THE ROLE OF COMMUNITY CONVERSATION IN RAISING AWARENESS LEVEL OF THE COMMUNITY ABOUT THE DETERMINANT OF HIV/ AIDS

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THE ROLE OF COMMUNITY CONVERSATION IN RAISING AWARENESS LEVEL OF THE COMMUNITY ABOUT THE DETERMINANT OF HIV/ AIDS IN QELO AND KACHUER KEBELE, KAMISE CITY ADMINISTRATION , OROMYIA ZONE, AMHARA NATIONAL REGIONAL STATE

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By

SIYOUM KEBEDE

SUPERVISER NAME ADDIS ALEM ADEM

November, 2015

DECLARATION

I here declare that this thesis entitled THE ROLE OF COMMUNITY CONVERSATION IN RAISING AWARENESS LEVEL OF THE COMMUNITY ABOUT THE DETERMINANT OF HIV/ AIDS IN QELO AND KACHUER KEBELE, KAMISE CITY ADMINISTRATION , OROMYIA ZONE, AMHARA submitted by me for the partial fulfilment of the MSW to Indira Gandhi Open National University , (IGONU) New Delhi is my own original work and has not be submitted earlier , either to IGNOU or to any other institution for the fulfilment the requirement for any other programme of study . I also declare that no chapter of this manuscript in a 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. SIYOUM KEBEDE student of MSW from Indira Gandhi Open National University, New Delhi was working under my supervision and guidance for his project work for the course MSWP-001.his project work entitled , by Siyoum Kebede, entitled "THE ROLE OF COMMUNITY CONVERSATION IN RAISING AWARENESS LEVEL OF THE COMMUNITY ABOUT THE DETERMINANT OF HIV/ AIDS IN QELO AND KACHUER KEBELE, KAMISE CITY ADMINISTRATION , OROMYIA ZONE, AMHARA " which he is submitting is his genuine and original work.

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ACRONYM

AFNRS Afar National Regional State

AIDS Acquired Immune-Deficiency Syndrome

ANRS Amhara National Regional State

ANC Anti Natal Care

ART Antihero Viral Treatment

CC Community Conversation

CEDAW Convention on the Elimination of All Forms of Discrimination against Women

CSA *Central Statistics Agency*

CSWs Commercial Sex Workers

EDHS Ethiopian Demographic and Health Survey

EGLDAM Ethiopian Association to Eliminate Harmful Traditional Practices

EPRDF Ethiopia People Republic Democratic Front

FGM Female Genital Mutilation

FHAPCO Federal HIV/AIDS Control Office

HH House Hold

HAPCO HIV/AIDS Prevention and Control Office

HIWOT Health Improvement and Women Owned Transformation

HIV	Human Immunodeficiency Virus
HTP	Harmful Traditional Practice
IGONU	Indira Gandhi Open National University
KCHO	Kamise City Health Office
m.a.s.l	Meters Above Sea Level
MDGs	Millennium Development Goals
MOH	Ministry Of Health
NCTPE	National Committee for Traditional Practices in Ethiopia
NGOs	Non-Governmental Organizations
OZAAD	Oromia Zone Administration Agriculture Department
OZAED	Oromia Zone Administration Education Department
OZAHD	Oromia Zone Administration health Department
PA	Peasant Association
PLWHA	People Leaving With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PITC	Provider Initiated Testing and Counseling
PASDEP	Programme for Accelerated and Sustained Development and Ending Poverty
SNNPR	South Nations Nationalities and Peoples Region
SRH	Sexual and Reproductive Health

STDs Sexual Transmitted Diseases

UNAIDS United Nations Program on HIV/AIDS

UNDP United Nation Development Program

UNDP-CCE United Nation Development Program Community Capacity Enhancement

UNICEF United Nations Children's Fund

VCT Voluntary Counselling and Testing

WHO World Health Organization

WMS Welfare Monitoring Survey

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Contents

1 Introduction

Globally, an estimated 35.3 million people were living with HIV in 2012. An increase from previous years as more people are receiving the life-saving antiretroviral therapy. There were 2.3 million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 million in 2001. At the same time the number of AIDS deaths is also declining with 1.6 million AIDS deaths in 2012, down from 2.3 million in 2005. As this report reveals, striking gains have been made towards many of the 2015 targets and elimination commitments, although significant challenges remain. (UNAIDS, 2013)

Since the beginning of the epidemic, almost 75 million people have been infected with the HIV virus and about 36 million people have died of HIV. Even if globally, 35.3 million people were living with HIV at the end of 2012. An estimated 0.8% of adults aged 15–49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults living with HIV and accounting for 71% of the people living with HIV worldwide (fact sheet 2013).

At the end of 1999, an estimated 3 million people in Ethiopia were infected with the HIV virus, making this the third largest infected population worldwide after South Africa and India, and an estimated 280,000 people had died of AIDS (UNAIDS 2000). The complexity of the HIV/AIDS epidemic and the high demands successful programs make on planners, administrators and people at risk constitute a tremendous challenge for Ethiopia. According to a recent World Bank report, HIV/AIDS now poses the foremost threat to Ethiopia's development and its future depends on responding to the epidemic forcefully and fast (World Bank 2000a). After seven years of limited prevention measures, the Ethiopian government implemented in 2001 a comprehensive, multisectoral HIV/AIDS 5-year strategic plan. Although the implementation, monitoring and evaluation of Ethiopia's HIV/AIDS strategic

plan, including the development of both preventive and treatment strategies, require extensive and reliable baseline data on the progression of the epidemic as well as its impacts on society, few studies have been carried out in these areas (Kebede *et al.* 2000). While epidemiological studies are necessary to answer questions about who, when, where and how people get infected or develop disease and thus to guide health policy and control programs, they are not sufficient to fully explain great disparities in the prevalence of HIV/AIDS among communities, regions and countries. It is well recognized that broader underlying socioeconomic, cultural and political factors, including poverty, women's rights and other gender issues, cultural factors and political, have to be considered as well (Caldwell 2000; Carael *et al.* 1997; Eshete *et al.* 1993; Farmer *et al*. 1996; Foreman 1999; Kloos 1993; Setel 1999). The objective of this paper is to examine the available epidemiological data on the distribution and spread of HIV/AIDS and risk behaviour in Ethiopia in the context of the socioeconomic, political and cultural environment, including relevant traditional practices and attitudes, and to evaluate economic, social and demographic impacts of AIDS.

1.1 The economic, social and demographic impacts of HIV/AIDS

Although the economic and social impacts of AIDS in Ethiopia have not been comprehensively quantified in Ethiopia they are significant. By undermining major determinants of economic growth and preventing increasing segments of the population from participating in the economy, HIV/AIDS increases poverty, on which it feeds in a vicious cycle. By 2000, hospitals had reported 83,487 AIDS cases to the Ministry of Health, nearly 40% from Addis Ababa. A World Bank study estimated that AIDS is already causing a 1% annual reduction in economic growth in Ethiopia, which, together with declining life expectancy and labor force reduction is systematically undermining the country's efforts to reduce poverty through improvements in health, education, agricultural production and household food security. Other sectors that may be severely affected are health care, insurance

and sectors requiring a mobile work force, such as the military, transportation, extension services and banking (Ministry of Health 1998:27). Two phenomena exacerbate the impact of AIDS on agricultural households. First, land that is no longer used by households after the death of a family member cannot be leased or sold in many areas due to government regulations, eliminating a potential source of income. Second, Ethiopian households are less inclined to help AIDS-affected neighbours than in other African countries, apparently the result of poverty. Rural households growing labour-intensive crops such as teff and enset or depending on coffee picking were particularly hard hit when family members died of AIDS (Bollinger *et al*. 1999).The direct and indirect costs of health and social care in the Ethiopian public and private sectors as well as lost earnings due to HIV/AIDS for the period 1997-2000 were estimated at US$32-49 million and the cost of preventive government services at US$56 million. A survey of four hospitals in regional towns and one in Addis Ababa showed that per capita outpatient cost for opportunistic infections was, on average, 3 to 10 times higher than inpatient costs for other diseases (Kello 1998; Kassie and Kloos 1993). Patient load is stretching the capacities of many hospitals, where more than 50% of the medical beds were occupied by AIDS patients in 1997, resulting in the denial of hospitalized medical services to patients with other diseases (UNAIDS 1997). The common perception that AIDS patients are preferably cared for in hospitals rather than at home. (Berhanu and Zakus 1995) add to the health services crisis, Production of businesses is also affected. One study of industrial firms found that half of all illnesses reported by employees between 1988 and 1993 were due to AIDS (MOH, 2000a). No comprehensive study has been carried out on the social impact of HIV/AIDS in Ethiopia. There is evidence that high morbidity and mortality in young adults, who traditionally provided care for both children and the elderly, are increasingly burdening this group with more care for a growing sick population and that children are being kept out of school to care for sick family members or to work in the fields. A study in Addis Ababa found

that many of the 1.2 million orphans had dropped out of school or were displaced or abandoned by their families (Bedri *et al*.1995). Mutual aid organizations dealing with funeral expenses, especially many Ider (social service organization) have become bankrupt in recent years due to the unprecedented number of deaths. A demographic impact study estimated that by 2024, HIV-related deaths in Addis Ababa would represent more than 70% of all deaths in the 15-65 age group (Mekonnen *et al.* 1999). According to a recent demographic model, life expectancy in the city will decline by 15 years by 2004 but AIDS prevalence will plateau in 2001 (Abdurehman and Enquoselassie 2001). The lack of reliable data on HIV incidence, renders these projections highly speculative. High HIV incidence is increasing tuberculosis morbidity and mortality in Ethiopia. Thirty per cent of Ethiopia's tuberculosis cases were estimated to be HIV-positive in 1998, more than in any other African country except South Africa (Dye *et al*., 1999). At least 90,000 new cases of tuberculosis due to HIV infection were estimated to have developed from latent TB infections in 1997, and these synergistic infections are expected to increase to more than 130,000 by 2014 (MOH 1998, 2000a; Eyoub *et al*. 1999).

There have been various measures taken to prevent and control the prevalence of HIV/AIDS in Ethiopia. Some of measures include community awareness rising, and provision of various services for people living with HIV/AIDS and their families. The services include the provision of antiretroviral treatment (ART), awareness creation, volunteer counselling and testing, providing nutritious food organizing, income generating schemes,

Community Conversation (CC) is an interactive process, which brings people together and engages communities to discuss and explore the underlying causes fuelling the HIV and AIDS epidemics in their environment and other heath related issue such as family planning, reproductive health and so on. Through CC people will discover unequal power relations, harmful traditional practices as drivers and maintainers of the epidemic. (Hibret Getaneh, *et al.* 2008)

The underlying assumption of community conversation is the belief that people have capacities, knowledge and resources to transform individually and collectively once they perceive ownership of a problem. The CC approach promotes democratic participation. It creates space for listening, speaking, being, inclusion and agreement. The aim of CC is to have a community's deep understanding, knowledge of HIV/AIDS and to facilitate decision-making and taking action to solve the problem. Conversation is an important part of community building. In conversation, we not only discover what we care about, we uncover new ideas for building healthy community. The Community Conversations enhance people to come together to talk about the things that matter to them, and to generate action for positive change. Community conversations happen when a small group of people gets together to talk. A conversation can take place wherever people can gather: kitchens, living rooms, offices, schools, libraries, community centres and places of worship. (BC Healthy Communities. 2006)

The Federal HIV/AIDS Prevention and Control Office (FHAPCO) initiated community Conversation in Ethiopia in 2002. Community Conversation was adopted in Amhara region of Oromia zone in the year 2009. Currently, there are a total of 208 community conversation groups in the zone, of which 14 community conversation groups are found in Kemise Town in the program. The aware ness creation program takes place in group members by creating free discussion free talking with members about HIV. (Oromia Zone HAPCO 2010)

The purpose of this study is to examine the contribution of CC programs focusing on those implemented in the study area by competing with those not conduct CC.

2 Statement of the Problem

HIV/AIDS has now been around for about three and half decades since first diagnosed in 1981. If we wish to curb the spread of HIV/AIDS effectively and sustainably, we need to design strategies that help mobilizing communities at large. Anti-HIV/AIDS Community Conversation

(CC) Programs are part of community mobilization activities introduced for the purpose of preventing and controlling the spread of HIV/AIDS. The study area is near to the capital of Oromia zone kamise city most of the dwellers of the study area are farmers they lead there life by mixed farming due to their near ness to the city they can face for HIV/AIDS. In other direction due to the near ness of the city most of the youngster pass their time for recreation in this town, this nearness expose for unwanted habit like chowing chat and drinking alcohol and influenced by their peers. Since they are young and they have irrigated land there, economic status is wall because they get money by selling vegetable and forest seedling .due to this fact it is expected they are exposed to unsafe sex. However, there is no clear data and evidence to show the magnitude and extent of it. In addition, to the knowledge and access of the researcher no such study had been under taken in community. So it is assumed that the study area is vulnerable because lack of awareness and near ness to town area, income of the youngsters and shininess of town life. so assessing the awareness level and examine effective ness of the implemented CC communication method is important for mobilizing the community and scale up .

2.1 Research Questions

What is the role of community conversation in raising the awareness level of CC group members regarding the transmission and factors enhancing for the spread of HIV/IDS?

Is there awareness level difference between groups conducting CC and other community members who are not involved in community conversation about the determinant of HIV/ AIDS?

2.2 General Objectives

To assess the role of community conversation in raising the awareness level of the community towards the transmission of HIV/AIDS

2.3 Specific objectives

To identify the difference in the level of awareness about HIV//AIDS transmission between groups conducting Community Conversation and other community members who are not involved in community conversation.

To study the relevance of CC to overcome stigmatization and mal practices

2.4 Significance of the study

Studies showed that there is high prevalence rate of HIV/AIDS in this region. The causes aggravating the problem are deep rooted in the culture, religion and lack of awareness about prevention of HIV/AIDS. In order to solve this problem, this research contributes a lot. the significance of this study is to empower the community to tackle any problem by free discussion, The study is also helpful for police makers by providing adequate data on the role of community conversation in enhancing the awareness level of the community regarding HIV/AIDS. The study also contributes to social work education through providing the role of group work as an effective approach in tackling social problems.

2.5 Scope of the Study

The study is limited to kelo and kachuer kebele, in kemissie town wareda administration. Therefore, the finding of the study can't be generalized to the total population in of Kemisse. Moreover, the study employs cross sectional design that the finding may not be feasible.

3 LITERATURE REVIEW

3.1 The prevalence of HIV & AIDS worldwide and in Ethiopia

3.1.1 Worldwide HIV & AIDS

An HIV/AIDS epidemic is defined by the HIV prevalence in the general population. HIV prevalence is the percentage of the population living with HIV.

There is either a generalized or concentrated epidemic. In a generalized epidemic, HIV prevalence is 1% or more in the general population. In a concentrated or low level epidemics, HIV prevalence is below 1% in the general population but exceeds 5% in specific at-risk populations like injecting drug users or sex workers, or HIV prevalence is not recorded at a significant level in any group. (WHO, 2000)

In order to understand the HIV and AIDS epidemic, it is necessary to look at certain figures. Researchers and epidemiologists usually compile the number of people living with HIV (the HIV prevalence), the number of new infections (the HIV incidence), and the number of people who have died of AIDS among other categories.

3.1.2 Global trends

The number of people living with HIV rose from around 8 million in 1990 to 34 million by the end of 2011. The overall growth of the epidemic has stabilized in recent years. The annual number of new HIV infections has steadily declined and due to the significant increase in people receiving antiretroviral therapy, the number of AIDS-related deaths has also declined.

Since the beginning of the epidemic, nearly 30 million people have died from AIDS-related causes. (UNAIDS, 2011)

AIDS is fundamentally changing the fabric and function of societies. The pandemic remains extremely dynamic, growing and changing character as the virus exploits new opportunities for

transmission. HIV is transmitted through various ways. People do not perform risky behaviours in a vacuum and instead, demographic, socio-cultural, economic and sexual factors affect both the likelihood and the consequences of these behaviours. (UN, 2004).

3.1.3 Global HIV and AIDS estimates, 2011

The latest statistics of the global and epidemic were published by UNAIDS, WHO and UNICEF in December 2012, and refer to the end of 2011. (UNAIDS, 2012)

Table 1 estimated global epidemic of HIV

	Estimate	**Range**
People living with HIV/AIDS in 2011	34 million	31.4-35.9 million
Proportion of adults living with HIV/AIDS in 2011 who were women (%)	50	48-53
Children living with HIV/AIDS in 2011	3.3 million	3.1-3.8 million
People newly infected with HIV in 2011	2.5 million	2.2-2.8 million
Children newly infected with HIV in 2011	330,000	280,000-390,000
AIDS deaths in 2011	1.7 million	1.5-1.9 million

Table 2Regional statistics for HIV and AIDS, end of 2011

Region	**Adults & children living with HIV/AIDS**	**Adults & children newly infected**	**Adult prevalence***	**AIDS-related deaths in adults & children**
Sub-Saharan Africa	23.5 million	1.8 million	4.9%	1.2 million
North Africa & Middle East	300,000	37,000	0.2%	23,000
South and South-East Asia	4 million	280,000	0.3%	250,000
East Asia	830,000	89,000	0.1%	59,000
Oceania	53,000	2,900	0.3%	1,300
Latin America	1.4 million	83,000	0.4%	54,000
Caribbean	230,000	13,000	1.0%	10,000
Eastern Europe & Central Asia	1.4 million	140,000	0.2%	92,000
North America	1.4 million	51,000	0.6%	21,000
Western & Central Europe	900,000	30,000	0.2%	7,000
Global Total	34 million	2.5 million	0.8%	1.7 million

* Proportion of adults aged 15-49 who are living with HIV/AIDS

With around 69 per cent of all people living with HIV residing in sub-Saharan Africa, the region carries the greatest burden of the epidemic. Epidemics in Asia have remained relatively

stable and are still largely concentrated among high-risk groups. Conversely, the number of people living with has more than tripled since 2000.

Note :Adults are defined as men and women aged 15 or above, unless specified otherwise.

All the statistics on this page should be interpreted with caution because they are estimates. (UNAIDS, 2012)

The HIV/AIDS pandemic continues to spread worldwide. Today some 37.8 million people are living with the virus, which killed about 3 million in 2003, and over 20 million since the first case of AIDS were identified in 1981. (UNAIDS 2004) Sub Saharan Africa, with only 10% of the total world population, is carrying the burden of 80% of the world HIV infection and AIDS cases With an estimated 1.5 million people living with HIV/AIDS and a national prevalence rate of 4.4% (12.6% urban and 2.6 rural), Ethiopia is one of the hardest hit countries by HIV/AIDS epidemic (MOH, 2004).

3.1.4 The HIV/AIDS Epidemic in Ethiopia

HIV infections were first found in Ethiopia in 1984, one to two years later than in most other Sub-Saharan countries but its main features resemble those elsewhere in Eastern Africa: the relatively virulent HIV-1 is the major strain of the virus in Ethiopia, transmission is largely through heterosexual contact and to a lesser extent to mother-to- child transmission, and the highest prevalence of infection is in the 20-39 age group, with higher rates in females than males in the younger age groups. Genetic diversification studies of the Ethiopian HIV-1 subtype C virus confirm its introduction in the early 1980s (Abebe *et al*. 2001). HIV/AIDS prevalence remained low in the 1980s but sharply accelerated through most of the 1990s, rising from an estimated 3.2% in the 15-49 years age group in 1993 to 10.6% by the end of 1999 (Kebede *et al*. 2000). Although difficult to measure, the impact of political, economic, and ecological crises since the 1970s on HIV and other sexually transmitted infections (STIs)

in Ethiopia has been significant as they created conditions conducive to the transmission of HIV. Among the factors contributing to the rapid spread of HIV are 1) seasonal migration of workers in search of employment and better economic conditions that tend to increase multi-partner sexual contacts, 2) dislocation of many people due to the civil war, 3) high STI rates in both high-risk groups and the general population, 4) increasing sexual activity among youth and 5) high unemployment rates, including the demobilized soldiers (AIDSCAP 2001).

During the early stage of the epidemic, the focus was on identifying high-risk groups and their sexual behaviour. In 1988, a sero epidemiological study of 6,234 female commercial sex workers in 24 communities throughout Ethiopia revealed infection rates between 1.3% and 38.1% in different towns. The mean infection rate was 18.3%, which increased to 29.2% during a follow-up survey in 1989. Rates above 20% were found in communities on major truck routes between Addis Ababa and Assab and from Addis Ababa to Bahir Dar and Mekele (Mehret *et al*., 1990a). Truck drivers have been identified as another high-risk group (17.3% infection in 1989) that is closely linked with commercial sex workers (Mehret *at al*. 1990b). Several studies reported a strong correlation between HIV and STI infections in both males and females (Aklilu *et al*. 1999; Zewde et al. 2001). Rates in commercial sex workers increased further in 1990 and 1991 but no comparable epidemiological data are available for female sex workers for subsequent years. In Addis Ababa rates among sex workers were 24.7% in 1988, 54.3% at STD clinics in 1990 and 73.4% in 1998, indicating that rates continue to increase also in other urban centers (Fig. 1; Mehret et al. 1990c; Aklilu *et al*. 1999). Soldiers, another highly mobile high-risk group exposed through multi-partner sex contacts, were stationed in many towns within the war zone characterized by high HIV infection rates. Troops could also have been infected during emergency blood transfusions, without HIV screening (Eshete *et al.* 1993; Kloos 1993). HIV infection rates in new recruits increased from 0.8% in 1986 to 2.6% in 1991 and in soldiers from 12% in 1990 to 27% in 1993 (Khodakevich and Zewdie 1993; Assefa *et*

al. 1994). About half a million soldiers had been demobilized and reintegrated into the rural economy by the mid 1990s (Dercon and Ayelew 1998). In the first study of risk behavior in rural areas, Shabbir and Larson (l995) demobilized soldiers reported that they had not changed their sexual behaviors. Studies in Uganda have shown strong spatial correlations between the source areas of soldiers recruited into the armed forces and subsequently high rates of AIDS in the general population in those same areas (Smallman-Raynor and Cliff 1991). Children, adolescents and young adults have become high-risk groups in recent years, with an estimated 250,000 children infected in 2000 and 11.9% of females and 7.5% of males aged 15-24. An estimated 1.2 million children were AIDS orphans in 1999 (Ministry of Health 2000a; UNAIDS 2000). No reliable data are available on mother-to- child-transmission in Ethiopia although the Ministry of Health estimated that prenatal transmission contributes up to 25% of all new infections (Ministry of Health 1999b). Many more young females are likely to enter prostitution if economic conditions do not improve. Although the 1993 national health policy addresses the health problems and related needs of adolescents (Transitional Government of Ethiopia, 1993), unmarried youth have no access to reproductive services in health institutions due to opposition of the major religions. HIV Infection in the General Population The AIDS surveillance system of the Ministry of Health based on monthly reports from hospitals identified only about a fifth of the estimated 400,000 AIDS cases nationwide because many ill persons in the rural areas have no access to hospitals. Even if they succeed in reaching hospitals and prove to be HIV positive the diagnosis may be reported as TB or another opportunistic infection instead (Kebede *et al*. 2000). Moreover, data on AIDS cases aggregated by age and sex were gathered only up to 1994, impeding the surveillance of AIDS incidence and the planning of control activities. Data on the prevalence of HIV infections in the general population of Ethiopia have been based mainly on infection rates among antenatal clinic (ANC) attendees (pregnant women) at several clinics in Addis Ababa and regional towns, with

supplementary data from blood donors and some special surveys. Most data are from urban populations and little is known about the occurrence of HIV infections in rural areas, where around 85% of the population lives. Although antenatal data are considered to be an acceptable indicator of the true prevalence of infection in the general population (Kebede *et al*. 2000), this relationship still needs to be clarified (Solomon and Murray 2001). Based on all available survey data the Ministry of Health estimated in 2000 the HIV prevalence in the sexually active population (15-49 years) to be 13.4% in urban Ethiopia, 16.8% in Addis Ababa and "about 5%" in rural areas (Ministry of Health 2000a). Rates in antenatal attendees at 13 clinic and hospital sentinel sites in 9 urban and rural communities, which were instrumental in estimating the national rates, varied between 4 and 21 % in 1999/2000. The highest rates were in Bahir Dar, Gambela and Addis Ababa (Ministry of Health 2000a; Table 1). In Addis Ababa, 6.4% of 11,587 blood donors and 9.1% of 10,930 visa applicants were sero-positive in 1999 (Kebede *et al*. 2000). A study of police recruits from the Awash Valley indicates that distance to truck stops is more important in HIV risk than rural residence per se (Zewde 2001). Surveys carried out in 1993 in the sexually active population in 6 rural communities in Shewa, Tigray, Bale and South Omo showed 0.7% of the population infected with HIV, similiar to the rates among antenatal patients at Attat and Gambo rural hospitals in 1998/99. But one year later, 4% of the Attat antenatals were infected (Ministry of Health 2000a; Table 1). It is not known if the low rate (0.2%) of infections in 1,800 Falasha resettled in Israel since 1991 (after Operation Solomon) (Fisher 1996) are representative of the rural population in Ethiopia. The gender ratio of HIV infection in Ethiopia has changed over the years, from male to female dominated rates (1:1.2 gender ratio) in the late 1990s (Ministry of Health 1994; UNAIDS 2000), indicating its spread in the wider population. Females now have significantly higher AIDS rates in the 15-19 and 20-24 groups, apparently due to their earlier commencement of sexual activity than males. This trend will increase mother-to-child HIV transmission levels among babies of mothers in

these age groups unless effective preventive measures are implemented soon. The high HIV prevalence rates in younger females also emphasize the need for testing and counseling among both males and females as a central part of the prevention strategy. The balanced male-to-female infection ratio in Addis Ababa (0.97:1) supports the general conclusion that the main mode of HIV transmission in Ethiopia is heterosexual (Fontanet, Wolde/Michael 1999). Absence of infection in the 6-13 age group in Addis Ababa (Fontanet *et al*. 1998), also reported from Uganda and other African countries, and very low rates of AIDS in 5- 14 year olds constitutes a "window of hope" if this age group can be helped to prevent infection once they become sexually active (Fig. 2; Lemma 1996). There is some evidence that HIV infection rates in Ethiopian towns are leveling off although this still needs to be confirmed. HIV testing among 3,877 pregnant women at four antenatal clinics in Addis Ababa between 1995 and 2000 revealed a 30% decline of infection rates (Kebede et al. 2000). HIV infection rates in blood donors in Addis Ababa and nine other towns for the period 1988-1999 also declined. The only data available for younger ages, which are a better indicator of the epidemic's progression—ANC attendees and blood donors aged 19-25—show a similar declining trend. It is not known if these declines are due to a decline in high-risk behavior or to other factors, particularly sampling bias, increasing efficiency of pre-screening blood donors, variable quality of ANC laboratory test data, or to maturing of the epidemic (Kebede *et al*. 2000; UNAIDS 1997). In Brazil, AIDS rates increased slower in the initially hyper endemic counties of the southeast than in low-prevalence counties in the north, indicating both a maturing of the epidemic characterized by the depletion of high-risk persons in the population and heightened awareness of the AIDS problem in high-prevalence areas (Swarcwald *et al*. 2000). A similar situation seems to prevail in Ethiopia between urban areas (where HIV first reached epidemic proportions and prevention campaigns have been most common), and the less affected and informed rural areas. This pattern is also consistent with reductions in high-risk behaviour

among students in urban areas, further discussed below, and recent reports of decreasing infection rates due to control efforts. However, HIV rates showed no declining trend for visa applicants between 1993 and 1999. Similarly, fairly steady HIV prevalence rates among visa applicants and increasing rates in Moslem pilgrims from 6.0% in 1996 to 11.2% in 1997 (Kebede *et al*. 2000) indicate that HIV transmission rates have not declined in some subpopulations of Addis Ababa. Furthermore, in Bahir Dar and Gambela, HIV prevalence in pregnant women increased from 13.0% in 1992/93 to 20.8% in 1999 in the former and from 12.7% in 1997 to 19,0% in 1999 in the latter (Kebede *et al.* 2000). The increase in HIV/AIDS in the rural areas cannot be quantified at this time in the absence of longitudinal sero-surveillance data for the regions, although there is no doubt that infections have significantly increased in many areas. The periodic visits by farmers to towns and the massive rehabilitation of soldiers appear to contribute significantly to the spread of the infection from urban to rural areas (Shabbir and Larson 1995).

Ethiopia hosts the fifth largest number of people living with the virus globally. Out of the 1.5 million PLWHA, 817,000 are women and 96,000 are children under 15 years. There are about 537,000-orphaned children due to AIDS. Some 245,000 PLWHA will be in need of ART during 2004. Deaths due to AIDS brought down life expectancy gains from 53 to 46 in 2001. If the current death trend continues the projected life expectancy gain to 59 years in 2014 will be reduced to 50 years. (MOH 2004)

In Ethiopia, the major mode of HIV transmission is heterosexual which accounts for 87% of infections. Another 10% of infections occur due to mother to child transmission. In addition, empirical evidences suggest that utilization of unsafe sharp and skin piercing instruments play a role in HIV transmission in the rural setting in particular. The first cases of HIV and AIDS were reported in 1986, but evidence of HIV infection was traceable from 1984 from stored blood samples. Since that time, HIV prevalence has been increasing rapidly, initially among

high-risk groups sex workers, men in uniform, and long-distance truck drivers before becoming a generalized epidemic. Current prevalence among pregnant women attending antenatal care is estimated at more than 10 per cent in urban areas and less than two per cent in rural areas.(FHAPCO. 2006.)

Single-point prevalence shows that, in 2009, 2.3% of Ethiopian adults ages 15-49 are estimated to be infected with HIV. More people are infected in urban areas than in rural areas (7.7 per cent HIV prevalence in urban areas nationwide and 0.9 per cent in rural areas) and more women are estimated to be HIV-positive than men (2.8 per cent female HIV prevalence and 1.8 per cent male). The infection is highest among women in their late 30s and men in their early 40s. Recent estimates show that 1.1 million people are living with HIV in Ethiopia, and more than 131,000 new infections occur every year. The prevalence of HIV has stabilized at a higher rate in urban areas, particularly in hotspot areas, such as small commercial towns along the major transport corridors, while steadily increasing in the rural areas. Tuberculosis (TB) continues to play a major role in the burden of disease, and serves as an important co-factor in the HIV epidemic (TB-HIV co-infection rates range from 25-47 per cent). Children ages 0-14 account for 72,945 HIV and AIDS cases, with 14,140 new cases in 2009.11 It is estimated that 18 per cent of all Ethiopian households are caring for at least one orphan**.** (MoH and FHPCO, 2008)

Following the diagnosis of the first case in 1987, Ethiopia has been significantly affected by the HIV epidemic. Heterosexual transmission accounts for 87% of transmissions, with women of 30-34 years old having the highest prevalence rate. Nationally, women are more vulnerable to HIV infection and make up 59% of the HIV positive population. (MOH, 2010).

The main factors increasing their susceptibility include: earlier age of sexual debut, inequitable sexual relationships that render negotiation of safe sex difficult, exposure to various forms of

violence and abuse, and prevalence of harmful practices, such as female genital mutilation. Furthermore, despite improvements in overall knowledge about HIV and its modes of transmission, only 19% of women and 32% of men have comprehensive knowledge of HIV transmission and prevention methods. (DHS, 2011)

Ethiopia, officially known as the Federal Democratic Republic of Ethiopia, is located in East Africa commonly recognized as The Horn of Africa. It is the tenth largest country in Africa. The population of Ethiopia in 2007 was estimated at 74 million. Currently, based on projections from the national census of 2007, it is estimated at 83 million, making the nation the second most populous country in Africa. The majority (83.9%) reside in rural areas. The average household size is 4.7. The average life expectancy is 51 years for males and 53 years for females. Population distribution by age group shows a pyramidal age structure, with 44% less than 15 years. While the sex ratio between male and female is almost equal, women in the reproductive age group constitute 24% of the population. (CSA, 2008)

Ethiopia is one of the countries with the lowest per capital income, estimated at 390 USD per annum. It is estimated that 32.7% of the population live below the absolute poverty line. Nevertheless, in recent years, the country has seen rapid progress in economic growth, expansion of social infrastructure, and in improving healthcare. Ethiopia has one of fast growing economies among non-oil producing countries in sub-Saharan Africa. (WB,2010/2011).

According to ANC surveillance results, HIV prevalence among pregnant women aged 15-24 declined from 5.6% in 2005, to 3.5% in 2007, and then to 2.6% in 2009; showing a declining HIV prevalence trend. DHS 2011 data show an overall prevalence of 1.5% among the general population. EPP/Spectrum estimates show 789,900 people currently living with HIV/AIDS

(607,700 adults and 182,200 children aged 0-14 years); and 952,700 AIDS orphans. (FHAPCO, 2008)

HIV infection probably began in the late 1970s or early 1980s with the first AIDS cases reported in 1986. Similar to other Sub-Saharan countries, the predominant strain is HIV-1 subtype C, predominantly spread through unprotected heterosexual intercourse. (FHAPCO, 2008)

In the early stages of the epidemic, HIV prevalence increased rapidly, initially among high risk groups like CSWs, men in uniform and long distance truck drivers. Most of the HIV surveys, therefore, were focuses on these well-recognized risk groups in major urban centres. However, the data generated did not provide much information on what was happening in the general population. Based on available research and survey data, the first systematic national report on HIV was produce in 1996. This synthesis report documented a progressive rise of HIV prevalence from 1% in 1989 to 5.2% in 1996, indicating a generalized epidemic (FHAPCO, 2008). The findings showed that the epidemic steadily increased, then reached a plateau and seemed to decline. This observation was more evident with the expansion of ANC sentinel sites to more geographic areas that yield more representative data compared to earlier years. This Sustain effort, declining new infections. Data indicate a declining trend of HIV prevalence is a success and cause for optimism! However, with nearly 800,000 people living with HIV, Ethiopia remains a country highly affected by the epidemic. Sentinel surveillance provides data in a specified age group of population and helps to monitor trends in HIV prevalence over the years. In Ethiopia, one important source of such data is sentinel surveillance among ANC clinic attendee women. Although earlier ANC surveillance sites were limited in number and largely distributed in urban areas, expansion of these sites has provided an opportunity to monitor trend among the ANC attendees and to generate more representative data.

Findings from the most recent ANC sentinel surveillance data show a declining prevalence of infection rates among women age 15-24 years attending ANC, from 5.6% in 2005, to 3.5% in 2007, to 2.6% in 2009. This trend was marked both in urban and rural areas. In urban centers the prevalence has halved, declining from 11.5 % in 2003 to 5.5% in 2009. The declining trend is even steeper in rural areas where prevalence declined from 4% in 2003, to 1.4% in 2009. Generally, 94% of the sentinel sites showed absolute decrease of which half of these were statistically significant. Ethiopia is one of the few sub-Saharan countries showing a decline of more than 25% in new HIV infections. (UNAIDS,2010.)

Another important source of HIV prevalence data in the general population is the Ethiopian Demographic and Health Survey (EDHS). Results from the 2005 EDHS indicate that 1.4% of Ethiopian adults age 15-49 were infected with HIV. Data for 2011 EDHS show a prevalence of 1.5%. For both men and women HIV prevalence levels rise with age, peaking among women in their early to mid-30's and among men in their late 30's. The age patterns suggest that young women are particularly vulnerable to HIV infection compared with young men. (CSA,2005).

According to mathematical modelling estimates there are nearly 789,900 people currently living with HIV/ AIDS (607,700 adults and 182,200 children aged 0-14 years); and 952,700 AIDS orphans (EPP/Spectrum estimates 2011). Overall, analysis of various sources of data indicates that overall the epidemic is generalized with HIV firmly established in the general population. However, an epidemiological synthesis report of available published literature indicates the epidemic may be more heterogeneous than previously believed (HAPCO, 2008)

3.1.5 Causes of HIV/AIDS in Ethiopia

A number of underlying factors contribute to the spread of HIV/AIDS in Ethiopia. These are poverty, illiteracy, stigma and discrimination of those infected/affected by HIV/AIDS, high rate of unemployment, wide spread of commercial sex work, gender disparity, population

movement including rural to urban migration, and gender based violence such as harmful cultural and traditional practices.

HIV/AIDS-related stigma can be described as a "process of devaluation" of people either living with or associated with HIV and AIDS. Discrimination follows the stigma and is unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Stigma is a complex social phenomenon involving interplay between social and economic factors in the environment and psycho-social issues of affected individuals. Stigma is caused by factors in the social, cultural, political and economic environments. Fear of HIV and AIDS is one of the principal causes of stigma against people living with HIV and AIDS and their families. HIV-related stigma occurring within society, within communities and within individual families and households will all combine to influence the nature and degree of stigma experienced by an individual person living with HIV and AIDS. This fear and uncertainty emerges from lack of knowledge about modes of HIV transmission (Khuat & Nguyen,2004.)

HIV/AIDS-related stigmatization displaces essential resources used to prevent the infection. People are victimized and blamed, social division are reinforced and reproduced, and new infections continue to emerge as long as people misread the nature of the epidemic and its cause. More importantly, while negative response of stigmatization and discrimination seemingly give cohesion to societies and communities, they lead to greater instability in the long term. The social categories and barriers that have been constructed around it cannot contain HIV/AIDS. HIV-related stigma and discrimination has accompanied the AIDS pandemic from the start. Fear of and actual experience with stigma and discrimination reduce an individual's willingness to practice prevention, seek HIV testing, disclose his or her HIV status to others, ask for (or to give) care and support, and begin and adhere to it. Therefore, many women and men hesitate to test for HIV and to disclose their HIV-positive status, even to

their husbands or wives and choose to keep silence that, in turn, aggravates the problem treatment (Nyblade and MacQuarrie, 2006.)

The rural population had markedly lower knowledge and awareness about HIV/AIDS compared to urban population. Rural women were found to be the least informed on HIV/AIDS. Therefore they are more likely to be infected with the virus. Ethiopia Demographic and Health Survey (EDHS) 2000 Contribution of Harmful traditional practices (HTPs)

The term harmful traditional practices (HTPs) refer to practices and cultures which affect the health and well- being of women. (UNICEF, 2009)

In Ethiopia, over 80 kinds of HTPs are practiced in different regions like Amhara, Afare,Oromia, South Nation Nationality… (National Committee on Harmful Traditional Practices of Ethiopia 1997). These practices adversely affect the physical as well as mental health of the victims. One of the widely practiced HTPs is female genital mutilation (FGM).

A study of the situation in Egypt, Ethiopia, Kenya, Senegal, Sudan and South Sudan concludes that female genital mutilation is conducted mainly because it represents the girl's chastity or morality, thus the girl who is cut is considered to be appropriate for marriage. (UNICEF , 2010) It is estimated that more than 125 million women and girls in 29 countries in Africa have undergone female genital mutilation, of which In Ethiopia 23.8 million girls and women have undergone female genital mutilation. This is one of the highest national numbers in Africa, second only to Egypt (UNICEF, 2013) but the most recent data indicates that attitudes are changing and female genital mutilation is declining in Ethiopia. According to the Demographic Health Survey (DHS), the estimated prevalence of female genital mutilation in girls and women (15-49 years) is 74.3% (DHS, 2005). This has decreased from 79.9% in 2000 (DHS, 2000), therefore showing a 5.6% decrease over 5 years. Other data (the NCTPE/EGLDAM survey) shows a decrease from 73% in 1997 to 57% in 2007, a 16% decrease over 10 years but

it should be noted that there are significant regional differences in the decline in prevalence. It is also noteworthy that while the proportion of girls under the age of 15 with female genital mutilation in 2011 is estimated to be 23% (WMS), the proportion of women with one or more daughters under the age of 15 with female genital mutilation in 2000 and 2005 was, respectively, 51.9% and 37.7% (DHS). Although some caution must be exercised with drawing conclusions from different data sets, if this trend is confirmed by subsequent surveys this is a significant decline. Female genital mutilation is widespread across Ethiopia and is carried out in the majority of regions and ethnic groups. Female genital mutilation is most prevalent, depending on which statistics are used for reference in the Afar region, in the north east of Ethiopia, where the rate of female genital mutilation is 91.6% (DHS, 2005) or 87.4% (EGLDAM, 2007); in the Somali region, in the south east bordering Somalia, where the rate is 97.3% (DHS, 2005) or 70.7% (EGLDAM, 2007); and Dire Dawa, where the rate is 92.3% (DHS, 2005). The prevalence rate is lowest in Gambela, a small region in western Ethiopia, with a rate of 27.1% (DHS, 2005) and Tigray in the north, with a rate of 29.3% (DHS, 2005) or 21.1% (EGLDAM, 2007).

National Region state	**% women with female genital mutilation**
Addis Ababa	65.7
Afar	91.6
Amhara	68.5
Benishangul-Gumuz	67.6
Dire Dawa	92.3
Gambela	27.1
Harari	85.1

Oromia	87.2
SNNPR	71.0
Somali	97.3
Tigray	29.3

Source DHS2005

The prevalence among ethnic Somalis is high regardless of national context, with the prevalence among ethnic Somalis in Ethiopia (and Kenya) being similar to that of Somalia rather than the national rates for Ethiopia (and Kenya). Ethiopia has a large number of distinct ethnic groups with differing concepts of identity. Of 66 of Ethiopia's largest ethnic groups (of 82 in total) 46 carry out female genital mutilation (EGLDAM, 2007). female genital mutilation is therefore practised by over half of Ethiopia's ethnic groups. The Oromo, Amhara, Somali and Tigray are all significant practising ethnic groups. The Afar are also noteworthy given the high prevalence of female genital mutilation within the Afar region, the severity of the type of female genital mutilation (infibulation), and the age at which girls are cut (often in infancy up to 8 days old). Of those women who have undergone female genital mutilation, 8% have experienced infibulation, and 92% (Type I) Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). (Type II) Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term 'excision' is sometimes used as a general term covering all types of female genital mutilation. Type III infibulation is most prevalent in Afar and Somali, but is also carried out to a lesser extent in Harari and Dire Dawa and other regions. There is a reported trend in areas where Type III infibulation is traditionally carried out, for some to adopt a less invasive form of Female genital mutilation. The age at which female genital mutilation is performed in Ethiopia depends upon the ethnic group, type of female genital mutilation adopted and region. More than 52.5% of girls who undergo female genital mutilation do so before the age of 1 year (DHS, 2000). In the

north, female genital mutilation tends to be carried out straight after birth whereas in the south, where female genital mutilation is more closely associated with marriage, it is performed later. Due to the diversity of ethnic groups that practise FGM, the reasons also can vary. For the Dassanach, for example, it is a marker of cultural identity, whereas for the Somali and Afar it is a perceived religious requirement, needed to ensure chastity and to prevent rape. Female genital mutilation is practiced by both of the main religions in Ethiopia. Ethiopian Orthodox Christianity and Islam. Muslim groups are more likely to practice female genital mutilation than Christian groups, with the prevalence among Muslim communities being 65.1% and that among Orthodox Christians being 45%. The prevalence of female genital mutilation among Muslims is not only higher but is also changing more slowly (EGLDAM, 2007). Although female genital mutilation is largely carried out by traditional practitioners, it is notable that according to the 2011 WMS survey, in Addis Ababa, health workers carried out over 20% of female genital mutilation on girls under 15 surveyed, and in SNNPR and the city of Harari the figure was over 10%. This may represent a trend towards the medicalization of female genital mutilation within Ethiopia, particularly in urban areas. Education appears to play an important role in shifting normative expectations surrounding female genital mutilation and facilitates its abandonment (UNICEF, 2013). In Ethiopia, the prevalence of female genital mutilation decreases with the level of a woman's education. The data on the status of daughters in Ethiopia shows that 18.7% of women with secondary education have a daughter who has undergone female genital mutilation, compared to 41.3% with no education. According to the data on attitudes to female genital mutilation, the percentage of women who support the continuance of female genital mutilation is 4.7% for women with secondary education or higher and 40.6% for women with no education. Between 2000-2005, support for female genital mutilation has halved. In 2000 there was a recorded 60% support rate for female genital mutilation but by 2005 this had dropped dramatically to a 31% support rate (DHS). The

EGLDAM data also shows a marked increase in the level of awareness of the harmful effects of female genital mutilation, from 33.6% in 1997 to 82.7% in 2007. (Boyden, Pankhurst and Tafere, 2013)

Like all other harmful traditional practices, female genital mutilation is performed by women, with a few exceptions (in Egypt, men are known to perform the operation). In most rural settings throughout Africa, the operation is accompany with celebrations and often takes place away from the community at a special hidden place. The operation is carried out by women (excises) who have acquired their "skills" from their mothers or other female relatives; they are often also the community's traditional birth attendants. The type of operation to be performed is decided by the girl's mother or grandmother beforehand and payment is made to the excise before, during and after the operation, to ensure the best service. This payment, partly in kind and partly in cash, is a vital source of livelihood for the excises.The conditions under which these operations take place are often unhygienic and the instruments used are crude and unsterilized. A kitchen knife, a razor-blade, a piece of glass or even a sharp finger nails are the tools of the trade. These instruments are used repeatedly on numerous girls, thus increasing the risk of blood-transmitted diseases, including HIV/AIDS. (Fact Sheet, 1987)

HIV/AIDS, in turn, contributes to the poverty situation of the individual, family and community and the nation at large. Thus HIV/AIDS creates a vicious cycle by increasing individual and community vulnerability to infection.

In Ethiopia, the spread of HIV/AIDS started and was initially localized in major urban areas located along major roads and commercial routes. The current surveillance report indicates a steady rise in HIV infection rate in the rural setting while on the other hand the trend in the urban areas seems to be stabilizing. Hence, without urgent attention and effective intervention,

a potentially devastating epidemic is a threat to rural areas, where the majority of Ethiopians live (>85%) and upon which the economy of the country heavily relies. (MOH 2004)

3.1.6 Unequal age partnership or marriage

Some marriages happen between older men and younger girls, that, men need such younger and active mate either for sex or for regeneration and culturally these marriages are believed to be rejuvenation of male.

According to Gage, 2007, large age gap between spouses may be associated with unequal power in the relationship, which may discourage partner communication about contraceptive use and family size desires, and safe sexual relations within marriage. This may, in turn, reduce the ability of a young bride to negotiate whether to have sexual intercourse or not and whether contraceptives and condoms to be used. Elder husbands, on an average have more sexual experiences, a greater number of sexual partners, and a greater lifetime risk of sexually transmitted infections, including HIV, which increases young women's vulnerability to these infectious diseases.

Many men use their greater status, incomes and access to other resources to marry younger women/girls in the case of death, infertility, or sexual inefficiency of their former wives. These sexually experienced men who had relationships with multiple sex partners may become HIV infected through their partner's behaviour and then transmit to the newly married innocent girls. Marriage done on unequal age, usually face two kinds of problems on women, divorce or miserable life due to over or under qualification of men's sexual behaviour. The sex practices that occur between inharmonious couples, therefore, contribute to HIV vulnerability as the cervix of young women or girls may be easily eroded and potentially enhancing risk of infection (James and Emanuel, 1999).

3.1.7 Early marriage

According to Gage (2007), the Amhara region of Ethiopia has one of the highest rates of child marriage in the world. In the Amhara region, the median age at first marriage was 16.6 years for women aged 25-29 compared to 24.2 years for men of a similar age (CSA and ORC Macro, 2006). Many girls may be married even earlier, as young as age eight or nine, and in some situations, are even promised for marriage at birth.

The gendered contours of HIV risks are profound. Women and girls, in particular, encounter numerous HIV-related risk factors that stem not from individual choice but that are embedded in the social relations and material realities of their societies. In some countries early marriage for girls and young women to elder men carries a considerable risk of HIV infection (Pisani, 2003). Elder men are more likely to have been exposed to HIV, the more so in countries with high HIV prevalence (UNAIDS, 2009).

A teenager's vagina is not well lined with protective cells as that of a mature woman. Her cervix will easily be eroded exposing them to chance of being infected. Therefore, the practice of forcing the girl child into marriage sometimes at an early age is not only traumatic but also physiologically devastating (James and Emanuel, 1999)

3.1.8 Domestic sex violence and marital rape

According to a study connected in Uganda, domestic violence leading to a heightened risk of HIV transmission is a widespread phenomenon, and research similar to that reported in that country could have been conducted in any one of a number of countries (Karanja, 2003).

According to World Health Organization, violence that exposes women to HIV/AIDS involves many direct and indirect forms. The direct transmission forms include sexual violence (forced or coercive sexual intercourse with an HIV infected partner, having multiple partners, engaging in transactional sex.) The indirect transmission form include inability to negotiate on condom

use, indirect transmission by partnering with riskier/ older men and, violence as a consequence of being HIV positive which create a barrier to women seeking HIV testing. Married women are at high risk of contracting HIV when cultural norms condone male supremacy or patriarchal control of the married couple's sexual activities. In such relation, women are obliged to have intercourse anytime and under risky conditions no matter what the male spouses have done before, whether he had had sex earlier and had come infected with any sexual disease. Men might demand sex at any time their desire arouses. Under such conditions, involuntary and forceful conditions lead women's organ to rip open causing trauma and increases the likelihood of HIV transmission (WHO, 2004).

3.1.9 The Effects of HIV/AIDS on Family

The consequence of HIV/AIDS pandemic on family disintegration has increasingly become serious, especially in certain East and Southern African countries. Evidence show that cases of orphan hood are being handled by either too young members of a household when either or both parents were afflicted and died or by a single parent or by too old guardian (grandparents), aggravating the psychological, economic and social problems of the remaining members. The fact that African society is characterized by extended familial relationship, the consequence of HIV/AIDS has been felt at all levels of the society: individual, household, community and national. Since the incubation period of HIV/AIDS is long, ranging between 5-10 years, the direct cost of hospitalization in certain areas in Africa has become so exorbitant that HIV/AIDS patients could not afford to pay from own resources and hence, the extended family, and the public or government have to face the direct and indirect burden sharing of the costs of the pandemic. The increase in expenditure for the treatment of HIV/AIDS pandemic and associated opportunistic illnesses and STDs implies reduction in the purchasing power at household and national levels with consequential effect on the outcome of universal health for all and child survival which were targeted to be achieved by the year 2000.(Pula,2001)

There is growing research and program literature on the impact of the HIV/AIDS epidemic on children. These impacts occur in a number of overlapping and interdependent domains, including children's psychosocial development. Some of these effects have been reviewed elsewhere (G Cornia (ed), 2002; J Gow & C Desmond,, 2002; S Hunter & J Williamson,, 2000; S Hunter & J Williamson,, 2002; L Richter, J Manegold & R Pather, , 2004.) and the main points from these reviews are reiterated here as an introduction to considering the impact of HIV/AIDS on children's development.

3.1.10 Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses: Loss of income of the patient (who is frequently the main breadwinner) Household expenditures for medical expenses may increase substantially Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person Death results in: a permanent loss of income, from less labour on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labour, resulting in a severe loss of future earning potential. In Ethiopia, a study of 25 AIDS- afflicted rural families found that the average cost of treatment, funeral and mourning expenses amounted to several times the average household income. Net farm income varies from 270 to 620 birr, depending on the region. Many times these expenses were paid for by selling productive assets, especially livestock.

Unlike other countries, where cooperation among households assists families with AIDS patients in coping with its impact, the vast majority of households in this survey, over 86%, reported not extending any support to other households. This probably reflects the fact that the households are too poor to be able to extend any material due to the status of women in Ethiopia, women who are widowed as a result of AIDS may often have to resort to commercial

sex work in order to support their families, further increasing their risk of HIV infection, if they are not already infected. (Demeke, M. 1993. The Potential Impact of HIV/AIDS on the Rural Sector of Ethiopia. A survey of 100 households throughout Ethiopia was performed in 1994 to assess the impact of HIV/AIDS on women and children. The workload of women who either had HIV/AIDS or lived in a household that was affected by HIV/AIDS, or both, were significantly different than the workload of women who lived in households that were not either afflicted or affected. The mean hours spent in agricultural tasks varied between 11.6 and 16.4 hours for households with HIV/AIDS, while women in non-AIDS households were able to spend 33.6 hours in the fields every week. The most significant difference can be seen in child care duties; women in non-AIDS households spent 25.7 hours per week caring for their children, while women in AIDS households spent between 1.9 and 13.1 hours per week. Clearly the difference in workload was due to the amount of time the women spent nursing the afflicted at home and outside the home Migration has been identified as an important family and community coping mechanism in the face of the HIV/AIDS epidemic. This is especially so in Southern Africa and, to a lesser extent, in Southeast Asia. Migration occurs for several reasons and people move both within and between rural and urban areas. Some identified forms of migration include 'going-home-to-die', rural widows moving to town to seek work or the help of relatives, and potential caregivers and dependents moving between kin households to achieve the most optimum care arrangements for all concerned. Children are frequently relocated. Adolescents are particularly affected by migration, as girls are sent to help out in other households, or as children are encouraged to try and fend for themselves by working including street work.

Changes in caregiver and family composition: As a result of death and migration, family members, including dependent children, often move in and out of households. Caregivers change and siblings may be split up. Separation from siblings has not only been found to be a

predictor of emotional distress in children and adolescents, (N Nampanya-Serpel,1998) but children become more vulnerable when they are cared for by very aged relatives due to the conditions of mutual dependency that often exist between adult and child. Death and migration may also result in the creation of child-headed households. These are most likely to form when there is a teenage girl who can provide care for younger children, when there are relatives nearby to provide supervision, and siblings either wish to stay together or are requested to do so by a dying parent. (G Foster, C Makufa, 1997)

New responsibilities and work for children: Several studies have shown that responsibilities and work, both within and outside of the household, increase dramatically when parents or caregivers become ill or die. In such circumstances, instances of work and responsibility being given to children as young as five have been observed. (UNICEF, 2000) Responsibilities and work in the household include domestic chores, subsistence agriculture and provision of caregiving to very young, old and sick members of the household. Work outside of the home may involve a variety of formal and informal labour, including farm work and begging for food and supplies in both the community and beyond. (S .Hunter & J Donahue,1997)

Education: In households affected by HIV/AIDS, the school attendance of children drops off because their labour is required for subsistence activities and, in the face of reduced income and increased expenditure, the money earmarked for school expenses is used for basic necessities, medication and health services. Even where children are not withdrawn from school, education often begins to compete with the many other duties that affected children have to assume. In addition, stigmatization may prompt affected children to stay away from school, rather than endure exclusion or ridicule by teachers and peers. A study in Zambia, for example, showed that 75% of non- orphaned children in urban areas were enrolled in school compared to 68% of orphaned children (UNICEF, 2000.) At a national level, a World Bank study in Tanzania suggested that HIV/AIDS may reduce the number of primary school children

by as much as 22% and secondary school children by 14% as a result of increased child mortality, and decreased attendance and dropping out. (Williamson, Levine & Foster, 2000)

Loss of home and assets: As effects on households deepen and parents die, children may suffer the loss of their home and livelihood through the sale of livestock and land for survival, as well as through asset stripping by relatives. (Horizons, 2003) Loss of skills also occurs because fewer healthy adults are present in the household and/or are involved in livelihood activities.

Health and nutrition: Children affected by HIV/AIDS may receive poorer care and supervision at home, may suffer from malnutrition and may not have access to available health services, although no studies have yet demonstrated increased morbidity and mortality among broadly affected children compared to unaffected control groups. In this regard, it has been suggested that the safety nets of families and communities are still sufficiently intact to protect the majority of children from the most extreme effects of the epidemic or alternatively, that orphans may not be worse off than peers living in extreme poverty. Indeed, with high levels of ambient poverty in most high-prevalence communities, it is difficult to ascertain which effects on children's health are attributable specifically to HIV/AIDS. (Foster &J Williamson, 2000)

3.1.11 Psychosocial Impact of HIV/AIDS

Affected and orphaned children are often traumatized and suffer a variety of psychological reactions to parental illness and death. In addition, they endure exhaustion and stress from work and worry, as well as insecurity and stigmatization as it is either assumed that they too are infected with HIV or that their family has been disgraced by the virus. Loss of home, dropping out of school, separation from siblings and friends, increased workload and social isolation may all impact negatively on current and future mental health. Existing studies of children's reactions suggest that they tend to show internalizing rather than externalizing symptoms in

response to such impacts depression, anxiety and withdrawal as opposed to aggression and other forms of antisocial behaviour .(Anarfi, 1997)

Long-term psychological effects of emotional deprivation: Children who grow up without the love and care of adults devoted to their wellbeing are at higher risk of developing psychological problems. (J Wild, 2002.) A lack of positive emotional care is associated with a subsequent lack of empathy with others and such children may develop antisocial behaviours. Not all children are, however, affected or affected to the same degree. Protective factors in the form of compensating care from other people, including teachers, as well as personality predisposition may lessen the impact on children of reduced care in the home environment.

The listed effects of the HIV/AIDS epidemic on children are likely to vary considerably by age. One might expect preschool-aged children, for example, to show primary effects on growth and health, and school-aged children to show education, work, psychosocial and vulnerability effects. In addition, none of the effects cited have been shown to be specific to children affected by HIV/AIDS, even if such a category of children can be more precisely defined. It is also impossible to isolate and exclude the effects of conditions that pre-date the death of a caregiver. Such pre-existing or development influences include poverty and social disorganization, parental preoccupation, depression and social isolation.

Of greatest concern, however, is the generality of these effects and their strong association with poverty. The impact of the HIV/AIDS epidemic on children and families is incremental; (G Foster & J Williamson, 2000) Poor communities with inadequate infrastructure and limited access to basic services are worst hit. Poverty amplifies the impacts of HIV/AIDS on children and renders their effects on children unrelenting. At the same time, changes associated with the illness and death of caregivers and breadwinners can push children into conditions of desperate hardship.

As John Williamson says: The common impacts of HIV/AIDS include deepening poverty, such as pressure to drop out of school, food insecurity, reduced access to health services, deteriorating housing, worsening material conditions, and loss of access to land and other productive assets. Psychosocial distress is another impact on children and families, and it includes anxiety, loss of parental love and nurture, depression, grief, and separation of siblings among relatives to spread the economic burden of their care. (J Williamson, 2000)

3.1.12 Vulnerability to Infection:

Apart from other impacts, children affected by HIV/AIDS are themselves often highly vulnerable to HIV infection. Their risk for infection arises from the early onset of sexual activity, commercial sex and sexual abuse, all of which may be precipitated by economic need, peer pressure, lack of supervision, exploitation and rape. Some studies of street children, for example, show that vulnerable children do little to protect themselves from HIV infection because the pressures for basic survival such as finding food—far outweigh the future orientation required to avoid infection. (J Wild, 2000)

3.1.13 Core Assumptions of Community Conversations

Community conversation (CC) is one of the intervention method which is used for prevention of HIV AIDS. It is an interactive process which brings people together and engages communities to discuss and explore the underlying causes fuelling the HIV and AIDS epidemics in their environment. Hence, people will discover about unequal power relations, harmful traditional practices or girls' vulnerability as drivers and maintainers of the epidemic. CC is explicitly based on the recognition that people have capacities, knowledge and resources to transform individually and collectively once they perceive ownership of a problem. The CC approach lays a unique ground which is participatory. It creates space for listening, speaking listening, speaking, being, inclusion and agreement. The aim is to deepen a community's

understanding of the pandemic, facilitate decision making and taking action in the local context. (Hibret Getaneh, *et al.* 2008)

3.1.14 The Unique characteristics of Community Conversation

What became clear early on was the incredible understanding and response that came forth from communities once knowledge of the science and epidemiology of HIV/AIDS was shared. Communities immediately began to recognize for themselves the values and actions that would have to change if what they were hearing about this new disease was true. They reflected on how it spread and caused disease throughout the body and in other individuals. They identified which behaviours and socio cultural practices would need to change if the epidemic was to be controlled. Such awareness came about through a process called 'Community Conversations'. This series of facilitated dialogues stands in contrast to conventional approaches in which people are grouped together for awareness-raising lectures, often accompanied by the distribution of pamphlets or posters. Such approaches often leave communities with bleak, prescriptive messages that deny them the benefits of dialogue on how the community could be affected. Communities are oftentimes overwhelmed and feel a sense of hopelessness following such events. A common comment after awareness-raising campaigns on condom use is, "If we do what they say, we'll never have any more children." (B.UNDPCCE, 2011)

In contrast, Community Conversations provide a platform for people to think through all the repercussions of a situation the way their individual values and behaviours, and those of their family and neighbours, affect people's lives. Community Conversations create a space for mutual learning and result in new perspectives. They help reshape relationships in line with transformed values. They are inclusive processes for enhancing the capacity of all Community is defined as a heterogeneous group of people living and/or working together sharing norms, values, and concerns, with common systems and structures for leadership, problem-solving and communication. Groups in the community make use of transformative tools and processes that

generate hope through the exploration of concerns, possibilities and opportunities for addressing the complex challenges of HIV and AIDS. They also create clarity on what needs to be done. All of this is accomplished within a methodological framework with specific steps. (B.UNDPCCE, 2011)

UNDP has identified a core set of human rights principles that guide the whole process of community conversation. These include equity, equality, non-discrimination, human dignity, non-violence, participation, inclusion, accountability and responsibility. The dignity of individuals and families is preserved and enhanced in an environment that encourages compassion, acceptance and accountability. Stigmatization, coercion and violence are avoided. (B.UNDPCCE, 2011)

3.1.15 Historical Development of Community Conversation

Community Conversations were adopted by UNDP as a result of their success in creating transformation at the community and institutional levels. The methodology, which emerged from the work of the Salvation Army (Zambia) and Enda Tiers Monde/Santé (Senegal) in the mid-1990s, has been enriched by the work on transformational leadership carried out by UNDP in 2001. UNDP has implemented the Community Conversations approach in a number of countries with very different social, economic and political situations those with high and low HIV prevalence rates, in highly urbanized as well as rural areas, in countries that are relatively high on the Human Development Index and others that are low. In all instances, this approach has brought about a fundamental shift in the way communities get work done resulting in a series of actions and decisions that have arisen from communities themselves. It is an approach that can be used to deal with other human development challenges as well, including wealth generation, democratization and good governance.(B.UNDPCCE, 2011)

Community Conversation was initiated in Ethiopia in 2002 by the National HIV/AIDS Prevention and Control Office (NHAPCO) and in a first phase rolled out by NGOs with UNDP financial assistance targeting HIV prevention. The original set-up encompasses eighteen discussion sessions of 50-70 people living in one Peasant Association (PA) who commit to follow the cycle, which is-completed over one year. CARE International in Ethiopia's HIWOT (Health Improvement and Women Owned Transformation) program adopted the approach. It initiated 105 CC groups in fourteen districts in four zones (5-7 districts), one per selected PA, on issues related to HIV and sexual and reproductive health (SRH) between 2006 and 2007. FHAPCO provided training materials, led the facilitator's training and participated in supervision Facilitators with leadership competencies were identified after volunteering for this activity. They were trained for two weeks prior to setting up their group. Three facilitators were trained per CC group and equipped with background information and skills to foster group dynamic processes. Literacy status was considered as a major selection criterion for CC facilitators, however, flexibility was allowed in pastoralist areas where literacy levels are generally low. At the beginning of each session one person was chosen to document the process while others facilitate the discussion and ensure adherence to ground rules. Supervision was provided as peer support by sharing challenges and lessons learnt at quarterly review meetings of CC facilitators at district health head offices. Ideally, participants of a CC discussion group are representative of different segments of the community. They include diverse community members: farmers, civil servants, shopkeepers, craftsmen, religious and informal leaders, PA administrators, men, women, adolescents, etc. Participation in these groups is voluntary. The participants are self-selected and motivated by an interest in HIV/AIDS issues. Most of the 105 groups fulfilled the criteria of representing all segments of the community, however, a slight gender imbalance was present in all four zones. . (Hibret Getaneh, *et al.* 2008)

3.1.16 The Role of Community Conversation in Preventing HIV/AIDS

There are a number of documented success stories of CC in many parts of Ethiopia since 2002. Our experience is the first of its kind in adopting CC on integrated HIV/SRH issues including harmful traditional practices and family planning. After 12 months of implementation, witnessed changes in risky behaviours and stigmatization in remote rural areas where HIWOT is working. Some CC groups have condemned early marriages in their communities and are committed to protecting schoolgirls from discontinuing their education due to early marriage and abduction. Forced and early marriages fuel health problems such as HIV transmission, complications during pregnancy and childbirth, and maternal mortality. Other CC participants decided to stop Female Genital Mutilation in their PA or penalize traditional circumcisers (frequently traditional birth attendants) who do not use new razor blades for each girl they circumcise. In some places, participants discussed harmful traditional practices apart from HIV/AIDS (for example milk teeth extraction), and passed by-laws to stop female genital mutilation in their locality. They charged village leaders with the responsibility to follow-up adherence to the new rules and report to the CC members and a legal body if anyone in the community is found practicing female genital mutilation. CC participants in some PAs reached a consensus to avoid practicing risky behaviours that predispose to HIV infection, such as going night club sand drinking alcohol, which is very common in the target community, as well as practices like widow inheritance. The sessions have helped reduce stigma and discrimination towards people living with HIV (PLWHA). In first sessions after CC group inception participants shared negative attitudes regarding PLWH, but through discussion they changed their mind and concluded that ‘all of us are at risk of acquiring HIV for one reason or another’ .Some CC groups started providing care and support to PLWHA and their families by contributing money monthly. Thus, affected families were encouraged to disclose their health and social problems as a positive HIV status was the entry point to receive support and linkages

with available associations. Other groups transformed into Anti-AIDS clubs, doing advocacy and fighting misconceptions. Some are giving social support to PLWHA. All CC groups in different sites agreed on the importance of utilizing Voluntary Counselling and Testing (VCT) services and most members underwent VCT. For example, in West Harerge district 2916 CC members and their spouses underwent VCT during the project period. Those who tested positive (13 female and 5 male participants) were referred to health facilities. (Hibret Getaneh, *et al.* 2008)

4 RESEARCH METHODOLOGY

4.1 Description of the Study Area

4.1.1 Location

Oromiya Zone is one of the eleven zones of ANRS and situated between 100 01'and 110 25' North 390 41' and 400 24' East bordering North Showa in South and West, South Wollo in North and in East the AFNRS, with capital town called Kemisse, 325 km along Addis Ababa – Dessie asphalt road. It has five rural and two town districts with101 rural PAs.

The total breadth of the study area is 6240 hectare and shares 1.59% of the total land mass of the zone. The study area bounds Dawacafa in the East, and in North Kamise city in West Antsokia districts (North Showa), and ArtumaFursi district in the South. The study area is agro ecologically classified as mid altitude lowland (kola) 100%.and annual rainfall range from 600-900 more of bimodal in patterns and erratic in nature . The elevation ranges from 1500-1650 m.a.s.l with temperature ranging from 22-28^{0}c. (OZAAD, 2013).

4.1.2 Population

The total population of the study area is estimated to be 4976, and out of this, males are 2435 and females constitute 2541. Ethnically, nearly 99% of the population of the study area is Oromo and the dominant religion is Muslim, constituting about 100% (OZAAD, 2013).

4.1.3 Agriculture

Farmers in the study area undertake mixed farming. Among the dominant crop type that are grown, are sorghum, maize and 'Teff "are the leading cereals. In addition, chickpea, etc are grown in small quantities in the area. In addition, Khat cultivation has become the major practice on sloppy areas using stone built bench terraces. Khat constitute major cash income source and also used for domestic consumption for both regular use and religious ceremonies

like ’Du’aa’ (prayer). The average farmland holding is 0.75 ha. Most of the agricultural output comes from fragmented peasant land holdings. Oxen serve as primary source of traction power and usually farmlands situated in the plains of Borkena valley are ploughed using motor power. The plain areas use very high number of hired labour for weeding, harvesting, threshing and transporting and therefore, the urban and rural areas would be congested by highlanders who come to seek jobs from the months of August to January. The farming system is mixed, comprising crop and livestock although, production and productivity is very low. The main livelihood strategy is on–farm activities and few still depend on off-farm activities. Due to erratic rainfall, agriculture in general and crop production in particular could not meet food demand of the families. The best alternative and widely used coping mechanism used these days is to send children, especially, girls to the Middle East countries investing all assets at hand, hoping future gains. Large numbers of males also flock to Djibouti, Saudi-Arabia, Yemen to mention some for temporarily or permanent work opportunities. In general, there is high mobility of people due to proximity of the zone to bordering countries and hence there is significant income gain from remittance to the families. (OZAAD, 2013).

4.1.4 Health

Today, many things have been improved as a result of joint effort of government and non-governmental organizations- like the World Vision Ethiopia to improve the status of rural health services of the zone and hence the number of health centres and community health posts has reached 26 and 101 respectively enabling the service coverage to reach 96% of the population. (OZAHD, 2013)

Situations pertaining to the study area are not unique and therefore, share the general milieu of the zone regarding current improvements. Regarding health service improvement and service provision, the current coverage has reached 100% and number of health centres and community health posts has reached 1 and 2 respectively (KCHO,2013).

4.1.5 Education

The zone was exceptionally forgotten prior to EPRDF regime, Situations have been changed within this nearly a one and half decades and education coverage for eligible age group has now reached 96% from 2% at zone level, and 100.6% for Kamise town administration (OZAED,2013). Today, gross enrolment ratio has alarmingly increased while the status of the adult illiteracy remained unchanged except some school dropouts who go back home (rural) to constitute this category. As clearly put in the country's MDGs to mitigate illiteracy by the year 2015, major activities are undertaken in the zone and number of schools starting from satellite station (in every 3-5 km) up to technical and vocational training centres have been flourished in these few years. However, majority of adults in the area are still in the trap of illiteracy, which makes dissemination of innovation hardly possible.

4.2 Sampling Procedures

Since the study area is pre urban and the population is homogeneous, simple sampling procedure has been employed for the purpose of data collection. The total house hold (HH) the study area is 1089 The number of sample respondents was totally 366, out of which 92 were CC member and 274 Non CC member I used Krejcie and Morgan, 1970 sample size table(MSW 006,block 3 page 20)to determine the sample size Then respondent selection in all Kebele Administration was by systematic random sampling procedure. Respondents were the heads of the selected households. The total population of CC members are 120 house hold where as the number of non-members is 969 The selection of respondents was done by a fresh list of households, which was prepared jointly with local key informants like the community representatives, village leaders, village elders and the Development Agents (DAs) working in Kebele.

4.3 Design

The study was conducted to assess the role of community conversation in prevalence of HIV in the study area. The qualitative and quantitative data were collected; the qualitative data were collected from key informant such as kebele health exestuation worker, kebele manager, kebele administrative and from Kamise city health office. The data were collected face to face by enumerators and researcher. Finally the questionnaires were arranged according to their code number and feed in to computer and analysed.

4.3.1 Types and Sources of Data

Qualitative and quantitative data were collected so that both together can complement each other and help to reduce some of the weaknesses of using single method. Primary data were gathered from 366 sample households, 8 key informants, and 4 focused group discussions with individuals who have ample knowledge and experience about community conversation.

4.3.2 Organization and Implementation of Data Collection Methods

The main methods of data collection in this study were the interview schedule, key informant interviews . Interview schedule was developed and administered to the randomly selected household respondents.

4.4 Data Collection Methods

The data for the study were collected from primary and secondary sources. The main source of primary data will be both kebele CC group members and non CC grouped family household survey. The survey was conducted from 366 households selected from both group in the kebeles. Structured questionnaire were used to collect data about the contribution of Community Conversation on HIV/AIDS control and HIV prevention. Relevant secondary data were collected from books, articles, and unpublished reports.

The pilot test was done using 15 participants from the already selected two kebeles Qello and Qachuer kebele CC Group. Some unclear and vague items were discovered during administration and it was also learned that researchers' assisted administration of the instrument is more appropriate than the self- administered version. Among the items of data collection tools one item was excluded and the researcher added an item that addresses harmful traditional practice.

4.5 Study population

The study population for this particular assessment were the two rural kebele kachuer and Qelo kebele HH population they are 1089

4.6 Instruments

The first and foremost data collection tool used in this study is:- interview , focus group discussion and key informant interview

4.6.1 Interviewee

Survey Structured questionnaire were prepared for interviewee to collect important data pertinent to answer research questions. The questions are aimed at collecting detailed data. Data were collected from heads of each selected sample household head. (Appendix1).

4.6.2 Focus group discussions

Focus group discussions were conducted at two rural kebele with purposively selected groups of adults and adolescents from each Kebele Administration. In each focus group discussion, the numbers of participants selected were seven adults (two females and five males) and two adolescents (one girl and one boy). Thus, one focus group discussion in each Kebele Administration were conducted and all together, the numbers of participants were 18. The focus group discussions were used to collect detailed and spontaneous information on issues pertinent to HIV/AIDS in the community such as demographic, socio- cultural, sexual, and how to get information about HIV/AIDS to combat against HIV/AIDS (Appendix 2).

4.6.3 Key informant interviews

Key informants were interviewed using a check list consisting of open-ended questions. All key informant interviews were conducted by the researcher. The interview lasted approximately 45-60 minutes and took place in the workplace or another private setting chosen by the participant.

In each of the selected kebele administration, key informant interviews were held with different individuals whose responsibilities and knowledge had a bearing on HIV/AIDS. They included: Community Health Extension Worker, kebele administration manager, kebele administration head, kebele development agent, CC facilitator Primary School head, person living with HIV/AIDS (PLWHA). The interviews were also intended to generate information on the leaders' perceptions of the gravity of the HIV/AIDS problem in the communities. These respondents were viewed as people who were in constant touch with the community, and therefore widely knowledgeable about the community dynamics. Interviews with them helped in generating information on what people perceived to be the factors influencing of HIV and the activities and responses given by the community in preventing HIV/AIDS. (Appendix 3).

4.6.4 Method of Data Analysis

Quantitative analysis techniques were employed to analyse the data that were collected from primary sources. The study used statistical tools including descriptive statistics for the analysis. Then from CC group 92 and from non-group 272 randomly selected sample households were asked the identified factors contributing to the prevalence and are made to place their agreement or opinion on a scale consisting five points- strongly agree, agree, neutral, disagree and strongly disagree with values of 5,4,3,2 and1respectively. Categorical response differences were generalized using percentages.

4.6.5 Descriptive analysis:

Descriptive analysis such as percentage were used to make analysis in the form of tables and to supplement the data that collected from focus group discussion and from key informant interviews were used.

4.7 Ethical considerations

The participants were informed about the purpose of the research the participants were also informed about if any risks they may face as a result of being part of the research. The participants were also informed about the benefits that might gain as a result of participating in the study. They informed to feel free to make an independent decision without fear of negative consequences such as stigma and any negative measure by the kebele official or without expecting positive privilege like pocket money from the researcher or the government.

5 RESULTS AND DISCUSSION

In this study, the participants indicated that the schedule for community conversation program session was decided through discussion and agreement by the CC members. The participants select the most comfortable day and time outside of usual working, marketing and praying time. In general, the schedule was comfortable for all participants and thus made them happy with the program. When planning a conversation sessions, it is important to consider participants' interest. It is also important to be flexible with the program according to the community's interest. This study found that the participants make the schedule for community conversation sessions as comfortable for them since it has been selected by discussing with all CC members.

In this study, the participants reflected that the community conversation program enabled the group members to accept accountability and responsibility for their issues. Most participants viewed that the availability of the CC program in their kebeles as a remedy for resolving the issue of HIV/AIDS. The participants indicated that behavioural changes seen in their community since the commencement of the CC program encouraged them to work more. After the community conversations started in their kebeles a number of behavioural changes were seen in the community conversation group members. The changes were such as decreased stigma and discrimination of HIV/AIDS victims or their families, minimized exposure to risk factors that could result in the spread of HIV/AIDS such as alcohol consumption.

Since the community conversations, the participants had awareness about HIV/AIDS, mode of transmission and method of prevention, and were even in a position to help the victims in different ways. According to participants, before the CC came into action, individual infected by HIV/AIDS had blamed each other, even took to the jungle to be killed, just to hide the information, because they perceived by community as prostitutes or breakers of the law of

Creator (Allah). But now a days the community conversation participants ares in a position to help the victims due to the fact that CC had changed the perceptions towards HIV/AIDS.

The finding revealed that CC program not only benefited and strengthened the home and community-based care program but also decreased stigmatization and discrimination against people living with HIV/AIDS. Positive change was observed as a result of CC in attitude related to HIV and AIDS, and there was a commitment to improve community-level responses to HIV and AIDS. The program also strengthened the sense of teamwork among the participants.

The participants indicated that HIV/AIDS awareness level increased due to the CC program, especially about common manifestation of HIV/ AIDS, mode of transmission and methods prevention. Improving HIV/AIDS awareness level, decreases high risk behaviours, which fuel the spread of HIV/AIDS in the community. This indicated that views towards HIV/AIDS victims had changed since the CC program started. The participants were also able to describe the HIV mode of transmission as through sexual intercourse, sharing sharp materials, and from mother-to-child during pregnancy.

The participants indicated that methods of HIV/AIDS prevention included abstaining from sex until marriage, being faithful to one partner, and using condoms. However, in using condoms there is different attitude some community conversation group members regarded the use of condoms as allowing illegal sex and violating the law of Allah and thus did not accept it personally. The finding of the interviewees and the discussion made with the key informant and group discussion organized as follows:-Attitude of respondents about Determinants of HIV/AIDS Prevalence among community conversation group and non- group respondents.

Knowledge of HIV status helps HIV negative individuals make specific decisions to reduce risk and increase safer sex practices so that they can remain free of disease. For those who are

infected with HIV, knowledge of their status allows them to take action to protect their sexual partners, to seek treatment, and to plan for the future.

Table 3 VCT test of respondent

Status of HIV/AIDS blood test * community conversation members Cross tabulation				
		community conversation members		
		yes	no	Total
Status of HIV/AIDS blood test	get blood tested	92	96	188
	not get blood tested	0	178	178
	Total	92	274	366

When we look at the response percentage statement- wise, we observe differences in perception between cc members and non cc members on determinants of HIV/AIDS as discussed below.

Statement 1: "HIV/AIDS is more prevalent, has got different understanding among strata with more than 89% responses in category of agree and strongly agree, for strata CC members and 41.97%for strata non CC members this exceptional higher score is recorded by community conversation group member's respondents, on "strongly agree " with This indicates that, community conversation group members respondents have better understanding about adolescent behaviours and their vulnerability in addition to their access to information.

Table 4respondent response on HIV infection

The HIV/AIDS infection is more prevalent in the active age group (18 - 49 due to their higher indulgence in unsafe sex practices * community conversation members Cross tabulation				
		community conversation members		Total
		yes	no	
The HIV/AIDS infection is more prevalent in the active age group (18 - 49 due to their higher indulgence in unsafe sex practices	strongly agree	80	94	174
	agree	2	21	23
	neutral	10	75	85
	dis agree	0	84	84
Total		92	274	366

Statement 2:"Women are more vulnerable to HIV/AIDS''_ has been perceived somehow differently by community conversation group members respondents. Because 94.5% of community conversation group members responses were between strongly agree and agree. while non-community conversation group members respondent in strongly agree and agree category with 50.36. % , This implies that the disproportionate prevalence of HIV/AIDS, the vulnerability of women than men the unequal power relation among men and women is not well understood by non- community conversation group members. This low score can be due to lack of information about the general disproportionate prevalence and wider vulnerability of women than men.

The finding also showed that religious and community-based institutions also play a significant role in violating women's right. One of the key informant interviewee has revealed some of the ways through which women's right are violated as follows.

Deeply entrenched gender inequities perpetuate the HIV/AIDS pandemic in the area since it grants women lesser status than men, restricting property, inheritance and other rights. Social, religious, economic and cultural practices create, enforce and perpetuate legalized gender inequalities and discrimination in all aspects of women's lives. As a result, women continue to be disproportionately vulnerable to HIV/AIDS. Even if there is improvement in the earlier time , women were not allowed to share property obtained throughout the periods of their stay in marriage at times of separation or divorce. Women, take that as religious commandments. Therefore, unknowingly they give up their rights fearing rejections to take the case to the court that follow from religious leaders or community. Therefore, Women are limited right to own property is a manifestation of gender inequity that has grave implications for them in the context of HIV/AIDS. (Interview with the manager of Qachuer Kebele)

The other key informant explain the right of women:- even if today show improvement In earlier time Women are mistreated and live in unequal position with their fellow men not only concerning human rights but owning or producing property, as well. Women are not allowed to produce their own property while in marriage. These force women to engage in prostitution or bartering sex for income after divorce. There was a proverb or a say of older people pertaining to women's' right to own property and stated as follows.

If a woman comes with heifer or cow during her marriage, sell and buy a male donkey, because the cow will multiply and your stall will remain empty during divorce, if she takes away what she had brought. This proverb works and therefore, women are obliged to look to the hands of

their husband for monetary needs and they may go for sex if they don't satisfy of their needs. (Interview with Qello Kebele administrator)

Statement 3: "HIV/AIDS is more prevailing among less educated people has got different perception among the categories. In community conversation group members, 94.56% response strongly agree to agree category and in non- community conversation group members 55% responses is within strongly agree to agree category. These better scores have been achieved by the recognition that behaviour exceeds education, in community conversation group member's strata.

Statement 4: "HIV/AIDS will spread more " has got different recognition and hence responses of community conversation group members 97.3% in community conversation group members strata shows strongly agree to agree category were as non- community conversation group members strata show 34.2% strongly agree to agree category This show that information is considered important in the community so community conversation is important to get information.

The data from focus group discussion showed that the program played an essential role in changing the attitude of some participants to freely talk about issues that they could not raise before because of fear and cultural taboos. While discussing HIV and AIDS in CC sessions, it was uncommon for participants to raise sex-related issues which the communities were not hitherto comfortable with. About two focus group discussants mentioned that because of the awareness they got through the CCs they had become courageous to speak out on sex related issues and thus contributed to the efforts to reduce the transmission of HIV. More than half of the focus group discussants also reported that they felt courageous enough to raise sex related issues and discuss sex with their children because of the lessons they got from the CCs.

One of the focus group discussant, for example, stated:-

> I used to discourage my daughters not to raise sex related topics at home. As a mother, I did not want my kids to mention sex organs which are considered taboos. But after taking part in the CCs, I have come to know that it is almost impossible to learn all about HIV and AIDS and other STDs without using such words. I admitted that it was wrong of me to discourage my daughters from raising sex related issues. Now I myself have started to raise and discuss such issues with my kids (focus group discussion member, Qello Kebele).

Statement 5: " Rape and abdication enhance the prevalence of HIV/AIDS", has also got different responses with nearly 97.8% and 37.2% responses of agree to strongly agree category in community conversation group members and non- community conversation group members respectively. This statement has got higher score in community conversation group member's strata because of increased awareness about domestic violence and its contribution to HIV/AIDS prevalence.

Focus group discussions and key informant interviews have revealed that, rape and abdication is a critical problem especially in the areas, although it is decreasing. A key informant interviewee from Kamise city HAPCO Office illustrate this by claiming that, Rape and abdication is still practiced in the two rural Kebeles. If a man rapes a girl, he then appeals to elders or religious leaders so that they go to the parent of the girl for mirage proposal negotiation. The family does not resist these honourable elders of the community and therefore settles the dispute disfavouring the raped. Then, the issue is solved before it reaches the court. This practice face to HIV (Key Informant Interview with, Kamise city HAPCO Office)

Table 5respondent response on rape and abdication

Abdication and rape enhance the prevalence of HIV/AIDS * community conversation members Cross tabulation				
		community conversation members		Total
		yes	no	
Abdication and rape enhance the prevalence of HIV/AIDS	strongly agree	83	72	155
	agree	7	30	37
	neutral	2	21	23
	dis agree	0	151	151
Total		92	274	366

Statement 6: "Traditional healing practices favour the prevalence of HIV/AIDS in the community" is believed by both strata with responses percentage values of 98.67% and 31.1% in the category of strongly agree to agree for community conversation group members and non-community conversation group members respondents respectively. This show that community conversation group members have the knowledge of that the practice is harmful. Therefore, the high response for this statement show that the community conversation method of communication is more power full to disseminate information and create change in perception about the danger posed by the practice.

Statement 7: "Harmful traditional practices enhance the prevalence of HIV/AIDS", is highly supported by community conversation group members respondents with 98.67% response in the category of strongly agree and agree and 41.78% of non- community conversation group

members responses with strongly agree and agree. This show that community conversation method is more successful to create awareness.

The community conversation share knowledge one of the focus group discussion member said that, ‘before I was not in CC, I used to encourage people to pull out milk teeth now thanks to CC I understood the problem that come from this practice (focus group discussion member Qello Kebele)

The other member also added by saying that he was one of the supporters of harmful traditional practice especially female genital mutilation. However, after he learnt about the effect of this practice from CC, he no longer practiced it on his daughters. He also influenced others by providing education on the negative effects of FGM on women. Consequently, people stopped practicing female genital mutilation in his area.

Statement 8: “Unequal age partnership in marriage also favors the prevalence of HIV/AIDS”, is supported by community conversation group members respondents, strongly agree 73.3% agree 25.34% and 1.33% neutral and non-community conversation group members strongly agree 18.67% , agree 12%, neutral 21.77%and disagree 47.55%. This low score is due to high practice of early marriage and unequal age marriage relationship in the society the effect of these practices is well understood in community conversation group members even if there is a neutral score. So community conversation method is effective way of changing the attitude of community.

Statement 9: “Blood test ”has gotten different recognition among the strata. 96.73% responses in community conversation group members and 49.2% in non-community conversation group members in the category of strongly agree to agree. These show that even if there is a trend of blood test before marriage, but they did it without knowledge of the use of pre marriage blood test. But in community conversation group members have better understanding than non-

community conversation group members then these indicate that community conversation as a method of communication it is very effective method. The data from focus group discussion is illustrated as follows. This program has initiated us to give a solution to our problems by ourselves. After a long conversation; all the CC members or participants got Voluntary Counselling and Testing.one of the (focus group discussion member from Qello kebele)the other focus group discussion member mention that it is decided in our Kebele by religious leader and other social institution not to perform engagement without HIV test but the difference is that most of them perform VCT one times they do not check after window period or after 3 months so they make a test by obligation not by knowledge.

Table 6 respondent attitude towards blood test

Blood test before marriage is helpful to reduce the spread of HIV/AIDS * community conversation members Cross tabulation				
		community connversation members		Total
		yes	no	
Blood test before marriage is helpful to reduce the spread of HIV/AIDS	strongly agree	83	75	158
	agree	9	60	69
	neutral	0	27	27
	dis agree	0	112	112
Total		92	274	366

Statement 10: “Khat chewing, smoking shisha and alcohol drink induces possibility of spread of HIV/AIDS due to risky sexual behavior”, has got 92.39% strongly agree to agree responses

from community conversation members group respondents and from non- community conversation members group respondents got response 37.5%. Theses better understanding scores in community conversation members group respondents this show that, community conversation communication method raise the understanding of people and built well conscious of the danger.one of the CC member said, He stopped chewing khat and drinking alcohol after he got the health effect of the substances and their risk in transmission of HIV infection. He also added that he is leading healthy family now.

Statement 11:“ polygamy, was one of the divisive issues among the respondents as observed during administration of the interview schedules. It is obvious that polygamy is allowed in Islam religion, where all of the sample in the study are Islam. This disparity has been observed on percentage scores, i.e. community conversation members group 95.65 % non- community conversation members group 40.14% responses. The practice of polygamy is deeper in non-community conversation members group categories. This might be the reason that non-community conversation members group respondents did not strictly understood the danger posed by the practice.

Table 7respondent response to polygamy

community conversation members * Men's polygamy enhances prevalence of HIV/AIDS Cross tabulation						
		Men's polygamy enhances prevalence of HIV/AIDS				
		strongly agree	agree	neutral	dis agree	Total

community conversation members	yes	81	7	4	0	92
	no	57	53	53	111	274
	Total	138	60	57	111	366

Statement 12: “Lack of adequate knowledge among people ”. This statement has got different recognition among strata but show relatively a similar recognition with majority of responses falling strongly agree category, 100% and 57.78% community conversation members group categories and non-community conversation members group categories respondents respectively. This shows that all respondents have better perception about the importance of knowledge in curbing the pandemic.

A man who had participated in one focus group discussion stated that he has learnt a lot about HIV and AIDS related issues. He admitted that previously he was not comfortable to live with people living with HIV. But after he had learnt in the CCs about how the virus is transmitted he no longer marginalized those living with the virus. He said since then he has been eating, drinking, hugging and associating with those living with HIV. These testimonies show that CCs somehow played a role in providing valuable information and changing some participants’ views about HIV and AIDS.

Statement 13: “Lack of information source is strongly agree and agree upon by all strata with the percentage score of 100% and 67.56% for community conversation members group categories and non-community conversation members group categories. These scores are achieved due to better understanding about the importance of information exchange in the community to mitigate the pandemic.

Statement 14: “Household poverty has got different perceptions. Responses of non-community conversation members group categories respondents have lower percentage score of 53 % compared to community conversation members group categories 95.67%. This show that community conversation members group have an access to information and know the influence of poverty but almost equal per cent of non-community conversation members group score for the statements is close to almost undecided and dis agree category that shows failure to recognize the danger of the practice in relation to HIV/AIDS prevalence.

Table 8 respondent response about vulnerable group

Household poverty and food insecurity lead the family more vulnerable to HIV infection through migration for labour * community conversation members Cross tabulation				
		community conversation members		Total
		yes	no	
Household poverty and food insecurity lead the family more vulnerable to HIV infection through migration for labour	strongly agree	81	108	189
	agree	7	39	46
	neutral	4	37	41
	dis agree	0	90	90
Total		92	274	366

Statement 15: “Mobility of labour, has got low response among non-community conversation members group categories respondents 50.67% and compared to community conversation

members group categories 90.67% respondents. The non-community conversation member's group categories score for the statements are close to almost half undecided and dis agree category. This show that the level of awareness between the two category, the community conversation members group and randomly selected respondents of non- community conversation members group.

Statement 16: "Occupational situations , has got greater values in terms of percentage of score in the category of agree to strongly agree scores among community conversation members group categories respondents than non- community conversation members group categories . percent score for community conversation members group categories is (96%) while it is 71.12% respondents respectively. Non-community conversation members group categories people's low response might be due to the fact that they do not well know the work condition of such people and in their religion sexual intercourse without nika(faith agreement) is not possible even why not for one day.

Statement 17: "Unsafe sexual behaviour ": community conversation members group categories and non-community conversation members group categories respondents have agreed with responses of 92% and 44.89% in the category of strongly agree to agree respectively. This shows that, all strata have different idea regarding the importance of condom to curb the pandemic. Even if there is religious connotation attached to its wider applications in the Muslim religion followers but the community conversation group members have highest awareness level than the non- community conversation group members.so the method of community conversation is effective means of communication. One of focus group discussion member say that as a knowledge condom is effective to protect from HIV and other STDs but I prefer to abstain till the engagement because the best way of overcome the problem of HIV is abstinence as our religion supports it (Focus group discussant Qello Kebele)

Statement 18: “Having multiple sexual partners is perceived differently by non-community conversation group members respondents. Only 46.67% responses are in the category of strongly agree to agree while 53.33% were in other categories that fall in undecided and disagree category. Community conversation group members responses were 100% fall in strongly agree and agree category these shows that different awareness and understanding case of the people is the way they got information so community conversation method of communication have an ability to build the conscious of the group members.

Statement 19:“urban people are more vulnerable than rural people due to different reason.”, has got better percentage score by community conversation group members respondents than the other strata with score (92%). Non- community conversation group members respondents reflected their disagreement and undecided by percentage score of 52.89% and with strongly agree and agree by 47.11% and 93.34% in strongly agree to agree category. Despite the fact that, community conversation group member’s people had better perception scores than non-community conversation group member’s respondents, the lower score for this statement might be lack of awareness of the respondents.

Statement 20: The statement that says, “Widow inheritance enhances the spread of HIV/AIDS” has got relatively less score by non- community conversation group members respondents than community conversation group members respondents of 69.7%, and 96.73% in the category of strongly agree to agree respectively. The per cent scores show that non- community conversation group members respondents response was undecided and dis agreed score 31.3 % to slightly agree and strongly agreed while community conversation group members respondents response was in the category of strongly agree and agree. These indicate that even if there are different method of communication to disseminate information to the people the community conversation method is the most effective one.

Table 9respondent response about window inheritance

* Widow inheritance enhances the spread of HIV/AIDS Cross tabulation						
		Widow inheritance enhances the spread of HIV/AIDS				
		strongly agree	agree	neutral	dis agree	Total
community conversation members	yes	70	19	1	2	92
	no	147	44	23	60	274

One of focus group discussion member in Qachuer Kebele said "I used to support widow inheritance I became a member of CC program. This is due to the fact that I used to think that children of the deceased father may face problems. Currently, I understand the negative effect of this culture on the spread of HIV/AIDS and violation of women's right.

Statement 21:"Transactional sex, where gifts or materials are rewarded for sexual intercourse, increases the chance of spread of HIV/AIDS" is well recognized by all strata with responses is non- community conversation group members respondents response 88.89% and community conversation group members respondents response 98.67%. This show that even if the score is somewhat near but the community conversation group members respondents are more informed than non- community conversation group members respondents.

Statement 22: "Discriminating PLWHA is the main reason to intensify HIV/AIDS prevalence" has got lower recognition among non- community conversation group members respondents. Discriminatory perception or idea is more prevalent in non- community conversation group

members respondents than community conversation group members respondents. The score of highly agree and agree was 48.17% and 100% respectively. This low score also emerge from lack of knowledge about the ways of transmission of the virus so community conversation method is effective way of transferring knowledge.

Table 10respondent response about discrimination

		Discriminating PLWHA is the main reason to intensify HIV/AIDS prevalence				
community conversation members		strongly agree	agree	neutral	dis agree	Total
	yes	81	11	0	0	92
	no	83	49	62	80	274
	Total	164	60	62	80	366

Statement 23: “Divorce and remarriage can lead to infection of HIV/AIDS”, has got different recognition among the strata. Percentage scores were 93.3% for community conversation group member’s respondents,56.89% non-community conversation group member’s respondents. community conversation group member’s respondents score was found greater than the non- community conversation group member’s respondents s that shows better recognition of the factor as contributor to prevalence because community conversation group member’s respondents people are accessible to many information sources than non- community

conversation group member's respondents or community. Remarriage after divorce are usually done without going for blood test and if they tested they don't wait for three month for the second check-up (window period) this exposed for HIV. Hence enhances the spread of HIV. Focus group discussion held with Qachuer Kebele discussants have revealed that divorce and remarriage how it spreads HIV/AIDS as stated below.

> After divorce or separation, some re-join by community mediators like elders or religious men. The question of blood test is a subject which widens the disagreement and hence rose by neither. Therefore they re-join without blood test. This also becomes a chance for the probability of expansion of the pandemic. (Focus group discussion Quchuer Kebele). The other focus group descendants' state:- Some divorced or separated woman want to put her spouse in envy by deliberately going with men for sex thinking that her husband will regret and take her back home. If she get a chance to re-join her husband there is a probability of exposed to HIV unless they take HIV test properly. (Focus group discussion, (Qello Kebele)

On the other hand, divorce cases are also mentioned as inhibitors of HIV prevalence to save one self and future generation. Qello Kebele key informant added how divorce can reduce the danger of HI/AIDS in some cases.

Sometimes, either the male or the female is not faithful to their partner. In this case, the innocent partnership will fall in danger of HIV/AIDS. If either of them suspect or have concrete evidence of extra-marital sexual relations, divorce can save innocent party. Therefore, in such case we see the advantage of divorce to escape from the epidemic. (key informant interview from Qello Health extension).

Over all the argument here is divorce by itself not the case for HIV but if it followed by remarriage without proper blood test it spreads HIV/AIDS**.**

6 CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This research was carried out to address components of the communication strategy which examine the awareness of level of community conversation members group by comparing with non-community conversation members group. The research was based on gathering and interpretation of qualitative and quantitative data. Based on these facts the following conclusions have been drawn.

It was found out that the CC program was making important contribution in preventing and controlling the spread of the virus because the CC member' shad significantly better awareness about HIV/AIDS than non- members, (safe) sexual engagement than non-members, attitude towards and participation in VCT than non- members and lesser stigma and discriminatory attitude. A number of other contributions were also captured from the qualitative data. Changing harmful traditional practices, resource mobilization, and care and concern for elders were amongst the most recurrent themes that emerged as added contributions of the CC program. I can also conclude that experience sharing, group members' cohesiveness, and self-disclosures were amongst the factors contributing for the success the CC programs. The problem of HIV/AIDS, with steady growth of economy, social services and limited resources are contributing to high mortality and morbidity rates particularly among the productive age group of the country. Prevention of the pandemic through behavioural change is the only strategy to mitigate these crises, i.e. to control the transmission of the virus and, to tackle death and morbidity caused by the pandemic. It is now widely accepted that prevention efforts need to take local context into consideration and must address both individual and social norms and structures. Although a large number of HIV/ AIDS interventions have focused on building awareness, there needs to be greater emphasis placed on individual and communal responsibility and accountability for the epidemic. To curb HIV problem community

conversation plays a great role to raise the level of understanding of the CC members and to make a behavioural change on the community. Effective HIV-prevention programming focuses on enhancing the capacity of the community about the epidemiology of HIV infection and interrogates how social and institutional factors such as sexual norms, gender inequality and HIV-related stigma contribute to the spread of the virus. Successful, sustainable interventions equip communities themselves to identify the drivers of the epidemic and develop relevant solutions. Programs like HIV/AIDS community conversations give CC participant the opportunity to develop their own internal problem-solving mechanisms, thereby embedding a problem- solving culture and enhancing the community's capacity to respond to the complex challenge of HIV/AIDS than non CC participants (from the witness of focus group descendants). This research also confirm that Community conversation play a vital role to raise the CC members awareness level when comparing non CC members. Community conversation emphasized to, transfer skills to the community, and move toward sustainability. The pilot program conduct by CARE International in Ethiopia's HIWOT (Health Improvement and Women Owned Transformation) in Ethiopia in East Harerge district and UNDP conduct in Alaba and Yabello under 'Upscaling Community Conversations in Ethiopia 2004 support this conclusion.

As the findings show, for some members of the community, CCs served as the main source of information and knowledge about HIV and AIDS and other problems of their areas. Because of their participation in CCs, some participants stopped marginalizing people living with HIV and AIDS, others started to talk about sex related topics without fear, and still others resolved some practical problems of their area and helped some poor community members. The fact that participants started discussing collective problems, sharing information and experiences, and solving some problems on their own, leads to the conclusion that the CCs empowered some people

A ‘culture of silence’ in which fear and discrimination thrive surrounds AIDS in many societies impede the control system. It has been found that families do not talk about the consequences and control of the pandemic with their children but the group organized in community conversation started discussing about HIV/AIDS with their groups and their families.

Strong misconceptions are heard during the investigation. There are many people that relate HIV/AIDS with evil spirit and do religious prayer (dhua) than taking the patient to health institutions. Religious thinking that AIDS is a plague brought by Allah to punish the adulators is also put the risk on certain individuals that hinders HIV/AIDS to be a societal problem.

Khat, Shisha and alcohol drinks are the major cause that drives the youth into unsafe sex. It has been investigated that many of the youth spend their time by engaging the selves taking these substances. The study indicated that the community conversation group members made breakthrough through bringing behavioural change among the youth.

The use of CC as participatory communication attracted a considerable number of people to come together and deal with issues of common concern. Almost all the focus group discussants pointed out that the CC session were the only chance they had to discuss HIV and AIDS with their community members. The willingness of participants to come together, devote their time and discuss issues of common concern could be seen as one positive factor. The interest of facilitators to devote their time in helping their communities without getting any financial support was also positive things. The presence of a large number of participants can to some extent be evidence of the fact that the CC was a popular communication platform. From my observation I understood that many participants had a positive outlook towards the CC program. For meaningful interactions of any participatory program, facilitators’ skills and credibility play a key role, even if the skill of the facilitator under question selecting facilitators from the community is one of the positive side of community conversation which enable the

community to run by the community and empower the community. The facilitator were selected and assigned to facilitate in the same Kebele communities whose cultural values, norms and the life style, language and communicate style they were already familiar. Hence, selecting facilitators from the target community indicates that the initiative made an effort to meet one of the prerequisites of participatory communication. Due to the above fact CC session is increase the participation of the community and successful method to raising the level of understanding the prevalence of HIV/AIDS. By virtue of their exposure to different media and discussion groups, the community conversation group members has found to have better understanding on factors that cause HIV/AIDS than those members of the community who are not engaged in community conversations.

Despite the contributions recorded above implementation of CC programs is likely to experience different challenges due in part to limited experiences in implementing them. Interview held with key informants and focus group discussion underscored the following major challenges experienced so far.

Role of facilitators:- As for the role of facilitators, the data gathered through and the focus group discussants show varied answers. Almost all the key informant stated that during the CC sessions the facilitator facilitated discussions 'properly'. According to them, the main activities that performed by the facilitator in the CC sessions were to: give equal opportunities to all participants to set discussion agendas, encourage participants to ask and answer questions, give a chance for participants to reflect on their ideas, listen attentively and recapitulate important points, mediate contradictory ideas and draw conclusions. Some participants in the focus group discussants agreed with what the key informant mentioned, others did not agree. The latter pointed out that some facilitators set discussion topics by themselves, did not encourage participants to take part in discussions and spent most of the CC time teaching and informing the CC members about HIV and AIDS and other important issues. Although the interviewed

key informant stated that they facilitated CCs 'properly', it was clear from some participants and facilitators' responses, during interviews, that some facilitators 'taught' instead of facilitating. From (researcher memo) similarly, when they were asked about the facilitators' roles, some of the focus group discussants referred to their respective facilitators as 'teachers'. This shows that some participants thought that facilitators were there merely to 'teach' them about HIV and AIDS among other social problems. This gives the impression that either some facilitators might have misunderstood the purpose of the CC session or they preferred teaching to facilitating or they did not understand the difference between teaching and facilitation.

participation In relation to the participants' role, most of the key informant (four out of the six interviewed) said that during CC sessions, participants freely expressed their ideas about the topics raised, listened to others attentively, asked and answered questions, and took an active part in the discussions. Some of the focus group discussants agreed with key informants, but others were of the contrary view. Out of the 20 focus group discussants, 3 participants pointed out that they did not often contribute their ideas as they spent most of the CC sessions listening to a few participants who got the chance to present their ideas. According to these discussants, this happened mainly because of the large number of participants and limited time dedicated to the discussions the rest two Key Informants also share this idea.

Asked about the number of participants, venue of discussion and time allocated for CC sessions, the coordinator and all of the key informants stated more or less the same thing. Facilitators said they usually invited 60 participants for one CC session and an average number of 50-60 people attended the CCs as some participants did not manage to come for every session. The allocated time for one CC session was one hour, but sometimes by the well of the participant the time may extend some discussion sessions up to fifteen minute when the issues under discussion required more time. However, the limited discussions and the failure of most participants to present their ideas indicate that participation in CCs was not often meaningful.

The fact that many of the participants were not able to get the chance of taking part in the discussions shows that participation seems to have been equated to mere inclusion or involvement in the sessions. Even if it has the above shortage or limitation from all key informant, facilitator and participant understood that CC is a powerful means of communication

7 Recommendations

The finding of the study showed that the community conversation group members have high awareness than those who are not engaged in community conversation program. For successful implementation of community conversation program and curbing of HIV/AIDS in the area, the following recommendation points need to be considered by the concerned parties.

The programme designers should either change their criterion for the numbers of participant (70 participants for one session) is not manageable and conduct CCs with manageable groups or they should train other facilitators so that the groups could be split into smaller more interactive groups. Also, facilitators, participants, and other stakeholders need to set clear guidelines which could help them foster lively discussions and interactions.

Programme organizers need to check the CCs discussion to react when some issues get beyond the participants and facilitators capacity to explain, and may help to get immediate answers. Further, organizers of the programmes should focus on giving power to participants to help participants to own the programme so that they keep organizing the CCs and discussing their common problems by themselves. The organizers and facilitators need to follow up on the progress of the CCs till the evaluation studies inform them that the participants have become empowered to run the programme by themselves.

The programme organizer and facilitators need to inculcate the objective of the initiative into the community so that participants do not claim to have other incentives for their participation than discussing and mitigating HIV and AIDS and other problems of their area. To achieve this, sponsors need to conduct baseline and formative studies into the participants living conditions and arrange CC sessions accordingly.

Continuous monitoring and evaluation or process evaluation of the programme will help to identify the major weaknesses and strengths of the programme. Hence, making use of the

strengths and working on the challenges will ultimately help improve participatory communication in the CCs.

Training and new facilitation skills need to be provided for program trainers and facilitators at regular basis.

Government and NGOs need to be encouraged and scale up to fuel further expansion of the CC strategy of community mobilization among different groups.

To increase utilization of VCT services and make it as a culture to all people

Strengthening large-scale CC programs need to be given more attention by the Government and Non-government.

Using the CC approach to Strengthening the participation of the youth and the female through their organization to initiate the community in VCT campaign.

Condom use is not preferred by many people as a way of controlling HIV/AIDS transmission and its promotion is taken as insisting adultery or giving alternative for immoral sexuality. Therefore, its current and future use is under question so even if the solution is scientific the implementation should be according to the culture and social norm.

The community conversation approach offers a promising way to draw upon the ideas, insights, relationships, and resources of the wider community to generate creative solutions to the barriers encountered by community so the government and NGO's should scale up this approach.

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9 APPENDIX'S

Appendix 1. Interview schedules

. Interview schedules

A/ Socio-demographic data of the sample respondents

"Perception evaluation the awareness level of CC group and ungrouped member abut determinants of HIV/AIDS prevalence in the case of kamise town administration qello and kachuer rural kebele, Oromyia Zone, Amhara National Regional State

Name of the enumerator……..

Date…….

Respondents' address: Kebele Admnstration……Goth……..Code…….

Part one :-Blood test statues of the respondents

1. Status of HIV/AIDS blood test. 1. Get blood tested ☐ 2/Not get tested ☐

Part two:- Perception statements to evaluate the awareness level of CC group and ungrouped about determinants of HIV/AIDS prevalence

Please choose any one of the five options as your response from the five alternatives.

SA = Strongly Agree, A = Agree, N = Neutral, DA = Disagree, SDA = Strongly Disagree

No	Statement	Response				
		SA	A	N	DA	SDA
1	The HIV/AIDS infection is more prevalent in the active age group (18 - 49 due to their higher indulgence in unsafe sex practices					
2	Women are more vulnerable to HIV/AIDS infection due to physiological reasons and unequal power relations to men.					
3	HIV/AIDS is more prevalent among less educated people due to lack of proper awareness					
4	HIV/AIDS will spread more if there is no open discussion and knowledge sharing in the community					
5	Domestic sexual violence and rape enhance the prevalence of HIV/AIDS					
6	Traditional healing practices (like local dental service, extraction of milk teeth ,tonsillectomy and etc.) favor the prevalence of HIV/AIDS in the community					
7	Harmful traditional practices like FGM and early marriage enhance the prevalence of HIV/AIDS					
8	Unequal age in partnership or marriage also favors the prevalence of HIV/AIDS					
9	Blood test before marriage is helpful to reduce the spread					

No	Statement	Response				
		SA	A	N	DA	SDA
	of HIV/AIDS					
10	khat chewing , smoking shisha and alcohol drink induces possibility of spread of HIV/AIDS due to risky sexual behaviour					
11	Men's polygamy enhances prevalence of HIV/AIDS					
12	Lack of adequate knowledge among people on the cause and spread of HIV/AIDS and its preventive measures is one major reason for its prevalence					
13	Lack of information source use such as community conversation , meetings, discussion with experts etc. favour's the prevalence of HIV/AIDS among the people					
14	Household poverty and food insecurity lead the family more vulnerable to HIV infection through migration for labour					
15	Mobility of labour from rural to urban areas or other places is another major factor, which enhances chances of spreading HIV/AIDS					
16	Occupational situations like working as CSW street traders, Long truck drivers etc. increases chances of risky sexual life and there by the prevalence of HIV/AIDS					
17	Unsafe sexual behavior like sex without condoms causes					

No	Statement	Response				
		SA	A	N	DA	SDA
	spread of HIV/AIDS					
18	Having multiple sexual partners is another major cause of prevalence of HIV/AIDS					
19	Urban people is vulnerable than rural due to various reason					
20	Widow inheritance enhances the spread of HIV/AIDS					
21	Transaction sex, where gifts or materials are rewarded for sexual intercourse increases the chance of spread of HIV/AIDS					
22	Polygamy enhances chance of spread of HIV/AIDS					
23	Discriminating PLWHA is the main reason to intensify HIV/AIDS prevalence					
24	Divorce and remarriage can lead to infection of HIV/AIDS					

Appendix 2: Interview Guide for FGD with respondent groups

What are the main factors responsible for the spread of HIV/AIDS in this area?

How HIV/AIDS spread can be prevented in this area, in your opinion?

What Source of information is available to you to have an awareness about HIV/AIDS?

What are the roles of community conversation in this community?

Appendix 3**. Key Informants' Interview Guide**

What are the factors influence the prevalence of HIV/AIDS?

Probing questions: Widow Inheritance and community perception?

Polygamy and community perception?

Stigma and discrimination?

Local healers and harmful practices?

Unsafe sex practices like multiple partners and sex without condom?

abduction and rape?

What are the roles of community conversation regarding HIV/AIDS?

Indira Gandhi Open National University /IGONU/project proposal

THE ROLE OF COMMUNITY CONVERSATION IN RAISING AWARENESS LEVEL OF THE COMMUNITY ABOUT THE DETERMINANT OF HIV/ AIDS

Student's Name: Siyoum Kebede

Enrolment number ID11150009

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December, 2014

PERFORMA FOR SUBMISSION OF MSW PROJECT PROPOSAL FOR APPROVAL FROM ACADEMIC COUNCILLOR AT STUDY CENTRE

Enrolment number ID1115009

Date of submission December 11/2014

Name of the study centre 8105

Title of project: The role of community conversation in raising awareness level of the community about the determinant of HIV/ AIDS case study kemissie administrative town, rural kebele oromia zone amhara region Ethiopia.

Approved /Not approved

Name and Address of Guide Name and signature of student

Addisalem adem siyoum kebede

Signature---------- Signature----------

December 11/ 2014 December 11/2014

ACRONYM

AFNRS Afar National Regional State

AIDS Acquired Immune-Deficiency Syndrome

ANRS Amhara National Regional State

ANC Anti Natal Care

ART Antihero Viral Treatment

CC Community Conversation

CEDAW Convention on the Elimination of All Forms of Discrimination against Women

CSA *Central Statistics Agency*

CSWs Commercial Sex Workers

EDHS Ethiopian Demographic and Health Survey

EGLDAM Ethiopian Association to Eliminate Harmful Traditional Practices

EPRDF Ethiopia People Republic Democratic Front

FGM Female Genital Mutilation

FHAPCO Federal HIV/AIDS Control Office

HH House Hold

HAPCO HIV/AIDS Prevention and Control Office

HIWOT Health Improvement and Women Owned Transformation

HIV Human Immunodeficiency Virus

HTP Harmful Traditional Practice

IGONU Indira Gandhi Open National University

KCHO Kamise City Health Office

m.a.s.l Meters Above Sea Level

MDGs Millennium Development Goals

MOH Ministry Of Health

NCTPE National Committee for Traditional Practices in Ethiopia

NGOs Non-Governmental Organizations

OZAAD Oromia Zone Administration Agriculture Department

OZAED Oromia Zone Administration Education Department

OZAHD Oromia Zone Administration health Department

PA Peasant Association

PLWHA People Leaving With HIV/AIDS

PMTCT Prevention of Mother to Child Transmission

PITC Provider Initiated Testing and Counseling

PASDEP Programme for Accelerated and Sustained Development and Ending Poverty

SNNPR South Nations Nationalities and Peoples Region

SRH Sexual and Reproductive Health

STDs Sexual Transmitted Diseases

UNAIDS United Nations Program on HIV/AIDS

UNDP United Nation Development Program

UNDP-CCE United Nation Development Program Community Capacity Enhancement

UNICEF United Nations Children's Fund

VCT Voluntary Counseling and Testing

WHO World Health Organization

WMS Welfare Monitoring Survey

Table of Contents

1. Introduction

Globally, an estimated 35.3 million people were living with HIV in 2012. An increase from previous years as more people are receiving the life-saving antiretroviral therapy. There were 2.3 million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 million in 2001. At the same time the number of AIDS deaths is also declining with 1.6 million AIDS deaths in 2012, down from 2.3 million in 2005. As this report reveals, striking gains have been made towards many of the 2015 targets and elimination commitments, although significant challenges remain. (UNAIDS, 2013)

Since the beginning of the epidemic, almost 75 million people have been infected with the HIV virus and about 36 million people have died of HIV. Even if globally, 35.3 million people were living with HIV at the end of 2012. An estimated 0.8% of adults aged 15–49 years worldwide are living with HIV, although the burden of the epidemic continues to vary considerably between countries and regions. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults living with HIV and accounting for 71% of the people living with HIV worldwide (fact sheet 2013).

At the end of 1999, an estimated 3 million people in Ethiopia were infected with the HIV virus, making this the third largest infected population worldwide after South Africa and India, and an estimated 280,000 people had died of AIDS (UNAIDS 2000). The complexity of the HIV/AIDS epidemic and the high demands successful programs make on planners, administrators and people at risk constitute a tremendous challenge for Ethiopia. According to a recent World Bank report, HIV/AIDS now poses the foremost threat to Ethiopia's development and its future depends on responding to the epidemic forcefully and fast (World Bank 2000a). After seven years of limited prevention measures, the Ethiopian government

implemented in 2001 a comprehensive, multispectral HIV/AIDS 5-year strategic plan. Although the implementation, monitoring and evaluation of Ethiopia's HIV/AIDS strategic plan, including the development of both preventive and treatment strategies, require extensive and reliable baseline data on the progression of the epidemic as well as its impacts on society, few studies have been carried out in these areas (Kebede *et al.* 2000). While epidemiological studies are necessary to answer questions about who, when, where and how people get infected or develop disease and thus to guide health policy and control programs, they are not sufficient to fully explain great disparities in the prevalence of HIV/AIDS among communities, regions and countries. It is well recognized that broader underlying socioeconomic, cultural and political factors, including poverty, women's rights and other gender issues, cultural factors and political, have to be considered as well (Caldwell 2000; Carael *et al.* 1997; Eshete *et al.* 1993; Farmer *et al*. 1996; Foreman 1999; Kloos 1993; Setel 1999). The objective of this paper is to examine the available epidemiological data on the distribution and spread of HIV/AIDS and risk behaviour in Ethiopia in the context of the socioeconomic, political and cultural environment, including relevant traditional practices and attitudes, and to evaluate economic, social and demographic impacts of AIDS.

Community Conversation (CC) is an interactive process, which brings people together and engages communities to discuss and explore the underlying causes fuelling the HIV and AIDS epidemics in their environment and other heath related issue such as family planning, reproductive health and so on. Through CC people will discover unequal power relations, harmful traditional practices as drivers and maintainers of the epidemic. (Hibret Getaneh, *et al* 2008)

The underlying assumption of community conversation is the belief that people have capacities, knowledge and resources to transform individually and collectively once they perceive ownership of a problem. The CC approach promotes democratic participation. It

creates space for listening, speaking, being, inclusion and agreement. The aim of CC is to have a community's deep understanding, knowledge of HIV/AIDS and to facilitate decision-making and taking action to solve the problem.

Conversation is –an important part of community building. In conversation, we not only discover what we care about, we uncover new ideas for building healthy community. The Community Conversations enhance people to come together to talk about the things that matter to them, and to generate action for positive change. Community conversations happen when a small group of people gets together to talk. A conversation can take place wherever people can gather: kitchens, living rooms, offices, schools, libraries, community centres, places of worship.

The National HIV/AIDS Prevention and Control Office (NHAPCO) initiated community Conversation in Ethiopia in 2002. Community Conversation was adopted in Amhara region of oromia zone in the year 2009. Currently, there are a total of 208 community conversation groups in the zone, of which 14 community conversation groups are found in Kemise Town (OZAHAPCO)

2. Statement of the problem

HIV/AIDS has now been around for about three and half decades since first diagnosed in 1981. If we wish to curb the spread of HIV/AIDS effectively and sustainably, we need to design strategies that help mobilizing communities at large. Anti-HIV/AIDS Community Conversation (CC) Programs are part of community mobilization activities introduced for the purpose of preventing and controlling the spread of HIV/AIDS. The study area is near to the capital of Oromia zone kamise city most of the dwellers of the study area are farmers they lead there life by mixed farming due to their near ness to the city they can face for

HIV/AIDS. In other direction due to the near ness of the city most of the youngster pass their time for recreation in this town, this nearness expose for unwanted habit like chowing chat and drinking alcohol and influenced by their peers. Since they are young and they have irrigated land there, economic status is wall because they get money by selling vegetable and forest seedling .due to this fact it is expected they are exposed to unsafe sex. However, there is no clear data and evidence to show the magnitude and extent of it. In addition, to the knowledge and access of the researcher no such study had been under taken in community. So it is assumed that the study area is vulnerable because lack of awareness and near ness to town area, income of the youngsters and shininess of town life. so assessing the awareness level and examine effective ness of the implemented CC communication method is important for mobilizing the community and scale up .

What is the role of community conversation in raising the awareness level of CC group members regarding the transmission and factors enhancing for the spread of HIV/IDS?

Is there awareness level difference between groups conducting CC and other community members who are not involved in community conversation?

2.1 General Objectives

To assess the role of community conversation in raising the awareness level of the community towards the transmission of HIV/AIDS

2.2 Specific objectives

To identify the difference in the level of awareness about HIV//AIDS transmission between groups conducting Community Conversation and other community members who are not involved in community conversation.

To study the relevance of CC to overcome stigmatization and mal practices

2.3 Significance of the study

Studies showed that there is high prevalence rate of HIV/AIDS in this region. The causes aggravating the problem are deep rooted in the culture, religion and lack of awareness about prevention of HIV/AIDS. In order to solve this problem, this research contributes a lot. the significance of this study is to empower the community to tackle any problem by free discussion, The study is also helpful for police makers by providing adequate data on the role of community conversation in enhancing the awareness level of the community regarding HIV/AIDS. The study also contributes to social work education through providing the role of group work as an effective approach in tackling social problems.

2.4 Scope of the Study

The study is limited to kelo and kachuer kebele, in kemissie town wareda administration. Therefore, the finding of the study can't be generalized to the total population in of Kemisse. Moreover, the study employs cross sectional design that the finding may not be feasible.

3. LITERATURE REVIEW

3.1 THE PREVALENCE OF HIV AIDS WORLD WIDE AND IN ETHIOPIA

3.1.1 Worldwide HIV & AIDS

An HIV/AIDS epidemic is defined by the HIV prevalence in the general population. HIV prevalence is the percentage of the population living with HIV.

There is either a generalized or concentrated epidemic. In a generalized epidemic, HIV prevalence is 1% or more in the general population. In a concentrated or low level epidemics, HIV prevalence is below 1% in the general population but exceeds 5% in specific at-risk populations like injecting drug users or sex workers, or HIV prevalence is not recorded at a significant level in any group. (WHO, 2000)

3.1.2 The HIV/AIDS Epidemic in Ethiopia

HIV infections were first found in Ethiopia in 1984, one to two years later than in most other Sub-Saharan countries but its main features resemble those elsewhere in Eastern Africa: the relatively virulent HIV-1 is the major strain of the virus in Ethiopia, transmission is largely through heterosexual contact and to a lesser extent to mother-to- child transmission, and the highest prevalence of infection is in the 20-39 age group, with higher rates in females than males in the younger age groups. Genetic diversification studies of the Ethiopian HIV-1 subtype C virus confirm its introduction in the early 1980s (Abebe *et al*. 2001). HIV/AIDS prevalence remained low in the 1980s but sharply accelerated through most of the 1990s, rising from an estimated 3.2% in the 15-49 years age group in 1993 to 10.6% by the end of 1999 (Kebede *et al*. 2000). Although difficult to measure, the impact of political, economic, and ecological crises since the 1970s on HIV and other sexually transmitted infections (STIs) in Ethiopia has been significant as they created conditions conducive to the transmission of HIV. Among the factors contributing to the rapid spread of HIV are 1) seasonal migration of workers in search of employment and better economic conditions that tend to increase multi-partner sexual contacts, 2) dislocation of many people due to the civil war, 3) high STI rates in both high-risk groups and the general population, 4) increasing sexual activity among youth and 5) high unemployment rates, including the demobilized soldiers (AIDSCAP 2001).

During the early stage of the epidemic, the focus was on identifying high-risk groups and their sexual behaviour. In 1988, a sero epidemiological study of 6,234 female commercial sex workers in 24 communities throughout Ethiopia revealed infection rates between 1.3% and 38.1% in different towns. The mean infection rate was 18.3%, which increased to 29.2% during a follow-up survey in 1989. Rates above 20% were found in communities on major

truck routes between Addis Ababa and Assab and from Addis Ababa to Bahir Dar and Mekele (Mehret *et al*., 1990a). Truck drivers have been identified as another high-risk group (17.3% infection in 1989) that is closely linked with commercial sex workers (Mehret *at al*. 1990b). Several studies reported a strong correlation between HIV and STI infections in both males and females (Aklilu *et al*. 1999; Zewde et al. 2001). Rates in commercial sex workers increased further in 1990 and 1991 but no comparable epidemiological data are available for female sex workers for subsequent years. In Addis Ababa rates among sex workers were 24.7% in 1988, 54.3% at STD clinics in 1990 and 73.4% in 1998, indicating that rates continue to increase also in other urban centers (Fig. 1; Mehret et al. 1990c; Aklilu *et al*. 1999). Soldiers, another highly mobile high-risk group exposed through multi-partner sex contacts, were stationed in many towns within the war zone characterized by high HIV infection rates. Troops could also have been infected during emergency blood transfusions, without HIV screening (Eshete *et al.* 1993; Kloos 1993). HIV infection rates in new recruits increased from 0.8% in 1986 to 2.6% in 1991 and in soldiers from 12% in 1990 to 27% in 1993 (Khodakevich and Zewdie 1993; Assefa *et al*. 1994). About half a million soldiers had been demobilized and reintegrated into the rural economy by the mid 1990s (Dercon and Ayelew 1998). In the first study of risk behavior in rural areas, Shabbir and Larson (l995) demobilized soldiers reported that they had not changed their sexual behaviors. Studies in Uganda have shown strong spatial correlations between the source areas of soldiers recruited into the armed forces and subsequently high rates of AIDS in the general population in those same areas (Smallman-Raynor and Cliff 1991). Children, adolescents and young adults have become high-risk groups in recent years, with an estimated 250,000 children infected in 2000 and 11.9% of females and 7.5% of males aged 15-24. An estimated 1.2 million children were AIDS orphans in 1999 (Ministry of Health 2000a; UNAIDS 2000). No reliable data are available on mother-to- child-transmission in Ethiopia although the Ministry of Health

estimated that prenatal transmission contributes up to 25% of all new infections (Ministry of Health 1999b). Many more young females are likely to enter prostitution if economic conditions do not improve. Although the 1993 national health policy addresses the health problems and related needs of adolescents (Transitional Government of Ethiopia, 1993), unmarried youth have no access to reproductive services in health institutions due to opposition of the major religions. HIV Infection in the General Population The AIDS surveillance system of the Ministry of Health based on monthly reports from hospitals identified only about a fifth of the estimated 400,000 AIDS cases nationwide because many ill persons in the rural areas have no access to hospitals. Even if they succeed in reaching hospitals and prove to be HIV positive the diagnosis may be reported as TB or another opportunistic infection instead (Kebede *et al*. 2000). Moreover, data on AIDS cases aggregated by age and sex were gathered only up to 1994, impeding the surveillance of AIDS incidence and the planning of control activities. Data on the prevalence of HIV infections in the general population of Ethiopia have been based mainly on infection rates among antenatal clinic (ANC) attendees (pregnant women) at several clinics in Addis Ababa and regional towns, with supplementary data from blood donors and some special surveys. Most data are from urban populations and little is known about the occurrence of HIV infections in rural areas, where around 85% of the population lives. Although antenatal data are considered to be an acceptable indicator of the true prevalence of infection in the general population (Kebede *et al*. 2000), this relationship still needs to be clarified (Solomon and Murray 2001). Based on all available survey data the Ministry of Health estimated in 2000 the HIV prevalence in the sexually active population (15-49 years) to be 13.4% in urban Ethiopia, 16.8% in Addis Ababa and "about 5%" in rural areas (Ministry of Health 2000a). Rates in antenatal attendees at 13 clinic and hospital sentinel sites in 9 urban and rural communities, which were instrumental in estimating the national rates, varied between 4 and 21 % in

1999/2000. The highest rates were in Bahir Dar, Gambela and Addis Ababa (Ministry of Health 2000a; Table 1). In Addis Ababa, 6.4% of 11,587 blood donors and 9.1% of 10,930 visa applicants were sero-positive in 1999 (Kebede *et al*. 2000). A study of police recruits from the Awash Valley indicates that distance to truck stops is more important in HIV risk than rural residence per se (Zewde 2001). Surveys carried out in 1993 in the sexually active population in 6 rural communities in Shewa, Tigray, Bale and South Omo showed 0.7% of the population infected with HIV, similiar to the rates among antenatal patients at Attat and Gambo rural hospitals in 1998/99. But one year later, 4% of the Attat antenatals were infected (Ministry of Health 2000a; Table 1). It is not known if the low rate (0.2%) of infections in 1,800 Falasha resettled in Israel since 1991 (after Operation Solomon) (Fisher 1996) are representative of the rural population in Ethiopia. The gender ratio of HIV infection in Ethiopia has changed over the years, from male to female dominated rates (1:1.2 gender ratio) in the late 1990s (Ministry of Health 1994; UNAIDS 2000), indicating its spread in the wider population. Females now have significantly higher AIDS rates in the 15-19 and 20-24 groups, apparently due to their earlier commencement of sexual activity than males. This trend will increase mother-to-child HIV transmission levels among babies of mothers in these age groups unless effective preventive measures are implemented soon. The high HIV prevalence rates in younger females also emphasize the need for testing and counseling among both males and females as a central part of the prevention strategy. The balanced male-to- female infection ratio in Addis Ababa (0.97:1) supports the general conclusion that the main mode of HIV transmission in Ethiopia is heterosexual (Fontanet, Wolde/Michael 1999). Absence of infection in the 6-13 age group in Addis Ababa (Fontanet *et al*. 1998), also reported from Uganda and other African countries, and very low rates of AIDS in 5- 14 year olds constitutes a "window of hope" if this age group can be helped to prevent infection once they become sexually active (Fig. 2; Lemma 1996). There is some

evidence that HIV infection rates in Ethiopian towns are leveling off although this still needs to be confirmed. HIV testing among 3,877 pregnant women at four antenatal clinics in Addis Ababa between 1995 and 2000 revealed a 30% decline of infection rates (Kebede et al. 2000). HIV infection rates in blood donors in Addis Ababa and nine other towns for the period 1988-1999 also declined. The only data available for younger ages, which are a better indicator of the epidemic's progression—ANC attendees and blood donors aged 19-25—show a similar declining trend. It is not known if these declines are due to a decline in high-risk behavior or to other factors, particularly sampling bias, increasing efficiency of pre-screening blood donors, variable quality of ANC laboratory test data, or to maturing of the epidemic (Kebede *et al*. 2000; UNAIDS 1997). In Brazil, AIDS rates increased slower in the initially hyper endemic counties of the southeast than in low-prevalence counties in the north, indicating both a maturing of the epidemic characterized by the depletion of high-risk persons in the population and heightened awareness of the AIDS problem in high-prevalence areas (Swarcwald *et al*. 2000). A similar situation seems to prevail in Ethiopia between urban areas (where HIV first reached epidemic proportions and prevention campaigns have been most common), and the less affected and informed rural areas. This pattern is also consistent with reductions in high-risk behaviour among students in urban areas, further discussed below, and recent reports of decreasing infection rates due to control efforts. However, HIV rates showed no declining trend for visa applicants between 1993 and 1999. Similarly, fairly steady HIV prevalence rates among visa applicants and increasing rates in Moslem pilgrims from 6.0% in 1996 to 11.2% in 1997 (Kebede *et al*. 2000) indicate that HIV transmission rates have not declined in some subpopulations of Addis Ababa. Furthermore, in Bahir Dar and Gambela, HIV prevalence in pregnant women increased from 13.0% in 1992/93 to 20.8% in 1999 in the former and from 12.7% in 1997 to 19,0% in 1999 in the latter (Kebede *et al.* 2000). The increase in HIV/AIDS in the rural areas cannot be quantified at this time in the

absence of longitudinal sero-surveillance data for the regions, although there is no doubt that infections have significantly increased in many areas. The periodic visits by farmers to towns and the massive rehabilitation of soldiers appear to contribute significantly to the spread of the infection from urban to rural areas (Shabbir and Larson 1995).

3.2 Core Assumptions of Community Conversations

Community conversation (CC) is one of the intervention method which is used for prevention of HIV AIDS. It is an interactive process which brings people together and engages communities to discuss and explore the underlying causes fuelling the HIV and AIDS epidemics in their environment. Hence, people will discover about unequal power relations, harmful traditional practices or girls' vulnerability as drivers and maintainers of the epidemic. CC is explicitly based on the recognition that people have capacities, knowledge and resources to transform individually and collectively once they perceive ownership of a problem. The CC approach lays a unique ground which is participatory. It creates space for listening, speaking listening, speaking, being, inclusion and agreement. The aim is to deepen a community's understanding of the pandemic, facilitate decision making and taking action in the local context. (Hibret Getaneh, *et al.* 2008)

3.3 The Unique characteristics of Community Conversation

What became clear early on was the incredible understanding and response that came forth from communities once knowledge of the science and epidemiology of HIV/AIDS was shared. Communities immediately began to recognize for themselves the values and actions that would have to change if what they were hearing about this new disease was true. They reflected on how it spread and caused disease throughout the body and in other individuals. They identified which behaviours and socio cultural practices would need to change if the epidemic was to be controlled. Such awareness came about through a process called 'Community Conversations'. This series of facilitated dialogues stands in contrast to

conventional approaches in which people are grouped together for awareness-raising lectures, often accompanied by the distribution of pamphlets or posters. Such approaches often leave communities with bleak, prescriptive messages that deny them the benefits of dialogue on how the community could be affected. Communities are oftentimes overwhelmed and feel a sense of hopelessness following such events. A common comment after awareness-raising campaigns on condom use is, “If we do what they say, we’ll never have any more children.” (B.UNDPCCE, 2011)

In contrast, Community Conversations provide a platform for people to think through all the repercussions of a situation the way their individual values and behaviours, and those of their family and neighbours, affect people’s lives. Community Conversations create a space for mutual learning and result in new perspectives. They help reshape relationships in line with transformed values. They are inclusive processes for enhancing the capacity of all Community is defined as a heterogeneous group of people living and/or working together sharing norms, values, and concerns, with common systems and structures for leadership, problem-solving and communication. Groups in the community make use of transformative tools and processes that generate hope through the exploration of concerns, possibilities and opportunities for addressing the complex challenges of HIV and AIDS. They also create clarity on what needs to be done. All of this is accomplished within a methodological framework with specific steps. (B.UNDPCCE, 2011)

UNDP has identified a core set of human rights principles that guide the whole process of community conversation. These include equity, equality, non-discrimination, human dignity, non-violence, participation, inclusion, accountability and responsibility. The dignity of individuals and families is preserved and enhanced in an environment that encourages compassion, acceptance and accountability. Stigmatization, coercion and violence are avoided. (B.UNDPCCE, 2011)

3.3.1 Historical Development of Community Conversation

Community Conversations were adopted by UNDP as a result of their success in creating transformation at the community and institutional levels. The methodology, which emerged from the work of the Salvation Army (Zambia) and Enda Tiers Monde/Santé (Senegal) in the mid-1990s, has been enriched by the work on transformational leadership carried out by UNDP in 2001. UNDP has implemented the Community Conversations approach in a number of countries with very different social, economic and political situations those with high and low HIV prevalence rates, in highly urbanized as well as rural areas, in countries that are relatively high on the Human Development Index and others that are low. In all instances, this approach has brought about a fundamental shift in the way communities get work done resulting in a series of actions and decisions that have arisen from communities themselves. It is an approach that can be used to deal with other human development challenges as well, including wealth generation, democratization and good governance.(B.UNDPCCE, 2011)

Community Conversation was initiated in Ethiopia in 2002 by the National HIV/AIDS Prevention and Control Office (NHAPCO) and in a first phase rolled out by NGOs with UNDP financial assistance targeting HIV prevention. The original set-up encompasses eighteen discussion sessions of 50-70 people living in one Peasant Association (PA) who commit to follow the cycle, which is-completed over one year. CARE International in Ethiopia's HIWOT (Health Improvement and Women Owned Transformation) program adopted the approach. It initiated 105 CC groups in fourteen districts in four zones (5-7 districts), one per selected PA, on issues related to HIV and sexual and reproductive health (SRH) between 2006 and 2007. FHAPCO provided training materials, led the facilitator's training and participated in supervision Facilitators with leadership competencies were

identified after volunteering for this activity. They were trained for two weeks prior to setting up their group. Three facilitators were trained per CC group and equipped with background information and skills to foster group dynamic processes. Literacy status was considered as a major selection criterion for CC facilitators, however, flexibility was allowed in pastoralist areas where literacy levels are generally low. At the beginning of each session one person was chosen to document the process while others facilitate the discussion and ensure adherence to ground rules. Supervision was provided as peer support by sharing challenges and lessons learnt at quarterly review meetings of CC facilitators at district health head offices. Ideally, participants of a CC discussion group are representative of different segments of the community. They include diverse community members: farmers, civil servants, shopkeepers, craftsmen, religious and informal leaders, PA administrators, men, women, adolescents, etc. Participation in these groups is voluntary. The participants are self-selected and motivated by an interest in HIV/AIDS issues. Most of the 105 groups fulfilled the criteria of representing all segments of the community, however, a slight gender imbalance was present in all four zones. . (Hibret Getaneh, *et al.* 2008)

3.3.2 The Role of Community Conversation in Preventing HIV/AIDS

There are a number of documented success stories of CC in many parts of Ethiopia since 2002. Our experience is the first of its kind in adopting CC on integrated HIV/SRH issues including harmful traditional practices and family planning. After 12 months of implementation, witnessed changes in risky behaviours and stigmatization in remote rural areas where HIWOT is working. Some CC groups have condemned early marriages in their communities and are committed to protecting schoolgirls from discontinuing their education due to early marriage and abduction. Forced and early marriages fuel health problems such as HIV transmission, complications during pregnancy and childbirth, and maternal mortality. Other CC participants decided to stop Female Genital Mutilation in their PA or penalize

traditional circumcisers (frequently traditional birth attendants) who do not use new razor blades for each girl they circumcise. In some places, participants discussed harmful traditional practices apart from HIV/AIDS (for example milk teeth extraction), and passed by-laws to stop female genital mutilation in their locality. They charged village leaders with the responsibility to follow-up adherence to the new rules and report to the CC members and a legal body if anyone in the community is found practicing female genital mutilation. CC participants in some PAs reached a consensus to avoid practicing risky behaviours that predispose to HIV infection, such as going night club sand drinking alcohol, which is very common in the target community, as well as practices like widow inheritance. The sessions have helped reduce stigma and discrimination towards people living with HIV (PLWHA). In first sessions after CC group inception participants shared negative attitudes regarding PLWH, but through discussion they changed their mind and concluded that 'all of us are at risk of acquiring HIV for one reason or another' .Some CC groups started providing care and support to PLWHA and their families by contributing money monthly. Thus, affected families were encouraged to disclose their health and social problems as a positive HIV status was the entry point to receive support and linkages with available associations. Other groups transformed into Anti-AIDS clubs, doing advocacy and fighting misconceptions. Some are giving social support to PLWHA. All CC groups in different sites agreed on the importance of utilizing Voluntary Counselling and Testing (VCT) services and most members underwent VCT. For example, in West Harerge district 2916 CC members and their spouses underwent VCT during the project period. Those who tested positive (13 female and 5 male participants) were referred to health facilities. (Hibret Getaneh, *et al.* 2008)

4 RESEARCH METHODS

4.1 Description of the Study Area

4.1.1 Location

Oromiya Zone is one of the eleven zones of ANRS and situated between 100 01'and 110 25' North 390 41' and 400 24' East bordering North Showa in South and West, South Wollo in North and in East the AFNRS, with capital town called Kemisse, 325 km along Addis Ababa – Dessie asphalt road. It has five rural and two town districts with101 rural PAs.

The total breadth of the study area is 6240 hectare and shares 1.59% of the total land mass of the zone. The study area bounds Dawacafa in the East, and in North Kamise city in West Antsokia districts (North Showa), and ArtumaFursi district in the South. The study area is agro ecologically classified as mid altitude lowland (kola) 100%.and annual rainfall range from 600-900 more of bimodal in patterns and erratic in nature . The elevation ranges from 1500-1650 m.a.s.l with temperature ranging from 22-28^{0}c. (OZAAD, 2013).

4.1.2 Population

The total population of the study area is estimated to be 4976, and out of this, males are 2435 and females constitute 2541. Ethnically, nearly 99% of the population of the study area is Oromo and the dominant religion is Muslim, constituting about 100% (OZAAD, 2013).

4.1.3 Agriculture

Farmers in the study area undertake mixed farming. Among the dominant crop type that are grown, are sorghum, maize and 'Teff "are the leading cereals. In addition, chickpea, etc are grown in small quantities in the area. In addition, Khat cultivation has become the major practice on sloppy areas using stone built bench terraces. Khat constitute major cash income source and also used for domestic consumption for both regular use and religious ceremonies

like ’Du’aa’ (prayer). The average farmland holding is 0.75 ha. Most of the agricultural output comes from fragmented peasant land holdings. Oxen serve as primary source of traction power and usually farmlands situated in the plains of Borkena valley are ploughed using motor power. The plain areas use very high number of hired labor for weeding, harvesting, threshing and transporting and therefore, the urban and rural areas would be congested by highlanders who come to seek jobs from the months of August to January. The farming system is mixed, comprising crop and livestock although, production and productivity is very low. The main livelihood strategy is on–farm activities and few still depend on off-farm activities. Due to erratic rainfall, agriculture in general and crop production in particular could not meet food demand of the families. The best alternative and widely used coping mechanism used these days is to send children, especially, girls to the Middle East countries investing all assets at hand, hoping future gains. Large numbers of males also flock to Djibouti, Saudi-Arabia, Yemen to mention some for temporarily or permanent work opportunities. In general, there is high mobility of people due to proximity of the zone to bordering countries and hence there is significant income gain from remittance to the families. (OZAAD, 2013).

4.1.4 Health

Today, many things have been improved as a result of joint effort of government and non-governmental organizations- like the World Vision Ethiopia to improve the status of rural health services of the zone and hence the number of health centres and community health posts has reached 26 and 101 respectively enabling the service coverage to reach 96% of the population. (OZAHD, 2013)

Situations pertaining to the study area are not unique and therefore, share the general milieu of the zone regarding current improvements. Regarding health service improvement and

service provision, the current coverage has reached 100% and number of health centres and community health posts has reached 1 and 2 respectively (KCHO,2013).

4.1.5 Education

The zone was exceptionally forgotten prior to EPRDF regime, Situations have been changed within this nearly a one and half decades and education coverage for eligible age group has now reached 96% from 2% at zone level, and 100.6% for Kamise town administration (OZAED,2013). Today, gross enrolment ratio has alarmingly increased while the status of the adult illiteracy remained unchanged except some school dropouts who go back home (rural) to constitute this category. As clearly put in the country's MDGs to mitigate illiteracy by the year 2015, major activities are undertaken in the zone and number of schools starting from satellite station (in every 3-5 km) up to technical and vocational training centres have been flourished in these few years. However, majority of adults in the area are still in the trap of illiteracy, which makes dissemination of innovation hardly possible.

4.2 Sampling Procedures

Since the study area is pre urban and the population is homogeneous, simple sampling procedure has been employed for the purpose of data collection. The total house hold (HH) the study area is 1089 The number of sample respondents will be totally 366, out of which 92 were CC member and 274 Non CC member. To determine the sample size I will use Krejcie and Morgan, 1970 sample size table(MSW 006,block 3 page 20)Then the respondent selection in all Kebele Administration will be by systematic random sampling procedure. Respondents are the heads of the selected households. The total population of CC members are 120 house hold where as the number of non-members is 969 The selection of respondents will be done by a fresh list of households, which was prepared jointly with local key informants like the community representatives, village leaders, village elders and the Development Agents (DAs) working in Kebele.

4.3 Design

The study will conduct to assess the role of community conversation in prevalence of HIV in the study area. The qualitative and quantitative data will collect; the qualitative data will collect from key informant such as kebele health exestuation worker, kebele manager, kebele administrative and from Kamise city health office. The data will be collect by face to face contact by enumerators and researcher. Finally the questionnaires will arrange according to their code number and feed in to computer and analysed.

4.3.1 Types and Sources of Data

Qualitative and quantitative data will collect, so that both together can complement each other and help to reduce some of the weaknesses of using single method. Primary data will gather from 366 sample households, 8 key informants, and 4 focused group discussions with individuals who have ample knowledge and experience about community conversation.

4.3.2 Organization and Implementation of Data Collection Methods

The main methods of data collection in this study will be the interview schedule, key informant interviews. Interview schedule will develop and administer to the randomly select household respondents.

4.4 Data Collection Methods

The data for the study will be collect from primary and secondary sources. The main source of primary data will be both kebele CC group members and non CC grouped family household survey. The survey will be conduct from 366 households selected from each group in the kebeles. Structured questionnaire will be used to collect data about the contribution of Community Conversation on HIV/AIDS control and HIV prevention. Relevant secondary data will also be collect from books, articles, and unpublished reports.

The research will be start after pilot testing is undertake on fifteen participants who are randomly selected from the already selected two kebeles.

4.5 Study population

The study population for this particular assessment will be the two rural kebele kachuer and Qelo kebele HH population they are 1089

4.5.1 Instruments

The first and foremost data collection tool will use in this study will be :- interview , focus group discussion and key informant interview

4.5.1.1 Interviewee

Survey Structured questionnaire will prepare for interviewee to collect important data pertinent to answer research questions. The questions are aim at collecting detail data. Data will collect from heads of each selected sample household head.

4.5.1.2 Focus group discussions

Focus group discussions will conduct at two rural kebele with purposively selected groups of adults and adolescents from each Kebele Administration. In each focus group discussion, the numbers of participants selected will seven adults (two females and five males) and two adolescents (one girl and one boy). Thus, one focus group discussion in each Kebele Administration will conduct and all together, the numbers of participants will be 18. The focus group discussions will used to collect detail and spontaneous information on issues pertinent to HIV/AIDS in the community such as demographic, socio- cultural, sexual, and how to get information about HIV/AIDS to combat against HIV/AIDS

4.5.1.3 Key informant interviews

Key informants will interview using a check list consisting of open-ended questions. All key informant interviews will conduct by the researcher. The interview will last approximately 45-60 minutes and will take place in the workplace or another private setting chosen by the participant.

In each of the selected kebele administration, key informant interviews will hold with different individuals whose responsibilities and knowledge had a bearing on HIV/AIDS. They included: Community Health Extension Worker, kebele administration manager, kebele administration head, kebele development agent, CC facilitator Primary School head, person living with HIV/AIDS (PLWHA). The interviews were also intended to generate information on the leaders' perceptions of the gravity of the HIV/AIDS problem in the communities. These respondents will view as people who were in constant touch with the community, and therefore widely knowledgeable about the community dynamics. Interviews with them will help in generating information on what people perceived to be the factors influencing of HIV and the activities and responses given by the community in preventing HIV/AIDS.

4.5.2 Method of Data Analysis

Quantitative analysis techniques will be employ to analyse the data that were collected from primary sources. The study will use statistical tools including descriptive statistics for the analysis. Then from CC group 92 and from non-group 272 randomly selected sample households will ask the identified factors contributing to the prevalence and are made to place their agreement or opinion on a scale consisting five points- strongly agree, agree, neutral, disagree and strongly disagree with values of 5,4,3,2 and1respectively. Categorical response differences will generalize using percentages.

4.5.3 Descriptive analysis:

Descriptive analysis such as percentage will use to make analysis in the form of tables and to supplement the data that collected from focus group discussion and from key informant interviews will use.

5 Ethical considerations

The participants will inform about the purpose of the research the participants will also inform about if any risks they may face as a result of being part of the research. The participants will also inform about the benefits that might gain as a result of participating in the study. They informed to feel free to make an independent decision without fear of negative consequences such as stigma and any negative measure by the kebele official or without expecting positive privilege like pocket money from the researcher or the government.

Time table

The research will have two phases of time schedule/the proposal writing and the final Research phase, it is depicted as follows

No.	Activities	Name of Months										
		Dec	Jan	Feb	March	April	May	June	July	August	Sep	Oct
1	Selection topic and submitting											
2	Proposal writing and first draft submitting											
3	Final draft proposal submitting											
4	Questioner preparation											
5	Selection of the study areas of kebele											
6	Identification of key informant by names, organizing group descendant selection of interviewee by random sampling											

7	Selection of enumerators											
8	Duplication of questionnaires											
9	Training of enumerators											
10	Data collection											
11	Data organizing											
12	Data entry											
13	Data analyzing and interpretation											
14	Reporting of the first draft											
15	Compiling and submission of the final research paper											

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Professional CV

1. PERSONAL INFORMATION

Full Name: AddisalemAdemAbdella

Nationality: Ethiopian

Date of Birth : 26/6/1986

Place of Birth: Shambu, East Wollege (Oromia)

Sex: F

Marital Status: Married

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2. EDUCATIONAL BACKGROUND

PhD student in Social Work and Social Development, Addis Ababa University, September, 2012 to present

Masters of Arts (MA) in Social Work, Addis Ababa University, July, 2010

Bachelor of Arts (BA) in Sociology, Gondar University, July, 2007.

High School: Nekemte Comprehensive High School, Nekemte, June, 2004

3. TEACHING ACTIVITIES

Lecturer at Madawalabu university in the Department of Sociology since September,2007 to present

Courses Taught: Introduction to Sociology, Anthropological Theories, Social Institutions I, Social Institutions II, Social Problems, Social Policy and Planning, Social Welfare and Rehabilitation Services and Introduction to Sociology for health science students at MaddaWalabu University and various private colleges such as Alkan College, Keamed, College Enat Medical College and Yardstick University College.

4. RESEARCH WORKS

1) Attitude of psychology students to wards premarital sex in the case of Gondar University
2) Community assessment of Gorgora Community, Gondar, 2006
3) Factors Hindering Family Planning services in Gondar Town
4) Asset Based community Assessment of Afincho Ber Community, 2009, AddisAbabaUniversity
5) Action Research Project on 'Amba Amist' Community, Addis Ababa, Addis Ababa University, 2009.
6) Qualitative Study on access of reproductive health services to the youth of Lideta Sub city of Addis Ababa
7) Exploring the experience of sexually abused female street children in Addis Ababa: Challenges and coping mechanisms
8) Enhancing the participation of Sociology students in group discussion: Action Research, Madawalabu University, 2011
9) The Resilience in Children: A Literature Review, 2014.

5. SERVICES

a) Coordinator of Gender Office at MadaWalabu University

b) Chairperson of tutorial program for slow learner female students at the school of behavioural science, Madawalabu University

c) Book Club member and Coordinator at Madawalabu University

d) Volunteer counsellor in the school of Behavioural Science of Madawalabu University

6. TEACHING MATERIALS

Addisalem, A. (2012). Social welfare and Rehabilitation services. MadaWalabu University, Department of Sociology

Addisalem, A. (2012). Social policy and planning. MaddaWalabu University, Department of Sociology

7. PRESENTATIONS

1) AddisalemAdem (2011). Sexual violence among female students (presented on training conducted for madawalabu university female students)
2) Addisalem A. (2011). Stigma and Discrimination Associated with HIV/AIDS (presented on world AIDS Day Conference)
3) Addisalem A. (2010). Reproductive health services in Ethiopia: policies and access to RH services to the youth. Addis Ababa University (presented on Advocacy project conducted in Lideta Sub city

4) Enhancing the participation of students in group discussion (Presented on seminar organized by Higher Diploma Program)

8.SEMINARS AND WORKSHOPS ATTENDED

a) Training of trainers on Applying Social Work Skills to Psychosocial Needs of People Infected and Affected by HIV/AIDS in 2010.

b) Higher Diploma Program 2007- 2008.

c) Qualitative Data Collection conducted at Population Council, Ethiopia

d) Qualitative methods, Addis Ababa University, 2013 (a seminar conducted by Professor David Moxley)

9. AWARDS

a) Awarded a certificate for Best Action Research in Higher Diploma Program

b) Received a certificate of award for excellent performance among female students of Faculty of social Science and Humanities at Gondar University

7. PROFESSIONAL INTERESTS

Research, teaching and Community Service in the area of sexual abuse, street children, resilience, community development, and capacity building

8. COMPUTER SKILLS

a) Excellent user of Microsoft word, Microsoft Excel, Microsoft Power Point,

b) Proficient in using SPSS

9. LANGUAGE SKILLS

Fluent in speaking, listening, reading and writing English, Amharic, and Afan Oromo

10. REFERENCES

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