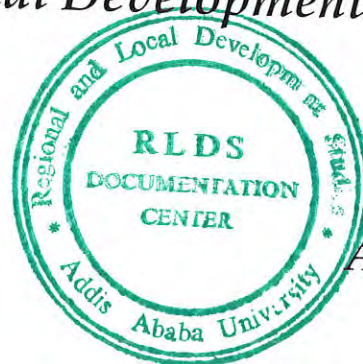


**CHALLENGES IN THE  
RESPONSE TO THE HIV/AIDS  
PROBLEM: *The Case of  
Nekemte Town***

**By  
Teshome Dugassa**

*A Thesis Submitted to the School of  
Graduate Studies of Addis Ababa  
University in Partial Fulfillment of the  
Requirements of the Degree of Masters in  
Regional and Local Development Studies*



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***ADDIS ABABA UNIVERSITY  
SCHOOL OF GRADUATE STUDIES***

***Challenges in the Response to the HIV/AIDS  
Problem: The Case of Nekemte Town***

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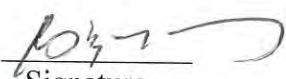
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## *List of Abbreviations*

AAE	Action Aid Ethiopia
ACP	AIDS Control Program
ADF	Africa Development Forum
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
CBOs	Community Based Organizations
ECC	Ethiopian Catholic Church
EECs	Ethiopian Evangelical Churches
EECMY	Ethiopian Evangelical Church Mekane Yesus
EFE	Employment Federation of Ethiopia
EIASC	Ethiopian Islamic Affairs Supreme Council
ELCA	Evangelical Lutheran Church in America
EOC	Ethiopian Orthodox Church
ETB	Ethiopian Birr
EWZHD	East Wellega Zone Health Department
FBOs	Faith Based Organizations
FDRE	Federal Democratic Republic of Ethiopia
FELM	Finnish Evangelical Lutheran Mission
FGDs	Focus Group Discussions
FHI	Family Health International
GOs	Government Organizations
GPA	Global Program on AIDS
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
HPR	House of Peoples 'Representatives
IEC	Information Education and Communication
LGAs	Local Government Authorities
LWF	Lutheran World Federation
MoE	Ministry of Education
MoH	Ministry of Health
MoLSA	Ministry of Labor and Social Affairs
NAC	National AIDS Council
NACP	National AIDS Control Program
NACS	National AIDS Council Secretariat
NCA	Nekemte City Administration
NGOs	Non-Government Organizations
OHB	Oromia Health Bureau

ONRS	Oromia National Regional State
OSSA	Organization of Social Service for AIDS
PHC	Primary Health Center
PLWHA	People Living With HIV/AIDS
SPSS	Statistical Package for Social Scientists
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infection
TOT	Training of Trainers
UNAIDS	United Nations Joint Program on AIDS
UNICEF	United Nations International Children Emergence Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WB	The World Bank

## ***Abstract***

The purpose of this research was to assess the role played by local level HIV/AIDS implementing organizations in coping with the HIV/AIDS epidemic in Nekemte town, and hence the performances of GOs, NGOs, FBOs and CBOs were assessed. In this study, two organizations (OSSA and EECMY) were considered as the major implementers of the anti-HIV/AIDS activities and evaluated with regard to the services they being provided to their beneficiaries. The activities of other community institutions were also assessed based on the qualitative data obtained from these organizations. Hence, samples of 400 beneficiaries (227 females and 173 males) were successfully interviewed. To supplement the quantitative method, 69 representatives of implementing organization were interviewed by administering un-structured (qualitative) questions. Moreover, two focus group discussions were conducted.

Accordingly, the performance levels of both organizations in IEC and care and support for AIDS orphans were rated as medium while counseling service, care and support for PLWHA and training undertakings were low. Few efforts were being made in coping with the problems of HIV/AIDS by the local government and very few NGOs were working in the area of HIV/AIDS interventions during the time of the study. The existing and recently adopted initiatives were those in which very few organizations (NGOs) took part. The activities of the selected organizations and other community institutions ranged from capacity building to provision of IEC, care and support for AIDS patients and AIDS orphans.

The overall performance of the program being undertaken by implementing organizations was reported as being not satisfactory by more than half of the respondents of the study. This shows that the beneficiaries were not satisfied with the services being provided, indicating the existence of challenges that hinder effective implementation of the program. These were reported to be mainly because of limited capacity (financial, human), coordination problem and lack of awareness creation about the program by the implementing organizations.

Based on the findings of the study, further improvement in the provision (allocation) of adequate financial and human resource, coordination as well as undertaking sustainable awareness creation and training about programs by designing local level strategies are recommended to improve the situation of the identified problems.

# ***CHAPTER ONE***

## ***1. Introduction***

### **1.1. Background**

Globally, the HIV/AIDS epidemic is becoming the foremost development crisis that threatens the demographic, social and political stability of various nations. It was reported that the epidemic killed about 3.1 million people in 2005 and the number of newly infected people with the virus in the same year was estimated to be 5 million, which makes the number of PLWHA 40.3 million around the world (UNAIDS, 2005).

Developing countries are the major ones that are affected by many aspects of the HIV/AIDS epidemic. Africa is identified as the continent most affected by HIV/AIDS. In Africa, AIDS is not only the problem of health but rather it is a multi-dimensional problem. It affects every aspect of development and major economic and social sectors. It has also negative impacts on population, education, health, agriculture, economy and business (UNAIDS, 2001).

In sub-Saharan Africa, HIV prevalence has remained relatively steady, generally at high levels for the past several years across many of the regions. This is because high levels of new HIV infections are persisting and are now matched by high levels of AIDS mortality. The latest report produced by UNAIDS showed that 2.4 million people were died due to AIDS, 3.2 million newly infected with HIV, and 25.8 million people were living with HIV by the end of the year (UNAIDS, 2005).

In Ethiopia, the first evidence of HIV infection was recognized in the early 1980s. The first two AIDS cases were reported in 1986. Since then, the disease has spread at an alarming rate. Currently, the country is home to the fifth largest infected population (HAPCO, 2004).

According to the 5<sup>th</sup> AIDS report produced by Ministry of Health, the estimate for the adult prevalence rate of HIV infection is 4.4 percent (2.6% for rural and 12.6% for urban). The report also indicated that there were 1.5 million people living with

HIV/AIDS and 0.9 million orphans due to AIDS alone and 90,000 people have died due to AIDS (MOH, 2004)

Oromia is one of the regions that was highly affected by HIV/AIDS epidemic. According to the data from Oromia Health Bureau, there were 330,392 people living with HIV, 55,604 newly infected people (46,675 adults and 8,929 children), 26,976 new AIDS cases (20,504 adults and 6472 children) and 25,081 annual AIDS deaths (18,762 adults and 6,319 children). As a result, there were 190,692 orphans due to AIDS alone by the year 2003 (OHB, 2004).

In study area (Nekemte), the first evidence of HIV infection was recognized in 1990. It was when 45 commercial sex workers made blood test in Nekemte health center that 15% of them showed HIV-positivity. In the same year, 6 AIDS patients were reported. The epidemic is affecting those between 25-34 years of age and since 1990, 3,696 cases have been reported (EWZHD, 2004).

#### **1.1.1. Institutional Arrangements and Efforts Made to Combat the Epidemic**

Realizing the enormous implications of AIDS in terms of human suffering social effects, and costs for health service, the national taskforce on the prevention and control of HIV-infection and AIDS in Ethiopia was established in 1985 (Debrework et.al, 1990; Kloos and Haile Mariam, 2004).

Initially, measures focused on the development of a national policy on AIDS, specific operational guidelines, a situational analysis of the problem, and an assessment of the existing capability to cope with the problem. The Ethiopian Short Term and Medium Term Plans for the prevention and control of AIDS were developed in March and May 1987 respectively in collaboration with experts from the global program on AIDS (GPA) (Debrework et.al, 1990).

In September 1987, an office within the MOH responsible for directing and coordinating the implementation of AIDS control program (ACP) was established at departmental level. The objectives of the NACP are to prevent HIV transmission and reduce the morbidity and mortality associated with HIV-infection. Following this strategies were developed. Some of the strategies were Information, Education and Communication (IEC), surveillance and research, clinical aspect of AIDS, laboratory and blood transfusion, and STD control (Debrework et.al, 1990).

In May 1989, a review team evaluated the implementation of the programme and concluded the programme was centrally planned and managed, and suggested to decentralize the programme activities to the peripheral establishment and to integrate with relevant departments of the MOH. These recommendations were considered as the leading strategy in planning the activities for this program implementation (Debrework et.al, 1990).

General guidelines on decentralization of ACP were developed and a national training seminar was conducted having the following objectives: mobilizing the regional PHC committees for implementation of AIDS in the region, to apply the strategy in the Ethiopian context, decentralization within the district health development network, training of health workers and AIDS diagnosis surveillance, and on psycho-social support. Thus, following the agreed priority to decentralize the programme to the regions and districts, implementation of the decentralization strategy began in the first quarter of 1990 (Debrework et.al, 1990).

Realizing the devastating effect of HIV/AIDS on national development and poverty reduction efforts, the government of Ethiopia took the leadership to scale up the response in the fight against HIV/AIDS by forging multi-sectoral and multilevel partnership with various stakeholders. A national policy on HIV/AIDS was enacted in the August 1998 (FDRE, 1998).

In April 2000, the government also established the national AIDS council, charged with implementation, monitoring of performance, and evaluation of the HIV/AIDS program. The council, headed by the president of Ethiopia, involves leaders from multiple sectors, the major religious and private organizations and is to have office in all regions and Weredas (NACS, 2000).

Following that, the MOH coordinated a process of strategic planning and program development in Ethiopia's nine regions and two city administrations. This process involved National and Regional governmental institutions, the major regional sector offices, NGOs, religious organizations, and other stakeholders (HAPCO, 2003). This has resulted in the five-year Federal level multi-sectoral HIV/AIDS strategic plan and accompanying Regional multi-sectoral HIV/AIDS strategic plans. These plans were synthesized into the strategic framework for the national response to HIV/AIDS in Ethiopia for 2001-2005 (NACS, 2001). The strategic framework focuses on reducing the transmission of HIV and associated morbidity and mortality, and its impact on individuals, families and the society at large. The strategy is built on four issues: multi-sectoral participation, leadership and efficient management including adequate monitoring and evaluation (HAPCO, 2003). The National strategic framework is being revised and the priority areas are redefined.

In order to implement the various interventions, the government has adopted a multi-sectoral approach. This has resulted into an expansion and scaling up of the national response to HIV/AIDS in a multiplicity of interventions in various sectors and levels of government structure, as well as NGOs, FBOs, CBOs, civil society associations and multilateral and bilateral organizations (HAPCO, 2003).

However, these early intervention efforts were inadequate in scale and largely ineffective. Lack of adequate stakeholder participation in planning, multi-sectoral coordination and integration, and lack of financial and human resources were major impediments (Kloos and Haile Mariam, 2004). Therefore, it is necessary to mobilize

the efforts of government and non-government organizations such as FBOs, CBOs and other stakeholders. This study intends to review the existing intervention programs implemented by these parties to prevent and control the spread of HIV/AIDS at local levels and the problems and challenges encountered in the intervention program in Nekemte town.

### **1.1.2. Description of the Study Area**

Nekemte town was founded under the auspices of King Moroda Bekere as a small hamlet, on an area of 18 acres in 1873. The town has its legal status as municipal town and an urban master plan in 1950 and 1975 respectively. Due to the population increase and socio-economic development, the town had sprawled unguided over large area, before the town development plan now at work was developed in 1994. According to this plan, the surface area of the town has been enlarged to 3,192 hectares of land (NCA, 2005).

The town is located in the western sub-region of Oromia at a distance of 331 km west of Addis Ababa. According to the city administration, the total population of the town is estimated to be 70,000 during 2005. There are eight ethnic groups living in the town namely: Oromo (79.4%), Amhara (14.8%), Guragie (4%), and Tigrai (1.8%). In terms of religious affiliation Orthodox, Protestant, Muslim, Catholic and others constitute 59.4%, 26.7%, 12.6%, 1%, and less than 0.3% of the town's inhabitants respectively (EECMY, 2004).

The annual growth rate of population on average was estimated to be 4.11%. The factors contributing to the growth of the town's population are: migration, concentration of educational institutions, the need for employment and other economic opportunities. Even though there are no recent data on unemployment rate, the 1994 population and housing census showed that it was 18% and 22% for males and females respectively (NCA, 2005).

Currently, the town is selected among the 20 notable towns of Oromia and is administered by a mayor and a mayor's committee, in accordance with the urban proclamation No 65/2003, and has municipality services. It is divided administratively into 6 sub-urban administrative divisions, 78 clusters and 301 development groups.

The sub-urban divisions are:

1. Bakanisa Keep ...former kebeles of 01 & 04
2. Bakke Jama... former kebeles of 06 & 09
3. Burka Jato... former kebeles of 07 & 11
4. Chalalaki ... former Kebeles of 03 & 12
5. Darge... former Kebeles of 02 & 10
6. Kasso... former Kebeles of 05 & 08

#### **1.1.2.1 Description of the Organizations Included in the Study**

Organization for Social Service for AIDS (OSSA) is an indigenous and humanitarian organization founded by volunteer organizations. It was founded in 1989/90 with an intention of fighting the spread of HIV/AIDS and caring and supporting of infected and affected individuals and groups. OSSA Nekemte branch is one of the first OSSA-Ethiopia branches and was opened in 1994 with a motto of fighting the spread of HIV/AIDS through promoting individuals and institutional participation. The branch is a humanitarian non-organization that focuses and works on HIV/AIDS prevention, and care and support in Nekemte town.

The Ethiopian Evangelical Church Mekane Yesus (EECMY) is another organization that has been undertaking anti-HIV/AIDS activities. It launched the HIV/AIDS prevention and control program in 1988. Since then, the church has been involved in implementing IEC and surveillance using the structure of synods, presbyteries and area work and health institutions. Each church unit assigns a social health coordinator to manage and implement HIV/AIDS prevention program in their respective areas (AAE, 2002). The EECMY-CS Nekemte branch is undertaking two HIV/AIDS related Programs namely: the prevention, and care and support programs.

## **1.2. Statement of the Problem**

HIV/AIDS is the largest killer disease that affects the productive age group in the country and is, therefore, becoming a serious threat to socio-economic development. If it remains uncontrolled, it will retard growth, weaken human capital, discourage investment, aggravate poverty and inequality and leave the next generation increasingly vulnerable to further socio-economic impacts of the epidemic (NAC, 2001). Hence, effective national response to HIV/AIDS can contribute to poverty reduction and to the overall development efforts.

The most important lesson learned in the prevention and control of HIV/AIDS is that it is not solely a medical or health problem. Rather, the pandemic is a complex socio-economic development problem and as such threatens the sustainable development of developing countries (UNAIDS, 1999). Thus, it requires the efforts of multi sectors in the intervention programs.

In this relation, Africa Development Forum (ADF) realized that, the fight against HIV/AIDS encompasses government, non-governmental, youth and women's organizations, the private sector, civil society, religious organizations, political parties, traditional and customary leadership, PLWHA, academia and the media, and health sector (ADF, 2000). Hence, the gravity of HIV/AIDS emergency dictates higher level of commitment and co-ordination from external and internal parties.

According to World Bank, despite the compelling arguments for government to confront AIDS, social norms and politics make designing and implementation effective AIDS policies uniquely challenging. The specific problems and their solutions will vary across countries. Nonetheless, four types of issues have commonly arisen: denial that HIV/AIDS may be problem, reluctance to help people who practice risk to avoid infection, preference for moralistic responses, and pressure to spend on treatment, at the expense of prevention (WB, 1997). According to HAPCO, stigma and discrimination are the main obstacles and challenges in responding the problem of HIV/AIDS. Lack of

personnel, organizational incapability and lack of coordination among donors and local leaders are the major problems and these lead to duplication and wastage of resources (HAPCO, 2004). Therefore, such an emergency campaign requires proper planning and programming, harmonious coordination among various leaders (GOs, NGOs, FBOs, CBOs) and community at large, and political commitment in implementation of the program.

As it was mentioned in the forgoing pages, the government of Ethiopia in response to the HIV/AIDS epidemic has undertaken many measures. AIDS policy and guidelines were formulated, strategies were redefined and structural arrangements were made. However, despite all these efforts and decentralized activities to local levels, local implementing organizations face a number of problems in the intervention. Lack of capacity, lack of coordination among key actors, inadequate institutional capacity at local levels, insufficient involvement or commitment of governmental sector adversely affects the implementation program. For these and other reasons, the prevalence of HIV/AIDS has increased steadily.

According to the ANC surveillance conducted at urban sites, the percents of HIV prevalence for Nekemte town in the years 2001, 2002, 2003 and 2004 were 9.1, 11.3, 13.0 and 13.8 respectively (MOH, 2004; NCH, 2005). These figures are the indication of an increasing trend of the HIV-prevalence for the town and the town took the first rank as compared to urban ANC sites that have been selected from Oromia region.

In addition, Nekemte is a communication center for western Oromia and many passengers daily come from various directions as well as less attention has been given to zonal towns. These aggravated the vulnerability (high risk) of the study area to the HIV/AIDS epidemic. In relation to research undertakings, in the study area some studies in related to knowledge, attitude, behavior and practice about HIV/AIDS were conducted. However, no research has been undertaken in relation to challenges in response to HIV/AIDS in the study town. Therefore, conducting research about the challenges encountered in the response to the HIV/AIDS epidemic is timely and

reasonable to fill research gaps and this is a study conducted to assess anti-HIV/AIDS activities in Nekemte and to identify the challenges encountered in undertaking these activities.

### **1.3 Significance of the study**

A successful national response to HIV/AIDS requires coordinated and effective engagements of all stakeholders such as government and non-governmental organizations, community - based organizations (CBOs) and faith based organizations (FBOs).

Accordingly, the major purpose of this study was to assess the role played by local community leaders and problems encountered, and to fill the research gap in this area. Therefore, this study was aimed at assessing the challenges facing in undertaking the anti HIV/AIDS activities and the findings of the study might contribute to the improvement of the efforts of partners by indicating possible solutions for the problems.

### **1.4. Study Objectives**

#### **1.4.1. General Objective**

The overall objective of the study was to assess the role played by the implementing organizations and to examine the challenges they encountered in their activities to cope up with the HIV/AIDS problems.

#### **1.4.2. Specific objectives**

- To examine the implementation of the HIV/AIDS programs in order to prevent and control the spread of the epidemic at local level....
- To assess the degree of involvement as well as achievements of local administrative units and their partners.
- To assess and examine the extent of partnership that exists among local administrative units and various organizations.
- To assess the availability of the necessary resources at local levels to prevent and control HIV/AIDS.
- To examine the challenges encountered in activities to cope with HIV/AIDS.

### **1.4.3. Research Questions**

The study tried to answer the following basic questions

- What are the intervention programs undertaken at local levels?
- What are the magnitude of involvement and achievements of local implementing organizations in the intervention programs?
- What is the extent of partnership exists among local implementing organizations?
- What is the nature of resources allocated to HIV/AIDS prevention and control?
- What are the challenges encountered in the intervention program?

### **1.5 Scope of the Study**

The scope of the study was delimited to HIV/AIDS program implementing organizations (NGOs, FBOs, GOs, and CBOs) that were undertaking anti-HIV/AIDS activities in the town and beneficiaries of two implementing organizations. This is due to time constraint and to make the study manageable.

### **1.6 Limitation of the Study**

The study has some limitations. One is, lack of recent data in the study area on poverty, unemployment and income levels of the community that have direct relationship with HIV/AIDS. There was also lack of written documents and reports on HIV/AIDS in the study town.

### **1.7 Organization of the Study**

This study has six chapters. The first chapter deals with the introduction part. The second chapter incorporated that review of related literature. The third and the fourth chapters are about methodological framework and descriptive analysis of the activities of the organizations respectively. The fifth chapter is about analysis and interpretation of the results. The last chapter presents summary, conclusion and recommendations.

## **CHAPTER TWO**

### ***2. Review of Related Literature***

#### ***2.1 The Spread, Transmission and Prevention of HIV/AIDS***

##### ***2.1.1 The Spread and Transmission of HIV/AIDS***

The prevalence of all infectious diseases correlates strongly with the prevalence of poverty and substandard living conditions. It is no surprise that HIV/AIDS shows the same correlation. The overwhelming majority of the HIV-positive people (93%) live in the developing world, out which 70 percent are in Africa, the poorest continent of the world (Hunter, 2001).

In other regions of the world where HIV/AIDS has strong hold, it is tough among the members of poorer population groups. For instance in china, HIV is spreading among heterosexuals on the eastern seaboard and the gap between rich and poor increases. A similar situation is found in Thailand and other Asian countries. The distribution of HIV/AIDS is no accident, but can be traced to specific causes. Individual poverty, especially among women, poor health care system reduce the livelihood that poor women and men will receive care for STDs, a major co-factor in infection. In addition, poor nutrition increases the possibility that HIV will progress to AIDS, and increases the livelihood and severity of opportunistic infections (Hunter, 2001).

Hence, limited resources for prevention and care means that many people still do not know how to protect themselves from HIV transmission, nor do they have access to condoms for prevention, or testing and counseling to know their HIV status. Most cannot afford a diagnostic test where it available. As a result, some 90% of the world's HIV positive people do not know whether they carry the virus or not that will facilitate its rapid spread. In addition, once they are ill, therapy is not available for most HIV or AIDS affected people because it is too expensive (Hunter, 2001).

HIV can be transmitted from one person to another through various ways. The major transmission mechanisms for rapid spread of HIV infection in Ethiopia have been identified by the Ministry of Health (2000) as: heterosexual intercourse and multiple sexual partner (which is identified as the major route of transmission), mother-to-child transmission, unsafe blood transfusion with unscreened blood, and unsafe injection and illegal medical practices (UNICEF, 2002; HAPCO, 2004).

Poverty, a high rate of unemployment, wide spread of commercial sex work, gender disparity, illiteracy, population movement (rural-urban migration), harmful cultural practices and lack of openness with stigma and discrimination are the underlying factors fueling the spread of HIV/AIDS in Ethiopia (HAPCO, 2004).

### **2.1.2 Prevention of HIV/AIDS**

As there is one global economy, there is also one global public health prevention of infectious disease in any country, which is prevention for all. Worldwide prevention efforts focus on two types of prevention: *primary prevention*-preventing HIV exposure among uninfected individuals, and *secondary prevention*- preventing HIV transmission by those who are infected (Stine, 2003).

An HIV prevention program is one that is comprehensive and that addresses a community's prevention, care and treatment needs. Essential components of a comprehensive program include HIV testing and voluntary counseling, prevention of mother-to-child transmission, clinical care and antiretroviral treatment. Testing combined with voluntary counseling is an effective pivotal strategy in HIV prevention and care benefits for people who test positive as well as for those who remained HIV negative (Stine, 2003).

HIV can be prevented easily if a person knows how transmission occurs and is prepared to change his/her behaviors or to take the necessary precautions to prevent infection (UNICEF, 2002). Above all, prevention requires strong structural arrangements and political commitments of the government. This is because

prevention of the epidemic calls for campaign that every group of the society has to be mobilized and involved.

## **2.2 The Economic, Social and Demographic Impacts of the HIV/AIDS**

### **2.2.1 The Economic Impact of HIV/AIDS**

Although the economic and social impacts of AIDS in Ethiopia have not been comprehensively quantified, they are significant and growing. By undermining major determinants of economic growth and preventing increasing segments of the population from participating in the economy, HIV/AIDS increases poverty, on which it feeds in a vicious cycle (kloos and Haile Mariam, 2004).

It was estimated that AIDS is already causing a one percent annual reduction in economic growth of Ethiopia, which together with declining life expectancy and labor force reduction, is systematically undermining the country's efforts to reduce poverty through improvements in health, education, agricultural production, and household food security (kloos and Haile Mariam, 2004).

The agricultural sector, which is the major economic sector of Ethiopian economy, is severely affected due to the loss of productive and reproductive manpower. In addition, the non-agricultural sectors such as industrial sector, health and insurance were also affected by the epidemic. The impact of HIV/AIDS on industrial sector can be explained in the loss of workers due to increased AIDS deaths, lost in work days due to sickness and increased health care costs for AIDS patients (Negash, 2003).

In relation to this, a study conducted by the Employers Federation of Ethiopia (EFE), showed that the impact of HIV/AIDS is the most severe in the whole sales and retail trade followed by the manufacturing, agriculture and public service sectors. The major effects are found to be due to the following (EFE, 2003).

- HIV-related illness in workers resulting in reduced productivity,
- Many skilled workers quit their jobs because of sickness,

- Shortage of skilled manpower,
- Increased mortality in the workforce,
- Increased absenteeism,
- Rising medical cost due to HIV/AIDS.

AIDS has a profound impact on growth, income and poverty. For countries with HIV/AIDS prevalence rates of 20% or more, the GDP growth has been estimated to drop by an average of 2.6 percent annually (UNAIDS, 2002). The macro economic impacts can be identified as increased expending in foreign exchange in import of drugs. Lower government revenue and reduced private savings can cause reduction in savings and capital accumulation. Reduced worker productivity and investment lead to fewer jobs in formal sector.

### **2.2.2 The Demographic and Social Impacts of the HIV/AIDS**

The other impact of AIDS is increased in general mortality rates. One of the most visible impacts of HIV/AIDS on human welfare is its impact on both general and age-specific mortality rates (MOH, 2002). More than 60 million people have been infected with HIV since the beginning of the epidemic almost 20 years ago (UNAIDS, 2002).

According to the 5<sup>th</sup> report on AIDS by the Ministry of Health, the total population lost to AIDS was about 900,000 by 2003 and is projected to reach 1.8 million by 2008 if present trends continue. The report also indicated that adult (15-49 years) deaths due to AIDS are expected to rise tremendously, in the coming years and already account for about a third of all young adult deaths in the country (MOH, 2004).

One dramatic but not so visible consequence of HIV/AIDS is that it adversely affects the life expectancy at birth as well as at older ages. In Ethiopia life expectancy at birth in 1989, 2001, 2007, and 2014 were estimated at 43, 53, 55, and 59 years respectively. However, the increase in HIV-related deaths drastically slowed the rate of growth in life expectancy. Estimates taking into account the impact of AIDS resulted in life expectancy of 46 years instead of 53 years in 2001, and 50 years instead of the

expected 59 years in 2014 (MOH, 2002).

In relation to the social impact of AIDS, a study conducted by the Ministry of Labor and Social Affairs (MOLSA) showed that AIDS orphans unable to sustain their own livelihood are expelled from their parental residences following the deaths of their parents. Most AIDS orphans live with poor relatives with low educational background, who are often unable to provide for the physical, educational and health needs of child (MOLSA, 2003). In addition, they tend to drop out of school and repeat classes than their non-orphan counterparts (MOE, 2003). Clearly the increase in the number of orphans is likely to aggravate the already severe problem of homeless children who seek to make a living out of working and living in city street (MOH, 2002).

In addition, in all affected countries, the epidemic is putting the health sector under strain. Overall the quality of healthcare dropped. There is shortage of hospital beds and more health care personnel are affected while demand for health services is expanding (UNAIDS, 2002).

In general, HIV/AIDS has a visible effect and detrimental impact on Ethiopia's society and economy (MOH, 2004). It is killing individuals who are within the productive and reproductive age groups. Therefore, it has a greater impact on the socio-demographic and economic aspects of the population.

## **2.3 The Roles of Government and Non-government Organizations, CBOs and FBOs in the Response to the HIV/AIDS Problem.**

### **2.3.1 The Role of Government in Responding to the HIV/AIDS**

Governments have the fundamental responsibility to prevent HIV/AIDS, to protect the poor and to eliminate poverty, which are the major causes of the epidemic. The recent economic crisis or resource scarcity should not divert the attention of governments from making decisions based on national priorities and capacities. HIV/AIDS is a

development issue and there is a causal relationship between HIV/AIDS and socio-economic development (Sharifah, 2001). In relation to this the world Bank also put as, the national governments bear the responsibility for protecting their citizens from the spread of the HIV epidemic and of mitigating its worse effects once it has spread (World Bank, 1997).

Many countries are now making progress in developing and implementing national AIDS programs. In most cases, however, local governments have not received sufficient support in dealing with the epidemic, even though they are closer to the affected communities and their own capacity to deliver services is undermined by HIV/AIDS (Menbere Work and Flora, 2003). HIV/AIDS is a global epidemic but the greatest opportunity for addressing it rests at the local level. This realization has encouraged a shift towards supporting local responses to the epidemic largely by supporting response at the community level carried out by partners in civil society.

Therefore, local governments cannot continue with “business as usual” in the face of the AIDS epidemic. Hence, they need to be proactive and preemptive in order to avoid disruption of their core activities now or in the future (Menbere Work and Flora, 2003). Thus, the activities carried out by local government authorities will be a function of a range of factors. This includes, the extent and understanding of the local epidemic, existing activities and organizations dealing with HIV/AIDS, access to resources, communication channels to other stakeholders including national government and community participation in decision making at local level (World Bank, 2003).

In relation to roles of government (Sharifah, 2001) identified some strong political commitment areas as follows:

- Making AIDS a national agenda,
- Formulating AIDS polices that address gender, education, labor and migration to remove discrimination and criminalization,
- Developing laws, policies and strategies to eliminate poverty and the factors

that support the epidemic,

- Adopting a governance model that focuses on participation, inclusiveness, and representativeness of citizens,
- Allocating budget and other resources for AIDS Prevention and control,
- Strengthening government and non-government organizations, community-based organizations and faith-based organizations, collaboration and network at all levels and location, based on accountability and capacity building and identifying and mobilizing multi-sectoral involvement,
- Working with media to provide information which include sociological, cultural and economic perspectives,
- Facilitating research and conducting periodic review of research output including socio-behavioral research on HIV/AIDS and the sex sector as input for policy formation.

Therefore, much is expected from the government in policy formulation and implementation in responding to the HIV/AIDS problems.

As it was tried to mention in the introduction part of this paper, in Ethiopia, various institutional arrangements and efforts were made since the early emergency of the epidemic. One was the establishment of HIV/AIDS prevention and control offices (HAPCOs) at national and regional levels and the establishment of multi sectoral HIV/AIDS prevention and control programs were the major steps forward in the fight against HIV/AIDS and contributed to some noticeable achievements (HAPCO, 2004).

Some of the achievements were: -

- Increased level of awareness and positive trends in behavioral changes,
- Increased demand for VCT,
- Increased trend in condom distribution and utilization,
- Integration and expansion of mother- to-child transmission and ARV service,
- Positive trends in openness and reduction of stigma and discrimination,
- Encourage trends in involvement of PLWHA in the response,

- Integration and expansion of VCT.

However, the national responses and integrations are still far from adequate considering the magnitude of the problem. The following are some of the major weaknesses as identified by (HAPCO, 2004): -

- The health sector has been overwhelmed by the demand for services and because of its low capacity has failed to adequately spread head and integrate HIV/AIDS in health programs,
- There has been low implementation capacity in the education sector,
- There has been low implementation capacity in committees, and as a result lack of community ownership of the programs,
- There has been lack of focus on priority areas and target groups,
- There has been limited converge of basic prevention and care services including VCT, ARV, and PMTCT,
- There has also been duplication of efforts, wastage of resources and non – value adding, process oriented centralized activities,
- Some activities have resulted in dependency and externalization instead of community empowerment and mobilization,
- In general, limited capacity, inadequate leadership, problem of coordination, mainstreaming and ownership at all levels resulted in unchecked propagation of the epidemic.

From the above weaknesses one can infer that the responses of HIV/AIDS need additional arrangements that will fill the existing gaps. Therefore, integration empowering and mobilizing the community, improving leadership commitment and mainstreaming, coordination and networking need to be critically addressed in multi levels.

### **2.3.2 Why Should Local Government Authorities (LGAs) Address HIV/AIDS?**

Urban areas provide specific challenges and opportunities in fighting against HIV/AIDS. Regarding this, the World Bank (2003) has pointed out four core

arguments why LGAs should be concerned with responding to HIV/AIDS.

Primarily, urban areas are often the nexus for the spread of HIV/AIDS because of high population density and mixing, locus of location of transport hubs, and prevalence of vulnerable groups including youth, migrant workers, commercial sex workers and truckers.

Secondly, the urban poor are disproportionately affected by HIV/AIDS, with cost of care and loss of income resulting from HIV increasing the vulnerability of poor families. This is especially true among families living in informal settlements that have limited access to secure livelihoods, health care, and information.

Thirdly, the costs of HIV/AIDS to urban areas extend beyond the loss of life and increased suffering. Increased health service demands are coupled with a decreasing ability to pay for municipal services. A decreasing pool of labor supply, skills, and tax revenue also impede the ability of a municipality to pursue goals of development and threaten its ability to provide its core services.

Finally, LGAs are responsible for the social and economic development of the communities they serve through the delivery of many services. HIV/AIDS has the potential to undermine the considerable investments by national and local governments, donors, and other supporting agencies to strengthen municipal management, municipal finance, local service delivery and economic development. LGAs must therefore, define their response to HIV/AIDS within the context of their responsibilities.

On the other hand, all of the HIV/AIDS challenges facing urban areas also provide opportunity for action. Because, LGAs are closer to HIV/AIDS affected people and are; therefore, optimally placed to intervene. However, LGAs, by working closely with all levels of governments as well as working with local partners in the civil

society that are fighting HIV/AIDS at the community level (World Bank, 2003)

Thus, Local Governments have many functions, but implementing extensive HIV/AIDS responses has not traditionally fallen within their core business. Hence, their comparative advantage may be their capacity to foster an enabling environment by coordinating, managing, and contracting out new and existing local responses to HIV/AIDS. In addition, the most effective proportion strategies for HIV/AIDS may be very closely linked to how openly and honestly the threat of HIV/AIDS is addressed in local communities. Local leader may be able to do so a great deal to fight HIV/AIDS by using their position to fight stigma and facilitate open community discussion about the real and immediate impact of HIV/AIDS on family members, trends, and co-workers.

Therefore, by taking action against HIV/AIDS, local government authorities are securing the future of their town, cities and communities; and by supporting local government HIV/AIDS responses, national AIDS programs are fulfilling their mandates of supporting sustainable, accountable and local responses to HIV/AIDS (World Bank, 2003).

### **2.3.3 The Role of Faith-based Organizations (FBOs)**

FBOs are religious affinity groups that have various faiths. Although their primary aim is to provide spiritual teaching and guidance, most are enjoined by faith to undertake a social mission, which includes teaching, care and welfare (WB, 2003). In addition, before the development of the modern administrative state in the last century, FBOs were virtually the only providers of education, care and social welfare services. They continue to play important strengths: they have a strong commitment to education; care and social service numerous adherents, particularly in the developing world.

Faith-based organizations play an important role because believers will not do

anything they think their religion forbids. However, these organizations are working in the dominant cultural context where sex and sexuality are taboo subjects (Sharifah, 2001). According to Sharifah the involvement of religious leaders as influential to correct misconception includes:

- b. Incorporating universal core values in AIDS education (right to life, right to dignity, harm reduction, salvation, equality, love and compassion responsibility),
- c. Designing AIDS education program based on religious practices such as fasting, marriage contract and partnership, purification, prayer, alms etc,
- d. Recruiting religious 'influential' to:
  - Educate the congregation on moral values,
  - Provide counseling, care and support to PLWHA,
  - Collaborate with government and community groups at national, regional and international levels,
  - Strengthen interfaith networks.

On the top of these AAE (2002), has pointed out some advantages of the involvement of FBOs in the HIV/AIDS as follows:

- Operate in close proximity to group of people and have the opportunity to work with individuals, families, and community members directly affected by the epidemic,
- Often work with defined target population which present the scene to initiate dialogue and discussion with community members,
- The proximity to the community to better understand vulnerability to the impact of AIDS,
- Their targets are generally small in size and are less bureaucratic organizations, which present an opportunity to experiment different strategies and approaches relevant to HIV/AIDS programs,
- Local FBOs have an advantage to mobilize religious leaders and followers to their faith. These can particularly be employed in the fight against stigma; discrimination, and denial, to foster compassionate environment to the affected, to promote openness on sex and AIDS, and mobilize religious leaders

to a Faith-based response to the AIDS epidemic.

- Faith-based institutions, particularly churches, have played a major role in the introduction of modern medical services, manage health institutions and development of various social infrastructures, which avail opportunities to enhance access to HIV/AIDS related services.

In addition, churches play a preventive role in which they carrying out activities according to its means and in its own context, information and awareness-building sessions, training of trainers, design and distribution of educational posters, encouragement of serological testing before marriage.

Churches are also caring for people with HIV/AIDS and for orphans. This consists of attempts, in hospitals and in health centers belonging to the churches and other religious communities to treat the illness arising from and related to HIV/AIDS. Generally, these health structures are forced to send PLWHA back home, because they are unable to treat them properly.

Thus, religious institutions have a great importance in prevention, care and support and mobilizing their followers through their well-structured and cohesive system. In the case of Ethiopia, the Ethiopian Orthodox Church, the Ethiopian Islamic Supreme Council, the Ethiopian Catholic Secretariat and the Ethiopian Evangelical Churches are expected to play more active roles in the prevention, care and support activities. According to the Ethiopian strategic plan for intensifying multi-sectoral HIV/AIDS response document, these FBOs can play key roles in: IEC/BCC (promoting abstinence before marriage), counseling (spiritual support), providing welfare support to the infected and affected including hospices service providing care and support for OVC and promoting VCT before marriage (HAPCO, 2004).

In Ethiopia, FBOs have been involved in prevention, care and support programs and registered valuable achievements in complementing government's efforts. Because

they are parts and parcels of the community and have good understanding of the basic human needs, they are working in overall the country and have good access to resources, have long-term experiences in social services with relatively low overhead cost, and have committed leadership and staff to fight the epidemic. However, FBOs in Ethiopia and the study town have some limitations such as shortage of trained counselors, home based care providers, shortage of VCT centers to respond to the growing demand for testing, dependency on foreign financial assistances, in adequate utilization of local resources, inadequate human resources capacity and poor networking with other institutions (AAE, 2002).

#### **2.3.4 Community Based Organizations (CBOs)**

CBOs are typically grass roots membership organizations, often without a formal structure or registration. They are valued because they usually directly represent the ultimate beneficiaries. These are very important parts of local systems of care, and usually have membership requirements, responsibilities and duties. The members are residents of the community they serve, and are usually all volunteers (Hunter, 2001).

Most communities have developed a wide range of complex and innovative strategies to survive the adverse impacts of HIV/AIDS. Some studies revealed that in many areas, communities have spontaneously joined together to support and assist families and children affected by HIV/AIDS. The paradox is that community-based responses may be the most cost-effective interventions while being the least visible (UNAIDS, 1999).

In relation to community based approach, (Hunter, 2001) identified some of its advantages as follows:

- Encourages community self-reliance,
- Encourages voluntary and spontaneous links with HIV/AIDS prevention activities,
- Recognizes and builds on the reality that PLWHA and affected children get most their support from families and communities,

- Builds on natural family and community roles in protecting children and the elderly,
- Social workers and other professionals can focus on serving difficult cases, monitoring training, and support,
- Delivers more benefits effectively and inexpensively,
- Builds on African preference to maintain children within their families and communities.

Therefore, different community initiatives have sprung up to support and mitigate the impact of HIV/AIDS. It is showed that people affected by HIV/AIDS access help principally from family, neighbors, community institutions and local informal organizations. These community supports can take different forms. The major forms of community support and mitigation activities were identified by (UNAIDS, 1999) as follows:

- Community-based child care co-operative, day care and nutrition centers to free women to work in or outside the home,
- Orphan support in the form of nutritional and educational support,
- Repair of deteriorating houses,
- Home care and visiting orphans and AIDS patients,
- Preparation and distribution of school uniforms,
- Apprenticeship and training in the marketable skills for orphaned adolescents,
- Labor sharing,
- Income-generating projects to produce food and cash,
- Credit schemes for funeral benefits.

In Ethiopia for example, Iddirs were involved in HIV/AIDS prevention and care and support programs in various parts of the country. They are effective institutions to conduct the program because they can reach a wider area of the community, have experience in dealing with community problems, have community mobilization skills,

have effective structure and low overhead cost, and committed leadership.

The involvement of Iddirs are justified as they are working closely with the community and as they know members of the community who are affected by HIV/AIDS and the kind of intervention required to address the problem. Furthermore, the major potential of involving Iddir in the HIV/AIDS intervention program is considered to be: Iddir can mobilize the community easily, they are respected and recognized among members of the community, they are committed to support PLWHA and AIDS orphans and they are willing to participate actively in IEC and care and support programs.

On the other hand iddirs have some limitations such as the part-time nature of the job, have weak resource base and weak capacity in project proposal writing and implementation.

Therefore, communities have a great role in responding to the HIV/AIDS and other related problems. These necessitate strengthening the involvement of community in coping with prevention and control of the epidemic. The community responses to HIV/AIDS can be strengthened in a number of ways. These include the democratization and participation, reinforcement of the management skills of CBOs, training on project design, planning, management, monitoring and evaluation, the establishment of forum for NGOs and CBOs to exchange their views and experiences, and building links between donors, NGOs, CBOs, and the government (UNAIDS, 1999).

### **2.3.5 Non-Government Organization (NGO)**

NGO is any organization that is not public, not owned, run or directed by the government although it might have a close relationship to it or provide services on its behalf. It is usually used for not-for-profit groups. They can have a variety of sponsorships, including religious or educational and include foundations or trusts. The government of the country where they work or recognized by a host government as

registered in another country registers them. NGO staffs are usually not residents of the communities they serve and are usually paid although an NGO may have some volunteers (Hunter, 2001).

The NGOs in Ethiopia also took the first initiative in organizing the national workshop on HIV/AIDS with the theme “Breaking the Silence” in 1996. This particular initiative has opened the door for the sensitization programs that the NGOs later on conducted in order to prevent the spread of the disease (AAE, 2002).

There are a number of local and international NGOs implementing different care and support activities and providing financial support for the prevention and control of HIV/AIDS in the study region. Some of the activities include awareness building (through education and community conversation), care and support for OVC, condom distribution, and supporting community-based organizations such as anti-AIDS clubs, PLWHA by providing IGA schemes, iddirs, and youth associations. However, they have some limitations such as in adequate human resources, poor networking and collaboration, limited unreliable financial base and high staff turnover (AAE, 2002). In the study area, there are very few (5) NGOs working on HIV/AIDS related programs. From these NGOs, only one is working on HIV/AIDS programs while the others are working on reproductive health.

#### **2. 4 Collaborations and Partnership**

Collaboration has become a buzzword in discussion on the fight against HIV/AIDS, referring to a variety of efforts to bring people together for shared goals, projects or tasks. Donors and policy makers favor collaborative efforts among institution to bring about synergy. But true collaboration requires as set disposition, beliefs, commitments, and skills (Otaala, 2004). Even then, it is not easy to collaborate, especially across significant differences in geographical distances, cultural perspectives, experiences and personal, institutional or organizational histories. Policy makers and planners should recognize that HIV/AIDS is not only a health problem but

a development crisis, with an impact not only on community members, health but on nearly all aspects of community development. Policy and programs that seek to benefit HIV/AIDS affected families should be multicultural, linking the government, religious groups, NGOs, the private sector and the community in endeavors aimed at improving cooperation in supporting and strengthening community based responses (UNAIDS, 1999).

Collaboration is not a passive phenomenon, nor is it something one can check off one's strategic plan or assessment tool. Rather it is an ongoing work in progress, with all the highs and lows of human frailty and experience (Otaala, 2004). He further pointed out that collaboration, on the surface is about bringing together resources, both financial and intellectual, to work towards a common purpose. But true collaboration has an "inside" a deeper, more radical meaning. The inner life of collaboration is about states of mind and spirit that are open to do something.

In order to realize true collaboration, the government is expected to be committed. If government is committed then there will be evidence of support both at national policy level and involvement at local levels. The government is expected to play the leading role in creating an environment conducive to the promotion of sustainable development in the local areas.

All formal government organizations could play a bigger role if they reform their policies and programs to respond to the needs of the HIV/AIDS affected households. They can achieve this by reviewing the existing policies and programs and replacing them with one more responsive to the epidemic, and showing political and economic commitment for AIDS intervention (UNAIDS, 1999). By doing so, donors can help NGOs and CBOs to engage in long-term planning and capacity building. Multinational donors need to be more flexible with their funding in support of local initiatives, preferably by making many small grants rather than one large project grant. Moreover, roles and responsibilities in partnerships development of social service systems in resource deficit countries requires that all resources, including human

resources, be used with the utmost efficiency. In countries with evolving systems of family and community based care, the roles of partnerships are recognized and respected, realizing greater efficiencies of implementation (Hunter, 2001). Thus, in this way, long-term sustainability of community-based system is also more likely because communities are free to assume a wide variety of development roles.

As HIV/AIDS is not merely a health problem but a broad socio-economic crisis, it requires the active and continued involvement of all sectors at all levels. The involvement of a wide range of actors government sectors, the community, NGOs and FBOs, in the fight against the epidemic requires an effective and efficient coordination mechanisms and modalities; problem identification, information sharing planning implementation, monitoring and evaluation (HAPCO, 2004).

Coordination and networking between stakeholders and programs, avoids resource wastage and duplication of efforts, enhances success through documenting and disseminating best practices and research findings avail technical supports, and ensure a smooth flow of funds and information dissemination.

In Ethiopia, though initiatives have been taken to coordinate and facilitate multi sectoral responses through HAPCOs at different levels, coordination by no means enough, resulting in duplication of efforts, wastage of resources, and failure to achieve desired goals and objectives. This was due to partly lack of roles and mandates among stakeholders, poor management information systems, inadequate monitoring and evaluation and lack of transparency and accountability (HAPCO, 2004). Hence, institutional arrangements need to be reviewed to bring effective coordination and synergy.

## **2.5. Challenges in the Response to the HIV/AIDS**

The HIV epidemic is an unprecedented challenge to global public health. The prevalence and incidence of HIV are still rising rapidly in many places. And although few countries have achieved a measure of success in controlling the incidence, the number of people needing treatment continues to rise (Taylor, 2004). Yet the

HIV/AIDS problem is increasingly being viewed as a governance issue, while decentralization is at the far front of many governance discussions, there has been less focus on the impact of HIV/AIDS and on the role local government's authorities can play in the fight against HIV/AIDS (World Bank, 2003).

In addition, some factors such as policies and strategies, commitment and partnership, capacity (physical, human and financial), legal and donor priorities can affect the anti HIV/AIDS activities.

Inadequate institutional capacity is one of the challenges of HIV/AIDS intervention. Institutional levels of poverty, education, technical development, ethnicity, geography, and other factors all have critical importance to implement intervention program of HIV/AIDS (World Bank, 2003). Lack of coordination among key actors in terms of geographic and program component coverage absence of organizational structure, inadequate fund (at local levels), lack of political support and insufficient involvement of government sectors are the major problems facing the intervention program (Pact Ethiopia, 2000).

In Ethiopia, institutional arrangements were made earlier from national to the lower administrative levels (kebeles) involving various organizations and HAPCOs were established at national and regional levels since 2000. However, the role of HAPCOs is limited to national and regional levels to coordinate, mobilize resources and multi sectoral monitoring and evaluation. It is also limited to coordinate the interventions at Zonal, Wereda and Kebele levels through health structures without opening separate offices at these levels (HAPCO, 2004). The problem is the capacity of the local personnel at grass root levels and absence of responsible bodies at kebele levels to manage the intervention program.

Inadequate capacity at community level is another problem in response to HIV/AIDS. Community infrastructure is increasingly seen as having a major impact on health related issues including the implementation of HIV/AIDS program. Especially in countries with weak central governments, communities can play a vital role in

education, treatment and care (World Bank, 2003).

Gender inequality is another critical factor that needs to be addressed. In many countries of the world, women remain excluded from decision-making bodies in community councils and local government. Low level of education among women, particularly among some minorities, contributes to low level of awareness about the disease (World Bank, 2003). Therefore, limited involvement of the community in the process of program implementation adversely affects anti HIV/AIDS activities. Lack of health infrastructure are likely to impede the implementation of the HIV/AIDS program in the short term, particularly in the traditionally disadvantaged lowland areas at the periphery due to its high demand on resources and staffing (Kloos and Haile Mariam, 2004).

The shortage of trained manpower may also impede the decentralization process in short term, a constitutes and major problem in the disbursement of funds to end users at Kebele level, to co-ordinate projects, and to plan and monitor the overall implementations (Kloos and Haile Mariam, 2004).

The other challenge is that most people with HIV are in poor countries or in marginal groups and do not have access to Antiretroviral Therapy (ART) (Taylor, 2004). According to the scholar, ART is not a cure, but it diminishes the load and thus reduces damage to the immune system. It also reduces the statistical risk of passing the virus through whatever routes sexual or other bodily fluids, blood and breast milk. Treatment to prevent mother to child HIV transmission during birth or through breast-feeding can reduce pediatric infection rates by as much as 70 percent when combined with care for mothers and changes in feeding practices. Hence, treatment is also a preventive measure, reducing the chances of transmission by infected persons and enabling people with HIV to resist opportunistic infections, considerably reducing illness (Taylor, 2004). Evidences show that some 40 million people live with HIV about 6 million in need of treatment. But by 2003 only 400,000 people actually had

access to treatment, representing treatment coverage of 7 percent. Therefore, scarce resources and limited capacity means that many countries face problems in reaching existing goals for health services and social support (Taylor, 2004).

Social constraints and stigmatization are other areas of problem in response to HIV/AIDS. One reason societies are slow to come to grip with the HIV/AIDS crisis is that many aspects of the problem are considered taboo or are frowned on by large segment of the population (World Bank, 2003). It is difficult to raise awareness or build consensus on an issue that cannot be discussed openly. Thus, the problem is exacerbated by the fact that the majority of people affected by HIV/AIDS belong to groups that are marginalized by society.

Therefore, there is a need to change the environment of social constraints. This includes building political will and commitment, changing the legislative framework, and building capacity at the state and local level. In relation to this, the World Bank identified the critical steps that must be undertaken as follows (World Bank, 2003).

- Achieving and understanding of social context and influences,
- Disseminating public information at every level, including de-stigmatizing the disease,
- Provide education,
- Conducting workshops and seminars for health workers, educators, and community groups.

In general, effective responses would address the needs of each country, taking into account the status of the epidemic, the likely impact of a range of cost effective interventions in a given context, as well as the capacity for large-scale program planning, funding and implementation. The range of actions would include the development or strengthening of institutions for planning and coordination, multi-sectoral approaches to program development and implementation prevention of new infections, affordable care for persons living with HIV/AIDS, social support to mitigate the impact of AIDS on families and orphans, as well as effective monitoring and evaluation of program efforts (UNAIDS, 2001).

## CHAPTER THREE

### ***3. Methodological Framework***

Since this study is an evaluative in its nature, the program/process evaluation framework was used to analyze the study problem. A process evaluation is concerned with how a particular program actually operates. It focuses on staffing, budget, activities, materials and administration of the program. It also serves as assessing whether the program has been implemented as planned and in compliance with legal and regulatory requirements. In addition, process evaluation enables us to identify the problems that have been encountered in the implementation stage.

#### **3.1 Framework for Program/Process Evaluation**

The framework is comprised of a number of steps that must be completed in any evaluation, regardless of the settings. These steps provide the foundation and all steps should be finalized before moving to next steps (Baker et.al, 2000).

The first step is ***engaging stakeholders***: Stakeholders must be engaged in insure that their perspectives are understood. The primary groups of stakeholders are those involved in the program operations; those served or affected by the program, and the primary users of the evaluation results. The scope and level of stakeholder involvement will vary with each program being evaluated.

The second step is ***describing the program***: This step sets the frame of reference for all subsequent decisions in the evaluation process. At a minimum, the program should be described in enough detail that the mission, goal and objectives are known. Moreover, the program's capacity to effect change, its stage of development, and how it fits into the larger organization and community should be known.

The third step is ***focusing the evaluation design***: This step entails making sure that

the interests of the stakeholders are addressed while using time and resources efficiently. Among the items to be considered at this step are articulating the purpose of evaluation, determining the users and uses of the evaluation results, formulating the questions to be asked, determining which specific design type will be used and finalizing any agreements about the process.

The fourth step is *gathering credible evidence*: At this step, the evaluators need to decide on measurement indicators, sources of evidence, quality and quantity of evidence, and logistics for collecting the evidence.

The fifth step is *justifying conclusions*: This step includes the comparison of acceptability interpreting those comparisons, judging the worth, merit or significance of the program and creating recommendations.

The sixth step is *ensuring use and share lessons learned*: At this step, lessons learned in the course of action or in the implantation stage would be explained.

The purpose of process evaluation is towards the activity directed at describing or documenting what actually happened in the course of the program. It can be crucial for communicating best practices to others who want to replicate elements of the program. This element of the evaluation looks at what is happening with the strategy. It is also important in informing stakeholders what is happening in the program, what is working and what is not working. It also provides an opportunity to regularly report on activities in the implementation plan. In addition, process evaluation tracks the strengths and weaknesses of the program and seeks to identify what parts of the program are working and which are not (Baker et.al, 2000).

Therefore, in process evaluation the following important questions need to be addressed. These are, what are the program & how are they operated? How resources including staff, budget, and time are allocated and managed? What is the relationship

between program activities and program outcomes or objectives? To what extent has the program been implemented as planned? Is the program implemented as planned? Is the program implemented efficiently? What problems, both anticipated and unforeseen, have been encountered in the implementation stage? What adjustments in program operation and management are necessary to address the programs?

In general, in process evaluation some measures have to be examined as a part of an evaluation. These are, participants characteristics (age, sex, ethnicity, education, occupation, experience affected by the intervention); characteristics, organizational setting and process (types of intervention, activities, services including materials, staffing and administration); characteristics of program and objectives including satisfaction level and unanticipated outcomes both negative and positive); and cost associated with the program (personnel, materials, equipment, facilities) and benefits associated with program outcomes.

Therefore, based on the framework first, the objectives of the program were identified. Next, the activities planned and resources allocated to accomplish the program were assessed. Then, whether the program was implemented as planned and the problems encountered in the implementation stage were evaluated. Finally, the significance of the program and the necessary adjustments needed in the program operation and management was recommended.

### **3.2. Research Design**

The purpose of this study was to assess the role-played and challenges encountered in prevention and control of the HIV/AIDS in the study area. Thus, a survey study was selected because it was believed to be more appropriate considering the time allocated for the study and enables to undertake sampling of various segments of population at a point in time. It is also more appropriate to assess the current problems under investigation.

### **3.3. Source of Population**

The population of Nekemte town was estimated to be 70,000 during the year 2005.

The town has been restructured into 6 sub-administrations. There were anti-HIV/AIDS councils at town and each sub-administration levels.

There were also five NGOs (OSSA, FGA, FHI, MARIE STOPES and PACARD), four FBOs (EECs, EOC, ECC, EIASC), sixteen anti- HIV/AIDS clubs and CBOs (Iddirs, women's and youth's associations) operating on the intervention programs of the HIV/AIDS in the town. Therefore, in order to obtain clear picture and adequate information about the implementation of the anti-HIV/AIDS activities, the above-mentioned organizations and the beneficiaries of the two implementing organizations (OSSA and EECMY) were considered as sources of the study population for quantitative data while the rests were used for qualitative purpose.

### **3.4. Sample Population and Sampling Techniques**

It is often impossible, impractical, or extremely expensive to collect data from all population. Hence, a representative of the larger population was taken in order to undertake a study. Based on this reality, to collect quantitative data, a multi-stage sampling method was used to select the implementing organizations and their beneficiaries as the sample organizations population. Accordingly, out of all HIV/AIDS implementing organizations that were found in the town, two organizations, (EECMY and OSSA) were selected using purposive sampling procedure. This was because the two organizations were more involved in implementing HIV/AIDS programs in terms of duration of time and scope of activities that they were undertaking as compared to the others.

Regarding the selection of the beneficiaries (orphans, PLWHA, anti-AIDS, iddirs, youth and women associations), first a sample size determination formula for precision in single proportion was used to determine the sample population as follows:

$$n = P(1 - P)/e^2$$

Assuming P to be the proportion of the respondent beneficiaries that will positively

approve the anti-HIV/AIDS activities of the organizations and taking that proportion to be about 50% and 2.5% standard error, the sample size was computed to be 400 respondents.

$$n = 0.5(1-0.5)/0.025^2$$

$$n = 0.5(0.5)/0.000625$$

$$n = 0.25/0.000625$$

$$n = 400$$

Then, since the total numbers of beneficiaries of the two organizations were almost equal, 200 respondents from each organization were taken. After the sample size was determined, a list of the beneficiaries of the two organizations was used to screen out the illegible ones due to their ages. For the screened eligible beneficiaries a new list was prepared and 200 respondents from each organization were randomly selected using a simple random sampling method. This sampling procedure was used to give the respondents equal chance to be included in the study

To supplement the quantitative data, key informant interviews and focus group discussions were administered. Hence, four religious institutions (EECs, EOC, ECC, EIASC) were purposively selected because of their doctrinal differences. From these FBOs one representative from each was interviewed using purposive sampling technique.

To select CBOs first, one anti-HIV/AIDS club and one Iddir from each sub-administration were randomly selected to give the organizations equal chances. Then, two representatives from each selected Iddirs and anti-HIV/AIDS clubs were selected using purposive sampling method.

Similarly, one youth's and one women's associations from each sub-administration were considered and two representatives of each six sub-administrations were interviewed using purposive sampling procedure. In addition, one representative of the town's HAPCO and PLWHA were included in the study using purposive sampling technique.

Four government offices of the town administrative units (Municipality, Education, Information and Culture, and Women Affairs Offices) were purposively selected due to the nature of their duties and a representative of each was included in the study.

The participants of FGDs were selected from various HIV/AIDS program-implementing organizations. Hence, four religious leaders, three NGO officers, three Iddir leaders, six sub-administration leaders (one from each), and one person (representative) from town administration, PLWHA, women and youth associations were purposively selected and participated in FGDs.

### **3.5. Sources of Data and Method of Collections**

Both primary and secondary data were used in the research undertaking. For collecting primary data methods such as structured questionnaires, unstructured interview and focus group discussions were employed.

The structured questionnaires with both closed and open-ended items were administered for 400 beneficiaries. The items in the questionnaire were adapted from the activities being undertaken by the organizations and were prepared in English then translated into Amharic in order to make communication easy.

The unstructured interview guides were also used to secure information from 69 representatives of HIV/AIDS program implementing organizations such as officials of HAPCO of the town, sector offices, NGOs, FBOs, town sub-administrations; representatives of iddirs, anti-HIV/AIDS clubs, youth, women and PLWHA associations and two FGDs were conducted. Secondary data from various published and unpublished materials were used to complement the results of the primary data collection.

### **3.6. Method of Data Analysis**

The data gathered were analyzed in terms of the study objective already designed and the findings were considered at each methodological level. The process of analysis

was carried out by using largely descriptive and simple statistical method. The data obtained through the questionnaires were analyzed using simple statistical tools on SPSS program and discussed using tabulation for descriptive statistics like frequency and percentage; and a Chi-square test was used to check the associations between the variables.

The data gathered, through unstructured interviews and focus group discussions were analyzed using qualitative data analysis method. First, the data were checked for accuracy, usefulness and completeness. Then, the major ideas that recur during the classification of the data into groups were considered as themes around which the findings are organized.

Finally, the findings from the questionnaires were organized and these in turn were seen in relation with focus group discussions and key informant interview results. Then, the completely aggregated results were used for the inference of the conditions.

### **3.7. Variables of the Study**

The independent variables used in the study were: financial problems, lack of trained manpower, coordination and partnership problem; and lack of awareness creation programs.

The dependent variable used in the study was the success of the program, as perceived by the beneficiaries of the program as to the level of performance of the respective organizations.

### **3.8 Ethical Considerations**

Persons who were made the subject of research were informed about their entitlements on the confidential treatment of all information they gave on personal matters. In addition, a formal letter was written from the Department of RLDS and submitted to concerned authorities to get consent and support during data collection. All the respondents were informed clearly about the purpose of the study and their consent was asked before they responded to the questionnaire. The names of the respondents were not written on the questionnaires. Information through which individuals can be identified (lists of persons, interview materials, and the like) was kept under secret.

In general, the researcher showed due respect for individual's privacy. Informants were entitled to exert control over, whether or not to make sensitive information about themselves available to others. The informants had also been given all the information they need for reasonable understanding of the research and its consequences. Moreover, the demands and interest of organizations were taken into consideration.

## **CHAPTER FOUR**

### **4. Descriptive Analysis of Activities by Organizations**

#### **4.1. Organization for Social Service for AIDS**

Organization for Social Service for AIDS (OSSA) Nekemte branch is one of OSSA branches situated in the west part of the country, Nekemte town. Since its commencement, Nekemte OSSA branch has played an imperative role in addressing the challenges of HIV/AIDS. It helped the community by enhancing their awareness on HIV/AIDS prevention and mobilizing the resources to mitigate the impact. The branch has initiated community empowerment through organizing anti-AIDS clubs to promote awareness of their counter peer groups on prevention of HIV/AIDS and conducting capacity building to enhance the involvement of other implementing organizations in response to HIV/AIDS (Temesgen, 2005).

The major objectives of the organization in the year 2005 were:

- Prevent the spread of HIV/AIDS,
- Provide care and support for infected and affected individuals and groups,
- Scale up self-help program, and
- Reduce stigma and discrimination related to HIV/AIDS through promotion of organized community and home based care programs.

#### **4.1.1 Human and Financial Resource Allocations**

As can be seen from Table 4.1, the organization planned to have 12 required personnel and hired 11 employees during the year 2005. If one looks into the qualifications of the employees, only two (18.2%) were professionals while the remaining 81.8% were supportive staff. Thus, the organization significantly constrained by shortage of qualified manpower as compared to the nature of services to be delivered and the scope of activities to be performed during the year 2005.

As far as financial resource is concerned, OSSA allocated a total of ETB 560,522 to run the program for the year 2005. Out this, 249,900 ETB was allocated for care and support program while the remaining 122,887 ETB was for preventive program. From the total of money allocated, a program cost accounted 66.5% while the rest 35.5% was recurrent cost. Though the organizations allocated a significant budget for the programs, the amount of money allocated for recurrent cost was slightly inflated.

**Table 4.1, Manpower of OSSA by Qualification, Work experience and Monthly Salary**

No	Position	No		Qualification	Required experience	Monthly salary
		Required	Existing			
1	Coordinator	1	1	MPH	14 years	2015
2	Ass. Coordinator	1	1	Diploma	23 years	1560
3	Accountant	1	1	Diploma	4 years	1105
4	Secretary/Casher	1	1	Diploma	5 years	600
5	Guard	1	1	9 <sup>th</sup>	4 years	455
6	Guards	3	3	6 <sup>th</sup> , 8 <sup>th</sup> , 12 <sup>th</sup>	-	900
7	Store Keeper	1	1	12 <sup>th</sup>	-	300
8	Driver	1	1	12 <sup>th</sup>	3 <sup>rd</sup> years	450
9	Center coordinator	1	-	BA	2 years	1000
10	IGA Coordinator	1	1	12 <sup>th</sup>	4 years	300
	<b>Total</b>	<b>12</b>	<b>11</b>			<b>104,200</b>

#### 4.1.2 Organization and Management

OSSA head quarter is responsible for all activities and creates partnership with donor agencies. Internal monitoring and evaluation is conducted by the main office regularly where as external monitoring and evaluation is conducted by co-signatory bureaus and line departments. The main office also handles the administrative issues and releases budget according to the agreement made in the document. OSSA Nekemte branch office is, therefore, responsible for overall co-ordination and running of the activities.

### **4.1.3 Activities Planned Vs Accomplishments**

#### **i) Care and support**

As can be seen from Table 4.2, OSSA planned to provide care and support in the form of financial, facilitating adoption, provision of school materials and uniforms and tutorial services to 20, 20, 90 and 210 orphan children and made available to 55, 12, 138 and 136 orphan children respectively. In addition to this, the counselors provided the orphan children with counseling services. To accomplish these activities, the organization planned to provide 91,500 ETB and accomplished 79,813 ETB that makes its performance level 87.2% against its financial plan. The physical plans were over achieved except facilitation of adoption. The under achievement of the performance level of the organization was due to the performance of facilitating adoption, which was performed only 21% of the plan. (The details are shown in Table 4.2).

OSSA on the other hand, planned to address 110 needy PLWHA with 158,400 ETB and provided for 160 PLWHA 161,640 ETB. This made its performance level 137% and 102% against its physical and financial plans respectively. In addition, the organization has provided counseling services to HIV/AIDS victims and 80 PLWHA were under ART treatment in the year 2005.

The over achievement of the physical plan indicates the availability of high demand for support in the study area. However, the respondent beneficiaries reported that the amount of money provided to them was inadequate because people living with HIV/AIDS have had larger family size, have no other sources of income and cannot afford to work.

#### **ii) Prevention Program**

As it was stated earlier, one of the main objectives of the organization was prevention of the spread of HIV/AIDS through informing about the transmission of HIV/AIDS and enhancing the implementing community organizations.

**Table 4.2, Activities Physically and Financially Planned VS Accomplishment**

No	Activities	Physical			Financial		
		Plan	Actual	%	Plan	Actual	%
	<b>Program based Activities</b>						
<b>1</b>	<b>Care and support</b>						
1.1	Orphan care & Support	20	55	275	24,000	35,500	147.9
1.2	Facilitation of adoption	20	12	60	37,500	8000	21
1.3	Provision of school material and uniforms	90	138	153	18,000	18,850	105
1.4	Tutorial service for orphans	210	136	65	12,000	17,000	145
1.5	PLWHA care & support	110	151	137	158,400	161,640	102
	<b>Sub Total</b>				<b>249,900</b>	<b>241,453</b>	<b>96.6</b>
<b>2</b>	<b>Prevention</b>						
2.1	Training on RH for adolescent youth	30	30	100	6,000	5,499	92
2.2	Counselors' refresher training	22	18	82	7,500	5,925	79
2.3	Strengthening AACs	5	5	100	5,000	4,235	122
2.4	Training of counselors in orphan family life	15	16	106	2,916	2,916	100
2.5	Skill training for orphans	12	28	233	12,055	21,187	175
2.6	Orientation for vulnerable women in micro business	15	30	200	1,500	1,500	100
2.7	Provision of seed money for PLWHA	15	24	160	6,000	13,040	217
2.8	Provision of seed money for trained orphans	12	3	25	6,000	3,424	57
2.9	Provision of seed money for oriented women	15	30	200	6,500	6,500	100
2.10	Other program costs				69,416	68,980	99.3
	<b>Sub Total</b>				<b>122,887</b>	<b>133,206</b>	<b>108.4</b>
	<b>Program Cost Total</b>				<b>372,787</b>	<b>374,659</b>	<b>100.5</b>
<b>3</b>	<b>Recurrent</b>						
3.1	Salaries and related costs				152,935	104,864	68.5
3.2	Administrative cost				34,800	26,033	74.8
	<b>Sub Total</b>				<b>187,735</b>	<b>130,897.8</b>	<b>69.7</b>
	<b>Grand Total</b>				<b>560,522</b>	<b>505,556.8</b>	<b>90.2</b>

As it was shown in Table 4.2, OSSA planned to conduct various trainings in such as RH for adolescent youth and social skill, counselors' refresher training, training of counselors in orphan life education skill, training for orphans, training on micro business for vulnerable women and strengthening AACs (99 trainees) with a total of

34,971 ETB. Accordingly, the organization made available to 127 trainees with 41,262 ETB. The performance level was 128.3% and 117.9% against its physical and financial plans.

With the ultimate goal of reducing dependency on external support and vulnerability to HIV infection among AIDS orphans, PLWHA and vulnerable groups in the community through developing and strengthen IGA and self- help scheme, OSSA planned to address a total of 42 people with a total of 18,500 ETB and provided a total of ETB 22,964 seed money to 57 people that makes its performance level 135.7% and 124.1% against its physical and financial plans. This sub-component is very important and encouraging because it enhances to ensure sustainability and self-reliance.

In relation to reducing stigma and discrimination through home and community based care, the organization trained 57 volunteer caregivers and being provided home and community based care for chronically will patients.

#### **4.2. The Ethiopian Evangelical Church Mekane Yesus (EECMY)**

The Ethiopian Evangelical church MekaneYesus central synod set the following objectives to address the problem of HIV/AIDS victims:

- To provide necessary basic human needs to AIDS orphans,
- To provide the orphans the necessary school material and fees,
- Conduct training on HIV/AIDS for target groups.

##### **4.2.1 Human and Financial Resource Allocations**

EECMY-CS HIV/AIDS victimized orphan children rehabilitation project required four employees and hired three of them while one is not employed during the study year. As one can understand from Table 4.3, 75% of the required personnel existed in the program. When we look into the qualifications of the personnel, only one was diploma holder. The remaining were 12<sup>th</sup> completers and below. The preventive program of the organization handled by one coordinator that makes the total number

of employees of the organization four. From this, one can conclude that the organization faced largely with shortage of qualified manpower.

**Table 4.3, Manpower of the EECMY by Qualification, Service Year and Monthly Salary**

No	Position	Qualification	Service Year	Number		Monthly Salary
				Required	Existing	
1	Coordinator	12+2	22	1	1	1400
2	Social Worker	11+1	29	1	1	697
3	Social Worker	12 <sup>th</sup> Comp.	25	1	-	547
4	Casher	12 <sup>th</sup> Comp.	21	1	1	505
	<b>Total</b>			<b>4</b>	<b>3</b>	<b>3149</b>

In terms of financial resource, the branch allocated a total of 772,957 ETB. Out of this, 336,746.50 ETB was for program cost (249,000 for care and support and 76,746 for preventive) while the remaining 121,464 ETB was recurrent (administrative) cost. The program cost accounted 84.3% while the recurrent cost was 15.7%.

As the beneficiaries responded to the questionnaires administered, the amount of resources allocated to them was inadequate. This idea was also supported by the responses of key informants interviews held with various representatives of implementing organization and the result of focus group discussions. They confirmed that there is a gap (mismatch) between the need for services and supply capacities of the organization.

#### 4.2.2 Organization and Management

Nekemte is a center for the EECMY-CS. From this center administrative and coordination assistances are given to 10 parishes found in the surrounding five administrative zones. Therefore, the management of the project rests on the EECMY-CS, which is responsible for the overall coordination and running of the activities of the project.

#### 4.2.3 Activities Planned Vs Accomplishments in Care and Support

The activities physically and financially planned against their accomplishments were presented in Table 4.4 below.

**Table 4.4, Activities planned VS Accomplished Physically and Financially by the Organization**

No	Activities	Unit	Physical			Financial		
			Plan	Actual	%	Plan	Actual	%
	<b>A. Program based</b>							
1.	Care and Support							
1.1	Provision of food	Orphan	120	120	100	144,000	141,900	98.5
1.2	School uniform and clothing	Orphan	120	120	100	24,000	30,558.16	127.3
1.3	Provision of school material and school fees	Orphan	120	120	100	15,000	6,828.42	45.5
1.4	Conducting home visit	Orphan	120	120	100	6,000	20,757.20	346
1.5	Supplementary food and medical treatment	Orphan	12	12	100	10,000	17,087.98	170.7
1.6	Giving tutorial services	Orphan	12	12	100	10,000	10,117.30	101.2
1.7	Orphan get together	Round	2	2	100	6,000	-	-
1.8	Preparing workshops	Round	1	1	100	10,000	5,570.90	55.7
1.9	Training of Counselors	Round	1	1	100	10,000	-	-
1.10	House maintenance for target groups	No	5	10	200	10,000	36,640.18	366.4
1.11	Erecting electricity for needy groups	No	5	10	200	4,000	1329.59	33.2
1.12	Computer purchase	No	-	1		-	5000	-
	<b>Sub Total</b>					<b>249,000</b>	<b>275,770.03</b>	<b>110.3</b>
2	Preventive training and workshops	Trainees				76,746.50	60,461	78.7
	<b>B. Recurrent</b>					<b>121,464</b>	<b>116,970.83</b>	<b>96.3</b>
	<b>Grand Total</b>					<b>772,957</b>	<b>789,432</b>	<b>102.1</b>

The EECMY planned to provide support in the form of financial, material and

psychosocial services to 120 orphans and made available to all. The organization planned to provide a total of 249,000 ETB and provided 275,770 ETB that makes its performance level 110.7%. The over achievement was reported due to the increase in purchase price of materials needed for the program (sub-program). The details are shown in Table 4.4. The EECMY also planned to conduct various trainings and workshops with a total of 76,746.50 ETB and invested 60,461 ETB. The performance level of the organization against its financial plan was 78.7%. The performance level of OSSA is better than that of EECMY in undertaking training for the implementing organizations and HIV/AIDS victims.

### **4.3 Other Community Institutions**

Other community organizations such as FBOs, Iddirs, women and youth associations, anti-HIV/AIDS clubs, the association of PLWHA, and the local government units were included in the study.

#### **4.3.1 Formal FBOs and their Functions**

To this category belong a number of religious organizations such as the Ethiopian Evangelical Churches (EECs), Ethiopian Orthodox Church (EOC), Ethiopian Catholic Church (ECC), Ethiopian Islamic Affairs Supreme Council (EIASC) Nekemte branches were involved in the intervention.

The union of EECs in the study area constituted nine denominations. The union formed a taskforce that is comprised from each denomination, which deals with the response to HIV/AIDS. This task force has a regular meeting per month to monitor and evaluate the activities of churches in the anti-HIV/AIDS programs.

The churches have been undertaking the preventive (awareness creation); and care and support programs. It was reported that some churches undertake awareness creation for their believers using health personnel who are the members of the churches and church leaders.

In relation to financial and material support for AIDS victims, some churches

contribute money and materials like clothes from believers through HIV/AIDS committee of the respective churches and provide to the victims. Other churches have project fund for prevention and care and support.

The EOC has been undertaking the prevention and control of HIV/AIDS problem. The church undertakes awareness creation program for commercial sex workers, community leaders, TOT, and training of counselors. It also undertakes support for orphans and PLWHA by providing money.

The ECC is in the process of being involved in anti- HIV/AIDS activities. The church has designed a two-years action plan to undertake the preventive, care and support programs. The EIASC is also undertaking preventive, support and care activities for HIV/AIDS victims with money contributed from its followers.

#### **4.3.2 Community Based Organizations**

Curbing the epidemic can be undertaken effectively only through strong community mobilization by enlisting the support and participation of network of independent community institutions. Of these types of organizations, Iddirs, anti-HIV/AIDS clubs, youth and women associations were also undertaking the program.

##### **4.3.2.1 Iddirs**

Iddirs have different forms. They are organized, either by gender, by neighborhood, or by profession. Of all institutions, Iddirs are the most affected one by HIV/AIDS. They have consumed their resources, their time and energy for burial services. This has shaken the financial position of Iddirs. Because of this, Iddirs have shown interest in fighting HIV/AIDS.

Iddir leaders reported that they have been involved in fighting HIV/AIDS epidemic to some extent. The major strategies being undertaken by Iddirs are care and support, and IEC. The care and support program is carried out by identifying patients first and in

collaboration with FHI and OSSA. These two organizations provide training for Iddir members on how to give first aid and counseling services. Hence, the trained Iddir members provide care and support for patients in terms of preparing food, keeping their sanitation and in psychosocial support.

There are 91 Iddirs registered in Nekemte town. These Iddirs are currently merging and forming unions in each sub-administration and town administrative levels to strengthen their capacity and to be involved in solving the socio-economic problems of the community. To realize these issues, 8 Iddirs were selected from the town and have shared experience from Addis Ababa (Gulalle) Iddirs in the year 2004/2005.

According to the leaders of Iddirs, efforts are made to create coordination after sharing of experience from Addis Ababa. However, there is still resistance of Iddirs to be coordinated. They reported that it takes time to make consensus among Iddirs because some of them are suspicious of intentions from official structures.

#### **4.3.2.2 Anti-HIV/AIDS Clubs**

Anti- HIV/AIDS clubs have played an active role in disseminating information to the community. To do so, 16 anti-HIV/AIDS clubs have been established in Nekemte town. Out of these, 12 clubs were established by their own initiatives while the rests were formed by youth and women associations.

The anti- HIV/AIDS clubs have been involved in the fight against HIV/AIDS since 2000 in the town through preventive and supportive strategies. The preventive strategies include various demonstrations, coffee ceremony, and awareness creation during assembly through administrative structures. They also undertake the supportive activities in terms of renewal of houses, preparing food for patients of AIDS (PLWHA). The clubs reported that there is no annual or strategic plan to undertake the program because they do not have the capacity to prepare plans and projects. The association depends on any voluntary organization or individual who can prepare

plans and projects for them. In addition, there are volunteers who provide counseling and psychosocial support for members.

#### **4.3.2.3 Youth Associations**

The youth associations have also been involved in the intervention of HIV/AIDS program since 2003/04. They have been undertaking the preventive (IEC); and care and support programs. They undertake awareness creation programs for youth in and out-of-school and to the community members. In addition, they initiate youths to test their blood (VCT) and to fight stigma and discrimination. The associations also provide care and support for HIV/AIDS victims by renewing their houses, preparing food for patients etc. However, they reported that the programs are not being implementing as intended because youths are dependent of their families and leave the associations in search of job (members turnover), and shortage of fund base.

#### **4.3.2.4 Women Associations**

Women associations are expected to be involved in fighting the HIV/AIDS epidemic because the most affected groups of the society are women. The women associations of each sub-town administration have been involved in the intervention of HIV/AIDS. They reported that the associations are undertaking IEC program for their members and the whole women on meetings, using the administrative structure and coffee ceremony. They also provide support for PLWHA with material, psychosocial, preparing food and similar services. However, they reported that the association lacks capacity to implement the program properly.

#### **4.3.2.5 PLWHA Groups**

PLWHA association is an institution formed by HIV positive persons and AIDS Orphans. In Nekemte “Abdi” or “Tesfa” association has been established with a total number of 46 members of PLWHA. The objective of this association is to provide care and support service for members, educating the general public on HIV/AIDS epidemic and assisting PLWHA in the protection of their rights. To ensure these objectives the

chairman of the association participated in experience sharing with other association in Addis Ababa and Uganda.

The Association reported that the major constraint to be finance for developing income generating activities in the area of MSEs like trade, weaving, metalwork in order to strengthen the association. In addition, the Association needs training on advocacy program, project proposal writing, workshop on human right abuse and related issues. It also reported that there is problem of leadership support because the Association has no advisory board.

#### **4.3.3 Local Government Structures**

Governments have the fundamental responsibility to prevent HIV/AIDS and protect the poor from the epidemic. Because of local government's proximity to the society, they are expected to do more on behave of the community such as for example, to coordinate and give leadership support to the implementing organizations and mobilize the community.

The town's HAPCO coordinator reported that they are working in accordance with national legislations and other cultural work procedures in HIV/AIDS intervention program. The coordinator also reported that efforts have been made to coordinate the implementing organization since recent time even though it is not strengthened. The HIV/AIDS programs of sub-town administrations (Kebeles) have been led by committee constituting various groups of community leaders. In the case of government sectors the representatives of offices reported that due to the restructuring of the sector offices, the issue of HIV/AIDS was not given emphasis and there were no mainstreamed responses.

The local government units also reported that there is no adequate leadership support both technically and financially to undertake the program from the region. They reported that there is no adequate trained manpower to manage the program. Less

qualified health personnel with inadequate office facilities and other necessary materials are reported to lead the HAPCO of the town. At sub-town (kebele) administration levels, there are no responsible body and health personnel to undertake the program. In relation to the financial sources of the town, due to the recent restructuring of the town there is no fund base to undertake the program except few support is given from OSSA. In general, it is reported that there is a problem of human, financial and institutional capacity for undertaking the program.

Monitoring and evaluation activities are also reported to be weak. There is no continuous monitoring, evaluation and reporting system on HIV/AIDS program. This implies that there is less attention and weak structure of HIV/AIDS control. Unless activities are monitored, evaluated and reported timely, it is difficult to differentiate the successes and the failures. Hence, this will make planning and decision making difficult.

## ***CHAPTER FIVE***

### ***5. Analyses and Interpretation of Data***

#### **5.1 Socio-demographic Characteristics of the Study Population**

The socio-demographic characteristics of the study population are described in Table 5.1 below.

As shown in Table 5.1, half of the respondents (50.75%) were within the age group of 11-20 years. In addition, about 57% of the respondents for this study were females indicating that how far the epidemic is affecting more females than males.

Literate and high-level education attainers are more capable of understanding and channeling information. Table 5.1 shows that about 18% of the respondents have no formal education. Out of these, 13.75% are illiterate and 4.25% can only read and write. When we look further into the level of education among the literate respondents, about 70% of the respondents have attained primary and secondary education. Out of these, 37.25% and 32% have attained primary and secondary education, respectively. Those who have had the opportunity for education at certificate or above level were only 12.75%.

*Table 5.1 Socio-demographic Characteristics of Respondents, March 2005*

Variables	Sex		Total	Percent
	Male	Female		
<b>Occupation</b>				
Student	89	86	175	43.75
Government Employee	12	16	28	7
Unemployed	38	39	77	19.25
House wife		69	69	17.25
Daily laborer	16	8	24	6
Others	18	9	27	6.75
<b>Total</b>	<b>173</b>	<b>227</b>	<b>400</b>	<b>100</b>
<b>Age</b>				
11-20	104	99	203	50.75
21-30	23	63	86	21.5
31-40	29	43	72	18
41-50	13	18	31	7.75
51 and above	4	4	8	2
<b>Total</b>	<b>173</b>	<b>227</b>	<b>400</b>	<b>100</b>
<b>Marital status</b>				
Single	123	118	241	60.25
Married	26	31	57	14.25
Divorced	5	14	19	4.75
Separated	3	7	10	2.5
Widowed	16	57	73	18.25
<b>Total</b>	<b>173</b>	<b>227</b>	<b>400</b>	<b>100</b>
<b>Religion</b>				
Orthodox	75	91	166	41.5
Protestant	86	116	202	50.5
Catholic	7	4	11	2.75
Muslim	5	16	21	5.25
<b>Total</b>	<b>173</b>	<b>227</b>	<b>400</b>	<b>100</b>
<b>Ethnicity</b>				
Oromo	132	182	314	78.5
Amhara	28	36	64	16
Guraghe	10	3	13	3.25
Tigray	3	6	9	2.25
<b>Total</b>	<b>173</b>	<b>227</b>	<b>400</b>	<b>100</b>
<b>Education level</b>				
Illiterate	14	41	55	13.75
Read and write	11	6	17	4.25
Primary	69	80	149	37.25
Secondary	47	81	128	32
Certificate and above	32	19	51	12.75
<b>Total</b>	<b>173</b>	<b>227</b>	<b>400</b>	<b>100</b>

Marital status of the study population could be attributed to the age distribution of most of the respondents, which belongs to the younger age groups. Urban centers are also characterized by relatively delayed in age at first marriage both for girls and boys. Table 5.1, shows that more than half (60.25%) of the respondents were unmarried where as the married ones account for about 15% of the study population. Similarly, the percentage of widowed also shows a significant figure (18.25%) that indicates the effect of HIV/AIDS is being observed in marital status.

The distribution of religious affiliation as can be seen from Table 5.1, the followers of protestant and orthodox religions account 92% of the study population. Out of these, 50.5% and 41.5% of the respondents are protestant and orthodox respectively. The remaining 8% of the respondents is followers of Catholic and Muslim religions.

In relation to ethnicity, the Oromo ethnic group comprises more than three-fourth (78.5%) of the sample population. Amhara and Guragie follow constituting 16% and 3.25%, respectively. The remaining (Tigrai) accounts less than 3%.

As it is shown in the Table 5.1, about 44% of the respondents are students, indicating that how far the HIV/AIDS affects the education sector. The unemployed respondents also account 19.25%.

## 5.2 Respondents' Ranking of Extent of Service Given by the Organizations

The respondent beneficiaries ranked the extent of service given by the organizations as high, medium and low as shown in Table 5.2 below.

*Table 5.2 Respondents' Ranking of the Extent of Services Given by Organizations*

Activities	EECMY			OSSA	
	Score	Freq.	Percent	Freq.	Percent
IEC	Low	21	10.5	22	11
	Medium	101	50.5	106	53
	High	78	39	72	36
	<b>Total</b>	<b>200</b>	<b>100</b>	<b>200</b>	<b>100</b>
Care & Support for AIDS Orphans	Low	49	24.5	43	21.5
	Medium	123	61.5	92	46
	High	28	14	65	32.5
	<b>Total</b>	<b>200</b>	<b>100</b>	<b>200</b>	<b>100</b>
Care & Support for PLWHA	Low	97	48.5	100	50
	Medium	77	38.5	70	35
	High	26	13	30	15
	<b>Total</b>	<b>200</b>	<b>100</b>	<b>200</b>	<b>100</b>
Counseling Service	Low	94	47	106	53
	Medium	80	40	51	25.5
	High	26	13	43	21.5
	<b>Total</b>	<b>200</b>	<b>100</b>	<b>200</b>	<b>100</b>
Training undertakings	Low	156	78	144	72
	Medium	39	19.5	47	23.5
	High	5	2.5	9	4.5
	<b>Total</b>	<b>200</b>	<b>100</b>	<b>200</b>	<b>100</b>
Are the HIV/AIDS programs being implemented as intended?	Yes	74	37	77	38.5
	No	126	63	123	61.5
	<b>Total</b>	<b>200</b>	<b>100</b>	<b>200</b>	<b>100</b>

As can be seen from Table 5.2, more than half of the respondents of the study population rated the performance level of both organizations in conducting IEC as medium. In this case, OSSA seems to perform better than EECMY because 53% of the respondents rated, as medium while it was 50.5% in the case of EECMY. This implies that there is a problem in undertaking IEC program, which was also corroborated with the organizations' officials as they have mentioned the pressure of a challenge in the implementation of IEC program because of lack of financial and human resources.

The extent of care and support services provided for AIDS orphans with EECMY and OSSA were rated as medium by 61.5% and 46% of the respondents respectively. More than 24% of respondents of EECMY and 21 % of the OSSA 's respondent beneficiaries rated the performance level of these services as low. It can be generalized that the extent of care and support service provided by both organizations is medium, indicating that there is a challenge in the provision of care and support services. This was also supported by interview results that the amount of money provided is not adequate for the PLWHA. Because some have large family size, have no other source of income and some others cannot afford to work.

Table 5.2 also shows that about half of the respondents under the study rated the degree of counseling service provided by the organizations as low. OSSA in this case, seems to provide better than EECMY because 21.5% of the respondents rated its performance level as high where as it was 13% in the case of EECMY. In addition, as the researcher realized during the study, OSSA assigned voluntary caregivers and they are providing counseling services 3 days per week.

As it can be seen from Table 5.2, the extent of training undertakings of EECMY is rated as low by 78% of the respondents. In the case of OSSA, 72% and 23.5% of the population study rated as low and medium respectively. This shows that there is a problem in undertaking training in both organizations. The EECMY is evaluated as much weaker in this activity.

As can be seen from Table 5.2, 63% and 61.5% of the EECMY's and OSSA's beneficiaries reported that the programs are not implementing as intended, respectively. This shows that more than 60% of the respondents (beneficiaries) were not satisfied with the services provided. From this we can infer that there are challenges in the intervention programs.

### 5.3 Association Between Implementation Challenges and Perceived Success of the Programs

To assess the degree of association between the implementation challenges identified by the reviewed projects and the community's perception of program success, a bivariate analysis was done as shown in the Table 5.3 below:

**Table 5.3 Associations Between HIV/AIDS Program Implementation Challenges and their Impact (independent variables vs. dependent variables)**

Types of implementation challenges	Are the HIV/AIDS programs being implemented as intended?			Total	Pearson chi-square value	Asymp..sig. (2 -sided)
	Yes	No				
Financial problem	Yes	76	173	<b>249</b>	14.664	.000
	No	75	76	<b>151</b>		
	<b>Total</b>	<b>151</b>	<b>249</b>	<b>400</b>		
Lack of skilled man power	Yes	42	98	<b>140</b>	5.505	.019
	No	109	151	<b>260</b>		
	<b>Total</b>	<b>151</b>	<b>249</b>	<b>400</b>		
Coordination problem	Yes	27	77	<b>104</b>	8.311	.004
	No	124	172	<b>296</b>		
	<b>Total</b>	<b>151</b>	<b>249</b>	<b>400</b>		
Lack of awareness creation	Yes	46	78	<b>124</b>	.033	.857
	No	105	171	<b>276</b>		
	<b>Total</b>	<b>151</b>	<b>249</b>	<b>400</b>		

To see the associations, the value of Pearson's chi- square statistical test was used. Accordingly, among the four implementation challenges, financial problem, lack of skilled manpower and coordination problem showed significant associations with community perception of degree of success of the programs. However, the association between lack of awareness creation and the community perception of success in the program implementation was not statistically significant though it was reported as one of the major implementation challenge under the study.

#### **5.4 Challenges Identified in Response to the Epidemic by the Organizations**

As officials of the two organizations reported, both organizations have had strategic and annual plans in place to undertake the programs and technical capacity to develop projects. However, the responses of quantitative data from the beneficiaries and qualitative data from key informants and focus group discussions showed that there are challenges facing in responses to the epidemic by implementing organizations.

The major challenge encountered in the response to the HIV/AIDS problem is reported to be the inadequacy of resources. Both organizations are dependent on foreign donors. The sources of fund for OSSA, for instance, are from German Development Service, individual sponsorships and religious organizations. The Lutheran World Federation (LWF) also funded the EECMY in the first phase and the Finnish Evangelical Lutheran Mission (FELM) has been supporting the program since 1991. Currently, the Evangelical Lutheran Church in America (ELCA) also started financial support for the training program to curb the spread of HIV/AIDS epidemic by increasing awareness and knowledge among the community to bring behavioral change as well as easing the suffering of PLWHA since the year 2000. Even though these foreign donors fund the organizations, the amount of money obtained is not adequate for the implementation of the program (there is incompatibility of the need and supply).

Similarly, the representatives of other community organizations (key informants) responded that lack of financial resource is the major problem in responding to the HIV/AIDS problem. According to the respondents, the problem of financial capacity is related to budget allocated for the program on one hand and the poverty and unemployment rate of the people of the town on the other hand. Even though there are no recent dependable data on poverty and unemployment, it is assumed to be larger proportion.

Financial resource will affect the realization of the program and other capacity of the organizations. Shortage of money means inadequacy of the provision of materials, lack of awareness creation and training programs, shortage of human expertise and absence of behavioral changes. These in turn, result in the over all failure of the program and will contribute to the spread of the HIV/AIDS.

The other challenge that was identified and is related to financial resource is that of the human resources. The number of human resource of the organizations is very small. For instance, the EECMY has only two unit coordinators for each prevention and cares and support service programs and one supporting staff. OSSA has also only two professional staff members. The care and support (counseling) programs are undertaken by volunteers. Therefore, the human resources of the organizations are not adequate in number as well as in necessary professional expertise.

The representatives of local administrative units also reported that there is no responsible body that will coordinate the program at sub-administration levels. They reported that HIV/AIDS program is considered as additional activity (tasks). The absence of officially assigned skilled manpower with required knowledge means poor design and implementation of activities and eventual failure of the overall program.

In relation to coordination and partnership, the representatives of implementing organizations responded that there is a start in forming partnership among voluntary institutions to mobilize the community and identify the vulnerable groups of the community. HIV/AIDS prevention and control program requires both horizontal partnership (with implementing organizations) and vertical relationships with next administrative levels. However, the respondents reported that partnership initiatives with evangelical churches and other implementing organizations are not usually implemented in sustainable manners. In general, the intervention efforts seem to be poorly coordinated in the area.

Weak coordination will result in misuse and duplication of efforts and resources. Unless the prevention and control program of HIV/AIDS is managed in coordinated manner, it could not be met the desired goal and bring the required change. In addition, weak coordination has also impact on institutional capacity of implementing organizations. The issue of HIV/AIDS requires local legislations and work procedures that fit with the traditions of the community in coordinated manner.

The sub-town administrative leaders reported that there is no clarity of mandates and directives that guide the implementer of HIV/AIDS programs. This has resulted in management problem within the implementing organizations as well as poor efforts in mobilizing the community on sustainable manner. The sector offices are also not fully involved in the intervention program due to the newly restructuring of the town and there are no mainstreaming responses and monitoring and evaluation mechanisms.

The association of PLWHA reported that the right of PLWHA is not fully respected. There is still stigmatization and discrimination even by health workers as well as by the society at large. Due to this, some HIV carriers hesitate from declaring their status with implications for fueling the transmission.

In general, the above challenges are some of the major problems that are encountered by the community organizations and need to be solved in the future. Some are internal weaknesses had to be solved by themselves while the others need the involvement of other parties. For instances, the financial, human and poverty and unemployment problems cannot be solved by the local organizations alone. These require support from regional government and other partners.

## ***CHAPTER SIX***

### **6. Conclusions and Recommendation**

#### **6.1. Overall Assessment**

The study was conducted with a general objective of assessing the role played by local leaders and examining the challenges encountered in coping with anti-HIV/AIDS activities.

There have been very limited numbers of NGOs in the study area, which have launched their HIV/AIDS programs since early 1990s. Organization of Social Service for AIDS (OSSA) and the Ethiopian Evangelical Church Mekane Yesus were the major ones that have been undertaken the preventive, care and support programs of HIV/AIDS.

Information, Education and Communication (IEC) is one of the main national HIV/AIDS prevention strategies in relation to prevention of the HIV infection. The two implementing organizations under the study played a major role in providing technical assistance and accessing trainings for other HIV program implementing organizations and beneficiaries. In addition, they have conducted education sessions in various intervention areas. However, more than half of the respondents reported that the extent of IEC program conducted was evaluated as medium, indicating the dissatisfactions of the beneficiaries with program being undertaken by the respective organizations. These dissatisfactions were mainly because of lack of the capacity of the organizations.

Care and support is also the other global and national HIV/AIDS prevention strategy being undertaken in multi levels. Thus, the need for care and support to AIDS victims is currently gaining recognition owing to the growing number of those living with virus and their dependents as well as the growing numbers of orphans and homeless young persons. In order to mitigate such problems, the implementing organizations are undertaking care and support programs. Accordingly, OSSA and EECMY have

provided support in terms of financial, material and psychological to AIDS victims. The amount of money and material provided to AIDS orphans was rated as medium with about 54% for both organizations. This is due to the capacity of the organizations and incompatibility of the need and supply of resources.

Similarly, the provision of money and materials for PLWHA is reported to be low by half of the respondents. This indicates that the amount of money provided was not adequate for PLWHA. The reason for inadequacy of money is reported that larger family size, absence of source of income and inability to work.

The other component of care and support strategy is counseling services. This is very important needy area to address the problem of HIV/AIDS victims and mend their moral. In this regard, the study showed 75% of the respondents rated the performance level of the implementing organizations as low indicating inadequacy of the service being provided.

Training is also a very important activity to strengthen the capacity of actors in HIV/AIDS intervention. It is one of the national strategies to be used in prevention and control of the epidemic. The two organizations are undertaking training for various community leaders, government and non-government organizations. The performance of training undertakings of EECMY and OSSA was evaluated (rated) as low by 78% and 72% of the respondents respectively, indicating that there is a problem in training undertakings. Weak training means inadequate capacity of implementing organizations, which in turn, affects the intervention program negatively.

One globally and nationally accepted and efficient strategy in fighting HIV/AIDS pandemic is, the issue of coordination and partnership. To ensure this, the commitment and political will of the respective authorities is decisive. In the study area, it was observed the local authorities of the town showed less commitment in creating close

partnership among implementing organizations in fighting the epidemic.

The other issue related to coordination and partnership is, mainstreaming responses and monitoring and evaluation strategy. The national strategy in response to HIV/AIDS dictates these two strategies in multi-sectors. However, in the study area these strategies were not given emphasizes and were not implemented.

The overall performances being undertaken by the implementing organizations were reported not as intended by more than 60% of the respondents. This shows that the beneficiaries are not satisfied with the service being provided and programs undertaking, indicating the existences of challenges that hinder effective implementation of the programs.

## **6.2. Conclusions**

1. As it was indicated in the study, two major strategies namely, the preventive (IEC and training); and care and support (financial, material and psychosocial support for HIV/AIDS victims) have been undertaken by the implementing organizations in the study area. Attempts made in the prevention and care and support for HIV/AIDS infected and affected groups of the society was valuable and encouraging. However, the degree of involvement of implementing organizations and the achievements of the programs were inadequate as compared to the scope of the problems and were not implemented as intended.

2. In order to undertake effective implementation of the HIV/AIDS programs, the availability of sufficient resources are very decisive. In the study area, the implementing organizations invested a significant amount of resources, sustained the lives of AIDS victims, and contributed to the prevention of the epidemic. In this regard, the result of the study showed that there were inadequate resources like financial, human and material allocations that could not satisfy the needs of target groups and have hindered the proper success of the programs.

3. The intervention of the epidemic is not the responsibility of few or a single institution. It requires a collective involvement of individuals, groups, government and non-government organizations and community institutions. In the study area it was observed that there was a good start some organizations showed coordination and partnership in response to HIV/AIDS programs. However, the findings of the study indicated that the implementing organizations have weak coordination and partnership in undertaking the activities of HIV/AIDS programs.
4. Prevention programs should emphasize on enhancing individuals capacity to translate knowledge of modes of transmission into knowledge of means of prevention and focus to be made on the adherence to consistent application of means of protection in daily life. In this regard, though efforts made by the implementing organizations in conducting awareness creation programs, the result of the study showed that there were inconsistent and inadequate awareness creation and advocacy programs.
5. Undertaking capacity building through training has major implications for prevention of the HIV/AIDS in government offices, FBOs and CBOs involved in the intervention programs. In relation to this, the two organizations contributed in training the beneficiaries, counselors and other representatives of organizations. But the findings of the study showed that there were inadequate provisions of training for the beneficiaries and other HIV/AIDS program implementing organizations.
6. The intervention of HIV/AIDS program requires multi-sectoral and multi-level responses. In this regard, mainstreaming responses to the pandemic in all development programs were not accomplished and there were poor monitoring and evaluation strategies in controlling the programs in the study area.

### **6.3 Recommendations**

1. The financial deficiencies have to be filled by allocating adequate money for effective implementations of the program at town and sub-town administration levels. Hence, the fund base has to be widened through mobilization of internal and external sources, and community at large.
  
2. To solve the problem of skilled manpower, the local government of the town and the implementing organizations have to assign or hire the required qualified personnel and design short-term training programs for the representatives of government structures and community institutions that will complement the efforts of the existing actors at work place and on community bases.
  
3. To undertake coordinated and efficient HIV/AIDS intervention activities, the local authorities in all levels have to be committed to mobilize the community towards the program. Hence, the local government units of the town have to take the responsibility of creating conducive environment for close partnership to avoid duplication of efforts and providing effective leadership to address the existing problems of HIV/AIDS.
  
4. The local government of the town has to arrange consistent awareness creation programs and has to be committed to mitigate those factors that will contribute to the spread of the epidemic such as poverty and unemployment.
  
5. In order to strengthen the capacity of the existing HIV/AIDS implementing organizations, additional capacity building strategies need to be designed. Hence, the local government has to develop projects to solicit funds and attract more NGOs working in the area of HIV/AIDS program to the study town.
  
5. Mainstreaming responses to the pandemic in all development programs and in multi-sectors need to be accomplished and the local government should devise monitoring and evaluation mechanisms in order to undertake effective responses to the HIV/AIDS program.

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***ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE STUDIES  
DEPARTMENT OF REGIONAL AND LOCAL DEVELOPMENT  
STUDIES***

The purpose of this questionnaire is to gather the necessary information on the current implementation of HIV/AIDS program by two NGOs, identify major challenges and come-up with possible solutions.

**CONSENT REQUEST**

All information given by you will be strictly confidential. Your name will not be registered in this format and will not be used in connection with any information you telling me. I greatly appreciate your cooperation in responding to this study. Would you be willing to participate? If yes, proceed. If no, thank and stop here.

Signature of the interviewer certifying the informed consent has been given by the respondent.

Name \_\_\_\_\_ signature \_\_\_\_\_ date \_\_\_\_\_

***PART I background information***

1. Residence: Town \_\_\_\_\_ Kebele \_\_\_\_\_

2. Occupation: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Sex:

- a) Male                      b) Female

5. Marital status:

- a) single                      b) married                      c) divorced

- d) separated                      e) widowed

6. Religion:

- a) Orthodox                      b) Protestant                      c) Catholic

- d) Muslim                      e) others



7. Ethnic group:

- a) Oromo                      b) Amhara                      c) Guragie  
d) others

8. Educational level:

- a) Illiterate                      b) read and write                      c) primary  
d) secondary                      e) certificate and above

***Ii. Issues related to the HIV/AIDS program activities of NGOs***

9. To what extent the activities of the NGOs are being implemented? (3 = high,  
2 = medium, 1=low)

No	Activities	3	2	1
1	Information, education and communication (IEC)			
2	Care and support for AIDS orphans			
3	Care and support for PLWHA			
4	Counseling services			
5	Training undertakings			

10. Are these programs being implemented as intended?

- a) Yes                      b) No

11. What challenges have been encountered in the implementation stage?

- A) Financial problem  
B) Lack of skill manpower  
C) Coordination problem  
D) Lack of awareness creation

12. What adjustments in program operation management are necessary to address these challenges?

**Guiding Questions for interviewees (NGOs officials)**

1. Are stakeholders involved in planning process and project development?
2. Do you have technical capacity to develop projects?
3. What type of plans do you have? Annual? Strategic?
4. Is administrative, finance and accounting system in place? Are there any gaps in terms of implementing HIV/AIDS programs?
5. Do you have network with other institutions?
6. What is your capacity to solicit fund? Do you have diversified funding base?
7. Is there a link between staff capacity and your HIV/AIDS program?
8. Is there participatory monitoring & evaluation and reporting system in place?
9. What challenges do you see in fighting the epidemic?
10. What do you recommend for the future?

**Guiding Questions for interviewees (CBO representatives)**

1. Is your organization involved in fighting the HIV/AIDS epidemic?
2. Do you have technical capacity to develop project?
3. How do you involve the community in the fighting against the epidemic?
4. What is your source of fund?
5. What are your capacity needs?
6. What problems have you encountered in implementing the program?
7. What do you recommend for the future?

### **Guiding Questions for interviewees (FBO representatives)**

1. What is the program of your organization in relation to HIV/AIDS?
2. Do you have technical capacity to develop projects?
3. What type of plan do you have? Annual strategic?
4. Are administrative, finance, and accounting systems in place? Are there any gap in terms of implementing HIV/AIDS programs?
5. What is the role of the FBOs in mobilizing the community in HIV/AIDS?
6. Do you have strategy on HIV/AIDS?
7. Are there networking, Coordination and collaboration among FBOs and other implementing organization?
8. Do you mainstream HIV/AIDS in your developmental programs other than health?
9. What is your fund base? Do you have any strategy? Is there local resource base?
10. Is participatory monitoring and evaluation in place?
11. Is there sectoral expertise in the organization on HIV/AIDS?
12. What challenges do you see in fighting the epidemic?
13. What do you recommend for the future?

**Guiding Questions for interviewees (representative of PLWHA Association)**

1. Do you think the rights of PLWHA are respected?
2. Do you have a membership recruitment strategy?
3. Do you involve members in the planning of your project?
4. Is there board providing leadership?
5. What is your capacity to demand and utilize resources?
6. What capacity gaps are there? (In terms of governance, management practices, financial system and program implementation capacity)?
7. What challenges do you envisage for fighting the epidemic?
8. What are your priority capacity needs?
9. What do you recommend for the future?

**Guiding Questions for interviewees (representatives of Local Government Structures)**

1. What are the programs of your organization in relation to HIV/AIDS?
2. What is the role of the leadership in fighting the epidemic?
3. Are stakeholders involved in planning process and project development?
4. Do you have technical capacity to develop projects?
5. What type of plans do you have? Annual? Strategic?
6. Is there collaboration among HIV/AIDS program implementing organizations?
7. Is administrative, finance and accounting systems in place?
8. Do you network with other institutions?
9. Do you have fund raising strategy?
10. Is there a link between staff capacity and your HIV/AIDS program?
11. Is participatory monitoring, evaluation and reporting systems in place?
12. What challenges do you see in implementing HIV/AIDS?
13. What do you recommend for the future?


### **Guiding Questions for Focus Group Discussions**

1. What activities are being undertaken to prevent and control HIV/AIDS?
2. Are these activities implemented as planned? Are there any gaps in terms of implementing HIV/AIDS programs? Are there monitoring and evaluation systems?
3. What changes do you perceive/see in relation to prevention and control of HIV/AIDS?
4. Do you have the necessary capacity (financial, human and institutional) to implement HIV/AIDS program?
5. Is there coordination and partnership among HIV/AIDS implementing organizations?
6. What challenges do you see in implementing the programs?
7. What do you recommend for future to solve the existing challenges?

**Declaration**

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

Name Teshome Dugassa

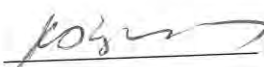
Signature 

Date \_\_\_\_\_

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

Damen Haile Mariam (M.D., Ph.D.)

Advisor



Signature

14/12/06

Date