The Situations of HIV/AIDS Infected and Affected People in Dessie Town, Amahara Regional State, Ethiopia

By
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A Thesis Submitted to the Research and Graduate Programs of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master in Social Work (MSW)

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ACRONYMS

AACs	Anti AIDS Clubs
ART	Anti Retroviral Therapy
ARV	Anti Retro Viral
ASRH	Adolescent Sexual Reproductive Health
BCC	Behavioral Change Communication
CBOs	Community Based Organizations
EECMY	Ethiopian Evangelical Church Mekane Yesus
FBOs	Faith Based organizations
FHI	Family Health International
FSCE	Forum for street children Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
IEC	Information Education and Communication
IGA	Income generating activities
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
NGO	Non Governmental organization
OSSA	Organization for Social Services for AIDS
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV/AIDS
RH	Reproductive Health
SCUK	Save the Children United Kingdom
SRH	Sexual and reproductive health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UNAIDS	United Nations joint program on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
ZOA	ZOA refugee care

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ABSTRACT

The population structure of *Dessie* town is one of the main towns in *Amahara* regional state of Ethiopia where the young constitutes the largest proportion. The situation of **HIV/AIDS** in the region is one of the worst is the country with persistently high prevalence. It is estimated about three thousand HIV/AIDS infected people are found and Orphans and vulnerable children (OVC) are considered some of the groups most heavily affected by the HIV/AIDS pandemic in the town. A combination of quantitative and qualitative methods was used to investigate the situations of **HIV/AIDS** infected and affected people in the town. For the quantitative part, survey questionnaire was utilized, and focused group discussion as well as key informant interview was used to collect qualitative data. Both qualitative and quantitative findings show that there is luck of sufficient access to basic services like food, health care, Shelter, education and economic support for **HIV/AIDS** infected and affected people in the town. There is lack of coordination of efforts and resources among the stakeholders. Programs and projects have also been identified as being developed without studies and response analysis of the beneficiaries. Therefore, the study findings suggest the recommendations basically the coordination, follow up and control of **HIV/AIDS** activities in Dessie town should be strengthened.

1. INTRODUCTION

According to UNAIDS, globally there are more than 40 million people infected with HIV/AIDS. Sub-Saharan Africa is the region of the world that is most affected by HIV and AIDS. An estimated 25.4 million people are living with HIV and approximately 3.1 million new infections occurred in 2004. In just the past year, the epidemic has claimed the lives of an estimated 2.3 million people in this region. Around 2 million children under 15 are living with HIV and more than twelve million children have been orphaned by AIDS (UNAIDS, 2OO4).

The extent of the epidemic is only now becoming clear in many African countries, as increasing number of people living with HIV are now becoming ill. In the absence of massively expanded prevention, treatment and care efforts, the AIDS death toll on the continent is expected to continue rising before peaking around the end of the decade. This means that the worst of the epidemic's impact on these societies will be felt in the course of the next ten years and beyond. Its social and economic consequences are already being felt widely not only in health but also in education, industry, agriculture, transport, human resources and the economy in general.

The HIV/AIDS situation in Ethiopia has evolved from two reported cases in 1986 to cumulative total of 147,000 by mid 2003, but the vast majority is unreported and many more died unnoticed and unaided. The cumulative number of people living with HIV/AIDS is about 1.5 million, out of which about 96,000 are Children under age 15 years. The estimated number of new AIDS cases in the adult population in 2003 was 98,000 (46% male and 54% female). This is a staggering number to cope with for the resources of poor country. Results in the last few years indicate some encouraging

progress that the epidemic going at lower rate; however, the rate of change is not sufficient to be complacent (MOH, 2004b).

Currently in Ethiopia, four million children are estimated to be orphans (having lost one or both parents) out of whom 720,000 have lost their parents due to AIDS. This means that 11% of all children in Ethiopian are orphans, a rate that is estimated to remain the same in the coming decade (UNAIDS, 2004).

1.2 STATEMENT OF THE PROBLEM

Behavioral surveillance survey (BSS), a second-generation surveillance tool, was introduced in Ethiopian in 2001 to complement the extensive sero-prevalence and HIV surveillance system instituted nationally (HAPCO, 2002). Several recent surveys including the BSS have indicated a high level of awareness for HIV/AIDS. However, strong evidence for actual change in behavior is lacking. Nearly two out of three young people out of school reported that they are sexually active and had sex with two or more partners and significant proportion of young people do not always use condoms with non-regular partners, though they knew condoms protect from HIV/ADIS (HAPCO, 2002).

According to the Amhara HIV/AIDS Prevention and Control Office annual report of 2004, the situation of HIV/AIDS in the Amhara region is one of the worst in the country with persistently high prevalence, particularly in the urban area. Even though there is no study showing reasons for this great variation between the national and regional figures, there are some speculations like high rate of poverty, drought and famine, illiteracy, unemployment, rural to urban migration, silence about HIV/ADIS among family members, harmful traditional practices like early marriage and female

genital mutilation, and societal practices like polygamy that are highly prevalent in the region to be the possible causes. The report also showed that orphans and vulnerable Children (OVC) are considered some of the groups most heavily affected by the HIV/AIDS pandemic that has hit Ethiopia, leaving children and families in a vulnerable position, requiring both short and long-term interventions that will address the growing needs (Amhara Regional HAPCO, 2004).

The population structure of Dessie is typical of developing countries where the young constitutes the largest proportion. In the same regional report, it is indicated that addressing the issue of HIV/AIDS exclusively as a health problem, limiting the task of combating the spread and the impact of the disease to the role of the government and a few other actors using conventional approaches are ineffective. Government and human service organizations have been undertaking several interventions to prevent the spread of HIV/AIDS. However, most activities are inadequate poorly coordinated and poorly targeted (Amhara Regional HAPCO, 2004).

Therefore, this research writer has taken the initiative to conduct a study on the situations of HIV /AIDS affected and infected persons in Dessie town in order to make recommendations for future intervention and coordinate the responses being made by different stakeholders.

1.3 OBJECTIVES OF THE STUDY

The study has the following specific objectives:

1. To indicate the risk and vulnerability factors to HIV/AIDS among the population and the main modes of transmission in Dessie town.

2. To assess the socioeconomic situation of orphans and PLWHA, stigma and discrimination, and the availability and accessibility of support and services.
3. To identify the existing and planned HIV/AIDS prevention, care and mitigation response by different stakeholders (e.g. government organization, FBOs, CBOs, NGOs).
4. To identify gaps that may exist and recommend future interventions.

1.4 METHODOLOGY

1.4.1 Study Area and Population

Dessie is capital of South *Wollo* zone in the Amhara regional state, located 400km northeast of Addis Ababa with an altitude of 2600m. Dessie is currently structured as a city administration with a population of 210,000 and constituted of 20 *kebeles* (Dessie Town Trade, Industry and Investment Expansion and Coordinating Office, 2005).

According to Dessie Woreda Health Office, the town has one referral hospital, one health center and 3 health stations owned by government, and 19 private clinics of various categories. There are also seven pharmacies, two drug stores and four drug vendors in the town. Geographic health services coverage of the town is 100%. The population structure of Dessie is typical of developing countries where the young constitutes the largest proportion.

There are more than 136 *Idirs* in Dessie and among these 115 form a coalition known as "General *Idir's* Association", at the city level and they are actively participating in different development endeavors and in prevention and controlling HIV/AIDS with the government and other development partners including NGOs.

According to a senior HIV/AIDS counselor in the Dessie hospital, the first AIDS case was diagnosed in Dessie in September 1991; just 5 years after the first two cases were notified for the first time in the country in 1986 (Eshete and Sahlu, 1996). There is no recorded document that tells the estimates of people living with HIV/AIDS (PLWHA) in Dessie. However, the head of Dessie HAPCO told that it is estimated that 30,000 PLWHA living in Dessie town.

1.4.2 Sample Size and Sampling

Sample size was determined by using the sample size specification method for random sampling of quantitative variables from the population. The total sample size was 50 consisting of 25 AIDS orphans and 25 PLWHAs. As this study focuses mainly on the situations of HIV/AIDS affected and infected people, the researcher selected all respondents from PLWHA and orphans in simple random sampling. There are twenty *kebeles* in Dessie and two respondents (one PLWHA and one orphan) from each *kebele* were selected. A household was picked based on the set interval and a first encounters PLWHA and/or orphan was interviewed in each household. It also identified four key informants from different organizations working directly in tackling the HIV/AIDS problem in the town. Totally twenty focus group participants who are selected ten from PLWHA and ten AIDS orphan children. For this research totally 74 respondents were participated.

1.4.3 Data Collection and Analysis

Data collection was done during March 1st to 10, 2006. The data was collected from people living with HIV/AIDS (PLWHA), AIDS orphans an some selected human

service organizations managers as well as from the town HIV/AIDS Prevention and Control Office (HAPCO). For the quantitative data collection, a comprehensive questionnaire was developed and translated into Amharic language. It was pre-tested to ensure the clarity of the questions and their appropriateness with regard to social and cultural norms of the area. Comments from the pretest were incorporated and the final version was duplicated. The questionnaire has two parts: a part to be filled only by OVC and another part to be filled only by PLWHA (Annex 1&2). In the questionnaires, it was attempted to obtain the information about the respondents' demographic characteristics. The questions also obtained the information about the current situations of AIDS orphans and PLWHA and their problems as well as the availability of care and support services. To assure the quality of data, the researcher directly participated in collecting the data from all respondents.

Qualitative data was collected from two sources: from focus group discussions and from key informant interviews. In both cases, outlines (Annexes 3 and 4) were prepared. The researcher conducted two focus group discussions (FGD) and four key informant interviews. In the FGD, some selected active respondents from PLWHA and orphans were included in order to capture their collective idea and attitude towards the provision of care and support conducting by different human service organizations and government bodies in the town. The FGD participants were selected among the registered PLWHA and AIDS orphan beneficiaries of OSSA who are not participated in the survey questionnaire interviews. Each FGD had ten participants. The information about the current and planned interventions was also gathered from different human service organizations working directly or indirectly on HIV/AIDS, management of STI and

reproductive health services. The key informants were HIV/AIDS Prevention and Control Office (HAPCO) Dessie Branch, Organization for Social Service for AIDS (OSSA), Anti-AIDS club and Health Offices. The discussion was conducted with the head and other relevant people of the organizations. Relevant written documents were also reviewed whenever possible. Information from both qualitative and quantitative sources was compiled and is presented in text, tables and graphs.

1.5 ETHICAL ISSUES

Special efforts was taken to insure that the respondents to understand their rights and willingness to give the information and answer for the questions. They were told that the information collected from them will not identify the respondents in any way and there will be no adverse consequences to them for the participation in this study. In this regard, the consent form was read to each interviewee and his/her agreement asked to confirm orally before going to answering the questions.

2. THEMES AND LESSONS FROM THE LITERATURE

This section reviews the literature on HIV/AIDS, its impact and the responses. It briefly highlights the dimensions of the epidemic and presents the conceptual framework for understanding the impact of HIV/AIDS on children and the people living with HIV/AIDS.

It is important to understand what the existing literature can tell us and to situate the existing work on impact into a clear theoretical framework in order to adequately begin to think about care and support to these HIV/AIDS infected and affected people.

2.1 GLOBAL CONTEXT OF THE PROBLEM

According to the global HIV/AIDS pandemic has been changing human lives and the shape of societies for more than 15 years in the heavily infected countries of Sub-Saharan Africa, Asia, Latin America and the Caribbean. It has reversed decades of development gains in health, and slowed economic and social improvement across the board and in ways that will change relationships at family, community and national levels forever. One measure of the massive social change still to come is the number of orphans, children affected by HIV/AIDS, and other children made vulnerable by the pandemic. According to revised 2000 estimates, currently 34.7 million children under age 15 in 34 countries have lost their mother, father, or both of their parents to HIV/AIDS and other causes of death. By 2010, that number will be 44 million. Without AIDS, the total number of children orphaned would have declined by 2010 to less than 15 million. In 2010, 20 percent to 30 percent of all children under 15 will be orphaned in 11 Sub-Saharan African countries, even if all new infections are prevented and some form of treatment is provided to slow the onset of AIDS in those infected with HIV (Hunter and Williamson, 2000).

2.2 HIV/AIDS SITUATION IN ETHIOPIA

Ethiopia, a country of over 71 million inhabitants estimated in mid-2004 (CSA, update of the censes report of 1999), with over 80 ethnic groups, is home to some of the most ancient civilizations in recorded history. Ethiopia is one of the Subs –Saharan African countries characterized by absolute poverty with GDP per capita $ 115 political, economic, social welfare, education and health challenges (Save the Children Alliance, 2001) and recurrent drought. Besides to theses problems, Ethiopia is also known for frightening prevalence and alarming spread of HIV/AIDS. HIV/AIDS, which evolved

from two cases in 1986, is spreading alarmingly and infected 1,475,000(658,000 males and 817,000females) people in the country (Ministry of Health [MOH] 2004b). The impact of HIV/AIDS in Ethiopia has been devastating.

Some 245,000 people living with HIV/AIDS (PLWHA) were in need of antiretroviral treatment (ART) in 2003 and some 90,000 adults and 25,000 children had died of AIDS also in 2003. There were an estimated 539,000 AIDS orphans in 2003 (MOH, 2004a)

According to the MOH fifth report, the national HIV incidence rate in Ethiopia is leveling off, the rate at which it is progressing is declining over the last few years, and the epidemic appears to be stabilizing, particularly in urban areas, indicating some behavioral change in the population.

Many orphans are living out side of their familial environment and face environmental, physical and social hazards. According to a 2003 study conducted by the Ministry of Labor and Social Affairs (MOLSA), AIDS orphans unable to sustain their own livelihood are expelled from their parents. Most AIDS orphans live with poor relatives with low educational backgrounds, who are unable to provide for the physical, educational, and health needs of the child (MOH, 2004a).

2.3 THE HOUSEHOLD AND SOCIETAL IMPACT OF HIV/AIDS

Research suggests that the chance of infection with the HIV virus might be reduced in individuals who have good nutritional status, the onset of disease and death might be delayed where HIV positive individuals are well nourished and diets rich in protein, energy and vitamins might reduce the risks of vertical transmission (Gillespie and Loevinsohn 2003).

Illness and death are likely to have a marked effect on food production and food security. This will be detrimental to the nutritional status of children, especially those who already live in poverty. Childcare, makeup of diet, ability to send children to school and care of orphans will also be adversely affected. Girls' education may be sacrificed to ensure that boys can attend school. Consequently, many girls will grow up illiterate and with little or no job training. This ultimately makes them economically dependent on men, and robs them of independence and the power to protect them. At a macro level, the demands on health and welfare services will increase and education will be faced with multiple new challenges. In the workplace, the cost of labor will increase whilst productivity will decrease.

HIV/AIDS affects the vulnerability context for households and communities. For an individual household, HIV/AIDS can be seen as a shock, in which illness and death increase the vulnerability of the household. Stokes (2003) argues that HIV/AIDS represents an extreme source of livelihood and food insecurity shock that requires multiple adjustments on the households to this threat to their survival

AIDS is unusual in that the impact of illness and death is not a short or a sudden shock but continues over the long term for both households, as more family members become sick, and for communities. HIV/AIDS can also therefore be seen as a trend in increasing vulnerability over the long term, for example, through worsening dependency ratios or diminishing economic opportunities. As Barnett and Whiteside (2002) argue, 'it is useful to begin thinking about impact as a continuum between a sharp shock and slow and profound changes.' HIV/AIDS can also impact on seasonality, the third leg of the

vulnerability context. For example, a deepening trend of vulnerability may extend the drought season for poor households.

HIV/AIDS also needs to be considered in the context of policies, institutions and processes in the sustainable livelihoods framework. HIV/AIDS has impacts on government, private sector and civil society structures and customs, culture and practices. There is a developing literature showing the extent to which HIV/AIDS is eroding the capacity of governments to deliver social services such as health and education, especially in rural areas (Topouzis 1998). Mutagandura (1999) has shown how civil society institutions are both weakened by HIV/AIDS but are also adapting to the impacts of the epidemic.

2.4 HIV/AIDS AFFECTED CHILDREN AND THEIR NEEDS

Globally, more than 15 million children under the age of 15 have lost one or both parents due to AIDS. This figure represents 12% of all children in Africa. Orphans are often the first to suffer deprivation forced by poverty and food insecurity and they often suffer greatly from exclusion, abuse, discrimination and social stigma (World Food Program 2003).

Neither words nor statistics can adequately capture the human tragedy of children grieving for dying or dead parents, stigmatized by society through association with HIV/AIDS, plunged into economic crisis and insecurity by their parents' death and struggling without services or support systems in impoverished communities (UNICEF, 1999).

The Convention on the Rights of the Child (CRC) is the universally accepted framework that guides program for all children, including other vulnerable children (OVC). The four pillars of the CRC are:

- The right to survival, development and protection from abuse and neglect;
- The right to freedom from discrimination;
- The right to have a voice and be listened to; and
- The best interests of the child should be of primary consideration.

In 1998, a UN General Discussion on "Children living in a world with AIDS" was held. The Committee stressed the relevance of the rights contained in the Convention on the Rights of the Child to prevention efforts, recalling that HIV/AIDS was often seen primarily as a medical problem, while the holistic, rights-center approach required to implement the Convention was more appropriate to the much broader range of issues which must be addressed by prevention and care efforts. More recently, in June 2001, the UN general assembly special session declaration of commitment, set specific targets for all signatory nations recognizing that children orphaned and affected by HIV/AIDS need special assistance.

Social upheaval, rapid urbanization, war, drought, famine and acute political and economic stress have threatened the integrity of the extended family and have undermined its efficacy as a social support network. And now, at a time when the family is most needed as a support system for children in distress, the stigma associated with HIV/AIDS is affecting the willingness of families to take in orphaned children. This is resulting in increased child mobility and the exploitation and neglect of children.

Orphans are sometimes described as maternal, paternal or double orphans. Such a classification is less helpful than one that describes degrees of vulnerability. However, regardless of how an orphan is described, the needs of these children start with the knowledge that someone in their family is infected and continue until their social and sexual maturity (Save the Children Fund-UK, 2000).

AIDS produces younger orphans and these younger children are especially at risk. They tend to be nutritionally deprived (at a time when they have higher nutritional needs). In many communities, children whose parents have died of AIDS are at greater risk of dying of preventable diseases, because their illnesses tend to be attributed to AIDS and thus untreated. Orphans are also less likely than other children to be immunized and to have their health care needs adequately met. For the extended family, additional children increase financial hardships and pressures on relationships, weakening the capacity of the family to cope. The overriding constraint to the care of additional children therefore is the capacity of the extended family to cope (Parry, 1998)

2.5 WHAT ARE THE NEEDS OF AIDS ORPHANS?

As Save the Children UK (2000) indicated in the rapid appraisal conducted in South Africa HIV/AIDS affected orphan children should have to fulfill the following physical, intellectual, material and psychological needs.

> ***Food and food security***
> *These children are vulnerable to both malnutrition and under-nutrition, due both to the scarcity of food and to the weak position they occupy within guardians' homes in the household resource distribution process.*
> ***Housing, clothing and bedding***
> *Elderly grandparents and children often cannot maintain their homes in good repair. Poverty within the extended family frequently results in repairs being neglected. Often the family's supply of bedding is reduced because the deceased parent was bedridden and incontinent before death*

and it is common for children to sleep on sacks on the floor. Many children have no footwear at all and own only one set of clothes.

Health care

Immunization and simple medical care may not be reaching these children, and children under the age of five are particularly vulnerable.

Educational needs

These include books, school fees, uniforms, shoes and school trip funds. For the younger children there is also the need for after-care facilities.

Income generating skills

There is a need to provide older children with simple, marketable skills.

Parenting

Most children have not come to terms with the reality of being orphaned and feel the loss of parental attention and of physical and social security. With the death of their parents, the normal grief process is aggravated by guilt that they were unable to save their parents, often resulting in behavioral problems. Because the independence of the nuclear family has been compromised, they are unable to participate effectively in the kinship network where they are perceived as a liability and many, as a result, show socialization problems. Child heads of households confess to being ill equipped to provide proper parental guidance and discipline to their siblings let alone the love and care which they themselves need. There is also no moral and ethical guidance for these children, where the only adult attention may be in the form of irregular and inadequate supervision.

Friends and recreation

Most children report having lost their social friends due to their rigid time budgeting which does not allow them time for play.

Non-discrimination and legal protection

Freedom from discrimination within school, foster families, orphanages etc is another need. Where an infected parent may have been ostracized or rejected, after death the stigma may continue to cling to the orphaned children. These children require legal protection, with respect to inheriting land and other material goods as well as protection from unscrupulous guardians, relatives and others who may abuse their rights in any number of ways. They also require a peaceful; violence and crime free environment (Save the Children UK, *2000:24).*

2.6 WHAT THE PEOPLE LIVING WITH HIV/AIDS (PLWHA) NEED?

Appreciation and understanding of the care and support needs of PLWHA are essential in order to develop relevant and adequate care responses. Studies have revealed that needs of PLWHA go beyond clinical care and treatment. PLWHA's needs also include, for the most part, social support to alleviate the socio-economic impact of HIV

(e.g. basic needs for food, school fees and shelter), psychological support to cope with the implications of having a life-threatening condition, PLWHA's right to protection in employment, to confidentiality, to medical care and access to new treatments, counseling, emotional, protection against discrimination and stigma, social support for their orphans left behind after the patients die, etc. (WHO/UNAIDS, 2000).

According to the working document of the WHO and UNAIDS (2000), it is explained the importance of care and support to the people living with HIV/AIDS (PLWHA) as follows.

> *The consensus about the importance of care highlighted the fact that health care is a human right.*
> *Access to care and support also contributes to the prevention of HIV infection. Care provision offers an opportunity to discuss with the client and significant others how they might prevent further spread of the infection, and support them in their choices to do so, e.g. by availing access to interventions that reduce mother to child transmission of HIV, enabling them to increase their safety as a sexual partners through safe sex and condom use, and through use of antiretroviral therapy.*
> *Care and support for PLWHA decreases the spread of infectious diseases that are common among HIV-infected people, in particular TB and STI by early diagnosis and treatment of these conditions.*
> *By caring openly and compassionately for HIV infected people, their caregivers alleviate the fear of their community for HIV infection, and alleviate stigma and discrimination.*
> *Social and economic benefits of care and support for PLWHA arise from recognizing that when PLWHA live longer and healthier, the loss of income for themselves and their families is postponed, and the future of their dependents will be better. In addition, the economy will benefit through the better performance of its workforce.*
> *Care and support for PLWHA builds confidence and hope in clients: if the quality of life of PLWHA improves as a result of care and support, hope will be instilled to the benefit of the individual and the family, and as a result to the society at large.*
> *Care and support for PLWHA supports the greater involvement of people living with HIV/AIDS in the fight against the epidemic. Beyond opening the possibility of involving PLHA in policy and decision-making, and target action against the epidemic with more precision, GIPA enables the personalization of HIV infection in provision of health care, prevention, peer counseling, community care and HIV/AIDS advocacy. This makes*

> *non-infected people, institutions and policy makers realize that HIV is also their problem, and motivates them to do something about it (WHO/UNAIDS, 2000:26).*

To meet the physical, emotional, social and economic needs of PLWHA, care and support should be governed by the following principles and values:

Respect for human rights, ethics, confidentiality, informed consent, privacy, and individual dignity. Human rights and ethical practices apply equally to PLWHA as to other individuals. Fighting discrimination, enhancing respect of individual autonomy and human dignity, and pursuing informed consent are all relevant to HIV care and support.

Equity: affordable care of acceptable quality should be provided to all people regardless of gender, age, race, ethnicity, sexual identity, income and place of residence. More attention should be given to those groups of the population that have more problems to access care: widows and orphans, pregnant women, children, the elderly, the uneducated and the poor.

Quality of care: care should be of good quality. Interventions and services have maximum benefit if they are of good quality. There ought to be continuous improvement in quality of the services. Quality can be measured in terms of the nature of services provided and in the specific interventions. Measures of quality of services include indicators such as waiting time, attitude of health workers and the type of facilities available. Indicators of specific interventions include compliance with recognized standards in administering the interventions. Quality of services is a strong indicator of how responsive the services are to the expectations of the people.

Efficiency and effectiveness: care should be provided at reasonable societal costs. Resources invested should be result-oriented and there should be corresponding concrete

quantifiable results. Efficiency considerations fuel the need to coordinate and integrate health systems so as to ensure the continuity of service delivery among different providers and different levels of care.

Accessibility and availability: all levels of the health system should make care accessible to as many people as possible. The provision of care appropriate to the resources available and levels of HIV prevalence need to be decided through local consensus building that involves the whole community. This requires regular review with all stakeholders.

Sustainability: initiatives in provision of care and support will remain meaningful - and other principles of care and support will only be viable - where they are embedded in a sustainable program of provision. This requires taking into account human, logistic and financial resource requirements (WHO/UNAIDS, 2000).

It is a widespread belief that the majority of health care needs of PLWHA can be addressed by ensuring access to medications, in particular antiretroviral therapy. However, this idea falls short of effectively meeting their complete range of medical, emotional, social and economic needs. PLHA require comprehensive care and support, not just medicines.

For a care and support package for HIV to be comprehensive, it should include elements of voluntary counseling and testing for HIV infection, psychosocial support, home and community-based care, and clinical management (including medical, nursing and counseling care).

2.7 CARE AND SUPPORT STRENGTHENS PREVENTION

An important role of care and support is its impact on prevention and behavioral change strategies. The literature emphasizes the integral connection between care and support and prevention strategies. In a study conducted in rural Thailand, increased contact with PLWHA over time resulted in more tolerant and receptive attitudes towards PLWHA and HIV/AIDS (Takai.1998).

Providing counseling support facilitated family and community acceptance of PLWHA and affected behavioral change such as increased condom use (Kaleeba, 1997). When care and support are provided in the community, awareness and acceptance of HIV/AIDS as a community problem is promoted. Further studies have shown when care and support are provided, people are more inclined to reveal their HIV status, understand the need for prevention, and are motivated to protect others as opposed to when no services are provided and they feel abandoned by the health care system (MacNeil and Anderson, 1998). Finally, people receiving care and support services are in ‘captive environments’ where behavioral change interventions can be initiated and supported over a period of time (Takai, 1998). Hence developing a continuum of care, which offers prevention, and care and support services, is a more comprehensive and effective strategy than prevention on its own (MacInnis, 1997).

In sum the literature suggests that integrating community care and support strategies, as well as prevention, within a continuum of care, can have a positive impact on mitigating and decreasing the spread of HIV/AIDS. Community-based services are more accessible to clients and their families, decrease isolation, and provide needed interventions that can contribute to the quality of life for PLWHA. Patients may live longer, experience a better quality of life and improved health status. The burden on both

clinics and hospitals may be reduced as people learn to cope with minor symptoms, addressing them before they progress to more complex diseases requiring clinical intervention. Emphasizing care and support for PLWHA also results in greater community acceptance and a normalizing of the disease enabling people to talk about it openly. PLWHA feel valued and are willing to disclose their status.

2.8 HUMANITARIAN RESPONSE AND HIV/AIDS

The humanitarian system has been relatively slow to take on board the scale and the impact of the HIV/AIDS epidemic. Smith (2002) found that,

> *Many agencies providing humanitarian assistance have not included considerations of HIV/AIDS in their written policies or strategies for emergencies. In agencies' thinking and policy development, HIV/AIDS has, at best, generally been understood as a sub-topic within broader subjects, notably medical practice, sexual health and sexual violence. Policies specifically addressing HIV/AIDS in emergencies exist but tend to focus on technical and biomedical issues, or on minimizing the risks of infection faced by humanitarian workers. (Smith 2002: 13)*

However, some progress has been made. Key developments include:

- UNAIDS produces Guidelines for HIV Interventions in Emergency Settings (1996).
- UNAIDS produces a technical update on Refugees and AIDS in 1997
- UNHCR updates its policy on HIV/AIDS and refugee populations in 1998
- Security Council debates HIV/AIDS in January 2000 and resolution 1308 calls for a coordinated response to HIV in peacekeeping operations.
- UN General Assembly declaration in June 2001 recognized that populations destabilized by armed conflict, humanitarian disasters and natural disasters are at

increased risk of exposure to HIV and called on UN agencies and NGOs to incorporate HIV prevention, care and awareness strategies into their programs.

The focus of these guidelines tended to be on HIV prevention, with comparatively little attention given to mitigation and care aspects and little or none to the wider impact of HIV/AIDS on poverty, food security and vulnerability to emergencies. The focus on prevention was also narrow and largely focused on biomedical aspects, such as contaminated blood, inadequate sterilization facilities or deficient health education (Smith 2002).

Save the Children UK and Oxfam (2002) for example, in their guidelines on mainstreaming and integrating AIDS in emergencies, make the following point; “There should be a continuing focus on gender analysis, given the close link between gender inequity and vulnerability to HIV.” Many of the ideas raised are relevant to a gender aware approach also and focus particularly on preventing sexual and gender based violence. Gender and protection are also therefore inextricably linked.

World Food Program (2003) argue that; “although HIV/AIDS requires an emergency response such a response must be based on a long-term approach.” They recommend that HIV/AIDS be considered as a basis for long-term relief programs, a modality previously only used in long running conflicts. “When HIV/AIDS threatens food security and influences mortality in ways similar to other disasters, WFP will consider HIV/AIDS as a basis for a PRRO (protracted relief and recovery operation).” (WFP 2003)

The question of how to target households affected by HIV/AIDS without adding to the stigma that these families might be facing is a difficult and critical point. Save the

Children UK and Oxfam (2002) suggest the following principle: “Targeting of people living with HIV/AIDS may increase stigma and discrimination against this group so should only be undertaken after careful consideration and with the participation and consent of the beneficiary group.”

One of the ways in which organizations are approaching the dilemma of supporting people affected with HIV/AIDS without increasing stigma is to aim to work with existing community organizations that are already working with HIV/AIDS affected households. For example, WFP (2003) states; “WFP will support established community based organizations when carrying out HIV/AIDS activities in order to avoid the negative consequences associated with HIV stigma.”

Just as the impact of HIV/AIDS on food security implies the need for the long-term welfare provision; it also implies the need for long-term and more adequate support and financing for health care systems.

3. FINDINGS AND ANALYSIS

3.1 SOURCES OF INFORMATION ABOUT HIV/AIDS AND SERVICES IN DESSIE

Key informants were asked about the sources of information on HIV/AIDS for the public in Dessie, and it was learnt that radio and TV are the major sources of information. But AACs, *Idirs*, schools, health services institutions, the FGAE youth center, IEC materials produced and distributed by organizations like OSSA are also pointed out as sources of information about HIV/AIDS.

The All key informants have stressed that provision of information on HIV/AIDS should focus not only on creating awareness but also on bringing sustainable behavioral changes among the population in general and adolescents in particular. According to

some of the key informants, small scale implementation of community conversation programs like coffee ceremonies started by some Anti-AIDS clubs (AAC) should be well strengthened to bring about the positive and protective behavioral change.

3.1.1 Risk and Vulnerability Factors

The Most of key informants perceive that unemployed young people are more vulnerable to HIV infection because they usually spend their time by chewing '*chat*' and smoking '*shisha*' and cigarettes. These behaviors further lead to what they call '*chebsi*', consumption of alcohol at the end of the day to get rid of the stimulant effects of 'chat' and tobacco. Getting drunk at the end leads them to unprotected sex that exposes them to HIV infection. Almost all key informants indicated that the geographic areas where risky behaviors take place are usually around "bars and night clubs where sex workers are based".

Dessie HAPCO and OSSA Dessie branch office mangers cited factors in the key informant discussion that make women more vulnerable than men mentioned many causes. One of the contributing factors for women to be more vulnerable is that an increasing number of young women having older male sexual partners ("sugar daddies"), which is due to very low economic status of the women. This increases the risk of infection of the women as these men usually have multiple sexual partners. The key informant interviews have also disclosed that lack of sex negotiation skills by young girls and women compounded by male dominance in the society makes women very vulnerable to HIV infection. It was stressed that empowering girls and women and educating them on life skills particularly to have capacity to negotiate and discuss about sexual affairs need to be fostered to reduce vulnerability of women in the town.

According to a key informant from Dessie town Anti AIDS youth club, housewives and servants are also vulnerable to HIV infection as most of them have no access to information about HIV/AIDS, and are also sexually abused. Children born from infected mothers were also identified in all key informant interviews as high risk and vulnerable group to HIV infection.

3.1.2 Prevalence and Magnitude of HIV/AIDS in Dessie

The researcher could not found any literature, no matter how old it is, that tells about the prevalence of HIV in Dessie Town. According to the Ethiopian Federal Ministry of Health June 2004 estimate, prevalence of HIV among adults in urban settings is 12.6% (MOH, 2004). This may be taken as proxy indicator of prevalence of the disease in Dessie. However, I have tried to explore findings of the survey that may give clues to the situation of the disease in Dessie.

Focus Group Discussion with PLWHA also confirmed this as the participants of the discussion said, “The magnitude of HIV/AIDS is high in Dessie and more efforts are needed to mitigate its diverse impacts”.

According to a counselor in Dessie hospital, HIV infection seems ever rising in Dessie since the first AIDS case was diagnosed in the town in September 1991. Sources of information that may give clues of prevalence of the disease are hospital morbidity data and reports from blood bank and VCT centers. These sources are, in many cases confronted with recording and reporting problems as a result of which figures obtained from them underestimates the true picture. On the other hand, people who may seek these services may have a characteristic peculiar to them, and the data, as a result, is lacking in terms of representing the situation. “Given lack of a sentinel survey site in Dessie, a

prevailing poor health information system and under diagnosis, prevalence of HIV/AIDS in Dessie is underestimated," said a key informant from OSSA. Unfortunately, Dessie is not a site for national sentinel sero-survey. However, prevalence from other urban sentinel survey sites in 2003 in Amhara Region range from 10.5% for Addis *Zemen* health center to 20.2% for *Bahar Dar* health center. The national average for urban during the same period is 12.6% (MOH, 2004).

Data from Red Cross blood bank of Dessie Town shows that among 780 people who donated blood in 2004, 46 (5.9%) were found to be HIV positive. This is slightly higher than the national prevalence of 4.7 % among blood donors in 2003 (MOH, 2004). Similarly, from 8099 (male: 4267, female: 3832) people who had VCT in the different centers in Dessie in 2004, 1252 (15%) were tested positive. This is lower than the national prevalence of 16.6% among VCT clients in 2003 (MOH, 2004). The range for VCT positive rate varies from 10% for Dessie health center to 35 % for *Selam* Higher clinic. Positivity rate is generally higher in private centers than government and NGO reports (table 1). This is probably due to selective presence of service seekers, meaning more sick people visit private health facilities while many people going to government facilities are mainly going for premarital test. According to the Dessie hospital report, out of 522 (286 male and 236 female) suspected and tested for HIV/AIDS in 2004/05, 23% were positive for the disease, the rate for male and female being 22% and 25%, respectively.

Prevalence of sexually transmitted infection among the population may be another proxy indicator of prevalence of HIV, as both share common predominant mode of transmission and personal behaviors. According to the head of Dessie HAPCO, the

problem with this indicator is that there is always under-recording and reporting, as many of the patients opt to go to private institutions and often also for self-treatment.

In Dessie hospital in 2005, out of the 38885 outpatient visits only 65 (0.2%) were STI cases. Similarly, out of the total outpatient visits to Dessie health center during July 2004 – June 2005 only 1% was due to STI. The situation is more or less similar in private and NGO health facilities. At Marie Stopes's clinic, for instance out of 265 out patient visits in similar year diagnosed only 4 (1.5%) STI cases. *Mitiro* health station, a government owned small facility run by paramedical staff and located downtown is slightly different. Out of 8765 visits in 2003/04, 684 (8%) were syndrome STI cases. When aggregated, STI constitutes only 1.4% of outpatient visits in Dessie town.

Table 1

VCT centers in Dessie and number of people received the service in 2005.

VCT Center	Tested			Positive			Remarks
	M	F	Total	M	F	Total	
Dessie Hospital	286	236	522	62 (22%)	59 (25%)	121 (23%)	(July 2004 - June 2005)

Dessie Health Center	200	187	387	15 (8%)	22 (12%)	37 (10%)	Started service in January 2005 up to Desember2005
OSSA VCT Center	1234	1275	2509	201 (16%)	229 (18%)	430 (17%)	2005 data
FGA main clinic	1690	1366	3056	234 (14%)	175 (13%)	409 (13%)	2005 data
FGA Youth Center	669	616	1285	74 (11%)	86 (14%)	160 (12%)	2005 data
Bikat Diagnostic Lab	170	136	306	51 (30%)	32 (24%)	83 (27%)	Started service in January 2005, up to Desember2005
Selam Higher clinic	18	16	34	6 (33%)	6 (38%)	12 (35%)	Started service in January 2005, up to Desember2005
Ethio-Higher Clinic	--	--	--	--	--	-----	Could not get data despite repeated attempts
Total	4267	3832	8099	643 (15%)	609 (16%)	1252 (15%)	

3.2 SITUATION AND LIVING CONDITIONS OF ORPHANS AND VULNERABLE CHILDREN IN DESSIE

The concepts of orphans and vulnerable children are social constructs that vary from one culture to another. In addition, these terms take on different definitions that can be at odds with one another depending on whether they were developed for the purpose of gathering and presenting quantitative data or for developing and implementing policies and programs. For quantitative purposes, the term orphan may refer to a child who has lost only one or both parents. The concept of vulnerability is complex and may include children who are destitute from causes other than HIV/AIDS.

There is no known well-designed study done in Dessie to accurately estimate the number of orphans and vulnerable children in the town. In 2003, Dessie town HAPCO tried to get number of orphans in Dessie through kebele administration, and a list of 904 orphans was obtained. This number did not include orphans supported by Mekdim, OSSA or any other non-governmental organizations. “That list was by no means exhaustive. Even then the figure definitely increases and this time no less than 1500 orphans exist in Dessie”, said head of Dessie HAPCO. In the same year, South *Wollo* Labor and Social Affairs Office in collaboration with UNICEF conducted a more comprehensive survey of orphans, vulnerable and street children in Dessie. According to this survey, there were 1654 orphans, 470 vulnerable and 1038 street children (table 7). The assistance Program coordinator of OSSA has similar view about the magnitude OVC in the town. He said, “close to 2000 orphans and 500 vulnerable children may be found in Dessie”. A conservative estimate of current situation based on these evidences may be 1700-2000 orphans and 500-700 vulnerable.

Table 2

Registered Orphans, Vulnerable and Street Children in Dessie Town

Ser. No.	Description	Number	Remark
1	Double orphan	867	A child who lost both parents
2	Single orphan	787	A child who lost one parent
	Total (orphans)	1654	

3	Vulnerable	470	
4	Street children	1038	
	Total	3162	

Source: South Wollo Zone Labor and Social Affairs Office; a study conducted by UNICEF and Labor and Social Affairs Office, 2003.

To assess the situation and living conditions of orphans and vulnerable children in Dessie, issues were raised on all FGD and key informant interviews in quantitative survey. Participants explained that among the many vulnerable members of society, children who have lost one or both parents are the most vulnerable of all. All participants of FGD and key informant interviews generally agree that the support to orphans and vulnerable children is not adequate. The needs of AIDS orphans could be seen in terms of access to education; health care; prevention of physical violence; social, economic and emotional supports. The head of Dessie HAPCO said that orphans and vulnerable children in Dessie are not getting love, trust and respect by the community as much as their non- AIDS orphans peers do. He further added, “Significant number of AIDS orphans in Dessie is not able to attend school due to lack of food, uniform, school fees and other materials.” According FGD participants, vulnerability of children orphaned by AIDS starts well before the death of a parent. The emotional suffering of the children usually begins with their parents' distress and progressive illness. This is compounded as death of one or both parent causes drastic change in family structure resulting in a heavy economic blow, requiring children to become caretakers and breadwinners for younger siblings.

Of the 25 AIDS orphans interviewed during the study 16 (64%) get some form of support from NGOs, 7 (28%) from CBO and 2 (8%) was not receiving any support. The

type of support varies from counseling or psychological support to cash and food assistances. All said either themselves or their siblings were receiving education materials including school uniforms. This is so probably because these AIDS orphans were registered either by *Mekdim* or OSSA and are likely to receive some sort of support including education. Had unregistered AIDS orphans been found and included in the study, the proportion of unsupported children would have been much higher. About 84% and 36% receive money and counseling services, respectively. Food assistance, house rent and clothing were also provided to smaller proportion of the interviewed orphans. However, the supports are felt as either not always enough or not enough at all by 64% of orphan interviewees. Furthermore the large numbers who are working to seek money indicates the unmet need of the orphans. This strengthened by the fact that 20% of these orphans report they are currently working to get money, though 88% of them are students. Two of the orphans said their siblings dropped school because there was no one to support them.

These findings are similar to the comments of the key informant interviews. According to the head of Dessie HAPCO, currently 501 AIDS orphans are getting some sort of social support including food assistance, education materials, skills training, and start up money for IGA and cash assistance from all sources. This is less than one third of the estimated orphans in the town. Some orphans receive more than one type of support, for instance education materials and food assistance, based on severity of their problems and hence recorded and reported more than once. Therefore, the actual number of orphans getting support may be even less than the above figure.

During the FGD held with AIDS orphan children, it was remarked that there are efforts by organizations like OSSA, *Mekdim* and *Netsebrak* Anti-AIDS and reproductive health club to provide care and support. From the FGD reports, it appears that these efforts are however not well coordinated and very inadequate in terms of addressing the very essential needs of AIDS orphans. To improve the support efforts, the FGD participants suggested that the local community structures should be well capacitated by both technical and financial supports from the government and partners.

3.2.1 Psychosocial and HIV Issues

Most of the key informant interview participants noted that the psychosocial need of orphans and vulnerable children would continue to be one of the most neglected areas of support in Dessie. According to the informants, the fast spreading of the disease in the past years and increasing number of AIDS cases has increased the urgency to address psychological problems of children in parallel with other interventions. Children are affected by the changes in their parent's emotional and physical state. They may not know what is happening to their sick parents and become confused and frightened. When a parent becomes terminally ill, older siblings are often forced to take on a premature parenting role for their younger siblings and providing care for their bedridden sick parents. Without proper support mechanisms upon the death of a parent children experience a profound sense of loss, grief, hopelessness, fear and anxiety. "Truly speaking, this is a forgotten aspect of AIDS orphans support in Dessie," said the key informant from OSSA. A key informant from OSSA said that long-term consequences of the psychological problem of AIDS orphans could include chronic depression, low self-esteem, and low levels of life skills, learning disabilities, and disturbed social behavior.

According to him, before a parent dies it is essential that the children have access to psychosocial support to enable them cope with aftermath. Before a parent dies it is also essential to deal constructively with plans for their children's future: how and with whom they will make their living and how they will stay in school, etc. When a parent is terminally ill and the other parent is not alive, ideally extended family members who can become a guardian of the child need to be identified with the child/children together. This can help ease the psychological burdens of both the parent and child. Keeping siblings together also provides them with an important sense of continuity and is a source of support and identity. Religious and traditional practices of dealing with grief and mourning permit the expression and release of intense emotions.

3.2.2 Educational Concerns

According to the FGD participants, AIDS orphans in Dessie have problems continuing their education as regularly as their unaffected peers do, and even if they attend their academic achievements are poor. A growing number of children who are not able to attend or stay in school and the rising number of pupils whose ability to take advantage of schooling are aggravated by other factors including poor nutrition, psychological stress, socioeconomic problems etc. As recommended by key informants, different interventions including establishing mechanisms to ensure that primary education is available to all children regardless of their social and economic situation need to be implemented. Educational activities aimed at AIDS orphans need to be linked to other interventions, such as nutrition and psychosocial supports to have a holistic program that addresses influencing factors on vulnerable children's ability to attend school and maximize the benefits of education.

3.2.3 Role of Community Support

During the FGD with children it was remarked that extended families, neighbors and the community are responsible for fulfilling the needs of AIDS orphans. The role of *Idirs* is very important in this endeavor; NGOs and the schools themselves can play vital role to fill the gaps in provision of support for AIDS orphans.

3.2.4 Abuse, Exploitation, and HIV as Obstacles to Health Care

During the FGD held with the children, it was disclosed that AIDS orphans in Dessie area are often at greater risk of illness, abuse, and sexual exploitation than their non-vulnerable peer children. They may not get the health care they need, and sometimes this is because it is thought that they are infected with HIV and their illnesses are untreatable. Orphans and vulnerable children are generally at a greater risk of being malnourished than children who have parents to look after them. Focus group discussions and key informant interview participants further noted that for the maximum well-being of AIDS orphans and other vulnerable children to be achieved, they and their guardians need to have access to basic services such as health care including clinical and preventive services, nutritional and psychological support and home-based care, if appropriate.

3.2.5 Child Headed Households

Participants of FGD with the children as well as PLWHA remarked that there are many households in Dessie headed by very young children less than 10 years old and one the participant child who is taking care of her tow younger brothers said "I am taking care of my brothers and provided them all necessary things however, I can not study my lesson well. If my neighbors or our family ex friends supported me, maybe I can follow my education properly and doing my home work on time." Here one can understand form this child that there should be given a special attention to child-headed households and

families with young children headed by the elderly. The FGD participants also added that to mitigate impacts in sustainable ways, local community structures must be strengthened very well as community based programs could mobilize resources and help to implement community-based interventions.

3.2.6 Inheritance, Property and Caregiver Selection Issues

During the FGD with the children it was highlighted that, many children in Dessie face problems inheriting their parents' property when parents die. This may be partially due to cultural traditions concerning property inheritance at death, or probably due to unfairness of people. However, in both cases children are deprived of inheritance and as result face economic problems. If relatives and not the children themselves inherit property, it is expected that those relatives would then take on responsibility to care for the affected family. However, sometimes relatives may take the property without taking on the responsibility of caring for the child. At times orphans are also forced to live with relatives whom they do not want to stay with simply because these relatives will posses the property of the deceased by the virtue of being care giver of the AIDS orphans. Key informants also stressed that the necessity of clear and compelling rule to protect such rights of AIDS orphans. AIDS orphans should be allowed to inherit properties of their deceased parents and also to decide with whom to live. During a FGD held with the children, it was said that some relatives or foster parents of AIDS orphan children are abusing the financial and material supports provided to the children by OSSA, HAPCO add/or other sources. The Key informant from OSSA pointed out that there are reports reached to our office that some *kebele* officials in Dessie are also expelling AIDS orphans from their *kebele*-owned rental residences in a very illegal and inhuman way.

It is widely recognized by all participants of the FGD and key informant interview participants that most of the problems faced by AIDS-affected children and households result either directly or indirectly from the economic impact of AIDS. To mitigate the socioeconomic impact of AIDS, communities must be able to identify children and households most in need, prioritize their needs, and use local and external resources to increase their well being and strengthen community safety nets.

3.3 CARE AND SUPPORT TO AIDS ORPHANS IN DESSIE

In this section it is reported that human service organizations currently working on care and support to AIDS orphans in Dessie. Currently, there are four NGOs, which are providing a different type of support for 861 AIDS orphans children (see Table 3).

OSSA Dessie branch provided 100 orphans with education materials and 29 with different skill trainings. As part of developing sustainable income generating mechanism, OSSA provided 10 orphans with 2000Br/family as start-up money. It also has AIDS education activities focused on street children and marginalized youths.

Mekdim Dessie branch supports AIDS in collaboration with other partners. The association financially supported 20 AIDS orphans. It provided 83 AIDS orphans with education materials, paid school fee for 137 and bought school uniform for 47. In all other anti-AIDS youth clubs also priority is given to AIDS orphans and vulnerable children in their interventions.

EECMY is currently supporting AIDS orphans in collaboration with different partners. It has launched a five-year social support intervention to assist 340 AIDS orphans by providing 155.00 Birr/month food assistance and education materials in Dessie.

Forum on Street Children Ethiopia Dessie branch works closely with CBO and other partners with the objective of preventing children from leaving home by helping them when they are with their parents or families. One activity of FSCE is to enabling 20 AIDS orphans to have access to primary education (grade 1- 4). It works to expand access of children to primary education by supporting schools to increase uptake of such children and also provide education materials to the children. Currently about 850 children are beneficiaries of this activity. This includes street children, AIDS orphans and those whose families cannot afford to send them to school. These children are provided with education materials and schools are capacitated technically and materially. According to the head of Dessie HAPCO, the assistance provided in the town is not proportional to the magnitude of the problem, and he further noted that his office may need to device more efficient ways of identifying and financing more projects.

Table 3

Summary of Organization and Currently Supported AIDS Orphan in Dessie

Organizations	**Number of AIDS orphans assisted**	**Types of support**
OSSA	139	Financial support and Start up fund
MEKDIM	362	Different types of social supports
FSCE	20	Different support
EECMY	340	Financial support
Total AIDS orphans supported	861	

3.4 SITUATION AND LIVING CONDITIONS OF PLWHA IN DESSIE

3.4.1 Community Perceptions of PLWHA Needs

In order to assess how the community recognizes the situation and living conditions of PLWHA in Dessie, participants of FGD and the key informants were asked to discuss their opinions. Most of them analyze the needs of PLWHA from different perspectives: material needs social needs, health care, emotional support and psychological issues. Material needs that include provision of food supplements, clothing and housing were identified as the outstanding necessities of people living with HIV/AIDS.

3.4.2 Food Related Issues

Even among the material needs, food subsistence, be it in kind or cash, was frequently mentioned and identified by all FGD participants as top priority of PLWHA. The focus group perceived that the majority of people in question belong to lower classes and therefore do not get the balanced diet they need to cope with their illnesses. It is a well-established fact that the amount and quality of nutrition has a direct bearing on his or her longevity and capacity to withstand the debilitating effects of HIV. However, nutritional support for PLWHA is more complex than the mere supply of food items or money to buy with. FGD participants pointed out that current food item or cash supports are neither adequate nor sustainable. “The food assistance from OSSA and *Mekdim* which are mainly in the form of wheat, cooking oil, and *teff* may not meet the felt nutritional needs of the recipients,” said the participants. It was stressed that even such supports are often on-and-off depending on availability of resources, which is not usually easy. Another issue raised by the participants as important to look at is the stigmatizing nature of food ration to PLWHA. They said that the community tends to associate the

food assistance with HIV/AIDS and think that “PLWHA are not capable of working and are therefore considered as weak persons and inferior to the rest of the community”, a thought that has a psychological impact on the assistance recipients. Therefore, PLWHA suggested during FGD, there is a need to reassess the current food support both in relation to the mode of administration and the beneficiaries’ needs. Furthermore, FGD participants commented that the coverage of food support is currently limited to those infected with HIV but need to be expanded to include children of PLWHA, as well as other dependents.

3.4.3 Service Limitations

The group also further noted that OSSA or *Mekdim* has limited resources to give support for all PLWHA and other partners need to take part in care and support. According to the group, majorities of PLWHA are living miserable lives because of lack of care and support. They said “probably only about 10% of those who deserve are getting care and support”. They further explained that last year 14 of their friends died mainly due to lack of care and support. Shelter was also raised as one of the problems of people living with HIV/AIDS not only because of lack of money to pay rent but also due to stigma and discrimination. “Problem of stigma and discrimination is decreasing but is not yet get of the scene,” said group of PLWHA who participated on focus group discussion. They further added that people are chased out from rented house because of their HIV status. The FGD and key informant interview participants revealed that PLWHA need social acceptance and sympathy from the community as part of care and support. According to the group discussion, PLWHA have a strong internal urge to acquire affection and concern of others. They said love and attention from the community

strengthen their sense of security and enable them to withstand the stress caused by their illnesses, while discrimination has adverse effect on themselves and their families. “However,” said focus group participants, “they lack many of these supports mainly because stigma and discrimination is still prevalent. Thus, continuous awareness creation and behavioral change activities need to be intensified with in the community.”

3.4.4 PLWHA Reports on Services and Living Situations

Some questions to be responded by PLWHA were included in the questionnaire survey to assess how these people see their situation and living conditions. All the 25 PLWHA said they seek medical care in NGO clinics while 20% get additional care at government facilities. Again, for 83% of these people, their medical expense is covered by NGOs. When asked what type of support they currently receiving, 83% said medical care (does not include ART), 67% counseling and 17% food assistance. In 96% of cases the support, what so ever, are provided by NGOs. Two third of this PLWHA said their current living conditions are not good and out of them 50% are optimistic that their living situations will improve in the future.

3.4.5 Community Education Needs

Strengthening community education and awareness rising endeavors, though do not a guarantee for attitude changes, are activities that were mentioned by group discussion and key informant interview participants. They also recommend that more intensive approach of behavioral change and communication as a crucial activity that should widely be undertaken to bring change in people’s attitude towards people living with the virus, and the epidemic itself. Any effort towards achieving this objective needs

to be viewed as a part of the overall struggle to deal with the epidemic, as well as a response to one of the unmet needs of PLWHA.

3.4.6 Health Care Needs

Optimal and comprehensive health care service was another priority need of PLWHA identified by most of the focus group discussion participants. This ideally needs to include diagnosis and treatment of opportunistic infections, anti retroviral therapy, professional counseling and psychological support. Home-based care is also mentioned as an important support for PLWHA need and a growing demand as many are becoming bedridden one. According to focus group discussions, just few organizations provide this support covering only small proportion of those who need it. They also emphasized that this is probably the most challenging service for the providers, but also a crucial service to PLWHA.

3.4.7 Income Support Needs

Group discussions with people living with the virus and others came out with another felt need of PLWHA, which is an income generating mechanism for them and their families. Most of people living with HIV/AIDS can do jobs to generate income especially at the early stage of their illness. All the FGD participants mentioned that there is a need identifying what is appropriate and profitable to work and start up capital along with continuous technical support. Providing income-generating mechanisms was suggested not only for PLWHA but also for their families – spouse, children and other dependents. Vocational and skill trainings should also be widely given to them and their families as part of creating career opportunities and developing entrepreneurship.

3.5 CARE AND SUPPORT TO PLWHA IN DESSIE

In this section it is reported that human service organizations currently working on care and support to PLWHA in Dessie. Currently, there are four NGOs, which are providing a different type of support for 589 PLWHA.

Table 4

Summary of the Organization and Currently Supported PLWAH in Dessie

	Organizations	**Number of PLWHA Assisted**	**Types of support**
Currently Supported PLWHA	OSSA	80	Financial support including Home based care
	MEKDIM	123	Financial support including Home based care.
	NETESEBRAK	86	Financial support
	FGA	300	Financial support
Total PLWHA supported		589	

According to the Assistant Program coordinator of OSSA, financial support is being provided by OSSA Dessie branch to 80 PLWHA. Out of 80, thirty-three PLWHA received clothing. The organization also provides home-based care to PLWHA and orphans by 4 trained voluntary counselors.

Mekdim Dessie branch is one of few organizations that provide home-based care for PLWHA. It has 4 full time trained staff for this service. *Mekdim* also provides individual, group, family and couple counseling to people infected and affected by HIV/AIDS using these trained full time counselors, mainly in office. *Mekdi*m provides skill training and seed money, depending on the availability of fund; to PLWHA to enable them create their means of living. The financial supports by different partners to Mekdim members, for instance range from 75 to 150 Birr/person/month and the duration of support also vary greatly. The association currently has 806 members (492 PLWHA and 314 AIDS orphans) most of whom joined it to get some sort of support. Of all registered PLWHA in *Mekdim*, 123 currently receiving support from the organization and its partners.

North Eastern Branch of Family Guidance Association Ethiopia is providing home-based care with financial support for 300 PLWHA beneficiaries in Dessie. The service, which includes nursing care, management of opportunistic infections and nutritional support, is provided by trained and volunteer youth. The system was devised in such a way that the activities are closely monitored by *Idirs*. This was initially a pilot but now fund is secured for one year as of April 2005. FGA clinics in Dessie provide free medical care to people living with HIV/AIDS.

Nestebrak is providing a home-based care to PLWHA using 80 trained volunteers who themselves are marginalized, like homeless and living with HIV. Forty-five people living with the virus are currently getting meals two times a day from 6 hotels through a deal made by the organization. *Nestebrak* is assisting sex workers who are HIV positive in seeking alternative means of income generating activities. Totally the organization

assisted 86 PLWHA in the town. Coffee ceremony with families of PLWHA and their neighbor are organized and used as a forum for educating people and introducing and handling over of a new HIV positive community member.

3.6 INTERVENTIONS OF DIFFERENT ORGANIZATIONS IN RESPONSE TO HIV/AIDS IN DESSIE

Following the issuance of the National HIV/AIDS Policy Councils and HIV/AIDS Prevention and Control Offices (HAPCO) were established at all levels. Dessie Town HAPCO was established in 2001 as part of this structuring of the national response to HIV/AIDS. The main objective of these councils and HAPCO is to coordinate HIV/AIDS control and prevention activities by the government and partners at all levels. Dessie town HAPCO is playing its role of financing small projects; coordination different efforts follow up and control of prevention and control activities in the town. However, “had it not been limited by shortage of manpower and budget, the office could do better,” said head of Dessie town HAPCO to describe the limitation of his office. According to this key informant of Dessie HAPCO, though attempts to coordinate activities through a coordinating committee established from among government offices, NGOs, CBO, it is not strong enough to carry out its duties probably due to various problems that need to be solved at higher level.

Dessie HAPCO provides support to projects on awareness creation, training, and care and supports of orphans & PLWHA in the town. Twenty *kebeles* found in the town also received supports in order to run their projects in awareness creation and care & supports. “Demand is far more than this and there were many important projects which should have been supported. But regional HAPCO accepted just few of the submitted proposals”, said the head of Dessie HAPCO. He further added that in 2005 his office

screened 25 projects for funding from which regional HAPCO approved only 7. In other words, only 28% of projects selected as viable by Dessie HAPCO was approved and funded in the year.

A critique about lack of adequacy and coordination of responses was put by one of the key informants, as, “With regard to prevention and control activities in Dessie, both the quality and quantity are not up to the expectations. Prevention activities should be coordinated among the partners to create synergies and to bring true changes in the transmission of the disease and its impacts. For me conducting unnecessary workshops, trainings and seminars now and then for similar people doesn’t bring any change except unwisely spending money for refreshment and per diems.” He commented “minimizing carrying out a series of trainings/workshops on awareness creation, which is already achieved, and think about allocating the resources for care and support services particularly for orphans education support and availability of ART drugs for PLWHA. In order to achieve sustainable impacts through care and support activities, orphans should be encouraged and supported to continue their education up to the higher level, and healthy PLWHA should be organized into small groups so that they can run small scale income generating activities.”

This study has discoursed that almost all partners working on HIV/AIDS in Dessie have some forms of prevention activities at various levels. The study focuses on the responses in the town in relation to broad intervention areas that are important in controlling of the epidemic and the impact of the disease in the town.

Table 5: *Summary of the Intervention of HIV/AIDS and the Major Activity Area in Dessie*

Ser. No	Activity	Organization	No. of Beneficiaries	Remark
1	Condom distribution	OSSA	22500	Through different partners and outlet
		FGAE	3908	Clients of the youth center
		Netesebrak	20000	Through sex workers, AAC, etc
		Abyssinia	10000	Through different partners and outlet
2	Training	OSSA	147	RH, HIV/AIDS, peer education, club management
		FGAE	656	Topics include SRH, HIV/AIDS.
		Mekdim	16	Home based care
		Netesebrak	1400	Peer education, HIV/AIDS, BCC
		SC-UK	555	HIV/AIDS, RH, Counseling, Care and support, Project design, IEC
3	IEC material distribution	OSSA	18083	Through different partners
		FGAE	7704	
		Mekdim	2100	HIV/AIDS and related issues
		Netesebrak	3500	HIV/AIDS and RH
		Negat	-	No IEC material distribution
		SC-UK	2500	HIV/AIDS and related
		Abyssinia	28,320	Produced by Abyssinia and others in Addis Ababa
4	Support to AAC	OSSA	5 AACs (171 members)	
		FGAE	5-10 AACs	Not regular support /stationeries
		FSCE	7 schools	Mini media material and training
		SC-UK	6 schools	HIV/AIDS Awareness, Peer education, RH issues
5	Counseling	OSSA	2700	VCT
		FGA	2074	Includes VCT, FP, HIV/AIDS, condom use & negotiation, and other SRH
		Mekdim	3259	Includes individual, group, family, couple and home based counseling
		Netesebrak	1550	On going counseling for youth and HBC givers
		Abyssinia	529	HIV/AIDS, RH Peer Counseling, and referral to clinics
6	Home Based Care	Mekdim	1129 visits	Visits to PLWHA
		Netesebrak	86 PLWHA	240 visits to PLWHA only

The above table attempts to describe what has been undertaken by government organizations, NGOs, CBOs and the private sector under the following major areas:

3.6.1 Efforts on Behavioral Change of the Community towards HIV/AIDS

OSSA Dessie branch organizes and supports youth Anti-AIDS Clubs (AAC) that also uses to access and educate youths on reproductive health including HIV/AIDS. It

provides training to youth AAC members on peer education, IEC/BCC, life skills and prevention of early marriage. The youth clubs play important roles in educating their peers and the community on HIV/AIDS and positive sexual behaviors. Youths are also trained by OSSA in project planning and entrepreneurship skills so that they can create their own income generating mechanism. The organization has also community mobilization activities through panel discussions, support to faith based organization (FBO) and community based organization (CBO) and using Ethiopian coffee ceremonies to bring about change in risk sexual behaviors in the community. OSSA distribute IEC materials that produced by the branch office and receive from head office or other partners.

In the endeavor of activities of awareness creation and promotion of positive sexual behaviors, Dessie branch of *Mekdim* Ethiopia National Association works with schools and out of school youths, CBOs, PLWHA, orphans, families and the community. It gives AIDS education using its members as educators who are living with the virus. Education provided by members of *Mekdim* seems to be creating lasting memories among the public as these people present live examples from their own experiences. *Mekdim* also produces IEC materials it receives or acquires.

Family Guidance Association of Ethiopia North Eastern Branch, located in Dessie town is probably the biggest institution dealing with the youth in Dessie. The branch main clinic provides comprehensive reproductive health service. The branch also has a model youth center where the office using to disseminate HIV/AIDS information, a center for recreation, training and other activities provided for the youth of the town. The youth center has organized and is supporting 5 youth clubs – theatre and drama, music,

library, girl's and literature & mini-media clubs – with total member of more than 100 youths. It also provides family, reproductive health counseling, library, recreational (indoor and outdoor games) and IEC services. Trainings on reproductive health assertiveness, family life & sex education, and peer education are other services that are provided to the youth both in and outside the center. According to its report of 2005, the model youth center was able to make more than 58,000 person-contacts, most of which were youth, with the aforementioned and other services. The youth center also develops and produces IEC materials that mainly target the youth.

Ethiopian Evangelical Church *Mekane Yesus* North-Central Ethiopia Synod has AIDS education and awareness creation activities that target high-risk groups mainly sex workers, community and religious leaders, schoolteachers and students.

Nestebrak Reproductive Health and Social Development Organization is a local NGO established in August 2004. It is working on HIV/AIDS education and awareness creation by organizing workshops, panel discussions, accessing people during health center visits and at market places and by training youths on peer education.

Ethiopian Red Cross Dessie Branch has a three-year (2003–2005) HIV/AIDS prevention project funded by HAPCO. It works on the area of AIDS education mainly through organizing clubs, training peer educators, and supporting community-based organizations, specifically *Idirs*. The project supports 8 schools and 8 out of school clubs and 10 Idirs in Dessie by providing trainings and IEC materials for dissemination of AIDS information. It also organizes advocacy meetings with *woreda* and administrative bodies, religious leaders, and PLWHA.

`Marie Stopes Clinic, as part of its reproductive health services, performs AIDS awareness creation activities that include training of peer groups in schools and house-to-house education through community based organization (CBO). The CBO also use community forums like *Idir* meetings to disseminate information.

Forum on Street Children Ethiopia, Dessie Branch provides AIDS education through peer educators (both adults and youths), Ethiopian coffee ceremonies, at market places and in schools. It also assists anti-AIDS clubs by providing media materials for educating people

Nigat Association for Children Protection & Prevention from Harmful Traditional Practice is a local NGO working with other partners on the prevention of HIV. It organizes sex workers into associations and gives peer training so that they in turn educate fellow women. Coffee ceremonies and family educations are also activities undertaken by *Nigat*. Family education is focused to help mothers understand how youth behave and their needs, so that conflicts arising between them and their young children as a result of change in behavior is reduced.

ZOA Refugee Care also has HIV education activities in Dessie and trained people who are giving education by going to bars, hotels and organizing coffee ceremonies.

Information education communication (IEC) and behavioral change communication (BCC) are probably the most commonly implemented activity as part of HIV/AIDS intervention in Dessie. Almost all partners working on any aspects of HIV/AIDS have some sort of activities in this area. However, most of these intervention activities are designed to create awareness in a traditional way of communicating information about HIV/AIDS to the target population. This should be changed to BCC approach as several

studies show that people's awareness about the disease is high in the country (MOH, 2004). What is lacking now is bringing about positive behavioral changes that would protect individuals from the disease, and this is better achieved by designing and implementing BCC strategies.

3.6.2 Promotion and Distribution of Condoms

Regarding to this effort, OSSA promotes and distributes condom through AAC, government health institutions and its own clinic. AAC particularly distribute condoms to sex workers, bars, hotels and vulnerable youths.

FGA North Eastern Branch promotes condoms and distributes it through several outlets including its two clinics, youths and clubs. Targets of the distribution are its clients of the reproductive health services, in-and-out of school youth, sex workers.

Nestebrak distributes condoms through different mechanisms. It organizes a condom night every two weeks where volunteer youths provide condoms to bars, hotels, sex workers and youths. *Nestebrak* also refills a coin box condom machine established in partnership with Dessie HAPCO, where people can get a pack of condom for 30 cents.

Marie Stopes Clinic promotes and distributes condom in the clinic, in schools through peer leaders and in the community through CBO. FSCE promotes and distributes condom through peer educators. *Nigat* promotes and distributes condom through organized and trained sex workers.

3.6.3 Efforts on Prevention and Control of STI

Virtually all health facilities, be it government, NGO or private, are engaged in diagnose and managing sexually transmitted infections in Dessie. OSSA clinic provides diagnosis and management of STI as part of HIV control activities. Family Guidance

Association (FGA) model youth clinics in Dessie also provide syndrome STI diagnosis and management services that is free for the public. The biggest public health facilities Dessie hospital and Dessie health center run STI control programs. *Tilm* Integrated Rural-Urban Development Project and Marie Stops Clinic also provide STI diagnosis and management services as part of HIV control activities in Dessie. STI diagnosis, treatment and counseling service is provided by Marie Stopes Clinic as part of its reproductive health services.

3.6.4 Efforts on Providing Safe Blood Supply

Ensuring safety of the supply through blood screening and reducing unnecessary transfusions are key elements of blood safety programs. In Dessie, the Ethiopian Red Cross Dessie Branch blood bank is the only facility that collects and provides blood for transfusion.

3.6.5 Voluntary Counseling and Testing (VCT)

Dessie hospital has probably one of the busiest VCT centers in the town, serving on average 20-25 people each day. According to the counselor nurses, many people come from outside Dessie mainly for premarital tests. Dessie health center has also started a VCT service as of January 2005. Both these government health facilities render the service every day; however, percentage of the large number clients, they are considering limiting the number to be served everyday. OSSA and both main and model youth center clinics of FGA are running VCT centers in Dessie that provide the service for free to the public. Three private facilities have recently started providing VCT services in Dessie. These are *Bikat* diagnostic laboratory, *Selam* higher clinic and Ethio Higher clinic. All VCT centers, be it government, NGO or private, provide all types of counseling (pre-test,

post test, follow-up or on-going), do blood test and referral for social support and antiretroviral treatment (ART). Social support referral places for most of the VCT centers are at OSSA, *Mekdim*, *Nestebrak* and rarely EECMY, while all refer to Dessie hospital for ART whenever they feel that the patient "requires" it. Patients are given ART prescription from Dessie hospital and they get drugs from the Hospital pharmacy freely.

3.6.6 Efforts to Building the Capacity of Community Based Organization as Part of Response to HIV/AIDS in Dessie

According to key informants from the *Abyssinia* Anti-AIDS club and OSSA, capacity building has to be an important strategic component of HIV prevention and control, and care and support activities in Dessie. It was learnt that anti-AIDS youth clubs have problems in designing their programs and/or projects and in proper monitoring and evaluation of their own activities. This is particularly relevant for out of school youth clubs. OSSA in Dessie has been building the management capacity of AAC for the last six years but this should be complemented by follow up and monitoring by local government bodies. Almost all the key informants stressed the reason why there is no registration system for AIDS orphans and PLWHA in place in Dessie is mainly due to lack of capacity and resources. The key informants from the *Abyssinia* Anti-AIDS club and OSSA also urged that planning for capacity building has to connect with the specific capacity building strategy and focus on human resources, organization and systems development. As explained by key informants, capacity in planning programs/projects, implementation of projects, mainstreaming, coordination, leadership, financial management, monitoring and evaluation requires special attention.

Key informants agree that strengthening the capacity of AAC, community associations, local authorities and community leaders has undeniable effects on the

implementation of HIV/AIDS programs in Dessie. As noted by FGD and key informant participants, creating an enabling environment and protecting the rights of people living with HIV/AIDS, and AIDS orphan children, will enable the HIV/AIDS infected and affected to live with dignity and responsibility and will limit the spread of the virus.

The fight against AIDS and the preventive, care and support interventions have not yet brought intended changes, mainly due to inadequate ownership and empowerment of the community at large. Therefore, community capacity should be built to enable communities to identify problems in their respective localities, and to develop and implement their own plans to the extent of ratifying social norms and regulations.

Most programs in Dessie as noted by key informants are not well coordinated and community oriented. Informants also indicated that community participation has to be ignited and sustained from within, rather than imposed from above without complete understanding of the issues raised by the local communities.

Key informants have indicated that poor community mobilization and empowerment is one of the weakest links, a serious gap in the HIV/AIDS response, and an important contribution to sluggish change in HIV situation. During the discussion with key informants, it was explained that support provided to *Idirs* and the communities must be in harmony with community needs for social mobilization in order to break the current dependency. Such re-orientation to community mobilization and empowerment, coupled with community capacity building, will create sustainable local response and releases the untapped potential of the communities.

During the discussion with a key informant it was reported that OSSA has been providing trainings for religious leaders of both Christians and Muslims. After these

training sessions, the religious fathers were organized in a task force for both prevention and care endeavors. It was disclosed that financial, material supports were mobilized from the community by these trained preachers for supporting AIDS orphan children PLWHA. Such endeavors should be strengthened to mobilize the community effectively.

3.7 CHALLENGES AND GAPS OF HIV/AIDS INTERVENTONS IN DESSIE

During both qualitative and quantitative parts of this study critical challenges and gaps were tried to spot out.

- Information education communication (IEC) and behavioral change communication (BCC) are probably the most commonly implemented activity as part of HIV/AIDS intervention in Dessie. What is lacking now is bringing about positive behavioral changes that would protect individuals from the disease, and this is better achieved by designing and implementing BCC strategies.
- Production and distribution of IEC/BCC materials does not seem sufficient as most of the partners working on HIV/AIDS were complaining about shortage of these materials. Production of these materials is quite expensive and is planned only by few partners.
- As no one is responsible to coordinate IEC/BCC interventions, duplication of efforts and resources for different IEC activities by different stakeholders in Dessie have been noticed. For instance, Ethiopian coffee ceremony as a means of getting neighbors gathered and having education about HIV/AIDS seems to be undertaken by every organization.
- Peer education activities have been carried out by many AAC, but the peer educators have not been provided with adequate support and follow up by

government or other stakeholders. Clubs and other youth and community groups lack capacity to monitor and evaluate their own IEC/BCC efforts.

- Condom promotion and distribution activities seem to be in a better position compared to other interventions in Dessie. However, many partners who get supply from others were complaining about shortages of condoms as a result of which some distribution programs are cancelled.
- All kinds of care and support to PLWHA and AIDS orphan in Dessie are insufficient neither in quantity nor in the variety of support. Only less than one third of each category is getting any kind of support. Probably because care and support programs are the most difficult and resource intensive activities in HIV/AIDS endeavors, only few partners are providing this service in the town.
- Care and support activities lack sustainability. All partners providing care and support said that the continuity of the activities depends on availability of fund, which is often not easy to ensure.
- There is no coordination of care and support activities of partners and as a result some people reportedly receive support from more than one source while others are on a long waiting list.
- Home-based care is provided by few organizations and clearly many PLWHA who badly need this support are left out. The community is also not adequately involved in home-based care.
- Care and support activities are not well monitored, evaluated and documented by relevant stakeholders in Dessie. There is no systematic OVC and PLWHA

registration and referral system established to enable partners to plan for care and support.

- Few NGOs have been engaged in creation of IGA for very few affected families in Dessie and many more PLWHA and OVC who need this support are left out.
- Medical care including treatment of opportunistic infections for PLWHA is again provided by only few organizations and there is high unmet need in this regard. In fact many PLWHA and OVC who took part in this survey put medical care as their priority need.
- ART service is provided from only one center in Dessie i.e. Dessie referral hospital. This may further limit choices of individuals as to where to get the service, and hence may hinder some people from seeking treatment. VCT centers also do not have link also with Dessie hospital, the only place where ART service is provided in the town. As a result, they refer people for ART but do not receive feedback.
- Many clients prefer the VCT centers at Dessie referral hospital and Dessie health centers, and as a result these centers provide services to larger numbers of people per day than recommended for a counselor. For instance, a report from Dessie hospital shows that as many as 25 people are counseled and tested in one day. This is much higher than a recommended average of 8 people per day for one counselor and in turn may have implications on the quality of the counseling.
- VCT centers are not well coordinated with care and support programs. All VCT centers refer needy people for care and support to *Mekdim* or OSSA and rarely to EECMY. However, none of the VCT centers have made any arrangements with

these care and support providers in order to make sure that the referred people get the intended support.

- Coordination, follow up and control of HIV/AIDS endeavors in Dessie town has largely fallen on the shoulder of Dessie town HAPCO. However, this office does not seem to be in a position to do so because of shortage of budget and manpower, as described by the head of the office. The capacity of HAPCO has been very weak to discharge its mandates of carrying out monitoring and evaluation tasks on HIV/AIDS projects being implemented by different partners in Dessie.
- Many HIV/AIDS intervention programs are not well documented by stakeholders. Others do not access some of the available documents easily to utilize for future planning and programming of activities. Lack of clear and easily accessible documents like activity plans, monitoring tools, review and evaluation reports, etc of programs and activities were problems observed in relation to recording and documentation.
- It has been discovered that many HIV/AIDS projects lack a baseline survey against which their achievements are measured later. Some of them have not even defined indicators for their success or failure. In such circumstances, it is not possible to make a sound evaluation of a project no matter how best it has performed.

4. CONCLUSION AND RECOMMENDATIONS

This study has revealed that awareness raising efforts by a majority of stakeholders should be redesigned geared towards creating sustainable behavioral change

at the community level. The study has also looked into the situation HIV/AIDS infected and affected people and it was found that they lack sufficient access to basic services like food, health care, shelter, education and economic support. It has been noted that local community structures should be well supported to mitigate impacts being staved off by HIV/AIDS on orphan children and PLWHA. Lack of coordination of efforts and resources has been seen among stakeholders. Programmes and projects have also been identified as being developed by stakeholders with out proper situation and response analysis.

Therefore, the study findings suggest the following recommendations to better plan for future interventions and co-ordinate the responses being made by different stakeholders.

Coordination, follow up and control of HIV/AIDS activities in Dessie town should be strengthened. This implies building the capacity of Dessie town HAPCO, which is responsible for these tasks in all aspects. Better coordination and networking of stakeholders' endeavors may help to fill gaps and avoid duplication of efforts. Resource mobilization needs improvement. There are many viable projects developed by partners that could not be implemented due to lack of funds. Dessie HAPCO should be able to finance more projects, as only about one quarter of the Amhara Regional HAPCO approved the projects it selected in 2004/05.

An HIV/AIDS resource center should be established in Dessie town. This will help to get access to information on what is being done and by whom. It also helps to

make the coordination activities better. Stakeholders need to give emphasis on establishment of baseline information and indicators before starting interventions.

Monitoring and evaluation is intricately tied to the planning process of any activities. Likewise, this needs to be explicitly put in place at the start of any HIV/AIDS intervention program. A comprehensive program monitoring and evaluation plan should be developed to address process and outcome, and possibly even impact assessment indicators need to be set, to determine program progress and effectiveness.

HAPCO's monitoring and evaluation capacity of HIV/AIDS programs should be strengthened in terms of manpower and finance so that it would carry out its duties and responsibilities effectively.

Mechanisms need to be devised to coordinate the production and distribution of appropriate IEC/BCC materials so that resources can be pooled and utilized efficiently, and better distribution mechanisms are also designed. Emphasis should be given to ensure that young girls and women have equal access to HIV/AIDS and sexual health information. Anti AIDS Clubs (AAC) and other community based group should be supported to encourage girls and women participation in HIV/AIDS and sexual health issues.

Condom distribution via a coin box machine, which might be the first in its kind in Ethiopia, is a very innovative and effective outlet. This should be replicated and not one but many condom machines should be set in Dessie.

Care and support to PLWHA should be scaled up as only a small proportion of needy people have access to it. This may be better achieved by establishing a network of

care and support by different stakeholders. Priorities should be identified by participatory techniques and supports should be individualized.

A reorientation of home based care towards broad community mobilization and development is essential, with effective structures and true grassroots participation. The magnitude of the epidemic and ever increasing need for home-based care accentuates the need to maximize community mobilization with reliance on volunteers rather than direct-service professionals.

More efforts of stakeholders should be geared towards ensuring access to basic services like food, health care, education and livelihood needs of AIDS orphans. Family and community-based responses are the most affordable and acceptable ways to care for HIV/AIDS affected children. Centralized systems of care and institutional care may be the last resort. Community capacity and willingness to care for the children have to be encouraged and at the same time communities must be capacitated in both human and financial resources in order to sustain care.

In all care and support endeavors, partnerships with community-based organizations like Idirs, religious organizations and other civic associations should be strengthened.

Health care to PLWHA and OVC need to be expanded very well. Stakeholders should be proactive in provision and/or support of medical treatment including opportunistic infections by covering expenses and at the same time building the capacity of health facilities to provide these services. This may be done by supporting specific health facilities, where these people will get the services, in terms of training of staff and making essential drugs available.

The capacity of government VCT centers, namely Dessie hospital and health centre, need to be improved as the client load currently overwhelms them. Increasing the number of counselors who actually provide the service in these centers would probably help to tackle the problem.

Strong links should be established between VCT centers and care & support providers so that effective utilization of the small resources available for care and support will be achieved. VCT centers should also have a strong referral link with Dessie hospital where ART and follow up service is provided.

Income generation activities supported with market and viability studies need to be designed for PLWHA, AIDS orphan children and their families and these schemes have to be planned with true participation of the beneficiaries themselves. Enough start up money and technical assistances should be provided and follow up of the implementation should also be made.

Programmes in Dessie should consider capacity building of AACs and other community based organizations to strengthen behavioral change interventions like community conversation and/or stepping stones approaches of communication and relationship skills development for a healthy sexual life.

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Annex One

Questions for Orphans and Vulnerable Children (OVC)			
1	What is your age	_____ year	
2	Sex	1-- Male	
		2-- Female	
3	Which parent did you lose?	1-- Father	
		2-- Mother	
		3-- Both	
4	Do you know what the cause is?	1--yes	
		2--no	Skip to next
	What is the cause?	1-- AIDS	
		2-- Natural cause	
		3-- Accident	
		4-- Don't know	
		5-- Other (specify)_____	
5	With whom are you currently living?	1-- Father	
		2-- Mother	
		3-- Grandparents	
		4-- Brothers and sisters	
		5-- Relatives	
		6-- No one to live with (street child)	
		7-- Other (specify)	
6	Who is supporting you currently?	1-- Father/mother	
		2--Grand parents/Relatives	
		3--Brothers/Sister	
		4--CBOs (specify)_____	
		5--NGOs (specify)_____	
		6--Government	
		7--No one (self support)	skip to next
		8-- Other (specify_____	
7	What kind of support do you receive?	1-- Food assistance	
		2-- Money	
		3-- Education materials (including uniform)	
		4-- Clothes	
		5-- House rent	
		6--Counseling/psychological support	
		7-- Other (specify)_____	
8	How frequently receive the support/s?	1-- Every month	
		2-- Every three months	
		3-- Every six month	
		4-- Every year	
		5-- Other (specify)_____	
9	Do you feel that the support you are getting is enough?	1-- Yes	
		2-- Not always	
		3--Not at all	
		4-- Other (specify)_____	
10	Are you currently working to get money?	1-- Yes	
		2-- No	
11	Are you in school?	1-- Yes	
		2-- No, I am high school complete	
		3-- No, because no one to support me	
		4-- Other (specify)_____	
12	Did you drop school because of lack of support?	1-- Yes	
		2-- No	
13	Do you feel that you are stigmatized or discriminated?	1-- Yes	
		2-- No	
		3-- I don't know	

14	If so, where?	1-- In school	
		2-- In the community/neighborhood	
		3-- At work place	
		4-- At recreation places	
		5-- Other (specify)_____	

Annex Two

Questions for People Living with HIV/AIDS (PLWHA)			
1	What is your age	_____ year	
2	Sex	1-- Male	
		2-- Female	
3	Marital status	1-- Married	
		2-- Single	
		3-- Divorced	
		4-- Widowed	
4	What is your religion?	1-- Orthodox Christian	
		2-- Muslim	
		3-- Catholic	
		4-- Protestant	
		5-- Other (specify) _____	
5	Are you literate?	1-- Yes	
		2-- No	skip to next
6	Level of education completed	1-- No formal education	
		2--Grade 1 to 6	
		3-- Grade 7 to 8	
		4-- Grade 9 to 12	
		5-- College/University	
7	Occupation	1-- Civil servant	
		2-- Merchant	
		3-- Student	
		4-- Unemployed	
		5-- Other (specify)_____	
8	Where do you seek health care whenever you fall sick?	1--Government health facilities(HS, HC, Hospital)	
		2--Private clinics	
		3--NGO clinics	
		4--Make self treatment (buy drugs without prescription)	
		5--Traditional healers	
		6--Seek no care	Skip to next
		7--Other (specify)_____	
9	Who covers your health care expenses?	1-- Myself	
		2-- Family/relatives	
		3-- An NGO	
		4-- Sympathizing individuals	
		5-- *Idir*	
		6-- Produce exemption paper	
		7-- Other (specify) _____	
10	What kind of support are you getting currently?	1--Medical care including ART	
		2--Food assistance	
		3--Clothes	
		4--School fee and materials	
		5-- Counseling and psychological support	
		6--Training/education	
		7--Other (specify)_____	
		8--Don't need any support	
11	In the past 6 months, have you got any counseling service?	1--Yes	
		2-- No	
12	How do you generally feel about your current living situation?	1--Generally good	
		2--Fair	
		3--Not good	

		4--Don't know	
13	How do you generally feel about your future, especially about your options for survival?	1--Generally good	
		2--Fair	
		3--Not good	
		4--Don't know	
14	What kind of support do you need?	1--Medical care	
		2--Food assistance	
		3--Clothes	
		4--School fee and materials	
		5-- Counseling and psychological support	
		6--Training/education	
		7--Other (specify)_____	
		8--Don't need any support	
15	Do you know any organization providing care and support to PLWHA in Dessie?	1-- Yes	
		2-- No	skip to next
		3-- I don't know	skip to next
16	Which organizations providing care and support to PLWHA?	1-- CBOs like Idir	
		2-- NGOs	
		3-- HAPCO	
		4—Anti AIDS Clubs	
		5-- Government organizations	
		6-- Others (specify) _____	
17	Who do you think should provide care and support to PLWHA?	1-- Government	
		2-- NGOs	
		3-- CBOs like *Idir*	
		4-- Every community member	
		5-- Family members and relatives	
		6-- Anti AIDS clubs	
		7-- Others (specify) _____	
		8-- I don't know	
18	Based on your own judgment, do you think care and support to PLWHA is sufficient?	1-- Yes	skip to next
		2-- No	
		3-- I don't know	skip to next
19	Which support area do you think need to be improved?	1-- Financial and material support	
		2-- Health care provision	
		3-- Psycho-social support	
		4-- Home-based care	
		5-- Shelter	
		6-- Education materials	
		7-- Others (specify) _____	
20	Who do you think should improve the existing care and support to PLWHA?	1-- Government	
		2-- NGOs	
		3-- CBOs like *Idir*	
		4-- Every community member	
		5-- Family members and relatives	
		6-- Anti AIDS clubs	
		7-- Others (specify) _____	
21	Do you feel that you are stigmatized or discriminated?	1-- Yes	
		2-- No	end of interview
		3-- I don't know	end of interview
22	If so, where?		
		1-- In the community/neighborhood	
		2-- At work place	
		3-- At recreation places	
		4-- Other (specify)_____	

Annex Three

Questions for Focus Group Discussion with PLWHA

Date of FGD_____
Venue_____
Investigator_____
Time FGD started_____
Time FGD ended_____

Thank you for agreeing to be part of this study of the situations of HIV/AIDS Infected and Affected people in Dessie town.

The objectives of the study are to conduct a comprehensive study on the situations of HIV/AIDS infected and affected people in Dessie. The information we collect will not identify you in any way and there will be no adverse consequences to you for your participation in this study. The information I collect will be used to full fill the requirement of the MSW degree.

1. Who do you think are most vulnerable to HIV infection in Dessie?
2. What do you think about the risky behaviors in the community that expose people to HIV infection?
3. What are the most important needs of and PLWHA in this community? Who should be responsible for fulfilling these needs in this community?
4. What are the common problems faced by orphans and PLWHA in your community?
   - Regarding the availability of food, shelter, health care and education
   - Regarding the exposure towards violence, rape, abuse and neglect
   - Regarding the right of inheritance (land/house/etc.)
   - Regarding stigma and marginalization
5. Do you think that PLWHA are getting optimum care and support in terms of:

- Provision of food, shelter and health care?
- Creating economic opportunities and maintaining their livelihood?
- Schooling?
- Reducing stigma and discrimination?

6. Which area of care and support to PLWHA do you think need improvement?
7. What do you think about the role of HIV/AIDS committees, NGOs and anti AIDS clubs in your community with regard to provision of care, protection and support for PLWHA?
8. Are there any other comments that anyone of you would like to make about the effect of HIV/AIDS on the important needs or rights of PLWHA?

Thank you all!

Annex Four

Questions for Focus Group Discussion with orphan children

Date of FGD_____
Venue_____
Investigator_____
Time FGD started_____
Time FGD ended_____

Thank you for agreeing to be part of this study of the situations of HIV/AIDS Infected and Affected people in Dessie town.

The objectives of the study are to conduct a comprehensive study on the situations of HIV/AIDS infected and affected people in Dessie. The information we collect will not identify you in any way and there will be no adverse consequences to you for your participation in this study. The information I collect will be used to full fill the requirement of the MSW degree.

1. What are the most important needs of orphan children in this community? Who should be responsible for fulfilling these needs in this community?
2. What are the common problems faced by orphans in your community?
   - Regarding the availability of food, shelter, health care and education
   - Regarding the exposure towards violence, rape, abuse and neglect
   - Regarding the right of inheritance (land/house/etc.)
   - Regarding stigma and marginalization

3. What are your views about the effect of HIV/AIDS on the important needs of the children particularly orphans in your community?
4. Which area of care and support to orphans do you think need improvement?
5. What do you think about the role of HIV/AIDS committees, NGOs and anti AIDS clubs in your community with regard to provision of care, protection and support for orphan children?
6. Are there any other comments that anyone of you would like to make about the effect of HIV/AIDS on the important needs or rights of orphan children?

Thank you all!

Annex Five

Interview questions for key informants

Thank you for agreeing to be part of this study of the situations of HIV/AIDS Infected and Affected people in Dessie town.

The objectives of the study are to conduct a comprehensive study on the situations of HIV/AIDS infected and affected people in Dessie. The information I collect will not identify you in any way and there will be no adverse consequences to you for your participation in this study. The study will be used to full fill the requirement of the MSW degree.

Organization_____
Position/Title_____
Sex of informant_____
Age of informant_____
Education of the informant _____
Date of interview_____

Venue_____
Investigator_____
Time interview started_____
Time interview ended_____

1. In your opinion, what are the most likely sources of HIV infection in Dessie?
2. Which segment/s of the population is/are more vulnerable to HIV in Dessie and why?
3. Please explain how lives of OVC and PLWHA are affected (in terms of their socio-economic situation, school attendance and work situation, stigma and discrimination, the availability and accessibility of support and services)?
4. What are your priority suggestions to prevent or solve these problems, and who do you think is/are responsible for these activities?
5. In your opinion, how is people's attitude towards OVC and PLWHA, are they providing proper care and support for them? What do you think are the reasons this is to happen/not to happen?
6. Would you please tell about how often stigma and discrimination occurs to PLWHA and OVC in Dessie?
7. Please discuss about the availability of care and support to PLWHA and OVC in Dessie town and who provides.
8. What do you think about the HIV/AIDS prevention and control activities being undertaken by the government, CBOs, NGOs, the community, private sector, etc in Dessie in terms of quantity and quality of services? Is there unmet need and why? What could be done?
9. Who do you think should take the lead in the process of improving HIV control and prevention activities?
10. What are the sources of HIV/AIDS information to the public in general and to young people in particular in Dessie?
11. Do you suggest establishment of specific facility/facilities to improve the HIV/AIDS prevention and control activities in Dessie town? If so, please discuss the detail.
12. Would you please tell me the name of all organizations you know that are currently working on any aspect of HIV/AIDS? Do you think these activities are optimal? Do you see any gap or overlap of activities of these organizations?
13. Are there any other comments that you would like to make about the HIV/AIDS control and prevention activities and the effect of HIV/AIDS on the important needs or rights of PLWHA and OVC in Dessie town?

Thank you!

Annex Six

Consent form

The Consent form verbally read for participants of questionnaire survey

Introduction: "My name is Tesfaye Wolde I'm studying my masters of social work I am interviewing people, like you in order to assess the situation of AIDS orphans and PLWHA in Dessie. The objectives of the study are to conduct a comprehensive study on the situations of HIV/AIDS infected and affected people in Dessie. Therefore your honest and genuine participation by responding to the questions prepared is highly appreciated.

Confidentiality and consent: "I'm going to ask you some very personal questions that some people find difficult to answer. Your answers are completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviors. We would greatly appreciate your help in responding to this survey. The survey will take about 30-45 minutes to ask the questions. Would you be willing to participate?"

Declaration

I, the undersigned, declare that this thesis is my original work, has never been presented in thesis or any other university, and that all resources and materials used here in, have been duly acknowledge.

Name: Tesfaye Wolde

Signature: _____

Place Addis Ababa University, Ethiopia

Date of submission: _____

This thesis has been submitted for examination with my approval as university advisor.

Name: Dr. Nathan L. Linsk

Signature: _____