Running head: Role of Faith Based Organizations in Combating HIV and AIDS Epidemic in Addis Ababa

Role of Faith Based organizations in Combating HIV and AIDS Epidemic in Addis Ababa: Case Study of Ethiopian Kale Heywet Church

Abebaye Hailu

Addis Ababa University

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Advisor: Professor Sandhya Joshi

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Acronyms and abbreviations

AAC	Anti AIDS Club
AAU	Addis Ababa University
AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavioral Change Communication
CBOs	Community Based Organizations
ECC	Ethiopian Catholic Church
CETU	Confederation of Ethiopia Trade Union
EEF	Ethiopian Employment Federation
EECMY	Ethiopian Evangelical Church Mekane Yesus
EKHC	Ethiopian Kale Hewyet Church
EOC	Ethiopian Orthodox Church
FBOs	Faith Based Organizations
FMoH	Federal Ministry of Health
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home Based Care
HIV	Human Immune Deficiency Virus
ICA	Intelligent Community Agency
IEC	Information, Education and Communication
KII	Key Informant Interviews
MoH	Ministry of Health
NAC	National AIDS Council
NGOs	Non governmental Organizations
PLWHA	People Living With HIV/AIDS
TB	Tuberculosis
UNAIDS	United Nation AIDS
VCT	Voluntary counseling and testing
WHO	World Health Organization A

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Abstract

The emergence of HIV/AIDS epidemic has brought multi faceted challenges among the entire nations across the world. Particularly, it has affecting the developing countries human and material resources with retarded socio economic growth. In Ethiopia millions are infected and affected and suffering with result of huge impacts.

This study tries to see the role of Faith Based Organizations (FBOs) played in fighting against HIV/AIDS in Addis Ababa. It focuses on case study of Ethiopian Kale Heywet Church (EKHC) MEDAN ACTS Addis Ababa HIV/AIDS project in ***Kirkos*** sub-city. The study set out objectives and used qualitative methods and selected 25 samples using random sampling technique among 250 beneficiaries. The data sources are interview of beneficiaries, key informants interview of church leaders, Junior Secondary Schools directors, ***Iddir*** leaders, project manager and senior project staffs like IGA officer.

The thesis examines the involvement of FBOs in the prevention and control of HIV/AIDS in the past decades. Few literatures indicated that major religions organizations have played positive role in fighting HIV/AIDS including EKHC. EKHC has various departments working on different development issues including prevention and control of HIV/AIDS. Under EKHC intervention of HIV/ AIDS program indicate that the church has big share to combat HIV/AIDS. The thesis found that the majority of the respondents faced different challenges such as stigma, shelter problem, shortage of food and lack of medical treatment.

Thus, the findings insist to give recommendations to service providers, humanitarian organizations, FBOs, policy makers and other associations working on HIV/AIDS to be involved actively in bringing effective and better performance to fight HIV/AIDS epidemic.

I. Introduction

HIV/AIDS disease ravages humankind regardless of boundaries, sex, race, religion and the like. Currently, there are an estimated 40 million people living with HIV/AIDS (PLWHA) Worldwide (***Judy, 2003:2***). Especially, Sub Saharan Africa is the most affected region in the World with 70 percent of the World's HIV/AIDS population (***Judy, 2003:2***). HIV/AIDS epidemic in the region is fuelled by poverty, inequality, migration, war and other catastrophe (***Judy, 2003: 6***). In Ethiopia, HIV/AIDS National adult prevalence rate is 4.4 percent with rate of 12.6 percent in the urban and 2.2 percent in the rural areas. The 2003 annual report of MoH estimates PLWHA is 1.5 million including 96,000 children (***MoH, 2004:11***). HIV/AIDS is not only "public health" rather it is a "socio- economic problem" ravaging vast majority of the younger generation (***Savita Sharma, 2004: 1***). In response to this situation, a policy framework is essential and established to ensure that all strive to prevent HIV/AIDS effect in the country. Strategies were devised to guide actions for prevention, control, care and support. Attempts were also made to strengthen it by a multi -sectoral approach to mainstreaming of HIV/AIDS.

Against this background, this paper aims to assess intervention being undertaken by Faith Based Organizations (FBOs) in response to the alarming situation of HIV/AIDS in Addis Ababa with particular reference to Ethiopian Kale Hewyet Church (EKHC).

1.1. Statement of the Problem

Ethiopia is one of the hard hit countries of the World concerning HIV/AIDS. This according to HIV and AIDS Prevention Control Office (HAPCO) is related to various factors such as high current rate of adult prevalence exacerbated by wide spread of poverty, low educational level, cultural barriers, resource constraints and limited capacity of government to respond actively (***HAPCO, 2001: 8***). The number of population infected and affected stands

next to India and South Africa (***GTZ-IS, 2004:1***). Ethiopia's HIV/AIDS deaths rank order is 7th out of 148 countries from reported death cases (***World fact book 2003***). The other source indicates, projected estimation of HIV/AIDS cases by 2010 will be 7 to 10 million (***Intelligent Community Assessment (ICA), 2004: 10***). Among the social factors are stigma and discrimination against PLWHA, denial about the extent of the problem in the country, promiscuity, abduction, rape, female genital mutilation and the like (***HAPCO, 2001:8***). The over all effect of HIV/AIDS is so immense and alarming that it increases the number of orphans and results in major social crisis ranging from discrimination to various forms of stigmatizations (***Lisa, 2003:61***). As WHO report, Ethiopia features the sixth highest number of TB cases in the World (***ibid***).

In short, the impact of HIV/AIDS is so immense that it results in a heavy toll of life decline in absolute figure of productive population, increased health expenditure at macro-economy and above all in the erosion of household assets, family disintegration, etc. HIV/AIDS resulted in the high death rate of all ages and decline life expectancy of the generation (***MoH, 2003:11***). It is estimated that by 2014 there will be a cumulative 5.3 million AIDS deaths (***Lisa, 2003:60***), which is likely to affect the resource potential and development of the country (***UNAIDS, 2004: 41***), and decimating the labor force as well. AIDS impact on social relationships often causes stigma and discrimination and brings economic vulnerability to the family and the burden of caring families and relatives' falls on women and siblings (***MoH, 2003:11***). This overwhelming condition prerequisite-concerted effort by various actors including Faith Based Organizations engagement and innervations for the control care and support of the pandemic. To this end, EKHC has been engaged in such activities since eleven years ago and said to have played important role in the efforts to prevent the wide spread of

the diseases, provide substantial support to people living with AIDS and care and support to the infected and affected, including orphan and vulnerable children.

Hence, this paper intends to assess the extent to which the services of EKHC have been substantial in terms of the prevention, control and care and support to the set beneficiaries.

1.2. Definition of Faith Based Organizations

FBOs are different religious institutions whose primary mission is preaching and teaching about spiritual life. In this study, FBOs mean various sects of Christianity involved in prevention, control, care and support on HIV and AIDS pandemic.

1.3. Objectives

1.3.1. General objective

To assess and understand the role played by EKHC in combating HIV/AIDS in Addis Ababa over the past five years.

1.3.2. Specific Objectives

- To assess the kind of services provided by Ethiopian Kale Heywet Church in the prevention and control of HIV and AIDS epidemic
- To identify the ways and means by which various services are being delivered to target beneficiaries,
- To identify positive contribution made by EKHC in combating HIV and AIDS epidemic.

1.4. Study Methodology

1.4.1 Method

The study employed qualitative data collection methods. Such methods are better suited to gather information on the values, attitudes, and beliefs of any study population. However, it has used key informants interview from Community Based organizations (CBOs) such as ***Iddir*** leaders, Church leaders, Junior Secondary Schools directors and Ethiopian Kale Heywet Church Health and HIV/AIDS department manager and senior staffs. Out of 250 beneficiaries, 25 clients have been taken as a sample for the case study.

1.4.2 Data Sources

Primary data has been collected from key informant interviews, semi structured questionnaire used to gather relevant information from direct beneficiaries.

Secondary data was gathered through documents review, annual and mid term reports, and survey reports.

1.4.3 Data Collection Instruments

The study made use of such instruments as semi-structured questionnaires and it applies for key informants and beneficiaries. It also used supportive electronics apparatus like tape recorder, photograph camera, and so on.

1.4.4. Study Design

1.4.4.1 Coverage

The study covers EKHC Health and HIV/AIDS ***MEDAN*** ACTS Addis Ababa project at ***Kirkos*** sub-city in five ***Kebeles*** (***Kebele*** 05,06,07 / ***Kebele*** 08,09/ ***Kebele*** 10/ ***Kebele*** 11,12 and ***Kebele*** 13,14).

1.4.4.2 Sample Selection

The study has covered ***MEDAN*** ACTS project in ***Kirkos*** sub city and 25 respondents were picked up out of a total number of 250 beneficiaries group. Respondents were drawn from the project ***Kebeles*** then making up a total of 25. All of the beneficiaries were those for whom the program was designed and currently are receiving services from on going EKHC program.

1.4.4.3 The Scope of The study

This study was limited to five-year project implementations of Health and HIV/AIDS at ***Kirkos*** sub-city.

1.4.5 Target Area and Population

1.4.5.1 Area

The study focused on one of Faith Based organizations called Ethiopian Kale Heywet Church and its HIV/AIDS ***MEDAN*** project activities in Addis Ababa.

1.4.5.2 Target population

Target population is direct beneficiaries consisting of females and males. Other respondents were project manager, community Based organizations, junior secondary schools directors and religious leaders. The unit of analysis is ***MEDAN*** ACTS project and it activities. All selected respondents were interviewed on an individual basis in their residence area.

1.5. Ethical and Human Values considerations

Before commencing the study, every respondent was clearly told about the purpose of the study. The research work was carried out only with the consent of participants. Confidentiality issue was thoroughly addressed.

II. Introduction to Literature Review

The literature review has seven sections reflecting different issues related to HIV and AIDS epidemic. As HIV and AIDS is a greater challenge than any other health issue and has a big impact and pressure on nation's economy, human resource and disruption of social relations of the families and community at large. Thus, each section will discuss on different topics and sub topics cited below.

Section one covers the historical overview and magnitude of HIV and AIDS incidence at the global, regional and national level. It gives springboard ideas and current condition of HIV/AIDS all over the World particularly Sub Saharan African countries including Ethiopia.

Section two focuses on the factors that contribute to the wide spread of HIV/AIDS epidemic across the country. This gives clue to the study regarding the level of HIV transmission and affect health.

Section three includes HIV/AIDS impacts resulted in multi- dimensional problems that requires more efforts to reduce the devastating outcomes. It also probes the impact that helps to see other HIV/AIDS related activities.

Section four tries to see the different responses to HIV and AIDS problem from various organizations such as NGOs, associations, and private sectors including government.

Section five is one of the major parts of the study discussion on faith based organizations starting from the story of establishment and responses of different religious institutions on HIV and AIDS epidemic. Section six is the case study of the research about Ethiopian Kale Heywet Church history and overview of the development services. Section seven gives more emphasis on EKHC Health and HIV and AIDS Department. It shows the department major activities and future strategic plan and MEDAN ACTS Addis Ababa HIV/AIDS project is the focus of this research work.

2. Theoretical Background of HIV/AIDS and Responses of Faith Based Organizations

Section One

2.1. Historical Overview of AIDS

When AIDS was first recognized as disease in 1981 and giving a name what is now, it manifests in different signs and symptoms with homosexually people. People confused much about the incidence of the epidemic and medical professionals also have some difficulties to identify its complex nature, which contain more signs and symptoms, diseases at a person at a time. Later on, AIDS is further defining in medical term as" Syndrome" (set of symptoms, which occur together). AIDS officially adopted as Acquired Immune Deficiency Syndrome by the centers for disease control (CDC) in1982 (***Shalina Mehta and Suninder K.Sodhi, 2004:1***).

In the beginning, several theories and ideas have been propounded regarding the origin of HIV and AIDS. In short, there was no shortage of thoughts raised at different corners where and what causes HIV and AIDS (***Ibid: 5***). People have various outlooks towards AIDS disease. Some believed that it is an act of God and religious curse or penalty against homosexual for practicing Biblically unaccepted life style, which include drug, Alcohol and sexual promiscuity (***Gerald, 2002: 26***). Different religious leaders such as priests and Reverend and others had already accepted as God's judgment for wrong doing people. Reverend Bill Gram said that, "AIDS is a judgment of God". Religious based perspectives on HIV and AIDS general reflected as curse or punishment of God. Because of this, religious institutions become more reluctant to teach and participate in prevention and control of HIV and AIDS epidemic (***Gerald: 6***).

Others people out of faith believe and understand in many ways. Nevertheless, scientists who are experts in the field of study associate the human immune deficiency causes

with infectious agent (***Gerald: 6***). Different perspectives of AIDS deliberately targeted as "gay men" health problem. Such kind of thoughts is exposed mass people to the rapid spread of AIDS epidemic through out the World and causes many "socio-economic" and "public health" issues. Because of this thinking, people also less attentive to work on HIV and AIDS prevention and become at risk of contracting the virus (***Savita Sharma, 2004: 2***).

2.1.1. HIV and AIDS at the Global Level

As various UNAIDS sources indicate AIDS epidemic spread at alarming rate and it seems that nothing stops its devastating feature of the disease. It affects everybody without any distinction based on conventional boundaries, geographic location, race, nationality, color, sex, age, religion etc and time bound (***Judy, 2003:2***). Globally, it is the fourth most common cause of death especially to the productive age force. There is also variation in the pattern of spread among countries, within countries like urban and rural areas (***UNAIDS, 2000:7***).

According to 2005 UNAIDS report, the number of people living with HIV and AIDS continues to grow from 37 million in 2003 to 40.3 million in 2005. In addition, the estimated total people newly infected with HIV are close to 5 million, where as total AIDS deaths are 3.1 million. HIV/AIDS has killed more than 25 million people since the emergence of the disease. Now days, HIV and AIDS infection reaches at the highest level with multi dimensional challenges (***UNAIDS, 2005: 7***)).

AIDS pandemic make differences among developing and developed nations. In industrialized World, anti retroviral drugs and other supportive medicines are available, which reduce the speed of HIV infection to develop AIDS. As a result of medicines and technology, the number of deaths due to AIDS decreases in the developed countries. Regarding this, in America AIDS related deaths approximately 70 percent from 1995 to 2000, from 51,670 deaths in 1995 to 15,603 deaths in 2001(***Shalina Mehta and Suninder K.Sodhi, 2004:1***).

On the contrary, in developing countries where AIDS is the most common disease results in many forms such as cut overall life expectancy, infant mortality, HIV positive pregnancies and births. As different sources indicate mother to child transmission of HIV is prevented in the industrialized countries and reduces below 3 percent. Few middle-income countries in Asia and South America have also prevention work on mother to child obtained undeniable results (***Shalina Mehta and Suninder K.Sodhi, 2004:1***).

Apart from health problem HIV has different impact on women and children. Majority of women all over the World are at risk of contracting HIV because of their biological anatomy and exposed to social stigma and pressures. Some culture imposed negative influence against women and does not give their right ***(CPA2005: 13***). In addition, children are orphaned by AIDS and remained without guardians. These children lost the ownership of their fathers' property by close relatives and even relatives forced the children to leave their home (***CPA2005: 13***). AIDS pandemic has also critical impact on economic and social development. It mainly affects the most vital and productive segment of population such as adults between 20 and 49years old (***MoH, 2004: 16***).

2.1.2. HIV and AIDS in Sub Saharan Africa

Sub-Saharan Africa region is one of the hot zones and severely affected by HIV and AIDS epidemic through out the World (***UNAIDS, 1999:35***). HIV and AIDS is the leading cause of death of young women and men in the early life of age (***Shalina Mehta and Suninder K.Sodhi, 2004:1***).

It also causes productive loss, increase number of AIDS orphan, family disintegration, loss of skilled professionals, shortage of civil servants, food insecurity; decrease individual and households income (***UNAIDS, 2004: 42***). The region accounts over 10 percent of the World's population but out of this figure above 60 percent of (25.8 million) all people living

with HIV and AIDS. Still high prevalence rate of HIV and AIDS incidence seen in the region. For instance, the UNAIDS 2005 report estimates 3.2 million people become newly infected and 2.4 million adults and children died of AIDS (***UNAIDS, 2005:17***).

In the region, religious organizations have confusion in dealing with HIV and AIDS and have taken time to accept HIV/AIDS epidemic as a disease rather than God punishment (***CPA, 2005: 23***). Later on, religious leaders have changed the previous thought and take full responsibility in teaching, support and care of PLWHA. Churches also incorporate HIV and AIDS in the curriculum of its theological medium level schools. It also offers AIDS awareness education for the church members, local communities and youth. Organize short-term courses for church workers, seminars and panel discussion. The graduate of the Bible schools teach on HIV and AIDS in their daily pastoral work and ministry. All these efforts brought the decline of HIV/AIDS prevalence rate in countries like Uganda (***CPA2005: 23***). The other reason for the decline of HIV/AIDS is strong community organizations involvement in provision of different services such as care and support, mobile home care to PLWHA. Motivate the community and make campaign for educating the people about AIDS to avoid this infection. Mobilize communities to support changes in social norms and harmful practices that encourage risk reduction. Give training to many community workers to provide basic care and health education about AIDS. All these effort consistently high levels of donors support the programs and activities (***UNAIDS, 1999:9***).

2.1.3. The Status of HIV and AIDS in Ethiopia

HIV infection was first discovered in Ethiopia in 1984 and the first AIDS case was reported in 1986. HIV and AIDS prevalence was low in the early 1980s and increased rapidly through the 1990s and rose from an estimated 3.2% of the adult population in 1993 to 7.3%(MoH, 2000) by the end of 1999(***NAC, 2001:8***).

The 2003 report shows that, HIV prevalence is higher among women (5%) than men (3.8%) and higher in the urban (12.6%) than the rural areas (2.6%). In 2003, there were also 197,000 new infections, 98,000 new AIDS cases and 90,000 AIDS deaths in adult population in (***MoH, 2004:11)***. A total number of 128,000 HIV positive pregnancies and estimated 35,000 positive births occurred (***MoH, 2004:11)***. Among children between ages 0-14 years, there were 35,000 new HIV infections, 25,000 new AIDS cases and 25,000 deaths (***MoH, 2004:11***). 4.6 million Children under the age of 17 in the country are estimated to be orphans for different reasons of which 537,000 were due to AIDS. The highest prevalence rate is recorded among the group of 15-24 years of age representing recent infections. 91% of infections occur among adults between 15-49 years. The people living with HIV/AIDS in 2003 are 1.5 million (1.4 million adults and 96,000 children) (***MoH, 2004:11***). HIV and AIDS prevention and control office of Addis Ababa (**HAPCO**) technical document summarize the epidemic AIDS in 2005 shows as follow: Number of people living with HIV are 251,379 and people newly infected 30,323 and AIDS deaths 23,612. The Addis Ababa administration HIV prevalence rate is 14.5 percent and for women 15.9percent and men 13.0 percent.

In Ethiopia, 91percent of reported AIDS cases are in the age group between 15-49 years. In this age group, close to 87% of infections are due to heterosexual transmission. The peak ages for new HIV infections are 15-24 for females and 15-34 for males while the peak ages for AIDS cases are 20-29 for females and 25-34 for males (***NAC, 2001:23***).

Section two

2.2. Factors that Facilitate the Spread of HIV/AIDS in Ethiopia

The causes, which bring the rapid spread of HIV/AIDS epidemic in Ethiopia, are unprotected sex with multiple sex partners. There are additional factors that promote the direct causes and the major are cited below:

2.2.1.Poverty and the Low Health Status of Majority People

The poverty situation of the country gives a fertile ground for the high prevalence of HIV/AIDS. There is a high rate of unemployment and economic migrants that also leads to high-risk sexual behavior and a high rate of prostitution (***NAC, 2001: 8***).

2.2.2. Denial

Many people still assert that AIDS is a problem of urban centers. Such idea originated from what people see the challenges of AIDS in the cities and others said which is not true. Many people still want to believe that HIV/AIDS is the disease for 'them' and not 'us'. In short, there is also denial about the extent of the epidemic in the country and this leads to silence about the epidemic (***Mutua Mulonzya, 2003: 11***).

2.2.3. Harmful Traditional Practices

A number of harmful traditional practices that have been practiced for a long time have a high potential of spreading HIV. These include female genital mutilation, traditional make up like tooting face skin, neck, ears and gingival. There are also cultural barriers such as taboo to talk about sex within the family and the community (***Ibid***). In addition, there are other harmful traditional practices such as abduction and early marriage has contribution to HIV virus (***NAC, 2000: 8***).

2.2.4. Multiple Sexual Relationships

People who have many sexual partners have an increased risk of acquiring the HIV virus from those partners ((***Shalina Mehta and Suninder K.Sodhi, 2004:1***). Commercial sex workers have a particularly high risk because of the large number of different clients they have (***NAC, 2000: 11***). Surveys conducted in several Ethiopian cities in the mid 1990s have documented high rates of HIV infection among commercial sex workers. Infection levels are 69 and 65% among commercial sex workers in *Bahir Dar* and *Nazareth* respectively (***Ibid***).

2.2.5. War and Displacement

Ethiopia has long suffered from prolonged conflict, both internal and external, and recurrent drought, resulting in internal displacement as well as migration. A great deal of migration is non-voluntary resulting in refugees and internally displaced persons. There is the presence of a big mobile military population in the country, a huge displaced population and permanent mobile populations. Abductions, rape and promiscuity are common in such a scenario (***NAC, 2003:8***). Population movements either voluntary or involuntary may result in the spread of HIV infection. Internally displaced people and the returnees and refugees are more vulnerable to HIV infection. This is because limited access to health and reproductive health services, low economic status and social status, and violence against women such as sexual harassment (***CPA, 2004: 13***).

2.2.6. Ignorance

There is low awareness of HIV/AIDS and misconceptions about the virus, its transmission and prevention (***NAC, 2001:8***).

2.2.7. Gender inequality

Women are more vulnerable to HIV infection and they are unable to make negotiate safe sex. Due to culture and religious barriers, women have no right to select their mate and even after death of husband, widow will inherit by brother or close relatives. Harmful traditional practices like abduction, rape, and other forceful action against women may expose to HIV infection (***Rachel, 2005: 40***) poverty and women's limited access to and control over family income or property, and other gender norms are factors enhancing vulnerability of women to HIV infection (***NAC, 2001: 8***).

Section Three

2.3. Impact of HIV/AIDS in Ethiopia

The impact of HIV and AIDS in Ethiopia has devastating nature and exacerbates different socio-economic problems (***NAC, 2001: 9***). Different data sources show many people infected and affected by HIV/AIDS in the country and most challenges are manifested in the urban areas, lead to shortage of various services and increase the cost of medical care. (***NAC, 2001:9***). HIV/AIDS is known as a disease and leading causes of adult morbidity and mortality in the country. As a consequence, it has various influences on population growth and decline of life expectancy as compared with the previous decades (***Lisa, 2003: 60***). AIDS has increased the number of deaths and there will be a cumulative total of 5.3 million AIDS deaths by 2014 (***Ibid***).

As different sources indicate, the majority of AIDS cases are between the ages of 20 and 49 years old. These ages are the most important and crucial time for active economic production and to establish family and become parenting (***MoH, 2004: 16***). AIDS affects the household incomes and consumption patterns and reducing income, savings and

remittances and increasing expenditures on health care and funerals ceremony and exposed the family to economic vulnerability and psychosocial problems (***Lisa, 2003: 60***).

AIDS made a number of children become orphan in the country. As a result, orphan children are vulnerable to malnutrition, illness, abuse, child labor and sexual exploitation. In addition, they suffer HIV/AIDS related stigma and discrimination (***Lisa, 2003: 60***). Traditional extended families ability to foster orphans care reduced due to AIDS burden. Even, small girls will be more responsible than boys after the death of both parents, may become heads of households responsible for caring the younger siblings (***Lisa, 2003: 60***).

HIV/AIDS has a serious impact on agriculture sector especially food and cash crop production and loss of labor force. Because of this, AIDS makes it difficult for families to feed themselves and less probable to be food crop self-sufficient. Thus, AIDS could affect both the production of cash and food crops (***Lori Bollinger, John Stover and Elini Seyium, 1999: 5***).

AIDS also has an effect on the industrial sector. Since prevalence of HIV infection is higher in urban areas, the industrial workforce is hardest hit than the rural workforce (***Lori Bollinger, John Stover and Elini Seyium, 1999: 5***). HIV/AIDS also reduces productivity through increased absenteeism due to illness, death, and decrease in the number of trained manpower. It also increased costs in provision of medical services and treatment (***Lori Bollinger, John Stover and Elini Seyium, 1999:6)***.

Section Four

2.4. Different Responses to HIV/AIDS Problem

2.4.1. Government

It could be seen that the federal government of Ethiopia has made a considerable effort to curb the wide spread of HIV/AIDS since the first case of virus is reported in1986. Accordingly, the government took prior initiatives to produce and implement guidelines on sentinel surveillance and counseling. And it has established institutional and policy framework to respond to devastating impact of HIV/AIDS on human and social capital development. A task Force composed of multi- sectoral and multi-disciplinary members was among the first initiative followed by the coordination office for National AIDS control program and the formation of National AIDS council in 2000 (***HAPCO, 2004:10***). Two medium term prevention and control plans were designed and implemented between 1987 and 1997 to raise the awareness of the general public on HIV/AIDS and accordingly with such as activities IEC and BCC, condom promotion, Surveillance, patient care and expansion of HIV screening laboratories in different health institution (***HAPCO, 2004:10***). The formation of HIV/AIDS policy towards 1998 has been instrumental to develop a comprehensive multi sectoral response mechanism at intra- governmental departments, regional and local levels. The five years strategy framework (2001-2005) has set the major priority intervention areas, target groups and selected strategies for affordable services. As response to HIV/AIDS fundamentally requires relation and coordination efforts of operators in all sectors, various non- governmental actors also played important role. ***Kebele*** and CBOs, which are prominent structures in the communities, have been able to organize HIV/AIDS intervention in their localities (***HAPCO, 2003:3***).

2.4.2. Community Based Organization (CBOs)

In Ethiopia, most community-based organizations are traditional institutions and Anti AIDS clubs (***HAPCO, 2003:16***). All CBOs are established to perform specific purpose. For instance, ***Iddir*** is one of the CBOs providing support to families of deceased after death. It has very limited capacity to involve in prevention and control of HIV and AIDS epidemic (***HAPCO, 2003:16***). But in recent time, in different places, ***Iddirs*** have expanded their role in the fighting against HIV and AIDS (***HAPCO, 2004:14***).

As some sources indicate that Community based organizations services has also a solution to minimize stigma and discrimination against HIV positive people (***UNAIDS, 2005: 37***). CBOs have composed diverse members with different skills, vocations, and resources. This diversity by itself strengthens and offers many various ways to introduce sustain and follow up clients as they receive care and treatment (***UNAIDS, 2005: 37***).

Youth Anti AIDS Clubs (AAC) was motivated to run their activities using their own initiative and resources (***HAPCO, 2003:16***). Different types of associations were formed to involve in HIV/AIDS response. For instance, commercial sex Workers associations in Afar, the virgin girl associations in Amhara and associations for the deaf and disabled in Dire Dawa (***Ibid***).

2.4.3. Non-Governmental Organizations (NGOs)

From the out set NGOs contribution is said to be remarkable, as these organizations have been widely spread in different parts of the country. NGOs concentrate on HIV/AIDS awareness, few focus on VCT, community based care, or social support (***Lisa, 2004: 84***).

2.4.3.1. Organization for Social Services for AIDS in Ethiopia (OSSA)

One of the NGOs working on HIV and AIDS is OSSA organized by religious and faith based organizations and other NGOs after the National AIDS conference having interventions in

HIV/AIDS to support the initiative of the ministry of health. The founding members are the major religious institutions and Christian affiliation NGOs (***HAPCO, 20003: 16***). OSSA has coordinating and assisting HIV/AIDS programs over a decade's experience in effectively at the national level (***HAPCO, 20003: 16***). The primary work is serving as a network and offers a forum for experience sharing and professional support to member organizations. OSSA developed guidelines on community based home care, a resource databank and provide training consultancies to the National AIDS Council (***HAPCO, 20003: 16)*** OSSA has an HIV/AIDS prevention program and through establishment of many Anti-AIDS clubs in its branches and sub branches spread throughout the country. The Anti-AIDS clubs reach the youth and the grass root community creating awareness and establishing peer-learning groups. It has also established the Dawn of Hope, an organization that caters for the needs of people living with HIV/AIDS. The clubs at all levels motivate in and out of school youth for open discussion related to AIDS and disseminate information, education and communication materials such as video films, slides and puppets (***HAPCO, 2003: 16***).

OSSA has a support program that facilitates income-generating activities for AIDS orphans and people living with HIV/AIDS (***HAPCO, 2004: 14***). The aim of the program is also to make the beneficiaries self-supportive. It entails skills training and the provision of equipment and seed money for starting the income generating activities. The material and financial support is conditional, provided when a needy person is terminally ill, and is limited to income generating projects at group and family level. It also establishes sustainable income generating projects, self help activities through food for work program, occupational skills training and micro-credit scheme and provides intensive psychosocial support to grow up children, bereaved families and caregivers to avoid emotional vulnerability and economic hardship (***Mutua Mulonzya, 2003: 26***).

2.4.4. PLWHAs Associations

Now, there are two national PLWHA associations namely, Dawn of Hope and Mekdim Ethiopia. The members of the associations are HIV positive people, AIDS orphans and other voluntary people (***Lisa 2004:84***). Each association has prepared a three-year strategic plan to prevent and control HIV/AIDS. Moreover, it provides care and support services for members, educate the public on HIV/AIDS epidemic and assisting PLWHA in the protection of their human rights (***HAPCO, 2003: 14***). In their advocacy programs, the organizations are pursuing with the government for the provision of antiretroviral treatment, the adequate provision of medical care and the right to employment and inheritance of deceased spouse's property to people living with HIV/AIDS (***Mutua Mulonzya, 2003: 31***).

2.4.5. Private Sectors

At the national level the private sector like Ethiopian Employment Federation (EEF), the confederation of Ethiopia trade union (CETU) and chamber of commerce have positively contributed to the on going HIV/AIDS prevention and control program (***HAPCO, 2003: 16***). The Confederation of Ethiopian Trade Unions and the Addis Ababa Chamber of Commerce are implementing workplace HIV/AIDS program (***Mutua Mulonzya, 2003: 29***).

2.4.6. Different Associations (Women, Youth and others)

2.4.6.1. Youth and HIV/AIDS

Many youths in and out of school are likely to have more risk to be infected with sexually transmitted diseases like HIV. Since this segment of population is sexually active without adequate information and education on reproductive health and sexually transmitted infections (***Mutua Mulonzya, 2003: 32***). Furthermore, many young people are poorly informed about the facts of basic human sexuality and reproduction. This is because of lack of social skills, limited access to health care and counseling services, and less involvement of young people in HIV/AIDS

prevention programs aggravates their vulnerability to HIV infection (***Mutua Mulonzya, 2003: 32***). The youth association works on prevention and control of HIV and AIDS epidemic. The association organizes youth in different groups and provides peer educators training through the cooperation of NGOs and faith-based organizations. It educates the youth in relation to sexually transmitted diseases and reproductive health and family planning. The association also establishes recreational places and prepares drama play and shows in order to protect youth from bad habit and drug abuse. In short, the association contribution has a lot to deal with HIV and AIDS epidemic devastating nature (***NAC, 2001: 12***).

2.4.6.2. Women and HIV/AIDS

Women are more vulnerable to HIV infection due to biological, cultural and socio-economic reasons. They exposed to risks of unwanted pregnancy, unsafe abortion, rape, abduction, early marriage and sexually transmitted infections that expose them to HIV infection (***NAC, 2001:13***). The government has plans to establish forums in women associations, ***Kebele*** associations, non-governmental and community based organizations that will address gender and HIV/AIDS issues (***Mutua Mulonzya, 2003:32***).

Section Five

2.5. Historical Background of FBOs.

Faith based organizations (FBOs) were established at different times and places in Ethiopia and associated with the emergence of the first Christianity in Africa south of Egypt (***Peter Lang, 1996:17***). In the fourth century A.D. with the nine saints who came from Syria, baptized, and converts the then kings and their families, noblemen to Christianity. Then it goes to the people and follows massive conversion occurred.

As a result, Christianity spread over the entire empire at alarming rate and having enormous followers *1(***Wondiye Ali, 2003: 13**). In addition, it gives chance to create a strong bond between religion and government to rule the people in cooperation. Even though, kings were the leaders of the country as the same time head of religious institutions. Such kind of affiliation contributes that the churches play a role on different development or other activities (***Wondiye Ali, 2003:53***).

However, some of them in Ethiopia have a long time history and have played tremendous role over centuries beyond spiritual development, security of the people, resistance against invasion and colonialism, conflict mediation between two different interested groups to bring peace and tolerance and co-existence with differences. In earlier times, faith based organizations and churches serve as the centre of education and other sources of development (***EEMYC brochure***).

2.5.1. FBOs Response to HIV and AIDS

Though difficult to comprehend about all FBOs achievements and contributions from scanty information, it could be said that some FBOs have played positive role in response to the HIV/AIDS epidemic. Out of these FBOs, the efforts being made by EOC, EEC, and EECMY present one of fundamental move to respond to the epidemic (***HAPCO,*** 2003:16). These organizations jointly established HIV/AIDS coordinating office, and the office designed project to provide care and support to people affected and infected by HIV/AIDS (***HAPCO,*** 2003:16). FBOs have important place in advocacy, provision of technical assistance and training and in provision of home based care services (Isabel 2004: 24). Out of these, the major churches have different response to HIV/AIDS program implantation and target population (***Mutua Mulonzya***, 2003:34).

Footnote

**1.Wondiye Ali: The author of the first name is Wondiya and Ali is father name as Ethiopian traditional name*

However, most of them are engaged in awareness creation, sexually transmitted diseases management through training of health workers and voluntary testing and counseling. Provide material and financial support to the infected and affected people to mitigate the socio-economic impacts of epidemic (***Mutua Mulonzya,*** 2003:35). In addition, churches have also developed church policy on HIV/AIDS that addresses pastoral ministry, employee welfare, and seek to reduce stigma and discrimination of PLWHA. They also rehabilitate vulnerable group such as commercial sex workers and give life skills and financial support for the income generating activities of the rehabilitated women (***Mutual Mulonzya***, 2003:35)

Section Six

2.6. Brief History of EKHC

Ethiopian Kale Heywet Church (EKHC) is one of the oldest Evangelical churches in Ethiopia over the past 75 years. The primary founders are the European and American missionaries with the indigenous believers (***Wondiye Ali, 2000: 53***). The missionary for the purpose of Evangelism work uses EKHC in the beginning called Sudan Interior Mission (SIM) and this name can help the missionaries to go up to the Sudan. The missionaries with cooperation of indigenous evangelists made intensive preaching to evangelize the people. This effort enhances the building of many churches at different parts of the country especially in the southern region (***Wondiye Ali, 2000: 53***).

Kale Heywet Church later on Ethiopian Kale Heywet Church was established as a national church on June 28, 1955. It is registered under the former Ministry of People Security in the name of Ethiopian Evangelicals Churches Followers, Ethiopian Kale Heywet Church 2(***Getachew Belete, 2000:42***) *. The church has its own regulation in accordance with to carry out

Footnote

**2 Getachew Belete: the author name is Getachew where as Belete is father name*

the following activities and services are mentioned. Building schools at local church area, provide medical service to the community, open Bible schools and other vocational training centers, and implement different activities, and establish charity projects and the like.

2.6.1. Overview of EKHC Development Services

EKHC is among the faith-based organizations that have been engaged in various social and economic activities for more than half a century. As described in the previous section, the EKHC is one of the biggest evangelical churches in the country. It has 5million members with 5600 local churches in different regions. The church is structured into eleven zones with a central coordinating office in Addis Ababa. Nine zonal offices coordinate respective local churches and development activities (***Mutua Mulonzya, 2003: 20***).

The church developments activities lay on the central teachings of the Bible that is helping the weak and disabled people. Other parts of Scripture also further elaborate that, "faith without good work is dead." Therefore, church might be forced by the word of God to provide assistance to disadvantaged community members (***Aklilu Dalilo, 2003: 19***). But, Evangelical churches miss for some times to serve "whole person" in fulfilling physical and spiritual needs (***Aklilu Dalilo, 2003: 21***). However, during the severe famine and drought crisis in 1984/85, EKHC has got the opportunity to extend her development activities (***EKHC, 2003: 5***). This and other problems obliged EKHC to see ministry gap in association with satisfaction of one's physical, social, mental, economic and spiritual needs. In deed, in recent time, EKHC has observed this problem and begun promoting integrated holistic ministry.

Hence, the church works on a full-fledged and impressive holistic ministry encompasses development programs run at different regions and localities. Currently, the church conducts various projects under its different departments in collaboration with partners (***EKHC brochure***). The various departments of the work of the church are cited as follows.

2.6.1.1. Relief and Development Department

Relief and development department is one of the departments established under the church works to undertake temporary as well as permanent development activities. One of the primary missions of the department was providing food supply to drought-affected people in different parts of the country during famine period. Now, it also run different activities such as selected seeds, providing farming tools and distribution of oxen to poor peasants and mobilized the local and abroad resources for humanitarian aid and national development (***Aklilu Dalilo, 2003: 40***).

2.6.1.2. Child Care and support

The EKHC focuses on childcare projects working with donors to save thousands children in many ways. It supports their families in the form of supplying different agricultural in puts to bring better improvement on the production (***Aklilu Dalilo, 2003:47***). This project works on cattle cross breeding to increase milk production to make the peasants self-sufficient, to ensure food security and further strengthen soil and water conservation to protect environmental degradation and avoid different natural crisis. (***Aklilu Dalilo, 2003: 49***).

2.6.1.3. Integrated Water and Sanitation Department

The aim of this department is to supply clean and safe drinking water to rural villagers and towns residents. It works for years at different regions and localities with multiple activities like spring development and capping, construction of borehole at arid and semi arid places, construction of communal water points and laying pipe lines, Bio sand water filtration system and community education on hygiene and sanitation (***Aklilu Dalilo, 2003: 50***).

2.6.1.4. Urban Ministry Department

The Urban ministry has given emphasis to work on urban problems, which are already identified by the government. It performs major activities like designation of projects to satisfy children from poor families. In addition, it constructs communal pit latrines, water points and

drainage system, making roads and pathways in various parts of the city (***Aklilu Dalilo, 2003: 65***). The department has already played a role on community mobilization with cooperation of local churches. It provides assistance and identifies basic needs of the community to plan and implement relevant projects (***Aklilu Dalilo, 2003: 67***). It organizes low-level people under self-help groups to learn and develop culture of saving system and to facilitate credit services. As a result, it brings over all changes in socio- economic and political life of the people. It promotes self-employment schemes and as the same time it increases income (***Aklilu Dalilo, 2003 68***).

2.6.1.5. Education and Training Department

This department offers training program on leadership, community based on development approaches, and prevention of harmful traditional practices. The department used strategies for training to trainees of trainers (TOT) to the lower levels and assigned change agents at zones. It prepares and dispatch manuals to give important information on various issues (***Aklilu Dalilo, 2003: 73***). The training facilitates exchange of experience and share important ideas and suggestions from church leaders, communities, regional governments and established networking with different donors' organizations (***Aklilu Dalilo, 2003: 74***).

2.6.1.6. Advocacy Services

In the Bible, church has responsibility to speak beyond the disadvantaged and marginalized voiceless people. The church Advocacy Department has been established in recent time and works on peace, justice, stability and mediation between two different interested groups to avoid conflicts (***Aklilu Dalilo, 2003:75***). Advocacy Department disseminates its aim through awareness creation training, workshop on peace, development and human rights issues (***Aklilu Dalilo, 2003: 76***).

2.6.1.7. The Kuriftu Children and Integrated Development Center

The Kuriftu center serves as home for orphan children who have lost their parents during the famine period in 1984/1985. It assists thousands children living with their families at different towns of Oromaya region. Children with their families receive food, clothes, educational materials and medical services. The Kuriftu center aim is to build orphan children capacity and become self-reliant lead sustainable life. It encourages and support young adults to pursue their tertiary level education (***Aklilu Dalilo, 2003: 63***) 3*.

Section Seven

2.7. Health and HIV and AIDS Prevention and Control Department

The establishment of Health and HIV and AIDS department is associated with the early foundation of Sudan Interior missionary medical services. The missionaries who are entered into the country in 1927 and involved in rural areas and gradually constructed different public institutions such as hospitals and clinics. In addition, the missionary trained primary medical personnel to fill the gap as the same time strengthen government's heath care system beside trained manpower (***EKHC, 2003:5***). The HIV and Health department, which was rearranged in 1995, is now working on preventive and curative medical services in the country around its established clinics. Now, the health department works in six localities, four in Southern region and two in Oromaya (***EKHC, 2003:7***).

The church medical ministry lies on the spiritual teaching that God created man and woman in His image with equal dignity and worth. The believers in Christ used this as instrument to proclaim and promote life. An epidemic such as AIDS with high prevalence rate is considered as terminating life. It ravages the lives of people especially younger generations

Footnote

**3 Aklilu Dalilo: the author name is Aklilu and Dalilo is father name*

following family disintegration and creates barriers to national development (***EKHC, 2003:8***).

HIV and AIDS have serious implication for the nation and the church in many ways. Hence, HIV and AIDS department has launched "Wholistic" approach to meet the spiritual and physical needs (***EKHC, 2003: 9***). Based on this, it focuses to attain spiritual and physical needs in order to strengthen HIV and AIDS prevention, care and support work (***EKHC, 2003:12***). The church responses that HIV and AIDS are not the only crisis referred to as health problem in the country. It has impact on social bonds and diminishes traditional ways of relations of the community. It threatens and affects human resources, erodes the national economy, and kills the productive ages and declines life expectancy (***Rachel, 2005: 21***). The Ethiopian Kale Heywet church understands the severe consequences of HIV and AIDS and is committed to implement community based prevention projects in some regions and has a plan to extends the project places in the future to other (***EKHC, 2003: 15***). Therefore, the church starts to fight against HIV and AIDS epidemic based on the vision and mission it has. The vision says "… to see people living as God intended as spiritually, socio-economically, and emotionally healthy communities with to develop and utilize sustainable holistic and reproducible health and development programs" (***EKHC, 2003: 15***). The mission of the church is "…to serve God through serving the poor or under privileged people specially women and children of Ethiopia and transforming communities through the seamless combination of disease, prevention, evangelism and holistic community development" (***EKHC, 2003: 15***).

Therefore, ***MEDAN*** ACTS project carries out its major activities at different regions, towns and city like Addis Ababa, ***Jimma, Awassa, Dilla and Nazereth.*** ***MEDAN*** is an Amharic word defined as salvation, to be saved or saving the generation from HIV and AIDS epidemic and the word ACTS stands for AIDS, Control, Treatment and Supports (***Mutua***

Mulonzya, 2003: 21). Its activities are cited as follows: IEC/ BCC, counseling, home based care (HBC), psychosocial support, prevention of mother to child transmission of HIV/AIDS (PMTCT), reproductive health and family planning services and advocacy.

2.7.1. Future strategic Plan

The future strategic plan focuses on the following broad areas:

- Strengthening the existing health and HIV/AIDS programs.
- Geographical expansion of activities into major regional cities, towns, and villages.
- Organizational and partners' capacity building (***EKHC, 2003:42***).

In addition, the future plan composed of income generating activities for low-level income and unemployed PLWHA. Establishment of hospices and give services to bed ridden patients without family or relatives support and voluntary counseling and syndrome management of STDs (***Ibid: 43***). Reduce vulnerability of orphan children through skill development, vocational and life skills. Prevention of mother to children transmission, advocacy and institutional capacity building are also included and the future strategies (***Ibid: 47***).

2.7.2. *MEDAN* ACTS Addis Ababa HIV/AIDS Project

The project is one of HIV and AIDS department projects implemented in Addis Ababa. The study area covers 10 local administrations ***(Kebeles)*** (05, 06, 07, 08, 09, 10, 11, 12, 13, & 14) of **Kirkos** sub city (***Kifle Ketema***). The total population of the whole sub city (***Kifle Ketam)*** is about 350,000 and that of the ten local administrations (***Kebeles***) is about 180, 000.

III. Analysis of Findings

3. Introduction

The analysis of findings reflect many important points like church perspectives to wards HIV and AIDS, types, ways and means of services delivery to clients, characteristics and perspectives of respondents to church HIV/AIDS program, strategies of church to fight HIV/AIDS and reduce stigma and discrimination against PLWHAs, majority problems that clients face and tackled by the practice of church to fight HIV/AIDS and others are included and cited. The main interest of this part is to meet the designed study objectives regarding EKHC ***MEDAN*** ACTS Addis Ababa HIV/AIDS project.

3.1. DATA COLLECTION

Data has been collected from ***MEDAN*** ACTS Addis Ababa HIV/AIDS Project located in ***Kirkos*** sub-city carried out by Ethiopian Kale Heywet Church. In the above mentioned sub city the project has operated into five local administrations (***Kebeles***) and the details are shown in the next table.

Table I: - Name of local administrations (*Kebeles*) and Number of Beneficiaries

S. no	Name of *Kebele* (Local administration)	Beneficiaries		Total
		Female	Male	
1	***Kebele*** 05/06/07	55	15	70
2	***Kebele*** 08/09	45	16	61
3	***Kebele*** 10	18	12	30
4	***Kebele*** 11/12	33	13	46
5	***Kebele*** 13/14	33	10	43
Grand total		184	66	250

Out of 250 beneficiaries, 90 females and 20 males in total 110 are under home care and receive care and support. While 55 are orphan children with the composition of 34 females and 21males and 63 females 22 males in total 85 are the beneficiaries of income generating scheme. As it can be seen from the table, there are varying numbers of beneficiaries found in each ***Kebele***. The study initially propose to take 25 respondents out of a total of 250 beneficiaries group using purposive sampling technique in representing each ***Kebele***.

The data collection methods are interview of direct beneficiaries using semi-structured interview schedule, four key informant interviews of the current church leaders at various levels, three community based organizations like ***Iddir*** leaders and two junior secondary school directors, ***MEDAN*** ACTS Addis Ababa HIV/AIDS Project manager and other senior staffs. The other data sources are review of project document, annual reports, progress reports and base line survey of the project. In addition, there are also review of archival records such as service records of voluntary counseling and testing which is available through project manager, organizational charts over a period of time and relevant commodities.

3.2. Limitation of Study

Data collection has faced unexpected problem that arises from respondents who are not available exactly at their residence due to different reasons such as going to far places in searching of Holy Water therapy and traditional treatment. Others are reluctant to reveal their home address due to fear of disclosing their HIV status to the public if strangers visit them. Thus, the study is forced to change its sampling technique into convenience sampling and gather data when respondents were receiving services like subsistence allowance at the center. The study has focused on the organization activities that are performed in the past two and half years, that is since its inception.

3.3. Key Informants Interview of Church Leaders

3.3.1. Basic Aim of Church Establishment

The four church leaders, key informants, describe the main aim of church establishment as: to accomplish the mission of "Great Commission" as cited in Mathew 28: 19-20. Its primary purpose is to teach and preach the Word of God for people who are not exposed to spiritual education. The key informants states that, Holy Bible also encourages Christians' people to testify about life after death, eternal life, freedom and peace in God to others. Beside spiritual ministry, church gives a significant place to work on and satisfy physical needs of the people. Therefore, church has integrated and expanded its services to fulfill physical and spiritual needs of the community through different developmental activities. Gradually, it starts to build holistic ministry to support the people in both ways.

3.3.2. The History of Ethiopian Kale Heywet Church Development

According to four key informants of church leaders, the Ethiopian Kale Heywet church carries out different activities at the national, regional and local levels for more than half a century. The church major developmental work focuses on health and HIV/AIDS, water and sanitation, agriculture and the like. The local level developments activities execute by local churches provide different services such as education of community about HIV/AIDS and supporting poor people by establishing income-generating activities for active HIV Positive individuals. Moreover, informants further stated that, the local churches offer vocational and skill training especially to low-income level of women to raise the income of their households.

Notwithstanding, the key informants stressed that all Ethiopian Kale Heywet local churches do not run the above activities except few of them. But, the developmental efforts will eventually grow and expands through time to cover the whole local churches. Then, it is

possible to reach all local churches at one time and integrate physical and spiritual services together.

In addition, the leaders also indicate the fund source of the church. As they said, “church has no special fund source except the contribution of members in the form of Tithes, offerings and gifts.” Of course, there are Para churches relations in aboard to work development in collaboration with EKHC. However, some key informants said that church has not yet mobilized members and communities to organize local resources and utilize for local development and prevention and control of HIV and AIDS project.

3.3.3. Church Perspectives towards HIV and AIDS

Regarding perspectives towards HIV and AIDS, the four church key informant leaders said that, for a long time the church has a misconception and stand against HIV/AIDS epidemic to be involved in prevention and control. There was very much-distorted outlook, which considered HIV/AIDS disease as God's judgment for sinners, and it is a curse. Nevertheless, AIDS impact has affected many of church members direct or indirect way at all levels. Hence, the church arrived at a decision to combat the epidemic and work hard on HIV/AIDS. Church has already changed the old perspective related to, as God punishment shift into AIDS is one of the systemic or localized diseases. Key informants further elaborated that, currently, church is going to correct wrong outlook and takes part in handling HIV/AIDS crisis in the church communities. As a result of fundamental outlook change, it vow to work hard on HIV and AIDS prevention and control activities with primary church day-to-day spiritual ministry.

However, as key informants' emphasis that, great effort is expected from church and its members to work on HIV and AIDS prevention and control. Church and faith organizations

primary aim is to teach as well as to give services in order to facilitate all human kinds to establish a better life.

3.3.4. Strategies to Prevent and Control HIV/AIDS Epidemic

The key informants indicated that, the church's main strategy is to prevent and control HIV/AIDS as cited. Initially, the church has strong belief on creating awareness of the people about the overall nature of HIV/AIDS. This awareness raising will bring behavioral and attitudinal change to the community. Other than this, the church leaders said, one of the methods of prevention is provision of support to victims and counseling service either professionals or pastoral one. In addition, it gives free drugs to those who needs anti retroviral treatment. However, church does not give anti retroviral treatment except using referral system to government hospital. In addition, counseling work is not yet started to provide to AIDS victims and others. Church also encourages members and communities to make voluntary counseling and testing and taking this effort as one of the strategies to curb AIDS. One of the key informants indicated that, in his local church there is weekly announcement to church members and communities regarding HIV/AIDS. Through announcement, people are invited to make voluntary counseling and testing. If the test result is positive and people are required to report to the church to access different services, self-disclosing and to give community awareness creation about HIV/AIDS. In short, weekly announcement has both advantages for the church and HIV positive people. For the church, it gets information about the number of HIV/AIDS people in order to prepare the church to support victims. For the positive people it helps to resist the HIV/AIDS challenges through different mechanism such as counseling service, income generating work and subsistence allowance.

As the key informants said that, church also works for despised and voiceless people including PLWHAs. This can be done through advocacy and it rests on education to fight and

reduce stigma and discrimination. The church believes mobilization of community through different associations like community based organizations, youth, women and Anti AIDS Clubs and these entire associations serve as a media for education. The church leaders request medical certificate of HIV sero- status of marriage couple. This idea came after the church's perspectives have been changed on HIV and AIDS because of God punishment. This considered by the church as one of the means to identify cases and to prevent the spread of HIV/AIDS among the members and at a wider community.

3.3.5. Role of Community to Curb HIV and AIDS Epidemic

As the church key informants indicated, **church has a significant place in the community and has power to be listened by the followers.** The purpose of the church in this World is not only teaching and preaching Gospels but also mobilizing and coordinating local community and resources for different development activities. As the key informants further underlined the church members have responsibilities based in the Bible to work on HIV and AIDS awareness raising and helping communities. However, now days, people have adequate knowledge about HIV and AIDS. But the current main question is how to apply the existing information into practice so as to bring the desired behavioral and attitudinal change. In addition, key informants explained that Ethiopian Kale Heywet local churches across the country have potential work force and resources. As the majority informants describe that, churches have not gone far enough to mobilize community as well as local resources as expected to utilize effectively.

EKHC has both strong and weak sides to mobilize community and local resources. Key informants give emphasis that church primary focus should be on mobilizing community as well as local resource. If church do these then it is possible to have adequate resources in order to carry out effective prevention and control HIV/AIDS work.

3.3.6. Role of Church in providing Supports and Services

The Key informants of church forward that church has played an important role in responding to the challenge of HIV/AIDS. Church has educated and mobilized members and communities to develop networks to support people with HIV and AIDS. As the key informants indicated, currently, church provides different services to AIDS patients and orphans like food, clothes, school fees, subsistence allowance and home based care through health workers and trained caregivers from the church and community. The church key informants leaders forward their ideas concerning to give loan service without interest rate to promote the previous work or create new one. On the other side, church passes information to members and community about the risk of HIV/AIDS in mass number, small groups during pastoral ministry. The informants said that, church provides reproductive health and family planning to members and communities. In addition, church informants leaders forward information about local churches plan to give prevention mother to child transmission of HIV for positive mothers and spiritual services to AIDS patients and their families. As they further elaborated, the church pastors and evangelists pass message of hope, peace and love of Jesus. Pastoral bereavement counseling service is given to AIDS victims and families during sickness and after death. Church also takes initiative to run funeral ceremony after death of AIDS patients by allocating budget for burial service.

However, church has a big role in providing services and support to HIV infected and affected people. Some key informants say that church is not well organized to cover all the required support for AIDS people. This is because church is not ready to mobilize and utilize local resources effectively rather than expected donor fund.

3.3.7. Role of Church in Building Community Support for PLWHA

One of the key informants of church who is the general secretary of Addis Ababa region Kale Heywet church said that, church is found and living in the community and working for the community including HIV/AIDS. In the past, church has reluctant to involve in prevention and control activities due to misconception about HIV/AIDS. All church key informants said that, the church conduct any project including HIV/AIDS under community based approach and the role of church is to motivate the community to have more concern about problem solving of their locality. Through time community develops belongingness toward the ongoing project, as a result, support the project in contributing materials and labor.

Furthermore, key informants indicate the importance of sharing vision and mission with the community. Most of the church HIV/AIDS project cannot undergo without sharing vision and mission of the organization. After recognition of the community, the primary work of church is to mobilize the community for different responsibilities. The first step after mobilization is established selected committee of beneficiaries and offer training for home-based caregivers selected out of the community.

3.3.8. Church plan to assist AIDS Orphans

According to church leaders key informants indicate that church has no special plan than the existed one. Orphans and vulnerable children need different supports such as food, shelter, clothing, love and emotional support and health care and education. Key informants elaborated that even orphans children are more disadvantaged and may face stigma and discrimination in the community. Thus, church has role to take part in orphans supporting in psychosocial, financial and protection. As one of the key informants as indicated in his church working how orphan children are supported. As he said, “church does important things as

parents do to their children. Church loves children to avoid their grief and forget the passed parents and to lead normal life."

However, church key informants have no saying about siblings' care and old people households. But, most of key informants agree to work on HIV/AIDS is a new approach in the church and through time, church might fill all gaps created in relation to HIV/AIDS.

3.3.9. Informants Recommendations to Prevent and Control HIV and AIDS

Church leaders of key informants have given recommendations that indicated the future direction in prevention and control of HIV/AIDS. According to their ideas that, church take more initiative to motivate and mobilize the community to solve their problems rather than dependent on outsider supports. As they said, "church primary work focuses on community capacity building and develops belongingness and positive ideas for ongoing development project." Church empowers the people to be self-supported within local resources and free from donor fund dependence. On the other hand, they said, "church teaches love and respect PLWHAs, give hope, man is mortal and death is natural phenomena and common for human beings without differences like the poor and rich." Such efforts might encourage HIV positive people to be restrained from revenge action against innocent people. As one leader indicates, "any one would live with high discipline and in righteous way with fear of God and faithful with sexual partners and stick to marriage rules and regulations." Such kind of behavioral activity can be served as one of prevention mechanisms.

All key informants agree on responsibilities of community, family, church members and church servants to give care for AIDS patients. In addition, providing counseling either professional or spiritual one contributes to AIDS patients to make hopeful to have sustain life.

3.4. Key Informants Interview of *MEDAN* ACTS Project Manager and Senior Staffs

3.4.1. Church HIV/AIDS Policy

One of the Health and HIV/AIDS department spiritual service head indicate that, the Ethiopian Kale Heywet church has already draft HIV and AIDS policy and disseminates it to the local churches, churches elders and leaders, and Servants for discussion to come up for ratification. As he said that the policy enshrined many important things, which would enable the church to implement HIV/AIDS projects at various levels. It mainly focuses on the following issues.

- Either condom promotion only focuses on positive partners or negative and positive couples after marriage with respect of individual decision for the case of positive and negative marriage couples.
- Rehabilitate and support HIV and AIDS infected and affected servants in the church.
- Enhance HIV positive people to access counseling, care and support.
- The church is expected to mainstream HIV and AIDS into all churches development and spiritual ministries.
- Daily church pastoral services include HIV and AIDS education as one of the components of church program.
- Church role to take strong advocacy on AIDS victims
- Produce current teaching aid materials based on church contextual.

The church draft policy has covered vital issues regarding to HIV/AIDS prevention and control, provision of services and the like. However, since the policy draft is still on process of discussion without ratification. Hence, HIV/AIDS project might face difficulty to

accomplish its activities among church members and communities unless concerned body approves the policy within short period.

3.4.2. Staffing and Management

The project has staffs with different qualification and levels of responsibilities for each member and cited below in the table.

Table II. Staffing List and Qualification

No	Staff Position	Quantity	Qualification	Type of Employment	Responsibility
1.	Project manager	1	BA in sociology	Fulltime worker	Coordinator
2.	IEC/BCC	1	BA in sociology	Fulltime worker	Educator
3.	IGAs officer	1	Diploma in accounting	Full time worker	Micro finance
4.	Nurses	3	Diploma in nursing	Fulltime worker	Counselor
5.	Laboratory technicians	1	Diploma in medical lab.	Fulltime worker	Technician
6.	Social workers	3	12th grade complete	Fulltime worker	
7.	Social worker	1	Diploma in social sc.	Fulltime worker	
8.	Cleaners	2	12th grade complete	Fulltime worker	
9.	Guards	4	6th grade complete	Fulltime worker	

The above table contains lists of full time employ staffs and qualification gathered from interview of project manager. The manager stressed that the current number of staffs and qualification is enough for the time being to carry out the intended project activities.

However, the project main document does not show staffing plan and composition of qualified professionals and it is difficult to give comment about the project staffs.

3.4.3. Strategies to Prevent and Control HIV/AIDS

The project manager interview indicates ***MEDAN*** ACTS Addis Ababa HIV/AIDS project main purpose is to curb the spread of HIV virus and save the generation from death. Church has responsibility and plays roles in the prevention and control of HIV/AIDS. The magnitude of HIV/AIDS problems increased at alarming rate and affect many thousands people. As the project manager said, the project uses strategies such as provision of care and support to AIDS people and orphans children through the cooperation of community based organizations (***Iddir, Maheber, Senbete***). In addition, psychosocial support through volunteer clubs, training of counselors, developing home based care and support by trained family caregivers and volunteer workers.

On the other hand, the manager further elaborated that care for orphans and vulnerable children given through community, local NGOs, and faith based organizations. The project uses local organizations as a means to identify children in critical needs and coordinate service provision of food, shelter, clothing and other requirements. Moreover, the project gives education through IEC/BCC relay on the involvement of peer educators like influential community leaders, elders and in and out of school youth. The teaching aids include the use of drama, one to one education, and media like school mini media, public panel discussion and dispatch leaflets. In addition, coordinate the local community to give care and support services to PLWHA and encourage any one of the residents to make blood testing to know the level of his/her HIV status.

MEDAN ACTS Addis Ababa HIV/AIDS project has already applied the national strategic framework for response of HIV/AIDS except condom promotion. Church advocates condom use only for selective cases like HIV positive and negative couples after marriage

contract with consent of both partners of the positive and negative and positive husband and wife.

3.4.4. Relationships with Other Institutions and Agencies

MEDAN ACTS Addis Ababa has different relationships with local churches of EKHC to build capacity of each church to fight HIV/AIDS epidemic. EKHC Health and HIV/AIDS at the department level has also relation with NGOs, Evangelical churches, Ethiopian Orthodox ***Tewahedo*** Church, Ethiopian Catholic Church and other faith organizations. The project manager has indicated that, the relation rest on organizing different trainings, workshops, participate National and International HIV/AIDS conference and public panel discussion. This relation creates churches unity against HIV and AIDS epidemic to coordinate concerted efforts. The manager elaborates that there are also communications at the project level run by different organizations to share experiences and exchange information about the situation of HIV/ AIDS around the project sites. Even if the projects operate in the same area clear about clients who is, belong to which organization in order to avoid abusing organization support by clients. The project has intimacy work relation with ***Kebeles*** administration, community-based associations like ***Iddir,*** youth and women associations, PLWHAs associations and others.

Church networking and relation with different churches is a big shift to combat HIV and AIDS epidemic. It is apparent that in the past, different churches and religious institutions have no cooperation among them and even it was unthinkable. This interfaith cooperation is great work and thanks to all religious organizations strong effort to save the life of younger generations.

However, the manifestation of HIV and AIDS with its hard devastation nature creates unity of churches to fight the epidemic together. Church to church relationship should not be

based on participation of workshops, trainings and others. It should be established sustainable relationship.

3.4.5. Community Participation in the Organization

The project manager gives some ideas concerning to community participation in the organization. He said that the community has many and undeniable contribution to the project implementation especially in identification of community needs. Some of the community members work on volunteer basis to give different services such as identification of AIDS patients and AIDS orphans and vulnerable children, encourage youth to establish Anti AIDS Clubs and giving free house services for the club office for a certain period. In addition, the community responded any call from the project for different purposes such as mass education about HIV/AIDS, home based and peer education trainings. Currently, most home care to AIDS bed-ridden patients are given by community caregivers.

However, community participation in the project is not limited only in the above mentioned areas. It goes more than this, because, HIV/AIDS requires huge resources contributed from the community. Thus, community works on mobilization of local resources and fund raising to cover the required huge expenditure to support HIV/AIDS infected and affected people.

3.4.6. Admission Criteria of Clients

The project manager indicated the selection criteria of beneficiaries based on medical certificate of HIV positive status, low or non-income and number of family size. Selection run through recruitment committee composed of different groups from Iddir members, women and youth associations, ***Kebele*** administration and PLWHAs. The selection committee made decision in common and gives prioritization based on the situation of the clients. For instance,

children without guardians and close relatives will select first then it goes to double orphan and lastly to single one and similarly it works for AIDS patients.

However, beneficiaries explained that they become the client of the organization through ***Kebele*** administration rather than selection committee. The other criterion is to have medical certificate of HIV positive status to be eligible client for the project. Some clients can use forged medical certificate to get privilege from the project services. It is necessary to make check up of the selected clients whether eligible or not.

3.4.7. Type of Services Render to the Beneficiaries

3.4.7.1. Care and Support

The project manager interview shows the organization renders different services to beneficiaries. The project has direct and indirect beneficiaries and direct includes HIV positive, AIDS patients; orphans and vulnerable children, homeless and street children and HIV risk group especially commercial sex workers. The AIDS patients have received different services such as financial and psychosocial support, home based care and treatment of sexual transmitted infections by referral system.

However, clients have complained about subsistence allowance during interview session. The less amount of financial support does not cover the required expenditure of each client.

3.4.7.2. Voluntary Counseling and Testing

The project manager and main project document both indicate that establishment of counseling center integrated with other activities. In the center as of this date, there are 4998 clients have received voluntary counseling and testing services and out of this 11% are HIV positive and some of them become the client of the organization and receive services like allowance and loan. In addition, the center uses referral system with local health center and

government hospital found in Addis Ababa like Zewuditu Hospital. The project document also shows that, the project will establish its clinic with qualified physician and nurses and can run medical check up and provision of drug at the center clinic. However, the clinic is not yet established.

3.4.7.3. Prevention of Mother to Child Transmission of HIV

The project manager said that, currently, ***MEDAN*** ACTS project provides PMTCT service to the whole Addis Ababa city. The mechanism to address the service through the project is provision of voluntary counseling and testing, reproductive health and family planning and conduct laboratory service. In addition, women are encouraged to know their HIV sero status to benefit from the intervention. Positive mothers have access and to receive anti retroviral drugs during pregnancy and a child also gets appropriate treatment and feeding after delivery.

3.4.7.4. Services to AIDS Orphans and Vulnerable Children

The manager interview shows that, the project provides support to orphans children through extended families, mothers or fathers who care for the orphans. Orphan children under the project support have access to formal and informal education, food, shelter, clothes, school fees, school uniforms and educational materials.

The project document shows plan of action for five years orphan support and counseling. However, the annual report does include only support of orphans in different forms without counseling service. In addition, the project manager interview indicates that, there is no psychosocial counseling for orphans and vulnerable children for the time being. Counseling is essential for orphans and vulnerable children to establish better life and cope up with the environment. But, the project could not indicate counseling service to orphan children.

Orphan children have different socio- economic problems and also face stigma and discrimination. They need various efforts to alleviate such challenges and every agency or institution work to tackle all sources of orphans problems. Psychosocial support is one of the many efforts that creates better situation for orphan children. The main document and the project manager dealt with the importance of psychosocial support that inspires strength but there is no actual work seen in the annual or quarterly progress report.

3.4.8. Modus of Operandi to HIV and AIDS Awareness Education

The organization uses peer education as a strategy to promote behavioral and attitudinal change. The activities rest on the participation of in and out of school youth, community influential leaders, and local known elders as peer educators. The teaching methods include the use of drama playing, one to one education, educational competitions and questions answering sessions related to HIV/AIDS. In addition to this, there are different educational means like mass media, particularly mini-media at school levels, public panel discussion, literature and dispatch appropriate and current leaflets and posters to the community at large. It also uses traditionally accepted practice such as coffee drinking ceremony.

However, the project document shows, HIV/AIDS awareness raise at the school, community level and it has been given by PLWHA. These people lack teaching methodology and access to current information to pass proper message to the people. As a result, it brings misunderstanding and develops confusion. As one interviewee said that, he has attended awareness raise session about HIV/AIDS and he has learned from a lecture that AIDS is simple like common cold. Then he responded to the lecture and asks how AIDS compare with common cold. Each has quite different nature and no relation at all. He tried to give some

correction for the mentioned case. If such message goes far from the main point then many of them will be confused which subsequently encouraged people to do wrong practice.

3.4.9. Income Generation Activities to Beneficiaries

The project ensures economic and food security activities like using income generating. The recognized beneficiaries are HIV positive people who are active and able to work, commercial sex workers, sellers of traditional drinking business like ***Tella**** and ***Teji**** and orphans children above 18 years of age.

The income-generating officer said that primary work of the project is to identify and select the beneficiaries according to pre set criteria. Then organize them into primary group composed of five to six members and offer counseling about income generating activities. The aim of counseling is to evaluate their capacity whether to conduct income-generating activities and to make decision to carry out scheme.

However, the project effort toward credit and saving service, and vocational skill training has important place for active HIV positive people and others. Nevertheless, the IGA officer said that most beneficiaries are not successful due to different reasons such as health, low or absence of market demand and family problem. During interview session, most clients bow their neck due to failures of their income business. One client said that, I have already started good job but unfortunately my child sick and I spent the seed money for the treatment of my son. Other client said that, I have taken 1000 Birr for income generating work but I used it for broken house construction. After construction, I divide the house into two parts one for me and the other one is for rent and I get100 Birr per month. However, I feel shame when I see the organization staffs because I could not turn the loan on the given time. These two

Footnote

* Tella and Teji are traditional local made alcohol drinking substances

clients response shows that income-generating work is important to them but it could not continue as it is planned due to various social and economical challenges.

3.4.10. Vocational and Skill Training

The IGA officer indicates that, the project first offered vocational training on the basis of identify products that are demanded by the current market. The eligible beneficiaries are HIV positive active people, orphans above 18 years of age and commercial sex workers. The selection criteria for skill training may consist of age, educational status, etc. The skill training focuses on the following topics such as price, promotion, and place and profit maximization. Vocational skill training is useful to active HIV positive people, commercial sex workers, adult boys, girls, and others. Indeed, ***MEDAN*** ACTS project document and interview information both sources indicated about vocational skill training. However, there is no report and hard to find any document related to vocational and skill training.

3.4.11. Evaluation of Project Activities

Evaluation of Project activities will be in different ways and used different methods as cited below

- Report includes monthly, quarterly, mid, annual and handed to Health, HIV and AIDS department.
- Feed back from the beneficiaries through dispatching and collecting official formats.
- Management and staffs monthly dialogue
- Partners' timely evaluations.
- Outsiders evaluators make midterm and finial evaluation.

The project has made two annual reports to Addis Ababa Administration Disasters, Preparedness and Prevention Commission. However, there is no mid term evaluation since the project started its work two and half years ago.

3.4.12. Networking with other organizations

The project has more linkages with ***Iddir***, women and youth associations, ***Kebele*** administrations, NGOs, GOs, FBOs and others in the catchments area. There are meetings especially between NGOs if it is necessary to share experience and exchange information to avoid duplication of clients. The project manager replied during the interview session, the linkages with the mention organizations and institutions are very important to carry out HIV/AIDS prevention and control activities together. In addition, there are networking with health institutions especially government health centers and hospitals. The project has frequent relation with the mentioned institutions for referral system for those who need special medical examination.

HIV/AIDS work by its nature requires collaboration efforts from all organizations and agencies. However, as one of ***Iddir*** leaders indicate that MEDAN ACTS Addis Ababa HIV/AIDS has no frequent relation with ***Iddirs***. Therefore, it requires establishing strong bondage with different organizations to achieve its goals and objectives and also to integrate common efforts.

3.4.13. Sustainability of the Project

The project has been conducted after sharing vision through the community discussion about the project objectives and activities. Then, the community will show their interest and develops the idea of belongingness to carry out the project implementation. Community involvement manifests in many ways such as voluntary identification of clients through the cooperation of local administration (***Kebele***), participate in mass education, attend various training and public panel discussion and other related activities.

As project main document shows sustainability can be ensure taking the following measures to specific project components such as persistent of HIV and AIDS clubs and

committees, continuity role of peer educators, VCT, develop income generating activities, care and support for PLWHA and orphans and the role of communities volunteers. The role of the project is instrumental and focuses through out the program to be self-sufficiency of beneficiaries to avoid any dependency at the end of the project period.

> The project sustainability is important to achieve its objectives. Hence, the project may expand its services to the community. However, sustainability is not only guarantee by expanding and provision of services except strong participation of the community into different components of the project.

3.4.14. Plan to Reduce Stigma and Discrimination

The project manager said that, one of the primary work and strategy of the project is to fight stigma and discrimination against people living with HIV/AIDS. He further stresses that, stigma and discrimination develop due to wrong orientation and poor teaching system about the disease in the earlier time. Now days, situation of stigma and discrimination is not strong as the previous time. But still the problem exists and needs solution to reduce it. The project major approach for this challenge is educating the community to develop the required awareness and understand the nature of HIV/AIDS epidemic. The manager adds that, advocacy is the other method playing in reduction of stigma and discrimination. This can be done through mobilization and create awareness to community leaders, journalists and the public at large to increase understanding about the problem facing PLWHA. In addition, the project encourages PLWHA to share their life experience, disclose them, and teach the community about the general situation of HIV/AIDS.

EKHC uses the Word of God taken from John chapter eight verses seven and prepare poster to reduce stigma and discrimination. In Biblical teaching, no one is free from doing mistake and sin. When it associates this teaching with stigma, any one can be infected and affected by HIV/AIDS at any time. Therefore, it is not necessary to make partiality against HIV positive

people and AIDS patients including orphans, because who knows tomorrow you will be one of the victims.

However, the project document and manager interview put advocacy as one of strategies to reduce stigma and discrimination. But there is no work and report beside advocacy.

3.4.15. Practice of Church in Combating HIV/AIDS.

> The Ethiopian Kale Heywet Church has first undertaken experience acquiring and learning study tours to the neighboring countries where churches had been involved in HIV/AIDS to map out successful project implementation methods. The project manager said that, the church has long years practice and had successful history in different development activities. Before implementation of HIV/AIDS program under the church, there was a tour conduct outside the country to get experience. He further stated that, the tour has helped very much to design HIV/AIDS project. Ahead of the project implementation, the church has done base line survey that helped to follow correct strategies based on the needs of target population. He added that, such kind of effort makes the church to be successful and the project owned by local community and ensure sustainable. He also stated that, any project implementation goes with sharing vision and mission to the community and go-ahead response is expected from the community. Each project at anywhere gives importance to community needs and respects them.

The project has also learned many things from the deep effort of community to support each other to solve their local and common problems. It has adequate potentials to overcome any kind of challenge if mobilize for the purpose of that particular issue. The project manager said that, coordination, passionate, commitment, supports each other in time of emergency and cooperation is the nature of community and the project acknowledges the mentioned values of the community and indigenous knowledge. However, the project can learn many things as mentioned from the above one and others, which is useful to launch other projects with better implementation and accomplishment.

3.4.16. Opportunities and threats of the organization

The organization/project face different temporary challenges such as reaction from the community as you preach religion not to fight AIDS. Nevertheless, it did not take much time

the community to understand the aim and effort of the church. The other challenge is the demand of the clients, which is incompatible with the organization capacity. In addition, donors interest fluctuation from time to time following with reduction of budget and change into other project. For instance, in the beginning donors show interest to support bed ridden AIDS patients. Later on the same donors develop different ideas and think that awareness education is better rather than care and support. Then, immediately changed the first stand into the new one, which is education and they, report to us to shift into education. As a result, care and support services hurt and clients may fail into problem.

Furthermore, the project has good opportunities such as workable government HIV/AIDS prevention and control policy. PLWHA have greater interest to teach people about AIDS and people may understand the presence of HIV and AIDS epidemic through their teaching. High cooperation and involvement from community based organizations like ***Iddir**** to work together. Government also helps HIV/AIDS projects not concentrate and duplication into one area.

Footnote

* Iddir is a traditional association save money and other resources to support members during the death of family and close relatives.

However, some negative reactions of the community arise from due to weak explanation of the organization objectives. Before any operation of project activities, first it requires consent of the community to say go ahead. Moreover, it stops dispute and avoid unnecessary doubt.

3.4.17. Organization recommendations

The project manager forwarded some recommendations, which contribute important things to HIV and AIDS prevention and control activity. The first one is education focus on family level and youth centered, home-to-home education, teaching about harmful traditional practices such as rape. The project believes that, societal system change starts at the individual level, high involvement of religious institutions and communities and the like. Female genital mutilation was one of the big problems little earlier time came from harmful traditional practice. But through education, people have brought behavioral and attitudinal change and consider the previous practice as harmful. As a result, currently, people cease female genital mutilation without any external pressure. Therefore, education system covers life experience which is good example and easy to teach people. Moreover, there is also plan to work on youth focus on marriage and reproduction area. In this marriage issue, there is early marriage and taboo to talk about sex in family. Thus, education helps to break and reduce such traditional barriers and incidences.

HIV/AIDS has a big attachment with poverty and poverty reduction activities concerning to family, community, women, youth and other segment of population. Such kind of poverty reduction effort might bring and enhance the prevention and control of HIV/AIDS. In addition, prepare recreational services and places to establish sport clubs and games and most youth can participate in sport activities.

However, the recommendations of the project are important to be more fruitful in its activities. Some of the points should go with the implementation of the project but not done right after implementation. There is also no other mechanism planed by the project to reduce poverty except income generating activities for HIV positive people. In addition, in the project document there is plan to organize in and out door games but do not cover annual or any kind of report.

3.5. Characteristics of Respondents

3.5.1. Age and Sex distribution of Respondents

Table III: - Age and Sex distribution of Respondents

No	Age Category (Years)	Sex				Total	
		No of Males	Percentage	No of Females	Percentage	No of People	Percentage
1	15-19	1	4.0%	-	-	1	4.0%
2	20-25	-	-	2	8.0%	2	8.0%
3	26-30	3	12.0%	11	44.0%	14	56.0%
4	31-35	2	8.0%	3	12.0%	5	20.0%
5	36-40	2	8.0%	-	-	2	8.0%
6	Above 40	1	4.0%	-	-	1	4.0%
Total		**9**	**36.0%**	**16**	**64.0%**	**25**	**100%**

A significant number of sixteen (64.0%) of respondents are females. As many researches show majority of HIV and AIDS victims age found at 15-49 years old. However, in this study finding, fourteen (56.0%) of respondents' age is ranging from 26-30 years. In addition, most of infected segment of populations are women and it is seen in UNAIDS and MoH reports.

3.5.2. Birth Place of Respondents

Table IV: - Birth Place of Respondents

No	Region	Sex				Total	
		No of Males	Percentage	No of Females	Percentage	No of People	Percentage
1	Amhara	-	-	4	16.0%	4	16.0%
2	Oromya	1	4.0%	3	12.0%	4	16.0%

3	Southern Region	1	4.0%	4	16.0%	5	20.0%
4	Addis Ababa	3	12.0%	5	20.0%	8	32.0%
5	Tigray	2	8.0%	-	-	2	8.0%
6	Not Known	2	8.0%	-	-	2	8.0%
Total		9	40.0%	16	60.0%	25	100%

Eight (32.0%) of respondents are born in Addis Ababa at different Sub cities and ***Kebeles***. The other respondents are born in ***Amhara*** four (16.0%), ***Oromaya*** four (16.0%) and Southern region five (20.0 %).

3.5.3. Marital Status of Respondents

Ten (40.0%) of respondents are widow due to AIDS deaths of husbands and five (20.0%) are married and have stable family. Three (12.0%) are divorced after they know blood-testing result. Even some of them escape away from their home without notification of husbands, friends and relatives to far places like coming to Addis Ababa. As the respondents said that they live alone without contact to parents and close relatives after making divorce. The common living area for the majority they prefer is monastery and Holy water station like ***Entoto Kidanmeheret*** Holy water site. The rest divorced groups live in different ***Kebeles*** and hide themselves from the public. No body knows who are they and where they came from and as said they feel comfort especially free from stigma and discrimination. The married HIV positive couples live in peace and harmony. As one respondent said that, we live together in harmony because we have access to persistent counseling and spiritual affiliation. Seven (28.0%) of respondents are unemployed males and have low or non-income to establish families.

3.5.4. Education Attainment of Respondents

Nine (36.0%) of respondents' education attainment is found at secondary level. The women who are infected by HIV/AIDS are not only lack of education but also not access to current and proper information about HIV/AIDS. In addition, it is possible to rape either by students or others because of different barriers emanating from cultural and gender influences. Seven (28.0%) respondents are illiterate and have no adequate knowledge to understand even what AIDS is unless assisted by others. Another seven (28.0%) of respondents have primary level education and two (8.0%) are able to read and write.

3.5.5. Religion of Respondents

Twenty three (92.0%) of respondents are Christian and followers of Ethiopian Orthodox ***Tewahedo*** church and two (8.0% are protestant. Similarly, the base line survey report of the ***MEDAN*** ACTS project shows high population is Ethiopian Orthodox ***Tewahedo*** church members.

3.5.6. Respondents Number of Children and dependents

Fifteen (60.0%) of respondents have children without father or mother and six (24%) have no children. In addition, three (12.0%) of respondents have dependents and one (4.0%) of respondents is an AIDS orphan.

3.5.7. Occupation of Respondents before they joined the Organization

Sixty eight (68.0%) of respondents are females who are working different activities such as selling fire wood (4.0%), bar lady (8.0%), cleaner (12.0%), caregiver (4.0%), house worker (8.0%), selling different goods (4.0%) and clothes merchant (16,0%) daily laborer (4.0%) and unemployed (8.0%). The female respondents said that, they are involved in long hours working in private households without adequate rest. As they said, they work like

cleaning, laundry services, fetching water, without adequate wage. Those who are selling goods and second hand clothes locally called "***salevage***" selling around main streets running after city policemen. As they said that, they try to sell goods or clothe the whole day without income. One respondent said that, my profit is walking around streets and exposed to strong sun heat and my face turn into dark. No profit at all what shall I do once I born and I have to survive in getting some income. Currently, most of them are weak to work as the previous time and dependent to subsistence allowance. Eight (32.0%) of respondents are also participated in various works like metal workers (4.0%), military (4.0%), assistance taxi driver (4.0%), unemployed (4.0%), daily laborer (12.0%) and student (4.0%). These respondents have minimal wage when they are active in their work. Most of them are weak to participate in job because of health problem. When they asked about skill training, they replied that, if I feel well I have interested to engage in any activities.

3.6. Perception of Respondents about Church's HIV/AIDS Program

3.6.1. Situation of Health Status of the Respondents

Twenty-one (84.0%) of respondents are HIV positive and AIDS patients. They replied during interview session, "I am HIV positive and I have medical certificate". Among these, eight (32.0%) have taken antiretroviral treatment (ART). Concerning to antiretroviral treatment, they said, "I was very sick and even I lost my weight and my body develops wounds around my mouth and lips and skin rashes all over the body, my hair also become thin and bold. When I take the medicine, I recover from my sickness and now I feel strong and healthy." When HIV positive people without ART asked and they replied that, the doctor has not prescribed the medicine for me and he has told me that, you do not need for the time being. Because, your CD4 is found in a normal condition. Some of them among positive people who are not taking ART respond that, the doctor has advised me to take the medicine

but I use traditional medicine like Holy water therapy and others. If once I take the medicine my body addicts it and it is bad for me. Two (8.0%) of respondents have attacked with different diseases like epilepsy of mental health problem in combination with HIV. These people report, “I am HIV positive with mental sickness of epilepsy.” When they asked about access to treatment, they said, “No, I did not get any treatment because I have no money to get the treatment.”

Others respondents (4.0%) are negative status for HIV virus but have diseases like heart and chronic gastritis. These people have access to treatment and one of them said, “I have anti gastritis and heart medicine prescribed by doctors but I could not get improvement. I live without assistance, and I am poor without help during my sickness.” The other respondents (4.0%) are found under good healthy condition they have no complained about sickness but their problem is subsistence support and they are unemployed without daily income. Of course, this group organized under the organization income-generating scheme to work on different activities to get income.

3.6.2. Respondents Support from Close Relatives, Friends and Neighborhoods

Twenty (80.0%) respondents have no support from close relatives, friends and neighborhoods. Even most of them have left their original living place after they know the status of HIV positive and hide them by going far place. Majority of them said that, I have no close relatives around my living area. No body knows me, because, I am a new comer for the area. I have already left the original place in fear of stigma and discrimination. Even I feel shame when I infected by HIV and I consider my self as a criminal. How can I see my parents face, still I feel shame. Because of this, majority of respondents have no support from close relatives, friends and neighborhoods at all. But, five (20.0%) of respondents have access to little material and financial supports from cousin’s son, friends, sisters, daughter, families and

group of people like youth. One of respondents has access to support from her sister and she said that, I have only one sister provide support to me. She is very kind and she encourages and gives me money for house rent, food and clothes. She cares me when I sick and sleep on bed. One of respondents said that, I came from region, I have no close relatives but I have my cousin's son who provides support for me. I sometimes disappear and hide myself from him. Whatever I did, he does not dislike me and he found me where I am. One of respondents also said that, No body stand for me. I am alone, but I have daughter and she lives with me. She provides whatever I want and she cares me when I sick and become weak. She further elaborated that the surrounding youth are very cooperative and giving care and support, financial assistance, clothes for my small daughter. These youth are better than adults and elders. They are open and free from stigma and discrimination outlook and practice. One respondent also said that, I live with my family and they know my HIV positive status and they encourage me and provide different support. I am free from any negative influence for the time being. One of the respondents again indicates that, he has different materials support like firewood, water and others from his neighborhoods.

3.6.3. Respondents Communication with Families and Local Community

Eleven (44.0%) of respondents have no communications with their families and local community. They face negative communications with stigma and discrimination challenge from the families, neighborhoods and community. Most respondents said that, the family and close relatives make difference with them and expressed their hatred in the form of insult, giving food on an old and broken food utensils, allow them to sit outside home, not touch clothes and water pipe and dislike them not to do anything. One respondent said that, she lives with her husband parent's house. She has well and good family relations and has two sons. When her husband died due to AIDS, every thing has changed and a relation has broken and

sends out of their house with her two sons and left them in the street. The same respondent further elaborates that her aunt makes a big partiality. She said that, I grew in her house and serve for a long time even she has not taught me. But, I support her sons and daughters. Now, they are big men with having different responsibilities. To day, when they see me they dislike me very much even they are not allowed to enter their house. Just I sit outside and give me food with broken utensils as beggar. What shall I do, I am poor and sick, I receive the food to eat for my self and I take the extra one for my children.

Furthermore, four percent of respondents have been fired from their job place due to disclosing HIV positive sero status to colleagues. As they said that, when I disclose the HIV status people dislike and decrease communication with me. Those who play and discus together with me immediately stop their intimacy without unknown reason. Through time I feel shame and develop fear, because of this I leave my job and resign with my interest. Others eight percent respondents face stigma and discrimination from house owners. For the first time without disclosing HIV/AIDS case, house owners are voluntary to rent their house. But when disclose occur house owners develop fear and turn into stigma and discrimination. They usually said, “I need the house and would you leave it very soon. If the response is late they make different negative activities like inhibition of water and even sometimes insult and do not touch the pipe you might contaminate it with HIV/AIDS.” In general, majority respondents have complained about negative reaction from the community, which is a big problem than the infection of HIV. They face avoidance and influence not to access house rent and abandon from their living home even from parents house. Five (20.0%) respondents have good communication with families and community. As they said, they get encouragement support from neighborhoods and surrounding community. Even the community, sometimes provide material assistance and visit when they sick. One of the respondents said that, I have

good communication and relation with the community. I have already disclosed myself and they know me as AIDS patient. They visit me when I sick and prepare food and drinking like coffee and also play with me for long hours. She concludes that, in my part I have no pressure and stigma from the people due to HIV/AIDS infection. I thank all the people especial my neighborhoods.

Six (24.0%) of respondents have replied that still they have no stigma and discrimination problem from the community. This is because, they did not disclose themselves to the community and as a result, they live in peace and harmony. One of the respondents said that, people have great fear about HIV/AIDS and they do not allow joining and playing with us if I make self disclosing. They might make big differences and partiality against us. That is why most respondents do not want to disclose their HIV status to the people. If the people violet their humanity due to HIV/AIDS disease, then how can they live with the community disclosing their case. As one respondent said, "on behalf of me, I do not want to talk about my HIV/AIDS case to my neighborhoods. If I said some thing about my HIV/AIDS case people immediately dislike me and I loose my peace to live in harmony with the community. I have seen such action happened to other HIV positive people" He further elaborates that, I know my current HIV status and I can live with discipline and abstinence without telling to the people. Then, why it is necessary to say about HIV/AIDS to the people, if the people hate and consider you as a guilty. Very few respondents are also normal and free from HIV/AIDS and they have no complaints towards HIV/AIDS problem.

However, respondents forward different comments regarding stigma and discrimination. Majority respondents have already faced stigma due to self disclosing while few have not met such kind of problem. Therefore, stigma and discrimination vary according to communities and places. It depends on the awareness of the community on HIV/AIDS.

However, twenty (80.0%) of respondents express their interest during interview session not to disclose to the public to avoid stigma and live in peace.

3.6.4. Participation of Respondents in Social Activities

Twenty (80.0%) of respondents have no participation of social activities like ***Iddir***. This is due to requirements of high amount of seed money and most respondents have none or low-level income to pay membership fees. One of the respondents said that, I am a new comer and I do not have ***Kebele*** rented house and neighborhood consider me as not permanent inhabitants. No one knows me around my residence area. The ***Iddir*** has regulations to be a member is that the candidate should have permanent address and fixed to one ***Kebele.*** Three (12.0%) of respondents who are dependent to their families have ***Iddir*** and register through their parents. Others two (8.0%) of respondents who are living for years have their own ***Iddir*** and have received services during death of family members like husband. One lady respondent said that, I have ***Iddir*** inherited from my parents and I have received materials and labor services during the death of my husband.

However, respondents have no recognition as ***Kebele*** dwellers and access to house. Owning ***Kebele*** house through rent is a means access to different services and also has permanent address.

Respondents Access to Shelter

Nine (36.0%) of respondents are living in rented houses from private owners. One of the respondents said, “I live in rented private house and paid 50 Birr/month which I get from the organization 100 Birr financial support.” She elaborates further, I pay rent on time every month but I have influence because of my sickness. Most of the time, the owner insults me in association with electric light consumption, use of latrine or pipe water. I always feel shame

when the owner strongly speaks at me in front of many people. I have house problem equal to my health situation. Three (12.0%) of respondents live in their parent house and inherited house. One lady respondents indicate, “I have no house problem because I live with my parent. I am very happy to live with my parents and relatives and I get care and support from them during sickness.” Others five (20.0%) of respondents are dependent to friends, monastery, around Holy water area, old age people and the like. One respondent said “I live at ***Entoto kidanmeheret*** with the nun for Holy water shower. The nun is very passionate and she supports me in giving food and assists me during Holy water shower.”

Four (16.0%) of respondents are living in ***Kebele*** house with minimum rent. They get the house before ten or above years. As one respondent said, “I thank God because he has provides me ***Kebele*** house with low price. Now, I am free from any pressure and I have freedom to live with high satisfaction.” Others four (16.0%) respondents have no income at all to rent private house. In response to this issue, ***Kebele*** administration has consider the severity of their problem and provides temporary shelter made from Zinc and free of charge. One respondent explain about the shelter, “When my parent in law discharge me from their home with my kids. I have the only chance to live around street. When I apply the case to ***Kebele*** and the ***Kebele*** replied my problem in making temporary shelter and give me to live it. Now, I am living in the shelter and it is not convenient to live it, because, it becomes cold or hot according to the variation of temperature.”

However, nineteen (72.0%) of respondents have exposed to house problem, which is not easily tackled by them. Except living with parents and ***Kebele*** houses, the rest suffer with different challenges such as violation of rights and other discriminatory action.

3.6.6. Respondents Frequencies of Daily Meals

Twelve (48.0%) of respondents are eating twice daily usually eat lunch and dinner. One respondent said that, I eat two times a day ***Injera*** with ***Shuro Wote.*** I need to eat more than what I mentioned here. My income amount has limited me to eat only twice. No one can give me food except financial support from ***MEDAN*** ACTS project. Nine (36.0%)of respondents are also eating three times. One lady respondent said that, I thank Almighty God, I eat three times a day because, I get subsistence allowance from the organization as well as I live also with my parents. In short, I have support from both sides to eat three times. Four (16.0%) of respondents eat one time daily. One respondent indicate that I have no adequate income to eat more than one time a day. I eat my lunch or dinner as I get. Rarely my neighborhood gives me food especially during occasion like holidays. In addition, my neighborhoods provide food for my kids daily. I thank them very much for their help. Majority respondents who take antiretroviral treatment need more food. One respondent elaborates that, the drug makes me to eat many times what ever I get in my home but usually I eat the tradition food like ***Injera*** with ***Shuro Wote,*** bread, ***Kolo***. Otherwise, I can not resist the hungry and feel gastric pain."

However, twenty-five (100.0%) of respondents are eating traditional food like ***injera*** with ***Shuro wote***. A significant number of respondents who are using antiretroviral treatment eat more and increased frequency of daily meals.

3.6.7. How Respondents Pass the Daytime.

Five (20.0%) of respondents especially women spend their daytime carry out different activities at home like cleaning and laundry services. One respondent said that, I work the whole day at my home. I have no rest, if I feel sick I sleep on my bed since I recover from my sickness. Four (16.0%) of respondents go to church to pray and listening word of God and the other four (16.0%) of attending Holy water therapy. One respondent indicate that, I live

around Holy water and church with spiritual men and my usual duty is worshiping and Holy water shower. I enjoy it and I pass the daytime in this way. Others five (20.0%) of respondents have passed the day time walking on the street and taking rest and sitting at near café and tearoom playing with their friends and other people. Two (8.0%) of respondents give home care to AIDS patients around their residence. Others five (20.0%) of respondents pass their time in sleeping on their bed and four percent of respondents attending regular school.

3.6.8. Respondents Interest to Engage Income-generating Scheme

Fifteen (60.0%) of respondents are not interested to involve income-generating activities because of on and off sickness and health problems. One respondent said that, I like to work on different income activities but I am not strong and healthy to work and get income. Five (20.0%) of respondents are very much interested to work any income business. As one of them said that, I can work any type of job if any agency can have work for me since I am healthy and strong. The other five (20.0%) of respondents specify income-generating sources as trading and eight percent and driving and one percent metal work. This shows their inclination towards previous experience and work.

However, majority respondents have no interest to involve income-generating activities. This is because of health problem even they are weak to engage in hardship work for the whole day.

3.6.9. How Respondents Become the Beneficiaries

Ten (40.0%) of respondents are access to the organization support through the indication of local administration (***Kebele).*** One of the respondents said that, when I face a serious problem of food, shelter and others then, I report to ***Kebele*** to get support. And it has already sent me in this organization and it provides me financial assistance every month. Nine (36.0%) respondents have received information from individual about the organization

services. The rest of two (8.0%) respondents are used friends information, reading notice board of the organization, Two (8.0%) of respondents through the help of ***Iddir*** and two (8.0%) after blood testing in the organization as a source of access to become a client. Thirteen (52.0%) of respondents have received support from the organization for maximum of one to two years. The rest twelve (48.0%) respondents have also received various durations like starting from three months goes to ten months. These respondents may receive services since the termination of the project after five years.

3.6.10. Types of Supports and Services to Respondents

Twenty (80.0%) of the respondents take one hundred Birr financial support monthly from the organization. One respondent forward her comment about subsistence allowance. She said that, in the beginning I was empty hand without a single coin and I exposed to severe famine. But when I join to this organization, I get allowance to my survival. Now, I am saved from famine death.

Three (12.0%) of respondents have access to credit services with low interest rate. One-lady respondents said that, I have taken loan from the organization used as seed money for trade business. I have tried my best to be successful but in the mean time I face family problem and I lost the money to solve the mentioned problem. Others two (8.0%) respondents have received food supply from the organization.

However, the organization provides different services like financial support, materials, educational and food supply and the like.

3.6. 11. Respondents Interest towards Vocational and Skill Training

Seven (28.0%) of respondents have no interest to participate skill training and this is due to sickness and low level of knowledge. Even they said that, what to do after this sickness and it seem hopeless. One lady respondent indicates that, I do not think to engage in income

generating work since I am weak to work. In addition, I am illiterate and how can I train vocational skill. I am not voluntary to attend training. I just sit down and wait my death time and everything is finished in my part. The rest eighteen (72.0%) respondents show their interest area of vocation like hair make up (12.0%), hand craft (4.0%), wood (4.0%), metal work (4.0%), trade (8.0%), any skill training (8.0%), and tailoring (12.0%) food preparation (8.0%), tailoring (8.0%) and driving technique (4.0%).

However, few (28.0%) of respondents have no interest to participate in vocational skill training due to health and other problems. Even interested respondents for skill training also have different barriers such as low level of education, health and others.

3.6.12. Organization Support to Promote Respondents Income

Twenty two (88.0%) of respondents have only access to subsistence allowance and food supply rather than other income supports. One respondent replied that, I have health problem to do income-generating activities. But the organization has advised and encourages me to involve and promote my income.

However, respondents indicate most of them have advised by the organization to work and get additional source of income. Three (12.0%) of respondents have already taken credit from the organization to promote their previous business to increase income level of the family.

3.6.13. Respondents Recommendations about Church's Role

Twenty two (88.0%) of respondents believe that churches and faith-based organizations are very important institutions to take initiative for development and defend any human hazards caused by HIV/AIDS. As most of them agree that faith organizations have strong resources, work force and qualified professionals and it is possible to coordinate such kind of potentials in fighting the devastating nature of HIV/AIDS. The primary work of faith-

based organizations is providing spiritual services and currently they can incorporate anti AIDS work in daily pastoral ministry. The members and crowds can listen and learn from churchmen. In short, as majority respondents said, “church has responsibilities to teach and make advocacy and counseling work to reduce stigma and discrimination, and giving care and support to AIDS patients, orphans and other vulnerable children.”

However, three (12.0%) of respondents have no idea about faith based organizations and even they prefer to be reserved not to give opinion. One lady respondents said that, who are these organizations? Are these organizations working on prevention and control of HIV/AIDS? I know these are spiritual organizations working for spiritual one not for AIDS. Such kind of answer may be responded due to lack of knowledge and associated faith based organizations work only with spiritual service than working for both fulfilling physical and spiritual needs of man.

3.6.14. Plan of Respondents Regarding to their Life and Family

Ten (40.0%) of respondents have a long and a short-term plan to carry out different activities such as rearing children, healed from the current HIV infection disease and become more capable to work on income generating activities to have adequate income. Nevertheless, Fifteen (60.0%) of respondents have no plan and even they are frustrated to live in this world for a long period. Even some of them said that they prefer to die within short time to be relieved from various challenges and sickness. In short, majority of respondents have no hope to live in peace and health. This resulted due to severe sickness, stigma and discrimination and poverty and less access to basic needs.

3.7. Interview of Key informants (Schools Directors and CBOs Leaders)

3.7.1. Situation of HIV/AIDS Epidemic in the Community

Two key informants of junior secondary school directors forward their opinion regarding the situation of HIV and AIDS prevalence rate. Both informants said that, HIV/AIDS has declined very much as compared to the previous time. This is due to mass education and concerted efforts of different organizations and institutions such as government, non- government and faith based organizations. They further elaborate that, one of the teaching media is school and its communities have also direct or indirect responsibilities to teach the society about the prevention and control of HIV and AIDS. The school directors have strong beliefs on students to teach and bring overall change among the entire society. As they said that, students are also very important part in the community used as HIV/AIDS awareness educators. Majority of younger generations is found in schools and more responsible for the coming years to carry out different development activities and protect the people against HIV/AIDS epidemic.

As key informants interview and other sources indicate that HIV/AIDS prevalence rate become decline through time due to different concerted efforts of organizations and agencies. Yet more can be done ahead as some schools not properly used to bring desired change in the community.

3.7.2. The Role of Faith Based organizations in Fighting HIV/AIDS

The key informants of school directors reflect their view relations to faith based organizations participation to prevent and control of HIV/AIDS disease around their area. One of the informants of the directors said that, these organizations are available in our community perform their activities in cooperation with schools, community based organizations like ***Iddir.*** Faith organizations particularly EKHC through ***MEDAN*** ACTS HIV/AIDS work in mobilization of the local community, offer workshops, provides peer educators trainings, awareness raise and the like. Almost all key informants agree that, FBOs have adequate

potentials to mobilize and coordinate the community to take involvement in the area of development or prevention and control of AIDS. The Ethiopian Kale Heywet church ***MEDAN*** ACTS Addis Ababa HIV/AIDS project carries out different activities in schools. One of its activities is building school capacity for teaching about AIDS to students in providing mini-media apparatus used for dissemination information at schools before starting classes and break time. As one of the directors said, ***MEDAN*** ACTS project encourage and cooperate us to establish Anti AIDS Clubs and now it has already established to teach students and the community as well as to give care for HIV victims.

Key informants indicate that ***MEDAN*** ACTS project also uses different teaching methods focus on traditional values such as coffee drinking ceremony type of approach is helpful to disseminate information about HIV/AIDS. The key informants also said that, faith organizations have wide opportunity to use traditional associations like ***Iddi****r*, ***Maheber*** and ***Equib*** as forums for education and possible to access mass people. Faith based organizations have high potential of resource and labor force to work in partner with traditional association, government and public schools to pass current information on HIV/AIDS.

However, there is only effort rather than actual use of social institutions such as public schools, ***Maheber*, Equib*, Senebete**** and the like. Faith organizations or other agencies ought to use these social gatherings to bring behavioral change among the society. Because, majority of younger generations are found in schools and this segment of population might serve as a lot in fighting HIV and AIDS pandemic.

3.7.3. Support of FBOs to AIDS Orphans in Schools

According to two schools key informants indicate that, schools do not know who is orphan and who is not but orphans are mostly identified through local administrations (***Kebele***) in cooperation with community. In schools as obvious, there are orphans who need

support from the community and FBOs and others. As one of the school directors said that, the school can take some responsibilities to assist orphans. It provides free education service and finds agencies that can support orphan students to pursue their education. In addition, the other director said that, school also made frequent follow up the condition of orphans families or guardians, coordinate the school and local communities to contribute certain amount of money to cover the expense of some occasions like religious or national holidays.

However, school directors key informants interview indicate that any faith based organization has not yet provides support to orphans student in school. Faith organizations have the opportunity to access orphans at school and help them in collaboration with school communities

3.7.4. Stigma and Discrimination against PLWHA

The key informants of school directors forward their ideas about stigma and discrimination against AIDS orphans in schools. As they said that, stigma and discrimination is not manifested in any form of it at school compounds. As the directors assume that, in school there is persistent dissemination of information to boys and girls every day through mini media rather than any other organizations. Such activity might help to acquire adequate knowledge about AIDS related stigma and discrimination. As the key informants' interviews show that there is no involvement against any negative action toward orphans and PLWHA in school compounds. In addition, the school key informants further state that, the school community has also taken steps to reduce stigma and discrimination against HIV positive people and AIDS patients by establishing and using Anti AIDS Clubs, and uses this as a teaching means. In addition, schools supports and given special favor toward either HIV positive students or whose parents are HIV positive. The directors stressed that the school did

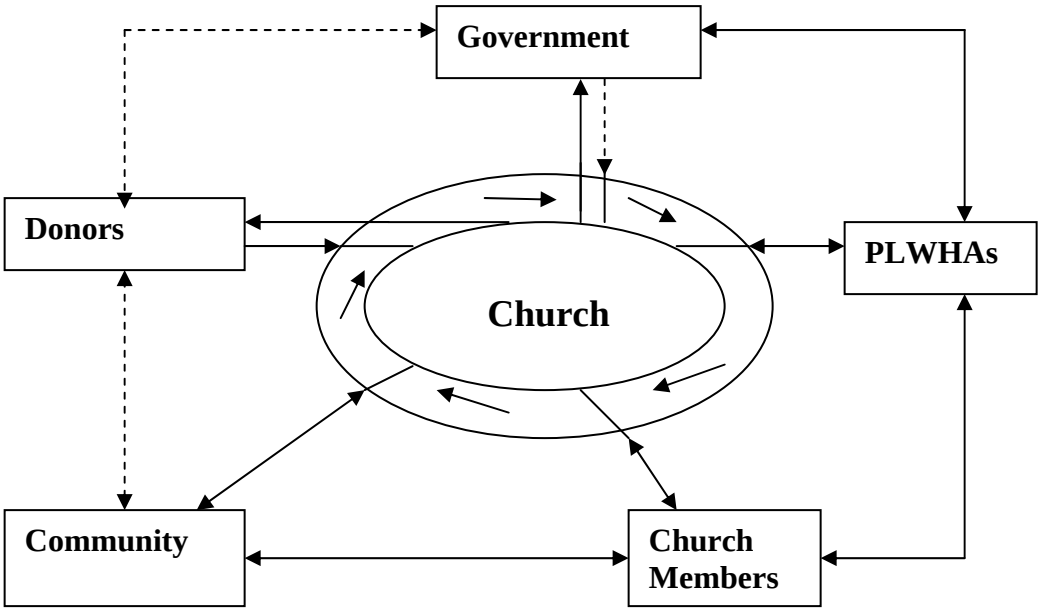
not consider any punishment action against orphan students either late or missing class for sometimes because of different problems originated from the family or any other sources.

However, the school directors know that, there is insignificant stigma action in the community especially at the neighborhoods level in their residence area. This happens because of lack of knowledge and confusion about the nature of AIDS disease in the previous education.

In the community associations like ***Iddir***, as three ***Iddir*** leaders key informants indicate that, there is no stigma and discrimination against HIV carriers and AIDS patients in the ***Iddir*** settings. It is clear that to all people who are a member of ***Iddir*** know its regulations very well. It is strictly forbidden to create differences among members based on income level, ethnicity and sickness particularly to AIDS patients. One of key informants said that, currently many ***Iddirs*** in our ***Kebele*** try to form union to established one big institution under the autonomy of single ***Iddir*** in its local settings. As he elaborates that, the union ***Iddir*** primary focus is to solve social problems of the community through supporting and participation way. It is a special one than the tradition. The union of ***Iddir*** has started to give care and support to victims of AIDS and vulnerable group of people like orphans and old people without guardians. As the ***Iddir*** leader further said, "majority of inhabitants and ***Iddirs*** member have very much interested to contribute financial and material support to AIDS people during national holidays and other occasions through the union."

Faith based organizations have good opportunity to work with traditional and local associations like ***Idder***, ***Maheber*** and ***Senbete,*** different schools and other agencies to bring attitudinal and behavioral change among the wider community towards stigma and discrimination. But, it is hard to find consistent activities of EKHC integrated with social associations, schools and others except irregular relation for mass education and the like.

3.8. Analytical Model of the Study



Remark

Strong and frequent relation

Strong but not frequent

Weak relation

Bilateral weak relation

HIV/AIDS may be thoroughly tackled through church participation and mobilization of the community. Church is found in the center of the community and leaders are also well recognized. As a result, it is possible to link with donors, government, and influential people in the community. In short, church has multi-lateral strong relations that contribute concerted effort to fight HIV/AIDS and its impact. Relations can be classified into direct and indirect one and it depends on the role played in the interventions of HIV/AIDS program. The direct relation is manifested among community, church members, PLWHA and government. The indirect one is related to donors' relations and donors have less involvement with direct implementation of HIV/AIDS program except receiving report on time basis.

Church is free and open to members and local community to offer services like spiritual, care and support, counseling, orphans care, advocacy and the like. It also motivates and encourages members to provide care to PLWHA. In addition, the community can involve in resource mobilization and fund raising to give financial support to PLWHA and AIDS orphans.

In general, church has adequate potential to organize human and material resources through using the power of listening by the community. Church also empowers people who are infected and affected by HIV/AIDS using different mechanisms. In addition, church runs capacity building of the community to solve their problems using local resources.

Footnote

*Senebete is an orthodox Christian fellowship for the purpose of praying together during Sunday in the church compound.

* Equip is a traditional way of saving institution.

* Maheber is a type of ritual ceremony held at each member house every month to met together for praying.

4. Conclusion and Recommendations

4.1. Conclusion

HIV/AIDS is rampant and has a serious impact in urban settings than rural. The majority of HIV/AIDS victims are women than men. As the case study findings show, most respondents are born in Addis Ababa and they are women. HIV/AIDS at the beginning was taken as God punishment for wrong doings and sinners. As a result, most FBOs were reluctant to get involved in prevention and control of HIV/AIDS. But, when the problem is aggravated and affected many church members, then, the leaders were obliged to see HIV/AIDS as any other disease. Sources gathered from church leader indicate that, leaders have misconception in the earlier time. But now they have changed their old perspectives and played a role in fighting against HIV/AIDS.

EKHC is one of the FBOs, currently working on different activities like provision of care and support, capacity building and IEC/BCC to prevent and control HIV/AIDS. In addition, the church has also a draft HIV/AIDS policy forwarded for discussion at various levels of local churches. This policy might clear ethical problems and encourage church communities to have more response against HIV/AIDS.

The church extends efforts and developed HIV/AIDS prevention and control mechanisms through education, advocacy to reduce stigma and discrimination, counseling and income generating activities. EKHC has a plan to mainstreaming HIV/AIDS program into different sectors of development. Even, few departments have already started to work on HIV/AIDS. Sunday pastoral services also offer awareness education and encourage people to make VCT.

The church has a power to be listened by the followers and using this, it can mobilize local communities for different activities like home-based care. The church respected the

existing values and social capital of the community and can be used as pillars to prevent HIV/AIDS. This view helps in turn to develop sustainable community based project. ***MEDAN*** ACTS HIV/AIDS Addis Ababa project has been established two and half years ago. Since then, it has encompasses 250 beneficiaries to provide services like care and support, income generating activities and orphans. All clients have suffered from lack of shelter, food, medical treatment and others. The characteristics of 25 samples of case study respondents are women and men with various levels of education attainment and marital status and perception of church role to prevent and control HIV/AIDS. Majority of them did not take initiative to make self-disclosing to the public due to fear of stigma and discrimination. Almost all respondents' primary life challenge is stigma and discrimination rather than the infection. Most respondents live without close relatives away from their original place of residence. Moreover, respondents have no adequate income except project supports of allowance, income-generating activities like taking loan to promote their income. Orphans receive food, educational materials and other forms of assistances. Respondents forwarded their appreciation about church's HIV/AIDS program except giving comments regarding low subsistence allowance.

Other information gathered from directors of junior secondary schools show that the prevalence rate of HIV/AIDS declines in their community. There is also no stigma and discrimination against PLWHA or AIDS orphans in the school compounds. The schools work on HIV/AIDS in cooperation with ***MEDAN*** ACTS HIV/AIDS project and the project provides mini media apparatus for schools. In turn, schools used mini-media as a teaching media of students and schools communities. In addition, community based organizations leaders like ***Iddir*** are not fully involved in curbing against HIV/AIDS epidemic. But, in recent time, the local ***Iddirs*** take initiative to form unions of many ***Iddirs*** to create one responsible body to manage HIV/AIDS related problems in their area.

The major findings of the case study indicate that the church has played a vital role in the prevention and control of HIV/AIDS epidemic. Its primary work rest on provision of care and support, home based care to bed ridden patients, economic empowerment of HIV and AIDS patients and their families through vocational skill training and income generation, voluntary counseling and testing, PMTCT, HIV/AIDS awareness creation, reduce stigma and discrimination through advocacy and education, orphans support and the like. As the respondents confirm through their interviews, the majority faced different challenges such as stigma and discrimination, shelter problem, shortage of food and lack of treatment, before they get support from ***MEDAN*** ACTS HIV/AIDS Addis Ababa project. After they became the client of the project, their socio economic problem has been reduced from time to time, and now they lead a better life.

4.2. Recommendations

- HIV/AIDS has a devastating nature and ravage millions of different segments of population. It requires concerted efforts from NGOs, FBOs, and others. Especially FBOs who are not currently involved in HIV/AIDS prevention and control should take the first initiative in fighting the pandemic.
- Government, International humanitarian agencies and donors should encourage and provide financial support towards FBOs to carry out sound HIV/AIDS prevention and control activities.
- Churches and FBOs should mobilize the local community and resources for care and support for HIV/AIDS victims rather than expecting from outside donors

- Clients subsistence allowance is low that does not cover the necessary expenditure. The project should seek means to increase financial support in relation to current market price and exchange rate.
- FBOs, churches and other organizations further strengthen advocacy work among the community to reduce stigma and discrimination against PLWHAs.
- FBOs, churches and other organizations should facilitate intensive vocational skill training to active PLWHAs and risk group to access additional income to lead a stable life.
- FBOs and other humanitarian organizations should give emphasis for AIDS patients' families to build their income through income generating activities.
- Churches and FBOs should give place to professional and spiritual counseling to maintain and build hope of desperate HIV and AIDS patients and orphans.
- Churches spiritual ministry should encompass HIV/AIDS education schedule and teach people about HIV/AIDS to increase awareness and reduce stigma against HIV/AIDS.
- Well-trained people who have current information about HIV/AIDS should give HIV/AIDS awareness raising activities. There should be selected educators to disseminate proper information among the community. All concerned bodies should assign proper educators to disseminate reliable information in order to protect the community against confusion
- HIV/AIDS infected and affected more strong and put influence on women as it is seen from the study data. To alleviate such kind of pressure upon women

give priority and educate and empower them to build their own income to be self-supported.

- HIV/AIDS awareness creation additionally focuses on youth and marriage, reproductive health and family planning.

ANNEXES

Annex I

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Annex II

Case Study Interview Guideline for Key Informants

(Junior secondary schools directors and Community Based organizations leaders)

I. General Information

1.1. What is the name of your organization and where is it address?

1.2. What is your responsibility to your organization?

1.3. Do you know faith based organizations working on HIV and AIDS epidemic in your area? Please cite its name

II. Key Informants Interviews on HIV and AIDS

2.1. What is the current situation of HIV and AIDS epidemic in your community?

2.2 Do you think the number of HIV and AIDS people in your community has changed in the last five years?

2.3. Does the family provide any kind of care and support for HIV and AIDS patients?

2.4. Does your organization participate in prevention and control on HIV and AIDS epidemic? If yes, please elaborate it

2.5. What is the role of faith based organizations in fighting HIV and AIDS epidemic around your locality?

2.6. Is there any faith based organization working in cooperation with your organization on HIV and AIDS epidemic? Please mention it

2.7. What Kind of services does this Faith based Organization (FBO) provide to the community?

2.8. What type of support can HIV and AIDS people get from the Faith Based Organization (FBO) and the community?

2.9. Are there AIDS orphans who need support from the community and faith based organization (FBO)? If yes, please describe it

2.10. Is the community doing anything to address the needs of AIDS patients and orphans in cooperation with faith based organizations (FBO)?

2.11. Have you seen any gaps in terms of implementing HIV and AIDS prevention and control program by faith based organization? Please forward your ideas

2.12. Have you ever participated in HIV and AIDS awareness education through faith based organization?

2.13. Have you ever observed stigma and discrimination against HIV and AIDS people? If yes, would you elaborate it?

2.14. List the most important things you would like to be done for HIV and AIDS people from faith based organization.

2.15. What is your recommendation towards HIV and AIDS prevention and control program of the organizations like faith based organizations? Please give your comment

---------- **Thank you** ----------

Case Study Key informant Interview for Church Elders

Key informants of the church elders are the current leaders of the church found at various levels and actively participate in different church ministries. The general secretary of Ethiopian Kale Heywet church in Addis Ababa region, local church leaders around Medan ACTS project in Kirkos sub-city.

I. Background Information of the Church

1.1 When was your church established?
1.2. Why you established your church?
1.3. What kind of development activities does your church involved now?
1.4. What type of services does your church provided to members and local communities?
1.5. What seems your church relationship with other churches? (International and local churches)
1.6. What is the contribution of members to the church and local communities?
1.7. What is your funding base? Is there any local resources? Please describe it

II. Church's Role in Fighting HIV and AIDS

2.1. What is the current perspective of church toward AIDS epidemic?
2.2. What is your church role played in fighting against HIV and AIDS epidemic?
2.3. What is your church approach to create HIV and AIDS awareness to the local community?
2.4. Is there HIV and AIDS awareness raise education given to members?
2.5. What Kind of strategy does the church use to prevent HIV and AIDS epidemic?
2.5.1 What type of method does the church use to control HIV and AIDS epidemic?
2.6. Does your church encourage members to make voluntary counseling and testing?
2.7. What are the mechanisms to encourage members?
2.8. What is the contribution of community to prevent HIV and AIDS through the mobilization of your church?
2.8.1. What is the role of the community to control HIV and AIDS?
2.9. Does the church make advocacy for HIV positive people to reduce stigma and discrimination?
2.10. What is the contribution of community to prevent and control HIV and AIDS epidemic through mobilization of your church?
2.11. Does the church request medical certificate of members HIV sero-status during marriage? If yes, why?

III. Provision of Church Services to PLWHAs

3.1. What is your church participation in providing health services to PLWHAs?
3.2. What does your medical service cover?
3.3. Does your medical service include the HIV and AIDS people families? If yes, please explain it
3.4. Does the church provide prevention of mother to child transmission of HIV virus? Please explain
3.5. Does the medical service reach to AIDS orphans children? If yes, please explain the situation
3.6. Does the church give reproductive health and family planning service to clients? If yes, how?

3.7. Does the church provide home based care to AIDS patients? If yes please describe
3.8. Does the church provide food supply to AIDS patients?
3.9. Does the church cover house rent for those who have no shelter? Please describe the situation
3.10. Does the church have close contact with people living with HIV and AIDS families? Please give your comment
3.11. Is there any kind of support to HIV and AIDS people families? If yes, please define it
3.12. Does the church provide recreational service to ambulatory AIDS patients? Are there recreational services to bed ridden AIDS patients?
3.13. Does the church give support to AIDS orphan? What kind of support is it?
3.14. What are the opportunities do your church face in fighting HIV and AIDS epidemic?
3.14.1. What are the threats do your church face in fighting HIV and AIDS epidemic?

IV. Church's Economic Support

4.1. Does the church give saving and credit service to HIV and AIDS people? If yes please explain
4.2. Does the church design income generating activities to HIV people? If yes, please describe
4.3. Is there credit and saving service in the church? And is there training on credit and saving management? If yes, please describe it
4.4. How often church offer training to credit and saving management?
4.5. Does the church provide subsistence allowance per month to the clients? Please explain
4.6. Does the church give financial support to AIDS orphan? If yes, how much?
4.7. What is the role of church's in building community support for PLWHAs?
4.8. What is the role of church's reducing stigma and discrimination against PLWHAs?

V. Psychosocial Support of Church

5.1. Does the church give counseling service pre and post HIV test? If yes, please describe it
5.2. When does the church start voluntary counseling and test? Please explain the situation
5.3. How does the church give spiritual service to AIDS patients including their families?
5.4. How does the church assist AIDS orphans in giving psychosocial support?

VI. Church's Work plan

6.1. Does the church intended to provide more services to the clients? If yes, please elaborate it
6.2. What kind of strategy does the church use to reduce stigma and discrimination in the future?
6.3. What type of plan does the church have to prevent and control HIV and AIDS epidemic?
6.4. Is there any intention to increase income of HIV and AIDS people and their families? If yes, please indicate your plan
6.5. What is the church plan in mobilizing the community in prevention and control on HIV and AIDS epidemic?
6.6. Are there any gaps that the church does not cover it for the time being? If yes, please indicate it

6.7. Do you have planned to give assistance to AIDS orphan children? If yes, please mention it the type of support.

6.8. What are the church recommendations to prevent and control HIV and AIDS as well to give care and support?

---------- Thank you ----------

Case Study Key informant Interview Guideline for Ethiopian Kale Heywet Church HIV/AIDS Department

I. Background of the Organization

1.1Name of the organization_____
1.2. Address_____
1.3. Telephone_____
1.4. E-mail_____
1.5. Date of established_____
1.6. ID of person interviewed (title) _____
1.7. Type of organization_____
1.8. Does your organization work relate to people with HIV /AIDS? Yes/No
1.9. Why you established this organization?
1.10.Is your organization registered with_____
1.11. Does your organization have a policy regarding to HIV and AIDS?
1.11.1. If no, does your organization plan to develop a policy?
1.12. Are people living with HIV and AIDS included on the board of committee?
1.13. How often does the board of committee met?
1.14. List the organization staff members by titles and their activities

Titles of staffs members	Number of staff		
	Full time	Part time	Volunteers

1.15. How many HIV/AIDS projects do you have under this organization?
1.16. What are the organization's catchments areas served?
1.17. Are the catchments areas primarily urban [ ] Rural [ ]
1.18. Have you noticed an increase in the need to address the well-being of people living with HIV and AIDS (PLWHA) in the area or population you are working with? If yes, describe it
1.19. What kind of strategy do you use to prevent HIV and AIDS epidemic?
1.19.1. What type of method do you use to control HIV and AIDS epidemic?
1.20. How do you work the prevention and control of HIV and AIDS projects?
1.21. Do you have working relationship with Community based organizations, government and Non-governmental organizations?
1.22. Do you have networking and coordination with similar Faith Based Organizations and others? Please elaborate it
1.23. Is there community participation in your organization work? If yes, please describe it.
1.23.1. If no, how do you enhance community participation?
1.24. What are the organization sources of funding?

II. Focus of services

2.1. What services does your organization provided?
2.2. Who are the major beneficiaries of your services?
2.3. What are your selection criteria to admit your client?
2.4. How many clients do you have in Addis Ababa in total? Would you put the number of your clients in each sub city and Kebele?
2.5. What type of plan do you have to provide your services? (Annual or strategy)
2.6. Does the organization provide medical service to AIDS patients? If yes, what does it cover? For how many clients did you give in each year?
2.7. Does the organization medical service covers orphan s children? If yes please elaborate it
2.8. Does the organization give prevention of mother to child transmission? If yes, please explain it
2.9. Does the organization provide reproductive health and family planning service to the clients? If yes, how?
2.10. How many of your HIV/AIDS projects have voluntary counseling and testing centers?
2.11. How many people in Addis Ababa visit your voluntary counseling and testing center in a year?
2.12. Is there HIV/AIDS awareness raising education offered to the community? If yes, please elaborate
    2.12.1. If yes, what are the modes of operandi to education? How many people have received this education in each year? Where and by whom?
2.13. Are there any income generating activities in your organization for People living with HIV and AIDS (PLWHA)?
2.13.1. If yes, how many people has involved in this activities in each year?
2.14. Does the organization provide saving and credit service to HIV and AIDS people? If yes, how much and for how many clients? Please explain it
2.15. Duos the organization gives training on saving and credit system? If yes, how often the training offer and what type of training does it covers?
2.16. Did you give subsistence allowance to AIDS patients per month? If yes, how much
2.17. Does the organization provide support to people living with HIV and AIDS families? If yes, what kind of support provided and for how many families each year?
2.18. Does the organization provided skill training to those interested and capable clients including their families? Please describe it
2.19. Does the organization cover house rent cost for those who have no shelter? If yes, how much per month?
2.20. Does the organization provide recreational services to AIDS patients? If yes, what kind of recreational services?
2.21. Does the organization give home based care to bed ridden AIDS patients? If yes, who make this care?
2.22. Does the organization give support to AIDS orphan? If yes, how many and types of support
2.23. How does the organization provide AIDS orphans psychosocial support counseling?
2.24. How does the organization give different psychosocial support services such as spiritual and bereavement counseling to AIDS victims?
2.25. Is your organization working with children in need or orphans? If yes, please describe it in detail

2.26. Does the organization give legal services to people living with HIV and AIDS rights violated by others? If yes, when? And how many people have access to legal service in each year?

III. Sustainability of the Organization

3.1. How does your organization evaluate its activities?
3.2. Which organizations does your organization have more linkages with?
3.3. How does the community contribute to your organization's program?
3.4. How your organization ensures sustainability of its program?
3.5. Does the organization intended to provide other services than the ones you providing now? If yes, please elaborate.
3.6. What kind of activities plan does your organization will use to reduce stigma and discrimination against HIV positive people?
3.7. What is your organization plan toward mobilizing the community participation in prevention and control on HIV and AIDS?
3.8. Are there any gaps in terms of implementing HIV and AIDS program? If yes please indicate the area
3.9. In what areas does your organization require assistance?
3.10. What are the lessons learned by your organization from your programming?
3.11. Does your organization required to employ more qualified professionals? If yes, please mention the type of professionals.
3.12. What opportunities and threats do you face your organization in fighting HIV and AIDS epidemic?
3.13. How do you overcome when you face difficulties during implementation of HIV and AIDS program?
3.14. How long do the people living with HIV and AIDS stay under your organization support?
3.15. What do you recommend regarding to HIV and AIDS prevention, control, care and support?

---------- Thank you ----------

Case Study Interview Guideline for Beneficiaries

Sampling Respondent

The study will cover 25 respondents will be picked up out of a total of 250 beneficiaries. The selection will be used to identify respondents from the selected Kebeles then making up a total of 25. All of the beneficiaries will be those for whom the program is designed and currently are receiving services from on going Ethiopian Kale Heywet church program.

I. Background Information

1.1. Sex Male_____ Female_____
1.2. Age in year _____
1.3. Place of birth: region _____ Zone_____ Woreda _____ Kebele
1.4. Marital status: Married _____Single____ Separated_____ Divorce_____ Widow_____
1.5. Religion: Orthodox_____ Muslim____ Catholic____ Protestant_____ Others_____
1.6. Educational attainment: Illiterate_____ Read and write_____ Primary level_____ Secondary level_____ Tertiary Level___
1.7. Number of children alive Female_____ Male_____
1.8. Number of dependents Female_____ Male_____
1.9. Are you dependent? If yes, to whom you are dependent?

II. Socio-economic Situation

2.1. What was your occupation before you become the client of this organization?
2.2. What was your source of monthly income? How much did you get per month?
2.3. Do you have health problem? If yes, what type of health problem do you have?
2.4. When and where did you infected by the mentioned disease?
2.5. What types of medical treatment have you received for your sickness?
2.6. Have you been received anti retroviral treatment? If yes, when did you start?
2.7. Did you get support from your close relatives? If yes, what type of support is it?
2.7.1. Have you received any Kind of support from your neighborhoods? If yes, please mention
2.7.2. Did you get support from your friends? If yes, what type of support is it?
2.8. What kind of assistance did you get from the organization? If yes, please describe
2.9. What was the relationship with your community after you sick by the mentioned disease? Please give detail information on the situation.
2.10. Did you participate in local social activities like ***Iddir***? If no, why?
2.11. Have you received any form of assistance from social institutions such as ***Iddir***? If yes, when did you receive? Please mention the kind and amount of assistance
2.12. Do you have your own house? If no, where did you live? Are you dependent?
2.13. Did you get food assistance from the organization? If yes please describe it
2.14. How many times a day did you eat?
2.15. What is your daily common meal?
2.16. How do you pass the day time after you sick? What do you do the whole day?
2.17. Have you been adequately access to your basic needs (food, clothes, and shelter)?
2.18. Are you interested to work on income generating scheme to increase your income?
2.19. What is your contribution in teaching people to raise awareness on HIV and AIDS?
2.20. What kind of precaution you take for the care giver of you?

III. Access to Organizational Support

3.1. When did you become the organization client?
3.2. How did you become the organization client?
3.3. How long have been assisted by the organization?
3.4. What types of services did you get from the organization?
3.5. Does the organization support your families? If yes, in what way?
3.6. Have you received food supply from the organization?
3.7. Are there any recreational services provided by the organization?
3.8. Are you interested to take skill training? If yes, what kind of training do you like?
3.9. What is the support of the organization to promote your income?
3.10. Does the organization give you allowance per month? If yes, how much
3.11. Have you access to credit support of the organization? If yes, please explain
3.12. What is your comment to ward services which you receive from the organization?
3.13. What is your recommendation to prevent and control HIV and AIDS epidemic through church?
3.14. What is your plan regarding to your family, income, organizational support and the like?

----------Thank You----------

Annex III
ADDIS ABABA UNIVERSITY, GRADUTE SCHOOL OF SOCIAL WORK

Verbal Consent Format for Key informants

INTERVIEW IDENTIFICATION NUMBER [____]____]____]

INTRODUCTION:
My name is Abebaye Hailu from graduate school of social work at Addis Ababa University; I am currently collecting data regarding Role of Faith based organizations in combating HIV and AIDS Epidemic in Addis Ababa: Case study of Ethiopian Kale Heywet Church, to understand the present situation of HIV and AIDS epidemic in Addis Ababa at Kirkos sub city. As part of my assessment, I am talking to a wide cross section of people in the sub city, including community based organizations leaders, Ethiopian Kale Heywet church region and local leaders and junior secondary schools directors. I would use the information for fulfill my thesis requirement and to present information to help those concerned bodies to plan activities that will address the identified needs of people living with HIV and AIDS.

Confidentiality and consent: I may ask some personal questions that some people find difficult to answer. Your answers are completely confidential. Your name will not be written on this form and will ever be used in connection with any of the information you tell me. You don't have to answer any question that you don't want to answer, and you may end this interview at any time you want. However, your honest answer to these questions will help me better understand the present situation of HIV/AIDS, faith based organizations prevention, control, care and support. I would greatly appreciate your help in responding to this study. The interview will take maximum 1 hour. Would you be willing to participate?
Signature if interviewer_____
(Respondents have given certifying that informs consent verbally)

Interview Log

	VISIT 1	**VISIT 2**
Date		
Interviewer		
Comment		

Interviewer Code: [____]____] Name of Interviewer_____
Date of Interview: [____]____]2006]

Annex IV

ADDIS ABABA UNIVERSITY, GRADUTE SCHOOL OF SOCIAL WORK

Verbal Consent for Beneficiaries

INTERVIEW IDENTIFICATION NUMBER [____]____]____]

INTRODUCTION:

My name is Abebaye Hailu from graduate school of social work at Addis Ababa University; I am currently collecting data regarding Role of Faith based organizations in combating HIV and AIDS Epidemic in Addis Ababa: Case study of Ethiopian Kale Heywet Church, to understand the present situation of HIV and AIDS epidemic in Addis Ababa at Kirkos sub city. As part of my assessment, I am talking to a wide cross section of people in the sub city, including community based organizations leaders, Ethiopian Kale Heywet church region and local leaders and junior secondary schools directors. I would use the information for fulfill my thesis requirement and to present information to help those concerned bodies to plan activities that will address the identified needs of people living with HIV and AIDS.

Confidentiality and consent: I may ask some personal questions that some people find difficult to answer. Your answers are completely confidential. Your name will not be written on this form and will ever be used in connection with any of the information you tell me. You don't have to answer any question that you don't want to answer, and you may end this interview at any time you want. However, your honest answer to these questions will help me better understand the present situation of HIV/AIDS, faith based organizations prevention, control, care and support. I would greatly appreciate your help in responding to this study. The interview will take maximum 1 hour. Would you be willing to participate?

Signature if interviewer_____

(Respondents have given certifying that informs consent verbally)

Interview Log

	VISIT 1	**VISIT 2**
Date		
Interviewer		
Comment		

Interviewer Code: [____]____] Name of Interviewer_____

Date of Interview: [____]____]2006]

Declaration

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

Name of student: Abebaye Hailu

Signature _____

Date June 20, 2006

Advisor: Professor Sandyha Joshi

Signature_____

Date_____