONS POINTS PER LEVEL
X. THE QUESTIONNAIRE FOR INDIVIDUAL INTERVIEWS IN URBAN SETTING
XI. THE QUESTIONNAIRE FOR INDIVIDUAL INTERVIEWS IN RURAL SETTING
XII. THE COMPILATION OF THE RESPONSES;
XIII. OVERVIEW OF THE OBSERVATIONS AT INSTUTIONAL LEVEL
XIV. PROGRAMME OUTPUTS:-
- DISTRIBUTION OF IEC MATERIALS
- TRAINING COVERAGE
XV. OVERVIEW SIX YEAR BUDGET USE PER ACTIVITY
XVI. HEALTH STATUS EN HEALTH CARE INFORMATION
XVII. MAIN FEATURES OF THE FEDERAL AND ANRS MULTI-SECTORAL HIV/AIDS STRATEGIC PLANS
XVIII. LOGICAL FRAMEWORK WITH MONITORING AND EVALUATION INDICATORS

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Annex I

TERMS OF REFERENCE

I. Background:

The Amhara National Regional State which stretches from 150 km north of Addis up to 800 where it joins the Eritrean border to the north, to the west it joins Sudan and to the East it joins the Afar Region. In the Region infectious diseases and malnutrition account for 95% of illness and death. Health coverage is below 45%. There are 6 zonal and 5 rural Hospitals, 55 Health Centres and 537 Health Stations to serve over 15 million people in Amhara Region. The ratio of Medical Doctors to the population is 1:68,000 (approx. 170,000 in densely populated Zones) and that of a Nurse to population is 1:17,241. It is estimated that there are over 600,000 people living with HIV/AIDS in the Amhara National Regional State.

Centro Volontari Marchigiani (CVM, an Italian NGO), with the West Gojjam Zonal Department of Health, initiated a collaborative HIV/AIDS Prevention and Control Programme in the Zones of West Gojjam and Bahir Dar Liyu, in 1994, to respond to the fast growing number of AIDS cases in the Zones. At the time very little prevention activities existed in the Amhara Region. The major objective was to achieve a decline in the spread of HIV/AIDS through an integrated approach to the problem in both Zones. Co-ordination and technical committees were formed at different levels in both these Zones from Zonal down to Kebele level.

The main actors involved, along with CVM, are the Executive Committee of the Regional Council, representatives from all Regional Bureau's, Zonal Departments, Religious Institutions, local Associations, Kebelle leaders, and prominent selected people at community level eg teachers, health personnel, women, religious leaders, youth etc. The role of CVM as lead agent concentrates on facilitation and co-ordination together with provision of financial and material resources. Implementation of the activities is the main responsibility of the Zonal health authorities, health facility personnel and the trained volunteers. All local parties participate in the management and monitoring of the programme down to Kebelle levels .

Project Goal and objectives:
The long term goal of the HIV/AIDS control and prevention programme is to achieve a declining in the number of HIV infected people in West Gojjam.

The intermediate objectives to be achieved by the end of 1999, are as follows:

1. Improve the capacity of Local Government and Institutions in the prevention of HIV/AIDS;
2. Promote an integrated approach to the problem;
3. Foster behavioural change;
4. Promote care and solidarity for HIV/AIDS patients and their respective families.

The following results were to be achieved within the project period:

1. Organise effective management of the programme and promote co-operation with the concerned personnel from Ministry Offices and Institutions in the Zones;
2. Strengthen the operational capacity of the Zonal Health Department at various levels to prevent the spread of HIV and to cope with AIDS patients;
3. Encourage communities and local institutions to provide support for terminally ill PWA's and their families;
4. Train counsellors and communicators to ensure the availability in all Health structures, Schools and 15% of the E.O.C. parishes;
5. In every Woreda 50% of the population will be aware of HIV/AIDS, modes of transmission and prevention;
6. Uphold positive local traditions and values, functional to the prevention of HIV/AIDS;

Activities undertaken to achieve the results:
Training, IEC, Support to Health Structures, Patient Care, Income Generating Activities Research

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II. General Objectives:

A.) After six years the lead agent, the programme implementers, funding agencies and other interested parties want to know if the programme is having an impact on the spread of HIV/AIDS in the two zones and which lessons can be learnt both for the future of this programme as for other programmes.

Limitation:
In respect to the goal of the programme "to achieve a decline in the number of HIV infected people in West Gojjam and Bahir Dar Zones" an Assessment of the Impact would mean, in strict terms, that proof is to be sought whether a decline is taking place or not. However as no baseline measurement was undertaken, at the moment of the start of the programme, and as no structural surveillance could yet be installed an Impact Assessment in strict terms is not feasible. On top of this experience, in several countries, has shown that the time needed to achieve actual impact on the spread of HIV/AIDS is longer than the six years that the programme has now been implemented.

On the other hand the intended results / outcomes, of the approach selected, the intermediate objectives set and the activities carried out, aim to change the factors that influence the spread of HIV/AIDS. Therefore assessment of changes of these factors should allow to draw conclusions towards the possible effects on the decline of the spread of the disease.

In strict terms therefor the assessment is to establish the progress in achieving the results intended: an outcome assessment.
In view of the nature of the disease and the major factors contributing to its spread, the essential questions thus pertain to:

- *are knowledge, attitude and behaviour of the general public, specific high risk groups, health care personnel and authorities changing towards preventing the transmission of HIV/AIDS and ensuring adequate care of PLWA'S;*
- *are these changes related to the programme organization, inputs and outputs;*
- *which internal or external actions can increase the possibilities to achieve the impact foreseen in a sustainable way.*

To establish whether the intended changes have been achieved by the programme a comparison with the situation before the start of the programme is necessary. However as no baseline data have been recorded this is not possible. Therefore to be able to compare the outcomes with a zero situation the option to compare the intervention zones with non-intervention zones has been chosen.

B.) As since the start of the programme the number of parent-less children, due to death of parents with AIDS, has rapidly grown the lead agent CVM and the donors also wish an indicative assessment of possible strategies to support care for orphans in the communities.

C.) The lead agent, programme management and the donors feel the need to improve continuous monitoring and evaluation of progress. This comparative assessment exercise should allow to develop a proposal for a monitoring and evaluation tool for this aim.

III Specific Objectives:

1. External Environment:
Assess, in the light of the national Health care policy, the National AIDS programme and this programme, the external factors and actions that are conducive or obstructive for the effective functioning of the programme.

Assess the views of external parties regarding the programme and its value towards the National AIDS programme, other AIDS control and prevention programmes and actors.

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Assess the effectiveness of the exchange of information, communication and co-operation of the programme management with the Regional and national authorities in view of obtaining recognition and support and recommend actions that the programme management can undertake to improve co-operation and support.

2. Programme Organization and Management:

Assess, in the light of the programme objectives, intended result and activity plans, in how far the present organizational facilitates effectiveness and recommend adaptations where necessary;

Assess the effectiveness of the programme management to ensure timely implementation of the activities, analyse problems and correct where necessary. Assess the capacity of the management to respond effectively towards unexpected situations / problems. Assess which external factors hamper the effectiveness of the management. Recommend adaptations to improve effectiveness.

Assess the capacity and performance of the programme management to organize, execute, supervize, monitor and adapt training programmes / activities. Assess how new training needs or needs to change training courses are become known to the management and how they are acted upon. Assess which the external obstacles hamper effective training activities. Recommend adaptations where feasible.

3. Implementing level: Zonal Health department and health Institutions:

Assess the operational capacity and effectiveness of the Zonal Health Department to plan, implement and monitor training and prevention activities, to support and monitor training and prevention activities of others and to ensure the adequate functioning of the health institutions. Assess the factors that the Zonal department and the programme management can influence and recommend feasible adaptations to improve effectiveness.

Assess the operational capacity and effectiveness of the health facilities to implement prevention activities, to support prevention activities in the communities, to ensure safe blood transfusions, to test for HIV, to council persons, to care for patients in a supportive way. To treat opportunistic infections and to refer patients.

Assess which factors can be influenced by the Zonal Health Department, programme management and health institution and recommend feasible adaptations to improve effectiveness.

Assess in how far the knowledge, attitude and behaviour of health care staff has changed towards preventing the transmission of HIV, positive support for HIV/AIDS patients and their family. Recommend, if necessary, possible other approaches and activities to facilitate change of attitudes and behaviour.

Assess available counselling capacity and willingness, and in how far persons needing and wanting counselling are receiving it. If necessary, recommend ways to improve access to counselling for persons wanting it.

Assess in how far the health personnel is actively involved in training activities and in how far this responds to the needs and opportunities that present themselves. Assess the factors that enhance or hamper their participation in training activities. Where feasible recommend activities to improve health personnel's participation in training activities.

4. Community level:

Assess in how far the knowledge, attitude and behaviour change of the general public, women, youth, teachers, bar workers, community leaders and religious leaders are changing towards preventing HIV transmission, acceptance of PLWA'S and positive support of PLWA'S and their families.

Assess the availability and activities of volunteer counsellors and communicators in health facilities, schools and E.O.C. parishes and communities and in how far they have an influence on the changing of knowledge, attitudes and behaviour.

CCRDA

Assess the opinions of the volunteer counsellors and communicators regarding the training received and its influence on their activities in the community.

If possible assess which factors are conducive or obstructive to enable volunteers to continue their activities and which support could strengthen their involvement, motivation and continued activity.

Assess in how far the IEC strategies and materials have influenced changes in knowledge, attitude and behaviour of the target groups. Assess opinions of the addressed groups regarding the appropriateness of the IEC strategies and materials. Assess whether the distribution of IEC materials was adequate in respect to the aims and target group.

Assess which other factors influenced the changes of knowledge, attitudes and behaviour towards preventing HIV transmission, acceptance of PLWA'S and positive support for PLWA'S and their families.

Assess whether local institutions, community organizations and community members actually undertake activities to facilitate safe sexual behaviour.

Assess whether the youth centres are facilitating safe sexual behaviour of the youth.

Assess whether the local institutions, community organizations and communities members actually undertake activities to express solidarity with, to support and care for chronically ill patients and their families.

If possible assess the effect of the Income Generating Activities on the possibilities of the PLWA's and their families to cope with the situation and contribute to their social acceptance.

Assess, if possible whether local traditions and values, affecting the spread of HIV/AIDS are being questioned and whether traditions and values that can assist towards prevention of HIV/AIDS are being retained;

Where necessary recommend alternative strategies and activities to facilitate knowledge, attitude and behaviour changes towards prevention of transmission of HIV, acceptance of PLWA'S and support of PLWA'S and their families.

5. Integrated Approach:
Assess in how far the integrated approach facilitates the two main intended outcomes: increased prevention of transmission and improved support and care for the patients. Where necessary and feasible recommend actions to strengthen the effectiveness of the integrated approach.

6. Sustainability:
If possible, assess in how far the programme is cost effective, whether alternatives exist to improve cost effectiveness and recommend ways to achieve them. Assess the possibilities to increase local funding for the activities and resources needed per level of implementation and / or responsibility and, where possible, recommend feasible strategies to increase local funding.

7. Monitoring and Evaluation Tool:
In the light of the National Health Information System, the National AIDS Monitoring and Evaluation guidelines and the programme objectives determine the main indicators that will allow to monitor progress in input, output, outcome and which indicators indicate effect. Assess how these can best be measured, which data needs to be registered at which interval and which intermittent data collection activities are needed. Determine which analysing activities and frequency are needed, how the outcomes need to be reported and who has which responsibilities in the process.

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8. Indicative assessment of possible strategies to support care for orphans in the communities:

Collect available information regarding the extent of the problem, the expectations with respect to future developments and national views and plans. Collect available information regarding coping mechanisms that exist at family and community level to support and care for orphans. Endeavour to assess whether these mechanisms are benefiting orphans of parents that died of AIDS. Collect information that may allow to draw conclusions regarding the actual capacity of these mechanisms and how they could be strengthened. Collect information on orphan care programmes in the country, their approaches, experiences, costs and funding.

Recommend feasible strategies to support care for orphans in the communities or recommend additional research which can enable the lead agent to develop such strategies.

9. Indicative assessment of unmet needs, additional activities and unintended effects:

During the exercise, assess whether there are indications that there are needs at the level of health services, communities or patients that are not being met.

Are there prevention activities that could strengthen the effectiveness of the programme which at present are not included in the programme.

Assess the reasons for not answering the needs or not adding the activities. When feasible recommend ways to integrate new activities to address the unmet needs and activities in view of improving the effectiveness of the programme.

Also assess whether there are indications that the programme inputs or activities are having effects on health services, communities, patients or other parties that are not intended and how these are to be valued. Recommend ways to avoid negative effects and / or ways to ensure that the positive effects are strengthened.

IV. Methodology:

The Comparative Impact Assessment will be undertaken by three external consultants: one European Public Health consultant, one Anthropologist and one Ethiopian Public Health consultant. The European consultant is the team leader.

Staff of CVM and the Regional Health Bureau are part of the assessment team as resource persons and facilitators.

Preparation:

The preparation will consist of document study and finalizing the data definitions, design and methods.

Documents:

- Project Description HIV/AIDS Control and Prevention Programme, West Gojjam, 1994-1999;
- Annual Reports 1994, 1995, 1996,1997, 1998, 1999, of the same programme;
- The Evaluation Report of the same programme of1997;
- Survey of KAB on AIDS and Ethnographic study of Western Gojjam (Solomon Gebre Consultant)
- Coming to terms with the Epidemic, the Anthropological Study of 1995 By Christopher Cruise:
- Learning to survive on epidemic the influence of HIV/AIDS information on young Ethiopians (Chloe Dear);
- Document "National AIDS programmes, a guide to monitoring and evaluation".

Data collection:

Statistical data will be collected from the national, regional and zonal authorities as well as the programme management. During a field study, of three weeks, data will be collected in the intervention zones and non-intervention zones:

- At the level of authorities and programme management and implementers: through observation, semi-structured interviews with individuals, committees and groups; and visits to health institutions;
- At the level of the target population through observation, group discussions with the assistance of a questionnaire (open and prompted questions) and interviews of randomly selected individual

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representatives of target groups, also with the assistance of a questionnaire containing open and prompted questions; as well as visits to the youth centres.

See list of persons and groups to be met in annex.

Analyzing data:
The Assessment team will analyze the data together and determine the main conclusions.

Reporting:
At the end of the field study, if time allows to analyze the findings during the last days of the filed presence, preliminary conclusions will be shared with the main actors at the programme level.
After the interviews and the data collection at the level of Addis Ababa and the analysis of the findings the assessment team will present the main conclusions and be debriefed by the lead agent.
If time allows the draft report will be compiled in Addis before the debriefing. If this proves impossible due to time constraints the team leader will compile the draft report in Europe. The co-consultants will then receive the draft report for their amendments etc. The corrected draft will then be presented to the lead agent and programme management. The report will be finalized with their comments and amendments, in as far as these represent oversights, and misunderstandings.
In case necessary and if the budget still allows the consultants may be requested to discuss the report with the lead agent and / or present the findings to the main stakeholders of National, Regional and Zonal level.

The draft report will be presented within one month of the end of the field work.
The final report will be presented within two weeks of receipt of the comments.

V. Outputs:

The outputs of this Comparative Impact Assessment will be:

1. A report of not more than 25 pages, not including the annexes in which the main finding, with respect to the general and the specific objectives, are adequately reflected together with recommendations that can assist the lead agent and programme management to improve the effectiveness of this programme and improve the plans for a new programme in other zones.
2. A proposal for a monitoring and evaluation tool that can facilitate continuous monitoring and evaluation of progress of inputs, outputs, outcomes and impact of own programmes and other HIV/AIDS control and prevention programmes.

NB. The development of the proposal for the monitoring and evaluation tool may require additional time. The assessment team will inform the lead agent within two weeks of the start of the field work whether its development is feasible in the time foreseen now for the exercise.

VII. Time schedule

The entire exercise will take place between May and August 2000.
Preparation: 2 days for each consultant;
The field work, analysis, preliminary reporting and debriefing: June 15 to July 15, 2000: 30 days for the entire assessment team.
Report writing, corrections and finalizing: 5 days for team leader, 1 day for co-consultants.

VIII. Required qualifications of the consultants

The assessment requires skills and expertise in Public Health, Anthropology, the Ethiopian Health Care System and programme planning. Therefore the external consultants are: one European Public Health and programme planning expert, an Ethiopian Anthropologist and an Ethiopian Public Health expert. The filed work will be carried out together.

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Annex II

ASSESSMENT TEAM COMPOSITION

External consultants:

Dr. Gemetchu Megersa	Anthropologist University of Addis Ababa
Mrs. Marieke Verhallen	Public Health consultant

Local facilitators

Dr. Tesfaye Ayalew	RBOH AIDS expert
Dr. Wendemagegn	Head of Health Programme Department
Mrs. Yeshi	Social Anthropologist University of Bahir Dar

CVM staff / resource persons:

Sr. Tizita Bedaso	CVM Gender Promotion Officer
Ato Aynalem Yigzaw	CVM Project Co-ordinator, Bahir Dar
Ato Geremeu Akiesa	CVM Communicator, Bahir Dar
Ato Elias Abebe	CVM IEC expert, Bahir Dar
Ato Hailu Jezus	CVM Communicator, Finot Selam
Ms. Gelsomina Viscione	CVM volunteer
Mrs Marian Lambert	CVM Project Co-ordinator Italy

Observer:

Dr. Melaku Samuel	Ireland Aid, Head SZ AIDS office

Advisor:

Fr. Owen Lambert

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Annex III

ITINERARY

15/06/2000	Arrival Addis Ababa
16/06	Travel to Bahir Dar
	First briefing meeting CVM team
17/06	Meeting of the Assessment team
	Continuation of briefing by CVM team
	Consensus discussion Terms of Reference
18/06	Finalizing methodology by Assessment team
	Determination of points of discussion for each level
19/06	Finalizing questionnaires for the individual interviews
	Typing and correcting questionnaires
	Start of training of interviewers
20/06	Training of interviewers and testing of questionnaires among the students
21/06	Start of field work

COMMUNITY ASSESSMENT TEAM:

21/06 - 23/06	Hamusit
24/06 - 26/06	Durabete
27/06 - 29/06	Finot Selam
30/06 - 02/07	Dejen
03/07	Return to Bahir Dar
04/07 - 15/07	Compilation of the responses and report
09/07	Return to Addis Ababa

INSTITUTIONAL ASSESSMENT TEAM:

21/06	Dera Woreda level meetings at Dera
22/06	South Gondar Zonal level meetings at Debre Tabor
23/06 - 24/06	Achefer Woreda level meetings at Durabete
25/06 - 26/06	Jabitehnan Woreda level meetings at Finot Selam
27/06	East Gojjam Zonal level meetings at Debre Markos
28/06	Dejen Woreda level meetings at Dejen
29/06	Return to Bahir Dar
30/06 - 08/07	West Gojjam and Bahir Dar Zonal level meetings and meeting with Regional Sectors
09/07	Return to Addis Ababa
10/07 to 13/07	Meetings at National level

COMPLETE TEAM ACTIVITIES:

	Meetings to review first findings, assessment methodology issues and data compilation
06/07 - 07/07	Review of outcomes and conclusions Assessment team and CVM team
07/07	Debriefing to members of the Regional Co-ordinating Committee
13/07	Review of outcomes and conclusions Assessment team with CVM Team
14/07	Debriefing to Head of National department Of HIV/AIDS Control

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Annex IV

PERSONS AND GROUPS MET

Dera Woreda
- Health Officers
- Head of Health Centre
- EOC Priest
- Co-ordinating Committee

South Gondar Zone
- Head of Health Department
- Co-ordinating Committee
- Communicable Disease Expert
- Director of the Hospital

Achefer Woreda
- Technical Committee
- TC Secretary
- Co-ordinating Committee
- Head of Health Office
- Head of Health Centre and new Medical Doctor
- Representatives of the EOC
- Group of Teachers
- Representatives of Islamic Council
- Representatives of Women's Association
- Animators of Youth Centre

Jabitehnan Woreda
- Medical Director of the Hospital
- Animators of the Youth Centre
- Technical Committee
- Priest Co-ordinator EOC
- Community Counsellor
- In charge of Bloodbank
- Co-ordinating Committee
- Women's group
- Teachers of Elementary School
- CVM Co-ordinator / educator based in Finot Selam

East Gojjam Zone
- Department of Health
- Technical Committee
- Co-ordinating Committee

Dejen Woreda
- Health Centre Staff members
- EOC Parish Priest
- Technical Committee
- Co-ordinating Committee

West Gojjam Zone
- Head of Education Office
- Head of Agriculture Office
- Head of Health Department
- Technical Committee
- Co-ordinating Committee
- Head of Labour and Social Affairs

Bahir Dar Liyu Zone
- Department of Education
- OSSA
- Group of PLWA
- Head of Health Department
- Technical Committee

Felege Hiwot Hospital
- Group of Hospital Counsellors
- Medical Director

Amhara Regional State
- Bishop and Administrator EOC Diocese
- Islamic Council
- Bureau of Labour and Social Affairs
- Bureau of Health
- Bureau of Justice
- Bureau of Women's Affairs
- Bureau of Education
- Bureau of Agriculture
- Secretary and two members of Co-ordinating Committee

National Level
- CRDA
- UNICEF
- European Commission
- DICAC
- OSSA
- Dawn of Hope (association of PLWA)
- Ethio – Netherlands AIDS Research Project (ENARP)
- Roman Catholic Church: Bishop of Addis Ababa and Amhara Diocese
- Ethiopian Women Lawyer Association
- WHO
- UNAIDS
- Head of National Department of AIDS

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Annex V

DOCUMENTS CONSULTED

PROJECT DOCUMENTS:

- Project Description HIV/AIDS Control and Prevention Programme, West Gojjam, 1994-1999;
- Annual Reports 1994, 1995, 1996,1997, 1998, 1999, of the same programme;
- The Evaluation Report of the same programme of1997;
- Survey of KAB on AIDS and Ethnographic study of Western Gojjam (Solomon Gebre Consultant)
- Coming to terms with the Epidemic, the Anthropological Study of 1995 By Christopher Cruise:
- Learning to survive on epidemic the influence of HIV/AIDS information on young Ethiopians (Chloe Dear);
- The Terms of Reference for the Comparative Impact Assessment of the same programme.

COUNTRY DOCUMENTATION:

- Ministry of Health (MoH): Programme Action Plan for the Health Sector Development Programme, 1998;
- Amahara Region Bureau of Health: Health Sector Five Year Plan;
- WHO: The World Health Report 2000;
- Federal Government: Policy on HIV/AIDS, 1998;
- MoH: Strategic Framework for the National Response to HIV/AIDS for 2000 – 2004;
- MoH: Summary Federal Level Multi-sectoral HIV/AIDS Strategic Plan, 2000-2004;
- MoH: Summary Regional Multi-sectoral HIV/AIDS Strategic Plan, 2000-2004;
- UNAIDS: Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted diseases;
- MoH, Diseases Prevention and Control Department: Estimating National HIV Prevalence in Ethiopia Using Sentinel Surveillance Data, draft document June 2000;
- MoH, Diseases Prevention and Control Department: Current Status of HIV Sentinel Surveillance Data and AIDS Case Reporting in Ethiopia;
- Technical Working Group on HIV/AIDS in Ethiopia and UNAIDS: The Epidemiology of HIV/AIDS in Ethiopia: A Review, March 2000;
- Federal Government and World Bank: Ethiopia Multi-sectoral HIV/AIDS Program, draft July 2000;
- Ethiopian Medical Journal: A special issue on HIV/AIDS in collaboration with the Ethio-Netherlands AIDS Research Project.

GENERAL DOCUMENTS:

- Document "National AIDS programmes, a guide to monitoring and evaluation", UNAIDS/WHO Dr. T. Boerma;
- Sustainability the role of NGO's, A. Stefanini, WHO Bulletin, vol. 15, 1995)

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Annex VI

Annex VI MAP OF AMHARA REG

ADMINISTRATIVE DIVISION OF THE AM



AHARA REGION

Population - July 1, 2001 - 16792335

E AMHARA NATIONAL REGIONAL STATE



I. NORTH GONDER

1. Gondar Zuria
2. Dembia
3. Dabat
4. Jan Amora
5. Bayeda
6. Wegera
7. Lay Armachaho
8. Chilga
9. Adi-Arkay
10. Sanja
11. Belesa
12. Metema
13. Quara
14. Alefa
15. Debark
16. Gondar town

II. SOUTH GONDER

17. Farta
18. Dera
19. Fogera
20. Kenkem
21. Ebinat
22. Estie
23. Simada
24. Lay Gayint
25. Tach Gayint

III. WEST GOJAM

26. Bahir Dar Zuria
27. Achefer
28. Merawi
29. Adet
30. Bakola
31. Quarit
32. Aba Techan
33. Dembacha
34. Buro Wenbermariam
35. Duga Damot

IV. AGEW

36. Dangla
37. Guanga
38. Ankasha
39. Banja
40. Fagata

V. EAST GOJAM

41. Metekel
42. Gozamen
43. Baso Liben
44. Awabel
45. Dejen
46. Shebel Berentia
47. Enamayo
48. Enarge Enawga
49. Hulet Eju Enesie
50. Goncha Siso Enesie
51. Enebse Sar Midir
52. Debay Tilatgin
53. Bebugn

VI. NORTH SHEWA

54. Shenkorana Minjar
55. Berehet
56. Hagremariam
57. Angolela Terana Asagrt
58. Debre Birhan Zuria
59. Ankober
60. Sayadebir Wayu & Ensaro
61. Moretna Giru
62. Mafud Mezezo
    Mojana Wadera
63. Laybetna Tachbet
64. Geramidirna Keya Gebrel
65. Lalomidirna Mamamidir
66. Kewot
67. Efratana Gidim
68. Gesha Rabel
69. Antsoklya
70. Debre Birhan Town

VII. OROMIYA

71. Artumana Forsen Jille
72. Cheffa Gelana
    Dawi Rhimid
73. Bati

VIII. SOUTH WOLLO

74. Tehulu Ederie
75. Dese Zurla
76. Kalu
77. Wereylu
78. Jamma
79. Woromo Majetena Medina
80. Kellela
81. Magete
82. Debre Sina
83. Legambo
84. Sayint
85. Mekdela
86. Tenta
87. Kutaber
88. Ambasel
89. Were Babo

IX. NORTH WOLLO

90. Habru
91. Gubalefto
92. Kobo
93. Gedane
94. Dawentnea Delanta
95. Wadela
96. Mekane
97. Bugna

X. WAGE HIMERA

98. Sekota
99. Dahana
100. Zequla

XI. STATE CAPITAL

1. BAHIR DAR

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THE AMHARA NATIONAL REGIONAL STATE



I. NORTH GONDER

1. Gondar Zuria
2. Dembia
3. Dabat
4. Jan Amora
5. Bayeda
6. Wegera
7. Lay Armachoho
8. Chilga
9. Adi-Arkay
10. Sanja
11. Bellesa
12. Metema
13. Quara
14. Alefa
15. Debark
16. Gondar town

II. SOUTH GONDER

17. Farta
18. Dera
19. Fogera
20. Kemkem
21. Abinat
22. Estie
23. Simada
24. Lay Gayint
25. Tach Gayint

III. WEST GOJAM

26. Bahir Dar Zuria
27. Achafer
28. Merawi
29. Adet
30. Bakola
31. Quarit
32. Aba Techan
33. Dembacha
34. Buro Wenbermariam
35. Doga Damot

IV. AGEW

36. Dangla
37. Guangua
38. Ankasha
39. Banja
40. Fagata

V. EAST GOJAM

41. Metekel
42. Gozamen
43. Baso Liben
44. Awabel
45. Dejen
46. Shebel Decentia
47. Enamayu
48. Enarge Enawra
49. Hulet Eju Enensil
50. Goncha Sisot Enensil
51. Enebse Sar Midir
52. Debay Tilatgin
53. Bebugn

VI. NORTH SHEWA

54. Shenkorana Minjar
55. Borchet
56. Hagremariam
57. Angolela Terana Asagi
58. Debre Birhan Zuria
59. Ankober
60. Sayadebir Wayu & Ensa
61. Moretna Giru
62. Mafud Mozezo
    Mojana Wadera
63. Laybetna Tachbet
64. Geramidirna Keya Gebre
65. Lalomidirna Mamamidir
66. Kewot
67. Efratana Gidim
68. Gesha Rabel
69. Antsoklya
70. Debre Birhan Town

VII. OROMIYA

71. Artumana Forsen Jille
72. Cheffa Galana
    Dawi Rhimd
73. Batl

VIII. SOUTH WOLLO

74. Tehulu Ederie
75. Dese Zuria
76. Kalu
77. Wereylu
78. Jamma
79. Woromo Majetena Medina
80. Kellela
81. Magete
82. Debre Sina
83. Legambo
84. Saylnt
85. Mokdela
86. Tenta
87. Kutaber
88. Ambasel
89. Were Babo

IX. NORTH WOLLO

90. Habru
91. Gubalefto
92. Kobo
93. Gedlane
94. Dawentnea Delanta
95. Wadela
96. Mokale
97. Bugna

X. WAGE HIMERA

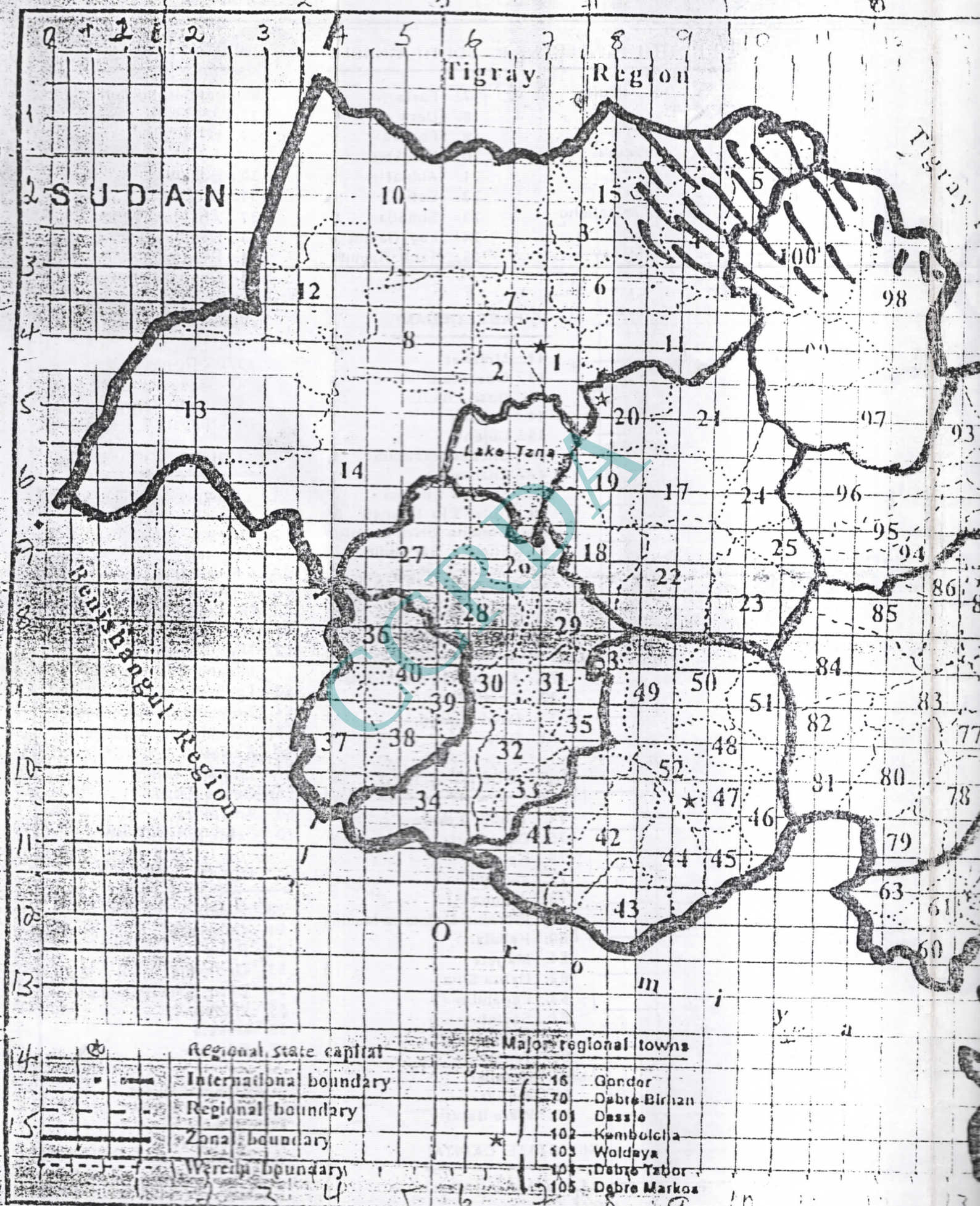
98. Sokota
99. Dahana
100. Zaquia

XI. STATE CAPITAL

1. BAHIR DAR

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ADMINISTRATIVE DIVISION OF THE A



Annex VII

PROFILE OF THE ZONES, TOWNS AND KEBELLES INCLUDED IN THE ASSESSMENT.

Profile of the Sites included in the Assessment

	Intervention				**Non Intervention**	
Zone	West Gojjam		Bahir Dar		South Gondar	East Gojjam
Population	1,961,886		112,009		1,876,979	1,838,923
Zonal Capital	Bahir Dar		Bahir Dar		Debre Tabor	Debre Markos
Coordinating C'tee	Active since 2 y / high turnov		Installed 2 y/ not compl		active since 1 year /incomplete	installed since one year /incompl.
Technical C'tee	Active s 2 years/former MtC'tee		Installed 2 y/ not compl		active since 1 year /incomplete	installed since one year /incompl.
Health facility	Regional Hospital in Bahir Dar				Zonal Hospital	Zonal Hopital
Woreda	Achefer	Jabitehnan				
Population	261,297	219,488			Dera	Dejen
Woreda Capital	Durabete	Finot Selam			323,586	144,826
Coordinating C'tee	Active since 2 years	Active since 2 years			Dera	Dejen
Technical C'tee	Active s 2 years/former MtC'tee	Active s 2 years/former MtC'tee			active since 1 year /incomplete	1st meeting for assessm./incompl
Health facility	Health Center	District Hospital			active since 1 year /incomplete	1st meeting for assessm./incompl
					Health centre	Health Centre
Urban / Rural Assessment Kebeles	Durabete 01/Debkan	Finot Selam 02 /Arbaitu Ensisat			Hamusit 01 /Gemhar	Dejen 01 /Zemetu
Coordinating C'tee	yes	yes			no	no
Technical C'tee	yes	yes			no	no
Health facility	Health Center	Hospital			Health centre	Health Centre
Nearest testing facility	Bahir Dar (60 km)	own hospital or Bahir Dar (240 km)			Debre Tabor (65 km) or Bahir Dar (130 km)	Debre Markos (70km) or Addis Ababa (560 km)
Schools	Elementary	Elementary and Secondary			Elementary and Junior Secondary	Elementary
Specific Characteristics	Main North - South route goes through the town	Main North - South route goes through the town and stopover for publicand private transport	Regional State capital		Main North - South route goes through the town	Main North - South route goes through the town and stopover for public and private transport
		Military Training Camp			Former regional captital	
		Two former state farms				

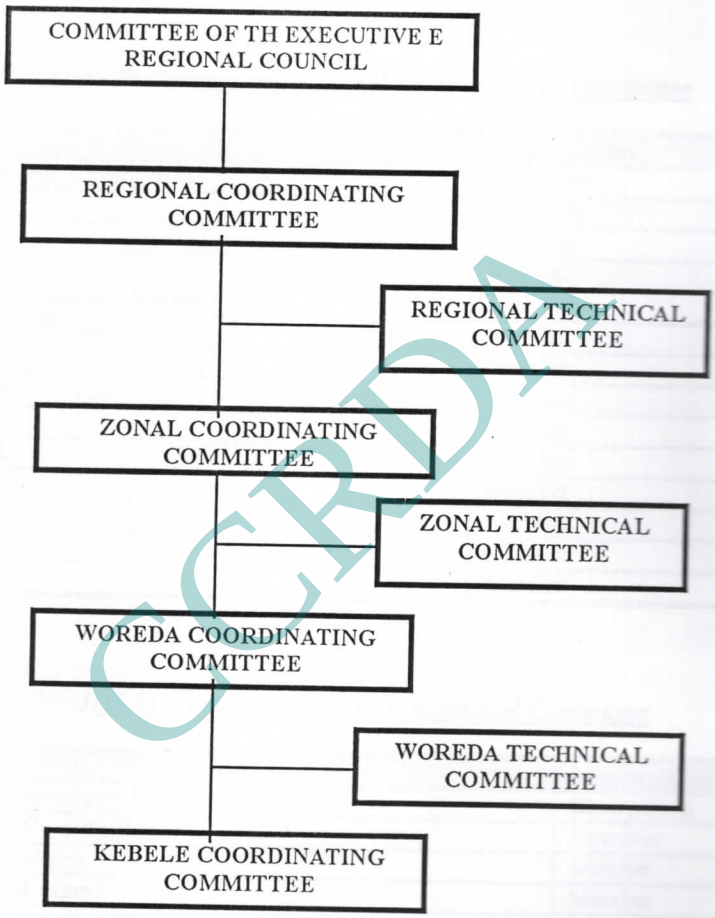
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Annex VIII

ORGANIZATIONAL CHART AND DESCRIPTION OF ANRS HIV/AIDS CONTROL AND PREVENTION CO-ORDINATING AND TECHNICAL COMMITTEES

AMHARA NATIONAL REGIONAL STATE

HIV/AIDS CONTROL & PREVENTION CO-ORDINATING COMMITTEE



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Amhara National Regional State
HIV/AIDS Prevention and Control Co-ordinating Committee

General Objective

Recognising the alarming rate at which HIV/AIDS is spreading in our region, we have come to the conclusion that a serious commitment and participation of individuals, families, communities, spiritual institutions, private organisations, NGO's and all government structures in the region is of paramount importance. The Regional Government, therefore, has found it appropriate to establish a co-ordinating organ which is proved to be indispensable according to the nationally and internationally accepted strategies for combating HIV/AIDS.

MEMBERSHIP

Members shall be drawn from all governmental and spiritual institutions, women's and professional associations, NGO's, traditional associations and the private sector.

Regional HIV/AIDS Prevention and Control Co-ordinating Committee

Institution	*Responsibility*
Executive Committee of the Regional Government	Chairman
Regional Health Bureau	Secretary
Regional Education Bureau	Member
Regional Agriculture Bureau	Member
Regional Culture, Tourism and Information Bureau	Member
Regional Labour and Social Affairs Bureau	Member
Regional Justice Bureau	Member
Regional Women's Affairs Office	Member
Ethiopian Orthodox Church	Member
Regional Islamic Affairs Council	Member
Amhara Development Association	Member
Amhara Women's Association	Member
NGO (CVM)	Member
Others	Member

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Regional HIV/AIDS Prevention and Control technical Committee

Institution	*Responsibility*
Regional Health Bureau, Health Programmes Department Head	Chairperson
RHB, HIV/AIDS/STD Programme Co-ordinator	Secretary
Regional Education Bureau, senior expert	Member
Regional Agriculture Bureau, senior expert	Member
Regional Culture, Tourism and Information Bureau, Department Head	Member
Regional Labour and Social Affairs Bureau, senior expert	Member
Regional Women's Affairs Office	Member
Ethiopian Orthodox Church	Member
Regional Islamic Affairs Council	Member
Amhara Development Association	Member
Amhara Women's Association	Member
NGO (CVM)	Member
Amhara Teachers' Union	Member
Others	Member

Zonal HIV/AIDS Prevention And Control Co-ordinating Committee

Institution	*Responsibility*
Zonal Government Executive Committee	Chairperson
Zonal Health Department	Secretary
Zonal education Department	Member
Zonal Agriculture Department	Member
Zonal Culture, Tourism and Information Department	Member
Zonal Labour and Social Affairs Department	Member
Zonal Women's Affairs Office	Member
Ethiopian Orthodox Church	Member
Zonal Islamic Affairs Council	Member
NGO	Member
Others	

Zonal HIV/AIDS Prevention And Control Technical Committee

Institution	*Responsibility*
Zonal Health Department	Chairperson
Zonal HIV/AIDS/STD Programme Co-ordinator	Secretary
Zonal Education Department, expert	Member
Zonal Agriculture Department, expert	Member
Zonal Culture, Tourism and Information Department, expert	Member
Zonal Labour and Social Affairs Department, expert	Member
Zonal Women's Affairs Office, expert	Member
Ethiopian Orthodox Church	Member
Zonal Islamic Affairs Council	Member
NGO	Member
Zonal Teacher's Union	Member
Others	Member

Woreda (District) HIV/AIDS Prevention And Control Co-ordinating Committee

Institution	*Responsibility*
Chairman of Woreda Council	Chairperson
Woreda Health Office	Secretary
Woreda Education Office	Member
Woreda Agriculture Office	Member
Woreda Women's Office	Member
Ethiopian Orthodox Church	Member
Woreda Islamic Affairs Council	Member
Others	Member

Woreda (District) HIV/AIDS Prevention And Control Technical Committee

Institution	*Responsibility*
Woreda Health Office	Chairperson
Communicable Diseases Expert	Secretary
Woreda Education Office	Member
Woreda Agriculture Office	Member
Woreda Women's Office	Member
Ethiopian Orthodox Church	Member
Woreda Islamic Affairs Council	Member
Others	Member

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Kebelle HIV/AIDS Prevention And Control Co-ordinating Committee

Institution	*Responsibility*
Chairman Of Kebelle Council	Chairperson
Head of Kebelle health institution	Secretary
Headmaster of Kebelle school	Member
Religious leaders in the Kebelle	Member
Kebelle Agricultural development agent	Member
Kebelie community health agent	Member
Kebelie traditional birth attendant	Member
Kebelie association leaders	Member
Prominent individuals (2)	Member
Members (2-3) of Kebelle Executive Committee	Member
Others	Member

REGIONAL COORDINATING COMMITTEE

1. Tasks And Responsibilities

- ensures that policies, regulations and manuals to prevent and control HIV/AIDS are correctly applied in the Region;
- establishes a technical committee which shall be responsible for day to day activities in HIV/AIDS prevention and control;
- approves plans of action and budget proposals prepared by the technical committee;
- renders support and advice to Zonal co-ordinating committees; provides guidelines and manuals and monitors their correct implementation;
- devises means for soliciting material and financial support for programmes to prevent and control HIV/AIDS;
- signs agreements based on applicable laws
- presents regular reports to the Executive Committee of the Regional Council
- commissions studies and investigations on the prevention and control of HIV/AIDS
- undertakes other nationally and internationally accepted strategies and activities to alleviate the impact of HIV/AIDS on society.

2. Accountability

With regard to all activities, guidelines, programmes and regulations pertaining to HIV/AIDS prevention and control the Regional Co-ordinating Committee is accountable to the Executive Committee of the Regional Council.

3. Duties

- shall execute all tasks and responsibilities entrusted in it;
- shall present draft regulations and manuals pertaining to its activities to the Executive Committee of the Regional Council;
- finances programmes and projects according to the budget approved by the Executive Committee of the Regional Council;

REGIONAL TECHNICAL COMMITTEE

1. Responsibilities

- presents action plans to the co-ordinating committee for activities to curb the spread of HIV/AIDS in the Region;
- prepares manuals and standards to the co-ordinating committee and monitors their correct implementation after approval so as to ensure that the universally accepted strategies for HIV/AIDS prevention and control
    a. preventing HIV transmission
    b. reducing vulnerability to HIV infection
    c. providing social and clinical support
    d. alleviating the impact of AIDS
    e. research

  are applied with due regard to situations prevailing in the region;
- renders support and advice to Zonal committees and monitors their activities closely
- reports quarterly to the co-ordinating committee;

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- explores means for soliciting material, financial and technical support for activities to prevent and control HIV/AIDS and presents its recommendations to the co-ordinating committee;
- carries out other activities as instructed by the co-ordinating committee.

2. Accountability

The Regional HIV/AIDS Prevention and Control Technical Committee is accountable to the Regional HIV/AIDS Prevention and Control Co-ordinating Committee.

3. Duties

- carries out its tasks
- presents draft regulations and manuals pertaining to its activities to the Co-ordinating Committee for approval;
- implements approved regulations and manuals;

ZONAL COORDINATING COMMITTEE

1. Tasks And Responsibilities

- ensures that policies, regulations and manuals to prevent and control HIV/AIDS are correctly applied in the Zone;
- establishes a technical committee which shall be responsible for day to day activities in HIV/AIDS prevention and control;
- approves plans of action and budget proposals prepared by the technical committee;
- renders support and advice to Woreda co-ordinating committees; provides guidelines and manuals and monitors their correct implementation;
- devises means for soliciting material and financial support for programmes to prevent and control HIV/AIDS;
- signs agreements based on applicable laws
- presents regular reports to the Executive Committee of the Zone;
- commissions studies and investigations on the prevention and control of HIV/AIDS
- undertakes other nationally and internationally accepted strategies and activities to alleviate the impact of HIV/AIDS on society.

2. Accountability

With regard to all activities, guidelines, programmes and regulations pertaining to HIV/AIDS prevention and control the Zonal Co-ordinating Committee is accountable to the Executive Committee of the Zone.

3. Duties

- shall execute all tasks and responsibilities entrusted in it;
- shall present draft regulations and manuals pertaining to its activities to the Executive Committee of the Regional Council;
- finances programmes and projects according to the budget approved by the Executive Committee of the Zone;

ZONAL TECHNICAL COMMITTEE

1. Responsibilities

- presents action plans to the co-ordinating committee for activities to curb the spread of HIV/AIDS in the Zone;
- monitors the correct implementation in the Zone of manuals and standards prepared by the Regional Co-ordinating Committee on the universally accepted strategies for HIV/AIDS prevention and control
    a. preventing HIV transmission
    b. reducing vulnerability to HIV infection
    c. providing social and clinical support
    d. alleviating the impact of AIDS
    e. research
- renders support and advice to Woreda committees and monitors their activities closely
- reports quarterly to the Zonal Co-ordinating Committee;
- explores means for soliciting material, financial and technical support for Zonal activities to prevent and control HIV/AIDS and presents its recommendations to the co-ordinating committee;
- carries out other activities as instructed by the co-ordinating committee.

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2. Accountability

The Zonal HIV/AIDS Prevention and Control Technical Committee is accountable to the Zonal HIV/AIDS Prevention and Control Co-ordinating Committee.

3. Duties

- carries out its tasks
- presents draft regulations and manuals pertaining to its activities to the Co-ordinating Committee for approval;
- implements approved regulations and manuals;

WOREDA CO-ORDINATING COMMITTEE

1.Tasks And Responsibilities

- ensures that policies, regulations and manuals to prevent and control HIV/AIDS are correctly applied in the Woreda;
- establishes a technical committee which shall be responsible for day to day activities in HIV/AIDS prevention and control;
- approves plans of action and budget proposals prepared by the technical committee;
- renders support and advice to Kebelie co-ordinating committees; provides guidelines and manuals and monitors their correct implementation;
- devises means for soliciting material and financial support for programmes to prevent and control HIV/AIDS;
- presents regular reports to the Executive Committee of the Woreda Council and Zonal Co-ordinating Committee;
- commissions studies and investigations on the prevention and control of HIV/AIDS;
- undertakes other nationally and internationally accepted strategies and activities to alleviate the impact of HIV/AIDS on society.

2. Accountability

With regard to all activities, guidelines, programmes and regulations pertaining to HIV/AIDS prevention and control the Woreda Co-ordinating Committee is accountable to the Executive Committee of the Woreda Council and to the Zonal HIV/AIDS Prevention and Control Co-ordinating Committee.

3. Duties

- shall execute all responsibilities entrusted in it;
- finances programmes and projects according to the budget approved by the Executive Committee of the Zone;

WOREDA TECHNICAL COMMITTEE

1. Tasks

- monitors the correct implementation in the Woreda of manuals and standards prepared by the Regional Co-ordinating Committee on the universally accepted strategies for HIV/AIDS prevention and control:
  a. preventing HIV transmission
  b. reducing vulnerability to HIV infection
  c. providing social and clinical support
  d. alleviating the impact of AIDS
  e. research
- renders support and advice to Kebelie committees and monitors their activities closely
- reports quarterly to the Woreda Co-ordinating Committee;
- explores means for soliciting material, financial and technical support for Woreda activities to prevent and control HIV/AIDS and presents its recommendations to the co-ordinating committee;
- carries out other activities as instructed by the co-ordinating committee.

2. Accountability

The Woreda HIV/AIDS Prevention and Control Technical Committee is accountable to the Woreda HIV/AIDS Prevention and Control Co-ordinating Committee.

3. Duties

carries out its tasks

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KEBELIE HIV/AIDS PREVENTION AND CONTROL CO-ORDINATING COMMITTEE

Tasks And Responsibilities

- co-ordinates control and prevention activities in the Kebelle based on guidelines and manuals prepared at the regional level;
- ensures that all activities undertaken in the Kebelle are in accordance with the strategies for HIV/AIDS prevention and control;
- establishes sub-committees as it sees fit for carrying out its tasks;
- performs other tasks as instructed by the Woreda Co-ordinating Committee;
- reports monthly to the Woreda HIV/AIDS Prevention and Control Co-ordinating Committee and the Kebelie Council;

2. Accountability

The Kebelie HIV/AIDS Prevention and Control Co-ordinating Committee is accountable to the Woreda HIV/AIDS Prevention and Control Co-ordinating Committee and the Kebelie Council.

3. Duties

- carries out its tasks and responsibilities

Note:- The Technical committees at all levels shall divide itself in to the components:-
IEC, Training, Patient Care and Research.

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Annex IX

LIST OF DISCUSSIONS POINTS PER LEVEL

Region

Intermediate Objectives

1. Improve the capacity of Local Government & institutions to prevent HIV.

- Capacity of Local Government and Institutions to prevent HIV/AIDS
- Ability of community /families, individuals to address cope/react to HIV.

2. Promote an integrated approach.

- To what extent has integrated approach taken place .

3. Foster Behavioral Change.

- To what extent can the team asses that the stigma of HIV/AIDS is broken?
- What measures are people (youth) taking to protect themselves.
- What skills to foster behavioral changes.

4. Promote care & solidarity for HIV/AIDS patients and their families

- Are (traditional) coping mechanisms functioning for PLWAs?

Discussion Points:

Regional Coordinating Committee

1. What do you think of the HIV/AIDS prevention and control program in West Gojjam and Bahir Dar ?
2. What problems have you faced in implementing the policy (Natl.) on AIDS? what support do you recieve from the National Level to implement the policy.
3. Amhara Regional state was the first region to establish committees to address the problem of HIV/AIDS, what lessons have you learnt?
4. What is the magnitude of the problem of AIDS in the region? Is it putting a strain on your resources?
5. Do you have problem of orphans in other zones and in the Region? How are you addressing it?
6. What suggestions have you got for activities in the future ? What are the unmet needs.

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Regional Technical Committee

1. What do you think of the HIV/AIDS prevention and control program in West Gojjam and Bahir Dar ?
2. What is your experience on the prevention and control of HIV/AIDS in zones other than West Gojjam and Bahir Dar?
3. What difficulties have you faced?
4. Positive aspect
5. Negative aspect
6. What aspect has been more successful? By what measures?
7. How is the integration approach working in the other zones

II. Zone

Intermediate Objectives

1.Improve the capacity of Local Government & institutions to prevent HIV.

- Capacity of Local Government and Institutions to prevent HIV/AIDS
- Ability of community /families, individuals to address cope/react to HIV.

2. Promote an integrated approach.

- To what extent has integrated approach taken place .

3. Foster Behavioral Change.

- To what extent can the team asses that the stigma of HIV/AIDS is broken?
- What measures are people (youth) taking to protect themselves.
- What skills to foster behavioral changes.

4. Promote care & solidarity for HIV/AIDS patients and their families

- Are chronically ill persons being taken care of in their families?

  Are there some who are not been taken care of? why?

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Discussion Points:

- What do you think of the HIV/AIDS prevention and control program in West Gojjam and Bahir Dar?
- Success regarding prevention eg:- patient care (Hospital Referral)community stigma.
- Communication effective from up/down/ regarding problems.
- Value of integrated approach
- Effect of IEC, Training etc. at grass root level
- Coverage adequate
- Working relationship between committee members
- Orphans extent , who takes care of the children, what are the obstacles, what are future plans
- Monitoring and Evaluation
- Sustainability.

III. WOREDA

Intermediate Objectives

1. Improve the capacity of Local Government & institutions to prevent HIV.

- Capacity of Local Government and Institutions to prevent HIV/AIDS
- Ability of community /families, individuals to address cope/react to HIV.

2. Promote an integrated approach.

- To what extent has integrated approach taken place .

3. Foster Behavioral Change.

- To what extent can the team asses that the stigma of HIV/AIDS is broken?
- What measures are people (youth) taking to protect themselves.
- What skills to foster behavioral changes.

4. promote care & solidarity for HIV/AIDS patients and their families

- Are chronically ill persons being taken care of in their families?
  Are there some who are not been taken care of? why?

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Discussion Points:

- What do you think of the HIV/AIDS prevention and control program in West Gojjam and Bahir Dar?
- Name for the disease (new disease / educated and non educated)
- Effectiveness of IEC Training etc. coverage
- Has self-sufficiency been attained
- Patient care (attitude, behavior, stigma.)
- Impacts on: students, women, families etc..
- Level of integration (problems/ gaps)
- Participation at various levels
- Working relationships between the c'tee members
- Feed back-up /down (reporting)
- Monitoring and evaluation
- Orphans extent , who takes care of the children, what are the obstacles, what are future plans
- Sustainability (funds and other categories)

IV. KEBELE

Intermediate Objectives

1. Improve the capacity of Local Government & institutions to prevent HIV.

- Capacity of Local Government and Institutions to prevent HIV/AIDS
- Ability of community /families, individuals to address cope/react to HIV.

2. Promote an integrated approach.

- To what extent has integrated approach taken place .

3. Foster Behavioral Change.

- To what extent can the team assess that the stigma of HIV/AIDS is broken?
- What measures are people (youth) taking to protect themselves.
- What skills to foster behavioral changes.

4. Promote care & solidarity for HIV/AIDS patients and their families

- Are chronically ill persons being taken care of in their families?
  Are there some who are not been taken care of? why?

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Discussion Points:

- Name for the disease (new disease / educated and non educated)
- Taboos /practices -a problem.
- Behavioral change (stigma)
- Committee functioning? who? where? what?
- Community segment to prioritize
- Effectiveness of IEC (oral, radio, drama, literature) in relation to illiteracy
- Training etc. coverage counselors and communicators
- Participation of EOC, Mehabers, Idir and others
- Income Generating Activities (urban Fenote Selam)
- Reporting to W.T.C How? , What? (monitoring and evaluation)
- Orphans extent , who takes care of the children, what are the obstacles, what are future plans
- Sustainability (funds and other categories).

V. Others

- AIDS-a problem? / HIV awareness
- How are people coping with the problem
- Is knowledge, attitude and behavior changing with respect to AIDS
- Self protection /measures (life skills)
- Treatment where?
- AIDS education, when in schools, starting grade?
- Anti AIDS clubs in your schools? Youth centers?
- Participation in the committees
- Who supports families affected by HIV/AIDS
- Care for AIDS persons / people in the community that the family cannot take care off
- Orphans extent , who takes care of the children, what are the obstacles,
- what are future plans
- unmet needs

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VI. WOMEN

- Self-protection?
- Information about AIDS, where, How?
- Traditional practices Vs HIV/AIDS.
- Major AIDS concerns.
- Usefulness /practicality of AIDS information.
- Open discussion between Husband and wife and family.
- Discussion with Daughter / sons.
- Cultural practices that expose one to HIV/AIDS
- Care for chronically ill (HIV/AIDS) patients
- Orphans and parentless children

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Annex X

THE QUESTIONNAIRE FOR INDIVIDUAL INTERVIEWS IN URBAN SETTING

Comparative Impact Assessment HIV/AIDS Control and Prevention Programme
West Gojjam and Bahir Dar Lieu Zones.
June / july 2000

Questionnaire for Urban Population.

Explain the aim of the interview very carefully. The interviewee should understand the importance of this project.

I. The name of the interviewer _____

Code number of the interviewee _____

Address of the interviewer

Zone_____

Woreda_____

Kebele_____

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II. Individual Details

1.Sex Male Female

2.Age: under 10☐ 10-17 ☐ 18-45☐ 46-70☐

3.Religion: Orthodox ☐ Muslim ☐

Other denomination (specify):_____

4. Marital Status now: Single ☐ Married ☐ Divorced ☐

Widowed ☐ Others (specify):_____

5. Age when first married ? _____

6. How many times did you marry? Once ☐ Twice ☐ Three and above ☐

7. If not married do you have regular partners: Yes ☐ No ☐ Sometimes ☐

8. Do you have children: Yes ☐ No ☐

9.How old is your youngest child: 6 months to 2 year ☐ 3-10 ☐ 10-20 ☐

over 20 ☐

10 How many children do you have:_____ Boys:_____ Girls:_____

11. Have you been to school: Yes ☐ No ☐ Sometimes ☐

12. Up to what level: 6 the grade ☐ 8 th grade ☐ 12 th grade ☐

Religious ☐ Others (specify):_____

13. If student, with whom do you live: both parents ☐ mother ☐

father ☐ other (specify)_____

14. What do you do for living : farm ☐ housewife ☐ professional ☐

not working ☐ others (specify)_____

15. Do you a have radio at home: Yes ☐ No ☐

III. Knowledge questions on AIDS:

1. Have you ever heard of the disease AIDS: Yes ☐ No ☐ Sometimes ☐

Not sure ☐

2. Do you believe this disease really exists: Yes ☐ No ☐
3. If yes: Why:_____ If no: Why not_____
4. Where do you get your information about HIV/AIDS:

A. Television ☐
B. Radio ☐
C. Books and News papers ☐
D. Specific AIDS information materials ☐
E. Family ☐
F. Friends ☐
G. Religious leaders ☐
H. Political leaders ☐
I. Teachers ☐
J. Health workers ☐
K. others specify : _____

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5. How do you think HIV/AIDS is transmitted:

a. _____

b. _____

c. _____

6. How do you think HIV/AIDS can not be transmitted:

a. _____

b. _____

c. _____

7. Do you know a person with HIV/AIDS: Yes ☐ No ☐

8. How did you know that the person has HIV/AIDS:_____

_____

9. Can a healthy looking person be infected with HIV/AIDS: Yes ☐ No ☐

10. Is there a cure for AIDS: Yes ☐ No ☐ If not why not:_____

_____

11. What do you think one should do in order to prevent getting HIV/AIDS:_____

a._____

b._____

c._____

12. Are there groups particularly at risk: Yes ☐ No ☐

If yes: who are they:_____

Why:_____

IV Questions regarding Attitudes towards HIV/AIDS:

1. Do you ever think about HIV/AIDS: Yes ☐ No ☐

2. Are you afraid of catching HIV/AIDS? Yes ☐ No ☐

If yes, why:_____

If not. why:_____

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3. How would you react if your close friend happen to be infected with HIV/AIDS:

Leave ☐ Take care ☐ Do not know ☐ Other(specify)_____

4. Do you think that HIV/AIDS infected person should live with his family and friends who are not infected: Yes ☐ why:_____

_____

No ☐ why:_____

_____

5. Would you care for a family member with HIV/AIDS:

Yes ☐ why:_____

_____

No ☐ why:_____

_____

6. Do you know of families taking care of chronically sick people: Yes ☐ No ☐

7. Do you know of chronically sick people who are not being taken care of:

Yes ☐ No ☐ If yes are they a few ☐ or many ☐

8. Do you think some one with HIV/AIDS, who is not ill, can continue to work:

A teacher: Yes ☐ No ☐ Not sure ☐

A nurse: Yes ☐ No ☐ Not sure ☐

A shopkeeper: Yes ☐ No ☐ Not sure ☐

Others (specify)_____ Yes ☐ No ☐ Not sure ☐

_____ Yes ☐ No ☐ Not sure ☐

9. Do you think the education on HIV/AIDS that is currently given through the different channels of communication is sufficient?

Yes ☐ why:_____

_____

No ☐ why:_____

_____

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10. What more do you think should be done to improve on the present?

_____

_____

_____

11. Have you come across specific material that you appreciated well: Yes No

If yes: where is it from:_____, who produced it:_____

IV. Questions regarding Behavior towards HIV/AIDS:

1. Do your parents discuss the problem of HIV/AIDS in your presence:

Yes ☐ No ☐

If yes what do they discuss:_____

_____

_____

2. What have you heard about HIV/AIDS from religious leaders?

_____

_____

Where: Church Others (specify:_____

3. What have you been taught about HIV/AIDS in the school:_____

_____

4. What have you been taught about HIV/AIDS outside of school: _____

_____

Specify where this was:_____

5. Did you ever hear about HIV/AIDS during election campaigns: Yes ☐ No ☐

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VI. Prevention Behavior:

1. What do you think of the advertisement of condoms over the radio and T.V.:

_____

_____

_____.

2. Have you ever used condoms: Yes ☐ No ☐

If not why not:_____

3. Do you believe condoms could protect from HIV/AIDS: Yes ☐ No ☐

If yes why:_____

If not why not:_____

4. Where do you get them from: Counselor ☐ Health Worker ☐ Shop ☐

Others (specify):_____

5. What do condoms cost:_____

6. Do you volunteer to be tested to know whether you are infected with HIV/AIDS or not?

Yes ☐ No ☐ Not sure ☐

7. What are you doing to prevent HIV/AIDS: _____

_____

8. Do you know what is being done:

a. in your family:_____

b. in your community:_____

c. in your school:_____

d. in your workplace:_____

e. others (specify):_____

_____

9. Who initiated these activities: Health worker ☐ Priest ☐

Counselors ☐ Community leaders ☐ Others (specify)_____

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10. What else do you think should be done:

a. in your family:_____

b. in your community:_____

c. in your school:_____

d. in your workplace:_____

e. Others (specify):_____

11. Who would be able to do more do you think: Health worker ☐ Priest ☐

Counselors ☐ Community leaders ☐ Others (specify)_____

12. What do you think the government should do to control this disease:_____

_____

13. Are there orphans in your community: Yes ☐ No ☐

If yes: few ☐ or many ☐

14. Who do you think has the responsibility to take care of the orphans at community level:

Relatives ☐ Ider ☐ Mehaber ☐ Church ☐

Others (specify)_____

Only when applicable:

15. Women: do you have access to the same information as men: Yes ☐ No ☐

16. If no: why not:_____

17. We know that women are more at risk to get HIV/AIDS. What do you, as a woman, do to protect yourself: _____

_____

At the end:

18. Do you have any suggestions for us concerning the program:_____

_____

Thank you very much for your time and information!!!

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Annex XI

THE QUESTIONNAIRE FOR INDIVIDUAL INTERVIEWS IN RURAL SETTING

Comparative Impact Assessment HIV/AIDS Control and Prevention Programme
West Gojjam and Bahir Dar Lieu Zones.
June / july 2000

Questionnaire for Rural Population

Explain the aim of the interview very carefully. The interviewee should understand the importance of this project.

I. The name of the interviewer _____

Code number of the interviewee _____

Address of the interviewer

Zone_____

Woreda_____

Kebele_____

II. Individual Details

1.Sex Male Female

2.Age: under 10☐ 10-17 ☐ 18-45☐ 46-70☐

3.Religion: Orthodox ☐ Muslim ☐

Other denomination (specify):_____

4. Marital Status now: Single ☐ Married ☐ Divorced ☐

Widowed ☐ Others (specify):_____

5. Age when first married ? _____

6. How many times did you marry? Once ☐ Twice ☐ Three and above ☐

7. If not married do you have regular partners: Yes ☐ No ☐ Sometimes ☐

8. Do you have children: Yes ☐ No ☐

9.How old is your youngest child: 6 months to 2 year ☐ 3-10 ☐ 10-20 ☐

over 20 ☐

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10 How many children do you have:_____ Boys:____ Girls:_____

11. Have you been to school: Yes ☐ No ☐ Sometimes ☐

12. If to school: up to what level: 6 the grade ☐ 8 th grade ☐ 12 th grade ☐

Religious ☐ others (specify)_____

13. If student, with whom do you live: both parents ☐ mother ☐

father ☐ other (specify)_____

14. What do you do for living : farm ☐ housewife ☐ professional ☐

not working ☐ others (specify)_____

15. Do you a have radio at home: Yes ☐ No ☐

III. Knowledge questions on AIDS:

1. Have you ever heard of the word AIDS: Yes ☐ No ☐ Sometimes ☐

Not sure ☐

2. Has this disease always been around: Yes No

3. What is the local name for it:_____

4. How do you get HIV/AIDS:

a. _____

b. _____

c. _____

5. How do you not get HIV/AIDS:

a. _____

b. _____

c. _____

6. Are there groups particularly at risk: Yes ☐ No ☐

If yes: who are they:_____

Why:_____

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7. When did you first hear the existence of the disease AIDS: 1 month ago ☐

6-12 months ago ☐ Longer: ☐

8. Who did you hear if from: Health center ☐ Friends ☐ Family ☐

Others (specify)_____

9. Where did you hear it: Market ☐ Home ☐ Church ☐

Mosque ☐ Others (specify)_____

10. Have you heard of AIDS from the radio: Yes ☐ No ☐

11. Have you seen or read material on the disease AIDS: Yes ☐ No ☐

12. If yes: which_____ by whom_____

13. Which material did you like best: by whom_____

14. Do you discuss AIDS with close friends: Yes ☐ No ☐ With some ☐

15. What kind of close friends do you discuss AIDS with _____

16. What should one do not to be infected with AIDS:

a._____

b._____

c._____

17. How would one know a person infected with AIDS:

_____

18. Can a healthy looking person be infected with HIV/AIDS: Yes ☐ No ☐

19. Have you ever seen a person infected with the disease: Yes ☐ No ☐

20. What is the cure for AIDS:

_____

21. Have you ever heard of the term Condom: Yes ☐ No ☐

22. Who did you hear it from: Counselor ☐ Health Worker ☐ Shop ☐

Other (specify):_____

23. Where do you get condoms form: Health institution ☐ Shop ☐

Others (specify):_____

24. What is the use of condoms:_____

25. What does a condom cost:_____

26. Have you ever used it : Yes ☐ No ☐ Sometimes ☐

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P.O.Box 5674

IV. Question to measure Change of Attitude and Behavior.

1. Has hearing about HIV/AIDS changed your attitude towards sexual relationships:
   Yes ☐ No ☐ Do not know ☐ Not sure ☐
2. How have you changed your attitude:_____
3. Do you discuss HIV/AIDS with family members: Yes ☐ No ☐
   If yes with whom: Wife ☐ Husband ☐
   Daughter ☐ Son ☐
   Sister ☐ Brother ☐
4. If a member of your family become an AIDS patient would you be willing to take care of him/her: Yes ☐ No ☐ Not sure ☐
   Others (specify)_____
5. Do you know of families taking care of chronically sick people: Yes No
6. Do you know of chronically sick people who are not being taken care of:
   Yes ☐ No ☐ If yes are they a few ☐ or many ☐
7. Would you be willing to eat and drink with some one with HIV/AIDS:
   Yes ☐ No ☐ Not sure ☐ Do not know ☐
8. Do you think some one with HIV/AIDS, who is not ill can continue to work:
   A teacher: Yes ☐ No ☐ Not sure ☐
   A nurse: Yes ☐ No ☐ Not sure ☐
   A shopkeeper: Yes ☐ No ☐ Not sure ☐
   Others (specify)_____ Yes ☐ No ☐ Not sure ☐
   _____ Yes ☐ No ☐ Not sure ☐
9. Supposing you are given the chance to be tested to know whether you have been infected with HIV/AIDS or not do you agree to be tested? Yes ☐ No ☐
10. What are you doing to prevent HIV/AIDS: _____

_____

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11. Do you know what is being done:

a. in your family:_____

b. in your community:_____

c. in your school:_____

d. in your workplace:_____

e. others (specify):_____

12. Who initiated these activities: Health worker ☐ Priest ☐

Counselors ☐ Community leaders ☐ Others (specify)_____

13. What else do you think should be done:

a. in your family:_____

b. in your community:_____

c. in your school:_____

d. in your workplace:_____

e. Others (specify):_____

14. Who would be able to do more do you think: Health worker ☐ Priest ☐

Counselors ☐ Community leaders ☐ Others (specify)_____

15. What do you think the government should do to control this disease:_____

_____

16. Are there orphans in your community: Yes ☐ No ☐

If yes: few ☐ or many ☐

17. Who do you think could take care of the orphans at community level:

Relatives ☐ Ider ☐ Mehaber ☐ Church ☐

Others (specify)_____

Only when applicable:

18. Women: do you have access to the same information as men: Yes ☐ No ☐

19. If no: why not:_____

At the end:

20. Do you have any suggestions for us concerning the program:_____

Thank you very much for your time and information!!!

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Annex XII

THE COMPILATION OF THE RESPONSES

Respondents by sex:

	Hamusit		Durbete		Finot Selam		Dejen	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
male	50	50	50	48	50	50	47	50
female	50	50	44	50	50	49	50	50

Respondents by age:

	Non Intervention		Intervention		Intervention		Non Intervention	
	Hamusit		Durbete		Finot Selam		Dejen	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
under 10	0	0	2	0	0	0	0	0
10 to 17	13	6	17	13	7	20	7	13
18 to 45	60	63	57	76	67	69	72	75
46 to 70	27	28	23	11	25	10	21	12
70 and above	0	3	0	0	1	0	0	0
Total	100	100	99	100	100	99	100	100

Respondents by Marital Status and Sites

	Non Intervention		Intervention		Intervention		Non Intervention	
	Hamusit		Durbete		Finot Selam		Dejen	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Single	15	17	3	29	5	50	9	45
Married	60	62	86	59	82	36	80	33
Divorced	22	14	5	8	8	8	9	15
Widowed	3	6	5	5	5	5	2	7
Total	100	99	99	101	100	99	100	100

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Table 5
Distribution of Respondents by Educational Status and Sites

	Non Intervention		Intervention		Intervention		Non Intervention	
	Hamusit		**Durbete**		**Finot Selam**		**Dejen**	
Education	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
illiterate	77	45	72	19	69	12	53	15
6 the grade	12	15	15	21	9	10	15	17
8 the grade	1	10	1	21	4	12	8	15
12 the grade	0	17	0	31	2	58	7	51
Religious	5	5	3	1	2	0	1	1
Others	5	8	9	1	15	7	15	1
Total	100	100	100	94	101	99	99	100

Table 6
Distribution of Respondents by Occupation and sites

	Non Intervention		Intervention		Intervention		Non Intervention	
	Hamusit		**Durbete**		**Finot Selam**		**Dejen**	
Occupation	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Farm	65	4	71	5	92	0	88	0
House wife	11	13	17	20	0	13	0	6
Professional	0	8	0	19	0	8	0	9
not working	2	9	3	4	0	5	0	6
Others	22	56	4	51	8	73	12	79
Total	100	90	95	99	100	99	100	100

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Table 7 A
Distribution of Male Respondents by first source of Information on HIV/AIDS and Site *

	Non Intervention		Intervention		Intervention		Non Intervention	
	Hamusit		**Durbete**		**Finot Selam**		**Dejen**	
Source of information	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Television		19		32		40		37
Radio	15	40	37	42	20	48	15	47
Books and newspapers		15		36		37		40
AIDS Information material	7	12	21	24	19	39	11	28
Family	2	7	0	14	1	21	1	18
Friends	14	17	14	14	5	30	14	27
Religious Leaders		21		32		35		31
Political Leaders		5		10		14		17
Teachers		4		14		31		36
Health workers	14	29	22	33	28	40	16	42
Others	21	4	19	5	22	3	22	1

Table 7 B
Distribution of Female Respondents by first source of Information on HIV/AIDS and Site *

	Non Intervention		Intervention		Intervention		Non Intervention	
	Hamusit		**Durbete**		**Finot Selam**		**Dejen**	
Source of information	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
Television		10		17		20		27
Radio	4	29	3	35	12	39	8	42
Books and newspapers		5		15		24		25
AIDS Information material	0	2	2	9	3	17	3	22
Family	13	24	5	31	16	26	8	33
Friends	11	23	10	27	11	30	18	37
Religious Leaders		16		26		20		28
Political Leaders		5		9		11		16
Teachers		9		12		20		25
Health workers	4	12	12	20	16	39	16	31
Others	35	4	23	0	25	0	21	1

*includes answer in rural questionnaires regarding information received by radio and material seen

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Respondents by religion

	Non Intervention						Intervention						Intervention						Non Intervention					
	Hamusit Rural			Hamusit Urban			Durabete Rural			Durabete Urban			Finot Selam Rural			Finot Selam Urban			Dejen Rural			Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Orthodox	48	45	93	37	39	76	44	50	94	47	50	97	48	50	98	49	45	94	46	49	95	45	47	92
Muslim	5		5	17	11	28				1		1	2	0	2	1	2	3	3	4	7	1	2	3
Other		2	2													2								

Table 3
Age at first marriage by sex of Respondents

	Non Intervention			Intervention			Intervention			Non Intervention								
	Hamusit Rural			Hamusit Urban			Durabete Rural			Durabete Urban			Finot Selam Rural			Finot Selam Urban			Dejen Rural			Dejen Urban		
Age at first Marriage	M	F		M	F		M	F		M	F		M	F		M	F		M	F		M	F	
below 10	1	5			6		0	10		0	4		4	17		0	5		0	17		0	11	
10 to 15	5	29		4	19		10	39		0	18		3	31		1	19		10	24		4	13	
16 to 20	14	6		12	2		27	5		11	12		34	1		5	8		31	2		21	8	
above 20	24	0		25	20		8	0		22	6		9	0		12	3		5	0		9	0	

Table 4
Distribution of Respondents by number of times married

	Non Intervention			Intervention			Intervention			Non Intervention								
	Hamusit Rural			Hamusit Urban			Durabete Rural			Durabete Urban			Finot Selam Rural			Finot Selam Urban			Dejen Rural			Dejen Urban		
Number of times married	M	F		M	F		M	F		M	F		M	F		M	F		M	F		M	F	
Once	27	29		21	23		21	20		20	21	41	15	6		6	19		11	11		15	13	
Two times	8	4		13	13		21	15		7	17	24	12	9		3	10		17	13		7	9	
Three times and more	10	8		6	11		3	13		4	2	6	19	34		2	10		18	20		1	1	
Total	45	41		40	47		45	48		31	40	71	46	49		11	39		46	44		23	23	

Not married - regular partners

	Non Intervention						Intervention						Intervention						Non Intervention					
	Hamusit Rural			Hamusit Urban			Durabete Rural			Durabete Urban			Finot Selam Rural			Finot Selam Urban			Dejen Rural			Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes		1	1	3	3	6			0	2	2	2				4	1	5				5	20	25
No	6	19	25	22	12	34	7	2	9	20	34	54	9	9	18	26	19	45		37	37	45	30	75
Some times	3	0	3		1	1					1	1	1		1	0	0	0				0	0	0

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June / July 2000

Married - regular partners:

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			Durbete Urban			Finot Selam Urban			Dejen Urban		
	M	F	Total	M	F	Total	M	F		M	F	Total
Yes	7	1	8	7	2	9		1	1	2	6	8
No	28	39	67	20	34	54	21	28	28	24	14	38
Some times												

Having children

	Non Intervention						Intervention						Intervention						Non Intervention					
	Hamusit Rural			Hamusit Urban			Durabete Rural			Durabete Urban			Finot Selam Rural			Finot Selam Urban			Dejen Rural			Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	36	33	69	32	36	68	38	41	79	25	38	63	42	39	81	14	20	34	39	39	78	18	25	43
No	11	13	24	12	13	25	10	5	15	9	3	12	8	11	12	29	12	41	10	5	15	18	15	33

Age of youngest child

	Non Intervention						Intervention						Intervention						Non Intervention					
	Hamusit Rural			Hamusit Urban			Durabete Rural			Durabete Urban			Finot Selam Rural			Finot Selam Urban			Dejen Rural			Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
6 months to year	15	9	25	7	4	11	23	7	30	3	4	7	9	1	10	5	5	10	4	0	4	10	13	23
1-5 Year	9	13	22	16	17	33	12	20	32	13	15	28	15	15	30	4	5	9	19	14	33	13	15	28
5-10 year	8	7	25	6	5	11	2	11	13	9	5	14	6	14	20	3	5	8	7	13	20	22	10	32
10-20	-	2	2	3	9	12	3	-	3		3	3	1	2	3	3	6		0	12	12	0	8	8
Over 20	7	2	9		1	1	-	6	6				10	5	15	0	1	1	7	0	7	0	0	0

Number of children

	Non Intervention						Intervention						Intervention						Non Intervention					
	Hamusit Rural			Hamusit Urban			Durabete Rural			Durabete Urban			Finot Selam Rural			Finot Selam Urban			Dejen Rural			Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Between 1-3	22	24	46	19	25	44	answers lost			12	19	31	9	15	24	11	16	24	5	9	14	16	46	62
Between 4-6	6	6	12	9	8	17				12	4	16	3	13	16	2	4	29	3	16	16	33	6	39
More than 6	2	2	4	12	5	17				2	6	8	2	2	4	2	3	4	6	15	21	10	3	13

CORE

Questions on knowledge about HIV / AIDS

Heard of HIV/AIDS

Rural

	Non Intervention Hamusit					Intervention Durbete					Intervention Finot Selam					Non Intervention Dejen				
	Yes	No	Some time	Not Sure	Total	Yes	No	Some time	Not Sure	Total	Yes	No	Some time	Not Sure	Total	Yes	No	Some time	Not Sure	Total
Male																				
under 10											2				2	2				2
10-17	4				4						23	1			24	36				36
18-45	16	11	2		29	1				1	24				24	10				10
above 46	14	2			16	47				47	49	1			50	48				48
Total	34	13	2		49	48				48										
Female																				
under 10						2				2	5	1			6	6				6
10-17	5		2		7	11	4	1		16	39	3			42	35	1			36
18-45	22	8	3	3	36	23	1	1		25	2				2	8				8
above 46	1	3	1	1	6						46	4			50	49				50
Total	28	11	6	4	49	36	5	2		43										

Urban

	Non Intervention Hamusit					Intervention Durbete					Intervention Finot Selam					Non Intervention Dejen				
	Yes	No	Some time	Not Sure	Total	Yes	No	Some time	Not Sure	Total	Yes	No	Some time	Not Sure	Total	Yes	No	Some time	Not Sure	Total
Male																				
under 10						1				1										
10-17	15	2			17	10				10	9				9	5				5
18-45	13	5			18	31				31	38				38	40				40
above 46	13	4			17	8				8	4				4	5				5
Total	41	11			52	50				50	51				51	50				50
Female																				
under 10																				
10-17	3				3	3				3	11				11	10				10
18-45	28	5			33	45				45	31				31	34				34
above 46	13	1	1		15	2				2	6				6	5				5
Total	44	6	1		51	50				50	48				48	49				49

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Comparative Impact Assessment West Gojjam and Bahir Dar HIV/AIDS Prevention and Control Programme
June / July 2000

Questions on knowledge about HIV / AIDS

Is the disease new

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	37	36	73	50	37	87	45	35	80	47	46	93
No					2		4	2	6		1	
Do not know	2	8	10				1	1	2	1	1	2

Belief disease exists

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	Yes	No	Total	Yes	No	Total	Yes	No	Total	Yes	No	Total
Male												
10 to 17	5	3	8	8		8	18		18	5		5
18 to 45	20	3	23	32		32	34		34	35		35
above 45	15	4	19	9		9	4		4	10		10
Female												
10 to 17	5		5	2		2	11		11	10	5	15
18 to 45	20	5	25	32	10	42	21	6	27	35	3	38
above 45	15	5	20	2		2	4	2	6			
Total	80	20	100	85	10	95	92	8	100	95	8	103
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Reasons Yes												
Mass media	24	1	25	2	5	7	14		14	13		
Seen patients	30	15	45	37	16	53	34	23	57	33	34	
Information/Education	3	2	5	3	1	4	8		8	1	8	
Heard from community		16	16	8	9	17						
Reasons No												
Do not believe	5	7	12		1	1						
Do not know	3	2	5		3	3						
Never seen / heard												
							4	6	10		2	

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Length of time since information regarding HIV/AIDS was acquired

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			Durbete Rural			Finot Selam Rural			Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
1 month ago	3		3	1		1	1		1			
6 to 12 months ago	1	2	5	3	19	22	2	5	7	1	4	5
longer	36	30	66	38	30	68	47	43	90	43	45	88
no information		14	14									

Location where information regarding HIV/AIDS was acquired

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			Durbete Rural			Finot Selam Rural			Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Market	9	19	28	9	20	29	8	11	19	5	18	23
Home	3	10	13	3	10	13	2	18	20	4	17	21
Church	6	5	11	15	16	31	19	15	34	1	2	3
Mosque		1	1				1		1			
Village / town	1	3	4							7		7
Others	11	9	20	30	7	37	20	25	45	23	7	30
Health Institution	2	2	4								5	5
School											4	4
Do not know	3	3	6									

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Table 9
Distribution of Respondents regarding Knowledge of Transmission of HIV / AIDS

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			Durbete Rural			Finot Selam Rural			Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Blood contact	6	5	11	34	11	45	32	33	65	21	24	45
casual contact	10	10	20	10	13	23	5	6	11	10	6	16
sexual intercourse	29	23	52	48	28	76	46	40	86	43	38	81
mother to child	2	0	2	0	0	0	0	1	1	0	1	1
God's order / punishment	0	0	0	0	1	1	0	0	0	0	0	0
Others	3	5	8	1	5	2	0	0	0	2	3	5
I don't know	18	21	39	1	16	42	4	6	10	3	6	9

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			Durbete Urban			Finot Selam Urban			Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Blood contact	28	17	45	43	47	90	43	41	84	43	41	84
casual contact	6	13	19	2	4	6	3	5	8	5	10	15
sexual intercourse	40	30	70	42	44	86	46	44	90	51	47	98
mother to child	2	0	2	0	0	0	6	0	6	0	0	0
God's order / punishment	0	0	0	5	0	5	0	0	0	4	0	4
Others	10	4	14	2	0	2	0	1	1	0	1	1
I don't know	6	12	18	1	5	6	1	3	4	2	4	6

ECRD

Actions that do not transmit HIV/AIDS

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Kissing / droplets	6	8	14	23	15	38	11	9	20	27	17	44
drinking and eating	16	11	27	12	24	36	44	11	55	20	19	39
shaking hands	21	12	33	5	13	18	19	16	35	18	19	37
body contact / playing		9	9	1	16	17		7	7	3	3	6
sleeping in same bed	12	6	18							8		8
abstain from sexual contact	1	1	2				2	1	3			
one to one relation				7		7				5	1	6
using condom	1		1	3	4	7	4	6	10	4	3	7
avoid sharing sharp tools							2	3	5			
do not know	8	24	32	7	4	11				7	14	21
wrong answers:												
sharing needles	2		2		3	3					4	4
sexual relations				7		7						

CCRDA

Christian Relief & Development Association
L I B R A R Y
P.O.Box 5674

Comparative Impact Assessment West Gojjam and Bahir Dar HIV/AIDS Prevention and Control Programme
June / July 2000

Particular groups at risk
Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	21	16	37	30	19	49	26	22	48	24	25	49
No	14	27	41	20	22	42	20	23	43	16	24	40
Groups												
soldiers	1		1									
people in town	5	10	15		8	8	5	6	11	1	11	12
sex workers	7		7	20	3	23		5	5	11	11	22
youth					1	1				5	1	6
drivers					2	2	2		2			
do not know								4	4			
Reasons												
multiple sexual contacts	11	1	12	19	8	27	18	5	23	20		20
use of alcohol							6		6			
wrong information	3		3									
lack of information /education				4		4						
presence of sex wokers	7		7									
way of earnnig /surviving										7	14	21
more diseases in town				3	2	5					4	4

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	34	26	60	33	35	68	42	31	73	34	13	47
No	14	18	32	15	10	25	9	13	22			
Groups												
commercial sex workers	16	19	35	21	5	26	45	18	63	21	18	39
drivers	2	3	5	3	7	10	4	5	9	14	7	21
merchants	1	3	4									
youth	7	3	10	11	9	20	15	4	19	9	5	14
farmers / rural people				2	1	3				1		1
poor	1		1									
unmarried				1	7	8						
Reasons												
multiple sexual contacts	2	21	23	4	18	22	27	18	45	18	20	38
lack of inform./ understanding							4	2	6	3		3
difficult age	2	3	5	3	4	7	12	3	15		4	4
do not use condom	1		1									
experimentation	2	4	6									
do not know				3	2	5						

CORDAID

Know / seen a person with HIV/AIDS

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	21	10	31	32	10	42	32	13	45	21	13	34
No	25	39	64	14	37	51	18	34	52	23	34	57
Do not know	4		4									

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	Yes	No	Total	Yes	No	Total	Yes	No	Total	Yes	No	Total
Male												
10 t0 17				8	3	11	3	2	5	1	3	4
17 to 45	15	15	30	23	11	34	4	6	10	23	16	39
above 45	10	10	20				19	9	28	7		7
Female												
10 t0 17	13	17	30	1	2	3	6	5	11	12	6	18
17 to 45	5	10	15	27	20	47	19	12	31	10	12	22
above 45	2	3	5				2	4	6	10		10
Total	45	55	100	59	36	95	53	38	91	63	37	100

CCRDA

Comparative Impact Assessment West Gojjam and Bahir Dar HIV/AIDS Prevention and Control Programme
June / July 2000

Symptoms of HIV/AIDS

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			Durbete Rural			Finot Selam Rural			Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Test evidence	30	1	31				14	8	22	1		1
weight loss	30		30	46	31	77	32	37	69	29	44	73
changes to body	2		2				7	16	23			
skin darker/changing	7		7		6	6	10	1	11	9	41	50
coffing					1	1						
diarhoea							5	6	11	1		1
does not recover								1	1			
do not know	16	23	39	1	15	16		1	1	7	8	15

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			Durbete Urban			Finot Selam Urban			Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Test evidence		1	1	1	1	2	8	5	13			
weight loss	11	12	23	25	19	44	11		11		18	18
changes to body								23	23	19		19
skin/hair changes		12	12	13	8	21	2		2			
coffing												
diarhoea					1	1						
does not recover /dies					2	2				1		1
patient told me	2		2				6		6	1		1
someone told me	4	1	5	4		4	7		7	4	4	8
was exposed				2		2						
do not know	4	1	5							1		1

CCRDA

Can healthy looking person be infected

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	17	2	19	30	7	37	27	5	32	21	9	30
No	19	48	67	18	40	58	19	42	61	19	33	52
Do not know	8		8					2	2			

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	27	16	43	44	25	69	42	22	64	49	33	82
No	21	33	54	5	21	26	3	20	23		17	17
Do not know					2	2						

Is there a cure for HIV/AIDS

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
no cure	18	18	36	22	33	55	42	31	73	24	34	58
do not know	29	24	53	16	8	24	5	14	19			20
take medicine / go to health unit	1	3	4	5		5	1			3		3
one to one relationship					3	3			0			4
use condom							1		1			

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	8	1	9	14	3	17	5	2	7			
No	40	44	84	33	39	72	46	36	82	49	47	96
Do not know				5	3	8		4	4			

CCRDA

Table 10
Distribution of Respondents regarding HIV / AIDS Prevention

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Abstinence	9	8	17	15	15	30	10	15	25	20	24	44
Faithfullness	26	18	44	19	9	28	28	18	46	26	17	43
Use Condoms	1	0	1	1	1	2	3	3	6	5	3	8
Avoid sharing sharp instruments	4	2	6	18	3	21	27	18	45	11	18	29
Avoid illegal injections / traditional practices	1	1	2	2	1	3	1	0	1	1	0	1
Not going to town	3	5	8	2	7	9	12	4	16	8	7	15
Others	20	12	32	4	10	14	5	15	20	6	3	9
I don't know	11	17	28	2	23	25	5	5	10	2	4	6

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Abstinence	3	3	6	11	10	21	12	9	21	9	14	23
Faithfullness	44	34	78	40	31	71	49	30	79	47	32	79
Use Condoms	11	9	20	13	9	22	19	17	36	26	24	50
Avoid sharing sharp instruments	16	6	22	18	15	33	23	13	36	18	25	43
Avoid illegal injections / traditional practices	2	0	2	6	9	15	1	0	1	1	0	1
Others	7	10	17	8	7	15	6	4	10	1	6	7
I don't know	4	11	15	2	2	4	1	3	4	1	1	2

CORDA

Sources of knowledge regarding condoms

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
counsellor				1		1				1		
health worker	1	2	3	17	6	23	18	15	33	23	8	31
shop	1		1	1	2	3	7	1	8	1		1
others:												
friends	6	7	13									
radio	2	1	3				6	1	7		2	2
community				21	8	29	8	13	21		2	2
other persons	2		2									
do not know				3		3	3	1	4			
no information received		8	8		5	5						

CCRDA

Comparative Impact Assessment West Gojjam and Bahir Dar HIV/AIDS Prevention and Control Programme
June / July 2000

Provision of condoms from

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
counsellor												
health worker	7	1	8		1	1	14	9	23	19	2	21
shop	5	6	11	26	12	38	18	10	28	9	15	24
others:								6	6	3		3
hotel				1		1						
do not know	10	24	34	11	15	26	12	9	21	5	15	20

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
counsellor		1	1	5		5	1		1	23		23
health worker	7	10	17	12	8	20	23	18	41	23	16	39
shop	25	25	50	27	23	50	40	23	63	37	40	77
others:					3	3						
hotel	1	1	2	4		4	4		4		1	1
do not know	2	11	13		2	2	3	14	17		5	5
no response		8	8									

What is the use of condoms

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Protection from HIV/AIDS	8	7	15	21	3	24	34	15	49	21	17	38
Protection form STD's							2	9	11			
Contraceptive	3		3	10	2	12	1	2	3		4	4
Do not know	19	34	53	11	25	36	9	19	28	10	18	28
wrong answers					3	3						

ECRDA

Price of condoms

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Free of charge												2
3 cents							3		3			
5 cents				2	1	3	1		1			
10 cents				5	13	18	2	1	3			3
15 cents							1		1			
Do not know	24	1	25	27	26	53	37	33	70	35	33	68

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Free of charge					2	2						
3 cents				5	9	14						
5 cents			14	1		1	7		7			
10 cents			13	4	6	10	26	10	36	5	3	8
15 cents			1							1		1
20 cents and more			7	1	4	5	8	4	12	22	17	39
Do not know			29	29	15	44	24	19	43	14	26	40

CORDA

Comparative Impact Assessment West Gojjam and Bahir Dar HIV/AIDS Prevention and Control Programme
June / July 2000

Seen / read specific information materials on HIV/AIDS

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	7	37	44	21	2	23	13	3	16	11	3	14
No		41	41	32	40	72	31	44	75	39	45	84
Produced by												
Government						3						
CVM						1						
Development agent						8			1			1
Media / magazines						3			1			1
Student Bulletin									1			1
Orthodox Church									5			
Do not know			7			4			2			6
Particularly appreciated												
Church material									1			
One world one hope									1			
Do not know			2									

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	14	5	19	25	7	32	35	16	51	25	14	39
No	28	33	61	24	35	59	15	23	38	23	37	60
Do not know												
Origin												
Health Centre			6			1				5	8	13
Local town									1			
Bahir Dar			2	11	1	12			6	3	1	4
School						2			5	2	7	9
Do not know			5	1	1	2				7	4	11
Produced by												
Health workers			2							3	2	5
CVM				10	2	12			16			
Amhara Government					1	1			4			
Students/AAC									9	2	4	6
Teachers						1						
Red Cross										2	1	3
Military										1	3	4
Do not know			6	7	2	9			13			

CORDAF

Questions concerning attitude and behaviour with respect to HIV/AIDS

Think about HIV/AIDS

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	43	10	53	43	31	74	46	32	78	40	na	
No	17	31	48	7	19	26	3	15	18	10	na	
Not sure												

Afraid of catching HIV/AIDS

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	24	20	44	34	27	61	38	32	70	24	26	50
Reasons (most cited)												
Unfaithfulness		10	10		3	3						
Difficult to take care / many ways of transmission	8		8						13			
No cure / afraid of dying	3	7	10	18	2	20			34	10	9	19
Am a bar worker											4	4
sharing sharp material		5	5	4	3	7			11	1		1
No	27	26	53	16	20	36	13	12	25	25	22	47
Reasons (most cited)												
Practice abstinence		9	9		2	2			8	3	7	10
Have one to one relationship / being faithfull	5		5	8	3	11			9	5	3	8
Listen to parents		9	9									
Know how to protect / am taking care	2	2	4	3	1	4			7	3		3

CERDA

Ways attitude have changed

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Want to be faithful/monogamous	15	4	19	25		25	28	5	33	21	5	26
Want to abstain		8	8	3		3					3	3
Not start / stop sexual contacts	2		2		3	3		1	1		2	2
Testing before mariage	1		1									
Advise people/husband	1		1				1	2	3	1	2	3
Do not know	1	9	10					5	5			
No change					10	10	1	5	6	4	9	13

Discuss HIV/AIDS with family members

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	Yes	No	Total	Yes	No	Total	Yes	No	Total	Yes	No	Total
Male												
10 to 17	2	2	4				2		2		2	2
17 to 45	12	17	29	19	12	31	16	9	25	21	11	32
above 45	5	7	12	9	2	11	19	5	24	8	2	10
Female												
10 to 17	3	6	9		14	14	2	3	5	2	4	6
17 to 45	6	28	34	10	15	25	20	22	42	13	23	36
above 45	1	5	6	1	6	7	1	1	2	2	5	7
Family members	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Wife	13		13	27		27	30		30	27		27
Husband		5	5		5	5		17	17		8	8
Daughter	7	2	9	24	2	26	23	13	36	14	4	18
Son	7	3	10	23	4	27	25	15	40	14	3	17
Sister	11	3	14	13	2	15	12	4	16	16	4	20
Brother	11		11	17	1	18	14	2	16	15	2	17

CCRDA

Willingness to take care of family member infected with HIV/AIDS

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	36	33	69	38	28	66	42	37	79	29	31	60
No	8	17	25	12	22	34	8	12	20	9	19	28
Do not know										2	1	3

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	45	45	90	45	43	88	49	39	88	46	44	90
No	10	6	16	5	2	7	2	2	4		4	4
Reasons to take care												
Have the responsibility	30	26	56	16	3	19	25	5	30	6		6
For the family / need to care	15		15	2	7	9		5	5	1	16	17
Culture	3		3									
To avoid he/she has psychological problems /is lonely	10	8	18	13	4	17	19	6	25	28	3	31
Hope to live	1		1					8	8	4		4
Know how to prevent				1	5	6	2	1	3	1	2	3
Prolong life of patient							3	14	17			
Reasons not to take care										na	na	na
Disease is transmitted by living together	4	2	6									
No cure	2	2	4	2	1	3		2	2			
Concern of government				1		1						

Reaction to friend infected with HIV/AIDS

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Leave	2	14	16	5	11	16	2	4	6	1	11	12
Take care	42	31	73	44	37	81	46	37	83	43	40	83
Do not know	5	6	11		1	1	1	2	3	3	1	4
Others												
Person should be isolated										2	1	3

CORDA

Willingness to share meal with person infected with HIV/AIDS

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	9	6	15	3	5	8	17	1	18	8	7	15
No	33	39	72	38	46	84	18	43	61	38	41	79
Not sure	2	2	4	7		7	4	2	6	2		2
Do not know	2	2	4					1	1	1	1	2
Total	46	49	95	48	51	99	39	47	86	49	49	98

Acceptance of persons infected with HIV/AIDS living with family -friends not infected

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	36	34	70	43	44	87	41	40	81	39	37	76
No	14	13	27	5	5	10	9	1	10	6	11	17
Reasons yes												
Is not transmitted by living together/ or caring	14	4	18							15	3	18
member of the family	5		5							13		13
avoid isolation	4		4								3	3
Reasons not												
Fear of contamination / transmitted by living together	7	7	14	3	2	5			7		3	3
Incurable				1	2	3						
disease does not exist											5	5

ACHCD

Awareness of families taking care of chronically ill

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	18	14	32	17	7	24	13	8	21	5	2	7
No	36	32	68	36	40	76	31	42	73	42	43	85
Do not know												

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	16	12	28	23	12	35	17	13	30	19	10	29
No	30	33	63	26	39	65	33	34	67	30	39	69
Do not know												

Awarenes of chronically ill persons not taken care of

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	11	8	19	7	3	10	5	9	14	1	1	2
No	36	44	80	42	46	88	45	41	86	46	44	90
Few	7	8	15	2	2	4	3	5	8	1	1	2
Many	1		1	1		1		2	2			

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	16	14	30	15	12	27	20	19	39	20	13	33
No	33	36	69	31	36	67	30	29	59	25	36	61
Few	6	9	15	11	10	21	11	18	29	10	na	10
Many	2	4	6	2		2	6	2	8	7	na	7

CORDA

Acceptance of persons infected with HIV/AIDS continuing to work

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure
Teacher	26	54	11	42	48	6	55	26	15	50	35	10
Nurse	23	55	11	41	49	9	56	26	15	50	35	10
Shopkeeper	25	54	11	42	46	8	56	26	15	52	33	10
Others:												
Total	74	163	33	125	143	23	167	78	45	152	103	30

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure
Teacher	60	25	16	77	19	4	83	8	2	72	21	5
Nurse	60	25	16	74	22	4	79	12	1	67	27	5
Shopkeeper	60	25	16	76	21	3	82	9	2	70	22	5
Others:												
Total	180	75	48	227	62	11	244	29	5	209	70	15

Willingness to be tested voluntarily

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure
Male												
10 to 17	13	8					2			1	1	
17 to 45	6	7		25	3		20	3		30	3	
above 45	6	7		6	3		21	2		11	3	
Female												
10 to 17	4	5		9	8		4	1		2	3	1
17 to 45	11	23		10	15		31	12		23	12	
above 45	3	3		2	5		1	1		5	1	1
Total	43	53		52	34		79	19		72	23	2

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	32	25	57	40	34	74	43	35	78	38	30	68
No	18	19	37	5	11	16	5	8	13	7	16	23
Not sure		8	8		2	2	1	2	3			

Table 10
Distribution of Respondents regarding HIV / AIDS Prevention

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Abstinence	9	8	**17**	15	15	**30**	10	15	**25**	20	24	**44**
Faithfullness	26	18	**44**	19	9	**28**	28	18	**46**	26	17	**43**
Use Condoms	1	0	**1**	1	1	**2**	3	3	**6**	5	3	**8**
Avoid sharing sharp instruments	4	2	**6**	18	3	**21**	27	18	**45**	11	18	**29**
Avoid illegal injections / traditional practices	1	1	**2**	2	1	**3**	1	0	**1**	1	0	**1**
Not going to town	3	5	**8**	2	7	**9**	12	4	**16**	8	7	**15**
Others	20	12	**32**	4	10	**14**	5	15	**20**	6	3	**9**
I don't know	11	17	**28**	2	23	**25**	5	5	**10**	2	4	**6**

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Abstinence	3	3	**6**	11	10	**21**	12	9	**21**	9	14	**23**
Faithfullness	44	34	**78**	40	31	**71**	49	30	**79**	47	32	**79**
Use Condoms	11	9	**20**	13	9	**22**	19	17	**36**	26	24	**50**
Avoid sharing sharp instruments	16	6	**22**	18	15	**33**	23	13	**36**	18	25	**43**
Avoid illegal injections / traditional practices	2	0	**2**	6	9	**15**	1	0	**1**	1	0	**1**
Others	7	10	**17**	8	7	**15**	6	4	**10**	1	6	**7**
I don't know	4	11	**15**	2	2	**4**	1	3	**4**	1	1	**2**

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Christian Relief & Development Association
L I B R A R Y
P.O.Box 5674

Knowledge of prevention activities being undertaken

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Family												
counselling			1							8	8	16
education			4	2	10	12	7	5	12	3	10	13
care / support			3						7			1
one to one			1			4			1			
do not know	15	47	62			2	29	28	57	9	25	34
nothing						34			4	7	6	13
Community												
education						22	17	1	18	7	3	10
advise / discussing together									2			
patient care									1			
do not know			44				13	20		12	6	18
nothing										4		4
School												6
education						1			2			
discussions									1			
do not know			46						13			13
nothing												5
Workplace												
education						1						1
do not know			44						13			8
nothing												1
Others												1
education through mass media						9			2			

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Knowledge of prevention activities being undertaken

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Family												
counselling / advising	7	11	18	4	2	6	7	13	20	14	24	38
education				9	10	19	5	3	8			
general prevention /discussing	11	8	19	3	2	5	2	5	7			
care / support												
one to one / faithfulness	3		3					3	3	2	4	6
avoid sharp instruments/use disposable syringes				3	1	4	2	6	8			4
use condom								1	1			
do not know	13	17	30	6	13	19				5	15	20
nothing / not enough		4	4	6	13	19	8	13	21	6	6	12
Community												
education	13	4	17	23	8	31	18	7	25			14
advising / counselling		2	2	2		2			4			36
discussing together	1		1	1		1			4			3
faithfulness/one to one									1			
condom use												1
avoid sharp instruments/use disposable syringes								1				
patient care												
do not know	3	26	29	3	5	8						25
nothing	2		2		2	2			15			10
School												
education	6	11	17	8	10	18	19	15	34	12	6	18
discussions							3	1	4			
Anti Aids club	2		2									
counselling		3	3				3	1	4			7
subjects are included in the curriculum		1	1									
do not know	3	21	24	2	5	7						13
nothing							5	10	15			9
Workplace												
education	1	3	4	6	3	9	6	3	9			5
discussions/messages	2		2		1	1		1	1			3
advice												7
do not know	1	25	26	1	6	7						
nothing / no answer			16		1	1	5	11	16	13	8	21
Others												
education through mass media			1							4	1	
nothing/too little												4

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Parties who initiated these activities

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Health worker	8	11	19	24	21	45	21	33	54	12	28	40
Priest	1	4	5	2	5	7	17	11	28	1		1
Counselor					1	1						
Community leaders	2	1	3				3	1	4	1	2	3
Others:						19	2	8	10			
Agricultarist			1									
Governement			1									
Radio			1									
Do not know	31	13	43			6	10	8	18	6	17	23

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Health worker	14	23	37	25	38	63	34	35	69	33	48	81
Priest	3	1	4	1	7	8	1	1	2	18	8	26
Counselor					4	4	1		1	3		3
Community leaders	3	4	7	1	2	3	2	1	3	3		3
Others:												
Individuals / family		2	2									
Radio /TV	8	1	9		1	1						
Teachers							5		5		5	5
Community itself							6		6	3	4	7
Government				1		1				4		4
Do not know	4	19	23	5	4	9		5	5		4	4

CORDA

Additional prevention activities needed

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Family												
Education		7		21	3	24						
Counselling									16		6	6
Community support		2										
Faithfulness / one to one relationships					6	6			6		9	9
General prevention/taking care	3	9			1	1	23	23	46	5	2	7
Health examinations									4			
Avoid sharp instruments									10			
Big programme											5	5
Do not know	36	4		5	29	34			32	7	25	32
Community												
Education			5	14	1	15	16	16	32	4	8	12
Counselling			3									6
General prevention/taking care										1	5	
Supply medicine			1				5	5	10			
Big programme									.		1	1
Do not know			24				11	3	14		10	10
School												
Education			4	3	1	4					4	4
Counselling			3								1	1
General prevention/taking care								1	1			
Big programme											2	2
Do not know			25				11	2	13		13	13
Workplace												
Counselling			1									
Big programme											2	2
Do not know			25						14		10	10
Others: isolate carriers									3			

CORDA

Additional prevention activities needed

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Family												
Education	14	8	22	21	5	26	20	9	29	13	2	15
Counselling		15	15					13	13	2		2
Discussions	6	3	9	2	3	5				1	8	9
Faithfulness / one to one relationships	5		5	4	5	9		6	6	6	7	13
General prevention/taking care	6		6		2	2						
Abstain				3	1	4						
Use condom		1	1					1	1	5		5
Avoid / incinerate sharp instruments				3	2	5	3	9	12			
Do not know	3		3		22	22	11	11	22		23	23
Community												
Education	24	9	33	27	8	35	24	14	28	17	11	28
Counselling		3	3	2	2	4		5	5			
General prevention/taking care		5	5				3	4	7			
Supply medicine	2		2									
Faithfulness					1	1						
Avoid / incinerate sharp instruments								1	1			
Use condoms					1	1				2		2
Do not know	2	11	13	2	5	7	10	7	17		14	14
School												
Education	10	15	25	8	8	16	18	17	35	13	10	23
Counselling		5	5		2	2	2	5	7	2	10	12
General prevention/taking care												
Anti AidsClub support	1	1	2							1	2	3
Do not know	1	13	14	2	3	5	14	5	19		12	12
Workplace												
Education	4	5	9	4	3	7	11	5	16	7		7
Counselling					1	1		1	1		2	2
Distribute condoms	1		1									
Discussions	3	2	5	1	4	5						
Organize AIDS Committee										2		2
Do not know							6	5	11		8	8
Others:												
Give responsibility to government										3		3

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Parties required to intitiate additional prevention activities

Rural

	Non Intervention Hamusit Rural			Intervention Durbete Rural			Intervention Finot Selam Rural			Non Intervention Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Health Worker	26	26	52	24	34	58	34	41	75	40	30	70
Priest	4	3	7	14	5	19	6	16	22	8	3	11
Counsellor							2		2			
Community leaders	2		2	1		1	5	1	6	1	1	2
Others:		18	18				1	6	7			
Government	2	1	3	5		5						
Teacher	1		1							2	1	3
Educated persons					1	1					1	
Do not know	1	7	8		6	6	2	1	3	5	7	12

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Health Worker	35	45	80	47	39	86	44	43	87	33	48	81
Priest	8	11	19	10	6	16	13	5	18	18	8	26
Counsellor	1	9	10	5	1	6	7		7	3		3
Community leaders	7	2	9	4	3	7	7	2	9	3		3
Others:												
Government	1		1							4		4
Teacher											1	1
Citizens	2		2									
Everyone should participate					2	2	2		2	4	1	5
School community				1	2	3	2		2			
Do not know		4	4	1		1	1		1		4	4

CORDA

Action Expectations from the Government

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			Durbete Rural			Finot Selam Rural			Dejen Rural		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Education	4	2	6	21	2	23	18	9	27	19	5	24
Research for medicine	17	16	33	20	21	41	14	7	21	19	19	38
Collect patients in one place / isolate	1		1		5	5	1	3	4			
Governments duty to act	5		5									
Make condoms available to all								1	1	1		1
Give treatments / care							10		10	8	4	12
Counselling							2	1	3		2	2
Do not know	14	16	30	11	22	33	19	12	31	12	17	29

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			Durbete Urban			Finot Selam Urban			Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Education	20	11	31	35	10	45	31	14	45	22	16	38
Give information	2	11	13									
Research for medicine	16	24	40	8	21	29	8	11	19	4		4
Collect patients in one place / isolate								5	5			
Governments duty to act/allocate budget							4		4	4		4
Make a law							4	1	5			
Make condoms available to all					2	2		2	2		6	6
Share information from other countries reg. education etc										11		11
Start programme	1		1									
General prevention measures	2	7	9		3	3						
Give treatments / care	1		1	3	9	12						
Counselling		2	2		2	2						
Find other income for barworkers	1	1	2								8	8
Help the poor							3		3			
Do not know	4	7	11		5	5	2	14	16		9	9

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Opinion regarding current education via media

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Sufficient	22	19	41	18	19	37	15	26	41	17	27	44
Motivation												
Information is sufficient	19		19	9	1	10	3	11	14	5	11	16
Mass media are enough		15	15									
Education is continous	12		12							1		1
Education is divers							10	8	18			
Not sufficient	25	19	44	30	18	48	37	16	53	28	22	50
Motivation												
More education is needed	7		7	5	5	10				15	16	31
One to one should be taught	1		1		1	1						
Improvement are needed					2	2						
Does not reach illiterate					2	2						
Does not reach rural pop.					2	2						
Does not reach poor												
Other methods are needed											3	3
										2		2
No answer	16	11	27									
Do not know	13			2	7	9			12	2	11	13

Additional mass media education activites needed

Urban

	Non Intervention Hamusit Urban			Intervention Durbete Urban			Intervention Finot Selam Urban			Non Intervention Dejen Urban		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Continous programmes needed	7		7		4							
More Education needed	27	13	40	11	30				35	7	8	15
Government needs to support	2		2									
NGO's need to support	2		2						14			
One to one education										1		1
Infected persons should teach about disease									3	1		1
Special programme / committee	2								5			
Anti Aids clubs											4	4
Adapted programmes / methods										18	1	1

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HIV/AIDS subjects treated by Religious leaders

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Modes of prevention		6	6	2	2	4		4	4	4		4
One to one relationship	7	2	9		5	5				9	19	28
Faithfulness		2	2	16	11	27		13	13			
Abstain	1		1									
It is God's punishment		5	5	4	1	5	20	4	24	10		10
Spiritual education	7		7		1	1						
Taking care				3	4	7		2	2		4	4
Nothing		27	27	4	12	16		10	10	7	13	20
Do not know	24		24								3	3

HIV/AIDS subjects treated at school

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Facts about HIV/AIDS	8		8				3	1	4	3		3
Modes of transmission and prevention	3	3	6	11	10	21	5	1	6	4	10	14
Anti AIDS club activities		4	4									
Incurability of the disease / no medicine	2	2	4	9	3	12	3	2	5	4		4
Need to be faithful or abstain				4	2	6				4		4
A healthy person can be infected					2	2						
Use condom										4	3	7
Do not know	32	7	39									
Nothing	13	13	26	5	7	12	5	9	14	3	8	11
No answer	21	21	42									

ECRDA

HIV/AIDS subjects during election campaigns

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	9	3	12	3		3	1	1	2	2	4	6
No	38	47	85	39	12	51	49	46	95	47	43	90
Place												
NB answers not consistent to question												

Belief in condoms as protection measure

Opinion on Condom adverstisement

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Good	24	15	39	33	14	47	29	19	48	29	29	58
Not good	8		8				10	5	15	12		12
Advertising for condoms is not good	1		1							1		1
Only advertise for abstinence	1		1								4	4
Never heard/seen		20	20		2	2	3	8	11		5	5
Do not know	8		8									
No response /suggestions		2	2	9	19	28					8	8
Reserved								15	15			

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Table 11
Distribution of Respondents on knowledge and use of Condoms

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Heard of:												
yes	18	14	**32**	42	20	**62**	40	29	**69**	40	20	**60**
no	31	37	**68**	13	30	**43**	10	21	**31**	11	30	**41**
Use of:												
yes	0	0	**0**	2	0	**2**	0	0	**0**	0	0	**0**
no	25	41	**66**	36	44	**80**	39	40	**79**	41	39	**80**
sometimes												

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Knowledge of:												
yes	24	15	**39**	23	14	**37**	39	39	**78**	49	36	**85**
no	20	20	**40**	9	21	**30**	3	8	**11**	0	13	**13**
Use of:												
yes	3	0	**3**	6	2	**8**	9	5	**14**	9	11	**20**
no	47	45	**92**	43	50	**93**	41	42	**83**	45	38	**83**
sometimes												

Reasons for not using condoms

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Faithful to my partner	37	17	54	na	8		9	4	13			na
Abstain	8	3	11	na	4		13	6	19			na
				na								na
Do not need					1							na
Do not trust them				na	3		3		3			na
Do not have the information		3	3	na	1							na
Do not know	10	9	19	na	1							na
No response		8	8	na								na

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Believe condoms can protect from HIV/AIDS

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	20	15	35	37	17	54	51	21	72	32	32	64
No	22	25	47	10	19	29	18	13	31	15	16	31
Do not know					9	9	4	16	20			
Reasons yes												
It protects / prevents transmission	19	10	29	19			19	9	28	21	16	
Better than nothing	2	2	4									
Approved by the government	5	5	10									
Does not let semen through					4	4						
Received information				9	4	13	4	8	12	4	10	14
Have seen from others				2		2						
There is no contact										3		3
Do not know		1	1							1	2	3
Reasons not												
It is not safe	4		4	2	1	3						
Does not protect	5		5		2	2	9		9			
It can break							2	5	7			
Difficult to use	3	3	6							6	4	10
Never needed to use					2	2						
Protecting oneself by faithfulness is only solution				4	1	5				1	5	6
Believe condom is disease itself										1		1
Do not believe		4	4							5		5
No knowledge		3	3									
Do not know	10	5	15									
No response		3	3									

CORDA

Position of women

Do women have same access to information as men

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Similar		11			11			17			20	
Not similar		37			33			34			34	
Reasons for differences												
Usually stay at home		27			28			28			25	
Men go to town / have contact with others								3			10	
No information		3										
Too busy					1							
No participation in public meeting								1				
Do not know					1							

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Similar		7			11			29			29	
Not similar		41			34			19			30	
Reasons for differences												
Usually stay at home		34			27			17			15	
Men go to town / have contact with others											4	
Inequality		4			1							
Think differently					1							
Lack of interest								1				
No participation in public meeting											2	
Do not know											2	

CORDA

Increased risk of women: taking additional protection measures

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
One to one relationship / remain faithful		28			30			13			18	
Abstaining		13			9			21			10	
Less frequent sexual contact		2									6	
Using condom		6			2			4			9	
Avoiding sharp instruments / blood contact		3			7			9			6	
Attend education		2										
Avoid working in bars					3			3				
Discuss HIV/AIDS with partner								2				
Do not know		1										
Trust in God / Maria					1						2	

CCRDA

CCRDA

Orphans

Presence of Orphans in Community and suggestions regarding who should take care of them

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	16	6	22	11	6	17	7	10	17	4	1	5
No	30	45	75	38	38	76	43	37	80	43	44	87
Few	14	5	19	8	10	18	7	10	17	3	2	5
Many	1	1	2	4		4				1		1
Who to take care												
Relatives	8	16	24	14	8	22	14	21	35	15	15	30
Ider	2		2		2	2	2		2	1		1
Mehaber	1		1				2	1	3			
Church				1		1	1		1			
Others:	4		4	2	1	3						
Government	1		1				5	19	24	2	15	17
Do not know	2	7	9									

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Yes	19	12	31	20	9	29	21	22	43	18	10	28
No	30	38	68	28	39	67	30	25	55	26	34	60
Few	15	9	24	14	5	19	18	14	32	18	5	23
Many	5	2	7	4	2	6	3	6	9	6		6
Who to take care												
Relatives	18	6	24	20	8	28	18	8		15	7	22
Ider	4		4	1	1	2	2	1		3	1	4
Mehaber	2		2		1	1	5			5	1	6
Church	2	1	3				4			3		3
Others:												
Government	9	10	19	5	4	9	12	23		10	25	35
Municipality										1		1
Community								2				
Friends					7	7						
CVM								2				
NGO's				1		1						
Do not know	7	5	12									

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Suggestions for the Programme

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Continue to teach		15	15									
Increase education	1		1									
It is good / continue				5	11	16	8	17	25	5	5	10
Increase youth education				1		1						
Increase advice to men										1		1
Increase advice to patients										2		2
Government to do more				1		1						
No suggestions	9	29	38		24	24	12	10	22	2		2
Do not know				9		9						

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Update the information			3						na			
it is good / continue			28			17			na	7	24	31
Increase education for the youth										7		7
Increase the size of the programme			4						na			
Increase co-operation NGO's - Government workers									na	7		7
Cover the whole area										2		2
No suggestions						7			na	3		3
Do not know											21	21

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Table 9
Distribution of Respondents regarding Knowledge of Transmission of HIV / AIDS

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Blood contact	6	5	**11**	34	11	**45**	32	33	**65**	21	24	**45**
casual contact	10	10	**20**	10	13	**23**	5	6	**11**	10	6	**16**
sexual intercourse	29	23	**52**	48	28	**76**	46	40	**86**	43	38	**81**
mother to child	2	0	**2**	0	0	**0**	0	1	**1**	0	1	**1**
God's order / punishment	0	0	**0**	0	1	**43**	0	0	**0**	0	0	**0**
Others	3	5	**8**	1	5	**2**	0	0	**0**	2	3	**5**
I don't know	18	21	**39**	1	16	**42**	4	6	**10**	3	6	**9**

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Blood contact	28	17	**45**	43	47	**90**	43	41	**84**	43	41	**84**
casual contact	6	13	**19**	2	4	**6**	3	5	**8**	5	10	**15**
sexual intercourse	40	30	**70**	42	44	**86**	46	44	**90**	51	47	**98**
mother to child	2	0	**2**	5	0	**5**	6	0	**6**	0	0	**0**
God's order / punishment	0	0	**0**	0	0	**0**	0	0	**0**	4	0	**4**
Others	10	4	**14**	2	0	**2**	0	1	**1**	0	1	**1**
I don't know	6	12	**18**	1	5	**6**	1	3	**4**	2	4	**6**

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Table 10
Distribution of Respondents regarding HIV / AIDS Prevention

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Abstinence	9	8	**17**	15	15	**30**	10	15	**25**	20	24	**44**
Faithfullness	26	18	**44**	19	9	**28**	28	18	**46**	26	17	**43**
Use Condoms	1	0	**1**	1	1	**2**	3	3	**6**	5	3	**8**
Avoid sharing sharp instruments	4	2	**6**	18	3	**21**	27	18	**45**	11	18	**29**
Avoid illegal injections / traditional practices	1	1	**2**	2	1	**3**	1	0	**1**	1	0	**1**
Not going to town	3	5	**8**	2	7	**9**	12	4	**16**	8	7	**15**
Others	20	12	**32**	4	10	**14**	5	15	**20**	6	3	**9**
I don't know	11	17	**28**	2	23	**25**	5	5	**10**	2	4	**6**

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Abstinence	3	3	**6**	11	10	**21**	12	9	**21**	9	14	**23**
Faithfullness	44	34	**78**	40	31	**71**	49	30	**79**	47	32	**79**
Use Condoms	11	9	**20**	13	9	**22**	19	17	**36**	26	24	**50**
Avoid sharing sharp instruments	16	6	**22**	18	15	**33**	23	13	**36**	18	25	**43**
Avoid illegal injections / traditional practices	2	0	**2**	6	9	**15**	1	0	**1**	1	0	**1**
Others	7	10	**17**	8	7	**15**	6	4	**10**	1	6	**7**
I don't know	4	11	**15**	2	2	**4**	1	3	**4**	1	1	**2**

Table 11
Distribution of Respondents on knowledge and use of Condoms

Rural

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Rural			**Durbete Rural**			**Finot Selam Rural**			**Dejen Rural**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Heard of:												
yes	18	14	**32**	42	20	**62**	40	29	**69**	40	20	**60**
no	31	37	**68**	13	30	**43**	10	21	**31**	11	30	**41**
Use of:												
yes	0	0	**0**	2	0	**2**	0	0	**0**	0	0	**0**
no	25	41	**66**	36	44	**80**	39	40	**79**	41	39	**80**
sometimes												

Urban

	Non Intervention			Intervention			Intervention			Non Intervention		
	Hamusit Urban			**Durbete Urban**			**Finot Selam Urban**			**Dejen Urban**		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Knowledge of:												
yes	24	15	**39**	23	14	**37**	39	39	**78**	49	36	**85**
no	20	20	**40**	9	21	**30**	3	8	**11**	0	13	**13**
Use of:												
yes	3	0	**3**	6	2	**8**	9	5	**14**	9	11	**20**
no	47	45	**92**	43	50	**93**	41	42	**83**	45	38	**83**
sometimes												

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Annex XIII

OVERVIEW OF THE OBSERVATIONS AT INSTUTIONAL LEVEL

The assessment team compared the West Gojjam and Bahir Dar Zones, Achefer and Jabitehnan Woreda to the non intervention Zones of South Gondar and East Gojjam and the Woreda's Dera and Dejen. The following is an overview of the main impressions gained from the interviews of the Committees, sector and EOC representatives and various groups met by the team that assessed the institutional level.

Non Intervention Zones / Woreda's

A. South Gondar Zone

Debre Tabor town: the Zonal Committees are in place since approximately 2 years and active since 1 year. They are not complete as not all sectors are member and not all development partners. A first combined zonal activity plan is in execution but behind schedule. A number of Woredas have presented their plans. Due to a number of constraints the TC and the sectors are mainly active in the town it self. The EOC is active through the parish priests.

The ZHD carries the brunt of the responsibilities. Patient information indicates a rapid spread. The ZHD is experiencing serious obstacles ranging from lack of priority at other levels and in other sectors to lack of infrastructure and resources. The drought of the last two years has compounded problems in many area's.

During the discussions in the CC we felt that the awareness of the seriousness and all the issues was still limited.

The hospital feels the rise in cases: 60 to 70% of medical patients are suspected AIDS patients, TB cases are increasing and at least 40% are related to HIV/AIDS. It has serious problems of lack of staff and turnover of staff as well as lack of material resources. Testing is only done for blood transfusions by HIV spot check. For diagnostic testing blood samples or the patients are sent to Gondar hospital. Due to absence of counsellors testing could not be done for nearly a year. Recently 2 new counsellors were trained, they combine counselling with other responsibilities.

There are a limited number of local and international NGO's active in the Zone. OSSA has been active in HIV/AIDS training and individual support. GTZ gave the ZTC some material support.

Dera Woreda, to which Hamusit town belongs: the situation and developments are comparable to that of the zone. No Kebelle HIV/AIDS Co-ordinating Committees have been set up yet and the Kebelle Council of Hamusit was uncooperative towards the assessment activities.

B. East Gojjam Zone

Debre Markos: The Co-ordinating Committee (ZCC) met for the second time and the Technical Committee (ZTC) for the third time at the occasion of our visit. A first activity plan has been formulated but implementation is lagging far behind. Here again the Health Department is the main active party. Concern is very high, certainly amongst the EOC representatives, but awareness of all the issues at stake is very limited. Not all sectors and possible actors are involved and no budget is available for activities. The CC members also stressed the problems of lack of staff, as many are leaving for jobs in the private business, and the high priority that had to give to national issues. Solutions and funds are expected from outside: regional and federal level or from NGO'S.

The department of Education lost 51 teachers suspected of AIDS and the Department of Agriculture 36 DA's.

The hospital has an Elisa machine but it is broken so no testing is available in the Zone at the moment.

Dejen Woreda: both the WCC and the WTC met for the first time upon our request. Their composition does not yet correspond with the regional proposition. Some activities are reported to be on the way. During the discussions the impression was given that the official nomination and one off instruction to the sectors should be sufficient to get things done. Another overriding opinion was that nothing could be

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started as no funds or other support was available. None of the issues at stake were known let alone that they had been explored.
The health centre staff gives information during outreach services. There are no testing facilities patients are referred to Addis or Bahir Dar.
Contrary to the impression given by the Committees the results of the individual interviews showed a level of knowledge similar to that in the neighbouring intervention area of Finot Selam. Further investigation showed that the MoH/Woreda Health Office and OSSA had undertaken a number of training's of intermediaries during the past three years (health staff, bar workers, Anti Aids Club animators). New officers were apparently not aware of this.
As far as could be established no Kebelle Co-ordinating Committees are established and here the Kebelle Council members were uncooperative towards the assessment activities as well.

Intervention Zones / Woreda's

A. West Gojjam Zone
The assessment meetings here were hampered by the closing of the fiscal year.
The ZCC meeting: the group was not complete during the meeting and about 80% of the heads of departments were new. In depth discussion was possible but a lot of attention was given to issues related to CVM's budget. Previous meeting had been 9 months ago.
The ZTC: group was not complete either during meeting. Meetings are not held regularly. The exploration of the issues reached a significant depth. Communication with lower and higher level is not strong. Complaint no budget for supervision. Integrated supervision not envisaged.
Both committees see the programme as CVM's programme.
Sectors: the most concerned sectors (Health, Education and Labour and Social Affairs), which have some continuity of staff, have a high level of awareness of the issues and are trying their utmost to ensure continuity of activities. Some sectors have new heads of department who are not yet fully aware of the programme nor the issues.
Important obstacle noted by all: high turnover of staff and the absence of own budget for HIV/AIDS activities.
The EOC personnel is highly committed and has mobilized all the priests in the rural parishes.
The Felege Hiwot hospital functions as hospital for West Gojjam and Bahir Dar Hospital and as Regional Hospital. Testing at the hospital has been disrupted several time because of lack of laboratory technicians and now the Elisa machine is out of order. Temporarily the regional laboratory performs tests for the hospital. A new group of counsellors has been trained and together with their doyen (an experienced counsellor) they have revived counselling services. Co-operation with director and staff is good. The largest problem is that patients are not willing to be tested (the policy determines that all counselling and testing has to be voluntary).

Durabete, Achefer Woreda: this is one of the woredas were the programme started. There is a high level of awareness and motivation among WCC and WTC members. The police is member of the WCC: only committee were this is the case. The Woreda Council has given the secretary an office for co-ordinating activities. The level of activities is high. All the main sectors are involved and committed. Participation of the sectors in the committees is good but practical co-operation on the ground still needs to be developed. Recognition that there are no signs of behavioural change is present but actions to explore the problem or try out new approaches have not yet been undertaken. On the other hand this is the first woreda to be aware of the rise in the umber of orphans and to execute a count.
Meetings are not regular and often postponed for other priorities and activities or when CVM lags behind: ownership of the problem and the programme is not complete. It is seen as CVM programme.
At Kebelle level a large number of Co-ordinating Committees have been initiated. The ones met in Durabete town were very active and assisted much in the assessment activities.
The health centre has recently been opened. No testing is available, patients are referred to Bahir Dar. Whether they go is not known the hospital does not provide feed back or return referrals. The health centre has just become one of the pilot centres for the new TB programme.(200 cases in three months: suspect around 60 to be HIV pos.). The lab can test smears but smear negatives have to go to BD for X-

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ray, these patients are often lost. STD seems to be on the rise. On the other hand the stigma connected is very strong and now that the private drug sellers can provide antibiotics self medication is increasing.
A general complaint is the lack of supervisory support from the Zone and Regional level.
The results of the individual questionnaires indicate that knowledge and attitude changes in Durabete are well advanced in comparison to the non intervention areas but less than in Finote Selam.

Finot Selam, Jabitehnan Woreda: the level of concern and activities both in the WCC, WTC as in the individual sectors is high. The explanations lie firstly in the fact that HIV/AIDS prevalence is perceived as high (stopover town for Addis to Gondar traffic). Secondly a CVM educator/project co-ordinator is based here for this and the surrounding woredas. The WCC had not met for a long time. The WTC is felt to be effective: it is in fact the former Management Committee. Also here the recognition that risky behaviour is not changing has not yet lead to further exploration and adapting actions.
Kebelle Co-ordinating Committees are rapidly increasing in number. Assistance from the Kebelle Council and Co-ordinating Committee in the assessment activities was very good.
The hospital is experiencing serious problems ranging from lack of resources, lack of staff, to low staff motivation and abandoned and terminally ill. Testing and counselling activities are few. All three counsellors have many other duties. The blood bank provided under the programme is not much used. A system of voluntary blood donation could not yet be installed. People are not willing and recruitment falls under the Red Cross, who till now, have not been felt to do much about it. STD's are frequent and the highest number of new infections comes from the high school. Bar ladies seldom are diagnosed whether this is in line with increased condom use or due to self medication is not known.
All officials spoken to here regret the low level of supervision and support from higher levels.

B. Bahir Dar Lyu Zone
This special zone is relatively new. Only the TC could be met. As the town contains so many more institutes and enterprises there is a larger diversity of members in the TC. Potential is even greater. The special zone does have all sector departments in view of the special status. Not all members were present during the meeting. The EOC is a member of the TC and CC.
Due to the specific urban situation (Regional Capital with a population of around 110.000) the prevalence is perceived as very high. On top of this many infected persons and orphans come to stay in town when their rural relatives can not cope or they do not want it known. Thus the level of awareness and concern of the problems is high as well as the number of activities. Practical inter-sectoral co-operation is starting: a programme to care for street children is under way carried out by the EOC with support from the Zonal Labour and Social Affairs Department (funds from UNICEF).

Amhara Regional State

This part is presented in the main report.

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Annex XIV

PROGRAMME OUTPUTS: DISTRIBUTION OF IEC MATERIALS

AVERAGE DISTRIBUTION OF IEC MATERIALS IN

1994-1999

ZONE	TYPE OF IEC MATERIALS									
	Newsletter Hulachinm	EOC fly sheet	Islamic Fly sheet	Women's Journal	Farmers Journal	Student Bulletin	WAD Flysheet	Poster	Sticker	EDU Material
N/GONDER	15,000	15,200	15,000	6,000	14,400	12,000				
S/WOLLO	16,000	9,000	30,000	6,000	22,850	12,000				
W/GOJJAM	149,900	328,400	36,000	19,500	263,000	190,880	177,975	2,384	3,150	48,700
AWI	9,000	8,000	8,000	3,000	9,500	8,000				
L/ZONE	25,450	41,400	8,000	200		4,300				
S/GONDER	12,500	13,200	11,500	5,500	21,900	12,000				
N/WOLLO	14,300	13,000	22,500	5,500	16,300	12,000				
WAGHIMTA	5,500	8,000	4,000	1,500	8,,150	8,000				
OROMIA	5,750	3,800	10,000	2,400	8,300	8,000				
E/GOJJAM	17,000	13,200	17,000	6,000	7,600	12,000				
N/SHOA	16,000	9,200	16,000	6,000	18,900	10,000				
TOTAL	286,400	462,400	178,000	61,600	390,900	289,180	177,975	2,384	3,150	48,700

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Training Coverage

No	Wereda	Councellors	Muslim Councellors		Counsellors Communicators		Elementary School Teachers		Youth Animators		Training of Trainers		Dev't Counsell
		M	F	M	F	M	F	M	F	M	F	M	F
1	Bahir Dar Zuria	37				7							
2	Mecha					6							
3	Y/Densa					6							
4	Achefer					6							
5	Sekela					6							
6	Bure					6							
7	Jabi Teheran	37				6							
8	Dembecha					6							
9	Quarit					6							
10	D/Damot					6							
11	Bahir Dar Town					6							
12	All Weredas (Not specified)												
	Total	74	0	0	0	67	0	0	0	0	0	0	0

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gents - rs/Comm.	Health Personnel Counsellors		Team Building		Behavioural Change		Laboratory Technitians	Medical Per.	Educators Training
M	F	M	F	M	F	M	F&M		F & M
	6	20		86					
							3		
0	6	20	0	86	0	0	3	0	0

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No	Wereda	Councellors	Muslim Councellors		Counsellors Communicators		Elementary School Teachers		Youth Animators		Training of Trainers		Dev't Counsell
		M	F	M	F	M	F	M	F	M	F	M	F
1	Bahir Dar Zuria	5											
2	Mecha	5											
3	Y/Densa	40			10	22							
4	Achefer	5											
5	Sekela	5											
6	Bure	5											
7	Jabi Teheran												
8	Dembecha	5											
9	Quarit	5											
10	D/Damot	5											
11	Bahir Dar Town	5											
12	All Weredas (Not specified)	50											
	Total	135	0	0	10	22	0	0	0	0	0	0	0

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gents - rs/Comm.	Health Personnel Counsellors		Team Building		Behavioural Change		Laboratory Technitians	Medical Per.	Educators Training
M	F	M	F	M	F	M	F&M		F & M
				1					
				1					
			6	16					
		34							
0	0	34	6	18	0	0	0	0	0

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No	Wereda	EOC Councellors		Muslim Councellors		Counsellors Communicators		Elementary School Teachers		Youth Animators		Training of Trainers		Dev't Counsell
		M	F	M	F	M	F	M	F	M	F	M	F	
1	Bahir Dar Zuria													
2	Mecha	39		5		33								
3	Y/Densa	35		5										
4	Achefer			5										
5	Sekela													
6	Bure			1										
7	Jabi Teheran			4	26									
8	Dembecha			4										
9	Quarit													
10	D/Damot													
11	Bahir Dar Town			25										
12	All Weredas (Not specified)				42									
	Total	74	0	49	68	33	0	0	0	0	0	0	0	0

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gents - rs/Comm	Health Personnel Counsellors		Team Building		Behavioural Change		Laboratory Technitians	Medical Per.	Educators Training
M	F	M	F	M	F	M	F & M		F & M
				80					
				62					
				14					
				9					
				27					
				18					
				11					
				17					
	2	2					1		
			12					30	91
0	2	2	12	238	0	0	1	30	91

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No	Wereda	Councellors		Muslim Councellors		Counsellors Communicators		Elementary School Teachers		Youth Animators		Training of Trainers		Dev't Counsell
		M	F	M	F	M	F	M	F	M	F	M	F	
1	Bahir Dar Zuria													
2	Mecha													
3	Y/Densa													
4	Achefer													
5	Sekela													
6	Bure													
7	Jabi Teheran									15	15			
8	Dembecha													
9	Quarit	24				16				15	15			
10	D/Damot	23				10					3			
11	Bahir Dar Town				20						8			
12	All Weredas (Not specified)									34				
	Total	47	0	0	20	26	0	0	0	64	41	0	0	0

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gents - rs/Comm	Health Personnel Counsellors		Team Building		Behavioural Change		Laboratory Technitians	Medical Per.	Educators Training	Farmers Orientation
M	F	M	F	M	F	M	F & M		F & M	
				70		161				
				99	171	128				6000
				17						
		6		11						
2		2		11						
						41	1			
						70			32	
2	0	8	0	208	171	400	1	0	32	6000

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No	Wereda	Councellors	Muslim Councellors		Counsellors Communicators		Elementary School Teachers		Youth Animators		Training of Trainers		Dev't Counsell
		M	F	M	F	M	F	M	F	M	F	M	F
1	Bahir Dar Zuria				25								
2	Mecha	36			25	17							
3	Y/Densa	36			25	17							
4	Achefer				25								
5	Sekela	36			25	17							
6	Bure	36			25	17							
7	Jabi Teheran	36			25	17							
8	Dembecha				25								
9	Quarit				25								
10	D/Damot				25								
11	Bahir Dar Town				25								
12	All Weredas (Not specified)					85						42	
	Total	180	-	-	280	170	-	-	-	-	-	42	-

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gents - rs/Comm.	Health Personnel Counsellors		Team Building		Behavioural Change		Laboratory Technitians	Medical Per.	Educators Training	Orientation Workshops
M	F	M	F	M	F	M	F & M		F & M	
										875
							1			812
			332	443						1,480
-	-	-	332	443	-	-	1		-	3,167

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No	Wereda	Councellors	Muslim Councellors		Counsellors Communicators		Elementary School Teachers		Youth Animators		Training of Trainers		Dev't Counseli
		M	F	M	F	M	F	M	F	M	F	M	F
1	Bahir Dar Zuria												
2	Mecha												
3	Y/Densa												
4	Achefer								7	53			
5	Sekela				6	11							12
6	Bure				6	11							12
7	Jabi Teheran												12
8	Dembecha						11	16	36	9			
9	Quarit												
10	D/Damot												
11	Bahir Dar Town												12
12	All Weredas (Not specified)	76	24	41				27				49	
	Total	76	24	41	12	22	11	43	43	62	-	49	48

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gents - rs/Comm	Health Personnel Counsellors		Team Building		Behavioural Change		Laboratory Technitians	Medical Per.	Educators Training	Orientation Workshps
M	F	M	F	M	F	M	F & M		F & M	
										321
40									26	
40										
40			65	74						
			65	74					35	1,090
			65	74						
40										
			65	74					45	1,700
			6	34						81,807
160	-	-	268	329	-	-	-		106	84,918

CCRDA

No	Wereda	Councellors	Muslim Councellors		Counsellors Communicators		Elementary School Teachers		Youth Animators		Training of Trainers		Dev't Counsell
		M	F	M	F	M	F	M	F	M	F	M	F
1	Bahir Dar Zuria						11	9					
2	Mecha						13	11	1	1			
3	Y/Densa						7	18	3	1			
4	Achefer						5	16	12	9			
5	Sekela						5	9					
6	Bure						12	11	6	14			
7	Jabi Teheran								2	5			
8	Dembecha						11	4	9	10			
9	Quarit						5	10	1	1			
10	D/Damot						5	10	2	2			
11	Bahir Dar Town						8	8	9	1			
12	All Weredas (Not specified)												
	Total	-	-	-	-	-	82	106	45	44	-	-	-

CCRDA

gents - rs/Comm	Health Personnel Counsellors		Team Building		Behavioural Change		Laboratory Technitians	Medical Per.	Educators Training	Orientation Workshop
M	F	M	F	M	F	M	F & M		F & M	
									11	
									10	
									11	
			44	71					10	
									10	
									8	
			76	270			1		12	
									13	
									9	
									8	
							2		9	200
60										169,273
60	-	-	120	341	-	-	3		111	169,473

CCRDA

Annex XIV

Facilitated by the Programme - per Type and Wereda
August 1994 to June 2000

No	Wereda	EOC Councellors	Muslim Councellors		Counsellors Communicators		Elementary School Teachers		Youth Animators		Training of Trainers		Dev't Agents - Counsellors/Comm.	
		M	F	M	F	M	F	M	F	M	F	M	F	M
1	Bahir Dar Zuria	42	-	-	25	7	11	9	-	-	-	-	-	-
2	Mecha	80	-	5	25	56	13	11	1	1	-	1	-	-
3	Y/Densa	111	-	5	35	45	7	18	10	54	-	-	-	-
4	Achefer	5	-	5	31	17	5	16	12	9	-	-	12	40
5	Sekela	41	-	-	31	34	5	9	-	-	-	-	12	40
6	Bure	41	-	1	25	23	12	11	21	29	-	-	12	40
7	Jabi Tehanan	73	-	4	51	23	11	16	38	14	-	1	-	-
8	Dembecha	5	-	4	25	6	11	4	24	25	-	-	-	-
9	Quarit	29	-	-	25	22	5	10	1	4	-	-	-	-
10	D/Damot	28	-	-	25	16	5	10	2	10	-	-	12	42
11	Bahir Dar Town	5	-	25	45	6	8	8	43	1	6	16	-	-
12	All Weredas (Not specified)	126	24	41	42	85	-	27	-	-	-	91	-	60
	Total	586	24	90	390	340	93	149	152	147	6	109	48	222

ECRDA

NB. Female numbers may be underestimated as in the absence of specific information the number has been take as "Male"

Annex XIV

Facilitated by the Programme - per Type and Wereda
August 1994 to June 2000

No	Wereda	Health Personnel Counsellors		Team Building		Behavioural Change		Laboratory Technitians	Military Medical Per.	Educators Training	Farmers Orientation	TOTAL Trained Counsellors
		F	M	F	M	F	M	F & M		F & M		
1	Bahir Dar Zuria	6	20	-	86	-	-	-	-	11	-	120
2	Mecha	-	-	-	81	-	-	-	-	10	-	193
3	Y/Densa	-	-	-	132	-	161	-	-	11	321	285
4	Achefer	-	-	44	85	-	-	-	-	36	-	152
5	Sekela	-	-	-	9	-	-	-	-	10	-	172
6	Bure	-	-	65	101	-	-	-	-	8	-	215
7	Jabi Tehanan	-	-	141	444	171	128	1	-	47	7,965	231
8	Dembecha	-	-	65	109	-	-	-	-	13	-	104
9	Quarit	-	6	-	22	-	-	-	-	9	-	102
10	D/Damot	-	2	-	28	-	-	-	-	8	-	152
11	Bahir Dar Town	2	2	71	90	-	41	8	-	54	2,712	167
12	All Weredas (Not specified)	-	34	350	477	-	70	-	30	123	252,560	530
	Total	8	64	738	1,663	171	400	9	30	340	263,558	2,428

ECRDA

NB. Female numbers may be underestimated as in the absence of specific information the number has been take as "Male"

Annex XIV

Facilitated by the Programme - per Type and Wereda
August 1994 to June 2000

No	Wereda	
1	Bahir Dar Zuria	
2	Mecha	253
3	Y/Densa	281
4	Achefer	214
5	Sekela	176
6	Bure	187
7	Jabi Tehanan	433
8	Dembecha	180
9	Quarit	52
10	D/Damot	169
11	Bahir Dar Town	145
12	All Weredas (Not specified)	
	Total	

CCRDA

NB. Female numbers may be underestimated as in the absence of specific information the number has been take as "Male"

Annex	XV				
		OVERVIEW SIX YEAR BUDGET USE PER ACTIVITY			
	Comparative Impact Assessment				
	HIV/AIDS Control and Prevention Programme				
	West Gojjam and Bahir Dar Liyu special Zone, Amhara Region, Ethiopia.				
	June - July 2000				
			Overview 6 year Budget and Expenditures		
Year		**Budget line**	**Total Amount allocated**	**Amount spent per annum**	Difference
1994	1	IEC material		44,492.63	
1995				164,045.13	
1996				525,042.09	
1997				383,885.52	
1998				411,796.40	
1999				441,705.10	
		Total	782,900	1,970,966.87	252%
1994	2	Training		76,796.50	
1995				412,542.05	
1996				164,708.17	
1997				197,564.00	
1998				331,943.85	
1999				359,113.09	
		Total	764,954	1,542,667.66	202%
1994	3	Improvement of Health infrastructure safety conditions		460,784.13	
1995				2,251.40	
1996				329,050.39	
1997				601,025.02	
1998				225,649.69	
1999				175,505.74	
		Total	2,441,680	1,794,266.37	73%
1994	4	Patient Care			
1995				78.00	
1996				1,900.80	
1997		98% for medicines for opportunistic infections		394,414.18	
1998				4,678.60	
1999				5,461.00	
		Total	1,368,000	406,532.58	30%
1994	5	Research			
1995				8,738.35	
1996				72,795.60	
1997				8,122.10	
1998				3,000.00	
1999					
		Total	unspecified	92,656.05	

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1994	6	Income Generation activities			
1995					
1996				1,187.25	
1997				1,722.00	
1998				3,563.00	
1999				36,476.00	
		Total	857,600	42,948.25	5%
1994	7	Monitoring and administration		7,922.29	
1995				142,788.44	
1996				132,993.69	
1997				213,953.18	
1998				243,981.78	
1999				254,227.17	
		Total	766,200	995,866.55	129.97%
		Total budget foreseen:			
			7,961,171		
		Total expenditures:		**6,845,904.33**	**85.99%**

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Annex XVI

HEALTH STATUS AND HEALTH CARE INFORMATION

COUNTRY

At the time the 'HIV/AIDS Control and Prevention Programme West Gojjam' was initiated such programmes were seen as belonging to the health sector. The entry point for CVM was the Zonal health office and the hospital in Bahir Dar as key staff members recognised the need to undertake action. From the beginning the main actors aimed at multi-sectoral co-operation and integration of activities. In the country and in the Amhara National Regional State the health sector remains the key sector both as first entry point for the patients and as leader in the multi-sectoral control and prevention strategies. For these reasons the health sector and its constraints are described more extensively here.

The health status of the population of Ethiopia can be ranked amongst the most disfavoured of the developing countries.
Some national average key indicators are (1994 Population & Housing Census of Ethiopia):
Crude birth rate: 28.3 — Life expectancy at birth: 50.7
Total fertility rate: 4.3 — Child mortality rate: 171
Infant mortality rate: 110 - 128 — Maternal mortality rate: 500 - 70
The total burden of disease, as measured by premature death from all causes, is approximately 350 DLY's lost per 1000 population (compare: Kenya 170 / East Africa as a whole 280).
The top ten causes of mortality are: peri-natal and maternal conditions, acute respiratory infections, malaria, nutritional deficiencies, diarrhoea and HIV/AIDS, tuberculosis, measles, cardiovascular diseases and trauma's. These diseases account for 74 % of all deaths. Though largely preventable, childhood, maternal illnesses and communicable diseases are the major causes of death.
The underlying causes of the poor health status are widespread poverty, low education levels (especially among women), inadequate access to clean water and sanitation facilities ad poor access to health services.

At present the overall health service coverage is calculated at 48.5% (MoH Health and Health Related Indicators, January 1998), but the differences between the regions and between urban and rural areas are quite large (Afar Region 11% and Harari Region 62% / Addis Ababa 75% compared to rural area's with 10%).
The national averages for health service coverage in 1997 were calculated as:
TT2 for pregnant women: 32% — Attended deliveries: 10.2%
EPI coverage: 67% — Post natal: 3.5%
Children under five: 20.6% — Family planning: 9.8%
Ante-natal: 30.4%
The main reason for the poor coverage of health services is the limited number of health facilities combined with unequal geographical spread. In the twenty-year health sector development strategy the government has proposed a four-tier health service structure. Compared to this plan the present national facility to population ratio's are as follows:

Current			Proposed	
Facility Type	Number	People Covered*	Facility Type	People Covered
Hospitals	89	1: 587,620	Specialised hosp's.	1 : 5,000,000
			Zonal hospitals	1 : 1,000,000
			District Hospitals	1 : 250,000
Health centres	242	1 : 222,850	PHC units (health centre with	1 : 25,000
Health posts	1,175	1 : 44,509	five satellite community clinics: Health posts	1 : 5,000
Health stations	2,515	1 : 20,795		

* these calculations are probably based on a former population count of around 52 million.

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The quality of health services is being compromised by inadequate and poorly maintained infrastructure and equipment, scarcity of personnel and the unavailability of drugs and pharmaceutical supplies. As example the health personnel to population ratios are amongst the lowest in the world (1996/77):

- Overall: one health worker for 2,850 inhabitants;
- All medical Doctors is 1 per 38,910 (in 1978 this was 1 per 38,200 / Addis Ababa takes 22%);
- MD specialists: 1 for 209,851 (in 1978 1 per 124,500 / Addis Ababa share: 47%);
- GMP health officers: 1 for 49,020 (1978: 1 per 60,000 / Addis Ababa share: 16%);
- Pharmacists: 1 per 389,090 (1978 : 1 per 280,000 / Addis Ababa: share 31%);
- Nurses: 1 : 13,770 (1978: 1 per 20,400/ Addis Ababa share: 23%);
- Health Assistants: 1 : 5,400 (1978 1 per 5,400 / Addis Ababa share 10%)

The training schools are operating at only 55% of their capacity due to a number of reasons. More importantly job dissatisfaction is high because of inadequate working conditions, poor remuneration and lack of career development opportunities. This is leading to a high turnover and attrition.

The health sector is financed through a variety of sources of which the relative share in 1996 was: general government resources 42.9%, donor assistance and foreign loans 17.3%, user fees and community contributions 39.3% and various types health of insurance 0.5%. Though important efforts are being deployed to increase the budget for health (1990 1% of GDP- 1996 2.7%) the per capita government expenditures for health stood at 1.20 US$ in 1996 (compared to the Sub Saharan average of 10 US$ per capita). Since the shift of responsibilities to the Regional Governments variations of per capita expenditures per region are appearing.

Utilization: Total outpatient statistics of government health facilities suggest that, on average, there are about 0.25 visits per person per year. However the recent study 'Policy on Human Resource Development Study' revealed that only 10% of persons reporting illness actually obtained treatment at a health facility (government or private). Utilization by the rural population (9.8%) is lower than the national average as compared to the urban population (14%). The three most important determinants of the low utilization are: cost of treatment, the distance to a health facility (or absence), the quality of services and the educational status of the mothers.

Health Sector Development Plan: in 1998 the Ministry of Health of the Federal Government formulated the National Health Policy and a five year Health Sector Plan after a critical examination of the health status and health system problems and issues. The overriding goal of the health sector is to improve the health status of the population. The present plan aims at developing a health care delivery system which provides (a) comprehensive and integrated primary health care services, based at community – level health facilities and (b) appropriate first – referral and other hospital services. The overall focus is set on communicable diseases, common nutritional disorders and environmental health and hygiene, with special attention on the conditions constituting the major elements of the burden of disease. At this point HIV/AIDS is explicitly mentioned. The main eight components of the plan are: service delivery and quality of care; health facility rehabilitation and expansion; human resource development; strengthening pharmaceutical services; information, education and communication; strengthening health sector management and management information systems; monitoring and evaluation and finally health care financing. Amongst the general strategies selected the following take a prominent place:

- decentralization of the major parts of decision-making with respect to health care organization, capacity building, planning, implementation and monitoring to the zones and subsequently to the districts (from central level to the regions has been achieved during the period of the transitional Government);
- community involvement and participation throughout the process (from problem identification to evaluation) to ensure responsiveness of services and co-responsibility of the population;
- partnerships: involving the civil society as all a whole but specifically (potential) providers and actors from within and outside the government to ensure that the aims can be achieved and the sustainability can be improved. Particularly NGO's are invited to join forces with government in certain services and programmes.

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AMHARA NATIONAL REGIONAL STATE

The health status of the population of the ANRS largely coincides with the national averages (see 4.1.2). The estimates for maternal mortality are higher: 500 to 1000 per 100.000 live births.
The leading causes of mortality during hospital admission in 1995 were: malaria, all forms of tuberculosis, pneumonia, accidents, fevers of unknown origin, intestinal obstructions, circulatory system disorders, HIV/AIDS, diabetes, typhoid. The underlying causes coincide with the national assessment.

In 1997 the health service coverage was as follows (Source: MoH, Health and Health Related Indicators, January 1998):

First line facilities: 37%
TT2 for pregnant women: 21%
EPI coverage: 61%
Children under five: 19.6%
Ante-natal: 18.4%
Attended deliveries: 5.5%
Post natal: 3%
Family planning: 7.2%

The health facility to population ratio and the health worker to population ratio stood as follows in 1997 (for a comparison with the national ratio's please refer to chapter 4.1.2.):

Health Institutions

Facility Type	Number	People Covered
Hospitals	11	1 : 1,363,636
Health centres	53	1 : 283,018
Health stations	532	1 : 28,195
Health posts	132	
Hospital beds		1 : 14,353

Health care personnel

Category	People Covered
Medical Doctors	1 : 52,602
Nurses	1 : 23,173
Health Assistants	1 : 4480
Pharmacists	1 : 423,792
Lab. Technicians	1 : 153,714
X-Ray Technicians	1 : 553,372

Of the hospitals: 5 are district hospitals, 3 zonal hospitals, one hospital belongs to the Ministry of Defence and one, the Gondar College of Medical Sciences hospital, falls under the Ministry of Education. The number of private not for profit (NGO) clinics is quite limited (24) and the number of private for profit clinics is slightly higher (46). The number of private drug shops and drug vendors is rising rapidly.
Though Community mobilization and participation have been pursued for a number of years the number of active community health committees is not large and the number of registered and active Community Health Agents (CHA's) and Traditional Births Attendants (TBA's) is quite limited compared to the population (respectively 423 and 394).

Utilization of health services: very few statistics are available. In 1998 the total outpatient attendance for the region was 2,921,594 of the population of 15 million (0.2 visits per person / the totals in the preceding 6 years were similar). The total number of admitted patients was 41,748 (the six year overview shows a gradual increase from 27,172 in 1992).

Health sector financing: the ANRS obtains its share of the national budget for health. Further funding comes from user and community contributions and external aid. The State is not able to add own financial resources to the health budget and thus expenditures are similar to the national average (+/- 1.2 USD per capita)

Health Policy and Sector Development Plan: has been formulated as part of / in line with the Federal Health Policy and Sector Plan. The goal and objectives are similar for the coming five years: improving the health status and raising health service coverage and quality. Important components of the plan are: MCH and Family Planning; EPI; Malaria & other vector borne disease control; TBC and Leprosy control; HIV/AIDS and STD control; Blindness prevention and control; Surveillance and Epidemic control; Hygiene & Environmental Health; Health facilities rehabilitation and expansion; Human Resource development; Provision of Pharmaceuticals; Information/Education & Communication; Strengthening Management and Information System. The strategies selected concur with the national strategies.

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ANNEX XVII

MAIN FEATURES OF THE FEDERAL MUTLI-SECTORAL HIV/AIDS STRATEGIC PLAN 2000 - 2004[1]

General Objective:

Providing an enabling environment for the prevention and control of HIV/AIDS in the country.

Policy Objectives:

- Establish effective HIV/AIDS preventive and control strategies in order to curb the spread of the epidemic;
- Promote a broad multi-sectoral response to HIV/AIDS epidemic, including more effective co-ordination of the activities of different sectors and the and the mobilization of resources for the control of the epidemic;
- Encourage government sectors, NGO's, private sectors and the communities to take measures in order to alleviate the social and economic impact of HIV/AIDS;
- Promote proper institutional, home and community based health care and psycho-social support for people living with HIV/AIDS, orphans and surviving dependants;
- Safeguard the human rights of people living with HIV/AIDS and avoid discrimination against them;
- Empower women, youth and vulnerable groups to take action to protect themselves against HIV/AIDS;
- Promote and encourage research activities targeted towards preventive, curative and rehabilitative aspects of HIV/AIDS.

The National Strategic Plan and the ensuing Regional Plans aim at reducing the transmission of HIV, the associated morbidity and mortality as well as the impact on the level of the individual, family and society at large. The approaches selected are multi-sectoral and multi-dimensional and focus on mobilizing the population at every level using the available implementation channels of the public and private sectors.
The main objectives are to promote reductions in the number of sexual partners; encourage delays in the onset of sexual activity among the adolescents; promoting the availability and use of condoms and strengthening the STD control programmes. It is expected that the combination and simultaneous implementation of these four interventions can reduce the projected prevalence by nearly 55%.
The main areas of activities will be:

Prevention:

- Improve access and quality of STD/HIV/AIDS services to meet the needs of the vulnerable groups;
- Increase the provision of comprehensive STD management in health care facilities;
- Increase access to education in general and of HIV/AIDS education and communication in particular;
- Increase accessibility and availability of condoms;
- Promote IEC messages that are continuous, appropriate, acceptable and effective for behavioural change;
- Contribute to the national initiatives of alleviating poverty and increasing employment opportunities, particularly for youth and women;
- Empower women and girls to reduce their vulnerability to HIV infection;
- Prevent HIV transmission in hospital settings.

Care and Support:

- Provide clinical and nursing care for AIDS patients;
- Increase social support to AIDS patients and their families;
- Establish an ethical, legal and human rights framework for HIV/AIDS infected people;
- Expand an accelerate sector specific impact reduction interventions;
- Increase HIV/AIDS research and surveillance.

[1] Federal Policy document and Multi-Sectoral HIV/AIDS Strategic Plan 2000-2004.

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MAIN FEATURES ANRS MULTI-SECTORAL HIV/AIDS STRATEGIC PLAN 2000 - 2004[2]

The general and specific objectives are

i. Create a conducive environment for an expanded response to the HIV epidemic:
   - Policy formulation and dissemination,
   - Formulation of guidelines.

ii. Prevent the transmission of HIV/AIDS:
   - Promote adoption of safer sexual practices including condom use;
   - Prevent transmission through blood in health care setting;
   - Prevent transmission through blood in non health care settings;

iii. Alleviate the personal and social impact of HIV/AIDS:
   - Ensure comprehensive care and support for PLWA and their families;
   - Reduce the social and economic impact of HIV/AIDS on affected communities;

iv. Foster a multi-sectoral approach to HIV prevention and control:
   - Establish HIV/AIDS multi-sectoral committees;
   - Support multi-sectoral implementation, monitoring and evaluation;

v. Promote HIV/AIDS research:
   - Undertake operational HIV/AIDS research;
   - Monitor trends of HIV/AIDS epidemic

The main parties to participate in the programme are: Health; Education; Agriculture, Women's Affairs; Culture, Tourism & Information; FGAE; Teachers Association; OSSA; Save the Children Fund (SCF-UK) and CVM. The plan does not mention the EOC, which is strange in view of the involvement in the West Gojjam programme and the commitment of the church leaders at ANRS level. Neither does it mention the Red Cross Society which is in charge of the recruitment of blood donors. This is probably related to the fact that neither organization can commit financial resources to the programme.
The budget foreseen for four years is slightly over 10 million USD excluding the programme that is being negotiated between the Region, CVM and its donors. The other above mentioned NGO's will contribute around 2 million.

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[2] Summary Regional Multi-Sectoral HIV/AIDS Strategic Plan 2000-2004.

ANNEX XVIII: MONITORING AND EVALUATION GUIDELINE
ANRS AND CVM HIV/AIDS PREVENTION AND CONTROL PROGRAMME

Objectives		Indicators	Means of measurement / verification	Report frequency	Responsibilities
Overall Objective: Improve the health status of the people in the Amhara National Regional State.		- Life expectancy - Maternal mortality - Infant mortality - Mortality Communicable diseases	- Census data - Health Facility, District (Woreda), Zonal, Regional and National HMIS	- Unknown - Annual reports each level	- Ministry of Health - Per level of health system
Development Objective: Reduce the number of HIV new infections and number of people contracting AIDS by bringing about behavioural change in the Amhara National Regional State as a whole and the 4 new focus Zones in particular.		Context: - Accepting attitudes towards HIV infected persons Impact: - HIV prevalence among pregnant women - Syphilis prevalence among pregnant women - HIV prevalence among blood donors Outcome: - Condom use at last risky sex - Condom use by clients at last commercial sex - Women leaving sex trade for other income generating activity - Women negotiating safer sex with husbands - Median age at first sex - Condom use by youth at last premarital sex - Median age of girls at marriage Output: - Population requesting HIV tests and receiving results - Pregnant women counselled and tested for HIV - Orphans being cared for in the community	- KAB surveys with standard prompted questions - Sentinel surveys - Ante-natal screening / HMIS - Blood bank screening report / HMIS - KAB survey - KAB survey among formal and informal sex workers - KAB survey among formal and informal sex workers / women groups - KAB survey women groups and association - KAB survey in- and out of school youth and plot calculation - KAB survey in – and out of school youth - KAB survey and Church / Municipality registrations - Population survey / HMIS - Population survey / HMIS - Community survey / reports Kebele Co-ordinating c'tee	- Once a year - Once a year - Annual calculation - Annual calculation - Annual calculation - At beginning and end of three year implementation period " " " " " " " " " " " " " " " " - At beginning and end / annual calculations - " "	- Health authorities Region and Zones / Programme management - Researchers

CCBDA

Christian Relief & Development Association
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Results four new Zones:	Activities	Indicator	Means of verification	Report frequency	Responsibilities
1. Co-ordination: AIDS prevention committees will be set up and strengthened throughout the Region and are expected to function regularly and carry out their duties and responsibilities as per directives.		Outcome: - Percentage C'tees meeting at least 4 times/year, implementing an annual plan / reviewing progress and adapting activities to improve outcome and impact	- Activity report programme - Annual plans and quarterly, six months annual activity reports of the c'tees;	- Twice a year - Four times a year	- Regional and Zonal Health authorities + Programme Management - Co-ordination Technical C'tees (CC/TC's).
	1.1 Ongoing animation of Regional Representatives annually over the life of the programme focusing the problem of HIV/AIDS, its consequences and sustainability.	Output: - Number of meetings - Issues addressed and taken up - Amount of local contributions	- Activity and financial reports of programme - Reports of workshops / sessions - Reports of C'tees	- Twice a year - Per activity - Four times a year	- Programme management - Reg.C'tee chairpersons
	1.2 Orientation of the programme for Regional Co-ordinating and Technical Committees at the regular meetings of the committees.	- Number of meetings of CC and TC - Issues taken up	- Activity and financial reports of programme - Reports meetings - Reports of C'tees	- Twice a year - Per activity - Four times a year	- Programme management - Reg. C'tee chairpersons
	1.3 Organisation of one Regional workshop per year for Regional Co-ordinating and Technical Committees and representatives of Zonal Co-ordinating and Technical Committees.	- Workshop held - Number and function of participants - Programme of workshop - Number of resolutions implemented	- Activity and financial reports of programme - Report of workshop - Reports of C'tees	- Twice a year - Four times a year	- Programme management - Reg.+Zone C'tee chairpersons
	1.4 Organization of review workshops at Zonal level for Zonal Co-ordinating and Technical Committees and representatives of Woreda Co-ordinating and Technical Committees (six-monthly) of the 6 focus Zones	- Number of review workshops held per level per CC / TC - Number and function of participants - Percentage of participants that attended all workshops - Programme of workshops - Number of conclusions carried out	- Activity and financial reports of programme - Report of workshops - Reports of C'tees	- Twice a year - Per activity - Four times a year	- Programme management - Zone + Woreda C'tee chairpersons

CORDA

Results four new Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	1.5 Organization of workshops at Wereda level for representatives of Wereda Co-ordinating and Technical Committee and representatives of Kebele Co-ordinating Committees (annually) of the 6 focus Zones	- Number of workshops held for WCC/ TC and KCC - Number / functions of participants - Percentage of participants that attended all workshops - Percentage of Kebele representatives - Number of conclusions / plans carried out	- Activity and financial reports of programme - Report of workshops - Reports of C'tees	- Twice a year - Per activity - Four times a year	- Programme management - Woreda and Kebele C'tee chairpersons - Trainers
	1.7 Production and distribution of 360,000 newsletters (30,000 per issue) to ensure net-working / co-ordination in the Region	Input: - Number of newsletters produced - Number of copies per issues distributed Output: - Feedback on content - Percentage of articles contributed by represent's of target group	- Activity and financial reports of programme - Distributions reports - 'Letters to editors' and reports of field staff; - Survey among C'tees - Contents of newsletters	- Twice per year - Per newsletter - Once a year - Per newsletter	- Programme management - IEC personnel - CC/TC's - Field staff
2. IEC: At least 90% of the eligible (5 years and above) people (12.5 million people) living in the Amhara Region are aware of the modes of HIV/AIDS transmission and prevention.		Output: - Knowledge of HIV prevention - Number of incorrect beliefs about AIDS - Comprehensive knowledge about HIV/AIDS	- KAB surveys with standard prompted questions - " " - " '	- At beginning and end of three year implementation period	- Regional and Zonal Health authorities - Programme management - Researchers
	2.1 Orientation workshop to at least 100 people per Kebele for the 1,667 target kebeles (approximately 167,000) in 4 of the 6 focus Zones.	- Workshop held - Number of participant per Kebele / Zone	- Activity and financial reports; - Workshop reports	- Twice per year - Per workshop	- Programme Management - Zonal and Kebele CC/TC's

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Results four new Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	2.2 Support the production of students bulletins for junior and secondary schools, Farmers journals, EOC pamphlets, Islamic fly sheets, posters and / or stickers	Input: - Number of bulletins / pamphlets /posters produced per year per target group - Number distributed per issue - Issues / subjects addressed - Evolution of material / financial support provided per issue / target group Outcome: - Percentage of articles contributed by target groups per issue - Feed back on issues	- Activity and financial reports of programme - Distribution reports - Review of articles - Review of contributions - 'Letters to editors' and reports field staff; - Contents of newsletters - Survey among target audience	- Twice per year - Per issue - Once per year - Per newsletter - Once a year	- Programme management - IEC personnel - Field staff - Representatives of target groups
	2.3 Support the preparation and broadcasting of programmes on Amhara Regional Radio	Input: - Number of broadcasts - Issues / subjects addressed - Evolution of support - Feedback on the broadcasts by target groups	- Activity and financial reports of programme - Review of articles - Review of contributions - 'Letters to editors' and reports of field workers - Survey among target audiences	- Twice a year - Once a year - Per broadcast - Once a year	- Programme management - IEC personnel - Staff ANRS Radio - Field staff
	2.4 Support the preparation and content of programmes on the Regional Educational Media	- Number of educational programmes - Issues / subjects addressed - Evolution of support - Feedback from students	- Activity and financial reports of programme - Review of contents prog's - Review of contributions - Letters to editors - Survey among students	- Twice per year - Once a year - Per prog' - Once per year	- Programme management - IEC personnel - Regional Education staff - Teachers
	2.5 Purchase Stencilling/Printing Machine	- Printing machine bought - Use made of machine	- Activity and financial reports of programme - IEC material production reports	- Year of purchase - Twice per year	- Programme management - IEC personnel

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Results four new Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
3. Advocacy: Concerned Government offices, institutions and Civil Society Organisations will address the needs of vulnerable groups and promote care for PLWA's in Amhara Regional National State.		Output: - Measures installed to protect women, sex workers , youth, PLWA and orphans - Employers not discriminating against those with HIV	- Activity reports - Changes in existing laws / new laws - Instructions to police / social workers / employers - Survey among employers and employees	- Annually - Twice in implementation period of three years	- Programme management - National and Regional authorities
	3.1 Training of 1,400 women as animators in 45 Weredas of the new 4 focus Zones	- Number of training's held - Number of participants per zone/woreda - Number of animators active - Number of issues brought to attention of other sectors / next level	- Activity and financial reports of programme - Workshop reports - Activity reports of animators - Activity reports of animators and Zone / Woreda sectors	- Twice per year - Per workshop - Twice per year	- Programme management - Trained animators
	3.2 Production and distribution of 240,000 women's pamphlets throughout the Region	- Number of pamphlets produced per issue - Number distributed per issue - Subjects addressed - Feedback form women - Number of contributions from women groups	- Activity and financial reports of programme - Distribution reports - Review of articles - 'Letters to editors' reports field staff and animators; - Survey among women	- Twice per year - Per issue - Once per year - Per pamphlet - Once a year	- Programme management - IEC pers. - Field staff - Animators - Repres' of women groups
	3.3 Production of 120,000 educational booklets for primary schools throughout the Region	- Number of booklets produced - Number of booklets distributed - Number of contributions by teachers and pupils - Feedback from teachers and pupils	- Activity and financial reports of programme - Distribution reports - Review of subjects and authors - 'Letters to editors' reports field staff and animators - Survey among teachers and pupils	- Twice per year - Per booklet - Once per year - Per booklet - Once a year	- Programme management - IEC pers. - Reg /Zonal education staff - Repres. Teachers and pupils

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Results four new Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	3.4 Organisation of three workshops, at Regional level, on women's issues, 'Rights of the Child' and 'Youth and HIV'	- Number of workshops held - Number and functions of participants - Programme of workshops - Number of conclusions carried out / taken to higher levels	- Activity and financial reports of programme - Workshop reports - Reports of Reg. CC/TC's - Follow up on conclusions	- Twice per year - Per workshop - Quarterly - Per action	- Programme management - Reg. CC / TC - Trainers - Workshop participants
	3.5 Organise workshops with the Ethiopian Women Lawyers Association, Teachers Association, etc in each of the 6 focus Zones	- Number of workshops held - Number, sector and function of participants - Programme of workshops - Number of conclusions taken up/ brought to attention of other sectors and higher levels	- Activity and financial reports of programme - Workshop reports - Reports of associations - Follow up on conclusions	- Twice per year - Per workshop - Annual - Per action	- Programme management - Zonal CC / TC's - Trainers - Associations
4. Capacity Building: The capacity and the involvement of Government Departments, Religious Institutions and Civil Society Organisations to prevent HIV/AIDS will be enhanced.		- Percentage of Zonal, Woreda and Kebele multi-sectoral annual plans carried out and addressing emerging issues and obstacles effectively	- Activity reports program - Annual plans Zones , Woredas and Kebeles - Progress / activity and financial reports Zones / Woredas / Kebeles	- Twice per year - Annual - Per quarter And annual	- Programme management - Zonal /Woreda and Kebele CC / TC's
	4.1 Orientation /Training of the programme for 6 focused Zonal Co-ordinating and Technical Committees with Representatives from the Region	- Number of orientation / training workshops held - Number, sector and function of participants - Programme of workshops - Number of participants continuing activities of the programme after one, two and three years - Number of conclusions carried out	- Activity and financial reports of programme - Workshop reports - Review in annual reports Region and Zones and programme - Follow up review in annual reports	- Twice per year - Per workshop - Annual - Annual	- Programme management - Regional sector heads - Zonal CC and TC's - Trainers

CORDAID

Results four new Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	4.2 Training of 40 Zonal TOT's from the 4 new Zones	- Number of training's carried out - Number of TOT's trained per zone - Number of training activities carried out by the TOT;s per zone - Number of TOT's active after one, two and three years	- Activity and financial reports of programme - Workshop reports - Activity reports of TOT's - Review in annual reports of Zonal TC and programme	- Twice per year - Per workshop - Twice per year - Annual	- Programme management - Trainers - TOT's - Zonal CC TC's
	4.3 Training of 25 Hospital counsellors per year in the 6 focus Zones.	- Number of counsellors trained per zone / hospital - Number of counsellors still active in their workplace after one, two, three years - Number of persons counselled per counsellor	- Activity and financial reports of programme - Workshop reports - Review in quarterly reports - Activity reports of counsellors report	- Twice per year - Per workshop - Each quarter - Each quarter	- Programme management - Zonal CC/TC - Trainers - Hospital management - Counsellors
	4.4 Training of 124 Health Centres counsellors in the 6 focus Zones	- Number of counsellors trained per zone / health centre - Number of counsellors still active in their workplace after one, two, three years - Number of persons counselled	- Activity and financial reports of programme - Workshop reports - Review in quarterly reports - Activity reports of counsellors report	- Twice per year - Per workshop - Each quarter - Each quarter	- Programme management - Zonal CC/TC - Trainers - Health centres management - Counsellors
	4.5 Training of 360 Woreda TOTs from 45 Weredas in the 4 new Zones	- Number of training's carried out - Number of TOT's trained per Woreda and zone - Number of training activities carried out by the TOT's per Woreda - Number of TOT's active after one, two and three years	- Activity and financial reports of programme - Workshop reports - Activity reports of TOT's - Review in annual reports of Woreda TC's and programme	- Twice per year - Per workshop - Twice per year - Annual	- Programme management - Trainers - TOT's - Woreda CC TC's

CORDAID

Results four new Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	4.6 Training of 3,240 animators selected among Development Agents, Government employees, Religious leaders, teachers, and health personnel in 45 Weredas in the 4 new Zones	- Number of training's carried out - Number of animators trained per group and per Wordea / Zone; - Activities carried out by the animators per Woreda - Number of animators still active after 1,2 and 3 years	- Activity and financial reports of programme - Workshop reports - Activity reports animators - Review in activity reports	- Twice per year - Per workshop - Per quarter - Twice per year -	- Programme management - Zone and Woreda CC/TC's - Trainers - Animators
	4.7 Strengthen the Health Management Information System of Regional Health Bureau purchase computer, printer and consumables	- Machines and consumables purchased - Evolution of the HMIS - Number of reports produced and distributed on time	- Activity and financial reports of programme - HMIS reports of Health Centres / Hospitals / Woreda HO / ZHD / RBOH	- Twice per year - Quarterly and Annual	- Programme management - RBOH / ZHD/WHO/HC 's and Hospitals
	4.8. Participation in International seminars 2 persons per year	- International seminars attended - Number of persons attending - Information from seminars to local c'tees	- Activity and financial reports of programme - Seminar reports by participants - Reports of C'tees	- Twice per year - Per seminar - Twice per year	- Programme management - Participants - CC/TC's
	4.9. Provide scholarship for one project manager to participate in a Diploma Management Course in an appropriate European Training Institute	- Scholarship allocated - Performance of the trained manager after return	- Activity and financial report of programme - Bondage contract - Progress report trainee - Exam report of school - Performance and activity report of trainee	- Twice a year - Twice a year - End training - One / two years after training	- Programme management - Employer of trainee - Trainee
	4.10 Establish an IV Fluids Production Unit	- IV fluid production unit established - Production and distribution of IV fluids realized	- Activity and financial report of programme - Installation report - Production and distribution reports report	- Twice a year - After installation - Quarterly	- Programme management - Hospital management - Production staff

CORDA

Results in four new Zones	Activities	Indicators	Means of measurement /verification	Report frequency	Responsibilities
5. Data collection: Sociological and epidemiological data will be available to guide interventions on HIV/AIDS in the Region.		Output - Availability of data to guide interventions and to evaluate progress, outcome and impact (see specific indicators and data requirements)	- HMIS reports at all levels - Reports of programme - Plans and progress reports of CC/TC's at all levels - Council plans and reports at all levels	- Four times year - " " - " " - Annual	- Health Authorities at all levels - Programme management - CC/TC chairpersons - Council chairpersons
	5.1 Conduct KAB surveys at the beginning and end of the programme in selected localities of 6 focus Zones	- Number of KAB surveys carried out per zone - Use made of findings	- Activity and financial reports of programme; - Reports of KAB surveys - Plans and progress reports CC/TC's	- Twice a year - Per survey - Annual	- Programme management - Researchers - CC/TC's
	5.2 Support Sero-surveillance among target groups in the Region	- Number of sero surveillance's carried out per group - Distribution of results - Use made of prevalence data - Evolution of the support provided	- Activity and financial reports of programme - Reports of sero-surveillance exercise carried out - HMIS reports - Plans and progress reports CC/TC's at al levels - Review of contributions provided	- Twice a year - Per exercise - Annual - Annual - Twice per year in prog. reports	- Programme management - Health authorities and researchers - CC/TC's

CCDA

Results two old Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
6. IEC: 100% of the eligible population (2 million persons) in West Gojan and Bahir Dar Zones receive relevant information on problems and experiences as a result of HIV/AIDS.		Output: - Knowledge of HIV prevention - Number of incorrect beliefs about AIDS - Comprehensive knowledge about HIV/AIDS	- KAB surveys with standard prompted among target groups in selected zones - Activity and financial reports of programme	- Twice a year - At beginning and end of three year implementation period	- Programme management - CC/TC's - Researchers
	6.1. Support the production of Children' bulletin, Students bulletin, Women's pamphlet, Farmers journal, EOC pamphlet, Islamic fly sheet, poster and / or stickers	Input: - Number of Issues produced per year per target group - Number distributed per issue - Evolution of material / financial support provided per issue / target group Outcome: - Percentage of articles contributed by target groups per issue - Feed back on issues	- Activity and financial reports of programme - Distribution reports - Review in reports - Review of articles per issue - 'Letters to editor' and reports of field workers - Survey among target groups	- Twice a year - Per issue - Twice a year - Twice a year - Twice a year - Once a year	- Programme management - IEC staff - Sector and institution heads - CC/TC's - Field workers
	6.2 Provide raw material for IEC production	- Quantity of raw material provided	- Activity and financial reports of programme - Distribution report of materials - IEC material produced	- Twice a year - Per purchase of bulk material - Twice a year	- Programme management - CC/TC's - Fieldworkers
7. Advocacy: Concerned Government offices, institutions and Civil Society Organizations will actively be involved in the needs of vulnerable groups and promote care for PLWAs in West Gojjam and Bahir Dar Zones.		Outcome - Measures installed to protect women, sex workers , youth, PLWA and orphans - Employers not discriminating against those with HIV	- Activity reports - Changes in existing laws / new laws - Instructions to police / social workers / employers - Survey among target groups, employers and employees	- Annual review - At beginning and end of three year implementation period	- Concerned authorities - Repr's of target groups - Programme management - Researchers
	7.1 One workshop per year at Zonal level on the issue of Orphans	- Number of workshops held - Number and origins / functions of participants per zone - Number of conclusions carried out	- Activity and financial reports of programme - Workshop reports - Activity reports of CC/TC's, field workers	- Twice a year - Per workshops - Review twice a year	- Programme management - Zonal CC/TC's - Trainers - Fieldworkers

CORDA

Results two old Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	7.2 Data collection, Situation Analysis and Identification of options for Orphans in 10 weredas of West Gojjam Zone	- Number of activities and studies carried out - Use made of data and information	- Activity and financial reports of programme - Reports of collection activities and studies done - Plans and progress reports of CC/TC's	- Twice a year - Per activity - Twice a year	- Programme management - CC/TC's - Researchers - Community groups
	7.3 Retracing and Reunification of Orphans through the trained counsellors	- Number of orphans reunified with relatives - Number of orphans still living with relatives after 6 months and one year	- Activity and financial reports of programme - Activity / follow-up reports of counsellors - Progress reports CC/TC's	- Twice a year - Quarterly - Quarterly	- Programme management - Counsellors - CC/TC's - Community groups
	7.4 Implementation of pilot project on support of the orphans in 3 selected Weredas in West Gojjam	- Pilot project carried out - Number of orphans taken care of - Use of knowledge gained	- Activity and financial reports of programme - Pilot project plan, progress and evaluation reports - Plans and progress reports of the three CC/TC's	- Twice a year - Quarterly - Twice a year	- Programme management - Community counsellors / educators - Community groups - Three CC/TC's
	7.5 Promotion of the establishment of the branch of "Dawn of Hope" Association in Bahir Dar or a similar Organization	- Branch of 'Dawn of Hope established - Number of PLWA member of branch - Activities and persons reached by branch - Members satisfaction	- Activity and financial reports of programme - Constitution and by-laws of branch / organization - Membership records - Activity reports of branch/organization - Survey among members	- Twice a year - At moment of recognition - Annual - Twice a year - Once a year / minutes general assembly	- Programme management - PLWA - Branch chairperson + members

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Results two old Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
8. Capacity Building: The capacity and involvement of Government and Social Institutions in Testing, Referral, Counselling and Care for the vulnerable individuals and groups (Orphans, PLWAs, etc.) is enhanced.		- Percentage of Zonal, Woreda and Kebele multi-sectoral annual plans carried out and addressing emerging issues and obstacles effectively - Number of testing – counselling centres with conditions for quality service - Percentage population, requesting HIV test, counselled, tested and receiving results	- Activity and financial reports of programme - Zonal, Woreda and Kebele annual plans - Zonal, Woreda and Kebele progress + financial reports - Activity / testing reports of centres - HMIS - Quality control survey report - HMIS - Population survey	- Twice a year - Annual - Quarterly - Quarterly - Quarterly - Once a year - Quarterly - Begin and end of 3 yr	- Programme management - CC/TC's at each level - Regional and Zonal Health authorities - Laboratory staff - Counsellors
	8.1 Organization of refresher courses for 73 trained TOTs	- Refresher course held - Number of participants - Training activities of the TOT's - Number of TOT's still active after 1,2,and3 years	- Activity and financial reports of programme - Workshop reports - TOT activity reports - Review in annual reports of Zonal TC and programme	- Twice a year - Per workshop - Quarterly - Annual	- Programme management - Zonal CC/TC's - Trainers - TOT's
	8.2 Organization of training workshop for 330 elementary school teachers	- Workshops held - Number of participants per school - Number of conclusions carried out	- Activity and financial reports of programme - Workshop reports - Plans and Activity reports of teachers - Zonal and Woreda education department plans / progress reports to CC/TC's	- Twice a year - Per workshop - Twice a year - Twice a year	- Programme management - Zone Woreda Education depart / office - Teachers - Trainers - CC/TC's
	8.3 Purchase of 4 ELISA machines for West Gojjam and Bahir Dar Zones	- Elisa machines purchased - Sero data available for monitoring and evaluation - Number of machines operation after 1,2 and 3 years - Quality of services - Percentage Population, requesting HIV test, counselled / tested at the hospitals and receiving results	- Activity and financial reports of programme - installation reports of elisa machines - HMIS - Activity / testing reports of centres - Quality control survey report - HMIS - Population survey	- Twice a year - Per hospital - Quarterly - Quarterly - Once a year - Quarterly - Begin and end of 3 yr	- Programme management - Reg. / Zonal Health Authorities - Hospital managemts - Lab. staff - Counsellors - Health staff referring patients

COPDA

Results two old Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	8.4 Purchase of Autoclaves and Centrifuge for Felege Hiwot Hospital	- Autoclave and centrifuge purchased - Quality of sterilzation and laboratory services	- Activity and financial reports of programme - Purchase and installation reports - Hospital reports - Quality control survey	- Twice a year - Once - Quarterly - Once a year	- Programme management - Hospital management - Lab/sterilisat. staff
	8.5 Purchase of protective materials	- Material purchased - Availability of protective materials during year (frequency and duration of time out of stock)	- Activity and financial reports of programme - Distribution reports - Hosp/ HC reports : evolution of stocks report - Survey on wards	- Twice a year - Per purchase - Quarterly - Once a year	- Programme management - Region/ Zone health auth/ - Hosp./ HC management - Ward staff
	8.6 Monitoring of the counselling system at the Hospitals	- Percentage of population, requesting HIV test, counselled, tested and receiving result - Pregnant women counselled and tested - Percentage of Health staff advising and referring patients to be tested - Quality of post HIV test counselling	- Activity and financial reports of programme - HMIS - Hospital user survey - HMIS - Antenatal service user survey - Hospital user survey and counsellor survey - Counsellor Observation study	- Twice a year - - Quarterly - Once a year - Quarterly - Once a year - Once a year - Once a year	- Programme management - Health authorities - Hosp. Mgt - Counsellors - Laboratory staff - Ward staff
	8.7 Support the Referral System at community level	- Evolution of support provided - Percentage of patients referred to higher level presenting themselves - Percentage of patients returning to their community facility with information of treatment received	- Activity and financial reports of programme - Review Hospital, health centre and clinic reports (HMIS) - Review Hospital, health centre and clinic reports (HMIS) - Population survey	- Twice a year - Quarterly - Quarterly - Begin and end of 3 yr	- Health authorities - Programme management - Health facilities managemts - Health staff

CRDA

Results two old Zones:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	8.8 Support single parent families to be re-united with extended families	- Evolution of support - Number of single parent families re-united with extended family - Number of single parent families still living in extended family after 1,2,and 3 years	- Activity and financial reports of programme - Review of contributions - CC/TC's reports - Community educators/ counsellors activity reports - Survey among target population	- Twice a year - Twice a year - Quarterly - Quarterly - Once a year	- Programme management - CC/TC's - Community educators / counsellors - Community groups
	8.9 Support the investigation and placement of single parent families (with no relatives) in supporting situation	- Evolution of support - Number of single parent families placed in support situation - Number of families still living in support situation after 1,2,and 3 years	- Activity and financial reports of programme - Review of contributions - CC/TC's reports - Community educators/ counsellors activity reports - Survey among target population	- Twice a year - Twice a year - Quarterly - Quarterly - Once a year	- Programme management - CC/TC's - Community educators / counsellors - Community groups
	8.10 Construction of counselling unit in Felege Hiwot Hospital (Bahir Dar)	- Counselling unit constructed - Number of persons counselled / tested - Quality of post test counselling services	- Activity and financial reports of programme - Progress and financial report of construction - Activity / testing reports - Counsellor observation study	- Twice a year - Quarterly - Quarterly - Once a year	- Programme management - Hospital and constructor - Counsellors/ laboratory staff
	8.11 Provide support to Civil Society Organizations for local initiatives to support PLWAs and their families	- Evolution of support - Initiatives developed and implemented - Number of PLWA /families assisted - Number of PLWA / families remaining in own community	- Activity and financial reports of programme - Review of support provided - Activity reports of civil society organizations - Survey among PLWA and families	- Twice a year - Twice a year - Quarterly - Once a year	- Programme management - Civil society organizations - PLWA and families - Community groups

CCRDA

Management results	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
9. Management: The established project office will have sufficient capacity to ensure proper implementation and sustainability of the programme.		- The programme is carried out according to plan, internal obstacles are solved before they affect progress, external obstacles are taken up with other partners as soon as possible - Activity and financial reports are produced in time to assist planning and evaluation	- Programme description - Programme time schedule - Quarterly and annual work plans - Activity and financial reports of programme - Plans and progress reports of CC/TC's - Review of report publication dates versus planning deadlines	- Once - Annual - Quarterly - Four times a year for internal use Twice a year for external use - Once a year	- Programme management - Programme staff - CC/TC's
	9.1 Employment of Project Co-ordinator	- Project co-ordinator employed	- Activity and financial reports of programme - Report recruitment proceedings - Performance reports	- Twice a year - After employment - Twice a year	- Programme management - Project co-ordinator
	9.2 Employment of project advisor (expatriate volunteer)	- Project advisor employed	- Activity and financial reports of programme - Report recruitment proceedings - Performance reports	- Twice a year - After employment - Twice a year	- Programme management - Project advisor
	9.3 Employment of accountant	- Accountant employed	- Activity and financial reports of programme - Report recruitment proceedings - Performance reports	- Twice a year - After employment - Twice a year	- Programme management - Accountant
	9.4 Employment of secretary /cashier	- Secretary / cashier employed	- Activity and financial reports of programme - Report recruitment proceedings - Performance reports	- Twice a year - After employment - Twice a year	- Programme management - Secretary/cashier
	9.5 Staff orientation training	- Training carried out - Number of participants - Number of resolutions carried out - Number of staff till on the jog after 1,2,3 years	- Activity and financial reports of programme - Workshop reports - Follow up reports / CC/TC reports - Review of staff evolution	- Twice a year - Per workshops - Twice a year - Twice a year	- Programme management - Programme staff - CC/TC's

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Management results:	Activities	Indicator	Means of measurement / verification	Report frequency	Responsibilities
	9.6 Establish Management Information Systems (MIS)	- MIS installed - Number of reports produced per year - Number of reports compiled in time for planning and evaluation purposes - Pertinence of data collected	- Activity and financial reports of programme - Plans and progress reports of CC/TC's - Review of report publication dates versus planning deadlines - Review of data collected in comparison to obstacles requiring solutions	- 4 times year for internal use / External publication twice a year - Twice a year - Twice a year	- Programme management - Programme staff - CC/TC's
	9.7 Participation to International seminars	- International seminars attended - Function of the participants(s) - Report to colleagues and other partners in programme - Use made of information /insight obtained	- Activity and financial reports of programme - Seminar attendance reports - Review of Management minutes - Review of CC/TC reports	- Twice a year - Per seminar - Twice a year - Twice a year	- Programme management - Staff who attended seminar - CC/TC's
	9.8 Employment of office support staff	- Support staff employed	- Activity and financial reports of programme	- Twice a year	- Programme management
	9.9 Purchase of vehicle for general use	- Vehicle purchased - Maintenance of vehicle carried	- Activity and financial reports of programme - Vehicle log books	- Twice a year - Quarterly	- Programme management - Drivers

CCRDA

10 Review, monitoring and evaluation	Activities	Indicators	Means of measurement / verification	Report frequency	Responsibilities
	10.1 Ongoing monitoring and Consultancies	- Monitoring reports compiled - Number of specific consultancies carried out - Number and nature of observations addressed - Number and nature of recommendations implemented	- Activity and financial reports of programme - Consultancy reports - Bi-annual recommendations - Bi-annual adjustments to priority setting and work plans	- Internal use 4 times - External publication 2 times a year - Per consultancy - Twice a year	- Programme management - Authorities - Consultants - Staff of programme
	10.2 Final Evaluation by Regional Line Bureau's	- Terms of Reference elaborated and agreed upon by all concerned - Evaluation carried out - Number and origin of evaluators - Recommendations to all parties concerned	- Activity and financial reports of programme - Terms of Reference documents - Evaluation report	- Twice a year - Per evaluation	- Programme management - Line Bureau heads - Line Bureau evaluators - Programme staff - CC/TC's
	10.3 Final external evaluation	- Terms of Reference elaborated and agreed upon by all concerned - External evaluation carried out - Number and origin of evaluators - Recommendations to all parties concerned	- Activity and financial reports of programme - Terms of Reference documents - Evaluation report	- Twice a year - Per evaluation	- Programme management - Authorities - CC/TC's - Programme staff

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