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DEPARTMENT OF COMMUNITY HEALTH

ASSESSMENT OF COMMUNITY AND ORGANIZATIONAL RESPONSE AGAINST THE IMPACT OF HIV/AIDS IN TIGRAY REGION, NORTH ETHIOPIA

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List of tables showing findings in organizations of the five woredas of Tigray region, Ethiopia, April 2006

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ACRONYMS

AAC	Anti Aids Committee
ABC	Abstinence, Be Faithful and Condom Use
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti Retro Viral
ARVD	Anti Retroviral Drug
ART	Anti Retroviral Therapy
BCC	Behavioral Change Communication
CBO'S	Community Based Organizations
CRDA	Christian Relief and Development
Association	
CSO	Civil society organizations
CSW'S	Commercial Sex Workers
DECSI	Dedebit Credit and Saving Institution
DHO	District Health Office
E.C	Ethiopian calendar
EFY	Ethiopian Fiscal Year
FAO	Food and Agriculture Organization
FBO'S	Faith Based Organizations
FGA	Family Guidance Association
FGD	Focus Group Discussion
FPP	Focal Point Person
HH	House Hold
HIV	Human Immuno Deficient Virus
HMIS	Health management information system
HSDP	Health Service Development Program
HTP'S	Harmful Traditional Practices
IDIs	In-depth interviews
IEC	Information, Education, Communication
IP	International Precaution
KAP	Knowledge, Attitude and Practice
MDGs	Millennium Development Goals
MOH	Ministry Of Health
MTCT	Mother -To -Child Transmission
NGO	Non-Governmental Organization

NSF	National Strategic Framework
NTF	National Task Force
OI	Opportunistic Infections
OVG	Other Vulnerable Groups
OSSA	Organization for Social Services on AIDS
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLWHA	People Living With HIV AIDS
PMTCT	Prevention of mother- to- child
Transmission.	
RHAPCO	Regional HIV /AIDS Prevention and Control Office
RHB	Regional Health Bureau
REST	Relief Society of Tigray
STI'S	Sexually Transmitted Infections
SWAP'S	Sector Wide Approaches
UNICEF	United Nations International Children Emergency Fund
UNDP	United Nations Development Program
UNAIDS	United Nation Agency for International Development
UNFPA	United Nation Fund for Population Action
VCT	Voluntary Counseling and Testing

ABSTRACT

AIDS is an extraordinary kind of crisis; it is both an emergency and a long-term development issue. In 2003, the Global PLWHA was 38 million out of which 2/3 (25 million) are in Sub-Saharan Africa. In Ethiopia, there are an estimated 1.5 million PLWHA with a prevalence of 4.4 % in 2003. In Tigray, Northern Ethiopia, the adult prevalence of HIV/AIDS is 4.4 % with an estimated 100,000 PLWHA in 1997 E.C.

The Epidemic is reversing the social and development gains and deepening poverty. The Government of Ethiopia initiated the response in 1985. The response include the establishment of NTF, HIV/AIDS prevention and control department at MOH,HIV/AIDS prevention and control council and HAPCO ,development of HIV /AIDS policy and NSF.

The objective of this study is to assess the community and organizational response against the impact of HIV/AIDS and to draw best practices and weaknesses in Tigray region.

Data were collected from February –April 2006 in five districts of Tigray region using in-depth interview, FGD, document review and observation. Four zones were selected conveniently and from that five woredas were selected on lottery method .All available organizations in the five woreda were eligible for the study.

Generally, the effort to curb HIV/AIDS epidemic is very poor. Absence of workplace HIV/AIDS policy, implementation guideline, misunderstanding of the concept and method of mainstreaming, lack of leadership commitment, lack of capacity and poor NGO and community involvement are among the major findings.

Development of workplace HIV/AIDS policy and implementation guideline, repeated sensitization efforts to enhance high level commitment, rewriting of the role and responsibility of the FPP, financing mainstreaming and strengthening the capacity of coordinating organization.

Introduction

AIDS is an extraordinary kind of crisis; it is both an emergency and a long-term development issue. In 2003, the Global PLWHA was 38 million**.** Sub-Saharan Africa is home to just over 10% of the world's population and almost two-thirds of all people living with HIV. An estimated 25 million PLWHA live in sub-Saharan Africa. [1]

With an estimated 1.5 million PLWHA, Ethiopia is the third most highly affected country worldwide interms of absolute numbers. The prevalence of HIV infection in Ethiopia is 4.4 % in the population in 2003 [2].In Tigray, Northern Ethiopia, the adult prevalence of HIV/AIDS is 4.4 % and an estimated 100,000 PLWHA [3].In Ethiopia heterosexual transmission is responsible for the majority of infections (87%) followed by mother-to-child transmission (MTCT) 10%.

The Epidemic is reversing the social and development gains, deepening poverty, challenging the National priority of expanding and maintaining essential services and reducing labor and intellectual productivity [4]. HIV /AIDS have a cross-cutting negative effect on the millennium development goals (MDGs) [5].

Various attempts have been made to curb HIV/AIDS epidemic so far in Ethiopia. The Government of Ethiopia initiated the response in 1985 soon after the first report of laboratory confirmed HIV/ AIDS cases. Among the major steps taken are, Establishment of National task force (NTF) within the Ministry of Health (MOH), Establishment of AIDS control program at a department level in the MOH, Adoption of HIV/AIDS policy, establishment of National HIV/AIDS prevention and control council, establishment of HIV/AIDS prevention and control office (HAPCO) and National strategic framework (NSF) for intensifying HIV/AIDS response to be applied from 2004-2008.The NSF include,

Capacity building, community mobilization and empowerment, integration of HIV/AIDS activities with health programs, leadership mainstreaming, coordination , networking and targeted response[4,5].

The realization that the reach of the burden of the problem was beyond that which the health sector can solely manage despite of the various efforts and the huge impact of HIV/AIDS on societies, economies, cultures and demography's have forced organizations, institutions and communities to respond to this predicament in a holistic way (multisectoral approach). The Governments of Ethiopia established HAPCO and EMSAP (Ethiopian multisectoral HIV/AIDS control project) to make the NSF operational [5].

A multisectoral and expanded response to HIV/AIDS is central to current strategies for combating the epidemic. A multisectoral response means involving all organizations of society Government, business, civil society organizations, communities and PLWHA at all levels, National and community in addressing the cause and impact of HIV/AIDS epidemic. The Objectives of a multisectoral approach is to link HIV/AIDS to all poverty reduction strategies and other action aimed at improving quality of life. The Key aspects of a multisectoral response are considering HIV/AIDS and its implication in all areas of policymaking, involving all organizations in developing a framework to respond to the epidemic, at international, National, Regional, District and community levels [4].

Mainstreaming is often used interchangeably with multisectoral response. Mainstreaming has been defined in different ways by different agencies. For example, A process of analyzing how HIV/AIDS impacts on all sectors now and in the future, both internally and externally, to determine how each organization should respond based on its comparative advantage [6]. Mainstreaming is about change; it starts at the individual level where it must be internalized by the people in the institution [7]. The UNDP African regional HIV/AIDS

team defined mainstreaming conceptually as bringing HIV/AIDS to the center of the development agenda.

Mainstreaming requires a change in thinking, strategy and structure. It is different from integration that is simply introducing HIV/AIDS interventions in to existing project/program with out much interference within the specific core business. In This study there fore mainstreaming is to mean incorporation or assimilation of HIV/AIDS program in to existing program(s) and implementing as part of the program.

Multisectoral approach and HIV/AIDS mainstreaming in Ethiopia was started in August 2003, a year after the establishment of HAPCO (June 2000).Tigray region were among the regions which took the lead of establishing HAPCO by proclamation and initiated the multisectoral approach and HIV/AIDS mainstreaming.

To date, many of the interventions described in NSF have been implemented and a number of accomplishments recorded including increase in awareness, increased number of VCT and PMTCT sites and increase in number of people testing. How ever, it was found that the National response and intervention were still far from adequate considering the magnitude of the problem [4, 5, and 16].

The huge impact of HIV/AIDS on National development implies the need for comprehensive response interventions with close monitoring and evaluation of interventions. Only few studies about the implementation of NSF programs and components have been conducted. All of which are National ministry level but never been studied at grass root level. This study attempts to fill the gap of information about mainstreaming and multisectoral approach in the region. There fore the findings of this study can be helpful in highlighting decision makers about the HIV/AIDS response, strength and weakness and recommend necessary corrective measures. Since the study is the first of its kind, it also contributes a lot as a baseline for further studies.

Literature review

No policy sector is immune to or unaffected by the impact of HIV/AIDS; all organizations suffer from rising employee attrition, increasing absenteeism, declining moral and low productivity.

THE IMPACT OF HIV /AIDS IN DIFFERENT ORGANIZATIONS

Agriculture sector—Seven million Agricultural workers already lost and at least 16 million more who could die before 2002 in sub-Saharan Africa. A study by FAO in Namibia showed that, for all type of house holds in farming communities, AIDS death also meant "a loss of productive resource through the sale of Livestock to pay for sickness, mourning, and funeral expense, as well as sharp decline in crop production". The AIDS death of extension workers and teachers can undermine the transmission of knowledge and know-how and the local capacity to absorb technology transfer [8, 9].

Education sector - An estimated 4 -5 teachers die of AIDS each day in Zambia and 30% of teachers in Malawi are infected with HIV in 1999 alone [10]and estimated 860,000 primary school children in sub Saharan Africa lost their teachers to AIDS [8]. A 5% Increase in death of teachers between 1998/99 and 2000/2001, absenteeism of one week out of a semester and increased drop out rate of students in Ethiopia [2].

Health sector--The Health sector is affected profoundly by the impact of HIV/AIDS in health services .Bed occupancy rate(BOR) has reached levels 60-80 percent .This has worsened the chronic shortage of equipment, supplies and medicine ,making it more difficult to provide basic health services. Illness and abstinence of health workers are worsening the shortage of service delivery [5].

Labor-- HIV/AIDS brings about reduced labor quality and supply, more frequently and longer absenteeism loses in skill and experience and makes training and benefits more costly, tax contribution decline while the needs for public service increase [11].

On total population size -- In Ethiopia the population lost to AIDS was about 900,000 by 2003 and is projected to reach 1.8 million by 2008 if present trends continue. AIDS deaths account for a third of all young adult deaths in the country and Increases number of AIDS orphans [2].

Women- impact of HIV/AIDS is more profound in women. Lack of control over sex and reproductivity, growing female poverty, trafficking and sexual work, lack of information, stigma and discrimination, women's care giving role and HTP's play a role in the impact [12]. In Ethiopia the HIV prevalence is higher in women (5.0%) than men (3.8%) [2].

MDG: In addition to being a challenge in its own right, HIV/AIDS has a vast and cross-cutting negative impact on all the Millennium development goals. This is true through out the world and especially in sub-Saharan Africa. HIV/AIDS affects negatively the MDG through reducing productivity, increasing consumption needs, depletion of house hold assets, lessening teaching time, increasing student drop out (especially girl students), Increase infant and child mortality due to the effect of HIV/AIDS on house hold food security and hence on child nutrition, MTCT of HIV/AIDS, increase in maternal death due to the higher infection rate of teen age girls and young women, disproportionate risk of infection among poor and illiterate young women and the overstretched health services[4].

Studies in Tigray

In Tigray region 1346 civil servants died from 1988-1995 E.C. Though the cause was not registered it was estimated to be HIV/AIDS related deaths from the age distribution that 1129 (83.9 %) are productive age (23-42 Yrs) people .In Another study conducted in 22 civil organizations of the region in 1995 E.C, 55 deaths occurred. Out of these, colleagues suggested that 60% deaths was suspected to be due to HIV /AIDS .In these 22 organizations 48 employees abstain from work per week (2-3 employees /Week/Sector). Fifty-five percent cause of absenteeism was sickness, funeral and mourning [13].

Policy Environment and Back ground of Ethiopia

The Ethiopian Health Policy developed in September 1993 emphasizes on preventive and promotive health services, decentralization and democratization of healthcare system, short health care referral system, participation of private, non governmental organizations and the community [14]. The HIV/AIDS policy developed in August 1998 with the objective of establishing effective HIV/AIDS prevention and control strategies, promote broad multi-sectoral response to HIV/AIDS, encourage Government, non Government, private organizations and communities [15].The Policy on Ethiopian women that emphasizes on the equity between men and women the right to own property and empowerment of women in any social and development activities [16] are the umbrella policy environment that supports and creates favorable condition for the National fight against HIV/AIDS.

From the mid to late 19990's Ethiopia has been moving towards sector wide approach in key sectors such as Education and Health as well as the reform in the various sectors enable the integrated development programs to be decided by the Government and donors to pool their fund to these strategies [17]. NSF for HIV/AIDS was developed in 2000 to cover a

period of 2001-2005 and NSF for intensifying the response against HIV/AIDS that covers a period of

2004-20086 that states all ministries and organizations must mainstream HIV/AIDS i.e. all organizations must commit themselves to plan and make available resources for integrated responses. This must include plans within each sector for its own activities that will contribute to the National fight against AIDS, analysis of factors contributing to the spread of HIV/AIDS, the impact of the disease on its workforce and products and consequences for both sector and the community. All Government ministries have a key role to play, not just the MOH. For example, the Ministry of labor (MOL) can promote workplace prevention and care program, while the ministry of Education (MOE) can ensure that AIDS education is taught in schools. Therefore all organizations need to mainstream HIV/AIDS according their comparative advantage.

Partnerships should be developed to involve collaboration with businesses, non-Governmental organizations and communities across different organizations and at various levels [18]. NGO are good partners in that they serve remote rural areas where there were no Government facilities. High utilization of NGO services, innovation and less bureaucratic in decision making characterizes NGO services as compared to Government sector services [19].

Multisectoral approach in Ethiopia so far

In Ethiopia, insufficient involvement of Government organizations in the implementation of HIV/AIDS activities, lack of coordination among key players in terms of geographic and program component such as socio-economic impact alleviation and very limited visible community involvement efforts, inadequate funding, shortage of supplies of all sorts, lack of political Governmental support and acute shortage of skilled human resource are among the major pitfalls [4, 5]. Pace of implementation of mainstreaming project was not proceeding as desired. Government organizations did not mainstream, plan and implement their respective HIV/AIDS intervention. There was mix-up of goals, strategies, objectives and activities. In some of the plans, mismatch between the amount of workload and the available human resources, Inadequacy of offices and office facilities and lack of understanding of the concept of mainstreaming and adequate orientation and technical support were not put in place [4].

Experiences of other countries

UGANDA had runaway HIV infection rates until the early 1990's the highest prevalence in the world, but has used a multisectoral approach to curb them. Widespread public information campaigns, participation of state, local, nongovernmental and community based agencies, mainstreaming HIV/AIDS in the budget with the poverty eradication action program and involvement of civil society and private organizations like Uganda Business Council on HIV/AIDS (UBCOA) established by the business community to support the promotion of prevention and care program in the work place. As a result, adult HIV prevalence rate estimated to have dropped from greater than 30 percent in 1993 to below 8 percent in 2000 Rate of infection among girls aged 13-19 years dropped from 4.4 percent in

1989-1990 to 1.4 percent in 1996-1997. This also has resulted to provide ARV therapy and information to HIV employees, Achieved success in mobilizing senior level management in the fight against HIV/AIDS epidemic; UBCOA started orphan apprenticeship programs and support insurance schemes. This has been realized through a lot of advocacy and sensitization [20,21].

BURUNDI has started National level exercise for mainstreaming of HIV/AIDS prevention, control, and care and support program in to the Government structure. This program came into being due to the high level political advocacy .The launching of the program has brought about reduction of stigma on PLWHA, Improvement of access to treatment for AIDS patients with reduced price. Mainstreaming of care and support at the National level has also raised the awareness of HIV/AIDS within the Governmental ministries, uniformed people and trade unions etc [9, 20].

Namibia has mainstreamed HIV/AIDS in to the National development plan. The fact that it has included the financial commitment necessary to address the development challenges of HIV/AIDS made the National mainstream as the true mainstreaming [9,20].

Tanzania to meet the needs of the adolescent, a group of NGOs, The district health management and UNICEF formed an adolescent health task force that established use-friendly health services. They mobilized political commitment, trained peer educator, and established links between NGOs, clinics and young people. The National power company (TENESCO), local Government Authorities and health service have worked together to implement HIV/AIDS prevention activities among migrants and laborers working on the construction of hydroelectric project at Kihansi falls [20, 21].

What can we learn from these experiences?

The experience of Burundi has demonstrated the importance of high-level political commitment in HIV /AIDS prevention. The Role Model from high level serves as a motivator for regional and woreda level initiatives.

The Namibians experience shows that reliance on resource available at hand is best option for the sustainability of mainstreaming and thus HIV/AIDS should be budgeted.

The Uganda experience demonstrates that Government alone can not meet the huge task of controlling HIV/AIDS .It is mandatory to work with the Private sector, Religious organization, civic and other segment of the society. It should be the duty of the Government to sensitize, organize, facilitate and mobilize other organizations. We learn from all experiences that "unity is strength" Multisectoral approach gives greater output than the individual sum of each sub unit produces to the organization. There fore Ethiopia needs to follow these examples in order to reduce and control the highly prevalent problem. The policies and strategies on Anti AIDS campaign at Federal level should be implemented at the community level. Leadership commitments, political will, community involvement and coordination of activities was the central in all Anti- AIDS campaigns.

GENERAL OBJECTIVE

- To assess the community and organizational response against the impact of HIV/AIDS and to draw best practices, weaknesses and challenges in Tigray region.

Specific objectives

- To assess the proportion of organizations mainstreamed, stage and level of HIV/AIDS mainstreaming implementation in prevention and control activities of core Governmental organizations.
- To assess the level of response of Community Based Organizations, Faith Based Organizations, NGOs and civil associations against the impact of HIV/AIDS.
- To identify facilitators, barriers, and challenges in the response against HIV /AIDS.

METHODOLOGY

STUDY AREA:

The study was conducted in five districts of Tigray Region. Tigray Region is the North most National Regional state of Ethiopia. It is located between latitude 12^0 and 15^0 north. The Region covers 54,572.6 square kilometers. The total population of Tigray projected for 2005 is 4,215,944 of which 82.6% are rural and 51% are female. The Region is divided in to six administrative zones namely Southern Zone, Mekelle Zone, Eastern zone, Central zone, Northern zone and West North zone .The Region is further subdivided into 47 administrative Woreda and 688 administrative kebelles.

Study design

This study design assessed HIV/AIDS mainstreaming and multisectoral approach using a qualitative methodology. Proportion was used to indicate the number of organizations involved to a given activity (variable). The qualitative method was chosen because it was suitable for input and process evaluation, helping to understand the stage and level of implementation of National HIV/AIDS prevention strategy, which is the multisectoral approach (mainstreaming). This design triangulates different data collection methods and respondents. In-depth interview with key informant, focus group discussion (FGD), document review and participatory observation were used to get deeper insight into the research question.

The study comprises two separate questionnaires of the multi sectoral approach strategy. The questionnaire for HIV/AIDS mainstreaming and questionnaire for the contribution of HIV/AIDS response, implementing organizations which are mostly NGO'S involved in the prevention and control of HIV/AIDS.

Emphasis was given to the assessment of input, process (activity) at each level. Input was assessed as indicated by the sensitization and mobilization effort, organizations' concern to mobilize and allocate resources like FPP, budget, Time , office facilities and supplies. Process was evaluated for the organizations concern to initiate and sustain HIV/AIDS related activities like IEC, condom promotion, care and support activities, research and reporting.

Study unit

Governmental and non-Governmental organizations and institutions were illegible for the study. Depending on the nature of the sector all Government organizations and some NGOs, FBO'S, CBO'S in the selected study area were assessed for the stage and level of mainstreaming HIV/AIDS program in to organizations' development activities. The response implementing organizations (most of NGO'S, FBO'S and CBO'S) were assessed for their contribution to the different program components and the target group they focus. The organization, Human and documents are there fore the study units.

Size of the study unit

A total of 104 organizations were included in the study. Out of which 84 were assessed for mainstreaming and the rest 24 were non-Governmental and civil society organizations working at the region on the HIV/AIDS prevention activities and assessed for their contribution.

Selection method

The selection of zones and woredas was based on the concept of the uniform distribution of organizations, managerial capacity and resource through out the Region. Therefore

convenience method was used to select four zones out of the six zones, (southern, Mekelle, Eastern, and Central) excluding North and North West zones.

Selection of woredas

A lottery method was used to select five woredas one from each zone, except central zone where two Woredas were nominated due to its wider geographical coverage. As a result Mekelle town, Axum rural administration, Wukro town Administration, K/Tembien Rural administration, and Maichew town administration were selected.

Selection of study organizations

All Government organizations in the selected Woreda were included in the study regardless of the number of employees and other criteria. As a result 84 organizations and institutions were contacted for mainstreaming implementation.

NGO'S, CBO'S and FBO'S were not registered formally as association by the responsible organization. There fore they were identified using guides from resident of respective Woreda. A total of 24 identified organizations were included in the study.

Five Regional Core Bureaus were also included in the study for the purpose of comparison of the response at the different administrative levels in the Region. The core Regional Bureaus were selected based on their number of employees, customers and their role in the HIV/AIDS response and National development. These are Regional Agriculture Bureau, Regional Education Bureau, Regional Justice Bureau, Regional Police Commission, and Regional Information Bureau.

Data collection method

Guided by Ethiopian Strategic plan for intensifying multi-sectoral response a structured closed and open-ended questionnaires were developed separately pertaining to mainstreaming and NGOS' response. The questionnaires include questions about back ground information, resource availability, leadership commitment, and coordination and sensitization efforts.

Questionnaires were developed in English version, translated into local language (Tigrigna), pre-tested in non-study organizations and improved. A three days training about the data

collection were given to twelve-diploma level and above health professionals. Data were collected from February –April 2006 GC. In-depth interview were used to collect information from key informants (sector head or FPP).

FGD were conducted in two Woreda sector representatives. Since the status of HIV/AIDS mainstreaming in the sector were not known by the investigator before in-depth interview is started, topics for FGD were prepared after a brief field review of the results of the in-depth interview.

The purposes of the FGD were to dig out the facilitating and hindering factors for the effective response of HIV/AIDS and to extract innovative practices and to assess their concept about mainstreaming which could not be gained through in-depth interview. The FGD was conducted by the principal investigator being the moderator, whose role is, guiding the discussion and note takers were two health professionals from the data collectors with previous experience, their duties were to list topics discussed, monitor reaction of group participants and ensures that the discussion recorded.

The participants were head of the all interviewed organizations; each focus group consists of 8 respondents. The group was homogenous in terms of position in the sector, sex, and age. The FGD was guided by semi-structured questions. Discussion focused on the meaning of mainstreaming, the position of the sector regarding mainstreaming status, knowledge about HIV/AIDS and its impact on the sector, reasons for not mainstreaming HIV/AIDS activities, and solutions to solve the problem(see annex 4). All discussions were tape recorded in Tigrigna, transcribed and translated to English.

Professional observation and record review were also used in the study. Observations on the HIV/AIDS activity during our visit, availability of HIV related posters on the wall or notice board, availability office and office facilities, supplies, condom distribution outlet etc were

observed and recorded as an evidence of the verbal information of in-depth interview. Areas that need document review were identified and indicated by arrow on the questionnaires. Information gathered from Regional Bureaus was compared wit that of respective district organizations for consistency during analysis.

Data analysis method

Data were analysed using the frame work for staging HIV/ AIDS mainstreaming jointly prepared by the HAPCO and UNDP Ethiopia country office (See appendix 1). Open code and manually for the qualitative aspect of the data, and computer EPI –Info version 6 were used for data entry and to display frequency tables.

Based on the Frame Work the organizations were labelled from ZERO to FOUR. A Stage Zero indicates that there is no sector HIV/AIDS activity. Stage one and stage two indicate the availability of internal (work place) mainstreaming and Stages three and four indicate the (external /Client) related mainstreaming.

The leveling of implementation of HIV/AIDS mainstreaming from Region to community and house hold level, were based on the stages of mainstreaming at Regional Bureaus, district offices community level and House Hold level.

Seventeen organizations that were contacted but witnessed not mainstreamed and never conducted the ad-hoc activity of HIV/AIDS and seven organizations which were not willing to give information despite of all efforts to clarify the objective of the study, were excluded during the analysis.

OPERATIONAL DEFINITION

1) **AIDS fund association:** Are associations established within an organization to support infected and affected staff and his/her family
2) **Civic associations are:** associations, which are established based on age, sex or other criteria for common interest, aims on protection of right of each member e.g. women, youth and farmers associations

3) **Civil society organizations:** is a term that is used to include CBO's, FBO'S and associations.

4) **Community Based Organizations (CBO'S):** are those NGO'S established by the community for self-help and support purpose.

5) **EDIR**: is a social self-help association, organized by people with common interest (Area, sex etc) aimed at helping each other during death, disease and some times disaster.

6) **EQUIB**: is a social self-help association, organized by people with common Interest, Serve

as a local saving and credit association.

7) **External mainstreaming (Demand):** HIV/AIDS actions related to the delivery of the organizations services or products.

8) **Faith based organizations (FBO'S):** are those NGO'S which are organized for Religious oriented relief and support.

9) **GOVERNMENT ORGANIZATIONS**: are those organizations, which are owned by the Federal Government of Ethiopia.

10) **HIV/AIDS response organizations:** are all organizations that are contributing directly or indirectly for the prevention and control of HIV/AIDS.

11) **Internal mainstreaming (supply)**: HIV /AIDS actions directed to the organizations internal human resource.

12) **KEBELLE**: the smallest administration boundary organized by the regional Government. A kebelle Comprise at least 5000 people.

13) **MAHIBER**: is a social self-help association, organized by people with common interests in the name of God and Angeles. Mainly used as a stage for religious discussion and conflict resolution.

14) **NGO's**: are a voluntary, not-for–profit, not self –serving, non-Governmental; non partisan and independent organization or association involved in the promotion of social justice and development (CRDA definition).

15) PLWHA association: are associations established by PLWHA for the purpose of supporting each other and educating others about the disease.

16) Private for profit NGO's: are those NGO'S whose main objective is profit making and Share the profits within the members of the organization.

17) **Private not-for- profit NGO'S:** are those NGO'S whose main motive is not profit making. The profits they gain are used for expansion of the program.

18) **Professional associations:** are association's established based on profession for the protection of the right and responsibility of the professional members and ethics of the profession.

19) **SUNDAY SCHOOLS**: are associations organized by people (esp. youth), for Religious purpose.

1. RESULTS

A total of 108 organizations were contacted. Out of which 84 were for mainstreaming HIV /AIDS activities in to sectoral activities and the rest 24 were NGO'S and CSO'S interviewed for their contribution in the fight against the impact of HIV/AIDS. Out of the 84 organizations contacted for mainstreaming 56 (67%) claimed mainstreamed and interview continued, the rest 24 (21%) claimed they never been sensitized and not conducted

HIV/AIDS related activities, so that interview stopped. The rest 4 (7%) were not willing to respond. Out of the 24 organizations contacted 21(88%) were found appropriate to continue the interview and the rest 3 were not implementing HIV/AIDS related activity.

1.1 Mainstreaming related results

Out of 56 organizations 48(85.7%) are Government organizations that comprise 5 (10.4%) are Regional Bureaus and the rest 43 (89.6%) are organizations and institutions at district level. All organizations that said that they have mainstreamed HIV/AIDS activity are discussed in this paper. Many other organizations, which were found not having the concept of mainstreaming and not started, are excluded from the discussion and analysis part.

Table 1: Distribution of 56 organizations interviewed for mainstreaming by ownership in the five woredas of Tigray Region April 2006.

wner of institution	Frequency	Percent
Governmental	48	85.7
NGOs for- profit	2	3.6
Civil association	4	7.1
CBO's	2	3.6
Total	56	100.0

1.1.1 Sensitization and training about mainstreaming

High-level management of the organization should attend sensitization and training. Out of the 56 organizations contacted 28 (50%) said they have got sensitization /training about HIV/AIDS mainstreaming from the regional HAPCO or the respective DHO. Out of which only 12 (42.8%) were the appropriate person (See table 2).

Table 2: Sensitization and training about HIV/AIDS mainstreaming received by 56

organizations in the five woredas of Tigray region, Ethiopia, April 2006.

ACTIVITY	Total	Yes	%
Took Sensitization and training	56	28	50
Position of the trainee in the sector			
Sector head	28	7	25
Department head	28	5	17.8
Low level employee	28	16	57.2

1.1.2 Organizing, policy and planning efforts of the organizations

This section was a priority of focus of document review. Out of the organizations that said yes to almost all were not able to show the document (See table 3).

TABLE 3: Organizing and planning effort for mainstreaming HIV/Aids by the 56 organizations in the five Woredas of Tigray region, Ethiopia, April 2006.

ACTIVITY	FRQU.	%	Document
HIV/AIDS related Vision	1	1.8	1
HIV/AIDS related Mission	1	1.8	1
Sectoral HIV/AIDS policy developed	20	35.7	2
Guidelines for sectoral HIV/AIDS developed	18	32.1	1
Sectoral SP for HIV/AIDS prevention developed	23	41	-
Annual plan of HIV /AIDS for customers	0	0	-
Annual plan of HIV/AIDS prevention for workers	27	48.2	27
HIV/AIDS prevention and control activities	35	62.5	35
Committee for supporting staff PLWHA	8	22.8	-
Anti AIDS committee they know	25	71.4	-
Organizations membership of AAC	21	60	-

1.1.3 RESOURCE AVAILABILITY (INPUT)

Focal point person (FPP), budget and supplies

Twenty-nine (51.8%) organizations said they have focal point person (FPP) for the organization. Out of which twenty- three (79.3%) FPP'S had training on HIV/AIDS and only 8 (27.6%) are female. Inappropriateness of FPP'S in terms of position and experience,

absence of time, budget facility and supplies prevents the implementation of intervention (See table 4)

Out of the 56 organizations, 8 (14.3%) said they have allocated Government Budget for HIV/AIDS activities. Teaching materials and condoms were available in 21(37.5 %) of the organizations. Most materials are written teaching material like posters, leaflets and Male condom. (See table 4)

Table 4: Availability of Resource for HIV/AIDS mainstreaming of 56 organizations In five Woredas of Tigray region Ethiopia**, April** 2006.

Input type	Total	Yes	%
Focal point person available	56	29	51.8
Male FPP	29	21	72.4
Female FPP	29	8	27.6
Position of FPP in the sector			
Sector head	29	0	0
Department/unit head	29	3	10.3
Low level employee	29	26	89.7
Working time for FPP			
Full time	29	6	20.7
Half time	29	4	13.8
No time	29	19	65.5
Trained FPP	29	23	79.3
Budget for HIV activities	56	8	14.3
Material/supplies	56	21	37.5
Work place for FPP	29	6	20.7

1.1.4 Implementation of activities (Process)

Out of the 56 organizations, which claimed mainstreamed, only 35(62.5%) organizations were found implementing HIV/AIDS activities for organizational workers. Thirty (85.7%) organizations implemented HIV/AIDS prevention activities. IEC, Male condom distribution and training of staffs constitute the major prevention activity respectively. Prevention activities like Female condom distribution, treatment of STI'S, VCT is very weak. Only 3(8.6%) of the organizations claimed to practice care and support part the prevention and control strategy (see table 5)

Table 5: HIV/AIDS prevention and control activities implemented by 35 organizations in the five woredas of Tigray region ,Ethiopia April 2006.

Activity	Yes	%
IEC	30	85.7
Male condom distribution	18	51.4
Training of staffs	15	42.8
Counseling	9	25.7
VCT	8	22.8
Treatment of STI'S	2	5.7
Female condom distribution	1	2.8
Care and support		
Free medical care	3	8.6
Free ARVD	3	8.6
Financial support for families	1	2.8

1.1.5 Reporting system

Out of the 35 organizations, which have implemented HIV/AIDS response activities

31 (88.6 %) claim that they report HIV/AIDS activity, out of them 18(51.4%) report to the responsible organizations (RHAPCO, AAC, DHO).Five (14.3%) of the organizations report on monthly basis. Use of standard reporting format was reported by 12(38.7%) of the organizations (see table 6)

Table 6. Reporting system of 31 organizations regarding HIV/Aids activity in the five study woredas in Tigray Region, Ethiopia, April 2006.

Report	Yes	%
Use standard reporting format	12	38.7
Report to RHB	2	5.7
Report to DHO	9	25.7
Report to respected AAC	3	8.6
Report to regional HAPCO	6	17.1
Report to higher officers	19	54.3
Reporting time		
Monthly	5	14.3
Quarterly	17	48.6
Bi annually	7	20
Annually and above	2	5.7

1.1.6 Stage and level of mainstreaming HIV/AIDS

The proportion of organizations mainstreamed, stage of mainstreaming and level of mainstreaming is summarized as, (see table 7)

Table 7: Mainstreaming stage by ownership and level of the 80 organizations Interviewed for mainstreaming in five woredas of Tigray region, Ethiopia, April 2006.

Organization	Total	Stage zero		Stage one		Stage two	
		No	%	No	%	No	%
Total	80	53	66	24	30	3	4
Regional core Government Bureaus	5	0	0	5	100	-	-
District Government Organizations	61	42	69	19	31	-	-
Authorities and private organizations	4	1	25	-	-	3	75
CBO'S	10	10	100	-	-	-	-

1.1.7 Problems encountered

Budget constraint, shortage of supplies, coordination problem , lack of concern from sector leaders, lack of capacity of planning & incorporating , shortage of man power and lack of knowledge are the major problems(See table 8 below)

Table 8: Major problems encountered to implement HIV/AIDS mainstreaming by 35 organizations in five woredas, in Tigray region, Ethiopia, April 2006.

Problems	FRQU	PERCENT
Shortage of budget	31	88.5
Shortage of materials	23	65.7
Weakness of coordinating sector	21	60
Lack of concern of leaders	21	60
Capacity of planning and incorporation activity	17	48.6
Shortage of man power	14	40
Lack of HIV knowledge	6	17.1

1.1.8 Results from FGD, Document review and observation

The information about the status of HIV/AIDS mainstreaming in the region was not available. Therefore a brief on the field review of in-depth interview results were used to develop initial point of discussion (See annex 4). The Principal investigator specially conducted FGD and document review, with the support from data collectors. Checklists for points that need document review are indicated by arrow in the questionnaire. The availability of teaching materials and supplies with their placement, any HIV/AIDS related activities were observed. These were discussed up on within the data collectors.

Almost all discussants respond that they know HIV/AIDS affects the organizations activity through loss of skilled and labor productive worker and abstinence from work due to illness.

Most of them said their organization is responding to the negative effect of the epidemic through IEC, training of staffs and condom promotion.

Asked for whether this response is mainstreaming or not, almost all said this is what they consider as mainstreaming.

Explanation was given about the concept and method of mainstreaming and again asked if they still consider their response as mainstreaming. All discussants agreed that they have

misunderstood the concept of mainstreaming and that they were doing the response as integration or on ad-hoc.

The problems they faced during implementing mainstreaming as they discussed were absence of Government budget. The Government finance policy does not allow budget for HIV/AIDS activity and orders to pool any money from activity or sells of used equipment to district finance and economic office. This prevents organizations from devising fund raising mechanism and requesting budget from the finance office. The workload and the result oriented appraisal system also contribute to the delegation of low-level employee as FPP or not assigning at all.

All discussants said writing the implementation guideline and other guidelines that could be used as starting point of mainstreaming by respective organizations and high-level commitment is important to the implementation of the mainstreaming.

Results document review

During review of the organizations documents and plans no policy, guideline and strategic plan related to HIV/AIDS were found documented or incorporated with the organizations document.

The Annual plans about prevention and control of HIV/AIDS that was developed in the organizations were reviewed. In almost all organizations the plan was not developed as part and parcel of the main developmental plan of the organizations. The plan also lacks analysis of the risks and impacts of HIV/AIDS, problem in clarity of objectives and lack of necessary resources to achieve the objective.

The financial documents were reviewed in some organization and allocated budget for the Prevention and control of HIV/AIDS were very small (less than 0.01% of the sector annual Government budget) and in all organizations the budget was not allocated from the finance and economic development, but it was a sort of earmarked fund of Government source.

Results from Observation

During observation the major findings were the presence of posters and other written materials on walls, notice board and rooms of some employee. But most written materials and posters were not that developed in local language. In many condom boxes it was observed that the condoms were old looking, greasy, broken and inappropriately placed.

1.2 Results of Ngo's and civil society organization contribution

A list of NGO'S, FBO'S, CBO'S and other civil society organizations pertaining their ownership, geographical area of intervention and objective was not available in the responsible organizations to coordinate them. There fore local guiders were used to identify these organizations. As a result they were able to identify 15 organizations working on HIV/AIDS response that totalled 21 as a result of double appearance of the organization in different woredas. Two international, two National and the rest 11 local NGO'S and associations were interviewed (see annex 3).

1.2.1 Geographic distribution of the organizations

Out of the 21 organizations 80% of them were found on Mekelle and Axum. (See table 9)

TABLE 9: Distributions of the 21 organizations interviewed for their response On HIV/AIDS by Woreda in Tigray Region, Ethiopia April 2006.

WOREDA	Number	Percent
AXUM	8	38.1
Wukro K /Tembien	3	14.3
Mekele	9	42.9
MAICHEW	1	4.8

Total	21	100.0

While for the 16(76.2%) HIV/AIDS response is an additional response to other developmental activity only 5(23.8%) organizations work particularly on HIV/AIDS.

1.2.2 Target group of intervention of NGO'S

Most organizations are responding to the epidemic holistically interms of covering most vulnerable group. Duplication of target groups on some population group were seen .The method of contribution to the response were direct provision of service and financial support to programs like PHC, HSDP and CBO'S (see table 10)

Table 10: Target group of intervention of the 21 organizations interviewed for contribution in five woredas of Tigray region, Ethiopia, April 2006.

Activity	Yes	%
HIV orphans	15	71.4
PLWHA	13	61.9
School youth	10	47.6
Commercial sex workers	8	38.1
College students	6	28.6
Farmers	6	28.6
Out of school youth	5	23.8
Government employees	5	23.8
Drivers	4	19.0
Mobile laborers	3	14.3
Prisoners	3	14.3
Factory workers	3	14.3

1.2.3 Prevention Related Activities Implemented

Nineteen organizations out of the 21 were involved in direct provision of prevention activities of HIV/AIDS (See table 11).

Table 11: Prevention related services provided by the 21 organizations interviewed for their response in the five woredas of Tigray Region, Ethiopia, April 2006.

Type of prevention activity	Yes	Percent
Face to face IEC	16	76.2
IEC with Written materials distribution	14	66.7
News paper	4	19.0
Radio	3	14.3
Male condom distribution	11	52.4
Female condom distribution	0	0
Treatment of STI'S	4	19.0
Counseling	12	57.1
VCT	13	61.9
Blood safety and International precaution	4	19.0
Post exposure prophylaxis	3	14.3

1.2.4 Implemented Care & support activities

The care and support activity is less considered by the organizations as compared to the prevention activities. But the effort to cover most of the interventions in care and support is appreciable (See table 12).

Table 12: Care and support related services provided by the 21 organizations interviewed for their response in the five woredas of Tigray Region, Ethiopia, April 2006.

Type Care and support	Total	%
Institution based care and support	3	14.3
Provision of ARVD	1	4.7
Treatment of opportunistic diseases	1	4.7
Home/ community based care and support	8	30
Legal protection of PLWHA	2	9.5
PMTCT	4	19
Care & support for HIV orphans	7	33.3

1.2.5 Socio-economic impact alleviation activities

Out of the 21 organizations 10 (47.6%) provided financial support for the care and support. Out of the 10 organizations that financially support HIV/AIDS, 8(80%) the support goes to PLWHA, 10(100%) to HIV/AIDS orphans, and 4(40%) to the prevention of social stigma & discrimination. The amount of financial support were very little from all organizations

1.2.5 Reporting system

Only 16(76.2%) organizations report HIV /AIDS activities out of which only 14(66.7%) use standard reporting format. There is a great discrepancy on the time and place of reporting (see table 13).

Table 13: Reporting system of the 16 organizations claimed to report in the organizations interviewed for contribution in the five woredas of Tigray Region, Ethiopia April 2006.

ACTIVITY	Yes	%
To whom to report		
Report to RHB	5	31.3
Report to regional HAPCO	9	56.3
Report to AAC	1	6.3
Report to DHO	1	6.3
Report to Higher institution	10	62.5
Report to donor organization	9	56.3
Report time		
Monthly	3	18.6

Quarterly	11	68.8
Bi-Annually	2	12.6
Annually	1	6.3

1.2.6 Coordination and research

While 12 (57.1%) of the organizations said they have conducted partnership forum once in 1997 EC. Only 7(33.3%) said they know the responsible body to coordinate their organization.

Only four Researches were conducted, out of which 2 are Impact Assessment of HIV/AIDS and the other two are KAP on HIV/AIDS and Business Coalition to Fight AIDS.

1.2.7 Major problems encountered

Budget constraint, capacity problem, coordination problem, material shortage and lack of concern from the leaders were the major problems felt by the organizations (See table 14).

Table 14: Problems felt by the 21 organizations interviewed for their contribution in the five woredas of Tigray region Ethiopia, April 2006.

Problems encountered	Yes	%
Budget constrain t	12	57.1
Capacity problem	8	38.1
Coordination problem	7	33.3
Material shortage	5	23.8
Lack of concern	2	9.5
Lack of knowledge	1	4.8

2. Discussion

2.1 Mainstreaming

2.1.1 Sensitisation and training from coordinating organization

From the document review & interview, the regional HAPCO and RHB are doing their best by conducting repeated sensitization, training of community & political leaders, developing & distributing teaching materials, conduct forums and raising and distributing funds. However, only 50% of the organizations claim that they have received training / sensitization about mainstreaming. This can be due to the high turn over of trained personnel or may be explained by the finding that 57.2% of the trainees were not the appropriate person for the training. So the members of the organization may not have discussed result of training, remaining an experience of a single person. It could be also explained by poor coordination of training. This implies the lack of high level commitment that is measured by attending of HIV/AIDS mainstreaming training by organization head [5].

2.1.2 Organizing and developing policies, guidelines and plans for mainstreaming

HIV/AIDS mainstreaming can involve fundamental changes in sole work of an organization. In order that an enabling policy environment exists for these far reached changes high-level support is needed within the organization and among that are influential in determining the policy and resources of the organization. High level organization leaders attending mainstreaming training, availability of intersectoral committee with regular meeting and communication, considering HIV/AIDS in every major organizational decisions and the extent of commitment to support and allocate resource are some of the indicators of high level commitment [5].

The success story of many African countries on the prevention and control of HIV/AIDS relies on the participation of different segments of the community, Religious organizations, NGO'S and Government organizations. The civil society was involved through establishing various committees .For example the Uganda Business Council has established Uganda Business Council On HIV/ AIDS (UBCOA) enabled to reduction of new HIV infection, increase access to information and ARVD with reduced price and mobilization of high level political leaders. A group of NGO'S, district health management and UNICEF formed an adolescent health task force to meet the need of the adolescent in Tanzania [20]. Uganda's successful combination of ABC strategies was rooted in a community-based National response in which both the Governmental and nongovernmental organizations (including faith-based, women's, and other grassroots organizations) succeeded at reaching different population groups with different messages and interventions appropriate to their need and ability to respond [20].

The NSF emphasizes on the participation of Government, non-government, civil society and community as a whole in the HIV/AIDS response. The establishment of Anti AIDS committee is one component of the plan. The committee comprises political & community leaders and Government & Non Government organizations and responsible for the identification of HIV/AIDS risk factors in a given area, follow up of the magnitude so as to revise appropriate mechanism and responding accordingly [2].

In this study it was found that the contribution of the various associations and committees were insignificant. Eight organizations all of which are Authorities and big companies had established the AIDS fund association within the organization, but only three organizations that have good support from the National Head Office are making use of it. This implies the importance of High-level political advocacy and role model of leadership for the implementation of the strategy. Though the availability of AAC is known by most of the organizations, almost all organizations said meeting was not conducted for long period of time and they do not know the meeting schedule. The finding that only three organizations were reporting to AAC, absence of feed back and monitoring from AAC also justifies that

the AAC is almost non functional. The contribution of other well organized associations like the Women, Youth and Farmer and Teachers association and the Chamber of commerce was insignificant as compared to the problem they face, resource they own and access they have to the community.

All these findings indicate the lack of high-level commitment. This has resulted in poor organizational implementation of mainstreaming as explained by number of organizations developed workplace HIV/AIDS policy, guideline and strategic plan 20(36 %), 23(41%)and 18(32%) respectively. The HIV/AIDS workplace policy, mainstreaming guideline and strategic plan of those organizations claimed to develop were not found in the organization document. Therefore it is hardly concluded that they have developed in those organizations. The preparation of annual plan was the reason to consider them selves as mainstreamed. This implies that most organizations are confused with the concept and method of mainstreaming.

2.1.3 Resource availability

FPP

One of the first steps that many Government organizations take in starting to mainstream HIV/AIDS is to establish focal point person who have the responsibility of acting as a catalyst to mainstream HIV/AIDS activities within their department and or organization. In Uganda, the MOE and sport nominated FPP'S in each department with one lead FPP in a more influential position. The MOE of Ghana has developed criteria for selecting

HIV/AIDS FPP and the roles and responsibilities of the FPP and appointed one FPP at National level ministry and one in each of the 15 agencies for different roles of the MOE. Each of these agencies has appointed one FPP per region [22].

In Ethiopia the Ministry of Youth, Sport and Culture established focal committee containing 8 staffs that are in a position to mobilize resources and influence people. Ministry of Agriculture suited the focal committee in the department of extension with full support from the management [4].

In the study area FPP's were available in 52% of organizations out of which 90% of the FPP's are low-level employees including guards and guardians who cannot influence people and hold agenda in the management. There fore only 10% of them are considered the appropriate FPP. The in availability of criteria for selecting FPP has resulted to the inappropriate designation of FPP for the purpose of completing the procedure. As A result most FPP found it difficult to convince people and the management committee regarding their HIV/AIDS related responsibility.

Training of FPP'S is one of the strategies to kick-start the mainstreaming process. In Ghana the FPP'S were mentored. The FPP'S were twined with consultants with expertise in mainstreaming. The FPP'S were returned to their own departments to develop HIV/AIDS plans. They met up again with their twined consultants to review their plan and resolve any concern they had. This mentoring method provided FPP'S with much needed support [22]. In the study area, though 23 (79.3%) FPP'S were trained; the training was focused on the facts about the transmission and progression of HIV/AIDS, myths and misconceptions about the virus. Therefore FPP'S have limited knowledge and experience of what is involved in the role, what is the difference between mainstreaming and HIV/AIDS integration, and how they should implement a mainstreamed response.

Financing mainstreaming from within is critical for the sustainability of the HIV/AIDS mainstreaming activity. Ideally, if HIV/AIDS is so well mainstreamed within the core development budgets of the organization, there are arguments that there is no need for separating "mainstreaming Fund". But the interlinkage between organizations, its works and HIV/AIDS are not being taken in to consideration in policies, planning and implementing process. Hence funds are needed to" kick-start" the mainstreaming process [5]. The Ethiopian NSF allows the allocation of 2% of organizations' annual Government budget for HIV/AIDS mainstreaming activities [2].

The common wealth Parliamentary association emphasises the need to keep HIV high on the list of priorities and ensure that an adequate allocation of funds is available in their National budgets and that the funds are properly utilized. Pouring resources in to fighting HIV/AIDS has been the reason for Senegal's success story [20].

Namibia's financial commitment necessary to address the development challenges of HIV/AIDS made the National mainstream as the true mainstreaming [5].

In the study area, only 8(14.3%) of the organizations claim allocated Government budget. The budget was found very few (below the recommended) and also it was an earmarked fund allocated from other organizations of Governmental sources. During FGD most organizations indicated that the restriction of such request from respective finance and economic development office and lack of request from the respective organizations as the reason for the absence of budget. The lack of financial commitment for mainstreaming HIV/AIDS in the area indicates that the initiated activities in the organizations are not true mainstreaming method and will face the danger of sustainability problem.

Teaching materials like posters and leaflets and male condom were available 37.5% of organizations. Since health sector has adequate amount of these supplies and a program for providing organizations with these supplies, the in availability could be due to the lack of request and inappropriate handling. The availability of supplies alone couldn't satisfy the objective of prevention and control of HIV/AIDS. Almost all organizations

witnessed these supplies especially condom is not utilized. The observation of old, torn and dusty condoms in condom box implies that organizations are failing to utilize appropriately available materials.

2.1.4 Gender and HIV AIDS mainstreaming

Women hold families and communities together and are a source of great strength in the face of HIV and AIDS. Women-friendly health services improve access to care for women and children and the society [1].

Many women and girls are vulnerable to HIV because of the high-risk behaviour of others. In Ethiopia females are at higher risk of HIV infection than male with at least 1.2 times greater risk [16]. Gender mainstreaming in all development plans and activities is well addressed now a days .The availability of women's policy and gender sensitive projects and efforts to increase the decision making role of women are some of the encouraging activities. Though the study lacks adequate information for conclusion, the findings that female FPP'S constitute 8(28%) and absence of female condom indicates the lack of gender consideration in HIV/AIDS response.

2.1.5 Implementation of HIV/AIDS prevention and control activities

Abstaining from sexual activity, mutual monogamy, and condom use are three key behaviours that can prevent or reduce the likelihood of sexual transmission of the AIDS virus. These behaviours are often included together under a comprehensive "ABC" approach [20]. Taking IEC as the major prevention program; we can see that 85.7% organizations render the prevention program. The IEC rendered is based on the "ABC" approach. But the major problem of this activity is the limitation of knowledge by FPP'S. The finding from document review and observation indicates that, almost all health education conducted were unplanned and not target oriented and the teaching materials found were that developed at National level and might not suit the socio-cultural condition of the area. The condom availability is in a better position compared to other activities, but it was not possible to show how many are using the condom due to the poor documentation and reporting system in all organizations. The observation of old and torn condoms in a condom box and the poor IEC activity may lead us to the conclusion that condoms are not utilized by staff due to the lack of awareness and openness. Prevention activities like counselling, VCT, treatment of STI'S remain very weak in all organizations.

Care and support for staff infected and affected by the epidemic is one arm of the HIV/AIDS prevention and control strategy that needs high level political advocacy [5]. The commonwealth parliamentary association recommends to scale up care and support arm of the multisectoral approach for PLWHA and to address stigma and discrimination [20]. In

Burundi nation wide implementation of care and support has brought about reduction of stigma on PLWHA, Improvement of access to ARVD with reduced price and also raised the awareness of HIV/AIDS within the Governmental ministries, uniformed people and trade unions etc [4, 20].

In the study area not more than 3 (8.5%) organizations tried to implement care and support activity like financial support for medical care when an infected employee gets sick, cost sharing for ARVD, financial supports to family etc. This indicates that very few organizations are responding to the impact beyond the routine unplanned Health education and condom distribution.

Any effort to prevent the spread of HIV with out care and support for those infected and affected will end up with failure to achieve the desired results. The low involvement of most organizations in the care and support, the finding that only three organizations have functional AIDS fund association and the absence of income generation activities within the sector can be due to lack of commitment, the misconception of care and support for PLWHA as the responsibility of the health organization and the lack of awareness about the impact of HIV/AIDS on the organization.

2.1.6 Reporting system

The most commonly used way of sharing information and monitoring and evaluation of any program is the use of regular activity report. Though, the National HIV/AIDS prevention strategy recommends monthly organizational HIV/AIDS related activity report to respective AAC using standard reporting format, only 3 (8.6%) report to AAC, 5 (14.3%) report monthly and 38.7 % organizations use standard reporting format. The rest didn't report or report to the wrong organization and on wrong timing. This might be due to the misunderstanding of the importance of reporting. Since most organizations are not working on HIV /AIDS they may not think reporting is important. It could be also explained by the lack of monitoring and evaluation of the program by the management of the organization. The malfunctioning of the AAC could also worsen the poor reporting system. This implies the lack evidence for any kind of decision-making.

2.1.7 Research and surveillance

For any organization it is important to develop understanding of the situation of HIV/AIDS and its effect to the community and their organization (situational analysis) both internally and externally. Understanding can be achieved through research and surveillance.

The members of the parliament should encourage research work on HIV/AIDS and especially its human capital, social and economic impacts [20]. In our set up the research and surveillance system is very weak. As a result in the study areas no sector had conducted research regarding the impact of HIV/AIDS on their sector. It is not expected to conduct a research from a sector that lacks the commitment to allocate resource for the routine HIV/AIDS activities. The absence of research and surveillance might enhance the un clarity about the impact of HIV/AIDS on the sector. This intern will prevent the initiation and commitment to prevent HIV/AIDS for the next time.

2.1.8 STAGES OF MAINSTREAMING AT DIFFERENT LEVEL

General status of the response in the study areas

Using the Frame work developed by HAPCO and UNDP Ethiopia country office, The response of the organizations can be fairly staged as almost one third of the organizations didn't start mainstreaming (stage zero), 24(30%) are at stage one and the rest 3(4%) could be labeled under stage two. Here it should be known that labeling of an organization to a given stage is decided taking the major elements of the each stage. For example, availability of annual plan of HIV/AIDS for stage one and availability of policies and strategies for stage two, otherwise no organization was found that fulfill all the elements at every stage (See Annex 2).

Mainstreaming at regional core Government bureaus of the region

Five (100%) of the Regional Government Bureaus are labeled at stage one of the staging criteria. This implies no regional government bureau have developed workplace policy and HIV/AIDS mainstreaming guideline. The annual plan developed in all organizations lack AIDS risk analysis of the organization. Though it is good that all regional bureaus have initiated mainstreaming, traditional planning by the highest decision makers at the region implies the little attention given to the response and can influence lower level organizations negatively.

Mainstreaming stage of Authorities and private not for profit organizations

Authorities like North Region Telecommunication and Tigray Rural road Authorities. Private organizations like "Mossobo" cement Factory and Trans Ethiopia were included in the study. It was found that the first three organizations were better responding to the HIV/AIDS impact. They have at least analysed the impact of HIV/AIDS in their respected organizations developed strategic and annual plan & drug policy (Tele). These organizations have budgeted HIV/AIDS activity from within. Document review findings indicate that there are good supports from the central head offices. These organizations have gone a step forward beyond the routine activities conducted in most Government organizations, in that they are trying to support the infected employee for medical care and family support. These Authorities and private organizations can be labelled under the stage two of UNDP mainstreaming staging criteria. This implies the importance of a good role model from high level leaders to implement the response at a lower level.

Mainstreaming stage at district organizations and institutions

Government organizations and institutions at district level constitute 61(76.2 %) of the total organizations .Out of the 61 organizations and institutions at district level only 19(31%)

were found to have organization HIV/AIDS plan, hence labelled at stage one. The remaining 42 (69 %) are at stage zero. We learn here that whenever there is a poor leadership role model in, there will be even worse response at each lower level organization.

2.1.9 Level of mainstreaming

To determine the level of mainstreaming at regional level it is adequate to look in to the data categorized at regional, district, community and household level. From the stages we can see that all regional organizations and less than one-third of the district organizations are at stage one of HIV/AIDS mainstreaming and almost all CBO'S are at stage zero. Accordingly we can conclude that the mainstreaming implementation is initiated to some extent and suspended at Regional and district level .The community and house hold level which should have been the major implementation focus and destination of the strategy are not implementing mainstreaming strategy.

3. Discussion non-governmental and civil society organizations response

Serving remote rural areas where there were no Government facilities (Filling the gap), innovation and less bureaucratic in decision making characterizes NGO services as compared to Government organization services [14,19]. Success story of Uganda in the

fight against HIV/AIDS was due to the widespread public information campaigns and promotion of the participation of state, local, nongovernmental and community based agencies [20].

Though the financial and donor policy that the country and region follows might hide the contributions of the organizations through other methods, the finding that only 15 organizations were found to contribute their share on HIV/AIDS prevention and HIV/AIDS response being additional work to 16(76.2%) of the organization together with the financial and skilled human resource shortage may lead as to the conclusion of poor NGO and civil society involvement in the response.

As opposed to their characteristics, NGO'S in the study area are found concentrated in the relatively well-urbanized cities of Tigray, Mekelle and Axum (81%). This could be due to the poor or absence of need assessment for HIV/AIDS interventions and the poor reporting and recording system. The in availability of registered list of NGO'S by the responsible coordinating body, the finding that few organizations know the responsible organizing body for NGO's activity and the finding that many organizations claim lack of coordination as a problem can also justify the poor involvement of the none governmental and civil society organizations.

Having the limitation in resource, responding to the epidemic holistically, and intervening on the target groups uncovered by Government organizations observed. The most vulnerable groups like HIV/AIDS orphan, PLWHA, school youth, CSW's and college students were the target of most organizations that were supported through either direct service provision or financial support.

The Media have always been a major tool in importing AIDS knowledge to the public. The media have an essential role to play in reversing the progression of HIV. Education to

promote awareness of HIV/AIDS is a key factor in the fight against the disease, and clearly, media organizations have an enormous potential to undertake these activities [24]. Though more than 90% of the organizations were providing the prevention and control activities, the use of radio by 3(14.3 %) and using News paper 4 (19%) organizations for dissemination of HIV/AIDS facts and information's make their contribution very important. In the region where 10 % of those who need ARVD are accessed, one organization is involved in distribution ARVD at a lower cost.

The nation wide poverty reduction strategy is the major strategy that addresses the socio-economic impact alleviation for the population at large and in particular to the vulnerable groups. But the Regional local NGO'S like REST, Regional Orthodox Church and OSSA are the only three organizations involved in socio-economic impact alleviation through establishing saving & credit programs, strengthening the income generation scheme & supporting orphan settlement camps.

The final objective of multi sectoral approach and mainstreaming is implementing the program at individual and family level. CBO'S are thought to be the major implementers and owners of HIV/AIDS prevention activities. But out of the 4 kebeles, 2 EDIR and one MAHIBER, No one were involved in the planned HIV/AIDS prevention activities .The kebelles work in ad-hoc when they get earmarked fund (mostly from RHAPCO) and report through the focal person assigned in district finance & economic offices. Though Anti - AIDS clubs were formed in every school there is no one that work consistently and in a planed manner.

Surveillance & research is the core strategy to combat HIV/AIDS impact, but in these organizations only four Assessments have been conducted in the last three years. This lacks timeliness and adequacy to identify the multidirectional impact of the disease. The financial constraint and lack of skilled manpower contributes to the absence of research.

It is known that the National and Regional prevalence of HIV/AIDS prevention and control activities implemented and gaps that need to be filled can be identified through the routine reports. Eighty one percent of organizations claim reporting while the rest 20% activities are not reported and 19(91%) report to donor organization ignoring the coordinating office for HIV/AIDS activities. Eighty two percent organizations use the National standard reporting format and only 17 % report in the right time (monthly) and majority 64.7 % report quarterly.

Budget constraints, capacity problem, coordination problem and material shortage are the four major problems the organizations are facing (57.1%, 38%, 33.3% and 23.8%) respectively.

Conclusion of Mainstreaming

- The response to HIV/AIDS is very poor as compared to the impact it poses on the organizations and the development as a whole. Few organizations started mainstreaming. There is inappropriateness and incompleteness of mainstreaming process in those started to mainstream. As a result HIV/AIDS response can be considered integrated rather than mainstreamed.

- There is gross misunderstanding of the concepts, component and method of mainstreaming HIV/AIDS.
- High level decision makers at each level lack the attention and commitment to respond to the epidemic. The thought that HIV/AIDS response as the responsibility of the health sector as is still dominant.
- Absence of workplace policy, HIV/AIDS mainstreaming implementation guideline and monitoring and evaluation tool and system are among the major contributors to the poor response.
- Focal point persons are not designated in most organizations, most of FPP's designated are low level employee who is not in a position to influence staff, mobilize fund and organizational resources for HIV/AIDS mainstreaming. As a result FPP'S found it difficult to implement mainstreaming due to the limited knowledge and experience of what is involved in the role, what is the difference between mainstreaming and integration and the work load involved with mainstreaming in addition to the existing workload of organizational task.
- Absence of budget for HIV/AIDS activities, lack of commitment to allocate resources including working facilities and supplies and support to FPP, and lower level organization
- The external mainstreaming (client related or demand) part of mainstreaming is completely not recognized and/ or ignored. The HIV/AIDS mainstreaming trial is suspended at regional and district level. The community and house hold levels are ignored.
- Monitoring and evaluation tool not developed and institutionalized at each organization level. Support from decision makers is lacking. As a result HIV/AIDS activities are poorly recorded and documented and not reported or reported to the wrong channel.
- Weakly organized and functioning intersectoral committee and poor involvement of NGO 'S, civil society and faith based organizations.

- ☞ The surveillance and research part of the prevention strategy have got little attention from Government organizations.

5. Conclusion Interviewed For Contribution

- ✓ Poor NGO involvement in the combat of HIV/AIDS impact. Non Governmental organizations and civil society organizations are few in number and weak financially
- ✓ Poor coordination for NGO'S and community organizations that can be expressed by duplication of interventions and concentration in geographical distribution.
- ✓ Poor surveillance, research and reporting system
- ✓ Local CBO'S like "EQUIB", "MAHIBER" and Civil associations like Women association, youth association are not contributing their share.

6. RECOMMENDATIONS

- Further sensitization, mobilization and training to clarify the confusion around the concept of HIV/ AIDS are needed at Regional each level with due attention to community, political and community leaders and decision makers.
- Developing and/ or revising HIV/AIDS workplace policy and mainstreaming implementation guideline at regional level that can be used as a reference to be adopted by every organization according their comparative advantage.

- Establishing or strengthening intersectoral committee, like Anti AIDS committee, civil society committees at each level with a regular forums and evaluation time.
- The HIV/AIDS mainstreaming should be financed .A clear statement about the source and means should be written and implementation guideline developed that ensures the sustainability of the program.
- Ensure that the FPP to be appointed is sufficiently senior, and in good position to influence the core work of the sector and to mobilize the attention and commitment of the staff. The focal points job description needs rewriting to include the new HIV/AIDS mainstreaming responsibilities and to ensure that enough time is allowed within the FPP existing workload.
- A minimum criterion should be developed centrally to select a focal point person so every sector can use it with some improvement according the organizations condition.
- Monitoring and evaluation tool for measuring implementation of HIV/AIDS mainstreaming should be developed, discussed up on and institutionalized at each level. The HIV/AIDS mainstreaming activity should also be included as one of the key activities of the sector and FPP in the performance appraisal.
- Training of FPP should be designed in a way that enables him to plan and implement HIV/AIDS activities. Teaching manuals should be developed and distributed to equip with HIV/AIDS mainstreaming process, facts about the virus and the epidemic and reporting system.
- Efforts should be made to coordinate the work of NGO'S and civil society organizations and to attract NGO'S which work on HIV/AIDS.
- Regular partnership forums must be conducted to discuss and reach agreement regarding most activities including the reporting system.
- The responsible organization to coordinate this huge responsibility of organizing multisectoral response needs strengthening in number and capacity to coordinate.

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STRENGTH AND LIMITATIONS OF THE OF THE STUDY

STRENGTHS

- The study being the first of its kind in the region.
- The study triangulates multiple data collection method.

LIMITATIONS

- Lack of previously performed similar evaluation researches for comparison.
- Its inability to evaluate the output of the activities started.

- The recent restructuring of the regional and district offices and resulting turnover of managers and workers created problem in getting past experience of the organization.

Annex 1: The staging criteria prepared by HAPCO and the UNDP Ethiopia

STAGE	ACTIVITIES
0	No sectoral HIV/AIDS interventions
1	Sector HIV/AIDS plan with the following elements Aids risk analysis of sector workers Evidence based communication for behavioral change Condom promotion Focal point person designated

	Financial resource made available
2	Components in stage one plus Impact analysis conducted of the impact of AIDS on the sector Policies strategies and actions developed Actions to mitigate impact implemented
3	Components in stage two plus Analysis of sector policies, strategies and actions and reflections on these policies nd interventions in order to determine their negative or positive influence on the spread f HIV/AIDS in the community they serve Implement change to ensure that positive actions are maintained Implement change to end negative actions Develop and implement a monitoring and evaluation frame work
4	Components in stage three plus • Incorporate lessons learned in to sectoral policies, strategies and actions

Annex 2: List of institutions interviewed for mainstreaming in the five woredas of Tigray region, Ethiopia April 2006.

Name of institution	Wereda						Total
	Axum	Wukro	/Tembien	ekelle	Maichew	Regional	
Agriculture	-	1	1	1	-	1	4
Junior schools	1	1	-	-	1	-	3
Justice sector	1	1	-	-	-	1	3
Agricultural college	-	-	-	-	1	-	1
Technique college	2	-	-	-	1	-	3
ospital	-	1	-	-	1	-	2
atural resource	1	1	1	-	-	-	3

BoFED	1	-	-	-	1	-	1
Regional Telecommunication	1	-	-	-	-	1	2
Nursing college	1	-	-	-	-	-	1
Food security	-	1	-	-	-	-	1
Education sector	-	1	1	1	1	1	5
DPPC	-	1	-	-	-	-	1
Information bureau	-	-	-	-	-	1	1
Regional Road construction	-	-	-	-	-	1	1
Municipality	-	-	-	1	1	-	2
Mossobo Cement factory	-	-	-	1	-	-	1
Mekelle University	-	-	-	1	-	-	1
Trans Ethiopia	-	-	-	1	-	-	1
Kebelles	1		-	-	1	-	1
Women's association	-	-	1	-	1	-	2
Farmers association	-	-	1	-	-	-	1
Health sector	1	1	1	-	-	-	3
Youth association	-	-	1	-	1	-	2
Police	1	1	1	-	1	1	5
Administration	1	-	-	-	-	-	1
High schools	1	1	1	-	1	-	4
Total	13	10	9	7	11	6	56

ANNEX 3: name and ownership of NGO'S interviewed in the five woredas of Tigray region, Ethiopia, April 2006.

	Frequency	%	wner
Red cross	4	19	NGO not-for-profit
Orthodox church	2	9.5	FBO
Mekelle chamber of commerce	1	4.8	Civil association
REST	3	14.3	GO not-for-profit
OSSA	1	4.8	ivil association
Dimtsi- weyane radio	1	4.8	GO not-for-profit
Moms for moms	1	4.8	GO not-for-profit
Medicine Démodé	1	4.8	GO not-for-profit
FGA	1	4.8	GO not-for-profit
Anti Aids association	1	4.8	ivil association
DECSI	1	4.8	GO for-profit
Nebi Mohamed Edir	1	4.8	CBO
St marry Edir	1	4.8	CBO
St. George Edir	1	4.8	C BO
Kebelle	1	4.8	CBO
Total	21	100.0	

Annex 4: Questions prepared for discussion during FGD

1. Do you know how HIV/AIDS affects your organization?
2. Do you think the organizations activity can contribute to the expansion of HIV/AIDS?
3. Does your organization have devised mechanisms to reduce the risk of the staff to HIV infection?
4. Does your organization have devised mechanisms to care and support affected and infected staff?
5. Is the response explained mainstreaming?
6. Explanation about mainstreaming was given at this stage
7. How do you see now the response your organization is delivering in relation to mainstreaming?

QUESTIONAIR FOR ORGANIZATIONS REGARDING MAINSTREAMING HIV/AIDS

1. Total number of employees in the sector _____

2. What is the annual overhead cost of your organization?

- Governmental source_____
- Other source _____

3. Do you have a clinic in your organization? (Circle) Yes / No

4.Vission of the sector(Write full statement)----------

_____

_____.

5.Mission of the sector (Write full statement)

_____

_____

_____

6 When did you first know about mainstreaming HIV/AIDS in sectors activity?

(Month)_____year 19_____

<u>INSTRACTION</u>: FOR ANY QUESTION MARK ''X''IN ONE OF THE THREE OPTIONS, (NK=No knowledge, DOC=documented, ND =Not documented)

No	A. ORIENTATION AND SENTISIZATION (if the answer to question 1 is "NO" skip to table "B"	yes	no	NK	Evidence	
					DOC	ND.
1	.Have you ever received any orientation or seminar about how to respond to HIV/AIDS (mainstreaming)?					
2	Have you got manuals about how to mainstream during the sensitization?					
3	Were the manuals translated in local language?					
4	Who attended the orientation or seminar					
	Sector head					
	Department head					
	Unit head					
	Non managerial subordinate					
5	When did you take the orientation or seminar of mainstreaming	month----------year 199---------				
6	Have you discussed about HIV/AIDS mainstreaming with the staff in the general assembly? If yes for how long?	For _____ days				
7	Did the staff got manuals about mainstreaming?					

8	Were the manuals translated in local language?					
9	Have you given orientation or seminar to your lower level organization?(at district or kebeles level)					

S.	B. PLICY, GUIDELINE ,STRATEGY(SP) RELATED	yes	no	NK	Evidence	
					DOC	ND
1	Do you have sectoral policy regarding HIV/AIDS?					
2	When did you develop the policy	month----------year 199---------				
3	Are these policies translated in to local language?					
4	Do you have guidelines for sectoral HIV/AIDS prevention and control activities?					
5	When did you develop the policy(Year)?	month----------year 199---------				
6	Are these guidelines translated in to local language?					
7	Do you have SP regarding HIV/AIDS for the year 1997? /					
8	Is that plan incorporated with the sectors SP?					

S.	C. PLNNING RELATED ISSUES (if the answer to question 1 is "NO" skip to question 5	yes	no	NK	Evidence	
					DOC	ND
1	Do you have annual plan of HIV/AIDS prevention and control for your workers(internal domain)					
2	Do you have annual plan of HIV/AIDS prevention and control for your customers(external domain)					
3	Did you asses how your sector activity contribute to the expansion of HIV/AIDS					
4	Did you asses how your sector activity contribute to reduce the impact of HIV/AIDS					
5	Do you have any association established to help workers affected and infected by HIV and their dependants? "Mahiber"					
6	Do you have anti-Aids committee? **(if the answer 1 is "NO" skip to table "D"**					
	At regional level (for regional sectors)					

	Woreda level (for woreda sectors)					
	Keble level (woreda sector and institution)					
8	Are you member of that committee					
9	How frequent do the Anti Aids committee meet?					
	Every Week					
	Every two weeks					
	Every month					
	Beyond that /infrequently					
10	Is there integrated woreda /Region HIV/AIDS development plan					

S. No	D.ORGANIZING,RELATED(if the answer to question 1 is "NO" skip to question 5	yes	no	NK	Evidence	
					Doc	ND
1	Do you have focal person/unit responsible for HIV/AIDS activities					
2	What is the gender of the focal person					
	Male					
	female					
3	What was the job description of the focal person in the sector			----------		
4	Time allowed to the focal persons HIV/AIDS activity per days			----------Hrs / day		
5	Does the focal person has an office					
6	Is the focal person trained about the facts and intervention of HIV/AIDS? (last training?) (in Year)	Month----------year 199-------				
7	Do you have allocated government budget for HIV/AIDS activities (if yes how much?)			1997----------Birr 1998----------Birr		
8	Do you have any external fund for HIV related activity			1997----------Birr 1998----------Birr		
9	Do you have fund raising methods in your organization for HIV/AIDS activities(List in the Evidence box)					

	SUPLIES	Yes	No	Varity	unit	quantity
10	Do you have necessary supplies for HIV related activities?					
	IEC materials(Leaflets Posters Flip charts News letter Video cassette)(underline the available material)					
	Female condoms					
	Male condoms					
	Reporting format					
	HIV Kits					
	OTHER(List)					
11	IS there HIV related posters / messages on the wall ?(observe)					
12	Where do the condoms placed?					
	Office of the focal person					
	In Place where privacy is kept					
	In condom box					
	Other (specify)					

INSTRUCTION-PREVENTION CARE AND SUPPORT ACTIVITIES PERFORMED IN 1997 E.C ONLY

S. No	**E. IMPLEMENTATION RELATED ISSUES (if the answer to question 1 is "NO" skip table "F")**	**yes**	**no**	**No answer**	**Evidence**	
					documented	**Not documented**
1	Do you have work place intervention program of HIV/AIDS prevention and control?					
2	Are work place interventions implemented					
3	Do you report sectoral HIV related activities					
4	To whom do you report					
	To regional health bureau					
	District health office					
	Regional HAPCO					
	Anti AIDS committee					
	Sectors head office					
	Funding organization					
5	How frequent do you report					
	Monthly					
	Every three months					
	Every six months					
	annually					

	F. PREVENTION RELATED ACTIVITIES in 1997 E.C? ((if the answer to question 1 is "NO" skip to table G)	**yes**	**no**	**If yes the No of people received**	
				Freq.	**number**
1	Did you implement HIV /AIDS prevention activities?				
2	IEC/BCC(awareness creation) /training /seminar				
3	Female condom distributed				
4	Male condom distributed				
5	Treatment of STI'S				

6	Counselling				
7	Other sector related safeguard(specify)				

	G. implemented care and support activities for people affected and infected in the sector (if the answer to question 1 is "NO" skip to table H)	Number OF PEOPLE	Unit cost	Total cost	remark
1	Did you provide care and support activities for people affected and infected in your sector				
2	For treatment when he / she gets sick				
3	For ARV drug				
4	For legal protection				
5	For economic support of families				
6	For mourning and funeral				
7	Other				

	H. SOCIO ECONOMIC IMPACT ALLEVIATION if the answer to question 1 is "NO" skip to table I)	yes	No	Frequ enc cy	Nº of people	Birr
1	Did you provide any SE impact alleviation program					
2	Financial and material support for orphans and ovc at institution					
3	Financial and material support for orphans and ovc at community					
4	Promote human right for PLWHA					
5	Prevention of social stigmatization					
6	HBC / community based care					

	I. EMPOWERMENT OF VULNERABLE GROUPS(if the answer to question 1 is "NO" skip to table j)	yes	No	Frequ enc cy	Nº of people	Birr
1	Did you provide empowerment Activities?					
2	Encourage and support the participation of female in school					
3	Address the issue of traditional and cultural harmful practices					
4	Establishing saving and credit groups for women					
5	Community income generating scheme and economic project					

SURVEILLANCE AND RESEARCH

	TOPIC OF THE RESEARCH	COLLABORATED SECTOR	date and year finished	cost of the research
1				
2				
3				
4				

	J. MONITORING AND EVALUATION if the answer to question 1 is "NO" skip to table k)	yes	No	Evidence
1	Do you evaluate and monitor HIV /AIDS activities?			
2	Do you discuss HIV/AIDS issues in management meeting?			
3	How frequent is the management committee meeting program?			Every ----------days
4	How frequent does the management discuss HIV related activities			Every ----------days
5	Do you have a minute of HIV/AIDS performance?			
6	Is the minute record book prepared for HIV/AIDS activities only?			
7	Do you evaluate HIV/AIDS activity performance at the general assembly?			
8	How Frequent do you evaluate at the general assembly?			
	Rarely			
	annually			
	In every meeting of the general assembly			

7	Is there any major decision made in 1997 about HIV /AIDS in the sector? (If Yes list below)			
A				
B				
C				
D				
8	Do you get feed back from the coordinating committee?			
9	How frequent do you get the feed back?			
	Monthly			
	Quarterly			
	Semi annually			
	Annually			

S. No	**K. WHAT SUPPORT HAVE YOU DONE TO YOUR SECTORS AT LOWER LEVEL (if the answer to question 1 is "NO" skip to table L)**	yes	no	No answer	evidence	
					documentd	Not documented
1	Did you support your lower level sectors?					
2	Orientation on mainstreaming					
3	Developing and distributing guidelines and frame works					
4	Assigning focal person					
5	Financial support					
6	Evaluation and monitoring					
7	HIV/AIDS related supplies and materials					
8	Other					

S. No	**L. MAJOR PROBLEMS THAT YOU FACE TO IMPLEMENT THE ACTIVITIES**	RANK (1-6)	Evidence
1	Lack of orientation and sensitization		
2	lack of Sectoral capacity of planning and integrating HIV activities		
3	Shortage of manpower		
4	Shortage /absence of governmental budget		
5	Lack of leadership commitment		
6	Shortage of supplies and equipments		
7	Lack of the knowledge of facts and interventions of HIV/AIDS		
8	Lack of coordinating and supporting body		
9	Other(specify)		

M. Any suggestions about your organization response to HIV / AIDS and recommendation for future improvement ----------

---

THANK YOU !!!

Ques. N^{o} _____

QUESTIONAR FOR ORGANIZATIONS RESPONSE

Back ground information (NGO'S and civil society organizations)

1. WOREDA_____ No of population of woreda_____
2. Name of organization _____
3. Ownership of organization

   1. Private for –profit

   2 Private not for-profit (Underline)

   2.1 Is the organization International / National / Local / Other_____?

   3. Religious/mission organization (underline)

   3.1 Is the organization International /National /Local /other ----------

   4. Civil Association

   5. Professional association

   6. Community based organization

   7. Other (specify) _____

4. Year established 19_____ E.C

5 Name of informant_____

Position in the organization_____

Address Tel (office) _____Mobile _____E-mail _____

6. **Number and qualification of staff**

type	Certificate and less	Diploma	Degree	Masters+
Health professional				
Other technical				
Administrative				
TOTAL				

7. **Interventions other than health related (if present)**

1. _____
2. _____
3. _____

Activity related questions

1. Vision of the organization_____

_____

_____

2. Mission of the organization_____

_____

_____

3. Source of fund of the organization
    1. Government
    2. community
    3. fee for service
    4. fund raising
    5. NGO(specify)_____

4. What is the annual budget of your organization in 1997 E.C?
    - Governmental source_____ Eth.birr
    - Ngo source _____ Eth.birr
    - Other source_____ Eth.Birr

5. What is the method of support you use on HIV/ AIDS response (circle)
    A. Direct support activities addressing HIV/AIDS
    B. Financial support directed to components of HSDP
    C. Financial support directed to components of PHC
    D. Earmarked fund for major program component of HIV/AIDS
    E. Earmarked fund to grass-root organizations(CBOs)
    F. Other(specify)_____

WOREDA CODES

western(01)- (01) k/ humera (02)tsegede (03) welkayt, **n/western(02**)--- (01) tselemti (02) a/ tsimbila (03) t / koraro (04) m / zana (05) l / adiabo (06) t / adiabo **central (03**)---(01) t / maichew (02) n / adiet (03) l / maichew (04) adwa (05)m / leke (06) ahferom (07) w / leke (08) k / tembien (09) t / abergele (10) d / tembien **eastern(04**)----(01) a / womberta (02) klte –wlaelo (03)s / t / emba (04) hawzen (05) g / mekeda (06) g / a / shum (07) erob **mekelle zone (05**) **southern (06**)-----(01)alamata (02) r / azebo (03) ofla (04) alage (05)h / wajerat (06) s / samre (07) enderta (08) e / mehoni

6. WHERE IN THE REGION DO YOU PROVIDE YOUR SERVICES

Zone	**Zone code**	**Woredas**									
		Write the number of kebeles served in each woreda									
		01	02	03	04	05	06	07	08	09	10
Western	**01**										
N/west	**02**										
Central	**03**										
Eastern	**04**										
Mekelle	**05**										
Southern	**06**										

7. Which of the following are your interventions target group? (tick "X '')

		Yes	Remark
Vulnerable groups like	CSW		
	Out of school youth		
Mobile groups	Trackers		
	Migrant Labourers		
Non mobile /movement restricted groups	School youth		
	College students		
	Prisoners		
	Refugees settled in camps		
People affected and infected	PLWHA		
	Child who lost one or both parents and dependants and OVC		
working groups	Farmers		
	Industry workers		
	Governmental and non governmental workers		

8. HOW DID YOU CHOOSE TO WORK IN THE SPECIFIED DISTRICTS

	Reason (Tick on your reason)	Yes	Evidence
1	Assigned by the organizing body of the region		
2	Studied and found to be appropriate by the organization		
3	Other interests of the organization		
4	Assigned by higher management body at national level		
5	For profit purpose		
6	Other		

9. WHAT TYPE OF SERVICE DO YOU GIVE IN 1997 E.C?

A	PREVENTION RELATED ACTIVITIES	Number of People received	Unit cost (eth. Birr)	Total cost (Eth. birr)	remark
1	IEC/BCC				
	Face –to –face				
	Distribution of written material				
	News letter_____ times per week				
	Radio _____times per week for _____minutes /once				
2	Female condom distribution				
3	Male condom distribution				
4	Treatment of STI'S				
5	Counselling				

6	VCT				
7	Blood safety and universal precaution				
8	Post exposure prophylaxis				

B	**care and support for people infected and affected**	Number of people received	Unit cost (Eth.Birr)	Total cost	remark
1.	Institutional based clinical care				
2.	Supply of ARVD				
3.	Treatment of opportunistic infections				
4.	Community / home based care				
5.	Counselling				
6.	Legal protection and human right for PLWHA				
7.	PMTCT				
8.	Care & support for orphans				
9.	other (specify)				
10.					
11.					

C	**FINANCIAL SUPPORT TO INSTITUTIONS**	Amount (eth. birr)	Received organization	Remark
1	For HIV/AIDS service providing organizations			
2	for orphans settlement institution(refugee camp)			
3	CBOs			
4	For HSDP			
5	For PHC			
6	Other			
A				
B				
C				

D	**FINANCIAL SUPPORT TO people infected and affected**	No of people received	Unit cost	Total Birr	Received organization	Remark
1	PLWHA					
2	orphans					
3	Promotion of human right for PLWHA					
4	Prevention of social stigmatization					
5	Research on HIV/AIDS					
6	Other					
A						
B						

E	EMPOWERMENT OF VULNERABLE GROUPS	COST IN BIRR	No OF beneficiary /Group	ORGANIZATION received	REMARK
1	Encourage and support the participation of female in school				
2	Address the issue of traditional and cultural harmful practices				
3	Establishing saving and credit groups for women at risk & other women				
4	Community income generating scheme and economic project				

F. Target group AND Number of trained people on each topic

	Target group for training	IEC/BC	Condom USE	Counselling	VCT	PMTCT	Peer education	UP and PEP	Mgt of STI'S	E/M	Mgt of oi'ss	ARV therapy	other
1	Teachers												
2	School youth												
3	Out of school youth												
4	leaders												
5	community												
6	Women												
7	CSWs												
8	Mobile work force												
9	Mid level HPs												
10	Higher level HPs												
11	Farmers												
12	Uniformed people												
13	Gov't/ NGOt workers												

G	COMMUNITY LEVEL INTERVENTIONS	supported		ESATBLISHED		
		Number	cost	number	Area	REMARK
1	Edir					
2	Equb					
3	Mahiber					
4	Kebeles					
5	Offices					
6	School youth					
7	Out of school youth					
8	Sunday schools					
9	Anti aids clubs					

H. REASEARCH AND SURVEILANCE

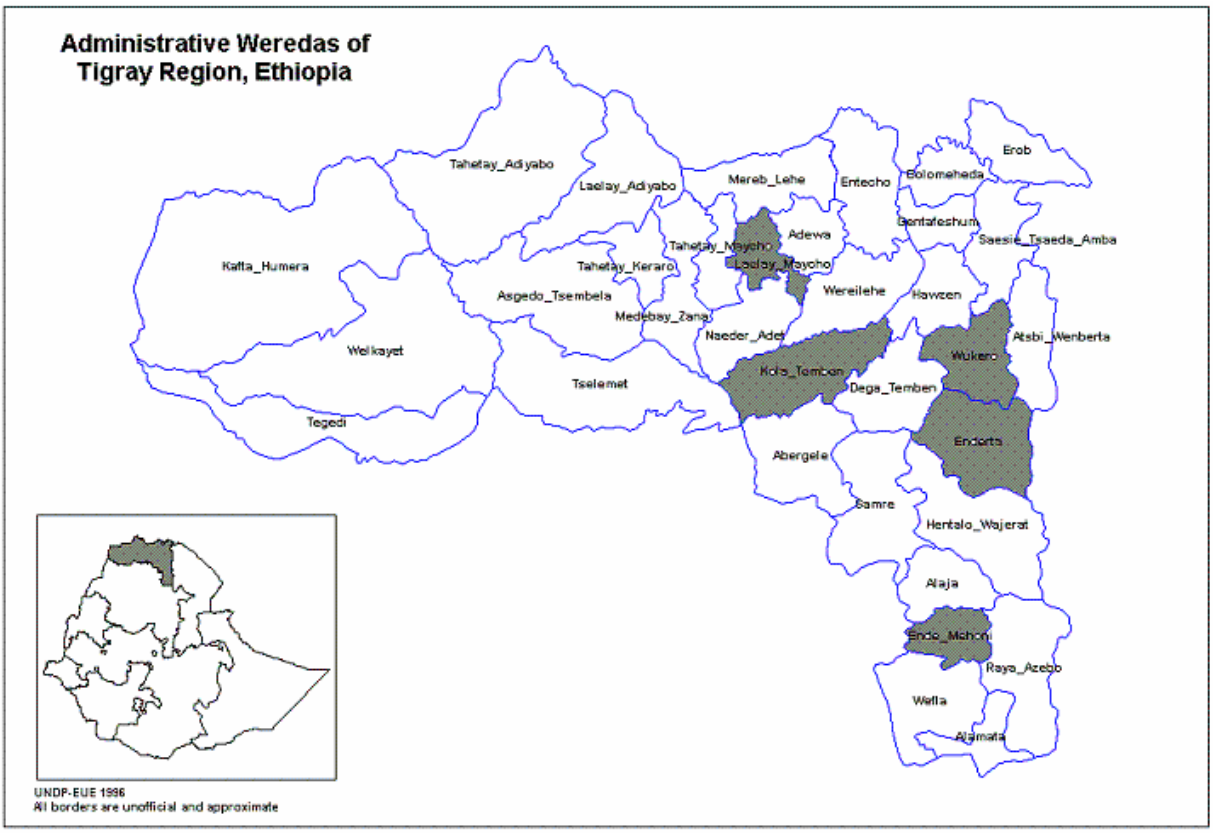
	Topic of research	Cost	Collaborating sector	Remark
a				
b				
c				
d				

I . REPORTING AND COMMUNICATION

S. NO	ACTIVITY(if the answer to number 1 is "no' skip to question 5)	YES	NO	I K	EVIDENCE	
					Documented	Not documented
1	Do you report sectoral HIV related activities					
2	Do you have standard reporting format					
3	To whom do you report					
	To regional health bureau					
	District health office					
	Regional HAPCO					
	Anti AIDS committee					
	NGOs					
	OTHER					
4	How frequent? Monthly					
	Every three months					
	Every six months					
	Annually					
5	How many partnership forums did you participate in 1997?				---------- forums	
6	do you have electronic reporting methods ?					
7	Who are the partners that you communicate with?					
a						
b						
8	Is there coordinating office for NGOs at regional level?					
9	Which organizations(List)					
A						
B						
c						

S. No	J. Major problems that you face to implement the activities/ for not implementing	Rank from 1 to 6	Evidence
1	Lack of orientation and sensitization		
2	Lack of guidelines for NGOs		
3	Lack of joint meeting and partnership		
4	Shortage of manpower		
5	Shortage /absence of governmental budget		
6	Lack of leadership/ government commitment		
7	Shortage of supplies and equipments		
8	Lack of coordination and support		
9	Other(specify)		

ANNEX 5 STUDY WOREDAS OF TIGRAY



Key Study Woredas