TRANSPORTATION CORRIDOR PROGRAM

Outstanding – Budget (approximate ceiling budget $4,500,000/year) and Application Format

SECTION C - PROGRAM DESCRIPTION

C.1 OVERVIEW

Summary

USAID/Ethiopia's Office of Health, AIDS, Population and Nutrition requests applications to implement a set of activities designed to serve populations at risk of acquiring and transmitting HIV in urban and peri-urban areas along designated transportation corridors. Anticipated activities focus on preventing the sexual transmission of sexually transmitted infections including HIV and increasing HIV/AIDS service utilization for populations at risk of STI/HIV infection, specifically HIV counseling and testing (HCT), STI syndromic treatment and HIV care and treatment services.

Results Framework

Objective:

Prevent new HIV infections among at risk populations using interpersonal and interactive behavioral change activities, improved health interventions and stronger linkages for persons living with HIV to care and support services including ART in towns along major transportation corridors (see table 1).

Expected Results:

1. Increased access to and availability of interpersonal counseling, health services and social support activities for at risk populations
2. Improved quality of interpersonal counseling, health services and social support activities available to at risk populations
3. Increased demand for interpersonal counseling, health services and social support activities among at risk populations
4. Improved social and policy environment for averting new HIV infections among higher risk populations

C. 2. PROGRAM CONTEXT

Country Context

Ethiopia's total population is approximately 80 million people, which makes Ethiopia the second most populous nation in sub-Saharan Africa. With an annual population growth rate estimated at 2.9%, the country, by 2025, will have more than 117 million people.

The 2005 Demographic Health Survey (DHS) indicated that overall HIV prevalence in Ethiopia was lower than originally estimated, with 1.4 percent of Ethiopian adults between the ages of 15-49 infected with HIV. However, data from urban and peri-urban

areas within transportation corridors show substantially higher rates of HIV prevalence (6 percent urban versus 1 percent rural). In June of 2007, The Ministry of Health released the *Single Point HIV Prevalence Estimate* report which gives the latest estimate of national HIV prevalence. That report places the adult prevalence rate at 2.1%, while the corresponding rate in urban populations is more than 3 times higher (7.7%); while the disparity in HIV prevalence for urban versus rural females is even greater – see Figure 1.

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Data from the 2005 Demographic and Health Survey show that among urban women who had higher risk intercourse in the past 12 months, only about 40% reported using a condom. Among younger women (15-24 years of age) who had higher risk intercourse in the previous year, the portion reporting condom use was even lower, 28%. Around 50% of young (15-24 years of age) males who had higher risk intercourse reported the use of a condom. Generally, however, condom use among urban populations is higher than in rural dwellers. Recent observations suggest that urban women, 25 years of age and older, have some of the highest prevalence of HIV and is an important population to receive intensive HIV prevention of sexual transmission and HCT services.

HIV Prevention in Ethiopia:

A) Factors Affecting Risk of HIV Infection

The US government reviewed existing HIV prevention activities and analyzed primary and secondary data available on the HIV epidemic and developed specific recommendations to inform HIV prevention activities as outlined below.

Transactional Sex and the Urban Epidemic

The high prevalence rates in urban settings suggest sexual network structures and transmission patterns that are characteristic of both concentrated and generalized epidemics. Available surveillance reports and mapping exercises in high risk populations suggest that formal sex work appears to be prevalent in many urban settings, but that formal sex workers report high levels of consistent condom use with their clients, which may help to mitigate their risk. However, at least two focused assessments reveal that formal commercial sex work may only represent a small fraction of a broad continuum of transactional sex in urban centers in Ethiopia. It is possible that much of the transactional relationships are: less formal in nature; often perceived to be less risky; and feature lower levels of consistent condom use. A high prevalence of both formal sex work and informal transactional sex appears to be at the core of the high HIV prevalence in urban centers and in transportation corridor "hotspots" in Ethiopia.

Gender Inequalities and Risk for Women

The HIV prevalence data presented earlier in this section highlights the fact that women compose the larger portion of the HIV-positive population, particularly in urban areas. A complicating factor for some women engaged in at-risk behaviors is the lack of other competitive income-generating alternatives to engaging in transactional sex. Transactional sex becomes a normative approach for many girls and women, in urban

areas along the main transportation corridors, to fulfill their economic and social wants and needs. Gender disparities in opportunities for or access to employment, business, trades or other income-generating pursuits that produce a meaningful income may increase the prevalence of transactional sex.

Social Marginalization and Risk
Infection risks appear to be far greater among vulnerable and potentially marginalized sub-populations, including divorced/widowed women, and higher-risk youth. According to the 2005 Demographic and Health Survey (DHS), HIV prevalence among widowed/divorced women is 8.1 percent, and is more than five times higher than prevalence among married women. Compared to many other countries in eastern Africa the age of sexual debut is late among many youth in Ethiopia. However, the HIV prevalence among sexually active never-married females in the 2005 DHS was 9.3% – even higher than that among widowed/divorced women. Among women who reported non-marital, non-cohabitating partners in the past year, HIV prevalence was 12.3%.

Age and Risk
Data from the 2005 DHS show that HIV prevalence peaks among women between the ages of 35 and 39 years, suggesting a peak incidence of HIV infections among women in their late 20s and early 30s. A focus on programming for youth is likely insufficient to mitigate high HIV risk in adult populations in Ethiopia. More specific and structured programmatic approaches to meet the prevention needs of high-risk adults are likely needed.

B) Defining Most at Risk Populations (MARPs) in Ethiopia

The US Mission to Ethiopia has identified priority at-risk populations identified for emphasis in this activity as outlined below.

Commercial sex workers - This are a highly variable group of individuals identifying themselves as commercial sex workers from different socio-economic groups; migrating from a variety of geographic areas; highly transient; originating from various cultural backgrounds, and education levels. These individuals are at a very high risk of HIV infection. Condom use among commercial sex workers is reported to vary from 78.3-98.2 percent (HIV/AIDS Behavioral Surveillance Survey (BSS) Ethiopia 2005 Round Two) though consistency and correct use remains poorly investigated. Limited information is known about STD prevalence or unintended pregnancies among this population. Self-risk assessment among this population is variable though it appears there is a relatively higher perception of their own personal risk for becoming infected despite low levels of care seeking behavior. Substance abuse, specifically alcohol and khat, appears to be prevalent. Work settings for commercial sex workers include brothels, on the street, roadside bars, larger hotels, nightclubs, party-houses, *tella* and *arak*i houses

depending on the size the urban area. The commercial sex workers are often abused or influenced by the proprietors of their settings in return for food and shelter.

Females involved in cross generational and/or transactional sex - This is a larger segment of the at-risk population, having heterogeneous backgrounds, who have fewer sexual partners than commercial sex workers, but who may also have dramatically lower perceptions of personal risk. Without an understanding of the risks, this group may also practice lower levels of consistent condom use in sexual encounters. Implementation may still be able to identify interventions or service-extension modalities that are likely to reach them with prevention services in the venues (such as bars and entertainment establishments) where prospective partners are commonly met.

Males engaged in transactional sex including male clients of commercial sex workers - The client/partner group consists largely of urban and mobile men with some financial means or disposable cash. Assessments of high-risk groups in Ethiopia indicate that clients can include, Truck drivers and their assistants; Cross-city bus drivers and their assistants; Migrant day laborers/unskilled construction workers; Farm/plantation workers; Uniformed government employees; In-school youth (secondary & college); Out-of-school youth; Petty traders/informal traders and other men with disposable income or mobility. Key opportunities to reach such individuals may exist through targeted interventions in settings in which they meet prospective sex partners and areas where men congregate.

For both females and males engaged in transactional sex, the clients/partners of these individuals may underestimate the infection risks associated with informal transactional relationships. It is possible that these individuals come from a variety of backgrounds and exhibit differing patterns of transactional sex.

Implementation Context

USAID envisions this program to serve as a follow to the successful High Risk Corridor Initiative (HRCI). USAID support to the HRCI offered community-oriented HIV prevention, HCT and palliative care services along the Addis Ababa – Djibouti transportation corridor. Implementation activities focused on providing HIV prevention services and community-based care and support services in at risk communities to improve the health and welfare of persons with HIV/AIDS and their families. HIV-related care and support is provided to individuals in urban areas. HIV prevention activities utilized several methods to address youth, the general population and several at risk populations in these communities.

In order to meet the set objectives the Transportation Corridors program will complement several other on-going activities which the implementing agency is expected to collaborate with. These activities including:

<u>USG Partners –</u>

HIV/AIDS Care and Support Project seeks to: 1. Provide quality integrated HIV/AIDS prevention, care and treatment services at health centers; 2. Deploy case managers to personalize care and strengthen referrals between health centers, hospitals and community services; 3. Deploy outreach workers to support family-focused prevention, care and treatment in communities and; 4. Implement HIV prevention activities utilizing best practice "Abstinence, Be Faithful, and Condom" (ABC) interventions incorporating stigma, discrimination and gender concerns.

USAID Civil Society Program the intended goal of this program is to maximize coordination and strengthen civil society to improve the quality and availability of HIV care and support, counseling and testing and adherence activities within communities to improve the outcome of HIV positive Ethiopians and their dependents.

Health Communication's Partnership (HCP) implements new programs targeting high risk groups including university students and commercial sex workers and continues to expand its three existing programs: Youth Action Kit (YAK), Sports for Life (SFL) and Beacon Schools (BCS) to reach people with HIV prevention education.

Centers for Disease Control activities including support of hospitals and health centers to provide HCT, ART and facility based care and support for HIV/AIDS along various transportation corridors.

USAID/Targeted HIV Prevention Program implements condom targeted promotion to at risk populations nationwide. The contract will work closely with a consortium of local and international civil society in major urban areas to improve community access and utilization of male condoms among identified at risk populations.

USAID/Private Sector Program implements mobile HCT (HCT) services in thirty five major towns in Amhara and Oromia to increase access to HCT beyond health facilities. To date the program has tested approximately 50,000 clients. To support long term access to HCT services the program supports 160 private for-profit clinics in Addis Ababa, Amhara and Oromia deliver confidential TB/HIV services. A key component of the PSP is the tracking of appropriate referrals for individuals receiving HCT.

USAID/ROADS Project is a unique program to reach mobile and vulnerable populations along the East and Central African transport corridors. It is a comprehensive program that recognizes the imperative of organizing strong prevention measures combined with treatment and care and support with in- built sustainability- both organizational and financial. Specifically, the objectives of the project are:

- Link mobile populations and communities along transport corridors to prevention, care, treatment and support services
- Share state-of-the-art practices
- Test innovations through pilot programs

Gender equity will underscore all implementation activities. It will be necessary to assess and address barriers which limit access to services for women and girls, while ensuring that both male and female service providers are part of the implementation process.

Essential Implementation Modalities

Local Partners –

To facilitate implementation the implementing agency will support and build capacity among local counterpart organizations to provide quality services and to, over the course of the contract, to take a lead in monitoring and evaluation of program results through training, ongoing supportive supervision, and the provision of job aids to facilitate their work. Additionally, the implementing agency is expected to work with the district health offices and town health administrations to strengthen the capacities of their local organization counterparts and the participating communities to provide quality and integrated service delivery.

Specifically, in order to enhance the sustainability of the Transportation Corridors Program it is expected that the successful implementing agency will support and build capacity in local organizations based in the towns of intervention (see table 1). Partnerships with local organizations will include grants and sub-agreements to assist with:

1. Training of trainers in A,B and C messages;
2. Organizational capacity development including monitoring and evaluation;
3. Material support with prevention education materials and
4. Vouchers to improve *access to* syndromic STI kits and HCT etc.
5. Implementation of program activities

Geographic Scope -

Recent data shows the highest HIV prevalence rates occur in urban areas located along major transportation corridors. A high level of mobility among commercial sex workers and transportation workers along these corridors pose challenges to access reduces the likelihood that they will exhibit health seeking behaviors from conventional service delivery points. In response, USAID/Ethiopia intends to support additional HIV prevention and care services along major transportation corridors that link urban and peri-urban areas of the country. To the extent possible the recipient should implement through well positioned indigenous civil society maintaining access to at-risk populations and communities.

The table below notes USAID's proposed areas of intervention. This broadly highlights several key transportation corridors which may contribute to substantial inter-regional truck transport. It is expected that implementation will begin in the 21 original towns that the HRCI has been working in and expand to the towns along the transportation corridors listed below in Table 1. The towns in Table 1 are suggested, however if after analysis of need the implementing agency identifies towns with greater need of risk than those listed below then those towns should be exchanged. The implementing agency is expected to detail the timing of scale up to these towns in order to meet the targets listed in section C.5.

Table 1

Target Towns							
South	**Southwest**	**West**	**Northwest**	**North**	**Northeast**	**East**	**Southeast**
Akaki	Alem Gena	Burayu	Muketuri	Sheno	Gewane	Adama	Aleta Wondo
Kaliti	Butajira	Holeta	Fiche	Debre Birhan	Mile	Wonji	Adola
Bishftu	Warabe	Addis Alem	Gebre Guracha	Debre Sina	Semera	Metahara	Shakiso
Modjo	Hossana	Ginchi	Dejen	Ataye	Asiata	Merti	Negele Borena
Meki	Sodo	Ambo/Guder	Debre Markos	Kombolcha		Kereyu	
Ziway	Arba Minch	Geddo	Fenote Selam	Desse		Asela	
Adami Tulu	Wolaita	Bako	Chagni	Bati		Awash	
Arsi Negele	Shone	Nekemte	Bahir Dar	Kemissie		Bordede	
Shashemene	Alaba	Gimbi	Woreta	Woldia		Asebot	
Wondo Genet		Nejo	Adis Zemen	Alamata		Miesso	
Awassa		Asossa	Gonder	Maichew		Asebe Teferi	
Yirgalem			Metema Yohan.	Sekota		Bedessa	
Dilla				Mekele		Gelemso	
Agere Maryam				Inda Silase		Hirna	
Yabelo				Adigrat		Karamile	
Moyale				Zala Anbesa		Kobo	
				Adwa		Deder	
				Aksum		Chelenko	
						Kulubbi	
						Kersa	
						Alem Maya	
						Dire Dawa	
						Mile	
						Dichoto	
						Ayisha	
						Harar	
						Babile	
						Jijiga	
						Hartishek	

C.3. ACTIVITIES/COMPONENTS

1. Program Activities

Expected Result #1: Increased access to and availability of interpersonal counseling, health services and social support activities for at risk populations

Structured curriculum-based approaches, like the widely used *Youth Action Kit* and *Life in the City*, exist to help meet the HIV prevention needs of youth and female student populations. Although considerable HIV prevention work is underway USAID envisions more deliberate efforts to promote behavioral change and enable preventive behaviors by at risk populations in selected towns. The successful implementing agency shall implement a portfolio of interpersonal counseling, interactive and mass media efforts that broadly address at risk populations. These messages should be developed in collaboration with specific at risk populations including, but not limited to truck drivers, commercial sex workers, sexually active widowed/divorced/never married women, young and middle-aged people engaged in transactional sex, etc., using client centered communication. Improving access to services will likely include vouchers for HCT. Additionally the implementing agency can increase access to evidence-based health services or medical products that can be delivered outside of the health facility by peers including syndromic management of STIs and male condoms.

USAID/Ethiopia has identified two essential entry points to improve HIV/AIDS outcomes for at risk populations: 1) Making STI services and HCT services accessible to members of at risk populations is a key element of HIV/AIDS care and treatment services and 2) HIV prevention activities including HCT for HIV negative individuals engaging in behaviors that place them at risk of HIV infection. Therefore, USAID emphasizes the importance of the implementing agency to:

A) Engage at risk individuals through local organizations,
B) Build mechanisms to ensure that HIV positive individuals complete referrals into HIV/AIDS care and treatment services and
C) Strengthen on-going counseling support to individuals who are HIV negative but at high risk of infection given their probability to exposure.

The implementing agency is encouraged to develop innovative ways for expanding services among at-risk groups considering the highly transient nature of many at risk populations, specifically CSW and transportation workers along transportation corridors. For example, in partnership with a number of transport companies, the High Risk Corridor Initiative program introduced behavioral change interventions targeting transport workers and their assistants and also created “safe” environments for them. Similar collaborative undertakings may expand STI and HCT services among at-risk and mobile groups. In addition, placing a strong emphasis on the provision of rigorous risk-reduction counseling in conjunction with STI treatment and HIV testing shall have important prevention benefits for at risk populations.

The implementing agency is encouraged to subsidize services for at risk individuals to reduce barriers to access for at risk populations. The implementing agency is expected to partner with community organizations through technical and financial support in the form of grants. Selection of local partners that can access at-risk populations and locations where formal and informal transactional sex occurs and may support the provision of quality HCT services will be an important component of implementation. USAID supports HCT in community organizations, health facilities, private clinics and mobile settings in towns along transportation corridors.

Illustrative Activities:

- Develop behavioral change activities for targeted at risk populations for HIV prevention in a participatory manner. These messages should be developed in collaboration with specific at risk populations including, but not limited to truck drivers, commercial sex workers, sexually active widowed/divorced/never married women, young and middle-aged people engaged in transactional sex, etc., using client centered communication.
- Integrate risk perception and risk reduction behavioral objectives into all activities.
- Support accessibility of male condoms to at-risk population segments.
- Integrate, promote and strengthen linkages between syndromic STI kits, and health services including HCT and ART into interpersonal prevention activities.
- Prioritize the involvement of at risk populations to develop, implement and evaluate HIV prevention activities
- Provide targeted referrals and subsidy to increase utilization of STI treatment, HCT service and ART access to at risk populations, specifically commercial sex workers, truck drivers, and individuals engaged in transactional sex;
- Identify practical economic strengthening to reduce vulnerability for at risk populations.
- Integrate violence and substance abuse topics into interpersonal prevention activities.
- Collaborate with USAID-supported partners to expand access to counseling and testing outreach through innovative outreach and promotion designed to access harder-to-reach, adult at-risk populations, especially truck drivers, commercial sex workers, sexually active widowed/divorced/never married women, young and middle-aged people engaged in transactional sex.

Please note: USAID does not envision this program to provide technical assistance to public or private health facilities to implement clinical services except in the area of STI diagnosis and treatment in public and private facilities. However, targeted subsidy to support availability and access to syndromic STI kits and HCT is envisioned.

Expected Result #2: Improved quality of interpersonal counseling, health services and social support activities available to at risk populations

The implementing agency shall address actual and perceived quality of interpersonal counseling, health services and social support activities by at risk populations. These populations are “hard to reach” and have low utilization rates of health services. Best effort should be made to improve service quality through the development of counseling standards and support to high risk individuals including through the use of case

management methodologies. Preventing or delaying HIV transmission among high risk individuals, specifically CSW, may substantially impact HIV transmission patterns through sexual networks.

Geographic coverage of comprehensive HIV/AIDS services in public and private health facilities are expanding throughout most urban and peri-urban areas in Ethiopia. Urban hotspots and locations along transportation corridors where at-risk populations congregate and form sexual partnerships are locations through which targeted subsidy and promotion of STI syndromic treatment kits, HCT services and ART services may improve health seeking behavior at risk populations. Community-based counseling and promotion of service utilization is limited outside of Addis Ababa. Despite expansion of clinic based services, it is difficult to determine service utilization by at risk populations. Continued promotion and facilitation of service utilization of STI, HCT and ART are important elements to reduce HIV transmission among at risk populations.

Illustrative activities:

- Quality improvement approaches to interpersonal counseling based on feed back from at risk populations and service providers
- Respondent driven methodologies to improve service awareness and inform service delivery
- Client education materials on health services and social support services produced in collaboration with at risk populations
- Frequent program assessments followed by modifications based on feedback from clients and service providers
- Implementation of performance based evaluations of service providers
- Identifying and facilitating mentoring opportunities for service providers, especially new staff and staff at risk of burn-out

Expected Result #3: Increased demand for interpersonal counseling, health services and social support activities among at risk populations

Increased behavioral change communication and client education are required for individuals to have an accurate risk perception of STI/HIV transmission associated with multiple and/or concurrent sexual partners or inconsistent condom use. Findings from behavioral surveillance surveys suggest that consistent condom use in transactional relationships remains low (probably because these relationships are not viewed as particularly risky). Although most CSW claim to consistently utilize condoms many have longer term relationships and some have unintended pregnancies. Therefore, further attention to self-risk perception for those in cross generational and transactional relationships is a priority. To date, greater attention has been given to commercial sex workers, but there is a larger group of individuals participating in informal transactional sex that may not understand their risk.

A number of prevention programs promote “be faithful” concepts however; few focus specifically on individuals who practice informal transactional sex with the objective of raising perceptions of risk associated with having multiple or concurrent sex partners.

The role of alcohol use/abuse appears to be a contributing factor in increased higher-risk behaviors. Prevention activities could more directly address the possible contribution of alcohol use or abuse to HIV risk, especially in venues in which individuals may meet sex partners.

USAID/Ethiopia encourages the implementing agencies to segment at risk populations noted in the program description and identify behavioral change objectives and mechanisms for each population segment. This may include interventions to increase self-risk perception, be faithful and condom utilization, and health seeking behaviors for STI, HCT and ART services. USAID/Ethiopia encourages the implementing agency to utilize structured interpersonal and interactive approaches to achieve changes in behavior that places at risk populations at greater risk of HIV transmission. Interventions should include activities to support utilization of STI syndromic management, HCT services and ART services. Furthermore, USAID encourages the implementing agency to address access and demand barriers concurrently by using targeted subsidy.

Illustrative activities:

- Collaboration with other USAID partners to ascertain best practices for reaching at risk populations
- Promotional activities to increase demand among the at risk population segments identified previously
- Intensive education/peer education of at risk clients who test negative for HIV, ensuring that messages given are appropriate to each at risk population segment
- Training of at risk individuals as lay-counselors

Expected Result #4: Improved social and policy environment for averting new HIV infections among higher risk populations

The social dynamics that contribute to the likelihood of women engaging in commercial or transactional sex (formal or informal) are complex however; poverty, gender inequalities and the absence of realistic economic alternatives play an important role. Transportation corridors, and the urban centers along these routes, create a unique set of circumstances for women entering into or continuing the practice of transactional sex. Helping women avoid taking part in transactional sex and assisting those already engaged in transactional sex to find alternative forms of livelihood can make a significant contribution to HIV/AIDS prevention and control efforts in Ethiopia.

In addition, when an individual is known to be HIV-positive, previous livelihoods can become threatened and income generation options limited. The economic viability of HIV-positive individuals, their families or households can be severely impacted and may affect the ability to seek care or practice adequate prevention measures to avoid transmission to others. Finding viable alternative livelihoods or income generating options may enable more HIV-positives to be or remain treatment and prevention compliant.

This component is part of a larger PEPFAR Ethiopia program to reduce risk through a range of multi-sector responses that build household assets. Result four is designed to provide creative options for alternative livelihoods and income generation activities for those engaged in formal and informal transactional sex and HIV-positives in economic need.

Illustrative activities:

- Training and hiring of at risk individuals as lay-counselors
- Training and hiring at risk individuals as peer educators
- Targeted scholarships for at risk individuals to participate in a range of education options

C.4. MONITORING EVALUATION AND KNOWLEDGE MANAGEMENT

1. Context of Monitoring, Evaluation and Knowledge Management

Gender equity will underscore all implementation activities. It will be necessary to assess and address barriers which limit access to services for women and girls, while ensuring that both male and female service providers are part of the implementation process.

To facilitate implementation the implementing agency will partner with and build capacity among local counterpart organizations to provide quality services and, over the course of the contract, to take a lead in monitoring and evaluation of program results through training, ongoing supportive supervision, and the provision of job aids to facilitate their work. Additionally, the implementing agency is expected to work with the district health offices and town health administrations to strengthen the capacities of their local organization counterparts and the participating communities to provide quality and integrated service delivery.

Given the fact that quality assurance is an integral part of effective service delivery, the implementing agency is expected to describe its approach to monitoring and the mechanisms it would apply for quality monitoring/ assurance and results monitoring. The description should include how capacity will be built in local partners' abilities to monitor and assure quality and results.

Commodities required (such as test-kits or condoms) to support outreach services should be coordinated with the Supply Chain Management Systems (SCMS) Activity. The Implementing agency may procure limited supplies as needed for activity implementation.

USAID requires that the implementing agency provide a specific statement on collaboration and the use of joint work planning with other U.S. government implementing partners involved with Health Communication's Partnership, HIV/AIDS Care and Support Project, CDC partners along transportation corridors, USAID/Targeted HIV Prevention Program, USAID/Civil Society Program and USAID/Private Sector

Program to synchronize activities to avoid duplication and extend services to as many possible Ethiopians in need of prevention and CT services.

USAID requires that the implementing agency provide a specific statement on how local partners will be selected, how grants to local partners will be awarded and monitored.

2. Elements and Approaches for Most-At-Risk Outreach Evaluation and Analysis

2.1. Analysis expected prior to implementation

When targeting MARPs in Ethiopia, there are several issues which can affect the success of implementation and the magnitude of program outcomes. Among those requiring particular attention are:

- *Formative research on risk perception* – 1. Risk perception within MARPs and 2. The level of income and or other opportunities necessary to alter high risk behaviors associated with transactional sex in Ethiopia are not understood. The potential for meaningful behavior change and more effective prevention communication would be enhanced if specific information about the nature of risk perception among target at-risk populations. Formative research on risk perception within MARPs and what activities would support behavior change will enhance programming for the Transportation Corridors Program.

- *Acceptability of HIV/AIDS service to at risk populations* – Acceptability within the target group needs to be measured and could be impacted by experiences of stigma and discrimination, perceptions of privacy and confidentiality, appropriateness and relevancy of interpersonal communication and printed materials, involvement in program planning and implementation, positive and negative experiences, and overall satisfaction.

- *Access to HIV/AIDS services* – Measuring and monitoring access is dependent upon an operational definition relevant to the service delivery networks. Access can be affected by such factors as distance to and location of service-delivery sites, stigmatization of clients by facility guards or other clients, waiting times, hours when outreach occurs, timing in conjunction with the likelihood of risky behaviors, degree of socio-cultural commonality with the outreach worker and convenience to clients.

- *Targeting of services* – Whether services are reaching the *specifically* targeted MARPs is a critical question that must be answered to determine the effectiveness of outreach. Optimizing coverage of MARPs may involve introducing alternative outreach efforts when gaps in coverage are discovered.

- *Monitoring uptake and individual coverage*- While geographic coverage provides information on the availability of services, the assessment of geographic coverage does not typically provide information on the uptake of services. Because people

in MARPs are often marginalized and face stigma and discrimination, even when services are available, they may not use them. So, it is important to monitor the utilization of key services for MARPs as an important component of assessing coverage.

3. Monitoring and Reporting

Among MARPs, it may be difficult to record the number of clients rather than client-visits or contacts. Nevertheless, information systems are needed that allow the tracking of individual clients. While client registers may contain personal identifying information, others may use a unique identification number. Drop-in services for MARPs may, for example, provide clients with a membership card containing a unique identification number. This allows individual clients to sign in for services without divulging personal identifying information. When conducting outreach in bars, cruising places, or at other venues, outreach workers may ask clients if they have been contacted by outreach workers previously and responses noted in a log book after providing outreach services to the client.

The implementing agency will develop and implement methodologically sound monitoring, analysis and evaluation of outreach mechanisms utilized in Expected results 1, 2, 3 and 4. The implementing agency is expected to employ baseline data collection and in-process monitoring of comparable indicators at the various preventive care implementation locations. Assessments will be evidence-based and be used to help decide which outreach interventions or service-delivery modalities most effective for most-at-risk populations along transportation corridors. The information made available will be used to determine which outreach-modalities are most attractive for wider replication in Ethiopia.

In implementing Component 4, the implementing agency is expected to apply its expertise and draw from its experiences to ensure that the monitoring, analytical and evaluation activities are robust and sufficiently rigorous to allow confidence in data or findings generated. Some of the monitoring and evaluation efforts envisioned for outreach work with most-at-risk groups include:

- Identifying key evaluation questions for high risk groups and prevention services; design and implement comprehensive M&E for high risk prevention services.
- Using current epidemiological data to guide strategic decision making re: geographic and high risk group programming and resource allocation.
- Utilizing formative evaluation techniques to identify gaps in knowledge regarding risk behaviors and context for high risk populations.
- Using a standardized monitoring system/approach to collect a common set of input and output data for service delivery.
- Applying a strategic process to evaluation, documenting implementation and the methods for adapting services to specific MARP sub-groups.
- Developing an outcome evaluation agenda for select, priority outreach programs and MARP sub-group populations.

- Developing and implementing a plan for feedback of data to service providers and managers with a focus on data use for program improvement.

The information generated is expected to measure or assess outcomes at multiple levels, including:

- Individual, client-based outcomes (such as, changes in clients': use of services, circumstances, status, quality of life or knowledge, attitude and behavior);
- Program or activity-level outcomes (such as, improved access to services, expanded livelihood alternatives, strengthened project partnerships);
- Community outcomes (such as, increased civic participation, wider involvement of local organizations in service-delivery).

4. Performance Indicators:

The Contractor shall incorporate the following indicators into quarterly progress reports. The following standard PEPFAR indicators are required to be tracked and reported regularly. All indicators should be disaggregated by gender, age and MARP wherever applicable.

Prevention/Condoms and Other Prevention Activities

- Number of individuals reached through community outreach for HIV/AIDS prevention through abstinence and/or being faithful
- Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence or being faithful
- Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful

Counseling and Testing (CT):

- Number of outlets providing counseling and testing according to national/international standards
- Number of individuals receiving CT for HIV and their test results
- Number of individuals trained in CT according to national/international standards

Alternative Livelihood and Income Generation:

- Number of individuals given scholarships and participating in educational opportunities
- Number of individuals participating in alternative livelihood or income generation activities
- Number of locations where alternative livelihood or income generation services are offered
- Number of Ethiopian organizations offering alternative livelihood or income generation activities because of program

In addition, other indicators should be proposed to track implementation progress and contribute to assessments of overall contract performance. Illustrative indicators should include, but are not limited to:

- Number and names of towns added to the network of expanded HIV/AIDS services by type (CT, prevention and alternative livelihood);
- Number and name of civil society organizations participating and receiving capacity-building assistance;
- Number of service outlets serving specific MARPs (disaggregated by age, gender and type of MARP including by occupation, marital status and participation in transactional sex)
- Prevention or CT counseling promotional materials/tools produced and distributed to client-level service sites/outlets;
- Number of individuals (disaggregated by age, gender and type of MARP including by occupation, marital status and participation in transactional sex) reached by CT, prevention and alternative livelihood extension efforts at each service outlet;
- Number of service referrals and percent of referral uptake
- Number of new training curricula/materials developed and adopted for use outreach services to MARPs.
- Work plan for collaboration with other USAID partners including in which areas of program design and implementation collaboration will occur. Work plan should outline how efforts will be coordinated and duplication will be avoided.

C.5. SCHEDULE OF DELIVERABLES

1. PEPFAR Indicators

PEPFAR Indicators	Number of individuals served, by sex	Number of people trained	Number of service outlets	Number of organizations provided w/ TA
Program Area				
Prevention				
Abstinence and/or Be faithful	400,000	5,000	1,500	
Abstinence	400,000	5,000	1,500	
Other Behavior Change	345,000	7,000	1,200	
Palliative Care (Facility/Community or Home-Based)				
Basic Palliative Care	350,000	7,000	300	
OVC	75,000	1,000		
Counseling and Testing	500,000			
Other Policy Analysis and Systems Strengthening				
Institutional Capacity Building		750		200
Stigma and Discrimination Reduction		750		
Community Mobilization for Prevention, Care and/or Treatment		1,000		

2. Targets (disaggregated by age, sex and type of MARP wherever applicable) Targets are listed annually, not cumulative:

	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
1. Number of Towns reached -	40	25	25	15	15	120
2. Number of MARPs reached with the following: a. Be Faithful Counseling or, b. Condom Counseling or, c. Vouchers for Syndromic STI kits and HCT services	300,000	350,000	350,000	250,000	250,000	1,500,000
3. Number of MARPs trained in risk reduction	85,000	85,000	85,000	45,000	45,000	345,000
4. Completed referrals for STI treatment	25,000	30,000	30,000	15,000	15,000	115,000
5. Completed referrals for HCT	125,000	125,000	125,000	85,000	85,000	545,000
6. MARPs participating in IGA's (participating defined as having received education, material/economic seed resources and currently implementing the IGA)	7,000	7,000	7,000	3,000	3,000	27,000
7. Percent sub-granting completed to local organizations	35%	45%	45%	50%	50%	NA
8. Number of local partner organizations reached with capacity development training ("capacity development training" is defined as the training necessary to address identified capacity deficits within the partner including: Monitoring and evaluation, quality assessment, financial management and leadership)	25	30	30	20	20	125
9. Number of Condom outlets available	400	250	250	150	150	1,200
10. Number of service providers trained in syndromic diagnosis and treatment of STI	400	400	600	300	300	1,600

- END OF PROGRAM DESCREPTION -