THE ROLE OF FAMILIES AND COMMUNITIES IN HIV/AIDS PREVENTION AND CONTROL

BY

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A Thesis Submitted to the School of Graduate Studies, Addis Ababa University in the Partial Fulfillment of the Requirement for the Degree of Masters of Public Health

April 2004
ADDIS ABEBA

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

THE ROLE OF FAMILIES AND COMMUNITIES IN HIV/AIDS PREVENTION AND CONTROL, JIMMA TOWN

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DECLARATION

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DEDICATION

To My Beloved Family

ACKNOWLEDGEMENT

First of all I would like to express my heartfelt appreciation and gratitude to my advisors Professor Yemane Berhane and Dr Gail Davey for their constructive advice and unreserved support during the whole process of the study. I very much appreciate your kindness and readiness to assist me.

My appreciation goes to Dr. Nigussie Deyesssa, Dr. Getnet Mitike, Dr. Alemayehu Worku and Dr. Damen H/Mariam for their invaluable comment during the study.

I would like to gratefully acknowledge Action Aid Ethiopia for funding my thesis research and I would also like to express my gratitude to staff of Action Aid Ethiopia Ato Berhanu zeneber and w/ro Atsde for facilitating the work.

I would like to express my warm thanks to my friend Dr. Ashenafi Negash for his assistance in questionnaire review and follow up during the whole data collection. I would also like to acknowledge the assistance obtained from Dr. Meseret Yazachew and Ato Fasil Tessema.

I would like to gratefully acknowledge the families, communities and CBOs leaders who are involved in the study. I am indebted to the hard working supervisors particularly Dr. Yehenew Alem, Dr. Yeshigeta and Ato Dereje Ayele and data collectors for their help in accomplishing the data collection smoothly.

I would like to express my heartfelt appreciation to my classmates for the support they gave me especially during my data entry and analysis. Thank you.

I am also very much indebted to my family who were always at my side offering me all kinds of assistance and encouragement; I don’t have a word to express my appreciation to them. Thank you mom, my brothers especially Sami and my sisters I really appreciate your support. My utmost gratitude goes to my husband, Deme, for being my inspiration in all the success I have. I love you and I owe you a lot.

I would like to express my heartfelt gratitude to w/rt Selamawit Tilahun, W/rt Haimanot Tilahun and Ato Brook Tesfaye for their help in computer use. Thank you for your care and unreserved support.

Last but not least, my appreciation goes to Ato Mekonnen, WHO librarian, Ato Lemma, and Messeret, Department of Community Heath Librarian and staffs of AIDS resource center for their cooperation in searching the necessary materials.

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LISTS OF ABREVATIONS

1. **CBOs**:- Community Based Organizations
2. **PLWHA**:- People Living With HIV/AIDS
3. **MOH**:- Ministry Of Health
4. WHO:- World Health Organization
5. **HIV/AIDS**;- Human Immuno-deficiency Virus/ Acquired Immuno Deficiency Syndrome
6. **STIs**: Sexually Transmitted Infections
7. **NGOs**: Non Governmental Organizations
8. **GOs** : Governmental Organizations
9. **FGD**: Focus Group Discussion
10. **HAPCO**: HIV/AIDS Prevention And Control Office
11. **E.C**: Ethiopian calendar
12. **VCT**: voluntary counseling and testing

ABSRACT

HIV/AIDS has seriously affected the well-being of adolescents in Ethiopia and has posed serious concern for their parents. However, parental and community involvement in HIV prevention and control activities has been limited due to top-down approach adapted in the program. To assess the role of families and communities in the prevention and control of HIV/AIDS among adolescents. A cross sectional community based study was conducted in Jimma town from January to February 2004 using a mixture of quantitative and qualitative research methods.

A total of 602 parents were randomly included in the study. Majority of parents agreed to most of the questions used to assess the risk reduction potentials but only 121(48.4%) fathers and 149(42.6%) mothers agreed with regard to the role of parents in the promotion of condoms use among sexuality active young adults. On the other hand the responses of the study subjects were below 50% for most of the vulnerability and impact reduction potential questions. Education and family income were found to be determinant factors for the perceived risk, vulnerability and impact reduction potential ($p < 0.05$). Four hundred and sixty two (76%) and 358(59.6%) of parents reported that they made discussion about HIV/AIDS and sexuality with their children respectively. Yet only 130(21.7%) of the parents reported that they had ever advice the use of condoms to their sexually active children. Scope of knowledge of modes of transmission and means of prevention of HIV/AIDS is still worrying. This study identified the presence of major misconceptions pertaining condom use. CBOs showed an encouraging commitment in participating in the HIV/AIDS prevention activities. They also have showed a sense of program ownership and believed that they can serve as a link between the policy makers and the community.

Parents and community members are aware of their potentials contributions and are willing to actively participate in HIV/AIDS prevention and control activities. Therefore, parents and communities have to be given a chance to participate in HIV/AIDS prevention and control activities as they are at the front in bearing its burden.

Key words: family ,CBOs and HIV/AIDS prevention,

1. Introduction

The HIV/AIDS epidemic poses one of the most serious threats to the health and well being of people in sub Sahara Africa. In those countries affected by the epidemic most health, demographic and socio-economic parameters are severely affected. The level of death and dislocation threatened by the pandemic is worse than any natural disaster or war that Africa has faced for during the last century [1-5]. It has also posed extra ordinary leadership challenges [6].

Ethiopia is among those countries that are most seriously affected by the HIV/AIDS epidemic with an estimated 2.1 million of its population living with the virus at the end of 2001[6, 8, 10]. Given the meager health infrastructure and overall scarcity of resources to effectively combat the epidemic, the adoption of innovative strategies to involve the community in the prevention and control of the problem is among the important issues that should get the attention of policy makers and health professionals.

Currently, the government of Ethiopia is undertaking the process of decentralization in all sectors including that of health. One of the most important benefits of decentralization is that it takes the management process to a level that is conducive to foster community involvement [12].

Families being the milestone of any community and society, they are the first burden bearer as a result of a multitude of problems associated with HIV/AIDS. It is obvious we all learn everything from our families first and are shaped by them. They have every role in directing or modifying our future including our sexuality. The next social status is the community. As

communities share everything in common, their effort is of paramount for mitigating the problem [13,14].

Families have great influence over a person, and that influence can last a lifetime. Even people who are no longer or never were in touch with their family are influenced by their absence. One half of all persons with HIV became infected during adolescence or early adulthood (ages 15-24). Working with families as early as possible in children's lives helps solidify healthy behaviors and relationships, thus preventing risk before it happens [13-16].

HIV prevention has traditionally focused on the individual and not the family. Yet families can have both positive and negative impact on sexual and other health problem using behaviors that put a person at risk for HIV and other disease. Families are important determinants of adolescent sexual behavior that affect men and women as they "come out" as husband and wife and as they gain and lose ties to family throughout the years [13].

Parents can help protect themselves and their children from risky sexual behaviors and other health problems. Family connectedness and parent child communication is a key for ensuring healthy behaviors [14]. Likewise, when families are not connected and adolescents feel they can't talk to the adults in their lives, there is a greater risk of unhealthy behavior. Information as a valuable means to delay an early initiation of sex in adolescents should have started early at home by the family and primary school teachers.

Grass root organizations, both formal and informal should be the mechanisms for fostering community involvement in the prevention and control of HIV/AIDS. Utilizing informal indigenous institutions for this purpose has various advantages. These institutions considered as coping mechanisms during times of crisis by the community members themselves

This study will try to answer the following research question: Do families and communities participate in the prevention and control program? If not, why are not they participating? What are the specific resources the families and communities have to reduce risk, vulnerability & impact? What additional resources are needed to involve them actively? Hence, this study aims to identify the roles family and community can play and the factors that affect their effective participation in the HIV prevention and control program.

2. Review of literature

General overview of global HIV/AIDS

According to the UNAIDS recent global estimate, the AIDS epidemic claimed more than 3 million lives in 2002, and an estimated 5 million people acquired HIV in the same year bringing the total number of people infected with the disease to 42.0 million with about 90% of them living in developing countries [(7)].

Sub-Saharan Africa is severely affected by HIV/AIDS where more than 28 million of the 40 million people live with the disease causing agent. The adult prevalence rate has risen to 7.5% in 1997-8 in this region. In this same region where only 10% of the world's population lives, there was an estimated 3.4 million deaths recorded due to AIDS alone in the year 2001. The disease is the leading cause of adult mortality and morbidity in the African region. About 3.8 million children are born infected with HIV/AIDS to mothers in nine sub- Saharan Africa countries in which HIV/AIDS sero-prevalence was estimated to exceed 10 percent in adult population. Life expectancy at birth in those countries is projected to decline 48 years in 1998- 2000 where as it could have reached 58 years in the absence of AIDS, a loss of 10 years. It was estimated that an additional 45 million people would become infected with the disease in 126 low- and middle-income counties between 2002 and 2010 unless drastic prevention intervention methods are put in place [(7)].

1.2 HIV/AIDS situation in Ethiopia

The probable start of the spread of the disease in Ethiopia was in the early 80's. The first report of HIV infection was in 1984 and the first case was found in 1986. Since then it has spread at an alarming rate reaching to its current adult (15-49 year old) prevalence rate of 6.6 %. The average number of infections within a day is about 767. Ethiopia is one of the most highly affected countries in Africa with respect to the number of infected people and death rate; and it is second in Africa following South Africa. It is estimated that about 2.2 million people in Ethiopia are currently infected with HIV. Since the advent of the HIV/AIDS pandemic, it has spread in all regions both in urban and rural areas [8].

The major risk factor for transmission include: unprotected sex with multiple partners; seasonal migration of workers; dislocation of people due to the civil war and resettlement programs and high STI rates in the general population. About 91 percent of the infection occurs among the age group between 15 to 49 years. As the age group encompasses the economically productive segment of the population of any country, the high number of cases adversely affects labor productivity and hence economic development [6, 10].

A few years ago most people in Ethiopia had never heard of HIV/AIDS and even those who had heard of it thought that it was a problem of western societies where deviant sexual behaviors were being practiced. It is now being recognized as a major public health problem that has serious impact on developmental effort of all sectors [1]. Unfortunately the hope of developing an effective vaccine or therapy in the foreseeable future is dim. If all efforts become successful, it will take several years to be available at an affordable cost to all people in the developing world.

Until such time, however, the only practical option left for us is to work hard to stop the further spread of the disease by breaking the route of transmission through prevention interventions aimed at changing the sexual behavior of the people so that they practice safe sex through behavioral change communication programs [1, 11].

Ethiopia like many other countries has adopted strategies to prevent the spread of the disease by establishing an HIV/AIDS control program as early as 1987. Following the creation of that control program, extensive efforts have been made to bring the information to high-risk people and to educate the public about HIV/AIDS. However, the impact of that program was evaluated and it was found that it was not as effective as it should have been for many reasons one of which was that it was run by only one sector. Currently, it is considered as not only the problem of the health sector but rather a socio- economic one and hence it needs a multi-sectoral approaches are being implemented. The government of Ethiopia has formulated and ratified HIV/AIDS policy in 1998 [11], Following the policy, different strategic framework documents have been released which mainly focus on government apparatuses at federal, regional, woreda and kebele levels.

This top-down approach has its own limitations in dealing with a complex health problem as HIV/AIDS. It is important that the role of the family and community be addressed and to look for other options to answer why people fail to develop the expected behavioral changes. It is important to recognize that it is the family followed by the community, as the core of the society, which shoulders the severe blow of the disease. There are a number of efforts to address why people fail to achieve the expected positive behavior towards HIV/AIDS. According to the BSS

report 98% of people have good knowledge about HIV/AIDS but the expected change of behavioral practice is not impressive. For instance, the same survey found that own risk perception was very low in almost all target groups and despite high knowledge levels a significant number of youth are at risk of infection [8]. The overall effort is being affected by the fact that different risk levels are being exhibited by different segments of the population.

A cross- sectional study done in Jimma town assessed knowledge, attitude, and practice of TTBAs on HIV/AIDS. The study showed that 70% of the respondents were found to have good knowledge while 30% had poor knowledge on HIV/AIDS. In summary the proportion of people who cited at least two acceptable ways of protection from HIV among adults was 95% (males) and 84 %(females) in urban areas [17].

The concerted effort until now mainly focuses on top- down policy not bottom-up approach and the major strategies used the formal governmental structure to address the HIV/AIDS related problems focusing mainly on individuals, with little emphasis until recently to the role of families and communities and their organization [18]. Different strategies used to mitigate the epidemic include IEC, condom promotion, surveillance, patient care and support, and expansion of HIV screening laboratories in different health institutions. CBOs in Ethiopia are self-motivated and are readily accessible by community members. Since they are also widely reputed for doing what they are expected to do effectively; there is quite high potential to use them for grass roots level HIV/AIDS prevention, care and control activities [19].

Adolescents who feel connected to their families and perceive their parents as caring are more likely to postpone their sexual debut, use contraception, and have fewer pregnancies and fewer children [13]. Two key aspects of parenting that are influential to adolescents are their beliefs that their parents know who they spend time with, and know where they are when they're not at home or at school [14].

Families that have problems often produce children who have problems. Stress, poverty, violence, and substance abuse in families leads to less family cohesion, less communication and less tolerance. As a result, teens experience more abuse, neglect and risky drug use and sexual behavior. Neighborhoods with few job opportunities and high levels of risk behavior and violence have a negative impact on young children sexual behavior [13].

Research has shown that family programs for adolescents and their mothers work to increase parental knowledge about HIV and sexuality issues and increase comfort when discussing these issues with their children. These programs give mothers and youth a chance to interact and bond, as well as a chance to communicate with each other. Women in the program were more likely to talk to their adolescents about sex. In the study the researchers found that women were overwhelmingly identified as a source of support: mothers, sisters, aunts and cousins [14].

Communities are the next social stratum to that of the family. This social stratum is the next affected segment of the population by impact of HIV/AIDS and other diseases. A study done in USA which assessed the neighborhood AIDS-prevention awareness events, led to a 50% increase in condom use and demonstrated that local leaders could effectively mobilize their

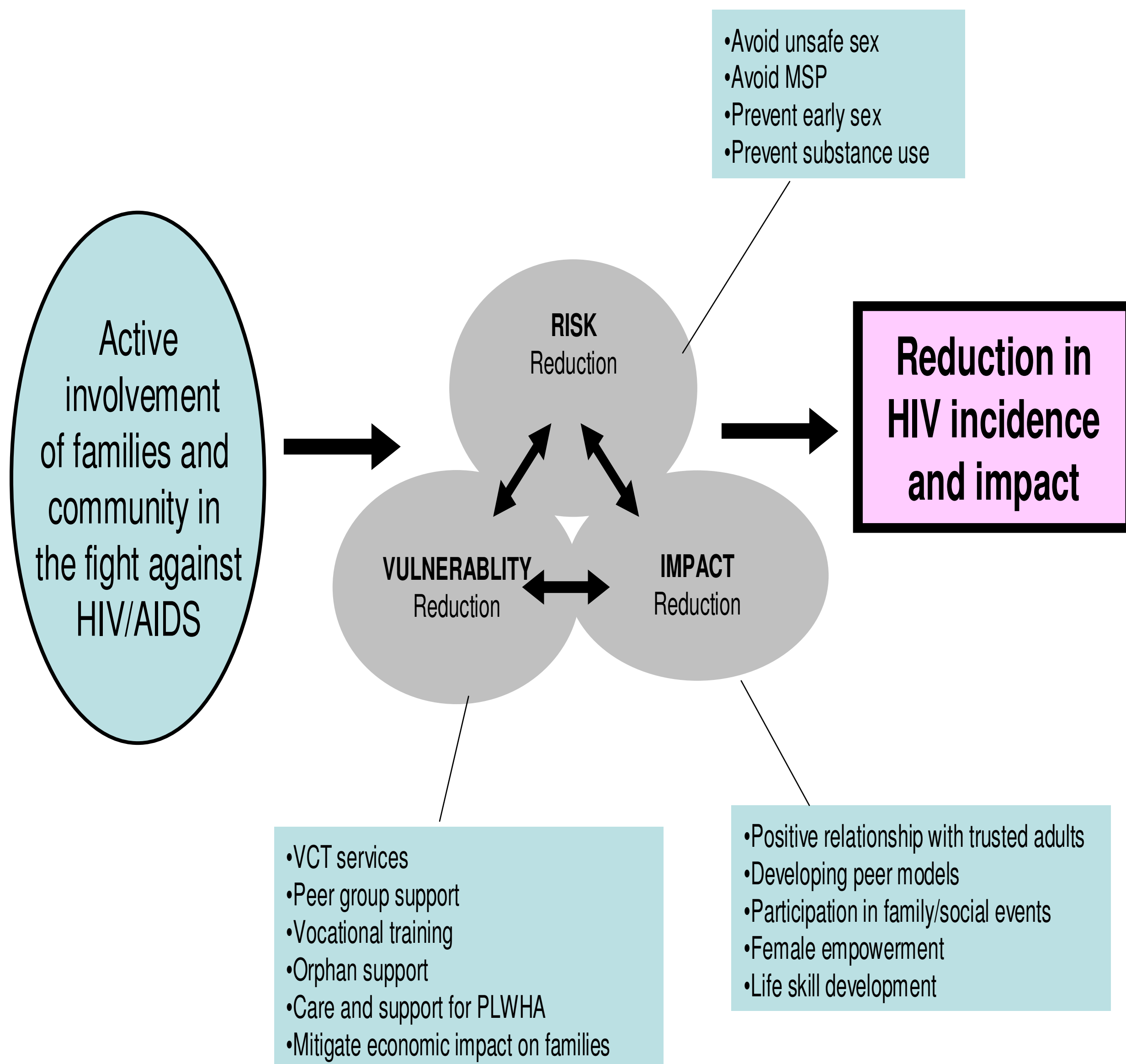
neighbors to help fight the spread of AIDS/HIV. "Women took it upon themselves to educate their neighbors about HIV and, in the end, became their communities' single most effective defense against AIDS [15].

In another study, traditional healers have been trained as educators and counselors to disseminate HIV/AIDS information and prevention practice among their peers and the community of sub-Saharan Africa. The initial outcome and challenges of such new initiatives in Zambia, Uganda, Botswana and South Africa indicated that though none of the projects completed a comprehensive evaluation of different approaches used on population served, all indicated that traditional healers are biomedical counter parts in prevention and control of HIV/AIDS [20]. Community institutions such as churches and traditional mutual assistant organizations such as *'iddirs*', women's associations, '*mahibers'* can work with prevention programs to educate their members.

The community-level intervention developed has shown much promise as a means of helping the community develop HIV risk reduction skills and redefining social and peer group norms to reinforce risk reduction changes. Families and communities need support to increase communication and build strong bonds as early as possible. The factors responsible for the success of community- level prevention approaches may be the involvement and mobilization of credible members of the target population itself in the delivery and endorsement of risk reduction messages of their own friends, acquaintances, neighbors and peers [16, 21].

This study tries to emphasize the importance of grass roots level active participation in the fight against the HIV/AIDS epidemic. The strengths and inter-relatedness of the family, the neighborhood and self-motivated organizations in relation to the HIV epidemic will be explored.

Role of families and Community organizations in the fight against HIV: Conceptual framework



3. Objective

General objective

To assess the involvement of parents and communities in the prevention and control of HIV/AIDS in Jimma town.

Specific objective

- To assess the potential role of parents, communities and CBOs in reducing the HIV risk, vulnerability and impact.
- To assess factors that influence participation of parents and communities in HIV/AIDS prevention and control activities.
- To assess the effect of the AIDS deaths on community based organizations with particular reference to *'iddirs'*.

4. Methods and subjects

4.1. The study area and period

The study was carried out in Jimma town, Oromia Regional state, Ethiopia. The town, the capital of Jimma Zone, is located 335KMs south west of Addis Ababa. Jimma Zone is one of the twelve zones of Oromia regional state. It is one of the major urban centers of the region as well as the country. The 1994 national housing and population census projection for the year 2003 suggests a total population of Jimma town of 119,018 with 50.6% female. It also suggests that 24.4% of the total residents are adolescents, and there are 6000 households with at least one adolescent in the family [22, 23].

Administratively, Jimma town is divided into three woredas and 20 kebeles. Residents of the town are composed of civil servants, traders of varying levels, private employees and retired soldiers. There is 24hr hydroelectric power supply, road and air transportation services and a digital telephone system. Other communication facilities available for the town include radio, TV and newspapers. In the town there are one referral teaching hospital, one health center and one MCH clinic. All the health care facilities are used by Jimma University for training. In addition, there are two higher and five medium clinics and ten privately owed pharmacies, and there are ten NGOs working on HIV/AIDS.

The fact that Jimma zone is one of the main coffee producing areas means that there is a high influx of people of the economically productive and sexually active age groups from different areas of the country. Besides, it is an important trade center and a transit point for passengers from the whole southwest part of the country traveling to and from Addis Ababa.

4.2. Study Design

This study utilized a cross – sectional study design. Quantitative and qualitative method were employed to collect relevant data on the potential involvement of parents and communities in the prevention and control of HIV/AIDS in Jimma town.

4.3 Study Population

The source population for the study was all parents with adolescent children in the family for the interview and for FGD, communities (community opinion leaders, religious leaders) and all Community based organizations (CBOs) actively functioning in Jimma town.

A. **Focus group discussion** - CBO leaders namely '*Iddir'* leaders, school teachers, '*mahiber'* leaders, religious leaders, Kebele officials, Anti AIDS club members working in the town, in and out of school adolescents and opinion leaders were included in the focus group discussions.

B. **Survey** – parents of adolescents in three selected kebeles of the town formed the study population.

4.4 Sample and sample size determination

A. Sample selected for focus group discussion

CBOs	**Number of FGD**
1. Iddirs	
. Facilitators for change in Ethiopia supported *Iddirs*	2 groups

. Unsupported *Iddirs* 2 groups

2. Adolescents

. Out of school adolescents 1group

. In- school adolescents 1group

3. Women's association 1group

4. Anti- AIDS club 1group

5. Kebele officials 1group

6. Kebele opinion leaders 1group

7. Teachers from two schools 1group

8. Religious leaders (orthodox & Muslim) 1group

The above mentioned groups were selected randomly for focus group discussion sessions after identifying their respective community- based organizations. Six to ten individuals participated in each focus group discussion session.

B. sample size determination for the survey

The sample size for interview was calculated using the formula to investigate a single population proportion. A study in Ziway showed that parent - adolescent communication on sexual matter occurs among 20% of the families [(24)], therefore to get adequate sample size with a design effect of 1.5, 95% confidence level (alpha 0.05), and desired precision 5%, the sample size calculated was 355. Adding a 5% non response rate gives a total sample of 372 houses holds using the following formula:

$$n = \frac{Z_{\alpha/2}^{2}\, p(1-p)}{d^2}$$

where, $Z_{\alpha/2}$ = The standard normal distribution corresponding to a significance level of 5%.

P = proportion of parent adolescent communication (20%)

d = desired precision,5%

4.5. Sampling procedure

A. The focus group discussion:- After obtaining the list of Community Based Organizations 13 groups were selected randomly from their respective groups.

B. Survey

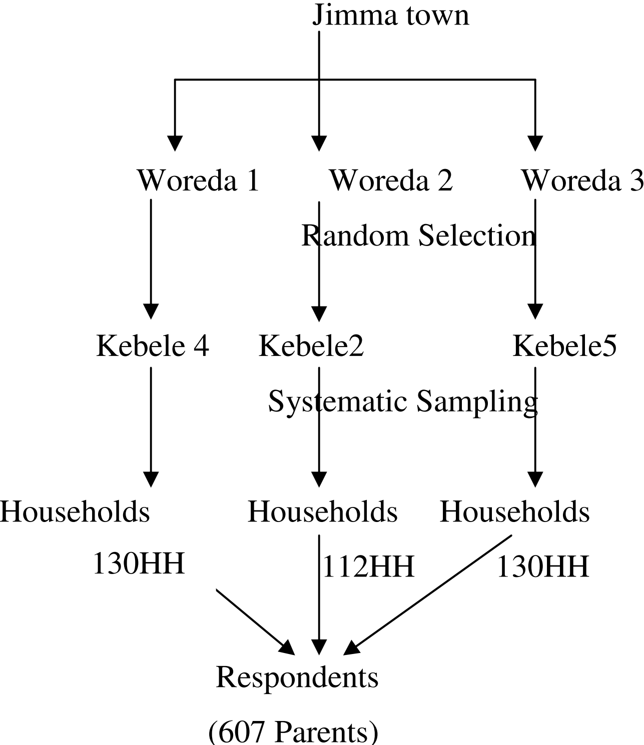
Rapid assessment of administrative kebeles was conducted by the investigator along with three residents who were knowledgeable about the town residents.

From the assessment, the major characteristics such as occupation and educational level were found to be almost uniformly distributed throughout the kebeles of each individual woreda whereas a difference was observed between the three woredas of the town. Therefore one representative kebele was selected from each woreda using random numbers after listing the kebeles of each woreda. The sample was allocated to each woreda based on the proportion of population size in each woreda

A systematic sampling technique was used assuming that parents with at least one adolescent in the family were uniformly distributed throughout the kebele. The first household with at least

one adolescent was randomly selected and taken as the starting point for interview and then parents in every second household with an adolescent in the family were interviewed.

Schematic representation of sampling procedure



4.6. Data collection tools and procedures:

A. For focus group discussion

CBO leaders and key-informants were identified and included in the focus group discussion. The principal investigator guided the discussion using a prepared checklist; an experienced data collector was jotting down the points while the discussion was tape-recorded. Group discussions with the discussants were conducted in a quiet place.

B. SURVEY

Questionnaire development

A structured questionnaire was first designed in English and later translated into the national language (Amharic), and back translated to English to ensure that the original meaning was retained. Two assistant professors from Jimma University validated all the versions.

The questionnaire was pre-tested among a total of 40 parents (20 male and 20 female) non-randomly selected from the three kebeles, who were not included in the final interview. The reliability coefficients (Cronbach's alpha) for risk, vulnerability and impact reduction questions were calculated. Cronbach's alpha for risk reduction was 0.738, for vulnerability reduction 0.871 and for risk reduction 0.869. Some modification as to the sequencing of questions, re-wording of some ambiguous terms, and correction of skip patterns were made.

4.7. Data Collection

Twelve data collectors (equal numbers of males and females) who had completed 12th grade and who had previous experience were recruited, and three supervisors who had experience in this activity were also selected from Jimma University. Training was given for one day. The objectives of the study were discussed. The structured questionnaire was discussed in detail going through every question, with clarification of each doubt. The procedure of interviewing couples and the method of reporting to the immediate supervisor was also discussed thoroughly. The role and communication of supervisors to data collectors and coordinators was thoroughly explained.

A day's practice was carried out using the prepared format outside the selected communities for pre-testing. Fathers were interviewed by male data collectors and mothers by female data collectors. Supervisors were in close follow up everyday to control as well as support data collectors. Checks were regularly carried out on each completed questionnaire and necessary feedback offered to interviewers the next morning. Random counter checks were also made by the supervisor to ensure completeness of the data collected. Whenever the identified interviewees were not found at home (mostly males), a maximum of two revisits was made to trace them.

Record review

Data on deaths from the communities were collected from registers of the selected three *Iddirs*, using carefully designed structured formats by the principal investigator.

4.8. Data Quality Control

In order to ensure quality of the data, data collectors and supervisors were trained, appropriate follow up of the data collection activities were carried out and re-interviewing of 3% of the sample was done by different data collectors and supervisors. Reliability test for risk, vulnerability and impact reduction items were calculated

4.9. Data Analysis

The collected data were entered into a computer using the SPSS + PC version 11.0 statistical package. The data were cleaned and edited before the analysis.

For descriptive analysis risk, vulnerability and impact reduction potential was assessed using 6,8 and 5 questions respectively on a five point Likert scale ranging from 1 for strongly disagree to 5 strongly agree for each questions. All items in each construct were summed up and mean, standard deviation, minimum and maximum score was calculated as a single construct for Risk, Vulnerability and Impact reduction potentials. Finally items under each construct were put in a table as disagree, not sure and agree. We used independent t- test to analyze difference by selected variables. For descriptive analysis, the specific knowledge the parents had towards transmission and preventive methods and their practice in prevention of HIV/AIDS as dichotomous variables whether the parents had knowledge and practice in prevention of

HIV/AIDS was examined. For these variables chi- square analysis to determine significant difference by sex/gender was also done.

The findings are presented using tables, graphs and texts. All analysis was conducted using SPSS for windows 11.0.

4.10. Ethical Issues

Before the study began, ethical clearance was obtained from the Ethical Committee of Addis Ababa University Medical Faculty, Department of Community Health. Then officials at different levels in the study area were communicated with through letters from the Department of Community Health, AAU. Letters of permission were presented to all concerned zonal, woredas, kebeles and CBO officials. Verbal consent was secured from each individual who participated in interviews and focus group discussions. The response to the survey was anonymous.

Operational definition

Involvement:- taking part in the process of HIV/AIDS prevention and control efforts/program. i.e. participation in Anti-AIDS clubs , discussion with a peer educator, participation in social events with an HIV/AIDS theme, discussion about HIV/AIDS with friends, sexual partners, families or other community members and support of people infected and affected HIV/AIDS

Risk behavior:- behavioral practices that predispose adolescents to HIV infection.

Family:- parents(father and mother), siblings ,foster parents and the children

Community organization:- any formal or informal structures of society including mutual assistant organization , NGO, churches or mosques.

Risk:- is a factor that increases the likelihood of acquiring HIV

Vulnerability:- is a factor that increases the chance of practicing HIV related high risk behavior

Impact:- is the effect that is caused by HIV/AIDS on the family and community

Knowledge:- knowledge of HIV prevention was assessed using five conventional questions on prevention of HIV/AIDS, respondents were considered to be knowledgeable about HIV prevention if they correctly identified the three major ways to prevent HIV transmission i.e. abstinence; faithfulness to uninfected partner and condom use .

Practice:- if parents were able to discuss about HIV/AIDS transmission and prevention methods with their children i.e. they discussed about HIV/AIDS, sexuality and condom use.

Risk, vulnerability and impact reduction potential: respondents were considered as having high risk, vulnerability and impact reduction potential and if they were scored above the mean score, if they below the mean score they were considered low risk, vulnerability and impact potential.

Source: Ethiop. j. health dev. and expert advise

5. Results

5.1 Socio- demographic characteristics of the parents

Of the targeted 372 households for the study, 233 households comprised both parents (father and mother) and the remaining 139 households were inhabited by single parents. Of the sampled households, 369 responded to the study making the response rate of 96.4%. Three parents refused and 27 households' fathers were missed even after repeated visits.

There were 602 people who responded to the interview of which 250 (41.5%) were fathers/males and 352 (58.5%) mothers/females in the study. The mean age for males was 48.2 and for females 40.8 years. Of the study subjects, 371 (61.6%) were orthodox Christian, 218(36.2%) were Oromo, 506(84.1%) were married. The majority 403(70.3%) had primary level education and 204(34.5%) had monthly family income between 201 and 500 Birr. (See table 1)

The majority 250(41.5%) of the mothers were housewives and 62(17.6%) and 34(9.7) of them were wage labourer and government employees respectively whereas the majority 108 (43.2%) of fathers were government employees followed by 87 (34.8%) in private business.

Table1:- Percentage Distribution of General Characteristic of the Respondents Jimma Town, 2004

variables	Number	Percent
Sex		
Male	250	41.5
Female	352	58.5
Age		
24*-50	453	75.6
Above 50	146	24.4
Mean age (±SD) Total		
Male	48.2	-
Female	40.8	-
Educational status		
Illiterate	98	16.3
Primary	252	41.9
Secondary	170	28.2
Above 12th grade	82	13.6
Religion		
Orthodox	371	61.6
Muslim	154	25.6
Protestant	68	11.3
Others	9	1.5
Ethnicity		
Oromo	218	36.2
Amara	180	29.9
Gurage	56	9.3
Others*	148	24.6
Marital status		
Married	506	84.0
Never married	18	3.0
Widow/widower	56	9.3
Divorced/ separated	22	3.7
Family monthly income		
<200 Birr	199	34.7
201-500	204	35.6
>501 Birr	170	29.7

*Others include yem, Dawro, Tigre, keffa,
*Age is low because of the foster family

5.1.2 Perceived Risk, vulnerability and impact reduction

The perceived potential of parents' participation in risk, vulnerability and impact reduction was assessed. There were six questions for assessing risk reduction, out of these 222(37%) of the respondents disagreed and 108(18%) were not sure of the role of the family in promoting condom use to their children. Similarly, 586(97.7%) agreed that the family can promote the avoidance of unsafe injection and traditional practice as it is one of the risk factor. The majority 574(95.6%) agreed that the families can prevent substance abuse by their children thereby they reduce risk behavior. Significant variation was observed between mothers and fathers on the variable, families and communities can help in reduction of VCT and regular ANC follow up and the difference was statistically significant (X^2= 19.3, P- value <0.01). (See table 2)

The perceived vulnerability reduction was also assessed using eight questions. The results showed that the majority 573 (95.9%)of parents agreed that families can give care to PLWHA and play major role in stigma reduction, Five hundred and sixty five (93.6%) of the respondents agreed that families/ communities can help in protecting human rights and promoting controlling action perpetuating HIV/AIDS within the community followed by 554 (92.6%) of the study subjects agreed that families/ communities can have a more active role in improving access to VCT services and educational program to the community . Five hundred and thirty two (88.6%) of the respondents agreed that young people can be protected from unacceptable and risky behavior if they are allowed to actively participate in family and community affairs. Four hundred and eighty two (80.5%) of the interviewee agreed that families can positively influence young adults by closely relating to them in all aspects whereas about 117(19.5%) of the respondents either disagreed or were not sure. Significant variation was also observed between

mothers and fathers on their perception on families can promote good behavior by supporting peer group/youth associations and on families and communities can play a more active role in improving access to VCT and educational program to the communities. The difference was statistically significance (X^2= 7.9and P- value < 0.05). (See table 3)

Five questions were used to assess the perceived impact reduction potential. The majority 575(96.0%), of parents agreed that other families/communities can create a vocational training opportunity for the affected families. Five hundred and seventy-three (96.0%) of the respondents agreed that families/ communities can improve the quality of living of AIDS orphans by providing them human care. Similarly, 572 (95.8%) of the study individual agreed that society should take a more proactive role to prevent rape and other forms of forced sexual violence. About 569(95.2%) of them agreed that PLWHA can participate in any social life of the society. There was also statistically difference between the two groups(mothers and fathers) with respect to perception of the two variables i.e. society should take a more proactive role to prevent rape and other forms of forced sexual intercourse and families/ communities can improve the lives of PLWHA by supporting them. The difference were statistical highly significant for both variables (X^2 = 9.74, P- value 0.01and X^2 =9.4 and P- values < 0.01). (See table 4)

Table 2:- Percentage distribution of perceived risk reduction potential of the parents to participate in HIV/AIDS prevention, Jimma town, 2004

Variables	Male (%)	Female (%)	X^2	P-value
Families/ community can help young adults postpone early sexual intercourse at a young age				
Disagree	10 (4.0)	30 (8.6)		
Not sure	6 (2.4)	8 (2.3)	4.898	0.086
Agree	234(93.6)	312 (89.1)		
Families can promote the use of condoms among sexually active young adults to reduce the risk of HIV.				
Disagree	95 (38.0)	127 (36.3)		
Not sure	34 (13.6)	74 (21.1)	5.826	0.54
Agree	121 (48.4)	149 (42.6)		
Families can help young people to reduce their number of sexual partners.				
Disagree	21 (8.4)	18 (5.2)		
Not sure	18 (7.3)	33 (9.5)	3.272	0.195
Agree	209 (84.3)	298(85.4)		
Families/community members can help reduce Mother-to child transmission of HIV by promoting VCT and regular ANC follow up				
Disagree	3(1.2)	6 (1.7)		
Not sure	36 (14.4)	15 (4.3)	19.302	< 0.001*
Agree	211 (84.4)	329 (94.0)		
Families can prevent substance use among young adults to reduce the risk behavior that exposes them to HIV/AIDS				
Disagree	5 (2)	5 (1.4)		
Not sure	4 (1.6)	12 (3.4)	2.138	0.343
Agree	241 (96.4)	333 (95.2)		
Families can promote the avoidance of unsafe injection and traditional practices thereby reducing the risk of HIV/AIDS				
Disagree	0	3 (0.9)		
Not sure	4 (1.6)	7 (2.0)	2.94	0.318
Agree	246 (98.4)	340 (97.1)		

Table 3:- Percentage distribution of perceived vulnerability reduction potential of parents to participate in HIV/AIDS prevention, Jimma town, 2004.

Variables	Male %)	Female (%)	X^2	P-values
Families can positively influence young adults by closely relating to them.				
Disagree	27(10.8)	37(10.6)	0.007	0.99
Not sure	22(8.8)	31(8.9)		
Agree	201(80.4)	281(80.5)		
Families can promote development of good behaviors by supporting peer groups/youth associations.				
Disagree	2(0.8)	13(3.7)		
Not sure	20(8.1)	19(5.4)	6.4	0.04*
Agree	226(91.1)	317(90.8)		
Young people can be protected from unacceptable and risky behaviors if they are allowed to actively participate in family/community affairs				
Disagree	2(0.8)	14(4)	5.8	0.56
Not sure	22(8.8)	30(8.6)		
Agree	226(90.4)	306(87.4)		
Participation of families in social events together with young adults can help reduce the risky behavior				
Disagree	3(1.2)	7(2)	0.83	0.7
Not sure	14(5.6)	23(6.6)		
Agree	223(93.2)	320(91.4)		
Family support in empowering women helps the vulnerable girls				
Disagree	5(2)	6(1.7)		
Not sure	23(9.2)	19(5.4)	3.3	0.19
Agree	221(88.8)	325(92.9)		
Families/ community can give care to PLWHA and play a major role in stigma reduction				
Disagree	3(1.2)	8(2.3)	3.4	0.18
Not sure	3(1.2)	11(3.2)		
Agree	243(97.6)	330(94.6)		
Families / community can help in protecting human rights and promoting controlling actions perpetuating HIV/AIDS within the community				
Disagree	0(0)	7(2)	5.4	0.07
Not sure	9(3.6)	16(4.6)		
Agree	239(96.4)	326(93.4)		
Families/community can have a more active role in improving access to VCT services and educational programs to the community	2(0.8)	2(0.6)	7.8	0.02*
Disagree	25(10)	15(4.3)		
Not sure	221(89.1)	33(95.1)		
Agree				

Table 4:- Percentage distribution of perceived impact reduction potential of parents to participate in HIV/AIDS prevention, Jimma town, 2004

Variables	Male	Female	X^2	P-value
Families/community can improve the lives of AIDS orphans by providing them human care.				
Disagree	1(0.4)	2(0.6)	4.6	0.098
Not sure	4(1.6)	17(49)		
Agree	243(98)	330(94.6)		
Persons living with HIV/AIDS can participate in any social life of the society.				
Disagree	2(0.8)	9(2.6)	3.1	0.21
Not sure	6(2.4)	12(3.4)		
Agree	241(96.8)	349(94)		
Society should take a more proactive role to prevent rape and other forms of forced sexual intercourse.				
Disagree	0(0)	5(1.4)		
Not sure	3(1.2)	17(4.9)	9.5	0.008*
Agree	245(98.8)	327(93.7)		
Families/community can improve the lives of people living with HIV/AIDS by supporting them.				
Disagree	1(0.4)	4(1.1)	9.4	0.009*
Not sure	4(1.6)	23(6.6)		
Agree	244(98)	323(92.3)		
Families/community can create vocational training opportunity for the families affected by HIV/AIDS				
Disagree	1(0.4)	1(0.3)	5.2	0.8
Not sure	4(1.6)	18(5.1)		
Agree	244(98)	331(94.6)		

The responses were further analyzed by taking the totaled value and mean score (±SD) for questions about risk, vulnerability and impact reduction potentials. The score for risk reduction ranged from 18 to 35, for the vulnerability reduction from 22 to 40 and for impact reduction from 14 to 25.The mean score/ standard deviation for perceived risk reduction potential was 28.95 (3.35) and parents with low risk reduction potential score were 319 (53.4%) whereas parents with high risk reduction potential score were 278 (46.6%). For vulnerability reduction potential the mean score (±SD) was 33.69 (3.94) and parents with low vulnerability reduction potential score were 352 (59.5%), whereas parents with high vulnerability reduction potential score were 240 (40.5%). For impact reduction potential the mean score (± SD) was 21.82 (2.39) and parents with low impact reduction potential score were 321 (54.0%) whereas parents with high impact reduction potential score were 273 (46.0%).

The mean perceived risk, vulnerability and impact reduction potential scores among parents with selected variables were compared. Accordingly education, income and family size (P value <0.001, 0.002 and 0.042 respectively) were found to be statistically significantly associated with the perceived risk reduction potential.(see table 5) As shown in table 6, for perceived vulnerability reduction potential, only educational status was found to be statistically significantly associated (p < 0.01). Concerning perceived impact reduction potential, educational status and family income were found to be statistically significantly associated with (P value < 0.01 and 0.032 respectively. (See table 7)

Table5: - The mean perceived risk reduction score among parents by selected characteristics, Jimma Town, 2004

Variables		Mean score (+SD)	P - value
Sex			
Male	248	28.96	0.956
Female	349	28.95	
Age			
24-50	271	29.18	0.578
Above 51	285	29.01	
Marital status			
Married	501	28.91	0.459
Single	96	29.19	
Education			
Illiterate	96	27.39	< 0.001**
Literate	501	29. 26	
Income			
<500 birr	399	28.74	0.002**
>500 birr	169	29.67	
Family size			
<5	276	28.66	0.042*
>5	320	29.22	

**** p value is <0.001, * P value < 0.05**

Table 6 :- The mean perceived vulnerability reduction score among parents by selected characteristics , Jimma Town, 2004

Variables		Mean score (±SD)	P - value
Sex			
Male	245	33.85	
Female	347	33.57	0.404
Age			
24-50	215	33.87	0.847
Above 51	285	33.87	
Marital status			
Married	498	33.72	0.075
Single	94	35.52	
Education			
Illiterate	95	31.28	< 0.001**
Literate	497	34.15	
Income			
<500 birr	396	33.60	0.20
>500 birr	169	34.24	
Family size			
≤5	272	33.62	0.695
>5	319	33.75	

**** P value less than 0.001, * p value <0.05**

Table 7:- The mean perceived impact reduction score among parents by selected characteristics, Jimma Town, 2004

Variables		Mean score (±SD)	P - value
Sex			
Male	247	22.14	0.005
Female	347	21.59	
Age			
24-50	216	21.78	0.545
Above 51	283	21.91	
Marital status			
Married	500	21.81	0.892
Single	94	21.85	
Education			
Illiterate	96	20.53	< 0.001**
Literate	397	22. 07	
Income			
<500 birr	391	21.71	0.032*
>500 birr	170	22.18	
Family size			
<5	272	21.80	0.828
>5	321	21.84	

**** P value <0.001, * P value < 0.05**

5.2.1 Knowledge on modes of transmission and preventive measures on matters related to HIV/AIDS

The knowledge level of the study group on issues related to HIV/AIDS was also assessed. The most commonly mentioned modes of transmission were sexual intercourse 591 (98.2%), contaminated sharp utensils 532 (86.9%), followed by blood transfusion 468 (77.7%). About 281(46.0%) of the respondents reported that the diseases cannot be transmitted during delivery and 317(52.7%) said it cannot be transmitted during breast feeding. Mother to child transmission during lactation was the least mentioned transmission methods 284 (47.2%). (See table 8)

As shown on table 8, among the preventive measures of HIV/AIDS mentioned were abstinence 560 (93%) and faithfulness (limited to one sexual partner) 503 (83.6%) whereas only 242 (40.2%) mentioned regular condom use as one of the conventional preventive method. Of those who responded that HIV/AIDS cannot be protected by regular condom use, 225(62.5%) were females and the difference was statistically significant (X^2=5.579 and p-value <0.01).

Table: 8 Percentage distribution of knowledge on modes of transmission and preventive methods of the study group, Jimma town, 2004

Variables	Male (%)	Female (%)	X^2	P value
Modes of Transmission				
Sexual intercourse n = 602				
Yes	249(99.6)	342(97.2)		
No	1(0.4)	10(2.8)	3.59	0.058
MTCT during pregnancy n =602				
Yes	180(72)	224(63.6)		
No	70(28)	128(36.4)	4.63	0.031*
MTCT during delivery n =602				
Yes	145(58)	176(50)		
No	105(42)	176(50)	3.76	0.053
MTCT during lactation n =601				
Yes	120(48)	164(46.7)		
No	130(52)	187(53.3)	0.09	0.76
Contaminated sharp utensil n =602				
Yes	221(84.4)	312(88.6)		
No	39(15.6)	40(11.4)	2.30	0.13
Blood transfusion n =602				
Yes	197(78.8)	271(77)		
No	53(21.2)	81(23)	0.28	0.59
Preventive measures				
Abstinence from sex n =602				
Yes	238(95.2)	322(91.5)		
No	12(4.8)	30(8.5)	3.12	0.07
Faithfulness (limiting partner to one) n=602				
Yes	223(89.2)	280(79.5)		
No	27(10.8)	72(20.5)	9.92	0.02*
Regular condom use n =602				
Yes	115(46)	127(36.1)		
No	135(54)	225(63.9)	5.98	0.01*
Avoid sharing sharp utensils n =602				
Yes	163(65.2)	267(75.9)		
No	87(34.8)	85(24.1)	8.13	0.01*
Avoid blood transfusion n =602				
Yes	126(65.2)	177(50.3)		
No	124(49.6)	175(49.7)	0.01	0.98

5.2.2:-Practice of the study group on matters related to HIV/AIDS prevention

Practice of the study group on matters related to HIV/AIDS was also assessed. There were 462(76.9%) parents who ever talked about HIV/AIDS with their children, 358 (59.6 %) ever discussed sexuality with their children and 130 (21.7%) parents who ever advised their children to use condoms. 243 (40.4%) never discussed sexual matters with their adolescent. Some of the reasons given by the parents for not communicating with their adolescent children were, 86 (35.5%) "Don't have the necessary knowledge to communicate with them" 68 (28.1%) "It is not appropriate to talk with them about sexual affairs" 49 (20.2%) "It is not cultural" and 14(5.8%) said "my religion won't allow me" Only 164 (27.3%).Parents were participated in HIV/AIDS activities in the community

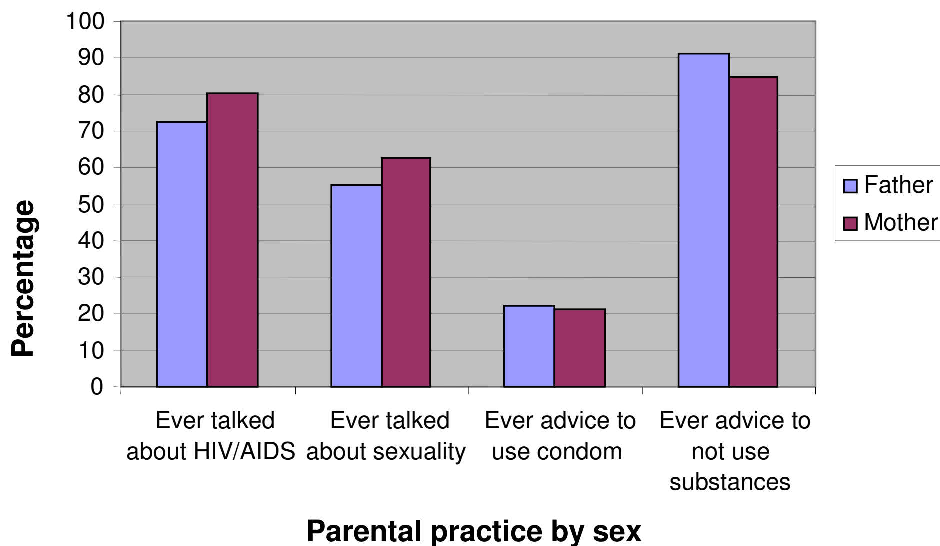


Fig 2. Distribution of parental practice on matters related to HIV/AIDS, Jimma Town, 2004.

5.2.3 Focus group discussion summary result

In this study, specific research questions were prepared under six major headings, the community's/CBO's perception about HIV/AIDS, major contributions made to the against HIV/AIDS, effectiveness of these contributions, barriers to effective intervention, and resource needs for effective future contributions.

The Community's perception of HIV/AIDS

The group discussion started with the general question whether they perceived HIV/AIDS as a major problem or not in the communities. All categories agreed that it was the most serious health and social problem of the communities. This was because it is a killer disease with no cure and no vaccine and many people were dying from it. A participant from a religious group said that *"At first it was a taboo to mention about HIV/AIDS but now everybody talks about it because information about the disease and the death toll have increased over time*".

Most of the participants agreed that youth and poor women were the most affected segments of the population. One participant from *iddir* said that *"This disease affects the poor because they are selling their body to eat and put some clothes over their body so I can say that it is the economic problem that aggravates the disease."*

Another participant from the anti-AIDS club pointed out

"This disease mostly affects youth because they were the victims of unemployment that eventually leads to substance use (alcohol & chat) and ultimately leads them to acquire HIV infection." A participant from '*iddir*' member said *"the living status of the women is so low that it makes the women vulnerable to HIV/AIDS."*

Amazingly, misconceptions are rampant among the participants. One teacher said *"I don't want to teach my students about condoms because I am convinced that condoms have virus on them and also encourage them to have multiple sexual partners so it is better not to teach about condom."*

Major contributions made to fight against HIV/AIDS

Almost all the participant agreed about the need for communities, families and CBOs to contribute in the fight against HIV/AIDS in reducing risk, vulnerability and impact. CBOs ('*iddir*', anti-AIDS club, women association and religious group) with assistance from NGOs, reported that they do some work in the fight against HIV/AIDS. For example, the two *'iddirs'* which were included in the focus group had reported that they had a planned work on HIV/AIDS prevention and control. They participated in the teaching of their members (communicating HIV prevention messages), provided care and support for affected and infected families, orphan support, vocational training for the youth (driving license, computer skills, tailoring, hair dressing, and technical school), loan service to assist for poor women and youth in starting for small scale trading. They were offering Kindergarten service to generate income and give free service to those children unable to pay for the school fees, and also offering street children support.

Whereas the non-supported *'iddirs'* though they wish to do the work, they cannot because of the lack of necessary support either from the government or civil society organizations. For example a participant from an *'iddir'* said *"Until now we didn't work on it but now we want to participate in the development work to help our members because we have many poor widowed and single women and unemployed out of school youths that are predisposed to HIV infection but need technical assistance for NGOs and GOs on how to revise our iddir by-law to include HIV/AIDS intervention."*

Another participant from the other '*iddir'* said,

"We are now on the process of changing our 'iddir' by-law to include integrated development work because we have seen the benefit of development work from other NGO supported 'iddirs.'" Another participant said, *"We think that we can bridge the government and the community or be used as an entry point in the community in the fight against HIV/AIDS because we can win the trust of the community."*

The effectiveness of the contribution

The CBOs that were working on HIV/AIDS programs were also invited to discuss the effectiveness of their contribution and most agreed that it was much better than before. For instance one participant said, "*Most poor women and youth have benefited from the loan service they were provided from those CBO's that are actively implementing integrated development work*". This eventually would decrease vulnerability to HIV/AIDS. They also reported that "*Our orphan support program also was going smoothly and people's attitude about the disease is*

beginning to change." It was also discussed that there is also an encouraging optimism that the community supports each other in time of need. They were agreeing that some 'iddirs' have moved beyond the funeral ceremony and started development work.

Barriers to effectiveness of CBO activities in HIV/AIDS programs

The study participants were also invited to discuss the barriers to effectiveness of their HIV/AIDS activities. The participants pointed out that the following challenges were faced by them while implementing their programs, for example, lack of money, leadership and technical capacity to run developmental work, lack of legislation on adolescent substance abuse (alcohol, chat and drugs), lack of enough support from GOs and NGOs, unemployment, economic problem, lack of integration between families and school communities, lack of consideration of parents in HIV/AIDS prevention and control programs (parents were forgotten in the prevention program) and stigma associated with the disease and promoting condoms.

Resources needed for effective future contribution

The participants also discussed the resources needed for effective future contribution. They all agreed on the need for:-

- Financial and material support from GOs and civil society.
- The need for capacity building on leadership and planning an integrated community development work.
- Continuous close follow-up and encouragement from GOs and NGOs to grass root organizations.

- The need for legislation on adolescent substance use and illegal pornographic video houses.
- The need for networking GOs, NGOs and CBOs in order to support to reduce unemployment and poverty in an integrated manner.
- The need for empowerment of women and youths.
- The need for strong enforcement of the law on rape prevention.
- The need for experience sharing between CBOs

5.3:- Summary of Record Review

Record review was also done on three selected "*iddirs*" to explore the impact of mortality of HIV/AIDS and its effect on each '*iddir's'* capital. The results showed that the majority 93 (32.0%) of deaths occurred in the age group above 49 years, 72 (24.7%) in 25-34 age group, followed by the age group 35-49, 68(23.4%). The overall death occurrence was also higher among females 150 (51.1%) than males 141(48.5%) but male deaths were higher than females in the age group of 15-24. The overall mean age of death was 38.8. (See fig 2)

Table 12:- Age and Sex Structure of Members of '*Iddir'* during from 1991-1995E.C in three *iddirs*, in Jimma town.

Age group	Male n(%)	**Female n(%)**	Total n(%)
0-14	11 (64%)	6 (35.3%)	17 (5.8%)
15-24	26 (63.4%)	15 (36.6%)	41 (14.1%)
25-34	34 (47.2%)	38 (52.8%)	72 (24.7%)
35-49	31 (45.6%)	37 (54.4%)	68 (23.4%)
50+	39 (41.9%)	54 (58.1%)	93 (32.0%)
Total n (%)	141(48.5%)	150 (51.5%)	291(100%)

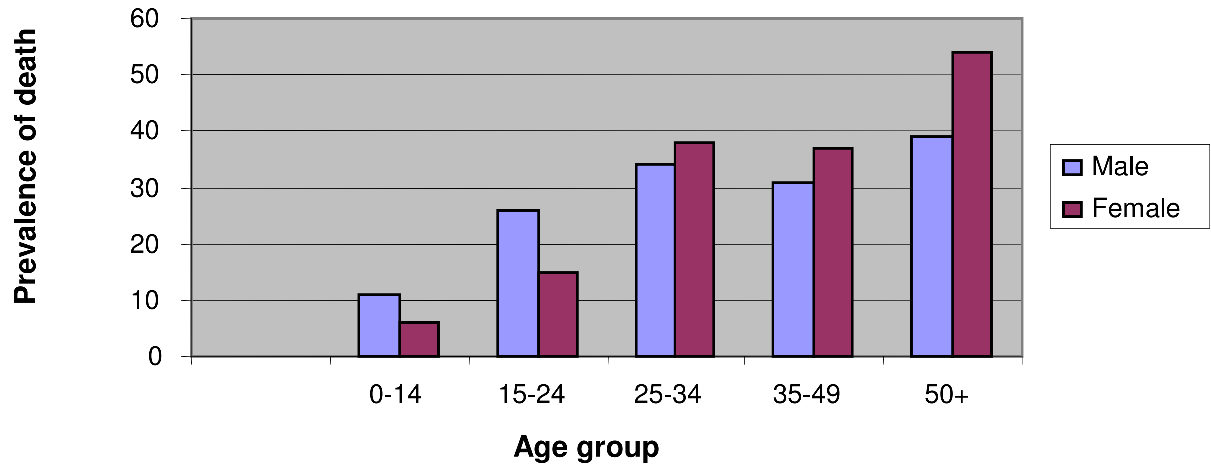


fig.3 Age sex structure of members of
'*iddirs*' who died from1991-
1995 EC in Jimma
Prevalence of death
60
50
40
30
20
10
0
0-14
15-24
25-34
35-49
50+
Age group
Male
Female

The effect of mortality

The effect of death on each '*iddir'* was discussed by the '*iddi*r' leaders. Some of the major problems identified were shortage of financial reserve, time and technical capacity to run the *iddir* as a social and development organization.

They reported that there was a decrease in the amount of financial deposit as a result of frequent payments for the increased deaths, and also some *iddirs* had started financial support for those who were sick and unable to afford medical bills. Unfortunately, this situation had seriously affected the financial reserve and hence they were forced to stop their help to the sick. But they said they will resume this support whenever they get other means of income in the future. To cope with the financial problems encountered by the *iddirs*, they were forced to stop giving money for those relative dying outside the residence area and had also decreased the amount of payment for the deaths in the residential area. Further action taken by the iddir to increase the contributions including collecting additional money regularly from its members and raising the amount of premiums.

The other major problems identified by the study participants were time needed for the funeral service and time for organizing and leading the *iddir*. They reported that the time needed for routine iddir ceremony had increased as a result of very frequent deaths of their members. The last major challenge raised was the lack of leadership and management capacity of *iddir's* leaders in making their iddir survive and serve the underlying objective and hence make it an organization that moved beyond funeral service by rendering integrated community development work and contributing to overall social welfare.

6. DISCUSSION

A significant proportion of parents have agreed about the risk, vulnerability, and impact reduction potential but parental practice is still low. Scope of knowledge of modes of transmission and means of prevention of HIV/AIDS is still worrying. Both quantitative and qualitative studies methods identified the presence of major misconceptions pertaining to condom use. Condoms as preventive strategies are not widely accepted. CBOs show encouraging movement in participation in HIV/AIDS. There is also a sense of ownership and confidence in their intervention. Iddirs could serve as source for mortality data.

The main limitation of this study is that since the measurements were self reported behaviors and action it might run the risk of information bias and since these are the sensitive issues it might also carry social desirability bias. In the record review, there might be a recall bias on the age information because we used the key informant to collect the data on age of the deceased. But, effort was made to control the possible confounders and bias. The tool was pre-tested, and the reliability coefficient (Cronbach's alpha) was calculated for the risk, vulnerability and impact reduction questions and the questionnaire was validated by different experts in the field. Random selection of households was used and same sex data collectors were used for interview. Re-interviewing on 3% of the data by different data collectors was also done. In addition to that the quantitative method was also complemented with qualitative data and record review to triangulate findings.

This study was done in Jimma zone taking households as the sampling unit. From the identified household, there were 602 subjects interviewed. Most subjects of the study have primary level

schooling and have family income less than 500 birr per month with family size of more than 5. Such scenario is known in increasing the risk for health problems particularly to HIV/AIDS which also is the finding of this study [17].

It is believed that addressing HIV/AIDS by using all means and models is of paramount importance. Hence attempts were made to assess different risk reduction potentials of families and communities as it is obvious that these segments of the population have been neglected in the overall top-down HIV/AIDS mitigation approach. Their role in design, leadership, program ownership and decision making at all level pertaining HIV/AIDS prevention and control has been minimal. It is important to note that the disease affects the families and communities immediately and painfully [13].

Concerning the risk reduction potentials of the family, it was noted that the majority agreed to have some degree of influence over factors such as rape reduction, the use of unsafe injections and sharp tools, multiple sexual partners, substance abuse, and peri-natal transmission which all are potential risk for HIV/AIDS transmission. It was found out that families agreed that they can contribute a lot in influencing their children's behavior. These findings can create a fertile opportunity for any successful HIV/AIDS intervention program design and implementation. On the other hand, the family's role in promoting condom use by their children in this study was found to be very low as only 45% of the parents agreed to it. This finding was also identified in the result of the focus group discussions with CBO and community representative. This is similar with the study done in ziway by Nigussie [24]. Such low condom use even by adolescent themselves have been observed in other studies [25-28].

More than 80% of the respondents agree that parental participation can reduce vulnerability by making their children more close and intimate, promoting peer support, protecting adolescents if they show undesirable and risky behavior, empowering women, providing care and reducing stigma and so on. This tells us that our families will be strong partners in the fight against HIV/AIDS if they are properly involved. This finding is similar to the finding that HIV/AIDS messages were best accepted if respected females teach females [20]. In this study families are willing to play an active role in improving access to VCT and provision of care to PLWHA in both cases where more than 90% have agreed. It is also encouraging to learn that to deal with this killer disease a pluralistic and multifaceted approach is suggested in the literature [19].

It is very encouraging to note that more than 90% of the respondents agreed to improve the lives of AIDS orphan by providing care, by playing a major role in reducing sexual violence, by provision of support for those people living with/ affected by HIV/AIDS, and by creating self support vocational training for the victims and their families. Such findings again will encourage any move in reducing the burden of AIDS and may indirectly tell us how the people at the grass root level are willing to help in the fight against the disease and its impact.

Parents with less education and poor seem to contribute less as compare to the literate and better off families therefore they need more support and follow up in order to increase their motivation to participate in HIV/AIDS prevention and control.

Several focal studies targeting the knowledge, attitude and behavior of adults conducted in Ethiopia also indicated similar finding. BSS examined the level of knowledge of AIDS in eleven regions and one administrative council has reported that 94% of male respondents and 84% of female respondents had knowledge on the three major preventive methods. Similarly, we found out that more than 90% of the respondents are knowledgeable on some of the common methods of HIV/AIDS transmission and preventive methods. However, those that know peri-natal HIV transmission are low for example 47% knows the potential risk of HIV transmission breast feeding [(29)].

Concerning prevention measures of HIV/AIDS, regular condom use as very important method of prevention is accepted by only 40%. This finding should deserve attention as it is one of most important and accepted conventional methods of prevention. In this study we also computed a similar finding that 44.4% of male and 39.9 % of female respondents were knowledgeable on three major preventive methods. The reason may be due to the major misconceptions existing about condoms among the community as documented in BSS report [(29)]. The focus group discussion result also depicted the presence of such misconceptions about condoms which a secondary school teacher has mentioned that using condoms could increase the spread of HIV/AIDS because condom itself has the virus and it encourage the adolescents to have multiple sexual partners. This was also documented in another study [(30)].

Parents practice concerning HIV/AIDS and sexuality shows that intra-family discussion of HIV/AIDS, sexuality, and advice not to use substances isn't as expected despite the seriousness of the pandemic and high level of awareness. It important to note that parents' role in advising their children to use condom is very small i.e. only 21.7% of the parents advised their children to use condoms. It is observed that talking about sexuality was not practiced by the majority. This will create a hurdle in the overall effort of HIV/AIDS prevention and control. This finding is similar with the study done by Nigussie in Ziway (24, 31). Some of the reasons given by parents for not communicating with their children are lack of knowledge, cultural taboos and influence, and religion all of which very hard to break. Therefore proper study needs to be done on how to impart the desired knowledge to the grass root level.

CBO participants perceive that HIV/AIDS is a killer disease and in recent times every body in their community is talking about it. They also identified that young people and poor women are the most affected by the disease as this group of the population are subjected to un-employment, substance abuse and economic dependence. Females go into the sex industry to support their poor families (32). It is important to note that there is still widespread misconception about the disease among the study subjects which corresponds with the result of BSS (29) . Such gate keepers having misconceptions could be a source for a wider diffusion of misconceptions and create major problems in the overall effort of mitigating the disease. UNAIDS reported that teaching adolescents about sex and advising them to use condoms was not related with increasing promiscuity so choosing the right model is important to address this issue (32) . It is an encouraging finding that the community have a good level of perception but more work needs to

be done to eliminate misconceptions as they create major challenges in the overall effort of dealing with the disease.

Some of the *Iddirs* have already started encouraging work such as participation in information dissemination; provision of care and support; and provision of vocational training to young people, needy women, and HIV/AIDS victims. It was observed that when they report the effectiveness of their intervention they use word like “our” which tells us the feeling of ownership. These efforts are seen in those *iddirs* that are supported by NGOs. Some *iddirs* have also started revisiting their by-laws to integrate the work of HIV/AIDS with their routines. It is also important for anyone who is working in the area of HIV/AIDS to take into consideration that they are a very important partners in order to have an effective and sustainable program because these CBOs have strong believes and accept that they can serve as a bridge between the government and the people at the grass root level as they believe they can win the trust of the community. This is similar with the study done in Addis Ababa [19, 33] .

CBOs leaders said they needed support in terms of building their leadership skill as they accept that they can serve as a link between government and other civil service organizations and community. Building the leadership and management capacity of CBOs leaders will also contribute immensely for the development of *iddirs* supportive mechanism which some have with the help of external assistant and their own initiative. This move further can be strengthened by having supported by law so that they can do better in controlling risk behaviors exercises by their members who contribute for getting exposed for HIV infection. It is fundamental to note that since such community based organizations originally established by their own members

initiative without the intervention of government or NGOs, one should take care of the development of dependency in dealing the problem of HIV/AIDS among their members. Such CBOs need to be self sufficient for most of their requirement in order to render a more sustainable service as they are doing high valued social services [34].

As a result of frequent deaths, which have necessitated more payments to families of the deceased, the financial reserve of most *iddirs* is getting less and some are on the verge of collapse. This situation has made *iddirs* stop the attempt in engaging in integrated development work and even reconsidering their regulations in order to survive. They are also forced to look for other coping mechanism to deal with the serious financial constraints. In addition *iddir* leaders are part timers and they report that they are faced with shortage of time which has made them weak in directing their *iddir* effectively, which is also augmented by lack of leadership skill. Changing the time wasted in attending funeral ceremonies should deserve attention so that the spared time could be used for other useful HIV/AIDS and other development works.

Iddirs documentation was found to be very incomplete particularly age which was not registered at all. However, it was possible to get some information about deceased members of the community form the key informants/iddir leaders/ which the information interpretation should be done cautiously. If proper support is given to iddirs in how to register vital events, they can serve as a potential source of vital statistic in the community. From such information it is possible to assess the impacts of disease such as HIV/AIDS [34]. In the record review female mortality picks later in life. This is contrary to what is reported in AIDS in Ethiopia for HIV. This could be due to missing data or due to error from the recall bias of the age of the deceased.

Conclusion

Based on the findings of the study, the following conclusions are made

- The risk, vulnerability, and impact reduction potential of families is high which shows there is fertile ground for good community intervention programs pertaining to HIV/AIDS.
- The poor and illiterate seem to be less likely to contribute as much as the literate and the better off families.
- The scope of knowledge of modes of transmission and means of prevention of HIV/AIDS is still worrying. Misconceptions prevail pertaining to condom use. Condoms as preventive strategies are not widely accepted.
- Parental practice is still low and shows us that discussion on sexual matter still continues to be a cultural taboo for parents. Majority did talk about HIV/AIDS among the family and about 60 percent discussed the issue of sexuality. But majority did not talk the potential preventive role of condoms with their children.
- CBOs show encouraging movement in participation in HIV/AIDS. There is also a sense of ownership and confidence in their intervention.
- *Iddirs* documentation was found to be very incomplete particularly age which was not registered at all.

Recommendations

1. Families and communities/CBOs at grass root level must be made partners in any HIV/AIDS intervention program giving special emphasis vulnerability and impact reduction and should be made to play a leading role in HIV/AIDS prevention and control as they are the first and foremost affected by the impacts of disease.
2. Poor and illiterate need more support and follow up in order to increase their motivation to participate in HIV/AIDS prevention and control activities.
3. Suitable heath education strategy should be designed for the families as well as to the communities in order to decrease the misconception and to promote condom. Since it is one of the most important and acceptable conventional methods of HIV/AIDS prevention.
4. To improve the role of CBOs, they have to be supported in their efforts to revisit their organization policies so that they become sustainable development partners.
5. There is a huge potential at lower level and hence future planning of any intervention program should be bottom-up.
6. The efforts of relevant legislative bodies are required to support communities with the necessary policies and law enforcement such as substance abuse (alcohol, chat etc), rape and porno graphic video houses.
7. Further support in the form of increasing awareness of the different preventive strategies should be made to empower families so that their huge potential in HIV/AIDS prevention can be exploited
8. *Iddirs* should be assisted in order to improve their recording with all the necessary information so that they could serve as potential source of vital statistic information.

9. Further study is needed towards identifying, promoting and strengthening efforts made by families, communities and CBOs in HIV/AIDS prevention and control.

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Annex 1: structured English questionnaire

Addis Ababa University Faculty of Medicine
The Roles of Families and Communities in HIV/AIDS Prevention and Control
For use with parents

001 Questionnaire identification number_________
002 Region   Oromia
003 City Jimma

Starting time of interview _________AM/PM   Finishing time _______ AM/PM

	Name	Date	Signature
Interviewer			
Supervisor			
Data Entry			

Introduction:
Hello!
My name is__________ and I am from departments of community health, Addis Ababa University. We are interested in asking you about involvements of parents in HIV/ AIDS prevention and control. The purpose of this study is to generate information necessary for planning of appropriate intervention therefore; your honest and genuine participation by responding to the questions prepared is highly appreciated. Everything you tell us will be totally confidential, and I will not be asking your name, and you should not worry that anyone will not know what you have told us. You do not have to answer any questions that you do not want to answer; you may end this interview at any time you want to.

Interviewer Visit

	Visit 1	Visit 2	Visit 3
Date			
Interviewer			
Result			

Result Codes: Completed 1; Respondent not available 2; Refused 3; partially completed 4; other 5.

N.B - Please, fill on each answer sheet as follows
Time of start of interview _________________________
Time of end of interview _________________________

Section 1: Background Characteristics

No.	Questions and Filters	Coding categories		Skip to
Q101	Family status of the interviewee	Father	1	
		Mother	2	
		Others Specify _______________	3	
Q102	How old are you?	Completed Years _________________		
		Do not know	88	
		No response	99	
Q103	What religion are you?	Orthodox	1	
		Catholic	2	
		Protestant	3	
		Muslim	4	
		No religion	5	
		Others (specify) ____________	6	
		No response	99	
Q104	Have you ever attended school?	Yes	1	
		No	2	→ Q106
		No response	99	
Q105	What is the highest level of school you completed?	Read and write	1	
		Grade 1-4	2	
		Grade 5-8	3	
		Grade 9-12	4	
		Above grade 12	5	
		No response	99	
Q106	What ethnic group do you belong to	Amhara	1	
		Oromo	2	
		Tigre	3	
		Gurage	4	
		kefa	5	
		kulo	6	
		Yem	7	
		Other (specify) _____________	8	
		No response	99	
Q107	What is your occupation?	Wage labor	1	
		Gov't employer	2	

		Private business	3	
		House wife	4	
		Private employee	5	
		Other (specify) ___________	6	
		No response	99	
Q108	How much is your average family monthly income?	Amount in Birr ____________	1	
		Do not know	88	
		No response	99	
Q109	Is your house rented	Yes	1	
		No	2	
		No response	99	
Q110	Do you have/own/radio and/or radio	Do not have both	0	
		I have both TV and radio	1	
		TV	2	
		Radio		
Q111	What is your current marital status?	Married, monogamous	1	
		Married, polygamous	2	
		Unmarried (never married)	3	
		Widow/Widower	4	
		Divorced/Separated	5	
Q112	Your family size in number	____________________		
Q113	How many children do you have (please write number of adolescent)	Male __________	1	
		Female __________	2	
		Total __________		
Q114	At present do you chew chat?	Never	0	
		Every day	1	
		Once or twice a week	2	
		One-three times a month	3	
		Less than once in a month	4	
		I don't Want to respond	99	
Q115	At present do you use tobacco?	Never	1	
		Every day	2	
		Sometimes	3	
		Don't want to respond	99	

Q116	How frequently did you use either of these drinks? (Tela, Teji, Arake, Beer)	Never 0 Daily 1 One to two times per week 2 One to three times a month 3 Sometimes (<1 time/month) 4 Don't want to respond 99	

SECTION 2: HIV/AIDS RELATED KNOWLEDGE ATTITUDE OPINION AND PRACTICE

Q201	Do you know anyone who is infected with HIV or who has died of AIDS?	Yes 1 No 2 Do not know 88 No response 99	
Q202	How could people protect themselves from HIV/AIDS?	Abstinence 1 One to one faithful relationship 2 Proper & consistent use of condom 3 Not contacting people with HIV/AIDS 4 Not using blood transfusion 5 Not using contaminated surgical instruments 6 Other specify __________________ 7 No response 99	
Q203	What routes of HIV transmission do you know?	Sexual intercourse 1 Mother to child during pregnancy 2 Mother to child during delivery 3 Mother to child during lactation 4 Through contaminated instruments 5 Through blood transfusion 6 Other specify ____________ 7 I don't know 88 No response 99	
Q204	What do you feel about people living with HIV/AIDS	We need to encourage them to participate in social life activities 1 We have to care and support them 2	

		They have to be in quarantine I don't want to make contact with them Other, specify_______________ No response Do not know	3 4 5 88 99	
Q205	Do you believe parents have responsibility to protect themselves and their children from HIV/AIDS?	Yes No I do not know	1 2 88	
Q206	Have you ever talked/discussed about HIV-AIDS with your children?	Yes No No response	1 2 99	
Q207	Have you ever talked about sexuality with your children	Yes No No response	1 2 99	 → Q209
Q208	If the answer to Q207 is yes, how often do you communicate?	Every time she/he in trouble Whenever they feel talking Every day At least once a week Other, specify________________	1 2 3 4	
Q209	If the answer to Q207 is No, what is the reason for not communicating?	The culture does not allow me My religion does not allow me I don't have the knowledge to communicate Communicating with them is inappropriate Other specify ________________	1 2 3 4	
Q210	If you think your daughter/son is practicing premarital sex, what would you do?	Advice to stop doing so Advice to use condom Punish him/her They are not my responsibility any more I will advice them to be faithful to one another I can't do any thing Other, specify ___________________ I don't know No response	1 2 3 4 5 6 7 88 99	
Q211	What is the importance of proper and consistent use of condoms?	Protect them from HIV/AIDS Protect them from STIs	1 2	

		Prevent unwanted pregnancy Other specify ________________ I don't know No response	3 4 88 99	
Q212	Do you know how to use condom?	Yes No Do not know No response	12 2 88 99	
Q213	Have you ever advice your son/daughter advice to use condom	Yes No Don't know No response	1 2 88 99	
Q214	Have you ever advice your daughter/son not to take substance (drugs) like khat or alcohol or other drugs in any form	Yes No I don't know No response	1 2 3 4	
Q215	What should be done to postpone first sexual intercourse?	Provide family health education Proper guidance of the family Controlling what they do Other specify________________ I don't know No response	1 2 3 4 88 99	
Q216	Are you willing to give care and support to HIV/AIDS patients	Yes No no response	1 2 99	
Q217	What would you do, if you have HIV/AIDS patient at your home	I will give care for him in private I will throw him of out my house I will separate him/her from my other children I will give care for him like other diseases No response	1 2 3 4 99	
Q218	Do you think your daughter/son confine to you if they faces with a problem of sexuality	Yes No No response	1 2 99	

Q219	Who do you think the appropriate person in the time of like this(Q218)	Parents 1 Other family members 2 Friends 3 Health personnel 4 Other, specify___________ 5 No response 99	
Q220	Is there an organization in your locality that help parents to discuses with their adolescent children about HIV/AIDS and other adolescent needs	Yes 1 No 2 I don't know 88 No response 99	
Q221	If your answer is yes to Q220, have you participated	Yes 1 No 2 No response 99	

Section 3: Model assessment

Questions		Strongly disagree	Disagree	Don't know/not sure	Agree	Strongly agree
Role of family/community in HIV Risk reduction: please indicate if you agree or disagree with the following statements						
Q301	Families/ community can help young adults postpone early sexual intercourse at a young age	1	2	3	4	5
Q302	Families can promote the use of condom among sexually active young adults to reduce the risk of HIV.	1	2	3	4	5
Q303	Families can help young people to reduce their number of sexual partners.	1	2	3	4	5
Q304	Families/community members can help reduce Mother-to child transmission of HIV by promoting VCT and regular ANC follow up.	1	2	3	4	5

Q305	Families can prevent substance use among young adults to reduce the risk behavior that expose them to HIV/AIDS	1	2	3	4	5
Q306	Families can promote the avoidance of unsafe injection and traditional practices their by reduce the risk of HIV/AIDS	1	2	3	4	5
Q307	Forceful sexual intercourse such as rape will increase the risk of getting HIV/AIDS	1	2	3	4	5
Role of family/community in HIV vulnerability reduction: please indicate if you agree or disagree with the following statements						
Q308	Families can positively influence young adults by closely relating to them.	1	2	3	4	5
Q309	Families can promote development good behaviors by supporting peer groups/youth associations.	1	2	3	4	5
Q310	Young people can be protected from unacceptable and risky behaviors if they are allowed to actively participate in family/community affairs.	1	2	3	4	5
Q311	Participation of families in social events together with young adults can help reduce the risky behavior	1	2	3	4	5
Q312	Family support in empowering woman help the vulnerable girls	1	2	3	4	5
Q313	Families/ community members can give care to PLWHA and play major role in stigma reduction	1	2	3	4	5
Q314	Families / community members can help in protecting human right and promoting controlling actions perpetuating HIV/AIDS with in the community	1	2	3	4	5

Q315	Families/community members should take a more active role in improving access to VCT service and educational program to the community	1	2	3	4	5
Role of family/community in HIV impact reduction: please indicate if you agree or disagree with the following statements						
Q316	Families/community members can improve the lives of AIDS orphans by providing them human care.	1	2	3	4	5
Q317	Persons living with HIV/AIDS can participate in any social life of the society.	1	2	3	4	5
Q318	Society should take a more proactive role to prevent rape and other forms of forced sexual intercourse.	1	2	3	4	5
Q319	Families/community members can improve the lives of people living with HIV/AIDS by supporting them.	1	2	3	4	5
Q320	Families/community members can create vocational training opportunity to the affected families by HIV/AIDS.	1	2	3	4	5

Thank you for your cooperation to respond to the questioners. Thank you for your valuable time.

Annex 2 English FGD guide

Introduction

Good morning! Welcome to our group discussion. I am_______________ and I came from ________________ (modulator and note taker introduce themselves). We are here today to discuss about the current major problem of the country, HIV/ AIDS. There is no right or wrong answer. All comments, both positive and negative, are welcome. We would like to have your points of view. We want this to be a group discussion, so you need wait for me to call on you. In order not to miss any points of the discussion, we will be using a tape recorder. Please, speak one at a time so that the tape recorder can pick up every thing. We would like to conform to you that all your comments are confidential and used for research purpose only. Your names will not be recorded to protect your confidentiality. Are you willing to participate in the discussion? Thank you for your willingness.

Points for focus group discussion for the families

General issues about HIV/AIDS

1. Is there a problem regarding HIV/AIDS in your community in general**?** How far is the community aware of the disease? Who are more affected? (Age, occupation, or behavior difference)

Contribution of families in HIV/AIDS prevention and control

2. Are families playing their roles in the fight against HIV/AIDS?

   If yes to this question

   - What are the roles/ contributions played /made? How/ why they manage to contribute?
   - How effective were the contributions? What are the results?
   - What should be made be done to strengthen future involvement?

   If the answer to the Q2 is No

   - What were the reasons not playing the roles? What are the major obstacles to alleviate the problems? Probe knowledge (technical), financial, material, culture or religious matter
   - What roles are believed to be played by families?
   - What should be done to encourage future involvement of families?

3. What should the government do to strengthen the effort of families?

Points for group discussion for community organization

General issues about HIV/AIDS

1. Is there a problem regarding HIV/AIDS in your community in general**?** How far is the community aware of the disease? Who are more affected?

Contribution of communities and CBOs in HIV/AIDS prevention and control

2. Are community organizations planning their roles in the fight against HIV/AIDS?

If the answer to the Q2 is yes**,**

- What are the roles/ contributions played/made?
- How/ why they manage to contribute?
- What should be done to strengthen future involvement?

If the answer to the Q2 is **No,**

- What were the reasons for not playing the roles? (Technical, material or financial)
- What roles are believed to be played by community organization?
- What should be done to encourage future involvement of community organizations?

3. What do you think the major obstacles to alleviate the problems?

Probe knowledge, economic factors, Culture, or religion matters

Annex 3

Structured Interview Guide for Iddir Leader and Iddir Record Review

I. **Background information**

1. Woreda – ___________
2. Kebeles- ____________
3. Name of Iddir -________
4. Years since the iddir was established - ___________
5. Number of members in the iddir- _______________
6. Number of beneficiary to the iddir -______________
7. Type of service provided by iddir

II. **Magnitude of the problem**

1. Is the frequency of burials in the past 3 to 4 years? What do you think is the reason?
2. How many orphans do you have among your iddir members?
3. Number of iddir members died in the past 10 years (record review)
4. Age – sex pattern of iddir members who died in the past 10 years (record review)
    - The age range of members who died in the past 10 years
    - The sex of the members who has died in the past 10 years

III. **Effect mortality on social capital**

1. What are the major problems is your Iddir facing currently? In terms of money, time and other resources
2. Change seen in the amount of deposit ____________
3. Why do you think this change occur__________
4. What are the major solution taken in response to the change you faced?

Annex 4 structured Amharic questionnaires

የአዲስ አበባ ዩኒቨርሲቲ የሕክምና ፋኩልቲ
ኤች.አይ.ቪ/ኤድስን በመከላከልና በመቆጣጠር ላይ
የቤተሰብና የህበረተሰብ ሚና

ለወላጆች የተዘጋጀ መጠይቅ

001 የመጠይቁ መለያ ቁጥር________ከፍተኛ_____ቀበሌ _የቤት ቁጥር______

002 ክልል ኦሮሚያ

003 ከተማ ጅማ

ቃለ መጠይቁ የተጀመረበት ሰዓት _____________ ጠዋት/ከሰዓ በኋላ የተጠናቀቀበት ሰዓት ________ ጠዋት/ከሰዓት በኋላ

	ስም	ቀን	ፊርማ
የቃለ መጠይቁ አቅራቢ			
ሠቆጣጣሪ			
መረጃ ወደ ኮምፒዩተር ያስገባው			

መግቢያ

እንደምን አደሩ/ዋሉ?

ስሜ ______________________________ ሲሆን የመጣሁትም ከአዲስ አበባ ዩኒቨርሲቲ የሕብረተሰብ ጤና ትምህርት ክፍል ነው። ኤች.አይ.ቪ/ኤድስ መከላከልና መቆጣጠር ዙሪያ ስለ ወላጆች ተሳትፎ ልንጠይቅዎ ነው። የዚህ ጥናት ዓላማ በሽታውን ለመቆጣጠር ተገቢ የሆነ የመፍትሔ እርምጃ ለማቀድ የሚረዱ ጠቃሚ የሆኑ መረጃዎችን ለማመንጨት ነው። ስለዚህም የርስዎ ጥያቄዎቹን በሐቀኝነትና በታማኝነት ምላሽ መስጠት ለጥናቱ በጣም ጠቃሚ ነው። የሚነግሩኝ ሀቅ በሚስጢር ይጠበቃል። ስምዎትን አልጠይቅም አልመዘግብም ማንኛውም ሰው እርዎ የነገሩኝን ያውቃል ብለው አይስጉ። መመለስ ያልፈለጉትን ጥያቄ አለመመለስ ይችላሉ። ቃለመጠየቁንም በማንኛውም በፈለጉ ጊዜ ማቋረጥ ይችላሉ።

የቃለመጠይቁ አቅራቢ ጉብኝት

	ጉብኝት 1	ጉብኝት 2	ጉብኝት 3
ቀን			
ቃለመጠይቅ አቅራቢ			
ውጤት			

የውጤቶቹ ኮዶች፤ የተጠናቀቀ 1፣ መልስ ሰጪ ቤት የሉም 2፣ መልስ መስጠት አልፈለጉም 3፣ በከፊል ተጠናቋል 4

ማሳሰቢያ፣

እባክዎትን በእያንዳንዱ መልስ መስጫ ወረቀት ላይ እንደሚከተለው ይሞላ

ቃለ መጠይቁ የተጀመረበት ሰዓት

ቃለመጠይቁ የተጠናቀቀበት ሰዓት

ክፍል 1፣ አጠቃላይ ሁኔታ

መለያ ቁጥር -------

ተ.ቁ	ጥያቄዎችና ማጣሪያዎች	አማራጭ ኮዶች		ወደ-እለፍ
ጥ101	የመልስ ሰጪው ቤተሰባዊ ሁኔታ	አባት	1	
		እናት	2	
		ሌላ (ይገለጽ) -------------	3	
ጥ102	ዕድሜዎ ስንት ነው?	------- ዓመት (ያጠናቀቁትን ዓመት ይፃፍ)	1	
		አላውቅም	88	
		መልስ አልመለሱም	99	
ጥ103	ሃይማኖትዎ ምንድን ነው?	ኦርቶዶክስ	1	
		ካቶሊክ	2	
		ፕሮቴስታንት	3	
		እስላም	4	
		ሃይማኖት የላቸውም	5	
		ሌላ (ይጠቀስ) ------------	6	
		መልስ አልመለሱም	99	
ጥ104	ለመማር ትምህርት ቤት ገብተው ያውቃሉ?	አዎ	1	
		አይ	2	→ጥ106
		መልስ አልመለሱም	99	
ጥ105	የትምህርት ደረጃዎን እስከምን አጠናቀዋል? (ከፍተኛውን የትምህርት ደረጃ ይመዝግቡ)	ማንበብና መፃፍ	1	
		1ኛ - 4ኛ ክፍል	2	
		5ኛ - 8ኛ ክፍል	3	
		9ኛ - 12ኛ ክፍል	4	
		ከ12ኛ ክፍል በላይ	5	
		መልስ አልመለሱም	99	
ጥ106	የየትኛው ብሄረሰብ ተወላጅ ነዎት?	አማራ	1	
		ኦሮሞ	2	
		ትግሬ	3	
		ጉራጌ	4	
		ከፋ	5	
		ኩሎ	6	
		የም	7	
		ሌላ (ይገለጽ) -----------------------	8	
		መልስ አልመለሱም	99	
ጥ107	ሥራዎ ምንድን ነው?	የጉልበት ሰራተኛ	1	
		የመንግስት ሰራተኛ	2	
		የግል ሥራ	3	
		የቤት እመቤት	4	
		ለግል ድርጅት ተቀጥረው የሚሠሩ	5	
		ሌላ (ይገለጽ)	6	
		መልስ አልመለሱም	99	

ጥ108	የቤተሰብዎ አማካይ የወር ገቢ ምንያህል ነው?	የገቢ መጠን በብር ----------------- አላውቅም መልስ አልመለሱም	1 88 99	
ጥ109	ቤትዎን ተከራይተው ነው የሚኖሩት?	አዎን አይደለም መልስ አልመለሱም	1 2 99	
ጥ110	በአሁኑ ወቅት የጋብቻዎ ሁኔታ ምንድን ነው ?	ያገባ (አንድ) ያገባ (ከአንድ በላይ) ያላገባ (ጭራሽ ያላገቡ) የሞተባት/የሞተችበት የተፋቱ/የተለያዩ	1 2 3 4 5	
ጥ111	የቤተሰብ ብዛት በቁጥር	---------------------------		
ጥ112	ስንት ልጆች አለዎት? ለአቅመ አዳም/ሄዋን የደረሱት ልጆች (ከ12-24 ዓመት) ቁጥራቸው ይጻፍ	ወንድ --------------- ሴት ----------------- ድምር ----------------		
ጥ113	በአሁኑ ወቅት ጫት ይጠቀማሉ?	አልጠቀምም በየቀኑ አንድ ሁለት ጊዜ በሳምንት ከአንድ እስከ ሶስት ጊዜ በወር መወር ከአንድ ጊዜ በታች መልስ ለመስጠት አልፈለጉም	0 1 2 3 4 99	
ጥ114	በአሁኑ ጊዜ ትምባሆ (ሲጋራ) ያጨሳሉ /ይጎርሳሉ?	አልጠቀምም በየቀኑ አልፎ አልፎ መልስ መስጠት አልፈለጉም	0 1 2 99	
ጥ115	ጠላ፣ ጠጅ፣ አረቄና ቢራ የመሳሰሉትን የአልኮል መጠጦችን በምን ያህል ጊዜ ይጠቀማሉ?	ተጠቅሜ አላውቅም በየቀኑ አንድ/ሁለት ጊዜ በሳምንት በወር ከ1-3 ጊዜ አልፎ አልፎ (በወር ከ1 ጊዜ በታች) መልስ መስጠት አልፈለጉም	0 1 2 3 4 99	

ክፍል 2፣ ከኤች.አይ.ቪ/ኤድስ ጋር የተያያዘ ግንዛቤ፣ ዝንባሌ፣ አመለካከትና ተግባር

ተ.ቁ	*ጥያቄዎችና ማጣሪያዎች*	*አማራጭ ኮዶች*		*ወደ-እለፍ*
ጥ201	በኤች.አይ.ቪ የተያዘ ወይም በኤድስ የሞተ ሰው ያውቃሉ?	አዎን አይ መልስ ለመስጠት አልፈለጉም	1 2 99	
ጥ202	ሰዎች ከኤች.አይ.ቪ አድስ ራሳቸውን እንዴት ይጠብቃሉ?	ከግብረ ስጋ ግንኙነት በመታቀብ አንድ ለአንድ በመወሰን	1 2	

		ኮንደምን በአግባቡ በመጠቀም	3	
		በኤድስ የተያዙ ሰዎችን በአካል ባለመንካት	4	
		ደምን አለመጠቀም	5	
		በቫይረሱ የተበከለ መሣሪያ በጋራ አለመጠቀም	6	
		ሌላ (ይገለጽ) ---------------------------------	7	
		መልስ ለመስጠት አልፈለጉም	99	
ጥ203	ምን ምን የመተላለፊያ መንገዶችን ያውቃሉ ?	በግብረ ሥጋ ግንኙነት	1	
		በእርግዝና ጊዜ ከእናት ወደ ልጅ	2	
		በወሊድ ጊዜ ከእናት ወደ ልጅ	3	
		ጡት ማጥባት ጊዜ ከእናት ወደ ልጅ	4	
		በተበከሉ መሳሪያዎች	5	
		የተበከለ ደም በመዉሰድ	6	
		ሌላ (ይገለጽ)-------------	7	
		አላውቅም	88	
		መልስ መስጠት አልፈለጉም	99	
204	ከኤች.አይ.ቪ ቫይረስ ጋር ለሚኖሩ ሰዎች ምን አይነት አመለካከት አለዎት?	በማህበራዊ ህይወት ውስጥ እንዲሳተፉ አበረታታለሁ	1	
		በቤት ውስጥ እንክብካቤና ድጋፍ በማድረግ እረዳቸዋለሁ	2	
		ለብቻቸው ተገልለው መቀመጥ አለባቸው	3	
		ከእነሱ ጋር ምንም አይነት መነካካት አልፈልግም	4	
		ሌላ (ይገለጽ) --	5	
		አላውቅም	88	
		መልስ ለመስጠት አልፈለጉም	99	
ጥ205	ወላጆች እራሳቸውንና ልጆቻቸውን ከኤች.አይ.ቪ/ኤድስ የመጠበቅ ኃላፊነት አለባቸው ብለው ያምናሉ?	አዎን	1	
		አይ	2	
		አላውቅም	88	
ጥ206	ከልጆችዎ ጋር ስለ ኤች.አይ.ቪ/ኤድስ ተወያይተው ያውቃሉ?	አዎን	1	
		አይ	2	
		መልስ ለመስጠት አልፈለጉም	99	
ጥ207	ከልጆችዎ ጋር ስለ ግብረ ሥጋ ግንኙነትና ስለሚያስከትላቸው ችግሮች ተወያይተው ያውቃሉ?	አዎን	1	
		አይ	2	→ጥ209
		መልስ ለመስጠት አልፈለጉም	99	
ጥ208	ለጥያቄ 207 አዎን ከመለሱ በምን ያህል ጊዜ ይወያያሉ?	መተቸገረ/ች በማንኛውም ጊዜ	1	
		መናገር በፈለጉ ጊዜ ሁሉ	2	
		በየቀኑ	3	
		ቢያንስ በሳምንት አንድ ጊዜ	4	
		ሌላ (ይገለጽ) -------------------	5	
ጥ209	ለጥያቄ 207 አይደለምን ከመለሱ ላለመወያየትዎ ምክንያቱ ምንድን ነበር?	ባህሉ አይፈቅድልኝም	1	
		ሃይማኖቴ አይፈቅድልኝም	2	
		የማወያየት እውቀቱ የለኝም	3	
		ከነሱ ጋር መነጋገር ተገቢ አይደለም	4	
		ሌላ (ይገለጽ) ----------------------------------	5	

ጥ210	ለአቅመ አዳምና ሄዋን የደረሱ ልጆችዎ ከጋብቻ በፊት የግብረ ሥጋ ግንኙነት እንደሚያደርጉ ከገመቱ ምን ያደርጋሉ?	ድርጊቱን እንዲያቆሙ እመክራለሁ ኮንዶም እንዲጠቀሙ እመክራለሁ እቀጣቸዋለሁ ከቤት አባርራቸዋልሁ አንድ ለአንድ አበረው እንዲኖሩ እመክራቸዋለሁ ምንም ማድረግ አልችልም ሌላ (ይገለጽ) --------------------------------------- መልስ ለመስጠት አልፈቀዱም	1 2 3 4 5 6 7 99	
ጥ211	ኮንዶምን ሁል ጊዜና በአግባቡ መጠቀም አስፈላጊነቱ ምንድን ነው?	ከኤች.አይ.ቪ ለመጠንቀቅ ከአባላዘር በሽታዎች ለመከላከል ያልተፈለገ እርግዝናን ለመከላከል ሌላ (ይገለጽ) ---------------------------------- አላውቅም መልስ ለመስጠት አልፈቀዱም	1 2 3 4 88 99	
ጥ212	ስለ ኮንደም አጠቃቀም ያውቃሉ ወይ	አዎን አይ አላውቅም መልስ ለመስጠት አልፈቀዱም	1 2 88 99	
ጥ213	ለአቅመ አዳምና ሄዋን የደረሱ ልጆችዎ ኮንዶምን እንዲጠቀሙ መክረው ያውቃሉ?	አዎን አይ መልስ ለመስጠት አልፈቀዱም	1 2 99	
ጥ214	ልጆችዎን እንደ ጫት፣ አልኮልና ሌሎች አደንዛዥ እፆችን በማንኛውም መልኩ እንዳይወስዱ መክረው ያውቃሉን?	አዎን አይ መልስ መስጠት አልፈቀዱም	1 2 99	
ጥ215	የመጀመሪያ የግብረ ሥጋ ግንኙነት የማድረጊያ ጊዜን ለማቆየት ምን መደረግ አለበት ብለው ያስባሉ?	ለቤተሰብ የጤና ትምህርት መስጠት ሔተሰብን በአግባቡ መምራት ልጆቹ የሚያደርጉትን መቆጣጠር አላውቅም መልስ መስጠት አልፈቀዱም ሌላ (ይገለጽ) -------------------------------	1 2 3 88 99	
ጥ216	ለኤች አይቪ ኤድስ ታማሚዎች ድጋፍና እንክብካቤ ለመስጠት ፈቃደኛ ኖት?	አዎን አይ መልስ መስጠት አልፈቀዱም	1 2 99	
ጥ217	በቤትዎ ውስጥ የኤድስ በሽተኛ ቢኖር ምን ያደርጋሉ?	ምጥንቃቄ ደብቄ አስታምመዋለሁ ከቤቴ አስወጣዋለሁ/ታለሁ ከጤነኞች ልጆቼ ጋር እንዳይገናኝ አደርጋለሁ እንደማንኛውም በሽተኛ አስታምመዋለሁ መልስ መስጠት አልፈቀዱም		
ጥ218	ወጣት ልጅዎ የሥነ ተዋልዶ ችግር ቢገጥማት እርስዎን መጥታ የምታማክሮዎት ይመስልዎታል?	አዎን አይ መልስ መስጠት አልፈቀዱም	1 2 99	

ጥ219	ለጥያቄ 218 መልስዎ አይ ከሆነ ይህንን መሳይ ችግር ለማማከር ተገቢ ሰው ማን ነው ብለው ያምናሉ?	ወላጅ ሌላ ቤተሰብ ጓደኛ የጤና ባለሙያ ሌላ ካለ ይገለጽ ---------------------- መልስ መስጠት አልፈቀዱም	1 2 3 4 5 99	
ጥ220	በአካባቢያችሁ ወላጆች ከወጣት ልጆቻቸው ጋር እንዴት በኤች አይቪ ዙሪያ ውይይት እንዲያደርጉ ትምህርት የሚሰጥ ድርጅት አለ?	አዎን አይ መልስ መስጠት አልፈቀዱም	1 2 99	
ጥ221	ለጥያቄ 220 መልሱ አዎን ከሆነ በትምህርቱ ተሳትፈው ያውቃሉ?	አዎን አይ መልስ መስጠት አልፈቀዱም	1 2 99	

መለያ ቁጥር --------------

ክፍል 3፣ የመገምገሚያ ሞዴል

ጥያቄዎች		በጣም አልስማማም	አልስማማም	እርግጠኛ አይደለሁም	እስማማለሁ	በጣም እስማማለሁ
ለኤች.አይ.ቪ/ኤድስ አጋላጭ መንስኤዎችን ለመቀነስ የቤተሰብና የሕብረተሰብ ሚና (በሚከተሉት ሃሳቦች መስማማትዎን/አለመስማማትዎን ይግለጹ)						
ጥ301	ወጣት ወንዶች/ሴቶች በለጋ ዕድሜያቸው የግብረሥጋ ግንኙነት እንዳያደርጉ ቤተሰብና ሕብረተሰቡ ሊረዱ ይችላሉ	1	2	3	4	5
ጥ302	ቤተሰቦች ኤች.አይ.ቪን ለመከላከል ወጣቶች ኮንዶምን እንዲጠቀሙ ሊያበረታቱ ይችላሉ	1	2	3	4	5
ጥ303	ቤተሰብ ወጣት ልጆቻቸውን ብዙ የወሲብ ጓደኞች እንዳይኖራቸው ሊረዱዋቸው ይችላሉ	1	2	3	4	5
ጥ304	የቤተሰብ/የሕብረተሰቡ አባላት የኤች.አይ.ቪ ቫይረስ ከእናት ወደ ልጅ መተላለፍን ለመቀነስ በፍቃደኝነት ላይ የተመሰረተ የደም ምርመራና ተከታታይ የሆነ የእርግዝና ክትትልን እንዲያደርጉ በማበረታታት ሊረዱዋቸው ይችላሉ	1	2	3	4	5
ጥ305	ቤተሰብ ለኤች.አይ.ቪ. ኤድስ አጋላጭ የሆኑ ባህርያትን ለመቀነስ ወጣቶች የተለያዩ እፆችን እንዳይጠቀሙ ሊከላከሉ ይችላሉ	1	2	3	4	5
ጥ306	ቤተሰብ ጥንቃቄ የሌለው መርፌ እና ጎጂ ልማዳዊ ተግባራትን በማጥፋት ለኤች.አይ.ቪ/ኤድስ አጋላጭ	1	2	3	4	5

	የሆኑ መንስኤዎችን የመቀነሱን ሂደት ሊያበረታቱ ይችላሉ					
ጥ307	በጉልበት የግብረሥጋ መፈጸም /አስገድዶ መድፈር/ በኤች.አይ.ቪ/ኤድስ የመያዝን ዕድል ከፍ ሊያደርጉ ይችላሉ	1	2	3	4	5
ለኤች.አይ.ቪ ተጋላጭነት መቀነስ የቤተሰብ/ሕብረተሰብ ሚና (በሚከተሉት ሃሳቦች መስማማትዎን ወይም አለመስማማትዎን ይግለጹ)						
ጥ308	ወላጆች ወጣት ልጆቻቸውን ወደራሳቸው በማቅረብ አዎንታዊ ጫና በልጆቻቸው ላይ ማሳደር ይችላሉ	1	2	3	4	5
ጥ309	ቤተሰብ የአቻ ቡድኖችን /ወጣት ማህበራትን በመደገፍ የበጎ ባሕሪያት እድገትን በወጣቶች ላይ ሊያበረታቱ ይችላሉ	1	2	3	4	5
ጥ310	ወጣቶች በቤተሰብ/በማሕበረሰብ ጉዳዮች ላይ በንቃት እንዲሳተፉ ብንፈቅድላቸው ተገቢ ካልሆንና አጋላጭ ከሆኑ ባሕርያት ሊጠበቁ ይችላሉ	1	2	3	4	5
ጥ311	የቤተሰብ በማህበራዊ ጉዳዮች ከወጣቶች ጋር መሳተፍ አጋላጭ የሆኑ ባህርያትን መቀነስ ይችላሉ	1	2	3	4	5
ጥ312	ለወጣት ሴቶች ልጆች የሚደረገው ልዩ ድጋፍ ለኤች.አይ.ቪ ሊጋለጡ የሚችሉትን ሴቶች ልጆች ከኤች አይቪ ኤድስ ይታደጋቸዋል	1	2	3	4	5
ጥ313	የቤተሰብ/የሕብረተሰቡ አባላት ከኤች.አይ.ቪ/ኤድስ ጋር ለሚኖሩ ሰዎች እንክብካቤ ቢያደርጉ መገለልንና አድልዎን በመግታት ረገድ ከፍተኛ ሚና ይጫወታሉ	1	2	3	4	5
ጥ314	የቤተሰብ/የሕብረተሰቡ አባላት የሰው ልጅ መብት በማስጠበቅ ሊረዱና ኤች.አይ.ቪ/ኤድስን ለመቆጣጠር በማህበረሰቡ ውስጥ የሚወሰዱ እርምጃዎችን ሊያበረታቱ ይችላሉ	1	2	3	4	5
ጥ315	የቤተሰብ/የሕብረተሰቡ አባላት በፍቃደኛነት ላይ የተመሰረተ የደም ምርመራ አገልግሎት አቅርቦትንና በሕብረተሰቡ ውስጥ ትምህርታዊ ፕሮግራሞችን ለማሻሻል የበለጠ ሚና ሊጫወቱ ይገባል	1	2	3	4	5
ኤች.አይ.ቪ የሚያስከትለው ተጽዕኖ በመቀነስ ረገድ የቤተሰብ/የሕብረተሰብ ሚና (በሚከተሉት ሃሳቦች መስማማትዎን/አለመስማማትዎን ይግለጹ)						
ጥ316	የቤተሰብ/የሕብረተሰብ አባላት በኤድስ ወላጆቻቸውን ያጡ ህፃናትን ሕይወት ሰብዓዊ እንክብካቤ እርዳታ በማድረግ የሕጻናቱን ሕይወት ሊያሻሽሉ ይችላሉ	1	2	3	4	5
ጥ317	ከኤች.አይ.ቪ ጋር የሚኖሩ ሰዎች በማህበረሰቡ ውስጥ በማንኛውም ማህበራዊ ሕይወት ሊሳተፉ ይችላሉ	1	2	3	4	5
ጥ318	ማህበረሰቡ አስገድዶ መድፈርን በመከላለሉ ረገድ ከፍተኛ ሚና ሊጫወት ይገባል	1	2	3	4	5
ጥ319	የቤተሰብ/የሕብረተሰቡ አባላት ከኤች.አይ.ቪ/ኤድስ ጋር	1	2	3	4	5

	የሚኖሩ ሰዎችን በማገዝ ሕይወታቸውን ሊያሻሽሉ ይችላሉ					
ጥ320	የቤተሰብ/የሕብረተሰቡ አባላት በኤች.አይ.ቪ/ኤድስ ለተጠቁ ቤተሰቦች የሙያ ስልጠና ዕድል ሊፈጥሩ ይችላሉ	1	2	3	4	5

መጠይቁ እዚህ ላይ ያበቃል

ጊዜዎን ሰውተው ጥያቄውን በመመለስ ላደረጉልን ትብብር እናመሠግናለን

Annex 5: Amharic FGD Guide

የጋራ መወያያ ነጥቦች

በጋራ ውይይቱን የሚያወያየው ቡድን ከሚከተሉት የማህበረሰብ አካላት የተውጣጡ ናቸው።

- **ወላጆች**
- **ወጣቶች** (**ከትምህርት ቤትና / ከትምህርት ቤት ውጪ ያሉ**)
- **የዕድር ሰብሳቢዎች**
- **የማህበር መሪዎች**
- **የሃይማኖት አባቶች**
- **የቀበሌ ሃላፊዎች**
- **የክለብ አባላት** (**ለምሳሌ፣ የፀረ-ኤድስ**)
- **ሌሎች ህብረተሰቡ ውስጥ ያሉ ሃሳብ ሰጪዎች** (**አማካሪዎች፣ ያገር ሽማግሌዎች**)

<u>በጋራ ውይይቱ ወቅት ለቤተሰብ የሚቀርቡ የውይይት ነጥቦች</u>

1. **በአጠቃላይ ማህበረሰባችሁ ላይ ኤች.አይ.ቪ/ኤድስን የተመለከተ ችግር አለ**? **ማህበረሰቡ ኤች.አይ.ቪ/ኤድስን በተመለከተ ምን ያህል ያውቃል**? **በበሽታው በጣም የተጠቁት እነማን ናቸው**?
2. **ቤተሰብ ኤች.አይ.ቪ/አድስን ለመዋጋት የራሳቸው ሚና እየተወጡ ነው**?

   መልሱ አዎ ከሆነ

   - **የቤተሰቡ ሚና** (**ተሳትፎ**) **እስካሁን ያከናወኑት ተግባር ምንድን ነው**? **ለምንና እንዴት ሊያከናውኑ ቻሉ**?
   - **ተሳትፎአቸው ምንያህል ስኬታማ ነበር** ?**ውጤቱ ምንድን ነው**?
   - **ለወደፊቱ የቤተሰብ ተሳትፎ እንዲጨምር ምን መደረግ አለበት**?

   መልሱ አይ ከሆነ

   - **የየራሳቸውን ሚና ያልተወጡበት ምክንያት ምንድን ነው**? **ችግሩን ለማቃለል የከለከሉት ምክንያቶች ምንድን ናቸው**? (**የገንዘብ የቁሳቁስ፣ የባህል ወይም የሀይማኖች ጉዳይ**)
   - **ቤተሰብ ምን አይነት ሚና ሊኖረው ይችላል ተብሎ ይገመታል**?
   - **ቤተሰብ ለወደፊት የራሳቸውን ሚና በተጠናከረ መልክ እንዲወጡ ምን መደረግ አለበት**?

3. **መንግስት**/ **መንግስታዊ ያልሆኑ ድርጅቶች የቤተሰብን ጥረት** (**ሚና**) **ለማጎልበት ምን ማድረግ አለበት**? (**ከመንግስት**/ **መንግስታዊ ካልሆኑ ድርጅቶች ምን ይጠበቃል**?)

<u>በጋራ ውይይቱ ወቅት ማህበረሰብ ለሚያቋቁማቸው ማህበሮች (ድርጅቶች) የሚቀርቡ የዉይይ ት ነጥቦች</u>

1 በአጠቃላይ ማህበረሰባችሁ ላይ ኤች.አይ.ቪ/ኤድስን የተመለከተ ችግር አለ? ማህበረሰቡ ኤች.አይ.ቪ/ኤድስን በተመለከተ ምን ያህል ያውቃል? በበሽታው በጣም የተጠቁት እነማን ናቸው?

2 የማህበረሰቡ ድርጅቶች (የህብረት ማህበሮች) ኤድስን ለመዋጋት ለሚያደርጉት ሚና እቅድ እራሳቸው ያወጣሉን?

መልሱ አዎ ከሆነ

- ሚናቸውና የሚከናውኑት ተግባር ምንድን ነው?
- ምንና እንዴት ሊያከናውኑት ቻሉ?
- ለወደፊቱ ተሳትፎአቸው እንዲጨምር ምን መደረግ አለበት?

መልሱ አይ ከሆነ

- ሚናቸውን ያልተወጡበት ዋንኛ ምክንያቶች ምንድን ናቸው? (እንዲመልሱ መገፋፋት (ማበረታታት))
- ማህበራቶቹ ምን አይነት ሚና እየተጫወቱ ነው ተብሎ ይገመታል ?
- ማህበራቶቹ ለወደፊት እንዲሳተፉ ምን መደረግ አለበት?

3 ችግሮቹን እንዳይቃለሉ የሚያስቸግሩ እንቅፋቶች ምንድን ናቸው? (እንዲመልሱ መገፋፋት (ማበረታታት)) /የኢኮኖሚ ችግሮች ነዉን?፣ የባህል ጉዳዮች ነዉን?፣ የሃይማኖት ጉዳዮች ነዉን?)

Annex 6 Structure Amharic interview guide for *iddir* leaders and *iddir* review recodes

1. እድራችሁ መቼ ተመሠረተ?
2. እድራችሁ ምን ዓይነት አገልግሎት ይሰጣል?
3. ባለአለፉት 3-4 አመታት ውስጥ ቀብር ጨምሯል ብለው ያስባሉ? መክንያቱ ምን የምስሎታል?
4. ምን ያህል እናትና አባት ያጡ ህፃናቶች በእድር ውስጥ አሏችሁ?
5. እድራችሁ ምን ዓይነት ችግር ገጥሞታል?
6. በዕድሩ ተቀማጭ ገንዘብ ላይ ያለ ለውጥ አለን ? ለለውጡ ምከንያቱ ምንድ ነው ብላችሁ ታስባላችሁ?
7. እድሩ ምን የማሻሻያ እርምጃዎች አድርጎአል?

<u>በጋራ ውይይቱ ወቅት ማህበረሰብ ለሚያቋቋማቸው ማህበሮች (ድርጅቶች) የሚቀርቡ የዉይይ ት ነጥቦች</u>

1 በአጠቃላይ ማህበረሰባችሁ ላይ ኤች.አይ.ቪ/ኤድስን የተመለከተ ችግር አለ? ማህበረሰቡ ኤች.አይ.ቪ/ኤድስን በተመለከተ ምን ያህል ያውቃል? በበሽታው በጣም የተጠቁት እነማን ናቸው?

2 የማህበረሰቡ ድርጅቶች (የህብረት ማህበሮች) ኤድስን ለመዋጋት ለሚያደርጉት ሚና እቅድ እራሳቸው ያወጣሉን?

መልሱ አዎ ከሆነ

- ሚናቸውና የሚከናወኑት ተግባር ምንድን ነው?
- ምንና እንዴት ሊያከናውኑት ቻሉ?
- ለወደፊቱ ተሳትፎአቸው እንዲጨምር ምን መደረግ አለበት?

መልሱ አይ ከሆነ

- ሚናቸውን ያልተወጡበት ዋንኛ ምክንያቶች ምንድን ናቸው? (እንዲመልሱ መገፋፋት (ማበረታታት))
- ማህበራቶቹ ምን አይነት ሚና እየተጫወቱ ነው ተብሎ ይገመታል ?
- ማህበራቶቹ ለወደፊት እንዲሳተፉ ምን መደረግ አለበት?

3 ችግሮቹን እንዳይቃለሉ የሚያስቸግሩ እንቅፋቶች ምንድን ናቸው? (እንዲመልሱ መገፋፋት (ማበረታታት)) /የኢኮኖሚ ችግሮች ነዉን?፣ የባህል ጉዳዮች ነዉን?፣ የሃይማኖት ጉዳዮች ነዉን?)