Mid-Term Evaluation Report (2011-2014)

HIV material and training to churches in Ethiopia - Financed by Norad, Digni and the Norwegian Bible Society and Implemented by the Bible Society of Ethiopia

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Acronym

A & B	Abstain and Be faithful
AAC	Anti-AIDS Club
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change Communication
BO	Branch Office
BSE	Bible Society of Ethiopia
CBO	Community Based Organization
CC	Community Conversation
CSA	Central Statistical Agency
CSWs	Commercial Sex Workers
CU	Church Unit
EDHS	Ethiopian Demographic Health Survey
FGD	Focus Group Discussion
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
FP	Family Planning
GME	Global Ministry of Exchange
GSP	Good Samaritan Project
HIV	Human Immunodeficiency Virus
HTP	Harmful Traditional Practice
IEC	Information, Education and Communication
IGA	Income generating activity
KAP	Knowledge, Attitude and Practice
KII	Key informant interview
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
NBS	Norwegian Bible Society
NGOs	Non-Governmental Organizations
OVC	Orphan and Vulnerable Children
PCP	Prevention and Control Program
PLHIV	People Living with HIV
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Children Transmission
RH	Reproductive Health
RHBs	Regional Health Bureaus
SMART	Specific, Measureable, Achievable, Realistic and Time bound
SRH	Sexual Reproductive Health
STD	Sexually Transmitted Disease
TAPI	Transparency, Accountability, Participation, and Inclusion
ToR	Terms of Reference
TOT	Training of Trainers
VCT	Voluntary Counseling and Testing
WoHOs	Woreda Health Offices Executive Summary

Executive Summary

Introduction

We the consultant team members are pleased to present the Evaluation Report of the BSE HIV/AIDS Prevention and Control Project (HIV PCP) which was funded by NBS from Digni and Norad. This report includes the findings, conclusions, and recommendations that the NHASCF evaluation team found during the course of the evaluation in December 2014.

Executive summary

Background

BSE/GSP implemented HIV prevention and control program since 2011 to date. During these times, the project played its role for the reduction of HIV prevalence in Ethiopia. Cognizant this fact, BSE and its back donor Norwegian Bible Society wants to evaluate the above mentioned program. This evaluation was aimed to identify the program's contribution for the reduction of HIV incidence and prevalence in the program areas and to see the whether the program achieved its predetermined outcomes.

Scope of the consultancy

The program was evaluated by taking Dire Dawa City as sample because BSE believed that the findings obtained from this area will best represent the BSE/ GSP HIV Program implemented in other parts of the country.

The program was evaluated using OECD-DAC and SCI criteria, i.e. accountability, impact, relevance, effectiveness, efficiency sustainability, quality.

Objectives of the Evaluation

The objective of the evaluation was to assess whether the project achieved its predetermined objectives efficiently and effectively. Furthermore this evaluation was aimed to see whether the project was relevant to beneficiaries and other stakeholders,. Assessing whether the project achieved the impact/outcome and the sustainability of the results were among the aims of this evaluation. Identifying the strengths, weakness, challenges and opportunities of the project were among the aims of this evaluation.

Program description

The project was the third phase and planned to be implemented from 2011-2015 which was financially supported by GSP. The immediate objectives of the project are: (1) o provide knowledge about AIDS and risky behaviour, (2) encourage VCT and sexual education, (3) eradicate stigma and restore human rights for PLWHA, (4) to renew the Church' social responsibility. BSE implemented the project in collaboration with the three main churches together (the Ethiopian Orthodox Church, the Ethiopian Catholic Church and the Evangelical Churches Fellowship of Ethiopia). The components of the project are IEC/BCC, ToT, social mobilization for VCT, eradication of stigma and discrimination, and sensitization of Church leaders and potential training of trainers from churches and church related organisations . The project was implemented in six regions of the country including Dire Dawa.

Methodology

This evaluation was conducted using the standard methods. The sample size was fixed purposely but the numbers of interviewees were clustered into different groups such as youth, women, congregation members, PLHIV, etc. After clustering, sampled respondents were randomly selected from the list provided to the evaluation team. Data were collected using both qualitative and quantitative tools. Sampled beneficiaries were interviewed using the structured questionnaire while stakeholder were asked using question guideline prepared for key informant interview and focus group discussions. Different documents, reports and secondary data were also referred. The results mentioned in the physical reports were triangulated by individual interview, key informant interview and FGDs. The quantitative data were entered to computer and analysed using SPSS V20 software.

Findings of the evaluation

1. In general the performance of the project can be said very good as almost all activities are accomplished above the plan.
2. The project was well designed but lacked log frame and has no documented base line data
3. The project was highly visible among the community members and outside them in the project areas

4. The project has contributed for behavioural change of the populations in the project areas.
5. The IEC/BCC materials were effective in conveying the HIV/AIDS prevention messages not only to beneficiaries but also other peoples who were not directly addressed by the project.
6. The project encouraged many people to take VCT and sexual education, but due to absence of data management system it is not easy to track this achievement.
7. The project played important role in reducing stigma and discrimination. .
8. The project was able to renew church's responsibilities in relation to playing their paramount role for the elimination of HIV and strengthening care and support services to these people.
9. With respect to financial management, BSE has well equipped accountant and there is inbuilt financial management system.
10. BSE does not having a separate M&E unit, and this activity is covered by the project manager.
11. The project has no phase-out strategy and plan.
12. The project partnership and cooperation with government and other stakeholder is strong.
13. In general; the evaluation results indicate that
    13.1 The project was relevant to the needs of beneficiaries, appropriate to the government organization
    13.2 The project was effective in addressing the desired stakeholders and beneficiaries.
    13.3 The project was efficient as it address many people with very low amount of money.
    13.4 The project has brought positive impacts and achieved its outcomes on beneficiaries and other community members particularly in respect of abstain among youth, reducing stigma and discrimination and renew church responsibility.
    13.5 Churches started to own the project in order to make the results sustainable.

Strength of the project

- The project works with church/congregation which is a good means to address mass population and helped to use influential persons.
- The strategy used such as community based organizations
- The Program ideas become parts of the church's teachings and will sustain in the future
- The use of volunteers as training facilitators
- The Program has been serving all people irrespective of their religion.
    - The use of school AAC as a learning media is the strength of the Program.
    - The Program mobilized many youth in different ways

Weakness of the Program

- Limited of budget was one of the barriers which made the Program unable to address the needs and expectations of the beneficiaries
- The program used printed materials and DVDs which needs to be updated in terms of language and proper terminology, and the DVDs do not consider the Ethiopian Culture
- Limited human labor
- Limited budget (compare to the work in the field)

Opportunities and challenges of the Program

- The church leaders and believers with different doctrinal background are willing to work on HIV
- The strong reputation of Good Samaritan program opens door to discuss with government officials at all levels
- Expectation of seating allowance from the community
- Resistance toward female trainers(in some community

Lessons learned, Best Practice and Recommendations

Lesson learned

- Properly designed project will facilitate the monitoring and evaluation process
- The existence of strong monitoring and evaluation will improve the performance of the project
- If there is commitment, it is possible to do a lot with little money

- Reputation of organization will facilitate the implementation of project activities
- Involving church leaders in HIV prevention activities will help to address many people and to make the project result sustainable.

Best Practices

The following are best practice taken as example among others

- The effort that BSE/GSP HIV Program did to persuade the non-Christian individuals in order to influence the community members to teach them about HIV prevention and control can be mentioned the best practice of the Program among others
- Culture of working together among different churches who used to be avoid each other
- The effort of BSE/GSP HIV Program in involving PLHIV as volunteer trainers best explained the seriousness of the existing problem to the community
- The strategy that BSE/GSP used to address vulnerable groups,
- Involving church leader in HIV/AIDS prevention activities,
- Management of low cost workshops

Conclusion

The project is found to be successful in achieving its objective when it is measured in accordance to OECD criteria. As discussed above the project was relevant, effective, efficient, has brought impact on beneficiaries and other community members and it is owned by churches for its sustainability.

Recommendation

We recommend the following points for this and other similar Program that will be developed and implemented in the future

1. BSE/GSP HIV Program should strengthen to receive feedback from partners and other stakeholders involved in the Program both at the time of their involvement and at a later date (for example, a year after their involvement) to assess and collect information on the Program's impact
2. It is paramount to conduct a baseline before designing a Program as done for community health need assessment and planning
3. The M&E system should be strengthen and the Program teams should be capacitated in monitoring and evaluation to improve the departments' performance

4. As there is only one branch coordinator more support should be given at branch offices level
5. The Program should strengthen its support on capacity building and experience sharing at all levels
6. The Program should allocate sufficient fund or should utilize the budget in a way it will bring change instead of dispersing in different regions here and there.
7. Program proposal should be prepared based on one of various methods that show indicators, of verification along with the achievable results on the target population.
8. The Printed materials should be updated and re written in different languages other than Amharic and Oromifa
9. In order to contextualize the messages the DVD drama should be done by Ethiopian young artists if possible in different languages
10. BSE/GSP HIV Program should prepare Program proposal with participation of potential beneficiaries and should made regular joint review meetings
11. BSE/GSP HIV Program should carefully design sustainability means and phase out strategy.
12. The beneficiaries and stakeholders should hear the independent evaluation report and their comments should be incorporated so that everyone will learn from previous problems and own the phased out Program

1. Introduction

1.1Background

Ethiopia is highly populated country and for the last ten years it has registered double digit economic growth. However, still more work is required to eradicate poverty from the country. With regard to health issue, it is to be recalled that Ethiopia was one of few countries where HIV prevalence was too high. But due to unreserved efforts of Government of Ethiopia, international community, and local and international non-governmental organizations, HIV prevalence rate was reduced by about 50% (from 2.4 in 2010 to 1.2 in 2014)[1]. The new incidence rate is also reduced by 90% (from 0.29% in 2010 to 0.03 in 2014)[2]. The introduction of ART and adherence of PLHIV in taking the drug, the mortality rate due AIDS was significantly reduced. EDHS (2011) and FHAPCO reports indicate that HIV knowledge among the population of Ethiopia is above 90% in major towns.

For all these remarkable results, the contribution of the aforementioned organizations was great. BSE/GSP HIV Program Ethiopia believes that its contribution in general for the above mentioned country results were significant. Its components of intervention such as raising the awareness of the Christian community regarding the prevention method of HIV, sex education, stigma and discrimination and the human rights and dignity of PLHIV had been viable.

Cognizant all these, NBS its back donor Digni and Norad for the Good Samaritan HIV Program Ethiopia wants to evaluate the Program which was implemented from 2011-2014. This evaluation was aimed to identify the Program's contribution for the reduction of HIV incidence and prevalence in the Program areas also to see the whether the Program achieved the predetermined outcome of the Program on direct and indirect beneficiaries by taking Diredawa City as sample.

This End evaluation report contains seven chapters including this background chapter. In the second chapter the scope and objective of the evaluation is explained. The third chapter describes the Program as it is to show the reader clue about the nature of the Program. Methodology is shown in the fourth chapter followed by the

[1] Single point HIV prevalence estimate 2007 and 2012, FHAPCO.

[2] Ibid

fifth chapter that shows the evaluation result of the Program. In the sixth chapter, the relevance, effectiveness, efficiency, impact and sustainability issue of the Program are explained. Finally, in chapter seven, conclusion and recommendation are shown.

1.2 Scope of the consultancy

As apparently indicated in the inception report, the evaluation was conducted in Diredawa. This is because the Bible Society of Ethiopia believed that the findings obtained from this area will best represent the GSP HIV Program implemented in other parts of the country.

The Program evaluated was implemented from 2011 to 2014 by BSE and during evaluation of this GSP HIV Program, the consultants took into account the OECD-DAC and SCI criteria, i.e. accountability, impact, relevance, effectiveness, efficiency sustainability, quality. The qualities of the implemented activities as well as their corresponding outputs including the effect of the Program on the day to day lives of beneficiaries were also evaluated. In addition to these, the ownership and sustainability of the established partnerships with various stakeholders as well as church contribution using the approach of the Program in building local capacity and upgrading the awareness were evaluated. The evaluation was guided by key questions designed on the basis of the terms of reference focusing on the aforementioned criteria

1.3 Objectives of the Evaluation

The evaluation was conducted in Diredawa covering the accomplishment of the activities and results of project period 2011 -2014, as detailed on the project document. The main objective of the evaluation was to assess whether the project achieved its objective as mentioned in the project document, and to answer the questions related to relevance, effectiveness, and efficiency of the project. Also, this evaluation aimed to assess whether the project has brought the desired impact/outcomes among the community members in the project areas and the sustainability of the results achieved after the project phase out. Furthermore, this evaluation aimed to identify the strengths and weakness of the project, lesson learned and challenges faced. Based on the findings, this evaluation was expected to forward recommendation for future projects.

2. Program Description

This is the project document and application for funding by Digni through the NoBS Norway for a third phase, 2011-2015, of the Bible Society of Ethiopia's HIV programme – 'Where is the Good Samaritan Today?' Since its start in 2006, it has successfully increased the churches and church related organisations commitment in the fight against the pandemic, to raise awareness and reduce the stigma associated with the disease for those infected and affected. The quality of the work has been recognised by the national authorities and was also highlighted in an evaluation made by Norad in 2008.

The Bible Society of Ethiopia, the Norwegian Bible Society and the HIV service is part of Global Ministry of Exchange (GME) in United Bible Societies. The spread of HIV is complex and relates to various aspects and dimensions of society. The strength of the United Bible Society is in the area of Information, Education and Communication. This is also the focus of the Good Samaritan Programme that combines the rich story telling tradition of many cultures in Africa with Bible based materials using both traditional communication methods and new media in interactive training sessions to promote change in attitudes and behaviour. The 'Training of Trainers approach (ToT) ensures the sustainability of the programme, and engages key leaders as facilitators in the churches/ communities disseminate the message through workshops with local church and community groups.

Since the start of the Good Samaritan Programme in two countries in 2004, it is today present in more than 20 countries in Africa. Each of the country programmes are implemented by the national Bible Society together with its member churches and other partners. We believe in the churches as an enabling environment. The country wide presence of the churches gives them an enormous potential to make a difference and act as supportive environment for sustainable results. The Bible Society of Ethiopia has made considerable efforts to bring the three main churches together (the Ethiopian Orthodox Church, the Ethiopian Catholic Church and the Evangelical Churches Fellowship of Ethiopia). The HIV Service in UBS has a supportive role to the programme: to develop the methodology, promote learning and sharing, and monitoring and control of the quality of the country programmes.

The development goal of the Good Samaritan programme is 'to contribute to the reduction of the spread of HIV and AIDS and the stigma of people infected by means of adequate material, training and awareness creation'. The immediate objectives are: (1) To provide knowledge about AIDS and risky behaviour, (2) Encourage VCT and sexual education, (3) Eradicate stigma and restore human rights for PLWHA, (4) To renew the Church' social responsibility. Sensitization of Church leaders and potential train the trainers from churches and church related organisations play a key role in reaching the primary target groups: youth groups, women groups, and leaders within the local community. People living with HIV and AIDS (PLWHA) play an important role in developing the material and takes an active part as resource persons in the training events.

The main focus of this third phase of the Good Samaritan programme is to: consolidate the work in the existing three regions; expand to six new regions, and to work together with the member churches to diversify the sources of external sustainability of the programme beyond the external funding from Norway. The total budget the five year period 2011 – 2015 is 6.4 M NOK.

3. Goals and Objective

The development goal of the Good Samaritan programme is 'to contribute to the reduction of the spread of HIV and AIDS and the stigma of people infected by means of adequate material, training and awareness creation'. The immediate objectives are: (1) To provide knowledge about AIDS and risky behaviour, (2) Encourage VCT and sexual education, (3) Eradicate stigma and restore human rights for PLWHA, (4) To renew the Church' social responsibility. Sensitization of Church leaders and potential training of trainers from churches and church related organisations play a key role in reaching the primary target groups: youth groups, women groups, and leaders within the local community. People living with HIV and AIDS (PLWHA) play an important role in developing the material and takes an active part as resource persons in the training events.

4. Methodology

Handling this specific consultancy work counts on basic methodology of integrated and participatory approach with a wider perspective of involving representatives of all stake holders at all levels. Such approach is believed to give the chance of having inputs from wider perspective in one hand, and development of ownership feeling to the extent of sharing responsibilities on the other.

Thus, with clear understanding of the objectives and scope of the consultancy work, the consultant team pursued the following methodology to gather quantitative and qualitative data for evaluation.

4.1 Preparing inception report

The inception report was prepared as it was the first and important activity that should be done prior to starting any activity related to the evaluation. As indicated below, the inception report showed the detail activities with their respective milestones, the types of instruments to be used, sampling method as well as data collection methods to be followed.

4.2 Document review

The consultant team gave due emphasis for reviewing of project document as it greatly helped to understand the project components, subsequent achievements, and also challenges associated with project implementation. Based on this understanding consultant team reviewed various project documents (including but not limited to the final version of the project document, the log-frame, and the Project Monitoring Plan, and other progress activity/financial reports).

4.3 Developing Data Collection Instruments

During evaluation four types of data collection instruments were used to gather quantitative and, qualitative data. To gather quantitative data from 123 expected interviewees were interviewed using structured questionnaire.

The second data collection instrument that was used during evaluation was semi-structured questionnaire in order to conduct in-depth interview with key informant interviewers. The key informant interviewee were pertinent staff who were drawn from relevant organizations including BSE.

The third data collection instrument that was used was a question guide for focus group discussion. This instrument was used to gather opinion and information from

group members who were drawn from different stakeholders that they represent. A total of 6 FGD sessions were held (i.e. two in selected kebeles:).

The fourth instrument that was developed and was used was observation check list helped to gather data regarding the material usage and content.

The fifth instrument that was planned to use was the success story that would be selected from individuals. Unfortunately, the consultant team due to the time constraint could not include success story but the stories we read noted on the annual reports to Digni had been impressive.

All information obtained through these instruments shall be triangulated in order to get strong evidence regarding the project's performance. As necessary, success stories shall be collected.

4.4 Sampling

As indicated in the inception report and technical proposal, 123 interviewees (41 from each kebele) were selected for the interview. These individuals were selected using systematic random sampling technique. The sample size was determined using the following statistical formula[3].

Taking "N" as number of individual respondent of in all organizations estimated as:

$$N = \frac{Z^2 * P(1-P)}{d^2}$$

Where:-

N = required sample size

P = proportion of respondents with the population of interest, which is 50%

1-P= the proportion of the remaining population 50%

Z = Confidence limit, which is usually at 90% level or 1.282

d = Margin of error level and usually estimated as 10% or 0.1

[3]This calculation is made with an assumption that 1,000 HHs are living in a kebele

5. Intended users of the evaluation

The intended users of this evaluation will be BSE and its subsidiaries, GSP and other stakeholders including government and non-government organizations, community based organizations and beneficiaries, among others. In addition, findings will be shared with stakeholders and a broader group of interested partners working in the area of HIV/AIDS prevention and control.

It is hoped that the good practices and lessons learned will be used by BSE, GSP and relevant stakeholders for the development, implementation and monitoring of HIV/AIDS Prevention and Control Project. The evaluation results will help in due course of designing and implementation future HIV/AIDS Prevention and Control projects.

6. Evaluation framework

This evaluation is summative evaluation as it is conducted towards the end of the project in order to determine the extent to which anticipated outcomes were achieved and to provide information about the worth of the project. Sometimes such evaluation is called impact evaluation in that it assesses the extent to which anticipated outcomes were achieved at the end of a planned intervention and making judgmental as to its worth (Rist & Kusek, 2004). The evaluation focused on implementation processes and the achievements of outcomes in each intervention context. Due attention was given to these contexts in interpreting the findings, identifying the lessons learnt and forwarding some recommendation for future implementation of similar projects.

Modern evaluation theories encourage evaluators to apply basic methodology of integrated and participatory approach with a wider perspective of involving representatives of all stake holders at all levels. Such approach is believed to give the chance of having inputs from wider perspective in one hand, and development of ownership feeling to the extent of sharing responsibilities on the other. Accordingly, the Evaluation team used the evaluation framework shown below and based on it different methods were designed and implemented to gather the necessary data.

Evaluation framework[4]

[4] Adopted from Learned Based on CDC Framework for Program Evaluation in Public Health, 1999

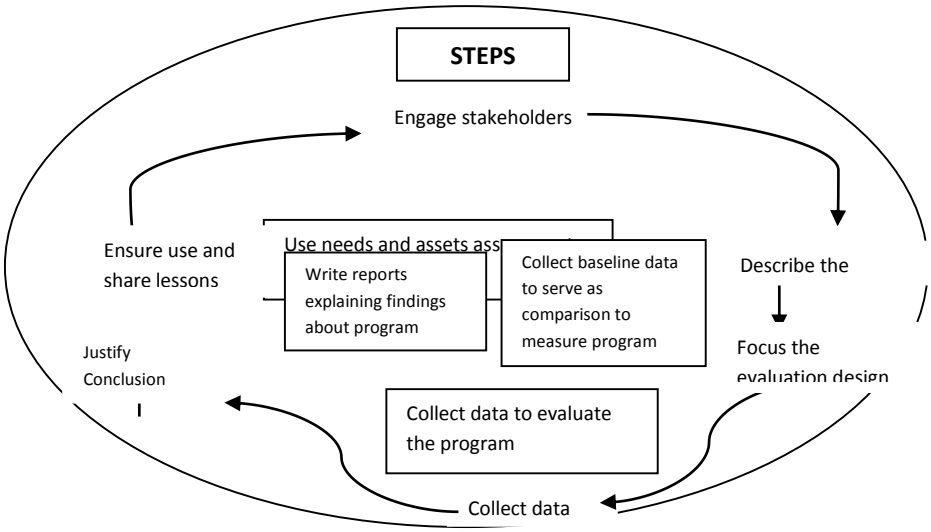


Figure 1: Evaluation Framework

This framework is important in improving the evaluation of health promotion and disease prevention programs particularly HIV/AIDS because:

- It provides guidance on how to write an evaluation plan
- It specifies some agreed parameters for good evaluation, for example, identifying a good study design for impact evaluation
- It specifies an agreed list of indicators ('the indicators'), which allows comparison of the impacts and outcomes of different programs.

7. Literature Review

7.1 Knowledge, Attitude and Practices of HIV and AIDS among the people of Ethiopia

It is apparent that HIV is transmitted mainly due to the unsafe sexual intercourse made by two sexual partners. In developing countries especially in Sub-Saharan Africa countries unsafe sex is prevalent.

Studied conducted on HIV/AIDS behavioral surveillance survey in different countries including Ethiopia indicate that many people have knowledge how to prevent themselves from HIV infection. However, among these people only few of them have comprehensive knowledge of HIV/AIDS. Women, in particular, have much lower knowledge of comprehensive knowledge of HIV/AIDS as compared to males. In other words, many people have misconception about HIV/AIDS transmission. These people believed that HIV will be transmitted from one person to another person by eating of raw meat prepared by HIV infected person, by eating uncooked egg laid by a chicken

that has swallowed a used condom, by mosquito bite, and by sharing a meal with an HIV infected person. These people again believed that any person can protect him/herself by consuming local hard liquor and hot pepper, a healthy looking person cannot have HIV in his/her blood' and the lubricant in condoms carries the virus (Alemayehu, 2007).'

According to EDHS (2011), above 95% (except Somali Region which is 82%) of the sampled interviewed individuals in the whole Ethiopia declared that they heard about HIV/AIDS. Even those people who are illiterate and assumed that they are far from information as compared to individuals who can read and write and above, 95% of them heard about HIV/AIDS. However, with respect to the knowledge of HIV prevention methods, only a little bit above 50% of the respondents know that it is possible to reduce the chance of becoming infected with HIV by limiting sexual intercourse to one uninfected partner who has no other partners and using condom. In this regard, the percentage of males who know both ways to reduce HIV risk is higher than females. The document further indicated that around 71% of the total interviewed individuals know that a healthy-looking person can have HIV. In spite of all these, according to EDHS (2011), only 18.5% of women and 31.1% of males have comprehensive knowledge about AIDS (CSA, 2011).

This indicates that even if the population of Ethiopia has high level of awareness about HIV, many people lack adequate know-how about HIV preventions and transmission as well as have misconceptions and. Similarly, the preliminary findings of the round two Behavioral Surveillance Survey (BSS) reveals that despite the high level of awareness about HIV/AIDS (more than 98 %), only about 55 % knew all the three methods of HIV prevention (abstinence, faithfulness and use of condoms--the ABC principles). A study conducted in Gambella town discloses that among the total 359 interviewed individuals, only 0.9% knew about mother to child transmission despite the fact that about 10% of new HIV infections in Ethiopia accounts for mother-to-child transmission (Yusuf, 2007).

With respect to practice, among males who have more than one sexual partner, 16% of them used condom during their last 12 months before interview (CSA, 2011).

7.2 Effectiveness of IEC/BCC

Studies conducted on the effectiveness of IEC materials in reducing HIV new infection and stigma and discrimination among people who are living in specific community indicate that there was remarkable improvement in knowledge and awareness in all the types of interventions and it sustained till the time of follow-up in all the four groups (Raizada & Somasundaram, 2004), also reduction in coercive attitude and avoidance behavior was observed after the dissemination of the IEC materials because they improved interpersonal communication among the people, created forums to discuss people on HIV/AIDS in group there by stigma and discrimination that were existed before were significantly reduced.

Information, Education and Communication (IEC) and Behavioral Change Communication (BCC) are strategies used by the Ethiopian Federal Ministry of Health (FMOH) to improve awareness and reduce HIV/AIDS related stigma and discrimination. Hence, IEC interventions like interpersonal communication, pamphlets and educational video movie or the combination of the three have been developed and implemented to improve awareness and reduce HIV/AIDS related stigma and discrimination. The study conducted in Addis Ababa, Ethiopia to assess the perceived sufficiency and usefulness of HIV/AIDS information, education and communication (IEC) messages and materials as well as to identify preferences for IEC sources and methods showed that over three quarters of the respondents believed in the usefulness of IEC. Findings from BSS round two in Ethiopia revealed that knowledge of prevention methods increased with increasing exposure to HIV/AIDS messages in various media sources (radio, TV, and printed media).

Even though in Ethiopia, there are research gaps regarding the magnitude and predictors of HIV/AIDS related stigma and discrimination and effectiveness of IEC interventions to achieve the desired changes in high school adolescents, there are few studies that were conducted in different parts of the country. Among these studies, a study conducted at Hawssa Town can be cited. This study, aimed to explore magnitude and predictors of HIV/AIDS related stigma and discrimination and more specifically the effectiveness of IEC interventions in reducing these attitudes among high school adolescents in Hawassa Town. The information generated from this study

will enable designing appropriate IEC interventions to reduce HIV/AIDS related stigma and discrimination in Hawassa and other similar settings (Bekele & Ali, 2008).

7.3 Can abstinence reduce the chance of getting HIV

Studies done on the abstinence only programs reported two opposite findings. Some studies found that a pledge of abstinence was the factor most associated with a delay in initiation of sexual activity. The research further identified that teens who take a pledge to remain virgins until they marry are much less likely to have sexual intercourse than adolescents who did not take the pledge. However, the study also found that the pledges were effective only when taken as part of a minority[5], although not too small, group. It appears that pledges of virginity have particular power only when those making the pledge feel they are part of a select group. The implication is, of course, that such pledges would not be effective for whole populations of students in any school or community.

These studies further indicated that teens cite moral and religious beliefs as significant factors in not engaging in sex, and that "[a]adolescents who are more religious hold more conservative views regarding sex." In addition, the studies found that "religious" young people are more likely to delay having sex. The study results point out that for many young people, a message emphasizing particular traditional and religious values can be powerful and positive. It must be remembered, however, that such messages will not resonate with some young people and that it would be unconstitutional to teach religion in schools. On the other hand the study conducted on program called postponing sexual involvement found that students enrolled in this program and who received instruction from peers were *more likely* to report becoming pregnant or causing a pregnancy. The study concluded that the program had no measurable impact on the initiation of sex, the frequency of sex, or the number of sexual partners (Collins, Alagiri, & Summers, 2002).

According to the study done by Feleke Doyore and Dube Jara (2014) messages communicated on HIV/AIDS prevention methods encouraged college students response in hierarchical order of abstinence, faithfulness and condom. Relative to other methods of prevention of HIV/AIDS college students' danger control responses

[5] Minority in this case refers to smaller group as opposed to larger group

towards abstinence is low even though being in danger control encouraged abstinence. The method used to convey messages to beneficiaries for whom the message is developed determines (a) the acceptance of the message by the beneficiaries and (b) the effectiveness of the message to bring behavioral change among the beneficiaries.

The above mentioned authors recommended that colleges, message developers, HIV/AIDS prevention and control offices, researcher and any organizations working in the area of HIV/AIDS prevention should follow the following recommendations.

• Large number of college students do not have comprehensive knowledge about HIV/AIDS prevention and transmission methods. So, intensified IEC campaigns focusing on misconceptions of HIV transmission and prevention should be undertaken particularly among young peoples.

• Further efficacy oriented messages in relation to abstinence and mythical beliefs should be promoted.

• Messages focusing on facts with reasons, comic jocks and entertaining should be promoted for this young people.

• Health personnel, schools/teachers, religious leaders and PLWHA should be involved to be persuasive communication for convincing the students.

• Fear appeal should not be used for the promotion of HIV/AIDS messages

• Should have continuous IEC/BCC intervention programs since low perception of susceptibility and severity was observed.

• Further studies, using the same model, should be conducted on the effect of communication factors on message response of whole behavior helps explicitly tailor the messages (Doyore & Jara, 2014).

From these studies it is possible to understand that abstinence will be effective among young adults as long as they are communicated very well through different IEC/BCC materials that contain messages related to moral and religion as well as ways to resist peer pressure.

7.4 Stigmatizing and Discriminatory attitudes

Stigma is nothing but it is an attitude that discredits and reduces from the population by tainting him/her due to any reason that happened on him/her. Stigma can result

from a physical characteristic, such as the visible symptoms of a disease, or from negative attitudes toward the behavior of a group. Stigma is not unique to HIV/AIDS, but has been documented with other infectious diseases like tuberculosis, syphilis, and leprosy and non-infectious diseases like mental illnesses. Stigma is most frequently associated with diseases that have severe, disfiguring, incurable, and progressive outcomes, especially when modes of transmission are perceived to be under the control of individual behavior.

Stigma encourages the development of discriminatory attitudes or prejudice. These attitudes are then often expressed in discriminatory behavior that draws attention to and reinforces the stigma.

Often times PLWHA are believed to deserve the disease since they have done something that is considered 'wrong' by society, such as adultery or being 'promiscuous'. Hence, they become the focus of gossip and rumors, segregated in schools, refused employment and housing, denied the right to marry, rejected by their communities and families, and even killed because of their HIV positive status.

Stigma is described as occurring when four interrelated components: distinguishing and labeling differences; associating human differences with negative attributes; separating 'us' from 'them'; and status loss and discrimination converge in the context of social, economic, and political power.

Discrimination, on the other hand, is treating a person unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. Stigmatization often leads to discrimination, which refers to any form of distinction, exclusion, or restriction affecting a person by virtue of a personal characteristic.

It is important to understand that stigma and discrimination exist in a vicious cycle (Bekele & Ali, 2008).

Widespread stigma and discrimination towards PLHIV can adversely affect both people's willingness to be tested for HIV and their adherence to antiretroviral therapy. Thus, reduction of stigma and discrimination is an important indicator of the success of programmer to prevent and control HIV/AIDS.

From this perspective individuals were asked if they are willing to care for a relative sick with HIV in their own households, if they would be willing to buy fresh vegetables from a market vendor who had the HIV, if they thought a female teacher who has the

HIV but is not sick should be allowed to continue teaching, and if they would want to keep a family member's HIV positive status secret. According to DHS (2011), most women and men age 15-49 (82%f and 93%m) would be willing to care at home for a relative with AIDS. Three women 15-49 of every ten (32%) and about five men 15-49 in every ten (47%) would buy fresh vegetables from a market vendor with the AIDS virus, and six women of every ten (59%) and seven men of every ten (70%) believe that an HIV positive female teacher who is not sick should be allowed to continue teaching.

More than half of respondents (59%f and 66%m) would not want to keep secret the fact that a family member is infected with HIV. Overall, men are more likely than women to express accepting attitudes regarding all four situations (28% compared with 17%) (CSA, 2011).

The Botswana AIDS Impact Survey conducted in the year 2001among adolescents showed that many of the adolescents expressed negative attitudes towards people living with HIV/AIDS. It was also revealed that misconceptions about HIV transmission often encourage stigmatization and discrimination of people living with HIV/AIDS.

Interestingly, although the majority of the adolescents stigmatize and discriminate against PLWHA, many of them are willing to care for a family member who has HIV/AIDS. But the study did not address the IEC material to be used to reduce the problem among the adolescents (Bekele & Ali, 2008).

Many studies conducted in Ethiopia, Zambia, Hong Kong Chinese, Uganda, Tanzania and Burundi indicated that stigmatizing attitudes and discriminatory behavior were found to pervade all spheres of life from home, the family, the workplace, the school, the health settings and in the community at large. Because HIV is associated with 'immoral behavior' and sexual promiscuity, PLWHA are often blamed for their condition and denied the sympathy and support given to people with other life threatening diseases These studies further indicated that HIV/AIDS related stigma and discrimination clearly depicted the causes, manifestations and consequences of the health and social problem among the study participants in the general population.

All forms of stigma may be illegal, particularly when they create discriminatory workplace environments or result in discriminatory actions, such as firing or rejection. Any form of stigma can be painful, regardless of how it is perceived. Stigma can take

the form of blame, rejection, exclusion, repulsion, ostracism and degradation (Bekele & Ali, 2008).

7.5 HIV and AIDS related Stigma and discrimination and Gender

In many developing countries, women are experiencing more of each form of stigma than men. They are often economically, culturally and socially disadvantaged and lack equal access to treatment, financial support and education. In a number of societies, women are mistakenly perceived as the main transmitters of sexually transmitted diseases (STDs). Together with traditional beliefs about sex, blood and the transmission of other diseases, these beliefs provide a basis for the further stigmatization of women within the context of HIV and AIDS. HIV-positive women are treated very differently from men in many developing countries. Men are likely to be 'excused' for their behavior that resulted in their infection, whereas women are not. Women and girls are disproportionately affected by these forms of victimization that are compounded by gender-based discrimination (Bekele & Ali, 2008).

Stigma also deters people from being tested or even using condoms for fear of being 'branded' as HIV positive. It is also expected that misconception of HIV transmission and prevention and stigmatizing as well as discriminatory attitudes hamper the uptake of VCT utilization. This affects the preventive measures of the epidemic. The study conducted in Nigeria on predictors of HIV Stigma in two populations indicated that those with misconception of routes of HIV transmission are less likely to use voluntary counseling and testing services. In terms of impact of stigma on the likelihood of accessing the use of voluntary counseling and testing services, the study shows that as the score for negative feelings increases, there is less likelihood that one will use VCT. The same response pattern is observed in the case of coercive policies. However, those respondents with higher scores of avoidant behaviors and attribution of blame are more likely to use VCT services than otherwise. In addition, it leads to challenges for HIV prevention efforts. Fear of negative social consequences of a positive HIV test result can deter some persons from getting tested (Bekele & Ali, 2008).

7.6 Community mobilization for counseling & testing

Community mobilization in HIV/AIDS refers to the deliberate soliciting of community support, involvement and action in response to HIV/AIDS. It is based on the belief that communities have in them untapped or under tapped abilities (social capital) which could enhance or accelerate the interventions in prevention, care and support. Communities should be involved in the effort of response to HIV/AIDS because it is a matter affecting them and when they are invited to be involve they feel honored and respected, from their involvement in interventions they will have better knowledge not only about the epidemic but also how to prevent themselves from infection and how to treat the infected person, it will help to reduce stigma and discrimination ((PACANet), n.d.).

Community mobilization engages all sectors of the population in a community-wide effort to address a health, social, or environmental issue. It brings together policy makers and opinion leaders, local, state, and federal governments, professional groups, religious groups, businesses, and individual community members. Community mobilization empowers individuals and groups to take some kind of action to facilitate change (CDC, n.d.).

Voluntary counseling and testing (VCT) is a corner stone for successful implementation of prevention, care and support services among HIV negative and positive individuals. VCT is also perceived to be an effective strategy in risk reduction among sexually active young people (Charles, et al., 2009). VCT consists of pre-test counseling by a trained counselor, followed by HIV antibody testing for consenting individuals and a counseling session during which results are given. Those who test positive are referred for care and treatment. In high-prevalence settings in sub-Saharan Africa, conventional approaches to VCT that rely on self-presentation do not reach enough people to meet public health goals. The reasons behind the limited uptake of HIV testing are complex. A Zimbabwean study noted that inconvenience of clinic hours (25.6%), location (20.7%), and cost (8%) were the primary deterrents (Morin et al. 2006). In Kenya, 46% of young people who wanted to get tested could not do so because of the lack of proximity to a testing center (Centre for the Study of Adolescence 2003). However, other studies suggest that even once availability is improved, uptake may remain limited. Persistent concerns regarding stigma,

discrimination and the fear of positive results remain barriers to VCT in many high-prevalence settings (Negin, et al., 2009).

Countries like Uganda have registered successful implementation of community prevention programmer due to community involvement and participation where different community support groups such as PLWHIV are utilized in mobilizing communities18. Community mobilization initiatives can be successful if they use already existing resources (Shumba, et al., 2013). Thus, community mobilization is innovative and effective way to increase the VCT clients

8Findings of the Evaluation

8.1 Evaluation of Program Design

Efforts were made to assess the quality of the Program proposal and the strategies designed in terms of whether they were well-conceived; relevant and responsive to the needs of target groups; validity of Program objectives and how effectively the needs of the beneficiaries have been addressed by the Program.

The Program proposal indicates that the objectives of the Program were formulated on the basis of the purpose. Interventions were also developed based on the purpose, objectives and strategies mentioned in the Program proposal. In addition to these, as the Program's objectives and strategies were in consistent with the Federal Democratic Republic of Ethiopia HIV/AIDS policy and strategy. Thus, the Program was designed with a view to supplement the Ethiopian government's efforts to the response to HIV/AIDS.

In general, the Program proposal meets the standard and took into account the need for strengthening the teaching about HIV/AIDS and sexual education youth, women, PLHIV and church leaders. It also consider churches to play their paramount role in response to HIV/AIDS.

In spite of these strengths of the Program, the Program proposal had the following weaknesses:

a) ***Though the Program has log frame*** which is a tool that has a power to communicate the essential elements of a complex a Program clearly, succinctly throughout the Program life cycle and helps to develop the overall design of the Program, improve the Program implementation and monitoring as well as to strengthen periodic Program evaluations some of t**he outputs and outcomes**

mentioned in the log frame are not SMART as no number or quantity/quality was mentioned for each output and outcome. These unable us to see whether the Program achieved or on the way to achieve the predetermined output as well a government.

b) **The Program did not have baseline data:** Even if the Program was a continuation of the previous Program and evaluation was done for the previous Program, no base line data was prepared for each output. As a result of this, it becomes difficult to compare performance of the Program against the base line and to forward possible recommendation

8.2 Evaluation of Program Implementation

The BSE HIV Program was funded by Digni and Norad through the Norwegian Bible Society and implemented since 2011 and it is expected that the current phase of funding will ends in 2015. As indicated in the Program proposal, the Program has four main interventions and the performances of the program are discussed below.

8.2.1 Visibility of the Program

The first and most important activity in Program implementation is magnifying the visibility of the Program to beneficiaries and stakeholders because without which it is difficult to accomplish activities to achieve the Program's objectives.

From this perspective, the Program had made extensive effort to introduce the Program to beneficiaries and stakeholders from grass root level up to the high level authorities.

Among those respondents who were asked about BSE/GSP HIV Program 93% (57%f) said that they know the Program. These individuals were asked how they could know about the BSE/GSP HIV Program and 96% (58%f) of the interviewed individuals said that they could know about BSE/GSP HIV Program through the training provided by BSE/GSP HIV Program.

Similarly, many of the people who were participated in KII and FGD told that they know the Program and its activities because of BSE DireDawa Branch invited and provided them TOT, school mini-media, posters and presentation done at schools, As the BSE DireDawa Branch coordinator explained, he and his colleagues invited people from church leaders and servants from different denominations, government

organization authorities, youth association leaders, Anti-AIDS Club leaders, etc and introduced about the Program and through these individuals and institutions they could address many people who did not have any idea about BSE/GSP HIV Program. Starting that time, according to his explanation, the Program was known among many people in DireDawa town. During field visit, it was observed that the Program was widely known by the residents of DireDawa. In general, it is possible to conclude that the Program was successfully visible among beneficiaries and stakeholder at all levels.

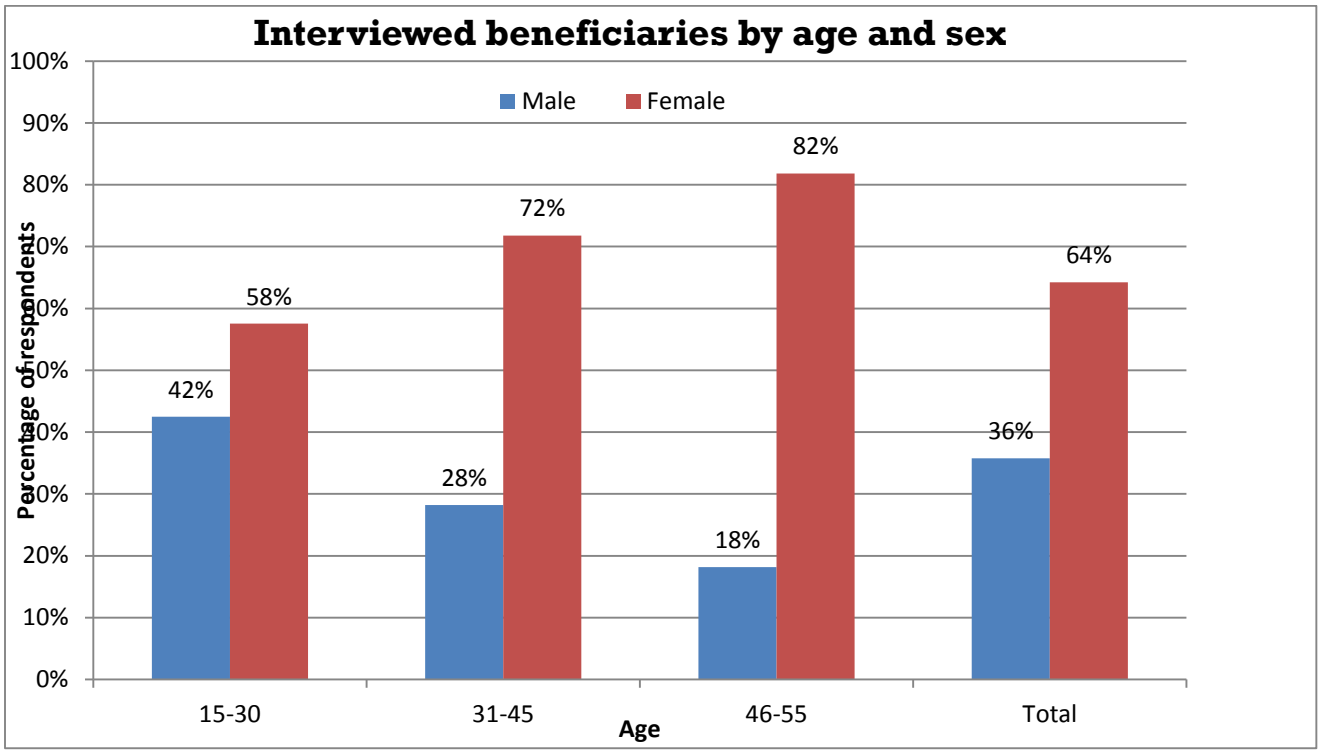
8.2.2 Relationship and Collaboration with Stakeholders

The Program has implemented its activities in collaboration with government and non-government organizations, churches, school AACs and others. Those individuals who participated in KII and FGD told that they have good relationships with the BSE Dier Dawa Branch and colleagues of BSE/GSP HIV Program at all levels and they work in collaboration for the achievement of the Program objectives. This indicates that BSE HIV Program had good relationship with stakeholders and partners.

The other important aspect that should be acknowledged is the personal commitment and communication capacity of BSE/GSP HIV Program Head Office Coordinator, DireDawa BSE Coordinator and DireDawa BSE/GSP HIV Program Coordinator. The above mentioned good quality of these staff enhanced the partnership and collaboration of stakeholders. Thus, it can be concluded that though the established relationship and collaboration with stakeholders is good, it was based on personal communications of the above mentioned staff. Also, there was not joint planning in designing the Program with stakeholders.

8.2.3 Demographic data of interviewed beneficiaries

Figure 2: Respondents by age and sex



The above figure show that the evaluation team interviewed 123 (36%m 64%f) individuals whose age ranges from 15 to 55. the majority of respondents (59%) are found in the age range of 15-30.

Table 1: Respondents by educational status

Sex of the respondent		Educational status of the respondent						Total
		Unable to read and write	Able to read and/or read only	Completer 1-4 grades	Complete 5-8 grades	Complete 9-12 grades	Graduate in Diploma and above	
Male	Count	0	0	1	0	11	32	44
	% of Total	0.0%	0.0%	.8%	0.0%	8.9%	26.0%	35.8%
Female	Count	1	2	0	7	30	39	79
	% of Total	.8%	1.6%	0.0%	5.7%	24.4%	31.7%	64.2%
	Count	1	2	1	7	41	71	123
	% of Total	.8%	1.6%	.8%	5.7%	33.3%	57.7%	100.0%

Table 1 above shows that among the interviewed individuals, around 58% (32%f) were graduates of Diploma and above followed by those beneficiaries who completed 9-12 grades.

With respect to religious category, 49% (34%f), 32%(22%f), 10%(6%f) and 8%(2%f) were Ethiopian Orthodox, Ethiopian Evangelical church, Muslim and Ethiopian Catholic Church members respectively.

As long as the employment status concerned, 46%(29%f) of the respondents were salary employed, 6%(3%f) were self-employed, 4% (2%f) were church/mosque servants, 9% (4%f) were unemployed and 36% (26%f) were students and engaged in different occupation other than mentioned above.

8.2.4. Performance of the HIV PCP

The performance of BSE/GSP HIV Program up to the mid of 2014 is presented in Table 1 as follows. The annual reports, 2011- 2013 obtained from NBS project office indicate that BSE/GSP HIV Program could produce and distribute 16,723 Good Samaritan booklets, 158 take charge booklets, 1,357 Resource Manuals, 336 Flipcharts, 1,183 who is Responsible DVDs and 1,174 do not bother us DVDs. In addition to this, the Project provided ToT for 4,150 (1905f) to different beneficiaries who were drawn from different church denominations, mosque, youth association, PLHIV associations, etc. Furthermore, through DW, nearly 40,000 (nearly 19,000f) were reached.

Openness is the second objective and intervention of BSE/GSP HIV Program and this objective was achieved through Community mobilization for counseling & testing. According to the 2011- 2013 reports, more than 80% of the Program participants did VCT as compared to nearly 15% of them prior to the program intervention. Therefore, the desired openness in the community achieved in the areas of our intervention given and the community started to talk about HIV and the silence also broken. Moreover, 78.2 % of the participants supported the idea of discussion on sexual issue with children towards sexual maturity. The BSE/GSP HIV Program was successful in this regard.

Eradication of stigma and discrimination towards people living with HIV was the third objective and intervention of the Program. In order to achieve the aforementioned objective the project made awareness in the community how stigma and discrimination PLHIV and also explained the indirect contribution of stigma and discrimination for the spread of HIV in the community. As the result, in the areas where the intervention was implemented the degree of stigma and discrimination reduced

at significant level. According to 2013 and mid-2014 reports, among the participants during pre-workshop survey 78.6 %, and 75% of them exhibited the attitude of stigma and discrimination towards PLHIV but after the end of the workshops, the post-workshop survey revealed that 92 % and 100% of the participant changed their attitude toward PLHIV respectively. The last intervention was renewing church/community social responsibility. The 2013 and 2014 reports revealed that most churches are engaged in awareness creation activities, most churches are integrated Good Samaritan activities in their daily routines, and renewed their social responsibility towards people who affected and effected by HIV/AIDS. As a result of this; churches took roles in comforting and supporting people who are affected. Almost all church leaders who participated in Good Samaritan workshop extended the intervention into their respective churches.

In fact, as clearly mentioned earlier, the Program did not have baseline data and it is impossible to measure whether the Program achieved above or below the target. With regard to reporting the annual achievements of the Program it is observed that beneficiaries data were consistently disaggregated by sex and the reports indicate that the proportion of females in all interventions are near to half which implies that the Program trying to adhere to gender equality principle.

Table 2: Performances of BSE/GSP HIV PROGRAM up to the end of 2013

INTERVENTION/COMPONENT	Planned Activity as per the Program proposal	Activity Performed
1. Basic knowledge on HIV/AIDS	Activity 1: 1Production and distribution of IEC materials.	In 2013 to mid-2014, 16,723 Good Samaritan booklets, 158 take charge booklets, 1,357 Resource Manuals, 336 Flipcharts, 1,183 who is Responsible DVDs and 1,174 do not bother us DVDs
	Activity 1.2 ToT and Decentralized workshops.	From the 2011 to mid 2014 BSE could reach 39,899 (46%f) individuals through decentralized workshop which is 346% above the plan. Moreover, in the same periods, BSE could provide ToT for 4151 (46%f) individuals. The performance was 182% above the plan.
2. Encourage VCT and sexual education	Activity 2.1: Encourage VCT	During 2011 to 2014, 664 (42%f) individuals could make VCT due to the intervention of BSE. The performance was 144% of the plan.

INTERVENTION/COMPONENT	Planned Activity as per the Program proposal	Activity Performed
3. Eradicate stigma and discrimination toward people live with HIV	Activity 3.1: Sensitization	The activity reports from the 2011 to mid 2014 indicate that the program has done a lot.
4. Renew church /community social responsibly	Activity 4.1: Workshop for church leaders	From the reports 2011 to mid 2014 it is possible to deduce that the program has done a lot.

Provide knowledge about AIDS and risky behaviour through IEC/BCC

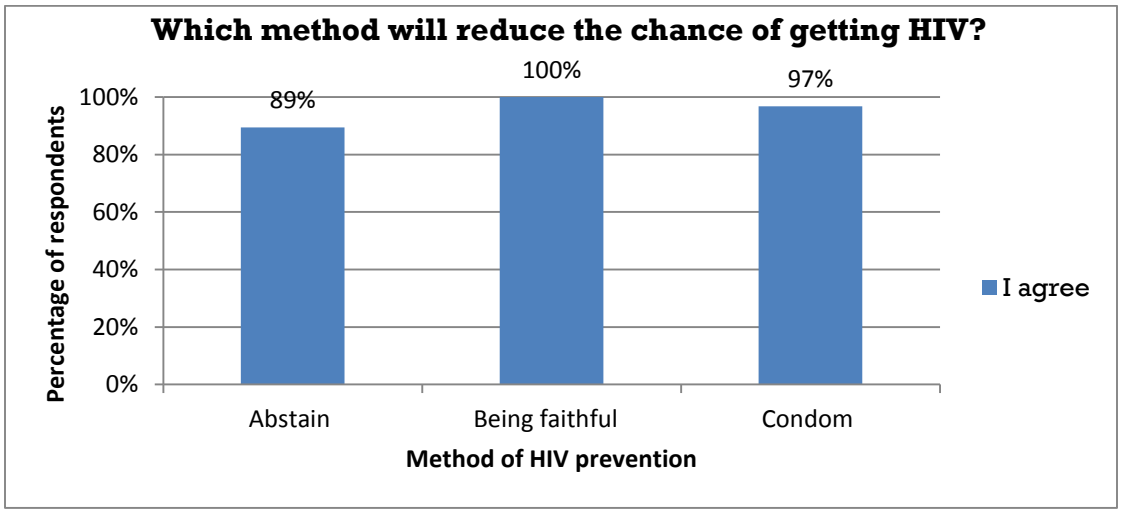
It is apparent that HIV/AIDS prevention messages focus on four important aspects of behaviors; abstinence, staying faithful to one uninfected and healthy partner, use of condoms and reducing the risk of mother to child transmission through antiretroviral therapy (CSA, 2005). The BSE/GSP HIV Program designed and implemented its Program based on well-studied method in order to improve the comprehensive knowledge of direct and indirect beneficiaries of the Program on HIV prevention.

To explore the level of knowledge of the aforementioned beneficiaries with regard to the above major prevention methods some specific questions were prompted and their responses are analyzed as follows.

Among the interviewed individuals, 83% (51%f) of the respondents have knowledge about HIV before they join BSE/GSP HIV Program. Of these, 34% (23%f), 27% (20%f), 20% (9%) and 20% (10%f) of the respondents get knowledge about HIV from medias, training, school and their clubs, and other sources respectively. This finding comply with the EDHS (2011) findings that says significant number of the population know about HIV. Nevertheless, those people who say 'I know about HIV' do not have comprehensive knowledge. The question that will be raised is that 'if people already have knowledge about HIV/AIDS prior to the intervention of BSE/GSP HIV Program what would be the impact of the Program on the population of the target areas.

From this perspective, the respondents were asked whether the Program enabled them to have proper knowledge about HIV prevention methods or how they can protect themselves from HIV and the result is discussed below.

Figure 3: Knowledge on method of HIV transmission



The BSE/GSP HIV Program promoted abstinence and being faithful as the main methods of HIV prevention and almost all people who were involved in the implementation of the Program advocated these issues. In order to know whether the advocacy worked or not sampled interviewees were asked 'can a person keep him/herself from getting HIV by abstaining from sex?' and as indicated in figure 2 above 89% (55%f) of them responded 'Yes'. These data were further analyzed in terms of educational status and it is found that among those respondents whose educational status is secondary school and above 81% (50%f) of them said that abstinence helps to reduce the chance to be infected by HIV while 19% (50%f) of respondents said the opposite respectively. This indicates that those youth who are sexually active determined to stay until they get married and to have better future life by protecting themselves from HIV. In fact, abstinence is not simply an issue of morality or keeping God's word, it is also a matter of public health. Many adolescents particularly in urban areas make unsafe and unlimited sexual intercourse not because they do not have knowledge about the consequences of such sex habit but absence of values. It is apparent that abstinence-only education message will play a central role in the decline of adolescent sexual activity, and related negative health outcomes.

In spite of the above mentioned facts, there are studies that say abstinence only education is ineffective, will lead youths to risky sexual behavior and will have more negative impacts in different ways on females. Also, when youth fails to adhere on abstinence, they fill guilty consciousness and as a result they may take some negative

action themselves (House, 2015; Woebse, 2014; Trenholm, Devaney, Fortson, Quay, Wheeler, & Clark, 2007; Kay & Jackson, 2008).

Thus, from these perspectives, it is difficult to conclude that abstinence is the best method of preventing HIV/AIDS. However, from the first perspective point of view, the BSE/GSP HIV Program achieved its objective in this regard. But the sustainability of such education is under question mark unless proper understanding about abstinence is in built in the mind of adolescents.

The next question raised for the sampled interviewees was about faithfulness. All respondents said that making sexual intercourse with one uninfected sex partner will reduce the chance of being infected by HIV.

This implies that the BSE/GSP HIV Program created good impact on beneficiaries to have better understanding about faithfulness. In this regard, it is possible to conclude that the Program achieved its objective.

As far as attitude towards condom is concerned, the response rates of the interviewed individuals were almost similar. The data collected and analysis indicated that 97% (61%f) of the respondents said that using condom properly will reduce the chance being infected by HIV. In fact, this sometimes might be controversial issue for faith based organizations as it contradicts with their theology. In any case, even though the BSE/GSP HIV Program did not officially taught this alternative HIV prevention method, the beneficiaries reached so far have better understanding about condom.

Those beneficiaries who participated in different FGD sessions confirmed that the project enabled them to have proper knowledge about HIV prevention and control methods even if they had prior knowledge about HIV.

These participants appreciated the strategy that BSE/GSP used to teach about HIV. In order to make this strategy more effective and relevant, they recommended that the videos should be prepared in Ethiopian context by Ethiopian actress and sign language should be included in order to address those people who have hearing impairment.

In general, the BSE/GSP HIV Program has played paramount role in increasing the awareness of the youth and adolescents, in particular, and the community members of the Program areas in general, to practice ABC methods (abstinence, being faithful to one uninfected partner, and condom use) in order to reduce the chance of being infected by HIV in that HIV infections are largely transmitted through unprotected sex with an infected person.

In conclusion, despite the above mentioned commendable results achieved so far, the central question is whether accurate information about sexual self-protection is to be made available. As many researches demonstrated, promoting abstinence and being faithful, promoting condom and providing basic health promotion information will contribute for the reduction of the risk of HIV infection as long as IEC/BCC materials are availed every time even after the phase out of the Program. From this perspective, it is hardly possible to say that BSE/GSP HIV Program availed such materials sufficiently at each church denomination unit and in other areas where more youth and adolescents spent their time. As a result of this, the sustainability and ownership of the above mentioned achieved results is questionable when the external funding is ceased.

In order to ensure that beneficiaries obtained proper knowledge about the transmission mechanisms and prevention method of HIV, sampled respondents were requested three questions as shown in table 3 below and majority of them responded properly.

Table 3: Comprehensive knowledge of beneficiaries

Question	**Response**	**Percent**
A person get HIV virus from mosquito bites	No	90% (57%f

It is possible to know has HIV just by looking	No	95% (59%)
A person get HIV virus from evil spirit or witchcraft	No	98% (59%f)

Regarding MTCT, 93%(59%f) of the respondents said that HIV will be transmitted to infants during pregnancy, delivery and breast feeding. With regard to the knowledge of ARV prophylaxis given to pregnant HIV positive women, 95% (62%f) of the respondents confirm that such medicine is prescribed by doctors and provided freely in health facilities. In addition to this, 98% (63%f) of the respondents confirmed that they know ARV is provided to PLHIV freely in health facilities. In spite of all these good achievements, the data analyses show that a lot of effort remains to increase the awareness of the people with respect to ART and PMTCT particularly for females. From the data analysis discussed above, it is possible to conclude that the BSE/GSP HIV Program contributed for the improvement of comprehensive knowledge of beneficiaries on HIV prevention even if it could not attain the target number of population as per the Program proposal.

In order to address this question, interviewees were asked some questions regarding the IEC/BCC materials they accessed and if they get sufficient knowledge from the Program's awareness raising program. Their response is analyzed below.

The sampled respondents were asked which IEC/BCC materials, among BSE/GSP HIV Program produced and distributed, they used. Accordingly, 91% (60%f) of the respondents used all IEC/BCC materials of BSE/GSP HIV Program. They were also asked where they did get the materials from and 96% (62%f) responded that they obtained the materials from BSE/GSP HIV Program-DireDawa. This implies that the project's beneficiaries who are residing in other project areas obtained the IEC/BCC materials from their respective BSE or BSE/GSP HIV Program offices.

With regard to the quality of the IEC/BCC materials, 98% (63%f) of the respondents said that the materials were attractive and 99%(63%f) of the respondents believed

that the materials contain sufficient information about the prevention method of HIV and 97% (63%f) of them said they understood the messages that the materials convey. The respondents were asked to mention some points regarding what they understood from the IEC/BCC materials 83% of the respondents properly understood the Suzane and James story and obtained sufficient knowledge from the program HIV in addition to the knowledge they had prior to the Program.

In general, it is believed that the IEC/BCC materials are said to be effective when they have the capacity to attract people for whom they are designed, when the messages they contained can convey the desired messages without creating significant understanding differences among their audiences, when the message transmitted are memorable for long time in the minds of audiences and when the messages transmitted through these materials have the capacity to influence or change the (unwanted) behavior of the uses or contributed to develop good behavior in the mind of users.

From this perspective, it is possible to conclude that the IEC/BCC materials produced and distributed were effective as they full fill the aforementioned criteria and contributed to bring behavioral changes among addressed beneficiaries and their surrounding community members.

This component is found to be cost efficient as it was observed during field that workshops were conducted with minimum costs, materials were distributed to many people, though they were not sufficient, and these people addressed other people who did not have the access to the project and could not be addressed by the project. Had the project had data collection system, it would be possible to see that large numbers of population were addressed. This implies with minimum fixed cost, large number of people were addressed which is the benefit obtained is much greater than the cost incurred.

The other point addressed during evaluation was the relevance of the message transmitted through the aforementioned IEC/BCC materials. Many beneficiaries including the FGD participants confirmed that the messages transmitted by the videos and booklets were highly relevant as the issues and situations mentioned and portrayed were similar to the beneficiaries who watched the videos and read the book

lets particularly to youth. Thus, it is possible to conclude that the project was successful in transmitting the relevant messages to targeted beneficiaries.

As mentioned earlier, the IEC/BCC materials distributed could contributed for behavioral change not only on the addressed beneficiaries but also to other people who have close relationship with them which is the desired outcome of the project also the project contributes for the reduction of new HIV infection at national level which is the impact the project.

With respect to the sustainability of the project, it is possible to say that the project had brought sustainable change among the population that the project addressed.

In general, the IEC/BCC materials contributed to

1. beneficiaries to have proper and comprehensive knowledge about HIV transmission and prevention mechanisms,
2. reduction of stigma and discrimination
3. be decisive on their sexual behavior i.e. to abstain, to be faithful or to use condom
4. behavioral change among the people
5. build self-confidence in the minds of PLHIV
6. strengthen community based care and support services to PLHIV

The project has the following strengths that contributed to the above mentioned achievements;

1. It did address many youth and adults regardless of their religion. Even if the IEC/BCC materials were prepared in the context of Holy Bible, Muslim peoples were also interested to accept the message and implement it.
2. The project did bring together those Christians who are attending in different denominations and created forum to discuss on common issue by avoiding their difference or sometimes unnecessary conflicts/disputes. It was interesting to hear that the Orthodox Christian servants serve the Protestant Christians and vice versa.
3. The project did bring church servants on board to speak about HIV to their members which was not possible before the implementation of this project,
4. The project used appropriate strategy to address many people with minimal costs

In spite of all these marvelous results achieved by the project, the project had its own weakness as mentioned below;

1. It has no data base system to gather information regarding the number, type, sex, like direct extracted data in case of how many had been sent to VCT, how many of the trained ones of the PLHIV had exposed themselves to public which and how many of church and social organizations had accepted the GSP strategy and started performing etc of the direct and indirect beneficiaries in order to know the coverage of the project.
2. The project does not have baseline to compare its achievement against the situation before the project implementation.
3. The book let materials need updating in terms of terminologies and information that contain
4. The Videos, though their messages were very interesting and acceptable as mentioned earlier, they do not reflect the common culture of Ethiopians.
5. The numbers of IEC/BCC materials supplied to the project branch offices were not sufficient as compared to the demand for them.

ENCOURAGING VCT AND SEXUAL EDUCATION (Openness)

The second component that BSE/GSP HIV Program implemented was Encourage to Voluntary Counseling and Testing (VCT), and to greater openness about HIV status, sexual issues and how to give sexual guidance to children and youths.

In fact, this component is the result of the first component which is 'Provide knowledge about AIDS and risky behavior through IEC/BCC.' When the first component is successfully implemented then the second component will be successful though it is not expected that the successfulness will be 100% in that it is apparent that all people who have appropriated knowledge will not come to VCT for various reasons.

As almost all of the FGDs participants explained youth and women are highly vulnerable to HIV. Most importantly, youth are vulnerable because of peer pressure, age factor, economic problem, lack of proper awareness regarding the transmission mechanisms of HIV, separation of families, Khat and Shisha, eager to exercise new things without thinking their consequences, and lack of parents' supervision, among others.

In order to address these problems and save these groups of people, the role of trainers and training facilitators who conduct decentralized workshops is vital. The trainers encourage those youth who participated in decentralized workshops to discuss about HIV openly with their family and to take VCT in order to know their sero-status and to make behavioral change for their future life either to keep themselves from HIV infection if they become HIV negative or to start positive living if they become HIV positive.

It is apparent that community involvement is at the core of the concept of HIV competence which was developed to describe the ideal health enabling community environment in the context of HIV/AIDS. Thus, community mobilization is widely advocated as a pillar for an effective HIV response because community involvement is a vital precondition for effective HIV/AIDS management. It plays an important role in enabling health-related behaviors and reducing HIV transmission, and in the reduction of stigma. It is also vital for facilitating timely and appropriate accessing of health and welfare services where these exist, and for supporting optimal treatment adherence.

An HIV competent community is one where community members work collaboratively to support each another in achieving sexual behavior change; the reduction of stigma; support for people living with AIDS and their careers; co-operation with volunteers and organizations seeking to provide HIV-prevention and AIDS-care; and effective accessing of existing health services

Central to the notion of HIV competence is a group's ability to engage in critical thinking about local challenges and strengths to develop strategies for improving care of PLWHA, prevention of new infections and appropriate accessing of available testing and treatment services.

From this perspective, BSE/GSP HIV Program took opened way to involve the community to address the unreached community members and to increase their awareness regarding HIV prevention and other related activities through the above mentioned training of trainers and decentralized workshops.

Accordingly, BSE/GSP HIV Program could address many community members in the Program target areas, it encouraged people take VCT. Among the interviewed people response 97% (63%) of respondents were tested of which 85% (56%) of them

made their sero-status in test in governmental health facilities. Many of GSP/beneficiaries confirm that they made test after joining and BSE/GSP HIV. Had the project had mechanism to follow up and register the number of beneficiaries who were tested for HIV, it would be possible to know the actual achievement of the project other than the sample response.

With respect to openness, the responses obtained from respondents confirmed that the Program has done well on it. For this evaluation openness was measured in terms of the discussion made about HIV among the family members. The sampled respondents were asked whether they discussed about HIV during family gathering and if they do so they further were asked to answer when they started. According to the responses collected it was found that 86% (56%f) of the respondents are discussing about HIV among their family members but 48% (32%f) of them started such discussion before they join BSE/GSP HIV Program while 38% (24%f) of them said they started to discuss after they join the Program. This indicates that the Program could contribute for the increment of the number of people who discuss about HIV among their family members that enhance the existing openness among the community members which subsequently play paramount role for the reduction of stigma and discrimination as well as increment of VCT, abstain, faithfulness and condom utilization, though the last one is not the Program major objective.

Thus, it is possible to say that the Program achieved commendable result with regard to openness because it could get reach many people even if it could not keep data.

The project was effective in mobilizing many people and it was cost efficient. The results obtained by the project are sustainable. This intervention has long term positive impact on people who attend GSP/BSE HIV PCP and their families

The strong sides of the project with respect to mobilizing people to VCT were its capacity to address more people at a time through church leaders and pursuing effective strategy to persuade people. In addition to these, the project enabled the youth to discuss not only about HIV but also sexual reproductive among their peers and their parents. .

Nevertheless, the project it could not avail VCT service during mobilizing people in collaboration with health facilities heads. Had such happen, many people would know their sero-status.

Thus, from this intervention the lesson that can be learned is 'if appropriate message is transmitted to people about HIV and SRH, people are ready not only to change themselves, but also they will change others.' Also, church leaders are the ability and authority to convince many people.

Thus, for the future, the project should train church leaders in counseling because teaching alone is not sufficient as there are members of respective church who need private counseling and this believers can be counseled by these leaders. In addition to this, BSE should assist churches to mainstream the HIV PCP in their usual annual work plan and should follow up whether they implemented their plan. This will help to build ownership of the project in churches and when the project is phased out churches will continue the project's activities in that HIV PCP is not a onetime activity rather it should continue until the prevalence rate reaches to zero.

Muslims are accepting the GSP/BSE HIV PCP, thus, both organizations should design new strategy to reach people who are outside Christianity.

ERADICATION STIGMA AND DISCRIMINATION TOWARDS PEOPLE LIVE WITH HIV

The epidemic of stigma, discrimination, and denial was one of the three phases that lasts long time since the start of HIV epidemic. HIV-related stigma and discrimination have fuelled the transmission of HIV, creating major barriers to prevent further infection, alleviate impact and provide adequate care, support and treatment. Discrimination is often described as a distinction made about a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong to a particular group. Stigma is generally accepted to be an "attribute that is deeply discrediting" that reduces the bearer "from a whole and usual person to a tainted, discounted one".

People discriminate and stigmatize those PLHIV mainly due to the misconception they have in their mind regarding the transmission mechanisms of HIV, assuming these individuals are adulteries or sinners thus they are penalized by God and these individuals are shame for their family. On the other hand, the PLHIV themselves stigmatize and discriminate themselves by assuming that they do not have hope to live in the future, and they are hated by the community.

Stigma and discrimination is revealed in different ways. The first one avoidant behavioral intentions which is the reaction of a person like avoid/not willing to go with PLWHA to any place, purchasing from PLWHA shop owner, eating food prepared by food handlers, eating meal with PLWHA, learning/working with PLWHA, physical contact with PLWHA and learning with student from PLWHA family. The second type of stigma and discrimination is blaming an attitude which is the feeling of individuals towards PLWHA. The person is said to be have blaming attitude when he/she feels that the person becomes sero-positive because he/she deserves because he/she has high risk behavior and when he/she feels that sero-positive person did not care if he/she infect others with HIV. The third way of revealing stigma and discrimination is coercive attitudes. When a person has coercive attitudes, he/she uses legal separation and restrict the sero-positive person from teaching, employment, use of medical facilities, working as health professionals, participating in public occasion, getting social service, working in schools, access to insurance services, enforce to publicize the sero-status, enforce to be tested especially high risk group and quarantine of sero-positive individuals. Having negative sympathetic feeling is also the fourth means by which Stigma and discrimination is revealed.

When the issue of stigma and discrimination issue is raised the aforementioned ways should be taken into account and the questions that are prepared for asking should address these issues.

Accordingly, for this evaluation six questions were prepared in a way they address the above mentioned facts. The responses of the sampled interviewed individuals are analyzed below.

Table 4: **Responses on stigma and discrimination**

Questions	Response	Sex of the respondent	
		Total	Female
PLHIV who has been denied, social, religious and/or health services	No	79%	49%
Are you willing to take care if one of your relative become sick due to HIV	Yes	97%	63%
Would you buy fresh vegetables from a shopkeeper or vendor knowing that he/she is PLHIV	Yes	99%	63%
In your opinion, should a PLHIV be allowed to work in area where there are plenty of people	Yes, should be allowed	87%	52%
Are you willing to eat with a PLHIV	Yes	99%	63%

Questions	Response	Sex of the respondent	
		Total	Female
What will you do if one of your family member become PLHIV	I will keep in secret	26%	20%
	I will not keep in secret but provide care	71%	42%

In Table 3 above the responses of individual interviewees are shown in detail. Accordingly, for the first question that says "Do you know someone who has been denied social, religious and/or health services because he/she has HIV in his/her blood?" 79% (49%f) of them said 'no' which means, according to the respondents answers, PLHIV are getting different services like any other patients when they required without stigmatizing and discriminating due to his/her sero-status.

This indicates that in the community where PLHIV are living, the community members as well as institution provided the necessary and required health, social and religious services and allow the participation of PLHIV in community events without any stigma and discrimination.

With regard to personal practice, 99% (63%f) of the respondents said that they will buy fresh vegetable from shopkeeper or vendor knowing that he/she has HIV. Similarly, 87% (52%f) of the respondents said a person whose sero-status is positive should be allowed to work in any organization where there are plenty of people who need the service from that organization.

With respect providing care and support 26% (20%f) of the respondents said they will provide care their relative who is HIV+ but with secret while the other 71% (42%f) of the respondents said they will provide care and support service by disclosing with other about the situation.

From these analyses, it is possible to infer that the BSE/GSP HIV Program has contributed to the reduction of stigma and discrimination at societal level but a lot effort still required to bring change at household level as still people want to hide the situation from the public when their relative becomes HIV patients. This might be due to fear of relatives and other people's attitude and not to lose social respect. Thus, for future or for new Program, BSE/GSP HIV Program needs to develop IEC/BCC materials in different languages and understandable way to show the consequences

of in house stigma and discrimination and thereby to reduce stigma and discrimination at all levels.

In addition to this, the role of church leaders in reducing stigma and discrimination is vital. Therefore, these leaders need be capacitated in order to make them exemplary in reducing stigma and discrimination.

RENEW CHURCH/COMMUNITY SOCIAL RESPONSIBLY

To achieve this objective, sensitization of Church leaders and potential train the trainers from churches and church related organizations play a key role in reaching the primary target groups: youth groups, women groups, and leaders within the local community. People living with HIV and AIDS (PLWHA) play an important role in developing the material and takes an active part as resource persons in the training events.

Based on this perspective, sampled respondents who were drawn from churches were asked regarding the quality of the training, whether they have the capacity to train other and whether they trained others so far.

Accordingly, it is found that all interviewed individuals took the ToT, 99% (64%f) of them said the training was sufficient, 96% (62%f) of them said the training was given to them regularly, 95%(59%f) of them said they have the capacity to train others. However, only 62% (42%f) of them could train to other and those trained individuals who did not provide training mentioned that their reasons were being busy and absence of opportunity to train.

As mentioned earlier, in order to make the HIV PCP results, Churches has irreplaceable role. One reason for this is that unlike government or nongovernment organization, Churches are more stable and in one or the other way people will come churches for worship. Since this the good opportunity for the church leaders, they have to be trained to use such chance to address more people.

This shows that though the Program has done a lot in providing training, it lacks follow up whether these trainees cascade the training and did not create opportunities to some of them.

9. Administration, Financial management and utilization of Funds

The BSE GSP HIV program is fully administrated under the BSE Office Ethiopia with unreserved professional support extended from the HIV Service and Norway offices. The BSE Board is the sole responsible implementer of the program. As BSE/GSP HIV Program in general has sound inbuilt financial system and funds are released to implementers through proper channel after getting approval of the concerned authorities. The financial transactions are managed by employees who are qualified and have adequate accounting skills and it is customary that every year the financial records are audited by internal and external auditors. It is apparent that such system would prevent any potential fraud and abuse of financial resource. Thus, it is possible to deduce that the fund NBS was managed as per the financial rules and regulation of BSE at all levels with free of any abuse or fraud. Because of this, the BSE/GSP HIV Program performs its activities within agreed budgets and contracts. During field visit for evaluation this procedure was observed.

To gain perspective on how resources have been allocated in this Program, the finance department of BSE/GSP HIV Program was asked to provide financial information that indicates how much fund GSP granted, what proportion of the financial resources were being allocated, how much of the fund was released to church units and how much fund was utilized by the BSE/GSP HIV Program at Central Office and Branch Office levels.

The financial management and utilization of the BSE/GSP at head office and branch level is shown below.

Table 5: Fund allocated and released

Budget allocated								
Years	DireDawa	Addis Ababa	Hawassa	Mekele	Jimma	Baherdar	Head Office	Total

2011	109,473	417,965	133,593	-	-		2,274,347	2,935,379
2012	417,892	465,328	366,692	324,078	-	324,078	985,543	2,883,610
2013	461,350	371,128	342,150	345,661	388,061	345,661	1,057,640	3,311,651
2014	332,150	334,158	305,750	332,190	332,190	341,790	1,140,024	3,118,252
Total	**1,320,865**	**1,588,579**	**1,148,185**	**1,001,929**	**720,251**	**1,011,529**	**5,457,554**	**12,248,891**

Budget released								
Years	DireDawa	Addis Ababa	Hawassa	Mekelle	Jimma	Baherdar	Head Office	Total
2011	191,950	465,574	134,668	-	-		2,526,721	3,318,912
2012	367,571	392,992	273,633	216,788	-	256,874	1,350,870	2,858,728
2013	325,939	354,577	268,500	192,195	105,315	239,832	1,735,664	3,222,024
2014	255,150	233,910	214,025	298,515	265,100	290,500	898,050	2,455,250
Total	**1,140,610**	**1,447,053**	**890,827**	**707,498**	**370,415**	**787,206**	**6,511,305**	**11,854,913**
Difference	**180,255**	**141,526**	**257,359**	**294,431**	**349,836**	**224,323**	**(1,053,751)**	**393,978**
% used	86	91	78	71	51	78	119	97
% Per area	10	12	8	6	3	7	55	100
Was to be	11	13	9	8	6	8	45	100

As indicated in Table 5 above BSE obtained more than ETB 12 million and of which it released to branches and head office little above ETB 11.8 million which is 97% of the allocated amount. When this is analyzed in terms of branch office Jimma obtained the least 3% where as Addis Ababa obtained 12% followed by Dire Dawa, Hawassa Baherdar and Mekelle 10% 8%, 7% and 6% respectively this working areas make 45% of the total and 55% was set to the head office where all the BCC/ACC printed materials and project office admin costs are incorporated with the balance. In this analyses we could see that the Head Office obtained above 100% of planned fund and no response was given for the over and under utilization. In our document review we have absorbed that the actual amount utilized correctness was ascertained by the yearly audited reports of the external independent auditors. the BSE/GSP HIV Program Financial management routine is basically of the BSE and it looks reliable system. BSE is using a centralized financial control mechanism for the GSP HIV Program the finance department of the head office is responsible for disbursement of funds and preparation of the financial reports. The other issue that should be mentioned here is during these years fund transferring to project sites had been always in the name of project coordinators instead of to branch bank account . The project coordinator is the overall responsible individual for all approval, expending the fund, and reporting back the utilization of the fund with its documentations. Since

this may create unwanted experiences and it shows there is loose internal control system, because of no segregation of duty principle and BSE should take into account this situation seriously.

In addition to these, from the report it becomes difficult to know the actual amount for which BSE entered agreement with GSP and how much money was allocated and utilized for the four interventions in each branch. We believe detailed reporting per project area is important to plan, intervene or hand over future interventions.

10. Monitoring and evaluation system

Monitoring and evaluation (M&E) is a part of a Program cycle and should be designed during the Program development stage. It is necessary to monitor and evaluate designed programmers in order to account and promote health of resources, improve programs and show whether the interventions are having the intended effect. In addition to this, monitoring and evaluation data can help to indicate how far interventions have progressed, at what stage they are "ready" for impact evaluation, and when there is sufficient supporting M&E documentation to make this possible.

In this perspective BSE/GSP HIV PROGRAM incorporated the monitoring and evaluation system in the Program proposal. The annual reports reviewed during evaluation indicated that the BSE/GSP HIV Program has conducted continuous monitoring by receiving regular report from branch office. The Program coordinator with the head office concerned staffs also mentioned that he tried to visit all Program areas at least once a year. In fact, the DireDawa branch office also confirms that there was continuous field visit for monitoring. BSE/GSP HIV PROGRAM had also been holding yearly stakeholders meeting to monitor and evaluate the program performance.

Monitoring and evaluation is generally strong but lacks organized and updated monitoring report from independent unit especially in terms of analyzing and using the information for informed decision making and implementation.

The project does not have standalone M&E officer that will monitor and prepare independent report about the project. Thus, it is paramount to have such person in order to ensure the quality of the project implementation and to improve the performance of the project.

11. Phase out strategy

In the Program proposal it is mentioned that the Program will pursue a set of key principles that will sustain the project from national to grass root level. Even if these principles are correct, in the Program proposal, nothing mentioned regarding the phase out strategy and even the BSE/GSP HIV Program did not prepare phase out plan. This highly affects the sustainability of the commendable results so far achieved.

Therefore, it is apparent that BSE/GSP HIV Program must devise a clear exit strategy that makes sure a reliable and functional the above mentioned strategy.

BENEFICIARY/CHURCHES and CBOs LEVEL

Mechanism that will ensure the sustainability of the Program's activities should be designed to beneficiaries so that they will implement the usual IEC/BCC intervention after the Program is phased out.

BRANCH OFFICE LEVEL

Since HIV prevention and control activity is not a one Program activity it should be integrated with other Programs and major activities should be implemented.

LOCAL PARTNERS – GOVERNMENT

It is obvious that the BSE/GSP HIV Program has established good relationship with different government authorities or offices at Program areas. So, for the sustainability of the achieved results this strong partnership should not be discontinued.

12. Partnership with Stakeholders

During filed visits, it is observed that BSE/GSP HIV Program has established strong partnership with local government offices, churches and other non-government organizations including different clubs and associations at Program areas. Because of this the BSE/GSP could get reputation from these organizations. But the interviewed focal persons or heads of these organizations expressed their fear that the already achieved result might be reversed unless some sustainable activities are done thus the BSE/GSP should find ways to continue or make sustainable the Program.

On the other hand, as BSE/GSP did not sign agreement with regional bureaus. The collaboration of the worked level government offices was just emanated from personal willingness.

13. Relevance and Appropriateness

Relevance is concerned with assessing whether the Program is in line with local needs and priorities as well as BSE's, government and donor's policies. From the perspective of this definition, the Program's overall goal was consistent with the beneficiaries' and the nation's needs because the data collected from the beneficiaries, the branch offices of BSE/GSP reports as well as the information obtained through KIIs and FGDs indicate that the Program's objectives were relevant to the needs of beneficiaries particularly in the promotion of A&B, awareness raising about HIV prevention, renew the Church's social responsibility and reduction of stigma and discrimination. From the point of view of the country as well as the six Regional States HIV/AIDS prevention and control policies, strategies and priorities also, the Program's overall goal and specific objective were relevant. The inputs and strategies identified to achieve the intended results were also realistic and appropriate. As mentioned earlier, the Program addressed the needs of the target groups and beneficiaries specifically in terms of achieving the aforementioned objectives. The sampled interviewed respondents (99%,63%f) said that the materials provided sufficient messages. Generally, it sounds plausible to conclude that the Program was relevant in every respect.

14. Effectiveness

The context of the extent to which the Program met its purpose and objectives was critical in the assessment of its effectiveness.

The effectiveness of IEC/BCC messages is a more important indicator than frequency of exposure. This is measured by the power of the messages that contribute for the reduction coercive attitudes towards PLWHA, avoidant behavioral intentions towards PLWHA blaming attitude towards PLWHA, sympathetic feelings towards PLWHA, and increasing the proper and comprehensive knowledge about HIV/AIDS as well as the practical change that brings in the community.

The capacity building intervention also played important role for cascading the appropriate HIV and SRH information to different beneficiaries and achieved the desired objective.

The sample respondents were asked to evaluate the effectiveness of the Program by asking them whether the IEC/BCC materials convey proper message about HIV

prevention and were sufficient to teach about HIV and 98% (63%) of them said the messages delivered through printed materials and DVDs were effective. The other question raised for these individuals was whether the materials were attractive and the trained pastors were capable to train others. For these questions, more than 86% of the respondents replied positively.

In addition to review of Program performance documents, the responses obtained through KII and FGD were also in line with the Program objectives even if some KII participants said that the Program lacks sustainability. From this perspective it is possible to conclude that the Program was effective in achieving its objective.

15. Efficiency

Program efficiency was assessed based on its outputs and how the entire Program was managed. Particular focus was placed on how productively the resources were used to realize the results paying particular attention to Program management and funds management.

As indicated earlier in this report, the Program obtained and released around Birr 11.8 million and thereby it reached many beneficiaries though the data provided did not show the exact number of reached beneficiaries. Even if this is the case many activities are implemented using little amount of money. This was observed in Program target areas. On the other hand, the efficiency of the Program was measured the strategy it was used which is known as technical efficiency. In this respect the Program's strategies were suitable to produce the desired output at less cost. However, it becomes difficult to see at the cost efficiency of activities at Head Office level and respective branch office level as the financial information provided was not detail. In spite of these, in general, it is possible to conclude that the Program was efficient.

16. Outcome and Impact

To measure the outcome of the Program sampled individuals were interviewed in addition to the documents reviewed. According to the response obtained from interview, 99% (63%f) of the respondents agreed that due to the Program the community members' or beneficiaries knowledge about HIV is improve, 98% (63%f) of the respondents said due to the Program the community members attitude towards PLHIV is improved. , and 99% (64%f) respondents said due to the Program the

community are showing their willingness to protect themselves from HIV and to provide care and support to PLHIV. All these show the Program has brought the desired outcome which is behavioral change. The KII and FGD participants also confirm that the Program has brought behavioral (Table 15.1below) change and increase the awareness of people even if few participants have different ideas. Thus, it is possible to conclude that the Program has achieved its outcomes.

Table 15.1: Pragmatic Impacts because of the BSE GSP HIV Program intervention in the community

PLHIV	Students and School Anti AIDS Clubs and youth associations	Christian denomination Congregation members and leaders	Muslims
1. Come out and expose themselves in the community 2. Contact other PLHIV to receive training 3. Encourage their follow PLHIV 4. Witness life experience 5. Share their problems openly 6. Expose openly the present challenges that they are facing	1. Openly hold dram of the Good Samaritan from the Bible 2. Talk with their friend about HIVAIDS and its ways of getting infected 3. Challenge their friends 4. Talk about the ways of its minimum prevention 5. Talk openly with their family members 6. Got a positive sentiment to assist people with HIV+	1. Talk openly no more taboo in the church programs about HIVAIDS and its community challenges 2. Started training with the medical wing of their church office 3. Assist and support PLHIV 4. Developed the sentiment of owning the Good Samaritan project 5. Encouraged members for VCT	1. Develop BSEGSP 2. Started member 3. Started 4. Guide H

17. Sustainability Ownership

The BSE/GSP HIV Program is designed in a way to create, maintain and sustain the learned knowledge within the community, and as a result of this the program is said to be good when its achieved results are sustained for longer time for which community ownership is inevitable. The sampled beneficiaries were asked regarding the sustainability of the Program and how it will be sustained. Among the interviewed respondents, 99% (64%f) of them said the community members will maintain their knowledge, attitude and practice about HIV and to PLHIV after the BSE/GSP HIV Program phased out notwithstanding the comment given regarding the absence of phase out strategy. In the aspect of Ownership: With every church congregations, stakeholder and partners building institutional ownership has not been easy. They all are fearing the financial implication. But when we review the individual trained trainers and the volunteers they have started taking it as their own task as the Good Samaritan did. In order to get the economics of scale the BSE GSP HIV Program needs to find ways to link these individuals with social institutions or government organizations who could take the responsibility of caring the activity as there is a tremendous need of continuing.

18. Strength and weakness of the Program

18.1 Strength of the Program

- Working with church/congregation is a good means to address mass population
- Involving church leader/ pastors as they are more influential persons to brought attitude change among the community
- The strategy used such as community based organizations
- The Program ideas become parts of the church's teachings and will sustain in the future
- The use of volunteers as training facilitators
- The Program has been serving all people irrespective of their religion.
- The use of school AAC as a learning media is the strength of the Program.
- The Program mobilized many youth in different ways

18.2 Weakness of the Program

- Lack of budget was one of the barriers which made the Program unable to address the needs and expectations of the beneficiaries
- The Program did not have formal documented joint evaluation report which details, its achivment and needed improvments with the concerned government organizations and other stakeholders.
- The program used printed materials and DVDs which needs to be updated in terms of language and proper terminology, and the DVDs do not consider the Ethiopian Culture
- Limited human labor
- Limited budget (compare to the work in the field)

19. Opportunities and challenges of the Program

- The church leaders and believers with different doctrinal background are willing to work on HIV
- The strong reputation of Good Samaritan Purse opens door to discuss with government officials at all levels
- Expectation of seating allowance from the community
- Resistance toward female trainers(in some community

20. Lessons learned, Best Practice and Recommendations

20.1 Lesson learned

- Properly designed project will facilitate the monitoring and evaluation process
- The existence of strong monitoring and evaluation will improve the performance of the project
- If there is commitment, it is possible to do a lot with little money
- Reputation of organization will facilitate the implementation of project activities
- Involving church leaders in HIV prevention activities will help to address many people and to make the project result sustainable.

20.2 Good Practices

The following are good practice taken as example among others

- The effort that BSE/GSP HIV Program did to persuade the non-Christian individuals in order to influence the community members to teach them about HIV prevention and control can be mentioned the best practice of the Program among others.
- The strategy that BSE/GSP used to address vulnerable groups,
- Involving church leader in HIV/AIDS prevention activities,
- Management of low cost workshops

21. Conclusions

Overall, the Program was very relevant in addressing the priority SRH and HIV needs of young and older people. HIV and AIDS still need much effort and this Program contributed well in complementing the national efforts to make sustainable the already achieved reduction of HIV prevalence. Furthermore, its relevance lay in its alignment with the respective national SRH and HIV strategies. The youth-led approach ensured active participation of young people in bringing change amongst themselves and their community. This approach proved to be effective in ensuring reach and breaking one of the major barriers to communication about SRH, HIV prevention and stigma and discrimination in the community. During filed visit it was observed that the participation of youth and church leaders extensive.

At the time of this evaluation, youth were observed to be still actively engaging in some of the Program activities.

The Program was also effective in achieving its intended objectives. The evaluation findings show that the Program was effective in raising awareness and increasing knowledge on SRH, HIV and AIDS. Results also show that to some extent the Program had been on course towards influencing the SRH behavior of youth in their communities particularly among those who were exposed to the intervention. As this was a community wide intervention, it is bound to have ripple effects.

BSE/GSP HIV Program was well coordinated the branch offices and conducted limited supportive supervisions even though the partnership it created with Regional State was weak.

The BSE/GSP HIV Program was effective in producing the required reports and getting the allocated fund from donor without delay in transferring fund to branch offices.

This success was a result of a combination of factors including the youth-led implementation approach, involving and ensuring active participation of youth, church leaders and community based organization along with the woreda government offices, schools, women associations and PLHIV clubs. This evaluation concludes that this Program has generated good lessons and is the type of Program that can be replicated with some adjustments to optimize impact.

22. Recommendations

We recommend the following points for this and other similar Program that will be developed and implemented in the future

1. BSE/GSP HIV Program should strengthen to receive feedback from partners and other stakeholders involved in the Program both at the time of their involvement and at a later date (for example, a year after their involvement) to assess and collect information on the Program's impact
2. It is paramount to conduct a baseline before designing a Program as done for community health need assessment and planning
3. The M&E system should be strengthen and the Program teams should be capacitated in monitoring and evaluation to improve the departments' performance
4. As there is only one branch coordinator more support should be given at branch offices level
5. The Program should strengthen its support on capacity building and experience sharing at all levels
6. The Program should allocate sufficient fund or should utilize the budget in a way it will bring change instead of dispersing in different regions here and there.
7. Program proposal should be prepared based on one of various methods that shows indicators, of verification along with the achievable results on the target population.
8. The Printed materials should be updated and re written in different languages other than Amharic and Oromifa
9. In order to contextualize the messages the DVD drama should be done by Ethiopian young artists if possible in different languages

10. BSE/GSP HIV Program should prepare Program proposal with participation of potential beneficiaries and should made regular joint review meetings
11. BSE/GSP HIV Program should carefully design sustainability means and phase out strategy.
12. The beneficiaries and stakeholders should hear the independent evaluation report and their comments should be incorporated so that everyone will learn from previous problems and own the phased out Program.

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Project's name: Where is the Good Samaritan today? HIV & AIDS Program 2011 -2015"

(Questionnaire for Key Informant Interview-BSE/GSP Project Coordinator)

Confidential Information

This in depth interview is conducted with the stakeholder of the HIV/AIDS Project which was implemented by the Good Samaritan program in Ethiopia in collaboration with Ethiopian Bible Society

For interviewer: Please read the following paragraph loudly to the interviewee

Introduction and consent form

Good morning/afternoon! I am Abera Tajebe I am consultant delegated by BSE/GSP to interview you. It is to be recalled that BSE with financial support of GSP implemented HIV/AIDS project in Ethiopia for the last five years. Thus, we are gathering data to evaluate the project's performance. The data collected will provide complete information regarding the project's performance to those governmental and non-governmental organizations that are working in your town and to those organizations and professionals who provided technical and financial support to the project. Furthermore, the data you will provide us will help to make the project that will be designed in the future fair, equitable and effective.

To achieve the aforementioned objective, BSE and its partners want to discuss with beneficiaries and stakeholders that are existing in your town.

You are kindly requested to participate in this interview with your free will and respond to questions to the best of your knowledge freely. We assure you that all the data you provide us will be kept confidential and will never be used for any purpose other than the intended objective.

The interview will stay at most for minutes only

Are you willing to participate in this interview? 1. Yes_____ 2. No_____(If you are not willing to participate, you can go freely)

A. To be filled by the interviewer before conducting the interview			
Region			
Town/Kebele			
B. To be filled by interviewer			
Name of interviewee Ato Fasil			
Occupation National Coordinator			
Organization's/Office's name and address			

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Interviewer's Name					Interviewer's signature	
Data collected	Date		Month		Year	
C. To be filled by supervisor after checking the accuracy of the questionnaire filled						
D. Supervisor's name					Supervisor's signature	
Questionnaire checked	Date		Month		Year	

1. How do you evaluate the project design?
2. In your opinion, what were the opportunities and challenges during implementation?
3. How do you comment the working relationship b/n your office and the Head office in Norway and in Kenya?
4. What working links do you have with the Office in Kenya?
5. Is the transfer of budget on time from HO to Your account in Ethiopia and from HO Addis to Project sites ?
   Ans. Yes we have not experienced any delay
6. How do you evaluate the relationship of the HIV Project Coordination section with donor, churches, and other stakeholders?
7. How do you evaluate the project's effort and achievement?
8. In your opinion, were the project's strategies used appropriate? If not, why?
9. In your opinion, was the project effective in achieving its objective as per the project document? Can you give me evidence?
10. Do you believe that the project used the resources (HR, finance and materials) efficiently?
11. Does the project have supportive supervision, monitoring and evaluation system? Did the project conduct joint monitoring and evaluation with its partners? If so, how frequent? If no why?
12. What were the strength and weakness of the project? What should be done?
13. In your opinion, what are the changes/impacts observed on beneficiaries, in particular and community in general? (Give examples),
14. Among the four interventions that the project implemented which one was successful in implementation and which one was not? Why? What should be done?
15. What were the activities that the project that performed to ensure the sustainability of the project? If no activity was done why? What should be done?
16. Does the project have exit strategy? If so, did it inform the stakeholders and beneficiaries? If no why? If it does not have exit strategy why the reason?
17. If the project should continue in the future, in which intervention it should continue?
18. Are there lessons you have learnt that you could like to share with us?
19. Do you have any issue that you want to raise?

I finished my interview! I thank you for your cooperation

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