

ASSESSMENT OF CBO's AND FBO's ROLES IN PREVENTING AND CONTROLLING HIV/AIDS: THE CASE OF DILLA TOWN

Bekuretsion Hailesilassie Abreha

Researcher

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Acronyms

ACORD- Agency for Cooperation in Research and Development

AIDS- Acquired Immune Deficiency Syndrome

ART-Anti Retroviral treatment

BSS- Behavioural Change and Communication

CBO- Community Based Organizations

FBO-Faith Based Organizations

FGD-Focus Group Discussion

GO- Government Organizations

HIV- Human Immune Deficiency Virus

IEC- Information Education and Communication

STD- Sexually Transmitted Disease

NGO -Non-Governmental Organization

IDDIR - A form of indigenous voluntary association meant for burial, mourning activities as well as related social security activities.

KEBELE- Smallest local administrative unit in the Ethiopian urban structure of Kifle-ketema - Sub-city unit, according to the recent urban re-structuring of Dilla town.

Abstract

The purpose of this research was to assess the roles played by CBOs and FBOs in prevention and controlling HIV/AIDS epidemic in Dilla town. In this research CBOs & FBOs are considered as the major community & faith based organizations that can ensure the mobilization of every section of the community in anti HIV/AIDS activities.

In order to assess the roles played by the different CBOs & FBOs, interview & focus group discussion were made with the leaders of the organizations. The study set out objectives and used qualitative methods and selected 15 samples using random sampling technique. The data sources are interview of NGOs leadres, key informants of church leaders, Iddir leaders. The activities of governmental and non-governmental organizations were assessed with regard to their activities in involving in HIV/AIDS intervention activities. It was found that increased mortality rate among majority of target group resulting in increased expenditure on burial and related activities progressively depleted the financial resources of the organizations.

Community based HIV/AIDS intervention that is undertaken in involving CBOs & FBOs in anti HIV/AIDS activities is in its infancy. Few efforts are being made to involve in anti HIV/AIDS activities by certain NGOs and GOs. Very few NGOs are currently working in the areas of HIV/AIDS interventions. The existing attempts are recently adopted in which very few took part. The existing activities of involved CBOs & FBOs are mainly reliant on the technical and financial assistance obtained from NGOs and GOs. The activities of NGO range from capacity building for local community based organizations like Iddirs, to provision of care and support for AIDS patients and AIDS orphans. The role of partner NGOs are considerable in taking part in HIV/AIDS interventions, as well as enhancing their role in these activities.

Partner NGOs implement projects, which obviously are limited in resources, time and area. The sustainability of many of these activities is limited. The activities of GOs include formation of Iddirs council and facilitate capacity building activities for the community in anti HIV/AIDS activities.

There is large amount of financial resources availed at the national level, which is meant

to enhance the financial capacity of CBOs in their anti HIV/AIDS activities. However, COBOs & FBOs rarely prepared project proposals to use the funds. Limited technical capacity is the major factor that hinders the success of such attempts.

CHAPTER I

1.1 INTRODUCTION

For two and a half decade, HIV/AIDS as an academic, sensitive topic and a health issue has been the subject of a large debate and concern, full of controversies. Most of the researches done on this topic have been carried out by Western scholars with greater focus on non-Western, developing or underdeveloped countries. Even though some have made strong statements about cancer, Alzheimer, or obesity being one of the most serious health crises facing the Western World, others prefer to look at the relatively brief history of HIV/AIDS, as becoming more than a ghastly and relentless disease. For Weeks, 'it has come to symbolize an age where fear, prejudice and irrationality battle against reason, responsibility and collective endeavour' (Aggleton and Homans 1988, 10).

Eventually, there are real enough reasons for debate. Some tens of millions of people throughout the world (i.e. adults and children estimated to be living with HIV around the world are infected by the HIV. More so, there are an increasing number of persons living with HIV who are unaware of their status in the world, even though emphasis has been made regarding the need of HIV testing being free of charge and most especially including a proper follow-up in terms of guidance, support, treatment and care. More still, it is understood that a later diagnosis may lead to much more suffering which can result in greater morbidity and mortality – as about 24% of all HIV positive death has been linked to late presentation.

Meanwhile, a number of factors have also been identified as encouraging the low testing rate. They are divided into two groups patient related: including the lack of perception of being at risk, lack of knowledge on testing possibilities, fear of positive results, concerns about lack of confidentiality and the fear of stigmatization. The other is health system related including populations marginalized

and excluded (migrants) and the geographic location.

1.2 BACKGROUND OF THE STUDY

Most societies have changed since the beginning of the AIDS pandemic. Some twenty years ago, persons with HIV/AIDS were perceived or regarded with fear and hostility; today, it seems they are more or less likely to arouse compassion and a sense of solidarity. The initial reaction of both individuals and governments was often to deny the existence of the virus/disease, but this has now been largely replaced by greater lucidity and understanding (Lawson 1999). In this study, we have observed the history of HIV/AIDS as a subject of large debate, full of controversies and polemic. Most noticeably, the origin and evolution of the disease - that which causes immense suffering to millions of people around the world. According to Iliffe (2006), the first traces of the human immunodeficiency virus (HIV) that causes the acquired immune deficiency syndrome (AIDS) was gathered in 1959 amidst the collapse of European colonial rule in Africa. In January, 1959 the control of the African townships of Leopoldville, the capital of the Belgian Congo was briefly seized by the protesters,

shocking its rulers into frantic decolonization. In the same year an American researcher studying malaria took blood specimens from patients in the city. When testing procedures for HIV became available during the mid 1980s, 672 of his frozen specimens from different parts of the Equatorial Africa were tested. The only one proved positive, came from unnamed African man in Leopoldville, now renamed Kinshasa. The test was confirmed by the Western Blot technique – generally considered the most reliable method – and by different procedures in three laboratories. Although nothing of this kind can be absolutely certain, as Iliffe puts it, there are strong grounds to believe that HIV existed at Kinshasa in 1959 and that it was rare. Iliffe continues that once AIDS was recognized as a medical condition early in the 1980s; researchers found several early accounts of patients whose recorded symptoms had resembled it and not implying the lone Kinshasa case as constituting the major beginning of the AIDS epidemic in Western Equatorial Africa.

But Luc Montagnier, whose laboratory first identified HIV, thought that an American man who died in 1952 after suffering fever,

malaise, and especially the pneumocystis carinii, pneumonia that afflicted later American AIDS patient, was the earliest case, but no blood had been stored for later testing and the symptoms demonstrated only suppression of the immune system, for which there could have been reasons other than HIV. The same was true of a Japanese Canadian who died in 1958 and a Haitian American in 1959. More convincing was the case of the fifteen-year-old, sexually active American youth who died in 1969 with multiple symptoms including an aggressive form of Kaposi sarcoma, a tumour common in later AIDS patients. His stored blood tested by Western Blot was HIV positive, but the finding was later questioned.

Other possible early cases were found in Western, Equatorial Africa. There was no stored blood by which to confirm a specialist's retrospective diagnosis of AIDS in an African woman who was hospitalized at Lisala on the middle Congo in 1958 and died in Kinshasa four years later after suffering wasting and Kaposi's sarcoma. But a Norwegian seaman contracted HIV sometime before 1966, possibly while visiting Douala on the coast of Cameroon in 1961-1962, and later infected his wife and

child, all three retrospectively tested HIV-positive, although with a form of the virus different from that found in Kinshasa in 1959 (Iliffe 2006).

Another controversy concerning the origin and evolution of HIV/AIDS is briefly explored in two scenarios by Feldman (1990). In scenario one he writes, 'it was the 1950s and we were in a biological warfare laboratory in possibly the United States or the Soviet Union. An experimental retrovirus, later to be named human immunodeficiency virus, type one (HIV-1), was manufactured using an existing animal retrovirus as a model – something went terribly wrong. The virus escapes and gradually made its way through sexual relations, infected needles, and blood transfusions to diverse at risk populations in different parts of the world'.

In scenario two, Simian immunodeficiency virus (SIV) mutated into human immunodeficiency virus, type two (HIV-2), perhaps from blood contamination while skinning an infected monkey, possibly in a remote West African village many decades ago. This now human retrovirus rapidly evolved, and as it inadvertently spreads through sexual transmission into new tribal

populations to the East, it took on a more aggressive and more lethal character. By the late 1950s, the new virus HIV-1 had entered into the Belgian Congo (now D.R. Congo) and perhaps elsewhere in central Africa. With the rise of urbanism and jet travel in central Africa, the virus spreads rapidly from city to city throughout central Africa, into Haiti, and among gay men in North America. By the late 1970s about four percent of all sexually active gay men in San Francisco were infected. By the early 1980s, about four percent of all men and women in the central African nation of Burundi were similarly infected.

However, it is possible that there are other viable sources of origin as well as evolution of HIV/AIDS but in any case persons of age group at least to the South West Province of the Republic of Cameroon, precisely in the town of Limbe think the virus originated among white middle class gay men in New York and San Francisco of the United States in the early 1980s. These thoughts are derived as a result of the HIV/AIDS sensitizing program that was carried out extensively throughout the country in the early 1990s. Most noticeably, prevention mechanisms like the use of condoms during

sexual intercourse and the idea of abstinence was introduced in every secondary and high school in Limbe. The campaign was successful especially as there was a general and real fear of the 'killer disease that has no cure'.

Perhaps, these controversies or speculations on the origin and evolution of HIV/AIDS could be causing greater consternation, distress, or harm by influencing individuals' perception, as well as the general organization of the disease. According to Farmer (1989), Haitian citizens were severely stigmatized due to the speculations that AIDS may have originated in their country. Tourists stayed away from Haiti. Economic investments declined, Haitian-Americans found themselves increasingly losing their jobs. It is possible that the economic pressure caused by this fear of AIDS may have, at least in part, been responsible for the overthrow of the 'Baby Doc' Duvalier regime in Haiti during the mid-1980s. Feldman (1989) argues that anti-African bigotry is flourishing as a result of the current speculation that AIDS may have begun in Africa. AIDS is blamed on Africans, or blamed on gays, or blamed on Haitians. AIDS is a stigmatized and

stigmatizing disease and social phenomenon that is perceived to pollute everyone and everything. Really, it does, as on the other hand a typical African man or woman could advise his/her children in their native language to be very careful not to contract the disease 'the white man brought'.

HIV/AIDS Situations in Ethiopia

The probable start of the spread of the disease in Ethiopia was in the early 1980's. The first report of HIV infection was in 1984 and the first case was found in 1986.

The major risk factor for transmission include: unprotected sex with multiple partners; seasonal migration of workers; dislocation of people due to the civil war and resettlement programs and high STI rates in the general population. About 91 percent of the infection occurs among the age group between 15 to 49 years. As the age group encompasses the economically productive segment of the population of any country, the high number of cases adversely affects labour productivity and hence economic development.

Ethiopia like many other countries has adopted strategies to prevent the spread of the disease by establishing an HIV/AIDS

control program as early as 1987(MOH, 2002). Following the creation of that control program, extensive efforts have been made to bring the information to high-risk people and to educate the public about HIV/AIDS. However, the impact of that program was evaluated and it was found that it was not as effective as it should have been for many reasons one of which was that it was run by only one sector. Currently, it is considered as not only the problem of the health sector but rather a socio-economic one and hence it needs multi-sectoral approaches to be implemented. The government of Ethiopia has formulated and ratified HIV/AIDS policy in 1998 (MOH, 2002). Following the policy, different strategic framework documents have been released which mainly focus on government apparatuses at federal, regional, woreda and kebele levels.

This top-down approach has its own limitations in dealing with a complex health problems such as HIV/AIDS. It is important that the role of the family and community be addressed and to look for other options to answer why people fail to develop the expected behavioural changes. It is important to recognize that it is the family followed by the community, as the core of

the society, which shoulders the severe blow of the disease. There are a number of efforts to address why people fail to achieve the expected positive behaviour towards HIV/AIDS. According to the BSS report 98% of people have good knowledge about HIV/AIDS but the expected change of behavioural practice is not impressive. For instance, the same survey found that own risk perception was very low in almost all target groups and despite high knowledge levels a significant number of youth are at risk of infection. The overall effort is being affected by the fact that different risk levels are being exhibited by different segments of the population.

The concerted effort until now mainly focuses on top-down policy not bottom-up approach and the major strategies used the formal governmental structure to address the HIV/AIDS related problems focusing mainly on individuals, with little emphasis until recently to the role of families and communities and their organization. Different strategies used to mitigate the epidemic include IEC, condom promotion, surveillance, patient care and support, and expansion of HIV screening laboratories in different health institutions (MOH 2002).

The current AIDS in Ethiopia report is the 6th in the "AIDS in Ethiopia" series. The present edition reports the 2005 antenatal based site-level surveillance findings and estimates the HIV and AIDS status in the country. Based on reports taken from VCT centers, blood banks, and ART programs, the cumulative number of people living with HIV/AIDS (PLWHA) is about 1.32 million (45% male and 55% female). This results in a prevalence rate of 3.5% (3% among males and 4% among females; 10.5% urban and 1.9% rural areas) for the total estimated population of 73 million.

The estimated number of new adult AIDS cases was 137,499. The number of new HIV infections was 128,922 (353 per day) including 30,338 HIV-positive births. Females accounted for 53.2% of new infections.

There were 134,450 (368 per day) AIDS-related deaths including 20,929 children 0-14 years (83.6% under age five). Females accounted for 54.5% of AIDS-related deaths. The number of AIDS orphans aged 0-17 years reached 744,100. The number of PLWHAs in need of antiretroviral treatment (ART) was 277,757 including 43,055 (15.5%) children aged 0-14 years.

. The Roles of FBO's & CBO's in HIV/AIDS Prevention & Control

Researchers say that community based organizations and faith-based organizations, which historically have played a key role in delivering health and social services in developing countries, could play an expanded role in helping raise awareness of HIV and reduce the stigma that surrounds HIV and AIDS. In addition, the researchers explained that community based organizations and faith-based organizations could advocate for greater access to health care and provide resources such as nutritious food and income-generating assistance to those with HIV. CBOs & FBOs have traditionally been involved in providing palliative care to people living with HIV (PLHIV). In developed country, CBOs & FBOs are in a position to target most-at-risk populations such as commercial sex worker & men who have sex with men (MSM) who may be missed by traditional outreach. For instance, in response to the HIV epidemic in Mexico, a FBO implement activities, such as workshops that disseminate information on HIV transmission and prevention and that focus on safer sex, condom distribution,

and human rights advocacy. The church continues to focus on HIV prevention today by sharing information during Sunday services, by leading discussions in self-support groups, and by providing counselling for individuals and couples. In addition, the CBOs & FBO promote adherence to antiretroviral therapy (ART), self-care, and patient education among PLHIV with the mission of encouraging reflection on the link between sexuality and spirituality.

CBOs & FBOs in Ethiopia are self-motivated and are readily accessible by community members. Since they are also widely reputed for doing what they are expected to do effectively; there is quite high potential to use them for grass roots level HIV/AIDS prevention, care and control activities.

Adolescents who feel connected to their families and perceive their parents as caring are more likely to postpone their sexual debut, use contraception, and have fewer pregnancies and fewer children. Two key aspects of parenting that are influential to adolescents are their beliefs that their parents know who they spend time with,

and know where they are when they're not at home or at school.

Families that have problems often produce children who have problems. Stress, poverty, violence, and substance abuse in families lead to less family cohesion, less communication and less tolerance. As a result, teens experience more abuse, neglect and risky drug use and sexual behaviour. Neighbourhoods with few job opportunities and high levels of risk behaviour and violence have a negative impact on young children sexual behaviour.

Research has shown that family programs for adolescents and their mothers work to increase parental knowledge about HIV and sexuality issues and increase comfort when discussing these issues with their children. These programs give mothers and youth a chance to interact and bond, as well as a chance to communicate with each other. Women in the program were more likely to talk to their adolescents about sex. In the study the researchers found that women were overwhelmingly identified as a source of support: mothers, sisters, aunts and cousins.

Communities are the next social stratum to that of the family. This social stratum is the next affected segment of the population by impact of HIV/AIDS and other diseases. A study done in USA which assessed the neighbourhood AIDS-prevention awareness events, led to a 50% increase in condom use and demonstrated that local leaders could effectively mobilize their neighbours to help fight the spread of AIDS/HIV. "Women took it upon themselves to educate their neighbours about HIV and, in the end, became their communities' single most effective defence against AIDS.

In another study, traditional healers have been trained as educators and counsellors to disseminate HIV/AIDS information and prevention practice among their peers and the community of sub-Saharan Africa. The initial outcome and challenges of such new initiatives in Zambia, Uganda, Botswana and South Africa indicated that though none of the projects completed a comprehensive evaluation of different approaches used on population served, all indicated that traditional healers are biomedical counterparts in prevention and control of HIV/AIDS.

Community institutions such as churches and traditional mutual assistant

organizations such as 'iddirs', women's associations, 'mahibers' can work with prevention programs to educate their members.

The community-level intervention developed has shown much promise as a means of helping the community develop HIV risk reduction skills and redefining social and peer group norms to reinforce risk reduction changes. Families and communities need support to increase communication and build strong bonds as early as possible. The factors responsible for the success of community-level prevention approaches may be the involvement and mobilization of credible members of the target population itself in the delivery and endorsement of risk reduction messages of their own friends, acquaintances, neighbours and peers (Franzoi, 2000).

1.3 STATEMENT OF THE PROBLEM

In Ethiopia in general & in Dilla town in particular, perhaps a little investigation has been made regarding the roles of CBOs & FBOs in HIV/AIDS prevention & control. Perhaps these organizations are playing some roles in HIV/AIDS prevention & control. However, no one can be sure what

roles they are playing unless such kind of research is done.

Therefore, this study tries to answer the following basic questions.

1. To what extent CBOs and FBOs participate in the prevention and control program of HIV/AIDS in Dilla town?
2. What HIV/AIDS related knowledge and behaviour of target community members changed as a result of CBOs and FBOs contributions?
3. Are there similarities & differences between CBOs & FBOs in the roles they play in relation to HIV/AIDS prevention & control in Dilla town?
4. What are the pros and cons of HIV/AIDS control and prevention program by CBOs and FBOs?

1.4 OBJECTIVES OF THE STUDY

1.4.1 GENERAL OBJECTIVES

The general objective of this study was to investigate the roles CBOs and FBOs played in HIV/AIDS prevention and control strategy in Dilla town.

1.4.2 SPECIFIC OBJECTIVES

The specific objectives of this study are to:

- identify the roles of CBOs and FBOs play in reducing and controlling the HIV risk, vulnerability and impact
- compare the roles that FBOs & CBOs play in reducing and controlling the HIV risk, vulnerability and impact
- assess pros and cons of CBOs and FBOs participation in HIV/AIDS control and prevention by CBOs and FBOs

1.5 SIGNIFICANCE OF THE STUDY

This study is hoped to create awareness among the people for effective management of HIV/AIDS. Moreover it provides opportunity to understand the functions/practices being carried out by CBOs and FBOs.

The CBOs & FBOs from different sub cities of Dilla town could get an opportunity to share ideas among one another when they make focus group discussion on the area. The study also provides conclusions, solutions and recommendations for further improvement and mitigation of the disease & the roles that FBOs & CBOs could play based on the findings. Perhaps as there are

no lots of researches done on this area it can contribute additional information and documents base for future studies.

1.6 SCOPE OF THE STUDY

1.7 LIMITATIONS OF THE STUDY

It is better to study all the CBO's & FBO's found in the town; however the effectiveness of this study was affect by several factors among these shortage of time given for the study, financial constraints, their reluctance to respond for the question raised. The participants might with hold crucial information for fear that the information may affect their future career, were some of the factors that hinder the efforts on the researchers to considerable extent from going deep in the investigation of the problem.

CHAPTER II

2. Review of Related Literature

2.1 THE CONCEPT OF COMMUNITY AND COMMUNITY DEVELOPMENT

UNAIDS (1999) has adopted a very broad definition. Community is "a group of people who have something in common and will act together in their common interest".

Allan, (1997) has similarly given definition for the term in a detailed manner. In modern societies individuals maintain membership in a range of communities based on geography, occupation, social contacts or leisure interest.

According to him Community is "... a specific group of people usually living in a common geographical area who shares a common culture, are arranged in social structure and exhibits some awareness of their identity as a group".

Young, (1999) refers to community development as an approach that involves placing individual member of the community in the centre of a development process. It also involves helping community members to realize their own potential for further development activities based on self-initiation. The community development approach emphasizes the participation of people from below, encourage a bottom-up approach and fosters self-reliance on the available community resources.

2.2 THE CONCEPT OF COMMUNITY BASED ORGANIZATIONS (CBOs)

Jalberth, (2000) defines community organization as "... a legal person, duly constituted as a non profit corporation, whose affairs are administered as a board of directors, made up in majority from the consumers of the service provided or members of the community it serves as whose activities are related to the fields of health and social services" (Jalberth, Pinault, Zuniga, 2000).

Community based organizations can be defined as part of an independent movement working towards social change. The overall purpose of community based organizations is to promote the social development, quality of life and welfare of those they serve. Their mission is not limited to identifying and serving needs, but to help change social structures; influences political decisions and identify alternatives that better respond to the needs of the society. The peculiarity of community based organizations is that they are arranged in a "bottom-up" approach (ibid).

Community based organizations can also be referred as local organizations which could

be viable vehicles for community involvement and participation in project design and implementation, when appropriate and timely guidance and encouragement is provided (Shiferaw, 2002).

2.3 CONCEPTUALIZING CIVIL SOCIETY ORGANIZATIONS (CSOs)

The concept of civil society organization is debated in terms of two opposing arguments. One approach claims that the total frame work of civil society organization include both formal and informal organization; and the other view that argues conceptualization of civil society organization is impossible outside the formal organization framework.

Tgist (2000) is one among those who argues in terms of the view that civil society organizations cannot be conceptualized outside the framework of formal organization. Accordingly, the range of civil society institutions include NGO, advocacy organization, professional associations, cooperatives, trade union, religious organizations and independent press (Tigist, 2000). Hence, according to him the

conceptualization of civil society organization excludes informal (or traditional) organizations that are common both in rural and urban areas and ethnic based self-help and development. There is lack of evidence, as to what extent these organizations contribute to the public interest during the last decades. This is the major rationale that has been provided to justify his argument for exclusion of informal organizations from the definition of civil society organization.

Shiferaw, (2002) on the other hand, argued that the concept of civil society organizations might comprise both formal and informal organizations. According to him, the range of civil society might include NGOs at international, national and local level; church organizations, grass roots and people's organizations. This category consists of residential area based associations, professional associations, burial associations, producers' and consumer's associations, credit associations trade unions, gender and age based organizations and various interest groups.

2.4 THE CIVIL SOCIETY APPROACH

The civil society approach is a recently growing development paradigm, which favours the partnership of local communities, NGOs and other development agencies with indigenous associations and institutions often referred to as community based organizations (CBOs). The principal aim of the civil society approach is prioritizing the local needs and involving the local community in planning, decision making, and implementation of development activities.

The major rationale for the civil society approach is that it ensures active involvement of grass root community members from planning, to decision making, to implementation and evaluation of development projects. It also can address the needs of the local community. Active participation of local communities in civil society approach enables communities to take over projects and contribute to sustainable community development.

Through the civil society approach, it is believed that the poorest can be reached more effectively, at lower cost and in more

innovative ways for effect equitable, fair and sustainable development. The civil society approach enables tactful mobilization of internal and external resources to alleviate poverty, and to promote change and development (Sietz 1995, Rooy, 1998 in Shiferaw, 2002).

This approach also mobilizes the community more effectively in its bottom-up development to address mass poverty.

The civil society approach enables citizens to play a major role in their local development programs. The role of community based organizations is those either represent the community members in particular, or can reach them more reliably than the existing government and market approach (Sietz 1995, Rooy, 1998, in Shiferaw, 2002).

There are a number of arguments to show the reason why civil society could or should be involved in development activities (Pankhurst (2001), Sietz (1998), Shiferaw (2002) etc.). Pankhurst (2001) has given three reasons as to why civil society organizations should be involved in development activities.

1. Civil society organizations are based on local autonomy and indigenous ways
2. Civil society organizations have greater legitimacy than institutions set up external agencies civil society organizations provide on-going sustainable structures.

2.5. RATIONALE FOR A COMMUNITY-BASED HIV/AIDS INTERVENTION

According to (Damen and Kloos, 2003), the urgency of HIV/AIDS and its impacts call for a concentrated effort to utilize community resources that have been largely neglected by many governments for health development in the past. In view of the problem of HIV/AIDS, the benefit of community involvement at the grass root level can be immense in all these dimensions. Accordingly, the situation of deepening poverty crisis and recurrent famine condition in north east Africa require that poverty alleviation programs need to be integrated with HIV/AIDS prevention and control programs at the community level. HIV/AIDS seems to be strongly related to the situation of poverty in Ethiopia, as it is so in any other sub-Saharan African countries.

A community-based response to HIV/AIDS implies the involvement of people where they live, in their homes, their neighbourhoods and their work place in the fight against HIV/AIDS. Community projects are as diverse as the people and culture that make up these communities. Some of the forms of the community based responses to HIV/AIDS intervention projects have been identified as "home grown" and self-sufficient. Sometimes they can get assistance from external agencies like religion centers, medical institutions, and in neighbourhood meeting places (UNAIDS, 2000).

Many of the community-based programs assisting those affected by HIV/AIDS are developed and run by community based organizations. Community based organizations generally can be considered as being democratic, represent in the interest of their members and to be accountable to them (UNAIDS, 1999).

In such regard, community based responses take the form of both formal and informal organizational groupings that are related to community based organizations. Informal set up, on one hand, include social support group, saving clubs and self help groups and

informal self-help groups. These traditional or informal groups are said to be effective in HIV/AIDS interventions.

"Traditional indigenous groups are major sources of support in community that are experienced the impact of AIDS epidemic" (UNAIDS 1999).

Formal community initiatives on the other hand, include formal community based organizations and AIDS support organizations which rely on external assistance (UNAIDS 1999).

Similarly, Damen and Kloos (2003) suggested that traditional and indigenous community based institutions are considered to be the most prominent and the most effective instruments for the HIV/AIDS prevention and control because utilizing informal indigenous institutions have multiple importance. Hence, grass root organizations, both formal and informal, should become the major advocates and vehicles for community involvement in prevention and control of HIV/AIDS.

This is because indigenous local associations have the track record of winning the confidence of communities and serve

community members during times of crisis (Damen and Helmut, 2003).

Hence, community based organizations can be considered as one of the most important mechanisms for the successful implementation of multi- sectorial response to HIV/AIDS epidemic as they are strategically placed to facilitate the involvement of the community at the grass roots level.

The prevalence rate of HIV/AIDS was reported for the last four editions of Ministry of Health. The adult prevalence rate was reported to be 0.00 percent, 2.7 per cent, 6.2 per cent, 7.1 per cent, 7.3 per cent and 6.6 per cent in the report years of 1984, 1989, 1993, 1997, 2000, and 2002. The rapid increase in prevalence rate can be derived from the above reports. The adult prevalence rate for the year 2002 in Ethiopia is 6.6 per cent which is less than the prevalence rate reported in 2000 that is 7.3. The change is not resulted in decline in the adult prevalence of HIV/AIDS epidemic. Rather it is the result of more extensive surveillance data and re-classification of site as an urban site (Ministry of Health, 2002).

2.6 TRANSMISSION MECHANISM OF HIV/AIDS IN ETHIOPIA

The major transmission mechanism for the rapid spread of HIV infection in Ethiopia is identified as follows (Ministry of Health, 2000).

- “ Heterosexual intercourse and multiple sexual partnerships- which is identified as the major means of transmission
- “ Unsafe blood transfusion with unscreened blood-In Ethiopia most blood is screened for HIV for transfusion.
- “ Unsafe injection - HIV is transmitted by injection with the same needle used to inject many people without sterilizing. Moreover, illegal medical practices and harmful traditional practices are indicated to be potential means of transmission.
- “ Prenatal transmission - An infected mother may transmit the disease during Pregnancy, delivery or breast feeding and sharing needle used for injection.
- “ Mother - to - child transmission seems to affect 30-40 per cent of babies born to HIV/AIDS positive mothers (Ministry of Health, 2002).

2.7 AIDS REPORTS IN ETHIOPIA

Ethiopian Ministry of Health used the sentinel surveillance method to collect and analyze up to date data to detect the prevalence of HIV in the population.

Sentinel surveillance is a globally accepted method for obtaining data in HIV/AIDS detection. It involves in a regular testing of selected groups for presence of antibodies for HIV/AIDS in order to monitor trends in the infection.

The process constitutes systematic collection, analysis, interpretation and dissemination of prevalence. The sentinel surveillance data are collected from health facilities that regularly provide antenatal service to pregnant mothers (Ministry of Health, 2002).

2.8 IMPACTS OF HIV/AIDS IN ETHIOPIA

Demographic, economic and social impacts of HIV/AIDS are identified to be the major impacts in Ethiopia.

1. Demographic and Health impacts

The major demographic and health care impacts of HIV/AIDS in Ethiopia are identified as follows (Ministry of Health, 2002).

- Increase in AIDS caused deaths
- Increased infant mortality, and child survival
- Fall in life expectancy at birth and at older ages. The fall of life expectancy is indicated that it was projected life expectancies are 45, 53, 55, and 59 in years of 1989, 2001, 2007, 2014 respectively. However, due to the impacts of HIV/AIDS the life expectancy falls to 46 and 53 in the years of 2001 and 2014 respectively, instead of being 50 and 59 as it was projected without the impacts of HIV/AIDS (Ministry of Health, 2002).
- Decrease in population size due to increased AIDS deaths
- Orphans and Vulnerable children
- HIV/AIDS and TB- increased rate of infection in TB is exhibited due to impacts of HIV/AIDS

2. Economic Impacts of HIV/AIDS

Other economic sectors that are severely affected by HIV/AIDS include non agricultural and industrial sectors. Certainly, Health care and insurance are likely to be significantly affected. Those sectors with

mobile workers like military, transport workers, extension service and banking are adversely affected.

The agricultural sector that is the major economic sector in Ethiopian economy is severely affected by the loss of productive manpower usually in their peak productive and reproductive age.

The impact of HIV/AIDS in industry sector can be explained in loss of workers and productive labour force due to increased AIDS deaths, lost in work days due to sickness, lost work days due to funeral leave and increased health care costs for AIDS patients.

It also affects the health sector through increased numbers of patients seeking medical care and expensive expenditure on the medical costs for AIDS patients. In 1994 health care costs in Ethiopia are increased significantly as the result of AIDS. It is also predicted that hospital bed occupancy will increase 28% as the result of AIDS (Abdulhamid, 1994).

Macro economic impacts also can be identified as AIDS deaths leading directly to a reduced in numbers of workers available; shortage of worker leading to higher domestic production costs; increased

spending in foreign exchange for 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 training (Bollinger, Stover, Seyoum, 1999).

3. Social Impacts of HIV/AIDS

The major social costs of HIV/AIDS in Ethiopia are manifested as follows (Ministry of Health, 2002):

Increase in number of orphans putting pressure at the family level with increased burden of caring for orphans. Extended family is the pressured in taking care of the orphans and dependents of those people who lost their breadwinner due to AIDS.

The structure of family is changed to be headed by orphan children as young as 10 and 12 years old.

Orphans lost the necessary financial, material and emotional support they need for schooling.

Increased vulnerability in women economical wellbeing as they lost their husbands usually their breadwinners

Death of member of family resulting permanent loss of income through treatment, funeral, mourning and Teskar; widows resorting to commercial sex in order to support their family and orphan children joining street life or commercial sex

Breakdown of social institutions

Increased funeral costs

2.9 THE THREAT OF HIV/AIDS EPIDEMIC ON IDDIR

As the number of death related to HIV/AIDS increases among certain communities, the existing local strategies are increasingly under pressure and these is need to design policies and programs that are capable of providing support when existing strategies became inadequate (UNAIDS, 1999). Certain researchers (Damen, and Kloos 2003 and Damen and Pankhurst 2002) tried to indicate the shortage of data on the impact of HIV/AIDS on the day to day life of Iddir. Since Iddir are established to contribute money for time of death of members or of their household members, increased mortality would create financial strains.

Current increase in mortality caused by HIV/AIDS may endanger the very existence of these grass root institutions. Therefore, Iddir are expected to play major role in coping with the epidemic along with efforts made by formal sector (Damen, 2003).

Similarly, Pankhurst (2003) argued that anti HIV/AIDS responses are important since Iddir are directly endangered by increased deaths rate, probably caused by AIDS. This situation may deplete the resources of Iddir or even threaten the viability of these institutions. Dissemination of information about the danger of HIV/AIDS is possible considering Iddirs' central focus on death. Moreover, these are the only grass roots associations, which exist throughout the country. These are certain attempts of involving Iddirs in joining hands for fight against HIV/AIDS in Zone 3 and 5 in Addis Ababa, Dire Dawa, Nazareth and Akaky (ACORD, 2002).

Certain research indicates that Iddir have been severely affected by the epidemic. The fact that Iddir contribute money during the time of death and misfortune, makes the existing resources of these institutions vulnerable to financial strains as mortality increases among members (Pankrust and

Damen, 2003). HIV/AIDS epidemics make an increase in mortality rate among the most productive and reproductive sections of the community, which makes the very existence of Iddir as the major community based organization vulnerable in the near future. HIV/AIDS may endanger the basic structure of the society (Pankhurst and Damen, 2003).

Recently, due to the killer disease HIV/AIDS some leaders have the fear that it may deplete their financial resources". Certain Iddirs in Addis Ababa are at the margin of disintegration due to high death rates and related financial depletion (Shiferaw, 2002). Certain Iddir are currently engaged in the fight against HIV/AIDS. This is a an of research and important area since Iddir are directly affected by increasing death rates, which are depleting their resources and even threatening the viability of some Iddirs. Given their central concern with death Iddir are obvious vehicles for dissemination of information about the danger of HIV/AIDS. So they can be identified as the clear stakeholders in coping with the HIV/AIDS epidemics (ACORD, 2002).

2.10 MAJOR STRATEGIES OF COMBATING HIV/AIDS

There are different strategies of HIV/AIDS intervention indicated by the Ethiopian Ministry of Health policy on the HIV/AIDS, which was adopted in 1998 (Ethiopian Ministry of Health, 1998).

1. Information Education and Communication (IEC) refers provision of IEC materials to all government ministries and institutions, NGOs, mass organizations, religious organizations, professional associations and the community at large. This larger coverage of IEC material distribution is meant for provision of adequate attention to the problem of HIV/AIDS and Sexually Transmitted Infections treatment and control.

Moreover, intensive and sustainable IEC activities through all possible media, material and methods taking in to account culture and belief of the community are also advocated for prevention and control of HIV/AIDS. Participation of people living with HIV/AIDS in education to the public as well as psycho-social support to each other is to be encouraged and adequate preparedness and consent. Community meetings are identified as the most

important sources of information on AIDS by both women and men.

2. Sexually Transmitted Disease (STD) prevention and control

Comprehensive management of STD patients includes risk reduction, education and counselling education on treatment compliance, condom distribution, notification and treatment of patients. Improved quality of STD health care service through training development and promotion of standardized treatment guidelines and ensuring the availability of effective STD drugs.

3. HIV Testing and screening -to encourage the provision of testing screening on a voluntary basis. It is also possible to make screening facilities available in as much public health care facilities as possible

4. Sterilization and dis-infection Provision of adequate sterilization and disinfection procedure to ensure adequate sterilization and dis-infection service. Moreover, provision of training for health care workers about universal sterilization and dis-infection.

5. Medical care and psychological support- the participation of government, nongovernmental organizations, religious organizations, bilateral, multilateral agencies, private sectors, and community based institutions and the community at large that includes mobilization to support people living with HIV/AIDS and affected families.
6. Home based Care - According to the Ministry of Health guidelines on community home based care , which was adopted in 2001, home based care is defined as " a program that through regular visit offer health care service to support the care process in the home environment of the person with HIV infection. Home visits may be the only service provided or that may be part of an intended program which offers the patient and their family's service in home, hospital and community".

It is underlined that for the functional and sustainable community home based care, there is need for gaining the confidence and involvement of the families and the community where the service is being implemented. The principal aim is to involve the community, patients and families and

community home based care program. It ranges from medical to psychological and other material support. The overall context of conducting community home based care for AIDS patients is described as follows (Ethiopian Ministry of Health, 2001).

The existing formal health service cannot cope with the demand, given the severity and prevalence of the epidemics

The socio- cultural structure in Ethiopia is conducive for such service.

The practice of unified families, extended families, system and culture of adoption of children by the nearest of kin and others provide greatest opportunities. Traditional associations such as Iddir can be optimally utilized.

CHAPTER III

3 Research Methodologies

3.1. The study area

The study was carried out in Dilla town, Gedeo Zone, SNNPR Regional state, Ethiopia. Dilla town is located 356 KMs south of Addis Ababa. Digital telephone system and other communication facilities available for the town include radio, TV and newspapers. In the town there are one

referral teaching hospital, one health centre and more private clinics. In addition, there are five higher clinics and three privately owned pharmacies, and there are NGOs working on HIV/AIDS.

The fact that Dilla town is one of the main coffee producing area & availability of Government University leads to a high influx of people of the economically productive and sexually active age groups from different areas of the country. Besides, it is an important trade centre and a transit point for passengers from the whole south part of the country travelling to and from Hawasa.

3.2 Study Design

This study utilized a descriptive study design. Qualitative method was employed to collect relevant data on the potential involvement of CBOs and FBOs in the prevention and control of HIV/AIDS in Dilla town. The data that was collected through interview, focus group discussion, document analysis and observation were carefully analyzed qualitatively.

3.3 Study Population

The source population for the study was all CBOs and FBOs actively functioning in the Dilla town. CBO leaders namely 'Iddir' leaders, 'mahiber' leaders, GO officials, Anti AIDS club, NGOs working in the town were included in the interview & FGD. FBO leaders such as project manager, pastors, preachers, bible study group leader, prayer band leader, deacons & priests were also interviewed.

3.4 Sample and Sampling Methods

CBOs such as Iddirs, Anti-AIDS club, Kebele officials, were purposefully selected for the interview and adolescents from school & out of school in the town were randomly selected for the FGD. Similarly, religious leaders from Orthodox, Muslim, and Protestant, were purposely selected based on their roles in FBOs. Besides religious leaders, pastors, deacons, priests & others were selected randomly from the religious affiliation mentioned above.

3.5 Data Collection Tools and Procedures

CBOs & FBOs leaders and key-informants were identified and included in the interview. The researchers guided the participants using a semi structured interview.

The interview questions were first designed in English and later translated into the official language (Amharic), and back translated to English to ensure that the original meaning is retained. Besides the interview made, record review was also made. Document analysis was also made to ensure the reliability of the data.

3.6 Data Analysis

The collected data was analysed using qualitative way of analysis which was described and narrated logically.

CHAPTER IV

4. DISCUSSION, FINDINGS, CONCLUSION S AND RECOMMENDATIONS

This chapter contains research finding and analysis that is organized into three main parts. The analysis of research is made based on the data obtained from three different directions. The first analysis is with regard to the efforts of implementer NGOs in involving anti HIV/AIDS intervention activities. The second relates to efforts of selected partner towards their anti HIV/AIDS activities. The third is the efforts of government offices to promote the roles in anti HIV/AIDS activities.

4. DISCUSSION

4. ROLES PLAYED BY THE SELECTED CBOs & FBOs IN HIV/AIDS PREVENTION & CONTROL

Based on the interview and FGD questions the following discussion was made with the participants.

4.1 The roles of governmental institutions/CBOs/ in prevention and controlling HIV/AIDS.

The following are the institutions included in the study:

4.1.1 The first interview was conducted with the zone HIV/AIDS mainstreaming head with regard to the objectives of the office. According to the expert, the main objectives of the office was educating workers to protect themselves from HIV/AIDS, conducting HIV/AIDS mainstreaming discussion, informing and controlling construction experts, woreda offices, and kebeles to include HIV/AIDS as a plan.

The main activities of the office are designing HIV/AIDS program, awareness creation , Posting posters and distributing of brushers, encouraging workers to read Newspapers and magazines distributing condoms, showing motivating films, written

materials, working in all processes as a mainstreaming issue working in coordination with Social affairs ,motivating woredas and offices, paying 400 Birr for those who have the virus in their blood based on the task force organized ,giving counselling and VCT service ,conducting research on the respective kebeles ,discussion about HIV/AIDS on coffee-tea ceremony.

The source of budget was from workers that is deduced 2 % from their monthly salary. The total amount contributed in 2011/12 is 15,000 Eth.Birr. Other institutions like flour factory gave thirty Kg. as a means of support for one person monthly

The strategies that the office used to minimize HIV/AIDS are through training, coordinating other offices found in the town, mainstreaming, supporting resources to the patients.

The scope of the strategy was initiated by self involvement within the institution, self motivation to educate the society, educating the farmers not to perform sex with other partners, educating prostitutes about the transmission and preventive

mechanisms of HIV/AIDS .The capacity building training has been given monthly with regards to the meaning of HIV/AIDS up to the prevention system. The training was given by experts, who are invited from the town HIV secretariat office, from zone office, Tesfa-Goh and Red –cross office of the town.

A total of 14,400 condoms were distributed to the 6 woredas and 2 administrative sections. According to the expert, no one has been reported as HIV/AIDS patient so that to provide financial and material aids .The major problems encountered in this office are organization of the program, skilled man power, hall for training and discussion, less budget allocation. In order to solve the problems the office tries to create linkage with NGOs, organizing training out of the town and coordinating the human resource of the office were some of possibilities to run the activities as per the schedule.

4.1.2 Zone Education Office

The major objectives of the zone education office are to:

- present the spread of HIV in public /private and formal/informal

education sectors by targeting learners, trainees, teachers, facilitators, families, children and other education sector staff in the zone

- mitigate the impact of HIV/AIDS on the sector by creating a supportive learning and teaching environment that is free from stigma and discrimination
- Mainstream HIV&AIDS interventions in to the education sectors structures and processes.
- integrate HIV&AIDS issues as pertinent research topics on schools

The strategies formulated to control HIV&AIDS in the zone education office was :

- Prevention: The main objective of prevention was:

Achieving behavioural change that prevents the spread of HIV/AIDS amongst learners', educators, and other staffs

Sanitizing, advocating and involving schools in HIV/AIDS prevention activities in and around schools.

Implementing all HIV/AIDS prevention activities with gender sensitivity

Implementing HIV/AIDS prevention at all levels of the education sector within life skills, peer learning, teaching and extra-curricular.

Combating all harmful practices that aggravate the transmission of HIV/AIDS within the education sector and within the society

Developing culturally appropriate and locally relevant HIV/AIDS prevention materials

Mainstreaming HIV/AIDS information, skills, and attitudes in to the school curriculum, educational materials, and research

- Care and support: The objective of care and support was to improve the health and nutrition status of teachers and staff living with HIV/AIDS in all schools, to facilitate access to medical care for learners, teachers and others staff living with HIV/AIDS.
- Mainstreaming the sector's response and research

The strategies in combating HIV/AIDS are through organizing HIV/AIDS clubs in schools, one to one discussion, community based discussion ,life skill training. The reason to involve in the controlling of HIV/AIDS is based on the Federal Health Minister and South Regional education bureau. The training was given by Dilla university experts in the area of family planning, four school directors and woreda focal persons were also involved in the training to promote the life skill education.

In this zone education office, there was an established fund raising unit and 0.50% has been deduced monthly from teachers and administrative workers. The number of HIV/AIDS patient clearly known in the zone is three teachers only. Accordingly, 400 ET. Birr was given monthly. From the three patients one individual was voluntary to educate the students and the community at large. Moreover, different teaching materials were distributed to 150 children and an income collection box is already opened to support the patients.

The main problems in the zone education office was no budget code, shortage of budget, absence of volunteers, not giving due consideration to the department, lower

rank assignment when the BPR document was prepared and approved.

Inorder to control the spread of HIV/AIDS the office organized a coffee-tea program for discussion within a week , giving training by focal persons at the woreda level, within the 216 schools giving short term training, in consultation with the regional education bureau and civil service minister creating a post, submitting proposal for code naming and based on the check list prepared by the office assigning quality assurance experts to evaluate the progress after finishing their supervision activities.

4.1.3 AROKE KEBELE

The chairman of the kebele confirmed that, the efforts taken in controlling HIV/AIDS are the following:

The activities of HIV/AIDSs prevention & control are included in the health program. The main objective of the kebele was to minimize the spread of HIV/AIDS by giving behavioural change awareness creation mechanisms. The activities run through inviting the youth and discussing about HIV/AIDSs by preparing tea-coffee ceremony weekly in the kebele , giving health education in the kebele through health extension experts. This discussion was

always sponsored by NGOs and different offices. Budget is not allocated to this issue. Different training has been given to the youth and mothers by the help of tea-coffee ceremony. The purpose of the training was to aware the youth and mothers about the spread and prevention system of HIV/AIDS, educating the HIV positive how they can live longer, informing the youth to apply VCT in their nearby clinic, encouraging for those people who can take ART.

The support given was in collaboration with women office by creating an income generating activities in order to help them, facilitating to receive loan from Micro finance so that they can save money.

The challenges observed in the kebele was people who lived with HIV/AIDS are unable to teach other people, the unwillingness of pregnant to visit a nearby clinic so that they cure from the disease, the support given to the kebele is minimum, no immediate response was given from the hospital for ART provision, shortage of budget to give training broadly. Currently, to solve the above problems the kebele tries to create link with NGOs & GOs for the accurate implementation and giving free counselling

service by the help of health extension experts.

4.1.4 WELDALA KEBELE

The head of the kebele indicated that the major aim of the kebele in controlling HIV/AIDS was educating the people with the help of Medan Act, Marry Joy to aware the people. The strategies were in meetings, discussion on tea-coffee ceremony. The budget gained was from Medan Act and Marry Joy. But now, the organizations are unable to support the kebele due to unknown reasons. There is no budget allocated for the purpose of HIV/AIDS. An organization known as Gelma provided blanket, soup, and cloths to HIV/AIDS patients. The only solution the kebele was giving information about the transmission and controlling system of HIV/AIDS when there is a meeting.

4.1.5 ZONE POLICE OFFICE

Vice Commander of the zone police & HIV/AIDS department head said that the office performs its duties by designing action plan. Accordingly, to run the objectives of the office the budget source was from workers 0.5% of their monthly salary. The amount of money given to the patients was 450 Birr for milk purpose. One

HIV person involved in the education of workers. The education focuses on ethical concern, community policing.

The office has mainstreaming section at the regional level. Training was given on the issues of HIV/AIDS, transmission and prevention mechanisms, importance of condom, educating HIV positive about ART usage. In the zone, there are four HIV positive persons (Wonago=1, Dilla=2, Gedeb=1,) who paid 450 Birr per month. No support has given to orphans still now.

The main challenges faced in the zone was workers are unable to involve in VCT activities due to frustration, the training given is not continuous, less control and evaluation, create dissatisfaction on the amount of money subtracted from the workers, shortage of budget and resources at the zone level, no assigned expert to run the program. However, the office tried to solve the problems faced by the help of the members in educating the others, counselling workers to cure themselves, and using the existing resources by saving.

4.2 The role of non- governmental organizations in prevention and controlling HIV/AIDS

The following non - governmental organizations are included:

4.2.1 MARRY JOY AIDS THROUGH DEVELOPMENT

Mary Joy Aid through Development is a local nongovernmental Organization working closely with the community at large in all kebeles. The major goal of the project is to the contribution of alleviating the socio-economic impacts of HIV/AIDS through effective HIV/AIDS prevention and control strategies. Its emphasis is on improving the socio-economic status of those affected and infected by HIV/AIDS and targets street children, commercial sex workers, and widow women as the target group for the project as the most vulnerable group for the infection of HIV/AIDS.

The major objectives of this institution is providing food support, health service, teaching aids, income generating activities(IGA),construction of house, legal services, and social and psychological support.

The budget allocated in the year 2010/2011 was 5 million; in the year 2011/2012 is 6 million. The type of training given to children was on the issue of life skills.

A total of 225 children has given the training, and hoped that cascading to 4500 children. The number of household who receive support in the year 2010/11 are 3000 children and the year 2011/12 a total of 4929 children had supported. The main challenges indicated in this institution was cheating of registration at kebele level, shortage of skilled man power, inability of kebeles to practice the program based on the plan.

4.2.2 ETHIOPIN KALEHIWOT DILLA MEDAN ACTS PROJECT

The objective of this organization is prevention, peer education system to commercial workers, training, organizing self help groups to develop the culture of saving, supporting orphans by providing teaching aids, clothes, blankets to children, and counselling services.

One big achievement performed in the case of education is that 12 schools have been opened in non formal modality and 1100 children have got the chance to graduate. And intern creates linkage in to the formal education system .The budget allocated for the year 2011/12 was 516.167 US dollar.

According to the respondent, this organization has worked for about 10 years .The main reason for initiation of this program was people considered HIV/AIDS patients as if irrelevant and devil. Due to this old thinking people were neglected. Hence, the organization started to educate and aware the society in bringing behavioural changes.

Training was given for 15 days to 320 workers in the area of HIV /AIDS care and support, & to children above 10 years training has given on life skills, daily ongoing treatment, psychological treatment, community management system and fund raising, mainstreaming, income generating activities. In this progress the number of children trained in this organization were 5000.Out of this 12 students were graduated in first degree and 52 children in diploma. The support given to the patients was financial, house allowance & material support. About 840 Orphans were supported with food and 965 patients were provided food and materials. The orphans registered in this organization are 5700 among these 800 children received special food, soup & cloths. However, in the year 2012 the project phased out due to

unknown reason. Hence, the only solution to solve the problem is searching funding or transferring the project to other organization is recommended by the manager.

4.2.3 CHORRA ANTI-AIDS & ENVIRONMENTAL PROTECTION ASSOCIATION

The main objective of this club is protecting the youth from danger and encouraging participating in to different clubs. The main strategies to control HIV/AIDs are through drama, literature, on job training and environmental studies. The budget gained to run the program is from Medan Act, different Non -governmental and kebeles. The initiation was taken to save orphans, prostitutes and others which are vernalable to HIV/AIDs. The training given was on family planning, community based discussion and reproductive health education. There were 300 orphans supported by the club among this 150 are enrolled at Dawit primary school. The main challenges in this club are shortage of budget, no food aid, no assistance given in educational materials and absence of organizations that encourage the club. According to the key informants in the club,

the only solution to solve the club's problem is reorganizing again in a new fashion.

4.2.4 MERRYSTOPS.

This organization focuses on reproductive health and family planning, HIV counselling services, HIV testing, awareness creation through face to face discussion only. There was no training given and support given to patients and orphans.

4.2.5 IDDRIS.

In Dilla town there are 37 Iddris functioning in the social aspect of the people. Some of the sampled Iddris were Addis Ketma Samugnet Iddir, Sodo Iddir, Shewa BerIddir, Fetno drash Iddir, Kidanemihret Iddir, and Kidus Micheal youth Iddir. The chair person of Addis Ketma Samugnit Iddir indicated that, the zonal administration of HIV/AIDs department made a meeting and organized an Iddir collaboration /yeiddir Timret/.on the meeting members were discussed and agreed to pay 50 birr annually and each member of the Iddir 1 birr annually. However, still now the Iddirs are not involved in practicing the decision made. The only major task performed by the Iddirs was providing food to orphans during Eastern. Training was given by the regional

HIV/AIDS secretariat at Hawasa and by Dilla University HIV/AIDS secretary office. The main challenges encountered the Iddirs are very few individuals tried to dis integrate the plan, lack of volunteers with HIV positive that can teach the society and there was no task force that enables to lead the Iddirs in well organized manner.

4.3 The role of FBOs in prevention and controlling HIV/AIDS

The following are faith based organizations which are engaged in preaching their followers religious wise:

4.3.1 MEKANA IYESUS CHERCH.

According to the head of the HIV/AIDS office of Mekane Iyesus, the objectives of the church are controlling HIV/AIDSs in the society at large. The activities were awareness creation, avoidance of discrimination among people living with HIV in the town. The training was given in eight sites by health experts, health extension workers. The kinds of training was: Traditional practices for 30 individuals, conference for 1000 individuals, peer education for 200 individuals, Anti-HIV/AIDS clubs for 120 individuals ,gender and equality in HIV/AIDSs for 40 individuals. The budget allocated in first and second quarter

of 2011 was 50,000 birr only. The budget for 2012 was not still announced. The strategy to run the activities were educating the people by the help of Wengelewiyan priests based on the action plan given to them and by the system let culturally discuss it. The challenges occurred in this organization was absence of clear discussion by connecting with their religion by asking the question 'HOW?'.

4.3.2 Muslim Mosque

The main goal of the Mosque is educating the people about the transmission and controlling systems of HIV/AIDS. There is no budget allocated to lead the plan. .However, usually, the religious leaders gave awareness after Solat for short period of time .No support was given to HIV/AIDSs patients and orphans. According to the respondent, there was no clear annual plan designed and no concerned body was assigned to monitor the program.

4.3.3 Orthodox Church

According to the head of the Sinodos some efforts has been done in prevention and controlling HIV/AIDS. After the end of Kidase, prestes and diakons give education with regards of the epidemic nature of the disease. There was no budget allocated to

organize the program. No capacity building was given to the people. In order to aware the people there was a written advice posted in Amharic language in different parts of the church i.e "ህመምተኞች መድሀኒት ያስፈልጋቸዋል "ማቴ.9; 12. And "እባክህ ወንድሜ በበሽታ ውስጥ ስላለሁ አታግልለኝ" ሲራክ 37: 6. From this poster we can understand that people can understand about the effect of the epidemic so as to take care of themselves. Besides, it has implication to give care for those persons living with HIV/AIDS.

CHAPTER V

5. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

5.1. FINDINGS

The involvement of CBOs and FBOs in further development activities was not as one expects. The minimum participation of CBOs in community development activities is due to preoccupation of impacts of AIDS which may further cause deepening of poverty.

HIV/AIDS being the major threat to development, poverty reduction cannot be conceptualized outside the frame of AIDS intervention activities. Hence poverty

reduction and development activities need to be coupled with HIV/AIDS intervention activities. Partnership between NGOs, Government organizations and Community Based Organizations as well as FBOs determines the qualities of development activities.

The urgency of AIDS calls for the involvement of all stakeholders in the Zone administration anti HIV/AIDS activities. However, to minimize the epidemic Community based HIV/AIDS interventions were not practiced effectively for the active involvement of community based organization at the grass root level.

CBOs and FBOs based HIV/AIDS interventions become possible with the involvement of people where they live, in their homes, their neighbourhood and their work place. But the concern given to control HIV/AIDS was not well organized.

CBOs and FBOs enable the involvement of the community at the grassroots level and full mobilization of each section of the community towards HIV/AIDS intervention. However, the mobilization process in educating the society was not encouraging.

CBOs and FBOs are identified as the major partners for NGOs and government

organizations in HIV/AIDS interventions given their representative nature for each section of the society. Moreover, Iddirs are one of those institutions, which are directly affected due to their basic nature. Nevertheless, the role of Iddirs in controlling HIV/AIDS seems poor.

Technical and financial assistance from NGOs as well as local authorities is very crucial for active involvement of CBOs and FBOs in HIV/AIDS intervention activities. But, there are financial as well as technical limitations in technical and managerial capacities of partner CBOs and FBOs.

Anti- HIV/AIDS efforts of CBOs and FBOs in Information Education and Communication involve conducting advocacy session during meetings. Partner NGOs played a major role in providing technical assistance and accessing health officials as well as people living with HIV during the advocacy session held during meetings, which mainly improve the qualities of advocacy sessions carried out. Currently, the NGOs cannot provide support and technical assistance due to unknown reasons.

A few attempts are being made by CBOs and FBOs to become involved in provision of care and support. However, these efforts

are limited due to shortage of financial and technical resources which restrict for further involvement in care and support.

Intervention activities are limited due to human, financial and technical resources. Inadequate awareness and limited access to capacity building training are also major shortcomings, which are also evidenced in the findings of the research. Limited technical knowledge, financial assistance from NGO as well as government bodies and lack of commitment also resulted in non involvement of CBOs and FBOs in anti AIDS activities.

The research findings also identified that NGOs took the major role in initiating CBOs to take part in HIV/AIDS interventions in conducting advocacy sessions during meetings, make some revisions in the bylaws concerning their anti HIV/AIDS activities. Capacity building activities also promote the activities of CBOs in anti HIV/AIDS activities. A few attempts are being made to establish Iddirs councils by Gedeo Zone administration in enhancing the involvement of Iddirs in anti HIV/AIDS activities. Moreover, government organizations' establishment of anti AIDS Council at kebele and wereda level

representing every section of the society has been a major part of activities undertaken by the zone administration. Such activities in establishment of the Iddirs, Anti AIDS Council are being made with the regard to cultural, social an organizational structure. However, limited technical capacity being unable to produce projects .proposals with sufficient quality is the major problem that inhibits from utilizing the funds for as much community based organization as it could. Despite the fact, the Iddrs was not functional due to management problems

5.2 Conclusions

Based on the findings of the study, the following conclusions are made:

The risk, vulnerability, and impact reduction and participation of CBOs and FBOs in HIV /AIDS prevention and controlling was very low.

The scope of knowledge of modes of transmission and means of prevention of HIV/AIDS is still worrying. Preventive strategies are not properly designed.

The practice of controlling was low and shows that discussion on sexual matters still not continues due the religious taboo for FBOs.

CBOs& FBOs gives less attention in controlling HIV/AIDS. There was no sense of ownership and confidence in their intervention.

Capacity building is one of the main instruments to update the community with regards of the intervention system of HIV/AIDS. The reality lies there was no budget allocated for training and prevention mechanism activities broadly.

There was no well organized system that leads the CBOs and FBOs to prevent and control HIV/AIDS .Hence, the monitoring and evaluation is loose.

5.3 Recommendations

1. CBOs and FBOs at grass root level must made partners in any HIV/AIDS intervention program giving special emphasis vulnerability and impact reduction and should be made to play a leading role in HIV/AIDS prevention and control.
2. The people need more support and follow up in order to increase their motivation to participate in HIV/AIDS prevention and control activities.
3. Suitable health education strategy should be designed for the families as well as to the communities in order to decrease the

misconception and to promote condom. Since it is one of the most important and acceptable conventional methods of HIV/AIDS prevention. Besides, effective collaboration between the health care system ,other governmental agencies and NGOs.

4. To improve the role of CBOs and FBOs, they have to be supported in their efforts to revisit their organization policies so that they become sustainable development partners.

5. Bottom –up planning should be designed and implemented, sufficient budget should be allocated to run the program. Besides, monitoring and evaluation should be the major task in combating HIV/AIDS.

6. Further support in the form of increasing awareness of the different preventive strategies should be made to empower CBOs and FBOs so that their huge potential in HIV/AIDS prevention can be exploited

7. *Iddirs* should be assisted in order to improve their recording with all the necessary information so that they could serve as potential source of vital statistic information.

8. Successful HIV/AIDS interventions need multi-sartorial partnership of each

stakeholder in fighting AIDS together. I.e. government organizations, non-government organizations as well as community based organizations and religious institutions needs to be strengthened in their efforts towards the HIV/AIDS interventions.

9. Voluntary counselling testing (VCT) should be increased within the town in different parts of the kebeles to bring attitudinal change.

10. Further study is needed towards identifying, promoting and strengthening efforts made by CBOs and FBOs in HIV/AIDS prevention and control.

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ANNEXES

Semi structure interview questions

1. What are the major aims of the organization?
2. What are the activities carried out by the institution?

3. To what extent is the budget allocated each year?
4. Mention the strategies used to combat HIV/AIDS?
5. What was the reason for involving in HIV/AIDS intervention?
6. To what extent is the degree of involvement in the activities?
7. Is there capacity building training given, If the answer is yes, mention the types of training, number of participants and the purpose of the training?
8. What are the supports given to AIDS patients?
9. What are the supports provided to AIDS orphans?
10. What are the major challenges faced in HIV/AIDS intervention?
11. Describe the efforts taken to solve the problem?