Community Health Education, Capacity & Knowledge Building (CHECK) Project
Towards achieving Sustainable Development Goals (SDGs)
SDG 3 "Ensure *healthy lives and promote well-being for all at all ages*"[1]
(SNNPR/Ethiopia)

Project proposal to the
Italian Agency for Development Cooperation

Submitted by UNAIDS Ethiopia

October, 2016

[1] SDG 3Target 3:3- "By 2030, end epidemics of AIDS , TB, Malaria & NTDs

Concept Note for
Project Community Health Education, Capacity & Knowledge Building (CHECK) Project
Towards achieving Sustainable Development Goals (SDGs)
SDG 3 " *Ensure healthy lives and promote w[ell-being for all at all ages*"[2]
(SNNPR/Ethiopia)

Country	Ethiopia
Project Budget	Euro 500,000.00
Intervention Areas	
Partners	
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[2] SDG 3Target 3:3- "By 2030, end epidemics of AIDS , TB, Malaria & NTDs

MAP OF PROJECT TARGET REGION

SNNPR

SNNPR Administrative Zones

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Acronyms

AICS	Italian Agency for Development Cooperation
AIDS	Acquired Immuno-Deficiency Virus
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs Drugs	Antiretroviral Drugs
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
CDs	Communicable Diseases
CHECK Project	*Community Health Education, Capacity and Knowledge Building Project*
CSO	Civil Society organization
CUAMM	Doctors with Africa
DHS	Demographic and Health Survey
EDHS	Ethiopia Demographic and Health Survey
EPHI	Ethiopian Public Health Institute
FBOs	Faith Based Organizations
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry Of Health
GTPII	Growth and Transformation Plan II
GBV	Gender Based Violence
HCT	HIV Counseling and testing
HEI	Higher Education Initiative
HDA	Health Development Army
HEW:	Health Extension Workers
HIV	Human Immuno-Deficiency Virus
IEC:	Information, Education, and Communication
IGAs:	Income Generating Activities
MEDHIN Association	Medhin Ethiopia Positive Elders Association.
MULU/MARPs Project	MULU/MARPs [USAID Funded] HIV Prevention Project
MSGs	Mother Support Groups
NEP+	Networks of HIV Positive People
NoSAP+	Network of South Association of HIV positive people
NGOs	Non-Governmental Organization
OI	Opportunist Infections
OVCs	Orphans & Vulnerable Children
PLHIV	People Living With HIV
PMCT	Prevention of Mother to Child Transmission
RHAPCO	Regional HIV/AIDS Prevention & Control Office
RHB	Regional Health Bureau
STIs	Sexually Transmitted Infections
SDGs	Sustainable Development Goals
SNNPR	Southern Nations, Nationalities, and Peoples' Region
TILLA Association	Tilla Association of Women Living with HIV
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
YSGs	Youth Support Groups

PROJECT SUMMARY

1.1 Project Goal

The Goal of this Project is to reduce Communicable Diseases (CDs), including HIV and STIs in SNNPR through several mutually reinforcing interventions focused on disease prevention, health promotion and peer support groups strengthening, with special focus on Women and Young People towards ensuring healthy lives and well-being (SDG3) and ending epidemics of AIDS , TB, Malaria & Neglected Tropical Diseases (NTDs) as public health threats by 2030 (SDG3 Target 3:3).

1.2 Project Objectives

The Project Objectives are:

- To Prevent CDs;
- To Generate demand and increase uptake of health services for Women & Young People &
- To Strengthen & capacitate Mother Support Groups (MSGs) and Youth Support Groups (YSGs) to serve as ongoing community peer support structures

1.3 Project Outputs

1. Consolidated baseline information, prioritization and well informed and designed project
2. Enhanced awareness, knowledge and education of key sectors on prevention of CDs including HIV/AIDS and STIs
3. Increased uptake on health services relating to women and young people, including HIV/AIDS & STIs services such as VCT, ART and PMTCT.
4. Strengthened peer support mechanisms at individual, community, zonal, Woreda and Kebele levels
5. Improved knowledge of intervention areas, best practices documentation and results dissemination

1.4 Key Activities

Preparatory Project activities

- **Rapid Programme assessment of existing interventions & best practices** to reduce duplication, maximize linkages & scaling up of best practices
- **Desk assessment to (i) review assumptions & consolidate baseline information** on needs as well ongoing related interventions; (ii) settle Project indicators, targets and benchmarks.
- **Train Project Facilitators**, where required, among HEWs, HDAs, Teachers, Kebele Community Leaders, CBOs, FBOs, MSGs, YSGs, Law enforcement Agents & Prison Authorities on CDS, including HIV and HIV
- **Conduct Mode of Transmission studies in SNNPR or alternatively synthesize existing information** and use as a base for prioritization of Kebele & Wereda for combination prevention programs.
- **Map out all hot spot areas in Kebeles, Woredas & towns** with high numbers of Female Sex Workers, Migrants Laborers and other Vulnerable Populations **and design programs on prevention of CDs**, targeting Female Sex Workers and Clients.

Full Project cycle activities

1. **Develop and produce Amharic tailored IEC materials on prevention of CDs** including HIV/AIDS and STIs
2. **Implement a combination of tailored interventions on health awareness, information** & **education and BCC on prevention of CDs** including HIV & STIs for Schools Students, Vulnerable Populations, Law Enforcement Agencies and Prison establishments in the identified hot spots
3. **Build capacities of WSGs, YSGs, Associations, CSOs and FBOs to generate demand and increase uptake of health services that benefit women and young people** as well as to serve as **ongoing community peer support groups on prevention of CDs**, including HIV & STIs at Zonal, Woreda and Kebele levels
4. **Build capacities of YSGs, WSGs, Associations, CSOs and FBOs on health promotion, information & education on prevention of HIV/AIDS and STIs** (including Gender Equality and prevention of Gender Based Violence).
5. **Expand peer support programs for PLHIV and OVC** including activities for psycho-social support, income generating activities, nutrition support, stigma reduction
6. **Support technically and financially YSGs, WSGs, Associations, CSOs and FBOs** working with PLHIV and OVC
7. **Establish and strengthen institutional IGAs to economically empower PLHIV**, especially Women and Young People

Project monitoring activities

- Organize planning & **periodic Project review meetings** with relevant Government entities, stakeholders & implementing partners
- Convene Meetings of **Project Coordination Task Force.**
- Undertake ACSI & UNAIDS **Project field assessment Missions**

End-line Project activities

- Conduct a **rapid assessment of key Project results achieved**
- **Draft & Publish project results**, including lessons learnt, best practices and human stories Organize a **Project results dissemination media Briefing** to publicize data and project results

1.5 Project Targets

Direct beneficiaries:

- 300 People comprising of Women from WSG; Youth from the YSG and PLHIV economically empowered through establishment of IGAs
- 500 OVCs benefit from psycho-social, nutrition and stigma reduction interventions and are supported to continue with their education
- 200 FBO, CSOs . WSGs and YSGs trained in prevention of HIV and STIs and other CDS and capacity built to serve as ongoing community peer support groups on prevention of CDs, including HIV & STIs at Zonal, Woreda and Kebele levels
- 1000 students trained with adequate skills & knowledge to serve as peer educators on prevention of HIV/AIDS and STIs and other CDS (including correlated subjects of Gender Equality and prevention of Gender Based Violence).
- 5 Enforcement Agencies and Prison establishments in the identified hot spots implement a combination of tailored interventions on health awareness & prevention of CDs including HIV & STIs
- 200 Police & Prison Officials equipped with knowledge and skills to design and implement programmes in their sectors o**n prevention of** HIV, STIs and other CDs
- 350 Female Sex Works and other MARPs educated on prevention of CDs including HIV & STIs (including on correlated issues of Gender Equality and prevention of Gender Based Violence).

Indirect beneficiaries

- 800 family members benefitting from IGAs
- 50, 000 community members from the 10 Woredas will be sensitised on prevention of HIV/AIDS , STIs and other CDs (including on correlated issues Gender Equality and prevention of Gender Based Violence).
- 500 Prisoners will be sensitised on prevention of HIV/AIDS , STIs and other CDs (including on correlated issues Gender Equality and prevention of Gender Based Violence).
- Families and partners of Female Sex Workers and MARPS will be sensitized will be sensitised on prevention of HIV/AIDS , STIs and other CDs (including on correlated issues Gender Equality and prevention of Gender Based Violence).

1.6 Project Location

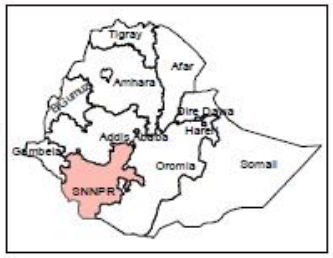
[See attached Administrative Region, zone and Woreda Map of SNNPR & project location national partners prioritization]

Precise final Project locations will be selected with implementing Partners & local authorities based on further situational assessment of (i) programmatic needs, (ii) low coverage values, (iv) risks & vulnerabilities and (iv) existing field presence of implementing partners including Italian NGOs

The 10 Zones outlines below & Woredas have been thus far identified as priority hotspot areas as well as areas that have ongoing and strong field presence by our earmarked national implementing partners:

1. **Hawassa City Administration**:
   [9 Subcities of Misrak, Menaharia , Tabor, Mehal Ketema, Hayk Dar, Addis Ketema, Bahil adarsh, and Hawella Tula]
2. **South Omo Zone:**
   [4 Woredas of Jinka, South Ari, Hamer, and Male]
3. **Sidama Zone:**
   [6 Woredas [Dara, Leku/Shebedino, Aleta Wendo, Aleta Chuko, Wansho & WondoGenet]
4. **Wolayita Zone**:
   [5 Woredas Dampote Gale, Humbu, Offa, Kindo Koisha & Damot Woyide]
5. **Gamo Gofa Zone**:
   [4 Woredas [Arba Minch Town, Chencha, Mierab Abaya, Kucha]
6. **Gedio** Zone:
   [4 Woredas [Wenago, Yirgachefe, Dialla Town, & Gedeb]
7. **Kembata Temabro Zone:**
   [2 Woredas [Dayo Gena & Hadero]
8. **Bench Maji Zone:**
   [2 Woredas Mizan, Sheka (Tepi)
9. **Gurage Zone:**
   [2 Woredas Meskan and Wekite]
10. **Hadya Zone:**
    [1 Woreda Hossana]

Administrative Region, Zone and Woreda Map of SNNP Region



36°0'0"E
39°0'0"E
8°0'0"N
6°0'0"N

Administrative Boundaries
Region
Woredas
Woreda name

Zones
Alaba
Amaro
Basketo
Bench Maji
Burji
Dawro
Derashe
Gamo Gofa
Gedio
Gurage
Hadiya
KAT
Keffa
Konso
Konta
Selti
Sheka
Sidama
South Omo
Wolayita
Yem

Abeshege
Kebena
Kokir Gedibano
Muhur Na Aklil
Soro
Cheha
Ezha
Meskan
Enemorina Eaner
Gumer
Geta
Selti
Misha
Gembora
Limu
Dalocha
Lanfero
Yem SW
Gibe
Sankura
Alaba SW
Dune
Tembaro
Hadero Tunto
Kacha Bira
Kedida Gamela
E. Badawacho
W. Badawacho
Boloso Bombe
Boloso sore
Damot Pulasa
Damot Gele
Damot Sore
Damot Weydie
Kindo Koysha
Kindo Dida
Sodo Zuria
Ofa
Humbo
Diguna Fango
Boricha
Shebe Dino
Goroche
Malga
Awassa Zuna
Wonde Genet
Wonosho
Arbe Gonna
Aleta Wendo
Bursa
Chuko
Hulla
Bona Zuria
Bensa
Chire
Aroresa
Dara
Dila Zuria
Wenago
Bule
Kochere
Kochere Gedeb
Loka-Abaya
Mirab Abaya
Arba Minch Zuria
Amaro SW
Burji SW
Derashe SW
Konso SW
Bena Tsemay
Hamer
Gnangatom
Dasenech (Kuraz)
Male
South Ari (Bako Gazer)
Selamgo
Kemba
Bonke
Basketo SW
Gelila(Semen Ari)
Ayida
Ubadebretsehay
Geze Gofa
Zala
Daramalo
Dita
Chencha
Melekoza
Denibu Gofa
Kucha
Boreda
Ela (Konta) SP Woreda
Tocha
Esira
Mareka
Loma Bosa
Gena Bosa
Menit Shasha
Menit Goldiye
Surma
Maji
Bero
Gurafereda
Debub Bench
Shay Bench
Sheka
Semen Bench
Decha
Cheta
Tulo
Menjiwo
Chena
Bita (Big)
Yeki
Anderacha
Gesha (Deka)
Getawa
Gimbo
Masha
Sayilem
GAMBELLA
OROMIA
SUDAN
KENYA

Disaster Risk management and Food Security Sector
Administrative Map of SNNPR
The delineation of national and international boundaries must not be considered authoritative
Data courtesy of DRMFSS

0 40 80 160 Km
N

Community Health Education, Capacity & Knowledge Building (CHECK) to Prevent HIV and STIs and Other Communicable Diseases

Prioritization of Project Locations

Association	Zone	Woreda	Awassa Town
Tila			
	Sidama	Boricha	All sub cities
		Dara	
		Shebedino	
		Wondo Genet	
		Wonsho	
		Gorche	
	Wolayita		
		Humbo	
		Ofa	
		Kindo koisha	
		Damote woide	
		Sodo town	
	Kenbata tembaro	Hadero	
		Doo gena	
	Gedeo	Wenago	
		kochere	
		Gedeb	
		Dila	
	Special Woreda	Alaba	
	Hawassa town Administration		
Medhin			
		All sub cities in Hawassa	Misrak sub city
			Menaharia sub city
			Tabor
			Mehal ketema
			Hayk dar
			Addis ketema
			Bahil adarsh
			Hawella Tula
NOSAP			
	Zone		
1.	Sidama	Dale	
		Aleta wendo	
		Leku/ shebedino	
		Dara	
		Boricha	
		Arbegona	
		Bona Zuria	
		Wondo genet	
		Aleta chuko	

		Bensa	
		Hula	
2.	Welaita	Humbo	
		Ofa	
		Dampote gale	
		Boloso sore	
		Humbo Tebela	
		Boloso Bombey	
		Kindo Koisha	
		Sodo	
3.	Kenbata Tembaro		
		Kedida Gamila	
		Tenbaro	
		Angecha	
		Hadero	
		Danboya	
		Doyo gena	
		Kacha bira	
4.	Gedeo		
		Yirgachefe	
		Bulle	
		Dila town	
		Wenago	
5.	Special Woreda		
		Alaba	
		Yem	
		Basketo	
6.	Hawassa Town Administration		
		Tula sub city	
		Menaharia sub city	
		Hayk Dar sub city	
		Mehal Kifleketam sub city	
		Misrak sub city	
7.	S. Omo		
		North Ari	
		Jinka	
		Bena tsemay	
		Hamer	
		South Ari	
		Male	
8.	Dawro	Mareko	
		Esera	
		Loma	
		Tercha	
		Tocha	

		Genebosa	
9.	Bench maji	Semen bench	
		Mizan	
		Sheka (tepi)	
10.	Gurage	Meskan	
		Izha	
		Gumer	
		Muhur aklil	
		Sodo	
		Meskan	
		Welkite	
		Enimur	
11.	keffa	Bonga	
12.	Sheka	Tepi	
		Masha	
13.	Segen	Derashe	
		Konso	
14.	Silte	Werabe	
		Halicho werero	
		Dalocha	
		Mierab azernet	
15.	Hadya	Anlimo	
		Hossana	
		Badwacho	
		Soro	
		Shashogo	
		Gibe	
		Duna	
16.	Gamo gofa	Chencha	
		Mierab abaya	
		Arba minch town	
		Gofa Saula	
		Kucha	

Label

Priority /hotspots in SNNPR

1.7 Proposed Implementing Partners
Tilla Association, Medhin Association, NEP+, NoSAP+ , MSGs, YSGs, CSOs, RHB, RHAPCO RHB, HEWs, HDAs, EPHI, FHAPCO, CUAMM, & University of Awassa
1.8 Project Budget & Donors
See attached Excel Total Project Budget is EURO 500,000 and has been requested from the AICS

2. BACKGROUND

2.1 National context

This project proposal is aligned to the Ethiopia national development and health Agenda and also the programme interventions fully advance the implementation of the National HIV Investment Case.

Ethiopia is at the pinnacle of its transformation agenda for development & the Health Sector, with an economy that has been growing in double digits over the recent past years.

The Ethiopia Second Growth Transformation Plan (GTP) (2016-2020) sets out key strategies in the spheres of macro-economic, Economic infrastructure, social services, human development & technology, infrastructure & Environmental protection & green Economy - all aimed at moving the country to Middle Income status by 2025 .

In tandem with the GTP the various sectors have developed their transformation Plans which stem directly from the GTP in overall Goals. The Health Sector Transformation Plan (HSTP (2016-2020) spells out the strategic objectives , interventions, performance measurements, costing & financing and implementation arrangements in achieving Quality & equity in health care in Ethiopia in the next 5 years.

By & large through UNAIDS Ethiopia work, HIV is well integrated in Ethiopia's next 5 years Development Plan (GTP2) as well as in the Health Sector Transformation Plan (HSTP).

The UNAIDS propelled "Fast Track approach" is fully embedded in both the GTP & the HSTP Frameworks:

1. Reduction of % of HIV incidence rate to 0.03 is a core target of the GTP2 &
2. Core indicators for the HSTP include:
    - *Reaching the 90 90 90 Treatment targets*
    - Increased access & use of Combination Prevention package services & STI diagnosis & treatment
    - *Achieving zero new infections in children*,
    - Increasing from 59% to *95% HIV positive pregnant mothers who receive ART* to prevent mother to Child Transmission of HIV

Young people are a priority pillar in the GTP, which calls for encouraging their active participation & benefit in economic, cultural development, democratic system and good governance.

At sub sector level, 2015-2020 *Ethiopia National HIV /AIDS Prevention Care and Treatment Strategic Plan an Investment case approach (*HIV Investment case), focuses on the vision of ending AIDS by 2030 (SDG3) through averting 70,000- 80,000 new HIV infections and saving about half a million lives in Ethiopia by 2020. The Targets set in this Investment Case are in line with the 90-90-90 treatment targets set by UNAIDS to help end the AIDS epidemic. This HIV Investment Case was developed and costed with the technical and financial support of UNAIDS Ethiopia.

The HIV Investment case includes four strategic objectives, namely:
1. Implementation of high impact and targeted prevention program including *Condom distribution and Use* for prevention of HIV/STI; *Blood safety* through quality- assured testing of all donated blood for HIV and *Behaviour Change Communication Interventions including:*

- Intensifying Behaviour change communication in priority geographical areas at risk population including Female Sex Workers, Truck Drivers, Migrant/Seasonal/Daily Labourers, Urban and Hot Spot area dwellers, out of School adolescents, mega projects workers and surrounding communities, uniformed forces, prisoners and PLHIV

- Strengthening School HIV education to sustain the low HIV prevalence among youth in school.
- Strengthening community based HIV BCC through Health Extension and Health Development Army
- Empowering communities

2. **Intensifying Targeted HIV Testing and Counselling Services** to raise the proportion of People living with HIV who know their HIV status from 60-65 % to 90% by 2020

3. **Attaining virtual elimination of PMTC** through**:**
   - Intensifying the primary HIV Prevention among women and men
   - Universal HIV testing of all pregnant women.
   - Improving the provision of family planning services to HIV positive women through integrating the
   - Family planning services and PMTCT
   - Roll out of PMTCT B option plus.

4. **Optimizing and sustaining quality care and treatment** through
   - Increment of enrolment for ART
   - Strengthening TB- HIV integration
   - Improving adherence and retention in care
   - Providing ART as prevention
   - Enhance the fight against stigma and discrimination
   - Strengthening Health system for successful care and treatment.

Additionally, 4 critical enablers identified as essential to deliver the HIV Investment Case include:

- Health system strengthening
- Enhancing Partnership, Coordination and Leadership
- Increasing Domestic resources for HIV response
- Gender equality and equity.

In Ethiopia, the HIV/AIDS epidemic has remained a major public health problem, mainly affecting people in their prime productive and reproductive age. In 2011 approximately 800,000 people were living with HIV and adult HIV prevalence was estimated at 1.5%; the highest rates being in urban areas and among women . The country is showing good progress towards Universal Access for HIV prevention, treatment, care and support.

There is recognition on the need for regions to analyse their situation, priorities, and prevention interventions and specifically develop their targeted interventions. The Strategic Plan for intensifying the multi-sectoral HIV and AIDS response in Ethiopia (SPM II 2010/11-14/15) indicates that “regions must have specific intervention plans to give special attention to risk groups”. Indeed, an epidemiological synthesis of HIV/AIDS carried out in 2008 concluded that because of the heterogeneity of the epidemic, HIV/AIDS programs should not be based on national-level statistics, but need to be more focused geographically, and directed to those regions, districts or communities exhibiting higher prevalence rates.

2.2 Regional Context

2.2.1 SNNPR overview

The SNNPR is the third most populous region in Ethiopia with a population size of over 17.8 million in 2012. The vast majority of the people in the region (about 90%) reside in the rural area. Administratively, the region is organized in 19 Zones/special Woredas. It has a vast land mass that accounts for more than 10 percent of the country's land area. The region is an extremely ethnically diverse region of Ethiopia, inhabited by more than 80 ethnic groups, of which over 45 (or 56 percent) are indigenous to the region[3]. These ethnic groups are distinguished by different languages, cultures, and socio-economic profiles

2.2.2 Health Profile of SNNPR

The population of SNNPR has low access to social services including health care. The potential health service coverage, defined as population living within 10km of a primary heath care unit is currently estimated to be 93%. However, actual utilization is estimated not to exceed 50%.

The burden of disease in SNNPR, as measured by premature death from all causes, comes primarily from preventable causes and is dominated by communicable diseases, reproductive health problems and nutritional deficiencies.

The health indicators in the Region are among the lowest in Ethiopia. It is currently estimated that , Neonatal, Infant and Under-Five mortality are 36, 85 and 142 per 1,000 live births, respectively. The crude birth rate is estimated to be 36 per thousand. Maternal mortality ratio of the region is estimated to be similar to that of the country 673/100,000 live births and Life expectancy is 48 years.

The ratio of population per health institution also shows significant variations. Currently, there are a total of 22 hospitals, 448 Health Centres and 3340 health posts. There are also 15 pharmacies, 49 drug stores and 449 rural drug vendors.

The burden of disease in the SNNPR, measured by premature death from all causes, comes from primarily preventable causes and is dominated by communicable diseases. The leading causes of morbidity and mortality in the region are mostly attributable to lack of clean drinking water, poor sanitation, and low public awareness of ways to prevent diseases and personal hygiene practices.

From the total geographic area of the region, about 60-70% is malarious and health facility reports imply that Malaria is one of the major causes of morbidity. The main reasons for high spread of Malaria include; lack of community-based environmental control activities, global warming, resistance of Malaria parasites and mosquitoes to drugs and Insecticide chemicals. Recently due to scaling up of high impact intervention such as ITNs and IRS the burden of the disease significantly reduced in relation of the previous years.

Moreover, HIV & TB are posing huge burden in the communities. On average about 20,000 TB cases are registered annually as compared five to eight thousands cases 8 years back. In the year 2002 EFY TB ranked fourth to a leading cause of morbidity (4.6%) and 3rd to death (6.17%) in Hospitals and Health Centres.

[3] Central Statistical Agency, National census. 1996 [Ethiopia]

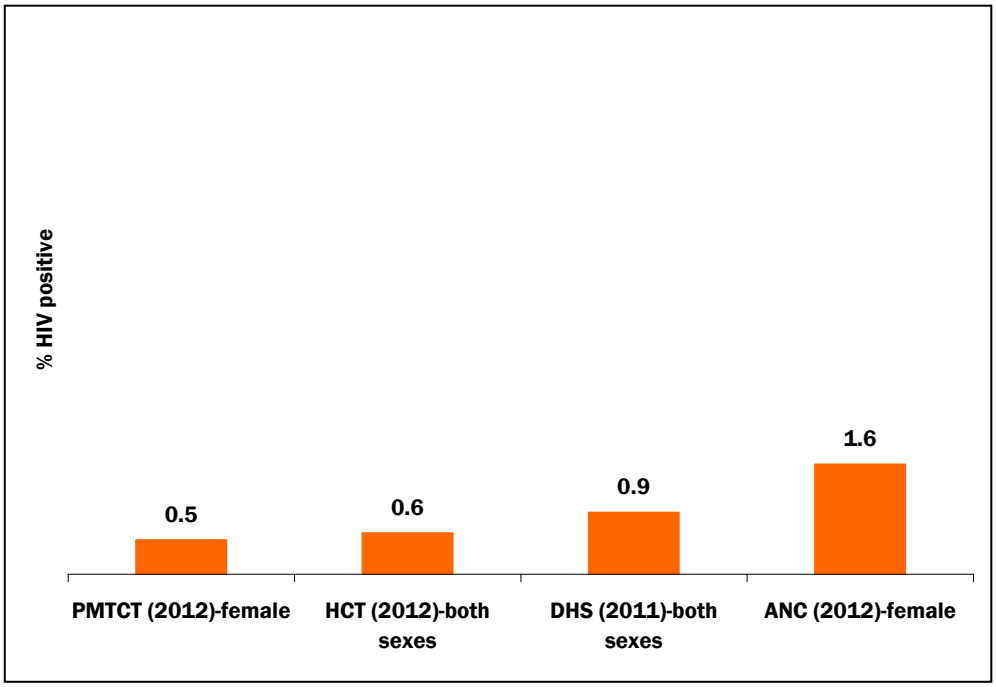
2.2.3 HIV/STI Profile of SNNPR[4]

This section describes the geographic heterogeneity of the HIV epidemic in SNNPR with particular emphasis to urban/rural divides, zone variation and identification of priority areas with an elevated risk for HIV ("hotspots").

Data from different sources clearly indicate that the SNNPR has a low level epidemic, as shown in Figure 1. The DHS and the HCT data provide comparable estimate of the scale of the epidemic (0.6-0.9%) while the ANC-based surveillance prevalence data estimated the region's prevalence at 1.6%, which is much higher than the other estimates. It is important to note that the ANC data is not intended to gauge the status of the HIV epidemic in the general population rather to monitor the progression of the epidemic through time. Besides, there are known drawbacks of the ANC-based HIV surveillance data including selection biases. Only those pregnant women attending ANC clinic are tested and this population groups do not represent the general pregnant women because of lower ANC attendance; leave alone the general population. Besides, females tended to have higher prevalence than the males and as a result of which overestimates the prevalence in the general adult population because the ANC does not provide data on males. Few ANC-based surveillance sites are available in the region (13 rural and 4 urban sites), which are not large enough to capture the diversity of the HIV epidemic in the region.

Indeed, SNNPR has consistently shown low prevalence since 2005. The first DHS+ survey in Ethiopia put the prevalence in SNNPR at 0.4%, which was the lowest in the country. Despite, the increase to 0.9% in 2011, it remained the lowest compared to all the other regions in the country.

Figure 1: HIV prevalence in SNNPR using different data source;



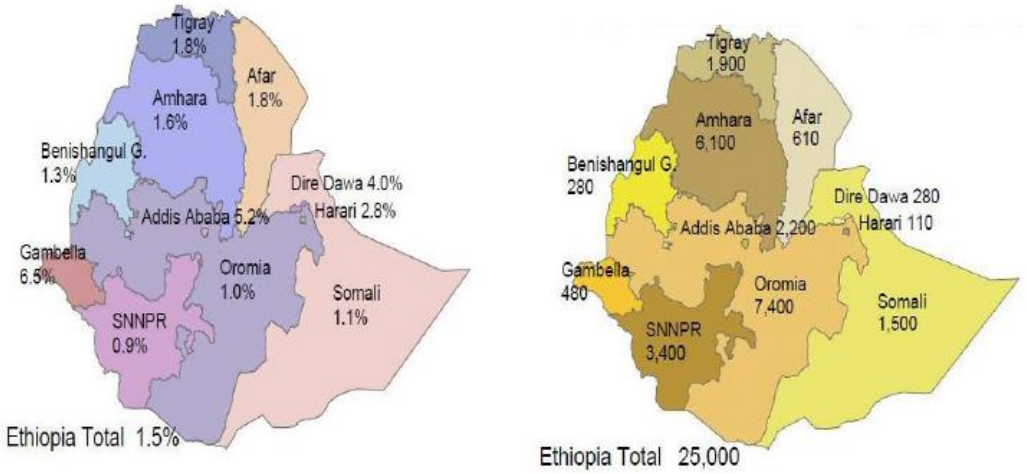
Low prevalence but high numbers of new HIV infections in SNNPR:

SNNPR contributes the 3rd largest number of new HIV infections in the country according to the 2011 estimate (Figure 2). The number of people living with HIV/AIDS are also notably high and the 3rd largest in the country reported at 108,000 in 2011.

[4] Unpublished "Synthesis Of The HIV Epidemic And Response In SNNPR, Ethiopia", December, 2014

This suggests that although SNNP has the lowest HIV prevalence in the country, it should remain amongst the priority regions for HIV/AIDS prevention and control efforts because it is home for large number of PLHIVs and 14% of the overall new HIV infection in the country.

Figure 2: HIV prevalence and new infections distribution in Ethiopia, 2011.



Geographic heterogeneity of the HIV epidemic in SNNPR

The SNNPR is the third most populous region in Ethiopia, predominantly rural with only a tenth residing in the urban. The region is the least urbanized compared to all the other regions in the country, according to the Ethiopian national census[5]. The region is home for over 45 ethnic groups and diverse cultures. Recently, the regions has seen increased urbanization following development activities such as road construction, expansion of higher education institutions, coffee plantations and other development projects. Population mobility, rural to urban migration of unskilled workers in search of job characterize the current demographics of urban SNNPR. Studies in sub-Saharan African countries show that high population mobility and the interaction of people from different walks of life is conducive for the emergence of high risk groups and the spread of HIV[6, 7, 8].

Urban-rural divide in HIV epidemic

Available data suggest excess HIV prevalence in the urban area than in the rural (Table 1). Both the DHS and ANC-based HIV prevalence data suggest that the urban prevalence is in the order 4 to 12 time higher than that of the rural. According to the DHS, only 0.4% of the rural population was infected with HIV in 2011 and this was much lower than the 3% prevalence in the urban, giving an urban-rural prevalence ratio of 7.5. This pattern holds for both sexes. The ANC-based HIV prevalence data also provide a relatively higher HIV prevalence estimates for the region and this is understandable because ANC-based estimates often overestimate the prevalence in the general population. Notably, the Urban-to-Rural prevalence ratio using the ANC-based data also show excess risk in the urban area than in the rural. zonal level HCT positivity rate data suggest significant variation in HIV infection rate across zones. The positivity rate ranges from a low of 0.07% in Kembata Tembaro to 1.9% in Gamo Gofa. Six out of the 19 zones/special Woredas had positivity rates exceeding 1%. These are Gamo Gofa, Bench Maji, Sheka, Gedeo, South Omo and Hawassa.

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[5] Ethiopia National Census, CSA. 2007

[6] Carael, M. and Holmes, K. "Dynamics of HIV Epidemics in Sub-Saharan Africa: Introduction", *AIDS*, 15 (Suppl 4) (2001): S1-4.

[7] Anarfi, J., "Sexuality, Migration and AIDS in Ghana: A Socio-Behavioural Study", *Health Transition Review*, 3 (1993): 45-67.

[8] Brockerhoff, M. and A. Biddlecom, "Migration, Sexual Behaviour and the Risk of HIV in Kenya", *International Migration Review*, 33 (1999): 833-56.

While Sidama and Segen exhibited a medium-level positivity rate at 0.6. On the other hand, about 11 zones/s. Woredas had their positivity rate at lower than 0.4%.

Figure 4 further confirms the noted zonal variation in HIV prevalence. It presents ANC-based rural HIV prevalence data along with the HCT data for nine zones where both data are available. As shown in Figure 4, there is a high positive correlation between the two data sources (correlation coefficient, R=0.83), as both showing relatively higher prevalence rates in zones such as Sheka, Gamo Gofa, Bench Maji, and South Omo. While both revelaed low prevalence in zones such as Hadiya, Dawro, Kambata Tembaro and Kaffa,

Several factors may explain this variation in HIV positivity rate across the zones including differences in the level of urbanization, concentration of key population at risk, population interaction and mobility between urban and rural areas, the presence of major transportation corridors, proximity to major development areas such as construction sites, big plantations and mining sites with high influx of people. Future study is warranted to describe the many factors explaining this zonal variation.

Figure 3: Proportion HIV positives among HCT clients, SNNPR, 2012

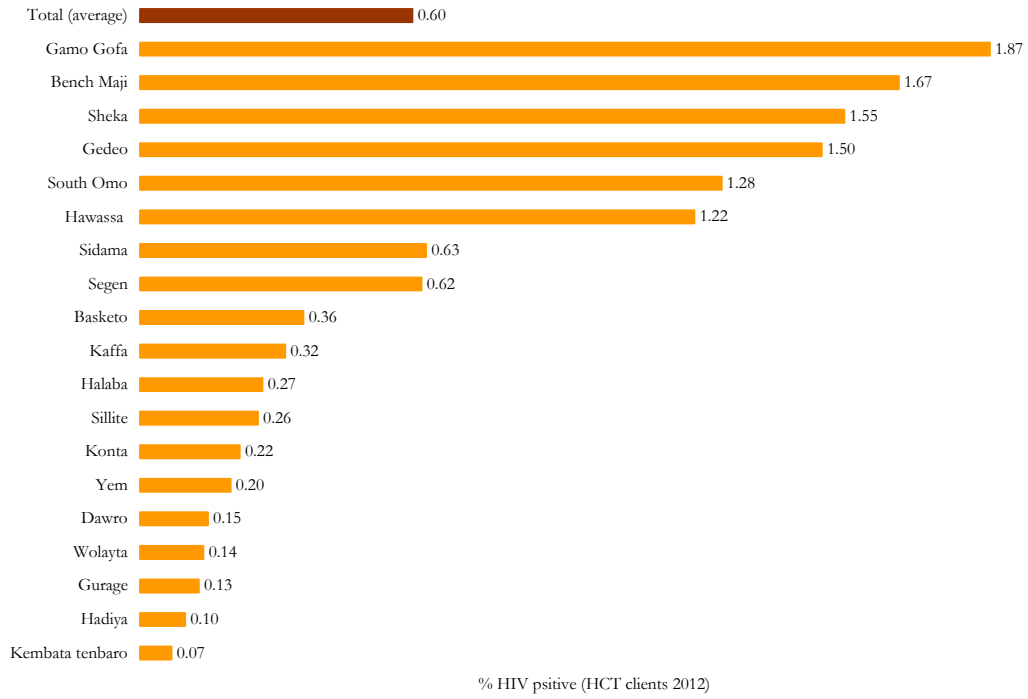
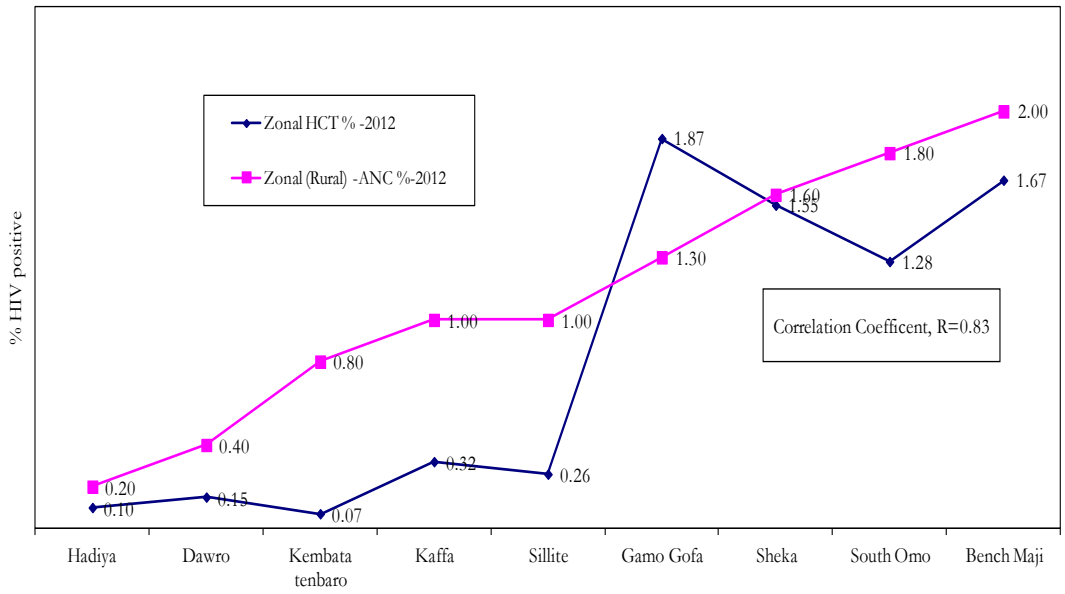


Figure 4:
Zonal variation in HIV prevalence as revealed by the HCT and ANC-based HIV prevalence data, SNNPR, 2012



Variation in HIV prevalence across urban areas

In general, all available data suggest that the urban epidemic in SNNPR qualifies for a generalized epidemic. However, it is anticipated that the urban epidemic is not uniform across towns as it is influenced by the presence and concentration of key population at risk (KPR).

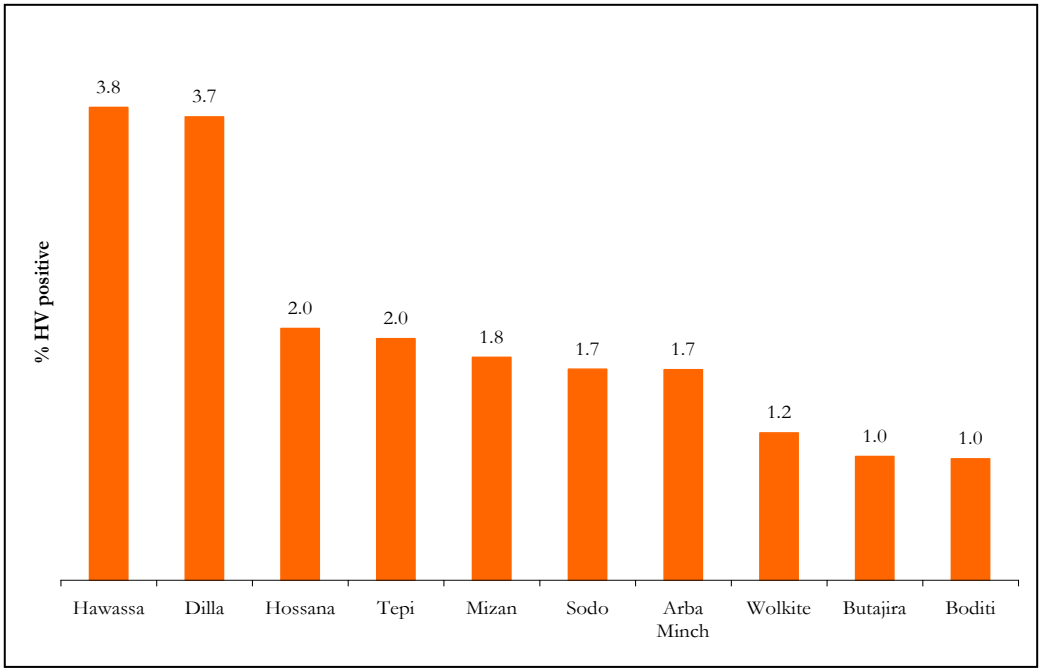
A recent (2012) Mobile counseling and Testing (MCT) study in 10 major towns of the SNNPR provide a good insight into the diversity of the HIV epidemic across urban areas in the region.

As shown in Figure 5, HIV prevalence among MCT clients ranges from a low of 1% in Boditi/Butajira to 3.8% in Hawassa. Towns with particular high prevalence include Hawassa, Tepi, Hossana, and Dilla. While medium-level prevalence rate was documented in Mizan, Sodo and Arbaminch. Wolkite, Butajira and Bodii on the other hand exhibited low prevalence. While this data is unique as it provides a good insight into the likely diversity of the HIV epidemic in the region, it should be interpreted with caution:

- First, several towns in SNNPR did not have similar data thus the MCT study only tells part of the story.
- Second, although the MCT predominantly tested mobile population, including daily laborers and other key populations, the socio-demographics of the population tested are unknown limiting further interpretation of the data.

With this caveat, however, the data signals the likely diversity of the epidemic in the urban area as well as the possibility of a sub-epidemic within the urban areas.

Figure 5: HIV prevalence among MCT clients in 10 major towns of SNNPR-2010.



Priority towns for HIV /hotspots

Aggregate level HIV prevalence estimates often fail to reveal the HIV/AIDS burden on smaller geographic areas and that the low level HIV prevalence in SNNPR does not necessarily mean that there are no specific localities and population groups in the region that are disproportionately affected by the epidemic.

In an attempt to identify "hotspots"/priority areas for HIV in SNNPR data/information from available sources was triangulated including experts' opinion through a Participatory Rapid Appraisal (PRA) and secondary HIV/AIDS related data such as ANC based data, HCT data, HIV data from PMTCT sites, MCT data, ART data, and STI data. The PRA was conducted with 20 regional experts that were drawn from different Departments/Offices of the SNNP regional Health Bureau.

The objective of the PRA was to get experts' views on priority areas and locally relevant key population at risk (KPR) in the SNNP region and also to gain a broader insight into available interventions for KPRs in the region. The PRA was guided by a tailor-made and previously tested approach and format. Experts rated the various zones, Woredas and towns of the region based on the concentration of key population at risk and their prior knowledge of the areas. The experts ranking results and the different data/information were triangulated to arrive at a list of potential priority areas in the SNNPR region. Finally, this exercise yielded 13 towns of varying characteristics as priority towns for HIV in the region. Almost all the major towns of the region including Hawassa, Dilla, Sodo, Hossana, and Arbaminich, and Wolkeiti were identified among the priority towns.

These towns are predominantly characterized by relatively high population size, rapidly growing population, influx of people from rural areas and other small towns, fast economic development activities such as road and building constructions, expansion of small and large scale industries, universities and other social services. Most of these towns have the potential to attract people due to increased job opportunity especially in construction related jobs and as a result of which the towns are the major destinations for daily laborers and other construction workers. Some of the towns especially Hawassa has recently become destination that attracts local and international tourists and

has also become an important hub for conferences and meetings. The small towns designated as priority areas include Tepi, Mizan Teferi and Jinka. These towns have characteristics that are conducive for the spread of HIV. For instance, Tepi is resided by a large population of permanent and temporary/seasonal plantation workers who are characterized by high mobility, engagement in multiple sexual relationship, paid sex, and causal sex in the plantation premises. .

Communicable Diseases in SNNPR (see above)

3. **PROPOSED PROJECT DETAILS**

3.1 ***Project Description***

This project proposal is aligned to the Ethiopia national development and health Agenda, GTP2 and HSTP, respectively and also the programme interventions fully advance the implementation of the National HIV Investment Case.

The project will aim to reduce Communicable Diseases (CDs), including HIV and STIs in SNNPR through several mutually reinforcing interventions focused on disease prevention, health promotion and peer support groups strengthening, with special focus on Women and Young People towards ensuring healthy lives and well-being (SDG3) and ending epidemics of AIDS , TB, Malaria & Neglected Tropical Diseases (NTDs) as public health threats by 2030 (SDG3 Target 3:3).
More specifically the project will contribute to:

(i) To preventing Communicable Diseases;
(ii) To generate demand and increase uptake of health services for Women & Young People &
(iii) To Strengthen & capacitate Mother Support Groups (MSGs) and Youth Support Groups (YSGs) to serve as ongoing community peer support structures

3.2 ***Coherence and relevance of the project in the local context***

The interventions in this proposals have already been identified as addressing the gaps and needs in the local population through verifications conducted by the SNNPR Regional Health Bureau in Zones, Woredas & Kebeles. These gaps and needs are outlined in the SNNPR Health Strategy Plan. Additionally UNAIDS and Partners synthesis on "Know your epidemic Know your Response" further reinforce the evidence base for the proposed interventions. UNAIDS has also consulted various CSOs, Community & other partners to assess what interventions are underway and gaps that need to be addressed.

3.3 ***Needs analysis***

The needs analysis has been conducted through (i) review of SNNPR Health and HIV Policy and programme documents; (ii) Analysis of SNNPR Health related Data and (iii) discussions and consultations with SNNPR CSO partners and communities undertaking programmes in various Zones, Woredas and Kebeles in SNNPR. The interventions proposed in this project specifically address these needs and gaps in specific populations and localities.
The needs analysis revealed that :

- The burden of disease in the SNNPR, measured by premature death from all causes, comes from primarily preventable causes and is dominated by communicable diseases. The leading causes of morbidity and mortality in the region are mostly attributable to lack of clean drinking water, poor sanitation, and low public awareness of ways to prevent diseases.
- Though the SNNPR regional prevalence rate is low, the HIV/AIDS burden on specific localities and population groups in the region is disproportionately high. These localities are predominantly characterized by relatively high population size, rapidly growing population, influx of people from rural areas and other small towns, fast economic development activities such as road and building constructions, expansion of small and large scale industries, universities and other social services.

- Health promotion and disease prevention programmes need to be scaled up and in an integrated manner, with special focus on communicable diseases such as HIV and STIs
- Women, young people and MARPs such as female Sex Workers and Prisoners require special focus as they are the most vulnerable and largely lack access to health related information, commodities (such as condoms) and services
- Community Peer Support Systems need strengthening and
- People Living With HIV require capacity and skills building

3.4. Project's strategy

The Project will be implementation bottom up informed by the full engagement of the communities concerned, CSOs & partners on the ground. It will be implemented in phases starting with the preparatory phase that will focus on consolidating the existing baseline through rapidly assessing existing programmes interventions & best practices to reduce duplication, maximize linkages & scale up of best practices. The Project implementation strategy includes the ongoing Project monitoring and evaluation to ensure relevance and mitigation of negative consequences and end-line project activities to document, analyze outcomes and disseminate results

3.5 UNAIDS comparative advantage

UNAIDS Ethiopia brings together the necessary expertise, experience and institutional mandates to implement this project . It brings added value through leadership and advocacy, coordination and joint accountability.

UNAIDS Ethiopia has had robust programmes in SNNPR over the last 10 years and has built long standing and trusted community based organisations, CSOs, People Living with HIV and Government entities. UNAIDS will build on this base .

At a broader level, the mission of UNAIDS is to lead, strengthen and support an expanded and integrated response to HIV and AIDS that includes preventing transmission of HIV, providing care and support to those already living with the virus, reducing the vulnerability of individuals and communities to HIV and alleviating the impact of the epidemic.

UNAIDS Ethiopia 5 strategic approaches outlined below will form the backbone of this project:

1. Leadership & advocacy for effective action ;
2. Strategic information and technical support;
3. Tracking, monitoring and evaluation ;
4. Civil society engagement and the development of strategic partnerships;
5. Mobilization of resources to support an effective response.

Additionally, UNAIDS it inherently also draws on the expertise and inputs of its 11 Cosponsors including UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, UN Women and the World Bank .

3.6. Correlation between project's outputs and activities

See matrix attached

3.7 Key partners and their roles

- *Government & Partners that will serve as advisors throughout the project implementation*: SNNPR Bureaus of Health, Women, Education; RHAPCO, SNNPR RHB, Prison Authorities, Ministries of Education, Youth & Culture, FMOH, FHAPCO Mulu/MARPs Project & ICAP; *UN Agencies*: WHO, UNESCO, UNFPA, UNWOMEN, ILO; *Others*: University of Awassa, EPHI, Higher Education Initiative (HEI)
- *CSOs & NGOS who will serve as local implementers*: Tilla Association, Medhin Association, NEP+, NoSAP+ , MSGs, YSGs, CUAMM and other relevant ACSI NGOs based in SNNPR.

3.8 Project Implementation and Management

- Planned implementation period is 16 months with a total budget of Euro 500,000.
- Overall oversight of the Project will be managed by Country Director, UNAIDS Ethiopia,
- Project will be supported by the UNAIDS Ethiopia Technical Staff managing areas of partnership & community mobilization; Strategic Information; Strategic Intervention, Monitoring and Evaluation as well as Project Administration & financial management.
- A Project Coordinator will be hired to further supplement UNAIDS capacity
- Interventions of the project will be implemented by pre-identified different partners (outlined herein) based on their comparative advantage re: knowledge, location & capacity

3.9 Project Coordination

An inter Partner & Stakeholder Task Force will be established for project Coordination.

4. FUND TRANSFER MODALITIES

- AICS will transfer the funds to UNAIDS Headquarters who will in turn allocated the resources to UNAIDS Ethiopia Workplan
- UNAIDS Ethiopia will disburse the Funds to Government & implementing partners based on agreed CHECK Project Intervention Contracts signed & disbursement schedules therein
- Some funds (as agreed by UNAIDS Ethiopia & AICS) will be allocated to UNAIDS Ethiopia for interventions & activities relating to management & coordination of the Project, including the fees for a Project Coordinator
- UNAIDS Ethiopia will produce financial & Technical Reports of the Project as per AICS & UNAIDS Agreement

6. PROJECT MONITORING & EVALUATION AND REPORTING

Some suggested standard mechanisms include (i) Project implementation filed monitoring visits; (ii) Periodic written updates; (iii) Stakeholder meetings; (iv) ACSI & UNAIDS Project field assessment Missions; (v) Endoline Project evaluation, Report & results dissemination

7. SUSTAINABILITY, IMPACT AND REPLICABILITY

- Nationally, the project focus is fully aligned with the targets set in the GTP, HSTP, National HIV/STI Strategic Plan [the Investment case approach], SNNPR RHB Vision, Mission & strategic Plan as well as subsidiary Government Policies, Strategies and workplans.
- Globally, the Project advances the SDGs, UN GA Declaration on HIV/AIDS (2016), UNAIDS cooperate Strategy
- Regional & Community based approach & ownership will enhance sustainability

8. RISKS AND RISK MITIGATION MEASURES:

Risks relate to mis-alignment of Project interventions and community needs.
Continuing stakeholder consultations, ongoing Programme monitoring will be core mitigating measures.

9. PROJECT RESOURCES AND RESULTS MATRIX

Project Goal: The Goal of this Project is to reduce Communicable Diseases (CDs), including HIV and STIs in SNNPR through several mutually reinforcing interventions focused on disease prevention, health promotion and peer support groups strengthening, with special focus on Women and Young People towards ensuring healthy lives and well-being (SDG3) and ending epidemics of AIDS , TB, Malaria & Neglected Tropical Diseases (NTDs) as public health threats by 2030 (SDG3 Target 3:3).

Project Objective:

The Project Objectives are:

- To Prevent CDs;
- To Generate demand and increase uptake of health services for Women & Young People &
- To Strengthen & capacitate Mother Support Groups (MSGs) and Youth Support Groups (YSGs) to serve as ongoing community peer support structures

Outputs/Indicators	Activities	Implementing Partners
	Preparatory Project activities	
Consolidatedbaseline information, prioritization and well informed and designed project	• **Rapid Programme assessment of existing interventions & best practices** to reduce duplication, maximize linkages & scaling up of best practices	UNAIDS & Partners
	• **Desk assessment to (i) review assumptions & consolidate baseline information** on needs as well ongoing related interventions; (ii) **settle Project indicators, targets and benchmarks**.	UNAIDS & Partners
	• **Train Project Facilitators,** where required, among HEWs, HDAs, Teachers, Kebele Community Leaders, CBOs, FBOs, MSGs, YSGs, Law enforcement Agents & Prison Authorities on CDS, including HIV and HIV	UNAIDS & Partners, (HEW, HDA, WSGs, YSGs)
	• **Conduct Mode of Transmission studies in SNNPR or alternatively synthesize existing information** and use as a base for prioritization of Kebele & Wereda for combination prevention programs.	UNAIDS & Partners (EPHI, FHAPCO, RHB)
	• **Map out all hot spot areas in Kebeles, Woredas & towns** with high numbers of Female Sex Workers, Migrants Labourers and other Vulnerable Populations and design programs on prevention of CDs, targeting Female Sex Workers and Clients.	UNAIDS & Partners (EPHI, FHAPCO, RHB)

	Full Project cycle activities	
1. *Enhanced awareness, knowledge and education of key sectors*[9] on prevention of CDs including HIV/AIDS and STIs 2. *Increased uptake on health services relating to women and young people,* including HIV/AIDS & STIs services such as VCT, ART and PMTCT. 3. *Decreased new incidence of HIV & STIs among girls & women and vulnerable populations*	• **Develop and produce Amharic tailored IEC materials** on prevention of CDs including HIV/AIDS and STIs	UNAIDS & Partners (EPHI, FHAPCO, RHB)
	• **Implement a combination of tailored interventions** on health awareness, information & education and BCC on prevention of CDs including HIV & STIs for Schools Students, Vulnerable Populations, Law Enforcement Agencies and Prison establishments in the identified hot spots	WSGs, YSGs, HEWs, HDA, CBOs, FBOs, PLHIV Associations, HEI
	• **Build capacities** of WSGs, YSGs, Associations, CSOs and FBOs **to generate demand and increase uptake of health services** that benefit women and young people as well as to serve as ongoing community peer support groups on prevention of CDs, including HIV & STIs at Zonal, Woreda and Kebele levels	RHB, RHAPCO, HEWs, HDAs, WSGs, YSGs, CBOs, FBOs, Associations of PLHIV
	• **Build capacities** of YSGs, WSGs, Associations, CSOs and FBOs **on health promotion, information & education on prevention of HIV/AIDS and STIs** (**including Gender Equality and prevention of Gender Based Violence**).	HEWs, HDAs, WSGs, YSGs, CBOs, FBOs, Associations of PLHIV
1. *Strengthened peer support mechanisms* at individual, community**,** zonal, Woreda and Kebele levels 2. *Decreased HIV Stigma & Discrimination*	• **Expand peer support programs for** PLHIV and OVC including activities for psycho-social support, income generating activities, nutrition support, stigma reduction	Tilla Association, Medhin Association, NEP+, NoSAP^{+}, MSGs, YSGs, CSOs, RHB, RHAPCO
	• **Support technically and financially YSGs, WSGs**, Associations, CSOs and FBOs working with PLHIV and OVC	Tilla Association, Medhin Association, NEP+, NoSAP^{+}, MSGs, YSGs, CSOs, RHB, RHAPCO
	• **Establish and strengthen institutional IGAs to economically empower PLHIV**, especially Women and Young People	Tilla Association, Medhin Association, NEP+, NoSAP^{+}, MSGs, YSGs, CSOs, RHB, RHAPCO

[9] WSGs, YSGs, Associations, CSOs and FBOs primary and secondary schools students, vulnerable populations, law enforcement agencies and prison establishments

	<u>Project monitoring activities</u>	
Systematic observation of project implementation & timely remedial measures	• Organize **planning & periodic Project review meetings** with relevant Government entities, stakeholders & implementing partners • Convene Meetings of **Project Coordination Task Force**. • Undertake ACSI & UNAIDS **Project field assessment Missions**	UNAIDS & Partners
Improved knowledge of intervention areas, best practices documentation and results dissemination	**<u>End-line Project activities</u>** • Conduct a **rapid assessment of key Project results achieved** • **Draft & Publish project results**, including lessons learnt, best practices and human stories • Organize a **Project results dissemination media Briefing** to publicize data and project results	UNAIDS, Partners(EPHI, FHAPCO, RHB) & University of Awassa

10. FINANCIAL PLAN & 11. DETAILED BUDGET (See attached)

Proposed Budget for the Community Health Education, Capacity & Knowledge Building (CHECK) Project in EURO					
Key Activities	**(October 2016 - September 2017/Budget in EURO)**				
	Q1	**Q2**	**Q3**	**Q4**	**Total**
1. Output 1 -Consolidated baseline information, prioritization and well informed and designed project					
1.1. Rapid Programme assessment of existing interventions & best practices to reduce duplication, maximize linkages & scaling up of best practices	3,523				3,523
1.2. Desk assessment to (i) review assumptions & consolidate baseline information on needs as well ongoing related interventions; (ii) settle Project indicators, targets and benchmarks.		3,523			3,523
1.3 Train Project Facilitators, where required, among HEWs, HDAs, Teachers, Kebele Community Leaders, CBOs, FBOs, MSGs, YSGs, Law enforcement Agents & Prison Authorities on CDS, including HIV and HIV		10,436			10,436
1.4 Conduct Mode of Transmission studies in SNNPR or alternatively synthesize existing information and use as a base for prioritization of Kebele & Wereda for combination prevention programs.		44,645			44,645
1.5 Map out all hot spot areas in Kebeles, Woredas & towns with high numbers of Female Sex Workers, Migrants Labourers and other Vulnerable Populations and design programs on prevention of CDs, targeting Female Sex Workers and Clients.		1,427			1,427
Subtotal	3,523	60,032			63,555
2. Output 2 -Enhanced awareness, knowledge and education of key sectors on prevention of CDs including HIV/AIDS and STIs					
2.1 Develop and produce Amharic tailored IEC materials on prevention of CDs including HIV/AIDS and STIs			5,254		5,254
2.2 Implement a combination of tailored interventions on health awareness, information & education and BCC on prevention of CDs including HIV & STIs for Schools Students, Vulnerable Populations, Law Enforcement Agencies and Prison establishments in the identified hot spots				18,063	18,063
Subtotal			5,254	18,063	23,317
3. Output 3-Increased uptake on health services relating to women and young people, including HIV/AIDS & STIs services such as VCT, ART and PMTCT.					

3.1 Build capacities of WSGs, YSGs, Associations, CSOs and FBOs to generate demand and increase uptake of health services that benefit women and young people as well as to serve as ongoing community peer support groups on prevention of CDs, including HIV & STIs at Zonal, Woreda and Kebele levels			19,535		19,535
3.2 Build capacities of YSGs, WSGs, Associations, CSOs and FBOs on health promotion, information & education on prevention of HIV/AIDS and STIs (including Gender Equality and prevention of Gender Based Violence).				24,619	24,619
Subtotal			**19,535**	**24,619**	**44,154**
4.Output 4- Strengthened peer support mechanisms at individual, community, zonal, Woreda and Kebele levels					
4.1 Expand peer support programs for PLHIV and OVC including activities for psycho-social support, income generating activities, nutrition support, stigma reduction			9,812		9,812
4.2 Support technically and financially YSGs, WSGs, Associations, CSOs and FBOs working with PLHIV and OVC			80,280		80,280
4.3 Establish and strengthen institutional IGAs to economically empower PLHIV, especially Women and Young People				38,534	38,534
Subtotal			**90,092**	**38,534**	**128,626**
5.Output 5-Systematic observation of project implementation & timely remedial measures					
5.1 Organize planning & periodic Project review meetings with relevant Government entities, stakeholders & implementing partners			36,572		36,572
5.2 Convene Meetings of Project Coordination Task Force.			31,220		31,220
5.3 Undertake ACSI & UNAIDS Project field assessment Missions			1,739	1,605	3,479
Subtotal			**69,531**	**1,605**	**71,271**
6.Output 6-Improved knowledge of intervention areas, best practices documentation and results dissemination					
6.1 Conduct a rapid assessment of key Project results achieved				3,523	3,523
6.2 Draft & Publish project results, including lessons learnt, best practices and human stories				13,666	13,666
6.3 Organize a Project results dissemination media Briefing to publicize data and project results				48,168	48,168
Subtotal				**65,358**	**65,358**
7. Programme Support Cost					

7.1 Consultancy fee to hire Project Coordinator	17,180	17,180	17,180	17,180	68,720
Subtotal	17,180	17,180	17,180	17,180	68,720
Totals	20,703	77,212	201,592	165,352	465,000
Programme costs					465,000
UNAIDS recovery cost (7 %)					35,000
Total					500,000

Proposed Budget for the Community Health Education, Capacity & Knowledge Building (CHECK) Project in EURO

Key Activities	(October 2016 - September 2017/Budget in EURO)				
	Q1	Q2	Q3	Q4	Total
1. Output 1 -Consolidated baseline information, prioritization and well informed and designed project					
1.1. Rapid Programme assessment of existing interventions & best practices to reduce duplication, maximize linkages & scaling up of best practices	3,523				3,523
1.2. Desk assessment to (i) review assumptions & consolidate baseline information on needs as well ongoing related interventions; (ii) settle Project indicators, targets and benchmarks.		3,523			3,523
1.3 Train Project Facilitators, where required, among HEWs, HDAs, Teachers, Kebele Community Leaders, CBOs, FBOs, MSGs, YSGs, Law enforcement Agents & Prison Authorities on CDS, including HIV and HIV		10,436			10,436
1.4 Conduct Mode of Transmission studies in SNNPR or alternatively synthesize existing information and use as a base for prioritization of Kebele & Wereda for combination prevention programs.		44,645			44,645
1.5 Map out all hot spot areas in Kebeles, Woredas & towns with high numbers of Female Sex Workers, Migrants Labourers and other Vulnerable Populations and design programs on prevention of CDs, targeting Female Sex Workers and Clients.		1,427			1,427
Subtotal	**3,523**	**60,032**			**63,555**
2. Output 2 -Enhanced awareness, knowledge and education of key sectors on prevention of CDs including HIV/AIDS and STIs					
2.1 Develop and produce Amharic tailored IEC materials on prevention of CDs including HIV/AIDS and STIs			5,254		5,254
2.2 Implement a combination of tailored interventions on health awareness, information & education and BCC on prevention of CDs including HIV & STIs for Schools Students, Vulnerable Populations, Law Enforcement Agencies and Prison establishments in the identified hot spots				18,063	18,063
Subtotal			**5,254**	**18,063**	**23,317**

Wossenu Abera:
Consultant band A for 10 days @320/day & DSA for 3days @ $50 per day
=(320*10)+(50*3)+ ticket $600

3,523

Consultant band A for 10 days @320/day & DSA for 3days @$50 + ticket $600

3,523

Wossenu Abera:
Three days project facilitators training:
DSA* (50*3* 40)
Transport (30*2* 40)
Hall rent (500*3*1)
Stationary (15*3*40)

10,436

Wossenu Abera:
Printing cost of the study on the Dynamics and Drivers of the HIV Epidemic and the Prevention Response

44,645

Wossenu Abera:
Hiring of band A Consultant for five days @$320/day band A

1,427

63,555

Wossenu Abera:
Cost to duplicate 1500 copies of DVD amharic IEC materials= 52300 ETB*1.15/22.25=$2700
-Consultant band A to develop IEC materials for 10 days= $320/day*10=$3200*.892=2,854 Euro

5,254

Wossenu Abera:
1 day awarness creation WS in three locations @ $6,750 per locations.
DSA (50*1* 50)
Transport (30* 2*50)
Hall rent (500 *1* 1)
Stationary (15* 1* 50)

18,063

23,317

3. Output 3-Increased uptake on health services relating to women and young people, including HIV/AIDS & STIs services such as VCT, ART and						
3.1 Build capacities of WSGs, YSGs, Associations, CSOs and FBOs to generate demand and increase uptake of health services that benefit women and young people as well as to serve as ongoing community peer support groups on prevention of CDs, including HIV & STIs at Zonal, Woreda and Kebele levels			19,535		19,535	19,535
3.2 Build capacities of YSGs, WSGs, Associations, CSOs and FBOs on health promotion, information & education on prevention of HIV/AIDS and STIs (including Gender Equality and prevention of Gender Based Violence).				24,619	24,619	24,619
Subtotal			**19,535**	**24,619**	**44,154**	44,154
4.Output 4- Strengthened peer support mechanisms at individual, community, zonal, Woreda and Kebele levels						
4.1 Expand peer support programs for PLHIV and OVC including activities for psycho-social support, income generating activities, nutrition support, stigma reduction			9,812		9,812	9,812
4.2 Support technically and financially YSGs, WSGs, Associations, CSOs and FBOs working with PLHIV and OVC			80,280		80,280	80,280
4.3 Establish and strengthen institutional IGAs to economically empower PLHIV, especially Women and Young People				38,534	38,534	38,534
Subtotal			**90,092**	**38,534**	**128,626**	128,626
5.Output 5-Systematic observation of project implementation & timely remedial measures						
5.1 Organize planning & periodic Project review meetings with relevant Government entities, stakeholders & implementing partners			36,572		36,572	36,572
5.2 Convene Meetings of Project Coordination Task Force.			31,220		31,220	31,220
5.3 Undertake ACSI & UNAIDS Project field assessment Missions			1,739	1,605	3,479	3,479
Subtotal			**69,531**	**1,605**	**71,271**	71,271
6.Output 6-Improved knowledge of intervention areas, best practices documentation and results dissemination						
6.1 Conduct a rapid assessment of key Project results achieved				3,523	3,523	3,523
6.2 Draft & Publish project results, including lessons learnt, best practices and human stories				13,666	13,666	13,666
6.3 Organize a Project results dissemination media Briefing to publicize data and project results				48,168	48,168	48,168
Subtotal				**65,358**	**65,358**	65,358
7. Programme Support Cost						
7.1 Consultancy fee to hire Project Coordinator	17,180	17,180	17,180	17,180	68,720	68,720
Subtotal	**17,180**	**17,180**	**17,180**	**17,180**	**68,720**	68,720
Totals	**20,703**	**77,212**	**201,592**	**165,352**	**465,000**	465,000
Programme costs					**465,000**	465,000
UNAIDS recovery cost (7 %)					**35,000**	35,000
Total					**500,000**	500,000

Wossenu Abera:
Twenty demand creation WS for WSGs,YSGs,CSOs & FBOs each for one day
DSA for 3 WS facilitators ($50*3)=$150
Hall rent (500* 1)=$ 500
Stationary & materials=$445

Wossenu Abera: 5days
Twenty Four buidling capacity WS for WSGs,YSGs,CSOs & FBOs each for one day
DSA for 4 WS facilitators ($50*3)=$150
Hall rent (500* 1)=$ 500
Stationary & materials=$450

Wossenu Abera:
Ten capacity building WS for CSOs & FBOs working with PLHIV & OVC(=$3,600/workshop*10 WS=$36,000)
-Technical & Fiancial Support for eleven YSGs,WSGs & PLHIV=($4500*12=$54,000)

Wossenu Abera:
Basic business skill & Cooperation Formation & saving approach training for 200 people=$4,000
-Vocational training for 200 OVC =$3,000
-Income Generation Activities(IGA) for 10 PLHIV & 7 OVC= $235/person*17=$3,995

Wossenu Abera:
Six project review meetings (5 in SNNPR & 1 in Addis Ababa):
DSA* (50*1* 50)
Transport (30 *2* 50)
Hall rent (500* 1)

Wossenu Abera:
Economic Strenthening activity for HIV positive womens project
-Mother Support activity=$5,000
-Enterpernurship training for PLHIV=$10,000
-Vocational training=$4,200
-Workshop for mkt linkage=$6,000
-Establishment of Institutional IGA-$18000

Wossenu Abera:
Five days project coordination task forcee meeting:
DSA* (50*5* 100)
Hall rent (500* 5* 1)
Stationary (15* 5* 100)

Wossenu Abera:
Consultant band A for 10 days @320/day & DSA for 3days @50+ ticket $600

Wossenu Abera:
Three days project coordination task forcee meeting:
DSA $50 for 5 days for 3 staff
- 2 field visit,ticket for 2 staff@ $600*2

Wossenu Abera:
• Design and printing of project result (100 pages) x 200 copies =200000*1.15*1.1=253000ETB=10,143 euro
-Project result consultant band A for 10 days @320/day & DSA $50 for 3days + ticket $600 =((320*10)+(50*3)+600) *0.892)=3,523 euro

Wossenu Abera:
Four days project dissemination workshop:
• Hall rent – 500*4
• Perdiam - 4days*200 participants x $50
• stationary – $15*4*200

Wossenu Abera:
Consultancy fee for Band A for one year =$6420/month*12 months*.892 euro

Wossenu Abera:
7% of euro 500000