

The regionally based teams were recognized early on as a critical mechanism through which decentralized activities could be implemented.



FAMILY HEALTH INTERNATIONAL

A HEALTH EDUCATOR DEMONSTRATES CORRECT CONDOM USE TO A GROUP OF YOUNG MEN IN ADDIS ABABA, ETHIOPIA, AS PART OF AIDSCAP'S HIV PREVENTION PROGRAMMING.

## **FOCUS SITE INTERVENTION TEAMS IN ETHIOPIA: REGIONAL COORDINATION FOR NATIONAL HIV/AIDS PROGRAMMES**

<b>128</b>	<b>INTRODUCTION</b>
<b>128</b>	<b>HIV/AIDS IN ETHIOPIA</b>
<b>131</b>	<b>FOCUS SITE INTERVENTION TEAMS (FSITS)</b>
<b>135</b>	<b>SUMMARY AND CONCLUSIONS</b>
<b>136</b>	<b>BEST PRACTICE CASE CRITERIA</b>
<b>137</b>	<b>AUTHORS</b>
<b>137</b>	<b>REFERENCES</b>

## **FOCUS SITE INTERVENTION TEAMS IN ETHIOPIA: REGIONAL COORDINATION FOR NATIONAL HIV/AIDS PROGRAMMES**

### **INTRODUCTION**

Within the broader context of the difficult economic, political and environmental challenges faced by many non-industrialized nations, AIDS control programmes struggle to implement interventions due to minimal funding and challenging logistical constraints. Nearly two decades into the pandemic, many localities have become environments where multiple overlapping interventions are being implemented by a wide variety of public and private organizations, all competing for the same limited resources in terms of funds, expertise and materials. Nevertheless, the continued spread of the HIV/AIDS pandemic and its devastating social and economic effects have increased the urgency of expanding interventions.

Effective management of the design, implementation and evaluation of multiple overlapping interventions from a central location and efficient coordination of new interventions with existing efforts become unrealistic without a locally based forum for bringing together key stakeholders.

This case study describes an example of a mechanism used in Ethiopia to improve the efficiency of HIV-risk reduction interventions in four regions of the country outside the capital, Addis Ababa.

### **HIV/AIDS IN ETHIOPIA**

In Ethiopia the first HIV-positive individuals were reported in 1986 among hospital patients.<sup>1</sup> Since then, HIV prevalence has continued to rise among all target groups and the general population, and in all regions. Rates among female sex workers (FSWs) were already 15 per cent in Awassa and 20 per cent in Bahirdar in 1988, over 50 per cent in large urban areas by the early 1990s<sup>2,3</sup> and more than 65 per cent in Bahirdar and Nazareth by 1991.<sup>4</sup> HIV prevalence among pregnant women in Addis Ababa was 2 per cent in 1992 and nearly 14 per cent in 1993.<sup>5</sup> In 1996 the median prevalence among pregnant women in major urban areas was 18.25 per cent, according to UNAIDS.<sup>4</sup> A 1993 serosurvey of 2,415 general population males and females aged 15 to 49 in six rural areas revealed an overall prevalence of 1.8 per cent.<sup>2</sup>

In 1994 in Addis Ababa, the prevalence of HIV in adults (15 years and older) was 6 per cent for males and 6.9 per cent for females, with a peak prevalence in the 25- to 29-year-old age group of 16.3 per cent for males and 11.8 per cent for females. From this same community-based study,

estimates of HIV incidence in Addis (per susceptible person per annum) for the 16- to 22-year-old age group ranged from 1.3 per cent to 3.7 per cent for males and from 2.4 per cent to 3.2 per cent for females.<sup>6</sup> By 1996, estimates of HIV prevalence in the capital ranged from 9 to 26.5 per cent in four antenatal clinics and from 40 to 60 per cent among FSWs.<sup>7</sup> The HIV epidemic is still in an expansion stage in Addis Ababa, and HIV incidence was high and growing during the two years separating the surveys in 1994 and 1996.<sup>7</sup> In 1998 UNAIDS estimates that 2.6 million Ethiopian adults and children are living with HIV or AIDS.<sup>4</sup>

The cumulative number of reported AIDS cases jumped from 4,884 at the end of 1992 to 51,781 by the end of 1997. However, the estimated number of actual AIDS cases in 1998 is 1.1 million, according to the latest data analyzed by UNAIDS.<sup>4</sup> Also based on UNAIDS calculations, the estimated number of adults and children who have died of AIDS since the beginning of the epidemic in Ethiopia totals about one million, with 250,000 having died in 1997 alone. In addition, an estimated 840,000 children (under age 15) have lost either their mother or both parents to AIDS since the beginning of the epidemic.<sup>4</sup>

Among the factors contributing to the spread of HIV in this country of 60 million people are: (1) seasonal migration of workers in search of employment and better economic conditions, leading to increased multiple partner sexual networking; (2) dislocation of populations due to the 17-year civil war, again creating social situations conducive to

increased sexual networking; (3) high sexually transmitted infection (STI) rates in high-risk and general populations; (4) increased sexual activity among youth; and (5) high unemployment rates, including 400,000 demobilized soldiers returning to rural areas, towns and cities after 1991.<sup>3,8</sup> For the past three decades severe political, economic and ecological crises—including a long civil war, unstable government, recurrent drought, massive environmental degradation and unfavourable international economic environments—have created the context for rapid spread of HIV.

**Curable STIs** Although national data on incidence and prevalence of curable STIs are not available for Ethiopia, the proportion of men aged 15 to 49 who reported episodes of urethritis in the last 12 months was 4.6 per cent in urban sites in 1994.<sup>4</sup> The proportion of pregnant women aged 15 to 24 who tested positive for syphilis at antenatal clinics was 8.8 per cent in 1994.<sup>4</sup> Also in 1994, the most recent year for which data are available, only 19 per cent of people presenting with an STI or seeking STI treatment in health facilities received basic advice on condoms and partner notification, and just 4 per cent of people presenting with STI in health facilities were assessed and treated in ways appropriate to national standards.<sup>4</sup>

**AIDSCAP Interventions** Between January 1993 and March 1997, Family Health International's (FHI's) AIDS Control and Prevention (AIDSCAP) Project, funded by the United States Agency for International

Development (USAID), collaborated with the Ministries of Health (MOH) and Education (MOE), DKT/Population Services International (PSI) and 14 nongovernmental organizations (NGOs) to implement a comprehensive set of HIV/AIDS prevention activities under two USAID/Ethiopia bilateral projects. Targeting female sex workers, factory and government workers, in- and out-of-school youth and the general population, these interventions helped fill gaps left by the decentralization of HIV/AIDS control activities that occurred at the beginning of AIDSCAP. Twenty sites participated in interventions designed to improve STI services. Of those, four focus sites (Awassa, Bahirdar, Mekele and Nazareth) developed a model of integrated, comprehensive interventions, coordinating public and private resources at the regional level and featuring improved STI care and outreach to individuals at risk of infection. National condom social marketing supported all activities. AIDSCAP/Ethiopia also funded projects in Addis Ababa, a city with a population of 2.3 million.

During the life of the project, AIDSCAP/Ethiopia provided training to nearly 5,000 people, reached over one million people with HIV-prevention messages, distributed nearly 650,000 pieces of educational materials and distributed or sold nearly 45 million condoms.<sup>9</sup> DKT/PSI has implemented condom social marketing programming nationwide since 1990, receiving part of its funding through AIDSCAP. Since then, it has sold over 80 million condoms throughout

the country. The DKT/PSI project markets 24 million condoms annually,<sup>9,10</sup> making it one of the most successful condom social marketing projects in Africa.

**HIV-Risk Behavioural Data** Prevention knowledge rates tend to be high in Ethiopia due to the previous government's early, aggressive approach to coping with the epidemic. In 1994, among samples of the urban general population, 94 per cent of males and 84 per cent of females could cite at least two acceptable methods of protection from HIV.<sup>4</sup> From the same survey, the proportion of sexually active people reporting at least one sex partner other than a regular partner in the previous 12 months was just 18 per cent for males and 5 per cent for females, while the proportion reporting condom use with a non-regular partner in the previous 12 months was 48 per cent for males and 47 per cent for females.

Among target populations reached by AIDSCAP interventions, improvements in most key indicators occurred during the intervention period (see Table 1), although sampling methods were not strictly identical for the two time periods. Data from focus group discussions and individual interviews combined with the quantitative data suggested that change is occurring among people reached by intensive and comprehensive interventions.<sup>11</sup> Unfortunately, the resources available to support sustained intensive interventions nationwide are grossly insufficient in comparison with the scope of the epidemic.

TABLE 1

**Key Baseline vs. Follow-up Comparisons: Percentages Reporting**

Indicator		1994/5	1996
Knowledge of 2 or more prevention methods	Out-of-school youth	78	98
	Sex workers	32	99
Belief that AIDS can be prevented by not touching an AIDS patient	Sex workers	91	21
Knowledge that an HIV-positive person can look healthy	Out-of-school youth	85	99
	Sex workers	69	55
Sexual activity	Youth	39–69	males 83, females 63
Access to condoms	Out of school youth	78	91
	Sex workers	95	95
Have been examined for STIs at an appropriate health facility during past 3–6 months	FSWs	55	73
>1 sex partner in past 12 months	Out-of-school youth	12–30	males 50, females 33
Have ever used a condom	Out-of-school youth	31–57	males 72, females 57
	Sex workers	48–97	97
Condom use at last sex with non-regular partner	Out-of-school youth	21–40	males 58, females 48
	Sex workers	45	80

Source: AIDSCAP/Ethiopia Country Program Final Report, Arlington, VA, USA: Family Health International, 1997

**FOCUS SITE INTERVENTION TEAMS (FSITS)**

Early in the project, USAID and AIDSCAP/Ethiopia observed that implementing agencies were often working in a fragmented and uncoordinated manner. For example, several agencies were targeting the same groups with similar interventions and producing similar educational materials for the same target groups. Some were also using the same peer educators and community workers, thus making unnecessary demands on their time. This kind of repetitive coverage wasted scarce resources. AIDSCAP moved to solve the problem by bringing together the implementing agencies

in each region to review needs and resources and develop a plan for improving the situation.

As a result, the regional health bureaus (RHBs) were approached and the concept of focus site intervention teams (FSITs) was developed. The bureaus took the lead in creating teams comprised of representatives from governmental (GOs) and nongovernmental organizations (NGOs), including religious groups and representatives from work sites, all of whom were working on HIV/AIDS prevention. At each regional site, the RHB representative acted as chairperson of the team, with an NGO or MOE representative as secretary.

FSITs have regular monthly meetings to discuss achievements, problems, plans and activities and to share resources, including information, education and communication (IEC) materials and information on HIV/AIDS and other STIs. Teams share expertise in training and project evaluation, use common resource persons and available STI services for joint referral, and organize and participate jointly in World AIDS Day and other activities. These activities have included organizing and conducting training and seminars for peer educators and managers/coordinators, developing and producing educational materials, sharing information about each others' activities and new ideas for prevention strategies and sharing educational aids, such as audiovisual materials, drama groups and puppets.

The FSIT strategy avoids duplication of efforts by ensuring that members target different population groups for HIV/AIDS-prevention activities and by integrating prevention efforts with support for people living with HIV/AIDS (PLHA). Especially important is the enhanced cooperation between governmental and nongovernmental organizations at the regional level.

One example of FSIT coordination is the sex worker project in Bahirdar, where the Zonal Health Department trained peer educators and supplied them with IEC materials produced in collaboration with the Family Guidance Association of Ethiopia (FGAE). The Ministry of Social Affairs in the zone supported the peer educators in organizing alternative income-generating activities for the sex workers. Condoms were supplied by DKT/PSI for a nominal fee. Sex workers received free STI treatment in the health centre when referred by the city council's sanitarian. The Regional Health Bureau (RHB) and FGAE

collaborated in conducting a baseline behavioural survey, and the RHB staff implemented overall monitoring and coordination.

Table 2 lists the names of FSIT member organizations across all four regions. Those marked with an asterisk were implementing partners in AIDSCAP/Ethiopia. The other members joined the FSITs as voluntary members and did not receive funding directly from AIDSCAP/Ethiopia.

**TABLE 2**

**FSIT Member Organizations in Four Sites, AIDSCAP/Ethiopia 1993-97**

Regional Health Bureaus*
Zonal Health Departments*
Hospitals/Health Centres*
Woreda Health Departments
Regional Education Bureaus*
Regional Social Affairs Office
Regional Women's Affairs Office
City Councils
Council of Representatives
Churches
Muslim Sherea Law Office
DKT/Population Services International*
Family Guidance Association of Ethiopia (in Awassa, Bahirdar, Mekele and Nazareth)*
Nazareth Children's Center for Integrated Development (NACID)*
Tigray Development Association (TDA)*
Organization for Social Services for AIDS (OSSA)*
Factories
Population Office
Tourism Bureau
Red Cross Society

\* Implementing partner of the AIDSCAP Project in Ethiopia

The regionally based teams were recognized early on as a critical mechanism through which decentralized activities could be implemented. These FSITs led to more efficient use of staff, materials, training and funds among the governmental and nongovernmental implementing agencies in the four project sites. Such collaboration enhances interaction, avoids duplication of efforts and facilitates effective coordination of activities.

Because of the existence of the FSITs, closer working relationships have developed among regional education bureaus and other USAID-financed implementing agencies in Mekele, Bahirdar, Nazareth and Awassa. The FSITs also helped sensitize policy-makers to the seriousness of the epidemic, paving the way for the evolution of the FSITs into regional HIV/AIDS-prevention teams in Mekele, Bahirdar and Nazareth. The FSIT in Awassa continues to operate as it had in the past. In the other three focus sites, the FSITs were still functioning as regional task forces for HIV/AIDS and STI prevention at the end of 1998, nearly two years after the end of AIDSCAP and almost three years after most of the NGOs' external funding had ceased.

In late 1996, FSIT-participating organizations met in Addis Ababa for three days to compare experiences and share lessons learned from the process of implementing HIV-prevention programmes in a decentralized, regionally based model.<sup>12</sup> While the FSITs were judged overall to have been a successful approach to organizing local efforts, several areas of concern emerged from the four

regional experiences. Summarized in Table 3, these challenges to effective implementation were drawn from the conclusions reached by FSIT participants during the seminar.

In early 1997, AIDSCAP/Ethiopia hosted a lessons-learned seminar for 75 representatives from government institutions, NGOs and USAID and other international organizations that had participated in AIDSCAP/Ethiopia activities. This group determined that the most significant lesson learned from four years of programming was the value of FSITs as a unique mechanism through which decentralized activities can be implemented in geographically distant regions. The group recommended that the FSITs should continue to function in the four AIDSCAP regions and that the model should be replicated in other regions.<sup>13</sup>

Four years of activities under AIDSCAP/Ethiopia laid a foundation of mutual support for effective implementation of activities. The member agencies within each FSIT know each other well and are aware of each other's strengths, weaknesses and available resources. They conduct regular quarterly meetings to plan and work together, and membership in each group continues to grow. Support from local policy-makers facilitated the conversion of the FSITs into regional HIV/AIDS intervention teams. On the other hand, as yet there is no budget for each team that could help strengthen the teams' coordinating functions. As the groups are voluntary, their sustainability is less assured without increased support from the government and international donors.

TABLE 3

**Implementing Focus Site Intervention Teams: Challenges and Recommendations**

Area of Concern/Issues	Recommendations
IEC approaches: drama, videos and innovative educational approaches were more acceptable over traditional didactic approaches, but areas outside the major cities lagged behind in access to information and levels of awareness.	FSITs could more effectively organize regional resources for wider outreach.
Outreach methods: using religious and traditional events to promote HIV awareness and prevention via peer education succeeded in effectively reaching hard-to-reach groups.	Religious and traditional outlets for HIV/AIDS IEC should be encouraged and expanded. Peer education, especially youth-to-youth, should also be expanded and diversified.
Evaluation of materials: need for more in-depth evaluation of educational materials and for tracking distribution of materials.	FSITs could take more of a lead in monitoring and evaluating design, and production and distribution of educational materials.
Availability of materials: exchange of materials between FSIT members helped reduce duplication and minimized production costs, but there were some shortages, some instances of culturally inappropriate materials and some distribution problems.	A balance needs to be reached between centrally produced and locally designed materials in order to maximize efficiency and local appropriateness. FSITs can increase their efforts to act as clearinghouses for regional materials.
Staffing of FSITs: team approach allowed resource people to be involved in multiple activities, but high turnover rate reduces efficiency. Member organizations need to be more supportive of FSIT members' involvement in FSIT activities.	Continue to strengthen FSIT teams; strive for early replacement of departing members with thorough briefing.
Support and commitment to the cause of HIV prevention: programmes do not run as smoothly when support and commitment are weak; inconsistent media coverage leads to denial of severity of the HIV problem by the public.	FSITs should extend sensitization training to health personnel in health facilities and to the military; selection of training participants needs to be gender-balanced; more income generating activities should be developed to encourage support; seminars and workshops for journalists should be held.
Monitoring and evaluation of programme effectiveness: not rigorous enough; problems with number and types of indicators, timing and continuity in evaluation activities needs improvement.	FSITs could participate more intensively in developing better standardized indicators, improving planning and time frames, improving the reporting of process indicator data and in supporting implementation of monitoring and evaluation activities.
Documentation and record keeping: problems with minutes of meetings, reports, training session materials and IEC samples.	FSITs should improve systems for recording and documenting minutes, cataloguing samples of IEC materials and recording and filing reports and training session materials.
Finances: working together as a team, FSITs enhanced fundraising efforts, but there was some unplanned use of funds that affected planned activities.	FSIT member organizations should allocate funds for FSIT activities; budget should be more detailed and linked to action plans.

## SUMMARY AND CONCLUSIONS

In collaboration with Regional Health Bureaus, AIDSCAP/Ethiopia developed the concept of FSITs so that HIV/AIDS risk-reduction interventions could be implemented in a more coordinated fashion at the regional level. The members were drawn from the regional and zonal health and education sectors, NGOs, government offices such as the municipalities, regional agricultural offices, factories, religious organizations, local health centres and regional DKT/PSI representatives. Their activities involved convening monthly meetings to discuss achievements and challenges and to plan complementary or joint activities among members. They also shared a wide range of innovative educational materials and tapped into each other's training resources. The FSITs have enabled implementing agencies within specific geographical areas to maximize the types of interventions being implemented and the types of populations being reached. They have also continued to operate beyond the end of AIDSCAP's activities.

Judging the effectiveness of FSITs is not an easy process. In theory, if they were effective, then intervention activities would be implemented more effectively, thus achieving increased levels of behaviour change, which would in turn result over the longer term in reduced incidence of HIV and other STIs. But documenting this wide range of potential changes in the current state of economic and political realities in Ethiopia is not at all a simple undertaking.

In Ethiopia, as in many other non-industrialized countries, non-experimental observational methods are routinely used in outcome evaluations due to resource limitations. The impact of cause and effect from such a design is

problematic because competing explanations for changes over time cannot be ruled out.

As a result of the methodological and practical problems of carrying out rigorous evaluation studies, many countries, implementing agencies and national programmes do not have quantitative and qualitative behavioural data, biomedical data, programmatic process data and detailed contextual data about the same target groups in the same geographical areas, collected at the same times, upon which to base decisions for future programmes.<sup>14,15</sup> In the case of Ethiopia, the success of the FSITs seemed obvious to all involved; however, independent verification of that success in terms of biological and behavioural change has yet to be made.

Qualitatively, the people participating in AIDSCAP/Ethiopia activities between 1993 and 1997 felt strongly that the FSIT concept greatly enhanced the effectiveness and efficiency of regionally based activities, particularly in regions where the distances and difficult transportation between regional capitals and Addis Ababa made frequent visits expensive and arduous. However, it is clear even from the limited HIV-surveillance activities undertaken so far that HIV incidence is not yet subsiding. Modest changes in some aspects of knowledge, awareness and behaviour have been documented among targeted populations, but better methods for tracking trends in HIV-risk behaviour are needed, including standardized indicators and a more rigorous behavioural surveillance system, to help evaluators understand the course of the epidemic and the impact of prevention interventions.

Nevertheless, assessing trends in behaviour change over multiple points in time (or simply pre- and post-intervention) is frequently

considered sufficient evidence to infer the effectiveness of interventions and models such as the FSITs, regardless of the degree of scientific rigour in evaluation research designs.<sup>15</sup> The practical realities of constricted budgets and the urgency on the part of local NGOs to implement activities and not “waste resources” on expensive, time-consuming research mean that programme implementers must use whatever data are available as they move forward with additional interventions and expand to new geographical regions within countries.

The available behavioural data for some of the target groups exposed to FSIT members’ interventions in Ethiopia suggest that change is occurring, although probably not at a rate sufficient to cause changes in HIV prevalence. From a public health perspective, it may not matter whether the observed changes are due to a particular intervention, but rather that sexual practices are becoming safer, and HIV infection numbers should eventually decrease. Programme implementers in Ethiopia feel that continued support of FSITs in the original four regions and expansion of this model to other regions will eventually result in enough behaviour change to reduce HIV-incidence rates nationwide.

#### **BEST PRACTICE CASE CRITERIA**

**Relevance** The emergence of the FSITs as strong coordinating entities happened logically in response to the government’s decentralization of all activities, particularly national AIDS control efforts. Particularly in a large country such as Ethiopia, with a population of 60 million people, regional coordinating bodies increase the likelihood that effective comprehensive efforts will make more of an impact at the local level.

**Efficiency** FSITs played a key role in implementing the monitoring and evaluation components of the AIDSCAP programme in Ethiopia and enabled efficient and timely sharing and use of materials, training resources and outreach staff.

**Effectiveness** Process indicator data exceeded expectations, especially for condom social marketing, which has been one of the most successful social marketing projects in Africa since it began in 1990. Although biological indicators as yet provide no evidence of decreasing HIV prevalence, behavioural indicators and qualitative research suggest that interventions are effective in producing changes in knowledge and behaviour.

**Ethical soundness** For the past three decades, severe political, economic and ecological crises have created the context for rapid spread of HIV in Ethiopia. The FSIT concept has been embraced as a locally-empowered approach to ensuring participation from all sectors, as well as matching central government’s decentralization mandates.

**Sustainability** Despite the cessation of AIDSCAP funding when the project ended in 1997, the FSITs have remained organized at the regional level in the four focus sites in order to better coordinate resources and plan activities. Most implementing agencies have managed to continue some activities under other funding; and, with planning support from FHI, the AIDSCAP/Ethiopia country programme office evolved into an independent NGO.

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