The Practice of HIV/AIDS Service Provisions at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa, Ethiopia

MSW Dissertation Research Project

(MSWP-001)

Prepared By

Lemlem Tale

Indira Gandhi National Open University (IGNOU)

School of Social Work

October, 2013

Addis Ababa, Ethiopia

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Enrolment No: **109100827**

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Declaration

I, the undersigned, declare that the dissertation entitled**" The Practice of HIV/AIDS Service Provision at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa"** submitted by me for the partial fulfillment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my original work, has never been presented in this or any other university, and that all resources and materials used here in, have been duly acknowledge.

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Certificate

This is to certify that Miss Lemlem Tale student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for her project work for the course of MSWP-001. Her project Work entitled*"The Practice of HIV/AIDS Service Provision at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa"* which she is submitting is her original work.

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Abbreviation and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retroviral Treatment
CRDA	Christian Relief and Development Agency
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FDRE	Federal Democratic Republic of Ethiopia
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
NGOs	Non-governmental Organizations
GO's	Governmental Organizations
OVC	Orphan and Vulnerable Children
PLWA	People Living with HIV/AIDS
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WWO	Worldwide Orphans Foundation

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Abstract

The standard service delivery guidelines for HIV/AIDS comprehensive care and support programming in Ethiopia, contains seven core service areas which are considered significant for people living with HIV. The seven service areas include; care and shelter, economic strengthening, health care, legal and social protection, psychosocial support, food and nutrition and education.

This paperexplores the practice of HIV/AIDS service provision at Worldwide Orphans Foundation in Yeka Subcity of Addis Ababa with the aim of assessing the comprehensive HIV/AIDS care and support services employed plusidentifying the major challenges faced and coping mechanisms employed by service providers. This study was undertaken by using non-experimental research design and descriptive sample survey methods by employing both quantitative and qualitative data gathering tools. Structured interview with the beneficairies of the organization, semi-structured interview with selected service providers and focus group discussion with the stakeholders are conducted. A total of 50 beneficiaries were randomly selected from WWO.

The key findings of the study indicate that although there are some care and support services available at the organizaiton that meets the needs of the beneficiaries there are also umet needs of clietns which needs to be addressed. The health care service offersacomprehensive medical care for adult and pediatric patients. Other components of comperhensive care and supportactivities like psychosocial support and educational support are also available for the beneficiaries. But the organization has not identified the full packages of comperhensive care and support where the felt needs of the clients are not adressed.This indicated that some beneficiaries of the organization require additional support of shelter and care along with the existing services for a sustained and better outcome. The multifaceted challenges of children that are not addressed by WWO are affecting the result of the existing services offered. These missing services are also causing work related stress and challenges to the service providers.

Chapter One

Introduction

1.1 Background of the Problem

The emergence of the HIV epidemic is one of the biggest public health challenges the world has ever seen in recent history. In the last three decades HIV/AIDS has spread rapidly and affected all sectors of the society. The first case of HIV in Ethiopia was reported in 1984, since then, HIV/AIDS has become a major public health concern in the country causing the death of millions of people.Ethiopiaisat the epicenter of the epidemic and continues to carry the full brunt of its health and socioeconomic impacts.

The Ethiopian government, in response to the epidemic, has developed different programs and strategies to mitigate the transmission of the virus at the prevention level as well as at the intervention level. Thegovernment initiated the response in 1985 soon after the first report of laboratory confirmed HIV and AIDS cases. The initial major step taken by the government was the establishment of a National Task Force within the Ministry of Health; this response focused on analyzing the situation, developing operational guidelines for prevention, and assessing the capacity required to arrest the spread of HIV infection. Since this first measure until the present different strategic plans for the multi-sectoral HIV/AIDS response were designed and implemented.

Because of these responses, even though there has been a decrease in prevalence of HIV/AIDS in the past years, Ethiopia is still categorized among the countries that is most affected by the HIV epidemic, with an estimated adult prevalence of 1.5%, the country has a large number of people living with HIV (approximately 800,000): and about 1 million orphans.(HAPCO, 2012).

Consequently, HIV/AIDS brings about multi-dimensional repercussions and impact on different aspects of the country in general and the concerned sections of the society in particular. One of the areas highly affected by the epidemic is the health workforces, who play an important role in the battle against HIV/AIDS by providing testing, care, and treatment for people living with HIV/AIDS (PLWHA). Service providers working with PLWHA face significant occupational challenges such as work-related infection risks, work load because of increased demand for services, inefficiency in the HIV care financing system and increasing physical and emotional stress.(Bennet et al., 1993, p.38).Overall, the growing number of AIDS cases, people living with HIV/AIDS, orphans, other vulnerable children and their continued needs for health care services have placed a significant burden on resources in the already inadequate health services in the country. In the meantime, provision of quality service to PLWA is also an important and required factor in responding to the needs of PLHIV.

As it was stated in the above paragraphs, the impact of HIV/AIDS is multifaceted which has led to the launching of comprehensive care and support programs by governmental and nongovernmental organizations as a response to the virus. Maintaining the optimal performance by the health care workforce and provision of comprehensive care and support for people living with HIV/AIDS becomes an urgent task for meeting the increasing needs of HIV/AIDS patients.The objective of all HIV/AIDS care and support professionals is sustaining quality service provision to people living with HIV/AIDS , although there are different factors that challenge the provision of comprehensive care and support for the HIV affected and infected households.This research is, therefore, being conducted to identify the gaps in the practice of HIV/AIDS service provision and the major challenges faced by the service providers in providing comprehensive care and support for people infected by HIV.

1.2. Statement of the Problem

HIV/AIDS has been devastating since its first emergence in the world. According to UNAIDS (2012), globally, 34.0 million [31.4 million–35.9 million] people were living with HIV at the end of 2011. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide.Ethiopia is one of the countries with high HIV prevalence, in 2011; the national prevalence of HIV was estimated to be 2.3 %.(HAPCO, 2012)

The impacts of HIV/AIDS in Ethiopia are multifaceted affecting the country'soveralldevelopment;HIV/AIDS is affecting the agriculture, education, industry, family andhealth sectors. Family and communities have also been significantly affected by the epidemic. The protracted morbidity and eventual mortality resulting fromHIV/AIDS also causes significant lost time to illness, reduced productivity, shortage of manpower,increased absenteeism and rising medical costs as well as increased number of orphans and vulnerable children worsening their socio economicsituations.When we specifically look at the impact of HIV/AIDS on children, according to USAID, Pact and UNICEF Document (2011-2016Program), there are 5.5 million orphans -15% of the total child population, 16% of them orphaned due to HIV/AIDS and there are 77,000 child-headed households. In the capital city Addis Ababa alone, from a total population of 2,975,608 with 940, 886(31.62%) child population, there are estimated 176,435(18.75%) AIDS OVCs and 70,574(40%) are in need of support. HIV/AIDS remains as a major public health concern in the country(MOWCA, 2011).

Because of the immediate response to the epidemic the national experience and expertise in the treatment and care of PLHIV have improved substantially and the number of persons receiving ART has doubled from slightly fewer than 160,000 to over 300,000 persons in the period 2007 to 2010.(WHO,2011.p.14).

According to the report produced by CRDA (2006), close to 400 NGOs in Ethiopia manage health projects or projects that potentially contribute in the alleviation of major public health problems in the country out of which 100 NGOs, which are members of CRDA, are engaged in HIV related work. Even with the increased efforts of the government to accelerate progress toward universal access to HIV prevention, treatment, care, and support, health care personnel are still scarce in Ethiopia, a country of 77 million people, with approximately 2,000 physicians, 700 health officers, 15,500 nurses, 5,200 paramedics, and 200 pediatricians are involved in HIV/AIDS service provision.(MOH,2006).

As it can be seen from the above statements, along with the government, many NGOs have also been engaged in HIV/ AIDS related work. Even though many people have been trained to work with people living with HIV, the number of trained professionals still remains very low in comparison to the number of HIV infected people who needs care and support which in turn might affect the provision of quality service.

Providing care to people living with HIV/AIDS and to their families requires a broad range of services that include not only clinical care focusing on diagnosis and treatment but also supportive and complementary services to ensure that adequate nutrition, psychological, social and daily living needs of the people living with HIV/AIDS are met. The standard service delivery guidelines for HIV/AIDS comprehensive care and support programming in Ethiopia, contains seven core service areas which are considered critical for people living with HIV. The seven service areas include; care and shelter, economic strengthening, health care, legal and social protection, psychosocial support, food and nutrition and education (FHAPCO, 2010, p. 12).To provide comprehensive HIV/AIDS care and treatment, family care coordination is also important as it has shown that coordination of medical and supportive services and communications among providers optimize health and wellbeing. (FMOH, 2006, p3).

Even though a lot has been done to eradicate the virus and its challenges, there are still many areas and people in need of these comprehensive care and support programs to help them rise out of anonymity. HAPCO has, for example, stated that about 74% of orphans are not in school currently, and there is high dropout due to social and economic problems. Overall, about 160,000 AIDS orphan and vulnerable children and PLWHA in the country demand psychosocial, educational, nutritional and training support for income generating activities (HAPCO, 2010)

The above paragraphs point to the prevalence, impact and trends of comprehensive care and support service provisions for HIV affected and infected section of the society in Ethiopia. All sectors involved in the care and support of people living with HIV/AIDS are required to provide quality service based on the service delivery guidelines set by the government. With an increased number of PLWAs and involved stakeholders working in the area of care and support, it is more important than ever to assess how well the needs of people living with HIV are being met by those services.

1.3. Research Objectives

1.3.1. General Objective

The general objective of the proposed research is to assess the practice of HIV/AIDS service provisions to people living with HIV/AIDS by various categories of care and support activities employedat Worldwide Orphans Foundation operating in YekaSub City of Addis Ababa, Ethiopia since 2005.

1.3.2 Specific Objectives

The specific objectives of the proposed study are:

- To assess the overall practice of HIV/AIDS services provisionsat the Organization;
- To identify challenges encountered by the service providers in the Organization;
- To identify the major coping mechanisms employed by professionals in service delivery practice in the Organization; and
- Toexamine the implications of the problems, challenges and coping mechanisms employed for HIV/AIDS services provision in the Organization.

1.4 Operational Definition of Concepts

Service Providers: -The men and women who make health care happen; these include nurses and midwives, pharmacists, laboratory technicians, physicians, social workers, community health workers and other care provider professionals.

Clients: - People living with HIV who are receiving one or more of the services offered at Worldwide Orphans Foundation.

Orphan and vulnerable Children (OVC): -It refers to orphan and vulnerable groups of children aged between 1-18 years old who have lost one or both of their parents' because of HIV/AIDS or are more exposed to risks than their age mates.

Comprehensive Care and Support Services: - These are packages of different services offered for people living with HIV/AIDS to help them overcome the challenges they face. These packages of services are health care, educational support, economic strengthening, psychosocial support, legal support and shelter and care.

1.5 Limitation of the Study

The results of this study cannot be generalized for other HIV/AIDS service providers in Yeka Sub City or Addis Ababa becausethe sample size for this study was not calculated stastically and then not representative of the targetpopulation.

1.6 Chapterization of Thesis

The MSW research report consists of five chapters. The First Chapter presents the introduction, statement of the problem, the objectives of the study, operational definitions of key concepts and limitations of the study. Chapter Two dwells on review of related literature. The Third Chapter presents description of the study area and elements of study design and methods. Chapter Four presents data analysis, interpretation and discussion of major findings. The Fifth Chapter draws conclusion and suggestions of the study.

Chapter Two

Literature Review

This chapter presents a comprehensive review of different related literatures concerning the practice of HIV/AIDS service provisions. Literatures related to the nature and prevalence of HIV/AIDS, the impacts of HIV/AIDS, governmental response to the epidemic, components of care and support services and challenges in HIV/AIDS care and support provisions are reviewed in detail.

1. The Global Prevalence of HIV/AIDS

AIDS stands for acquired immune deficiency syndrome, a pattern of devastating infections caused by human Immune Deficiency Virus (HIV). It is one of the major problems of our world. Lack of proper vaccination has persisted as a global challenge. Hence, the spread of the disease is resulting in a serious impact on psychological, social and economic makeup of the society.HIV/AIDS is a unique virus in human history in its rapid spread and extent in the depth of its impact since the first AIDS case was diagnosed in 1981, the world has struggled to come to grips with its extraordinary dimensions (UNAIDS and UNICEF, 1999).

According to UNAIDS (2012), globally, 34.0 million people were living with HIV at theend of 2011, where 0.8% of them are adults aged 15-49 years. Although the burden of the epidemic continues to vary considerably between countries and region, Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults(4.9%) living with HIV and accounting for 69% of the people living with HIVworldwide. Although the regional prevalence of HIV infection is nearly 25 times higher in sub-Saharan Africa than in Asia, almost 5 million people are living withHIV in South, South-East and East Asia combined. After sub-Saharan Africa, theregion's most heavily affected are the Caribbean and Eastern Europe and Central Asia, where 1.0% of adults were living with HIV in 2011.

Worldwide, the number of people newly infected continues to fall: the numberof people (adults and children) acquiring HIV infection in 2011was 20% lower than in2001. Here, too, variation is apparent. The sharpest declines in the numbers of people acquiring HIV infection since 2001have occurred in the Caribbean (42%) and sub-Saharan Africa (25%).

During the past decade, many national epidemics have changed dramatically. In39 countries, the incidence of HIV infection among adults fell by more than 25% from 2001 to 2011. Twenty-three of the countries with steep declines inHIV incidence are in sub-Saharan Africa, where the number of people acquiringHIV infection in 2011 1.8 million was 25% lower than in 2001 2.4 million.Despite these gains, Sub-Saharan Africa accounted for 71% of the adults and children newly infected in 2011, underscoringthe importance of continuing and strengthening HIV prevention efforts in the region.

The number of people dying from AIDS-related causes in Sub-Saharan Africadeclined by 32% from 2005 to 2011, although the region still accounted for 70%of all the people dying from AIDS in 2011. The Caribbean (48%) and Oceania (41%) experienced significant declines in AIDS-related deaths between 2005 and2011. More modest declines occurred during the same period in Latin America (10%), Asia (4%) and Western and Central Europe and North America (1%). Twoother regions, however, experienced significant increases in mortality from AIDS Eastern Europe and Central Asia (21%) and the Middle East and North Africa (17%).

The number of people newly infected globally is continuing to decline, but national epidemics continue to expand in many parts of the world. Further, declines in the numbers of children dying from AIDS-related causes and acquiring HIV infection, although substantial, need to be accelerated to achieve global AIDS targets.Despite these advances, still too many people are acquiring HIV infection, too many people are getting sick and too many people are dying from HIV-related diseases. (UNAIDS, 2012).

2. The Prevalence of HIV/AIDS in Ethiopia

HIV infection probably began in the late 1970s or early 1980s with the first AIDS cases reported in 1986. Similar to other Sub-Saharan countries, the predominant strain in

Ethiopia is HIV-1 subtypeC.In the early stages of the epidemic, HIV prevalence increased rapidly; initially among high risk groups' like commercial sex workers, men in uniform and long distance truck drivers**.** By 1988, high rates of HIV prevalence (17%) were detected among commercial sex workers residing along the main trading roads and long distance truck drivers (13%). In some urban areas, prevalence rates as high as 38% were recorded among sex workers. In Addis Ababa, HIV prevalence rates in female commercial sex workers rose rapidly, from 24.7% in 1988 to 54.3% in 1990. Since then the epidemic has expanded throughout the country into rural areas, especially in areas along road sides.(HAPCO & GAMET, 2008)

With a total population of over 73.9 million, about 800,000 people are living with HIV. Though the national prevalence is, estimated to be 2.3%, it isconsiderably, lower than rates in other Sub-Saharan African countries where the number of people livingwith HIV and orphans continue to grow (HAPCO, 2010).

Recent reports (FHAPCO, 2012) show that Ethiopia is one ofthe Sub-Saharan countries demonstrating more than a 25% decline in new HIV infections. The prevalence of new infections among pregnant women, 15-24 years of age, hasdeclined from 5.6% in 2005, to 3.5% in 2007, and 2.6% in 2011. Likewise, the use of preventivemethods and the number of people who were tested for HIV and utilizing treatment and care services hasincreased. For example, the number of people tested for HIV annually has increased from 40,000 in 2005 to nearly ten million (10,000,000) by 2011. Similarly, the proportion of women aged 15–49 who received HIVtest in the last 12 months and who know the results has increased from 1.9% in 2005 to 20.0% by 2011.

In Addis Ababa, where there were a total of 2, 975, 608 population with 940, 886(31.62%) child population there were estimated 176,435(18.75%) OVCs and from these children, 70,574(40%) are in need of support. The adult prevalence rate is 9.2% with 210,000 people living with HIV (MWOA, 2011).

3. Impact of HIV/AIDS

3.1 Overall Impact of HIV/AIDS

HIV /AIDS hascaused immense human suffering in the world. The most obvious effect of this crisis has been illness and death, but the impact of the epidemic has certainly not been confined to the health sector; households, schools, workplaces and economies have also been badly affected.HIV has created an enormous challenge worldwide. Since its recognition, HIV has infected close to 70 million people, and more than 30 million have died due to acquired immunodeficiency syndrome (AIDS). According to UNAIDS, 1.7million people died because of AIDS in 2011 and 2.5 million people were newly infected. From these people living with HIV, 14.8 million of them are eligible for treatment but only 8 million people are currently on treatment.(UNAIDS, 2012).More than 66% of the 40 million people living with HIV/AIDS are in sub-Saharan Africa, where AIDS is the leading cause of death.

Ethiopia is the second most populous and one of the seriously affected countries in Sub Saharan Africa, with more than 1.3 million people living with HIV and an estimated 277,800 people requiring treatment (MOH & HAPCO, 2007).During 2010 alone, an estimated 1.2 million adults and children died as a result of AIDS-related illnesses in Sub-Saharan Africa since the beginning of the epidemic more than 15 million Africans have died from AIDS-related illnesseswhilst people with HIV can live healthy and productive lives if they are accessing antiretroviral treatment, fewer than half of Africans who need treatment are receiving it.

HIV and AIDS affect economic growth by reducing the availability ofhumancapital.Without proper nutrition, health care and medicine that is available in developing countries, large numbers of people are falling victim to AIDS.They will not only be unable to work, but will also require significant medical care.

HIV/AIDS is increasingly affecting the agriculture sector, economically the most important sector in Ethiopia, accounting for an average of 48% of gross domestic product (GDP), and 90% ofexports. The fact that HIV prevalence is increasing in rural areas where 85% of the Ethiopians live, has become a major concern to the development efforts in the country.The

education sector is also being severely compromised by theHIV pandemic. A 5% increase in death amongst teachers in Ethiopia has been noted between1999 – 2001, some of which can be attributed to AIDS. The pandemic has hampered the effortsof the education sector by reducing the supply of teachers; reducing school enrollment andincreasing dropout rates.Business and industry are similarly feeling the effect of HIV. The fact that the pandemic ispredominately affecting individuals between the ages of 14-59, the productive age group, is asignificant loss of labor supply. The protracted morbidity and eventual mortality resulting fromHIV/AIDS causes significant lost time to illness, reduced productivity, and shortage of manpower, increased absenteeism and rising medical costs. The traditional right of funeral attendancefurther compounds workplace absenteeism.The severely constrained health care system is also being further challenged by the HIVpandemic. The increased number of patients seeking medical care for HIV/AIDS related ailments, such as Tuberculosis (TB) and other opportunistic infections (OI) is stifling the already limited health care system in Ethiopia.

3.2 Impact of HIV/AIDS on Orphan and Vulnerable Children

Since AIDS is responsible for leaving vast number of children without parents millions of children have already lost at least one parent because of the AIDS epidemic and millions are more likely to lose their parents over the next few years. As far as research is concerned, no other infectious diseases of the modern era have had such devastating impact on the world's youngest and reproductive citizens as HIV/AIDS. Yet as shocking as these deaths are, the impact of HIV/AIDS does not end on the victims. Because those dying from AIDS are mainly people in the prime of their lives who are often parents thus; a highly well-known effect of AIDS is the vast numbers of children orphaned by the disease.

As the years and decades a head the impacts of AIDS on children, their families and communities at large will grow far worse and expanding its dimensions of difficulty, if the problems remain un-arrested by bringing significant change in the global communities.

In Ethiopia, it is commonly understood and legally defined that an orphan is a child whois less than 18 years old and who has lost one or both parents, regardless of the cause of the loss.A vulnerable child, on the other hand, is defined as a child who is less than 18 years of age and whose survival, care; protectionor development might have been jeopardized due to a particular condition, and who is found in asituation that precludes the fulfillment of his

or her rights. The impact of HIV/AIDS is also very high on AIDS orphans, about 74% of orphans are not in school currently, and there is high dropout due to social and economic problems (HAPCO SDG, 2010).

As of 2009, Ethiopia is estimated to have 5,459,139 orphans of whom 855,720 are orphans due to HIV and AIDS, one of the largest populations of OVC in Africa. Given the context of Ethiopia, all OVC, directly or indirectly are vulnerable to HIV and AIDS and other health, socioeconomic, psychological and legal problems. This vulnerability may be linked to extreme poverty, hunger, and armed conflict and child labor practices, among other threats. All of these issues fuel andare fuelled by HIV and AIDS (MOWA& HAPCO, 2010).

In Ethiopia, about 160,000 AIDS orphan and vulnerable children and PLWHA demand psychosocial, educational, nutritional and training support for income generating activities (HAPCO, 2008). An increasing number of orphans have become one of the critical issues rose as challenges to development. In Addis Ababa alone, from a total population of 2, 975, and 608 with 940, 886(31.62%) child population, there were an estimated 176,435(18.75%) AIDS OVCs and 70,574(40%) are in need of support (MO CA, 2011).

4. Government Response to HIV/AIDS Epidemic

As reflected above, HIV/AIDS impacts the society at many levels and thus requires a multi - sectorial approach to tackle the epidemic. Of the estimated 15 million people livingwith HIV in low- and middle-income countries who needtreatment in the year 2010, 5.2 million have access—translating intofewer AIDS-related deaths (UNAIDS, 2010).

In the year 2012, a majority of people eligible for HIV treatment in low and middle-income countries—54%,a record eight million people—werereceiving antiretroviral therapy (UNAIDS, 2012). This means more people than ever who areliving with HIV are being helped to live longer, healthier and more productivelives. The reason for the increased

positive results in the fight of HIV/AIDS is improvedcollaboration between governments, donors, and partners.

From the early days of the epidemic, Ethiopia has shown commitment to prevent its spread and mitigate its impact. To this end, it has rallied support from national and global partners, including mainstreaming of HIV prevention programs to public and private sector businesses, and engagement of community-based organizations. During the earlier years, the government adopted a national AIDS policy and developed and implemented several effective strategies.

As part of this endeavor, the Government put in place a national HIV/AIDS policy in 1998 to create an enabling environment to fight the pandemic. Overall, support and commitment in relation to HIV and AIDS has increased over the years, and progress has been made in the development of specific HIV/AIDS related legislation and revising the HIV policy to promote and protect human rights. Moreover, there have been some encouraging efforts to enforce the existing policies, laws and regulations. Civil society involvement in the process of planning, monitoring and evaluation of HIV/AIDS responses at various levels are improving. Ethiopia joined the international community in the Political Declaration on HIV/AIDS of the UN General Assembly issued on June 2006, which committed all countries to move towards universal access to HIV prevention, treatment, care and support by 2010.In order to ensure that quality HIV/AIDS services are delivered at the community level, various guidelinesand standards were developed, distributed and being implemented in 2008 and 2009. Several policies and guidelines are in place to support the implementation and scale-upof the national response, including the National HIV/AIDS Policy, the National Strategic Framework on the Prevention and Control of HIV/AIDS, the Supply and Use of ARV Drugs policy. Based on these documents, and on the recommendations of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), the Government of Ethiopia launched its fee-based ART initiative in 2003 and free ART initiative in 2005. Currently 71,500 clients have accessed ART. The country has scaled up its ART program - the service is now provided at 241 sites- and is planning to decentralize the service further to existing health facilities.(HAPCO,2012). These guidelines are intended to serve as a basis for scale-up and decentralization of the free ART initiative

program management and its implementation at different facility levels. They should serve to coordinate, harmonize and standardize the HIV/AIDS care, treatment and support program.

The Government ofEthiopia has started integrating services such as PMTCT and HIV counseling and testing (HCT) with familyplanning and maternal, newborn and child health services. This direction is reflected in the variousprogram documents. (The HCT program has shown considerable improvement both in terms of service expansion as well asutilization. A total of 5.8 million people (53% male) received HIV counseling and testing in 2008/09, this is a22%increase from the previous year. As of end of 2009 there were a total of 241,236 people ever startedART and 176,644 currently on ART. A total of 11,000 children were ever started ART, including 8,761 currently on ART as ofDecember 2009.

Ethiopia is currently decentralizing HIV care and treatment services to selected healthcenters. Decentralization increases access by taking services closer to more people, reducing transport and related costs for patients and families, resulting in improved adherence and enrolment in care and treatment services early in the course of the disease. Decentralization follows the health network model, ensuring linkages between services at hospital, health center and community levels. Large scale in-service trainings in various programme areas have been carried out to build capacity of different cadres of health care providers. Efforts have been made to demystify HIV care and ART by developing standardized and simplified clinical tools, reference materials, and job aids. Building the capacity of clinical nurses to prescribe first-line ARVs for stable patients and provide primary chronic HIV care including ART was pioneered in 2006 (MOH& HAPCO, 2007).

Available evidence has demonstrated that the national response has shown improvement in the healthsector interventions, while there are still potential areas for improvement in non-health areas such as theeducation sector, workplace programs, and care and support to orphans and vulnerable children (OVC).The national strategic direction is to scale up prevention interventions particularly for most-at-risk populations, OVC and PMTCT, strengthen non-health sector responses, and improve strategicinformation generation and utilization on most at risk populations.(FHAPCO, 2010). An evaluation conducted at MENA

association on the HIV/AIDS care and support interventions showed tha the interventions are improving the living situations of persons living with the virus and their families(Dawit, 2006).

Despite the multi-faceted challenges caused by HIV/AIDS, Ethiopia has demonstrated that with commitment and effective strategies, there is hope for reversing the trend and minimizing the impacts.These concerted efforts have yielded encouraging results in reversing the rate of new infections and in mitigating the multi-faceted impacts of the epidemic. In fact, recent reports by UNAIDS show that Ethiopia is one of the Sub-Saharan countries demonstrating more than a 25% decline in new HIV infections. Anti Natal Clinic (ANC) sentinelsurveillance data show that prevalence of new infections among pregnant women 15-24 years of age hasdeclined from 5.6% in 2005, to 3.5% in 2007, and 2.6% in 2011. Likewise, demographic health survey data show that use of preventivemethods and the number of people who were tested for HIV and utilizing treatment and care services hasincreased. For example, the number of people tested for HIV annually has increased from forty-thousandin 2005 to nearly ten million by 2011. It is also worth noting that the nationalprogram has established an in-built monitoring system-indispensable to track progress and guide implementation of activities (UNAIDS,2011).

While the above progress is a reason for hope and encouragement, the fight against HIV/AIDS is far fromover. The problem is still huge as nearly 800,000 are living with HIV, more are orphaned, and the rate of newinfections is still high. This calls for a more robust and targeted response while at the same time scaling-up existinginterventions among high-risk population groups. Key challenges in delivering comprehensive care and support in the year 2012(HAPCO,2012), include low utilization of some of the existing services (especially PMTCT), emergence of new at-riskpopulation groups (young girls engaged in

transactional sex), and low coverage of interventions for most at risk populations, and ensuring quality of available services.

5. Components of Comprehensive HIV/AIDS Care and Support Programs

People living with and households affected by HIV/AIDS require a wide range of services, including psychological, social, legal and clinical ones. Care and support programmes must therefore be developed to respond to these needs and demands. Complicating the situation, these needs reflect an environment in both industrialized and resource-constrained settings in which stigma; discrimination, fear, neglect and impoverishment surround HIV/AIDS to various degrees in the community, workplaces and health care settings.

The FMOH approach to pediatric HIV/AIDS care and treatment is to maximize resources while ensuring provision of equitable care, to provide comprehensive HIV/AIDS care and treatment. This approach has at its heart at the patient and family with a multidisciplinary team of clinical and supportive staff providing efficient comprehensive care. Its goal is to reduce barriers within the health care system, improve the health of HIV-affected families, reduce the risk of prenatal transmission, support adherence to treatment and understand the role of families in HIV prevention. (FMOH, 2007).

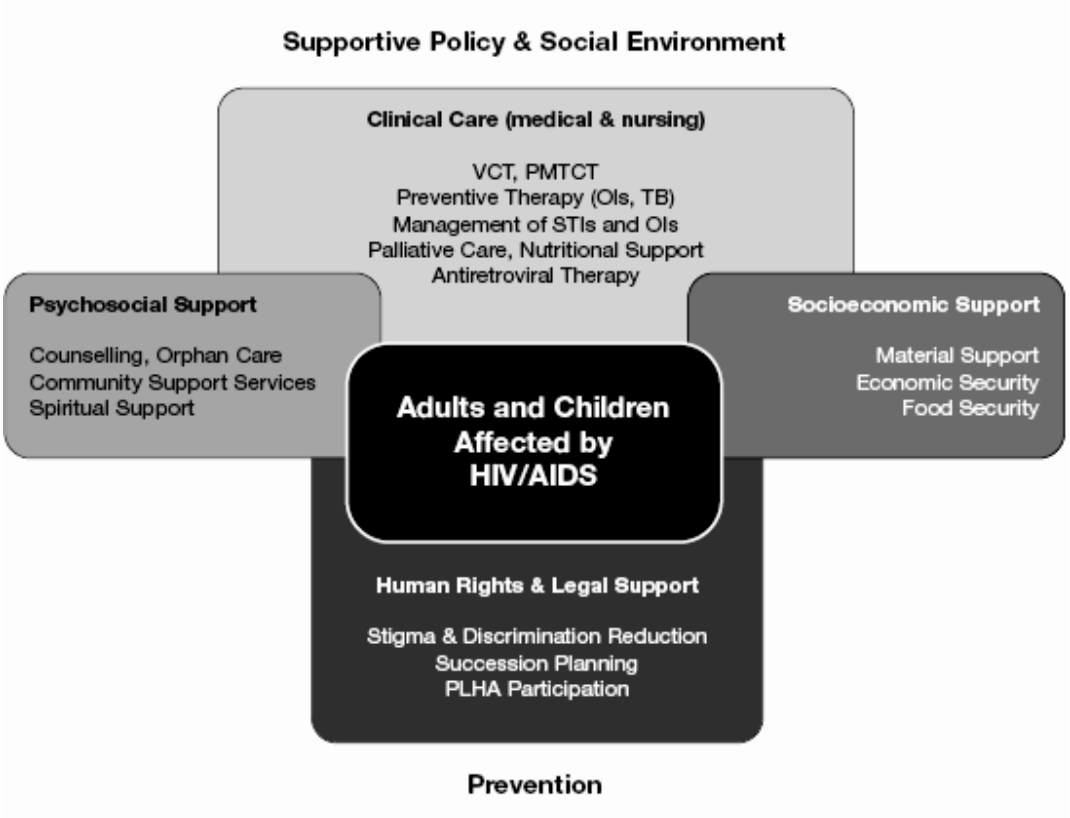
According to WHO,2007To address these needs of people living with HIV/AIDS, HIV/AIDS care and support programmes should have the objectives of:

- ensuring equitable access to diagnosis, health care, pharmaceuticals and comprehensive Supportive services;
- reducing morbidity and mortality from HIV/AIDS and related complications;
- promoting opportunities for preventing HIV transmission within the delivery of care and support services; and

• improving the quality of life of both adults and children living with HIV/AIDS and their families

The components of care and support packages are further stated in the below chart.

Figure 1 The Four Main Domains of HIV/AIDS Care and Support Services



Source: WHO, 2004, p.6.

Accordingly, both the governmental and non-governmental organizations have been striving to provide care and support to people living with HIV as well as working towards the prevention of the virus. These organizations follow different service delivery guidelines by Ministry of Health and Federal HIV/AIDS Prevention and Control Office (2009).For example, the Standard Service Delivery Guidelines document contains seven core service areas which are considered critical components of a set of services for programming targeting vulnerable children. The seven service areas include the following:

1. **Shelter and Care:** These services strive to prevent children from going without shelterand work to ensure sufficient clothing and access to clean safe water or basic personalhygiene. An additional focus is ensuring that vulnerable children have at least one adult whoprovides them with love and support. Depending upon the context, services might include:

- Child level: identifying potential caregivers prior to parent death, alternative care placementof child in institutional care, transitional care, or supported child-headed household.
- Caregiver/family level: assisting with reunification for children without parental care andreferral to programs that provide incentives for adoption, and foster care
- Community level: support of family-based care with home visits and other strategies,development of innovative community alternatives when family-based care is not anoption; and
- System level: policy development, regional and national coordination, education, mobilizationof local resource, and monitoring of institutional care when needed.

2. **Economic Strengthening:** These services seek to enable families to meet their ownneeds from an economic perspective regardless of changes in the family situation.Depending upon the context, services could include:

- Child/caregiver/family level: assess household situation in which OVC live and determinewhether there is income to support needs of children, vocational training for caregivers,income-generating activities involving small business, urban/rural agriculture, and accessto credit;
- Community level: mapping of related service providers in the community basedasset building; and
- Systems level: policy development, advocacy and creation of an enabling environment tohave access to financial institutions.

3. **Legal Protection:**These services aim to reduce stigma, discrimination and social neglectwhile ensuring access to basic rights and services protecting children from

violence, abuseandexploitation.Depending upon the context, the range of services might include:

- Child level: assisting with birth registration and inheritance claims, preventing siblingseparations, removing children from abusive situations;
- Caregiver/family level: support with parenting and care-giving responsibilities, assistancewith access to available services;
- Community level: support for Child Protection Committees, training members of thecommunity to identify and assist children needing assistance; and
- Systems level: legal and policy development, social mobilization, strengthening of socialcapital.

4. **Health Care:** These services include provision of primary care, immunization, treatmentfor ill children, ongoing treatment for HIV positive children and HIV prevention.Depending upon the context, the range of services might include:
   - Child level: assist children in receiving health services through referral and orientationtowards preventive health seeking behavior;
   - Caregiver/family level: train caregivers on a comprehensive range of health issues toeffectively monitor health and seek care appropriately, refer OVC to health services;
   - Community: conduct mapping of health services, mobilize and coordinate communityvolunteers
   - Systems level: policy development to ensure access and a service delivery model that meetsthe needs of vulnerable children.

5. **Psychosocial Support:** These services aim to provide OVC with the human relationshipsnecessary for normal development. It also seeks to promote and support the acquirementof life skills that allow adolescents in particular to participate in activities such as school, recreation and work and eventually live independently.Depending upon the context, services might include:
   - Child level: assess psycho-social needs of children, activities that support life skillsincluding peer teaching, individual and group counseling (including

spiritual) for children,rehabilitation for children who might be abused or neglected;

- Caregiver/family level: follow-up to monitor children's status, parenting and communicationskills for caregivers, support during illness (assist with disclosure of information, griefmanagement, succession planning, preserving memories, etc.);
- Community level: establish support groups, identify and address barriers for psychosocialsupport, increasing community understanding of psychosocial needs of vulnerablechildren; and
- System level: provide trained counselors within school systems and develop safe spaces forchildren to engage in play.

6. **Education:** These services seek to ensure that orphans and vulnerable children receiveeducational, vocational and occupational opportunities needed for them to be productiveadults. Depending upon the context, services might include:
   - Child level: school registration initiatives, direct assistance to subsidize school costs;
   - Caregiver level: assessment of educational needs of OVC and identify and address barriersto education, train health providers and caregivers to identify and refer children who arenot in the education system;
   - Community level: conduct resource mapping for education, community mobilization andadvocacy related to increasing access and developing appropriate curricula and tutorialsupport; and
   - Systems level: build capacity to support OVC among Parent-Teacher Association (PTA), teachers and community representatives and support services like Life skills and livelihoodopportunities as an integral part of the education program.

7. **Food and Nutrition:**These services aim to ensure that vulnerable children have access tosimilar nutritional resources as other children in their communities.Depending upon the context, the range of services to be providedinclude the following:

- Child level: nutritional assessment and counseling, supplementary feeding, and links toother health and nutrition interventions;
- Caregiver/family level: training on nutrition, diet, and food preparation.;
  Community level: community-based strategies to support vulnerable children, includinggardens and feeding programs; and
- Systems level: policy development, regional and national coordination, technical assistanceto the service providers, and advocacy.

8. Coordination of Care at the Point of Service Delivery

At the child/household level, coordination of care involves assessing needs, planning care for a child or family, monitoring care, and making adjustments to the combination of services when needed. Coordinators of care will usually provide both direct care and referral for services. Ideally, coordination of care involves a home visit so that all the relevant aspects of the child's situationmaybe reviewed, but tools and approaches can be modified so that this individual assessment cantake place in a group setting, such as a school, feeding program, or youth group. Regardless ofwhether the needed service is directly provided or arranged through referral, the home visitor should monitor all the services that the child is receiving on an ongoing basis.

A study condicted in 30 indigineous NGOs that are working with PLHIVIndiginious NGOs are not in a position to sucessefully and meaningfully affect the health, social, economic and political situations of their target PLHIVS.(p80)… about 46.7% of the organizations rataed their organizational capacity to provide protection to PLHIVs below the average and another 33.3% of them were rated just an average(Tewodros, 2011).

Table 1: Type of services offered for PLHIV in Addis Ababa for the year 2011/12

Sub-City	Population	Estimated PLHIV(9.2%)	PLHIV Needs Support (ART %)	TARGET(CURRENTLY ON ART)	Food Support (25%)	Shelter &care support (15%)	IGA (10%)	Psychosocial support(50%)	HCT Counseling and testing service	ANC VISIT	PMTCT Service Counseling and testing(90%)	HIV POSITIVE (9.2%)	PROPHYLAXIS (95%)
AkakeKaliti	196,909	13,897	4,638	3,443	3,474	2,084	1,390	6,948	53356.33	152.863	137.577	12.657	12.0242
Nefas Silk-Lafto	343,509	24,243	8,092	6,007	6,061	3,636	2,424	12,121	93080.46	266.67	240.003	22.0803	20.9763
KolfeKeraniyo	465,811	32,874	10,973	8,146	8,219	4,931	3,287	16,437	126220.6	361.615	325.453	29.9417	28.4446
Gulele	290,558	20,506	6,845	5,081	5,126	3,076	2,051	10,253	78732.35	225.564	203.007	18.6767	17.7428
Lideta	219,089	15,462	5,161	3,831	3,865	2,319	1,546	7,731	59366.44	170.081	153.073	14.0827	13.3786
Kirkos	240,147	16,948	5,657	4,199	4,237	2,542	1,695	8,474	65072.51	186.429	167.786	15.4363	14.6645
Arada	230,386	16,259	5,427	4,029	4,065	2,439	1,626	8,130	62427.58	178.851	160.966	14.8089	14.0685
Addis Ketema	277,204	19,563	6,530	4,848	4,891	2,935	1,956	9,782	75113.83	215.197	193.677	17.8183	16.9274
Yeka	376,518	26,572	26,572	6,584	6,643	3,986	2,657	13,286	102024.9	292.295	263.066	24.2021	22.992
Bole	335,474	23,676	23,676	5,919	5,919	3,551	2,368	11,838	90903.22	260.432	234.389	21.5638	20.4856
Addis Ababa Total	**2,975,608**	**210,000**	**70,095**	**52,035**	**52,500**	**31,500**	**21,000**	**105,000**	**806299**	**2310**	**2079**	**191.268**	**181.704**

Source: Ministry of Woman and Children's annual report, p.8. 2010/11

9. Problems and Challenges Faced by HIV/AIDS Service Providers

Service providers are those people who are working directly with people living with HIV/AIDS, this includes health care providers, counselors, social workers and home based care providers (HBCs). These professionals are responsible to provide service and their responsibilities are to best serve the people living with HIV/AIDS. According to WHO(2006), human resources for health are the men and women who make health care happen, these include nurses and midwives, pharmacists, physicians, dentists and other health professionals. They also include auxiliary health care workers, community health workers, practitioners of traditional medicine,

technicians and other paraprofessional personnel .They are important because the existence and quality of services to promote health, prevent illness or to cure and rehabilitate depend on the knowledge, skills and motivation of human resources for health.

Health caregivers, especially those dealing with people suffering from serious illness andthose exposed to multiple deaths, are at risk in developing work-related psychological disorders. Burnout is a result of chronic occupational stress (Pines and Maslach, 1978) andoccurs in every profession associated with AIDS and oncology care, including doctors, consultants, psychologists and social workers (Bennett et al., 1993).

Bennettet al. (1991) compared nurses working in HIV/AIDS with those in oncology unitsfound that there were no significant differences in the frequency of burnout. However, there was a significantly greater intensity of symptoms when burnout was observed in HIV/AIDS ensures. Similarly, Kleiber et al. (1993) found no differences in the levels of burnout reported by HIV/AIDS nurses compared with nurses in oncology and geriatrics. However, Stella etal.(2002) found that HIV/AIDS nurses had been on the job for shorter periods of time, suggesting that burnout for AIDS caregivers may have occurred more rapidly. Catalan et al. (1996) reported significant levels of burnout in about a fifth of health workers (70 doctors and nurses working in HIV/AIDS unit and 41 doctors and nurses working in oncology) with no significant differences between AIDS and oncology staff regarding levels of emotional exhaustion and depersonalization, but there were lower levels of personal accomplishment, in HIV/AIDS unit, both in terms of frequency and intensity.

Service providers have to deal with different people at their work places, listen to different stories and also deal with the other community members in their society. These all will put service provides at risk or burn out and stress in their work place which in turn affects their professional and personal lives.(WHO, 2006).

With the increasing number of high HIV prevalence, in addition to their existing duties, health workers are called upon to assist with recently introduced HIV/AIDS components of comprehensive care and support packages.

10. Summary

The literature presented in the above section briefly shows the prevalence of HIV/AIDS in the world ingeneral and in Ethiopia specfically. HIV/AIDS, although has been showing a decrease in prevalance because of immideate response by the government and NGOs, ther is a lot to be done to eradicatea the impact of the virus. People liivng with HIV/AIDS are facing multifacted challenges in their every day li ves. To tackle the challenges there are standard service deliver guidelines to be implemented by service providers for people living with HIV.

Chapter Three

Study Area, Research Design and Methods

3.1 Description of the Study Area

This study was conducted at Worldwide Orphans Foundation which is located in Yeka Sub City of Addis Ababa.Worldwide Orphans Foundation was founded in 1997 by Dr. Jane Arson. WWO brings love, play, health care and hope to orphans and vulnerable children through programs focused on attachment, early intervention, health care, sport and the art. WWO began providing comprehensive HIV/AIDS care for children and their caretakers in Ethiopia in 2005. WWO provides comprehensive HIV/AIDS care and diagnostic services for over 2,000 HIV infected clients.Besides the clinic,WWO has increased its service and has opened a primary school in 2007 for children with and without HIV/AIDS in Addis Ababa, Ethiopia. WWO also runs children's home for HIV positive children.

3.1.2 Vision and Goals of Worldwide Orphans Foundation

The vision of WWO isto transform the lives of orphaned children around the world. And the goals of the organization are:

- Provide healthcare to children and families living with HIV/AIDS
- Provide education, enrichment and residential care to orphaned children
- Prevent further orphaning by testing adults for HIV so they can know their status and reduce their risk acquiring or spreading the disease.

3.1.3 Mission of Worldwide Orphans Foundation

The mission of WWO is to transform the lives of orphaned children and help them to become healthy, independent, productive members of their communities and the world.

3.1.4 Programs ofWorldwide Orphans Foundation

The major programs implemented by the organization are described as follows:-

1. WWO-AHF Family health clinic: The Center is a full-service care facility for treating and monitoring the care of orphans and children in families with HIV/AIDS, and for the treatment of adults with HIV/AIDS. Under the clinic many HIV/AIDS comprehensive care and supports activities are provided like VCT, medical care, ART provision, laboratory services and psychosocial supports. The patients are treated with a qualified pediatricians and adult doctors and nurses.

2. WWO Academy: - This is a school established for both HIV positive and negative but vulnerable children who couldn't afford schooling starting from Kindergarten up to grade 5. In 2013, a total of 432 children from the orphanage and communities are enrolled. All children receive education, meals, enrichment and psychosocial supports.

3. WWO Children's Home: Des's village for children is a home for 39 HIV positive children aged 6 to 20. The programs at the center are comprehensives psychosocial care, health, academic and social development.

3.2 Study Design and Method

This study used non-experimental research design. In addition, the researcher has employed a combination of quantitative and qualitative research approaches and methods. Quantitatively, the researcher used descriptive sample survey through the use of interview

schedule. Moreover, qualitative research methods, like semi-structured interviews with key informants, focus group discussions with the stakeholders, observation of the overall setting of the organization and documentary analysis were used.

3.3 Universe of the Study

The universe of this study is HIV/AIDS service and care clients that have been receiving different types of services at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa since 2005. The HIV/AIDS services provision included in this study are pediatric and adult ART, voluntary counseling and testing, education, psychosocial and nutrition supports. Thus, the study is delimited to the care and support clients and providers in the Organization which has been operating in Yeka Sub City beginning from the fiscal year of 2005 to 2013.

3.4. Sampling Method

The researcher has purposefully sampled *Worldwide Orphans Foundation* to serve as particular reference in the assessment of the practice of HIV/AIDS service provisions. This isbecausethe researcher has close work relationship with the Organization and the availability of different services of care and support for people living with HIV/AIDS in a health setting.

Clients of the center that are above 16 years old were selected by using Non-probability, Purposive Sampling method in order to be able to get accurate data andSimple random sampling (SRS) was employed to select 50 patients ofthe center under the auspices of the Organization to assess the practice of HIV/AIDs service provision in Yeka Sub city of Addis Ababa.

3.5. Data Collection Tools and Procedures

The researcher has employed appropriate data collection tools to collect pertinent quantitative and qualitative data using both quantitative and qualitative research methods.Structured interview schedule were used to collected data from the sampled

HIV/AIDS service clients of the organization. The interview schedule contained both open ended and close ended questions.

Semi- structured interviews were also conducted to the service providers such as doctors, project directors, nurses, pharmacists, psychologists and lab technicians that are directly involved in HIV/AIDS service delivery to the needy ones in the intervention areas in Yeka Sub City of Addis Ababa using a less structured interview guide. This method is incorporated because of the advantages it has to get detailed data on different issues related to the research topic, especially regarding the challenges faced, the practice of service delivery and any mechanisms used by the management body to cope with the challenges.

The researcher has conducted focus group discussions with a total of eight participants selected fromthe stakeholders using FGD scheduled checklist at a convenient venue. In addition, the researcher was engage in observations of relevant aspects of the Organization's settings in the Sub City using observation schedule. All the data gathering tools were prepared by English language and then translated to the local language, Amharic.

The researcher has further employed documentary analysis to generate secondary data from project documents, progressive reports, the FDRE Constitution, policy, etc. Besides, secondary data was collected from published and unpublished web-based documents, thesis dissertations and so on.

3.6. Data Processing and Analysis

To analyze both the primary and the secondary data collected for the study, the researcher has used quantitative statistic techniques and qualitative data analysis techniques.

Information obtained from interview schedule, semi structured interviews,focus group discussion and observation were analyzed in the data processing process. The procedures taken during data analysis were to transcribe the audio tapes using rules of transcription for data's gathered through interview schedules and semi structured interviews .The primary data collected with the interview scheduled wasthen quantitatively analyzed manually and by use of computer by using SPSS software. In addition, the primary data using the semi -interviews, focus group discussions and observations was analyzed content and/or thematic analysis and presented in combination with the quantitative findings. Moreover, the qualitative and quantitative data were triangulated so as to show all possible indications in the responses gathered using the various data collection tools.

3.7 Ethical Issues

Ethical issues were considered by the researcher at all times of the research process. First of an agreement paper was signed between the researcher and Worldwide Orphans Foundation regarding the research process. Written and verbal consent was also obtained from HIV/AIDS service clients and service providers to assure confidentiality for all participants. Theinformed consent has incorporated information such as the nature and purpose of the research. After explaining the objective of the study in detail informed verbal and written consent from all study participants was collected to ensure that participants understand their voluntary participation.

Chapter Four

Data Analysis and Interpretation

This chapter presents analysis and interpretation of the data collected on HIV/AIDS services provided to fifty clients of Worldwide Orphans Foundation to assess the practice of HIV/AIDS service provisions in Yeka Sub City and the challenges faced by service provider's in providing comprehensive care and support services to people living with HIV/AIDS. In addition, data gathered through structured interviews, semi-structured interviews, FGDs and observations analyzed quantitatively and qualitatively, including documentary analysis will be presented. This chapter is thus categorized into six sections. The first section covers the background of the respondents which was gathered from the interview schedule. The second section deals with the interaction and integration of the clients with the Organization. The third section assesses the practices of HIV/AIDs services available to the clients. Section fouraddresses the unmet needs of the clients. The fifth section is about challenges encountered by the service providers and the last section highlights the coping mechanisms employed by the service providers to deal with their challenges in a context sensitive manner.

4.1 Socio-demographic Profile of Respondents

4.1.1 Frequency Distribution of Respondents by Sex

A total of fifty HIV/AIDS service clients from the Organization have participated in this study.Out of these respondents,more than three- fourth (64.0%) the clients were found to be females and the other 32.00 % of themwere males. This shows that the main beneficiaries of the HIV/AIDS care and support services offered by the Organization are women living with HIV. Therefore, this finding concurs with the general consensus on the fact that women are more vulnerable and susceptible to HIV infection than their male counterparts.

Table 4.1. Distribution of the Respondents by Sex

Sex	**Frequency(F)**	**Percentage (%)**
Female	32	64.0
Male	18	36.0

Total	**50**	**100.0**

4.1.2 Frequency Distribution of Respondents by Age

Table 4.2 shows that the age of the study participantsvary from 17 to 61 years old but more than one third of the clients fall under the category of middle age that ranged from 28 to 38 years old.In comparison clients in their late adulthood stages of 50 years old and above were found to be the smallest age group constituting 12% of the respondents.

One fifth (20.0%) of those clients who were clients of the HIV/AIDS care and support services provided by the Worldwide Orphans Foundation in Yeka Sub City were found to be in their early adulthood stages of 17 to 27 years old. Thus, the age of the clients varies from childhood until late adulthood stages which indicate the heterogeneity of the beneficiaries.One can deduce that the virus does not discriminate people from all walks of life against age. HIV affects people in all age categories elsewhere in the world.

Table 2 .Frequency and Percentage Distribution of the Respondents by Age

Age Category	**Frequency(F)**	**Percentage (%)**
17-27	17	34.0
28-38	19	38.0
39-49	8	16.0
50-60	5	10.0
> 61	1	2.0
Total	**50**	**100.0**

4.1.3 Marital Status of the Respondents

Table 4.3 indicates that the marital status of the clients came up with mixed results without outstanding and dominant marital status types. A total of 15(30.0%), 14 (28.0%) and 13(26.0%) were nevermarried, married and divorced clients of the Worldwide Orphans Foundation respectively. More than half of the respondents were in wedlock.

In contrast the data gathered from document analysis and semi- structured interview with the key informants' indicated that the majority of the clients at the Organization were mainly divorced women in their early adulthood ages. The data gathered from the sample of the service beneficiaries shows that the majority of the clients were single women in their early adulthood.

Table 4.3. Marital Status of the respondents

Marital Status	**Frequency(F)**	**Percentage (%)**
Single	15	30.0
Married	14	28.0
Divorced	13	26.0
Separated	8	16.0
Total	**50**	**100.0**

In the same framework, the data generated from analysis of relevant documents in the Foundation shows that the number of married and divorced clients is higher than that of the single ones. Therefore the most of the beneficiaries of WWO are married and divore people.

4.1.4 Frequency Distribution of Respondents by Educational Status

When we look at the educational status of the participant's most of the study subjects (36%) were at elementary level, 34% can read and write, while the other 18% are illiterate, has never been to school. Additionally, the other respondents that attended higher education at high school and university level were 6% each. Thus, this data implies that the educational level of the majority of the beneficiaries (88%) is very low ranging in between illiteracy and primary level of education.

Table 4.4 Distribution of the Respondents by Educational Status

Educational Status	**Frequency(F)**	**Percentage (%)**
Illiterate	9	18.0
Read and Write	17	34.0
Primary Education(Grade 1-8)	18	36.0

Secondary Education (Grade 9-12)	3	6.0
University level	3	6.0
Total	**50**	**100.0**

4.2. Respondents Interaction and Integration with WWO

4.2.1Duration of Clientship in the Organization

All of the subjects of this study were HIV/AIDS service clients of Worldwide Orphans Foundation. Most of these clients have been receiving the different service offered from the organization for long years; 22% of the respondents have been following up their health status at the organization for the past 7-8 years, the other 20% have been beneficiaries for the past 5-6 years and the rest of the respondents have been receiving the service for the past 3-4 years (24%).

Table 4.5: Duration of Clientship in the organization

Duration(Years)	Frequency(F)	Percentage (%)
1-11months	8	16.0
1-2 years	9	18.0
3-4 years	12	24.0
5-6 years	10	20.0
7-8 years	11	22.0
Total	**50**	**100.0**

The responses of the clients, therefore, imply that the beneficiaries of the organization are comfortable and satisfied with the existing services offered at the organization. It also indicates that there are mixed beneficiaries in the organization with new once joining the organization and the old beneficiaries staying in the organization for the services offered.

4.2.3 Sources of Information to Clients

Figure 4.1 depicts that the clients had mixed sources of information about the Worldwide Orphans Foundation and its service types. Most of the respondentsthat were following up treatment at WWO first learned about the organization through word of mouth 40 % (20) hearing about the work and services offered by the organization from significant others. The respondents have stated that they heard that the organization offers free medical treatment for HIV positive people and also that it has a better service than other hospitals and health care settings in the area. While the other 3o% of the respondents joined the clinic through referrals from other health care centers. The organization's mobile Voluntary Counseling and Testing(VCT) centers which are located in different parts of the city were found to be the other major source of information (28%)for the beneficiaries to become patients at the organization.

The data also show that most of the beneficiaries of the organization join the setting by hearing from other people and significant others but the organization does not work much on awareness raising or promoting the services offered to the public through media or IEC materials such as broachers and magazines, which implies the lack of consolidated activity in communication and information sharing with the public regarding means of transmission and interventions about HIV/AIDS and the services offered by the organization which might increase the likelihood of reaching more people.

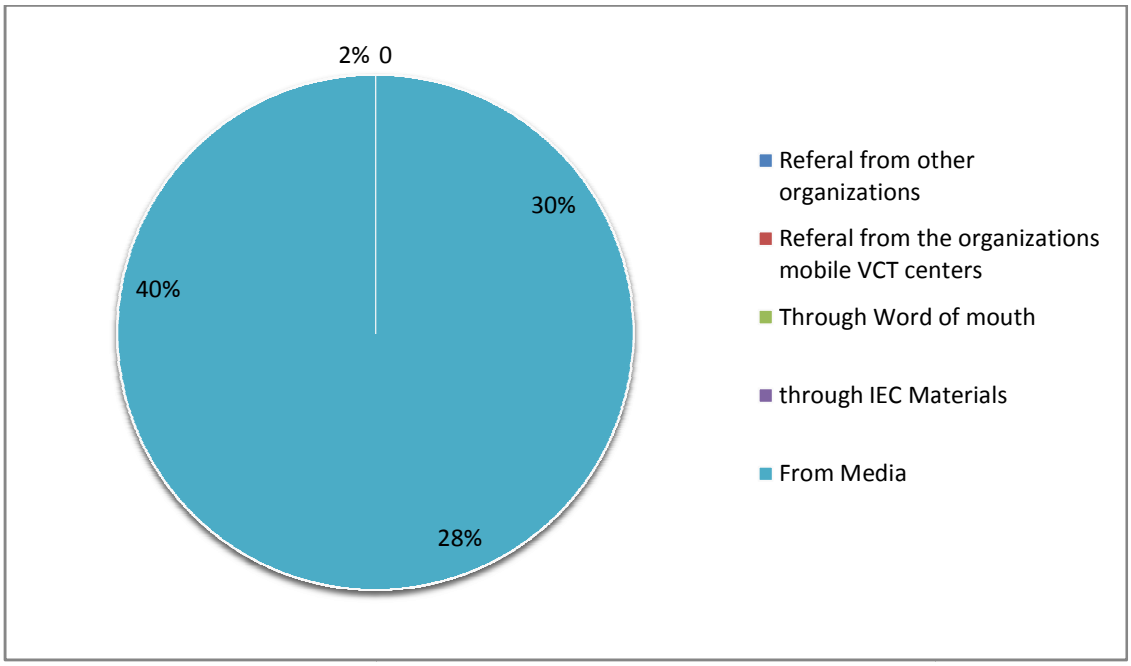


Fig 4.1: Respondents sources of Information about the Organization and Its Services

4.2.3 Beneficiaries' Participation in the Organization

One of the elements of providing quality comprehensive care and support service is the beneficiaries' participation in all of the project phases starting from identifying the problem up to designing the activities. But as per the information gathered through interview with the service providers and focus group participants there is no system in the organization that allows beneficiaries participation at all.

Based on the information gathered from the FGD discussants, it was mentioned that the direct beneficiaries of the organization are people living with HIV/AIDS (both adults and children) residing in orphanages and the community while the indirect beneficiaries are families of the beneficiaries and the entire community. But on the other hand, beneficiaries' awareness about the overall structure of the organization like the stakeholders, criteria's of selection for programs, sources of funding, number of employees and intervention areas was found to be very low.

This was also confirmed in the semi- structured interview conducted with the service providers who have stated that there is no participation of beneficiaries in the planning and implementation of the organization's overall activities either at individual,groupor community level. They have described thatthere is no participation of beneficiaries in assessing and accessing beneficiaries with the existing care and support services. The Project manager described the participation of the beneficiaries in the organization as follows:-

> *Beneficiaries of the organization are not involved in the development of the project activities so far because there are assigned professionals to identify the needs and to develop project activities. These professionals work closely with the beneficiaries, so they know the felt needs of the clients. We understand the importance of beneficiary participation but the nature of the organization's activities does not allow for direct clients participation.*

The findings, therefore, indicate that although the beneficiaries of the organization are aware about the direct and indirect beneficiaries of the organization by default, they are not involved in any part of the project implemented at Worldwide Orphans Foundation. This implies that there is little involvement of the beneficiaries on the overall undertakings of the programs in the organization and also they have low sense of ownership for the programs implemented by the organization. As well, there is lack of transparency on the overall planning, accomplishment and budgetary issues of the organization to the beneficiaries, employees and stakeholders.

4.3 Type of Services Available at the organization

4.3.1. Health Care Services

All of the study subjects have responded that they receive health care services from the organization; while all 50 (100%) of the respondents have stated that they have access to free medical care, laboratory examination service and treatments of opportunistic infection 22(44%) of the respondents have replied that they get all the above mentioned services plus different training on comprehensive range of health issues. Accordingly, as per the data gathered from beneficiaries, only 22(42%) of the respondents described that they receive intensive trainings on health issues but more than half of the respondents 38(68%) have stated that they get consultation about how to keep themselves healthy and how to take ART medication as part of the medical care during their regular appointments with the nurses and doctors but they never had a formal educational sessions on different health issues. From these 68% of the respondents only 19% indicated that they will benefit from educational sessions' on health issues while the other thought it is not necessary to have a separate training on health issues as they get their concerns and questions answered through their regular visits.

As per the information gained through semi-structured interviews with the service providers also shows similar type of services offered in the organization but a different service mentioned by the service providers was provision of pills and consultation on family planning, refund of any medical expenses that are not available at the organization and TB screening.It was also disclosed that WWO has nurses, pharmacists, laboratory

technicians with progressive trainings and medical doctors and a pediatrician that control and manage overall health situations of clients. As to the referral, all medical cases beyond their capacity are referred to other hospitals. It was also mentioned that the health care service is the most organized component of care and support services offered by the organization. This was also confirmed by the researcher through observation and document analysis.

When we look at the satisfaction of the clients towards the health care service, most of the respondents have thought that the service is excellent (64%) while the others 16% indicated that their level of satisfaction by the health care service is good and average. This indicates that the beneficiaries are happy about the health care services offered by WWO.

The majority, 96% of the respondents answered that they don't face any challenge when getting the health and care service offered by WWO but 2% of the respondents complained that it takes awfully long time to get the medical service and 1% of them described that their challenge is lack of admission for serious illnesses.

Overall, the health care service offers beneficiaries with comprehensive treatment services of medical treatment, laboratory service and pharmacy services with qualified professionals. Therefore, it can be concluded that WWO offers a quality health care service for the beneficiaries.

4.3.2. Food and Nutrition Services

Food and nutrition is one of the components of comprehensive care and support services for people living with HIV/AIDS, but at Worldwide Orphans Foundation only 24(48%) of the respondents have stated they have received food and nutrition service for their HIV positive malnourished children if they meet the criteria's set. From these beneficiaries 13 of them responded that they receive nutritional needs assessment and counseling while the other 11 of the participants replied that they have received supplementary feeding for their children who are under weight.From 24 of the respondents that receive food and nutrition

service half of the respondents complained of irregular supplementary food distribution and shortage of the nutrition supplied.

On the other hand, 26(52%) of the respondents, replied that they do not receive nutritional support from the organization. And all of them stated that they are not aware whether the organization offers food and nutrition service for the clients or not. In addition, 15(30%) of the study subjects have mentioned that they could benefit from food and nutrition support if it was to be offered by the organization but only 11(22%) of the respondents have described that they will not require this service even if its offered to them because they are in a position to afford their own nutrition.

More than half of the respondents, 60% have answered that they are not satisfied with the food and nutrition service because it doesn't meet the needs of the clients. While the other 36% of the respondents' level of satisfaction for this category of service is average on the other hand 4% of the clients thought the service is satisfactory as it meets their needs. In this regard one of the beneficiary's in the focus group discussion presented this challenge as follows:-

> *To be frank, it is hard to say food and nutrition service is offered at the organization as the supplementary food offered to malnourished children does not satisfy the nutritional needs of the children. For example my family, including my children, can't afford a proper meal and nutrition but when I asked for support I was told I don't meet the criteria of selection for the supplementary food.*

The data gathered from the project officer of the organization through semi-structured interview also shows that there is a limited food and nutrition service offered to the clients. They have mentioned that the food and nutrition service is offered for orphan and vulnerable children that are enrolled in the primary school run by the organization and for malnourished children clients' taking ART medication with low Body Mass Index Measurement (BMI) can get supplementary foods like Plummy nut and breed Love as per the criteria and guideline set by the government. The study participants have also mentioned that the standard measurement, BMI, is set very low so they are usually illegible to the service as the clients can't afford a balanced diet for their children. This was stated by the project officer as follows:-

We provide nutrition service for orphan and vulnerable children that are enrolled in our primary school but for the other beneficiaries' food and nutrition service is offered with limited access; this is because we don't have the budget assigned for food and nutrition. But we provide guidance on nutrition and Plummy nut foods for malnourished children. The service is not available for adults.

In conclusion, the service offered under this category is very limited and doesn't meet the needs of the clients at any level. Most of the services included under this category of support like provision of food for the needy, nutritional assessment and like are not offered to the beneficiaries, the only service offered in this category are counseling on nutrition and supplementary food for malnourished children.

4.3.3 Shelter and Care Services

Most of the respondents 42(84 %) have stated that they never received shelter and care service from the organization because it's not available but 16 % of the participants replied that they get some components of shelter and care services from the organization specifically sanitary facilities of clothing and provision of clean water.
Similarly 88% of the respondents have stated that their satisfaction of this service is poor and they are not aware of the availability of the service or the criteria used to select beneficiaries for this service while the other 12% thought that this service meets their need on average level as they had been getting clean water, soap and clothes from Worldwide Orphans Foundation.

The clients who have been receiving shelter and care services replied that the challenge they face when taking sanitary materials is lack of consistency in provision of the service. They have further mentioned that the service is not offered on a regular basis.

Both data gathered from the key informants and service providers through FGD and interview also indicates that there are no shelter and care services offered by the organization. The project officer of the organization stated that the reason for not offering shelter and care service is not because the organization does not recognize the need for this service but it is because of different internal and external factors like budget and government policies.

Overall, the finding indicates that most people living with HIV/AIDS are in need of shelter, family reunification, home based care and sanitary facilities which are not currently offered by the organization. This shows that lack of shelter and care service affects the effectiveness of the health care services as some patients terminate from ART treatment.

4.3.4 Economic Strengthening Services

Activities related with increasing the income of individuals and families are included under the component of economic strengthening. When we look at the availability of this service at Worldwide Orphans Foundation, 80% of the respondents have stated that they don't get any economic strengthening service from the organization because the service is not available from these 80% of the respondents, 65% of them have mentioned that they can be highly benefited from any economic strengthening activities as they don't currently have a stable way of income generating activity. On the other hand, the other 15% of the study participants have stated that they are economically stable and for that reason they do not need any assistance in this area.

On the other hand, 20% of the study participants remarked that the organization offered them opportunities of employment which had in turn help strength their income. But the study participants have also stated that the service does not meet their needs because the salarythey earnis enough to meet their socio economical needs. So, the participants have indicated that the economical strengthening service is poor.

This was also confirmed in the FGD and semi- structured interviews conducted with stakeholders and employees of the organization.One of the FGD discussant described it as:-

> I am a single mother raising two children all by myself, I don't have a stable means of income, and I work at individual households as a cleaner. I wanted to start a small businessto be able to have a stable means of income but I do not have any capital to begin the business…, I asked WWO for any financial assistance but I was informed that they can't assist me with a loan or any other means of income generating activity.

In conclusion, the objective of economical strengthening services is to enable people living with HIV/AIDS to meet their own needs from an economic perspective. Most of the clients

of the organization neither have an established means of income nor any financial support to help them strengthen their economy.

4.3.5 Psychosocial Support Services

All of the subjects of the study were found to be aware of the provision of psychosocial support offered by the organization but only 54% of them replied that they had received psychosocial support from Worldwide Orphans Foundation. 23% of the study subjects had benefited from the emotional support groups, 20% had received individual and group counseling services and 11% of them were part of the life skill and other psychosocial trainings offered through the summer camp programs.

The respondents had also mentioned that in the area of the psychological support the organization provides mainly post-test and ongoing counseling to address the emotional and social needs of the beneficiaries as well as stress management and promotion of living positively with HIV/AIDS. The counseling service conducted for individual, family, group (children and adult), and couples is the basis to meet psychosocial needs and problems of each client setting.21% of the study subjects who had received the psychosocial services mentioned that unavailability of time due to work had been their biggest constraint in following up sessions of group and individual counseling. They had also mentioned that the psychosocial activities offered at Worldwide Orphans Foundation are time consuming by nature but the beneficiaries don't have enough time to spend on psychosocial support.

The other 46% of the respondents have stated that they don't receive any kind of psychosocial support at the organization for reasons they are not aware about. From these respondents, 10% of them have mentioned that they have asked to be included in the support group available at the organization but have been informed to wait in line to participate in the emotional support group organized by the organization.

Most of the participants of the study have replied that the psychosocial support provided is poor as it had not satisfied there needs (30%), while 24% of the respondents that had received psychosocial support thought that the psychosocial supports provided by the organization have met their needs on average level and had therefore evaluated the service as very good.

The findings gathered from semi-structured interviews from the employees of the organization, on the other hand, shows that the service providers believed that there is a strengthened psychosocial support activities offered to the beneficiaries. The nurse counselor had stated this as follows:-

> *WWO offers strengthened psychosocial support activities both for pediatric and adult patients with qualified professionals; we have individual counseling, group social supports, life skill trainings, youth clubs, global art and summer camp programs. Some of these activities are very uniquely designed to meet the emotional needs of PLHIV. I believe all this addresses most of the clients' psychosocial needs.*

Overall, psychosocial needs assessment, individual counseling, support groups and trainings on life skill are provided for the beneficiaries at the organization. The services offered helped to foster hope and resilient as well as increased connection among themselves. The document analysis and observation findings indicated that there are a lot of psychosocial activities offered for the pediatric patients with a strengthened structure but the psychosocial support activities offered for adult beneficiaries are limited with decreased structure and emphasis.

4.3.6 Legal Protection Services

The majority of the study subjects 47(94%) have reported that they had never received any type of legal support service from Worldwide Orphans Foundation because it is not offered to the beneficiaries.Only 6% of the participants of the study have mentioned that they had received advice on how to protect their rights and assisted with access to available services and referral for appropriate legal services to other organization. These respondents have also stated that they arenot satisfied with the services offered.

The service providers have also confirmed that the legal support provision is not offered at the organization.The project officers explained that the absence of legal protection services decreases the quality of service WWO is trying to offer but the organization had not identified legal support as a primary need of the beneficiaries, therefore, the organization is focusing to address the prior needs of people living with HIV/AIDS.

Stakeholders of the organization hadalso mentioned in the focus group discussion that HIV/AIDS patients have needs of legal protection and need of guidance and assistance regarding their human rights because of the stigma and discrimination from the society but since the service is not availableat the organization the beneficiaries lack assistance in this area which creates a gap in the comprehensive care and support offered by the organization.

The findings in general, indicated that one of the components of comprehensive care and support is not offered by the organization. Services offered under the legal protection component are related with protecting PLHIV from any stigma and discrimination and assuring their rights but because of lack of this service beneficiaries of the organization are left without any assistance when it comes to legal protection.

4.3.7 Educational Support Provision

62% of the clients have responded that they receive free educational supports for their children enrolled at elementary level. Under this support the beneficiaries have described that their children get free primary education starting from upper kindergarten to grade 6. The had further mentioned that they receive scholastic materials of bags, exercise books, text books, pencil and pen as well as uniforms and school bags. It was also stated that free transportationservice and meals (breakfast and lunch) services are offered for their children at primary school level. In addition, 40% of the respondents have stated that they

are highly satisfied with the educational support offered while the other 22% of the respondents evaluated the service as satisfactory.

The other, 38% of the respondents, on the other hand, have mentioned that they do not receive educational support for their children for different reason. 31 % of them are not receiving the service because their children are older for primary level education which the organization is offering and the other 7 % do not have children. The study participants have suggested that if the educational support could also be offered for orphan and vulnerable children at high school and university level they will benefit highly.

These findings were also confirmed through semi-structured interview with the service providers. The Project officer of the school projected had described the services offered under this category as follows:-

> *The need for more than medical care urge led to the establishment of the WWO Academy, a place where 432 children from orphanages and the community, both HIV positive and negative, can get lunch, snacks, education and psychosocial support in an effort to overcome the stigma associated with HIV/AIDS. Educating and integrating HIV positive and negative children offers our best hope of eliminating the HIV/AIDS stigma and providing these children with an opportunity for a full life. We started from Kindergarten and now encompassing children until grade five by adding one grade level each year.*

Worldwide Orphans foundation is offering a standard level of free education for orphan and vulnerable children covering the student's academic, nutritional and psychosocial needs. The educational support service offered at the organization is very good and it offers a comprehensive package of educational support for orphan and vulnerable children.

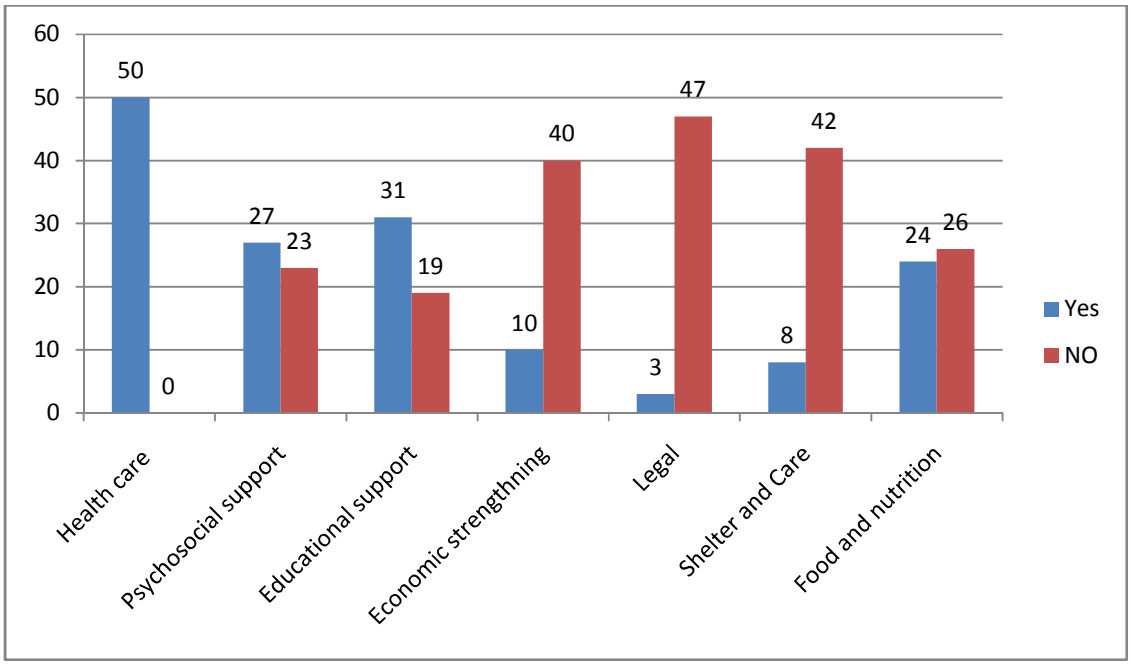


Fig 4.2.Existing HIV/AIDS Comprehensive Care and Support activities offered at WWO

To summarize the finding, Worldwide Orphans Foundation care and support activities are improving the quality oflife of PLWHAs and orphans. Based on this finding, the most significant and crucial support for people infected with HIV/ADS is found to be improved physical and emotional health through a strong medical care services and psychosocial components at the organizations free standing family care clinic. As well, the educational support offered at the organization's established school is changing the lives of many children through the provision of quality educational supports. On the other hand, the other components of comprehensive care and supports of economical strengthening, legal protection and shelter and care services are not offered by the organization which impacts the outcomes of the other services by not addressing these needs of PLWAs.

4.4Needs of Clients Unaddressedby the Organization

Different services are offered for people living with HIV/AIDS at the organization to address the needs and challenges of the beneficiaries. 58% of the respondents have reported that the services offered at the organization are indeed in line with their current needs but the other 42% of the clients receiving service from the organization have implied that some of their needs are not met by the services offered at the organization. The respondents have suggested that if economic strengthening (20%), home based care and

support for the sick (10%), nutritional support (4%), legal support (4%) and recreational activities (4%) are included along with the existing services,the service will be comprehensive for people living with HIV that meets their current needs. From the 42% of the study subjects that have stated that the services offered at the organization are not in line with their needs, 38% of them have mentioned that the major problems that they are currently facing are lack of stable means of income and lack of food for themselves and their families.

In addition, most of the beneficiaries of the organization, 60 % have thought that the services they get from the organization are comprehensive in comparison to services offered at other governmental hospitals and health care center.

Similarly information gathered from the service providers through semi-structured interview indicated that the services offered by WWO do not include all comprehensive care and support packages. The service providers have indicated that the organization has not identified the comprehensive care and support packages. They have indicated that provision of comprehensive care and support packages like economic strengthening, legal support, shelter and care are missing from the services, but, if these services were to be offered for the beneficiaries, the organization could be said to identify all the comprehensive HIV/AIDS care and support programs meeting the needs of the beneficiaries that are affected and infected with HIV.

In addition, the ideal HIV/AIDS care and support services mentioned by the service providers through the interview conducted were; provision of supplementary food for those taking ART and for pregnant patients, home based care, health care services including admission and house rent coverage, a strong networking system with other organizations and to provide shelter and care service to elderly people and orphan children. One of the project officers in the organization has stated the following when asked about an ideal HIV/AIDS comprehensive care and support indicating the impact of not providing comprehensive care and support to PLWAs:-

> *Clients taking ART, for example might tell you they work as prostitutes because they don't have other means of earning income. Therefore, indirectly they are highly transmitting the Virus to non-infected population but because there is no economic*

strengthening offered we can't do anything about it. Therefore, an ideal care will be to provide other income generating activity along with counseling.

The finding, thus, indicated that if activities of behavior change and communication services are not offered in line with all the packages of comprehensive care and support interventions, it cannot bring the desired outcomes. Since some of the beneficiary's economical needs are not met they do not respond well to the ART treatment offered.

Other ideal HIV/AIDS comprehensive care and support provision that meets the needs of the patients which was suggested by service providers was prevention and intervention service going side by side. It was stated that awareness creation about means of transmission along with comprehensive care and support services will bring a better impact than only focusing on HIV positive population.In addition, an integrated networking system and follow up for clients with low adherence in a form of home based care and support and social assessment to assure the physical emotional and social well-being of the clients was mentioned as a missing service that doesn't meet the needs of the clients at the organization. They stated that there are educational and other psycho social supports offered for children to help them build their confidence and for the children to adopt positive living styles but once they join University , there is no system to track these clients but this is the time where they need support, most of them face a challenge to keep adherence.

As a result, a comprehensive care and support that can adress the overall needs of people living with HIV includes both preventon and intervention activities that puts the economical, social, medical and psychological needs in mind. The findings indicated thatthe service providers at the organization prefer to offere an integrated comperhensive care and support service for small number of beneficiarie than offering limitted services of health care, educational support and psychological support for alarge number of people living with HIV/AIDS.

4.5. Challenges Encountered by Service Providers at WWO

As per the semi structured interviews conducted with the employees of the organization, there are many areas where the service providers face challenges when providing care and support activities for HIV/AIDS clients. Most of the sources of the challenging factors come from unmet needs of the clients by the project. The service providers have also mentioned that, generally, the working environment by itself is stressful as it is occupied by clients with numerous problems.

4.5.1Lack of Integrated Care and Support Activities for Holistic Support

WWO offers care and support services emphasizing on amenities of health care, psychosocial support and educational support for children and their families. Other components of care and support services are not provided strongly and this was found to be one of the major challenging factors for service providers in working with people living with HIV. The interviews conducted with the nurses, project director, pharmacists and lab technicians have indicated that lack of comprehensive care and support packages is the biggest challenge they are facing.

In this area, clients' low income to afford the basic needs of food and nutrition and the projects limitation to offer this service has decreased the effectiveness of the other services offered by the organization. The adult patient nurse has described this challenge as:-

> *Working with patients of low socio economic status is difficult and the results are ineffective as these patients require financial supports or shelter and when we don't assist them with their felt needs they usually terminate the ARTtreatment. If we had a strong networking system with the other organizations that offers the missing services of WWO it might decrease the challenge. What makes this situation worst is that we don't have a system or a person in place for tracking patients who failed to show up for a treatment.*

The interviewees', in addition, have implied that problems of the beneficiaries are vast which cannot be met by the service packages offered by WWO. The unavailability of networking system and a dedicated social worker intensify the challenge. This fact on the other hand, puts the employees working directly with the clients on a difficult condition of not being able to help the clients with different problems. One of the interviews participant working as a nurse counselor has stated the challenge as follows:-

Often time's patient's show up with a bunch of problems that cannot be solved with the services offered at WWO. Sometimes we use referral to meet the needs of the clients that are not by the services offered at WWO by networking with other service providers in the area but since there is no system or social worker assigned for follow up to the referral, we are forced to ignore the clients challenges because its beyond our capacity but ignoring their needs makes me feel bad and unsatisfied with what I do. "

The finding, in general, indicates that integrated care and support services are not strengthened in the organization which has created a challenge for quality service delivery. The beneficiaries fail for treatment because of unmet needs.

4.5.2 Needs of Pediatric Patients beyond WWO's Service Provisions

Working with children living with HIV/AIDS was found to be more stressful for service providers than working with adult HIV/AIDS beneficiaries. This is because of different reasons; the first reason mentioned by the service providers was the delay ofchildren for testing. They have mentioned that pediatric patients show up for testing and treatment when symptoms of opportunistic infections started to appear. As a result, most of the children are in a very critical medical condition making the intervention process difficult.

The other challenge mentioned by the service providers was caretakers'/ parents/ refusal to have their children tested for HIV. The service providers stressed that parents usually refuse to have their children tested for HIV after they know about their own HIV status because of fear of accepting their children's HIV test result. This fear of parents usually delays the children's testing and treatment process. In addition, children requiring more time for counseling and follow up and lack of child friendly environment for pediatric patients like unavailability of playground, posters, a separate room for counseling and treatment was also mentioned as a challenge.

Orphan or vulnerable HIV positive children without care takersand with sick and weak parents were also mentioned as a challenge by the service providers. This was explained by the project officer mentioned that Pediatric clients with sick parentsrequire other services of shelter or/ and food and nutrition that are not accessible at WWO leading to ineffective

results. It was also stated that these children either terminate their follow up or they will have low adherence because they don't have an adult to help them take their mediations.

This indicated that some pediatric beneficiaries of the organization require additional support of shelter and care along with the medical treatments for a sustained and better outcome. The multifaceted challenges of children that are not addressed by WWO are affecting the result of the existing services offered.

4.5.3 Clients Financial Problem

This was repeatedly mentioned as a challenge by the service providers. They have stressed that most of the clients are in need of livelihood supports of skill training, seed money provision for income generation scheme development, provision of money for housing rent coverage and transportation fee support for college students. In addition, service providers have mentioned that clients ask for financial support at all times and the workers are forced to give their money for certain tasks.

4.5.4 Adherence and Denial of Accepting HIV Status

Respondents replied that patients with low acceptance of HIV status is are a challenge for quality service delivery because they are not willing to start the treatment. Therefore, often times, clients after getting their HIV positive test results will not show up for treatment and there is no way of tracking these people for follow up and treatment.

4.5.5 Stress and Burnout

Work related stress and burn out was stated as a challenge by some of the interview respondents. High work load and dealing with unmet needs of the clients were found to be the major work related stressors. It was also mentioned that little has been done by the organization to asses or help employees to deal with their job related challenges and stressor factors. They have also implied that in times of stress their job performance and provision of quality service decreases.

4.5.6 Different Test Results

This was stated to occur often times during voluntary counseling and testing service provision. The counselor/nurse has stated that when married couples get tested and their

results turn out to be different it creates a chaos beginning from separation, divorce and blaming the positive couple of cheating. This will leave children and families to loss what they have built. It is a source of stress for the workers because usually the victims will not be willing to start ART treatment because of the disagreement in the family.

4.5.7 High knowledge Demand

From the explanation of one of the employees of the organization working as a direct service provider, there is a high knowledge demand by the employees working at different departments; as HIV/AIDS is a virus that changes itself from time to time and the study about the virus and the treatment is ongoing there are always new information and findings released by scientist, these information's are very important for service providers up to dated service provision. But since there is neither trainings nor means of accessing new information through the internet and newsletters, the workers are challenged to using old information which decreases the quality of service offered to the patients. This was further stated by one of the employees as foo lows:-

> *There is a high knowledge demand by the staff, as there is no other way of getting up to dated information about HIV/AIDS; there are no manuals, newspapers or an internet connection to help the staff learn about HIV. There are no trainings offered for the staff, it is not given a priority but it is really important to keep up with the recent information so that the workers can provide the right information to the clients.*

Overall, the finding shows that there is a high demand for trainings and access to new information by the staff for increased quality service provision but there is negligence from the management of the foundation on this regard.

4.6 Major Coping Mechanisms Employed by Service Providers at WWO

The data gathered from the interview conducted with service providers shows that in order to reduce burn out and work related stress while providing service to HIV/AIDS service clients, the employees use different coping mechanisms to deal with the challenges they face at a daily basis.

> *What keeps me going in working with the clients is when I see clients with challenges develop resilience and come up with solutionsfor their problems andcontinues their follow up. At the end of the day, no matter what the challenges are, it makes me realize that I am making a difference in the life of the clients to some extent and that belief helps me going.*

This indicates that there is a positive relationship with resilient clients of Worldwide Orphans Foundation and decreased stress of employees. When clients are able to solve challenges in their lives and continue their follow up, the service providers level of stress decreases.

The nurse counselor of the organization stated in the semi-structured interview that using personal initiatives to address the unmet needs of the clients through linkage and referrals to other centers and professionals help decrease job related stress. In addition, providing unconditional love, active listening and reading the bible were the other coping mechanisms used by the workers of the organization to deal with job related challenges. The ART department nurse stated this as:-

> *I always listen to the beneficiaries talk about their problems and challenges in lifeto help them decrease their stress, even if there is not much I can do to help solve their problems, it gives them a sense of relief.Showing them that I care about them by actively listening to their problems helps the beneficiaries as well as I, as it gives me a sense of satisfaction.*

The service providers have also mentioned that talking to their colleagues about the stressor factors and changing the nature and type of work from directly working with the beneficiaries to paper work and vice versa were used as a coping mechanism to the challenges say face on a daily basis.

Overall, the employees of the organization have stated that they used different coping mechanismsfor different challenges they face while providing service to people living with HIV. In addition, the interviewees have thought that the management of the organization doesn't acknowledge the stress and challenges faced by the workers while providing care and support service to the beneficiaries as well as the implication it has on the provision of quality service. One of the interviewees stated this factor as follows:-

> *There are not much effort made by the management of the organization to help the workers cope with stress, in fact when the workers are under stress there is low*

motivation and productivity but instead of finding alternatives for the employees to solve their problems the management of the organizationblames us for decreased performance.

In general, based on the qualitative data gathered regarding the coping mechanisms employed by service providers, it can be concluded that the employ's applied personal coping mechanisms of finding purpose in the work, finding solutions to problems of the beneficiaries, reading bible and changing type of work. Also,it was indicated that the issue of employees stress in providing service to people living with HIV was given low emphasis by the management of the organization.

Chapter Five

Conclusion and Recommendations

5.1 Conclusion

This study was conducted to asses the practice of HIV/AIDS care and support services at Worldwide Orphans Foundation. The seven core services considered as a

comprehensive care and support by ministry of health are health care, psychosocial support, shelter and care, economical strengthening, legal support and educational support. The finding showed that all packages of the comprehensive care and support services are not fully adopted by Worldwide Orphans Foundation. But the care and support services offered by WWO such as health care, educational support and psychosocial support are improving the lives of people living with HIV/AIDS and their families.

The major challenges service provider are facing while providing comperhensive care and support to people living with HIV/AIDS were found to be evolved around the lack of integrted care and support services available at the organization. The missing components of care and support like shelter and care, economic strengthening and legal supports affect the intended outcomes of improving the lives of PLHIV. Most of all, clients' economical and financial problems are the highest challenges faced by service providers. In addition, need of pediatric patients that are beyond WWO's available services is one of the challenges that are causing stress for the service providers.

The beneficiaries are overall satisfied with the services they are recieving from the organization but they have also indicated that their unmet needs by the organization are affecting them to have full funcitoning. From the missing services economic strengtning and shelter and care are found to be the most pending sevices that are not offered by WWO.

In conclusion, the economical and shelter needs of the beneficiaries at the organization are not addressed by the existing services which are in turn affecting the response of the clients to the ART treatment. In addition, these missing components of care and support services and lack of integration and networking were found to be the source of stress and a challenge for service providers. Although the management of the organization has not been giving emphasis about the stress the workers are facing while providing service the employees keep going by using their own coping

mechanism. The most common coping mechanisms used by the service providers in response to the challenges were found to be

Consequently, to address this gaps the organization should start by involving stakeholders and beneficiaries' participation in identifying their needs and designing activities to help them overcome the socio-economical challenge people living with HIV face for improving the conditions of PLHIV and for increased human functioning. Also, WWO should give emphasis for adressing the stress and challenges the employess face while delivering care and support for an increased outcome.HIV care and support programs need to be developed, implemented and strengthenedin line with the increasing needs of HIV infected peple. This is because as HIV infection steps forward, the types of services needed also change .Therefore, interventions need to be tailored to the local context, the stage of the epidemic and the existing community and national resources based on properly facilitated strategic planning to identify and prioritize the essential elements of the program based on the stage of the epidemic, contextual factors, and sustainability.

5.2 Recommendation

Based on those major findings and conclusions drawn from them, the researcher forwards thefollowing suggestions for further action or practices to enhance HIV/AIDS service provision practice:-

- Majority of the respondents have stated that some of theirimportant needs are not adressed by the services offered by WWO. These needs are economical strengthening, shelter services, nutrition and home based care. This implies that the organization should try to include these missing services for improved comprehensive care and support.
- Most of the problems of the beneficiaries that can not be adressed by the organization because of limitation of the project could be tackled throug strong networking and collaboration with other NGOs ans Gos. Therefore, WWO should give emphasis to create and develop networking system with other organization for referral and enhanced support of PLWAs.
- Monitoring and Evaluation of the outcomes of the project are not properly stated and documented, which had affected the organizationto assess major outcomes and constraints of the project.
- A gap was seen in following up clients that terminate ART follow up because of different reasons, therefore, it is recommended to have a designated social worker to follow up clients with social and psychological problems for enhanced income.
- The organization should create capacity buildingopportunities for the staff that are directly working with PLHIV. It is vital for the employees to be empoweredwith the current status of the virus as well as with the approaches and methods of interventions**.**

- Awarenessraising through IECs, media and other means of information disseminationtechniques should be carried out by the organization in order to be able to adress the larger population. Focusing only on intervention will not decrease the transmission of the epidemic; therefore, WWO should incorporate prevention activities.
- The level of involvement of the beneficiaries and other stakeholders with the organization was found to be very limited, therefore, it is reommended that increased participation of beneficiaries should be enhanced to identify and address the felt needs of people living with HIV/AIDS.

- This study assesed the practice of HIV/AIDS sevice provisionand the challenges faced while providing comperhensive care and support for PLHIV,it is recommended for further research to be conducted by using an adequate representative sample size to further understand the gaps in thepractice of HIV/AIDS service provision and the challenges faced by service providers.

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Annex

Appendix 1

Interview Schedule Guide for HIV/AIDS Service Clients

My name is Lemlem Tale and I am a student of Masters Programme on Social Work at St. Marry University College (IGNOU). Presently, I am doing my MSW thesis on the title: "**The Practice of HIV/AIDS Service Provision at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa.**

This research tool is prepared as one of the means of obtaining data on the practice of HIV/AIDS service provisions in through the clients' perspective.

In order to make it easier to understand and to be able to get all that you say in theactualinterviewing, I would also like to tape record the conversation. I will only tape record if you say that I can. If I have your permission to record, the recordings will be typed up to be analyzed at a later date. In the transcript, your name and any identifiers will not appear. Before I start, do I have your permission to record?

Thank you!

Part one: Identification

1. Date: (MM/DD /YY): _____
2. Name of the interviewer _____
3. Code of the interviewee _____

Part two: Background information

4. Sex ---------- Male☐ Female☐
5. Age ----------
6. Educational level:(Illiterate= 1,Read and write=2 , Primary Level=3,Secondary level=3
   College level=4 , University level=5) ☐

7. Marital status :(Married=1, Single=2 Widowed=3 Divorced= 4) ☐

8. For how long have you been following up your treatment at the organization? ____

   A.7-8Years B. 5-6years C.3-4 years D. 1-2 years E. 1-11 months

9. How did you learn about the organization and the services offered?

   A. Through referrals from other centers B. Referral from mobile VCT centers C. Mouth advertisement D. IEC materials E. Media F. Others please specify _____

10. Do you have access to Food and Nutrition service at the Organization? Yes☐ No ☐

10.1 If your response for question number 10 is 'Yes', can you circle/state the type of services you receive under food and nutrition?

A. Training on nutrition and appropriate food handling practices

B. Provision of nutrition and food for the needy

C. Nutritional need assessment and counseling

D. Supplementary feeding and links to other nutrition services

E. Others, please state_____

10.2 If your response for question number 10 is 'NO', can you describe why you are not receiving this service?

_____

10.3 How is your satisfaction of this service?

Excellent ☐ Good☐ Satisfactory☐ Poor ☐

11. Do you have access to Health care services at the Organization? Yes ☐ No ☐

11.1 If your response for question number 11 is 'Yes' can you circle/state the type of amenities you receive?

A. Access to free Medical care services

B. Training on a comprehensive range of health issues

C. Access to free laboratory service

D. Availability of different tests and opportunistic infection treatments

E. Others, please state_____

11.2 If your response for question number 10 is 'NO', can you describe why you are not receiving this service? _____

11.3 How is your satisfaction of this service?

Excellent ☐ Good ☐ Satisfactory☐ Poor ☐

12. Is there access to Educational support for Orphan and Vulnerable Children? Yes ☐ No ☐

12.1.If your response for question number 12 is 'Yes' can you circle/state the type of services offered for educational support?

A. Provision of scholastic materials

B. School registration initiatives, direct assistance to subsidize school costs

C. Capacity building to support OVC among Parent-Teacher Association and teachers

D. Services like Life skills and livelihood opportunities to OVCs

E. Others, please state_____

12.2 If your response for question number 102 is 'NO', can you describe why your eligible children are not receiving this support?

_____

12.2How is your satisfaction of this service?

Excellent ☐ Good☐ Satisfactory☐ Poor ☐

13 Are there Legal supports offered at the agency? Yes ☐ No ☐

13.1. If your response for question number 13 is 'Yes' can you circle/state the type of legal supports offered?

A. Support with parenting and care-giving responsibilities

B . Assistance with access to available services

C. Refer and link with appropriate legal services when required

D. Assistance with inheritance claims and removing from abusive situations

E. Others, please state_____

13.2 If your response for question number 13 is 'NO', can you describe why you are not receiving this service?

_____

13.3. How is your satisfaction of this service?

Excellent ☐ Good☐ Satisfactory☐ Poor ☐

14 Is there a Shelter and Care service offered in case of need? Yes ☐ No ☐

14.1. If your response for question number 14 is 'Yes' can you circle/state the type of services offered?

A. Construction and renovation of shelter

B. Availability of sanitary facilities and clothing (water and toilets)

C. Provision of short term shelter for needy clients

D. Reunification and referral for children without parental care

E. Others, please specify _____

14.2If your response for question number 14 is 'NO', can you describe why you are not receiving this support?

_____

14.3How is your satisfaction of this service?

Excellent ☐ Good ☐ Satisfactory ☐ Poor ☐

15 Are there economic strengthening activities/ supports offered at the organization? Yes ☐ No ☐

15.1. If your response for question number 15 is 'Yes' can you circle/state the type of services offered?

A. Provision of training on how to generate and manage income

B. Provision of financial support for needy

C. Vocational training or other income generating activities

D. Access to credit for generating income

E. others please specify, _____

15.2 If your response for question number 15 is 'NO', can you describe why you are not receiving this support? _____

15. 3 How is your satisfaction of this service?

Excellent ☐ Good ☐ Satisfactory ☐ Poor ☐

16. Are there psychosocial supports offered at the organization? Yes ☐ No ☐

16.1. If your response for question number 16 is 'Yes' can you circle/state the type of psychosocial supports offered?

A. Availability of support groups

B . Assessment of psychosocial needs
C. Individual and group counseling services
D. Life skill and other psychosocial trainings
E. others please specify, _____

16.2 If your response for question number 16 is 'NO', can you describe why you are not receiving this support?

_____

16.3 How is your satisfaction of this service?

Excellent ☐ Good☐ Satisfactory☐ Poor ☐

17. Please state any other services you receive from the organization other than the services mentioned above.

_____

_____

18. Are the staff and the services offered at the agency in line with your needs? Yes☐ No ☐
19. If your response for question number 18 is 'No'what kind of services would you suggest to be offered for a comprehensive care and support activities?

_____

_____

20. What are the major problems that you are currently facing that are not addressed through the services offered at the agency?

_____

_____

21. Are you receiving help/assistance for these problems? Yes ☐ No ☐
22. If your response for question number 21 is 'No'for which problems would you like help or assistance?

_____

_____

23. Do you face any challenges/ inconvenience in receiving service from the agency in the following categories of services?
    A. Food and Nutrition Yes ☐ No ☐ If yes, please list the challenges
    B. Health care Yes ☐ No ☐ If yes, please list the challenges

C. Shelter and care Yes ☐ No ☐ If yes, please list the challenges
D. Psychosocial support Yes ☐ No ☐ If yes, please list the challenges
E. Economic strengthening Yes ☐ No ☐ If yes, please list the challenges
F. Legal support Yes ☐ No ☐ If yes, please list the challenges

Thank you!!!

Appendix 2

Semi-Structured Interview Guide for HIV/AIDS Service Providers

My name is Lemlem Tale and I am a student of Masters Programme on Social Work at St. Marry University College (IGNOU). Presently, I am doing my MSW thesis on the title: "**The Practice of HIV/AIDS Service Provision at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa.**
This research tool is prepared as one of the means of obtaining information on the practice of HIV/AIDS service provision in Yeka sub city through HIV/AIDS service providers' perspective.

In order to make it easier to understand and to be able to get all that you say in theactual interviewing, I would also like to tape record the conversation. I will only tape record if you say that I can. If I have your permission to record, the recordings will be typed up to be analyzed at a later date. In the transcript, your name and any identifiers will not appear. Before I start, do I have your permission to record? Yes --- No _____
Thank you!

Part one: Identification

13. Date: (MM/DD /YY): _____
14. Name of the interviewer _____
15. Name of the interviewee _____
16. Profession _____

Part two: Background information

17. Date: (MM/DD /YY): _____
18. Sex ---------- Male☐ Female☐
19. Age ---------- ☐☐
20. Educational level
    (10th complete, 12th complete, certificate, diploma, Degree. Masters)
21. Type of training, if any _____
22. Marital status (Single=1, Married=2, Separated=3, Divorced=4) ------- ☐
23. What is your role in the organization?
24. For how long have you been working in the HIV/AIDS service provision?

25. What do you feel about your role and the provision of service to PLHIV?
26. What is your ideal HIV/AIDS care and support provision?
27. Can you describe the direct beneficiaries of your program?
28. Has the organization identified the essential elements of a comprehensive package of HIV treatment, care and support services? Yes ☐ No ☐

29. Do you face any kind of stress or work load due to your professional life?
30. If yes, can you specify the reason for your work related stress?
31. What are the methods through which you reduce your stress due to work?
32. What part(s) of your present job, in relation with providing comprehensive care for PLHIV, do you like least?
33. What are the types of service provided for people living with HIV/AIDS at the organization?

34. What are the standard core services offered by the program?	Response
A. Food and Nutrition Could you describe what you do to provide this service for PLHIV? Could you describe how you usually provide such service? Could you describe some of the major challenges you face when providing this service? Could you describe the mechanisms used to overcome the challenges mentioned above? Other comments you would like to share:	
B. Educational Support Could you describe what you do to provide this service for PLHIV? Could you describe how you usually provide such service? Could you describe some of the major challenges you face when providing this service? Could you describe the mechanisms used to overcome the challenges mentioned above? Other comments you would like to share:	

C. Psychosocial Support Could you describe what you do to provide this service for PLHIV? Could you describe how you usually provide such service? Could you describe some of the major challenges you face when providing this service? Could you describe the mechanisms used to overcome the challenges mentioned above? Other comments you would like to share	
D. Health Care Could you describe what you do to provide this service for PLHIV? Could you describe how you usually provide such service? Could you describe some of the major challenges you face when providing this service? Could you describe the mechanisms used to overcome the challenges mentioned above? Other comments you would like to share:	
E. Legal Protection Could you describe what you do to provide this service for PLHIV? Could you describe how you usually provide such service? Could you describe some of the major challenges you face when providing this service? Could you describe the mechanisms used to overcome the challenges mentioned above? Other comments you would like to share:	
F. Economic Strengthening Could you describe what you do to provide this service for PLHIV? Could you describe how you usually provide such service? Could you describe some of the major challenges you face when providing this service? Could you describe the mechanisms used to overcome the challenges mentioned above? Other comments you would like to share:	
G. Shelter and Care	

Could you describe what you do to provide this service for PLHIV? Could you describe how you usually provide such service? Could you describe some of the major challenges you face when providing this service? Could you describe the mechanisms used to overcome the challenges mentioned above? Other comments you would like to share:	

35. What challenges do you face while providing service to the people living with HIV?

Challenges	**Yes**	**No**
Few staff & heavy workload		
Lack of testing kits and other logistical support		
Lack of integrated care and support activities for holistic support		
Lack of child-friendly environment		
Unwillingness of HIV patients to the treatment		
Caretakers refusing children to be tested		
Sick and weak parents for HIV positive children		
Children require more time for counseling		
Most children are needy & orphans		
High knowledge Demand		
Low economic status of patients to respond to treatments		
Any other?		

Thank you!!!

Appendix 2

Focus Group Discussion Guide for Stakeholders of HIV/AIDS Service Provision

My name is Lemlem Tale and I am a student of Masters Programme on Social Work at St. Marry University College (IGNOU). Presently, I am doing my MSW thesis on the title: "**The Practice of HIV/AIDS Service Provision at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa.**

Iam interested in learning about your views on the practice of HIV/AIDS service Provision at Worldwide Orphans Foundation. I would like to ask your permission to be part of the discussion regarding HIV/AIDS service provision. If you prefer not to answer certain questions, please feel free to keep silent. It is important that you understand that any personal information that we gather in this discussion will be treated with the utmost confidentiality. I expect our discussion to last about 40 minutes. Do I have your permission to begin?"

1. Would you introduce yourself by telling your name,age, profession?

2.1 What can you tell me about Worldwide orphans Foundation?

2.2 What is your general understanding of the organization?

2.2.1. When was it established?

2.2.2. Where are the Organization's intervention areas?

2.2.3. What kind of organization is it?

2.2.4. In your opinion what are the source of funding?

2.2.5. What is the numberofemployees?

3.1. Do you know about the stakeholders of the Organization?

3.2. What do you know about the involvement of the stakeholders in the organization?

4.1.Who are the direct beneficiaries of the Organization? (sex, age, etc)

4.2. Who are the indirect beneficiaries?

5.1. How are beneficiaries of the Program recruited?

5.2. Who is involved in the selection process of the targeted beneficiaries?

6. Who are the decision makers at the Organization?

7.1 . What types of services are provided by the Organization to the beneficiaries?

7.2 . Please state list of services offered under each category?

7.2.1. Food and Nutrition Service

7.2.2. Health Care Service

7.2.3. Educational Support

7.2.4. Economic Strengthening Service

7.2.5. Legal Support Service

7.2.6. Shelter and Care Service

7.2.7. Psychosocial Support Service

7.3 . What do you think about the qualities of the services offered?

7.4 . Which services satisfy your needs most?

8 .In your opinion, do you think there are comprehensive care and support services provisions at Worldwide Orphans Foundation?If Yes/ No please explain.

9 If you could suggest any additional services that are important for providing comprehensive care and support to the targeted beneficiaries, what will those services be?

10 What do you think are the current major problems of people living with HIV/AIDS?

11 What kind of services do you consider as comprehensive care and support for people living with HIV/AIDS?

12 What do you think are the major challenges encountered by the service providers in providing service to PLHIV?

13 How do the service providers cope up with those challenges encountered?

14 Any other suggestions?

Thank you for your participation!

Appendix 3

Observation Checklist

1. Clinical Service Minimum Package		Available	Not Available	Comments
Infrastructure	Examination room			
	One private counseling room			
Equipment and supplies	Exam Tools and supplies (otoscope, stethoscope, blood pressure cuff)			
	Supplies (infection prevention materials, tongue blade)			
Human Resources	MD trained on ART			
	Post-basic ART trained nurses			
	ART trained nurses			
	Data clerk			
	ART trained health officer			
M&E/MIS	Log book			
	Recording/reporting forms			
	Special ART prescription			
Services	Comprehensive HIV services (VCT, PITC, PMTCT, TB, STI and OI Services, palliative care)			
Referral Systems	Referral slip, feedback forms Referral slip and feedback forms			
2. Pharmacy Service Minimum Package				
Infrastructure	On-site pharmacy			
	Secure storage space			
	Private counseling room or space			
Equipment & Supplies	Refrigerator			

Human Resources	ART trained pharmacy personnel			
	ART trained pharmacy personnel			
M&E/MIS	Drug supply and management system (bin card, stock card, receiving voucher, models, prescription forms, registration book, report forms			
	Lockable drawer			
3. Laboratory Service Minimum Package				
Infrastructure	Specimen collection area and laboratory room			
	Onsite or networked laboratory services			
	CD4 Count,			
	Clinical Chemistry (BUN Creatinine, LFT, Indian ink) Full blood count (HB, WBC and Diff.)			
	AFB smear Gram smear Ova & Parasite Malaria smear			
	Pregnancy test			
	Serology for HIV RPR / VDRL			
	Sterilizing equipment Microscope, Refrigerator, Centrifuge, Test Kits, IP supplies, Reagents			
Human Resources	2 trained laboratory personnel			
M&E/MIS	Log book			
	Recording/reporting forms			
Human Resources	2 trained laboratory personnel			
M&E/MIS	Log book			

	Recording/reporting forms			
4. Psychosocial care				
5. Shelter and care				
6. Food and Nutrition				
7. Economic strengthening				
8. Legal protection				
9. Educational support				
10. Integrated care and support				

List of Non Govermental Organization and Civic Society Assocciation

No	Name of Organization	Type
1	Mary Joy Ethiopia	NGO
2	Hiwot Integrated support Organization	NGO
3	Daugther of Charity	NGO
4	CCF	NGO
5	Integratead AIDS Care Association	NGO
6	Genete Association Children Home	CSO
7	Development Association	NGO
8	Netsebrak Association	CSO
9	Hope Assocaition	CSO
10	Vision New Life Development Assocaition	NGO
11	Lambadina Institute Health Communication	CSO
12	Ethiopian Mulu Wengel Chruch Development Organization	FBO
13	CHAD-ET	NGO
14	Mekdem National Association	NGO
15	Equal Opportunity Assocaiton	NGO
16	Hiwot Ethiopia	NGO
17	Orphan Protection and Rehabilitation Association	NGO
18	WISEF Project	NGO
19	Felege Hiwot Ethiopian Assocaition	CSO
20	African Service Committee	NGO
21	Yeka Harvest Church of God	FBO
22	OPRIEFS	NGO
23	Worldwide Orphans Foundation	NGO
24	Yeka Meker Children Development Project	FBO
25	Integrated Family Service Organizaion	NGO
26	Elderly Development Association	NGO
27	Vission of Africa	NGO
28	Hospse Ethiopia	NGO
29	Wongel Alem Church	FBO
30	Aba Selama Assocaiton	FBO
31	Eshet Childrens and Youth Assocaition	NGO
32	Edlawit Associaton	NGO
33	Bete Saida Children Association	NGO
34	Every Corner Association	NGO
35	OSSA	NGO
36	Abenezer Community Development Organiation	CSO
37	Global Infantil Association	NGO

PERFORMA FOR SUBMISSION OF MSW PROJECT PROPOSAL FOR ACADAMIC COUNSELLOR OF THE STUDY CENTER

Name of student: Lemlem Tale

Enrollment number:109100827

Place: Addis Ababa, Ethiopia

Phone Number: +251911357054

Date of Submission:_____

Signature of Student:----------

Title of Project: **The Practice of HIV/AIDS Service Provision at Worldwide Orphans Foundation in Yeka Sub city Of Addis Ababa**

Name of study center: St. Mary's University

Name and Address of Supervisor:-Mr, Sebsib Belay

Address: St. Mary's University College

Adiss Ababa, Ethiopia

E.mail: sebsib.belay@yahoo.com

Approved/Not Approved

Signature:_____

Date:_____

The Practice of HIV/AIDS Service Provisions at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa, Ethiopia

MSW Dissertation Research Project Proposal

(MSWP-001)

Prepared By

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School of Social Work

April, 2013

Addis Ababa, Ethiopia

Chapter One

1. Introduction

The emergence of the HIV epidemic is one of the biggest public health challenges the world has ever seen in recent history. In the last three decades HIV/AIDS has spread rapidly and affected all sectors of the society. The first case of HIV in Ethiopia was reported in 1984, since then, HIV/AIDS has become a major public health concern in the country causing the death of millions of people.Ethiopiaisat the epicenter of the epidemic and continues to carry the full brunt of its health and socioeconomic impacts.

The Ethiopian government, in response to the epidemic, has developed different programs and strategies to mitigate the transmission of the virus at the prevention level as well as at the intervention level. Thegovernment initiated the response in 1985 soon after the first report of laboratory confirmed HIV and AIDS cases. The initial major step taken by the government was the establishment of a National Task Force within the Ministry of Health; this response focused on analyzing the situation, developing operational guidelines for prevention, and assessing the capacity required to arrest the spread of HIV infection. Since this first measure until the present different strategic plans for the multi-sectoral HIV/AIDS response were designed and implemented.

Because of these responses, even though there has been a decrease in prevalence of HIV/AIDS in the past years, Ethiopia is still categorized among the countries that is most affected by the HIV epidemic, with an estimated adult prevalence of 1.5%, the country has a large number of people living with HIV (approximately 800,000): and about 1 million orphans.(HAPCO, 2012).

Consequently, HIV/AIDS brings about multi-dimensional repercussions and impact on different aspects of the country in general and the concerned sections of the society in particular. One of the areas highly affected by the epidemic is the health workforces, who play an important role in the battle against HIV/AIDS by providing testing, care, and treatment for people living with HIV/AIDS (PLWHA). Service providers working with PLWHA face significant occupational challenges such as work-related infection risks, work load because of increased demand for services, inefficiency in the HIV care financing system and increasing physical and emotional stress.(Bennet et al., 1993, p.38).Overall, the growing number of AIDS cases, people living with HIV/AIDS, orphans other vulnerable children and their continued needs for health care services have placed a significant burden on resources in the already inadequate health services in the country. In the meantime, provision of quality service to PLWA is also an important and required factor in responding to the needs of PLHIV.

As it was stated in the above paragraphs, the impact of HIV/AIDS is multifaceted which has led to the launching of comprehensive care and support programs by governmental and nongovernmental organizations as a response to the virus. Maintaining the optimal performance by the health care workforce and provision of comprehensive care and support for people living with HIV/AIDS becomes an urgent task for meeting the increasing needs of HIV/AIDS patients.The objective of all HIV/AIDS care and support professionals is sustaining quality service provision to people living with HIV/AIDS , although there are different factors that challenge the provision of comprehensive care and support for the HIV affected and infected households.This research is, therefore, being conducted to identify the gaps in the practice of HIV/AIDS service provision and the major challenges faced by the care givers in providing comprehensive care and support for people infected by HIV.

2. Statement of the Problem

HIV/AIDS has been devastating since its first emergence in the world. According to UNAIDS (2012), globally, 34.0 million [31.4 million–35.9 million] people were living with HIV at the end of 2011. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for 69% of the people living with HIV worldwide.Ethiopia is one of the countries with high HIV prevalence, in 2011; the national prevalence of HIV was estimated to be 2.3 %.(HAPCO, 2012)

The impacts of HIV/AIDS in Ethiopia are multifaceted affecting the country's overalldevelopment;HIV/AIDS is affecting the agriculture, education, industry, family andhealth sectors. Family and communities have also been significantly affected by the epidemic. The protracted morbidity and eventual mortality resulting fromHIV/AIDS also causes significant lost time to illness, reduced productivity, shortage of manpower,increased absenteeism and rising medical costs as well as increased number of orphans and vulnerable children worsening their socio economicsituations.When we specifically look at the impact of HIV/AIDS on children, according to USAID, Pact and UNICEF Document (2011-2016Program), there are 5.5 million orphans -15% of the total child population, 16% of them orphaned due to HIV/AIDS and there are 77,000 child-headed households. In the capital city Addis Ababa alone, from a total population of 2,975,608 with 940, 886(31.62%) child population, there are estimated 176,435(18.75%) AIDS OVCs and 70,574(40%) are in need of support. HIV/AIDS remains as a major public health concern in the country. (Ministry of Woman and Children's Affair, 2011).

Because of the immediate response to the epidemic the national experience and expertise in the treatment and care of PLHIV have improved substantially and the number of persons receiving ART has doubled from slightly fewer than 160,000 to over 300,000 persons in the period 2007 to 2010.(WHO,2011.p.14).
According to the report produced by CRDA (2006), close to 400 NGOs in Ethiopia manage health projects or projects that potentially contribute in the alleviation of major public health problems in the country out of which 100

NGOs, which are members of CRDA, are engaged in HIV related work. Even with the increased efforts of the government to accelerate progress toward universal access to HIV prevention, treatment, care, and support, health care personnel are still scarce in Ethiopia, a country of 77 million people, with approximately 2,000 physicians, 700 health officers, 15,500 nurses, 5,200 paramedics, and 200 pediatricians are involved in HIV/AIDS service provision.(MOH,2006).

As it can be seen from the above statement, along with the government, many NGOs have also been engaged in HIV/ AIDS related work. Even though many people have been trained to work with people living with HIV, the number of trained professionals still remains very low in comparison to the number of HIV infected people who needs care and support which might affect the provision of quality service.

Providing care to people living with HIV/AIDS and to their families requires a broad range of services that include not only clinical care focusing on diagnosis and treatment but also supportive and complementary services to ensure that adequate nutrition, psychological, social and daily living needs of the people living with HIV/AIDS are met. The standard service delivery guidelines for HIV/AIDS comprehensive care and support programming in Ethiopia, contains seven core service areas which are considered critical for people living with HIV. The seven service areas include; care and shelter, economic strengthening, health care, legal and social protection, psychosocial support, food and nutrition and education (FHAPCO, 2010, p. 12).To provide comprehensive HIV/AIDS care and treatment, family care coordination is also important as it has shown that coordination of medical and supportive services and communications among providers optimize health and wellbeing. (FMOH, 2006, p3).

Even though a lot has been done to eradicate the virus and its challenges, there are still many areas and people in need of these comprehensive care and support programs to help them rise out of anonymity. HAPCO has, for example, stated that about 74% of orphans are not in school currently, and there is high dropout due to social and economic problems. Overall, about 160,000 AIDS orphan and vulnerable children and PLWHA in the country demand psychosocial, educational, nutritional and training support for income generating activities (HAPCO, 2010)

The above paragraphs point to the prevalence, impact and trends of comprehensive care and support service provisions for HIV affected and infected section of the society in Ethiopia. All sectors involved in the care and support of people living with HIV/AIDS are required to provide quality service based on the service delivery guidelines set by the government. With an increased number of PLWAs and involved stakeholders working in the area of care and support, it is more important than ever to assess how well the needs of people living with HIV are being met by those services. Finding out the employed HIV/AIDS service delivery practices, the major challenges encountered during service delivery and the existing coping mechanisms service providers employee is what the proposed research will attempt to accomplish.

3. Research Objectives

3.1. General Objective

The general objective of the proposed research is to assess the practice of HIV/AIDS service provisions to people living with HIV/AIDS by various categories of care and support activities employedat Worldwide Orphans Foundation operating in YekaSub City of Addis Ababa, Ethiopia since 2005.

3.2 Specific Objectives

The specific objectives of the proposed study are:

- To assess the overall practice of HIV/AIDS services provisionsat the Organization;
- To identify problems faced and challenges encountered by the service providers in the Organization;
- To identify the major coping mechanisms employed by professionals in service delivery practice in the Organization; and
- Toexamine the implications of the problems, challenges and coping mechanisms employed for HIV/AIDS services provision in the Organization.

4. Study Design and Method

This study will use non-experimental research design. In addition, the researcher will employ a combination of quantitative and qualitative research approaches and methods. Quantitatively, the researcher will use descriptive sample survey. Moreover, qualitative research methods, like semi-structured interviews, focus group discussions, observations and documentary analysis will be used.

5. Universe of the Study

The universe of this study will be HIV/AIDS service and care clients that have been receiving different types of services at Worldwide Orphans Foundation in Yeka Sub City of Addis Ababa since 2005. The HIV/AIDS services provision included in this study are pediatric and adult ART, voluntary counseling and testing, education, psychosocial and nutrition supports. Thus, the study is delimited to the care and support clients and providers in the Organization which has been operating in Yeka Sub City beginning from the fiscal year of 2005 to 2013.

6. Sampling Method

The researcher has purposefully sampled *Worldwide Orphans Foundation* to serve as particular reference in the assessment of the practice of HIV/AIDS service provisions. This isbecausethe researcher has close work relationship with the Organization and the availability of different services of care and support for people living with HIV/AIDS in a health setting. Simple random sampling (SRS) will then be employed where 50 patients ofthe center under the auspices of the Organization will be selectedto assess the practice of HIV/AIDs service provision in Yeka Sub city of Addis Ababa.

7. Data Collection Tools and Procedures

7.1 Primary Data Collection

The researcher will employ appropriate data collection tools to collect pertinent quantitative and qualitative data using both quantitative and qualitative research methods.Structured interview schedule will be used for sampled clients.

Semi- structured interviews will also be conducted to the service providers such as doctors, project directors, nurses, social workers, psychologists, teachers, community workers, lab technicians and pharmacists that are directly involved in HIV/AIDS service delivery to the needy ones in the intervention areas in Yeka Sub City of Addis Ababa using a less structured interview guide. This method is incorporated because of the advantages it has to get detailed data on different issues related to the research topic, especially regarding the challenges faced, the practice of service delivery and any mechanisms used by the management body to cope with the challenges.

The researcher will conduct focus group discussions with a total of ten participants selected fromthe stakeholders using FGD scheduled checklist at a convenient venue. In addition, the researcher will engage in observations of relevant aspects of the Organization's settings in the Sub City using observation schedule.

7.2 Secondary Data Collection

The researcher will further employ documentary analysis to generate secondary data from project documents, progressive reports, the FDRE Constitution, policy, etc. Besides, secondary data will be collected from published and unpublished web-based documents, thesis dissertations and so on.

8. Data Processing and Analysis

To analyze both the primary and the secondary data collected for the study, the researcher will use quantitative statistic techniques and qualitative data analysis techniques. The primary data collected with the interview scheduled will be quantitatively analyzed using SPSS software. In addition, the primary data using the semi -interviews, focus group discussions and observations will be analyzed content and/or thematic analysis and presented in combination with the quantitative findings. Moreover, the qualitative and quantitative data will be triangulated so as to show all possible indications in the responses gathered using the various data collection tools.

9. Chapterization

The MSW research report consists of five chapters. The First Chapter presents the introduction, statement of the problem, the objectives of the study, operational definitions of key concepts and limitations of the study. Chapter Two dwells on review of related literature. The Third Chapter presents description of the study area and elements of study design and methods. Chapter Four presents data analysis, interpretation and discussion of major findings. The Fifth Chapter draws conclusion and suggestions of the study.

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