Report on Review of MMM Counselling and Social Services Centre, Addis Ababa, Ethiopia

A Lessons Learned and Documenting Exercise

February - March 2010

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Acknowledgements

I am indebted to all who made this review possible. In particular my special thanks go:

- To all who spoke with me and shared their ideas and lessons learnt especially support groups and beneficiaries of various activities of the Centre.
- To all the staff at the Centre, for their active participation in discussions in groups and in plenary meetings. Without their active collaboration, this review and lessons learnt exercise would not have been possible.
- To Sr Carol Breslin, the director of MMM CSSC for organising this review, providing logistical support and helping in every possible way to ensure the review was a fruitful exercise for everyone. She made available all the necessary reports and documentation. She also put in long hours compiling statistics.
- To Trocaire and CRS who funded this review and also contributed many valuable ideas to the review.

My hope is that this has been a learning experience for all who participated.

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19/4/2010

Acronyms

AACs	=	Anti-AIDS Clubs
ACS	=	Addis Ababa Archdiocese Catholic Secretariat
AIDS	=	Acquired Immune Deficiency Syndrome
ART	=	Antiretroviral Treatment
ARVs	=	Antiretrovirals
CAFOD	=	Catholic Agency for Overseas Development
CBR	=	Community Based Rehabilitation
CBO	=	Community Based Organisation
CDP	=	Community Development Programme
CHAD-ET	=	Children Aid Ethiopia
CMRS	=	Conference of Major Religious Superiors
CRDA	=	Christian Relief and Development Association
CRS	=	Catholic Relief Services
CWD	=	Children with Disabilities
DCs	=	Daughters of Charity
DOC-SML		Daughters of Charity - St Mary's Laboratory
ECC-SDCO	=	Ethiopian Catholic Church Social and Development Coordination Office
ETB	=	Ethiopian Birr
FIDO	=	St. Francis Integrated Development Organisation
HAPCO	=	HIV/AIDS Prevention and Control Office
HBC	=	Home-Based Care
HCP	=	Health Communication Partnership
HCT	=	HIV Counselling and Testing
HIV	=	Human Immuno Deficiency Virus
IGA	=	Income Generating Activity
KAP	=	Knowledge, Attitudes and Practices
LPA	=	Livelihood Promotion Activities
MMM CSSC	=	Medical Missionaries of Mary Counselling and Social Services Centre
NGO	=	Non Governmental Organisation
OVC	=	Orphans and Vulnerable Children
PICT	=	Provider Initiated Counselling and Testing
PLWH/As	=	People Living with HIV; People Living with HIV/AIDS
PMTCT	=	Prevention of Mother to Child Transmission
SCIAF	=	Scottish Catholic International Aid Fund
SILC	=	Savings and Internal Lending Community
SML	=	St Mary's Laboratory
VCT	=	Voluntary Counselling and Testing
YAK	=	Youth Action Kit

Executive Summary

After 18 years of work and service in the area of HIV and disabilities, the Medical Missionaries of Mary are handing over the Counselling and Social Services Centre in Addis Ababa to a Belgian Congregation of Brothers. Given that this handover is going to take place, it was felt that it was an opportune time to reflect and see what was learned over the last 18 years and see what developments had taken place since the last strategic planning exercise in 2006. Terms of reference were developed. Key stakeholders were consulted in order to see what achievements had been made. There was a particular emphasis on success stories and stories of changes that had taken place. A unique aspect of this review was a 'peer review' exercise carried out by other partners of the Joint Office of CAFOD, Trocaire and SCIAF. A workshop was organised in conjunction with the Joint Office to share what arose from the review and discuss relevant issues.

The review found that there was a significant improvement in the situation related to HIV. There was a decrease in the number of deaths from 70 in 1994 to 8 in 2009 and a decrease in the number of new clients from 518 in 1994 to 40 in 2009. The number of new orphans being supported decreased from 319 in 1994 to 103 in 2009. The Centre also had a number of other achievements:

- **Policy influencing** – MMM CSSC has been very effective in ensuring that there are effective Government policies in relation to HIV/AIDS. The Centre was also instrumental in influencing changes in beliefs and practices in relation to taking holy water and medicine together;
- **Collaboration with other institutions** – MMM CSSC and St Mary's Laboratory have both successfully collaborated with a number of Government departments, particularly key Government health institutions, in providing HIV tests and other tests necessary to start and continue on ART. This collaboration has been particularly successful according to Government officials;
- **Working with Orphans and Vulnerable Children** - From 1994 to 2009, 1,376 OVCs received various types of assistance from MMM CSSC;
- **Community-Based Rehabilitation** - MMM CSSC helped those with disability to come into the open and encouraged disabled children to go to school. It made a priority of integrating HIV and disability issues;
- **Use of innovative approaches –** The programme tried a number of innovative approaches in working with the community, such as house to house community awareness activities, having a home-based care programme by training caregivers in the community, holding inter-kebele sports competitions, and using the traditional Ethiopian coffee ceremony to provide education and basic facts about HIV.
- **Giving birth to new organisations** - 6 organisations working in the field of HIV/AIDS were founded by former staff or clients of the Centre.

A number of significant changes regarding HIV have taken place and the Centre has played a significant role in bringing about these changes. Increasing attention has been paid to HIV/AIDS in the media. This has helped to break down the silence, stigma, and discrimination associated with the virus. The introduction of the new Government policy in relation to HIV in 1998 was a significant milestone. The availability of ART has transformed the lives of so many people. The Centre made access to ART easier for many people and created an environment where people can live positively with an improved quality of life. The Centre follows up to ensure good adherence, which is critical to the success of ART. Access to ART has decreased stigma and discrimination.

Community awareness has increased. The number of people going for HIV tests has increased as people want to know their status.

In relation to the strategic plan significant progress has been made towards the achievement of the key objectives of the plan. The review also found that the Centre is well managed with an open and participatory management style. Appropriate autonomy is given to departments and career support leads to staff motivation. The Centre works in a focused geographical area, which contributes to the proper utilisation of resources, is cost effective, and enables timely supervision and follow up.

MMM CSSC has used a number of different strategies to implement its programme since 1992: networking and collaboration, empowering beneficiaries, being innovative and creative, working to change attitudes and behaviour, using community-based approaches and having phase in and phase out strategies. Many lessons have been learned as well as challenges faced from implementing these strategies and these have been documented in the review.

There has been a good relationship between the main donors and the programme. Apart from providing much needed funding for activities there has been a constant dialogue with all parties so as to learn from each other. One area where the programme learned from donors was related to savings and internal lending communities.

The Brothers of Our Lady of Lourdes (Brothers of Good Works), a Belgian Congregation, will take over the management of the Centre in mid 2010. There are a number of issues that are important to consider, especially in relation to maintaining the participatory management style and consolidating activities for the coming year. It is also important that current donors continue to fund for the next three years.

Recommendations include:

- The organising of a peer review of one partner of the joint office of Trocaire, CAFOD and SCIAF each year with a focus on lessons learned;
- The continuation of the participatory management style;
- The consolidation of activities for 2010 and the development of a new strategic plan in 2011;
- The continuation of funding for a further three years at a similar level to which the programme has been funded;
- The continuation of a link between MMM and the new management, especially in the early stages of the handover;
- The development of quality indicators for the programme;
- The addressing of the issue of incentives;
- The advocating with donors on the need for nutritional support for people taking ART.

Introduction

Ethiopia covers 1.25 million square kilometres, and borders Eritrea, Somalia, Djibouti, Kenya, and the Sudan. Ethiopia is organized into a Federal Democratic Republic composed of nine regional states and two administrative councils: Addis Ababa and Diredawa. Regional states are further organized into Zones, Kifle Ketemas (sub-cities) or Weredas (districts) and Kebeles. Kebeles are the smallest administrative units in Ethiopia.

Based on data for 2007[1], the total population of Ethiopia was 83,099,000, with 980,000 people living with HIV; this is a prevalence of 1.18%. About 67,000 people died of AIDS that year. The total number of people living with HIV requiring ART was 310,000 with about 90,000 people (29%), male and female, receiving it. The number of pregnant women needing medicine for prevention of mother-to-child transmission (PMTCT) of HIV was about 66,000 but the number that received it was 4,888 (7.4%). The number of children who had been orphaned by AIDS, i.e. lost mother, father, or both, and aged under 17 years, was 650,000.

Medical Missionaries of Mary Counselling and Social Services Centre (MMM CSSC) is a faith-based organisation that works under the auspices of the Ethiopian Catholic Church. A time line of the major events in the evolution of MMM CSSC is shown in Table 1.

Table 1: Major Events in the Evolution of MMM CSSC

Year	Major Event
1992	Beginning of MMM CSSC in September
1994	Client support group initiated
1995	AIDS Education moves from CMRS to MMM CSSC
1997	House-to-house awareness-raising activity MEKDIM receive legal recognition and CHAD-ET established
1998	Eth. government HIV/AIDS policy put in place
1999	CSSC catchment area Woreda 13 for all activities except Education MMM CSSC introduces Hospice concept in Ethiopia
2000	First community caregivers trained
2001	St Mary's Laboratory (SML) project agreement signed Laboratory begins HIV testing
2003	1st Braille book on HIV published
2004	Family caregivers trained and a 2nd Braille book published, on home care
2005	SML Outreach site began and ART is given free in government hospitals Sign language training for 10 staff
2006	5-year Strategic Plan, Community Development Program phased out and an agreement with Ras Desta Hospital on ART access is signed. 3rd Braille book on HIV counselling and testing (HCT) & PMTCT
2007	Agreement with St. Paul's Hospital on ART access is signed and phase-out from Yeka Kebele 05 takes place
2008	Food support is discontinued
2009	Phase-in CBR and Education activities in Arada K17. ART project reviewed 4th Braille book on ART is published and SML is handed over to DCs.

[1] Source: MMM Annual Report 2009 and Epidemiological Fact Sheet on HIV and AIDS, Ethiopia, 2008 Update

Methodology

Terms of reference were developed for the review; see Appendix 1 for a copy. In preparation for the field part of the review, all reports from 1994 were read in detail, as well as some selected proposals for Government and donors, and service agreements between hospitals and MMM CSSC and SML. The best practice survey and review of ART were also read. The new project director of the Centre joined the senior staff for the whole of the review. Regular meetings were held with the senior staff of the Centre during the whole review, especially on the question of lessons learnt.

Each department of MMM CSSC invited a selection of beneficiaries and other stakeholders, such as people living with HIV/AIDS (PLWHAs), members of anti-AIDS clubs (AACs), and savings and internal lending community (SILC) members. As well as getting the views of the various stakeholders on the work of the Centre and how it helped them, this also presented an opportunity to see who in the various groups was articulate and had something particular to offer for case studies and success stories to show the changing face of HIV.

A very particular aspect of this review was a 'peer review' exercise attended by partners of the Joint Office of CAFOD, Trocaire and SCIAF. Four partners as well as staff from Trocaire attended a half-day briefing by key staff from MMM CSSC on the activities of the Centre. The partners then met with some community members and visited a number of activities in the community. They then fed back their observations to staff of MMM CSSC, SML (now DOC-SML), and representatives of the Joint Office and Catholic Relief Services (CRS). This proved to be a very valuable learning experience for all and they asked that such 'peer reviews' continue in the future. Partners learned a lot from the experience and also made a number of valuable and incisive comments, some of which have informed this review.

A workshop was organised in conjunction with the Joint Office of CAFOD, Trocaire and SCIAF to share what arose from the review and discuss relevant issues. Appendix 2 is a copy of the schedule for the feedback meeting as well as the questions to guide the group discussion.

Recommendation: That the Joint Office of CAFOD, Trocaire and SCIAF select one partner per year and have a peer view of this partner with a focus on lessons learned.

Key Statistics 1994 - 2009

Appendix 3 gives a tabulated list of key statistics collected in MMM CSSC and St Mary's Laboratory (SML) from 1994 to 2009. Statistics from SML began in 2001. Table 2 is a summary of some of these indicators over selected years, i.e. every third year from 1994 to 2009.

Table 2: A Summary of Key Indicators of Achievement in MMM CSSC over selected years from 1994 - 2009						
Key Indicators	**1994**	**1997**	**2000**	**2003**	**2006**	**2009**
No. of clients who died	70			51	32	8
No. new clients for counselling CSSC	518	100	88	132	80	40
Cumulative total of clients	600	1,451	1,644	1,961	2,221	2,470
No. of orphans supported at end of yr	319	155	255	205	263	103
No. receiving pre test counselling CSSC				75	426	158
No. receiving pre test counselling SML				2,098	2,955	4,624
No. of new people getting care at home: CSSC				132	125	33
No. of home care visits: CSSC	118			2,712	3,140	837
No. who received training from Education Department: CSSC		590	611	767	269	217
No. of house to house visits: CSSC			21,469	15,085	2,227	6,624
No. of house to house visits: SML				4,827	5,035	9,804
No. of people reached by AACs + Peer Educators: CSSC		23,536	35,564	21,000	41,227	29,920
No. of disabled starting school	2	9	3	17	5	10
St. Mary's Lab.: No. HIV tests				2,675	2,740	3,618
SML: Total no. other tests				8,124	10,763	38,269

The table shows that key indicators used to measure the effects of HIV indicate a significant improvement in the situation:

- A decrease in the number of deaths from 70 in 1994 to 8 in 2009;
- A decrease in the number of new clients from 518 in 1994 to 40 in 2009;
- A decrease in the number of orphans being supported from 319 in 1994 to 103 in 2009. There are a number of reasons for this decrease. One was the phase out from Yeka Kebele 05 as well as an overall decrease in orphans, not just AIDS orphans but orphans in general. Another reason was that other NGOs took over some orphan support, e.g. Hope for Children;
- A decrease in the number getting home-based care from 125 in 2006 to 33 in 2009;
- There was a big increase in the number of people getting HIV tests in SML as well as other laboratory tests.

Numbers getting house to house awareness vary depending on the size of the kebele and the time of year the activity takes place. Motivators selected from the community provide the awareness and if motivator training takes place in the middle of the year, they start straight away and may cover a moderate number of homes for the rest of the year. If training takes place at the end of the year the motivators have the whole year to visit so numbers will be higher – hence the variation in houses visited from year to year.

Major Achievements

A number of key achievements were identified from reading of annual reports and feedback from various stakeholders.

Policy Influencing
The Centre has been very effective in ensuring that there are effective policies in place to help PLWHAs. The Centre and its first director, Sr Joanne Bierl, were very key activists[2] in ensuring that the Government put in place a policy in HIV/AIDS. This policy was eventually put in place in 1998. MMM CCSC was also instrumental in influencing changes in beliefs and practices in relation to taking holy water and medicine together. It led to the Patriarch of the Ethiopian Orthodox Church declaring that one could take both ART and holy water. He stood up at the Meskal feast in 2007 and said it was all right to take both holy water and medicine. Patients have now started to take both holy water and ART. A respected member of the Orthodox Church also came to the Centre and gave a series of sessions to Centre beneficiaries about holy water. As part of this review, one person stated that she had stopped taking ART as she was told she could not take it with holy water but after these sessions, she changed her mind and is now taking both.

Those attending the review feedback meeting stated that they had learned that it is possible to change what were seen to be fixed practices through negotiation. One example given was that staff influenced changes in religious attitudes and practices related to not taking ART with holy water.

According to the director of ECC-SDCO (of Addis Ababa Archdiocese), MMM CSSC has influenced thinking in the Archdiocese, and the Centre has given training for the ECS Healthy Choices HIV Programme.

Collaboration with Other Institutions
MMM CSSC and SML have both successfully collaborated with key Government health institutions. St Mary's Laboratory (SML) has been collaborating with St Paul's Hospital and Ras Desta Demtew Hospital for the last three years in providing HIV tests and other tests necessary to start and continue on ART. MMM CSSC then provided necessary social services for people to maintain adherence to treatment. MMM CSSC and SML staff provided and supervised home care services for those accessing ART. The medical director of St Paul's said that 'collaboration with MMM and St Mary's Laboratory was 'fantastic'. It was the first time for his hospital to co-operate with an NGO and he was not sure how it would work. However, "It has been a great success and I am delighted with the way it has worked," he said.

The programme has been collaborating with other institutions as well. There is very good collaboration between the Education Department of the programme and the Government-run AIDS Resource Centre. The Education Department has been working with anti-AIDS clubs (AACs). The Centre helped AACs to get operating licences and now clubs do education through entertainment such as drama, music and puppets. It is both entertainment and education. They use coffee ceremonies as a means to get youth together.

[2] From a personal communication with Sr Carol Breslin, the current CSSC director: Dr Agonafer of CRDA said that Sr Joanne would never be forgotten for what she had done to get a Government HIV/AIDS policy in Ethiopia.

Working with Orphans and Vulnerable Children (OVCs)
MMM CSSC has built up a good reputation for its work with orphans and vulnerable children (OVCs). From 1994 to 2009, 1,376 OVCs received various types of assistance from the Centre. According to CRS, MMM CSSC is the best of the 7 partners they support as they help the OVCs to stand on their own. One of the greatest examples of this ability to stand alone is a family of five orphaned boys.

Case Study
Within 200 metres of the palace of the former Emperor of Ethiopia, and now the residence of the Prime Minister, live five extraordinary boys in a small one-roomed house measuring 12 ft by 7 ft. While many boys in a similar situation would go on the streets in search of better opportunities, these five boys are determined to make the most of the opportunities they are receiving to educate themselves in the hope that education will open a bright future for them.

Having lost both parents, their mother in 2002 and their father in 2005, the five boys were left in their shabby one-roomed house, without any close relative to look after them. Their furniture consists of one bed and mattress, one sofa, a small table for study and a few cooking utensils. The room is very clean and is lit by an energy saving bulb and a small window. The toilet is 50 metres away.

The oldest boy is Abebe[3]. He had to leave school early. He used to be very active and hardworking and was able to feed his 4 younger brothers with the money he made selling chewing gum, tissue paper, candies and biscuits. He was also a good sports person: he was goalkeeper with a local club called Abyssinia FC. The pressure on the young shoulders of Abebe and the loss of both parents got the better of him. He turned in on himself and stayed at home all the time. He seemed to have become depressed.

His four brothers are all in school, each one doing better than the others and all in the top ten in their classes. One of the boys is doing exceptionally well and is second in his class this year. A few years ago he got a prize as the best student in his class. One of his teachers knew his story and she asked him to speak with the whole school on parents' day about his life so that he could inspire other students with the way he overcame adversity and suffering to reach the top of his class. The second boy, Samuel, will finish school next year and he hopes to get government support to study engineering in Addis Ababa University. The third boy, Abera, hopes to finish in 2012 and go on to study law. The fourth boy, Getenet, is also doing very well but due to sickness he lost three years in school and is in the same class as his younger brother Tesfaye. Getenet is the budding football star of the family and is a member of the school under 15 team. His team won a major competition last year. He scored 4 goals.

The pressure that Abebe felt on his young shoulders brought the boys closer together. They divided out roles and responsibilities. Samuel took over household responsibilities: he makes breakfast every morning and decides on the amount of food they need for the month. They buy bread or injera and cook the sauce themselves. There is no rota for cooking: whoever feels like it cooks and it works well, they said. Sometimes the

[3] These are not the real names of the boys.

neighbours invite them to their house or cook and bring them food. They are healthy, hardy looking boys.

Abera took over the responsibility for money and budgeting and he became the key contact person between the MMM CSSC and the boys. Their father had been counselled at the Centre before he died. The Centre helps the boys with fees when required, uniforms, medical expenses and some food. They also receive some support from a kind benefactor from Australia who channels his money through the Centre. Once they receive the money they buy all the food stocks they need. The Centre also renovated the shabby little room and made it into the cosy, compact room it is now.

Abebe has also got a new lease of life. He is now working in a local carpentry workshop and the money that he earns is used to buy clothes and shoes for the rest of the boys. He hopes to resume his footballing career one day.

They are very disciplined boys. They have their own house rules; everyone is up for 6.00 am, must be in the house by 8.00 pm, and light is turned off at 10.00 pm. If any of them needs to be out later in the evening he must be back by 9.00 pm. They are very religious and go to the local Orthodox Church every Sunday. It is their faith that gives them direction and strength to continue, the boys said. Their faith brought them through the crisis and continues to give them daily strength, they said.

Community-Based Rehabilitation

MMM CSSC helped those with disability to come into the open and encouraged disabled children to go to school. There were 168 children with disability going to school from the Centre catchment area from 1994 to 2009: see Appendix 3. Physiotherapy is very important for community-based rehabilitation and is very much appreciated by the families of children with disability.

MMM CSSC made a priority of integrating HIV and disability issues. CBR field workers work with the Counselling Unit and Education Department staff to mainstream HIV education into the CBR Department and vice versa. This helped to create good communication between parents of children with disabilities (CWDs) and PLWH/A. Nebyat is a young girl who has benefitted greatly from the use of this integrated approach. Her story is recounted in Appendix 5. Despite being severely handicapped and HIV positive, she is now on ART and is doing very well. When she first came in contact with the CBR Department at 8 months of age, her weight was 1.15 kg. It is now 12 kg. She gets regular physiotherapy from CSSC staff, which has been extremely beneficial. Nebyat will soon be able to walk on her own. Her mother plans to get her into a local kindergarten next year.

In 2003 the CBR Department for Children with Disabilities, in conjunction with the German Church School, produced 200 copies of a book in Braille with HIV information for the visually impaired. It was the first book of its kind in the country. In 2004, 200 copies of a second Braille book were published on HIV/AIDS home care. A number of staff attended sign language training to provide HIV counselling and education for persons with hearing impairment.

As well as integrating HIV and disability issues, the Centre has also encouraged a culture of openness regarding disability. Asheber Ademasu is one person living positively with

disability who talks openly about his situation and plans to use his name to create greater awareness on the issue.

Case Study on Community-Based Rehabilitation
Asheber Ademasu is a well known musician, singer and song writer and a talented music teacher. He was diagnosed with polio when 1 year old. Despite this challenge, he started school at the age of 6 in Kidane Meheret Catholic School and finished secondary school in Menelik II School. This school has facilities for handicapped. When he finished 12th grade he learned carpentry. He then used his carpentry skills for 4 months.

However in the back of his mind he had always wanted to be a musician and he felt he had skills in that area. Having received all the necessary qualifications, he had no instruments so he asked MMM CSSC if they could provide him with a keyboard. He had already been in contact with the CSSC some years previously when they helped him with splints he needed for his legs. Having received the keyboard, he launched himself into his musical career, playing at night clubs and weddings. He also began to teach students and he set up his own studio at the side of his parent's house. It is a narrow 12ft by 4 ft studio with two keyboards and a guitar. He is also a song writer and he arranges music for songs. He has appeared twice on Ethiopian TV singing his own songs and his songs are played regularly on radio. Currently he is preparing more songs for a TV appearance. He said that he is eternally grateful to MMM CSSC as they opened the door for him to realise his dream. Without their help, he would have been unable to purchase that elusive first instrument. He occasionally does some work for the Centre. He still has a passionate interest in disability and his next dream is to prepare some media programmes on disability. Appendix 5 gives more comprehensive details on Asheber.

Using Innovative Approaches
Another major achievement was the successful use of innovative approaches in working with the community. Some of the more innovative ones include:

- **House-to-house community awareness-raising** activities using community motivators. This reaches previously unreachable people such as housewives, house maids, the elderly, disabled, and unemployed: 16,428 people received awareness in this way in 2009. See statistics in Appendix 3. The person(s) in the house continue their work as the community motivator talks with those in the household. The visit usually lasts about an hour and there is a return visit to discuss the information. The motivator talks with those present about HIV. Those suspected of having HIV symptoms are identified and advised to go to the Counselling Centre or St. Mary's Outreach site for counselling. If necessary they are provided with support. Previously house maids would wash clothes that might be contaminated with body fluids without precautions; now they know it is dangerous and know how to protect themselves. According to people interviewed this awareness-raising approach proved to be very successful, both in providing HIV information and building relationships in the community, because until about 1998, CSSC personnel were unable to work directly in the community because of stigma and discrimination.
- **Having a home-based care programme by training caregivers in the community**. The caregivers were given appropriate training and one unique aspect was the encouragement that staff gave to the caregivers to use local herbal remedies with which they were familiar and knew to be effective. The family was also involved as much as possible. A home care handbook was published in Amharic and English, since at that time there was no standardized curriculum for home care.

- **Inter-kebele sports competitions** to mobilize the youth and generate media attention. General knowledge competitions are conducted to pass on HIV information to youth in Arada Kebeles 11/12 and 13/14 and Gulele. Young people organize the competitions in schools, kebeles, and anti-AIDS clubs, with technical help from the Education Department. According to members of AACs interviewed, children from the kebeles where MMM CSSC is active achieve a much higher score on general knowledge competitions organised by AACs in schools. According to those spoken with, more students and out of school youth from MMM CSSC catchment area look for HCT, compared to other areas. AAC members give HIV awareness in night schools. Many housemaids go to school at night and relax later with different partners, which make them vulnerable to getting HIV.
- **Using a traditional Ethiopian coffee ceremony** to provide education and basic facts about HIV, about disability and services available, and develop support for children with disabilities, people living with HIV, and their families. This activity targets the family, neighbourhood, and the community as families invite neighbours to their homes. It is a very effective way to get access to the community and aims to help reduce stigma and discrimination and facilitate open discussion about these issues.
- **Responding to people with special needs with activities** like the child-to-child program where children with disabilities are integrated with children who are non-disabled by playing together and helping disabled children in school and in their neighbourhoods. A mother-to-mother program was developed where mothers living in the same area that had children with the same type of disability met in their homes. Members shared their feelings and ideas openly, and developed companionship so they could make positive decisions for their children. Braille books and sign language are used to give HIV information to those with visual and hearing problems.

Giving Birth to New Organisations

Compared to other organisations working in the field of HIV, MMM Centre staff have a lot of experience, knowledge, and understanding of PLWH/As as well as practise in working with them. This has been a key factor in delivering the achievements outlined above. Many people availing of the services of the Centre noted the professionalism, knowledge, and understanding of staff.

This knowledge and experience has had another offshoot – the founding of 6 other organisations by former staff or clients of the Centre. The following organisations have been formed from the Centre.

- Hope for Children: Yewoineshet Masresha, a former staff member of the Centre founded it ;
- St. Francis Integrated Development Organisation (FIDO): a former staff member of the Centre, Zelalem G/Egziabiher, founded it;
- CHAD-ET: the first deputy administrator of the Centre founded CHAD-ET and is its director. Currently CHAD-ET has twelve major projects broken down into five major sectors: Health: HIV and reproductive health; Education: non-formal with a special focus on alternative basic education; Child Sexual Abuse and Exploitation: prevention and rehabilitation; Livelihood Promotion; Research and networking on children’s issues. Now CHAD-ET has an annual budget of approximately US$1million with twelve different donors.
- Mekdim: the first client of the Centre was one of the founders of Mekdim;

- Tesfa Goh (Dawn of Hope): one of the previous beneficiaries of the Centre founded it;
- Tesfa Berhan, an association of AIDS orphans, was started by an orphan who had received assistance from the Centre[4].

Mekdim and Tesfa Goh were the first associations of HIV positive persons in Ethiopia. Mekdim was started in 1997 from a support group at the MMM Counselling Centre, including the first client. In 1999 it became fully independent of the Counselling Centre. It now has a budget of 45 million ETB, according to one of its founders. Both CHAD-ET and Mekdim, have a budget significantly bigger than the budget of MMM CSSC.

CHAD-ET is one of the organisations which emerged out of the Centre and was founded by Anannia Admassu. He was one of the first employees of MMM CSSC. He saw the organisation grow from scratch and learned knowledge as well as practical skills on starting an organisation. Anannia saw a need for a specialised organisation to support children in need. In fact Anannia was so focussed on setting up a programme in Ethiopia that he even sacrificed the chance to go to live permanently in America. He won a lottery in 1995 that would have enabled him to go to America with his family and start a new life there. However he wanted to give to Ethiopia some of what he had received in terms of life and education.

In 1997, he left MMM CSSC with their blessing and started work immediately in CHAD-ET. Initially it was difficult. Through a strong recommendation from MMM, he got support from Oxfam to rent an office, buy a computer and photocopier, and received some seed money. Oxfam also gave him a used car but it was sufficient for his needs. Oxfam also funded some MMM CSSC activities at that time. When he had financial difficulties MMM CSSC gave him a loan, which he subsequently paid back. Since then he has never looked back. Now he has an annual budget of approximately US$1 million with twelve different donors. He calls MMM CSSC his mother organisation from which he learned all the basics of setting up an organisation to help others.

Good Management

The Centre is well managed with an open and participatory management style. In group discussion on the feedback from the review, three of the four groups noted that they learned that a participatory management system was able to achieve what was planned and helped in the development of new ideas. Appropriate autonomy is given to departments and career support leads to staff motivation, they stated. CRS stated that the management was very strong – on time with good reports and all their documentation is good. The director of ECC-SDCO made a similar point.

It is also noted that the Centre works in a focused geographical area. This contributes to the proper utilisation of resources. It is cost effective, enables timely supervision and follow up, and makes accessibility easier for beneficiaries.

Changes

A number of significant changes in the situation regarding HIV have taken place from the time the Centre first became operational. The Centre has been quite central to some of these developments. Since the late 1990s, the media gave increasing attention to the

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[4] This group is no longer in operation.

problem of HIV, and helped to break down the silence, stigma, and discrimination associated with the virus. There was frequent contact between the Centre and the media and a number of radio programmes and newspaper articles were written about people utilising the services of the Centre.

Another important step came in August 1998, when the Government of Ethiopia released a policy on HIV/AIDS. The policy states that its objective is to provide an enabling environment for the prevention and control of HIV in the country with a focus on proper home and community-based health care and psychosocial support for people living with HIV, orphans and surviving dependents. It was envisaged that non-governmental organizations, the private sector, and communities would be encouraged to take measures to alleviate the social and economic impact of HIV.

Availability of ART and the Changes that Have Taken Place in People's Lives

The availability of ART has transformed the lives of so many people. At the end of 2005, free ARVs were introduced through PEPFAR funding and Government health institutions. Previously one could get a three months supply if one had money, but this was out of the question for many people, including clients of the Counselling Centre. At a meeting with 25 members of a HIV support group the members had this refrain: 'Because of MMM, I am here'. Many used the word 'resurrection'; their lives have come alive again.

The Centre made access to ART easier for many people and created an environment where people can live positively with an improved quality of life. Some are beginning to earn their own living and send children to school; others are self employed. Kebede Chere is just one of a number of people living with HIVAIDS who spoke of the change that ART has brought to his life. Kebede worked as an assistant on a bus and lorry. He had many sexual partners on his various journeys outside Addis Ababa. Eventually he became infected with HIV and developed AIDS. He was very ill and suffered discrimination from his own family. Through a friend, he made contact with SML and following counselling, he went to St Paul's Hospital for treatment. He is now feeling much better and hopes to get on with his life. The story of Kebede is the story of many people spoken with who have AIDS but are now on ART.

Good adherence is critical to the success of ART. MMM CSSC follows up to ensure good adherence. According to the 2009 annual report, adherence of MMM CSSC and SML-counselled clients is almost 100%. The medical director of St Paul's Hospital verified this and commented on the positive effect of follow up to ensure adherence. Support groups seem to be particularly effective in encouraging ART adherence according to members of a support group spoken with. Sisay Demesse adheres to her treatment and is another living and inspiring example of the change that ART has brought.

Case Study

Sisay Demesse is a personification of the positive changes outlined above. Appendix 5 gives all the details of her story. While most people will have one or two traumatic experiences in life, Sisay has had to endure a number of such experiences. She had a very promising academic career. Twice she skipped a year having being promoted by her school. However it all changed one day when she was abducted by a soldier and raped when she was 14. She had two boys by age 18, buried the father of her two children by

19, and found out that she had AIDS when she was in her twenties. She said that her weight reduced to 23 kg and after 6 months of TB treatment, she had a HIV test in a Government hospital. When she heard she was positive, she burned her clothes and documents as she thought she was going to die. She was so angry that she did not want to see anyone, including her children. Given that she was so angry, she took a long time in counselling to accept her situation. Her neighbour told her about the MMM Counselling Centre and all the support she would get there. When she came to the Centre, she got counselling and some food. The counselling rebuilt her confidence. She even had the confidence to talk openly about her situation and her status. She received some training in the Centre and began to speak at coffee ceremonies, in factories and schools about her situation. In fact, when she realised the situation she had been in and the way she had been treated by 'her husband', this gave her the energy and confidence to talk openly. She now wants to teach other women about how to defend themselves and stand up for their rights. She said that she had no say in her life. When she was 'abducted' she had no say. She had no say on what her 'husband' was doing when he was out of the house. He confined her to slavery while he was away. She has had no other sexual partner and yet she has become the victim. While reflecting on this, Sisay says she gets energy to try and make life better for other women.

In her own words, Sisay has had a resurrection. She has gone back to school and is in grade 8 at present. She has found her peace and her calling, she says. While she gets many advances and requests from men she is determined to stay as she is, look after her children – the eldest is 14 and the second is 12 - and try and make Ethiopia a better place for some women at least.

Writing in MMM News in 2010, Sr Carol Breslin reflected on the impact of ART on people living with HIV/AIDS.

> "I was reflecting on how much the scene at the Counselling Center and in the homes of our clients has changed since treatment for HIV became generally available here at the end of 2005. When I now arrive in the morning, instead of meeting rows of very ill people and their desperate relatives awaiting what little we could provide for them in the way of medicine and food, I now encounter clients back to normal health, meeting to discuss how best to save their money in internal lending groups. I saw two men, previously bedridden, sharing a joke as they waited for others to arrive. Instead of seeing monthly client support group meetings with their members encouraging each other to live positively until they died - usually in a year or two - every day there are two or three meetings of clients, family members, young people, and others discussing topics related to behavior change. When our nurse-counselors and home care givers visit clients' homes they no longer come upon scenes of despair for families trying to cope with caring for their dying members. They don't meet young children, unable to attend school, caring for their ill parents and then becoming orphans. Instead of trying to cope with weekly funerals and their own burnout, counselling staff are now involved in counselling families about how to help their HIV positive members adhere to treatment and in doing pill counts. Children are now reminding their parents to take their medicines on time".

Staff are no longer experiencing burnout. In the past, staff experienced high levels of stress from nursing people with AIDS and attending funerals. They are now seeing positive developments. As one staff member said, 'We are now teaching people how to live; in the past we were teaching them how to prepare for death'.

Decrease in Stigma and Discrimination

Access to ART has decreased stigma and discrimination. Most of the PLWHs spoken with said that stigma had decreased. At a support group meeting of 25 PLWH/As, eight people spoken with said that stigma and discrimination had decreased. However they feel it is much more subtle nowadays. They said that they are no longer thrown out of their rented accommodation due to HIV but they are told that the rent has to be raised to a level they can no longer afford or they have to move out as a family member is coming to stay in the room.

PLWHs also feel that they are better able to cope with it. Sisay Demesse said that while there is less discrimination and stigma, she knows what discrimination is. She has been shunned by friends and neighbours but one particular incident brought home to her how people perceive her when they know she is HIV positive. There is a school where she does some training. She has a friend who teaches in the school. He did not know that she was positive until one day he heard that she had been in speaking to the children about her story. Since then he keeps '100 yards from me in case he might come in contact with me', she said jokingly. Another woman said, 'We used to cover our faces coming to MMM [CSSC] but now we talk openly and will talk with anyone; we are not afraid any longer'.

Increased Community Awareness

Community awareness has increased. The number of people going for HIV tests has increased as people want to know their status. This is a major change in the last eight years. See Appendix 4 for the reasons people go for a test in SML. The number going for a HIV test has increased from 1,065 in 2002 to 3,418 in 2009 – a 320% increase. The number requesting a test in order to know their own status increased from 481 in 2002 to 2,278 in 2009 – a 473% increase. This indicates a greater awareness of the benefits of knowing one's status and a greater openness among people to express their status. In Ethiopia, testing rates more than doubled between 2007 and 2008—from 51 tests per 1000 population to 121 tests per 1000 population respectively (AIDS Epidemic Update: November 2009 UNAIDS).

Reflecting at the presentation at the review feedback, the director of the Centre stated that nowadays the Centre is able to work mainly in the community – requests come from the community - whereas in the early days the Centre had to strongly encourage the community and schools to engage.

Progress Towards Achievement of Strategic Plan

The following is an update on the implementation of the strategic plan of 2006. Appendix 6 gives a detailed update on the implementation of the strategic plan.

Progress Towards Achievement of the First Objective

The first objective of the plan was to maximise the potential that new HIV/AIDS treatment regimes offered. The key strategy identified to achieve this objective was to use the comparative advantage of the Centre and the Laboratory and link up with Ministry of Health institutions authorised to give out new HIV/AIDS treatments. The Centre began to work first with hospitals because staff thought there might be too many patients to include health centres. In 2009, the Centre and SML began linking with health centres. The following are the key achievements:

- Management creates an environment whereby MMM CSSC and SML along with St Paul's Hospital and Ras Desta Hospital can collaborate effectively and efficiently. MMM CSSC and SML programme staff prepare clients to get ART. A CD4 count machine was purchased. Training on the use of the machine was given. Treatment guidelines for tests were developed and basic laboratory tests as a package are now being provided. MMM CSSC and SML staff follow up clients to ensure proper adherence and provide nursing care and psychological support. The hospitals provide the medication.
- One fruit of the collaboration was that in 2007 St. Paul's Hospital organized a 2-week introductory course on ARTs for nurse-counsellors from St Mary's Laboratory and the Counselling Centre. Topics included adherence counselling, ARTs and side effects, recognizing opportunistic infections, and family counselling. In 2010, St Paul's Hospital gave training on Provider Initiated Counselling and Testing (PICT), and trained SML and CSSC staff on how to do rapid HIV testing.

A review was carried out in 2009 of the pilot project between MMM CSSC and St Mary's Laboratory and Ras Desta Hospital and St Paul's Hospital. The review team interviewed 144 clients for the study, 46 from Arada Kebele 11/12, that mostly use Ras Desta Hospital, and 98 from Gulele Kebele 18 who use St Paul's Hospital. The following are the conclusions from the review:

- The consequences of HIV/AIDS fall mainly on women. Most clients on ART are women; they usually have little or no education or skills and the burden of care for the family falls on them. They often depend for their income on menial labour, begging, or are unemployed and depend for survival on outside support.
- Providing medicine is not enough. There are many hidden costs that are not covered by programs such as PEPFAR, such as transport to access ART-related services, adequate food to maintain adherence to treatment, and money for treatment for opportunistic infections.
- Hospitals and health centres are not able to follow-up clients who have started ART at home. They cannot provide psychosocial support or involve the family.
- Provision of social support is critical for most clients. Whether provided in cash or kind, these services have been almost totally dependent on support from donors outside the country and this raises serious questions about the sustainability of our projects to provide even the basic necessities of life to clients. As more people are put on treatment this raises serious questions about the sustainability of the provision of ART.
- Many clients, especially women, cannot support themselves adequately because they lack skills. Those who are widowed or separated and have young dependents cannot go to work.

The review concluded that overall the collaboration has worked well and seems to be an effective way of using available resources, using individual strengths, sharing services to help clients to access ART, and supporting them in adherence to treatment at home. The main gap identified in the approach was a lack of feedback between the parties and a lack of communication between some departments, e.g. on availability of social services.

Progress towards Achievement of the Second Objective

The second objective of the plan was to utilise the knowledge and experience of the Centre to strengthen the capacity of other HIV/AIDS organisations. A training co-ordinator was appointed; a brochure and a list of potential courses were prepared. A

resources materials document and an academic profile of Centre and SML staff were prepared. A payment structure for local and international organizations was prepared. The number of training courses conducted was very limited over the past 2 – 3 years as the level of requests was not as anticipated. This was due to an expectation from other organisations of free training services from the Centre. This had been the tradition in the past. Despite this, 30,340 ETB[5] has been taken in to date. The money has been used to set up a training room and pay for the equipment.

Progress towards Achievement of the Third Objective

The third objective of the plan was to build in phase-in/phase-out strategies in all programme activities. A 'phase-in/phase-out strategy, a typical cycle for HIV activities', was developed in 2008. Activities in Kebele 05/06 in Yeka Kifle Ketema were phased out completely by the end of June 2007. Plans for phase-out from Arada Kebeles 11/12 and 13/14 are in place. St. Mary's Laboratory was handed over to the Daughters of Charity on October 1, 2009. Phase-in in Arada Kebele 17 began in early 2007, first for the CBR Department for Children with Disabilities and then for the HIV Education Department.

In 2007, the Centre handed over general HIV education in schools to AACs. 'Licensed' anti-AIDS clubs (AACs) have their capacity built to deliver general HIV education. The Community Development Program (CDP) was phased out at the end of 2006. Remaining activities were integrated into the Social Services Unit.

With relevant staff, the executive director of the Centre revised and updated the current policies in relation to how to support people from outside the identified catchment areas and how to offer services of St. Mary's Laboratory to people from outside the service area of the laboratory.

Progress towards Achievement of the Fourth Objective

The fourth objective of the plan was to develop strong co-ordination mechanisms in all programme activities. In relation to internal co-ordination, weekly co-ordination meetings of all programme co-ordinators are held to share plans for the coming week, to see if areas of duplication can be addressed, and to share resources, especially transport. A weekly meeting with senior staff is also held to share activities of the previous week, provide information, and share common concerns. The holding of monthly management meetings of the management board and programme co-ordinators proved to be impractical. In terms of training, individual staff members are sponsored for various training courses. In relation to external co-ordination, efforts to avoid duplication were included in project proposals and networking activities. Written agreements were made with all partners and organisations working with the Counselling Centre and St. Mary's Laboratory.

Lessons Learnt

MMM CSSC has used a number of different strategies to implement its programme since 1992. Based on a reading of various reports and discussions with staff, six key strategies that the Centre used in implementing the programme were:

- Networking and collaboration;
- Empowerment of beneficiaries;

[5] €1 = 18 Ethiopian Birr (ETB) approximately

- Innovation and creativity;
- Working to change attitudes and behaviour;
- Community based approaches;
- Phasing in and phasing out

Discussions were held with staff to see what lessons they had learnt in the process of implementing these strategies.

Networking and Collaboration

This was a key strategy right from the very beginning of the programme. In the annual report of 1995 (p. 16) networking and collaboration with other agencies was flagged as an important aspect of the activities of the Centre in the future.

The following lessons have been learnt by the Centre:

- Networking and collaboration works. It has been very beneficial to the work and service provision of the Centre.
- Using networks and getting to know good collaborators is a means of ensuring access to quality services.
- It has been mutually beneficial as the Centre gained new knowledge, e.g. the Youth Action Kit (YAK) from Health Communication Partnership (HCP) and information obtained from the AIDS Resource Centre. The Counselling Centre was also able to provide knowledge and services as well as strengthen follow up to these organisations.

However there are a number of issues that one needs to consider when using a strategy of networking and collaborating based on the experience of the staff of the Centre:

- It takes a lot of time and energy;
- Members are not always equally committed, which means the burden of work can fall on a few committed people;
- It is most effective when the number of organisations involved is few e.g. collaboration between St Paul's Hospital and MMM CSSC is between two committed partners and the CBR Network has 14 members and is very effective. On the other hand, the Care and Support Network between the HIV/AIDS Prevention and Control Office (HAPCO) and NGOs is not effective. There are over 100 members and the Government tends to control such networks.
- Membership of a network should be voluntary, meeting a need of its members and not just meeting a Government need or requirement.
- Networking with local associations costs money as local associations like idirs[6] want to be paid to participate.
- Government Office to NGO networks tends not to be as effective as NGO to NGO networks.

Empowerment of Beneficiaries

Irish Aid (2006, p 28) found that key elements of an effective response to HIV include:

- The strengthening of local capacity to implement programmes;

[6] An idir is a traditional funeral association.

- The inclusion of people living with HIV/AIDS in programme development and implementation and support programmes that address the impact of HIV/AIDS on communities.

One means to empower beneficiaries was the use of livelihood promotion activities (LPAs) for PLWH/As and their dependents. Based on the experience of staff this approach works under the following conditions[7]:

- Do not always expect that the beneficiaries will be economically successful but it helps to build the self confidence, especially of PLWH/As. The organisation must be prepared in some situations to take a loss.
- An LPA has a better chance of succeeding if the person implementing it:
  - Is reasonably healthy i.e. able to work most of the time;
  - Has previous relevant business experience;
  - Is genuinely interested in the activity. Of particular importance are small family businesses where any family member can help out if and when needed – small shops, etc.

Livelihood promotion activities (LPAs) for anti-AIDS clubs (AACs) do not work because:

- AACs are not stable: members are mostly youth who are looking for a job and support is for a club, not an individual.
- AACs tend to have a lack of responsibility as well as a lack of commitment to the LPA.
- Economic support to groups in general tends not to generate income as there is a lack of ownership of the work: what belongs to all belongs to no one.
- It is difficult to organise youth into groups.

Some General Points

The following are some general points that staff have learnt from the various departments in relation to LPAs and income generating activities:

- Support to start an individual business should be given in kind not in cash.
- If staff are not business people it is difficult to help as required.
- Close follow up is critically important and members of LPA groups should make some financial contribution to the work of the group;

In relation to counselling and education:

Another means to empower beneficiaries is to help them with counselling and education. Family members in HBC and CBR are able to care for family members and other community members through community care givers. However with the decrease in bed ridden patients, community care givers, who are themselves HIV positive, are able to help with peer counselling and adherence counselling.

Innovation and Creativity

The Centre has tried out a variety of approaches to working with PLWHs and the community. Different approaches are needed for different target groups. For example

[7] In the process of the peer review, a representative of Mekdim shared their experience of income generating activities (IGAs). They found that IGAs are most successful for groups, but groups of women rather than men.

sports, music and drama target the youth; coffee ceremonies are an appropriate way to reach housewives and housemaids; and Braille books and sign language target the blind and deaf. Having used a variety of creative approaches staff have learned the following:

- A participatory management style is required, where ideas from all sources are welcome and discussed and implemented if felt appropriate;
- One needs to be a constant learner: be a learning organisation;
- Most of the staff are studying and this is encouraged and is a source of ideas (80 – 90% of fees are paid if the study is considered relevant).

Working to change attitudes and behaviour

The Centre has over the years worked to change attitudes and behaviour of different groups they are engaged with. There is evidence that change has taken place. For example MMM CSSC staff met with those in charge of the HIV programme at the Ethiopian Orthodox Church to see what could be done about the belief that one should not take medicines and holy water at the same time. As a result Orthodox Church programme staff arranged training and education for Church leaders, explaining that taking any medicine with holy water was not a problem. This culminated in the announcement by the Patriarch at the Meskel celebration. This was important in relation to ART and medication for epilepsy.

Attitudes have changed in relation to sharing information in relation to one's HIV status and the number of people going for HCT in order to know their status has increased. KAP surveys have shown attitudinal change: fewer people say that HIV is a punishment from God. These surveys also show increased knowledge about the transmission of HIV from mother to child. There is a large increase in the number of people willing to come forward and testify about their status and how it has affected their lives. Many people on ART have stopped smoking, drinking, chewing chat, etc.

The following lessons have been learnt from trying to change attitudes and behaviour:

- Working to change attitudes and behaviour takes effort, time, and patience. It needs intensive and varied approaches to bring about change.
- Intensive house to house visitation leads to an increase in number of people going for VCT.
- Involving PLWHs and children with disability and their families is very important in bringing change. For example, CBR field workers transferred their skills to the families and families are now taking care and responsibility for their disabled. Disabled people are now visible where previously they were not. Families now care for PLWH/As at home where previously this did not happen. Now the work load of the community care workers has greatly reduced.
- Staff need to keep updated on the most current information re HIV; this was noted as very important. The director of the Centre regularly provided staff with the most up to date information on HIV as well as information on CBR.

Community-Based Approach

This was a key strategy right from the very start. In the annual report of 1994 (p. 3), it was stated that there is a need to 'integrate the services made available for our clients with the community. The Center is making an endeavour to start community-based care for people with HIV/AIDS'.

Having used community-based approaches for the last 15 years the following lessons have been learnt:

- You can reach the community effectively using this approach;
- It saves a lot of time and resources as there is a multiplier effect through organised groups. You don't need to go continuously to the community: give them the knowledge and skills and they will do it. Using community groups gives access to a much wider audience;
- Working in the community gives one access to a whole range of groups one may not normally or easily come across e.g. idirs, women's groups, AACs, etc.;
- The community can do a lot of the work themselves: parents of CWDs run the physiotherapy programme at Kidane Meheret, community care givers do a lot of work in the community, etc. However, community care givers only work for a short time even when getting an incentive. They tend to leave once they get a job. This is similar for AAC members;
- While community-based organisations like idirs are willing to participate in training, they will not support people in need like PLWHs from their own resources e.g. to provide food, shelter, etc.

There are **challenges** in working through the community:

- The community assumes that money comes for them and that the NGO workers are using it for themselves. AACs face similar problems. Despite the AAC members truly being volunteers, the community believes that MMM CSSC has given the AACs money for the community but that the AAC members keep it for themselves. This discourages the members of the AACs.
- Different NGOs give incentives and the community tends to work with the organisation giving the best incentive. This has created an expectation of incentives.
- If you are known as a HIV support organisation like MMM CSSC, your presence can create stigma. Previously if a staff member of MMM CSSC was seen going to an area, it was assumed that there was someone in the area with HIV. People preferred to come to the Centre rather than being branded as having AIDS.
- Local coping mechanisms can be eroded, e.g. in Kebele 05, where a great deal of support was given, and this was one reason for phasing out of the kebele. The community previously had their own support mechanisms. When MMM CSSC started to work there, the Centre beneficiaries came to depend on MMM CSSC and many of their traditional mechanisms have broken down.

Phase In and Phase Out

The Centre made phase in/phase out a key strategic issue in the plan for 2006 – 2011. Based on the experience of using this approach the following lessons were learnt:

- Communities and people do not believe the organisation will phase out until it actually happens;
- There is resistance from the community and clients as dependency is deep rooted;
- There is a particular challenge when working with PLWHs and disability as their condition is long term;
- There is need to allocate a special budget for phase out activities;
- It is best not to take on long term clients once you know you will phase out in a 12 month period;
- It is best to inform clients that you will phase out at least 12 months in advance;

- Local CBOs like idirs will not take over activities without a budget and incentives;
- LPAs were provided for anti-AIDS clubs to generate resources for their work and become self-supporting but they did not work.

Challenges Facing the Programme

The Centre faced a number of challenges in implementing its programme. A recent but very significant challenge has been the substitution of cash for food for people on ART. All the care givers and guardians of orphans spoken with said that they prefer food and oil to money as the money is not sufficient to buy the basic necessities and is a minimum to cover expenses. One care giver said that two years ago she was able to buy one hen with 50 ETB whereas nowadays it takes 100 ETB to buy a hen. At times, staff have been hassled by PLWHs because the PLWHs think that department staff have control over the allocation of food and make decisions about what type of support those on ART receive.

One participant in the review felt that there is need for consistency in messages given through HIV education. In the peer review exercise, it was noted that there was some inconsistency in the education messages given through AACs. It was noted that fidelity was being confused with abstinence: youth were saying that they will be faithful to one partner when the message being communicated was abstinence. Peer reviewers said that there is a tendency of young people to say that they will be faithful to one partner even though the person may be twelve or thirteen years of age. There is need for clarity in the message that is being communicated: if one is teaching abstinence, this means abstinence. Fidelity is different.

There is a growing tendency to give incentives to primary and secondary school students to attend training: this issue was highlighted at the presentation of the review findings. It was a surprise issue for donors present. Many organisations are giving incentives for children to attend training on HIV. If the Centre staff are giving training in a school they may have to give 15 ETB for an incentive. Most organisations are doing this nowadays. When the Centre staff went to give education in the seminary, the seminarians asked for money. When they were given 25 ETB, they said that was not sufficient for adults. However this raises a serious question. Should seminarians be paid to have education that will be beneficial to their future work? There is reduced participation of local community groups in activities as they now have an expectation of incentives for their participation.

There is a challenge of working with local Government especially at kebele level (MMM Annual Report, 2005, p. 17; MMM Annual Report 2007, pp. 28, 36; MMM Annual Report 2009, p. 19). There is a high turnover of administrative staff in kebeles (MMM Annual Report 2007, p. 28). Kebele officials often act unilaterally with no prior information to demolish buildings used by AACs (MMM Annual Report 2005, 17). Teachers are also unable to give the required time to do HIV education because the government education policy states that teachers must use their time only for subjects on the curriculum. With two shifts teachers have little time for other activities.

Most AACs are not doing well with IGAs due to carelessness and lack of responsibility for the IGA as they are volunteers and therefore it is hard to make a consistent commitment; they are always looking for a job

The availability and positive impact of ART has offered new opportunities as noted already but also some challenges. There is an increasing laxity with sexual behaviour as some people with HIV feel that with effective ART they can continue with their old risk behaviours. Students have told CSSC staff that there is no problem about having sex with people whose HIV status is not known because one can always get post-exposure prophylaxis (PEP).[8] Pregnancy is becoming common after women start ART. In the Counselling Centre Annual Report 2009 (p. 33), it was written, “We consistently raised this issue (getting pregnant) during group and individual counselling so people could make informed decisions on this aspect of their lives. In this reporting year we had 9 pregnant women and 8 gave birth”.

There is a challenge handing over a centre like MMM CSSC to another congregation. While the Archdiocese of Addis Ababa had heard three years ago officially that MMM would be handing over the Centre, the initial reaction was one of shock and surprise, according to the director of ECC-SDCO of ACS. The reason for the shock and surprise was that MMM had such a central role in the development of both the church and government response to HIV/AIDS. Initially he did not believe that it would happen but then 12 months ago he realised it was actually going to happen. He feels that both the Congregation running a programme and the Archdiocese have to actively seek partners who would take over a programme as it is not an easy task to get a suitable partner. Based on this experience the director feels that one needs to think ahead regarding sustainability and the long term future of a programme as it is not easy get a suitable partner and transfer programmes from one congregation to another.

Resources Developed by MMM CSSC
MMM CSSC has developed a number of resources down through the years. Appendix 7 is a list of these resources. The resources are available for any interested organisation or group working in the area of HIV and community-based rehabilitation.

Contribution and Role of Partners/Donors in the Activities of MMM CSSC
MMM CSSC has a number of donors and supporters but two are the main ones. One is the Joint Office of Trocaire, CAFOD and SCIAF and the other is CRS. The relationship has been fruitful for all parties. Apart from providing much needed funding for activities there has been a constant dialogue with all parties so as to learn from each other. This point was emphasised particularly by the project officer from Trocaire. He said that he learns something new on each visit, e.g. that good adherence to ART is an indicator for measuring progress of PLWH/As. He also noted that MMM CSSC shared with Trocaire the research that it carried out on ART. Trocaire, in turn, shared it with others, especially to influence donor thinking on the impact of the food crisis on people on ART. He said that Trocaire used the findings of the research to discourage other donors from stopping food assistance to PLWH/As. In fact donors spoken with are sympathetic about the provision of food to people on ART and are hopeful that the new PEPFAR funding will make provision for food support for PLWH/As.

An area where MMM CSSC learnt from donors is related to savings and internal lending communities (SILC). This is an approach to saving introduced by CRS. SILC groups are

[8] PEP is recommended for health care workers and others who may have been exposed to infection with HIV. However, it is not always effective and must be given soon after exposure. It may not be easily available when needed.

groups of people who come together to save money and then loan out the savings to the members according to the rules of the group. For example, there are 7 SILC groups in the CSSC: 3 for adult clients, 3 for caregivers of orphans, and 1 in the CBR Department, with a total of 134 members. Each group has its own regulations. According to the regulations of one group a member can borrow money, which will be paid back in 3 months with 10% interest. A SILC group has 2 main purposes. The first is for the members to support each other and the second is to help each other generate income so that they can become self sustaining.

All the interviewed members of SILC groups in MMM CSSC were HIV positive but this is not a condition for membership. They were formed through their contact with the MMM CSSC programme and at one stage all the members of the two groups involved in this review were getting assistance from MMM CSSC. Today only 2 of the 15 members who met the review team were still getting assistance. One group had current capital of 4,500 ETB in a bank account at the time of the review. The second group had 2,500 ETB, kept in the house of the treasurer. Some members organized themselves into a subgroup to start a business in poultry farming. They began the process of being registered with the Kebele Credit and Savings Office to obtain legal status. Once registered, they can qualify for a loan from the Kebele but they cannot have another loan: one loan at a time is the rule.

Concerns and Issues for Follow-Up during Handover and after Phasing-out of the Medical Missionaries of Mary

The Brothers of Good Works, a Belgian Congregation (official name is Brothers of our Lady of Lourdes) will take over the management of the Centre in mid 2010. There are a number of issues that are important to consider.

Staff are very experienced. Ten of the thirty staff members have been with the Centre at least ten years and four of the eight members of the senior staff in the review have been with the Centre for fourteen years or more. They are able to do the day to day management of the Centre. It is important that the participatory management style that has been a feature of the Centre continue and that staff are supported to continue the work they have been doing.

It is also important that the Centre consolidate activities for this coming year. This will allow the new senior management to find their feet and allow the rest of the staff to get on with their work. The fact that there is still one year left in the strategic plan will facilitate this continuity. In 2011 the current strategic plan is due for review. It will be an appropriate time for the new management to do a new strategic plan in the light of their charism and vision for the Centre. Given the significant changes that have taken place in the environment in which the Centre operates, e.g. the increasing life expectation of PLWH/As, there is need to plan effectively to address this changing environment.

It is also important that current donors continue to fund for the next three years. It is a time of major transition and one of the potential destabilising factors in any programme is funding. If funding is assured at the current level for three years, it will give time for the incoming management to find their feet, develop a new strategic plan, and stabilise the programme.

To ensure an orderly transition and continuity especially over the first twelve months, it is important to create a link between MMM and the new management especially in the early stages of the handover. This may entail a number of mentoring visits and some ongoing correspondence between the outgoing MMM management and the incoming management.

There are a number of issues that arose during the review that need to be considered:

- There is need to emphasise quality indicators to see what works well and what does not work especially in the area of HIV education and in relation to LPAs. There is a need to closely monitor to see what are the best ways to effect behaviour change, what are the most effective media to use, the role and needs of AACs and what ought to be the content of messages. There is need to address the confusion between encouraging abstinence and the belief that fidelity to one partner is sufficient to reduce the spread of HIV. In relation to LPAs, what is the best way to promote these activities? What is the potential for SILC groups? The experience of Mekdim could act as an important resource. It is important that there be clarity in the objectives of LPAs.
- The issue of incentives has to be addressed. There is the issue of incentives paid to students in school to attend training. The Centre, in conjunction with its donors and the various networks, could spearhead a discussion on how best to address this challenge and see if it is possible to have a unified approach to address it. There is also the issue of incentives for some volunteer partners like AACs and idir members. It would be useful to visit and consult with other organisations to see what the Centre can learn and discuss this with the donors of the Centre.
- The Centre needs to advocate with donors on the need for nutritional support especially for people taking ART.

Recommendations

The following are the key recommendations:

- That the Joint Office of CAFOD, Trocaire and SCIAF select one partner per year and have a peer view of this partner with a focus on lessons learned;
- That the participatory management style that has been a feature of the Centre continue and that staff are supported to continue the work they have been doing;
- That the Centre consolidate activities for this coming year and that a new strategic plan be carried out in 2011;
- That current donors continue to fund the Centre for the next three years at a similar level to which they have been funding;
- That a link continue between MMM and the new management especially in the early stages of the handover, either through mentoring visits or ongoing correspondence between the outgoing MMM management and the incoming management;
- That quality indicators in the area of HIV education and in relation to LPAs be developed and closely monitored to see what works well and what does not work;
- That the issue of incentives to students and volunteers be addressed;
- That the Centre advocate with donors on the need for nutritional support especially for people taking ART.

Appendix 1: Terms of Reference for Review

'Lesson Learned and Documenting' Exercise
MMM Counseling and Social Services Center
Integrated HIV Program in Addis Ababa

Background to the review

Because the Medical Missionaries of Mary (MMM) are withdrawing from Ethiopia after many years of dedicated services in the area of HIV and AIDS, this review offers to the MMM, the Joint Office of CAFOD, Trocaire and SCIAF, CRS and the wider stakeholders an opportunity to learn from the MMM Counseling and Social Services Center activities in the last 18 years in Addis Ababa. The MMM Counseling and Social Services Center participated in a best practice survey and a strategic planning exercise that helped to document some achievements in the past. This participatory learning exercise will be useful in covering areas that were not covered adequately in the past, while giving more emphasis to developments since the last strategic planning exercise.

The MMM Counseling and Social Services Center (CSSC) was established in September 1992 as one of the pioneer HIV organizations in Ethiopia. It has provided a wide range of complementary services, including counseling social and food support, home care, HIV education and training, and orphan support. Its Department for Children with Disabilities has helped to meet the special needs of the disabled in relation to HIV. As part of its latest strategic plan it facilitated access to ART for people living with HIV in 2 kebeles in Addis Ababa.

In 2000 the MMM also took over St. Mary's Laboratory (now DOC St. Mary's Laboratory and Free-Standing HCT Center), previously run by the Daughters of Charity, and expanded the general laboratory to include HIV testing services. HIV counseling, education, and home care services are also provided. As part of the withdrawal process, the MMM handed over the Laboratory to the Daughters of Charity in October 2009.

The five year strategic plan, designed by the MMM Counseling and Social Services Center and St. Mary's Laboratory (SML) at the beginning of 2006, identified **4 major areas** of focus.

1) To complement the government's effort to provide increased free access to ARV treatment, the MMM CSSC and SML provided quick and affordable laboratory facilities such as HIV and CD4 tests; proper pre and post test, ongoing, and adherence counseling; and appropriate social and nutritional support for clients. CD4 tests are required as an ongoing part of ARV monitoring, and are fairly expensive.

2) The MMM CSSC has been instrumental in the emergence and proper establishment of many non-governmental organizations, CBOs and anti-AIDS clubs working actively today to reduce the spread of HIV and its impacts. The Counseling Center has been systematically documenting its experience to share this with others using various activities including formal training.

3) The Counseling Center planned a smooth phasing-out from its catchment area in 2006, which covered 6 Kebeles in 3 sub cities of Addis Ababa. As of these ToR, it has already moved out of 2 sub cities, including Gulele Sub-city, where DOC St. Mary's

Laboratory and Free-Standing HCT Center is located. The Strategic Plan (SP) incorporated a series of interventions intended to consolidate activities of the MMM CSSC, while facilitating a gradual phase-out from the existing geographical areas by the end of the SP period.

4) The MMM CSSC planned to develop stronger coordination between its varied program activities to minimize unnecessary duplication of efforts and to benefit from better sharing of experiences, plans, achievements, and challenges.

The MMM Counseling and Social Services Center has already made significant progress towards these strategic objectives, which have been captured on an ongoing basis in the periodic reports prepared by the CSSC and SML. Thus, it would be a good learning exercise to identify the major developments so far and reflect with other partners and stakeholders of the CSSC, the Joint Office, and CRS.

"It helps, now and then, to step back and take the long view. The kingdom is not only beyond our efforts; it is even beyond our vision. We accomplish in our lifetime only a tiny fraction of the magnificent enterprise that is God's work. Nothing we do is complete, which is another way of saying that the kingdom always lies beyond us. No statement says all that could be said. No prayer expresses fully our faith. No confession brings perfection; no pastoral visit brings wholeness. No program accomplishes the church's mission. No set of goals and objectives includes everything."[9]

The foregoing statement, which was quoted by MMM from Archbishop Oscar Romero's strong message, reminds us to be humble in whatever we do. However, it would also be equally important to take a proper record of all the successful accomplishments and challenges and document them properly as a lesson for our future work in helping those surrounded by different life challenges.

1. Aims

This review, which is intended to be a 'lesson learning' exercise, could help us achieve a number of goals:

- To examine in more depth the major achievements during the period before the Five Year Strategic Plan(1992- 2006) and to assess the progress made in relation to the selected four strategic focus areas of the five year strategic plan.
- To identify key 'success stories' or case studies with the potential to inform other works of the Joint Office, CRS, Government and other NGO projects.
- To benefit from **peer learning** by involving other organizations working in similar areas. Looking at issues together can help us work together and learn together for the benefit of ongoing and future collaboration. Involving other partners can expand this peer learning.
- To bring in outside expertise to: i.) see what has been achieved, what approaches have worked; ii) take on board other/outside views and experiences.

[9] Extract from Sr. Carol's 2009 annual report covering letter where she quoted Archbishop Oscar Romero's helpful words

- To share and discuss results of the program and follow-up the implications with beneficiaries, other community groups, and government offices.
-

2. **What issues to look at?**

Though we are aware that there has been some effort to document the lessons from the work of the MMM CSSC and St. Mary's Laboratory in Ethiopia for the period before the SP (1992-2006), it would be very useful to reflect again on some of the achievements and challenges faced since the beginning of the program. However, more emphasis needs to be given to the development after the new strategic plan. With this background, the lessons-learned exercise or review will focus on the following areas:

a. What worked well and why in relation to the main services and interventions provided by the MMM CSSC and SML: counseling, social services, education, orphan support, special services for the disabled, HIV testing, helping clients access antiretroviral treatment, etc. What are the major achievements in these areas?
b. What did not work well and why? What were the major challenges in the intervention areas mentioned above?
c. How did the face of HIV and AIDS change in Ethiopia as witnessed by senior staff members of the CSSC, SML, and beneficiaries? This is to see the **changing trends,** starting from the very challenging times of the early years while also trying to look at the foreseeable future.
d. Take full inventory of the resources developed by the MMM CSSC (hard and soft copies)
e. Assess the contribution and role of partners/donors in the activities of the Counseling Center.
f. Assess concerns and issues for follow up during handover and after phasing-out of the Medical Missionaries of Mary from Ethiopia.

3. **Methodology to be followed**

i. **Literature review**: Study of the available documentation to identify what worked well and what did not with reasons identified. Documents to be consulted may include:
    a. The five year strategic plan
    b. Current Project Proposal with government
    c. Project agreements with the funding partners, local partners, including the government hospitals, and local authorities
    d. Yearly Narrative and Financial Reports since 2006
    e. Best practice report, case studies, and stories documented

ii. **Case studies and stories of change (success stories)**: The consultant will interview relevant staff members and beneficiaries to show the changing face of HIV and AIDS and trends as mentioned above. This might also include case studies and stories developed in the past.

iii. **Peer review through field visit and discussion with beneficiaries and other stakeholders**

Partners and stakeholders of the MMM CSSC, DOC St. Mary's Laboratory and Free-Standing HCT Center, the Joint Office and CRS will reflect on the progress made so far in relation to the four strategic objectives. The relevant staff members of the Counseling Center will give a short briefing on the progress made in relation to each goal before the participants are invited to visit, observe, and discuss the actual work on the ground together with other staff members and beneficiaries involved. This will help to facilitate different informal interactions and learning for the participants and the Counseling Center. After visiting the work, each team will give a short presentation identifying the major lessons and recommendations for future improvement. This will be captured by the consultant for further discussion at a workshop in Addis at the end of the process. The consultant will be responsible for organizing the different groups and give them the necessary guidance. (2 to 3 days)

iv. **Reflection workshop**: This will be a one day workshop, which will involve key interested parties including partners, beneficiary and Sub-city representatives, regional bureau representatives, other NGOs working in Addis, etc. (one day after the completion of the peer review exercise, giving one day in between for preparation for the consultant)

v. **Documenting**: One of the key intentions of the exercise is to document this 'learning'. The emphasis will be to get a full documentation of the lessons from the MMM Counseling and Social Services Center and St. Mary's Laboratory activities in Ethiopia, including achievements, approaches followed, and challenges encountered. This can be prepared in the form of a review report, including 'case studies' and short stories that can be easily read and used by relevant actors in the future. The report is also expected to include the long lists of important resources developed by the MMM CSSC.

vi. Disseminating/sharing relevant information to stakeholders follows once documenting is completed.

4. Roles and responsibilities

The Joint Office of CAFOD, Trocaire and SCIAF, the MMM Counseling and Social Services Center, and CRS-Ethiopia have initiated this lesson-learning exercise or review to be conducted through the support of an external consultant.

The Consultant

- Will be responsible for undertaking literature reviews and organizing and facilitating the peer review sessions.
- Will prepare stories of change and case studies as outlined above.
- Will prepare and present the major findings of the review or the lessons-learned exercise at the stakeholder workshop.
- Will prepare the final report, documenting all the major findings of the learning exercise.

MMM Counseling and Social Services Center

- Will participate in the development of the ToR for the review.

- Will facilitate the review exercise based on the ToR developed and agreement signed with the Consultant.
- Will provide the necessary support to the consultant.
- Will organize the final stakeholders' workshop
- Will assign relevant staff members to give briefings at the beginning of the peer review exercise.

The Joint Office and CRS

- Will develop the ToR for the review.
- Will support the MMM CSSC in the identification of a consultant.
- Will help in organizing the peer review exercise.
- Will make finances available for the consultancy service and the final workshop

5. Time table

A maximum of 20 working days:

- Literature review by the consultant (5 days)
- Case studies and stories of Change (5 days)
- Peer review exercise including preparations (5 days)
- Review Report writing (5 days)

6. Fee and costs

- Fee for the consultant to be negotiated
- Transport for the consultant to be covered separately.
- All other costs, including accommodation and food, will be paid separately.

Appendix 2: Timetable for Review Feedback and Summary Points from Meeting

Activity	Person Responsible	Time
Opening of Workshop	Yared	9.00 – 9.10
Explanation of the Process	Eamonn	9.10 – 9.15
Presentation of Achievements - statistics	Abebe	9.15 – 9.30
Key Achievements	Abebe and Eamonn	9.30 – 9.40
Success Stories	Tiringo	9.40 – 9.55
Changes since 1990s	Sr Carol and Abraham	9.55 – 10.10
Update on Strategic Plan	Sr Carol, Sr Minia,Tesfaye, Getenet, Abeba	11.10 – 10.45
Coffee/Tea Break		10.45 – 11.05
Lessons Learned	Sammy, Alemu, Tsehaye, Tesfaye, Getenet	11.05 – 11.35
Challenges	Eamonn	11.35 – 11.45
Open Floor for Clarifications	Eamonn to facilitate	11.45 – 12.00
Lunch		12.00 – 1.00
Group Discussions		1.00 – 2.00
Feedback from Groups	Eamonn to facilitate	2.00 – 2.30
Discussion	Eamonn to facilitate	2.30 – 3.30
Closing	Yared	3.30

Questions for Group Discussions

- What were the three most important things you learned today based on the feedback?
- What are three issues that the programme has to address in the future?
- Are there any general issues (maximum of three) that emerged that might be a challenge to any organisation working in the field of HIV?
- Is there any advice (a maximum of three pieces) you want to give to the new management when it takes over later this year?
- Any questions or clarifications in relation to the feedback?

Summary Points from Feedback Meeting

To the first question: What were the three most important things you learned today based on the feedback?

The following is a summary of the consolidated answers:

- It is possible to change what were seen to be fixed practices through negotiation, e.g. staff influenced religious leaders to change practices related to not taking ART with holy water.
- The history of the Centre showed that it overcame many difficult challenges and did not give up, e.g. challenges like discrimination, the resistance of donors to provide funds, and the lack of availability of treatment. ART is now available but was only a dream in the 1990's.
- An open management system worked to achieve what was planned and helped in the development of new ideas. Appropriate autonomy was given to departments and career support lead to staff motivation: three groups.
- The use of a holistic approach, which is based on strong counselling, empowering the beneficiaries, offering social support, providing LPAs, and establishing SILC groups: two groups stated this.

- The Centre is a pioneer and parent organisation to other organisations like Mekdim, CHAD-ET, and FIDO. It was also the first to start HBC.
- Doing group IGAs is a very difficult task.
- The Centre is adaptable: it can change its program activities and polices depending on the situation.
- Working in a focused geographical area helps to utilize resources properly, is cost effective, enables timely supervision and follow up, and makes accessibility easier for beneficiaries.
- Empowerment of the beneficiaries by transferring new knowledge. Examples are: saving scheme, skills training, urban gardening, and LPAs.

To the second question: What are three issues that the programme has to address in the future?
The following are the consolidated answers:
- It is important to define the objective of activities. This is essential to evaluate their effectiveness and know what works well and does not work, e.g. LPAs, IGAs.
- Incentives and dependency is an issue. Can networking help with this?
- Sustainability can be developed through sharing others' experience in IGAs, e.g. Mekdim.
- Need to increase awareness raising activities in schools and with the youth (to focus on abstinence).
- There is need for a phase-out fund to sustain the LPAs.
- It is better to learn from other organisations.
- Nutritional support has to be continued for those on ART and those who are ill.
- The need for documentation of best practices.
- Create awareness early, before phase out.
- Strong networking with other organisations to avoid duplication of activities. Share experiences and mobilise resources.

To the third question: Are there any general issues (maximum of three) that emerged that might be a challenge to any organisation working in the field of HIV?
The following are the consolidated answers:
- Sustainability of ART;
- Sexual behaviour is a choice, but what messages are we giving? You cannot be abstinent or you can be faithful?
- Need for collaboration among groups working on HIV especially in regard to sustainability and provision of services, especially in poor populations;
- Incentive issues;
- Support: always asking for more food, especially for those on ART;
- Complacency: have we become complacent and are we simplifying the disease?
- Poverty: scarcity of resources;
- Rural → urban migration, e.g. the case of Gulele Sub-city;
- Using IT and computers for presentation, e.g. for this review seminar;
- Self-stigma creates dependency, high expectations, lack of motivation, and an expectation of incentives for voluntary activity.

To the question: Is there any advice (a maximum of three) you want to give to the new management when it takes over later this year?

The following are the consolidated answers:

- Learn from staff with experience, including an open management system.
- Be open to new ideas, e.g. technology and keeping staff updated.
- Prepare to address issues such as phase out fund and incentives.
- Prepare a strategic plan based on the good qualities of the previous one.
- Respect the legacy of the past.
- Increase target group and areas.
- Ensure community ownership.
- Look at the issue of incentives for primary and secondary school students.

Notes from Feedback

The following issues emerged during the plenary discussion:

- The issue of incentives, especially for children, was discussed and it was a surprise issue for donors present. Many organisations are giving incentives for children to attend training on HIV. If the Centre is giving training in a school staff may have to give 15 ETB for an incentive; most organisations are doing it nowadays. When the Centre staff went to give education in the seminary, the seminarians asked for money. When they were given 25 ETB, they said that was not sufficient for adults.
- What does 'holistic' mean? It can mean a package of activities and services or it can mean placing the focus on all the needs of a person and trying to meet these needs. It can be done in collaboration with other implementers and through good networking.
- Open management is the same as participatory management.
- Process was excellent, especially the means of presentation with each staff member doing a part.

Appendix 3: Key Indicators Showing Achievements of MMM Counselling and Social Services Centre 1994 - 2009

Key Indicators	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
No. of clients who died	70	106							58	51	49	45	32	19	12	8
No. new clients for counselling CSSC	518	386	365	100	62	43	88	111	74	132	120	60	80	127	82	40
Cumulative total of clients	600	986	1,351	1,451	1,513	1,556	1,644	1,755	1,829	1,961	2,081	2,141	2,221	2,348	2,430	2,470
New orphans		153	51		75	58	42	37	31		52	42	16	15	23	4
No. of orphans supported at end of yr	319		204	155	213		255	255	150	205	215	247	263	243	107	103
Cumulative total of orphans	319	472		935	1,010	1,068	1,110	1,147	1,178	1,224	1,276	1,318	1,334	1,349	1,372	1,376
No. receiving pre test couns.: CSSC									139	75	202	261	426	474	268	158
No. receiving pre test couns.: SML								38	1,065	2,098	2,018	2,828	2,955	2,906	3,153	4,624
No. of ongoing couns. sessions: CSSC	3,173	4,143	2,882						3,452	1,482	1,199	1,317	1,895	2,800	1,375	1,717
No. of ongoing couns. sessions: SML															51	642
No. of new people getting care at home: CSSC									74	132	120	120	125	132	82	33
No. of home care visits: CSSC: (from 2001 by nurses + caregivers)	118	323	238		300	300			3950	2712	6592	3156	3140	2702	670	837
No. who received training from Education Department: CSSC			399	590	597	517	611	791	556	767	1196	1009	269	229	301	217
No. who received training from Education Department: SML									28	131	65	65	54	71	138	66
People reached house to house: CSSC						2674	21,469	13,226	12,830	15,085	8165	19,248	2227	3711	4044	6624
People reached house to house: SML									13,293	4827	10,290	20,518	5035	6357	11,333	9804
No. of people reached by AACs + Peer Educators: CSSC			64,202	23,536	17,714	14,439	35,564	11,162	36,602	21,000	13,562	12,350	41,227	28,388	35,354	29,920
No. of people reached by AACs + Peer Educators SML														4,550	4905	
No. of disabled starting school	2	11	11	9	4	13	3	30	17	17	14	8	5	3	11	10
No. attending coffee ceremony re CBR						413	367	222	194	1096	877	738	821	1670	456	551
St. Mary's Lab: No. HIV tests								38	1435	2675	2378	3361	2740	2778	3417	3618
SML: Total no. other tests								6377	8422	8124	9208	12,225	10,763	23,384	31,515	38,269
No. of staff CSSC	13	19	27		28	28	33	31	30	29		31	31			29
No. of staff SML								7	10	9		12	12		13	13

Appendix 4: Reasons for requesting a HIV Antibody Test at St. Mary's Laboratory																
	2002		**2003**		**2004**		**2005**		**2006**		**2007**		**2008**		**2009**	
Reason	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
To know one's status	481	45.2	1,023	48.8	760	37.7	1,580	55.7	1,247	52.5	1,269	50.2	1,895	60.1	2,278	66.7
To go abroad (1)	119	11.1	153	7.3	662	32.8	222	7.9	179	7.5	607	24.0	721	22.9	528	15.4
For marriage	75	7	334	15.9	153	7.6	238	8.4	229	12.6	238	9.4	198	6.3	315	9.2
Health problem	175	16.4	242	11.5	127	6.3	225	7.9	155	6.5	79	3.1	87	2.8	44	1.3
Children for adoption (2)	132	12.4	250	11.9	144	7.1	170	6.0	79	3.3	118	4.7	92	2.9	46	1.4
Lost a partner/sick partner	56	5.3	33	1.6	15	0.7	36	1.3	68	2.8	4	0.2	11	0.3	55	1.6
Repeat	27	2.5	55	2.6	147	7.3	278	9,8	242	10.2	131	5.2	75	2.4	97	2.8
Employment			6	0.3	10	0.5	8	0.3	11	0.5	1	0.04	1	0.03	3	0.09
New relationship (3)							71	2.5	87	3.7	75	3.0	68	2.2	49	1.4
Rape (4)									6	0.3	8	0.3	5	0.1	3	0.9
Total (5)	1,065	100	2,096	100	2,018	100	2,828	100	2,373	100	2,530	100	3,153	100	3,418	100

Some comments:

(1) In 2006 there was a decrease in the number of people getting a HIV test for going abroad as the Government told SML not to give written results of HIV tests on their own. SML was able to include HIV results with results of all tests. The number getting a HIV test for going abroad decreased in 2009 as Amhara region now provides visas in Dessie and testing is also done there.

(2) The number getting HIV tests for adoption has decreased because of a new government policy that all orphaned babies should go to state orphanages. Also a test for the virus, PCR, previously only available for research purposes, is now done at birth for babies born to HIV positive mothers in government health institutions. This test is not available in St. Mary's Laboratory. Tests for HIV status in children that involve detection of antibodies are not accurate under about 18 months of age because of the persistence of maternal antibodies.

(3) An increasing number of people are getting a test before they enter a new relationship. This is evidence of the impact of awareness-raising.

(4) Rape is now a punishable offence and the Women Lawyers' Association is working on this issue. One has to go first to the police and then be sent to the laboratory with a letter requesting a HIV test. The first test is a baseline test and, if negative, subsequent tests are carried out to see if the person who has been raped later has a positive HIV test.

(5) The number of tests carried out in 2005 increased as free testing started in that year. However the number decreased in 2006 as a number of other centres then began to offer free testing. The number again increased in 2007 as SML started an outreach site and the laboratory purchased a CD4 count machine.

Appendix 5: Comprehensive Success Stories

Case Study of Sisay Demesse

Most people have one or two traumatic experiences in life. For some people life is a traumatic experience. How would you cope if you were abducted and raped when you were 14, had two boys by age 18, buried your partner by age 19, and found out you had AIDS when you are still in your twenties? Sisay Demesse is one such woman. After a very bright start to life – she skipped two classes in primary school and was doing very well in secondary - one day her life changed.

Sisay was born in 1976 in Debre Zeit, some 40 km south of Addis Ababa. She is one of four children: she has a sister and had two brothers who both died very young. Her father died when Sisay was very young, too young for her to remember him. Her mother died when she was six. When Sisay was four, her older sister brought her to Addis. She went to primary school in Menelik II School and did very well in school. She was so bright that she jumped two grades while in primary: grade 2 and grade 5. She went to secondary school while still very young. When she was fourteen and in grade 12, her final year, a soldier met her one day outside the school gate and abducted her. He had a gun in his hand and she had no option but to follow him. He took her to his house and raped her. She gave birth to her firstborn when she was fifteen. He did not allow her to continue school although he did allow her to sit her final exams. She did very poorly in these exams. According to custom at that time, if a man raped a woman he had to consult with her family – in this case, her sister - and take her to his house to live. She does not know to this day if he had any other wives. She lived like a slave in the house. Sisay said that he escorted her even when she was going to the toilet because she might run away. She subsequently gave birth to another child – a second boy. Soon after the husband fell sick and died. He had been taking medication but she did not know what it was for.

Sometime after his death some of his military friends came to visit her. They told her that he had died of AIDS but she had no idea what that was. She was living on her own with her two children. As she was not legally married, she could not get any assistance from the government. The husband had stored some food before he died. Along with food that his military friends and some neighbours gave her she was able to survive for 3 years. When all this food support dried up and she was no longer able to survive, she went to live with her sister who owned a bar. She started going around to different houses washing clothes for a few ETB that helped herself and her two boys. Her boys were able to go to Government school as it was free.

Sometime after going to her sister, she got sick. Firstly she began to get bad diarrhoea very often. Then she had a cough and was diagnosed with TB. Her weight reduced to 23 kg. After 6 months of TB treatment, she had a HIV test in a Government hospital. When she heard she was positive, she burned her clothes and documents as she thought she was going to die. She was so angry that she did not want to see anyone, including her children. Because she was so angry it took a long time in counselling for her to accept her situation. In the end it was a neighbour who was also HIV positive who brought Sisay to a Government hospital where she started ART. Despite her obvious intelligence she kept saying to herself that she was no good and all she could do was wash clothes. She had lost her confidence completely.

Her neighbour also told her about the MMM Counselling Centre and all the support she would get there. When she came to the Centre, she received counselling and some food. The counselling rebuilt her confidence and she was even able to talk openly about her situation and her status. She received some training in the Centre and began to speak at

coffee ceremonies, in factories, and in schools about her situation. In fact, when she realised the situation she had been in and the way she had been treated by 'her husband', this gave her the energy and confidence to talk openly. She now wants to teach other women about how to defend themselves and stand up for their rights. She spoke with great animation and conviction, especially when she spoke of the injustices that women suffer. She said that she had no say in her life. When she was 'abducted' she had no say. She had no say about what her 'husband' was doing when he was out of the house. He confined her to slavery while he was away. She has had no other sexual partner and yet she has become the victim. While reflecting on this, Sisay says she gets energy to try and make life better for other women.

She said that she also knows what discrimination is. She has been shunned by friends and neighbours but one particular incident brought home to her how people perceive her when they know she is HIV positive. There is a school where she does some training and she has a friend who teaches in the school. He did not know that she was positive until one day he heard that she had been in speaking to the children about her story. Since then he keeps '100 yards from me in case he might come in contact with me,' she said jokingly.

In her own words, Sisay has had a 'resurrection'. She has gone back to school and is in grade 8 at present. She has found her peace and her calling, she says. While she gets many advances and requests from men she is determined to stay as she is, look after her children – the elder is 14 and the younger is 12 - and try to make Ethiopia a better place for some women at least.

The Story of Kendu Assefa

Kendu Assefa was born in Koreb, Wollo in 1976 and was an only child. His parents divorced when he was 6 months old so he was sent to live with his grandmother. When he was 7 both his grandmother and his father died. His mother remarried and had 6 children – 3 boys and 3 girls. Kendu moved to live with his uncle but he did not like it there so when he was 13 he came to Addis Ababa to live with his aunt. He did not go to school so employment was difficult. Eventually he got a job in a hotel when he was 15. After a dispute, he left the hotel and found employment as a baby sitter. He started evening school and found work as a daily labourer doing metal work. When he reached 18 he joined the army and worked in a number of locations. While in the army he had 4 different short term partners. At the time of the transition from the Derg to the EPRDF he was arrested and put in jail. After 6 months, he was able to escape by posing as a cigarette seller.

When he escaped he started to work again as a daily labourer. He started evening classes and in the process he met his wife. They have 2 children. He also changed his job, finding employment in the government as a security officer. In 2005, he experienced health problems. His wife fell sick shortly afterwards with herpes zoster – a strong indicator of HIV. A neighbour told her that she might have AIDS and advised his wife to get a HIV test. They agreed that if they had HIV, they would live together and use condoms. Kendu said that they did not have a test before they were married so they do not know who was infected first. When they did get the news that they were both positive, it was very difficult to accept. They said that 'as we all have to die it is best to make the most of the time that is left'. Neighbours comforted them and said that nowadays there is treatment called ART and it would help them. Kendu went to the hospital and started ART. His wife started a year later as it took her a bit longer to accept her situation. Neighbours also told them about MMM CSSC and the support they give.

Five years ago Kendu came to the Centre and had counselling. He also received food support. Recently he got an opportunity to buy a condominium. He had registered a few years ago and one day he saw his name on a list on the door of the local government office. While he was overjoyed that he was getting this opportunity, he feared that he would lose it if he could not make the down payment. He heard that some organisations helped their staff to buy condominiums. He took courage in his hands, approached the MMM Centre and told them of his good luck. To his surprise and delight, the Center agreed to make the down payment. He said that he would be able to make the monthly payments for the next 20 years.

Kendu told his status to his boss who gave him great psychological support and changed his job. Now he feeds the animals in the park in Addis Ababa. His wife works as a street cleaner where she gets paid by the volume of rubbish she collects. His two boys are in school and he and his wife are healthy and looking forward to the future with hope. Both are back in school – he is in 9th grade and she is in 7th grade. He is delighted to be working and studying. 'If a sick person is working they can forget about their sickness but if they are not working they are always thinking of their situation'. Kendu is so happy with life he volunteers to go around and do HIV education, especially on transmission and prevention, as well as the importance of openness about one's status.

Nebyat – A Severely Handicapped Girl with Hope for the Future

Nebyat is a five year-old physically and mentally disabled girl. However she is a very hyperactive child who is into all sorts of mischief. If you take your eye off her she disappears to some unknown corner in a flash. She even unwittingly locked us all into her rented two-roomed house and a neighbor had to come and open the door from the outside. She also knows how to get what she wants; she screams and throws tantrums. However her mother is delighted that she is so active in the light of the earlier problems she faced.

Nebyat lives with her mother and old grandmother. Nebyat's mother, Frehiwot, left Nebyat's father soon after her birth. Frehiwot gave birth twice: once to a boy who is now 17 years old and the second time to twin girls. Nebyat was a small and very thin child, weighing 1.5 kg at birth. Her twin weighed 3.5 kg. Due to Nebyat's low birth weight, Nebyat, her mother, and twin sister all had to stay in Yekatit 12 Hospital for 4 months. For the first 2 months, Nebyat was in an incubator. One month after release from hospital, Nebyat's twin sister died unexpectedly. At this stage Frehiwot did not know that Nebyat was severely handicapped, therefore she does not know if Nebyat's twin sister was handicapped or not.

When Nebyat was 8 months old her mother brought her to the Health Center because she wasn't gaining weight. The doctor examined her and referred her to the feeding program sponsored by the MMM CSSC. When the CBR Department staff met her at the feeding program she weighed 1.15 kg. She could not open her eyes properly and could only open her mouth with difficulty because of a rash. She had little body movement. The field workers explained the feeding program to her mother and told her to bring Nebyat to the feeding program 3 days a week. After 3 months her progress was assessed. Because she still wasn't gaining weight, she was referred to Yekatit 12 Hospital pediatric clinic. The Centre gave her additional food at home while the field workers started to make her mother aware about good nutrition and HIV. The clinic doctor started Nebyat on Bactrim.

At 14 months of age, she had made some progress and had gained 1 kg. When her mother was made aware about HIV, she was referred to the MMM CSSC Counselling Unit. After counselling she decided to have a blood test and was told that she was HIV positive. After diagnosis she began to use holy water, hoping for a cure, and to use local medicine. She was upset and would not even tell her own mother. To this day her neighbors do not know her status. Three months after the positive test she was persuaded to start ART and she is faithful in taking her medication to this day. She also has a job cleaning in a nearby house. This gives her satisfaction and an opportunity to get out of her own house for a little while.

When Nebyat was 20 months old, she weighed 5 kg, which was very underweight for her age so the doctor suggested that she, too, have a HIV test. She was tested for HIV at 21 months and the result showed that she was positive. She was referred to another hospital to start ART and began the medicine when she reached 2 years of age. Frehiwot received material support from the Counselling Centre such as food and bed linen. As they were living in very poor conditions, the Social Services Unit of MMM CSSC arranged to have their house repaired. Nebyat is now 5 years old and weighs 12 kg. She gets regular physiotherapy from CBR Department staff. According to Frehiwot this has been extremely beneficial and Nebyat will soon be able to walk on her own. She has a walking frame and another larger frame outside the house where she can practice her steps. Life is looking up for Nebyat, to the extent that her mother now plans to get her into a local kindergarten next year. This progress could only have happened by looking at the multiple problems that Frehiwot and Nebyat had to face and addressing them in a holistic way.

Case Study of Asheber Ademasu

Asheber Ademasu has always dreamed of being famous and he is well on the way to achieving that dream. Although severely physically handicapped with polio, he is a well known musician, singer, and song writer. He is also a talented music teacher and when we met him he was in his small self built studio teaching one of his five students.

Asheber was born in 1980 in Addis Ababa and when he was 6 months old his baby sitter let him fall accidentally while he was having a bath. At the time the baby sitter did not tell his parents but he became very sick and had to be taken to hospital. It was there that they diagnosed that he had fallen and was injured. When he had reached a year, he was unable to stand so the parents brought him again to hospital where polio was diagnosed.

At the beginning he was treated in ALERT Hospital and at the age of 6 he was brought to Cheshire Services[10] where he got crutches and calipers. He had to return every 6 months to get the crutches and calipers readjusted till he was 15 years of age. He started school at the age of 6 in Kidane Meheret Catholic School and a year later he transferred to Behera Ethiopian School for 6 years. He had a happy experience in both schools. As Behera Ethiopia only had classes up to grade 6 he had to transfer to Atsenaod Primary School to finish. While there he experienced some discrimination and it brought out the tough side of him, he said. He used to quarrel with the other students who were giving him hassle. He became aggressive and fought his corner but the teachers understood his situation. For secondary school he went to Menelik II School, which has facilities for the handicapped. There were 4 others in a similar situation as well as a number of deaf and blind students. When he finished 12th grade he went to Aware Technical School, where he learned carpentry for 6 months. He then used his carpentry skills for 4 months.

[10] This is a rehabilitation centre that works with the disabled.

However in the back of his mind he had always wanted to be a musician and he felt he had skills in that area. As he did not get his matriculation to enter university, on his own initiative he joined Yared School of Music. He paid his tuition from fees he earned giving tutorials to other students. He said he was unable to get a diploma as only students sent by and paid for by the Government are eligible for a diploma. In order to get his diploma, he joined a private school: Aida School of Music.

Having received all the necessary qualifications, he now wanted to realise his dream. Because he had no instruments, he asked MMM CSSC if they could provide him with a keyboard. He had already been in contact with the CBR Department some years previously when they helped him with splints he needed for his legs. Having received the keyboard, he launched himself into his musical career. He played at night clubs and weddings, sometimes up to 8 weddings per month in the season for weddings. He also began to teach students and he set up his own studio at the side of his parents' house. It is a narrow 12 ft by 4 ft studio with two keyboards and a guitar.

He is also a song writer and he arranges music for songs. He has appeared twice on Ethiopian TV singing his own songs and his songs are played regularly on radio. He tries to reflect Ethiopian culture in his music. Currently he is preparing more songs for a TV appearance and has just written a number of songs for a fellow musician who is soon to release an album. He has just written some songs about disability but he has yet to release them. He has abandoned the night club scene; he said it was sometimes difficult to get paid and he prefers to focus on his teaching, song writing, and performing at weddings, exhibitions, and bazaars. He has a small band of 5 musicians and 3 singers who help him on these occasions.

He is eternally grateful to MMM CSSC as they opened the door for him to realise his dream. Without their help, he would have been unable to purchase that elusive first instrument. He occasionally does some work for the Counselling Centre, either carpentry or music related. He plays at some of their awareness raising days. However he does separate his HIV/AIDS work and his business. 'Business is business', he said, 'and you cannot mix awareness raising and work.' He has still a passionate interest in disability and his next dream is to prepare some media programmes on disability. He is now able to make a living for himself and support his parents. His final dream for now is to marry. As he becomes well known he should have no problem realising that dream.

Appendix 6: Update on Strategic Plan
The following is an update on the implementation of the strategic plan.
Strategic Objective 1: To maximise the potential that new HIV/AIDS treatment regimes offer

The key strategy identified to achieve this objective is to use the comparative advantage of the Centre and the Laboratory and link up with Ministry of Health institutions authorised to give out new HIV/AIDS treatments, i.e. hospitals and health centres, and appropriate community groups such as idirs, youth groups, anti-AIDS clubs, etc.

Key points of the above objective are as follows:

- It is a three-year pilot project to be carried out in 2 kebeles. This was carried out in Arada Kifle Ketema Kebele 11/12 and Gulele Kifle Ketema Kebele 18. Agreements were signed with Ras Desta Hospital (Arada) on 24 November 2006 for clients from Arada Kifle Ketema and on 25 January 2007 with St. Paul's Hospital for clients from Gulele Kifle Ketema (delay in the latter was due to change of Medical Director). Pre and post HIV test counselling was carried out at the Counselling Centre or St. Mary's Lab, and HIV testing and verification of suitability of candidate for ART was carried out in St. Mary's Laboratory (SML);
- Follow up counselling and support was done by staff from the Centre and SML;
- Other tests to assess status and progress re CD4 counts and other tests were carried out at the Laboratory;
- Counselling Centre and St. Mary's counsellors referred people identified with their HIV test, CD4 count, and basic tests to hospitals and/or health centres;
- Government hospitals and health centres supplied the treatment and/or preventive drugs;
- Hospitals and health centres involved with the programme referred clients selected for HIV-related treatments and/or prevention to the home care team at St. Mary's Lab Outreach Site or the Counselling Centre for integrated holistic home care;
- The Counselling Centre provided appropriate social and nutritional support for clients referred from home care teams;
- The Education Department taught communities and families about the importance of HCT, the importance of compliance to therapy, the benefits of PMTCT, general information about HIV-related treatments and prevention, and where these were available.

Some Notes:
The following are some points to note:

- The project proposal for the Counselling Centre was approved February 2008. There were numerous delays in obtaining approval. The project proposal itself had at least 6 revisions before being accepted. ECC-SDCO did not inform the Centre about a required change in format. The Centre only discovered this at a meeting it requested with ECC-SDCO when the proposal was not accepted after the first few revisions. Activities went ahead pending the approval.
- The Centre began to work first with hospitals because staff thought there might be too many patients to include health centres. In 2009, St. Mary's Lab began links with health centres.

- St. Paul's Hospital organized a 2-week introductory course on ARTs for nurse-counsellors from St Mary's Laboratory and the Counselling Centre. Topics included adherence counselling, ARTs and side effects, recognizing opportunistic infections, and family counselling. In 2010, St Paul's Hospital gave training on Provider Initiated Counselling and Testing (PICT), training SML and CSSC staff on how to do rapid HIV testing.
- A CD4 count machine was purchased and training on the use of the machine was given. Protocols for treatment and tests were developed and basic laboratory tests as a package are now being provided. Other health institutions referred clients for CD4 tests.
- Nurse-counsellors referred clients with all their tests to hospitals and/or health centres for ART and/or PMTCT. MMM CSSC and SML Outreach Site nurse-counsellors and home care team supervised caregivers and health workers in the following:
    - Follow-up counselling on adherence, disclosure, ART and side effects;
    - Counselling family about adherence, drugs and side effects, and giving support for family;
    - Counselling for difficult problems such as discordant HIV results;
    - Referring clients for social and spiritual support.
- MMM CSSC and SML nurse-counsellors and home care teams liaised with hospital and/or health centre for monitoring side effects, opportunistic infections, and other medical problems. Nurses supervised caregivers and health workers, who did the following:
    - Nursing care
    - Counselling on treatment and adherence
    - Pill counting
    - Brought clients for appointments
    - Identified potential clients
    - Taught families
- MMM CSSC and SML staff gave training and refresher courses for counsellors, health workers, and caregivers on adherence counselling, ARTs and side effects, recognizing OIs, and family counselling. The Centre gave incentives, transport, training for caregivers, and a salary for CHWs.
- Centre and SML management did the following:
    - Established links with hospitals and health centres with agreements about protocols and reporting formats as well as follow-up and feedback;
    - Contracts were made for health workers (time-bound);
    - Job descriptions were developed for nurse counsellors but not for the care givers.
    - CSSC paid for transport of clients and caregivers for medical appointments and visits to social worker.
- Social workers did the following:
    - Received referrals for social support from pilot project areas;
    - All people in pilot project areas were referred for social support to the Counselling Centre on a first come, first served basis, giving priority to the most ill people. There were some issues about adequacy of food provision when food given through CRS was stopped in November 2008. CRS now gives money to buy food as do other donors such as Trocaire and World Families Australia (for orphans).
- The Education Department educated the community about PMTCT, including where services were available, focusing on women of child-bearing age and community groups, especially couples. Education also focussed on HIV treatment and prophylaxis, including where services are available, and the importance of knowing one's HIV status.
- Management also developed a phase-out strategy by building capacity of clients and other organizations and networking with other groups working in the area.

• HIV-related treatments continued to be available and adherence to treatment was excellent;
• With a package of laboratory tests done before referral to hospital, hospital staff confirmed that burden on hospitals was lessened.

Conclusions of Review of ART Pilot Project

A review of the pilot project between MMM CSSC and St Mary's Laboratory and Ras Desta Hospital and St Paul's Hospital was carried out in 2009. The review team interviewed 144 clients for the study, 46 from Arada Kebele 11/12, who mostly use Ras Desta Hospital, and 98 from Gulele Kebele 18, who use St Paul's Hospital. The following are the conclusions from the review. The full review is available on www.mmmworldwide.org

1. From the point of view of MMM CSSC and SML clients:

Our experience at the MMM CSSC and SML is that the consequences of HIV/AIDS fall mainly on women. Most of our clients on ART are women; they usually have little or no education or skills and the burden of care for the family falls on them. They often depend for their income on menial labor, begging, or are unemployed and depend for survival on outside support. It is difficult to provide the basic necessities of life. In the past few years HIV treatment has meant a return to good health for most of our clients. However this study makes it clear that providing medicine is not enough. There are many hidden costs that are not covered by programs such as PEPFAR such as:

• Transport to access ART-related services, e.g. for HIV testing, lab tests, and ART, especially for very ill clients. Many clients are sick when they start to access these services, especially those who go to hospitals and health centers instead of free-standing HCT centers.
• The need for adequate food to maintain adherence to treatment, which many ill clients cannot obtain on their own
• Treatment for opportunistic infections, which affect people with compromised immune systems, is not free and is expensive. Clients cannot afford other tests and medicines that may be ordered.
• The provision of psychological support, individual and group, for people on ART. Many still suffer from stigma and they emphasize the importance of sharing their concerns with others with the same problems.

From the point of view of the government hospitals with which we have worked:

• While services directly related to ART provision are free, other medical tests or drugs that are ordered are not, nor are drugs to treat opportunistic infections. These are often expensive and even basic drugs are not always available.
• Hospitals and health centers are not able to follow-up clients who have started ART at home. They cannot provide psychosocial support or involve the family.

From the point of view of the MMM CSSC and St. Mary's Laboratory and Free-Standing HCT Center:

• Provision of social support was critical for most clients. It must be emphasized that whether provided in cash or kind, these service have been almost totally dependent on support from donors outside the country. At the end of 2008, food support, on which many of our clients depended, was discontinued. The Counselling Center continued to assist clients with money to buy food, entailing a considerable increase in social support costs. Even without the present financial crisis, this raises serious questions about the sustainability of our projects to provide even the basic necessities of life to clients.

- Our policy in relation to the provision of support to clients on ART was to assist until their health improved enough so that they were able to return to work or the care of their families. However many of our clients, especially women, cannot support themselves adequately because they lack skills. Those who are widowed or separated and have young dependents cannot go out to work.
- As more people are put on treatment this raises serious questions about the sustainability of the provision of ART.

Overall the collaboration between the government institutions, the MMM Counselling and Social Services Center and St. Mary's Laboratory has worked well and seems to be an effective way of using available resources. We have found collaboration with government health institutions in the pilot project a positive experience. We have been able to use our individual strengths and share our services to help clients to access ART and to support them in adherence to treatment at home. This support is both material and psychological, and has relieved the burden on hospitals for the follow-up and support of clients.

The main gap in the approach was a lack of feedback between the parties and a lack of communication between some departments, e.g. about the availability of social services if adequate support services were to be provided.

Strategic Objective 2: To utilise the knowledge and experience of the Centre to strengthen the capacity of other HIV/AIDS organisations.

The following **activities have been carried out:**

- A suitable training co-ordinator was hired;
- A brochure was prepared, other organizations were met and informed, and a list of available courses was prepared;
- There was frequent co-ordination with the AIDS Resource Centre and a resources and materials document was prepared;
- Academic profile of Centre and SML staff was prepared;
- A payment structure for local and international organizations was prepared. To date 30,340 ETB has been taken in, with 7,000 ETB coming from Addis Ababa Catholic Secretariat; 14,450 ETB from EECMY; 5,390 ETB from DOC; and 3,500 ETB from JRS. The money has been used to set up a training room and pay for the equipment in the room;
- Back up staff were available to fill in while trainers were away.

Strategic Objective 3: To build in phase-in/phase-out strategies in all programme activities

A 'phase-in, phase-out strategy: a typical cycle for HIV activities' was developed in 2008. The following table shows what has been achieved in each kebele.

Kebele	Phase-in/Phase-out Date
K 05/06 in Yeka Kifle Ketema	Phase completed by end June 2007
K 11/12 in Arada Kifle Ketema K 13/14 in Arada Kifle Ketema K 07/17 in Arada Kifle Ketema K 09/15 in Gulele Kifle Ketema K 08/16 in Gulele Kifle Ketema	Plans for phase-out from K 11/12 and 13/14 in place Phased into K17 early 2009 St. Mary's Laboratory was handed over to the Daughters of Charity on October 1, 2009.

Phase-in into Arada Kebele 17 began in early 2009, first for CBR Department for Children with Disabilities and then for HIV Education Department. One kebele around St. Mary's Laboratory where access will be facilitated for HIV prevention and treatment continues to receive support from St. Mary's Laboratory for the foreseeable future. This is Kebele 18, an isolated area with a marginalized population with poor resources. In 2007, the Centre handed over general HIV education in schools to AACs. 'Licensed' anti-AIDS clubs (AACs) are having their capacity built on an ongoing basis to deliver general HIV education. The Community Development Program (CDP) was phased out at the end of 2006. Remaining activities were integrated into the Social Services Unit.

With CSSC and SML staff the executive director of the Centre revised and updated the current policies in relation to how to support people from outside the identified catchment areas and how to offer services of St. Mary's Laboratory to people from outside the service area of the laboratory.

Strategic Objective 4: To develop strong co-ordination mechanisms in all programme activities

In relation to internal co-ordination weekly co-ordination meetings of all programme co-ordinators are held to share plans for the week, to see if areas of duplication can be addressed, and to share resources, especially transport. A weekly meeting with senior staff is also held to share activities of the previous week, provide information, and share common concerns. The holding of monthly management meetings of the management board and programme co-ordinators proved to be impractical. In terms of training, individual staff members are sponsored for various training courses.

In relation to external co-ordination, efforts to avoid duplication were included in project proposals and networking activities. Written agreements were made with all partners and organisations working with the Counselling Centre and St. Mary's Lab.

Appendix 7: MMM CSSC and SML Resources

Item	Department	Hardcopy	Softcopy	Remarks
Glossary of terms	Management	Yes	Yes	Revised October 2009
Phase-in and phase-out strategy: A Typical Cycle for HIV Activities	Management	Yes	Yes	January 2008 Developed by Annania Admassu
Best Practice Survey	Management	Yes	Yes	June 2004: Developed by Felly Nkweto & Eyerusalem Kebele
Review of FBO-Gov't. Collaboration to Facilitate Access to ART	Management	Yes	Yes	September 2009
A Training Manual on Issues Affecting Orphans and Other Vulnerable Children	Management	Yes	Yes	Revised March 2010
Home based care handbook in English & Amharic	Counselling	Yes	No	
Calendar	Education	Yes 2009		Each page had a message about CSSC/SML activities
Posters	Education	Yes	No	HIV-related topics, often for World AIDS Day
Leaflets	Education	Yes	No	HIV-related topics
Resource materials	Education	Yes	Yes if required	Information on HIV for teaching
Results of house-to-house surveys	Education	Yes	Yes	Pre and post education activity KAP surveys
Braille books	CBR	Yes	No	
1. HIV				
2. Home Care				
3. VCT & PMTCT				
4. ART				
Newsletter by CWDs "Enimamar"	CBR	Yes	No	3x/ year on epilepsy, disability & HIV
Amharic Newsletter "Tiri MMM"	Orphan Support	Yes	No	Every 2 months
English Newsletter "MMM News"	Orphan Support	Yes	No	3 times per year
HIV Laboratory Standard Operational Procedures Manual.	SML and Free-Standing HCT Center	Yes	No	2006
Quality assurance guide: 2008	SML and Free-Standing HCT Center	Yes	No	2008: Covering the pre-analytical, analytical, and post-analytical services of the laboratory
Research by students - AAU				
An assessment of Counselling Services provided by MMM	Kefiyalew Yismaw	Yes	No	Available to borrow. We only have one copy.
Case Report on Depressed and Anxious HIV Infected Person	Haile G Tilahun	Yes	No	
The Association between Substance Abuse and HIV Infection	Assefa Seme	Yes	No	
Self Disclosure of HIV Sero-status – Contribution to HIV Prevention	Hareg G Abate	Yes	No	