INDIRA GANDHI NATIONAL OPEN UNIVERSITY SCHOOL OF SOCIAL WORK

AN ASSESSMENT OF HOME AND COMMUNITY BASED CARE SERVICE TO PEOPLE LIVING WITH HIV/AIDS WITH SPECIAL REFERENCE TO BALCHA IDI R LIDETA SUBCITY WOREDA-3

Disertation Work Submitted For the Partial Fullfillment Of The requirements For the School of Social Work Masters Degree. Indira Gandhi National Open University (IGNOU)

by: FANTAYE TADDESSE ABERA

May, 2015

Addis Ababa Ethiopia

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May, 2015

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DECLARATION

I hereby declare that the dissertation entitled: **AN ASSESSMENT OF HOME AND COMMUNITY BASED CARE SERVICE TO PEOPLE LIVING WITH HIV/AIDS WITH SPECIAL REFERENCE TO BALCHA IDIR LIDETA SUBCITY WOREDA-3**

(write the title in block letters) submitted by me the for the partial fulfillment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirement for any other program of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

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CERTIFICATE

This is to certify that Mr. /Miss/Mrs. FANTAYE TADDESSE ABERA Student of MSW from Indira Gandhi National Open University; New Delhi was working under my supervision and guidance for his/her Project Work for the Course MSWP-001. His/her Project Work entitled: **AN ASSESSMENT OF HOME AND COMMUNITY BASED CARE SERVICE TO PEOPLE LIVING WITH HIV/AIDS WITH SPECIAL REFERENCE TO BALCHA IDI R LIDETA SUBCITY WOREDA-3**

Which he/she is submitting, is his/ her genuine and original work.

Place:……

Signature: …….

Date:…….
Name: ……

Address: of the supervisor ……

……

…….

Phone number; ……..

Acknowledgment

I would like to thank Almighty God, who has given me the opportunity, the capacity, and the strength to reach thus far.

I extend my deepest gratitude to my advisor Ato Dawit Tafesse who scarified his precious time to review my thesis and gave me constructive comments that have contributed positively to the final stage of the thesis.

Above and beyond, my deepest gratitude goes too my husband, Ato Debebe Bizuneh and to my beloved children Mekdim and Mahlet.

I owe my special indebitness to my mother Tsige Mekonene and also to my sisters Yeshimbet, Konjit, Menene, Netsanet, Marta, Hirut and my brother Dereje.

Last but not least, my thanks go to all my friends and Balcha idir HCBC committee, who encouraged me and support through all the process.

PRAISE TO GOD

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LIST OF ABRRIVATION AND ACRONYMS

AIDS: Acquired immune deficiency syndrome

ART: Anti Retroviral Therapy

FDREE: Federal Democratic Republic of Ethiopia

GO: Governmental organization

HCBC: Home and community Based Care

HIV: Human Immunodeficiency Virus

HIDO: Hiwot Integrated Development organization

MOH: Ministry of Health

NGO: Non Governmental Organization.

OVC: Orphan and Vulnerable Children

PMTCT: Prevention of HIV/AIDS from Mother to child Transmission

PLWHA: People living With HIV/AIDS

UNAIDS: United Nations program on HIV/AIDS

VCT: Voluntary Counseling and Testing

WHO: World Health Organization

Glossary

Home and community Based Care: is a care given to an individual in his/her environment by his/ her family and/or by Community volunteer care givers after given basic nursing skill, different counseling skills. To fulfill a person's psychological needs, physical need, material need and psychosocial need.

PLWHA: is a person living with HIV or having signs and symptoms of AIDS

Orphan: is a child less than 18 years of age that he lost his one or both of his parents regardless of the cause of the loss.

Vulnerable child: is a child less than 18 years of age and whose survival is compromised due to HIV/AIDS, parent's sickness, poverty.

Idir: is a traditional community based organization established by members voluntarily. The aim of establishment is to provide burial and bereavement services to the member of the Idir and his/her relatives.

Community volunteer care givers: member of the community recruited by Idirs and trained by skilled person to give home and community based care to PLWHA and family.

AN ASSESSMENT OF HOME AND COMMUNITY BASED CARE SERVICE TO PEOPLE LIVING WITH HIV/AIDS

Abstract

This study was conducted to explore the role and contribution of "Balcha Idir" in combating HIV/AIDS through Home and Community Based Care. Balcha Idir is in Addss Ababa Lideta sub-city Woreda-3." Idir" which is community based association of people established with the aim of helping each other during burial and bereavement at the time of death of members and their families. Balcha Idir established by 45 people in1954 ET. Cal Balcha Idir start delivering Home and Community Based Care (HCBC) to bed ridden People Living with HIV AIDS (PLWHA) because of sickness of members and stigma and rejection face by family members, neighbors and the community. Secondly Balcha Idir renders HCBC to members and people outside the idir is to respond the national call combating HIV/AIDS.

Balcha idir was looking for external support to strengthen its capacity because multi faces of HIV/AIDS. HCBC was impossible without working in collaboration and net working. At this time Hiwot Integrated Development Organization (HIDO) an endogenous organization which plan to work in collaboration with Idirs found Balcha Idir. Balcha Idir was one of the Idirs which HIDO build their capacity, with material and different trainings. After the trainings Balcha Idir members change their by law. "We shall start helping each other at the time of sickness of members and our families"After the capacity of the Idir build they Start delivering HCBC to the entire community of woreda-3 and other adjacent woredas.

The study employed both quantitative and qualitative research methods. The quantitative data gathering instrument is questionnaire and the qualitative data gathering instrument is in-depth interview and Focus Group Discussion. Subjects include in the study are PLWHA, Community volunteer care givers and HCBC committee members. The study involved strict respect for informed consent; participants of the study have the right to participate or not to participate. The study shows how Balcha IdirIdir contributes HCBC for the community and brought significant change that could improve the quality of life of PLWHA and their families. The study shows also the pervasive problems of PLWHA that are the problems of socio economic problems (Housing and food problems). The study recommended for the Idir and others who are concerned the following: prevention of new HIV infection, Job opportunities for PLWHA, holistic care and support to Orphans and vulnerable children, acknowledging community volunteer care givers and avail job opportunities, Balcha Idir capacity must be build for other development work.

CHAPTER ONE: INTRODUCTION

1.1. Background

Family Health International (FHI) training module (September, 2004), used the March 2001 Gaborone Declaration to define home and community -based care (HCBC) as:

> *Care given to an individual in his or her own natural environment by his or her family and supported by skilled social welfare officers and communities to meet not only the physical and health needs, but also the spiritual, material, and psychosocial needs*

According to the above definition HCBC emphasizes on holistic support to people living with HIV/AIDS (PLWHA) and their families. Service delivery was done primarily through the immediate circle of the PLWHA by the support of skilled social workers and community volunteer caregivers.

As to UNAIDS global report at the end of the year 2012 indicates, it was estimated that 32,500,000 people were living with HIV/AIDS. During the same year there were 2,250,000 new infections and deaths of AIDS were 1,750,000. In 2012, 9.7 million people in low- and middle income countries received antiretroviral therapies representing 61% of all who were eligible under the 2010 World Health Organization (WHO) HIV treatment guidelines (UNAIDS, 2012).

Sub-Saharan African countries to be the region most affected by the AIDS pandemic, Ethiopia being one among Sub-Saharan countries, HIV/AIDS has alarmingly created a huge suffering and health problem among its citizens. Since the time HIV/AIDS cases are identified, it has affected

all segments of the society in less than a span of three decades. According to the National AIDS Resource Center of Ethiopia (2012), adult prevalence rate of HIV/AIDS was 1.3 (male 0.9 female 1.8), total HIV positive population was 759,268 (male 296,491 female 462,777), new HIV infections total 20,158 (male 8,875 female 11,283) total annual AIDS death 41,444 (male 17,791 female 23,653) and total ART needs 398,686 (male 158,971 female 239,715).On the other hand children (0-14 years), HIV positive population is 168,598 (male 84,873 female 83,725), total new HIV infections 7,792 (male 3,949 female 3,843), annual AIDS deaths 11,310 (males 5,695 females 5,615), ART needs 75,097 (males 37,766 females 37,331) and pregnant women needing PMTCT 38,404 and HIV- positive pregnant women needing ART was 22,057.

Home and Community Based Care (HCBC) programs for People Living with HIV/AIDS are implemented in different African countries after the inception of the epidemic. In the past few years HCBC was one of HIV/AIDS prevention and control strategies like voluntary counseling and testing (VCT), management of sexually transmitted infections (STI's), information, education and communication/behavioral change communication (IEC/ BCC), management of opportunistic infections, universal precautions and post exposure prophylaxis, safe blood transfusion, Anti-Retroviral Therapy (ART), prevention of mother to child transmission (PMTCT), surveillance and research, care and support, and technical support to different sectors including human rights(AIDSMAP,2003).

In Ethiopia, particularly in urban settings, some studies indicated that bed occupancy due to AIDS has been reached level as high as 50% which is an extremely big burden on the health care infrastructure that is already constrained (MOH, 2004). Certainly, the high demand for care cannot be met by health service alone, even in the most optimal health service system. Given the

direct and the indirect costs that would be linked to this endeavor, home care could potentially offer a feasible option for patient care, mobilizing a currently constrained resource. This strategy could also have a potential impact in decreasing stigma and discrimination within the families and communities (Tibebu B, Gebremariam G, and Belachew T 2007).

A potential benefit of home-based care is that sick people are surrounded by people they love and are familiar with, so they can also receive more flexible and nurturing care. They will also not be exposed to hospital-based infectious diseases. As people with terminal illness generally spend their final moments at home, improving the quality of their care at home also removes the cost and distress of travelling to and from the hospital when they are weakest (Ogden, Simel & Caren, 2006).Furthermore, in being cared for at home, a person with HIV may be in a more ready position to work or look after family members for short periods of time while the primary earners work. The time the family would otherwise use travelling to and from hospital can instead be spent on house work and looking after other family members. Expenditure on transport and hospital costs is also reduced (Ogden et al. 2006)

Home-based care often results from necessity, as mentioned, health facilities may not be able to cope and furthermore, fear of stigma and discrimination from doctors and nurses directed towards people living with HIV could deter people from seeking care in a medical setting. The costs, both direct and indirect, associated with going to hospital regularly also mean that being cared at home is often inevitability rather than a choice.

In Sub-Saharan Africa where the HIV/AIDS epidemic is of paramount concern, the nature of the disease, weak public health infrastructure, spiraling health costs, and lack of resources has made community home based care a necessity in the continuum of care in Sub-Saharan Africa

(Coleblunders, R; Verdonck, K; Nachega, J; and Kotari, P. (2000). Likewise, in Ethiopia, HCBC programs are initiated and operated in a few areas of the country by adopting a strategy from other African countries. This directly applied to some big towns of Ethiopia especially in all sub cities of Addis Ababa in which, the majority of Idirs engaged in combating the epidemic. Among the many Idirs, Balcha Idir, which is found in Addis Ababa, Lideta sub city woreda 3 was one that engaged in the HCBC activities. Balcha Idir was established in1952 et.cal by 45 members. The aim of the Idir establishment was for funeral and bereavements purposes. But, later on, at the peak of the pandemic HIV/AIDS, Idir members changed their by law in order to help each other during sickness of members. Thus the Idir start the HCBC program by its few sick members and latter it extends the HCBC to the woreda community and neighboring woredas. Therefore, research is needed to properly understand the HCBC program under Balcha Idir, and its successful strategies. This study attempted to assess the HCBC service given by Balcha Idir to PLWHA and gather data from PLWHA, Community volunteer care givers, and HCBC committee.

1.2. Statement of the problem

Although people living with HIV and AIDS seemingly are healthy and strong and live perfectly 'normal' lives, they can experience a range of AIDS &HIV related problems that will affect their day-to-day life. In a survey of home-based care AIDS patients in Malawi just one in seven were able to live as if they did not have the disease. Around a third needed help with washing, walking and going to the toilet. (Bowie, 2006)

HIV/AIDS has been declared a national emergency in countries throughout the world. The United Nations has declared that HIV/AIDS may be the largest single obstacle to meeting in

Millennium Development Goals. (FMOH, 2006) HIV/AIDS is expanding in an alarming rate throughout the world. Accordingly the society is facing massive problem of loosing family members and relatives, leaving behind an array of child headed families, marriage and family break-down, unemployment, decrease in income, and loss of pride and respect due to stigma and discrimination. The impact of HIV/AIDS is shown in low productivity, increased medical cost, and increased funeral costs on community associations, high replacement of worker in organizations, work load in other workers, food insecurity and double burden for women. Since many families are not in a position to offer home based care, as result of inadequate awareness about the nature of the disease and lack of skill of caring the need of home and community based care was very high and become more complex over time. This highlights the need for substantial investment in the care of people living with HIV/AIDS and their families. The impact of HIV/AIDS has been drastic at national, community, family and individual level. Thus, for many resources – limited setting, like a case in Ethiopia, the only way to deliver care to PLWHA is HCBC. In such a setting, medical facilities often lack trained personnel and even the most basic medical supplies. Thus, HCBC is the most efficient and cost effective approach to health care delivery. HIV/AIDS is a national problem that has a great impact on the socio economic development of the country. The impact is especially felt in every urban neighborhood of this nation.

Children also affected by loss of their one or both parents (orphans). In this case, some young children became bread winners. In most cases, they are over burdened by caring to their younger siblings and to their severely ill parents. In response for this problem, Balcha Idir in Lideta Sub-city wereda 3 starts helping few HIV/AIDS victims of idir members. Later the Idir extend giving HCBC to PLWHA in response the call of nations to combat deadly disease in collaborate with a

Non Governmental organization called Hiwot integrated development organization (HIDO) which was support the HCBC program in all Sub-cities of Addis Ababa. The general objective was to improve the quality of life of chronically sick AIDS patients and strengthen resilience of households and communities affected by HIV/AIDS to address the socio – economic and health needs of chronically ill bed ridden patients.

Lideta Sub city wereda 3 is adjacent to the big market, Merkato. Because of its business activities and many brothel houses, the neighborhood is visited and frequented by many urban and rural dwellers. So the prevalence of HIV/AIDS is high thus the need for care and support has increased as other city neighborhoods of the country. The intention of the study was to answer the basic questions raise concerning the HCBC program rendered by Balcha Idir.

1.3. Research questions

1. What are the Problems of PLWHA and challenges of HCBC?
2. What are the types of HCBC services and its benefits to PLWHA?
3. What are the vital role played by Balcha Idir in rendering the service
4. What are best practice of Balcha Idir HCBC program to other Idirs and organizations?

1.4. General Objective of the study

The general objective of the study is to assess the home and community based care service given to PLWHA by Balcha Idir in Lideta sub-city woreda-3

1.4.1. Specific objectives

- To assess Problems of PLWHA and challenges of HCBC
- To assess types of HCBC services and its benefits to PLWHA
- To examine the vital role played by Balcha Idir in rendering the service
- To recommend the best practice of Balcha Idir HCBC program to other Idirs and organizations.

1.5. Significance of the study

This study Assessed problems of PLWHA, challenges of HCBC, types of Home and community based care given to PLWHA, benefits of HCBC services to PLWHA, vital roles played by Balcha Idir and It is also a complement to HCBC volunteers and acknowledges the importance of a community home and community based care service. Furthermore, this study can contribute to the future studies and also can help as an input for community-based organizations, which work on Community Based services.

1.6. Limitation and Scope of the study

The study will be conducted to assess the home and community based care rendered by Balcha Idir. The study assess problems of PLWHA and challenges of HCBC program, type of services given to PLWHA, vital role played by Balcha Idir in provision of HCBC service to PLWHA, and the study aim to Cognizant of these facts however the research may serve as a valuable entry point to set what HCBC has done to PLWHA.

Due to time and resource constraints, the total number of samples selected from Home and community Based Care beneficieries is small. Thus concerning Home and Community Based Care one can not come to any generalization.

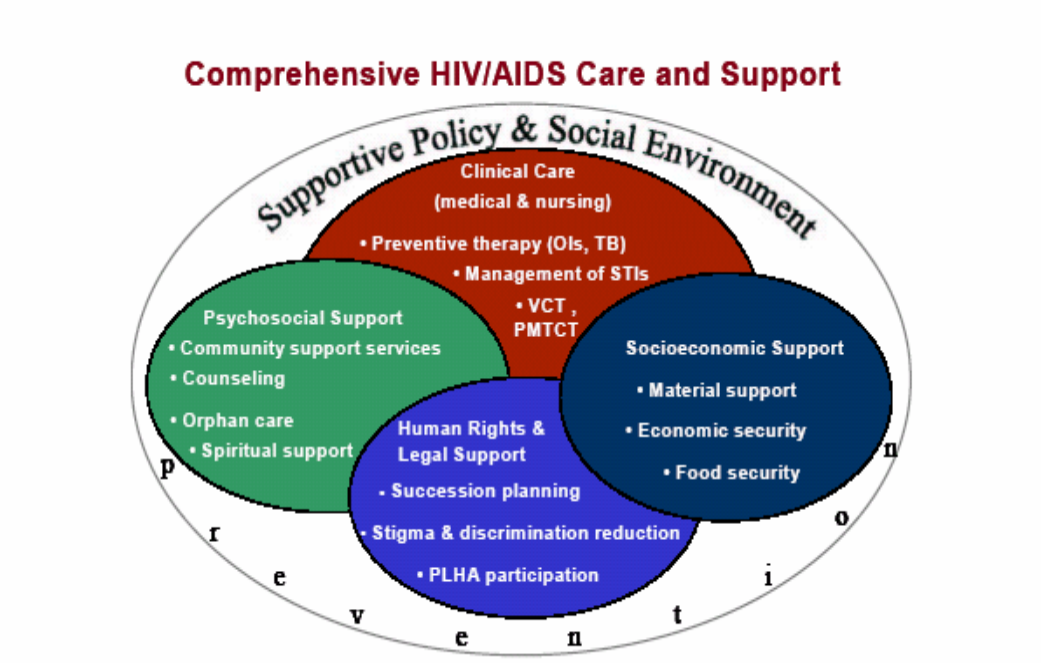
1.7. Structure of the Essay

For systematic arrangement and coherence, the organization of the study is classified in to five chapters. The first chapter consist the introduction, the statement of the problem, objectives of the study and the significance of the study. The second chapter contains literature review, which includes concepts and definitions of HBC; HCBC; Components of HBC; and HBC nursing care, benefits and challenges of HCBC program in African countries. The third chapter incorporates methodology; sampling techniques, data collection. The fourth chapter deals with data analysis and interpretations. And the last (fifth) chapter contains conclusion and recommendations.

1.8 Conceptual frame work of HCBC

To fight against HIV/AIDS there are different strategies, home and community based care is one component that could promote quality of life of PLWHA and their family. In addition home and community based care has many advantages to the community, to health facilities and the society at large. Home and community based care helps for PLWHA to alleviate psychological, psychosocial, physical, and mental problems and facilitate positive living. To the PLWHA family HCBC helps prevention of the transmission of HIV/AIDS, allowing spare time for family to play the role of bread winner, helps family in participating in caring their loved ones and it minimize cost of hospitalization and minimize stigma and discrimination. To the community HCBC helps to prevent new HIV infection, helps to minimize stigma and discrimination, and helps to participate in the caring process of PLWHA. To health facilities it

decrease burden of health personnel's and make easy their work and allows bed to other patients who need immediate treatment. HCBC has an advantage to the society at large helps by preventing new HIV infection; maintain health of sick PLWHA to be productive. HCBC program should be integrated and networked with other different services. Needy PLWHA and their families should be reffered to, Voluntary counseling and testing centers, ongoing counseling for HIV positive results, health institutions for Anti Retroviral Therapy (ART), linking PLWHA with food support programs: World Food Program, linking Orphan and vulnerable children's with food support, educational support, psychosoial support . Here we can understand how HCBC program was integrated to mitigate problems of infected and affected people. Below the diagram shows the conceptual framework of HCBC which indicate HCBC need to be networked with different services to give comprehensive care to PLWHA and their family.



These are psychosocial support, Human Rights and Legal support, socioeconomic support and clinical care.

Source: Family Health International, 2005

The availably of supportive social policy helped community based organizations to involve in HIV/AIDS prevention care and support program by networking HCBC programs with different servics. Balcha Idir in Lideta sub-city is one of the pioneer of community based organization which involved in the HCBC activity and can improve the quality life of PLWHA and their families by networking HCBC program with different service. This study is desined to explore the problems and challenges of HCBC, types of HCBC services and there benefits, role of Balcha Idir HCBC program. To collect data questionair developed and conducted, in-depth inerveew and focus group discussions conducted to PLWHA.And data also collected from community volunteer care givers and Idir HCBC committee by focus group discussions and in-depth interview.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

This chapter discussed the idea of Home Based Care from different publications. Some of them are ideal where as some of them are practical. It is common knowledge that HIV/AIDS is a recent phenomenon, whereby there are plenty of literatures circulating concerning the disease and its wide and far reaching impacts. And one can also get an insight from experiences of different countries on how home based care service improves the lives of PLWHA and their psychological, social, economical and emotional needs. The researcher discusses what is happening in the grass root level and how community based organizations (Idirs) are combating HIV/AIDS by mobilizing local resources and by referral and networking.

2.2. WHAT IS CARE GIVING?

Care giving for a patient, means providing special care for someone who needs help with taking care of him or herself. This can mean many different kinds of help. As a caregiver, you may find yourself being needed to act as the ill person's nurse, homemaker, cook, grocery shopper, messenger, letter writer, book reader, telephone answerer, cleaner, or listener. Overall, care giving is being a friend and companion (AIDS Coalition, 2001). Life has become full of fear, anger, fatigue, uncertainty, and without hope. Many of the very ill have become increasingly dependent and very isolated from their usual friends, family and community. In this regard HBC service became the best solution for the above mentioned problem. In a practical sense, because of the great unbalance in number of PLWHA which is enormously greater than the number of Home and community based care Givers (HCBCG) , it is difficult to perform all the above tasks in every house hold of PLWHA. Therefore, that is why, HCBCG transfer skill to PLWHAs

family members, on how to take care of the PLWHA. But for those who have no family, and/ or whose family are young children, the Home and Community Based Care giver became a nurse, a home maker, a cook, a grocery shopper, a messenger, a letter writer, a book reader, a telephone answerer, a cleaner, a listener, a lawyer or a councilor. Even though, these are huge tasks to perform in addition to one's own individual task at home, the HHBCG willingly perform it to the best benefit of PLWHA.

2.3. CONCEPT OF HOME-BASED CARE

HIV/AIDS has been declared a national emergency in countries throughout the world. The United Nations has declared that HIV/AIDS may be the largest single obstacle to meeting in Millennium Development Goals (FDRE MOH, 2006). But, during the early stage of the pandemic, Ethiopia was not considered it as emergency and was not declared to take measures on time. Only few individuals and organizations realize that HIV/AIDS was an emergency and try to give response to this huge problem.

After many people suffer and die of AIDS, after infected and affected families suffer by the societal reaction of stigma and discrimination, and after many children became vulnerable and orphaned; governmental and nongovernmental organizations declare that HIV/AIDS is an emergency and start to answer to the emergency. As stated by FDRE MOH, 2006. HIV/AIDS is the largest single obstacle to meet the millennium development goal set by UN. HIV is not only a health issue, it is an issue encompassing all aspects of daily life—access to water, sanitation, transportation, livelihoods, food security, legal issue, education, economic, political and agriculture sector.

Since HIV/AIDS is a chronic disease, it needs a long stay in hospital, which is difficult to the patient, patient's family, the community and even to the hospitals. This demands a lot of money and care. So, the poor cannot afford the expectation. To meet this demand, home based care activities started by individuals and community based organizations (e.g. Idirs, anti AIDS clubs) create a holistic community-driven response to HIV/AIDS. Home Based Care is useful to the patient in that it gives the chance to get care in a home environment. It also allows the patient to fulfill his/ her responsibility. Since the patient is at home the family is free from hospital related expenses. HBC allows the patient family to provide the patient's need easily. It also reduce stigma and discrimination in addition to awareness creation, at least, HBC decreases burden from health facilities, in that more than half of the hospital beds are occupied by AIDS patients. Home Based Care relief hospitals and give chance for those who are easily curable disease like Malaria to be treated in hospitals.

AIDS is widely regarded as the greatest health problem the world has ever known. Its fang is deeply penetrated the third world countries especially African Sub-Saharan courtiers. Ethiopia has over 2 million people living with HIV/AIDS (PLWHA) and more than one million AIDS orphans. Huge number of families is affected and the HIV/AIDS epidemic poses a significant threat to socio-economic development of the country (FDRE MOH, 2006). This is a huge figure to the country striving to regularly feed its own subjects. Bedridden PLHIV need more care and support rather than contributing to the country's economy. The researcher agree with FDRE MOH, 2006 that the number of infected and affected people is a huge number that has an impact to weaken the work force and decrease productivity, in addition to the escalating health cost. The affected family member also need care and support especially children need different types

of support psychological, psychosocial, educational, nutritional, legal and medical support and when their parents passed away the children's need will increase more.

The concept of caring for patient at home is not new in Africa. HBC has to be viewed as one component of the strong tradition of the extended family in continuum of care and services necessary for optimal health care service delivery to individuals with HIV. Among home care services those that provide a link or mechanism of referral to a formal health care provider are more and sustainable than those that do not (Max, E Mboup S & Kanki J 2002). It is true that caring for a patient at home was strong tradition of extended family but in the case of HIV/AIDS this long standing tradition is changed. Mothers afraid to care for their sick children, husbands leaves their wives, fathers avoid their children and most of the time the whole family may not interested to give care to the sick person. So it is HBC that restart the strong and very important tradition of caring to the sick, by awareness creation on HIV/AIDS to family members, friends, neighbors and community. Home Based Care need strong networking with health facilities but, in Ethiopia to make the HBC successful the net working must be multidisciplinary that means net working with food aid organization, for shelter problem with local Keble administration, education sector for orphan and vulnerable children to fulfill the basic needs in demand.

2.4. DEFINITION OF HOME-BASED CARE

A key component of palliative care is home-based care, which in many resource-limited settings is the only way to deliver care to the patient. It has been estimated that 50% to 60% of people with HIV/AIDS worldwide have no access to professional healthcare workers to address their medical needs. For example, in Uganda, 88% of the population lives more than 10 kilometers away from any kind of health facility and the nurse to patient ratio is 1:4,300 (Kikule, 2003). As

a key component of palliative care, home based care is the best way for many resource limited settings to deliver care and support to the patients. In these settings palliative care programs focus attention on integrated community and home based care are thus the most efficient and cost effective approach to health care delivery. Palliative care has different components to fulfill the need of HIV/AIDS patients from the time of the person know his /her status until the time of death and further to bereavement and orphan care. But when we come to Ethiopia‘s case the problem was vast and it was very difficult to give care and support to all who knew their HIV status. Only bedridden patients were getting the palliative care component that is Home Based Care.

Furthermore, the World Health Organization describes, “such care includes physical, psychosocial, palliative and spiritual activities with the goal to provide hope through high-quality and appropriate care that helps ill people and families to maintain their independence and achieve the best possible quality of life." (WHO, 2004)Home-based care is a holistic, collaborative effort by the hospital, the family of the patient, and the community to enhance the quality of life PLWHA and their families. It is comprehensive care across the continuum of care from the health facility through to community and home level. However it encompasses clinical care, nursing care, counselling and psycho-spiritual care, and social support (MOH, 2005). HBC programs deliver various types of HIV/AIDS care in the patient’s home.

Given the relative availability and affordability of home-based care programs for most resource-poor settings, these programs play a significant role in providing access to comprehensive palliative and supportive care for a large proportion of individuals and families infected and affected by HIV disease.

The introduction of comprehensive care into home-based programs requires the training and education of medical providers (e.g. nurses), community-volunteer care givers, and sensitization for the community at large. Therefore, HBC can be any form of care given to sick people in their own homes instead of in a hospital. Home-based care workers can transfer their skill to family members then It can mean the care given by family members at home environment that include physical, emotional, spiritual, and social aspects.

2.5. COMMUNITY HOME BASED CARE (CHBC)

Community home-based care (HCBC) is a care given to individuals in their own natural environment, which is their home, by their families: supported by skilled health workers, trained volunteers and communities to meet physical, psycho-social, spiritual, and material needs with the individual playing a crucial role.

According to WHO, CHBC is defined as any form of care given to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities. The goal of CHBC is to provide hope through high-quality and appropriate care that helps ill people and families to maintain their independence and achieve the best possible quality of life. (WHO, 2002). It is true CHBC is as WHO stated but for poor counties like Ethiopia it calls upon the resources, skills, time, energy and funds of communities and governments. It is implicit that health is the outcome of the overall social and economic development of the community. Therefore, no single entity is able to meet the total requirement and challenges of home-based care. A collaborative effort is fundamental to success. Care in the community must become care by the community.

In resource-limited settings, CHBC typically requires an interdisciplinary team approach that includes both formal and informal caregivers. The goal of the collaborative effort is to alleviate suffering and treat patients holistically — addressing their physical, intellectual, emotional, social, and spiritual needs in a way that is appropriate to each person's culture and economic situation. The team could therefore include nurses, community workers, community volunteer Home Based Care givers community based organizations (Idirs) and family members, and non-governmental organizations. Ideally, the integration of CHBC with broad clinical, social, and spiritual support into the care of someone living with HIV/AIDS should promote quality of life and realistic life planning.

2. 6. FOCUS ON THE PATIENT AND THE FAMILY

It can be extremely difficult to ensure that care is truly patient centered, that the patient's worries are heard and addressed in a timely fashion — and that care is continuous. It is not just a single visit but an ongoing process, which develops to trusting relationship. Patients are scattered in different places with problems of access. The personnel involved visit the sick only when they have finished their own routine works and often end up visiting and offering assistance at their own convenience, rather than that of the patients!" (John Hopkins, 2006). As stated here, it is extremely difficult to ensure patients worries are addressed in timely fashion. Some care givers are not devoted to address the patient's worries in timely fashion. But, others devoted and true care givers tried to fulfill patients need even in scarce resource by mobilizing the community for nutrition, clothing and, sometimes in few cases providing shelter by networking with Keble administrative body.

A lot of stigma is also attached to these visits. If word gets out that their neighbor is suffering from terminal AIDS then very likely the house owner is to throw out his sick tenant. Or the neighbors will socially ostracize the sick tenant as a result visits are usually done in the evening after dusk**,** with a lot of secrecy involved. If questioned by neighbors, the care giver will often be requested by the family members to not disclose the identity of the disease and any other ailment is offered as a diagnosis (John Hopkins, 2006). It is true that patents and family members request to not any one reveal the HIV status of the PLWHA. Accordingly visits are attached with a lot of stigma. The researcher also agrees and points out there are three types of Stigma. First, the patient stigmatized him/herself by decreasing social activities in fear of stigma. Second, others stigmatized the patient by not participate in social activities. Third, some HIV positive people or AIDS patients avoid or stigmatize volunteer care givers and health workers not to be branded. However with all these entire problems the care givers are fighting the stigma and discrimination by different mechanism, and also .these problems do not prevent volunteer care givers to meet the patients need. The care givers have time and patience for caring, for counseling, doing household work and teaching the patient how to care for himself and teaching the patients family how to care for the patient with skill and with precaution.

2.7. COMPONENTS OF CHBC

According to the training of trainers' manual on palliative care for nurse supervisors, organized by FHI-Ethiopia, the main components core package of care for PLWHA households through HBC consist of medical care, nursing care, spiritual care, psychological care, psychosocial care, and nutritional support. (FHI-Ethiopia.2007). Before HCBC started for PLWHA especially in Addis Ababa, a lot of people died due to lack of the above services but, after HCBC started

patient's life become improved. The researcher believes that most PLWHA in areas where HCBC service is delivered their health condition is improved due to the above services.

2.8. MEDICAL AND NURSING CARE

Home based nursing care vary according to the condition of the patient like persistent diarrhoea, loss of appetite, bed sores, etc. Some patients require institutional care followed by nursing care at home. Home based nursing care always includes personal and general hygiene, such as bathing, mouth care, nail care, washing hair in bed, feeding the patient in bed, back care and turning the patient in bed to avoid bed sores. It also includes attention to pressure areas, treatment of sores and handling of body fluids such as pus, urine, blood, stool, vomit, and sputum. To ensure continued daily care and prevent the transmission of HIV, it is important to give due attention to education and training of care givers in the home such as family members, neighbours and volunteers (ADF, 2000). Creating a supportive environment for the patient health the care givers need ensure the living area of the patients as clean as safe and as pleasant as possible in order to support physical and emotional health. Activities include making and changing the bed, handling solid bedding and clothing, general house cleaning and keeping the compound clean.

2. 9. BENEFITS OF COMMUNITY BASED CARE

Home-based care has benefits for the person living with HIV/AIDS and for family members in the sense that it allows the sick person to be cared for in a familiar environment and affords them opportunity to prepare for their death and die with dignity at home (www.heard.org.za). The researcher partially agrees in this idea because HBC is not only for preparation of death but, it

helps to improve the quality of life of PLWHA. Effective CHBC program for PLWHA can yield major health and social benefits starting from the patients and their families, and consequently to the entire community and to the health care system. However, this can only be achieved through a continual cohesive commitment between communities, governments, organizations and development agencies or donors.

Home-based care allows persons living with HIV/AIDS to take responsibility for their own welfare and well being; receive care in familiar environment; continue participating in family affairs; retain sense of belonging to social groups; and accept their condition more easily. It contributes to family solidarity; helps the family accept the infected person's condition; makes it easier to provide care and support; can reduce health care costs; and makes it easier for family members who provide care to attend to other responsibilities.(Ebun W M, Esther A, and Denis T 2002). It is true that home-based care helps reduce health care costs; affords opportunities for community members to confront stigma and provide support to persons living with HIV/AIDS; contributes to community cohesiveness; and raises awareness about the causes and impact of HIV/AIDS.

As some studies indicates hospital bed occupations is about 50%, therefore, strengthening home based care program benefits the health care system. Because home-based care helps ease the demand on health care facilities; does not require the creation of extra services, where none exist; and extends responsibility to individuals, families, and communities.(Ebun et al. 2002). The researcher agree that patients and families are not the only one benefited, home based care decrease burden for health worker in addition to hospitals.

2.10. CHALLENGES OF HOME and COMMUNITY BASED CARE

Home and Community Based Care (HCBC) have many challanges especially in resource limiting places. Challanges of Home and Community Based Care are challanges of Medical Care provision, Inaduquate Nutritional support and Challanges of care provider.

2.10.1 CHALANGES OF MEDICAL CARE PROVISION

Study in sub-Saharan Africa indicated that the vast majority of service providers reported their experienced challenges to providing pain relief.

> "…These were drug unavailability, lack of providers, transportation, stigma, and government restrictions. Additionally, other qualitative descriptions of challenges were: drug cost, lack of trained personnel to administer, lack of clinical expertise and awareness of pain control, patient inability to pay, fears of misuse of potent narcotics, under prescribing; appropriate pain relief drugs absent from essential drug lists; donor restriction on drug procurement; clinical disbelief in AIDS-related pain; patient not visit the hospital at late stages of disease; and lack of referrals. In addition, most of the programs addressed poverty effect on disease
>
> Management and progression. Further description reported this as achieved through collaboration with multi-sector mitigation program, nutritional assistance and supplementation, income generation projects, safe house system/accommodation, assistance for food production, and crisis admission".(Harding, R, Stewart K, O'Neil, JF; Higginson, IJ2003).

It is true that cost of medicine is very high in addition to other costs as mentioned above. Those drugs that alleviate severe pain or narcotic drugs are not available, thus the patients suffer and die in poor African countries like Ethiopia.

The researcher disagree in the idea that patients die with lack of referral to hospital in HBC programs because if the HBC program is well organized and if there is strict follow up the volunteer care givers could take the patient to hospital through the referral by the nurse or any health worker. So, to fill the gap the HBC program and linkage to health facilities must be aligned at the start of the program.

2.10.2. INADEQUATE NUTRITIONAL SUPPORT

In regards to nutrition, there has been emphasis on its significant influence on the success of ART. In resource limited settings, many PLWHA lack access to sufficient quantities of nutritious foods, which poses the challenges of affecting ART drug efficacy and adherence to drug regimes. [Castleman, T; Suemo- Foso & cogile B, 2004]. This is true that almost all PLWHA in a resource limited areas lack the access of nutritious food. It is obvious PLWHA need more balanced diet than the healthy. In HBC programs too, the nutritional problem remains a big issue. The problem of food also inhibits PLHIV not to take the ART drugs.

2.10.3. CHALLENGES OF CARE PROVIDERS

Caring for PLHIV is usually carried out by family members who serve as ‘primary caregivers’ and by community members who are recruited and trained to provide services as ‘volunteer caregivers’ [Akintola, 2004]. Unfortunately caregivers experience poverty, social isolation, stigma, psychological distress, and lack basic care giving education. Akintola’s idea might be true in some cases but, in other cases this conditions are not applicable. Care givers can get

training, and poverty is not a problem to give Home Based Care, the stigma and social isolation are not problems for the true volunteer Home Based Care givers. These problems for true volunteers cannot out weight the problem of PLWHA who are suffering because of lack of care and support.

CHAPTER 3: RESEARCH METHODOLOGY

3.1. Introduction

In order to achieve the objectives of the research, the service rendered to and the benefit gained by PLWHA; what was the sources of the resources; and also to understand the challenges and problems of the HCBC service with identification of the role of Balcha Idir, this research applied a cross-sectional descriptive research method.

3.2. Study Design

The researcher chose the cross-sectional research method to enable samples to represent the whole population. In addition, the descriptive study helps to show the researched reality in words. In this study both quantitative and qualitative data collection methods were used. The quantitative data collection method used in order to relate the quantity of HCBC service in numbers. The tool adopted for this method is self administered questionnaire that could translate the research objective into specific questions.

On the other hand, the qualitative data collection method was employed in order to explore contextual based HCBC activities, and the tool adopted for this method was an in-depth interview and Focus group discussions to draw rich information from samples.

3.3. Universe of the Study

The universe of the present study consist People Living with HIV/AIDS in Addis Ababa Lideta Subcity woreda-3, who were benefited from Home and Community Based Care rendered by Balcha Idir. Those PLWHA once were very sick, impoverished, stigmatized and rejected by their families, relatives and the community. PLWHA, Adults and children recived HCBC from Balcha

Idir Home and Community Based care program. Universe of the study are 140 PLWHA. In the study 30% (42) PLWHA are samples for quantitative study and 7% (10) PLWHA also selected purposively for qualitative study. Generally 52 PLWHAs are samples of the study Children less than 18 years are not included in the study, 11 community volunteer care givers selected for qualitative study and 5 Home and Community Based Care Committee members also participated included in the qualitatative the study.

3.4.Research Methods

The researcher chooses cross-sectional research method to enable samples to represent the whole population and to show the research reality in words descriptive study also will be used. The nature of the research, namely "An assessment of Home and community Based Care to People Living with HIV/AIDS with special Reference to Balcha Idir at Lideta sub-city woreda-3" demand both qualitative and quantitative research methods. Qualitative approach reveals the quality of services rendered to PLWHA while quantitative approach supports to show the magnitude of the services. In order to achieve the objectives of the research, the types of service rendered to PLWHA; and also to understand the challenges and problems of the HCBC service with identification of the role of Balcha Idir this research applied cross-sectional descriptive method of research.

3.5. Sample Size and Sampling Procedure

In this study both quantitative and qualitative data collection methods were used. The quantitative data collection method used in order to relate the quantity of HCBC service in numbers. The tool adopted for this method is questionnaire that could translate the research objective into specific questions. On the other hand, the qualitative data collection method was

employed in order to explore contextual based HCBC activities, and the tool adopted for this method was an in-depth interview and focus group discussions which helps to draw rich information from samples.

For quantitative data collection instrument questionair, samples selected by a simple random sampling method employed to enable each member of the opulation to have an equal chance of selection except PLWHA children under 18years excluded from the study. From 140 PLWHA, who receives HCBC service under Balcha Idir-HCBC program, 30% (male 5, female 37) PLWHA were selected by using simple random sampling technique. Since the population is homogeneous the reasercher choose small size samples. For the qualitative data collection, purposive sampling method used, this method employed to draw rich information from the subjects. Thus for qualitative study 7% (10) PLWHA selected by using a purposive sampling method to ensure selecting PLWHAs who stay long in the HCBC program. For focus group discussion (male 2, female 5) and for an in-depth interveew (male 1, female 2) participated. Therefore, the study selected a total of 52 PLWHA respondents (37%) from the total population for quantitative and qualitative study.

From 14 female HCBC Community volunteer care givers who most experienced and long stayed in the HCBC program 3 community volunteer care givers participated in in-depth interview and 8 of them participated for focus group discussion thus a total of 11 community volunteer care givers participated in the study.

All the Five BalchaI Idir -HCBC committee members, are included in focus group discussion and the chairman and one member also included for the in-depth interview inorder to get rich

information.In general in this study 52 PLWHA, 11 community volunteer care givers and 5HCBC committee totally 68 subjects participated.

3.6. Sampling Frame

The sampling frame for PLWHA is the registration book of PLWHA who benefited from HCBC service of Balcha Idir, the sampling frame for community volunteer care givers is the registration book of Community volunteer care givers who serve the full service year (one year and half year up to two years) and the sampling frame for Balcha Idir HCBC committee was the registration book of HCBC committee.

3.7. Tools and Procedures of Data Collection

Questionnaire was data collection instrument employed in the study, forty two PLWHA, (5 male and thirty seven female) PLWHA respondents participated in the study. Questions were demographic, socio economic, and HIV and HCBC related questions. FGD and in-depth interview participants also included in the demographic and socioeconomic questions in Table.1, Table .2, Table.3, presented. For quantitative data collection, two data collectors who knew the area recruited and got training how to collect data. Data collectors fill the questionnaires for those who cannot fill by themselves. PLWHA those who can fill by themselves filled the questionnaire. Willingness to participate or not asked with oral consent before data collection.

FGD was one of the data collection instruments in this study. There were three groups of FGD participants **PLWHA** group seven participants (2male, 5female) participated, **Balcha Idir committee** group five participants(4male, 1female) participated. **Community volunteer care giver** group eight female participants participated. A moderator facilitated and stimulates the

group discussions; FGD participants were active on the discussions. Participants were raise questions for questions that are not clear to them and also all the three groups were active in disscussions.

In-depth interview was the third data collection instrument from, **PLWHA** (one male two female) three PLWHA interviewed, **HCBC committee** two key informants, (one is the chairman male, and 1female) interviewed. Eight female **Community volunteer care givers** who stay long, experienced and passionated were interviewed.

A written guide line was used to standardize the data collection process. A moderator stimulates discussions for FGD participants in each group independently at different tine. Also he guides the participants and allows them to express their ideas and feelings. Each group took 45 minutes for discussion. All the three groups discussed on topics relevant to explore problems and challenges of HCBC program, the types of HCBC and its benefits to PLWHA, the role of Balcha Idir. Willingness to participate or not asked with oral consent before data collection. The researcher used a tape recorder to record the discussions by asking the willingness of the group participants and also observe the whole process. Note taker also records the whole process that helped to draw most important points. Willingness to participate or not asked with oral consent before data collection. Data collection process has done from March- April.

3.8. Methods of Data Analysis

The qualitative data collected and analyzed using qualitative data analysis techniques such as exploration description, and explanation of ideas to identify the theme of the discussion. The

facilitator emphasizes the points raised by participants at the end of each discussion session. The quantitative data also will be quantified manually.

3.9. Ethical consideration

From the point of view of ethical considerations, there are issues that should be considered. The following ethical consideration were fulfilled and assured in this study. Names are not mentioned to protect the identity of the respondent. PLWHA Children less than 18 years not included in this study. Participate in this study or not are the right of the client. But every study subject was included in the study after giving explanation on the aim of study and taking oral informed consent.

CHAPTER4: DATA ANALYSIS AND INTERPRITATION

The data analysis and Interpritation was carried out from April –May, 2015.

All 52 (37%) PLWHAwho participated in the study asked demographic and socioeconomic questions.

Quantitative Data collection instrument employed was: questionnaire: 42 PLWHA (5 male, 37 female) asked HCBC related questions in addition to demographic and socioeconomic questions.

Qualitative data collection instrument

1. Focus Group Discussion
    - PLWHA: (2 male and 5 female) participated in the discussion.
    - HCBC committee: (4male, 1 female) participated in the discussion.
    - Volunteer care givers: 8 female community volunteer care givers participated in the discussion.
2. In-depth Interview Participants
    - 3 PLWHA (1 male and 2 female) intervewwed.
    - HCBC Committee (1male and 1female) interviewed.
    - 3 female community volunteer care givers interviewed.

This section of the paper deals with analysis and interpretations of data. The data were collected from PLWHA who received HCBC from Balcha Idir, Balcha HCBC committee members, and community volunteer HCBC care givers. Questionnaires filled, in-depth interviews conducted and Focus group discussion done. Thus the study gathered factual information about HCBC service in the area of Balcha HCBC program. The information gathered has been subjected for

analyzing the data, clearly dealt with the objectives of this study. Those major areas are: (1) problems of PLWHA and Challenges of HCBC (2) Types of HCBC service given by HCBC program and benefits gained by PLWHA; (3) vital role of Balcha Idir. Before proceeding to the major areas, it is necessary to understand the socio-demographic characteristics of the PLWHA, thus all 52 PLWHAs demographic and socioeconomic statuses assessed.

4.1 SOCIO DEMOGRAPHIC STATUS OF PLWHA

The table below is demographic status of all 52 PLWHA (male 8, female 44) who participate both quantitative and qualitative study stated.

Table 4.1, Age of PLWHA

Age of PLWHA						
Age	Male	%	Female	%	Total	%
24-30	3	37.5	19	43.1	22	42.3
31-39	4	50	17	38.6	21	40.3
40-50	1	12.5	8	18.1	9	17.3

According table 4.1, table indicates respondents of PLWHA are greater than 24 years. Age 24 years -30 years are more than other age group (42.3%). The age range of Respondents 24 -30 years is smallest range than others but is the largest group in the HCBC program especially in the case of female PLWHA.The second largest age group is the age range 31-39 years which is (40.3%). These data Indicates that respondents were sexually active age group and this age group is a promising age group to the country.

Table 4.2, Sex of PLWHA

Sex compostion of PLWHA		
sex	Respondents	Percentage %
male	8	15.4
female	44	84.6

The above table shows the number of female PLWHA are greater than male, female are 84.6% which is three times greater than the number of female. Number of female PLWHA who were reciving Home and community based care are greater than male PLWHA. Biological factors and poverty contribute for increased number of female to be infected with HIV/AIDS or they demand HCBC than male PLWHA. Most women donot have theirown proper income to rely, thus seeking of HCBC service was mandatory.

Table 4.3, marital status of PLWHA

Marital status of PLWHA							
Single	%	Married	%	Divorce	%	Widow	%
4	7	17	32.7	9	17.3	22	42.3

One can easily identify from table 4.3 marital status of PLWHA respondents which widows took the greater share (42.3 %) from the whole population and from the general population. This indicates the death toll of the late spouses of these widows. The Economic and serious health problems push them to be enrolled in the HCBC program. The above statistics also indicates that

single parent families are at large in the areas. Women often lose social standing and ties when their husbands die. And it is also if widows

are HIV-positive the stigma and isolation can be extreme. The number of married PLWHA also is high (32.7) Some PLWHA partners might be included since some partners are not interested for the HCBC services.

Table 4.4, Family size of PLWHA

Family size of PLWHA					
1-2 family members	%	3-5 family members	%	6 & above family members	%
10	19.2	33	63.5	9	17.3

Table 4:4, indicates that, most of PLWHA have “big family sizes” above three family members comparing to their problems. PLWHA who have (3-5 family members 63.5% and 6 & above Family members 17.3%) together above 80% of PLWHA have “big family size” comparing their economic and health status. This is is too much burden for poor PLWHA in addition their sickness, PLWHA are struggling to feed their family,

Table 4.5 Employment status of PLWHA

Employment status of PLWHA						
Variable	Male	%	Female respondent	%	Total Respondent	%
Non Employed	2	25	27	61	29	55.8
Employed	6	75	17	38.6	23	44.3

In the above Table 4.5, 44% of PLWHA are self employed or daily labourer or working in factory where as 55.8% are not employed. If PLWHA are not making money they will be in problem with their family members. Most PLWHA are living with their family members, we have seen 80% of PLWHA have more than 3 family members. When we compare male respondents with female male are better engaged in work than female respondents. 75% of male respondents have got the opportunity while female PLWHA got less opportunity. 42.3% of PLWHA are widowed this also implies that PLWHA are in economic problem.

Table 4.6, Educational background of PLWHA

Educational background of PLWHA					
Illitrate	%	Primary education	%	Secondary education	%
29	55.8	14	26.9	9	17.3

Lack of ducational is known one of the factors which contribute for the transmission of HIV. Lack of education and information will result to be exposed for HIV infection in any society. Most people were not aware how HIV is transmiting from the infected person to healthy person. As shown in the Table 4.6, most of the respondents 55.8% are illiterate and 26.9% of respondents are primary and under primary, the rest 17 % are above secondary level this implies that this group cannot get basic information about HIV/AIDS and also cannot easily understood scientific knowledge and information. Conventional knowledge dictates, educated people are likely thought to be health-conscious and adhere to public health messages and other interventions. Education may also accord an individual the opportunity to access health information job opportunity.

Table 4.7 Income of PLWHA

Income of PLWHA							
Below 2oo birr	%	201-500 birr	%	501-700 birr	%	701 birr& above	%
21	40.3	26	50%	7	13.4	2	3.8

Table 4:7 shows income of PLWHA; around 50% are earning below 500.00 birr. PLWHA cannot do any thing with this amount of money. Money nedded for house rent, for food clothing, for children education and other expenses. Thus PLWHA are suffering with feable income with their families. As we have seen in table 4.2, 80% of PLWHA have large family size this also indicate they are burdened to fulfill the need of their family with this small amount of money. PLWHA body also need nutritious and balanced diet for building of defence mechanism against HIV virus. All this problems make PLWHA's life very difficult.

Table 4.8, Religion of PLWHA

Religion of PLWHA					
Orthodox christian	%	Muslim	%	protestant	%
36	69.2	12	23	4	7.7

Table 4:8, shows also religion of PLWHA whether one is a strong follower of the faith or a reluctant one, PLWHA are grouped themselves in one or the other group of religion. According the table the number of followers of the Orthodox Christian sect is by far larger (69%) then the followers of the Muslim sect (23%) and the Protestants followed (7.7%). The reason why need of growing momentum for faith group leaders to become involved in the fight against HIV/AIDS is the rising no of PLWHA in all religion. Beside spiritual teaching spiritual fathers should teach for follower of the religion about HIV/ AIDS.

4.2. Problems of PLWHA and Challenges of HCBC

For the quntitatve study 42 PLWHA (male 5, female 37) asked HIV & HCBC related questions. Below in the table responses are displayed.

4.2.1. Problems of PLWHA

Bellow in the table there are Problems of PLWHA those problems are psychological, psychosocial, nutritional, shelter and other described below in the table.

Table 4.9.Problem of PLWHA before HCBC

Problem of PLWHA							
No	Type of problem	Male	%	Female	%	Total	No
1	Stigma & discrimination Psychological &Psychosocial problem	5	100%	37	100%	42	100%
2	Nutritional problem	5	100%	37	100%	42	100%
3	Sickness of PLWHA	5	100%	37	100%	42	100%
4	Shelter problem	3	60%	28	75.7%	31	73%

4.2.1.1 Stigma and discrimination: psychological and psychosocial problems

The major Challenge of HIV/AIDS is stigma and discrimination. Most patients found under the Balcha Idir were stigmatized. According table 4:9, 100% of PLWHA face Stigma and discrimination, PLWHA does not disclose their HIV status, as stigma and discrimination will be an eminent results. And Stigma and discrimination hurt PLWHA than the disease. One respondent of this study told the researcher the following episode.

> *I knew my HIV status in one known hospital I kept it secret; I don't want to share my secret in fear of stigma. I have a feeling that every one looking me and I also I imagine what they could say about me. I knew there are Anti Retro Viral drugs in hospitals but my fear grows inside me day to day, while my body weight decrease day to day. One day I decided to tell my secret to one of my friends and I asked her what do you do if your friend acquired HIV/IDS? She answered me blatantly "no I don't want a friend with HIV/AIDS" without telling anything to her I also asked the second friend of mine the same question and also she gave me the same answer like the previous one. Desperately my last trial went to my third friend and it was successful. This friend of mine have the knowledge and information of HIV/AIDS and she replied like this "no problem I will accept that person as a friend, my mother too acquired the disease" it was at this time I told her my deep secret to my friend and she helped me to contact with volunteer care givers and to be enrolled in the Balcha HCBC program.*

As we go through the above story we can imagine how this young lady was troubled to disclose her status which she wants to disclose. This young lady wants to discuss her problem with her friends but she was not sure about her friend's acceptance, what so ever she told them. She was not lucky concerning her friends who told her that they are not interested to be a friend to a person with HIV. One can understand how PLWHA suffer with stigma, psychological and psychosocial problems in addition to other socio economic problems. The focus group discussion

participants also mentioned that they face stigma from family, friends, and the larger community. One of the participants of the focus group discussions recalls her experience of stigma as follows, "When my neighbors suspect my HIV status they used to tell me to bring my coffee cup to participate on the coffee ceremony but other neighbors are not expected to bring their Cups." And in some Cases they have been thrown out by house owners from the house owner's fear of infection.

One of FGD participants also explain how she stigmatized herself, when she knew her HIV status she stopped participating with friends and families. She feels that she is not accepted; she left her families and friends to die in one of countryside church. She resides in one of the Orthodox Church and wait death but death didn't come for months so she came back to her village. It was at that time community volunteers came to her and start counseling and enrolled her in the HCBC program.

Many PLWHA are victimized out of their day to day activities and develops psychological and psychosocial problems. One respondent remembers her situation as follows.

> *"When my neighbors know my HIV status, they start to gossip on me. After sometimes, they also discover the HIV status of my two children. As a result they stigmatize us. My children used to tell me that children insult them in connection with their HIV status. Then I completely withdraw from any societal activities I am not going to church, any invitations in the neighborhoods and even I stopped going for funerals.*

Stigma creates difficulties for PLWHA to be accepted by communities. The society detested and views them as useless and a burden. These Conditions leads PLWHA to stigmatize themselves and denial of their HIV status and hindering them from seeking treatment and care.

Community volunteer FGD participants also told to do surveillance in the community they walk through the village and ask dwellers if there is chronically sick person in the village. People might show them a house of sick person secretly and community volunteer care givers enter the house and tell the patient or his/her family that they are there for caring for chronically sick with any disease. They were hiding the real purpose of the volunteer care givers, caring for victim of HIV/AIDS because this might create fear of stigma to the patient from family and neighbors and he/she might reject the service.

PLWHA before the time of HCBC and ART face a lot of difficult conditions the recurrent attack of opportunistic infection, stigma and discrimination and nutritional problem all this cumulatively make the PLWHA hopeless and create psychological deep rooted problems even after the HCBC services. One of the respondents presents the situation as follow.

> *Before Home Based Care I was hopeless, no one was coming to me. People were not interested to come to me. They were giving me a food at a distance, so I became hopeless at last I proposed people if they could call ambulance to take me to "Mother Teresa" around Sidist Killo to die there. But in the mean time Balcha Idir volunteers heard about me from neighbors and start home based care now, I am taking*

ART my life changed my body weiht was 23kg prior the HCBC and ART now I became 52kg. But still I have a feeling of hopelessness because the food they are giving to me and my family (thirty six killo wheat and three liter oil) will be cut because my weight increased.

Most PLWHA who refuse the HCBC died with a lot of suffering from many opportunistic infections especially the one that refuses the HCBC program who lacks treatment of opportunistic infections. When PLWHA reach last stage they no more refuse, thus the community volunteers care givers are obliged to give both nursing and post mortal care. Even though PLWHA fear the sever suffering brought by opportunistic infection the fear of stigma is greater the future of their children also another problem that depressed and always make uncertain.

4.2.1.2. Nutritional problem

Ethiopia is one of the poorest countries in the world and this is seen in all city slums of the nation. As the researched group indicates, there were many instances where PLWHA and their families spent the night without food. As indicated in Table 4.9, the state of PLWHA at the time recruited in the HCBC is 100% of PLWHA have nutritional problems. One in-depth interview respondent of community volunteer described what she observed in her client home as follows.

When I always went to my client home I have fear what can I take to him because he was not getting food. At the first visit he told me that he doesn't want

any care without food he said to me ''It doesn't give me a sense washing a person who is hungry" this shows that the client is hungry. Until HIDO staffs bring Dube duket and create linkage with world food program (WFP)I was taking food for him from my own home or mobilizing food from his Neighbors to feed him.

Some PLWHA stopped working when they know their HIV status fearing the stigma and discrimination even though they are not sick. They become hopeless thinking they are going to die soon. Some PLWHA stop working because they are sick and unable to do it. Thus the lives of them become in danger for they cannot get money for food, clothing and unable to pay the house rent. Thus the most serious problem for community volunteer care givers in PLWHA household is the nutritional problem of the PLWHA. It was difficult to see PLWHA and their children without food; they ask bluntly the care givers and the HCBC committee to be enrolled in the WFP programs or saying "I am hungry". The FGD participants of HCBC committee give their testimony many PLWHAs are always begging to be enrolled in WFP program or complaining that there is no food in their house. It was also difficult to discharge PLWHA from WFP program when they graduate from the program and to substitute other poor PLWHAs since quotas are for few patients. Most PLWHA were crying and begging the HCBC committee not to be discharged from the program.

One In-depth interview respondent of community volunteer describe what she observe in one house hold 18 kg of wheat and one liter oil from WFP and that does not feet with the need of the household. The volunteer care giver used to take the above items monthly. The patient cannot go to take the ration because she is chronically sick. It is always difficult what to do with that, the

patient need balanced diet; there is a need of money for house rent and a need in the house hold for day to day activities. We can see here that PLWHA need highly nutritious balanced diet to survive and the availability of this balanced diet is null.

Getting water was also a problem, in urban areas many families were required to purchase water from the community tap or from any other person's house. This is particularly true for families living in the slums of Addis Ababa. Children who lost their parents or those whose parents are sick and bedridden are in danger of lack of food and clothing.

4.2.1. 3. The seriousness of the disease

The seriousness of the disease imprisoned the patient to bed for many months or years, thus the PLWHA is in painful condition even pain killers are not helpful for them. Some PLWHA are paralyzed and unable to care for themselves and to their family needs others support. PLWHA are exposed for different kinds of opportunistic infections. Since a patient reach AIDS stage a lot of opportunistic infections occur in the patient body system, fungal infections, viral infections bacterial infections and other types of infections manifests. The body of PLWHAs body defense mechanism is not working well. According table 4.9, 100% of PLWHA were seriously sick. PLWHA in poor economic situation cannot get enough balanced diets for the building of body defense mechanism, thus they are liable to develop repeated opportunistic infections. And in order to alleviate the pain they have to take many types of medicines and this in return made them "pill burden". This condition is best expressed by one PLWHA respondent as follows.

> *I was recurrently infected with Tuberculosis for three times, I have diarrhea on and off, and I have fever and sweating. I took anti Tuberculosis medicine two times and now this is my third time beside I am taking ART drugs. In*

addition to Tuberculosis I have suffered by other opportunistic infections. This made me to take additional medicines all the time. Despite all the medications, I experience no improvement in my health condition. I lost hope.

This situation made the community volunteer care giver to perform all the house hold works of a number of patients. According to the volunteer care giver, one of the PLWHA who was getting care always says, "I'm OK" and "I'm doing fine" not wanting to know her HIV status but her husband died of HIV/AIDS. Even she doesn't want the care provision of for fear of stigma and discrimination. Her physical condition (the skin and bone) expose her sickness she walk by support of stick. When her two children came home she tried not to show her pain and fatigue, immediately after the children left out the house she could no longer tolerate the pain and fatigue, then she lie down to rest. One day she said "If someone knew my health status they immediately ostracized me and my children too". Therefore, the PLWHA didn't want to be seen or visited by a volunteer care giver. What so ever against her will the volunteers visit the patient.

The FGD participants of PLWHA discuss the type of the diseases tuberculosis, almost all patients suffer from on and off diarrhea, oral and esophageal fungus, typhoid fever, vomiting occur in most cases repeatedly, all develop repeated fever that does not go ,fungal infection on their body, most patients were lose "many kilos" of their body weight. Some Patients claim that they were unconscious and cannot control their urine and stool. The pain from each disease was intolerable for the patient the family and the Community volunteer care givers.

The focus group discussion participants of community volunteers confirm the above all disesess can be manifest at one patient at the same time or at different time. They also mention some

patients were pass stool without losing their consciousness. Doctors of the patients told them this is a problem of loose anal sphincter. As the community volunteers this is also one problem to be stigmatized by their own family.

We can draw a conclusion that PLWHA suffer much because of seriousness of the disease and these also followed by stigmatized by their loved ones. Most families reject their loved ones because of burnout and fear of infection.

4.2.1.4. Shelter problem

As indicated in Table 4:9, 73 % of PLWHA face shelter problem. Shelter is also another problem that become difficult to be solved by the local administrative body. In fact the Keble administration and Balcha HCBC team are trying to do their best but, so far it remains one of the huge problems of PLWHA. PLWHA will be forced to leave their house since most of them are economically weak to pay the rent. Other reason to be pushed out from their house is stigma and discrimination. Few house owners may give order to leave their house when they learned the house renter is HIV positive. The problem will be doubled when the PLWHA have children, their peers may insult the children in connection with HIV/AIDS and leaving the house might be the decision of the PLWHA. The FGD participants of volunteer care givers experience a lot of bad experiences, finding for the pushed PLWHA cheap houses in far places from the present place not to be known. Due to these problems, community volunteers burnout because it incurs additional cost to travel far.

Despite all problems mention above, nutritional problems of PLWHA, Psychological and psychosocial problems resulted from stigma and discrimination, seriousness of the disease and

the problem of shelter to PLWHA community volunteer givers and Balcha HCBC committee perceived that HCBC is a continuum of care that help PLWHA by providing basic care according to their needs in their home.

4.2.2. Challenges of HCBC

Stigma and discrimination: is one factor that in table 4:9, 100% of PLWHA faces. PLWHA and family developed psychological and psychosocial problems, especially PLWHA rejected, neglected. This is one challenge for the program too PLWHA were not cooperative because they lost their hope.

Nutritional problem: also the big factor as table 4:9,100% of PLWHA PLWHA complains face hunger, food problem still remain problem for PLWHA.

Seriousness of the disease: also was problem for the HCBC too because PLWHA were sick now and thensick seriously. AS table 4:9, 100% of PLWHA were (PLWHA need too much money for transportation and for medicine, and needs man power)

Shelter problem: was also one of the challenges of HCBC program, in Table 4.9. 73% of PLWHA were in problems of shelter. Lack of money, stigma and rejection by family members and house owners push PLWHA to go far from the target area this also doubled the burden for the HCBC program.

Dependency syndrome: PLWHA were highly dependent on WFP programs

Lack of proper funding: or irregular food and material support from Balcha Idir partners.

4.3. Types of HCBC Services and their Benefits

There are many types of HCBC; PLWHA under Balcha Idir received the following services.

4.3.1. Types of HCBC services rendered to PLWHA

In the following table the types of HCBC services mentioned, by PLWHA, psychological, nursing care, counseling, food support, householdwork skill transfer.

Table 4:10, Types of HCBC services rendered to PLWHA

	Variable	Numbers of PLWHA					
	Type of services given	Male	%	Females	%	Total number	%
1.	Nutritional support	5	100%	37	100%	42	100%
2	Counseling for ART adherence, Psychological &Psychosocial support	5	100%	37	100%	42	100%
3	PLWHA who start ART and got Nursing care	5	100%	37	100%	42	100%
4	Household work and environmental sanitation	4	80%	20	54%	24	57%
5	Skill transferred to PLWHA family	1	20%	17	46%	18	43%

Table 4.10, PLWHA received the above HCBC services, most PLWHA receive 100% of the sevices. HCBC services especialy counseling for HIV positive results, (on going counseling) family planning, drug adherance, food support and nursing care. PLWHA might give one type of

service or he/she might take all services at time. Types of services are explained in the qualitative study.

4.3.2. Benefits of HCBC services to PLWHA

Nutritional support for PLWHA

As all respondent PLWHA indicated in Table 4: 10, 100% of PLWHA have got nutritional support for their survival. AS the FGD participants of HCBC committee members remember the nutritional support as follows, Patients could get Soya milk which provided occasionally for severely ill PLWHA, 2 kg Dube Duket*, every 15 days in irregular base Dube duket and Soya was brought by HIDO for seriously sick patients. We also enrolled PLWHA in WFP programs as severity of their health condition and enrolled those who are taking ART. We enrolled PLWHA according to WFP criteria: PLWHA whom body mass index is very low, who start ART, who are very poor (have low income). One PLWHA will stay in WFP program for six months only to substitute others. From WFP program PLWHA who have one to three family members got 18kg wheat and one liter oil. PLWHA who have three to five family members' got 36kg wheat and two liter oil. PLWHA who have family members above five got 45kg wheat and three liter oil. And some time when WFP brought famix (mix cereals flour) got additionally with the above rations. That item of foods came through the networking of Balcha Idir. This might improve the nutritional problem temporarily. As FGD participants of PLWHA Community volunteer take Dube duket to them and they were prepare soup that helped much to improve their health. In-depth interview Participants of the Community volunteer states that she and her friends were doing for PLWHA food out of Dube duket. She explain what volunteers done "PLWHA were

* Dube Duket : A mixed cereal flour

starved thus we were bring wheat and a Mix of flour called famix from WFP store and we prepare different kinds of foods. PLWHA were very weak even they can not eat food they were in difficult conditions. Balcha Idir in collaboration with HIDO and WFP try to fill the gap but the supply didn't match the demand. As conventional knowledge states, PLWHA need more balanced food more than healthy person. The relationship between malnutrition and AIDS is well recognized HIV infection compromises the nutritional infected individual, and in turn, poor nutritional status can affect the progression of HIV infection.

Counseling: ART, SRH and Psychological and Psychosocial support

According to Table 4:10, 100% the respondent PLWHA have got psychological and psychosocial support. HCBC was very vital to address the psychological and psychosocial problems, the community volunteer givers who was participant of in-depth interview explain how the HCBC doing repeated counseling to PLWHA, children, and other family members about the importance of HIV testing, positive living, and the importance of ART and also they were giving basic HIV/AIDS education to minimize the transmission of HIV virus and also minimizing stigma and discrimination.

As the PLWHA who participated in the in the focus group discussions, the care given by community volunteer care givers helped them a lot. The counseling they gave to alleviate their psychological problems day by day brings a good change in their psychology. They have been developed hate to the community and they were wishing to revenge the community to respond to stigma and discrimination. the counseling about poor awareness of the community about HIV/AIDS, the love that the community volunteer care givers given, and the care they gave ignite hope to PLWHA.

Beside these efforts, the repeated visit of the volunteer care givers to the house of PLWHA made the community to realize that visiting of PLWHA is not a dangerous thing. And this also made a lot of change in the positive thinking of the community to minimize stigma and discrimination. In addition preparing coffee ceremony in houses of PLWHA and in places of high concentration of people was the main duty of volunteer care givers. These practices are purposeful. The community volunteer whom participate the in-depth interview explain what purposes have coffee ceremonies in households and in the general community.

> *We were preparing coffee ceremonies at the households of PLWHA's to teach sexual and reproductive health, about condom usage, and contraceptives, when a patient face stigma and discrimination from the family, and from neighbors. We are transmitting messages about facts of HIV/AIDS, how to minimize stigma and discrimination, the importance of HIV counseling and testing, prevention of Mother to Child transmission and importance of ART drugs, and how one adhere to Anti Retro viral Therapies.* and *also we are preparing coffee ceremonies for the larger community to transmit the above message, great emphasis have been given the importance of avoiding stigma and discrimination. Usually we encourage coffee ceremony participants by initiate dialogue among the participants those coffee ceremonies resource*

mobilization for poor PLWHA have been done.

PLWHA who participated in the FGD also explain the benefits of coffee ceremonies one of the participant mentioned that she was not communicate with her mother and sisters she hated them because she was suspecting they gossip after her while they are not aware her HIV status. She was not happy when visitors came to her home, she pretended as she slept and try to hear if they say something about her. This PLWHA suffer a lot psychologically became suspicious of others. It was this times her family suspect by her new behavior. They started asking her what wrong with her, disagreement with the family members started. She stopped caring herself. It was at this time community volunteer care givers reach her take her to VCT center she learn her HIV status, they gave counseling to live positively to accept situation and to care for herself, the importance of ART, sexual and reproductive, Thus the volunteer care giver ignites hope. The counseling given by volunteer care givers helps PLWHA, to be tested to know their HIV status, to accept their status, to start positive living, to disclose their status to their partners and children and in some cases disclosure was too the larger community. As one respondent explains "now I am free, I do not have fear, I am not hiding any secret." The respondent was really free because she starts ART her child also became positive and is taking ART. The ART also brought greater change in her and her son's life. HCBC brought a greater change to PLWHA Physical, mental and health.

Due to the HCBC service stigma and discrimination is reduced within the community through awareness creation and awareness raising activities. According to one of in-depth interview key informant, her family stigmatized and stopped treating her as usual. She suffered much of stigma and discrimination, longing her death. It was at this time volunteer care givers came to her home

and recruit her in Balcha Idir HCBC program. Preparing coffee ceremony at family level to discuss about HIV/AIDS helps the family to minimize stigma and discrimination. She also acknowledged community volunteer care givers work to minimize stigma at community level. According to her community volunteers discuss about Ways of transmissions of HIV/AIDS, about voluntary counseling and testing, the importance of ART drugs, the disadvantages of Stigma and discrimination.

ART and Nursing care

Basic nursing care includes positioning, mobility, bathing, wound cleansing, skin care, oral hygiene, adequate ventilation and guidance and support of adequate nutrition to the client. Good personal hygiene (keeping the body clean) A person with who does not maintain cleanness is more likely to be infected by various disease. The HCBC program of Balcha Idir has been providing nursing care and counseling after training given to community volunteer care givers about basic nursing care and counseling. The training was given by Staff of HIDO.

AS shown in table 4:10,100 % of P LWHA were getting ART and nursing care. As the Volunteer care givers FGD respondent's response after getting training by HIDO staff, encouraged to find PLWHA in their surroundings. When they find PLWHA they were providing basic nursing, give counseling to go to VCT centers, initiate for ART, they were fight the false massage of ARTs and other types of cares And if the client is bed ridden and has family they will transfer Skill and if the patient has no family they were giving HCBC services. The nursing care that Volunteers give to PLWHA are, hair shampoo, mouth care, back care, nail care, wound care, and bed bath etc…when they were confined to bed. The volunteer care givers were responsible to give those cares to PLWHA who do not have family. For those who have family the volunteer

care givers transferred their skill to the family members and supervise whether the patient was got the proper care or not. According the FGD participants of PLWHA HCBC committee and community volunteer care givers played huge role on the initiation and adherence counseling of for ART remember what they receive from HCBC program as follows.

When we were bed ridden the community volunteer care givers were Washing our bodies, shampooing and braided our hair, doing dressing if we have wound. They massage our bodies with Vaseline, comfort us when our hands were paralyzed they brush our teeth, they massage the paralyzed part of our body. They usually help us to walk by support us physically helping us to do passive exercise after massage. They also were taking us to hospitals and health centers for treatment almost all of us start ART by the counseling of volunteers. They also were follow us whether we took our ART or not. bring us WFP and rations and flour from HIDO, and after we became healthy they have helped us to engage in different jobs, like small and micro Business, daily laborer and factory.

This shows the mammoth task of care service to PLWHA is shouldered by Community volunteer care givers. Life without HCBC might be difficult as one in-depth interviewee PLWHA remember. She starts getting HCBC services after her neighbors report to Balcha HCBC

committee member. The HCBC committee came to her home and asks what her problem is? At that time she was not happy and wants to hide her problem, later on she became convinced and joined the HCBC program. She was receiving nursing care like bed bath, hair shampoo, mouth care, and back care.

House hold work and environmental sanitation

Due to the information on Table 4:10, 57 % of the respondent of PLWHA has got the service of house hold work and environmental sanitation from volunteer HCBC givers. This service is mostly given to PLWHA, who do not have family and to PLWHA, who are confined to bed. As the respondents of volunteer care giver most PLWHA were in poor condition this situation will be more problematic when the patient became HIV positive. Because it is the responsibility of the volunteer care givers to give care and doing house hold works and environmental sanitation: Household works and environmental sanitation involves cleaning houses of bed ridden patients, washing the sheets and cloths, cooking foods bed making, environmental cleansing and purchasing. These activities are basically performed by volunteer care givers. PLWHAs who participate in FGD explain what have been done to them. The community volunteers arrive early in the morning as if they were going to work they gave they greet patient and the family, they ask if the patient eat breakfast or not if the patient didn't eat his breakfast they were preparing and feed the patient. It was after that nursing care followed. Washing dishes, cleaning the bedside, the room and the environment. Sometimes they prepare coffee ceremony in the house and in the surrounding. The community volunteer care givers were trace whether there is conflict in the PLWHAs home and if there is stigma. They also wash in group clothes and spoiled sheets of the patient and the family if both partners are sick and if children are under age.

If the patient has a family, the volunteer care givers transfer Skill to the family by showing how to do with preventive methods of HIV AIDS.

Skill transfer to PLWHA family

According to table 4:10, 43 % of PLWHA have families who can give care to PLWHA Skill transfer to family is one of the aims of Home and community based care program. Basic nursing skills have been transferred from the community volunteer care givers to PLWHA. According to in depth interview participant of community volunteer care giver, before giving a care community volunteers assessing the general condition of the patient, surrounding of the patient and families of the patient, then they will decide what to do. If the patient has family who can give care and support to the patient they transfer skill how to give the care with precaution (with safety measures), on the next day they allow the learner to do by himself, and the other day the learner will repeat the practice. The care giver also mentioned they transfer skill for PLWHA, they teach how to take care for him/her selves. And if the patient has no families the care givers will be the responsible person in giving the care to PLWHA.

according to table 4.10, 40.3% of care givers burden decreased through transferring skill to family members. Thus the community volunteer care givers will get spare time to help those who do not have family and also will get time to search for new unrolled PLWHA in the HCBC program.

Table 4:11 Improvement and satisifaction of PLWHA after HCBC

Improvement status of PLWHA				Satisifaction rate of PLWHA					
Not Improved	%	improved	%	Not satisified	%	satisified	%	Very satisified	%
3	7	39	93	-	-	11	26	31	74

Table 4:11, shows the improvment conditions of PLWHA, majority of PLWHA's health has been improved after the service of HCBC in Table 4:6, 93% of PLWHA's health improved. The rest 7% are not get improved due to many reason. Causes might be Nuitritional problem, poor drug adherance, and other causes that decrease the potency of ARTs. When we look Table 4.6, According to table 4.11, 74 % of PLWHA are very satisified, and 26 % of them also satisified thus all PLWHA (100%) satisified by the HCBC rendered by Balcha Idir.

HCBC helps them especially before the arrival of ART drugs, it maintain health of PLWHA until the arrival of ART drugs. According one respondent, "if home based care was not started survival was impossible". The respondent also mentioned that a lot of PLWHA were died before HCBC by lack of care and support. HCBC helps PLWHA to prevent opportunistic infections or to get immediate treatment at the time of infection. Community volunteer care givers were giving different care and support that could improves the qualities life of PLWHA and they were taking them to hospital at the time of infection. Stigma and discrimination reduced, which is taking the lion share of PLWHAs problem. Thus psychological problems alleviated, PLWHA

claim they do have fear and anxiety before HCBC program; some patients have to deal stigma from both their families and the broader community. One Community volunteer interviewee stated that when some family members find out about a patient's HIV/AIDS status they go as far as putting them out of the house. She stated that this was mostly due to the fact that most of the community lacked education about HIV/AIDS. The other FGD participant from PLWHA also explains the change followed by Visiting of HCBC committee.

I was bed ridden for a long time my family was not aware my HIV Status but when they learn that I developed AIDS everyone at home and my neighbors Stigmatized me. Balcha HCBC committee chairman came one day to visit me, sit beside me and we discuss I became happy. He said to me Volunteer care givers will help you; they will take you to hospital the next morning the volunteers came and took me to hospital, they helped my wife to go for HIV counseling and tasting and she became HIV negative and they counseled us about how to prevent the transmission of HIV by demonstrate usage of condom ART drug adherence counseling, Family planning counseling and how to live positive living, The visit of HCBC committee to my home change my family's attitude they no more Stigmatized and discriminate me. From that time on my neighbors too start visiting Me. Now I am taking my drugs I am healthy

I amsatisified doing my small business I would like to thank all who involved

in the HCBC program.

HCBC brought a lot of improvements at PLWHAs lives Balcha HCBC program has resulted in the reduction of self stigmatization. In that patients are relatively positive towards communicating with their families, neighbors, and visitors. PLWHA are in a state of stable psychological makeup, they are developing a positive attitude towards VCT, show improved self care and most patients have become ambulatory after accessing ART, Stigma from families, friends and the community are reduced. FGD participants of community volunteers explain there is difference after HCBC PLWHAs was not happy to communicate and they were hiding their faces now they are happy they are in good condition. All PLWHA FGD participants also expressed their satisifaction. They are happy because they start living as born again person, now people are not gossiping on them they are not afraiding to go out side their home. One woman said,

I donot want to remind the past it was horrible I always do not want to go

out side I afraid to see people when visitors come to my family home I hide my

self and remain in small room until they left, I see death in the mirror and some

times I was longing to commit sucide now is different I am happyhealthy and

I can help my family.

And for the same question the difference before HCBC and after HCBC one of them start by crying and the others FGD participant too brust in tears and after they became comfort all of

them answer they are happy and satisified by the HCBC. They recommend if Job opportunities available to PLWHA by the government becaust they have problems of food, house rent and other economic problems. We can draw a conclusion that Home and community based care counseling's and coffee ceremonies helps PLWHA, families and the community that could alleviate physical, psychological and psychosocial problems and helps PLWHA to live positive living.

At the family level, there is less stigmatization of family members with the signs and symptoms of HIV and families are willing to accept care givers into their households. There is improved acceptance of the skills transferred from the caregivers to family members or neighbors in caring for the patient. Misconceptions are in most cases avoided and there is better understanding of modes of transmission and methods of prevention. The denial and resistance from the side of families is much reduced when compared to the level it was at the start of the HCBC program. FGD participants of community volunteer care givers respnd for the question about how families accept the HCBC program at the begning. They recall the past how they were suffering, some families insult them, some families pushed them and say "there is no one here with HIV/AIDS" some families also say volunteers "you your self have AIDS". One of the volunteer also recalls how a woman was inhibiting her neighbor from getting HCBC by doing the following.

There was a woman who develops paralysis from HIV/AIDS and this woman is living in renting house. The house owner donot allow to enter the gate and she told us she afraid HIV and dislike PLWHA. We were always in trouble unless we enter to the patient home no one gives her breakfast, no one move and wash her she

always looking us with lomging eyes. Thus we will be out side of the home and wait until the house owner out of the house. After some time this PLWHA start getting improved, it was at that time the house owner called one of us and she disclose her HIV status is also positive. She was pretending that she dislikes HIV positive person while she knows her HIV status. After all she enrolled in the HCBC program and benefited from it.

One can understand how stigma and discrimination was the main barrior for PLWHA to be enrolled in HCBC program. Families and patients were tried to maintain their pride. The above story tells us how this woman was hiding herself while she knows the truth that HIV is a serious disease and need intervention, she choose to wait what is going happen to her. But at last she ddecide to disclose. HCBC program has brought a lot of changes as the FGD participants and indepth interview respondents. Most PLWHA are free to speak about their HIV statuus. It was result of HCBC that push the house owner to disclose her status. Stigma and discrimination reduced through coffee ceremonies, ART initiations, and ART adherance counseling also hhelp PLWHA tochange their attitude to wards ARTs. Thus PLWHA, families and the community benefited from Balcha HCBC program.

4.4 Vital Role of Balcha Idir

Balcha Idir has played a vital role to Give Home and Community Based Care to member of Idirs and for those who are HIV positive persons in lideta sub-city woreda-3 and adjacent woredas. Balcha Idir contributes for Lideta Sub-city Woreda -3 and adjacent Woredas when families,

friends and the community stigmatized HIV/AIDS infected and affected population. In the following section of the study we will go through how they stand the huge problem and became victorious.

4.4.1. Strengthen the Idir capacity for Inception OF HCBC

Neighborhood proximity, Gender, Place of work and other similar factors constitute, long standing community based organizations Idir in Ethiopia, the purpose of the Balcha's Idir establishment was for burial and bereavement to the neighborhood community. Idir members' sickness and the nationwide call is a factor that pushes Balcha Idir to fight against HIV/AIDS in an organized manner. Balcha Idir deeply involved in the HCBC services and engaged in facilitating efforts to curb the spread of new infections through the expansion of awareness creation. It also provides patient care and support by strengthening its internal capacity and by identifying external support. It was at this time the Idir contacted by NGO called HIDO. HIDO is an indigenous organization that was searching Idirs that who already engaged in fighting the Pandemic of HIV/AIDS. Thus HIDO contact other 19 Idirs who have good capacity to mainstream HCBC. And For those twenty Idirs trainings given to five members of each Idirs about Volunteerism, about Basic HIV/AIDS, leadership, communication, community mobilization, and resource mobilization. After that, the Idir organize community mobilization to initiate the community for volunteerism. Thus they found to many volunteers but for the purpose of supervision and management they recruit ten volunteers.The In-depth interview participant who is HCBC committee chairman remembers what was happened at that time:

It was the peak time of HIV/AIDS; victims were facing severe pain, hunger, rejection

from family and the community, stigma and discrimination, we found patients who was thrown out of their houses. Most of our Idir members also suffer from all those Problems, thus we select and start support for few who became destitute. It was at that difficult time HIDO contact us and gave training to build the capacity of HCBC committee. The other important event that help to engage HCBC program that the HCBC committee members sharing an experience with others who start HCBC Balcha Idir.

As the above story it is understandable how Balcha Idir engaged to rendering HCBC program by the problem of its own Idir members and other members of the community, and in addition to give response for the national calls combating the pandemic of HIV/AIDS. The HCBC committee became skillful in many ways to prevent new infection among the community, to care, and support PLWHA and family. The FGD participants of HCBC committee discussed as the following.

When we engaged in the HCBC program capacity of We the HCBC committee was also could convince our fellow Idir members to be engaged in the HCBC program to change idir by law to help each other at a time of sickness. The training first we receive were leadership, communication, basic HIV/AIDS and community mobilization for resources. These enabled us to start HCBC in organized manner, HIDO's support in

many ways helped us too much. We start the program by mobilized the community to contribute the its human resource, material and financial resources. Thus we have got plenty of volunteers and enough amount of resources to start the huge work.

The major activities that Balcha Idir has done at the initial period discussed by in-depth interview and focus group discussants. Balcha Idir build its capacity and searching external partner, and build the internal capacity by skills from the trainings that are basic knowledge of HIV/AIDS, communication skill, leadership skill community mobilization and resource mobilization skill these enabled them to start delivering Services to PLWHA and their families at their home environment.

As the respondent indicates, Balcha HCBC committee and the volunteer HCBC givers are working voluntarily, without payment. Without the devoted efforts of these groups, HCBC was impossible in this community

4.4.2. Community Mobilization

The above skills also helped the HCBC committee to survey the community to internalize the problems in the community and sort out possible solutions or resources in their own community. Thus the committee mapped their and found problems as well as resources in their own community. Recruiting ten community volunteers have been done, because volunteers were the main actor in the whole process HCBC program volunteers were expected to act as a close family member that gives love and care. The main objective of HCBC is to improve quality of life by giving holistic care. Thus giving holistic training to community volunteer care givers was mandatory. By collaboration of HIDO trainings about basic nursing care, basic HIV/AIDS

knowledge, post mortem, care Sexual Reproductive Health, family planning, condom demonstration, VCT and PMTCT services, and raising awareness of community members through coffee ceremonies given. The FGD participants of community volunteer care givers remember what have been done at the initial time. Trainings were given to them for two weeks theoretical and one week practical demonstration in hospitals and at community with the patient and the patient's families. Practical trainings in hospital helps them how to identify problems of the patients need and how to give nursing care. and give an understanding that PLWHA who have chronic disease is better to be at home environment, to allow the patient to fulfill its role at home (as a mother, as a father) minimize burden of the family and also helps neighbors to participate in caring process and minimize cost of visit.

After community volunteer care givers training Balcha Idir in collaboration with HIDO provide Kit. As one of the community volunteer care giver in-depth interview participant explanation the kit is filled by necessary materials like (gauze, bandage, cotton, alcohol, savlon, glove, scissor, nail cutter, umbrella and the bag it s elf. She also explain that on the umbrellas and the bags have written promoting ideas of HCBC it said "yebet lebet enkibekabe yhemumanene heyewt yashshelal" it means Home and community based care improves the lives of PLWHA. The volunteer care giver FGD participants also explain how they were doing with the kits and their umbrella as follows.

Balcha idir is not limited in our woreda but other neighboring woredas too were getting HCBC services. We have been told to carry our bags and using umbrella as advertisement and to patrole the villages. Patrolling help us to

identify PLWHA, people were calling us by looking our advertisements and show PLWHAs by distancing themselves not to be identified by the patient or his family. It was like this we and Balcha Idir HCBC prepared as a team to fight against HIV/AIDS.

Here we can draw a conclusion that Balcha Idir was prepared to help PLWHA and family by strengthening its entire capacity and also by reaching those who have the capacity to donate the HCBC program. By full commitment and combining the internal and external resources, Balcha Idir team (HCBC committee and community volunteer care givers) could deliver Home and Community Based Care in its target area effectively. The HCBC committee and community volunteer care givers are working voluntarily without payment. Without devotion of these HCBC team HCBC may not come true.

4.4.3 Net working

The Balcha HCBC program has referral networks different bodies these are, WFP programs, orphanages, hospitals, health centers, VCT centers, and other Government and Non Governmental organizations who give care and support to PLWHA. PLWHA were taken to hospital for treatment of opportunistic infections, VCT services, and to Anti Retro Viral therapies. The FGD participant of community volunteer care givers discussed as follows.

Our job description states that we should searching support for PLWHA.

Thus we always searching for Go's and NGO's for support of our PLWHA and

families. Asking woreda official's for hospitals free paper for PLWHA is our responsibility. The linkage that established with different bodieshelps our patients to get good response. In addition we Volunteers have Identity cards that indicate we are volunteers, this was helping us a lot in hospitals. At the first time we were helping more than five bed ridden PLWHA. and their families without the networking it was difficult to give the care and support in-addition to our responsibilities as a mother and as a wife at home. Sometimes in hospitals we might encounter problems waiting our turn and we back home late.What so ever we were very happy by what we were doing, we are satisfied by taking them to places of supports and if they are not able to go we have to replace PLWHA and took them place and act as a mother in schools and hospitals for vulnerable child also taking children to hospital.

The whole group of FGD participants stated that comparatively service delivery was good and life of PLWHA was improved because of the established networking. They also mentioned That HIDO was supporting by covering medical expenses and paying to them transport cost. However they mentioned some problems in some services like food supports, because they are not enough for PLWHA and their families who have weak economic situations. The FGD participants of community volunteer claim there was a problem of food when PLWHA graduates from WFP

and also food scarcity is in the houses of PLWHA because PLWHA were selling their WFP wheat to cover the cost of house rent. Thus housing problem of PLWHA is remaining PLWHAs main problem that couldn't be solved. All groups of participant claim that getting support for shelter was also another problem throughout the HCBC program.

4.4.4. Follow up and supervision

HCBC activities need strict follow up and supervision, since the whole process deal with human life. PLWHA's condition like unconsciousness, unable to feed by them, unable to go to clean by themselves, strict follow up of the service was one mechanism for the service delivery. The Indepth interview participant of the HCBC committee chairman explains the way of supervision as the following.

We monitor and evaluate our HCBC program at weekly, we receive reports from the community volunteer care givers and also it is their duty to give their plan and report for HIDO too thus HIDO could report to Sub -city HIV AIDS Prevention and Control office then Weekly the HCBC committee were doing meeting with the volunteer care givers and discusses about different issue. We were asked volunteers what problems happen in the past week, whether there are seriously sick PLWHA, whether there is a person in a problem, whether there are pregnant women who did not included in the PMTCT (Prevention Mother to Child Transmission, if there are PLWHA,s partner who did not Have done VCT, we also

check whether there are new PLWHA, to include in the service Like, WFP program, and to create linkage with other key supports to PLWHA. We were also going to PLWHA house to see whether they are taking proper care and support. If we donot supervise the care and support program may not come effective,some times we face volunteers who took PLWHAs items for their own or who do not deliver items properly. we immediately replace them by devoted and dedicated Community volunteer care givers.

Balcha HCBC program have been doing proper supervision as we followed the chairman s idea there was strict follow-up of the program. They were asking volunteers how they are doing ,what problems encounter, they were also asking PLWHA how their service delivery what services are poor and also HCBC committee doing need assessment by being present at home. Community volunteer care give FGD participants also explain how the service monitoring and follow up done.

There was weekly meeting between us and the HCBC committee and we learn each other by sharing experiences. There were difficult problems of patients for example if I have got a patient with serious problem I share experience with fellow care givers how to handle the case. In the mean time the HCBC committee members also helping in so many ways, they also asking us how we are doing, if we have new patients or not. The HCBC committee was also visiting PLWHA

especially when we enroll new patient, they were dong need assessment of the PLWHA and his family's house hold to recommend the need of the services.And also participating in Recruiting PLWHA for WFP program and also they were selecting PLWHA to graduate from the service. Community volunteer care giver report also was given to Balcha HCBC program and to HIDO which work in collaborate with us. The report also must report to HAPCO by HIDO which needs reports of HIV/AIDS activities and WFP Report.

Monitoring and evaluation was effectively done by the HCBC committee every week the HCBC committee attend meeting with community volunteer care givers. This meetings help to identify gap, to initiate volunteers and for experience sharing. Thus Balcha Idir HCBC was doing strict follow up and supervision for better service delivery.

CHAPTER 5, CONCLUSION AND RECOMMENDATION

5.1 Conclusion

This program intervention has made significant differences in quality of life at the individual, family and community level. Patients with improved health status are thankful for the service. The existence of dedicated caregivers in the program has brought tremendous attitudinal change in the community. There is a high appreciation by the FGD participants of PLWHA for what those caregivers are doing, as opposed to the resistance at the start of the program. Most caregivers are proud for what they contribute and have developed a sense of responsibility for their community In general, there is positive attitudinal change towards voluntarism and the caregivers are witnessing that participation in the service has had a positive impact on their personal lives due to the acquisition of knowledge and skills through their engagement in the HCBC program. The involvement of the caregivers in the care provision has positively influenced the neighborhood towards visiting and supporting patients in the neighborhood; In addition, emphasis has been given to the integration of Sexual and Reproductive Health in the HCBC program. This program has also brought a unique partnership between the community organizations, GOs and NGOs. The long standing Community Based organization Balcha Idir could show the community its own problem and also by mobilizing the community human, material, and financial resources could deliver HCBC for those infected and affected community members. In addition Balcha Idir also create referral and networking to give holistic HCBC service.

- Balcha Idir HCBC program initially started by sickness, hunger, destituteness, of fellow members due to HIV/AIDS. The second reason that Balcha Idir involving in combating the deadly disease to give response for the call of nation.
- Balcha Idir could support PLWHA and family by searching different means: mobilizing the community to tackle problems caused by HIV/AIDS and to bring its own human (Community Volunteer care givers), material and financial resources.
- Balcha Idir HCBC committee and community volunteer care givers were not paid they were promoting values.
- Balcha Idir HCBC committee were could convince their fellow Idir members to help each other at sickness of fellow member.
- Balcha Idir could help PLWHA in their woredas and neighboring woredas who are not Idir member, this could show Balcha Idir is showing responding the national call.
- Balcha Idir was leading the HCBC program wisely by networking and referral with other GOs and NGOs.
- Monitoring and supervision activities were done by the HCBC committee to give timely assistance of PLWHA by volunteer's field visits (in the PLWHA home) and attending weekly meeting were strategies employed to supervise program performance and effectiveness.
- Balcha Idir was addressing psychological and psychosocial problems could minimize stigma by create awareness through coffee ceremony programs at individual, family, and community level.

- The Community volunteer care givers who were the back bone of the HCBC program were serving their own community without payment.
- These dedicated and devoted volunteers were implementing the HCBC program. The community volunteer care givers were care giver, cooker, cleaner and confidante to PLWHA. And they were also were as a mother for vulnerable and orphan children.
- Community volunteer care givers were providing Holistic care to PLWHA.
- Community volunteer care givers were transferring skills for PLWHA and family that to initiate self care and family care. And it helps to maximize the number of PLWHA to be enrolled in the HCBC program.
- Community volunteer care givers are very happy and satisfied by their volunteer work.
- PLWHA were in problematic condition due to many factors –these factors are Psychosocial problems and psychological problems (resulted from stigma and discrimination), serious manifestation of the disease, poverty, food problem and shelter problem were which found by community volunteer care givers and HCBC committee assessment. But a problem even after the HCBC for most PLWHA.
- PLWHA are fully satisfied by the program of Balcha HCBC program that changed their life and could raise their children.
- Currently Most PLWHA are healthy enough to help themselves and their family but due to the economic condition still they are in need of food and shelter.

5.2. Recommendation

As the study indicate HCBC program came through the problem arise in the entire community of Balcha Idir and it is also the response for the call of nations. The program brought a change to

improve the life of PLWHA and their family, becaust the care was holistic in nature except for some cares like food and shelter which are insufficient. The Balcha Idir community could solve

its own problem by its own entire human (community volunteer care giver from the community) material and financial resources. The Idir also could change its byelaw which it states "the Idir established to help each other in burial and bereavement of fellow Idir members and their families". After getting different types of trainings the Idir HCBC committee could convince their members "to help each other during sickness of fellow Idir members" Thus the involvement of Balcha idir in HIV/AIDS Home and community based care service has a great amount of result in reduction of stigma and discrimination. Thus the researcher suggest some recommendation about the services rendered by Balcha Iddir HCBC program.

- In order to provide Job opportunities for once bed ridden PLWHA Balcha Idir by create net working with Go and NGO need to plan together for productive engagements of PLWHA. and or link the HCBC program with income generating activities to raise economic condition of PLWHA that PLWHA could got food and can pay for their shelter.
- The prevention of HIV/AIDS new infection needs to be inconsideration by concerned bodies.

- The case of orphan and vulnerable children needs greater consideration, wholistic care and support should avail through linkage with GOs and NGOs that could help them.
- To promote volunteerism community volunteer care givers must be acknowledged and job opportunities must avail through Go and NGOs.
- Community Based organizations like Balcha Idir must acknowledged and their capacity must be Build.
- Since the population of this study is very limited in size the researcher recommend further and wide study in the area.

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Appendex- 1 **Questions for PLWHA, community volunteer care givers and Iddir HCBC committee**

The questionair is intended to your genuine and frank response to the questions will have a paramount contribution to the success of this research.

Assessment of Socio demographic characteristics Balcha Idir beneficieries

No	Questiones	Response classification	code
1	Sex of the respondent	• Male =1 • Female=2	
2	How old are you in the last birth day?	• Age_____ • Don't know =99 • No response =89	
3	What is your marital status?	• Single=1 • Married=2 • Divorce=3 • Widow=4 • Other specify_____	
4	Religion	• Coptic Orthodox=1 • muslim=2 • Protestant=3 • No response=4 • Other=5	
5	What is your last level of education?	• Illiterate=1 • Read and write=2 • Grade 1-8 =3 • Grade 9-12 =4 • Collage -5	
6	What is your current occupation?	• Jobless =1	

		• Student=2 • Government employee -3 • Private employee =4 • Daily labor =5 • Petty trader =6 • House wife =7 • Other specify _____	

Assessment of HCBC service Questions for PLWHA in Balcha Idir

No	Questions	Response classification	code
1	When you start HCBC services?	Specify_____	
2	How was your health condition when you get first the HCBC services?	• Ambulatory =1 • Bed ridden =2 • Able to work =3	
3	What kind of services did you get from HCBC program?	• Counseling = 1 • Nursing care =2 • Nutritional support =2 • ART follow up =3 • Other specify =5	
4	Who was caring you? (can be more than one)	• My family =1 • Community volunteer =2 • My Neighbors =3 • Other specify _____	
5	If the answer to Q 4 is a volunteer in how many days a week give the service to you?	• Daily =1 • Every other day= 2 • Every two days =3	

		• Every three days =4 • Other specify =5	
6	Did the volunteer come on time?	• Yes =1 • No =2 • No response =3	
7	What is your satisfaction level of the HCBC service you get from the program?	• Not satisfied =1 • Satisfied =2 • Very satisfied =3 • No response =4	
8	Who perform the house hold work chores when you were sick?	• My family =1 • My neighbors =2 • Volunteer care givers =3 • No response =4	
9	Can you get the volunteer care giver, when you are in need of him/her?	• Yes =1 • No =2 • No response =3	
10	How much is your life changed after the HCBC service?	• Changed for better =1 • No change = 2 • Other specify =3_____	
11	Who was taking you to hospital when it is needed?	• By myself =1 • Family member =2 • My neighbor =3 • Volunteer care giver =4	
12	Who was covering transport and medical cost for you?	• Specify_____	
13	How satisfied are you with measure taken to assure the confidentiality about your HIV status?	• Not satisfied =1 • Satisfied =2	

		• Very satisfied =3 • No response =4	
14	Have you been stigmatized by others?	• Yes =1 • No =2 • No response =3	
15	If the answer for Q 13 is yes, then what was the response of the HCBC volunteer care giver? (Can be more than one)	• Awareness creation to family and others=1 • Proper counseling=2 • Do nothing =3	
16	Have you started taking ART?	• Yes =1 • No =2 • No response =3	
17	If yes for Q 16 have you got adherence counseling by the volunteer care giver?	• Yes =1 • No =2 • No response =3	
18	Is your health status allow you to engage to your daily activity?	• Yes =1 • No =2 • No response =3	
19	If yes for Q 19 in what type work you engaged?	• Specify_____	
20	What was your main problem due to your sickness? (can be more than one)	• Problem to get food=1 • Problem of stigma and discrimination =2 • Problem of shelter =3 • Psychological problem =4 • Other specify =5	

21	How you rate the whole HCBC program of Balcha Idir?	• Specify_____	
22	What was your problem that inhibits you from receiving HCBC at first?	• Specify _____	

In – depth interview for PLWHA to asses HCBC service in Balcha Idir

1. How did you become client of Balcha Idir?
2. Are you a member of Balcha ldir? If you are not a member of the Idir and how do Balcha Idir support you?
3. When the volunteer care giver came to you for the first time?
4. What are the types of HCBC services that you got?
5. Who is taking you to hospital? And how do they take you?
6. Who was doing the household chores?
7. Have you been stigmatized? How?
   Would you explain more?
8. How can you resist the stigma?
   Would you explain?
9. Are you satisfied by the work of volunteer care givers?
   Give an example
10. What was your benefit from the home and the community based care activities? \
11. Can you tell me the confidentiality level concerning your IV/AIDS status?
12. Do you have any suggestions and comments.

A Guide line of FGD for PLWHA

1. What kind of service you benefit from Balcha HCBC program
2. In what mechanism they provide the services? How do you get the approach?
3. Do you think the services were fulfilled the needs of PLWHA?If not what missed?
4. Do you get services that improve your psychological problems (counseling's)?
5. What is your opinion towards the community volunteer care givers service delivery?
6. What is your opinion towards Balcha HCBC committee leadership of the HCBC program?
7. Do you think the HCBC service improved the quality of life of PLWHA?
8. What is your feeling, attitude and reaction towards the service provided by Balcha Idir HCBC program?

9. What you observe in the Idirs members and the community's attitude as a result of HCBC program? Is stigma and discrimination reduced?

10. What was your challenge encountered to be enrolled?

Indepth interview guide and for FGD Guide line for community volunteer care givers

A Guide line of in-depth interview for community care giver

1. Are you community volunteer care giver?
2. What motivates you to become a volunteer HCBC?
3. Have you got HCBC training and how long was the training?
4. Describe the types of HCBC activities that performed by community volunteer Care givers? And how often you gave the service?
5. Describe how you conduct HCBC to PLWHA in your community? (Give details to approaches and types of cares)
6. How often your kit is refilled? And what was the source of the refilling?
7. How do you see the linkage with other programs (food aid, income generating activities)?
8. What is the involvement of HCBC committee in HCBC service?
9. What is the major problem you encountered during the provision of HCBC for PLWHA? And what was your response and solution for problem and challenges?
10. What mechanism do you use for prevention of HIV /AIDS in your community
11. What mechanism you use to minimize stigma and discrimination?

A Guide line of FGD for community volunteer care givers

1. How did you become a community volunteer care giver?
2. Have you got training about how to give care? What kinds of training you got?
3. What was care givers responsibility?
4. How do you get the problem of PLWHA before HCBC services?
5. What kinds of services were given to PLWHA and families?
6. How much the services were useful to PLWHA, family and the community?
7. How much the HCBC committees support you?
8. Did the services meet the needs of PLWHA and family?
9. Did you transfer skills to families and Neighbors? How?
10. How satisfied PLWHA by your service delivery? If did not satisfied why?
11. What was your challenge in rendering HCBC service?
12. Do you think HCBC service improved PLWHA's life?
13. What was your relationship with HCBC committee?
14. Do you have any suggestion or recommendation?

Guide line for in- depth interview of HCBC committee

1. Can you explain how Balcha Idir engages in HCBC activities?
2. Are you providing HCBC only to your ldir members?
3. Would you describe the linkage between Balcha Idir and other support programs? (Please mention the collaborative programs and organizations who working with you)

4. What is the role of Balcha Idir HCBC committee? (please explain)
5. Can you explain the role of Balcha HCBC committee particularly in community mobilization? (can you mention activities done by community mobilization)
6. What was your measure when difficult situations arise like problem of shelter?
7. What constraints does Balcha Idir encounter as you provide HCBC to PLWHA? (please explain)
8. Would you explain the level of support of your partners and stake holder's support?
9. Do you network to support the HCBC program? If yes with whom you are net worked?
10. Do you have any comment that you want to add on the overall activities of HCBC?

A Guide line of FGD for HCBC committee

1. For what purpose Balcha Idir established?
2. Have you changed your bylaw to help each other while the member is sick?
3. Why you start HCBC program? (What motivate you)
4. What problems you observe in PLWHA for the first time?
5. Are you rendering the service to your Idir members or are you giving for the outside community?
6. If you rendered the service to the outside community too why?
7. Do you have a partner to work with?
8. What was your source of income?
9. How can you get volunteer community care givers?
10. How you support the community volunteer care givers?
11. Do you visit bed ridden PLWHA?
12. What services you deliver to PLWHA and their families?
13. Do you think you meet the need of PLWHA and families?
14. Does member of the community involved? If yes how?
15. Do you have a mechanism to monitor and evaluate your program?
16. Do you Net work to support the HCBC program if yes with whom you network?
17. What was your challenge during rendering the services?

An assessment of Home and Community Based Care: Responses from PLWHA, Volunteer care givers and Balcha Idir HCBC comitee, in Lideta sub city woreda-3

APPENDEX- 2 Question for PLWHA, community volunteer care givers and Iddir HCBC committee

Concent form

Welcome to this interview.

My name is _____ I am here to collect information about Home and Community Based Care of Balcha Idir. Its aim is to assess the Home and Community Based Care and you were a beneficiary of the HCBC program, now I ask you some questions about Home and community Based Care program for that you may answer according to your knowledge and experience. All answers comments, suggestions are welcome. I would like to have your point of view and to be open to the interview. So feel free to express your opinion honestly and openly. Your name as well as address is not recorded in this interview to protect your confidentiality. You have also the right not to answer questions which might be inconvenient to you. However, your information is very important to evaluate and improve the program. Again we would like to confirm you that all your comments are confidential and used for research purpose only.

Therefore, are you willing to participate in this interview?

If yes, thanking her/ him and continue the questions.

If No, thanking him or her and stop in here.

Date of interview: _____

Name of interview ----------

Consent form

Welcome to this interview.

My name is _____ I am here to collect information about Home and Community Based Care of Balcha Idir. its aim is to assess the Home and Community Based Care and you were a community volunteer care giver in the HCBC program, now I ask you some questions about Home and Community Based Care program for that you may answer according to your knowledge and experience. All answers comments, suggestions are welcome. I would like to have your point of view and to be open to the interview. So feel free to express your opinion honestly and openly. Your name as well as address is not recorded in this interview to protect your confidentiality. You have also the right not to answer questions which might be inconvenient to you. However, your information is very important to evaluate and improve the program. Again we would like to confirm you that all your comments are confidential and used for research purpose only.

Therefore, are you willing to participate in this interview?

If yes, thanking her/ him and continue the questions.

If No, thanking him or her and stop in here.

Date of interview: _____

Name of interview ----------

Consent form

Welcome to this interview.

My name is _____ I am here to collect information about Home and Community Based Care of Balcha Idir, its aim is to assess the Home and Community Based Care and you were a Home and Community Based Care committee in Balcha Idir. Now I ask you some questions about Home and Community Based Care program for that you may answer according to your knowledge and experience. All answers comments, suggestions are welcome. I would like to have your point of view and to be open to the interview. So feel free to express your opinion honestly and openly. Your name as well as address is not recorded in this interview to protect your confidentiality. You have also the right not to answer questions which might be inconvenient to you. However, your information is very important to evaluate and improve the program. Again we would like to confirm you that all your comments are confidential and used for research purpose only.

Therefore, are you willing to participate in this interview?

If yes, thanking her/ him and continue the questions.

If No, thanking him or her and stop in here.

Date of interview: _____

Name of interview ----------

APPENDEX-3 Amharic version questions for PLWHA, community volunteer care givers and Iddir HCBC committee

በባልቻ ዕድር ሥር የቤት ለቤት ክብካቤ ሲያገኙ የነበሩ ከቫይረሱ ጋር የሚኖሩ ሰዎች የማህበራዊና ኢኮኖሚያዊ ሁኔታ ዳሰሳ፡፡

መልስ መስጫ

1. **የመልስ ሰጪው ፆታ** - **ወንድ** - 1
   - **ሴት** - 2
2. **ዕድሜ** _____
   - **ዕድሜ** _____
   - **ዕድሜዬን አላውቅም** - 99
   - **መልስ የለም** - 89
3. **የጋብቻ ሁኔታ**
   - **ያላገባ** - 1
   - **ያገባ** - 2
   - **የተፋታ** - 3
   - **የሞተበት (ባት)** – 4
   - **ሌላ ከሆነ ይለፁ** _____
     _____
4. **ኃይማኖት**
   - **ኦርቶዶክስ ተዋህዶ** - 1
   - **እስልምና** - 2
   - **ፕሮቴስታንት** - 3
   - **መልስ የለም** - 4
   - **ሌላ** - 5
5. **የትምህርት ደረጃ**
   - **ያልተማረ** - 1
   - **ማንበብና መጻፍ** - 2
   - **ከ1-8 ክፍል** - 3
   - **ከ9-12 ክፍል** - 4
   - **ኮሌጅ** - 5
6. **አሁን የሚሠሩበት ሥራ** **መልስ መስጫ**
   - **ሥራ አጥ** - 1
   - **ተማሪ** - 2
   - **የምግስት ሠራተኛ** - 3
   - **የግል ተቀጣሪ** - 4
   - **የቀን ሥራ** - 5
   - **ነጋዴ** - 6
   - **የቤት እመቤት** - 7
   - **ሌላ ከሆነ ይግለፁ፡** _____

ዕዝል 2

በባልቻ ዕድር ሥር የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ የተደረገላቸው ቫይረሱ በደማቸው ውስጥ ያለ ሰዎች የኤች አይ ቪ ሁኔታ ዳሰሳ፡፡

1. **የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ የተደረገሎት ከመቼ ጀምሮ ነው?**
   ይግለፁ፡
2. **የመጀመሪያውን ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ሲያገኙ የጤናዎ ሁኔታ እንዴት ነበር?**
   - **ተንቀሳቃሽ** - 1
   - **የአልጋ ቁራኛ** - 2
   - **አቅም ያለው መስራት የሚችል** - 3
3. **በማህበረሰብ አቀፍ የቤት ለቤት እክብካቤ ፕሮግራም ያገኙት አገልግሎት፡**
   - **ምክር** - 1
   - **የማስታመም አገልግሎት** - 2
   - **የምግብ ድጋፍ** - 3
   - **የፀረ ኤች አይ ቪ ኤድስ ህክምና ክትትል** - 4
   - **ሌላ ከሆነ ይግለፁ -** _____
4. **ማን ነበር የሚንከባከቦት (ከአንድ በላይ ሊሆኑ ይችላሉ)** **መልስ መስጫ**
   - **ቤተሰብ** - 1
   - **የማህበረሰብ በጎፈቃደኛ** - 2
   - **ጎረቤቶቼ** - 3
   - **ሌላ ከሆነ ይግለፁ** _____
5. **ለጥያቄ ቁጥር 4 የሰጡት መልስ "የማህበረሰብ በጎ ፈቃደኛ" ከሆነ በሳምንት ስንት ቀናት አገልግሎት ያገኙ ነበር?**
   - **በየቀኑ** - 1
   - **አንድ ቀን እያለፈ** - 2
   - **በየሁለት ቀኑ** - 3
   - **በየሦስት ቀኑ** - 4
   - **ሌላ ከሆነ ይግለፁ** _____
6. **በጎ ፈቃደኛው ሁሌ በሰዐቱ ይገኝ ነበር?**
   - **አዎን** - 1
   - **አይደለም** - 2
   - **መልስ የለም** - 3
7. **በማህበረሰብ አቀፍ የቤት ለቤት አገልግሎት ፕሮግራም የርካታዎ መጠን ምን ያህል ነው?**
   - **ምንም አያስደስትም** - 1
   - **ያስደስታል** - 2
   - **በጣም ያስደስታል** - 3
   - **መልስ የለም** - 4
8. **ታመው ሳሉ የቤትዎን ሥራ የሚሠራሎት ማን ነበር?**
   - **ቤተሰቤ** - 1
   - **ጎረቤቶቼ** - 2
   - **በጎፈቃድ ተንከባካቢዎች** - 3
   - **መልስ የለም** - 4
9. **በጣም በሚያስፈልግዎ ጊዜ የበጎፈቃድ ተንከባካቢውን ያገኙት ነበር?**
   - **አዎን** - 1

- አይደለም - 2
- ሌላ ከሆነ ይግለፁ _____

10. የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ካገኙ በኃላ ህይወትዎ ምን ያህል ተለወጠ?
    - ወደ ተሸለ ደረጃ ተለውጧል - 1
    - ምንም ለውጥ አልነበረም - 2
    - ሌላ ከሆነ ይግለፁ _____
11. አስፈላጊ ሲሆን ወደ ሆስፒታል የሚያመላልስዎት ማን ነበር?
    - ራሴ ብቻዬን - 1
    - የቤተሰቤ አባላት - 2
    - ጎረቤቶች - 3
    - በጎ ፈቃድ ተንካባካቢ - 4
12. የትራንስፖርት የህክምና ወጪ የሚሸፍንሎት ማን ነበር?
    - ይግለፁ _____
13. የእርስዎ የኤች አይ ቪ ሁኔታ ምስጢር መጠበቁ ምን ያህል ደስተኛ ነዎት?
    - ደስተኛ አይደለሁም - 1
    - ደስተኛ ነኝ - 2
    - በጣም ደስተኛ ነኝ - 3
    - መልስ የለም - 4
14. በሌሎች ተገልለዋል ወይ ?
    - አዎን - 1
    - አይደለም - 2
    - መልስ የለም - 3
15. ለጥያቄ ቁጥር 14 የሰጡት መልስ "አዎን" ከሆነ፣ የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ሰጪው የወሰደው ርምጃ ምንድን ነው? (መልሱ ከአንድ በላይ ሊሆን ይችላል)
    - ለቤተሰብና ለሌሎችም ስለ ጉዳዩ ግንዛቤ ማስጨበጥ - 1
    - ትክክለኛ ምክር መስጠት - 2
    - ምንም አለማድረግ - 3
16. የፀረ ኤች አይ ቪ ህክምና ጀምረው ነበር?
    - አዎን - 1
    - አይደል - 2
    - መልስ የለም - 3
17. ለጥያቄ ቁጥር 16 የሰጡት መልስ "አዎን" ከሆነ በበጎ ፈቃድ አገልጋዩ ከመድሀኒቱ ጋር የመላመድ ምክር ያገኙ ነበር?
    - አዎን - 1
    - አይደለም - 2
    - መልስ የለም - 3
18. የጤና ሁኔታዎ የዕለት ሥራዎን በትክክል ለመሥራት ያስችሎት በነር?
    - አዎን - 1
    - አይደለም - 2
    - መልስ የለም - 3
19. ለጥያቄ ቁጥር 19 የሰጡት መልስ "አዎን" ከሆነ፣ ምን ዓይነት ሥራ ነበር የሚሠሩት?
    - ይግለፁ _____
20. ከህመምዎ ጋር በተያያዘ ትልቁ ችግርዎ ምን ነበር? (መልሱ ከአንድ በላይ ሊሆን ይችላል)
    - የምግብ ማግኘት ችግር - 1
    - የማግለልና የመድልዎ ችግር - 2

- የመጠለያ ችግር - 3
- የሥነ ልቦና ችግር - 4
- ሌላ ካለ ይግለፁ _____

21. በባልቻ ዕድር ሥር ይሰጥ የነበረውን ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎትን እንዴት ይገልፀታል?
    - ይግለፁ፡ _____
22. ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤን ለመጀመሪያ ጊዜ ለመቀበል አደጋች የሆነበዎት ምክንያት ምን ነበር?
    - ይግለፁ፡ _____

በባልቻ ዕድር ስር ስለተከናወነው ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ዳሰሳ የኤች አይ ቪ ቫይረስ በደማችው ውስጥ ለሚገኝ ዜጎች የቀረበ ቃለ መጠይቅ

1. የባልቻ ዕድር አባል ነዋት ?
2. የዕድሩ አባል ካልሆነ ዕድሩ እንዴት ሊደግፎዎት ቻለ?
3. ለመጀመሪያ ጊዜ የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ሰጪ ወደ እርሶ የመጣው መቼ ነው ?
    - ይህንን ይበልጥ ሊያብራሩልኝ ይችላሉ?
4. እርስዎ ያገኙት የነበረው ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ዓይነቶች ምን ምን ነበር ?
5. ወደ ሆስፒታል የሚያመላልስዎት ማን ነበር? በምን ነበር የሚመላለሱት?
6. የቤት ውስጥ ሥራ የሚሠራው ማን ነበር?
7. መገለል ደርሶበት ያውቃል ? እንዴት እንደነበረ ይበልጥ ያብራሩልን፡፡
8. ይህንን መገለል እንዴት ተቋቋሙት ? ይበልጥ ያብራሩት፡፡
9. የቤት ለቤት እንክብዳቤ በሚሰጡት አገልጋዮች ደስተኛ ነበሩ ? ምሳሌ ይስጡ፡፡
10. ከማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት ያገኙት ጥቅም ምንድን ነበር ?
11. የስርዎን የህክምና ጉይዳ በሚመለከት ሚስጡርዎ ምን ያህል እንደተጠበቀ ሊገልፁልኝ ይችላሉ?
12. ሌላ ተጨማሪ አስተያየቶችና ጥቆማዎች ካሎት ይግለፁ

ቫይራሱ በድማችው ወስጥ ለሚገኙ የትኩረት ቡድን ውይይት መመሪያ

1. ከባልቻ ዕድር ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት ተጠቃሚ ሆነዋል ?
2. በምን ዓይነት መንገድ ነው ይህ አገልግሎት የሚደርሰዎ? አቀራረቡስ እንዴት ነበር?
3. ይቀርቡ የነበሩት አገልግሎቶች ቫይረስ በደማችው ውስጥ ለሚገኙ ዜጎች ተገቢውን ፍላጎት የሚያሟላ ነበር ወይ? ካልሆነ የጎደለው ምንድን ነው?
4. የስነ ልቦና ችግርዎን የሚያሻሽል አገልግሎት (ምክር(አግኝተው ነበርን) ?
5. ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት ሰጪዎች ላይ ምን አስተያየት አለዎት?
6. የባልቻ ዕድር ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት የቤት ለቤት አገልግሎት ፕሮግራም አመራር ላይ ያለዎት አስተያየት ምንድን ነው ?

7. የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት ቫይረሱ በደማቸው ውስጥ የሚገኝ ዜጎችና ቤተሰቦች ህይወት እንዲሻሻል አድርጓል ብለው ያምናሉ?
8. የባልቻ ዕድር ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት በተመለከተ የእርስዎ ስሜት አመለካከትና ምላሽ ምንድን ነው?
9. ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ፕሮግራም የተነሳ በዕድሩ አባላትና በማህበረሰቡ አመለካከት ላይ ያስተዋሉት ምንድን ነው? መድሎና ማግለል ቀንሷል ?
10. በቤት ለቤት እንክብካቤ በመታቀፍ ያጋጠመዎት ተግዳሮት ምንድን ነበር?

ለማህበረሰብ አቀፍ ቤት ለቤት እንክብካቤ ሰጪዎች ቃለ መጠይቅ መመሪያ

1. ማህበረሰብ አቀፍ ቤት ለቤት እንክብካቤ አገልግሎት ሰጪ ነዎትን ?
2. ማህበረሰብ አቀፍ ቤት ለቤት እንክብካቤ አገልግሎት ሰጪ ለመሆን ያነሳሳዎት ምንድን ነው?
3. ማህበረሰብ ኣፍ ቤት ለቤት እንክብካቤ አገልግሎት ስልጣና አግኝተዋል? ስልጠናውስ ለምን ያህል ጊዜ ነበር?
4. በማህበረሰብ የቤት ለቤት እንክብካቤ ሰጪዎች ይቀረብ የነበረው የአገልግሎት ዓይነቶችን ይብራሩ፡፡ እኒዘህንስ አገለግሎቶች በምን ያህል ጊዜ ያቀርቡ / ይሰጡ ነበር ?
5. በማህበረሰቡ ውስጥ ማህበረሰብ አቀፍ ቤት ለቤት እንክብካቤ አገልግሎት ቫይረስ በደማቸው ውስጥ ለሚገኝ ዜጎች እንዴት ታድርሱ /ታቀርቡ እንደነበረ ያብራሩ፡፡ (የአገልግሎቱ ዓይነትና አቅርቦቱን በዝርዝር ያስረዱ)
6. ለበጎ ፈቃደኛ የእንክብካቤ እቃዎች ቦርሣ /ሣጥን በምን ያህል ጊዜ እንደገና ይሟላሉ? የሚያሟላላችሁስ ማነው?
7. ከሌሎች ፕሮግራሞች (የምግብ ርዳታ አነስተኛ ገቢ ማስገኛ) ጋር ያላችሁን ተያያዥነት /ግንኙነት እንዴት ይታያል?
8. የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ኮሚቴ በእንክብካቤ አገልግሎት ውስጥ ያለው ተሳትፎ ምን ያህል ነው ?
9. እርስዎ ቫይረሱ በደማቸው ውስጥ ለሚገኙ ዜጎች ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ሲያደርጉ ያጋጠሞት ዋና ችግር ምንድን ነበር ? ላጋጠሞት ችግርና ተግዳሮት የሰጡት ምላሽና መፍትሔ ምን ነበር?
10. በህብረተሰቡ መካከል ኤቼ አይቪ .ኤድስን ለመከላከል ምን ዘዴ ተጠቅመዋል?
11. መድሎና መገለልን ለመቀነስ ምንዘዴ ተጠቅመዋል?

በማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ በጎ ፈቃደኛ አገልግሎት ሰጪ የትኩረት ቡድን ውይይት መመሪያ

1. የቤት እንክብካቤ በጎ ፈቃደኛ ሰጪ ሊሆን ቻለ?
2. አገልግሎቱን መስጠት እንዲችሉ ሥልጠና ወስደዋል ? ሥልጠናው ምን ዓይነት ነበር?
3. የእንክብካቤ ሰጪዎች ኃላፊነጽ ምን ነበር ?
4. ከማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገለግሎት በፊት ቫይረሱ በደማቸው ውስጥ የሚገኙ ዜጎች ችግር እንዴት ነበር
5. ቫይረሱ በደማቸው ውስጥ የሚገኝ ዜጎችና ቤተሰቦቻቸው የተሰጠው አገልግሎት ምን አይነት ነበር ?
6. ቫይረሱ በደማቸው ውስጥ የሚገኜ ዜጎች ፣ በተሰቦቻቸውና ለማህበረሰቡ አገልግሎት ምን ያህል ጠቃሚ ነበር ?

7. የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ኮሚቴ ምን ያህል ድጋፍ አድርጎለታል?
8. የቀረበው የእንክብካቤ አገልግሎት ባይረሱ በዲማቸው ውስጥ የሚገኝ ዜጎችንና ቤተሰቦቻቸውን ፍላጎት ያማከለ ነበር ወይ?
9. የርስዎን የእንከካቤ ክህሎቶትን ለተጠቃሚው፣ ለቤተሰብና ለጎረቤቶች አስተላልፈዋል ወይ?እንዴት?
10. ለእርስዎ እንክብካቤ አገልግሎት አሰጣጥ ቫይረሱ በደማቸው ውስጥ የሚገኝ ዜጎች ምን ያህል ረክተዋል ካልረሱ ለምን ?
11. በማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት ሲሰጡ ያጋጠሞት ተግዳሮት ምን ነበር?
12. ማህበረሰብ አቀፍ የቤት እንክብካቤ አገልግሎትቫይረሱ በደማችው ውስጥ የሚገኝ ዜጎችን ህይወት አሻሽሏል ብለው ያሰባሉ?
13. የእርሰዎና የማህበረሰብ አቀፍ የቤት ለቤት እንክካቤ ኮሚቴ ግንኙነት እንዴት ነበር ?
14. የሚሰጡን አስታያየት ወይም ጥቆማ ይኖራል ?

APPENDEX-4 Amharic version concent form **for PLWHA, community volunteer care givers and Iddir HCBC committee**

ለማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ኩሚቴ አባላት ቃለ መጠይቅ መመሪያ

1. ባልቻ እድር በማህበረሰብ አቀፍ ቤት ለቤት እንክብካቤ ውስጥ እንዴት እንደተሳተፈ ሊገልፁልኝ ይችለሉ?
2. ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት የምትሰጡት ለዕድሩ አባት ብቻ ነውን ?
3. በባልቻ ዕድር እና በሌሎች አጋዥ ፕሮግራም መካከል ያለውን መያያዝ ያብራሩልን እባክዎ (ከእናንተ ጋር በትብብር የሚሠሩ ፕሮግራሞችና ድርጅቶችን ይጥቀሱ)
4. እባክዎን የባልቻ እድር የማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ኮሚቴ የሥራ ድርሻን ይግለጹ፡፡
5. ህብረተሰቡን በማንቀሳቀስ ጉዳይ የኮሚቴው ድርሻ ምን እንደነበረ ቢገልፁ (ህብረተሰቡን በማንቀሳቀስ ምን ምን ስራዎች እንደተሰሩ ቢገልጹ)
6. የመጠለያ ችግርን የመሰለ አስቸጋሪ ሁኔታ ሲፈጠር ምለሻች ምን ነበር?
7. እባክዎን የባልቻ ዕድር ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎትን ቫይረሱ በደማቸው ውስጥ ለሚገኝ ዜጎች ሲሰጥ ያጋጠመው እጥረት ምን እንደነበረ ይግለፁልን?
8. የእናንተ አጋሮችና የሚመለከታቸው አካላት ድጋፍ ምን ያህል እንደነበር የግለፁ
9. ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ፕሮግራሙን ለማገዝ ከሌሎች አጋገሮች ጋር ጥምረት ፈጥራችሁ ነበርን? ከሆነ ከነማን ጋር ተጣምራችሁ?
10. በአጠቃላይ በማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ እንቅስቃሴ ላይ ሌላ አስተያየት ካሎዎት ይግለፁ

ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ኩሚቴ ትኩረት ቡድን ውይይት መመሪያ

1. የባልቻ ዕድር የተቋቋመበት ዓለማ ምን ነበር?
2. የዕድሩ አባል ሲታመም እርስ በርስ ለመረዳዳት የዕድሩን ህግ ቀየራችሁት ?
3. ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ፕሮግራም ለምን ጀመራችሁ ?ምን አነሳሳችሁ?
4. ቫይረሱ በደማቸው ውስጥ የሚገኝ ዜጎች ላይ ለመጀመሪያ ጊዜ ምን ችግር አስተዋላችሁ?
5. አገልግሎቱን የምትሰጡት ለእድሩ አባላት ብቻ ነውን ? ወይስ ከእድሩ ውጪ ላለው ህብረተሰብ ጭምር ነው?
6. ለምንድን ነው ከዕድሩ ውጪ ለሚገኘው ህብረተሰብ አገልግሎቱን የሰጣችሁት?

7. አብሮአችሁ የሚሰራ አጋር አላችሁ?
8. የገቢያችሁ ምንጭ ምንድን ነበር ?
9. ማህበረስ አቀፍ የቤት ለቤት እንክብካቤ አገልግሎት ሰጪ በጎ ፈቃደኞችን እንዴት አገኛችሁ?
10. ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ አገልሎት ሰጪ በጎ ፈቃደኞችን እንዴት ትደግ,ጋፏቸው ነበር?
11. የአልጋ ቁራኛ የሆኑ ቫይረስ በደማቸው ውስጥ የሚገኝ ዜጎችን ጉብኝተው ያውቃሉ?
12. ቫይረስ በደማቸው ውስጥ ለሚገኝ ዜጎችና ቤተሰቦቻቸው ምን ዓይነት አገልግሎት ሰጥተዋ ያውቃሉ?
13. ቫይረስ በደማቸው ውስጥ የሚገኝ ዜጎችና ቤተሰቦቻቸው ፍላጎትን አሚልተናል ብለው ያስባሉ?
14. ህብረተሰቡ በዚህ ተሳታፊ ነበርን ? አዎን ከሆነ እንዴት ?
15. ፕሮግራሙን የመከታተያና የመገምገሚያ ዘዴዎች ነበራችሁን?
16. ማህበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ፕሮግራሙን ለማገዝ ከሌሎች አጋገሮች ጋር ጥምረት ፈጥራችሁ ነበርን? ከሆነ ከነማን ጋር ተጣማራችሁ?
17. አገልግሎቱን ስትሰጡ ተግዳሮታችሁ ምን ነበር ?

<u>የፈቃደኛነት መልስ መስጫ ቅፅ</u>

በልደታ ክፍለ ከተማ፣ ወረዳ 3 የባልቻ ዕድር ማኅበረሰብ አቀፍ የቤት ለቤት እንክብካቤ ቫይረሱ በደማቸው ውስጥ ያለ አገልግሎትተጠቃሚ ሰዎች የፈቃደኛነት መልስ መስጫ ቅጽ።

ወደዚህቃለመጠይቅእንኳንደህናመጡ።

ስሜ_____ይባላል።

አሁን እዚህ የመጣሁት ስለ ባልቻ ዕድር ማኅበረሰብ አቀፍ ቤትለቤት እንክብካቤን በተመለከተ መረጃ ለማግኘት ነው። እርስዎ ደግሞ የዚሁ አገልግሎትተጠቃሚ እንደነበሩ ይታወቃል። ስለዚህም ከዚህ ቀጥሎ ለማቀርብልዎ ጥያቄ ከዕውቀትዎና ከሕይወት ተሞክሮዎ በመነሳት ሊመልሱልኝ ይችላሉ የሚል ዕምነት አለኝ።ሁሉምመልሶች፣ሃሳቦችናአስተያየቶች ሁሉተቀባይነት አላቸው። ቃለመጠይቁን ሳይጨነቁ በቅንነትና በግልጽነት እንዲመልሱ እያበረታታሁ፣ ምስጢርዎን ለመጠበቅ ሲባል፣ በዚህ ቃለ መጠይቅ የእርስዎ ሥምና አድራሻ አይመዘገብም። ሊመልሱት ፈቃደኛ ያልሆኑትን ጥያቄ ያለመመለስ መብትዎ የተጠበቀ ሲሆን፣ ለቃለመጠይቁ ሙሉመረጃ መስጠትዎ ፕሮግራሙን ለመገምገምና ለማሻሻልየሚረዳመሆኑን እንዲገነዘቡ እወዳለሁ።

አሁንም የሚሰጡኝ ምላሽና አስተያየት ሁሉ በምስጢር የሚጠበቅና ለጥናት ጉዳይ ብቻ የሚውል መሆኑን በድጋሚ አሳስባለሁ።

ስለዚህ በዚህቃለመጠይቅለመሣተፍፈቃደኛይሆናሉ?

- "አዎን"ከሆነምላሹ፣ አመስግነህጥያቄውንቀጥል።
- መልሱ"አይሆንም"ከሆነአመስግነህአብቃ።

የቃለመጠይቁ ቀን: _____

የቃለመጠይቁ አቅራቢ: _____

<u>የፈቃደኛነት መልስ መስጫ ቅፅ</u>

በልደታ ክፍለ ከተማ፤ ወረዳ 3 የባልቻዕድርማኅበረሰብአቀፍየቤትለቤትእንክብካቤ ሰጪ በጎ ፈቃደኞች የፈቃደኛነት መልስ መስጫ ቅጽ።

ወደዚህቃለመጠይቅእንኳንደህናመጡ።

ስሜ_____ይባላል።

አሁንእዚህየመጣሁትስለባልቻዕድርማኅበረሰብአቀፍየቤትለቤትእንክብካቤንበተመለከተመረጃለማግኘ ት ነው። እርስዎ ደግሞ የማህበረሰብ አቀፍ ቤት ለቤት ተንከባካቢ በጎ ፈቃደኛ እንደነበሩ ይታወቃል። ስለዚህም ከዚህቀጥሎ ለማቀርብልዎ ጥያቄ ከዕውቀትዎና ከሕይወት ተሞክሮዎ በመነሳት ሊመልሱልኝ ይችላሉ የሚል ዕምነት አለኝ። ሁሉም መልሶች፤ ሃሳቦችና አስተያየቶች ሁሉ ተቀባይነት አላቸው። ቃለመጠይቁን ሳይጨነቁ በቅንነትና በግልጽነት እንዲመልሱ እያበረታታሁ፤ ምስጢርዎን ለመጠበቅ ሲባል፤ በዚህ ቃለመጠይቅ የእርስዎ ሥምና አድራሻ አይመዘገብም። ሊመልሱት ፈቃደኛ ያልሆኑትን ጥያቄ ያለመመለ ስመብትዎ የተጠበቀ ሲሆን፤ ለቃለ መጠይቁ ሙሉ መረጃ መስጠትዎ ፕሮግራሙን ለመገምገምና ለማሻሻል የሚረዳ መሆኑን እንዲገነዘቡ እወዳለሁ።

አሁንም የሚሰጡኝ ምላሽና አስተያየት ሁሉ በምስጢር የሚጠበቅና ለጥናት ጉዳይ ብቻ የሚውል መሆኑን በድጋሚአሳስባለሁ።

ስለዚህበዚህቃለመጠይቅለመሣተፍፈቃደኛይሆናሉ?

- **“አዎን”ከሆነምላሽ፤ አመስግነህጥያቄውንቀጥል።**
- **መልሱ“አይሆንም”ከሆነአመስግነህአብቃ።**

የቃለመጠይቁቀን: _____

የቃለመጠይቁአቅራቢ: _____

<u>የፈቃደኛነት መልስ መስጫ ቅፅ</u>

በልደታክፍለከተማ፣ ወረዳ 3 የባልቻዕድር ማኅበረሰብ አቀፍ የቤት ለቤትእንክብካቤ ኮሚቴ የፈቃደኛነት መልስ መስጫ ቅፅ

ወደዚህቃለመጠይቅእንኳንደህናመጡ።

ስሜ_____ይባላል።

አሁን እዚህ የመጣሁት ስለባልቻ ዕድር ማኅበረሰብ አቀፍ የቤት ለቤት እንክብካቤን በተመለከተ መረጃ ለማግኘት ነው። እርስዎ ደግሞ የማህበረሰብ አቀፍ ቤት ለቤት እንክብካቤ ኮሚቴ መሆንዎ ታውቃል። ስለዚህም ከዚህቀጥሎ ለማቀርብልዎ ጥያቄ ከዕውቀትዎና ከሕይወት ተሞክሮዎ በመነሳት ሊመልሱልኝ ይችላሉ የሚል ዕምነት አለኝ። ሁሉም መልሶች፣ ሃሳቦችና አስተያየቶች ሁሉ ተቀባይነት አላቸው። ቃለመጠይቁን ሳይጨነቁ በቅንነትና በግልጽነት እንዲመልሱ እያበረታታሁ፣ ምስጢርዎን ለመጠበቅ ሲባል፣ በዚህ ቃለመጠይቅ የእርስዎ ሥምና አድራሻ አይመዘገብም። ሊመልሱት ፈቃደኛ ያልሆኑትን ጥያቄ ያለመመለ ስመብትዎ የተጠበቀ ሲሆን፣ ለቃለ መጠይቁ ሙሉ መረጃ መስጠትዎ ፕሮግራሙን ለመገምገምና ለማሻሻል የሚረዳ መሆኑን እንዲገነዘቡ እወዳለሁ።

አሁንም የሚሰጡኝ ምላሽና አስተያየት ሁሉ በምስጢር የሚጠበቅና ለጥናት ጉዳይ ብቻ የሚውል መሆኑን በድጋሚአሳስባለሁ።

ስለዚህበዚህቃለመጠይቅለመሣተፍፈቃደኛይሆናሉ?

- **“አዎን”ከሆነምላሹ፣ አመስግነህጥያቄውንቀጥል።**
- **መልሱ“አይሆንም”ከሆነአመስግነህአብቃ።**

የቃለመጠይቁቀን: _____

የቃለመጠይቁአቅራቢ: _____

አመሰግናለሁ!!!

INDIRA GANDHI NATIONAL OPEN UNIVERSITY (IGNOU)

SCOOL OF SOCIAL WORK

AN ASSESSMENT OF HOME AND COMMUNITY BASED CARE SERVICE TO PEOPLE LIVING WITH HIV/AIDS WITH SPECIAL REFERENCE TO BALCHA IDI R LIDETA SUBCITY WOREDA-3

by:

FANTAYE TADDESSE ABERA

Enrollment Number: ID1051138

Advisor: Dawwit Tafesse (Mr.)

May, 2015

Addis Ababa Ethiopia

INDIRA GANDHI NATIONAL OPEN UNIVERSITY SCHOOL OF SOCIAL WORK

AN ASSESSMENT OF HOME AND COMMUNITY BASED CARE SERVICE TO PEOPLE LIVING WITH HIV/AIDS WITH SPECIAL REFERENCE TO BALCHA IDI R LIDETA SUBCITY WOREDA-3

A Thesis proposal submitted to Indira Gandhi National open University School of Social Work A partial fulfillment for the Masters Degree of Social Work

by:

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February, 2015

ACRONYMS AND LIST OF ABBREVIATION

AIDS: Acquired immune deficiency syndrome

ART: Anti Retroviral Therapy

HBC: Home Based Care

HCBC: Home and Community Based Care

HCBCG: Home and Community Based Care

HIV: Human immunodeficiency virus

PLWHA: People Living With HIV/AIDS

PLHIV: People Living HIV/AIDS

OVC: Orphan and Vulnerable Children

WHO: World Health Organization

CHAPTER -1

INTRODUCTION

1.1 Background

Family Health International (FHI) training module (September, 2004), used the March 2001 Gaborone Declaration to define home and community -based care (HCBC) as:

> Care given to an individual in his or her own natural environment by his or her family and supported by skilled social welfare officers and communities to meet not only the physical and health needs, but also the spiritual, material, and psychosocial needs

According to the above definition HCBC emphasizes on holistic support to people living with HIV/AIDS (PLWHA) and their families. Service delivery was done primarily through the immediate circle of the PLWHA by the support of skilled social workers and community volunteer caregivers.

As to UNAIDS global report at the end of the year 2012 indicates, it was estimated that 32,500,000 people were living with HIV/AIDS. During the same year there were 2,250,000 new infections and deaths of AIDS were 1,750,000. In 2012, 9.7 million people in low- and middle income countries received antiretroviral therapies representing 61% of all who were eligible under the 2010 World Health Organization (WHO) HIV treatment guidelines (UNAIDS, 2012).

Sub-Saharan African countries to be the region most affected by the AIDS pandemic, Ethiopia being one among Sub-Saharan countries, HIV/AIDS has alarmingly created a huge suffering and health problem among its citizens. Since the time HIV/AIDS cases are identified, it has affected all segments of the society in less than a span of three decades. According to the National AIDS Resource Center of Ethiopia (2012), adult prevalence rate of HIV/AIDS was 1.3 (male 0.9 female 1.8), total HIV positive population was 759,268 (male 296,491 female 462,777), new HIV infections total 20,158 (male 8,875 female 11,283) total annual AIDS death 41,444 (male

17,791 female 23,653) and total ART needs 398,686 (male 158,971 female 239,715).On the other hand children (0-14 years), HIV positive population is 168,598 (male 84,873 female 83,725), total new HIV infections 7,792 (male 3,949 female 3,843), annual AIDS deaths 11,310 (males 5,695 females 5,615), ART needs 75,097 (males 37,766 females 37,331) and pregnant women needing PMTCT 38,404 and HIV- positive pregnant women needing ART was 22,057.

Home and Community Based Care (HCBC) programs for People Living with HIV/AIDS are implemented in different African countries after the inception of the epidemic. In the past few years HCBC was one of HIV/AIDS prevention and control strategies like voluntary counseling and testing (VCT), management of sexually transmitted infections (STI's), information, education and communication/behavioral change communication (IEC/ BCC), management of opportunistic infections, universal precautions and post exposure prophylaxis, safe blood transfusion, anti-retroviral therapy (ART), prevention of mother to child transmission (PMTCT), surveillance and research, care and support, and technical support to different sectors including human rights(AIDSMAP,2003).

In Ethiopia, particularly in urban settings, some studies indicated that bed occupancy due to AIDS has been reached level as high as 50% which is an extremely big burden on the health care infrastructure that is already constrained (MOH, 2004). Certainly, the high demand for care cannot be met by health service alone, even in the most optimal health service system. Given the direct and the indirect costs that would be linked to this endeavor, home care could potentially offer a feasible option for patient care, mobilizing a currently constrained resource. This strategy could also have a potential impact in decreasing stigma and discrimination within the families and communities (Tibebu B, Gebremariam G, and Belachew T 2007).

A potential benefit of home-based care is that sick people are surrounded by people they love and are familiar with, so they can also receive more flexible and nurturing care. They will also not be exposed to hospital-based infectious diseases. As people with terminal illness generally spend their final moments at home, improving the quality of their care at home also removes the cost and distress of travelling to and from the hospital when they are weakest (Ogden, Simel & Caren, 2006).Furthermore, in being cared for at home, a person with HIV may be in a more ready position to work or look after family members for short periods of time while the primary

earners work. The time the family would otherwise use travelling to and from hospital can instead be spent on house work and looking after other family members. Expenditure on transport and hospital costs is also reduced (Ogden et al. 2006)

Home-based care often results from necessity, as mentioned, health facilities may not be able to cope and furthermore, fear of stigma and discrimination from doctors and nurses directed towards people living with HIV could deter people from seeking care in a medical setting. The costs, both direct and indirect, associated with going to hospital regularly also mean that being cared at home is often inevitability rather than a choice.

In Sub-Saharan Africa where the HIV/AIDS epidemic is of paramount concern, the nature of the disease, weak public health infrastructure, spiraling health costs, and lack of resources has made community home based care a necessity in the continuum of care in Sub-Saharan Africa (Coleblunders, R; Verdonck, K; Nachega, J; and Kotari, P. (2000). Likewise, in Ethiopia, HCBC programs are initiated and operated in a few areas of the country by adopting a strategy from other African countries. This directly applied to some big towns of Ethiopia especially in all sub cities of Addis Ababa in which, the majority of Idirs engaged in combating the epidemic. Among the many Idirs, Balcha Idir, which is found in Addis Ababa, Lideta sub city woreda 3 was one that engaged in the HCBC activities. Balcha Idir was established in1952 et.cal by 45 members. The aim of the Idir establishment was for funeral and bereavements purposes. But, later on, at the peak of the pandemic HIV/AIDS, Idir members changed their by law in order to help each other during sickness of members. Thus the Idir start the HCBC program by its few sick members and latter it extends the HCBC to the woreda community and neighboring woredas. Therefore, research is needed to properly understand the HCBC program under Balcha Idir, and its successful strategies. This study attempted to assess the HCBC service given by Balcha Idir to PLWHA and gather data from PLWHA, Community volunteer care givers, and HCBC committee.

1.2 Statement of the problem

Although people living with HIV and AIDS seemingly are healthy and strong and live perfectly 'normal' lives, they can experience a range of AIDS &HIV related problems that will affect

their day-to-day life. In a survey of home-based care AIDS patients in Malawi just one in seven were able to live as if they did not have the disease. Around a third needed help with washing, walking and going to the toilet. (Bowie, 2006)

HIV/AIDS has been declared a national emergency in countries throughout the world. The United Nations has declared that HIV/AIDS may be the largest single obstacle to meeting in Millennium Development Goals. (FMOH, 2006) HIV/AIDS is expanding in an alarming rate throughout the world. Accordingly the society is facing massive problem of loosing family members and relatives, leaving behind an array of child headed families, marriage and family break-down, unemployment, decrease in income, and loss of pride and respect due to stigma and discrimination. The impact of HIV/AIDS is shown in low productivity, increased medical cost, and increased funeral costs on community associations, high replacement of worker in organizations, work load in other workers, food insecurity and double burden for women. Since many families are not in a position to offer home based care, as result of inadequate awareness about the nature of the disease and lack of skill of caring the need of home and community based care was very high and become more complex over time. This highlights the need for substantial investment in the care of people living with HIV/AIDS and their families. The impact of HIV/AIDS has been drastic at national, community, family and individual level. Thus, for many resources – limited setting, like a case in Ethiopia, the only way to deliver care to PLWHA is HCBC. In such a setting, medical facilities often lack trained personnel and even the most basic medical supplies. Thus, HCBC is the most efficient and cost effective approach to health care delivery. HIV/AIDS is a national problem that has a great impact on the socio economic development of the country. The impact is especially felt in every urban neighborhood of this nation.

Children also affected by loss of their parents in being single or double orphans. In this case, some young children became bread winners. In most cases, they are over burdened by caring to their younger siblings and to their severely ill parents. In response for this problem, Balcha Idir in Lideta Sub- city wereda 3 starts helping few HIV/AIDS victims of idir members. Later the Idir extend giving HCBC to PLWHA by collaborate with a Non Governmental organization called Hiwot integrated development organization (HIDO) which was support the HCBC program. Sub city wereda 3 is adjacent to the big market, Merkato. Because of its business

activities and many brothel houses, the neighborhood is visited and frequented by many urban and rural dwellers. So the prevalence of HIV/AIDS is high thus the need for care and support has increased as other city neighborhoods of the country. The intention of the study was to answer the basic questions raise concerning the HCBC program rendered by Balcha Idir.

1.3. General objective

The general objective of the study is to assess the home and community based care service given to PLWHA by Balcha Idir in Lideta sub-city woreda-3

1.3.1 Specific objectives

- To assess Problems of PLWHA and challenges of HCBC
- To assess types of HCBC services and their benefits to PLWHA
- To examine the vital role played by Balcha Idir in rendering the service
- To recommend the best practice of Balcha Idir HCBC program to other Idirs and relative organizations.

1.4. Significance of the study

This study finds out the types of Home and community based care given to PLWHA and their benefits, problems and challenges in rendering services in Lidetta sub-city. And vital roles played by community volunteer care givers and HCBC committee to recommend the best practice of balcha Idir to other Idirs or relative organizations. The significance of this study is to show the public how community Idir's contributing in the fight against HIV/AIDS.

It is also a complement to HCBC volunteers and acknowledges the importance of a community home and community based care service. Furthermore, this study can contribute to the future studies and also can help as an input for community-based organizations, which work on Community Home Based Care services.

1.5. Scope of the study

The study will be conducted to assess the home and community based care rendered by Balcha Idir. The study assess Problems and challenges of HCBC, type of services given

to PLWHA, vital role played by Balcha Idir in provision of HCBC service to PLWHA, the sources of resources for the HCBC program. Cognizant of these facts these facts however the research may serve as a valuable entry point to set what HCBC has done to PLWHA.

1.6. Structure of Essay

For systematic arrangement and coherence, the organization of the study is classified in to five chapters. The first chapter consist the introduction, the statement of the problem, objectives of the study and the significance of the study, limitation of the study. The second chapter contains literature review, which includes concepts and definitions of HBC; HCBC; Components of HBC; and HBC nursing care, benefits and challenges of HCBC program in African countries. The third chapter incorporates methodology; research methods, sampling techniques, data collection. The fourth chapter deals with data analysis and interpretations of data. And the last (fifth) chapter is for conclusion and recommendations.

CHAPTER 2: METHODOLOGY

2.1. Introduction

In order to achieve the objectives of the research, the service rendered to and the benefit gained by PLWHA; what was the sources of the resources; and also to understand the challenges and problems of the HCBC service with identification of the role of Balcha Idir, this research applied a cross-sectional descriptive research method.

2.2. Study Design

The researcher chose the cross-sectional research method to enable samples to represent the whole population. In addition, the descriptive study helps to show the researched reality in words. In this study both quantitative and qualitative data collection methods were used. The quantitative data collection method used in order to relate the quantity of HCBC service in numbers. The tool adopted for this method is self administered questionnaire that could translate the research objective into specific questions.

On the other hand, the qualitative data collection method was employed in order to explore contextual based HCBC activities, and the tools adopted for this method are an in-depth interview and focus group discussions that helps to draw rich information from samples.

2.3. Universe of the Study

The universe of the present study consist People Living with HIV/AIDS in Addis Ababa Lideta Subcity woreda-3, who were benefited from Home and Community Based Care rendered by Balcha Idir. Those PLWHA once were very sick, impoverished, stigmatized and rejected by their families, relatives and the community. PLWHA, Adults and children received HCBC from Balcha Idir Home and Community Based care program. Universe of the study are 140 PLWHA. In the study 30% (42) PLWHA are samples for quantitative study and 7% (10) PLWHA also selected purposively for qualitative study. Generally 52 PLWHAs are samples of the study Children less than 18 years are not included in the study, 11 community volunteer care givers

selected for qualitative study and 5 Home and Community Based Care Committee members also participated in the study.

2.4. Research Methods

The researcher chooses cross-sectional research method to enable samples to represent the whole population and to show the research reality in words descriptive study also will be used. The nature of the research, namely "An assessment of Home and community Based Care to People Living with HIV/AIDS with special Reference to Balcha Idir at Lideta sub-city woreda-3" demand both qualitative and quantitative research methods. Qualitative approach reveals the quality of services rendered to PLWHA while quantitative approach supports to show the magnitude of the services. In order to achieve the objectives of the research, the types of service rendered to PLWHA; and also to understand the challenges and problems of the HCBC service with identification of the role of Balcha Idir.

2.5. Sample Size and Sampling Procedure

In this study both quantitative and qualitative data collection methods were used. The quantitative data collection method used in order to relate the quantity of HCBC service in numbers. The tool adopted for this method is questionnaire that could translate the research objective into specific questions. On the other hand, the qualitative data collection method was employed in order to explore contextual based HCBC activities, and the tool adopted for this method was an in-depth interview and focus group discussions, to draw rich information from samples.

To draw conclusions about population, this study used both probability and non-probability sampling techniques. For quantitative data collection, a simple random sampling method was employed to enable each member of the population to have an equal chance of selection. From140 PLWHA, who receives HCBC service under Balcha Idir-HCBC program, 42 PLWHA 30% (5 male and 37 female) were selected. Whereas, for the qualitative data collection, purposive sampling method will be employed that could help to draw rich information from the

subjects. Thus 7% (10) PLWHA selected by using a purposive sampling method to ensure selecting PLWHAs who stay long in the HCBC program. For focus group discussion seven PLWHA (2 male and 5 female) PLWHA will participate and the rest three (1 male and 2 female) will also participate the in-depth interview. Since for homogeneous group small size sample is appropriate the study selected a total of fifty two PLWHA respondents. In addition the study exclude children less than 18 years.

From the fourteen, HCBC Community volunteer care givers who most experienced and long stayed in the HCBC program are selected, three for the in-depth interview and eight for Focus group discussion.

All the Five BalchaI Idir -HCBC committee members, are included in focus group discussion and the chairman and one member (1male 1 female) also included for the in-depth interview

2.5. Sampling Frame

The sampling frame for PLWHA who got HCBC was the registration book of PLWHA in Balcha Idir and the sampling frame for community volunteer is the registration book of Community volunteer care givers and the sampling frame for Balcha Idir HCBC committee was the registration book of HCBC committee.

2.6. Data Collection

Data collection instruments for qualitative data will be in-depth interview and focus group discussion. Instrument for collection of quantitative data will be questionnaire. The data collection took place after the researcher give a brief informed oral consent about the objective of the study to PLWHA, Community volunteer care givers and Balcha Idir -HCBC committee. The data collection will be done for those who are willing to participate. The questions are relevant for the study objectives and according to the local context. It initially prepares in English language and then translated to Amharic language for data collection process and at ease communication. Respondents, who can read and write will fill the self administered questions,

whereas, those who cannot read and write will fill the questionnaires by the help of the data collectors.

The questions for PLWHA are socio-economic, HCBC and HIV related questions. Questions for volunteer care givers are concerning HCBC services problems and challenges. And questions for Balcha -HCBC committee are concerning the role of Balcha HCBC committee in HCBC activities, problems, and challenges of HCBC.

Each in-depth interview will take a minimum of forty five minutes and not more than an hour. Each focus group discussion will take 45 minutes to one and half hour. The data will recorded by using tape recorded and note book.

2.7. Methods of Data Analysis

The qualitative data will be analyzed using qualitative data analysis techniques such as description, explanation and exploration of ideas to identify the theme of the discussion. The facilitator will emphasize the points raised by participants at the end of each discussion session. The quantitative data also will be quantified manually. The data collection time will be from March 15- March 28 and the data analysis and interpretation will be finalized on April 30

2.8 Ethical consideration

From the point of view of ethical considerations, there are issues that should be considered. The following ethical consideration were fulfilled and assured in this study. Names will not| mentioned to protect the identity of the respondent PLWHA. Children less than 18 years who have been in the service are not included in this study. Additionally, to participate on the study or not are the right of the client but every study subject was included in the study after giving explanation on the aim of study and taking oral informed consent.

PROFORMA FOR SUBMISSION OF MSW PROJECT PROPOSAL FOR APPROVAL FROM ACADEMIC COUNSELLOR AT STUDY CENTRE

Enrolment Number. : ID1051138.

Date of Submission: February2, 2015

Name of the study center: St. Mary University Collage

Name of the Guide: _____

Title of the project: AN ASSESSMENT OF HOME AND COMMUNITY BASED CARE SERVICE TO PEOPLE LIVING WITH HIV/AIDS WITH SPECIAL REFERENCE TO BALCHA IDIR.

Signature of the student: ……..

Approved/not approved

Signature ……

Name ……

Address of Guide …….

……. ..

……...

Date……..

Name and Address of the student:

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PROFESSIONAL PROFILE:

- Adaptable and dependable professional
- Working in collaboration in multicultural environment
- Proven relationship- builder with exceptional interpersonal and communication skills
- Strong organizational and supervisory skills
- Motivated ,resourceful, creative troubleshooter who works well in a team
- Good leadership and managing of resources. Flexible and able to work under stressful condition

EDUCATION:

Master of social work,	Indihar Gandhi Open University	January, 2010
Chemistry, BSc.	Alemaya University, Ethiopia	1997-2000
Computer science, Diploma	Addis Ababa University	2002-2004
Management and Leadership, (UK)	Institute of Leadership & Management, London	July 2010

EMPLOYMENT:

Ministry of Labor and social Affairs. Physical Rehabilitation Team Leader 2013 – Feb.2015

- Planning, implementation, monitoring and evaluation of program activities that are mandate of the ministry.
- Policy formation and modification.
- Study and research with partners. Problem identification and problem resolution.
- Mange project funds of partner organizations; prepare budget estimate, monitoring and evaluation
- Awareness, advocacy and training. Training needs analysis organizing trainings and workshops and implementation.
- Enforcement of laws, policies and strategies.
- Quarter, mid and annual reporting. Preparing periodic reports on the status of activities planned by the ministry or together with partners.
- Preparation of manuals, guidelines and pamphlets.
- Tripartite social dialogue for harmonious industry.
- Checking bylaws of industries and enterprises.

Addis Ababa bureau of labor and social affairs
2013-2014

- Ensure effective planning, implementation, monitoring and evaluation of activities inconformity with partners guidelines.

- Ensure effective implementation of the project through timely provision technical inputs, effective delivery of outputs, and monitoring and evaluation of project activities of partners.
- Gap assessment Study and training. Recommendation to management for remedial action.
- Collaboration with project partners, target groups and donors for planning and implementation of program activities.
- Coordinate with project partners to increase the project's visibility and facilitate the scaling up of project's interventions.
- Enforcement of laws and policies.
- Prepare periodic reporting on the status of activities planned by the ministry and partners.

Andinet International School September, 2006-Present

- Leading ,organizing ,planning and monitoring the Department members
- Organizing, evaluating and inspect physics, chemistry, biology Labs.
- Organize Annual Science Fair in a team work base.
- Designed and implemented middle school syllabus and curriculums.
- Develop daily, weekly and yearly lesson plans in accordance with the principles and guidelines of the school.

School of Tomorrow September 2005-Augest 2006

- Maintained academic programming for diverse learners
- Utilized various methods in teaching chemistry for pre-college students.
- Preparing the students for Grade Twelve National Examination
- Evaluated individual student progress and instituted support plan when necessary

Assai public School September 2003-February 2005

- Organize the new labs. in the school from the beginning
- Thought based on differential instruction and newly researched Brain Development of youngsters.
- Preparing students for Grade Ten National Examination
- Developed daily, weekly and yearly lesson plans in accordance with the principles and guidelines of the school
- Evaluated individual student progress and instituted support plan when necessary

PROFESSIONAL DEVELPOMNT /SEMINARS/CONFERENCE

- Occupational safety and health training
- Social budgeting and actuarial evaluation
- Social dialogue and harmonious industry
- Engaging everyone in critical thinking
- Learning Science Through modeling, charts, and simulation

Books and publications

- Chemistry and safety and health book
- Integrated science book (local language, Amharic)
- Environmental science book (local language ,Amharic)
- Safety and health in the construction and agriculture sector (study paper)
- Social dialogue for harmonious industry, case study of development enterprises (research paper)
- socioeconomic empowernment of marginslized urban women through self help group approach.

COMPUTER SKILLS:

- Advanced proficiency in MS Word, MS publisher and WWW
- Application software, SPPS

LANGUAGE:

- English and Amharic (fluent)

References

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