ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

CARE AND SUPPORT SERVICES FOR PEOPLE LIVING WITH HIV/AIDS (PLWHA) AND AIDS ORPHANS IN RELIGIOUS INSTITUTIONS: THE CASE OF DESSIE TOWN

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CARE AND SUPPORT SERVICES FOR PEOPLE LIVING WITH HIV/AIDS (PLWHA) AND AIDS ORPHANS IN RELIGIOUS INSTITUTIONS: THE CASE OF DESSIE TOWN

A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN SOCIAL ANTHROPOLOGY

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ACRONYMS

AACs	Anti AIDS Clubs
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
BCC	Behavioral Change Communication
CBOs	Community Based Organizations
CHBC	Community and Home Based Care
CNSA	Committee on a National Strategy for AIDS
CRDA	Christian Relief and Development Association
CYAO	Children and Youth Affairs Organization
DICAC	Development and Interchurch Aid Commission
DPPC	Disaster Prevention and Preparedness Commission
EDDC	Ethiopian Domestic Distribution and Corporation
EECMY	Ethiopian Evangelical Church Mekane Yesus
EOC	Ethiopian Orthodox Church
EPRDF	Ethiopian Peoples Revolutionary Democratic Front
FBOs	Faith Based Organizations
FGAE	Family Guidance Association of Ethiopia
FGDs	Focus Group Discussions
FHI	Family Health International
FSCE	Forum on Street Children Ethiopia
GOs	Governmental Organizations
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home Based Care
HC	Health Center
IEC	Information, Education and Communication
IGAs	Income Generating Activities
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
NGOs	Non Governmental Organizations
OHACC	Orthodox HIV/AIDS Campaign Center
OSSA	Organization for Social Services for AIDS

PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
SC/UK	Save the Children United Kingdom
STIs	Sexually Transmitted Infections
SWOT	Strength, Weakness, Opportunity, Threat
TB	Tuberculosis
TV	Television
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WCC	World Council of Churches

GLOSSARY

Catha edulis: A type of leaf chewed by people for its psychic stimulant effects

Gulit: A small scale level transaction along side the street on a daily basis

Idir: A community based voluntary association, established for the purpose of mutual aid in matters of burial and other community concern

Id – Alfetir: An Islamic holiday marking the end of Ramadan fasting days

Kebele: The lowest administrative unit

Shisha: A mixture that may include tobacco, honey, hashish and spices and smoked for its strong effects of stimulation

Tella: Local beer

Woreda: An administrative unit below the status of Zone

Yelij Tilla: A type of sore that is often associated with Herpes Zoster

Zone: An administrative unit above the status of Woreda

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PREFACE

This study attempts to explore the provision of care and support services to PLWHA and AIDS orphans in religious institutions in the town of Dessie. In the first chapter attempts have been made to provide the background information, set the statement of the problem, determine the objectives of the study and describe the methods employed. Besides, descriptions of the study site are provided and limitations of the study discussed.

The second chapter covers literature review. Here discussions are made with respect to the origin and concepts of care and the applications of care and support in the Ethiopian context. In addition, this chapter emphasizes the ideals of HBC for PLWHA and care for AIDS orphans with an overview of their limitations. It also offers discussions on the existing models of care and support for PLWHA and AIDS orphan children.

The third chapter examines the extent of HIV/AIDS interventions in the town with the prime objective to provide useful insights into the existing efforts by different stakeholders in preventing the spread of the pandemic. It also aims at seeking attention from service providing partners in addressing the increasing needs of PLWHA and AIDS orphans and indicates vulnerability factors, which provide an instance for the complexity of HIV/AIDS problems.

In chapter four discussions on the provision of care and support services to PLWHA are offered. In light of this, the scope and working relations of the EOC and EECMY with partner organizations and with each other are dealt with. Moreover, the needs of PLWHA and the challenges encountered in accessing care and support services are explored and survey results examined. Using case studies, discussions are also made on the coping strategies of PLWHA.

Care and support services for AIDS orphans in the EOC South Wollo diocese office and the EECMY North central synod are treated in chapter five. Thus, the entire processes of selecting orphans and the types of support provided by both Churches are explained with a focus on examining the problems of the recipients' survival. Also, discussions on the coping strategies employed by the children and caregivers are made and results of the sample survey presented. In the last chapter summary of findings of the study has been provided and conclusions drawn.

ABSTRACT

The central theme of this study is to investigate the existing care and support services for PLWHA and AIDS orphans in religious institutions, namely the EOC South Wollo diocese office and the EECMY North central synod. The prime objective is to help address the needs of HIV positive people and AIDS orphaned children through appropriate care and support services integrating religious approaches into the services provided. In carrying out the study, in-depth interviews, focus group discussions, case studies and observation (qualitative methods) and surveying (a quantitative strategy) were employed. Besides, secondary sources were used to supplement the primary data. The study involved PLWHA, AIDS orphans, home caregivers and different personalities working in service provider institutions.

Findings of the study demonstrate that care and support services to PLWHA and AIDS orphans by the EOC South Wollo diocese office and to AIDS orphans by the EECMY North central synod are not comprehensive. This is because the social, medical and legal supports are inadequate and not inclusive of affected family members except that psychological supports are relatively improved. The study also shows that the social and medical services constitute the most pressing needs of PLWHA and AIDS orphans with increasing demands for self-support in income generating activities.

Care and support services are interrelated with HIV/AIDS prevention and control. This is because PLWHA who could receive the appropriate care and support services tend to inspire people who wish to take VCT and disclose their serostatus and avoid suffering from lack of attention. In the sense of fighting HIV/AIDS, such support provisions would enable PLWHA to feel sympathetic about others and avoid unsafe sex as a result of hope in better future. In addition, those who tested HIV negative could draw lessons to practice safe sex.

The study also attempted to reveal that integrating religious approaches in care and support services would help PLWHA avoid stigma and discrimination associated with the pandemic and develop self-worth. Moreover, such activities promote the very concept of positive living with the virus and enhance the delivery of effective care and support services. It is believed that care and support services could be improved when the human resource capacity is strengthened, programs are designed based on the needs of care receivers, effective networking is established among stakeholders and income generating activities are promoted for sustainable self-support. Also, enhancing efficient utilization of resources and ensuring a combination of social, medical and psychosocial supports would bring about the desired outcomes in changing the life of PLWHA, AIDS orphans and home caregivers.

Chapter One

Introduction

1.1 Background

It is vivid that the threat of HIV/AIDS epidemic has become an issue of great concern to the peoples of the world. Very often the pandemic tends to have damaging effects in developing countries at individual, family, community and societal levels as a result of high death rates mainly in young people of reproductive age (Johnsen, 2003: 1). The provision of care and support for HIV positive people and those affected does not only constitute a human rights obligation, but also remains vital to make effective prevention activities. In most cases activities emphasizing solely the prevention of HIV/AIDS with no inclusion of care and support components could be regarded as partial responses to the pandemic and may secure little support and virtually prove futile in producing the intended outcomes (Gilks et al, 1998: 52).

A person living with HIV/AIDS experiences different needs and problems related to his or her status of HIV infection. These include a particular care needs that could be dealt with the formal health sector (consulting a health professional, diagnosis and treatment of a specific infection, relief of chronic symptom etc) and support needs, which include the provision of counseling, food, material and emotional support by counselors, community-based organizations or support groups in the circle of informal health sector. This entails that People Living with HIV/AIDS (PLWHA) have to be reached through a fully comprehensive provision of care and support through out the early, late, and terminal phases of the disease (Gilks et al, 1998: 51, 54; Uys, 2003: 4). In addition, such programs should necessarily involve those living with the virus in order to convince others that the disease is like other human health problems and enhance promotion to fight it (Green, 1994: 202).

It is evident that lack of adequate resources for clinical care worsens the health conditions of HIV positive people and tends to make death imminent with the early phase of the disease even before AIDS has developed. Early death is therefore, attributed largely to poor health care for HIV-related disease problems and exposure to opportunistic infections (Gilks et al, 1998: 32).

The demand for care depletes household resources through the costs of treatment of the sick persons and the indirect costs of their caregivers. But there are some ways in which households could be strengthened in response to the needs of HIV positive family members such as income generating activities, employment, family skills, capacity and availability of close relatives to assist, mobilization of material and spiritual support etc. Households that are not able to cover the costs of care and support services enter a cycle of impoverishment whereby properties may be sold to provide care and support for the sick family members. Thus, it can be argued that the quality of care for PLWHA provided by households could be affected by resource limitations (Gilks et al, 1998: 43).

It is evident that stigma and discrimination causes the loss of support of family, friends and community members for HIV positive persons, which in turn negatively affects all aspects of HIV prevention, diagnosis, treatment and care. Here lies the need for reducing such stigma in order to provide adequate care and support to those infected and affected and possibly ensure that the pandemic is checked through a holistic continuum of prevention and care structures. Often the absence of such supportive structures resulting from stigma and discrimination would make Voluntary Counseling and Testing (VCT) services little significant (Uys, 2003: 84).

In relation to this, Smart argues that the willingness of families to care for and support AIDS orphans is much complicated by the stigma associated with HIV/AIDS and this eventually results in child mobility, exploitation, and neglect of children. Smart also added that stigma and discrimination would practically make AIDS orphans and vulnerable children to be denied or discouraged from accessing basic services such as health care and welfare services. This implies that a response to such health and social problems of children due to HIV/AIDS needs to include training to enable AIDS orphans and affected children to cope more effectively with the situation (2003: 176, 189).

On the basis of this background, the major problem areas that this research provides insights into include: investigating the various types, components, scope, and prevailing networks of care and support services provided for PLWHA and AIDS orphans in religious institutions; assessing the needs of HIV positive people and AIDS orphans with explanations of how clients and caregivers perceive religious approaches in care and support services; and finally examining how PLWHA, AIDS Orphans and caregivers cope with the challenges they encounter.

1.2 Statement of the Problem

In Ethiopia, organized social welfare is of a recent origin and charity to the destitute and the orphans has been encouraged by religious and social customs in which the extended family system and the community carry on the responsibility of providing care (Andargachew, 1973: 375). In this regard, the worst consequences of HIV/AIDS have yet to be experienced in most settings because of the fact that the disease is still rapidly evolving in different societies. The issue of care and support has therefore, become imperative owing to the chronic and often weakening nature of the HIV/AIDS epidemic and providing care for people with HIV/AIDS is both a health and social policy issue (Lemelle, 1998: 117).

The delivery of appropriate care and support services to PLWHA and AIDS orphans necessitates the availability of community-level action and mobilization. Community groups such as women's groups, religious groups, people with HIV/AIDS etc have to focus their activities on psychological, social and material needs. In course of time such activities may grow and work out in a broad scope and with a community base many activities reach into the home and a variety of needs would be addressed. It is obvious that the provision of the necessary training and counseling to both family and community caregivers especially in the home nursing care and psychosocial support would tremendously improve the level of care patients need (MoH and Path Finder, 2000: 60). In fact, the availability of resources determines the provision of services, which includes support with household tasks, experience sharing, family counseling, health education, home-based care etc (Gilks, et al, 1998: 79-80).

The plight of children orphaned by HIV/AIDS has drawn attention because of the fact that the children are at risk long before either parent dies. In their emotional and social adjustment level, AIDS orphan children usually fall back behind the non-AIDS orphan children. This is attributed to issues surrounding the pandemic in which peers at school and people at other places often stigmatize and force them to lose comfort, security and hope for the future (UNICEF, 1999: 32). Being unable to sustain their life following the death of their parents, AIDS orphan children live with relatives, friends, neighbors, alone by themselves or get hired as house servants that makes them vulnerable to lack of familial care, affection, support and follow up. (MOLSA, 2003: 45).

In the extended family the task of looking after orphan children is given largely to women while in areas worst affected by the pandemic it is increasingly grand parents who provide care for large numbers of orphaned children with little support from the rest of the illness-depleted extended family. In some instances, the responsibility for taking care of such children will be carried on by foster caregivers in communities (Smart, 2003: 189). By and large, the provision of care and support for PLWHA and AIDS orphans plays significant roles in HIV/AIDS prevention and control by bridging the gap in addressing the basic needs of their life and maximizing their abilities to cope with infection and prolong survival time. As a result, this helps HIV positive people to avoid the feeling of hopelessness and unsafe sexual behaviors, which they might other wise practice.

However, there are a number of factors that are likely to make full-fledged care and support programs rather difficult and inefficient in achieving the desired goals of mitigating the impacts of HIV/AIDS. Some of the major challenges that impede the provision of appropriate care and support services thus, include caregivers' financial hardship, oppressive workloads, over involvement with care receivers, inadequate support, fear of disclosure and isolation, and diminished ties with care recipients (D' Cruz, 2004: 64, 68-69).

It is evident that few studies have been carried out in areas of care and support services to PLWHA and AIDS orphans. In the study site, a research was conducted by SC/UK in April 2005 on HIV/AIDS situation, needs and response analysis. However, little improvements in the life of care recipients have been gained due to several factors such as inefficient resource utilization and the imbalance between HIV positive persons and affected families seeking support and available resources. Moreover, the deterioration of the care receivers' living conditions could be attributed to the less emphasis laid on assessing the existing care and support services in religious institutions. This is because FBOs in the town such as the EOC South Wollo diocese office and the EECMY North central synod are among those partners providing care and support services for several clients. Thus, assessing the existing care and support structure with in these religious institutions would help to improve the life of PLWHA and affected families including AIDS orphaned children. In addition, religious approach is believed to be of great importance for effective service deliveries hence, it enables care recipients to avoid stigma and discrimination associated with HIV/AIDS and develop self-worth for better future.

This research is therefore, intended to help address the needs of PLWHA, AIDS orphans and affected families through appropriate care and support services that integrate spiritual components into the comprehensive management of the services provided. Apart from helping in mitigating the impacts of the pandemic on the care receivers and the community, the study would also make the sustained efforts to fight HIV/AIDS more progressive.

1.3 Objectives of the Study

General Objective

- The study is aimed at investigating care and support services provided for People Living with HIV/AIDS (PLWHA) and AIDS orphans in religious institutions and explore how clients cope with the consequences of the pandemic

Specific Objectives

- To examine the various types, scope and networking of care and support services provided for PLWHA and AIDS orphans in Faith-Based Organizations (FBOs)
- To assess the needs of HIV positive people, AIDS orphans and their families receiving care and support services in religious institutions with a focus on how recipients perceive religious approaches in care and support services
- To explain how PLWHA, AIDS orphans and caregivers cope with the challenges they encounter

1.4 Methods of the Study

The focus of this study is the town of Dessie in the Amhara National Regional State. Its central theme is to assess how care and support services are provided to PLWHA and AIDS orphans in religious institutions and explore the ways clients cope with the consequences of the pandemic.
On the basis of the appropriateness of each data collection method to the specific situations in the study, in-depth interviews, focus group discussions, case studies, observations and surveying by questionnaire are employed. Besides, the data collected in the field have been supplemented by

secondary sources. Initially it has been a difficult undertaking to approach PLWHA and caregivers to select potential informants because the issue of HIV/AIDS is sensitive and is often kept secret for fear of stigma and discrimination. It was therefore, possible to get the consent of the study target groups to participate in the study through Mekdim Ethiopia National Association Dessie branch, the Ethiopian Orthodox Church (EOC) South Wollo diocese office, the Ethiopian Evangelical Church Mekane Yesus (EECMY) North central synod and Idirs' coalition of the town.

In the qualitative methods employed in the study involving PLWHA, AIDS orphans and caregivers questions intended to explore the sources of income for the households, the types and extent of support they are receiving and the consequent improvements in their life conditions were addressed. In addition, basic needs for survival, problems encountered in accessing care and support services, coping mechanisms and issues regarding clients' perceptions about religious approaches in care and support were dealt with.

1.4.1 In-depth Interviews

In collecting the primary data, individual in-depth interviews were made with key informants. Thus, five representatives from each group of PLWHA, AIDS orphans and caregivers were interviewed. It was apparent that PLWHA and caregivers were selected owing to their contributions in Mekdim Ethiopia and Idirs' coalition of the town in recruiting community HBC workers and identifying AIDS orphans for support from service provider institutions. While the selection of AIDS orphans for in-depth interviews was based on the respondents' age limit and life experiences.

In-depth interviews were also made with eight individuals involved in the provision of care and support from Mekdim association, Family Guidance Association of Ethiopia northeastern branch (FGAE), the EOC South Wollo diocese office and the EECMY North central synod. In this regard, the problems of clients in receiving support, challenges in addressing their needs and possible ways of alleviating the problems were assessed. In an attempt to examine how PLWHA and AIDS orphans were receiving medical care from public health institutions and NGO clinics, in-depth interviews were made with five health workers at Dessie referral hospital, Dessie health

center, the Ethiopian Red Cross Society Dessie branch and the medical staff from FGAE and Mekane Yesus Church.

1.4.2 Focus Group Discussions

In order to obtain viable data through triangulation of different views of informants, six Focus Group Discussions (FGDs) were made with 30 PLWHA, 20 AIDS orphans and 16 caregivers. As a result, two FGDs were held with each group divided on the basis of sex. In terms of sex distribution, 10 males and 20 females among PLWHA, 8 boys and 12 girls among orphans and 4 males and 12 females among caregivers had participated in the study. In addition, one FGD was held with five representatives from each group of PLWHA, AIDS orphans and caregivers and another FGD was held with 15 AIDS orphans and 3 caregivers (guardians) at Abune Petros Childcare center. On the other hand, five individuals working in care and support services in the EOC diocese office and the EECMY synod were contacted together in FGD while another FGD was conducted with four representatives from Idirs' coalition and Anti AIDS Clubs (AACs). Moreover, six participants from Save the Children United Kingdom (SC/UK), FGAE and Netsebraq (a local NGO) had participated in one FGD while three individuals from Zonal HAPCO, Mekdim and OSSA had taken part in another FGD.

1.4.3 Case Studies and Observation

Four HIV positive persons, one male and three females were interviewed and presented as cases. The selection process was based on the respondents' life experience thinking that viable data could be obtained to explore how PLWHA and caregivers manage to cope with the challenges of their survival. The study also involved observation and this was carried out when PLWHA and AIDS orphans were at work places, homes, receiving social support, medical care, counseling services, interacting with friends, neighbors, relatives etc. The purpose of employing observation as a research strategy primarily lied on the need to obtain useful data by integrating the newly obtained information into what I have previously heard or felt about care and support provisions for PLWHA and AIDS orphans in religious institutions, their living conditions and coping strategies.

1.4.4 Surveying

In the survey, a small sample size (convenient sampling) was taken from PLWHA and AIDS orphans. Thus, the questionnaire administered consisted of questions such as the respondents' sex, age, educational status, religion, housing condition, type of caregiver, situation and size of the family and type of occupation. Besides, questions pertaining to financial and medical support, promotion of Income Generating Activities (IGAs) and vocational skills training, effectiveness of counseling services and Home Based Care (HBC), and so on are included in the survey.

The total number of PLWHA who participated in the study was 69 and selection was made purposely taking into consideration the willingness of respondents and their age limit particularly those above twenty. In selecting informants from AIDS orphans there was a problem not because the children refused to be part of the study nor the religious institutions providing them care and support objected the research, but due to age factor in which most of them were under 15. This provided me with good reason to include those who were 15 and above in the study to obtain viable information by selecting potential informants. Thus, a total of 70 AIDS orphans participated in the research while the number of caregiver informants was 29 and that of individuals from different partner organizations was 31. In aggregate, the number of people who took part in the study conducted was 199. The data collection process took place for about a month and a half between March and the middle of April 2006, but rapport was established earlier with concerned individuals and officials during which I attempted to grasp the situation of HIV/AIDS in Dessie.

1.5 Study Site

Dessie is one of the relatively older towns in Ethiopia that were founded in the 2nd half of the 19th century (Abdu, 1997: 1). It is located 400 kms north of the capital on the main road to Mekele and is situated at 39^0 38' East latitude and 11^0 07' North longitude surrounded by a range of mountains that overlook the town (Getnet, 2004: 113; National Water Resources Commission, 1982; 22). The elevation of the town ranges from 2,525 meters to 2,600 meters above sea level (Ministry of Works and Urban Development, February 1995: 1) with annual average temperature between 3.6^0c to 14.5^0c and receiving annual rainfall of 1501.4mm (Wondye, 2005; 39-40)

In 1930, a plan of action for the development of the town was first designed, and in succeeding years Dessie emerged as an important trade center whereby caravan traders from Gojjam and Tajura were frequently visiting the area (Abdu, 1997: 10-11). Dessie was growing as a commercial center in the heartland of Wollo particularly with the construction of the road linking Addis Ababa to Asmara and Dessie to Assab during the Italian occupation (Abdu, 1997: 38). However, the socio-economic growth of the town has been hindered by the difficult topographic structure, severe landslides, poverty and increasing number of unemployed people and street children (Getnet, 2004: 113). In addition, the inefficient local administration resulting from the absence of accountability on the part of the governors has affected the town's overall growth (Abdu, 1997: 125).

At present the town has assumed the status of administrative center of South Wollo Zone in the Amhara National Regional State. According to Dessie Woreda Municipality Office, there are 20 kebeles (the lowest administrative units) with a total population of about 210, 000 (Dessie Ketema Woreda, 2005: 2). Various business activities that include hotels, bars, illegal video houses and prostitutions do constitute a significant share of the town's economy (Getnet, 2004: 113). Based on the official reports of Dessie Woreda Health Office, the town has 1 referral hospital, 1 health center, and 3 health stations owned by the government and 19 private clinics (SC/UK, 2005: 12).

The situation of HIV/AIDS in the Amhara region is one of the worst in Ethiopia. Although it is difficult to tell exactly about the prevalence of HIV in Dessie due to the absence of sentinel survey site in the town and existing scanty health information, the Amhara National Regional State Health Bureau estimated in 2003 that the average for urban setting is 12.6% (Amhara Region HAPCO, 2004: 6). According to Dessie Woreda Health Office, the inhabitants of the town could get information about HIV/AIDS from different sources like radio, television, newspapers, magazines, relatives, friends, through community-based organizations like Idirs etc (SC/UK, 2005:18).

Dessie Woreda HAPCO was established in 2001 as part of the structuring of the national response to HIV/AIDS. Its main objective is to coordinate HIV/AIDS prevention and control activities that involve the government and non-governmental organizations, the private sector and

Community Based Organizations (CBOs) in the town. It also plays a role of financing small projects on awareness raising, training, and care and support for PLWHA and AIDS orphans alongside performing monitoring and evaluation of activities with stakeholders in order to enhance a successful implementation of project plans. Dessie HAPCO has a coordinating committee from among government offices, NGOs, and CBOs in order to implement its grand objectives efficiently. However, the limitations can be explained in the shortage of manpower, finance and inefficient resource utilization that often hinder its overall activities (SC/UK, 2005: 32).

1.6 Limitations of the Study

This research has not been carried out without some limitations. In the first place, I assumed that all religious institutions working on HIV/AIDS related activities in the town of Dessie could be included in the study. However, I found out that except the EOC and EECMY other faith-based organizations such as the Ethiopian Catholic Church, the Adventist Church, Full Gospel Church and Muslim Idirs do not have organized interventions in care and support services in the town though they promote IEC/BCC and related activities on a limited scale.

Second, I had some difficulties in identifying AIDS orphan children from non-AIDS orphans owing to the Christian moral principles that the EOC and EECMY have applied not to make differences between children who lost their parents to HIV/AIDS, other diseases, natural calamities or various problems as a priority for providing care and support services. Moreover, the process of selecting potential informants from the AIDS orphans was challenging as most of them were too young to provide the required information. Third, PLWHA and caregivers were unwilling to be part of the study due to the prevailing stigma and discrimination and obtaining their consent was a difficult task. Despite this, I have attempted to overcome the challenges and carry out the research.

Chapter Two

Care and Support: Conceptual Framework

2.1 Care: Origin, Definition and Components

It is difficult to make a precise reference to the social origins of the term care, but it was officially used in England in 1930 when there was a need to provide support for mentally handicapped people to live in the community. It was however, in the early 1960s that the term care in community found expressions in policy formulation. The notion is that the community is viewed as both a recipient and provider of care in which the increasing participation of individuals and voluntary groups in community care is encouraged as a way of eliminating the distinction between patrons and clients and establishing strong partnership between them (Bulmer, 1987: 21; Clarke, 2001: 184). Care as a comprehensive and integrated process refers to the range of needs for well being, which include services such as providing counseling and psychological support, medical care, legal and financial provisions (Esayas, 2004: 17).

It was as early as 1986 that the Committee on a National Strategy for AIDS (CNSA) in the USA described the system of AIDS care in terms of three components, namely hospital-care, outpatient care and community-based care. In hospital care, the act of identifying a disease and in-patient treatment will be made and plan is discharged to unite patients with outpatient and community agencies. On the other hand, outpatient services focus on delivering the medical management of patients with AIDS-related complications through dedicated AIDS clinics as well as counseling and health education while community-based care, which includes palliative care and social support occurs at a patient's residence to supplement or replace hospital-based care (Uys, 2003: 3).

In Africa, care and support services for PLWHA are said to have been first developed by hospitals in the form of Home-Based Care (HBC) due to the increasing number of AIDS patients. In Zambia for instance, HBC began in 1987 in the Salvation Army Hospital at Chikankata in the southern province of the country as a response to mitigate the impacts of the HIV/AIDS epidemic. In principle the program included a full range of care and support services, family

counseling and health education, linkage of HIV care with prevention activities, formal and informal education, a formal referral system and linkage with community health centers (Gilks, et al 1998: 78). In relation to this, the first indigenous AIDS Support Organization in Africa, TASO was founded in the same year in Uganda to provide appropriate care and support services to people living with HIV/AIDS (Seidel, 1998: 476). In fact, the needs of PLWHA were wider than medical care implying that the focus grew more inclusive of providing care and support for family members of PLWHA. In succeeding years following the Zambian experience, the HBC program was adopted by East and South African countries particularly by Church related hospitals and NGOs (Liyu, 2001: 15; Gilks, et al 1998: 79).

The concept of comprehensive care and support aims at linking an interdependent group of providers and services that can address the needs of people living with HIV/AIDS and their care givers. It is true that a network of social and economic relations in the home and the work place helps to construct the care giving role whose provision encompasses the emotional aspect of managing feelings and establishing and maintaining relationships. In this respect, the goals of providing care are aimed at assessment, treatment and education of people at risk and people already infected with HIV. Arguably, care ought to be provided through all stages of HIV infection with continuity between different modalities of care ranging from hospital-based to home-based. (Graham, 1983: 22; Corless and Patrice, 2003: 33).

The care needs of HIV positive people change with the progression of the disease implying that care and support needs are directly related to each phase of the disease in which responses required to address such needs vary considerably. In this context, the need to provide nursing care to PLWHA is intended to optimize the quality of their life and reduce mortality. To that effect medical services include treatment and prevention of TB, opportunistic infections and HIV related illnesses and provision of highly active ARV therapy although the capacity and health care systems and human and financial resources available determine the quality of level of medical care (Esayas, 2004: 15). In addition to the medical care, good nutrition is important for the patient because a well balanced diet will help the infected person to stay healthy thereby providing the nutrients the body needs to fight diseases (MoH and Path Finder, 2000: 29).

The provision of care for PLWHA and AIDS orphans is composed of formal care provided by institutions, agencies and medical professionals and informal care rendered by families, friends, relatives and communities (Lemelle, 1998: 117). There are now somewhat developed home-based care systems in most African countries although coverage and access is still much limited to urban areas due to resource constraints. However, it is noted that institutional care could have dehumanizing and damaging effects on the care recipients and this is an indication for the necessity of family or community care, which plays significant roles in the global response to HIV/IDS (Clarke, 2001: 183).

It is true that religion involves a set of moral values, which guide individuals' behavior and its function in society is largely defined in social control and integration (Durkheim, 1961: 62). With the growth of society and the beginning of religion, religious devotion became the most powerful incentive for supporting the helpless, the sick, orphans and the needy on the whole. This was a tradition in ancient religions such as Hindu philosophy, Babylonian and Egyptian codes, in Greek and Roman custom and in Jewish and Christian teachings (Friedlander, 1968: 10; Zerihun, 1999: 9). Religion therefore, enhances well being through social and spiritual relationships by providing meaning in life and enables the HIV positive person to cope with the physiologic and psychological difficulties of the disease (Anne, 2003: 67).

Christianity teaches that charity is motivated by the desire to receive the grace of God or to secure the merits of good deeds for eternal life although the involvement of the Church in dealing with social crises in the contemporary world can also be considered part of an attempt to promote societal development. (Zerihun: 1999: 9). In June 1986, the World Council of Churches (WCC) discussed the challenges and crises that the HIV/AIDS epidemic has brought upon the individual well being of the society. It stressed that member Churches have to involve in HIV/AIDS prevention and care by providing counseling and social services to the infected and affected and in creating awareness (Tariku, 2001: 28).

In light of this idea, religious institutions in Ethiopia play substantive roles in collaboration with other organizations in responding to the HIV/AIDS pandemic. In addressing issues related to HIV/AIDS, faith-based institutions are more successful because of the moral leadership they provide to hundreds of millions of people worldwide, the trust they have gained over generations

and better channels of communications and organizations that have been built. Places of worship with in communities including churches and mosques have undertaken their own initiatives to deal with HIV/AIDS and its impacts at local level. These initiatives include advocacy, change in local community attitudes, speaking out prejudice, fund raising and organizing Home-Based Care (Tariku, 2001: 27).

According to Action Aid Ethiopia, care and support services are more appropriate in faith-based institutions as they are much coupled with spiritual and moral components (Action Aid Ethiopia, 2001: 19). Spiritual development can be viewed as helping people to develop the impression about meaningful life and provide direction to it offering the very principles of integrating counseling into the understanding of humanity. It can be argued that secular counseling had its roots in the spiritual domain, which laid the basis for self-understanding. Spiritual considerations are therefore, essential components of comprehensive efforts to help clients in clarifying spiritual beliefs and promote a sense of acceptance and generate new hope as a motivational resource (Tesfaye, 2004: 9- 10).

The two major religions in Ethiopia, Christianity and Islam have large numbers of followers. Presumably, the role of these religions in the prevention and control of HIV/AIDS is magnificent because they are suitable to address the stigma and discrimination associated with the pandemic and further enable their congregations to develop sympathy for those living with the virus and AIDS orphans. It is apparent that the EOC, Ethiopian Catholic Church, EECMY and the Islamic Supreme Council have long accepted abstinence and faithfulness to sexual partners as major HIV/AIDS prevention strategies although condom use from religious perspectives is not a widely held practice (Belachew et al., 2000: 34).

Religious institutions in Ethiopia had first initiated HIV/AIDS prevention in the late 1980s, but it was in the late 1990s that most of them designed a structured and extensive anti AIDS programs (wyssiwyg://allafrica.com/stories/200012220164.html). In relation to this, training programs that involved the Orthodox, Catholic, Protestant and Muslim leaders in HIV/AIDS epidemiology, prevention, counseling and care and support have helped revise training and counseling materials and programs. However, its implementation has largely been impeded by the sensitivity of HIV/AIDS issues, condom use and traditions prohibiting religious leaders to discuss sexuality with their congregations (Belachew et al., 2000: 56).

The EOC has been giving due attention to the campaign against HIV/AIDS epidemic since 1998 with grand objectives of curbing the spread of the disease. Towards this end the Church has importantly advocated its HIV/AIDS programs on the basis of the following precepts. First, rally program also known as patriarchal campaign aims at helping couples to remain faithful to each other by obeying Christian norms and abiding by them in their marital life; second, moral authority that appears to be the center of communal life is addressed to the people and third, family pastoral care and counseling are provided in which every follower of the Church has one pastor who serves as a counselor for a harmonious life and good moral standards. In practice some types of pastoral duties are spiritual in character for instance, assisting people who are lonely and in despair, others are material in character such as feeding the hungry and liberating the captives (Kefyalew, 2002:1-3).

In 1999, The Orthodox HIV/AIDS Campaign Center (OHACC) was established to promote objectives in halting the spread of the pandemic through awareness creation among the community and providing counseling and care and support services (Tariku, 2001: 28-29). The strategies of OHACC thus, include the provision of training on prevention and care to the clergy, launching mass information campaign, providing the opportunity to individuals and Church structure to act against HIV/AIDS, contributing to the development of sustainable programs in collaboration with CBOs, NGOs and Government Organizations (GOs). In addition, OHACC aims at producing and distributing Information, Education and Communication (IEC) materials that are intended to bring about behavioral changes, and working on the idea of community involvement in order to strengthen family and community support for PLWHA (Tariku, 2001: 30).

The other religious institution working on HIV/AIDS prevention and control in the country is the Ethiopian Evangelical Church Mekane Yesus (EECMY). The EECMY as a national Church grew out of the works of the Lutheran Missions and indigenous evangelists who preached the Gospel in Ethiopia since the 1860's. As a national Church in Ethiopia, the EECMY was established in January 1959 (http://cc.msnscache.com/cache.aspx?q=3260765123997&lang=en-US&mkt=en-US&FORM=CVRE).

The old emphasis in the mission of the Church had been on the verbal teaching of the Gospel, but missionaries began to promote social services and development works in due course of time as a means of reaching the people or seeking work and residence permits. Due to enormous social needs however, the EECMY had to integrate evangelical works into development activities since the early 1970s. Consequently, the social activities of the Church became more defined to include development programs such as integrated rural development projects, health, child and youth care, education, water supply and since the 1980s HIV/AIDS prevention and control programs (http://cc.msnscache.com/cache.aspx?q=3260765123997&lang=en-US&mkt=en-US&FORM=CVRE).

2.2 Care and Support in the Ethiopian Context

In Ethiopia, the first cases of HIV/AIDS were reported in 1986. A year later the government established the National AIDS Control Program with in the Ministry of Health with the objective to direct and coordinate the implementation of the AIDS control strategy geared at preventing HIV transmission and reducing the morbidity and mortality, which could result from HIV infection (MoH, 2000: 47). Since the diagnosis of the first AIDS cases in Ethiopia, a number of NGOs, faith-based institutions, and civic societies in general have been involved in responding to the pandemic.

At the beginning they were nearly involved in Information, Education and Communication (IEC) to inform people about the risks of HIV infection and to encourage them to adopt protective behaviors. Gradually, the provision of training, psychological support, care, counseling and advocacy were added to existing programs (Action Aid, 2001: 2). However, these interventions were inadequate in scale initially owing to insufficient stakeholder involvement in planning and implementation particularly at the community level, low level of allocated resources in terms of material, finance and trained manpower, poor coordination and integration across sectors and among service providers and so on (Garbus, 2003: 69).

In 1998, the government of Ethiopia launched a National Policy on HIV/AIDS. The policy encouraged people to adopt protective behaviors and in specific context, it outlined the implementation of programs to provide care for those living with the virus and to reduce the adverse socio-economic effects of the disease (MoH, 2000: 47-48).

This policy has given due attention for guidelines related to Community and Home-Based Care (CHBC), which was effected in 1996 by the Ministry of Health. Accordingly, CHBC as an effective model of delivering care and support services constitutes the following program components: encouraging psychological, economic and medical supports to PLWHA and affected family members through eliciting established patients' familial and social network; providing counseling services to PLWHA by health workers and counselors; encouraging Income Generating Activities (IGAs) and enabling clients to become self-supportive. It also ensures the availability of drugs for the treatment of STIs and providing care for AIDS orphans (FDRE, 1998: 31-32; Red Cross and Red Crescent Societies, 2003: 11). Nevertheless, PLWHA in most urban and rural areas in Ethiopia do not yet have access to CHBC services because of insufficient involvement of public sectors and local associations. This entails that there is a need to strengthen the government's capacity to improve the participation of community-based organizations like Idirs. (MoH and UNAIDS, 2000: 46).

The establishment of the National AIDS Council in April 2000 with defined objectives to coordinate HIV/AIDS prevention and control activities in integrated approaches and alleviate the socio-economic and psychological impacts resulting from the pandemic has given strength to the overall efforts to fight the disease in the country (MoH, 2000: 49). The strategic framework for the national response to the HIV/AIDS epidemic in Ethiopia has been developed that includes multi-sectoral activities, participation, leadership, and efficient management with adequate monitoring and evaluation (Garbus, 2003: 69).

Despite efforts to address the issue of HIV/AIDS in the country, there have been several problems with the implementation of HIV/AIDS policy. Of the major bottlenecks, the following are worth noting. First, both human and material resources are inadequate and efforts are uncoordinated and poorly targeted; second, project preparation, financial planning, record keeping and reporting are serious shortcomings; third, there is poor capacity to appraise proposals at Woreda levels and a critical gap concerning the establishment of monitoring and evaluation systems even at the national level; fourth, the issue of networking among several actors and stakeholders is still a problem and finally, there is lack of skill to mobilize and involve the community in the fight against the pandemic (Action Aid, 2001: 6).

It is also my belief that poor house hold resources have deterred several people infected with HIV/AIDS in the country from accessing the appropriate care and support services although CHBC as a strategy appears to be an effective alternative to address the increasing needs of PLWHA and AIDS orphans. The problem partly arises from the failure to provide sustainable support for families and community care providers. CHBC can also be criticized for an attempt by the government to divert its responsibilities from or withdraw commitments to play the key role in coordinating efforts related to HIV/AIDS prevention and care and ultimately dealing with the crises.

Ideally care and support services have to be comprehensive. Here the implication is also for considering the needs of both recipients and home caregivers and this has been further strengthened in the following statements.

> The concept of comprehensive care across a continuum involves the major components of clinical care, psychological support (counseling), socio-economic support, and support for human and legal rights of people infected with and affected by HIV/AIDS (FHI, 2000: 5).

In HIV/AIDS prevention and care activities, the need to cope with the stigma attached to the pandemic and raise the level of living of PLWHA through mitigation of its economic consequences remain essential. In order to address the needs of AIDS patients, caregivers have to be given support like medical care for AIDS related conditions, family education on AIDS, voluntary HIV testing, supportive counseling, material support and HBC training (Gilford et al., 2000: 30).

Arguably, the successful implementation of such programs would prevent the engagement of HIV positive people from aggravating the spread of HIV/AIDS. In this respect, empowering the local government in its role of coordinating sector and developing accountability, transforming laws and the legal support services, emphasizing the betterment of the status of women, safety of public health, and taking anti discrimination measures are essential. Also, encouraging the involvement of the private sector and community would greatly enhance existing efforts to deal with the crisis of the pandemic (Liyu, 2001: 8).

2.3 Home-Based Care for PLWHA: Concepts, Advantages and Drawbacks

Home-Based Care is a type of care given by a family and friend caregivers (primary care providers) at home supported by a community caregiver. A primary care provider is an informal caregiver that may be either the genital father or mother of the sick person, spouse, children, friend, close relative or adoptive parent who provides most of the care to the person living with HIV/AIDS at home. (Uys, 2003: 4). In this regard, community caregivers usually perform tasks such as counseling, imparting information and providing psychological and emotional support. Community based care includes positive acceptance of the diagnosis, promoting disclosure especially to sexual partners and family caregivers, enhance understanding of the illness and a healthy life style and assist with preparation for death such as childcare and the family to deal with loss (Uys,2003: 7-8).

The involvement of the family in providing care and support may begin with the time the patient discloses his or her HIV status and end with the death of the patient. Thus, care providers need much counseling and teaching to be able to cope emotionally and physically with the illness of the individual. This implies that the concept of Community and Home-Based Care (CHBC) does not only constitute a health aspect, but also involves multiple dimensions because care providers have to respond to the medical, psychological, and socio-economic needs of individuals infected with the virus and the affected families as well (Uys, 2003: 5). In areas where there is high prevalence of HIV infection, severe economic hardship has been a problem. Needs assessment for instance, in Sub-Saharan Africa shows that material support is the most pressing requirement for PLWHA (Esayas, 2004: 17).

In Africa in general and Ethiopia in particular existing socio-economic structures allow HIV positive people to stay with in their environment ensuring the continuum of care. Such a tradition chiefly encourages family support and mutual obligation including consensus to designate a direct caregiver with in a family (Liyu: 2001: 16). Home-Based Care makes possible the involvement of volunteers, family members, relatives, friends and neighbors in providing care and support services. It helps to mobilize the potential of caring and sympathy that exists with in a community, which in turn allows bringing the pandemic out in the open and challenge distortions of facts and prejudices about the disease (Esayas, 2004: 18).

It is noted that Home-Based Care with the availability of the required resources has been regarded as the best option of addressing the care and support needs of individuals compared with hospital-based care. In order to realize the program resources are needed for instance food, clothes and assistance with other economic needs and social welfare services must be linked up. Care providers should also be given training in Home-Based Care and supports like family education on AIDS, supportive counseling and voluntary HIV testing need to be given by health professionals, counselors, and social workers (Gilford, et al. 2000: 34). Moreover, voluntary action initiated by community mobilization to provide care and support could help to reduce the discrimination of PLWHA because close contact is created with them. This raises community awareness and strengthens the effort to prevent the spread of HIV/AIDS and brings the community together in care of PLWHA and AIDS orphans (Liyu, 2001: 11).

Evidently, some more advantages in providing care and support services at home can be sought. It enables patients to become active and productive as possible, sick people are comforted by being in their homes and communities with families, friends, neighbors and volunteers around, and relatives may be able to carry out other duties more easily if patients are at home. Moreover, HBC gives relief to the over stretched health sector of countries that are highly affected by the epidemic, is usually less expensive for families and offers opportunities for educating family members and communities about HIV prevention by creating awareness (MoH, 2001:3-4; Gilks et al, 1998: 76).

The involvement of PLWHA in community mobilization could also facilitate HBC program and appears effective in gaining acceptance among the population at large. In Ethiopia, the cases in point are associations that consist of members from HIV positive persons and AIDS orphans such as Mekdim National Association of PLWHA and AIDS orphans and Dawn of Hope (PACT Ethiopia, 2000: 34). Without such a network, Home-Based Care could be of poor quality leading to the dissatisfaction of HIV positive persons and their families eventually worsening the life conditions of the care receivers and causing the growing rate of HIV infection (Uys, 2003: 10, 13).

In spite of wide range of advantages, Home-Based Care has some limitations. Children are more involved in caring for sick parents or relatives forcing them to withdraw from schools, the elderly

face the task of providing care for their sick children while they should be looked after at their old age, and care providers do not have the necessary training to efficiently address the care needs of patients (Liyu, 2001: 12). In addition, economic conditions and size of the household, the stage of HIV infection and family perception of the HIV positive person as innocent or guilty (since AIDS is usually regarded customarily as the outcome of sinful acts by the victim) for being infected have enormous effects on the care and support services provided to the care recipients (D' Cruz, 2004: 69). The sustainability of HBC thus, largely depends on support from the community and it requires flexibility and innovation on the part of caregivers, as the need to address the culture and ethical issues of the sick person is vital (MoH, 2001: 3). In this regard, establishing a solid system for this strategy and expanding the capacity for care with in the community could be useful to build a more acceptable and sustainable care delivery system (Abdool Karim et al, 2002: 412).

2.4 Care for AIDS Orphans and Perceived Challenges

One of the worst consequences of HIV/AIDS is the increasing number of AIDS orphans and vulnerable children. The economic problems of AIDS orphans are usually related to the treatment of their parents' disease. The longer the time PLWHA spend without work would mean decreasing income and the subsequent sell of owned property to survive. This results in enormous challenges to child survival because siblings have to carry on responsibilities to support the family members (CYAO 1997: 6). The provision of welfare services to the needy children is a comprehensive activity that includes the social, economic and health care services of public and private welfare agencies in order to secure and protect the wellbeing of the children in their physical, intellectual and emotional development (Frederickson, 1957: 12).

It is true that the existence of ordered social life can find expressions in the role institutions play in society. In addressing the main domains of response to HIV/AIDS such as prevention, treatment, care and support for PLWHA and AIDS orphans, different organizations both religious and non-religious have immense contributions although the degree of intervention differs. This can be manifested in strengthening the coping capabilities of individuals, households and communities (Sylvan et al, 2004: 23).

Institutional support for AIDS orphans is however, very limited primarily because of the deepening crisis that HIV/AIDS is causing. Thus, the social, economic and psychological consequences of illness and death of patients due to HIV/AIDS are strongly felt in the life of children whose needs fall in to the physical, emotional, health, educational and human rights needs. The physical needs may include food, clothing, housing and footwear while the emotional needs are the provision of counseling, love and attention to the children. On the other hand, the health care needs refer to child health services and especial care for children infected with HIV/AIDS. The educational and human rights needs of AIDS orphans could also be explained in child support to attend schools and protection from discrimination because of their HIV status or being members of affected families (Esayas, 2004: 19).

Most of the AIDS orphans in resource-constrained countries including Ethiopia are from the poor families who lack their basic needs. On the basis of a study conducted in Bahr Dar three years ago, it can be argued that orphan heads of households face problems, which include stigmatization, insuffiecient income, shortage of housing, lack of vocational and skills training, employment opportunities, health care and moral support (Garbus, 2003: 67-68).

AIDS orphan children could also be denied access to education if they are living with extended families that can't cover the costs of educating them. They do not also receive the appropriate medical care on the ground that they are AIDS affected or infected and their cases cannot be treated. Particularly AIDS orphan girls who do not receive the appropriate care and attention may be exposed to sexual abuses while boys could be forced to cope with survival problems in self-abusive, destructive and anti-social acts such as begging and theft (Mesfin, 2004: 19; MOLSA, 2003: 52). In sum, children in HIV/AIDS affected households face loss of their families, psychological distress, increased malnutrition, loss of health care, reduced opportunities for schooling, loss of inheritance, violence of human rights and exposure to HIV infection (Mesfin, 2004: 23).

It is argued that the basic goal of a child welfare program is aimed at bringing the child's well being, which includes physical, social and psychological growth. In order to bring this wellbeing various approaches and strategies have been designed in Ethiopia. Of these approaches home-based care, institutional care, adoption, and foster care are important (CYAO, 1997: 4).

2.5 Models of Care and Support

There have been some models of home-based care for PLWHA developed over the years, namely: the integrated home-based care, single service home-based care and informal home-based care models. The integrated home-based care model is functional by linking all the service providers with patients and their families in a continuum of care. The central idea of this model is that mutual support and collaboration among different components such as families, community care providers, clinics, hospitals, non-governmental organizations and community-based organizations could be enhanced. The system allows for referral between all service providers as trust is built and it develops capacity in all partners. The approach ensures that community care providers are trained, and then supervised and supported. In this model a small group is supported by a large group and growing network of services. Thus, all care provisions are based on palliative care standards whereby community caregivers assist family caregivers and patients towards making the sick person more comfortable, improving his or her health status and lightening the care load of the family caregivers (Uys, 2003: 5-8).

The single service home-based care model basically lies on service provisions through one service component such as a Church, NGO or hospital organizing home-based care by recruiting volunteers, training and linking them with patients and their families at home. The third type of care and support model for PLWHA, the informal home-based care works on the basis of concepts in which family caregivers carry on the responsibility of care for the patient at home with the informal assistance of their own social net work (Uys, 2003: 7).

I believe that it would be ideal to deliver home-based care for PLWHA through an integrated approach in resource-constrained countries like Ethiopia. This is because the model principally entails that the patient and his/her family could get all the services they need from the day the diagnosis is made through all the phases to terminal care with the quality of care being optimal. It is therefore, difficult to indicate the application of the integrated home based care model in this study given that effective collaboration of different service provider institutions in the study site is still unattainable.

Arguably, the other two models of care and support for PLWHA have also their own drawbacks. In spite of the concepts enshrined in the single service home-based care model, there are little opportunities in the town of Dessie to find a single service provider institution, which is capable of providing HBC training sustainably to volunteers. Hence, the sustainability of support is basically important in that resource limitations may cripple the activities of a single service provider institution. Consequently, care and support for PLWHA would be unreliable and little improved in the single service home-based care model. There are also limitations in the informal home-based care model where family caregivers do not have the necessary skills and training in HBC and lack in sustainable support from service providers.

In the context of this study, it is assumed that the informal home-based care model although with limitations of its own can be applied in enabling family caregivers to address the needs of HIV patients. This is because the model chiefly entails the existence of informal assistance particularly community involvement than often relying on external support. But, it should be noted that other partners need to involve in the system to enable PLWHA to support themselves sustainably, and programs should be gradually linked to formal health care providers.

Given the depth and extent of the HIV/AIDS consequences on the social life of the community, there is a growing need for active public intervention focusing on keeping the children with in the community (Sylvan, et al 2004: 232). In order to mitigate the impacts of HIV/AIDS on AIDS orphans, some models of care and support have therefore, been developed. These include independent living by orphans with external supervision and support, family foster care, institutional care, and the state or NGO sponsored community based support structures (Giese, 2002: 63; Smart, 2003: 181).

The objectives of home or community based care for AIDS orphans include the fulfillment of the basic needs of children in different circumstances while they are with in the extended families or members of the community and to create conditions conducive for them to grow up in the community and get socialized with the norms and values. The ultimate goal of the program is therefore, the creation of self-reliant, independent, reliable and cooperative citizens (CYAO, 1997: 4).

It is believed that the family and community based approaches of care and support for AIDS orphans could best meet the children's need for security and socialization and services can be delivered at a lower cost. As a result, it is more productive to allocate resources towards strengthening the abilities of families and communities to meet the long-term needs of the children such as education and training, and the immediate needs of households for economic security (Hirut, 2001: 13; Smart, 2003: 182). But, the challenges could be partly felt when the extended families deprive the orphan children of their love and attention being fearful of the outcomes of caring for them due to stigma associated with HIV/AIDS.

In contrast with the family and community based models for care and support of AIDS orphaned children, the models of independent living by orphans with external supervision and support and institutional care are less important. In the case of independent living by orphans with external supervision and support, there are problems that the orphan children could face. In the first place, allowing children to live alone being household heads would mean depriving them of the appropriate guidance and counseling for proper growth, which they might have acquired in the family or community based support. Second, children would not be able to develop good habits of work at early ages and lack in self-driven motives to support themselves at younger and adult ages (CYAO, 1997: 6).

On the other hand, institutional care for AIDS orphans is not generally commendable or an appropriate intervention because it can fail to meet the children's developmental and emotional needs and its relevance as a long-term solution is disputed. This is because it obliges the orphan children to leave their villages, lose their rights to their parents' properties and a sense of belonging to a family. (Giese, 2002: 69).Therefore, among the various approaches of care and support for AIDS orphaned children, the family foster care and community based support structures could best remain viable ways of meeting the needs of AIDS orphans. Thus, these models of care and support for AIDS orphans are likely to be applied in this study provided that caregivers at home or the community are strengthened financially and emotionally.

Chapter Three

HIV/AIDS Interventions in Dessie

3.1 Information, Education and Communication/Behavioral Change Communication (IEC/BCC) Efforts

The aim of presenting this chapter lies on the need to show the severity of HIV/AIDS problems in the town of Dessie and the existing efforts to raise awareness through IEC/BCC activities. In doing so, interventions by religious institutions, NGOs, associations, anti AIDS clubs and Idirs are described. Such descriptions will relate the care and support needs of those living with the virus and AIDS orphans to the HIV/AIDS prevention and control program. This chapter will enable readers to notice how much sensitive the issue of care and support has become in the town demanding due attention from stakeholders.

3.1.1 The Role of Different Stakeholders

It is widely believed that access to information is an important element in an attempt to bring about behavioral changes in HIV/AIDS prevention and control. In assessing the existing HIV/AIDS interventions in Dessie, it was necessary to collect primary data from different organizations, health institutions, Idirs, Anti AIDS Clubs (AACs) and so on. The data obtained showed that the sources of information about HIV/AIDS in the town included: radio, television, newspapers, magazines, leaflets, posters and other materials.

It has been emphasized that more information could reach the community through radio and television programs, but alongside this Anti AIDS Clubs (AACs), Idirs, schools, health institutions, Family Guidance Association of Ethiopia Dessie branch (FGAE), Organization for Social Services for AIDS (OSSA), Mekdim Ethiopia National Association, the EOC, EECMY and other institutions have had significant roles in producing and distributing IEC materials. Accordingly, the provision of information on HIV/AIDS needs to integrate awareness creation into eventually bringing behavioral changes among the population in general and adolescents in

particular. In this respect, the activities of Abyssinia and Beza Anti AIDS Clubs in initiating community conversation programs like coffee ceremonies are worth mentioning.

The need to bring about positive change in sexual behavior and promote safer sexual practices among the people of Dessie through BCC has been the most visible response to the AIDS pandemic, which is relatively considered by many partners working in the field.
Based on the data obtained from OSSA, the organization has been carrying out activities targeted at organizing and supporting anti AIDS clubs through which it could reach the youth about reproductive health issues including HIV/AIDS. Thus, it has provided training to the anti AIDS club members on peer education, behavioral change communication, life skills and prevention of early marriage. In turn, the anti AIDS clubs have played important roles in educating peers and the community on HIV/AIDS and positive sexual behaviors. The organization has also performed community mobilization activities through panel discussions and supported CBOs to bring about the desired changes in risky sexual behaviors among the community. Besides, it has contributed to the distribution of IEC materials of different types.

According to key informants, Mekdim association has worked with schools, out of school youths, CBOs, PLWHA, AIDS orphans, families and the community. It taught the public about HIV/AIDS particularly using its members who were HIV positive themselves. The efforts of Mekdim to reach the community through PLWHA appeared to be effective creating lasting memories among the people because those living with the virus presented live examples from their own experiences. Alongside this activity, the organization has produced and distributed IEC materials.

Informants from FGAE northeastern branch also noted that the organization was working on reproductive health and HIV/AIDS issues. FGAE has a model youth center in the town where it could reach young people on HIV/AIDS information and provide services such as recreation and training. In order to carry out its activities the youth center has organized five youth clubs with more than hundred young people as members. The center provided the youth clubs with financial and material assistance to perform their activities that included theatre, music show, and library services. Apart from this, the youth center provided training in sexual reproductive health, family planning, sex and peer education. It also provided counseling services to young people of the

town and contributed to the distribution of IEC materials. It was reported that the model youth center had contacted more than 58,000 people in the year 2004 most of whom young.

According to informants from the EOC diocese office and the EECMY synod, the roles of the Churches in promoting IEC/BCC activities as part of HIV/AIDS interventions in Dessie have been relatively significant. In this regard, both Churches were taking part in carrying out certain activities in collaboration with partner organizations such as FGAE north-eastern branch, Ethiopian Red Cross Society Dessie branch, Mekdim Ethiopia National Association, Netsebraq (a local NGO) and OSSA that were all operating in the town.

The major focus areas of both Churches included: awareness raising, teaching about reproductive health and family planning, the need to avoid sexual intercourse before marriage, inculcating faithfulness to partners, counseling, distributing IEC materials having spiritual components (each Church with its own distinct approach) and so on. The target groups were young people both at school and out of school, teachers, the community, sex workers, PLWHA, AIDS orphans and their families. However, it was stated in FGD held with care and support staff of the EOC and EECMY that the activities of the Churches in promoting IEC/BCC efforts were limited because of the inadequacy of funds secured from donors and mobilized from their congregations. Partly opposed to this view, interviewed PLWHA and caregivers disclosed that inefficient use of resources had also affected the efforts of the Churches to address particularly their material needs.

Apparently, in addressing the town's population with IEC/BCC activities, Netsebraq Reproductive Health and Social Development Organization was working on HIV/AIDS education and awareness creation by organizing workshops, panel discussions, contacting people during health center visits and at market places and by training the youth on peer education. The other institution working on HIV/AIDS was the Ethiopian Red Cross Society Dessie branch, which mainly focused on organizing clubs, training peer educators, and supporting community based organizations specifically Idirs. The project supported eight out of school and eight school-based anti AIDS clubs and ten Idirs in the town by providing training and IEC materials for dissemination of AIDS information. It also organized advocacy meetings with Woreda administrative bodies, religious leaders and PLWHA. In spite of these efforts, the spread of the

pandemic in the town seemed uncurbed with new infection rates increasing and the consequences much felt in the life of the community.

With regard to condom promotion and distribution as part of HIV/AIDS intervention programs, there were basically uncompromising views held by faith-based institutions on the one hand and other partners on the other. From the perspectives of the EOC and EECMY, the use of condoms among unmarried peoples was not a priority concern because it could not be the best alternative to stop the spread of the pandemic except that it would encourage adultery contrary to the teachings of Christianity. Rather, it has been the tradition of the Churches to teach the people to remain faithful to their partners as an effective option in responding to the HIV/AIDS epidemic.

Nevertheless, the EOC diocese office and EECMY synod tended to promote condom use only in cases where the couples were HIV positive. Accordingly, a nurse and a medical doctor respectively from both Churches explained that married PLWHA needed to use condoms to avoid the transmission of different virus strains to each other. They emphasized that this practice was encouraged since all married HIV positive individuals could not have exactly the same virus strains; one type may be stronger than the other seriously affecting the health of the person who had a weaker virus strain. In addition, the use of condoms among couples who are living with the virus was justified by the fact that it would avoid pregnancy and the risk of HIV transmission from mother to child.

In contrast, different partner organizations advocated the use of condoms as a basic strategy to prevent the spread of HIV/AIDS. They unanimously agreed on the point that condom use must increase among individuals at risk of HIV and Sexually Transmitted Infections (STIs). This could be realized when there is promotion to create and increase the demand for condoms and ensure adequate and sustainable supplies to the public in general and to the risk groups in particular. The intractable debates between the faith-based and non-faith based organizations therefore, centered on whether condom promotion and use should remain the basic strategy in HIV/AIDS prevention programs or it really gives much strength to sexual promiscuity.

Although it seems that the views held by faith-based and non faith-based organizations on the issue of condom promotion and use are uncompromising, the underlying realities show that

individuals at risk and vulnerable groups on one side and married PLWHA on the other should necessarily use condoms in sexual intercourses because this could immensely help the prevention of HIV/AIDS among the former and the transmission of different HIV virus strains among the latter. On the basis of these premises, it is convenient to argue that the Churches' long established principles regarding sexual partnerships among individuals have been functional only for those who are married since sex before marriage is not allowed. Nevertheless, realities bear witness that few people today strictly comply with the ethical rules of Christianity and the challenge comes here when most people are rushing into sex before marriage or commit adultery.

On the other hand, critically viewing the working principles of non-faith based organizations concerning sexual partnerships among married PLWHA; it is still difficult to find coherently conceived ideas that would help to promote the use of condoms among people living with HIV/AIDS. Perhaps this might have emanated from the misconception that the transmission of different HIV virus strains to each of them would bring no harm to their health. It can be summed up that there should be a strong association between the promotion and use of condoms for those at risk or infected with the virus and a comprehensive public teaching to remain faithful to partners. This is because endeavors to attain the intended outcomes of preventing and controlling HIV/AIDS only through one of these strategies would be unrealistic.

In distributing condoms to sex workers at homes, bars, hotels and vulnerable groups, both young and adult, the activities of some organizations like OSSA, FGAE, Netsebraq, Dessie Woreda HAPCO, Marie Stopes Clinic, Forum on Street Children Ethiopia (FSCE) Dessie branch, Abyssinia anti AIDS club and Nigat (a local NGO working on child protection and prevention from harmful traditional practices) could be mentioned. In this regard, there has been a program known as **condom night** (a practice of distributing condoms to individuals at hotels, restaurants and night clubs) promoted by Abyssinia anti AIDS club but recently, the club has focused much on community conversation programs and peer education training on HIV/AIDS.

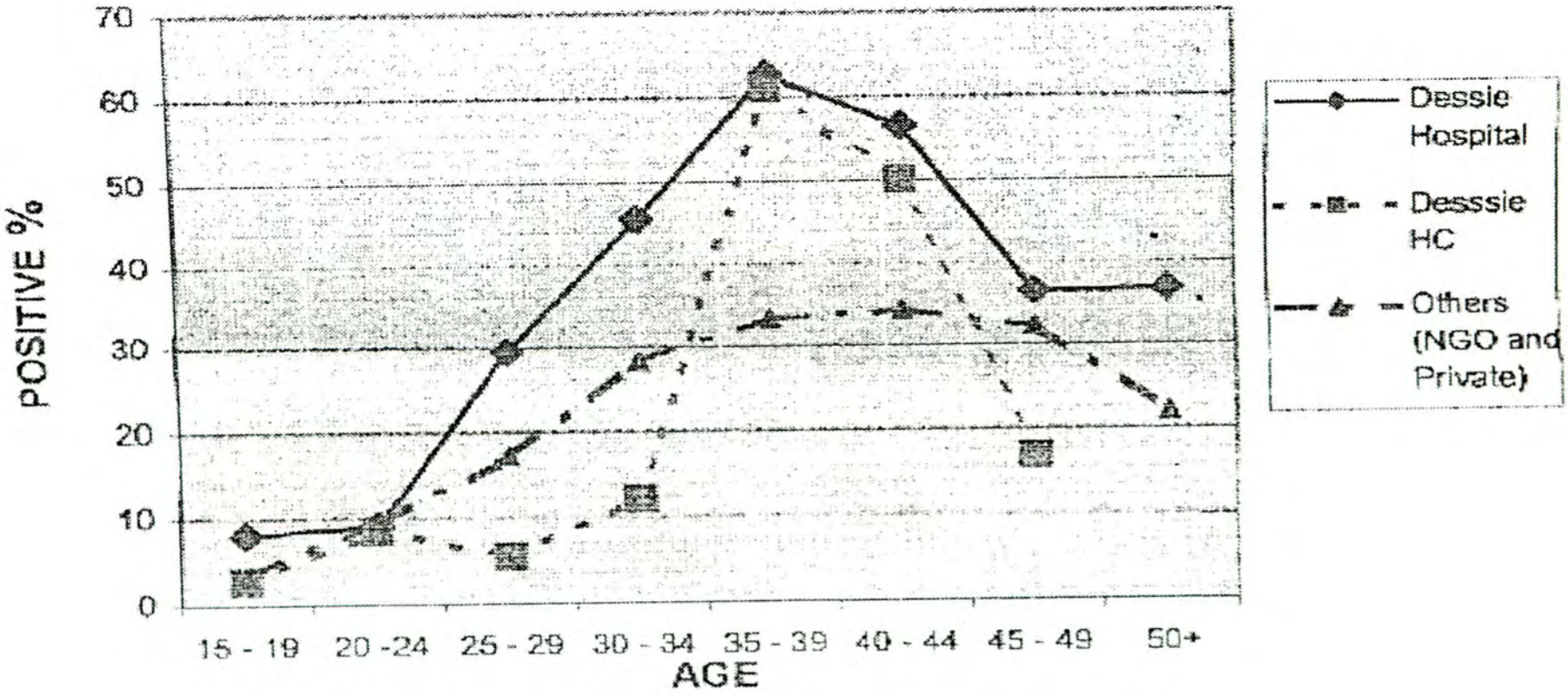
As one of the intervention areas in HIV/AIDS prevention and control programs, early detection and treatment of STIs need to be adopted. In the town of Dessie, nearly all public, NGO or private health institutions diagnose and manage sexually transmitted infections. For instance, OSSA Clinic and FGAE's main and model youth clinics provide diagnosis and management of

STI free of charge for all people while Dessie referral hospital and health center run STI control programs. In relation to this, Marie Stopes Clinic provides STI diagnosis, treatment and counseling service as part of its reproductive health services. Many people however, do not prefer private clinics because of unaffordable medical costs.

Noticing the importance of safe blood supply to HIV positive people and other patients, key informants from Dessie referral hospital and the Ethiopian Red Cross Society Dessie branch explained that the only institution in the town that collects and provides blood for transfusion is the Ethiopian Red Cross Society Dessie branch. In doing so, they added that a standard HIV test would be made to all blood types through blood screening to ensure the safety of the supply.

In the town of Dessie, there are some VCT centers, the busiest being Dessie referral hospital serving on average 20-25 people each day. Reportedly, many people usually come from outside the town for premarital test although individuals from the town itself would also visit the center not only for purposes of marriage but also for reasons associated with job opportunities and self-driven interests to know their HIV status for a healthy life. In addition, VCT services have been provided by OSSA and FGAE free of charge while the private health institutions provide the services with fees. In FGD representatives from NGOs noted that nearly all VCT centers in the town provide pre-test and post-test counseling services although follow up test counseling is not regularly given to clients. However, interviewed PLWHA disputed the idea that public health institutions would often provide pre-test counseling service unlike NGO or private clinics. It was also pointed out that centers for VCT service would send referrals for social support to institutions providing care and support and for Anti Retroviral Therapy (ART) provision to Dessie Referral Hospital where patients could get the drug for free.

Figure One: **VCT positive rate in Dessie**



Source: South Wollo Zone Health Department, Annual Report (2004)

The figure above depicts Voluntary Counseling and Testing (VCT) positive rate in percentage and age group in the town of Dessie in the year 2004. Accordingly, the highest positive rate in percentage is observed in Dessie referral hospital and health center in the age group 35-36. However, it declines as age increases. In contrast, the lowest VCT positive rate is prevalent among young people between 15-19 years old in Dessie health center, NGO and private clinics. Based on this, it can be assumed that most people tend to visit VCT centers at public health institutions.

Arguably, there are two basic reasons as to why people do not usually prefer to take VCT services at health centers owned by NGOs or private. In the case of NGO clinics, VCT service seekers want to avoid stigma the community attaches to PLWHA. This is because there is misunderstanding that people visiting the service centers are all HIV positive. In fact, this might have resulted from the inability to integrate VCT service centers into a general health system. With respect to private clinics, the preference of people is limited mainly because people seeking VCT services could not afford the expenses.

The major social support referral sites for VCT centers in Dessie include Mekdim, OSSA, the EOC and EECMY. However, there are other institutions such as SC/UK, FSCE, Netsebraq, the Ethiopian Red Cross Society Dessie branch and FGAE that are providing specific types of support to PLWHA and AIDS orphans in the form of counseling services and training for HBC workers. It is stated that the number of PLWHA demanding support in the town is increasing and several people are desperately looking for the appropriate care and support services.

3.2 Vulnerability Factors

The most common ways of HIV transmission among the population of Dessie are unsafe multiple sexual practices. In FGD with representatives from zonal HAPCO, Mekdim and OSSA it was emphasized that there were some other factors that made people vulnerable to HIV infection. These included alcohol and drug addictions, high level of unemployment, shared use of sharp objects, illegal abortions, harmful traditional practices and lack of recreational facilities especially for young people.

People were informed about HIV/AIDS given the extent of information release from different sources. In spite of this, the situation of HIV/AIDS in the town was rather worsening due to the deteriorating living conditions of women and young peoples' alcohol and drug addictions, which often aggravated vulnerability. In connection with this, the consumption of alcohol and drugs by unemployed people in the town and its possible effects on vulnerability to HIV/AIDS were further discussed. Arguably, unemployed people usually spent much of their time chewing *Catha edulis (Chat, an Amharic equivalent)* and smoking *Shisha* (a mixture that may include tobacco, honey, hashish and spices) and cigarettes, which they considered the best alternative to relax them with little consideration of their worst consequences on health. In most instances, what followed such practices was drinking alcohol in order to get rid of the stimulant effects of the drugs and tobacco. This could lead the addicts to unprotected sex exposing them to HIV infections.

In the town of Dessie, some people particularly young boys and girls at school and relatively well to do people wrongly understood what one to one sexual relationship was meant for. They thought that it meant having only one partner at a time regardless of the risks of HIV/AIDS associated with having many partners in a given space of time. Therefore, according to FGD participants from the EOC and EECMY, misconceptions about one to one sexual relationship have posed serious problems on individuals' infection with HIV/AIDS. However, it should be noted that it was not only failure to understand the essence of one to one partnership that has attributed to vulnerability of these groups of people but also the problem of remaining faithful to partners. Simultaneously, the issue of vulnerability difference between men and women was raised and it was argued that women were more vulnerable to HIV/AIDS than men owing to factors pertaining to economic dependence, sexual violence, abduction and biological reasons.

It was also marked that gender based vulnerability difference could result from the increasing number of young women having old sexual partners who in most cases had multiple sexual partners. This increased the risks of HIV infection on the part of women and showed how much they were more exposed to HIV/AIDS than men. In apparent cases, lack of sex negotiation skills by young girls and women compounded by male dominance in the society have made women the most vulnerable groups to HIV/AIDS. In an effort to alleviate such problems, empowering

women and providing them with the opportunity to learn to develop the capacity of sex negotiation is desirable.

In FGD with representatives from Mekdim association and partner NGOs, it was emphasized that sex workers (including those who were displaced from Assab in 1998 due to the Ethio-Eritrean conflict), students, house ladies, servants, children born into infected mothers (as the Prevention of Mother to Child Transmission has not yet been accessible) constituted the most vulnerable groups. With this, the geographic importance of the town in linking the northern part of the country to central Ethiopia exacerbated migration from different areas to Dessie and contributed to the vulnerability of the population to HIV/AIDS. As perceived by participants of the discussion, the preventive methods to be pursued included: abstinence, faithfulness, and the proper use of condoms, which appeared to be known to the people. But, the severity of HIV/AIDS problems has made the prevention activities to incorporate sex education in school curricula primarily to help the youth better understand HIV/AIDS as a health and social problem. In the next chapter presentation on care and support services for People Living with HIV/AIDS (PLWHA) is provided.

Chapter Four

Care and Support for People Living with HIV/AIDS (PLWHA)

This chapter presents the needs of People Living with HIV/AIDS, examines the challenges they encountered in accessing care and support services and provides insights into the coping mechanisms that clients employed. Emphasis has been given on the necessity of considering the felt needs of beneficiaries in designing care and support programs and ultimately enabling them to support themselves and their families. In doing so, efforts have been made to explore the scope and networking of care and support services by the EOC South Wollo diocese office and the EECMY North central synod. This is to show the extent of interventions in support of PLWHA and affected family members and existing relations with partner organizations to ensure effective service deliveries.

4.1 Scope and Networking of Services: The Cases of EOC and EECMY

The EOC has engaged in moral teachings through which the messages of remaining faithful to sexual partners were addressed to its congregations long before HIV/AIDS has occurred as a health and social problem. With the spread of the pandemic and the consequent adverse effects on human and material resources in the country, the Church began to respond to HIV/AIDS prevention and control activities in the notion that it could play substantive roles given its deep-rooted structure and acceptance among the Christian population (Kefyalew, 2002: 2).

In the late 1980s, the Ethiopian Orthodox Church-Development and Interchurch Aid Commission (EOC-DICAC) was established to promote development objectives. Considering the threat posed by HIV/AIDS on human survival, the EOC-DICAC began to implement awareness creation campaigns in 1998 by means of distributing IEC materials and patriarchal rallies focusing on teaching faithfulness among married individuals. In 1999, the EOC-DICAC project further expanded and established the Orthodox HIV/AIDS Campaign Center (OHACC), which enabled the Church to form branch offices successively in most administrative zones of the country where the effects of the pandemic were severe (Kefyalew, 2002: 1-2).

One of the branch offices of OHACC, the South Wollo diocese office HIV/AIDS Prevention and Control Office was established in June 2001. Since its establishment the office has mobilized 9,636 clergy men and 5,254 young Sunday school attendants in more than 545 parish churches in order to disseminate the Church's message of behavior change to the Christian population. The provision of basic knowledge of HIV/AIDS to the behavioral change communicators such as priests and Sunday school preachers has been important in the implementation of the diocese office's HIV/AIDS programs. (EOC-DICAC, 2002: 3).

According to informants from the diocese office, the EOC-DICAC South Wollo diocese office implemented its HIV/AIDS program components with financial assistance from Pathfinder International until June 2004. When the donor's project phased out, the office secured funds from the Federal and Regional HAPCO to implement programs designed for prevention and control of the pandemic including the delivery of care and support services. It was also remarked that the behavioral change educators were able to reach the local Christian community down to the rural parish church level on every day prayer, religious festivals or holidays and on burial ceremonies. However, PLWHA and caregivers believed that the efforts of EOC-DICAC in the period under discussion to prevent the transmission of HIV/AIDS in the town had borne little fruits probably because of the absence of integrated activities involving all stakeholders.

Based on the reports of South Wollo diocese office (September 2002), the scope of the office's HIV/AIDS prevention and control program included seven Woredas of the administrative Zone. These were Ambassel, Kalu and Dessie Woredas where both PLWHA and AIDS orphans were supported and Tehulederie, Worebabo, Sayint, and Kutaber Woredas where only PLWHA were receiving care and support services. In these project sites it was stated that there were Sunday schools, which were instrumental in implementing the designed programs. For instance, the number of Sunday schools in Dessie was 100 with 60 teachers or preachers and 1500 active members (EOC-DICAC, 2002: 6).

In connection with this, it is of paramount importance to have an overview of how the EECMY moved onto a social agenda along with its spiritual motives. With the beginning of the Wholistic Ministry as a guiding principle of the EECMY in 1972, the emphasis of Mekane Yesus Church shifted from spiritual to social actions, community development, winning freedom from

dehumanizing structures and involvement in nation building. Nevertheless, the experiences of the Church before the adoption of the Wholistic Ministry showed that carrying on social responsibilities or working towards the improvement of living conditions of humanity was considered side issue of expression of Christian charity. The Wholistic Ministry therefore, emphasized that the Church should address both the spiritual and physical or human needs. (http://cc.msnscache.com/cache.aspx?q=3260765123997&lang=en-US&mkt=en-US&FORM=CVRE).

The EECMY has given especial attention to HIV/AIDS prevention and control as early as the 1980s. Since then the Church has been working in major HIV/AIDS intervention areas that included awareness raising, IEC material production and distribution, BCC efforts and care and support services for PLWHA and AIDS orphans. The EECMY has therefore, integrated social works into evangelical activities.
(http://cc.msnscache.com/cache.aspx?q=3260765123997&lang=en-US&mkt=en-US&FORM=CVRE; Zerihun, 1999: 21).

In the town of Dessie, an informant from the EECMY synod argued that the Church has begun working on HIV/AIDS prevention and control programs in 1994, but its intervention in care and support services dated back to 2002. The synod has also been working on HIV/AIDS programs in some parts of the Amhara region. With respect to care and support services, it has expanded its programs in towns such as Kombolcha, Haiq, Dessie, Woldia, Bahir Dar and in Tehulderie Woreda of South Wollo zone.

According to the EECMY HIV/AIDS project document (April 2002), project sites selected for the provision of care and support for PLWHA and AIDS orphans included: Kombolcha and Haiq towns while PLWHA support prevails only in Tehulederie Woreda. In Dessie, Woldia and Bahir Dar the synod promotes AIDS orphan support. The reason why the EECMY emphasizes on AIDS orphan support in Dessie is because of the necessity of avoiding duplication of efforts. This however, does not mean that the Church has no intervention in the town in promoting IEC/BCC efforts and related activities in collaboration with other partners (EECMY, 2002: 9).

Based on the data obtained from the EOC and EECMY, it could be argued that the rational for creating effective networking with different partners working on HIV/AIDS programs is to

enhance efficient mobilization and management of resources, ensure timely and regular review of follow up mechanisms probably by committees at different levels, and promote effective awareness creation among the public. In addition, it is necessitated to avoid duplication of efforts, create consultation and partnership forum and give remedial solutions to common problems.

In this regard, the EOC-DICAC South Wollo diocese office and the EECMY North central synod have established networking with different organizations both government and non-governmental, PLWHA association, Idirs, and anti-AIDS clubs operating in the town. In relation to this, it was explained that both Churches had working relations with the South Wollo Disaster Prevention and Preparedness Commission (DPPC) and Labor and Social Affairs Office. Accordingly, the Churches had made agreements with the respective government offices to provide care and support services for PLWHA and AIDS orphans. The agreements stated that the signing parties had obligations to carryout the major objectives of the programs they were entitled to in a given project period. Despite this, key informants from the EOC and EECMY emphasized that these government bodies proved to be inefficient over the last two years in responding to the requests of the Churches for technical co-operations.

Strengthening this idea, informants from the EOC stressed that zonal DPPC and Labor and Social Affairs Office were unable to reveal the situation and living conditions of PLWHA and AIDS orphans and provide effective registration system of care receivers while informants from the EECMY remarked that the adoption of AIDS orphan children either at home or abroad was given little attention. Furthermore, based on information obtained from the EOC diocese office the relations between zonal DPPC and Labor and Social Affairs Office on the one hand and Idirs' coalition of the town on the other could be critically viewed as generally marked by irresponsibility and negligence of the former.

Following agreements with these government offices, both Churches had to consider the necessity of creating networking with different organizations working in areas of HIV/AIDS. Consequently, relations were established with the following institutions although the degree of effectiveness of such networking could not be of the same value and importance in all cases. Thus, both Churches had good relations notably with OSSA in the provision of counseling supports and Mekdim association in counseling and exchange of information on how to provide

the appropriate care and support services for PLWHA and AIDS orphans. Moreover, the Churches had noteworthy relations with the Ethiopian Red Cross Blood Bank Dessie branch for the transfusion of safe blood to bed-ridden HIV patients and infected children; Netsebraq Reproductive Health (RH) Social Development Organization on HBC training and social support to PLWHA, and Dessie referral hospital on STI control and prevention and dispensing ART.

Simultaneously, it was noted that there were some instances in which the EOC and EECMY had created networking with other partners distinctively. For instance, the EOC had formed working relations with FGAE Dessie branch clinic on STI control and prevention and medical care for PLWHA and AIDS orphans; Abyssinia anti-AIDS club on IEC/BCC activities and Beza girls' anti-AIDS club mainly on BCC efforts. On the other hand, the EECMY had setup working relations with SC/UK on training HBC workers and promoting IEC/BCC efforts and Marie Stopes clinic on STI control and prevention.

One might wonder however, the existing working relations between the EOC South Wollo diocese office and the EECMY North central synod did not appear smooth. This partly held true because informants from both Churches explained that except in cases where sensitization workshops on HIV/AIDS were organized by other partner organizations, the two Churches rarely exchanged information on the prevention of the pandemic in general and care and support services in particular. It could be assumed that such a gap in networking between the EOC and EECMY might have its roots in basic differences in religious practices and this could affect the overall care and support services for PLWHA and affected families. On the whole, despite efforts to coordinate HIV/AIDS programs in the town, it seemed that the needs of PLWHA and AIDS orphans were not adequately met.

4.2 Support for PLWHA in the EOC South Wollo Diocese Office

4.2.1 Needs of People Living with HIV/AIDS and Problems Encountered in Accessing Care and Support Services

The EOC South Wollo diocese office provided care and support services to 181 PLWHA in the town of Dessie of whom 45 were bed-ridden. The Church included PLWHA for care and support

services on the basis of the following criteria. First, the HIV positive person needed to have a serostatus certificate that could be obtained from governmental, private or NGO clinics where VCT service was available and second, the person had to bring a letter from Idir (if he or she was a member) or kebele administration for having no income or supporter at all. It was under these circumstances that the diocese office selected PLWHA to provide them support. (EOC-DICAC, 2002: 7). However, interviewed PLWHA explained that there were many more HIV positive people who did not yet obtain the support of the Church not only because of budget shortage but also due to priorities given to HIV positive people living in Dessie than those who came from other areas.

Based on information obtained from the diocese office, home-based care was the type of care the office provided to PLWHA. Thus, the basic types of care and support services included social support, medical and nursing care including referral services, spiritual and pastoral support and education and training of home caregivers. The social support is needed to reduce or lessen the burden of the breadwinner in giving care to the AIDS patient. It was ascertained that financial support, housing and clothing needs, income generating activities and vocational skills training were components of the social support. Accordingly, clients' needs for food, housing and clothing were identified as the utmost necessities of PLWHA.

4.2.1.1 Financial Support

According to PLWHA and caregiver participants in FGD, nutritional support in cash than in kind was their priority concern. It was also explained that food support for PLWHA in OSSA and Mekdim was mainly in the form of wheat and cooking oil. However, this could not meet the felt nutritional needs of the recipients and even such service provisions were not regularly available to the beneficiaries. The discussants stressed that what made the image of food provision in kind rather dark was that people often associated it with HIV/AIDS exacerbating existing stigma and creating emotional depression. It was also remarked that the majority of PLWHA had little income and could not get the diet they needed to cope with their illnesses.

Apparently, the financial support was not provided to all HIV positive persons who were registered as beneficiaries. Rather the diocese office has given priority to bed-ridden patients and

provided 100 birr per head monthly. This was supposed to be used for food, payment of house rent and purchase of soap and other materials needed. Interviewed bed-ridden patients expressed their worry about the insignificant amount of money they were receiving emphasizing that it was neither adequate to meet their needs nor was given regularly. They asserted that the amount usually varied between 50 and 100 birr. What made the situation of their living worse was not only the inadequacy of financial assistance but also their inability to receive additional supports from other service provider organizations due to inexorable rules preventing PLWHA from accessing support services other than the institution they were registered in. In this regard, an interviewed PLWHA expressed his feeling in the following ways.

> I was one of the first beneficiaries registered in the EOC diocese office to receive care and support services. However, I did not receive my utmost needs, material or financial except medical service, which by any standard is inadequate. What surprises me most is my inability to seek for support from other service provider agencies due to unalterable working principles that came into effect against our survival.

Furthermore, it was stated that financial support for PLWHA did not include children of the beneficiaries and other members of the family. In this regard, an interviewed bed-ridden woman expressed her deep concern that she had severe financial hardships. She said:

> I have three children, the eldest of whom is 12 years old. The financial support I am receiving from the EOC is too little to support my family because there is no other source of income to depend on. Being a person with full-blown AIDS, I need people's close attention. I am much worried about the future of my children when I die because this support may cease and chances for accessing other supports are little.

According to informants from the EOC diocese office and the EECMY synod, the rule that did not allow PLWHA to receive specific types of support from various partner organizations was put into effect to overcome the problems of service provision by reaching those who could not get the service. Besides, the scarcity of resources to provide all beneficiaries with their material needs made it necesary to limit their number and the types of services they could receive. This same idea was supported by FGD participants from OSSA, Mekdim, SC/UK, Netsebraq and other NGOs. However, the justifications made partly seem less convincing. This is because of the fact that the problems could also be attributed to the absence of effective networking among different agencies working on care and support services and mismanagement of resources that could be explained in spending excessive amount of money in organizing workshops, seminars and trainings and per diems for participants. Also, the absence of a responsible government body

to make consistent efforts to ensure the appropriate delivery of services has affected the existing care and support services to PLWHA.

It can therefore, be assumed that the problems of PLWHA in this respect could be somehow avoided if there is a diverse support structure that would enable them to access specific types of services from various partner organizations. It is believed that this would happen when there is coordination among service provider organizations with subsequent follow up systems.

4.2.1.2 Housing

The other important need FGD participants from PLWHA, caregivers and community members highlighted was the issue of decent housing. It was noted that not only financial problem but also stigma and discrimination associated with HIV/AIDS deterred PLWHA from having shelter. In relation to this, a woman living with the virus expressed what had happened to her family saying:

> I was living in a rented house with my only HIV positive child. I had often been cautious not to disclose my serostatus to the owners of the house fearing that they would chase me out. Once up on a time when I returned home from my daily labor work, I found my child shedding tears having no way to get into the house as it was locked. I also found all my household properties thrown away without my prior knowledge of the situation.

Many PLWHA believed that the kebele administration could not stand by them to solve their housing problems. They justified this on the ground that officials negotiated the transfer of kebele owned houses unofficially ignoring the demands of HIV positive people for shelter. According to beneficiaries what made the situation rather worrisome was the failure of Woreda HAPCO to work strenuously in their interest with the administration perhaps because of insignificant attention given to those living with the virus.

4.2.1.3 Clothing

The need for sufficient clothing was also brought into attention by PLWHA and caregiver representatives in FGD. It was emphasized that no service provider institution in Dessie had tried to meet the clothing needs of PLWHA ever since care and support programs had been operational in the town. They argued that this emanated from the misconception that needs of clothing were not of primary concerns as compared with that of food and housing.

4.2.1.4 Income Generating Activities

In FGD with PLWHA and caregivers, Income Generating Activities (IGAs) and vocational skills training were identified as important components of the socio-economic needs of PLWHA. Informants from the diocese office also argued that it was desirable to promote these activities for sustainable support of PLWHA and their families. It was emphasized that the most appropriate areas of IGAs in the town included: sheep fattening, running small shops and trading in pulses, grains, spices and so on. According to informants from the diocese office, the selection of micro business trainees involved some criteria such as serostatus certificate of the individual, strong motivation to work, past experience in small business trading, good health condition as people with deteriorating health could not work well and evidence that the person was not obtaining support from partner organizations other than the diocese office. Twenty PLWHA who met the requirements were therefore, selected and given the training in September 2005 by Dessie Woreda Industry, Micro enterprise and Investment promotion office.

The basic components of the training were entrepreneurship skills, successful person and self-esteem development, market training and Strength, Weakness, Opportunity, Threat (SWOT) analysis. The trainees were given 1000 birr each to start the small business. However, it was emphasized in FGD with PLWHA that beneficiaries could not be considered for other financial supports either by the diocese office or other organizations once they have taken the start up money to carry on income generating activities. They also maintained that the money was barely enough to do the business given that the price of goods has increased. Continuing their argument, PLWHA made it clear that the number of dependents in the family and their poor living conditions had obliged some of them to spend much of the money on food than doing the small business as planned.

Although the needs of many PLWHA to have this opportunity were measurably great, it was thought that there were some pitfalls to involve in IGAs. First, the diocese office said that it had limited capacity to allow all beneficiaries to work in IGAs and second, the question of obtaining the office's trust to receive the business skills training and take the start up money was difficult owing to the tendency of some of the clients to use the money for other purposes. As a result, lack of trust on the part of service providers to help PLWHA engage in IGAs had seriously

damaged their morale and dedication to work while they were still healthy. This according to PLWHA informants had left a gap in avoiding the feeling of dependency. In connection with this, it would be appropriate to present what a woman had commented in FGD.

> I am HIV positive living in Segno Gebeya with three of my children. Before my infection with the virus, I was self-employed as a small trader in pulses, but I stopped it when I came to know my serostatus because I had to spend the money I saved on taking care of myself. My family makes a living only on the financial support of Mekane Yesus Church, but this is not enough for our living expenses. Although I applied to some institutions to get the start up money to engage in IGAs, I did not find one responding to my needs. I thought this resulted from the mere generalization of service providers that I would spend the money unwisely.

In contrast with the disappointment of the woman for failure to carry on IGAs, another PLWHA woman discussant explained that she had received the micro business training sponsored by the EOC diocese office with 1000 birr as a start up money. She said that she had started to carry on sheep fattening, which she thought was a profitable business. Continuing her discussion, the woman tried to create an inspiration of engaging in IGAs among participants of FGD asserting that such business activities could be fruitful if all members of the family work together. But she noted that efforts to promote IGAs would be futile if the money was utilized for fulfilling other needs.

As part of the solution to gain the trust of service providers, PLWHA and caregivers ascertained that the diocese office or other partners had to consider support for all interested PLWHA to work in small business trading on condition that each beneficiary expressed his or her consent to refund at least one-fourth of the start up money in a given space of time. It should however, be noted that the realization of IGAs is mainly associated with assessment of market and viability studies apart from skills training, individual motivations and availability of adequate finance.

4.2.1.5 Vocational Skills Training

According to informants from the EOC, vocational skills training as part of carrier opportunities was given by the diocese office to selected trainees in various fields. It was argued that vocational skills could enable PLWHA to support themselves and their families. Before moving onto the details it may be useful to provide insights into how trainees were selected. In the first place, trainees were supposed to have motivation to work because it would be counter productive to

provide unmotivated PLWHA with training facilities as they would not continue working with the skills they acquired. Second, the health situation and academic level of the trainees would be considered for the selection process.

With the selection of trainees, the diocese office would assign them in their area of interests to receive the training for six months. So far the diocese office has given training to 12 PLWHA in fields such as embroidery, tailoring, barbering, photographing and hair dressing. In addition, one beneficiary was attending at Altabe Teachers' College. Informants also emphasized that these vocational skills were chosen because they involved less costs, did not generally require much energy in practical applications and were less likely to cause physical harms or injuries as working with heavy machines would do.

Nevertheless, PLWHA and caregivers described in FGD that employment opportunities were rare due to stigma and discrimination associated with HIV/AIDS. The office in this regard, did not either make meaningful attempts to facilitate ways of their employment in government or private sectors. At this point a woman trained in hairdressing suggested that public attitude towards HIV positive people has not yet changed despite efforts to raise awareness and disclosed that PLWHA were regarded as unproductive and unhelpful. It was also emphasized that the Woreda administration was not active to find other means of supporting such as arranging meetings with community, government, and non-governmental organizations so as to mobilize funds and enable beneficiaries to have tools or equipment to work together.

The views held by the participants were reflected by one of the persons living with the virus criticizing nearly all stakeholders for inconsistency in helping those who were trained to get employment. He thus, narrated the story how he managed to get employed as follows.

> Six months ago I was trained as a barber. With the completion of the training, it was difficult for me to get a job since HIV induced stigma still persists in the town. What I did to get some money to achieve my ends was a bit different than any one could imagine. I was wandering around hotels, bars, restaurants and shops day and night holding the skills training certificate I received. Fortunately, I was successful in my endeavor and got the money I needed to start my career as a barber. Thanks to God I am no more dependent.

However, it is difficult to think that this person's experience can serve as a model for other PLWHA who desperately need to get employment in barbering or other areas of training. This is

friends that lack devotion to carry on their duties. In this respect, a young man of 24 years old who had become bed-ridden AIDS patient expressed his feeling about medical treatment and care at home in the sense of sorrow and depression. He said:

> Four months have passed since I have become bed-ridden. My health problems are getting serious and I badly need health workers' follow up and better treatment but to no avail because I have no income to afford medical expenses and my parents too could not pay for costly treatment. Worst of all, my mother who used to give me care at home has become impatient about my health situation and I could see only a gloomy future.

On the other hand, clients explained that Dessie referral hospital was the only health institution for dispensing ART to all PLWHA in Dessie. This in fact, caused much workload for the health workers at the referral hospital whereby the feeling of impatience in treating patients would come to the surface complicating the process of obtaining the drug as prescribed on time. Health workers' less attention to PLWHA could also be manifested in situations where patients were seeking treatment in public health institutions holding assistance letters from kebele administrations. It was asserted that PLWHA were not respected and treated the way HIV negative people who could not afford their medical expenses were treated. This was viewed by beneficiaries as unethical expression of hatred for those living with HIV/AIDS as if they were hopeless deserving no care.

The shortage of medicine was also mentioned in FGD with PLWHA as a problem encountered in accessing services. They emphasized that highly needed medicines were rarely available in government health institutions where they could be obtained free of charge than in private clinics. However, most PLWHA had little opportunities to receive treatment at private health institutions because of low income to pay for treatment.

According to PLWHA informants, VCT services did not yet receive much attention by counselor nurses especially at government health institutions. This was due to the fact that many service seeking individuals who visited public VCT centers could not usually receive pre-test counseling probably because couselors would get tired of the routine nature of the work. Most PLWHA could not also visit private VCT centers because of unaffordable price and the option in NGO VCT centers was associated with community stigma considering service seekers as if they were all HIV infected. In addition to fear of stigma and discrimination, people who understood that VCT would be given without the appropriate pre-test counseling in public health institutions

might prefer to stay away from knowing their serostatus. As a result, this would eventually deter them from receiving care and support services.

4.2.1.7 Spiritual and Pastoral Support

It is true that PLWHA need social acceptance and sympathy as part of care and support services because love and attention could strengthen their sense of security. In light of this, spiritual and pastoral support under the HBC program of the diocese office was given to PLWHA to take care of themselves psychologically, morally and in terms of health. This was deliberately done to help PLWHA stay healthier, morally strong, emotionally stable and courageous to face challenges and overcome them. Key informants from the diocese office explained that spiritual and pastoral support was offered to PLWHA by trained counselors from Sunday schools and priests recruited from the Churches. Moreover, the diocese office provided psychosocial lessons, on going counseling and nutritional lessons to PLWHA by professional counselors in collaboration with FGAE and OSSA. Interviewed PLWHA also expressed that they received non-spiritual counseling services at Mekdim, which they thought was organized and effective.

According to informants from the diocese office, spiritual counseling and pastoral support combined with professional counseling services would help to create and promote positive attitude in the patient and the family. This idea was similarly reflected in FGD with PLWHA who expressed their positive views about counseling services provided by the EOC diocese office and other institutions. In relation to this, a discussant from PLWHA gave an account of her experience as follows.

> I am an active member of Sunday school at St. Gabriel Church. I was inspired to become a member intending to strengthen spiritual values. I found that counseling services provided by the EOC diocese office and Mekdim are quite important in giving me the hope to live longer and withstand the stress resulting from my illness.

In spite of this, some interviewed PLWHA described that spiritual and pastoral support of the diocese office was limited because neither the trained counselors nor the spiritual leaders often visited the homes of recipients to provide the spiritual and pastoral support needed for the home caregivers. In this regard, one of those interviewed expressed her feeling saying:

> I rarely see spiritual leaders or trained counselors visiting homes except that they could be in service on religious days to address congregations the usual message of avoiding stigma and discrimination of HIV positive people, which has long remained impractical.

In FGD with PLWHA and caregivers, it was explained that a number of factors could deter them from accessing care and support services. First, the problem of PLWHA themselves was mentioned. In this respect, there were two groups that wanted to avoid stigma associated with HIV/AIDS in one way or another. The first groups of PLWHA were those who did not want to be identified as HIV positive persons and preferred to stay away from service provider institutions lest their serostatus should be revealed. These people were often suffering from the psychological and physical impacts of the virus and would probably die without receiving support. The second groups of PLWHA included those who were registered as members of Mekdim to access care and support services but did not want to participate in meetings or appear on TV not to be identified as PLWHA.

The second factor was community misconception towards VCT services. It was stated that the community often associated VCT centers with HIV/AIDS whereby people visiting them were suspected of being HIV positive. Here it must be noted that this problem could be partly avoided if VCT services are provided as an integral part of the general clinical service at health institutions. In this regard, the case of Dessie referral hospital can be taken as a model.

Third, the attitude of service providers towards PLWHA had affected care and support services. In this regard, it was emphasized that care and support staff did not often think that PLWHA who dressed well and looked healthy needed care and support. According to them such attitudinal problems could arise from misconceptions that recipients had good income judging from their personalities. With respect to this, a girl living with the virus expressed that such problems indicate the absence of professional ethics and narrated what she had faced in the following manner.

> When I came to know my serostatus, I was hesitating whether to look for service provider institutions or not for some time. It was not the question of stigma that worried me much, but the thought that whether I could really find an agency that would consider me for care and support services because I am good looking and dress well that people do not often think that I am HIV positive.

The fourth factor that obstructed care and support services was the attitude problem of home caregivers. It was stated that many HIV positive people did not have confidence to tell their families that they were infected with HIV/AIDS because of fear of isolation. In some cases PLWHA would not disclose their health conditions even to their intimate friends thereby complicating the matter. Strengthening this idea, a young man living with HIV/AIDS asserted that he preferred to keep his serostatus confidential and argued:

> I am a taxi driver living with my parents. It was a year ago that I came to know my HIV status. I did not tell that I am HIV positive to my parents, brothers, sisters or friends to avoid the unbearable psychological trauma resulting from revealing it. It is only Mekdim association and Dessie referral hospital that knew my serostatus. I have decided not to take part in public meetings, group counseling services or other occasions that are likely to expose me as a person living with HIV/AIDS.

Under such circumstances it could be assumed that PLWHA who did not want to disclose their serostatus to family members due to fear of isolation might in the reverse lose the appropriate care and support services they could have received in the home environment.

In FGD with PLWHA it was also emphasized that stigma and discrimination was manifested in shared use of potable water and toilet when living in rented houses. The discussants believed that such problems were attributed to misconceptions about HIV transmission. Among PLWHA participants of the discussion, the experience of a woman whose husband died leaving her three children bore witness to how the problems were serious. The woman's story reads like this:

> We were living in a rented single room house. When my husband died, I was repeatedly asked to leave the house or pay the rent two fold, which I could not afford. I knew that this was a real indication that we were stigmatized and discriminated but could do nothing to reverse the owners' decision nor did find alternatives all of a sudden. Before finding a new house to rent, I was thrown out with my children like a rotten cabbage and felt that the identity and respect of a person living with HIV/AIDS or his family is dark with the pandemic.

Issues surrounding stigma also persisted in the administration. In an in-depth interview with an adult man who has lived with HIV/AIDS for the last three years, it was explained that kebele officials had little concern for the affairs of HIV positive people. The person described the problems of stigma and discrimination in the following manner.

Long before I was infected with HIV/AIDS, I was working as purchaser at Dessie municipality office. When I came to know my HIV status, I revealed the situation and became a member of Mekdim association in order to access care and support services. However, I did not realize that what I did could prevent me from continuing my work. Eventually, I was fired from the institution I was working in for no good reason although I was capable of working. I learned that this happened to me because the administration could not protect the rights of PLWHA.

4.2.1.8 Education and Training of Home Caregivers

According to key informants from the diocese office, the education and training of home caregivers such as family members, neighbors and volunteers was the other type of care and support service the diocese office provided to PLWHA. The provision of this service was intended to improve the quality of care given to the patient and enable caregivers to prevent the transmission of HIV and other infections with in the home environment. In order to realize this, they argued that training was given to thirty HBC workers all of whom HIV positive and ten volunteers recruited from the community with assistance from the town's Idirs coalition.

It was emphasized that the training of home caregivers was aimed at providing the necessary knowledge and skills of HBC to selective, active, and educationally qualified individuals who could provide the services efficiently to HIV patients and affected members of the family. Apparently, the trainees had received medical kits and the diocese office paid them 50 birr per head/month for transportation. Nevertheless, HBC workers explained that the transportation allowance was too little to cover the cost and remarked that it should increase reasonably to allow them to provide the services without difficulties.

Interestingly, PLWHA questioned the real commitments of community volunteers in providing the required home-based care. They argued that the recruitment of nearly all volunteers from the community was just a waste of time and resources because the service deliveries could not go beyond counseling irrespective of what they were trained for. Stressing this point, they added that community HBC workers did not for instance, help patients to take bath even using hand gloves, clean homes or wash the victims' clothes when necessary. In this regard, a 40 year-old HIV positive man who had become bed-ridden expressed his feeling about the inappropriate care provided by community HBC workers in the following ways.

> Seven months have already passed since I have become a patient with full-blown AIDS. I have no children or relatives who could provide me with the care I need at home except neighbors and HIV positive HBC workers. I have to be honest that community volunteers do rarely visit me and are little appreciated for rendering the services. They deliberately try to avoid washing my clothes, or helping me take bath thinking that the disease is communicable through physical contacts. Rather they spend the time talking to me, which I do not like at all. I cannot really imagine that they are genuinely carrying out their duties and I would rather suffer than expecting them to come to my help.

Responding to some of the views reflected by PLWHA on the failure of community volunteers to carry out their duties efficiently, key informants from the diocese office disclosed that the Church shared their feelings and would reconsider the recruitment of community HBC workers probably limiting the extent of HBC training to them with much focus on building the capacity of PLWHA. Finally, PLWHA and caregivers remarked that legal supports such as defending the rights of HIV positive people when fired from jobs due to their serostatus, reversing the unfair decisions of kebele officials in sending away children of deceased PLWHA from kebele houses and so on were not provided by Woreda HAPCO, the administration and service provider institutions. Presumably, the failure of stakeholders to carry out their duties in this respect was attributed to various factors of which negligence to consider the problems of HIV positive people as equally pressing as that of HIV negative persons was worth noting.

4.3 Discussion of Survey Results

This section of the chapter presents the results of survey conducted among People Living with HIV/AIDS (PLWHA) who were receiving care and support services from the EOC South Wollo diocese office. It is believed that the analysis would chiefly supplement the qualitative research findings.

Table One: The socio-demographic characteristics of PLWHA respondents

Sex	*Age*	*Educational status*	*Religion*
Male = 9 (36%) Female = 16 (64%) Total = 25 (100%)	**21-35** M = 4 (16%) F = 10 (40%) **36-45** M = 3 (12%) F = 4 (16%) **46 and above** M = 2 (8%) F = 2 (8%)	**No formal education** M = 2 (8%) F = 5 (20%) **1-8th grade** M = 4 (16%) F = 4 (16%) **9-12th grade** M = 1 (4%) F =6 (24%) **Above 12th grade** M = 2 (8%) F = 1 (4%)	**Orthodox** = 19 (76%) **Muslim** = 4 (16%) **Protestant** = 2 (8%)

As shown in table one above, the number of PLWHA respondents is 25. The table consists of the socio-demographic characteristics of the sample population, which include: care recipients' category of sex, age limits, educational status and religious backgrounds. It can be inferred that 36% of the respondents are males while 64% are females. Age wise category, PLWHA whose age limit is between 21-35 make up 56% of the sample, those who belong to the age group 36-45 constitute 28% while those who are 46 and above make up 16%. With respect to educational status, PLWHA who could not read and write constitute 28% of the respondents, those who attended 1-8th grade level make up 32%, 9-12th grade 28% and above 12th grade 12%. The religious category shows that 76% of the respondents belong to the Orthodox Church, 16% to Islamic faith and 8% to the Protestant Churches.

Table Two: The socio-demographic characteristics of PLWHA respondents (contd.)

Housing condition	*Type of caregiver*	*Family size*	*Type of occupation*
Private owners M = 2 (8%) F = 3 (12%) **Rented from kebele** M = 3 (12%) F = 7 (28%) **Rented from individuals** M = 4 (16%) F = 6 (24%)	**Self care** M = 5 (20%) F = 7 (28%) **Parent** M = 1 (4%) F = 1 (4%) **Spouse** M =1 (4%) F = 2 (8%) **Children** M = 1 (4%) F = 2 (8%) **Grand father or mother** M = 1 (4%) F = 4 (16%)	**1-5** M = 7 (28%) F = 11 (44%) **6-10** M =2 (8%) F =5 (20%)	**No occupation** M = 7 (28%) F =12 (48%) **Government employee** M =1 (4%) F = 1(4%) **Self employed** M = 1 (4%) F = 3 (12%)

Table two is an extension to table one and descriptions given show the other socio-demographic characteristics of the same sample population. Thus, it depicts PLWHA respondents' housing condition, type of caregiver, family size and type of occupation. Accordingly, those who live in their own houses make up 20% of the respondent PLWHA while those who live in houses rented from kebele and individual owners have equal percentages, 40% in each category. In contrast with the qualitative findings however, there are slight differences because the data obtained in the qualitative study indicate that few recipients could live in kebele houses. It is apparent that 48% of PLWHA are self caregivers, 8% receive parental care, 12% receive spouse's care, 12% are taken care of by children while those receiving grand parents' care make up 20%. Also, the table shows that 72% of PLWHA respondents have family size of about 1-5 while those having 6-10 members of the family constitute 28%. Finally, it is indicated that 76% of the respondents have no occupation at all, 8% are government employed and 16% self employed.

Table Three: Survey results of PLWHA respondents

Variables examined	*Yes*		*No*	
	Number	*Percentage (%)*	*Number*	*Percentage (%)*
Is financial support adequate?			25	100%
Is medical care appropriate?	3	12%	22	88%
Is spiritual counseling service effective?	23	92%	2	8%
Have you engaged in IGAs?	3	12%	22	88%
Have you received vocational skills training?	5	20%	20	80%
Do you have other means of income?	7	28%	18	72%
Are community volunteers providing HBC efficient?			25	100%
Are HIV positive HBC workers efficient?	22	88%	3	12%

The number of PLWHA respondents who participated in the survey was twenty five. Accordingly, it can be inferred from the table that the highest percentages of respondents said yes

to the variables such as the effectiveness of spiritual counseling service and the efficiency of HIV positive HBC workers. In contrast, in the remaining sets of variables dealt with, the respondents markedly said no. These variables include the adequacy of financial support, appropriateness of medical care, promotion of IGAs and vocational skills training, availability of other sources of income and efficiency of community volunteers providing HBC for PLWHA. Therefore, this implies that the provision of care and support services for PLWHA by the EOC South Wollo diocese office in Dessie has remained ineffective except in cases where spiritual counseling services are efficiently provided and home based care is properly given to bed-ridden AIDS patients by HBC workers who are living with the virus.

4.4 Coping Strategies of PLWHA: Case Studies

In this section the research results of the case studies will be presented. In selecting the case studies of some of my informants from those PLWHA who had participated in this study, I have given particular emphasis on few cases that I thought would give the reader the impression about how PLWHA were managing to make their living, problems they were facing and possible ways of coping with the challenges in supporting themselves and their families. For obvious reasons of avoiding stigma and discrimination associated with HIV/AIDS, I have used pseudonyms.

Case One: Kelemua

> I am 22 years old. I was born and brought up in Jimma. When I was in grade eight I came to Awassa due to family pressure to look for a job and make my own living. In Awassa, I began to work as a cashier at a hotel but my dream to pursue education was not realized since I was busy working day and night in the hotel. In the mean time, I came to know someone who often spent his spare time enjoying in the hotel I was working for. He insisted that he wanted to marry me but I did not take decision immediately until knowing what he was working just to make a better future of mine. Learning that he was working in a private institution as a senior accountant earning good salary, I married him but I had no knowledge of his sexual behavior and health status. Right after we left for Dessie as my husband wanted to work and live where his parents reside.
>
> Unfortunately, the health condition of my husband was not good as he was frequently falling sick especially of malaria and TB. As a result, he could not remain on duty because of deteriorating health. Then he took blood test at a VCT center of OSSA to know his HIV status and the result showed that he was living with the virus. This forced me to visit the VCT center for the same purpose and I too came to know my serostatus. It is now four years since I have known my HIV status and am taking ART. We are lucky that our only

daughter is HIV negative and genuinely speaking it is only God who knows the person that brought the virus home.

Being interested in how the couples were making a living, I asked her to tell me the story surrounding issues such as survival problems and mechanisms to deal with them. Responding to my question, Kelemua went on saying:

Since the time we came to Dessie my husband has been working in a non-governmental organization, but I had no job at all. Eventually, he did not continue working any longer as the effect of the virus has left him sight impaired. Thus, the family's only source of income ceased when he stopped working and this pushed me to begin to look for service provider institutions in the town. I first consulted a counselor nurse at FGAE clinic about my need to get support. She told me to become a member of Mekdim association and access care and support services. Having no choice of survival, I did not hesitate to become a member of the association revealing my serostatus. However, I would not have become a member of Mekdim if I had a job to support myself and the family because once people came to know that I am HIV positive they would stigmatize me in various ways beginning from the home environment to the public.

The social support provided by Mekdim is limited to bed-ridden patients. Therefore, being healthy the only support I could access from the association is counseling service. Ever since the family's income has stopped, we had to depend on the little support we could obtain from the relatives of my husband. Through Mekdim I was registered as a recipient in the EOC diocese office for social support services. However, I could not receive the financial or material assistance I needed because the office has given priority to PLWHA with full-blown AIDS cases. Instead, the diocese office allowed me to take vocational skills training in hairdressing and receive spiritual counseling services.

Despite my training, I had little chance of getting employment due to the stigma associated with HIV/AIDS. To make matters worse, my desperate attempts to look for support from other institutions have borne little fruits because of existing working principles that do not allow PLWHA to access care and support services from more than a single service provider institution.
These days, I am working as a shopkeeper and support my family with little income I am earning for my service. My future plan is to form women's PLWHA association in the town together with my friends in order to gain strength in protecting our legal rights and possibly mobilize resources for the improvement of our living conditions.

Case Two: Aregash

I am 44 years old and was born and brought up in the town of Dessie. I had no opportunity to attend formal education except that I could read and write, which I acquired in adult education during the Derg regime. I was married at 16 and have four children. My husband was a soldier in Eritrea when Mengistu was in power but he did not return home and this left me alone to shoulder the responsibility of brining up my children without supporter. Therefore, I was forced to go to Asayita in Afar region to look for a job

of any kind to support my family. After some time, I came to know someone in Asayita who had a small business there and engaged in marriage with him. However, I stayed there for two years and came back to Dessie in divorce.

Up on arrival in Dessie, I was in a state of confusion whether to live with my children here in the town or return to Asayita to stay for some more years until saving adequate money to do business well. I decided to live in Dessie taking care of my children closely despite ample opportunities for labor work or petty trade in Asayita. Five months after I came to Dessie, I suffered from Herpes Zoster (*Yelij Tilla,* an Amharic equivalent) although I was repeatedly falling sick of TB earlier. I told my mother what had happened to me and took blood test in a VCT center at Dessie referral hospital.

I did this because I suspected myself of being infected with HIV. The counselor nurse told me the result of the blood test and I came to know that I was HIV positive. It is now four years since I have been infected with HIV/AIDS and do not hesitate to put the blame on my ex-husband for the problem because I knew no one in sexual relationship except my first husband who left us and joined the army in 1978. I did not tell my children the bad news until later for fear they should be worried much about it and become hopeless, but my mother knew the entire story.

Aregash went on discussing why she became a member of Mekdim association focusing on her living conditions, survival problems and commitment to overcome the ups and downs in supporting the family.

I became a member of Mekdim association being driven by the motive to receive care and support services. Nevertheless, I realized that the association could not provide me with the support I badly needed except counseling services. This was due to the increasing number of new PLWHA and limited capacity of the association to provide all the support required.

Mekdim's contribution to enable me to get some kind of support services from other institutions is quite immense because it sent me to Dessie referral hospital for ART provision and to the EOC South Wollo diocese office for social support services. As a result, I am taking the drug monthly for free and the diocese office has provided me with skills training in small business trading with 1000 birr as a start up money to support myself and the family in income generating activities. This time I am working as a petty trader, but could not get additional financial assistance from the diocese office except for limited medical support when sick.

Regarding support services to her children and complaints about the inefficient kebele administration she said.

I am fortunate enough that one of my children is receiving monthly financial support from Mekane Yesus Church and the rest of my children also receive support from the Church to fulfill their needs for school uniforms, educational materials and school fees. Despite this, I have found it difficult to support my extended family where there are more

dependent members. Our most pressing need is housing as we are living in a single room rented from individuals. Thinking that the administration would favor PLWHA, I applied several times for kebele owned houses, but received no response at all and have lost trust in the administration.

Aregash expressed her feeling that she did not want to appear on the media and emphasized what she was planning to do to support the family as follows.

I have never appeared on the TV nor did participate in discussions about HIV/AIDS live on the radio. I intentionally did this and will do it in the future because of fear of stigma and discrimination of my children at school or else where in the town. If Allah gives me life and strength, I would continue doing my small business to support my family and enable my children to become successful in life.

Case Three: Tiruwork

I am 24 years old. I was born into a peasant family in Jimma but was brought up in Dessie with my aunt. When I was in grade 9 my aunt died and I had to drop out of school because none of my relatives wanted to support me. Thus, the only option I had to sustain my life was to be employed in a hotel as a waitress. While working there, I had unsafe sexual practices with many partners. Getting sick of Herpes Zoster *(Yelij Tilla)* after some time, I was unable to remain on my duty and developed interest to take VCT at Dessie referral hospital. Therefore, I came to know my serostatus and now four years have passed since I have identified myself as HIV positive person.

Then after, with an intention to access care and support services, I applied to Mekdim association. But it was not easy for me to get the support I needed owing to the influx of several new PLWHA seeking support. Fortunately, I assumed the position of education officer at Mekdim association for which I could receive a small salary. Following this, I was registered as a recipient in the EOC South Wollo diocese office for social support. The services I could access at the diocese office include medical support although not adequate, financial assistance to cover my educational expenses at Altabe Teachers' College and spiritual counseling service.

The counseling service at Mekdim is well organized and morally rehabilitative. I witness that my entire life has changed with new hope of living longer as a healthy woman. It was also through Mekdim that I managed to take the ART at Dessie referral hospital without fees.

Focusing on the need to impart the young generation with live examples to fight HIV/AIDS, Tiruwork has begun to appear on the TV screen. She argued that people have to develop sympathy for PLWHA alongside learning to protect themselves from the pandemic. Also,

emphasizing the need to avoid self-stigmatization on the part of PLWHA, she suggested that it is relatively possible to win community support. She then argued:

> I am living in a rented house. The owners knew my being HIV positive before I began to live in their house watching me on the TV while addressing the public on a workshop organized by the EECMY in the town. I sometimes feel that PLWHA have fears and doubts that they are stigmatized while developing a sense of self-stigmatization. What we have to do first is to show openness to the public and tell honestly that we need support and protection. I think this could help to win the heart of the community to steadily avoid stigma and discrimination.

Commenting on what spiritual counseling service should integrate in HIV prevention and control Tiruwork said:

> I believe that all religious leaders should insist on addressing their respective congregations about sexuality and condom use because it has been evident that few people who are strict adherents of their faiths have benefited from spiritual counseling service while the majority who could not yet follow and practice such counseling service well are only adding up the number of PLWHA. It is on this ground that religious counseling has to be built up in preventing and controlling the HIV/AIDS pandemic.

Expressing her concern about the absence of home caregivers especially when one becomes bed-ridden HIV patient, she empathically argued:

> As is the case with many PLWHA, I am now a caregiver to myself. But the hard time would come when we become patients with full-blown AIDS because the efforts of community HBC workers have proved largely insignificant to rely on.

Finally, Tiruwork described her most pressing needs, survival problems and the way she planned to cope with the challenges in the following manner.

> At present my most pressing need is adequate finance to improve my living condition. In the first place, the amount of money I am receiving from Mekdim in return for my service is too little to cover my living expenses. Secondly, I have to pay for better medical treatment at private clinics when I get seriously sick because the EOC diocese office could not take care of medical expenses beyond the limit it has already set. Although there are little alternatives to solve the problems I am facing now, I am determined to overcome them in the near future becoming a teacher when I finish my study.

Case Four: Faris

I am 45 years old and was born and brought up in the town of Dessie. With the completion of my studies at W/o Siheen Secondary School now a business college, I became a storekeeper at the Ethiopian Domestic Distribution Center (EDDC) in Dessie. However, I was laid off when the Ethiopian Peoples Revolutionary Democratic Front (EPRDF) took control of the county. Then I had to look for a job to support the family and help my three children continue learning. Despite my attempts, I could not find a job except becoming a daily laborer that in turn made me hopeless in life. This was the beginning of my addiction to alcohol and *chat* (catha edulis), which eventually led me to have unprotected sex with different partners.

As a result, I was sick of TB, malaria and later Herpes Zoster (*Yelij Tilla*), which I thought were symptoms of HIV infection. I did not hesitate to visit the VCT center at Dessie referral hospital for a blood test and came to know my HIV status. I told the story to my wife and she was shocked. She too went to hospital after some time for VCT and became the second person living with HIV in the home.

Her decision to divorce came with the bad news of her being infected with the virus and she put all the blames on me for bringing the incurable disease home. Certainly, I had to admit that I was responsible for all the problems causing the family to dissolve. Five years have passed since I have been infected with HIV and am living with two of my children whereas the third child has preferred to live with his mother.

Faris further explained why he disclosed his serostatus with details about support services he w

receiving. He said:

I am living in a rented house. My children have become shoe-shiners to support themselves for their schooling. I was motivated to become a member of Mekdim association disclosing my HIV status because of the need to access care and support services. Mekdim provides me with counseling services and has referred me to Dessie referral hospital to receive ART. I was also registered as a beneficiary in the EOC diocese office but could not get financial assistance.

Rather I receive medical support, which is inadequate and have taken skills training in barbering but could not yet obtain employment. This is because employers do not want to hire HIV positive persons although we are qualified for the job fearing that their customers would keep themselves away. I am of the opinion that the Church did not do what it is expected of in facilitating conditions for my employment. This is because there were limited attempts made to create effective networking with government or non-governmental organizations to enable us to work in group buying the implements. I also feel much concerned about the absence of support to any one of my children from service provider institutions and this has made the family to live miserably.

Regarding the most serious problems the family has faced and possible ways of alleviating t

Faris argued:

> Food and housing are the family's utmost needs. Since I am on ART, I always have to eat nutritious food. But, where can I get money to afford? It is a question of survival I am raising than of comfort. If any organization is planning to work on care and support services in Dessie, it should really rescue the lives of helpless HIV victims by providing them with food and facilitate conditions for decent housing.

Expressing his views of community stigma and discrimination he critically pointed out:

> The owners of the house I am living in are always faultfinders to accuse my children and myself of using too much water than allowed from shared potable water. The problem is not with the excessive use of water as they said, but the stigma associated with HIV/AIDS that our shared use of water would bring the HIV infection to them. The other side of the problem is that we are often discouraged not to use a shared toilet and even we are forbidden to have our washed clothes dried on a shared string.

In relation to the role of the administration in providing support for PLWHA and his plan to improve his living conditions he said:

> The administration has often been inefficient to carry out its responsibilities of providing support for us. For instance, it has lent us a deaf ear to our request for housing needs. I have observed that the officials rather prefer to deal with sensitive political issues than listening to the voiceless people.
> I am healthy capable of working. In order to improve my living conditions I have planned to run a small business either in Dessie or else where in the county provided that I could receive the skills training and the start up money from any partner organization. I believe that this is the best alternative I have to take to avoid my dependency ultimately.

Finally, he commented on what needs to be done to alleviate the problems of PLWHA and the necessity of providing care and support services. He argued:

> I wonder why various institutions working on care and support services in the town could not coordinate their efforts towards addressing our needs devising new workable system whereby each of us would receive specific types of services from each organization. I think this has double advantages: first, beneficiaries are likely to receive adequate care and support services; and second, service provider institutions could avoid duplication of efforts concentrating on a particular type of service delivery.

> HIV is not a problem of those infected only but also of the community and the nation at large. Failure to respond to our needs could exacerbate the existing HIV/AIDS problems than lessening its impacts. I am saying this because the victims would be in a position not to reveal their HIV status if appropriate care and support services are not available. In turn, this would make sexual vengeance likely to happen, which may result in an incalculable loss to life and property and deepening social crises.

Discussions on care and support services for AIDS orphaned children by the EOC South Wollo diocese office and the EECMY North central synod are offered in the next chapter.

Chapter Five

Care and Support for AIDS Orphaned Children

5.1 AIDS Orphan Support: The Cases of EOC South Wollo Diocese Office and EECMY North central Synod

This chapter investigates the types of care and support services provided to AIDS orphan children by the EOC South Wollo diocese office and EECMY North central synod. Focus has also been made on examining the felt needs of the orphans with further insights into the main problems they were facing and coping strategies the orphans and caregivers employed.

According to Frederickson H. all children have physical, emotional and intellectual needs, which must be met if they are to enjoy life, and develop their potential in to participating adults. The concept of child welfare is thus, broad that it incorporates the social, economic and health activities of public and private welfare agencies that secure and protect the wellbeing of all children in their physical, intellectual and emotional development (1957: 12).

The EOC and EECMY have AIDS orphan support programs in the town of Dessie. The Churches' ultimate goal of providing care and support services to the orphans rests on promoting the holistic development of the children through saving and rehabilitating their life, assisting with basic needs and education, encouraging for vocational and skill oriented training, offering medical care and counseling and enabling them to be self-supportive in their future life (EOC-DICAC, 2002: 1; EECMY, 2002: 2).

5.1.1 Support for Children Orphaned by AIDS in the EOC South Wollo Diocese Office

Based on information obtained from the South Wollo diocese office, the Church provided support for AIDS orphans in the town of Dessie in two different ways. One was the familial care arrangement (HBC) where the AIDS orphans were placed with extended families and friends and

the other was institutional support or orphanage at Abune Petros Childcare center. In the first part of this section the diocese office's home based care for the orphan children will be assessed followed by descriptions of its institutional support.

5.1.1.1 Home Based Care for Orphan Children

According to informants from the diocese office the Church provided care and support services to 37 AIDS orphan children of whom 8 were living with HIV. It was stated that the selection of beneficiaries took place on the basis of some criteria that each orphan child had to fulfill. The criteria included evidence for the child's loss of both or one parent to HIV/AIDS and absence of relatives or other people who could provide support to the orphan child. Based on in-depth interviews with the orphans and FGD with caregivers, it was possible to understand that the support seeking children had to obtain evidences required for consideration of the Church's support either from kebele administration or the town's Idirs coalition.

In FGD with community members, it was emphasized that the initial stage of screening out orphans for consideration of care and support services was an important task in the entire process of selecting beneficiaries. This was because it would take longer time contacting caregivers and evaluating evidences for screening. In this respect, the role of kebele administration was limited to identifying the orphan children assisted by members of Idirs' coalition. Once this task was accomplished, the evidences would be approved by an advisory committee consisting of members from the EOC South Wollo diocese office, Idirs' coalition, Health Department of Dessie, zonal DPPC and Labor and Social Affairs Office. And this would provide the basis for accepting the orphan children to give them care and support services.

According to informants from the diocese office there were no orphans who needed in-house care out of the orphan children the office provided support. However, it could be argued that the diocese office had no tradition of making assessment to identify the felt needs of AIDS orphans through group counseling and discussions after accepting them. This could have impacts on addressing the needs of those who were living with the virus and those who tested HIV negative. In FGD with orphans and caregivers, it was emphasized that the types of care and support

services the diocese office provided to the orphan children included financial support, medical care, vocational skills training, income generating activities and counseling services.

5.1.1.1.1 Financial Support

The financial support was 100 birr per head/month. It was intended to be used for food consumption and house rent. But, it did not include school fees, expenses for school uniforms and educational materials, which the office additionally supplemented to the children at the beginning of each semester. In spite of this, the orphans and caregivers complained that the financial support was not adequate and regularly given as they had to wait longer without having other alternatives. One of the women caregivers interviewed expressed that such a delay of the financial support had caused much suffering both physically and psychologically. In this regard, she described the difficulties she had faced as follows.

> My sister died of HIV/AIDS eight months ago. She had two children, both below the age of ten and I give them care at home. The EOC diocese office provides financial support to one of my nephews and that is the only assistance the family lives on. It is a pity that the children's parents had left no property to enable me to provide the orphans with appropriate care nor do I have a source of income to support the family. Two months have already passed since we have received the financial support from the diocese office and the children have stopped going to school. If the problem persists, we may be forced to go into the street for begging.

Caregivers involved in FGD explained that the problems of AIDS orphans would become more severe by the economic condition of the deceased parents and caregivers. They argued that the income level of dead parents and of caregivers would determine the orphan children's way of living. If for instance, deceased parents had nothing left for their children to inherit and caregivers either had little or no source of income, the living conditions of the orphans would be miserable. The situation would be much worrisome if caregivers and the orphan children were HIV infected. In light of this, it was emphasized that financial support of the diocese office had to include other members of the family. Supplementing this idea, a young girl of 12 years of age argued:

> I am a student in grade six at Kidame Gebeya Junior Secondary School. My father has died of HIV/AIDS and I am living with my mother who is HIV positive herself and two younger brothers. My mother has no job and does not either receive support from service

provider institutions. The family is living only on the financial support I receive from the EOC. I feel that the Church needs to consider support for my mother and my brothers as well or other organizations ought to provide them with their material needs.

Caregivers also highlighted that serious financial problems had hindered the orphan children and themselves from living in decent houses. They argued that their problems were complicated in conditions where they were HIV positive. This was because house owners would not usually allow PLWHA to rent their houses or would chase them out in case they came to know their HIV status after renting them.

5.1.1.1.2 Medical Care

Medical care was the other type of support the diocese office provided to the orphan children. In this respect, interviewed caregivers explained that the office would provide each AIDS orphan child with 50 birr per month and beneficiaries would be given treatment at FGAE clinic in the town. Nevertheless, it was noted that the amount of money allocated for medical expenses was inadequate and did not include caregivers to benefit from. Consequently, many of the orphan children and their families had no access to private clinics when facing serious health problems.

5.1.1.1.3 Vocational Skills Training

Vocational skills training was the other type of support provided to the orphans. According to informants from the diocese office this support was intended to enable orphans who were 14 years old and above to become self-supportive. The major program components of the training included sewing, photographing, barbering, typing and computer training. In addition, wood work and auto mechanics were added as training fields recently, but only those who were HIV negative were supposed to acquire these skills owing to the fact that both activities would require much energy and probably cause physical harms or injuries. Despite this, the orphan children involved in FGD maintained that only typing and computer training were given to few orphans ever since the program has been launched a year ago. They stressed that their requests for due consideration of training facilities in other fields were left unnoticed for reasons they did not know very well. The resentments of the orphan focus group discussants about the diocese

office's failure to provide them with vocational skills training of their choices were reflected in in-depth interview with a young boy aged 16.

> I am a student in grade 10 at Hote Comprehensive Secondary School. Being caregiver to myself, I need to acquire entrepreneurship skills so as to be self-supportive. Thus, I was selected by the diocese office to receive skills training in wood work three months ago. However, the office did not yet put into effect its training program and I was discouraged by the existing administrative pitfalls. My attempt to receive similar skills training provided by Forum on Street Children Ethiopia (FSCE) was also futile because of the rules that do not allow AIDS orphans to benefit from institutions other than they are registered in.

In contrast, informants from the diocese office had the opinion that it was due to lack of interest on the part of the orphan children that most of the training programs were not provided as planned. Although it seemed difficult to reconcile the different views held by beneficiaries and service providers on this point, there was no reason to believe that the orphan beneficiaries would certainly disagree to receive the skills training as long as they demanded them from the very outset as means of earning a living and alleviating the problems of their survival.

5.1.1.1.4 Income Generating Activities

Based on the data obtained from the diocese office, the Church considered IGAs as important components of support provision to the orphan children. Accordingly, small business training was given to six orphan caregivers allowing them to receive 1000 birr each to start the small business of their own choice. Reportedly, three of these caregivers were engaged in *Gulit* (a place where people locally engage in buying and selling on a daily basis) trading while the remaining beneficiaries were working on different activities. Considering the increasing demands for IGAs however, FGD participants from the orphan children revealed that the office had withdrawn its commitments for a mere reason that they were too young to undertake such business activities and their parents too could not be trusted because they would spend all the start up money for fulfilling other needs. Criticizing the views held by the office, one of the orphan girls who participated in the FGD emphatically argued:

It is puzzling to think about the diocese office's plan of income generating activities to benefit the orphan children and their families because we are regarded as if we were unable to carry on such duties for various unjustified reasons, but who else could do the job for us if we are considered kids and our parents not trustworthy.

5.1.1.1.5 Counseling Services

Based on FGD with caregivers and community representatives, it could be argued that the psychosocial problems of AIDS orphans would be caused by the absence of love and protection and persisting stigma and discrimination. Furthermore, the orphan children would start to experience psychosocial problems when they came to know that their parents were infected with HIV/AIDS. This was so because children would be much worried about their future in the event of their parents' death. The loss of parents would mean losing every thing the children had for instance, love, hope, protection and security, care and support and so on. Under such circumstances, the orphan children would face the unbearable grief and trauma resulting from the death of parents due to HIV/AIDS.

Interestingly, the orphans explained in FGD that they received better counseling service than other types of care and support services. They argued that most of them received the spiritual counseling services of the Church often given at the diocese office compound in group once in a week. The spiritual counseling service was centered on issues such as behaving properly, developing good values and ethical standards, showing sympathy for the needy, protecting oneself from HIV/AIDS through conformity to the rules of Christianity and advancing the causes of humanity on the whole. Quoting from what a preacher said to the orphans during group counseling service in my presence, *"Spiritual issues are basically important to all human efforts. Ignoring this fact would mean losing the quest for a viable set of life principles."* As perceived by the orphan children therefore, spiritual counseling service has relatively enabled them to cope with the pressures of the social stigma associated with HIV/AIDS. In this respect, a 16 year old orphan boy living with his mother expressed his feeling about spiritual counseling services provided by the diocese office as follows.

I am a regular attendant of the group counseling service provided by the diocese office at Medihanealem Church. I have also become a member of the Sunday school of the Church in order to gain spiritual strength through group discussions with Christian friends. I

witness that spiritual counseling service is much important. This is because it has enabled me to develop dedication to work, respect people and attain courage to overcome the difficulties in life and realize my educational ends.

The weak side of spiritual counseling service however, as the orphan children argued was lack of consistency in service provision particularly at individual or family level because religious leaders (preachers) did not regularly visit homes to carry on their duties. They associated the problems probably with the absence of incentives for the spiritual counselors. It was noted that non-Christian AIDS orphans who were recipients of the diocese office were allowed to receive spiritual counseling services of their own faith along with counseling services provided at Mekdim. The orphan children believed that this was intentionally done to give them religious freedom. In practice however, a number of orphans who had Islamic backgrounds were found to attend biblical teaching offered by the Orthodox Church.

Regarding professional counseling service, interviewed orphans were of the opinion that the diocese office encouraged them to receive the service at Mekdim where it was offered from scientific perspectives centered on medical, psychiatric and nutritional issues. According to the orphans the psychological comfort obtained from professional counseling support has also enabled them to have the moral strength to face the challenges of their survival and added that both spiritual and professional counseling services needed to be more frequent in an effort to properly address their counseling needs at most.

In view of the fact that adoption at home or abroad could be part of the solution to alleviate AIDS orphans' problems, caregivers explained that the diocese office had not tried to arrange the adoption of orphans outside the country. They asserted that this could be a difficult task for the office that lacked in professional staff and had no effective networking on the subject. However, the diocese office was considering adoption at home primarily through contacts with interested groups. By and large, it could be inferred that the provision of home based care for AIDS orphaned children by the EOC South Wollo diocese office needs improvement through assessment of the felt needs of beneficiaries.

5.1.1.2 Institutional Care

In the following section discussions will be made about care and support provisions for AIDS orphans at Abune Petros childcare center. The EOC provides childcare services in 36 childcare institutions throughout the country of which nine are found in the Amhara National Regional State. The Church provides support for children who lost their parents by natural and manmade problems. In 1978, the EOC childcare and family affairs organization was established as a result of the famine that occurred between 1973 and 1974 (Hizbayesh, 2004: 1; EOC-CAFO, 2003: 3). According to informants from Abune Petros Childcare Center, the institution was founded in the town of Dessie in 1980 in honor of the renowned bishop of Wollo, Abune Petros who was assassinated by the Italians in 1937 for his resistance to accept alien rule of the country.

The data obtained from the childcare center showed that the institution indiscriminately accepted orphans regardless of the causes of their orphan hood and religious backgrounds both from Dessie and other areas. The center was providing institutional support to 348 orphan children of whom 174 were AIDS orphans. Thus, the ultimate goal of the institution was to enable orphan girls to become self-supportive and productive citizens. The reason why the institution provided support only to orphan girls was due to the complexity of problems they were facing than orphan boys for instance, rape and abduction that could aggravate vulnerability to HIV/AIDS. Since the focus of this study is on assessing the service provision for AIDS orphans, I could see no relevance to discuss details about the institution's non-AIDS orphan support services.

Key informants from the childcare center stated that double AIDS orphan girls between 5-8 years of age could be admitted to the institution. Obviously, the reason why the center limited the age range of beneficiaries as specified above was mainly to widen the chance of the children to grow up being much inculcated in spiritual values and Christian ethics from child hood period. On the issue of accepting only double orphan girls, it was argued that priority was given to this group than single orphans taking into consideration the severity of their problems and the institution's limited capacity to provide the required services. The entire process of accepting the orphan girls thus, involved signing agreements with the respective government bodies namely, the regional and zonal Labor and Social Affairs Offices and the regional HAPCO. The childcare center

however, did not accept disabled and HIV infected orphans because of the absence of facilities for them. Informants from the institution further indicated that the center secured funds to run its childcare programs from the *Greek Community Association for the support of Ethiopian Children and the German Lutheran Church.*

The types of care and support services the childcare center provided include: the basic needs of the orphan children such as food, housing, clothing, educational, medical and spiritual counseling services. Alongside this, the center facilitated conditions for them to receive vocational skills training in woodwork, beauty salon, metal work, accounting and typing. Recreational facilities that included outdoor and indoor games and television programs were also part of the service provisions to the beneficiaries. In addition, the institution provided legal support to the children when they faced problems including HIV/AIDS related issues.

As perceived by the orphan children involved in FGD, basic service provisions at the center were relatively better off as compared with that of AIDS orphans receiving care at home. Unlike the cases of AIDS orphans receiving care and support at home, they argued that adequate food and decent shelter, which were their utmost physical or material needs, were provided by the childcare center. Regarding the availability of monthly financial assistance, sponsors of the orphan children would send the money the orphans needed once in six months. Besides, the children at the institution had no problems surrounding HIV/AIDS induced stigma.

With regard to clothing, the institution ensured adequate financial support from donors each year and gave out the money to the AIDS orphans or their guardians once in three months to buy clothes and shoes. Moreover, the childcare center's educational support to the children included supplies of educational materials, uniforms and payment of school fees. In FGD with the orphans and their guardians, it was emphasized that each orphan beneficiary had her own budget allocated by the childcare center for fulfilling educational needs.

Medical support was the other form of support the institution provided to the orphan girls. The beneficiaries in this respect remarked that the center had its own clinic in the compound where they could be treated for minor health problems. But when the children needed physicians' close

attention and treatment in severe health conditions, they would be referred to Dessie referral hospital and health center for appropriate medical services. The childcare center would therefore, take care of the children's medical expenses at the end of each month. In spite of this, the orphan children expressed that they could not receive the proper treatment partly because the amount of money allocated for this purpose was not enough and partly due to the negative attitude and mistreatment of health workers. In this regard, an orphan girl said:

> I came from Woldia and was admitted to the institution at the age of eight. Now I am a student in grade ten. Of all types of support the childcare center provides us with, medical service is inadequate. Moreover, we have limited chances to receive better treatment at private clinics. On top of this, health workers at government health institutions do not usually have positive attitude towards orphans and mistreat us. I feel that they wrongly regard us as if we were receiving treatment without fees.

The institution provided counseling services to the orphan children but the content of such services was purely spiritual intending to make them well versed in Christian teachings. According to interviewed orphans spiritual counseling services were offered to all of them once in two weeks in-group at the near by churches and had paramount importance to their moral and spiritual development. Furthermore, they expressed that most children particularly above the age of 15 had their own father confessors who gave them spiritual counseling services alone once in a month on how they had to behave towards others and integrate Christian ethical principles into humanly experiences. However, there was a feeling among some of the children that the institution had problems in addressing sensitive issues such as awareness raising about HIV/AIDS, reproductive health and sexuality. In addition, they explained that they had anxieties, which could be associated with the deaths of their parents. In connection with this, one of the interviewed girls remarked:

> I have often been depressed not because the spiritual counseling service provided by the institutions is inefficient, but because my mother's sister, the only person alive among my close relatives, is not willing to visit me even in times of holidays. I sometimes feel that I am lonely, unprotected and unloved.

The orphan children and their guardians involved in FGD pointed out that stigma persisted in Abune Petros Childcare center because the institution did not consider admission of children living with HIV. In the following paragraph the story of HIV positive woman whose infected child did not get acceptance for institutional care is presented.

> I am a daily laborer living on a very little income. My child who is six years old is living with HIV. Although I could access medical and counseling services from the EOC diocese office, there is no material or financial assistance I could receive. Life has become terrible to my child and me because I cannot fulfill his changing needs due to lack of attention from other service provider agencies. My attempt to help my child get admission to Abune Petros Childcare Center did not succeed for a mere reason that the center has no facility for infected children. Where can I any more apply to help my kid receive care? I have no choice except waiting to see what God is planning to do.

With respect to vocational skills training, the institution provided opportunities for the orphan children to receive training in various fields such as accounting, typing, wood work, beauty salon and metal work depending on their interests before or after completing their high school studies. It was stated that such skills training were provided at a level of certificate with a possibility of pursuing to a diploma level in accounting. The prime objective in the provision of vocational skills training according to key informants from the center was to help the orphan children who could not perform well at school to become creative, hardworking and productive. It was apparent that most of the children who had received training skills in various fields had no difficulties in getting employment until recently. As perceived by beneficiaries however, the rare job opportunities available this time had forced large number of trained orphans to remain idle. This in turn had an impact on the childcare center as it was responsible to support the orphans until they get employment.

According to key informants from the childcare center, the institution had a tradition of selecting guardians of the orphan children based on their educational status (usually those who completed grade 12 and above), level of work experience, and commitment to devote much of their time to taking care of the children. Once the guardians were selected, the institution provided them with in-service training on how they could carry on their duties responsibly. The orphan children expressed that guardians often acted as mothers and treated them well as children of their own.

The other point raised in FGD with the orphan children was the subject of property inheritance when their parents died. The discussants had different views on the issue. Some argued that it was due to the ineffectiveness of the law to protect the rights of AIDS orphans that they could not inherit the properties of their parents while others still believed that their parents had left them nothing to inherit. The experience of a 17-year-old orphan girl who was born in Kombolcha but

was brought up in Assab showed an instance in which her parents died of HIV/AIDS after selling all household properties for treatment and care.

> My parents were living in Assab. Following the Ethio-Eritrean conflict in1998, they came to Kombolcha but had no jobs to support the family. Having no options to make a living, my mother decided to work in a hotel as a cashier but my father had to spend the whole day at home without work. My mother was repeatedly falling sick a year later she had begun to work at the hotel. She then went to a clinic for blood test of HIV infection without telling my father.
> Unfortunately, she returned home with the bad news as she came to know her HIV status. It was only my elder sister and I who knew what had happened to her. What followed this was my mother's continuous absence from duties and staying at home instead. This was how my father began to suspect that she could be infected with HIV/AIDS while working at the hotel. He did not waste time to take blood test and he too was HIV positive. It is not difficult to imagine how this could harm the emotional stability of children. Having no supporter at all, my parents sold their properties in support of the family and treating themselves and died leaving nothing for us to inherit.

In FGD with the orphans, I tried to explore their feelings if they would prefer to reintegrate with their relatives either paternal or maternal descent. But, most of them responded that it would not be easy to think of reintegration with kinsmen who had hesitated to know their whereabouts.

The other point emphasized was the institution's practice of sending the orphan children when 18 and above for off-campus life (to live somewhere in the town) receiving 140 birr per head/month for their living expenses until completing a training and get employment. This according to informants from the center was to help the children develop skills of social interactions, which partly lays the basis for their future life. However, many wondered if this plan could really work in attaining the desired outcomes given that the orphan girls would easily be susceptible to unsafe sexual practices and develop other undesirable behaviors. Responding to this view, key informants from the childcare center stressed that the children had been learning moral principles and ethical values since their childhood and could understand what was good or bad without difficulties. Furthermore, they noted that there were no records of such problems in the history of the institution. Opposed to this view, a 20-year-old girl who was attending at Woizero Siheen Business and Management College said:

> Two years ago I began to live here in Piazza with two of my friends who used to live with me in Abune Petros childcare center. Since the day I left the center, I have been tempted by young boys with whom I had no relationship before. Their repeated request

was the same. It was to get my consent for a boy-girl relationship with one of their friends. Knowing that I remained opposed to their demonic interest, they bitterly beat me in the daylight.

It seems therefore, the childcare center's tradition of sending the children out for off-campus life when 18 and above has proved counter productive. Rather, it would be somehow helpful to consider the reintegration of the orphan girls with their relatives if found and willing in order to reduce their unbearable suffering.

5.1.2 AIDS Orphan Support in the EECMY North central Synod

The EECMY North central synod promotes HBC for AIDS orphaned children placed with extended families. The major objectives in the provision of care and support services for AIDS orphans center on the following fundamental principles. It is to enable the children to continue their normal childhood life in an extended family as members of the community, provide primary health care and counseling services to the orphan beneficiaries and their caregivers to help them lead a healthy life, and enable the orphans to become self-reliant and productive through the provision of educational facilities (EECMY, 2002: 6).

The ultimate realization of the stated objectives thus, lies on the provision of different types of support services to alleviate the social and psychological challenges of AIDS orphans and their caregivers. Furthermore, as would be shown later the synod promotes parallel programs to mitigate the problems of the poorest or needy children, their caregivers and possibly AIDS patients in the family in the form of compassionate support. The Church obtains financial assistance to its HIV/AIDS programs in South Wollo from different Lutheran Churches such as the Finnish, Swedish, German, US and Norwegian evangelical Churches (EECMY, 2002: 7).

5.1.2.1 Selection of Beneficiaries

According to key informants from the synod, the selection of AIDS orphan beneficiaries for a home based care was based on the following requirements. First, children had to be single or double orphans who were 12 years old or below and second, valid evidences needed to be presented for having no or insufficient income. With regard to the selection of the needy children

for compassionate support (a type of support the synod provided to needy children), especial consideration would be made to those whose parents were AIDS patients having little or no income. In most cases, it was the synod that notified the respective government bodies, zonal and woreda HAPCO about its plan and capacity to accept orphan beneficiaries and needy children. In selecting beneficiary children it was stated that the synod did not make differences between them with respect to places of origin and considered all applicants for support irrespective of religious affiliations or backgrounds.

Accordingly, orphans applying for the synod's support would bring evidences from the local Kebele administration and Idirs (in case their parents were members) asserting that they had lost their parents to HIV/AIDS and had no relatives to take care of. On the other hand, in the case of the needy children clients were expected to prove that their parents had little or no income to support the family. In both cases therefore, the selection of orphan and needy children would be made on the basis of supporting documents. According to key informants from the synod, the task of final approval would then be accomplished by an advisory committee, which consisted of members from the EECMY North central synod, Idirs' coalition, Dessie Health Department, zonal DPPC and Labor and Social Affairs Office.

It was noted that the synod often organized a sensitization or familiarization workshop for different administrative and concerned government offices, NGO representatives, community and religious leaders immediately before or after the selection of the orphan children. This was mainly to create positive feeling among participants in dealing with the social crises of AIDS orphan hood and give weight to orphan care and support in their HIV/AIDS programs. Key informants further stressed that after accepting the orphans the synod would provide group counseling and discussions to identify them for appropriate care and support provisions. So far the results of the assessment showed that there were 10 orphans needing in-house care while the remaining 65 were school age orphans. The synod therefore, provided support for a total of 75 orphan children of whom 18 were living with the virus. It was also explained that the Church would increase the number of beneficiaries to 100 by the year 2007.

With respect to support for the needy children, the synod provided compassionate support to 250 care recipients in the form of small financial assistance for school fees, educational materials and

school uniforms. They also received counseling services in their own choices either at Mekane Yesus Church, the Orthodox Church, mosque or from Mekdim association. In addition, caregivers of the needy children would be provided with medical support and in some cases the Church encouraged outstanding students providing their caregivers with financial assistance to help them engage in IGAs.

5.1.2.2 Care and Support for Orphan Children

5.1.2.2.1 Social Support

According to key informants from the synod the types of care and support services the EECMY provided to AIDS orphaned children included social, psychosocial and medical supports. The social support consisted of financial assistance, HBC training, Income Generating Activities (IGAs) and vocational skills training. It was emphasized that each orphan child received 115 birr per month to cover expenses for food and house rent. The synod also covered the children's medical expenses, school fees and educational materials with additional 60 birr for each beneficiary and the purchase of school uniforms, which was made once at the beginning of school year, had its own budget.

In FGD with AIDS orphans and caregivers however, it was noted that the synod could not provide the orphan children with clothing nor did it allocate budget. On this point, caregivers remarked that there were some instances whereby AIDS orphans were able to receive clothing support from the community. In this respect, specifically mentioned were the cases of Idirs in the town such as Robit Gebeya, Finote Hiwot and Mehal Idirs. These Idirs provided thirty orphan children with clothes in their respective kebeles in times of public holidays such as Christmas, Id-Alfetir and beginning of new Ethiopian year.

Nevertheless, given the depth of the problems of AIDS orphans in the town, the contributions of Idirs were much limited. Hence, several Idirs in other kebeles could not yet reach a number of AIDS orphans either due to lack of resources or failure to mobilize the community to act accordingly. The orphans and caregivers also raised the inadequacy of financial assistance and

stressed that food consumption, house rent, medical and educational expenses involved much cost and financial problem was severe in care and support services. In connection with the inadequacy of financial support and the difficulties in coping with survival problems, a woman caregiver who lost her brother to HIV/AIDS commented the following.

> I am caregiver to three children of my elder brother who died of HIV/AIDS a year ago with his wife. When the couple died, I took the responsibility to take care of their children as there were no close relatives to do so. The children are all below the age of nine and need much care. This time Mekane Yesus Church provides financial assistance to one of the orphans and the family depends on this support. However, our living condition is not good partly because the Church's support is inadequate and partly I am a house maid earning very little.

Under the social support provision, the synod promoted HBC program whereby training was given to HIV positive HBC workers and volunteers from the community with the purpose of providing care and support services to PLWHA and HIV infected orphan children. Based on the data obtained from the Church, ten HBC workers among those living with the virus and six volunteers were provided with the necessary training and medical kits. They received 50 birr transportation allowance per month to help them offer the services required. Key Informants from the synod emphasized that unlike the cases of voluntary HBC workers recruited from the community those who were HIV positive themselves could provide better services to bed-ridden HIV patients and infected children. This was because of commitments they showed, love and concern for care recipients in carrying out their duties honestly and responsibly. That was why the EECMY would prefer to select HIV positive HBC workers than voluntary ones.

According to informants from the synod, IGAs were mentioned as important activities through which the orphan children and caregivers could develop the sense of independence. It was emphasized that the Church provided some financial support for caregivers of few outstanding school age orphans who performed well at school. Despite this, they stressed that support for all caregivers to carry on IGAs was difficult due to budget constraints. Even earlier attempts to enable some beneficiaries to engage in small business had failed to produce the desired outcomes because of the tendency to use the start up money for survival needs. They also asserted that beneficiaries would in most cases move away from the town to other areas without notifying their whereabouts further complicating the Church's follow up system.

In spite of this, caregivers who participated in FGD said that the synod's plan to help them involve in IGAs was not workable for some reasons. This was attributed to insufficient attention to the implementation of the program and lack of trust on the part of service providers thinking that caregivers would spend the start up money for other needs due to appalling living conditions. In addition, caregivers remained strongly opposed to the view that families who got the Church's support to engage in IGAs would move to unknown places with the money they received. They justified their argument on the ground that those people who received financial assistance from the synod to involve in small businesses were still living in Dessie and no one had left the town. Instead, they associated the synod's case with some sex workers who got financial support from Mekane Yesus Church few years ago to carry on IGAs and disappeared soon. At this point it may be helpful to cite what a caregiver had commented on what had to be done to help them sustainably.

> It is difficult for the synod alone to meet all our needs adequately and some time in the future the support we are receiving now may cease. In order to avoid the imminent danger following the discontinuation of the Church's support, a concerted effort must be made to mobilize community support for AIDS orphans and their families and promote IGAs in all possible ways.

With regard to vocational skills training, interviewed caregivers argued that the need to provide the orphan children with different skills training was given insignificant attention. They remarked that the Church had just in principle outlined the provision of skills training in wood work, electricity and auto mechanics but little was done in practice. According to them the problems arose from the failure of the synod to assess the felt needs of the orphan children than just financial constraints. Therefore, the administrative problems of the Church largely deterred the orphans (those who completed high school studies but had no alternatives to make a living) from receiving the desired vocational skills training. This in turn forced the children to spend much of their time without work. In some instances, the orphans had developed undesirable behaviors that could possibly aggravate their vulnerability to HIV/AIDS. In this regard, an interviewed orphan boy expressed his disappointment.

> I receive financial assistance from Mekane Yesus Church monthly and have completed my studies in grade ten, but could not pursue further because of poor academic performance. In order to make my living, I applied to the synod to access opportunities for vocational skills training either in wood work or auto mechanics. Unfortunately, I did

not succeed owing to the inconsistencies on the part of the Church to go ahead with its plan to provide us with the training facilities.

Moreover, caregivers emphasized that the EECMY synod had made little efforts to establish effective networking with partner organizations so as to facilitate conditions for the orphan children to receive the skills training they needed.

5.1.2.2.2 Psychosocial Support

Psychosocial support was the second broad category of care and support service provided to AIDS orphans. Based on the data obtained from the Church, counseling services were provided at individual, family and group levels once in a week. It was stated that the counseling topics included spiritual, medical, nutritional and psychiatric aspects whereby five home visitors and five trained individuals from the synod provided the services to the orphans and caregivers. Evidently, the synod had a tradition of offering spiritual counseling services at individual and family levels while group counseling involved the medical, nutritional and psychiatric dimensions. It was emphasized that the home visitors provided spiritual counseling services to the orphan children and their caregivers while the trained individuals offered the scientific aspects of counseling services.

In FGD with the orphan children and their caregivers, it was highlighted that the synod encouraged clients to receive spiritual counseling services of the Church or of their own faith. Also, it facilitated conditions for every client to receive counseling services at Mekdim association. According to key informants from the synod, several Muslim orphans receiving support from the synod often preferred to attend Gospel teaching provided by Mekane Yesus Church showing little concern for strict adherence to their faith. The spiritual counseling services of the synod as perceived by interviewed orphans and their caregivers entirely focused on the need to inculcate Christian values and norms to help them protect themselves from HIV/AIDS and support the needy. In my observation of spiritual counseling service at home, I tried to explore the feeling of a 17-year-old orphan girl who was living alone about the benefits of such counseling services. She began to respond first expressing her appreciation of the Church in respecting the rights of orphans to worship and went on saying:

> Now I found myself on a solid ground where I could see a bright future in my life because my broken heart due to the death of my parents has been repaired through spiritual counseling. I firmly believe that I am morally rehabilitated and feel confident that I could be successful in my incessant efforts to improve my living conditions.

The girl's opinion about spiritual counseling services was similarly reflected in FGD with the orphan children in that the Church's spiritual counseling support was meant a lot to them as well because it helped them to feel psychologically comfortable and reduce the trauma of HIV/AIDS induced stigma. It was apparent that the trained counselors usually offered the group counseling service to clients at the prayer house of Mekane Yesus Church in the town.

Key informants from the synod explained that some of the clients received only spiritual counseling services while others still received both spiritual and non-spiritual counseling services based on their interests. However, the orphan children and caregivers involved in FGD did not hesitate to express what they thought should be done to make both spiritual and non-spiritual counseling services more effective in addressing their utmost needs. They argued that after hours of counseling services and the consequent moral strength to face the challenges in life, they would begin to think of their material needs that could not be avoided. Here was the problem where appropriate support was not available and some of the orphans had dependents at home expecting them to provide with all their needs. It can therefore, be assumed that the provision of counseling services to the orphan children and caregivers needs to go side by side with the delivery of material needs because the absence of survival needs would make every counseling effort ineffective.

According to informants from Idirs' coalition, there were some cases in which AIDS orphans in kebele 11 and 12 were initially opposed to be considered for social support in Mekdim. This was because of the feeling that receiving care and support services would bring them public isolation related to the death of their parents from HIV/AIDS. This implies that there was a need to provide counseling services to such children in order to help them receive care and support services.

5.1.2.2.3 Medical Support

Medical support was the other type of support provided by the EECMY to AIDS orphan children. According to informants from the Church, the synod also facilitated VCT services for caregivers with the possibility of providing ART for those living with the virus. In spite of this, the inadequacy of financial support had put a halt to their access to proper medical care both at public and private health institutions. Strengthening this idea, an orphan girl expressed that the medical problems of the orphan children were severe because the synod allocated only 25 birr per month to each recipient and this was inadequate to enable the children to receive the proper medical treatment.

In relation to this, caregivers remarked that orphans living with the virus could not receive the appropriate medical support due to the complexity of health problems associated with the virus. It was also emphasized that the inability of HIV infected orphans to take nutritious food due to financial problems further complicated treatment and follow up. Simultaneously, a woman living with HIV/AIDS taking care of her infected child expressed what she had faced as follows.

> I am living with the virus. It was three years ago that my husband died of HIV/AIDS leaving three children of whom one is HIV positive. This time, Mekane Yesus Church is providing financial and medical assistance to my infected child. But I have no other source of income to improve our living condition. Honestly speaking, I am much troubled with the changing needs of my child whose HIV status has completely changed his behavior and food habit. He always insists on taking nutritious food, but I could not afford.

The other relevant point in connection with the support provision of Mekane Yesus Church as pointed out by informants from the synod was the issue of protecting the legal rights of orphans and their families when they became victims of abuses on grounds of HIV. Substantiating this point, orphan children and caregivers explained that the Church had extended its legal support for few families in cases where AIDS orphans living in kebele owned houses were forced to leave the houses they were living in when their parents died. However, they remarked that the Church's support in this respect was not inclusive of most AIDS orphaned children and their families. Hence, there were a number of clients who were denied their rights to rent kebele houses.

5.1.3 Discussion of Survey Results

In this section of the chapter presentation is given on the results of survey conducted among AIDS orphans who were receiving care and support services from the EOC South Wollo diocese office and the EECMY North central synod. This discussion would largely back up the qualitative research findings.

Table Four: The socio-demographic characteristics of AIDS orphan respondents

Sex	*Age*	*Educational status*	*Religion*
Male = 8 (32%) Female = 17 (68%) Total = 25 (100%)	**15-18** M = 5 (20%) F = 9 (36%) **19-21** M = 3 (12%) F = 8 (32%)	**No formal education** M = 2 (8%) F = 5 (20%) **1-8th grade** M = 3 (12%) F = 7 (28%) **9-12th grade** M = 2 (8%) F = 4 (16%) **Above 12th grade** M = 1 (4%) F = 1 (4%)	**Orthodox** = 15 (60%) **Muslim** = 7 (28%) **Protestant** = 3 (12%)

Table four shows the socio-demographic characteristics of AIDS orphan respondents. It consisted of basic information such as sex, age, educational status, and religious backgrounds. As it could be observed from the table, the number of respondent orphan children is 25 in which 32% are males while 68% are females. In terms of age distribution, orphan children whose age falls between 15-18 constitute 56% of the respondents while those between 19-21 years old make up 44%. Concerning educational status, 28% have received no formal education, 40% have attended 1-8th grade level, 24% have learned in secondary sections (9-12th grade) and those who attended above 12th grade level constitute 8%.

Regarding religious backgrounds, 60% of the respondent orphans belong to the Orthodox Church, 28% to Islamic religion, and 12% to the Protestant Churches. On the issue of orphans belonging to Islamic religion however, the quantitative data do not give a clear picture whether the children are strict adherents to their faith or not while the qualitative study reveals that most Muslim orphans receiving care and support from both Churches attend Gospel teaching willingly.

Table Five: The socio-demographic characteristics of AIDS orphan respondents (contd.)

Housing condition	*Type of caregiver*	*Family size*
Private owners M = 4 (16%) F = 6 (24%)	**Self Care** M = 3 (12%) F = 7 (28%)	**1-5** M = 6 (24%) F = 11 (44%)
Rented from kebele M = 3 (12%) F = 7 (28%)	**Surviving Parent** M = 1 (4%) F = 4 (16%)	**6-10** M = 2 (8%) F = 6 (24%)
Rented from individuals M = 1 (4%) F = 4 (16%)	**Grand Father or Mother** M = 2 (8%) F = 4 (16%)	
	Aunt or Uncle M = 2 (8%) F = 2 (8%)	

Table five is an extension to table four showing the socio-demographic characteristics of the same AIDS orphan respondents. The table thus, provides information about the children's housing condition, type of caregiver and family size. The housing condition of the respondent orphans indicates that 40% of the children live in privately owned houses, 40% in kebele houses and 20% in houses rented from individuals. Nevertheless, in contrast with this data the qualitative study shows that several orphan children have little opportunities to rent kebele houses.

With respect to type of caregiver, it can be inferred that 40% of the orphan children provide care to themselves, 20% receive care from surviving parents, 24% receive grand parents' care while 16% live with their aunts or uncles. In comparison with the qualitative data, there is much similarity of findings, but it was able to understand in observation that some orphan children received care from their elder siblings as well. Finally, it is shown that 68% of the respondents have a family size of 1-5 members while 32% have 6-10.

Table Six: Survey results of AIDS orphan respondents

Variables investigated	*Yes*		*No*	
	Number	*Percentage %*	*Number*	*Percentage %*
Did you inherit property from deceased parents?	2	8%	23	92%
Do you have other sources of income?	3	12%	22	88%
Is financial support adequate?			25	100%
Is medical care appropriate?	2	8%	23	92%
Is spiritual counseling service efficient?	22	88%	3	12%
Have you taken vocational skills training?	5	20%	20	80%
Have you engaged in IGAs?	1	4%	24	96%
Are there dependent family members?	14	56%	11	44%

The total number of AIDS orphans who participated in the survey conducted was twenty five. The table above shows that of all variables examined, the highest percentage for which the respondents said yes was with respect to the effectiveness of spiritual counseling service. Fifty six percent of the respondents said they had dependent family members that in turn made their living conditions rather difficult. It can also be inferred from the table that the orphan respondents chiefly said no to other variables explored such as property inheritance, availability of other sources of income, adequacy of financial support, appropriateness of medical care and promotion of vocational skills training and Income Generating Activities (IGAs). This is an indication that care and support services to AIDS orphaned children by the EOC South Wollo diocese office and the EECMY North central synod are inadequate requiring improvement. In the last chapter summary of the research findings and conclusions drawn are presented.

Chapter Six

Summary and Conclusions

6.1 Summary

In this chapter an overview of the major findings of the study is presented. In the prevention and control of HIV/AIDS, the provision of care and support services to PLWHA and affected members of the family constitutes an important place. This is not only because it is a human rights concern, but also serves the purpose of avoiding the feeling of hopelessness among HIV positive people and enables AIDS orphans to become productive citizens. It is believed that care and support services to PLWHA would help to bridge the gap in meeting their utmost needs of life thereby enabling them to avoid unsafe sexual practices, which could result from desperation and are manifestations of vengeance for being infected with the virus. Presumably, care and support services to those infected with HIV/AIDS would initiate several others to take VCT services, disclose their serostatus if infected and display a responsible sexual behavior. And those who tested HIV negative would draw lessons to protect themselves from HIV infection through safe sexual practices.

The study is part of an attempt to show the necessity of integrating spiritual components into the existing care and support services to PLWHA and AIDS orphans. This in turn enables care recipients to avoid stigma and discrimination and develop self-worth. Moreover, it enhances the delivery of effective care and support services to mitigate the individual and social impacts of the pandemic and promote the idea of living with the virus positively.

Discussion of findings of the study has been made beginning with providing insights into the extent of HIV/AIDS interventions in the town. This is intended to highlight that care and support needs of HIV positive people and AIDS orphans are interrelated with HIV/AIDS prevention and control program. In this respect, it has been focused on existing IEC/BCC efforts to investigate the roles of anti-AIDS clubs, Idirs, religious institutions, NGOs, Mekdim association and so on in producing and distributing IEC materials and promoting BCC activities.

Vulnerability factors to HIV/AIDS have also been assessed. It is reported that unsafe multiple sexual practices are the most common ways of HIV transmission in the town. Other factors that make people vulnerable to HIV infection include alcohol and drug addictions, unemployment, illegal abortions and so on. In addition, gender based vulnerability differences result from lack of sex negotiation skills by young girls and women and male dominance in the community.

Large part of this study has focused on exploring the existing care and support services to PLWHA and AIDS orphans in the EOC South Wollo diocese office and the EECMY North central synod. The EOC diocese office has HIV/AIDS programs including the provision of care and support in seven Woredas of South Wollo zone. These include Ambassel, Kalu, Dessie, Tehulederie, Worebabo, Sayint, and Kutaber Woredas. Of these project sites, the diocese office provided care and support services to PLWHA and AIDS orphans in Ambassel, Kalu and Dessie while support only for PLWHA was given in the other Woredas. In carrying out its programs, Sunday schools were instrumental.

Similarly, the EECMY synod has been working on care and support services in Dessie, Kombolcha and Haiq towns and Tehulederie Woreda of South Wollo Zone. The synod provided support for both PLWHA and AIDS orphans in Kombolcha and Haiq towns while its support only for PLWHA prevailed in Tehulederie Woreda. In the town of Dessie it supported AIDS orphaned children. The rational for both Churches' support of AIDS orphans is to enable the children to become industrious. It is also noted that the EOC and EECMY have established networking of services with partner organizations. Although largely inefficient, such working environment was needed to ensure effective mobilization and management of resources in addressing the needs of PLWHA and AIDS orphans.

The EOC diocese office provided support for 181 PLWHA of whom 45 were bed-ridden patients who needed HBC services. The types of support provided to beneficiaries included social support, medical services, spiritual and pastoral support and education and training of home caregivers. Financial support, housing and clothing needs, income generating activities and vocational skills training were components of the social support. Notably, there was a feeling on the part of PLWHA that financial assistance was their basic necessity followed by medical services.

The study has also focused on examining the problems and coping strategies of PLWHA and caregivers. The major problems that PLWHA encountered in accessing care and support services included the following. First, clients were not allowed to receive support from different service provider organizations other than the institution they were registered in. Second, self-stigmatization of PLWHA has affected access to support services in which recipients did not want to reveal their HIV status and receive the appropriate care and support services. Also, community attitude towards PLWHA was detrimental to access services. This was manifested in situations where people often regarded individuals visiting VCT centers as if they were all infected with HIV/AIDS.

The other way in which PLWHA could be deterred from receiving support was the attitude of care and support staff towards them. This could be explained in conditions where PLWHA were considered not deserving support because they dressed well and looked healthy. In addition, the negative attitude of family members towards PLWHA might prevent individual members from seeking VCT services and know their HIV status. This in turn would affect care and support services. Admittedly, the problem resulted from fear of isolation as if members of the family living with the virus were offenders who violated the laws of God.

There were also other factors that PLWHA encountered in accessing care and support services. These included the persistence of stigma and discrimination in renting houses from private owners and biases of kebele officials in dealing with the problem; the inadequacy, delay and variation in the amount of financial assistance and lack of trust by the service provider institution to help them carry on IGAs.

The case studies presented show various life experiences of PLWHA, problems encountered with respect to survival needs, social stigma and coping mechanisms. We have seen for instance, Kelemua was obliged to drop out of school due to severe economic hardship and began to make a living as a cashier in a hotel. Being unable to support herself alone due to poverty, she married a person without knowing his HIV status. She then found herself living with the virus, but could not receive financial assistance to support herself and her family. The family thus, lived on little income she earned working as a shopkeeper and the unreliable support from her husband's relatives. Other case studies as well illustrate the social realities how people could be exposed to HIV/AIDS, the complexity of problems PLWHA would face and coping mechanisms.

With regard to the EOC support for AIDS orphans, there were 37 children receiving care at home living either alone, with a surviving parent, relatives or friends. Eight of these orphans were living with HIV needing close attention. The diocese office provided the orphan children with financial support, medical care, vocational skills training, IGAs and counseling services. In addition, it promoted institutional care to 174 AIDS orphan girls at Abune Petros childcare center. However, the institution has no tradition of accepting orphans who are HIV positive and disabled probably because of lack of facilities for them.

Under the HBC program, the EECMY provided support for 75 AIDS orphans of whom 18 were HIV positive. It is emphasized that the synod provided the children with social, psychosocial and medical supports. Moreover, it provided compassionate support to 250 needy children (whose parents were AIDS patients with little or no income). Unlike the cases of AIDS orphans, the needy children received little financial assistance for school fees, educational materials and school uniforms.

The problems of AIDS orphans are complex. Importantly, economic or financial problems, burden of care giving to surviving parents or younger siblings, absence of adequate support from service provider agencies and age and health problems of caregivers are worth noting. Besides, the negative attitude of the community towards AIDS orphans, psychosocial problems of the children resulting from persisting stigma and discrimination, maltreatment of the orphans by peers, neighbors and some members of the community would make the life of AIDS orphans much difficult.

Finally, the coping strategies employed by AIDS orphans and caregivers are discussed. In overcoming their problems, the orphan children and caregivers would be compelled to withdraw savings, sell household assets, seek support from service provider agencies, relatives, friends or the community and disperse siblings. In most cases the orphan children would engage in informal business activities such as shoe shinning and also become house servants, daily laborers or cowboys to support themselves and their families. It was however, at the expense of their education that the children managed to make their living and support members of the family seeking care. Worst of all was the tendency of some orphan girls to engage in commercial sex as a means of livelihood, which was likely to make them vulnerable to HIV/AIDS.

6.2 Conclusions

The provision of care and support services to PLWHA and affected families immense contributes to the prevention and control of the HIV/AIDS epidemic. This is due to the fact th several people who suspect themselves of being infected with the virus would be initiated to tak VCT services and reveal their serostatus. This in turn helps them to receive care and suppo services and avoid the possibility of unprotected sex that could be practiced when PLWHA los hope in life. The study therefore, attempts to demonstrate the necessity of integrating religiou approaches into the existing care and support for PLWHA and AIDS orphans to ensure th delivery of appropriate care and support services.

Given the existing socio-economic structures in Ethiopia in general and in the study site i particular, home based care for PLWHA could be practiced magnificently as compared wit hospital based care. However, the sustainability of home based care largely depends o community support. It is apparent that discussions on the models of care and support for PLWH have so far shown that the informal home based care model functions in the context of this stud than the integrated home based care and single service home based care models.

Taking into consideration that the involvement of service provider institutions in care and suppo program is limited in the town as opposed to the demands of many service seekers, it may b impractical to think about the effective application of the integrated home based care and singl service home based care models. This is because the integrated home based care model i workable when there is an opportunity for mutual support and collaboration among families community care providers, clinics, hospitals, NGOs and so on. However, this is not the case i the study site primarily due to insufficient attention to PLWHA and relatively due to resourc constraints.

With regard to the single service home based care model, there are some grounds that make it effectiveness less likely. First, the capacity of a single service provider agency may not b reliable and second, the possibility of ensuring efficient service provisions by community HBC workers is difficult given the complaints of several bed-ridden HIV patients. Arguably, th informal home based care model for PLWHA could be applied in this study. This is becaus

caregivers at home would be able to carry on their duties receiving informal support from th social network such as Idirs and assistance could be sought from service provider organizatio for ultimate self-support. Virtually, the model enables people to restore confidence in bringi solutions to their own social problems than often looking for external support.

Similarly, models of care and support for AIDS orphans that could meet the children's need socialization include the family and community based approaches. In this respect, the orph children would be able to acquire the norms and values of the society and learn to become se reliant and productive citizens. In fact, these models of care and support would be meaning when there are concerted efforts to strengthen the abilities of families and communities to ful the needs of the orphans. Therefore, it is arguable that the family and community based models AIDS orphan support could best be applied in the study conducted.

The establishment of effective networking among partner organizations working on HIV/AI program is of paramount importance for efficient mobilization and regular review of follow systems. In this regard, the EOC South Wollo diocese office and the EECMY North cen synod have created working relations with various institutions. In spite of this, the results gai are insufficient implying the need for more effective networking. Paradoxically, the Churches have not yet established direct working relations with each other on HIV/AIDS iss probably because of age old differences in religious practices. In order to ensure success in and support services therefore, they have to work closely on a common agenda irrespectiv religious matters.

Community support for PLWHA has been less significant except for some Idirs' contributi For instance, HBC workers recruited from the community could not provide the appropr services to bed-ridden AIDS patients. Perhaps this has resulted from lack of willingness. T the involvement of community volunteers in home based care has not been fruitful and focus to be made on providing HBC training for potential HIV positive persons. In addition, the fa circle deserves primary attention as the foundation of society. This is because educating mot is considered imperative to care for the entire family.

With respect to AIDS orphan support, the EOC South Wollo diocese office promotes bot familial and institutional care. Most AIDS orphaned children receiving care under the HB program have difficulties in accessing the services they need. For instance, financial support ar medical care are not adequate; and vocational skills training and income generating activities a restricted to few families. Of all services provided, counseling service is better off, but it could b more efficient on condition that the material needs of the orphans are properly met. In contra with the HBC, institutional care for the orphan children is somehow better. Neverthele counseling services focus much on spiritual aspects leaving wider gaps in addressing issues HIV/AIDS, reproductive health and so on. Apart from this, the orphans have little opportuniti for acquiring the norms and values of the society that affect their emotional development. At th point it may be convenient to argue that institutional care for AIDS orphans needs to be the la alternative if at all traditional childcare mechanisms are overburdened.

The EECMY North central synod is the other religious institution working on care and suppo for AIDS orphans. It promotes HBC for the children and provides them with different types support including counseling services. The orphans receiving care however, have problems accessing adequate material and medical supports. Income Generating Activities (IGAs) a vocational skills training too are not properly given to all clients or their caregivers desp programs designed. The only service that they could access efficiently is counseling service. B the inadequacy of material support and inappropriateness of medical services have often ma difficult the attainment of the desired goals in counseling services. The bottom line is that b the EOC South Wollo diocese office and the EECMY North central synod need to ma consistent efforts to provide care recipients with their basic needs along with meeting th emotional needs in counseling services. Certainly, the integration of these would bring ab improvements in the living conditions of the orphan children and their caregivers.

It is the author's belief that improvements in care and support services to PLWHA and AI orphans by the EOC South Wollo diocese office and the EECMY North central synod could gained with due consideration of the following recommendations.

- Strengthening the human resource capacity through short and long-term training packages and designing programs based on the expressed needs of beneficiaries
- Building better coordination or creating effective networking among public and private sectors, NGOs, CBOs, religious institutions and other actors that are implementing HIV/AIDS activities
- Training community-based reproductive health agents who can in turn train relatives of PLWHA could help bridge the technical support gap between health professionals and untrained primary care providers
- Strong government support and commitment is needed in scaling up the existing community-based prevention and patient care programs to a multi-sectoral HIV/AIDS program.
- Cultivating ethical standards, norms and values among the community in general and government officials in particular to ensure transparency and accountability
- Strengthening PLWHA associations to help HIV positive people involve in community mobilization, facilitate HBC program and gain acceptance among the population
- Promoting Income Generating Activities (IGAs) supported by market and viability studies to enable PLWHA, AIDS orphans and their families to become self-supportive
- Enhancing effective management of available resources through monitoring and evaluation and secure adequate funds to address the most pressing needs of PLWHA and AIDS orphans
- Ensuring the availability of appropriate social and medical supports along with spiritual and non-spiritual counseling services. This is because a combination of all types of support would be measurably effective in bringing about substantive changes in the life of care recipients

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Appendix: I Registered AIDS Orphans and Street Children in Dessie Town.

No.	Description	Number	Remark
1.	Double Orphan	867	Those who lost both parents
2.	Single Orphan	787	Those who lost either father or mother
3.	Total Orphans	**1,654**	
4.	Street Children	1,508	Street children may include vulnerable group
	Grand Total	**3,162**	

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

Appendix: II Summary of Support to PLWHA and AIDS Orphans in Dessie

No.	Activity	Organization	Number of beneficiaries	Types of support
1	Support to PLWHA	OSSA	80	social, medical and counseling services
		Mekdim	89	financial, medical and counseling supports
		Netsebraq	86	financial support and HBC training
		EOC	181	social, medical and counseling supports
	Total PLWHA supported		**436**	
2	Orphan support	OSSA	129	financial support
		Mekdim	362	financial, clothing and counseling supports
		FSCE	20	vocational skills training
		EECMY	75	social, medical and counseling supports
		EOC	37	social, medical and counseling supports
			174	institutional care
	Total orphans supported		**797**	

Source: South Wollo Zone HAPCO, Care and Support Interventions in Dessie, November 2005

Appendix III: Focus Group Discussion with PLWHA

Appendix IV: PLWHA Selected for Case Studies

Appendix V: Focus Group Discussion with AIDS Orph
and Caregivers

Appendix VI: Focus Group Discussion with PLWH
and Caregivers

Appendix VII: Observing PLWHA at home

Interviewed AIDS Orphans at the

DECLARATION

I, the undersigned, declare that this thesis is my original work. It has not been presented for a degree in any other university, and that all sources of material used for the thesis have been duly acknowledged.

Name: Mesfin Dessife

Signature: Mesfin.

Place: Addis Ababa

Date: November 2006

CONFIRMATION

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

Name: _____

Signature: _____

Date: _____