Assessing the Role and Challenges of Community Care Coalition (CCC) in Providing Support to HIV/AIDS Infected People: The Case of KolfeKeranio Sub City

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This is to certify that the thesis presented by Frehiwot W/Silassie entitled: Assessing the Role and Challenges of Community Care Coalitions in Providing Support to HIV/AIDS Infected People: The Case of KolfeKeranio Sub City and submitted in partial fulfillment of the requirements for the degree of Masters of Social Work compiles with the regulation of the University and meets the accepted standards with respects to originality and quality.

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Abstract

Community care coalition (CCC) currently represents the front line in the protection of the vulnerable children and people living with HIV/AIDS and the building blocks for a national system of social protection.The main objective of this study is assessing the role and challenges of CCCin providing support to HIV/AIDS infected people at KolfeKeranio Sub City. This study has used qualitative research approach. It has also followed case study analysis and the unit of analysis was "community care coalition" with a case offour ketenas. Purposive, non-probability sampling was employed to collect data from coalitions, PLWHA, and sectors. Five CCCs chairs, four sector representatives, eight vulnerable children and three people living with HIV/AIDS (a total of twenty two individuals) participated in in-depth interviews. Focus group discussion (FGD) was also conducted with three groups. A group that consist six and five vulnerable children andfive community core coalition members participated in focus group discussion. The inclusion criteria was between14-18 year for vulnerable children who received service, community care coalition working on child protection and who are interested, sectors representatives working on the issue and willing to participate and household members were engaged in income generating activities. Data was collected through in-depth interview, FGD, observation and document review and analyzed by using thematic analysis approach. The finding of the study showed that the identified packages of supports have brought changes to the lives of selected PLWHA and their family and venerable children. Capacity building, resource mobilization and data collection strategy is used by CCCs have guided positive change to happen on the lives of beneficiaries. Turnover of the CCC chairs, structural, financial and professional challenges have negatively affected the function of CCCs. Focusing on local resource, knowledge, institution, integrating formal and informal actors and using planned program are the key sustainability pillars of CCCs.

Key words: *Community Care Coalition, Role and challenges of CCC, Support provided to people living with HIV/AIDS*

Table of Contents

List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Anti Natal Care
CBO	Community Based Organizations
CCC	Community Care Coalitions
CCG	Community Care Groups
CHW	Community Health Workers
CSO	Civil Society Organizations
EDHS	Ethiopian Demographic and Health Survey
GO	Governmental Organizations
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activities
MoLSA	Ministry of Labor and Social Affairs
MoWCA	Ministry of Women and Children's Affairs
MVC	Most Vulnerable Children
NGOs	Non-Governmental Organizations
SNNPRS	South Nations, Nationalities and Peoples' Region
OVC	Orphan and Vulnerable Children
PLWHA	People Living with HIV and AIDS
WVE	World Vision Ethiopia

CHAPTER ONE

1.Introduction

1.1. Background of the Study

Ethiopia is one of the poorest countries in the world with millions of people that lacks access to basic services and high levels of food insecurity resulting in widespread of hunger and hardship. In spite of different developmental works done in Ethiopia and there is a lot of progress made towards improving the lives of vulnerable children and adults over the past decade but there is still a lot of homework to do. Some changes in economic growth, enhancement of social services and the improvements of different policies and interventions to address poverty and underdevelopment have helped to protect communities from risk and to support individuals in need. The situation of vulnerable groups, including children, people living with HIV/ AIDS, elderly, homeless and those suffering from illness or disability, are particularly affected. Living without the support of close and extended family members, informal traditional institutions, and neighbors, many fail to carry on with their life (MOLSA, 2017).

According to Ministry of Labor Social Affairs guideline (MOLSA, 2017), the situation of vulnerable groups, including children, people living with HIV/ AIDS, elderly, homeless and those suffering from illness or disability, are particularly affected. Living without the support of close and extended family members, informal traditional institutions, and neighbors, many fail to carry on with their life.In the country, the widespreadneighborhood and informal traditional institutions translated into the development of a range of diverse community-based structures. Throughout the country, these groups seek to respond to problems in their communities and to

care for those in need. Currently, Community Care Coalitions, represent the front line in the protection of the vulnerable and the building blocks for a national system of social protection.

The global HIV/AIDS pandemic has been changing human lives and the shape of societies for more than 15 years in the heavily infected countries of Sub-Saharan Africa, Asia, Latin America and the Caribbean. It has reversed decades of development gains in health, and slowed economic and social improvement across the board and in ways that will change relationships at family, community and national levels forever (FHI, 2001). Sathiya, (2015) underlined that HIV/AIDS epidemic is no longer merely a health problem but one of the greatest developmentchallenges the world has ever.

Still, the disease continues to spread with no cure yet in sight. The epidemic is rightly said to be associated with poverty, but the reality is much more complex. In many sub-Saharan African countries, Ethiopia in particular, HIV/AIDS remains one of the key challenges for the country's overall development. The country faces a mixed epidemic, where prevalence is low among the general population but high among sub-populations and certain geographic areas(Bunkers and Andrews, 2017).

The current population of Ethiopia is estimated to be approximately 110 million. The country has a very young profile with approximately 44% of the population less than 15 years of age, and 15% of the total population is under 5 years of age. Although there have been significant improvements in the economic development of Ethiopia in the past decade, an estimated 25 million Ethiopians "still remain trapped in poverty and vulnerability." Children remain vulnerable to HIV and other adversities related to their protection and well-being with an HIV

prevalence rate of 1.2%, and close to an estimated 900,000 orphans due to AIDS (Bunkers and Andrews, 2017).

HIV/AIDS remains a critical public health challenge in Ethiopia. Accurate and timely epidemiological data are essential for informing effective planning and response to the epidemic. HIV/AIDS in Ethiopia: An Epidemiological Synthesis 2013 Edition aims to provide an overview of the current status and recent trends of the HIV epidemic which will inform strategies for the prevention and control of HIV/AIDS in Ethiopia. This volume updates the first edition published by the Federal HIV/AIDS Prevention and Control Office (FHAPCO) and the World Bank in 2008. HIV prevalence among the general adult population was 1.5% according to the 2011 Ethiopia DHS. However, prevalence rates varied markedly by age (from 0.1% among 15-19 year olds to 2.9% among 35-39 years old), by gender (1.9% of adult women vs. 1.0% of adult men), by residence (4.2% urban vs. 0.6% rural), and by region (from 6.5% in Gambella to 0.9% in SNNPR) (Yibeltal, 2014).

Urban residents accounted for 17% of the national population but 64% of PLWHA in 2011. Between 2005 and 2011, HIV prevalence remained relatively stable in large cities with a hint of increase from 4.3% to 5.1% but fell sharply and significantly in medium and small size towns from 8.2% to 3.1%. Concentration of the epidemic along main transport corridors also intensified as the ratio of HIV prevalence within 5 kilometers of a major road relative to more distant locations increased from 2.5 to 4 times higher. Urban areas that border major roads regardless of region or town size yield HIV prevalence equivalent on average to the largest cities (5.5%). (Yibeltal, 2014). Consequently, in order to tackle this challenges community and government are establishing community care coalition (CCC) offices at local levels.

A coalition is a union of people and organizations working to influence outcomes on a specific problem. Coalitions are useful for accomplishing a broad range of problems that reach beyond the capacity of any individual member organization. These goals range from information sharing to coordination of services, from community education to advocacy for major environmental or policy (regulatory) changes. Groups providing care directly are community care groups (CCGs), those with mainly a coordination role are called CCCs. CCCs include heads of churches, volunteers, the government, businesses, NGOs and CBOs providing material and financial support locally (Cohen, 2011).

According to (Caitlin, et al, 2010), community care coalitions are groups of individuals and/or organizations at local level that join together for common purpose of expanding and enhancing care for People living with HIV/AIDS (PLWHA) and most vulnerable children in communities. Groups providing care directly are community care groups (CCGs), those with mainly a coordination role are called CCCs. CCCs include heads of churches, volunteers, the government, businesses, NGOs and CBOs providing material and financial support locally.

The Community Care Coalition (CCC) is first founded by World Vision's programming model for organizing and strengthening community-led care for orphans and vulnerable children (OVC), and people chronically/terminally ill. CCCs have been implemented as core model of the World Vision Ethiopia Initiative since 2004 and have become a foundational model for the Integrated Programming Model and for all WV's HIV and Health work. The program also focused on next generation program interventions by building sustainable CCCs. The intention is that they will become even more important in empowering communities in a wider range of program interventions (Andreas, 2011). To date, World Vision Ethiopia (WVE) facilitates and supports over 3700 such community care mechanism with over 934,500 orphans and vulnerable

children being supported by those groups in 20 African countries. Researches indicate that community led-child care established through strong community mobilization processes, well horizontally and vertically networked, are sustainable mechanisms for enhanced child and community well-being at the community level, (Claxton et al. ,2008).

The Government of Ethiopia has made recent investments in strengthening the social service system, updating the policy framework to add a National Implementation guideline for Community Care Coalition (MOLSA, 2018). This policy includes programs targeting the most vulnerable populations, the development of a para-professional social service workforce, and the establishment of community care coalition (CCC) offices at the local level. CCCs are linked, through the local woreda administration, to the woreda-level office of the Bureau of Women, Children and Youth Affairs. In a growing number of woredas, the woreda administration and institutionalized CCCs are responsible for identifying and managing referrals to services for highly vulnerable community members, including children. The establishment of a local CCC office has provided an important cornerstone from which to build the YekokebBerhan program writ large, and the CCC is well integrated into the case management system developed by the program. (Bunkers and Andrew, 2017).

1.2. Statement of the Problem

Some studies have been conducted on community care coalition focusing on coalition formation, capacity building, functioning, role and effectiveness. Kegler& Honeycutt (2010) have conducted a study on the influence of community context on coalitions in the formation stage. They found that community participation, geography, politics, history, norms and values have influenced coalition for agency selection, staffing and leadership, membership, processes

and structure. Other study was conducted by Grant (1996) on building community coalitions from academia in USA. His finding revealed the existence of strong correlation between length of time, efforts made to change the life of women and positive change on the lives of women.

Bebbington&Charnley (1990) researched on community care for the elderly at Ohio. Their finding ascertained the vital role of experienced coalition leaders in sustaining and using coalitions as vehicles. Fisher (1994) has undertaken his investigation on manmade care, community care and older male careers in England. His finding justified the need for fundamental reexamination of services which are based on negotiation than assumption and partnership than professional work. Huxley (1993) has conducted research on case and care management in community care and the introduction of case management in to a deprived service context.

Binega (2013) examined the role of community care coalitions in providing psychosocial support to HIV infected and affected people in Mekele city. His finding underscores the need for provision of psychosocial support as one separate care and support package within coalitions. Frazee, Stahmer, Lewis, Feder& Reed (2012) researched on building a research community collaborative to improve community care for infants and toddlers at risk for Autism spectrum disorder. The team comes up with the finding stating that the bridge collaborative coalition was highly productive by attainment of its goals due to actors integrat ion in coalition programming. Butterfoss (2006) conducted evaluative research on process evaluation for community participation and its intermediary role in health and social change outcomes. His finding ascertained that coalitions recruit less diverse partners than desired without substantive representation and measurements of process indicators alone are insufficient and researchers have to tie process evaluation to intermediate and long term goal.

The other research that was conducted byYeshewahareg (2015) focused on exploring effectiveness of community coalition services for protection of orphan and vulnerable children in Addis Ababa Keranyo area. The findings indicate, that community led-child care established through strong community mobilization processes, well horizontally and vertically networked, are sustainable mechanisms for enhanced child well-being at the community level.

Abebe (2016) has also conducted research on the role of community care coalition for child protection in Assosa City. His findings stresses on the packages of services that have brought changes to the lives of selected venerable children and families at three different levels as high, moderate and low. Capacity building, resource mobilization and data collection, organizing and documentation are identified to be the key strategies employed by CCCs that guided positive change. The pressing challenges that negatively affected CCCs functioning are turnover of chairpersons, structural, financial, and professional challenges. CCCs have focused on local resource, knowledge, institution, integrated formal and informal actors and using planned program as key sustainability pillars.

Most of the studies that have been conducted so far on community care coalition have focused on community facilitation and mobilization for health service in western context. To my information, only few studies are conducted on the role and challenges of community care coalitions in providing support to PLWHA in Ethiopia. The researches that I have come through focuses on the effectiveness and role of the community core coalition. But they didn't focus on the role and challenges while the community core coalition provides voluntary services to the people living with HIV/AIDS. So, contributing to the knowledge base to these literatures is critically important. Therefore, the major purpose of this study is to assess the role and challenges of community care coalition for HIV/AIDS infected people.

1.3. Objectives

General Objectives

- The general objective of the study is to assess the impact and challenges of the community care coalition in providing support to HIV/AIDS infected people.

Specific Objectives

- To investigate major services provided by community care coalition to HIV/AIDS infected people in KolfeKeranio Sub-City
- To understand the role and strategies of the community care coalition in supporting people infected with HIV/AIDS in KolfeKeranio Sub-City
- To describe the challenges of community care coalition in KolfeKeranio Sub-City while providing support
- To explore sustainability of community care coalitions in the KolfeKeranio Sub-City.

1.4. Research Questions

1. What are the major services provided by community care coalition to vulnerable children in KolfeKeranio Sub City?
2. What are the strategies employed by community care coalitions in providing support to people living with HIV/AIDS in KolfeKeranio Sub City?
3. What are the challenges triggering of community care coalitions while providing services to people living with HIV/AIDS in KolfeKeranio Sub City?

4. How can community care coalitions ensure service sustainability of people living with HIV/AIDS in KolfeKeranio Sub City?

1.5. Scope of the Study

This study is undertaken on the community care coalition established to respond to the case of people living with HIV/AIDS in Addis Ababa KolfeKeraniyo Sub City. The study focused on the service giver role and challenges while providing supports to the people living with HIV/AIDS. It has also identified the effectiveness and sustainability of services rendered by the coalition to improve the life of people living with HIV/AIDS in KolfeKeraniyo Sub City.KolfeKeraniyo Sub City is the scope of this study because it is one of the two projects Kolfe project in which World Vision operates in Addis Ababa. Kolfe was the largest project of the two and community care coalitions works in large in the area.

1.6. Significance of the Research

The study has explored the role and challenges of community care coalition (CCC) inKolfeKeranio Sub Cityin providing support to HIV/AIDS infected people. In addition it has tried to assess the strategy that community care coalition employed to provide the support and how they insure the sustainability of the program. In doing so, the study has identified and analyzed the role of community care coalition to HIV/AIDS infected people, the basic strategies employed by community care coalition in delivering support for them and the challenges encountered during support by community care coalition programming. By forwarding

community care coalition to focus on changing norms that predispose HIV/AIDS patients, this study has addressed the research questions stated.

1.7. Definition of Terms

- **Community Care Coalition:** refers to groups of individuals and/or organizations at the local level that join together for common purpose of expanding, coordinating and enhancing care for most vulnerable children in communities (Caitlin, Medley, Michael, & Kevin, 2010).
- **Community Care**: is providing the services and supports necessary for certain groups of people to be able to live as independently as possible in their own homes or in „homely" setting in the community (Slater, 1994).
- **Community Development:** is the capacity of people to work collectively in addressing their common interests (Henderson and Thomas, 2002).
- **Community:** Refers to a group of people that recognizes itself or is recognized by outsiders as sharing common cultural, religious or other social features, backgrounds and interests, and that forms a collective identity with shared goals.
- **Community-based structure**: Groups of individuals and/or organizations at community level who join together to provide care and protection to vulnerable people. Community-based structures may be initiated by communities or established with support from government or development agencies.
- **Faith-based organization: An** organization formed by people with a common religious belief.
- **Ketena:** The lowest, local government administrative unit in Addis Ababa city.
- **Orphans and vulnerable children:** Children who have been orphaned or affected by

HIV/AIDS (children living with sick parents, children living in highly affected communities, children living without adult care). Vulnerable children also include girls and boys whose rights to care and protection are being violated or who are at risk of those rights being violated. This includes children who are poor, abused, neglected or lacking access to basic services, ill or living with disabilities, as well as children whose parents are ill or in conflict with the law.

- **Psychosocial support:** The ongoing process of meeting people's physical, emotional, psychological, social and mental needs.
- **Referral service**: Is any form of service that needs the collaboration of other organization or individuals for programsthat are not implemented by the coalition due to different factors.
- **Social cash transfers:** Regular and predictable grants, usually in the form of cash, which are provided to vulnerable households and individuals.
- **Social protection:** A set of formal and informal interventions that aim to reduce social and economic risks, vulnerabilities and deprivations. Social protection measures help to ensure those children's and adults' right to an adequate standard of living if fulfilled, and help in the realization of other rights.

CHAPTER TWO

2. Literature Review

2.1. Introduction

The purpose of a literature review is to educate oneself in the topic area and to understand the literature before shaping an argument or justification. According to Minch (2018) a literature review is a piece of academic writing thatincludes current knowledge on a topic, substantive findings, theories and methodological contributions which are secondary sources, and do not report new or original. It is also an experimental work that demonstrate the knowledge of a topic, identify what has been done before andany gaps, provide a background to the enquiry and set out a research agenda, locate the project within current debates and viewpoints, support the study in reviewing and refining the research topic, question or hypothesis, help to analyze the findings, and discuss them with rigor and scholarship.

2.2. Defining community

The formation of CCC's plays an important for the people who are vulnerable and marginalized caused by AIDS. CCC's will share the burden of their community and provide support in order to strength communities' capacity (Goel, 2014). Community is defined in many ways: the earlier and most commonly held meaning of 'community' refers to people living in a place who have face–to-face contact with each other. But with changes in industrialized society, a new society emerged that was more alike to impersonal contact amongst its people. People related with each in formal ways and life was contractual and changed over time as community crossed physical

boundaries of place and people could connect with each other by using technologies and still fulfil most of the functions of the community (Goel, 2014).For communities to function and help their members to achieve their goals, compositional factors that include structural aspects and circumstances for growth such as poverty, crime, housing and environment; and physical location, including both natural and built environment are important(Chaskin, 2009, p. 32).

Community is important in the social, economic, spiritual and political life of human beings, it is far clearer that various functions that are performed by the community have a bearing on the extent of well-being and disadvantage experienced by its members. Communities through identification and symbolic things provide a sense of belongingness to their people. Human beings associate and form relationships with each other based on shared identity of place, class, race, ethnicity, cultural heritage and various other mechanisms that help form these identities.

This sense of belongingness connects people with each other and builds social capital that is referred to as relationships based on mutuality, trust and cooperation. A sense of belongingness opens up possibilities of establishing connections, networks and generating solidarity. This formation of social capital can be both inclusive and exclusive of marginalized and disadvantaged communities(Goel, 2014).

2.3. Community Care Coalition

A community care coalition is a community-based structure, recognized within the National Social Protection Policy. The National Social Protection Policy describes a CCC as a coalition of community activities that represents different parts of the society, and involves volunteers working to solve and alleviate social and economic problems in their areas. Its primary function

is to act as a hub for community leaders to identify, refer, and monitor support to vulnerable populations. This can include but is not limited to the provision of cash grants, enrollment in social service programs, and home visitations by community-based volunteers or para-social workers. CCCs are established by the government and supported with regulations issued by the Regional Government Council. CCCs are present at *ketena* and woreda levels. CCCs are designed to address vulnerability of all populations, including children, but also the extremely poor, disabled, and the labor constrained (Bunkers and Andrew, 2017)

According to Mezgebu, (2007), when societies face different crises and challenges they have their own way to manage and solve their disasters faced by their members in traditional society. One way of managing these destitution, illness and death of members is to support with each other during times. Butterfoss and Kegler, (2002) defines community care coalition as group of individuals representing diverse organization, factions or constituencies within a community who agree to work together to achieve a common goal. Others define community coalition as a group that involve multiple sectors of the community, and who comes together to address community needs and solve community problems (Wolf, 2000).

Community care coalitions are groups of individuals and/or organizations at local level that join together for common purpose of expanding and enhancing care for most vulnerable children and People living with HIV/AIDS in communities.

Community care coalitions include heads of churches, volunteers, the government, businesses, NGOs and CBOs providing material, financial and physical support at local level (Caitlin, et al, 2010).

Community coalition is different from other forms of coalitions. Community coalitions are composed of community members focusing mainly on local issues than national issues, addresses community needs, builds community assets, and helps resolve community problems through collaboration (Wolf, 2000). According to him, it is community wide and has representatives from community multiple sectors, works on multiple issues, is citizen influenced if not necessarily citizen driven and is long term not ad hock coalition.

2.3.1 Coalition Building

Successful coalition building has the following four basic components; condition, commitment, contributions and competence (Mizrahi & Rosenthal, 2001). First there must be political, economic and community conditions that must be right for coalition to form and develop. Second, there must be a core group of people representing different organization with a commitment to the coalition model as away to achieve the goal. Third, coalition must be able to obtain the necessary contribution (ideology, power and resource) from among the members to reach the goal and fourthly, a coalition must have at the same time the competence to move towards the social change goal, maintain the coalition leadership core and sustain its membership base.

The major conditions affecting coalition formation are political and economic realities, the type and level of resource possessed by organizations, community climate and past experience with alliances, the silence and urgency of social change goal, the timing of coalescence and actions and the feasibility of winning. Money, authority, distribution of resource and power, group origin, auspice and tasks are factors governing coalition formation, behavior and outcome (Mizrahi & Rosenthal, 2001). This indicates the reciprocal reaction of different factors in coalition building.

Commitment is usually understood as part of the dichotomy between self- interest and altruism, or between pragmatism and ideology. The pragmatic base of coalition formation is usually categorized as a quest for resource and power, whereas the ideological base of coalition formation are specific value based commitment. This in turn causes the general concept of public interest or the common good (Rosenthal &Mizrahi, 1994). Leadership which is the analytical and interactional skills needed to make a coalition work in an independent factor in coalition building.

The complexity of social change coalition leadership is based on having to manage three critical levels simultaneously, (1) sustaining movement towards external goal by influencing social change targets, (2) maintaining the organizational linkage among core coalition representatives, (3) developing thrust with, accountability to and contributions from coalition membership base (Rosenthal & Mizrahi, 1994). As intangible asset, leadership played critical role in coalition building. A variety of contributions are needed from participating organizations and other sources to form and maintain social change coalition. Three types of contributions benefit coalitions; resource, ideology and power. Resource can be tangible and intangible aspects like, staffing, funding, information and contacts supporting the coalition building process. Organizations with ideology contribute broader leadership, set tone for interaction and decision making. Coalition form collective power necessary to influence external target and achieve their goals (Mizrahi & Rosenthal 2001).

Mizrahi and Rosenthal (2001) on their research entitled "*complexities of coalition building: leader's success, strategies and struggles and solutions"* revealed that the need for organizations and agencies to join forces to revitalize their communities and create opportunities to influence larger social agendas. In between single issue organizations, social movement stand social change coalitions and the possibility of cultivating and deepening working relationship among diverse groups. For this to occur, coalition building must be viewed as increasing the possibilities, an investment of time and effort well worth the costs in terms of organizational benefits and external outcomes. Their finding

still affirms that sophisticated and experienced leaders are necessary for sustaining and using coalition as vehicles for community improvement and social change.

2.3.2. Coalition Structure, Focus and Role

CCCs have diverse structures that vary according to context, including incorporation into government structures, and diverse membership compositions, ranging from small and predetermined membership to very big and open community organizations. CCCs received various technical and organizational training, while follow-ups varied between sites. Organizational capacity varies to a great extent, ranging from simple organizational structures to more complex and sophisticated forms, including multiple grant managing community-based organizations. Support by CCC's is predominantly provided through home visits, care, and material, financial and labor contributions. Support is also given through advocacy work, sensitization on child protection issues and health education. Most have income-generating activities, but have difficulties in mobilizing resources from within their communities (World Vision, 2012).

For World Vision the CCCs are mainly an MVC (most vulnerable children) response, a link to communities and a means for monitoring, mobilizing and targeting child well-being. Generally speaking, they have become an integral part of World Vision community programming. For government officers, CCCs distribute and collect information and provide an extension of service to communities. In places where CCCs are incorporated into the government institutions, they are the official community-level structures. Impact on child well-being and child protection Children can live in difficult situations where their rights are at risk, and guardians are at times not able to fully care for them. CCCs actively support guardians to care for, protect and support

children. Still there are challenges in child protection, which are due to the limits of possible interventions of CCC members. Child participation in CCCs and communities varies, but is rather low in general. The overall levels of reported well-being of youth and children were moderate, although they increased due to home visits of CCC members (World Vision, 2012).

2.3.3. Coalition Capacity Building

After forming a coalition, a critical factor vital for coalition functioning indicating the failure and success of coalition depends on the level of capacity building. Capacity building according to Miller (1987), on his study of entrepreneurship as a community coalition approach to health care reform was linked to using capacity building efforts to regional and national networking of community entrepreneurial initiatives to accelerate both local innovation and national reforms with in communities. Capacity building is necessary for changing the mind setting of members in working with different issues of coalition. Discrepancy between aggregated aspiration level for communities and their capabilities of the opportunity structure leads to discrepancies. Communities that care coalitions with greater organizational linkages, and to a lesser extent, coalitions whose members acquired more new skills were more successful in achieving community wide adoption of a scientific prevention approach. Coalitions with greater organizational linkage and who gained new skills are successful in program implementation (Valerie, 2014). These empirical evidences explicitly indicate the necessity of capacity building in coalition and how it creates difference between those with capacity building efforts and those without.

Capacity building, according to Sanchez, Sanders, Andrews, Hale & Carrillo (2014) was linked with the length of time. Their finding states the presence of an association between length

of membership and decision making, positive leadership and shared vision. Long term coalition members were significantly more likely to report greater agreement with the quality and process of decision making than those with ten or fewer years. The relationship between length of membership and positive leadership may also indicate a relationship between length of membership and greater control over decision making. Long term members were also significantly more likely to report characteristics of positive leadership, including getting things done, seeking others views, consensus for decision making and working with others.

2.3.4. Effectiveness of Coalition

According to Edward (2006) effectiveness of coalition can be determined by two general indicators which are internal coalition functioning and external community changes. Internal coalition functioning measures how well coalitionbuilding actions have been executed, such as size of membership, amount of resources generated, or quality of strategic plans. External community-level changes measures results from strategic actions implemented by coalitions, such as reductions in mortality, morbidity, injury, or risky health behaviors. Although community-level changes are the ultimate indicators of coalition effectiveness, measures of coalition functioning may be plausible substitutes, as it may be that coalitions with high internal functioning have a greater chance of achieving external outcomes.

Two other types of research may provide insight on which coalition-building factors are essential ingredients for creating effective coalitions: (1) experimental designs testing whether coalitions affect community level changes; and (2) individual case studies explicating lessons learned about how to build effective coalitions. Experimental studies examining whether coalitions influence external outcomes, such as reductions in community-wide rates of mortality, morbidity, injury,

or risky health behaviors, have produced mixed findings. Case studies examining a single community coalition either with a comparison site, or without have reported modest positive effect (Edward, 2006).

Other evaluative research conducted by Butterfoss (2006) on process evaluation for community participation and its intermediary role in health and social change outcomes indicated that coalitions often recruit less diverse partners than desired with higher proportion of females, middle age and minority race professionals. Perhaps the focus should be achieving substantive representation, where members are selected by and accountable to community interests. As per this finding, measurements of process indicators alone are insufficient and researchers and evaluators must learn innovative ways to tie process evaluation to intermediate and long term goal attainment.

This indicates the necessity for recruitment and diversity of coalition members and necessity of linking process and outcome indicators for coalition's long term goal attainment for effectiveness.

2.4. Community Core Coalition model

The Community Care Coalition (CCC) according to World Vision (2010), project model is the foundational community structure for supporting various possible types of programming to ensure sustained child well-being for the most vulnerable boys and girls at the local level. The CCC project model, originally part of World Vision's Ethiopia initiative, seeks to strengthen community-led care and support for orphans and vulnerable children (OVCs). CCCs are formed by joining key community stakeholders into a coalition to identify OVC related issues and to

support PLWHA within the community and to develop and prioritize action plans for responding to these issues. CCCs normally recruit and supervise home visitors, who are trained by WV staff, to make visits to the homes of OVC and to provide essential forms of care and support.

The CCC project model may work with community groups mobilized by World Vision as well as pre-existing groups that World Vision may work with and through. The CCC model may be adopted as a foundation for other types of programming options. For example, CCCs could support a community health worker (CHW) project aimed at bringing Timed and Targeted Counselling (TTC) around health and nutrition messages into households. The project model's goal is to achieve improved quality of life for the most vulnerable boys and girls in a community. CCC has at least three project models which are, mobilizing and strengthening of a community-led response to protect and care for the most vulnerable children and their families, improving community capacity to secure resources for the care and support of OVC, and improving the coordination, collaboration, and advocacy of the community in which OVC live (World Vision, 2010).

2.5. The CCC programming approach

The Community Care Coalition was started from the mid-2000s by World Vision to mobilize and strengthen community-led care for vulnerable children and remains a formative approach to World Vision's community-based and transformational development. The idea was to, ideally, identify existing coordination mechanisms or CBOs supporting vulnerable children and strengthen their capacity to: coordinate, monitor and report on orphans and vulnerable children care, and HIV prevention activities in their area; identify and register orphans and vulnerable

children, chronically ill adults and volunteer caregivers; advocate for orphans and vulnerable children and raise resources for meeting identified needs of orphans and vulnerable children (World Vision CCC status report, 2012).

2.6. Values of CCCs (MOLSA, 2018)

According to MOLSA(2018), national implementation guidelines there are ten values of community care coalitions that should be implemented these are

Accountability: Being responsible for actions taken or not taken; being able to explain, clarify and justify actions/inactions to relevant others.

Cooperation: The act or process of working together to the same end; collaboration; joint action; teamwork; combined effort.

Development of saving habits: Cutting back on expenses and setting aside some money and other resources; budgeting oneself and keeping some money for the future needs.

Gender equality: Situation in which access to rights or opportunities are not affected by gender (being male or female); equal/same or similar access to resources such as economic participation and decision making regardless of gender.

Humanity/Humanness: Kindness; compassion; being sympathetic; charity and generosity; benevolence.

Inclusiveness: The quality of including many different types of people and treating them all fairly (irrespective of ethnicity, ability, religion, language, etc.).

Impartiality: Equal treatment of all persons irrespective of differences in gender religion, ethnic group, etc.; not prejudiced towards or against any person; basing judgments /decisions on objective criteria.

Participation: Consultation in decision making, goal setting, planning, etc.; information sharing and being involved.

Transparency: Being open to public scrutiny; provision of access to full information; being open, honest, and easily seen through.

Trustworthiness: Being honest or truthful; being reliable; worthy of confidence and being dependable.

2.7. Administration of services provided by CCC

2.7.1 Eligibility screening

Each CCC, which provides service, shall follow tailored eligibility criteria. Standardized tools should be developed for the evaluation and assessment of eligibility based on the criteria. The assessment tool should be adapted to reflect the needs of the community depending on the realities of each community.Identification criteria of the most vulnerable should be agreed upon by the community and later documented for wider sharing within the community through churches, mosques, other local institutions like *Idir, Iquib*, and community gatherings. As a first intervention, CCC may collect and organize information by age, gender, type of vulnerability, to help select beneficiaries.The process of selection should be objective, fair, transparent, relevant, and consistent across CCC programs. The woredalevel Community Care Coalition under the auspices of the woredaadministration administers the selection process.

2.7.2 Eligibility Criteria

The following shall be the criteria to be used for selection of beneficiaries.

1. Permanent membership of a particular woreda. In case of children, their parents/guardians should be permanent residents.
2. Individual/household vulnerability to risk.
3. Absence/lack of other support systems
4. Availability of resources under the CCC's mandate
5. Interest of the beneficiary to receive support from CCC

2.8. Services provided by CCC (MOLSA, 2018)

- **Identification and Selection/Screening -** Identification and selection/ screening of beneficiaries is one of the fundamental tasks of Community care coalition structure.
- **Education and Awareness Creation -** In addition to creating awareness among community members, educating beneficiaries and increasing their awareness level about CCCs and the need for assistance/contribution to the respective community would be done.
- **Resource mobilization** is one of the critical activities of the Community Care Coalition Structure. Resources, including money, labor, material, and people that can respond to the problem of the community are critical for the sustainability of CCCs. In mobilizing resources, CCC members focus on mobilizations of funds and materials. Such endeavors may vary from one CCC to another depending on their scope, regional and local situations.
- **Mobilization of funds:** Lack of enough finance is a major challenge for the effectiveness of CCCs. As such, community-based structures struggle to raise adequate finance to effectively support their activity. CCC members are expected to collect membership fees as one means of finance. CCCs are expected to look for financial support from different actors, including government and non-government organization, UN agencies and other donors. In addition to that, CCCs are expected to raise fund from community members, by organizing fundraising events, and generating income from small businesses (mills, selling of handicrafts).
- **Mobilization of material support:** Some CCCs have managed to gain the support of local authorities who have provided them with offices and working spaces. For the successful

implementation of their day to day activities CCCs are expected to get material support, including office spaces and office materials. CCCs are expected to collect grain, household items, building materials and other materials from the community and local businesses.

- **Mobilization of people:** CCCs could work effectively when they are made up of committed male and female volunteers. From different sectors, CCC members are expected to rally people who have the energy and passion to support vulnerable people and are ready to donate their time.

2.9. Role of Community Care Coalitions

Baldock (1983) on his research on community care rhetoric and action, has stated that action taken on community care is much more than deinstitutionalization, which indeed does not in itself abolish the institutional type of practices and attitudes. Community care is providing the services and supports necessary for certain groups of people to be able to live as independentlyas possible in their own homes or in homely setting in the community. Community care is helping people to organize for community activity. Community workers should not be so elitist about community care and social workers should not think of it as an easy task for organizing volunteers for social service development.

In Baldock's view, the growing interest in community care, a care provided by a community by ordinary peoples rather than in the community by professional staff, dominated social policy thinking from the early 1960s and provided the impetus for the boom in community development in social services department in 1970s (Baldock, 1983). He puts forward four arguments. First, community care is a valuable activity in itself. The criticism that community care lets statutory

authorities off their responsibilities is too simplistic. Volunteer help cannot replace statutory service, it must be controlled and directed by local people rather than professional and seen as a greater means of participation and involvement rather than an end in itself. Secondly, community care strengthens other community initiatives. Mutual aid or community assistance is a key activity for many community groups.

Thirdly community care provides a base for political or pressure groups actions as relatively uncontroversial form of practical activity that has a wide appeal. Fourthly, (Baldock, 1983) defined community care as voluntary welfare work carried out by community groups. Community care in pressure groups refers to people's involvement in the community care of children, physically handicapped and the elderly.

Community care is helping groups to organize, analyze the strength and needs of the area, promoting participation and encouraging groups to grow and change. He finally concluded that separating the two (Community care and community work) strive community care of necessary skills and contributes to an arid elitism on the part of the community work. Development and debate around social work on community care have been prominent since the Barclay committee introduced the notion of community social work. Barclay analysis of the role and task of social work depended up on the notion of community and informal careers who would invariably be female family members (Orme, 1998).

The gender analysis of community care has highlighted that what is required by social work and social care practitioners is recognition of diversity of care experiences. This recognition does not necessarily lead either to the deconstruction of users of the community care in to fragmented identities to which there can be partial response, or to universalizing experiences into categories of care needs which deny individuality. The identification of citizen status for user's ad careers

based on active agency avoids the competing need of users and careers and allows for participation of service planning, responsiveness to service allocation, and opportunities to reform if not to revolutionize the oppressive aspects of community care policy (Orme, 1998).

2.10. Responsibilities of CCC committee members

The implementation of Community care and support activities are undertaken at the community level. The communities' way of living, practices and norms play a vital role in the successful implementation of CCC services at the community level. The leadership and composition of the CCC Committee are also a critical component. For the sake of successful implementation of CCC services at the community level, helpful strategies must be developed to facilitate the promotion of effective leadership and the mobilization of the community for action. Community involvement includes the participation of male and female caregivers/providers, PLWHA, health care and social workers, community volunteers, traditional/spiritual healers and other community/ religious leaders, and traditional institution leaders like *Idir*, *Iqub*.

All these stakeholders should be involved at all levels of development, implementation, monitoring and evaluation to make sure that CCCs are operating inefficient and sustainable manner.

The key roles and responsibilities of the service provider at the community level are the following:

• Identifying who needs care and referring when necessary;

• Providing the necessary support, including physical, nursing, material, emotional and spiritual care;

•Providing support to the needy without discrimination;

• Providing education for PLWHA and caregivers;

• Establishing partnership with all service providers (private and public) at the community level;

• Communicating effectively with the woredaand within the community; and

• Attending community level coordination meetings; and

• Mobilizing resources through innovative strategies to sustain the CCC programme.

As much as possible CCC members need to get access to capacity building in the form of training, mentoring, field visits, and some provision of resources. A regular training on leadership and human resource management is mandatory. Gender has to be mainstreamed in the composition of leadership and in the day to day activity of CCC members.

Implementation of Community based cash transfer

Community-based cash transfer is the major source of finance for each CCC. However, the capacity of each CCC in different woredas variesbased on the amount of cash raised from each community. Therefore, each woreda decides on the minimum level of transfer based on the amount of cash and material they raise. The delivery mechanism is through a local microfinance institution, which has no targeting function. However, households with multiple vulnerability and those with large number of vulnerable family members are given priority.

Referral services

After identifying vulnerable beneficiaries the coalition is expected to provide the necessary services starting from cash transfer, facilitating access to education, and provision of free health ID card, providing capacity building for their families. Whenever referral service is needed CCC may refer the case to related stakeholders.

The first component of referralservicewhere CCCrefers their vulnerable children and households is Governmental Organizations**.** This type of referral service refers to a referral made by CCCs to support poor children and their families. Sectors referred by CCCs for this component refers to forefront child right sectors like Bureau of Labor and Social Affairs, Bureau of Women and Children Affairs, Police Commission, Bureau of Justice, Health Bureau and Education Bureau, and government Schools.

The second component of referral service where CCCs refer their vulnerable children and households is to civil society organizations. Civil society organizations in this context can be nongovernmental organizations, which are bilateral, trilateral, or United Nations Agencies who are working closely with community care coalition on child protection and community development programs. The third component of referral service CCCs are delivering is to private organizations in the locality that are assumed to have the capacity to support the referral.Whenever it is possible and depending on the case, CCCs are expected to refer children and other beneficiaries to the above-mentioned service providers (MOLSA. 2017 pp. 11-13).

2.11. Challenges and Sustainability Issues of CCC's

General challenges for CCCs are long distances, lack of financial resources, identifying partners, proposal writing, and financial management. Plus home visitors can be in need themselves. There can also be confusion about sponsorship work and voluntarism, and the rather low commitment of government representatives. World Vision needs to be careful to not overburden volunteers, and certain documents like monitoring forms would be more helpful in local languages. High staff turnover within World Vision and the government is challenging to establish good working relationships. World Vision and other NGOs need to better harmonize their activities. Ownership for activities can be low, while legal registration of the groups can enhance it. Voluntarism and commitment are generally high, and drop-outs usually occur in the early stages and due to unmet expectations. Appreciation is important to encourage volunteers. Organizational capacity building training is not fully implemented in all countries and there are some capacity gaps. Links between CCCs and other structures vary in quality and are highly dependent on the local institutional context (World Vision CCC status report, 2012).

2.12. Legal Framework for CCCs

Ministry of labor and social affairs (2018) has developed a legal framework that goes beyond regulation which is mandatory in all regions. The legal framework would vary from region to region depending on respective socioeconomic and cultural situations. However, the overarching legal framework will be within the NSPP, regional proclamation regarding the CCCs and the respective Implementation Guideline.

The legal framework shall serve as a base for the establishment and operation of CCC, human resource structure of the Woreda CCC, technical support from the woreda, governance

administrative structure, and administration of services, coordination, beneficiary data management, resources mobilization, financial management, monitoring and evaluation. Furthermore, the legal framework will lay down a mechanism through which vulnerable people get the required legal support, equal chance of employment opportunities, social insurance and financial and material support.

In order to enable CCCs become operational under a legal environment, the following legal actions need to be taken. (1) All regional states develop regulations that provide legal mandates for CCCs to operate under the general socio-economic development framework of the region and the country. (2) those regions with established regulations need to update the contents of their regulations to address gaps that hinder the operation of CCCs as independent community structures. (3) the federal government needs to establish and enact a national regulation for the establishment of CCCs. (4) both federal level regulation and regional level regulations require to clearly articulate the mandates, responsibilities, accountabilities and major activities to be shouldered by CCCs.

2.13. People Infected with HIV/AIDS

According to National Guidelines for Comprehensive HIV Prevention, Care and Treatment (2017 p.1), the first evidence of HIV epidemic in Ethiopia was detected in 1984. Since then, AIDS has claimed the lives of millions and has left behind hundreds of thousands of orphans. The government of Ethiopia took several steps in preventing further disease spread, and in increasing accessibility to HIV care, treatment and support for persons living with HIV. According to single point HIV related estimates and projections for Ethiopia 2014 the national

HIV prevalence is 1.14%. The recent 2011 EDHS shown that the urban prevalence is 4.2% which is seven times higher than that of the rural (0.6%). The 2011 EDHS also shows that the HIV prevalence varies from region to region ranging from 0.9% in SNNPR to 6.5% in Gambela. Furthermore, the HIV related estimates and projections indicate that the 2013 HIV prevalence in regions ranges from 0.8% to 5.8%. Currently there are 367000 adults and 23400 children under the age of 15 are taking ARV. Based on the 2014 estimate the 2014 ART need is 542 121for adults and 178500 for children under 15 years of age.

The HIV/AIDS situation in Ethiopia continues to be characterized by a lowintensity, mixed epidemic with significant heterogeneity across geographic areas and defined by independent self -sustaining HIV transmission streams within KP, PP, and general populations. Per spectrum preliminary estimate by PEPFAR, January 2017, adult HIV prevalence in Ethiopia in 2016 was estimated to be 1.1%. There is substantial prevalence variation by region (6.6% in Gambella, 5.0% in Addis Ababa, and 0.7% in Southern Nations, Nationalities and Peoples' (SNNPR) region). The HIV epidemic in Ethiopia is primarily associated with areas of urban concentration (5.1% in cities above 50 thousand compared to 3.1% in smaller cities and 0.6% in rural areas) and proximity to major transport corridors.

Those living within five kilometers of a major road have HIV prevalence rates that are four times higher than those who live further away. The two exceptions to this general pattern include Gambella region, a small and sparsely populated region that has the highest regional prevalence in Ethiopia (6.4%) and little distinction between urban and rural prevalence, and development schemes and seasonal migrant destinations that show elevated HIVrelated risk behaviorsdespite not being close to urban areas or major roads. Another defining feature of the Ethiopian HIV epidemic is the pattern of steep and steady declines in antenatal care clinic (ANC) prevalence by

as much as 60% since 2005 when PEPFAR and the Millennium AIDS Campaign signaled the start of a robust and successful national response (PEPFAR Country Regional/Operational Plan, Ethiopia, 2017).

CHAPTER THREE

3. Research Methodology

3.1. Introduction

Under this heading the research approach, research design, research method and methods of data collection are presented.

3.2 Research approach

The researcher used a qualitative research approach to make qualitative observations, analyses and interpretations of the issues under investigation. Qualitative research study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them that seeks to understand phenomena in context-specific settings, such as "real world setting where the researcher does not attempt to manipulate the phenomenon of interest" (Patton, 2002: 39). Patton (2002), elaborate on the concept of qualitative research and assert that qualitative research means "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification. He added that qualitative research usually emphasizes words rather than quantification in the collection and analyses of data. The researcher has employed a qualitative approach because the phenomenon under investigation involves the participant’s experiences, opinions and views that cannot be adequately quantified in numerical terms.

3.3. Study area and target population

The study was conducted in Addis Ababa city KolfeKeranyo sub city Woreda 12 Community called Keranyo. KolfeKeranyo is one of the ten sub cities in Addis Ababa and Woreda 12 is one of sub administrative area in the sub city. KolfeKeranyoWoreda 12 is located on the western part of Addis Ababa located at about 9.6km from the center of the city (CSA Report, 2007). Regardless of government's and others efforts, Keraniyo area population remains in the worst situation of poverty. Socio economically, the area is populated by the poorest of poor.

According to Jupp (2006:265), population refers to the group of people or the unit of analysis which is the focus of the study. Further elaborates on the concept population and states that a population is the entire collection of entities one seeks to understand or, more formally, about which one seek to draw an inference.

The population of this study is defined as all social workers rendering Community Care Coalition services in KolfeKeranyo sub city Woreda 12whose responsibilities (as part of their job descriptions) require them to establish and maintain workplace support groups for people living with HIV and AIDS, line sector representatives from World Vision Ethiopia who have the knowledge on the study and are willing to participate.Due to time and money constraints, the whole population of social workers rendering community care coalition services was not included in the study and the researcher has had to draw a sample.

3.4. Research design

A research design is defined as "the structure or the blueprint of research that guides the process of research from the formulation of the research questions to reporting the research findings"

(Kalaian, 2008:724). According to Patton, (2002), a research design provides the framework for the research process involving the collection of analysis and data. For the purpose of this research, the researcher employed an explorative, descriptive and contextual research design.An explorative design was employed because the subject under investigation is a relatively unknown area of research in the context of this study.

The descriptive research design was employed as one of the researcher's objectives because it describes the role and challenge of community care coalition services faced by the participants in establishing and maintaining workplace support groups for people living with HIV and AIDS inKolfeKeranio sub city woreda 12. Contextual design was used because the researcher has intended to study the phenomenon from the context in which it occurs, i.e. the workplace of the participant.

3.5. Sampling and sample size

A sample, to quote Bryman (2012:187) refers to "the segment of a population that is selected for investigation". For the purpose of selecting a sample from the population, the researcher employed purposive samplingto draw a sample of social workers rendering community care coalition services who were then interviewed. A small number of participants are normally included in a qualitative study, as "the depth of information and variation in experiences are of interest" (Hennink et al., 2011:84). This reference to "depth of information" requires from the researcher to go and look for participants with specific characteristics enabling them to best inform the research topic under investigation.

Based on this, qualitative researchers opt for "purposive recruitment" - This method of recruitment of participants from the population (as sample) to be included in the study, is

according to Hennink et al. (2011:85) “both deliberate and flexible. It is deliberate, as the name suggests, by selecting ‘on purpose’ people who are ‘information-rich’ on the study topic. Purposive recruitment is also flexible, as researchers can refine the types of participants selected during data collection, rather than following a rigid recruitment procedure from the outset”.

The researcher used the following criteria to select participants for inclusion in the study:

- Social workers rendering community care coalition services who are employee of Women and Children’s Affair Office
- Social workers rendering community care coalitionservices that as part of their job description have the responsibility to establish and maintain workplace support groups for people living with HIV and AIDS.
- Social workers who are willing and available to participate in the study.

In this study, a total number of eight participants were interviewed. This specific samplesize was not determined at the beginning of the research. The researcher collected the data until it reached the point of saturation, where no new data surfaced. This means for this particular study the researcher learned that the information collected are enough to analyze the study. According to Terre Blanche et al. (2006:372), saturation refers to the condition of an interpretive account where the account is richly fed by the material that has been collected, at least to the point where the researcher is able to say “I have thoroughly explored the data and have acquired a satisfactory sense of what is going on”.The researcher collected data from three people living with HIV/AIDS, eight vulnerable children whose age is between 14-18, five community care coalition chair persons, two representatives from Ministry of Labor and Social Affairs and two from Ministry of Women and Children Affairs. The two FGDs constituted five and six

participants for community care coalition representatives and vulnerable children. All interviews were conducted in participant's workplaces, and interviews lasted approximately 45 minutes each.

3.6. Method of data collection

Under this heading the following aspects are discussed: semi-structured interviews as the chosen method of data collection, the preparation of the participants for data collection, the interviewing-skills.

3.6.1. Semi-structured interview as chosen method of data collection

The method of data collection employed in this research was that of semi-structured interviewswith the aid of an interview-guide. According to Diccico – Bloom et al., cited in De Vos at et al. (2011:348), semi-structured interviews are defined as "interviews organized around areas of particular interest, while still allowing considerable flexibility in scope and depth".

An interview-guide is a guide that summarizes the content that researchers cover during interviews. Interview-guides involve a list of topics and aspects of these topics (not specific questions) which have a bearing on the given theme and which the interviewer should bring up during the course of the interview. Although all participants are asked the same questions, the interviewer may adapt the formulation, including the terminology, to fit the background and educational level of the respondents (Huysamen 1994:145). All interviews were conducted in Amharic. The researcher has used audio recording devices to capture all interviews, with the consent of social workers rendering community care coalitionservices.

3.6.2 The preparation of participants for the process of data collection

In preparing participants for the process of data collection, the researcher applied the following steps for preparation as suggested by McNamara, cited in Turner (2010:757): choose a setting with as few distractions as possible, explain the purpose of the interview, address terms of confidentiality, explain the format of interview, indicate how long the interview usually takes and make contact details available to the participants should they require them later. In addition to these steps, the researcher also addressed the issue of informed consent and voluntary participation by inviting and motivating participants to take part in the study and requesting volunteers to sign informed consent forms.

3.6.3 Interviewing skills

For the purpose of this research undertaking, the researcher has used the interviewing skills as outlined by Sidman, cited in Terre Blanche et al. (2006:299): listen more and talk less, follow-up on what the participant says, ask questions when clarity is needed, ask to hear more about a subject, explore, avoid leading questions, ask open-ended questions which do not presume an answer, follow-up and do not interrupt, keep participants focused and ask for concrete details, ask participants to rephrase or reconstruct responses, do not reinforce participant responses, tolerate silence and allow the interviewee to be thoughtful.

3.7. Method of data analysis

Data analysis forms a critical part of qualitative research. Babbie (2010:394) defines qualitative analysis as “the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships”. Data analysis is an integral part of qualitative research and constitutes an essential stepping-stone towards both gathering data and linking one’s findings with higher order concepts. There are many variants of qualitative research involving many forms of data analysis, including interview transcripts, field notes, conversational analysis and visual data, whether photographs, film, or observations of internet occurrences (Van Den Hoonaard and Van Den Hoonaard 2008:186).

After the data is collected using interview and document analysis, the raw data is analyzed by trying to represent fairly or without the bias of the researcher and communicate what was gathered. Patton stresses that developing some manageable classification or coding is the first step of analysis. Data analysisencompassesclassifying, coding, categorizing, classifying, and labeling the primary patterns in the data (Patton 2002). Creswell (2012) also underlines that for data analysis we first need to organize all the data that are collected from field into computer file. The second task is to transcribe the data that are gathered from interviews and audiotapes into text data. Then organize the data and consider whether we need more data.While conducting qualitative research the interpretation should begin with clarifying meanings. This has helped the researcher to interpret and report reliable data by balancing between the data collected and the understanding the researcher has. The researcher has followed these processes of analysis such as writing the raw data into computer, organizing coding, conceptualizing the data, connecting and interrelating the data, interpreting, and providing meaning for the data.

3.8. Limitation of the Study

This study has used qualitative research methods with exploratory nature which intensively focus on exploring the roles and challenges of community care coalition in providing support to people living with HIV/AIDS by focusing on limited number of participants who lives in KolfeKeraniyo sub city woreda 12 without statistical representation. Hence, this study would not represent all the community care coalition roles and challenges all over the country.

3.9. Ethical Consideration

A fundamental ethical principle of social work research is never to coerce anyone into participating; participation must be voluntarily (Krueger and Neuman, 2006). In conducting this study, ethical standards is expected to be followed by social work researcher in National Association of Social Work Code of Ethics relevant to the nature of the study were utmost be respected. The core ethical issues in the profession of social work like respecting the autonomy, the beneficence of the participants and justices were ensured in the study.

This was strengthened by code of ethics of article 5.2 of NASW by saying “Social workers engaged in research should ensure the anonymity or confidentiality of participants of the data obtained, should inform participants of any limits of confidentiality and the measures that will be taken to ensure confidentiality”.

Being guided by this code of ethics, the basic purposes and importance of the study was explained for participants and informed consent was obtained from each of them in written form. Researchers would protect privacy by not disclosing the participantś' that their identity will not be disclosed and their views would never be revealed by their name to any body and except for

the sake of the study purpose (Krueger &Neuman, 2006). The privacy of participants was maintained; they were informed that whatever information they provide was kept anonymous. For protecting participants from harm, false names and codes were assigned and data shared to the researcher at any point was reported in these assigned names. So, anonymity of information was strongly maintained in the whole process of the investigation by the researcher.

CHAPTER FOUR

4. Data Presentation, Analysis and Interpretation

4.1. Introduction

This chapter is divided in to four major themes based on the emerged codes and categories of the data. The first theme explains the roles played by community care coalition, which presents seven packages of services: economic strengthening, health support, educational support, counseling service, prevention and responding to the people living with HIV/AIDS and capacity building service.

The second part is concerned with the major strategies employed by community care coalition like training and advocacy, resource mobilization and data collection, organizing and documentation services. The third theme of the data presentation was concerned about the major challenges encountered by community care coalitions during the delivery of child protection service. These challenges are turnover in community care coalition chairs, structural challenge, financial, and professional challenge.

The forth part presented components of service sustainability of community care coalition program. This are focusing on local resource, knowledge, structure, linking of formal and informal actors and planned implementation of community care coalition programming besides analyzing the relationship between community care coalition and traditional support networks based on their purpose of establishment; their scope of operational and legal requirements needed.

4.2. Major Servicesfor people living with HIV/AIDS

4.2.1. Economic Support

Providing economic support is one of the means of service delivered to people with living HIV/AIDS households by community care coalitions at four *ketena* of the community care coalition. Economic support is any form of support given to these people living with HIV/AIDS to support their livelihood and basic needs of children. It is provided in two ways as revolving loan for income generating activities and direct cash support for nutrition and other related supports to them. According to individual interview with KI-5 economic support is the fundamental aspect of family empowerment by either training them business development service with provision of startup capital which it is called seed money to engage in activities of their choice or direct cash transfer for non-productive households supporting children.

> *Economic support is the important program of our office that brought changes on the life of families. We select the poorest people living with HIV/AIDS and give support them so that they can support themselves and their family. (KI-5)*

Economic support has different components. These are direct cash support and rotating loan for income generating activities which are presented as follows.

4.2.1.1. Support with direct cash

This is the first component which is named as economic strengthening to improve child nutrition. Its aims to help the survival of HIV affected poor children and older households who are unable to engage in productive income generating activities. Community care coalition has delivered

270,000 birr to twenty HIV affected households supporting children.This cash support program is most of the time delivered to households in cash and they engage in income generating activity of their willingness such as baking and sellingenjera. In the delivery of this program households with multiple vulnerability and those with large number of vulnerable children are given priority.Most of these beneficiaries are widows and elders living in difficult socioeconomic circumstances.

4.2.1.2 Rotating Loan for Income Generating Activity

The second component of economic strengthening program is revolving loan. Rotating loan is a form of economic strengthening program delivered to revolve among specific segment of vulnerable households under specific boundary (which can be *ketena* or woreda). Delivering revolving loan needs the joint efforts of different but related actors.

First, community care coalition screens household beneficiaries from the list documented by data collection, organizing and documentation work section. Then Ministry of Labor and Social Affairs communicates the source of fund to be notified to the community care coalition according to which the numbers of beneficiaries are determined. The third main actor was the City Micro Finance Office. Minstry of Labor and Social Affairs and Vision Fund Office formalize their agreement with memorandum of understanding and communicate community care coalition. The rotating loan was free from interest and has a time range of two years where the households save some amount of money.

Ministry of Labor and Social Affairs have transferred 596,000 birr to one hundred sixty-fourpoorest of poor households supporting vulnerable children from the budget that gets from different social sector organizations. Each household has received 3040 after taking business

development service training and submitting short business plan on their area of engagement. The beneficiaries have gone to the microfinance office to open saving and loan repayment account in the third quarter of 2019. After reviewing their business plan four thousand one hundred sixty fouris given to each of one of 124 households to start their income generating activity.The probation time for each beneficiary depends on the type of activity they engage.

Basically the activities are grouped into two for the sake of monitoring. The first was petty trade with a probation time of three months with a probation period of six months. Each household should save some amount of money and pay back after probation besides supporting their family. After the end of two years, the saving will be their money, once they finish the loan they will continue their income generating activity with their own saving. The money that is paid back will then revolve to other poor household every two year.

The four *ketenas* has screened twenty seven beneficiaries each constituting a total of one hundred sixty-four beneficiaries. They have started this program in January 2016 and have finished the program by January 2019. As per data from observation and focus group discussion the successful households due to previous experience in income generating activities by their own, progressive supervision of community care coalition and professional support of officers from microfinance and Ministry of labor and social affairs. The households have started supporting children they have, repaired their house and started paying back their loan, taken their saving and started other business of their own.

> *I am one of the persons that have benefitted from the training and rotating money. With the money that I have received I started to bake enjera and sell it. At first it was hard to save money on my saving account because I have to feed my family*

from the income. As I started to get more customers now I have already paid my loan and continued my business on my own. (KI-2)

Small amount of households were not successful due to lack of previous experience and by choosing (Income Generating Activities) IGA which cannot fit with their skills. These households did not brought positive changes to their family life and need profession based support. Community care coalition has started screening second round revolving loan beneficiaries for the next two years. According to the data gained from focused group discussion with female households, revolving loan is very important economic strengthening support that changed the family life. After training all of them received revolving loan and engaged in baking *Enjera*, sale of *coffee*, sale of hot drinks and pity trade as income generating activities. With the income from the IGAs they are supporting their children and family.

4.2.2 Giving Psychological support to PLWHA

According to the data generated from personal interview with KI-2, psychological support for people living with HIV/AIDS and their family is given to assist them to cope better with their illness and improve their lives. According to the key informant interview with KI-1, psychological support is very important support for them besides the financial support and stated that:

Giving more emphasis on psychological support for people living with HIV/AIDS because we believe that it is the most important and strong part of the support that is needed by the people living with HIV/AIDS and their families. We also believe

that giving psychological support for them is not only important to PLWHA but also for the society because it can prevent further transmission of HIV infection.

According to the data obtained from community care coalitions, psychological support is given to PLWHA by going to their home and by taking them to ALERT hospital. In-depth interview participant IIP-3 has indicated its importance and her experience by saying:

I get infected with HIV/AIDS from my partner that I didn't know he was a patient. I was sick and when I went to hospital they told me that I have HIV. I was upset, depressed and was thinking to kill myself. I didn't start the medicine and I was so sick that I couldn't even walk. One day when I was at home waiting for my death and one of the community care coalition member came to my home to visit me. She discussed with me about my situation and she told me that about other PLWHA who lived long life and convinced me to go to hospital. I said Ok and went to ALERT with her and I get the medication and psychological support that changed my life. Look at me, now I am happy and living with my family.

4.2.2.1. Low Awareness regarding HIV/AIDS Psychological Support

Some of the justifications are related to low awareness of implementing coalition on the importance of psychological support of PLWHA. This is clearly viewed on the interview data gained from community care coalition with IIP-4. The participant's justification for low participation was as follows.

We have never thought in this ketena and community care coalition office that psychological support is that much important, and we just focused on the medication

and financial support. Due to this reason, we were not successful in changing the life of some people living with HIV/AIDS permanently despite giving the financial support.

This finding indicated that low awareness was the main factor that challenged working with PLWHA people in changing their life. This low awareness is related with turnover of community care coalition chairs persons, financial and professional challenges. The stated challenges have affected the success of service delivery not only for community care coalitions I the four *ketena*sof kolfekeraniosubcity city administration woreda 12 but also in human service organizations working of community care coalition. The line of future intervention for community care coalitions have to focus on empowering them on how to give psychological support and make sure that how they will take PLWHA where they can get psychological and emotional support.

4.2.2.2. Giving priority topsychological support

Some other community care coalition like community care coalition participants II-3 has different reason for the low level of psychological support. IIP-3 has stated that low level of psychological support in our*ketena*in the issue of priority, not low level of awareness.

In our ketenawe focus on giving immediate financial support by community care coalition to PLWHA so that they can support themselves and their families. As coalition chair person I focus on how to link poor families to get food. But when there are PLWHA who are affected socially, psychologically and spiritually I assume that it is very important to give the psychological support before anything.

The finding of the data indicated that for community care coalitions the most important thing is that they delivering financial resources to PLWHA and change them economically which sometimes fail.

4.2.3. Giving Health Support

One of the many packages of services provided by community care coalition to people living with HIV/AIDS and their families is health service. According to the data gathered form in-depth interview participants IIP-1, health service refers to any form of service ranging from prevention of health problem, facilitating conditions for primary health care and covering health service fee for people living with HIV/AIDS and their poor households.

According to the data gained from community care coalitions, the major coordinator of the service, health service is the major area of intervention where people with HIV/AIDS and their families benefited a lot. According to them health service is divided is to three components. These are health problem prevention, issuing free service ID and financial support for PLWHAand their families.

4.2.3.1. Health Problem Prevention Service

This program refers to preventing the poorest of poor including people living with HIV/AIDS and their children from health problems encountering them. According to the focused group discussion with community care coalition, this program is implemented by community care coalition capacity building and advocacy work section where local para-social workers and the health extension worker are critical service delivering members. Starting from facilitating training planned by Ministry of Labor, Social Affairs, Ministry of Women and Children

Affairs and Health Bureau, capacity building and advocacy team of the community care coalition has annual plan for providing training to poor households on prevention of health service. This type of health problem prevention training is delivered by urban health extension worker in four *ketena* of the town administration where the coalition operates.

Other times, they invite health workers from KolfeKeranio sub city administration and have delivered various trainings on prevention of health problem through sanitation, HIV prevention, proper use of solid west, and adolescent reproductive health.

4.2.3.2. Giving Free Health Service

Community care coalitions are facilitating the delivery of free health service to people living with HIV/AIDS and their poor families. This free health service program has involved major actors. First community care coalition screens people living with HIV/AIDS and poor households by using its data gathering, organizing and documentation work section. After that the community care coalitions requests the Kebele and Ministry of Healthto order hospital and health center to accept and provide free medication for selected poor people living with HIV/AIDS.

The coordinator of community care coalition, Ministry of Labor and Social Affairs receives the list of beneficiaries screened by community care coalitions and issue them free health service identification card besides sending their list to Kolfe health center. The identification card (ID) is issued for two years where the children and the household of this identification card owner receive cost free medication starting from the day they received the card.

One of the PLWHA who received free health survive in Kolfe health center express the health service as follows

> *I am HIV/AIDS patients and I have to get different medication that I couldn't cover myself. The 01 ketena commonly care coalition has issued ID for me and my child to receive medication service via which I always go to hospital. Sometimes I got sick due to different reasons and thank God and for the community care coalition I get treatment freely.*

As the way of accessing health need to PLWHA and their families, community care coalition's free identification card enabled the selected beneficiaries freely access health care. This modestly reduced the pending process in hospitals and health center for receiving the service. This was further due to the order and support given to the Health Bureau and Kebele administration for beneficiaries to get attention in hospital setting for service recipients. The ID card helped them to be treated as emergency program.

4.2.3.3. Financial support for PLWHA and their families

The data gained from FGD with community care coalition has indicated that coalitions are providing and facilitating the provision of financial supports for PLWHA and their families at four *ketenas* levels of Keranio sub city administration. Community care coalition has also facilitated the provision of food support for poor households and their children from the budget that is acquired from different NGO's, individuals and communities by screening appropriate beneficiaries. This program has supported forty eightpoorest households which include people HIV/ AIDS by measuring their caloric intake and weight balance. According

to the data gathered from community care coalition with focused group discussion, if mothers are healthy then children will be healthy so free health service if issued in community care coalition to mothers and their child is important for the healthy living of the family. These beneficiaries receive their medication from Kolfe Health Center. Sometimes community care coalitions facilitate health service by providing transportation cost and support letter. For cases out of the capacity of Kolfe Health Center community care coalition covers medication cost and refers them for medication to ALERT and St. Paulos Hospital. With the training provided to the business community, Ring Road private clinic is providing medication to two children permanently.

In-depth interview participant IIP-3 stated that *We have supported five males and five females with a total of ten students whom their parents lives with HIV/AIDS, educational cost by the resource of community care coalition at SelamBer primary school.*

With regards to health service, supports resourced by civil society organizations in school follows the following medication procedure. During the time of sickness children in school go to hospital or government health center and get treatment. After treatment they bring the slip of the medication cost to the World Vision Ethiopia and which gives them the cash to pay for the hospital or health center. This is made easy by the agreement World Vision Ethiopia has made with hospital to give them treatment without asking them payment first until they bring it from World Vision. One of the beneficiaries testifies how her engagement with SelamBer School helped her to access free health service by expressing her experience as follows:

> *Since my father has died it is challenging for my mother to cover my needs. Due to this reason 01 ketena community care coalition has selected me in SelamBerSchool*

where I receive all services needed. Once up on a time I was sick, my mother brought me to hospital and the result has become typhoid and typhus. We did not pay because my school has agreement with World Vision Ethiopia. Finally, I brought the slip to school and the school gave me money to give back to hospital.

According to the sector interview data, Ministry of Labor and Social Affairs and Ministry of Women and Children Affairs are working with collaborate with the health bureau and World Vision Ethiopia to give health access and treatment for the PLWHA and their children. This is important for families who are poorest and don't have access to get medical assistance and reduce burden of the health centers who give medication freely.

4.2.4. Giving Educational Support

As one separate package of service which community care coalition provide, educational support is the leading service that was demanded by all children irrespective of their socioeconomic status and poverty level. According to the data gathered through personal interview with IIP-4, educational support is the most delivered community care coalition program package and still the most demanded program. This is due to the fact that the study targets even though poorest of the poor are children at the educational age between 12-18 years. The different components of educational support are three. These are educational material support by coalitions, by civil society organizations and educational support through facilitation.

Each of them is presented as follows.

Educational Support provided by Community Care Coalitions refers to any form of support that is directly delivered to poor children for education including children whom are

living with HIV/AIDS or their families are PLWHA. These support ranges from procurement and delivery of educational materials like exercise books, pens, school uniforms, school bags to paying registration free, educational fee and other costs with aim of improving child education. This support basically starts by the screening made by community care coalition data collection, organizing and documentation work section before the start of the academic year. School materials were made available by the finance and property procurement section of community care coalition by communicating with the resource mobilization section. After the school material need and available resources of the coalitions are substantiated, selected amount of children in need are directly given material support, registration and school fee.

Educational support is also provided by Civil Society Organizations (CSOs). Community care coalitions coordinated educational support programs that civil society organization has planned to work with them. This is coordinated based on memorandum of understanding with concerned line sectors like Ministry of Education, Ministry of Labor and Social Affairs and Ministry of Women and Children Affairs. For this program, community care coalition screen children who are supported and then inform to civil society organization.

The support will be made according to the memorandum of understanding. Organizations like World Vision, Fiker Le Hitsanet, Islamic Relief Organization for Social Development are involved in educational program of this provided by civil society organizations.

Sometimes educational supports that are delivered by community care coalition and civil society organization are not enough to send all of those children who are in need of educational material support. Thus, community care coalition is forced to write support letters to schools and organizations who are able to support these children. SelamBer School, EwuketWegane and MesereteEdgetSchool are working closely with community care coalition. They cover all

or part of the school material from resources mobilized by their school. Besides this Ministry of Education, Ministry of Labor and Social Affairs and Women and Children Affairs are financially supporting poor children from their program called individual support program in special need education, developmental social welfare, and child right core process respectively.

The interview data from IIP-4 supports the role of facilitating support letter. Support letter is written to *ketena* business men and women who have the capacity and interest in supporting targeted children. Twenty-five child school uniforms were covered and one t-shirt is given in addition to writing support letter for the schools for the twenty-five children to be accepted without paying registration fee.

Community care coalition has delivered a variety of educational supports to vulnerable children in need of education. According to the data gained through in-depth interview with CIP-4, SelamBer school covers all costs for selected poor children like (1) uniform every September, (2) School feeding three times a day except dinner, (3) exercise book every semester, (4) one pair shoes every year, (5) Christmas gift in every Christmas and (6) 40 birr per month for detergent like soap. These services are given to poorest, orphan or destitute children including whom their parents are PLWHA are selected and referred by community care coalition and accepted by World Vision organization. SelamBer as charity school teaches students from kindergarten one up to grade ten. After they finish grade ten they join other schools around them. Other in-depth interview participant CIP-6 being supported for all her education cost by Selamber primary school has testified the role of support letter to school by saying

> *I have got exercise book this year from Selamber School, with the support letter given to the school by 04 ketena community care coalition. School*

uniform, one pack of exercise book and four pens were given to me, after fulfilling the educational materials am know attending my grade seven class properly.

The data collected from individual interview with IIP-3 indicated that financial support has been given for a total of fifty-three children of which twenty-five are female and twenty-eight are male that progressed to 2018 and 2019. This was delivered with the collaboration of Minitryof Women and Children Affairs and financial support gained from World Vision Ethiopia. Besides this, for twenty eight children living with HIV/AIDS, 50 kilo of teff and twelve killo of grain is delivered by community care coalition.

Other interview data with IIP-1 indicated that twenty-eight children are attending school having received material for schooling. Support letter was written from 01 *ketena* community care coalition which has led to the collection of eleven thousand eight hundred birr for two children at the age of eighteen who joined university but unable to cover their transportation and subsistence cost. These two students who now graduated from university have been supported two thousand and four thousand eight hundred birr for three consecutive years to attend their undergraduate program at Jimma University and Hawasa Universities respectively.

4.2.5. Providing capacity building service

This is a foundation of all community care coalition support package was considered as specific support given to PLWHA, vulnerable children, their families and local

community surrounding their neighborhood. Capacity building refers to a set of capacity development program intended to enhance the capacity of children, family and their local community and sectors to increase their support for the prevention and response of major problems triggering HIV/AIDS. This may include business development service training as capacities building to households for engaging them to income generating activities. The other was HIV/AIDS prevention and traffic accident training given to children at school and short and long term training and experience sharing event made by sectors and community care coalitions.

With regards to community member's community dialogues and short advocacy events are part of capacity building program. Capacity building program delivered by community care coalition and sector offices was divided in to four categories. These are capacity building programs for community care coalition members, for local community, for line sectors and *ketene* leaders under the scope of the *ketena*.

This capacity building program is most important of the time delivered to the planned targets in line with the schedule of annual work plan. Unexpected change in the environment affects effectiveness of this capacity building program. Community care coalitions have delivered various capacity building activities to members of the community including PLWHA. Personal interview participant IIP-4indicated that they have delivered capacity building training four times this year for sector representatives, community care coalition members, *ketena*leaders and local community residents respectively.

Even through community care coalition's communication and referral with local community structures has led to the identification of service gaps and beneficiaries

eligible for intervention, still significant amount of vulnerable children is still out of the service. Strengthening the resource mobilization capacity coupled with referral leakage can lead to the identification of overlooked beneficiaries and service gaps. The center of this was full ownership of high government officials of community care coalition programming for integrated local community development.

4.2.6. Giving Referral Service

Referral service as an important package of service has got the attention of community care coalitions to be facilitated for children and their families in need of service. Referral service is any form of service that needs the collaboration of other organization or individuals for programs that are not implemented by the coalition due to different factors. KI-6 has stated the purpose of referral service in creating linkage between sectors and others which can provide information, training, material support, economic strengthening or other programs with the intention of facilitating supporting PLWHA. Referral service is most of the time made with line sectors and civil society organizations who agreed on the memorandum of understanding.

Generally, the data gained from different sources have indicated that the referral service community care coalitions and line sectors use for support of PLWHA are divided in to three basic categories. These are referral to government organizations, civil society organizations and private organization which are presented as follows.

4.2.6.1. Referral Service to Governmental Organizations

This type of referral service refers to a referee made by community care coalition to support PLWHA and their families to members of community care coalition functioning and their respective city administration and regional sectors who are assumed to have a direct role to the program being referred. Sectors referred by community care coalition for this component refers to forefront child right sectors like Ministry of Labor and Social Affairs, Ministry of Women and Children Affairs, Police Commission, Ministry of Justice, Ministry of Health and Ministry of Education , and government Schools.

The interview data collected from in-depth interview with IIP-3 stipulated that their community care coalition has referred ninety-two vulnerable children from poor household. This referral was made to Kolfe Health Center for free healthcare service, to Bureau of Labor and Social Affairs and Bureau of Women and Children Affairs.

4.2.6.2. Referral Service to Civil Society Organizations

The second component of referral service where community care coalitions refer their vulnerable children and households was to civil society organizations. Civil society organizations in this context can be nongovernmental organizations which are bilateral, trilateral or United Nations Agencies who are working closely with community care coalition on HIV/AIDS and community development programs. According to focus group discussion conducted with the four community care coalitions, the dominant civil society organizations working with community care coalitions are Civil Society Support Program, Save the Children, Islamic Relief, and World vision Ethiopia. The in-depth interview with IIP-4 has indicated that their community care coalition referred twenty

households and twenty children for support of house rent, grain and school material respectively and all of them have received the referred service.

In addition to that, fourteen females and ten males a total of twenty-four children are referred to educational and nutritional support to SelamBer Primary School.

This indicated the vital role and effectiveness of referral program delivered to civil society organizations than referee to governmental and private organizations.

4.2.6.3. Referral Service to Private Organizations

The third component of referral service community care coalitions are delivering is to private organizations in the locality that are assumed to have the capacity to support the referral. According to the data gained form key informant interview with KI-5, referral to private organizations may range from writing support letter for facilitating to directly delivering the referred service to the beneficiary PLWHA and their families.

The participant further continued by stating that individuals especially business men and women are significant in strengthening community based support program for vulnerable children and PLWHA which community care coalitions and line sectors are striving for. In this regards Bureau of Labor and Social Affairs have conducted a recognition and certification program for individuals who have supported finance to the community care coalition's resource mobilization work section and directly to thepoorest families and their children.

The interview with IIP-4 pointed out that the community care coalition service providers are given 360 Birr per month to support and raise a vulnerable child. With this children are being supported and attend their education regularly.

4.2.7. Providing Counseling Service

Counseling was provided by community care coalition to families, children and members of the local community to family who are in different problems. According to the data obtained from interview session, community care coalition provides counseling to many PLWHA. Though there are no trained counselor among the community care coalition, they provide counseling by capacity building section program officers.

The participant further stated that, the most commonly reported issues that needed counseling service are case of when people are told they have HIV/AIDS.

The participant indicated that

> *Usually, people living with HIV/AIDS don't want to be open during counseling time which is important for the counselor to help them. Oftentimes, when they are not willing to talk openly to the community core coalition because of the confidential issues we send them to hospitals to get counseling help.*

The focused group discussion conducted with community care coalition chairs and program officer's strengths this. The participants' shared cases and issues reported to community care coalition at four offices for the respective *ketenas*. This change was the

result of the counseling by community care coalitions, religious leaders, elders and counselors.

4.3. Major Strategies Employed by Community Care Coalitions

According to the data gathered from the community indicates that in the seven categories under the subject major service delivered to the people living with HIV/AIDS and their families are delivered by using the certain group of implementations mechanisms which are considered as strategies. These strategies that are followed by community care coalition are to plan how to help PLWHA, monitor and follow up. They also monitor and evaluate their strategies by discussing, reporting quarterly, annually and bi annually.

The other strategies are presented as follows.

4.3.1. Capacity Building and Advocacy

Community care coalition uses capacity building as one of the major strategies to providing wellbeing service to PLWHA, vulnerable children, families and local communities in impoverished living conditions.

Data gained from the in-depth interview conducted with IIP-2, capacity building and advocacy is the key strategy used for bringing community based support to PLWHA and family wellbeing. Capacity building can be a form of training, community discussion or the use of means for capacitating the understanding of the community.

There are basic services that are given to the community and this capacity building is given to the needy people by concerned key stakeholders to support PLWHA. In doing

so, community care coalition was used as long-lasting system for community development in general and giving support to PLWHA in particular. The capacity building programs are delivered to selected people for making aware. The other part of capacity building was establishment sectors understanding to play an appropriate role in accordance with their organizational mandate to reduce HIV/AIDS program. Capacity building program for key stakeholders from formal organizations is needed for strengthening collaboration with them. It was also proposed to create new thoughtful for key community members about the developing futures of reducing people from infected by HIV/AIDS. Gender focused capacity building efforts are the key ways of changing social norms that predispose women from getting HIV/AIDS.

4.3.2. Mobilizing Resource as a Strategy

Mobilizing resource as a strategy to support PLWHA is the second key component of community care coalition strategy which is measured as the vigorous input critically determining the achievement and disappointment of community care coalition service delivery is the efficiency of meansenlistment effort. According to the data obtained from focused group discussion participants with community care coalitions, community care coalition has started mobilizing local resources from members of the community in cash, in kind, in material and information. To mobilize resource as a strategy is organized by the community care coalition in order to mobilize resource for supporting PLWHA and family in difficult socioeconomic situations.

As per the data gathered by community care coalition IIP-3, recognizing and identifying the organization that have potential to support the coalition and individuals and then conversing with them is important aspect of initiating resource mobilization. This is followed by signing memorandum of understanding for making consensus on the amount and time of the support agreed by community care coalition and supporting actors. Grounded on the focus group discussion with the community data obtained from FGD-1, the resource mobilization work section has planned to mobilize sixteen thousand birr from members of the local community like willing individuals, social institutions such as Idir, Mahibers, Ekub and business organization that are found in the woreda, and locally operating civil society organization. To initiate the involvement of business organization to the support the coalition, credit and accreditation has been conducted in collaboration withMinistry of Labor and Social Affairs.

To mobilization resources is a motivating aspect to initiate the care coalitions in order to efficiently and effectively planand deliver the services. Resource mobilization is not pleadingothers but convincing the one who have more to share with the needy.

Regarding to the in-depth interview data gained from IIP-1, lasts and in effect communication has a role for resource mobilization success. She stated that

> *In our ketena there are different business organizations and individuals who have a potential to support the community. But many after promising to give support after a few times them will change their mind because of many reasons. Many are also not willing to support and don't have a heart to do so.*

Resource mobilization is a very challenging strategy as it directly related with money and financial issues. This is directly related with the community coalition members supporting PLWHA and having power changing lives of the needy and vulnerable children.

4.3.3. Data Collection, Organizing and Documentation as a strategy

Community care coalitions another important strategy is collecting data, organizing and documenting in order to effectively support PLWHA and deliver the service efficiently. This data collection which is conducted on the People Living With HIV/AIDS, vulnerable children and their families who are in need of support of any kind. The first thing is to collect data for get data of the people living with HIV and AIDSand to effectively provide support by community care coalition. Information is the importantmeans that controls intervention by community care coalition by collection, organization and documentation work section. According to the data gathered from individual interview with IIP-1, community care coalitions collect, organize data, type of vulnerability, service received and *ketena* for intervention, support and change the lives of the family.

4.4. Challenges Faced by Community Care Coalition

Providing support for PLWHA by employing the above three strategies by community care coalition is triggered by challenge of different type. These challenges have influenced the effectiveness of community care coalition program intervention at four *ketenas*.

The challenges that are faced by the community care coalitions are areoffice problem, turn over by the leaders and commitment of heads and respective officers. According to the data gained from focused group discussion with community care coalitions, the major challenges that affected support for PLWHA program by community care coalition can be categorized into four groups.These are turnover in community care coalition leaders, lack of office and infrastructural challenge, financial challenge and professional challenge.

Each of the four challenges are presented as follows.

4.4.1. Turnover in Community Care Coalition leader

Community care coalitions are established in the four respective *ketenas* of KolfeKeraniosub cityworeda 12 administration. Before the establishment of the community care coalitions, implementation guideline was developed by Ministry of Labor and Social Affairs by arranging inception worship.

The first major step made to initiate the community care coalition as local level support for PLWHA was delivering continuous training. This was conducted to *Ketenea*administrators, community members, government officials, sector core process owners and officers working on support services. The aim of this training was to raise awareness of key actors and to get the required support during program implementation. With training, workshops and advocacy events, concerned actors have made common understanding and community care coalition have been established.

The establishment was followed by delegating responsibility and assigning chair person, vice chairperson, secretary, accountant, cashier and three work section coordinators. The challenges have clearly become visible after actual program implementation.

After chairing community care coalition for six and seven months, two of the *ketenas* main chair persons have left coalition. Due to this, Bureau of Labor and Social Affairs is forced to shift vice chairperson. After one year the remaining two chair persons from the rest of the two CCCs have left coalition.

After the replacement of the trained coalition official, Bureau of Labour and Social Affairs is again burdened to train the guideline about all coalition programming to the assigned new chair persons. Even through the Bureau arranges the existing and new coming community care coalition officials, turnover in community care coalition chairs remained the bottleneck for coalition program implementation.

4.4.2. Lack of Office for CCC

The second challenge affecting community care coalition's service delivery was related to office and supplies constraints. According to the data collected from document review from Ministry of Labor and Social Affairs, the four community care coalition's structure has affected their community care coalition intervention. Community care coalition follows bottom up approach in their program planning, monitoring, evolution and reporting. This means that planning in initiated and implemented by the community care coalition offices. For doing so, coalition offices established at local *ketena* level need to strengthen their capacity to build the city administration coalition, then zonal and regional coalitions progressively.

For this purposes, the existing community care coalition programming has some office and supplies barriers. The current functioning of community care coalition is established in *ketena* administration with their separate office. But the offices needed for chair, vice chair, secretary and the three work sections are not arranged as the program requires, which is affecting their success.

Well organized office and availability of office suppliesis very important to bring service effectiveness.The current office setting does not allow community care coalition program officers to continue their work in the work simultaneously. The in-depth interview with KI-2, have shared his experience of how office setting affect their program delivery. He stated challenges of office structure as follows.

> *The ketena community care coalition members do not have office to have a meeting. We also don't have office supplies that we need to make meetings, discussion and handle our duties. So, we are forced to go to our office such as youth and children office and ask every time we have a meeting and other issue.*

Good office and office supplies have its own partfor the success of coalitionservices. Well organized office has high propensity of appealing workers and reducing work-related hazard as associated to the opposite. This indicates the negative importance of organizational barriers on the function of coalitions.

4.4.3. Financial Challenges

Community care coalition is a community based on vulnerable groups, including children, people living with HIV/ AIDS, elderly, homeless and those suffering from illness or disability, are particularly intended to catalyze local community

development.Catalyzing support for people living with HIV/AIDS and their family within local community requires financial resource.

According to the community care coalition implementation guideline, community care coalitions mobilize financial resources from the local community, organization, and from concerned governmental and civil society organizations with whom they work. Depending on the data generated from focus group discussion with community care coalitions, main source of their financial resource are gained from the *ketena*, local community development programs planned to be implemented with community care coalition from Bureau of Labor and Social Affairs in which they collaborate work with other Civil Society Organizations who provide supports to these bureau for HIV/AIDS program.

The major challenges that affected the community care coalition program implementation as a financial constraint was the imbalance between the collected financial resources and the needed finance by children and families living in poor economic situations. The allocated amount of budget by government didn't allow the implementation of support to PLWHA by implementing sectors. The other challenge was considering support given to PLWHA as previously done by different sectors is now reduced though the prevalence rate is becoming higher. The non-allocation of reasonable budget to PLWHA coordinating program offices was stated by different participants.

Key informant interview conducted with KI-2 stated that

> *We have no budget that the government allocates to us so; we have to see other means to have settle our financial issue. Government will allocate a little budge*

to cover some community care coalition programs but it is not enough. We have no choice to conduct training, support CCC officers and arrange support programs in the woreda. We are not giving needed services beneficiaries as we planned.

On the other side, community core coalition volunteer who give cares to the PLWHA have a challenge of getting immediate financial support to help people who need immediate support. IIP-2 stated that

Once there was a family of four that are mother, father and two children who were infected with HIV/AIDS and the mother was very sick. I went to their home and the mother was almost dying because of diarrhea and vomit. I had to take her to hospital and I didn't have money. At that time I was very sad because I didn't have money and I couldn't ask the concerned body right away and I thought she will die. So, I begged from the neighbors and called a taxi and I took her to Paulos Hospital and she got treatment.

The financial challenge is most commented part by participants to support the PLWHA who needs immediate support.

4.4.4. Professional challenge

Professional challenge is the other serious factor affecting the effective service delivery of giving support to PLWHA program by community care coalitions. According to the data collected from interview with the four community care coalition, chair persons leading community care coalitions are not trained on professions related to support the

PLWHA, vulnerable and orphan children. This has directly affected the HIV/AIDS program by community care coalition. The other professional challenges were observed by sectors coordinating and supporting community care coalition. Some sectors have employed professionals who are not totally related with health and community care coalition.

According to the data gained from key informant interview with KI-1, low professional engagement with community care coalitions support PLWHA program as follows:

> *We work closely with governmental organization and other stakeholders to support PLWHA and implement our programs effectively. Regardless in different sectors lacks professional staffs that can be effective in handling the job.*

Accordingly, supportof PLWHA and vulnerable children program needs expert and professional service. The inability of sectors in recruiting the right professional has affected the effectiveness of coalitions functioning. Other key informant interview conducted with Ministry of Women and Children Affairs has indicated that none of them have hired social work professional for the posts that are even stated as social worker. Anyone who has any degree can be hired as social worker and this will affect the program.

Even though paraprofessional workers are key change agents by community based on community care coalitions, trained professional are needed to support the service delivery.

Especially in areas of manual development for training, revising implementation guidelines and designing programs, trained professionals pertinent to the issues are vital. This indicates that professional and paraprofessional have to work together for providing kangaroo mother care for vulnerable children and their family.

4.5. Community Care Coalition Service Sustainability

The importantvalues guiding the service delivery of community care coalition was the principle of sustainability. According to the data collected from key informant interview with KI-5, community care coalition can ensure sustainability service by saying

> *Community care coalition can completelymake certainto deliver support to PLWHA sustainability program by giving community capacity building strategy. Increasing communities' awareness of on hand resources it will decreasehope of external resource. In addition, if a community is strengthenedand empowered successfully, knowledge sharing and transferring continues for generations and support others as well.*

4.5.1. Focusing on Local Domestic Resource

Community care coalitions mobilize indigenouspossessions for the implementation of all service packages intended in their annual work plan. Indigenous resources by their very nature are not spontaneous that happen at one point in time and unreachable in the other time. They are rather embedded into the local community and always available within the

local community until they are documented, deliberate and trained for their community development programs.

The major local resources organized by community care coalition are financial resource collected from members, human resources allocation the coalition, material resource and in-kind support as a resource.

4.5.2. Concentrating on Indigenous Knowledge and Organizations

The other pillar of community care coalition sustainability justification was building service delivery on local knowledge and institutions. The major challenge for bringingsocial service organization is founding new organizations and engaging professional that best suits to their specific service.

Using indigenous knowledge and institutions is the important part for the community care coalition. They will arrange, organize and facilitate the local community knowledge in order to give the services. This is the foundation for community care coalition in this context that reduces the founding challenges. This involves organizing *ketenas, Idirs, Ekubs, Mahibers* and other community organizations in the way they can support community care coalition programming.

4.5.3. Assimilation of Formal and Informal Community Care Coalition

Community care coalition delivers all packages of service directly, in collaboration and in the form of referral indicates the integration of service as far as the resource and capacity of the coalition allows in doing so. Integration is very important because all other sectors plan to intervene in community development and wellbeing as the community care coalition does as well. Some segments support adult people living with HIV/AIDS response program, others

focus on child vulnerability prevention programs while the rest cooperate on referral programs.

All these segments are engaged in supporting the needy people who are living with HIV/AIDS program. This state's community care coalition's assimilation ofcommunity led responses with concerned organizations. Assimilated service indicates that no significant component of service package and contributing actor is overlooked. The data collected from KI-4 stated as follows

> *Community care coalition confirmsto give service integrated with other organizations. For example, we have a program that focuses to support children of PLWHA and are very vulnerable. The government has done a guideline how all the service givers would support the vulnerable by integration so that we can change the community.*

The interview data with KI-1 indicated that appealing different governmental and civil society officialdoms operating in the local community has utmost importance to community care coalition programming. This fortifiesprevention of HIV/AIDS and response demanded by vulnerable children and poor of the poor households supporting children.

The spirit of assimilation is needed because different organizations are capable with different means and application mandate which needs cross sectorialteamwork.
According to the key informant interview with KI-4, supporting PLWHA with program is being harmonized by the engagement of different sectors. According to the personal

interview made with KI-5, sectoral integrations are the bases for integrated community care coalition programming.

4.5.3.1. Providing Volunteer Service

Volunteerism is asignificant segment of social service mechanism for giving new hope to community care coalition programming. In volunteerism, anyone who is interested to provide support a certain program of their choice without expecting any financial money for their service or time. Accordingly, in-depth interview with IIP-3pointed out that the community care coalition has engaged and trained five volunteers (three female and two male) and engaged them to the data collection, organizing and documentation and providing service work.

The data collected from in-depth interview with IIP-1, indicated how community care coalitions engage volunteers by saying

> *Youth and teenage members that live in this local community are the major volunteers and supporter of the program especially when it is during the rainy season. Occasionally we request professionals working in different organization to support our program during weekend and most of them are happy for helping community care coalition based on the convenient time appropriate to each professional.*

Regardless, the participation of volunteers in our community is very low in as we don't have the tradition of volunteering as a nation as a whole.

4.5.4. Community Care Coalitions Vs Traditional Support Systems

Community care coalition and traditional support systems have similarities and differences too. Community care coalition is a social wellbeing way that isrecognized by members of local community by using their association, knowledge and structure and coordinated by concerned sectors. On the other hand, traditional support network like Idir, Ekub and Mahiber are local community association established by members to support incorporated members during times of insecurity.

The relationship between community care coalition and traditional community support networks was explained based on the following elements for use them appropriately and sustaining coalition programming.

4.6. The Purpose of the community care coalitions formation

Community care coalitions and traditional support systems are formed for a purpose. The main purpose of community care coalition is bringing local community development by mobilizing resources from members of the community for supporting overlooked community members. As opposed to this, traditional support networks are created for the purpose of supporting members during times of shock and livelihood inconsistency by the contribution collected from members.

Community care coalition is a local strategy for implementing policy and plan of action as opposed to traditional support networks initiated by members' interest. Even though both are ways of supporting disadvantaged members in the community, they follow different approaches. Community care coalition approaches clients receiving service from

the perspective of human right and social justice. But the approach followed by traditional support networks is based on the strength of social network between members.

Traditional support networks rarely support others outside their members and are based on principle of philanthropy. As opposed to traditional support network, community care coalitions are planned service delivery with clearly defined roles between chair and members in formal organizational setting than services arranged anywhere else for traditional support networks.

4.5.4.2. The Scope of Community Care Coalition and Traditional Support Network

The second dimension for understanding the relationship between community care coalition and traditional support network is their scope of composition and operation. With regard to scope, community care coalition is larger than traditional support networks.

The scope of community care coalition ranges from individual, business organization, association consortium, civil society organization and key community leaders. But in the case of traditional support networks only individuals who are members and evolved in the contribution participate which makes it smaller in number of participants and scope of operation. In terms of the scope of operation, community care coalition function in specific city where they are established and become larger to provide service for all vulnerable segments of the community.In doing so, they provide different service packages while traditional support networks function around member's neighborhood on specific issue. Community care coalitions scope of operation is larger than traditional support networks.

4.7. The Effect of the role played by CCCs to Community Development

According to the data gained from FGD CCCs, Community development structures like CCCs are currently being implicitly stated in policy document as social welfare systems used to reach local community at its stake. The focused group discussion made with CCCs revealed that, CCCs are the foundations for community development which enables them to be at the center of local development for enhancing socioeconomic justice. CCCs has profound role in building community development. According to the discussion made with the four *ketena* CCCs, they are providing, coordinating and referring and strengthening needed by members of the community.

If all components' of community development programs including community building, community engagement, community mobilization and collective community action are in place by CCCs. This is impaling that there is no debt regarding CCCs role not only in ensuring community development but also in sustaining it.

CHAPTER FIVE

5. Conclusion, Recommendation and Social Work implications

5.1. Introduction

This chapter presents two major sections. The first part is the conclusion and the second part focus on social work implications. The conclusions stated are drown from key finding pertinent to the four research questions that are analyzed thematically for the four respective themes. The social work implications outline the implication of the research finding to different actors who are interested in incorporating the finding for future programming. Accordingly, four social work implications are stated in this study. These

are implications for intervention or community development practice, future research, social policy and education.

5.2. Conclusion

This inquiry is conducted with the objective of investigating the role and challenges of CCCs for supporting people living with HIV/AIDS. Accordingly, four major research questions were addressed focusing on major support provided to PLWHA, major strategies used, pressing challenged encountered and ways of sustaining service delivery by CCCs for the four objectives respectively. These research questions in the study are addressed by using in-depth interview, FGD, observation and document review as data generation tools. Thematic analysis approach was the main data analysis method used for coding, categorizing and creating theme to fit to research objective. The key conclusions drown form the four major research questions are summarized as follows.

The analysis of finding on the supporting of people living with HIV/AIDS indicated that, the service packages delivered by CCCs have brought positive changes to the living condition of PLWHA and their families at three different levels. The first category of finding indicated those programs that have high success rates by bringing significant change on their lives. These categories are the six key service packages like economic strengthening, health support, education support, capacity building, counseling, and referral services.IGAs as economic strengthening programs given to female households enhanced their income for selected households who have succeeded in revolving loan.

The other component states that CCCs have provided, coordinated and referred PLWHA and their families to access free health service. Educational materials and supports given

by CCCs have increased child's access to education besides capacity buildings program strengthening other service packages. Referral programs were effective in CSOs than governmental and private organizations in supporting PLWHA and their families for issues that are under their area of intervention. Weak inter sectoral collaboration in the area of origin and destination was the underlying cause for challenges for CCCs.

The strategies employed by CCCs have guided the coalition to bring positive change on the life of PLWHA and their families. This ascertained the direct linkage between the effectiveness of service and employment of appropriate strategy. Building capacity as a strategy helped the capability of actors involved in delivery of major service packages.

Local resource mobilization by CCCs as the second strategy has catalyzed the delivery of service packages. This indicated direct relationship of resource mobilization ability and effectiveness of CCCs functioning. The collection, organizing and documentation of data as third strategy, decreased the amount of time needed in the service delivery that reduced the pending of service schedules for intervention.

As the analysis of the finding on challenges encountered by CCCs depicted that, the challenges identified by CCCs negatively affected its functioning. Turnover in CCC chairs, structural barriers, mobilizing resource and linking service with professionals pointed out as major challenges. The CCCs structure has hindering effect on its functioning due to the shortage of space and office supply. Though finance is a key input for effective implementation of CCC program, financial challenges have brought the opposite effect.The low existence of professionals in CCCs programming is the other bottleneck affecting the functioning of the coalitions.

Despite the triggering effect by challenges above, CCCs have ensured sustainability in giving support to PLWHA. Its sustainability factor was due to its focus of local resource, local knowledge and institutions, planned intervention and the linkage of formal and informal actors. The use of vast array of strategies is the other component of service sustainability besides analyzing the relation of CCCs and traditional support networks based on their scope and purpose. Analyzing the relationship was important to utilize the issues to which they contribute their role. Due to these, sustainability factors depicted that CCCs are not ad hock program and sustains the support given to PLWHA and their families for longer period as a community development system.

5.3 Recommendation

As the finding from this research shows the existence of this community coalition has positive impact on the wellbeing of people living with HIV/AIDS and their children living at KolfeKeranyo sub city with regard to their health, food, psychological, and socio economic conditions. Despite the positive impacts the CCCs have different challenges such as high turnover rate of volunteer CCCS, structural barriers, mobilizing resource and linking service with professionalsTherefore, it is recommended that the concerned authority should think to support the community core coalition members to tackle their challenges. World Vision Ethiopia as the founder of CCCs should support the coalition financially in order to address more PLWHA. It is also recommended that the local community together with CBOs to mobilize resources and avail spaces for CCCs meetings and other activities so that they can provide support to PLWHA and minimize the challenges.

5.4. Social Work Implications

Articulating the different implications of the research based on pointed out key finding is a vital component of CCC investigation. This segregates the finding that gives clear category for those who are interested in using the finding for pertinent purposes.

This component beyond vitality, gives the motivation for the very existence of social work as applied and practice based profession. The need for categorization of the implication is due to the different purposes that the finding plays for agencies in need of intervention based on the pointed out conclusion. The key findings of this research have four social work implications. These are implication to community development intervention or practice, implication to future research, implication to social policy and implication to education.

With regards to community development practice, two major issues were used in the whole process of this research, assessing community care coalition and support given to PLWHA with the third on the roles of the former to the later. Community care coalitions were used as a system for supporting PLWHA and their family and community development structure. Without durable system and structure, supporting a vulnerable community living with HIV/AIDS in particular and community development in general is unthinkable. Developing local community needs identifying and involving locally operating institutions, actors, knowledge and leadership.

Sustaining community development needs critical efforts in linking the formal and informal intervention. In addition to the existence and functioning of formal and informal support mechanism, the linkage between the two has a great importance. This increases

ownership for formal organization from local community and increases the service network for informal functioning community institutions.

PLWHAand their families have benefited due to the roles played by community care coalitions. Many lives have changed due to the consistent support and care provided by community care coalition. Economic changes were brought in the lives of PLWHA by providing them financial and this has led them to support their children. In addition vulnerable children have also benefitted from the support of community care coalition by getting different provisions such as educational materials.

Community care coalitions have also played their roles to support PLWHA in coordination, in direct service delivery and referral. This brought significant changes to the lives of PLWHA and their families. Provision of support to PLWHA is not enough for building sustainable program but they also focus to household empowerment for those selected PLWHA through economic strengthening. In addition to this, counseling is given to help them cope with psychosocial challenges. Capacity building programs on HIV/AIDS infection prevention and referral service are delivered to PLWHA and their families.

This has implication to social work practice in community setting. The community care coalition works with collaboration with informal institutions like Idir, ekub and Mahiber. This finding advocates for CSOs, GOs and private organizations to use community care coalitions as main support for PLWHA s for any pertinent program. This implies the use of community care coalition as area of community development practice by nearby organizations. This givesperceptions to all how to focus on local assets for PLWHA and community development.

Strengthening collaboration between different organizationssuch as Ministry of Labour and Social Affairs and Ministry of Women and Children Affairs is the critical issue for intervention implication. This will help the community to get a better support and strengthen the community care coalition.

Financial challenge was stated as crippling the functioning and effectiveness of MoLSA and MoWCsin supporting PLWHA. So, governments have to refocus of the budget allocation procedure to ensure the life change of the PLWHA and their families. According to the finding from the inquiry, low level of professional engagement in the community care coalition has affected their effectiveness. Due to this, World Vision needs to place their professional staffs to practice in the community care coalition office and support coalition programming.

With regards to future research implication, in contemporary context of Ethiopia, the use of community development structures like community care coalition for sustaining community development service and sustainability is low. As Ministry of Labor and Social Affairs has done the national implementation guideline for community care coalition, it is really great if it is implemented accordingly.

Consequently, the finding of this research has implications to futures research conducted for academic and guiding intervention purposes. This inquiry reviewed literatures related to community development, community care, community care coalition, support given to PLWHA published in international journal articles with important policy and legal documents.

This gives future researchers to review and get access to the original documents to support their study with preexisting literature. Most importantly the main findings as stated in the finding section contributes to framing of their problem statement and serve as base line preexisting literature for discussing their finding. This vividly indicates the future research implication of the investigation for academicians and other researchers.

This investigation has a great implication to social policy in the context of Ethiopia. It paves away for social policy designers, health workers that focus on HIV/AIDSand policy evaluators by giving imperial finding to base their decision. This study pointed how community care coalitions function effectively, sustaining their longevity of support and the challenge of community core coalition. This finding fundamentally serves as situational analysis in the area for initiating development policy, strategies, programs and plans which are intended for reducing the plight of PLWHA and their families. The findings outlined for the strategies employed, challenges encountered and service sustainability.

The finding obtained from this inquiry serves as baseline for awareness creation programs of families in conflict. This study will also be used as a guide to social workers working on court in areas of family therapy and social work practice with families and children in justice system.

Sustaining community care coalition's support for PLWHA and their family is the other important area where the finding of this study will be used. Besides the implementation guideline used by community care coalitions, this finding will become a key input for the training and advocacy programs that will be prepared by community care coalitions capacity building and advocacy work section. This training will support the sustainability

of the program for refreshing the awareness of members and actors. The finding of this study serves as a base line for development of community care coalitions sustainable support mechanism.

Last but not least, besides giving substantive input in education institutions like universities, professional associations like social workers and sociologists will also use the finding of this study for different purposes.

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Annex-I: Interview Questionnaire

In-depth Interview Guide for People living with HIV/AIDS

I. Socio Demographic Information of Participant

1. Sex……..

2. Age……

3. Place of birth……..

4. Place of living…….

5. Religion……..

6. Education level……

7. Marital Status……

8. Who is the head of the household?

9. Do you own your home? ……

10. For how long have you been receiving service from the CCC?

II. Family background

1. How many adults/more than 18 years/ live in the house?
2. How many children /0-17 years' age/ lives in the house?
3. Who take of children in this house?
4. With whom are you living currently?
5. Do you have children? If yes how many?
6. Do you have a job? If yes what do you do for living? If not why?
7. Does anyone support you besides your family? If yes who, when and how?
8. Does any member of your family member died? If yes what was the cause and when?

III. Major Services delivered to people living with HI/AIDS

1. Have you ever received health service from community care coalition? if yes what are they? When is delivered?
2. Do you think that the services given by community care coalition are important for you and your family? If yes does how?
3. What kind of support do you seek from CCCs?
4. What support did u get so far?
5. How much do you know about CCCs activities?
6. Since when you know you have HIV?

7. What kind of medicine are you taking now? What is your health condition now?
8. What is your family health condition?
9. Do any of your family member received counseling service from community care coalition? If yes on what issues?
10. Have any of your family members received economic strengthening service (revolving loan and cash transfer) for income generating activity? If yes, what is the amount, when is it given and how are you using it and preferred area of work?
11. Have you ever received service from other organization by referral linkage created by community care coalition? If yes, what type services and from which organization? From governmental, nongovernmental, and private organizations?
12. Have you ever been participated on services delivered to people living with HIV/AIDS by community care coalition? If yes when regularly, sometimes, rarely, not at all. If no why?
13. Can you share me about your personal stories on how you become HIV/AIDS patient?
14. Do you have other points you want to add to this interview that can support the study?

IV. Key Informant Interview Guide for Concerned Sectors

Socio Demographic Information of Participants

1. Sex……
2. Age……..
3. Religion……
4. Education level……
5. Marital status……
6. Position in the organization…….

7. Year of experience……

Major issues to be addressed

1. Would you please tell me about how you understand community care coalitions?
2. Do you have any work relationship with the community care coalitions?
3. Do work closely with CCCs?
4. What do you know about CCC
5. What areas do you think we should focus to support CCCs?
6. Do you think that community care coalition have role for people living with HIV/AIDS? If yes what are the roles? If no why and in what way? Probe, major institutions engaged and feedback mechanisms.
7. Does your bureau have policy and strategy documents for monitoring and oversight of community care coalition program for people living with HIV/AIDS? If yes what are they? If no in what other mechanisms do you use?
8. Can you tell me about the major programs you implemented, coordinated or referred in your bureau for reducing the prevalence of HIV/AIDS?
9. What are the challenges that you faced in providing intervention to people living with HIV/AIDS? If so what are they? If not how do you managed to reduce their negative effect?
10. Do you think that community care coalition's in providing service to people living with HIV/AIDS is sustainable? If yes in what ways? If no what other mechanisms need to be employed for sustainability?
11. Is there anything you want to add to this interview?

V. In-depth Interview Guide for Community Care Coalition Chair Persons

Socio Demographic Information of Participants

1. Sex……

2. Age……..

3. Religion……

4. Education level……

5. Marital status……..

6. Position……...

7. Experience……..

Major Issues to be addressed

1. Does your community care coalition provide any type of service for people living with HIV/AIDS? If yes what are the types? If no how do you those people?

2. Does your community care coalition use any strategies for providing service to people living with HIV/AIDS? If yes what are they? If no how do you deliver your service?

3. What are the challenges that you encounter in delivering service for people living with HIV/AIDS?

4. What mechanisms do you use to reduce those challenges?

5. Do you think that community care coalition has relationship traditional support network like Idir, Equb and Mahiber? If yes in what dimensions?

6. Do you think that community care coalition can ensure service sustainability for people living with HIV/AIDS? If yes in what way? If not in what other ways do you thick can support sustainability?

7. Do you think that community care coalition bring service integration? If yes explain? If no in what ways? Probe (GO, NGOs and CBOs involved)

8. What other issues do you think are left?

VI. FGD Guide for Community Care Coalitions

Major Services provided to HIV/AIDS people by Community Care Coalitions

1. Would you share to me major service packages your community care provided to people living with HIV/AIDS?

- Economic strengthening (Cash, revolving loan), How much in birr? In what time range? what was the process involved?
- Capacity building training given by community care coalitions to people living with HIV/AIDS? Probing (Training family, sectors, community for strengthening their life)
- Referral service? Probing (GOs, CSOs and private organizations).

Major strategies employed by community care coalition

2. Would you share to me the strategies used by your community care coalitions for delivering service to people living with HIV/AIDS?

- Mobilize local resource get resource for your programming? Probing (Financial, Material Human resource)
- Data Collection- Probing (by age, sex, service need to guide intervention, referral, for media).

Challenges encountered and Service Sustainability

1. Would you please tell me the challenges triggering your community care coalition in providing service to people living with HIV/AIDS? Probe (financial, personal, social)

2. Tell me about your perception of the relationship between community care coalition and traditional support networks?

3. In what ways do you thick community care coalition ensure service sustainability?

4. Would you please share to me major actors involved in community care coalition program implementation. Probe (government and nongovernmental organizations).

FGD Guiding Questions to people living with HIV/AIDS

1. Explain to me basic health services you or your family received from CCC?

2. Does community care coalitions' given capacity building for you and your families? When?

3. Explain economic strengthening activities that are given to you and your families?

4. Have you ever received counseling referral service by CCCs? If yes when? On what issue?

5. Do you think that community care coalitions mobilize local resource to support people with HIV?AIDS? If yes what are the types?

6. Have you ever been registered by CCCs up tonow? If yes when and for what purpose?

Annex-II: Matrix Table (Analysis for Interview Questions)

Table 1. Key Informant Interview Participant Sector representatives

S.N	Sex	Age	Religion	Position	Education	Institution	Marital status	Experience
1	M	35	Orthodox	Child protection Officer	Maters	World Vision	Unmarried	12 Years
2	M	27	Protestant	Child right &wellbeing Officer	BA Degree	MOWCA	Unmarried	6 Years
3	F	27	Orthodox	Child right &welfare core process owner	BA Degree	MOWCA	Married	5 Years
4	M	46	Muslim	Head	BA Degree	MOLSA	Married	22 Years

5	M	27	Muslim	Developmental social welfare process owner	BA Degree	MOLSA	Unmarried	3Years
6	M	30	Protestant	CCC Program Officer	BA Degree	MOLSA	Married	5 Years

Source: Own interview questionnaire, 2019

Table 2. In-depth Interview Participants' Community Care Coalition Chairs

S.N	Sex	Age	Religion	Position	Education	CCC Name	*Ketena*	Marital status	Experience
1	F	21	Orthodox	CCC vice chair person	Diploma	CCC1	01	Unmarried	2Years
2	M	39	Muslim	CCC vice chair person	BA Degree	CCC2	02	Married	4 Years
3	M	42	Orthodox	CCC vice chair person	BA Degree	CCC3	03	Married	3 Years
4	M	46	Orthodox	CCC vice chair person	BA Degree	CCC4	04	Married	22 Years

Source: Own interview questionnaire, 2019

Table 3. In-depth Interview Participant Children

S.N	Sex	Age	Religion	Education	Place of birth	Place of living	Support CCC	*Ketena*
1	M	14	Protestant	Grade 8	Ziway	Addis Ababa	CCC1	01
2	F	16	Protestant	Grade 10	Dangila	Addis Ababa	CCC3	03
3	F	14	Orthodox	Grade 6	A.A	Addis Ababa	CCC1	01
4	F	16	Muslim	Grade 8	Shone	Addis Ababa	CCC3	03
5	F	18	Orthodox	1Years College	B/Dar	Addis Ababa	CCC1	01
6	M	15	Muslim	Grade 4	Arsi	Addis Ababa	CCC3	03

7	M	17	Protestant	Grade 8	Welkite	Addis Ababa	CCC2	02
8	M	14	Orthodox	Grade 7	A.A	Addis Ababa	CCC2	02

Source : Own interview questionnaire, 2019

Table 4. Focused Group Discussion (FGD) Participant Female Households

S.N	Sex	Age	Marital Status	No. of Childr en	Received support	Source of support	CCC	*Ketena*
1	F	43	Married, but husband died	2	❖ School material ❖ Revolving loan ❖ Free health service ID	❖ Fiker le Hitsanet via CCC ❖ MoLSA through CCC	1	01
2	F	37	Married	3	❖ School material ❖ House rent and grain	❖ Islamic relief through CCC	1	01
3	F	47	Married, but divorced	4	❖ Education material	❖ Fiker le hitsanet via CCC	4	04
4	F	39	Married, but husband died	6	❖ Nutritional support ❖ Cash for school martial	❖ World Vision via CCC	3	03
5	F	52	Married, live with her husband	2	❖ Free health service ID ❖ Revolving loan ❖ Educational material	❖ CCC ❖ MoLSA through CC	2	02

Source: Own interview questionnaire, 2019

Table 5. FGD Participant Children

S.N	Sex	Age	Religion	Name of School	Place of birth	Place of living	Support CCC	*Ketena*
1	F	14	Orthodox	Selamber	A.A	Addis Ababa	CCC1	01
2	F	16	Muslim	Selamber	Wolkite	Addis Ababa	CCC3	03
3	F	18	Orthodox	EwuketWegan e	D/Birhan	Addis Ababa	CCC1	01
4	M	15	Muslim	Selamber	Gondar	Addis Ababa	CCC3	03

5	M	17	Orthodox	MesereteEdget	A.A	Addis Ababa	CCC2	02
6	M	14	Orthodox	Selamber	Holeta	Addis Ababa	CCC2	02

Source: Own interview questionnaire, 2019

Table 6. FGD Participants' of CCC Chairs

S.N	Sex	Age	Religion	Position	Education	Institution	*Ketena*	Marital status	Experience
1	F	21	Orthodox	CCC chair	Diploma	CCC1	01	Unmarried	1 Year
2	M	39	Muslim	CCC Vice chair	BA Degree	CCC2	02	Married	4Years
3	M	42	Orthodox	CCC chair	BA Degree	CCC3	03	Married	2 Years
4	M	29	Orthodox	CCC Communication officer	BA Degree	CCC1	01	Unmarried	2 Years
5	M	37	Muslim	CCC Resource Mobilization Officer	BA Degree	CCC2	02	Married	2.5Years

Source: Own interview questionnaire, 2019

Code for each Interview questions

1. **Key Informant Interview Participant**

S.N	**Assigned Code**
1	**KI-1**
2	**KI-2**
3	**KI-3**
4	**KI-4**

2. **In-depth Interview Participants**

S.N	Assigned Code
1	IIP-1
2	IIP-2
3	IIP-3
4	IIP-4
5	IIP-5
6	PIP-1
7	PIP-2
8	PIP-3

3. **Focused Group Discussion Participants**

S.N	Assigned Code
1	CIP-1
2	CIP-2
3	CIP-3
4	CIP-4
5	CIP-5
6	CIP-6
7	CIP-7
8	CIP-8

4. **Focused Group Discussion Participants**

S.N	Assigned Code
1	FGD-1
2	FGD-2