IMPACT OF HIV/AIDS ON THE WELL-BEING OF THE RURAL POPULATION IN EAST GOJJAM, AMHARA, ETHIOPIA

HULET-IJU ENESSIE; GOZAMEN; SHEBEL-BERENTA Woredas (Districts)

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ABSTRACT

The HIV/AIDS epidemic is a global concern of every country in the world particularly, in most African countries where the spread of the virus is increasing at an alarming rate. Coupled with other socio economic and political problems such as poverty, high fertility, low literacy and political instability, the incidence of HIV/AIDS in most African countries like Ethiopia is becoming a serious challenge. Most victims of the epidemic are youths, who are the productive and industrious groups of the population.

Although the level of awareness of the community about the disease has increased over the past decade, a large number of people are being infected and die of HIV/AIDS everyday. In addition, due to the high level of stigmatization and misconception about the modes of transmission, people living with HIV/AIDS (PLWHA) are neglected, excluded and marginalized from the rest of the community. Thus, this attitude of the community at large toward AIDS victims is discriminatory causing migration of victims to other places, psychological instability and spread of the virus.

HIV/AIDS has a multifaceted impact on the economic, social and cultural factors of the population. It is different from most other diseases because it strikes people in the most productive age groups. The major impacts of the HIV/AIDS epidemic include food insecurity, low production, loss of income, substantial increase in household expenditure for medical expenses, and deterioration of the education, health and agricultural sectors. Consequently, school age children of the victim households are forced to withdraw from schools in order to take care of those virus infected people. In other words, children are forced to be involved in income generating activities instead of going to school.

Other members of the family become a burden and are also forced to go out on the street for begging. With regard to the epidemic's impact on the health sector, the growing number of AIDS patients increases the demand for health care facilities and medicines.

According to the data collected by the Central Statistical Authority (CSA) in 2004, though the HIV prevalence rate is lower in rural than urban areas of Ethiopia, the incidence of the epidemic is increasing at a rate of 2.6 percent in most rural areas, where 85% of the 73 million Ethiopian population lives. This incidence has therefore become a major concern of governments in their effort to sustainable development and achieving Millennium Development Goals (MDGs) in 2015

The survey on the impact of HIV/AIDS on the well being on the rural population in east Gojjam of the three weredas identified the following economic, social and cultural practices contributing to the spread of the epidemic.

- Harmful traditional practices such as early marriage, high level of remarriages and divorces and female genital mutilations (FGMs);
- Presence of extramarital affairs – having multiple sex partners is very common in the rural as well as urban areas of Ethiopia;
- Economic factors such as lack of income, low standard of living, inability to pay for health services, unavailability of drugs and lack of health facilities at public hospitals;
- Marketing related risks play a big role in fueling the rural epidemic. Rural markets are major social gatherings and are occasional places for recreation, even if there was no business to conduct. These places are acknowledged as an opportunity and best areas to meet secret lovers. Drinking on a market days is a

common and long established tradition that often leads to casual unprotected sex;

- Lack of awareness about HIV/AIDS - This may lead to a chain of reactions in the community and contribute to high levels of HIV prevalence rates.

  Awareness creation activities should therefore emphasize on the prevention and transmission methods, causes and impacts of the epidemic.

Information on the level of awareness, demographic and socio economic characteristics and attitudes of the society toward HIV/AIDS and other related issues are very important in assisting policy makers and planners in monitoring and evaluating the impact of the epidemic on the society.

In general, it has been found out that HIV/AIDS has negatively impacted the rural population of the surveyed regions. For instance, agriculture, being the major occupation of 85% of the population is severely affected as the active work force is increasingly being affected by HIV/AIDS. Moreover, the traditional family ties in Ethiopia forces many to cater for the needs of diseased families and decreasing their own income. This in turn has aggregate effect on decreasing economic sustainability. Socially, the epidemic has also negatively contributed to the wellbeing of the society at large.

The main recommendations suggested include:

- Poverty reduction strategies should incorporate HIV/AIDS related issues. These strategies are effective methods for controlling the spread of HIV/AIDS.

- Government and non-governmental organizations should be responsible for disseminating the appropriate information to the public, and particularly to the youth about the transmission and prevention methods of the virus, with emphases on abstinence and premarital and unprotected sex.
- The government should give due attention to the urban as well as the rural communities. Rural development programs should be designed in such a way that they incorporate HIV/AIDS related issues. Moreover, since health services in most of these rural areas are very scantly and ill-equipped both from the point of view of manpower, medical equipment, medicines and other basic facilities, serious intervention methods need to be urgently taken in rural areas.

- Development strategies need to address the threats of socio economic, political and cultural problems caused as a result of AIDS. In other words, the implications of national policies of countries on HIV/AIDS should take into account the challenges resulting from sharp increases of AIDS related deaths. The consequences of HIV/AIDS need to be incorporated into economic strategies and particularly poverty reduction strategies.

- Promote optimal translation of earlier commitments of leaders to resource provision, social mobilization and sustainable programming of poverty alleviation and reduction of the transmission of HIV/AIDS.
- Develop processes and procedures that would ensure a higher degree of political will to be translated into policies and strategies to control the impact of the pandemic based on concrete and evaluable plan of operations

- Develop internal and external resource mobilization mechanisms for the prevention, care and treatment of the diseases in question and sustainable allocation of budgetary resources to combat the epidemics
- Mobilise civil societies to redirect national and international policies and programmes to address the compelling and evolving implications of the HIV/AIDS epidemic so that it does not further reverse human and social capital development. To achieve the stated goal, the people and government of Africa should take ownership of the responsibility and commit resources to responding to apocalyptic challenges of HIV/AIDS in the context of human and social capital development. Building on its comparative advantage, and consistent with the overall mandate of generating global frameworks for joint action, institutions in the international community, will provide catalysing resources and guiding tenets for the urgency this epidemic calls for.
- Strengthen macro-level public and private sector capacity to HIV/AIDS in the context of development. This will focus inter alia on National Framework for HIV/AIDS Private sector (profit and not-so-for-profit) programs, and care for the affected and infected.
- Strengthen the use of social capital (religious groups, civil society organizations, NGOs, and professional associations) in responding to HIV/AIDS peril. Nothing else will have more impact than massive behavioural change within the population to stop the spread of this epidemic. Specific tools for exploiting the social capital in favor of the program will include, inter alia, participatory training for social capital development, participatory planning and implementation, community monitoring and evaluation through participatory action research and local resource mobilization for prevention, care and mitigation.

- Identify, generate and disseminate best practice on HIV and development, whose foundation will be policy dialogue and research, identification, networking and documentation and dissemination of best practice. This assists in mainstreaming HIV/AIDS programs in Regional States, Weredas and local communities.
- Strengthen the capacity of the national research organizations and international institutions to work towards an intensified and expanded research program into the virus, the epidemic and its impact on society and polity.

- Effective and broad-based community responses involving NGOs, CSOs, CBOs, and the entrepreneurial community with the main aim of engaging communities as citizens of a political society.
- Political will and engagement which supports a broad political, economic and social governance based response involving a wide spectrum of society and key governmental organizations and ministries
- An effective ethical, legal and human rights framework which addresses fear, stigma, denial, shame, discrimination through various means of networking and developing communities of practice.
- Finally, while effective prevention activities must remain central to a national response, there is now a need - in heavily affected communities – for policies and programs (actions) which address the impact of the epidemic on individuals and their families (especially the poor). There is a need to address the effects on communities and productive sectors. The scale of the challenge to be addressed has changed in highly affected countries and

integrated programs are now essential if the threat to social and economic systems is to be overcome.

- Address and create awareness about HIV/AIDS in adequate scope and depth. These key strategies can be elaborated along several distinct axis or "dimensions" including; the political and policy environment, thematic strategies, geographic strategies and institutional strengthening strategies. Within each arena, the national, sub-regional and regional co-ordination will require stakeholder to undertake the following measures. First, it is to increase their action on and resource allocation to elements of the response to HIV/AIDS, which fall under their respective mission and mandate and in which they hold a competitive and comparative advantage. Secondly, it is to seek, apply and evaluate effective ways to collaborate and co-operate with other partners towards a united international response to HIV/AIDS. Finally, it is to uphold the ultimate aim of national, and regional Intensified Action co-ordination, which, in particular in the context of HIV/AIDS is to promote human development, and national, and regional self-reliance for the Intensified Action.
- Develop technical capacity information management coordination to receive/collect, analyze and interpret data on HIV/AIDS and formulate prevention and mitigation plans that can be incorporated in the development plan.

ACRONYMS

ANRS	Amhara National Regional State
ART	Anti Retroviral Treatment
CADU	Chilalo Agricultural Development Unit
CBO	Community Based Organizations
CSA	Central Statistical Authority
CSO	Civil Society Organization
EA	Ethiopian Aid
EAFPRH	Ethiopian Aid Family Planning and Reproductive Health
FAO	Food and Agriculture Organization
FGD	Focus Group Discussion
FGMs	Female Genital Mutilations
GDP	Gross Domestic Product
GNP	Gross National Product
IEC	Information, Education and Communication
IMPS	Integrated Management Programme Software
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
MoH	Ministry of Health
MTP	Medium Term Plan
NGOs	Non governmental organizations
ORID	Other Related Infectious Diseases
PLWHA	People Living with HIV/AIDS
PSUs	Primary Sampling Units
RG	Regional Government
SPSS	Statistical Package for Social Sciences
SSA	Sub-Saharan Africa
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TFR	Total Fertility Rate
UNAIDS	United Nations Specialized Agency for AIDS

UNECA	United Nations Economic Commission for Africa
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WAC	Woreda Advisory Committee
WHO	World Health Organization

CHAPTER ONE - INTRODUCTION

1.1 BACKGROUND

The global epidemic of HIV/AIDS is rapidly becoming the worst infectious disease catastrophe recorded in history, surpassing the 14th century bubonic plague and the 1917 influenza epidemic which killed around 20 million people. During the early years of discovery, researchers were mainly concentrating on the end result, AIDS, rather than on the infection causing HIV.*

Over the past quarter of a century, HIV/AIDS has become an increasing global phenomenon and resulted in an enormous human suffering. It was primarily regarded as a health issue, but today it became a debilitating force affecting all social and economic aspects of human life reversing the economic development of countries. The HIV/AIDS pandemic affects the most productive age groups, working force and those who cater for a large number of dependents. The epidemic has placed stress on the individual, family, community and the nation at large.†

As a national priority, many countries have shown a great commitment in the fight against HIV/AIDS. Different programmes and projects have been designed in such a way that individual and community organizations are involved and receive the appropriate share of national and international donor resources. Governments tried to set multi-sectoral approaches to AIDS with the aim of reducing the spread of the virus, protecting the rights of PLWHA and reducing the stigma and

* Population Reference Brochure. 2002.
† UNAIDS. 2004.

discrimination that often hamper prevention efforts. Many national and international organizations have been providing home based care and support, counseling and nutritional support to those people with the virus.*

Appropriate information on the spread and diffusion of the virus, the magnitude and nature of the disease, methods of transmission, the fatal consequences and means of protection for HIV/AIDS are keys to alleviating the impact of poverty on communities.

1.2 STATEMENT OF THE PROBLEM

The impact of HIV/AIDS is felt first by the individual, their families and eventually it ripples outwards toward firms, business enterprises and then to the macro economic of the country.

Though governments of African countries made efforts in supporting orphans, providing voluntary counseling and testing services, school based education programmes, peer counseling services and antiretroviral therapy, the vast majority of PLWHA in Sub-Saharan Africa (SSA) suffer from this epidemic. High rate of population growth and fertility rate, lack of adequate family planning and reproductive health services in rural parts of Ethiopia increases the infant mortality rates, which in turn contribute toward the spread of HIV/AIDS.

The rapid spread of the HIV epidemic is predominantly due to poverty. Unless poverty is significantly reduced, there will be little or no progress either in reducing the transmission of the virus or enhancing the capacity to effectively cope up with the inevitable socio economic

* Ibid.

consequences. Focusing on implementation programmes that take into account the poverty factor is very important in the fight against HIV/AIDS. The problem of rampant poverty, HIV/AIDS epidemic and high infant mortality rate is further compounded by lack of funds and inappropriate and inefficient distribution and utilization of resources. Although funding has greatly increased over the past few years, internal and external resources are not effectively utilized to fight HIV/AIDS and bring the intended result.

The role of the government in the fight against the epidemic is to ensure an open and supportive environment for effective HIV/AIDS programmes and stimulate a multi-sectoral approach that includes all segments of the society. The government also plays an important role in creating a favorable condition in which prevention, care and mitigation programmes can succeed and in protecting the country's future development projects by making AIDS a national priority. In the case of Ethiopia, lack of political commitment in the fight against poverty and HIV/AIDS is one of the crucial problems.

The direct involvement of the political, governmental and non governmental leaders, regional and business groups plays a big role in advocacy and awareness creation activities within the community. In the case of Ethiopia, most of these groups and leaders are not directly involved in the implementation of HIV/AIDS prevention programmes. Moreover, absence of awareness creation activities and lack of appropriate information on the magnitude and nature of the disease, methods of transmission and the fatal consequences and means of protection aggravates the spread and diffusion of the virus throughout the country.

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Though the national and international community tried to give support to the control and management of HIV/AIDS in Ethiopia, effective health strategies are not yet being implemented by the government to enable people particularly in the rural areas protect themselves from the virus. As a result infection levels and prevalence rates in the rural areas of the country are very high, highlighting the need to intensify and refine the focus of prevention efforts and rehabilitation of more health centers. This underscores the need to redouble and extend efforts to score better results and reduce the impact of HIV/AIDS on the community.

1.3 OBJECTIVES OF THE STUDY

The main objective of the study is to assess the impact of HIV/AIDS on the wellbeing of the community of the three target areas of east Gojjam i.e.: Hulet Eju Enessie, Gozamin and Shebel Berenta.

The specific objectives of the study include:

- Review the trends, policies and strategies of HIV/AIDS and explore the reasons for the observed prevalence of HIV/AIDS in Ethiopia;
- Review the demographic and socio economic characteristics of the rural population in the three selected weredas, their knowledge and understanding about the modes of transmission and prevention and impacts of the pandemic on the socio economic conditions of the target population;
- Assess the extent of the multifaceted impact of HIV/AIDS on wellbeing of the target community and on the education, health and agricultural sectors;
- Draw policy recommendations and suggest possible measures that need to be taken to curb the spread of the epidemic and strengthen the ongoing programmes by identifying areas where there are

weaknesses in order to be able to mitigate the effects of HIV/AIDS on the community.

1.4 THE SITUATION, DATA SOURCE AND METHODOLOGY

1.4.1 THE SITUATION

The development studies conducted a survey on the impact of HIV/AIDS on the well being of the rural population of three Woreda of East Gojjam namely: Hulet Eju Enesie, Gozamin and Shebel Berenta. The objectives of the study were to collect information which can provide evidence on the socio-economic situations of the rural population, knowledge, awareness and understanding the multifaceted impacts of HIV/AIDS on social, economic and other areas. Based on the findings it was also aimed to recommend and advocate for an alternative action if necessary or suggest strengthening the ongoing programs by identifying areas where there are weaknesses in order to be able to mitigate the effects of HIV/AIDS on the community. The survey covered 745 respondents selected by probability methods in three Woredas of East Gojjam Zone of Amhara National State namely, Gozamin, Hulet Eju Enesie and Shebel Berenta Woredas. Data was collected from some AIDS victim groups like AIDS patient and relatives and for friends of AIDS victims. Relevant additional information is also collected from hospitals, health centers and other health care facilities, schools, Woreda education and health offices.

Findings of the survey show that knowledge about HIV/AIDS is high in these sampled rural Woredas, where ninety five percent of all respondents have ever heard of HIV/AIDS. Regarding the sources of information about HIV/AIDS survey results shows that on the average,

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44.6% heard about HIV/AIDS from Health Institutions. Similarly 56.3% of respondents in Gozamin and 38.6% in Shebel Berenta heard about HIV/AIDS from the health institutions while relatively larger proportion (38.8%) in Hulet Eju Enesie reported to have heard about HIV/AIDS from Radio/mass media. In general, the major sources of information on HIV/AIDS, are the mass media and public meetings in all three Woredas.

More than half of the respondents who know the cause of HIV/AIDS believe that the epidemic is caused by a virus. About forty Percent or more reported that human beings are the causes of HIV/AIDS.

Regarding ways of HIV/AIDS transmission, respondents believe that sexual intercourse is the main route through which HIV/AIDS can be transmitted,although the percentages vary from Woreda to Woredas namely 69.4 % in Hulet Eju Enesie and 36.8 % in Gozamin. Generally, nearly all respondents in Hulet Eju Enesie Woreda and about 90 % respondents of Gozamin and Shebel Berenta Woreda believe that sexual intercourse, blood transfusion from infected people and sharing needles/razor blades with infected people are the main routes of HIV/AIDS transmission.

The survey results indicated that almost all respondents (about 96 %) believe that HIV/AIDS can be prevented. Relatively larger proportions of respondents in Hulet Eju Enesie Woreda think that HIV/AIDS can be prevented. In this respect, nearly all respondents believe that having one sex partner only, abstaining from sex and using condoms are important methods to prevent HIV/AIDS. There are significant differences in the knowledge of methods of preventing HIV/AIDS between Woredas.

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Seventy five percent of the respondents believe that TB is the disease most commonly associated with or caused by HIV/AIDS. Similarly, 10.1% reported diarrhea as illness which is caused by HIV/AIDS. There are differences between Woredas. More than 70 % of the respondents in Gozamin and Hulet Eju Enesie described TB an illness that is caused by HIV/AIDS, while the corresponding figure for Shebel Berenta is 60.6 %.

The survey results on knowledge of drugs that prolong life show that about half (47.9 %) of the respondents know that there are drugs that prolong the life of HIV/AIDS patients. The knowledge about anti-retroviral drugs is higher among residents of Hulet Eju Enesie Woreda (74.2 %) as compared to those in Gozamin (65.0 %) and Shebel Berenta (57.4 %).

The results on sexual behaviour of respondents show that about 84 % or more had their first sex after marriage. This may suggest that sex before marriage is less common among these rural dwellers. Of those who had sex before marriage more than three-quarters practiced unprotected sex. In addition, 18.9 % of respondents in Gozamin Woreda and 14.1 % in Hulet eju Enesie reported to have had more than one sex partner.

Nine in ten respondents in Gozamin and Shebel Berenta and nearly all respondents in Hulet Eju Enesie believe that they are not at risk of contracting HIV virus. In addition results show that at least ninety five percent of the respondents have not been tested for HIV/AIDS. In this regard there is no difference between Woredas. However, more than three-quarters of the respondents would like to be tested for HIV/AIDS. Though knowledge about HIV/AIDS is widespread misconception about HIV/AIDS has not been observed. The findings also show that there is strong fear among the community regarding the relationships with

PLWHA. Accordingly, among those who knew some PLWHA more than 20% do not have good relationship with them. Regarding their willingness to be friendly with PLWHA, less than half of the respondents believe that they can establish friendship with a person who has HIV/AIDS. Relatively larger proportions of respondents (57.6 %) in Hulet Eju Enesie expressed that they can establish friendship with PLWHAs as compared to respondents in other Woredas.

More than half (57.3 %) of the respondents are willing to care for a person with HIV/AIDS. Respondents in Gozamin Woreda are more willing to take care for PLWHA. Table 4.12 also shows that about half of the respondents said they are willing to eat with PLWHA. The percentages of respondents who think they can eat with PLWHA vary by Woreda being slightly more than 50 % in Hulet Eju Enesie and Shebel Berenta. Less than 50 % of the respondents (46.3 %) are willing to be friendly with person living with HIV/AIDS.

There is also a better understanding of multifaceted impacts of HIV/AIDS. A substantial portion of the respondents believe that HIV/AIDS could affect the family in various ways, e.g. income, agriculture, occupation and the community development.

The additional survey result done on AIDS patients show that most of the patients are married and have children. Around 40 % of the patients lost their spouses. The survey findings reveal that the burden of looking after the patients is on the children. About half of the patients were taken care of by their children while they are ill in bed. For this reason about 60 % of the AIDS patients' children are not going to school. In addition to their care taking responsibilities school age children of AIDS patients were forced to withdraw from school due to economic problems.

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About half of the patients reported that there are no NGOs in the area which provide them care and support and results of this study have confirmed that there are no NGOs which provide home based care, counseling and nutritional support

As shown in the survey results, the attitude of the patients' family and health service providers towards AIDS patients are friendly. Half of the patients' relatives and neighbors have negative attitude towards them. Over 75 % of the community at large have negative or discriminatory attitude towards the AIDS patients.

The findings of the survey well indicate that the economic impact of HIV/AIDS is very high. Almost 80 % of the patients staffed that the family member replacing the bread winner of the family while he/she is ill in bed does not adequately provide for the food and other needs of the family. Some of the negative impacts of AIDS on the victims' family as reported by the patients are inability to afford food and paying for house rent discrimination, loneliness, lack of care-takers and children are obliged to be street dwellers.

According the result obtained from family members of the deceased (due to AIDS) AIDS deceased, 90 % of the family whose living condition was fair or good before the death of the AIDS patient, do not have enough food after the death of AIDS patient. About 75 % of children of the victims' family also discontinued going to school. The main reason mentioned is the economic problem of the family after the victim became ill or died This shows the negative economic impacts of AIDS on the AIDS patient or deceased family.

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The assessment of health status of the spouse of the deceased indicates that most of them are HIV-positive. About one third of the HIV-positive spouses are not getting medical treatment. The survey result also reveals if the spouse dies, in 85 % of the cases there is no one in the family who can take care of the dependents. This leads to the disintegration of family and most likely the children are forced either to go to the street or serve other family members instead of going to school.

The negative consequences on the family of the deceased are reported to be, lack of food, clothing, lack of money, medical treatment, discrimination, children dropping out of school and migration.

The findings of in-depth interviews done with the relevant institutions clearly show the economic and social impacts of HIV/AIDS in the study area. According to the discussions made with school directors and Woreda Education Offices, the number of teachers dying due to AIDS is increasing and the number of school dropouts increased. As a result of loss of parents hence lack of money to go to school.

The report obtained from some health care facilities or hospitals shows that the prevalence of HIV/AIDS has been increasing over the last three years. In some hospitals 20 % of the beds were occupied by the AIDS patients. The growing number of AIDS patient in the area leads to occupation of a significant number of hospital beds by these patients and this creates a serious shortage of beds for other patients.

1.4.2 BACKGROUND OF SURVEY

1.4.3 SURVEY METHODOLOGY

The 2005 Impacts of HIV/AIDS on the rural well-being of the population in East Gojjam Survey was designed to provide data on relevant characteristics for the zone and separately for each of the selected Woreda which is located in different agro-ecological zones. AIDS patients and relatives of persons who died of AIDS were also interviewed to obtain direct and authentic information. In addition, for qualitative analysis relevant and auxiliary information was collected from schools, health facilities, Woreda education and health bureau officials to complement the survey findings by FGD.

1.4.3.1 Sampling Frame

The list of Peasants' Associations (PA) from each Woreda which was compiled from the Woreda administrative office was used for selection of Primary Sampling Units (PSU). For the selection of ultimate sampling units (households), a fresh list of households was prepared by the enumerator in a sampled PAs using a prescribed listing instruction.

For patients' interview, the selection or contact is done through informants, care and support provider NGOs, and health care facilities. Family of the deceased persons were also contracted in a similar manner.

1.4.3.2 Sample Design

In order to meet the objectives and requirements of the survey, a stratified three-stage cluster sample design was used to select Woredas, Kebeles and households. Agro-ecological zones were treated as strata and Woredas formed the primary sampling units. The secondary sampling units were peasants associations and the tertiary (ultimate) sampling

units are households for which the survey questionnaires were administered.

1.4.3.3 Sample Size

Determination of sample size for a binomial variable (such as proportions, percentages and ratios) and totals are based on consideration of the desired degree of precision and level of confidence, along with a prior estimate of the statistic to be determined. By considering these factors 25% Kebeles were sampled from each Woreda. In each sample Kebele, 6% of the households were included in the sample. For patients module a representative sample of AIDS patients were interviewed for the different areas. Family of AIDS deceased persons were also contacted and the relevant information was collected by administering a survey module prepared for them separately. The determined size of sample Kebeles and households by Woreda and agro-ecology, and AIDS patients and deceased family is shown in the table 1.1.

Table 1.1 Sample Size by Woreda

	Agro-ecology	Woreda	Number of Sample	
			Kebeles	Households
1	Highland	Hulet Eju Enesie	12	288
2	Midland	Gozamin	11	418
3	Lowland	Shebel Berenta	5	75
		Total	**28**	**781**
4	AIDS patients			39
5	AIDS deceased family			32

1.4.3.4 Sample Selections

The selection of Kebeles (PA's) was done by systematic random sampling technique during the actual field survey from the list of Kebeles obtained from relevant Woreda office. In each sample Kebele a complete fresh listing of households was carried out by canvassing the households in the Kebele. After a complete listing of households during the listing operation in the selected PA, the households are serially numbered. From this list, a predetermined number of sample households were selected systematically. The systematic random sampling technique was employed here because of its application is simple and flexible, and it can easily yield a proportionate sample. The AIDS patients and AIDS deceased families were selected by non-probability methods since they are hard to reach.

1.5 DATA SOURCE AND METHODOLOGY

The survey on the impact of HIV/AIDS on the well-being of the rural population covered 745 respondents selected by probability method from the three weredas of east Gojjam zone of Amhara National State (ANS) namely Gozamin, Hulet Eju Enesie and Shebel Berenta. Primary data was collected from various governmental and non-governmental health centers, wereda and zonal health offices. A questionnaire was prepared and relevant data was collected from AIDS victims, non-affected households and wereda education offices. A focus group discussion (FGD) was fairly conducted with AIDS patients and their relatives, government employees, active groups from youth, religious and women associations to get relative and auxiliary information. Many secondary data from journals and the internet have proven to be of paramount importance to the study complementing the survey findings.

In order to assist the identification of primary sampling units (PSUs), households were selected randomly from peasants association of each

wereda. A stratified three-stage cluster sample design was used to select weredas, kebeles and households. Then questionnaires were distributed to the selected sampling units based on a prescribed listing instruction. The selection of those people living with the virus and families of the diseased is done by non-probability methods. The Statistical Package for Social Sciences (SPSS) economic software and the Chi-Square test of association are used for the descriptive analysis and cross tabulation of most variables. In addition, both qualitative and quantitative research methodologies were used for analyzing the data.

1.6 FIELD ORGANIZATION

The study was conducted both in Urban and Rural areas of the three Woredas (Districts) manly Hulet-Eju Enesie, Gozamin and Shebel. As explained in the report, these Woredas directly represent the environmental; social, economical and political situations of the region.

Both qualitative and quantitative research methodologies well used for collecting the information.

A senior social worker was deployed to the field with three junior social workers assigned each to one Woreda (District)

The senior social worker, the three junior social workers together with the Ethiopian Aid Family Planning of Reproductive Health (FP/RH) project coordinator from each Woreda received brainstorming instructions and explanation on the objectives of the study, its intended survey coverage, the identified Kebeles (localities) and the preparation of the questionnaires and how information should be collected.

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Accordingly as described in this report, from Hulet-Eju Enese (Woreda) 11 Kebeles from Gozamen (Woreda) again 11 Kebeles and from Shebel (Woreda) 5 Kebeles were selected. In each administrative central town of the Woredas the assigned junior social workers together with the Ethiopian Aid FP/RH coordinator conducted a brainstorming session for the Community Based Reproductive Health Agents (CBRHAs) of Ethiopian Aid assigned for each Kebele (locality). They were instructed on the objective of the survey, how to carefully conduct the survey and finalize the questionnaire. The (CBRHAs) were closely supervised in the field by the EA FP/RH Woreda Coordinators and the Asst. social workers.

Most of the survey was conducted in the field by walking as far as 10-15 km sometimes by motorcycle and when available renting mule service.

The Focus Group Discussion (FGD) was conducted in difficult circumstances. Since it was a national election period the political atmosphere was very tense, invited participants were reluctant to openly discuss the issue. Also the STIGMA associated with HIV never allowed free discussion as no body wanted to discuss the case on any body. This would create animosity within family members. However, the FGD was fairly conducted using government employees, active groups from the religious and Women associations. At least 5 representative agents from all walks of life participated. Especially the Ethiopian Aid (CBRHAs) were instrumental in providing needed information at all levels including FGD's

1.7 PRECISION OF SURVEY RESULTS

A survey is a valuable assessment tool in which a sample is selected and information from the sample can then be generalized to the entire population. The key to the validity of any survey is randomness. Unless

the respondents are chosen randomly it is difficult to generalize the survey results to the whole population with the known magnitude of error.

How well the sample represents the population is gauged by two important statistics – the survey's margin of error and confidence level. They tell us how well the samples represent the entire population.

The calculated margin of error for the most of variables lies between 2 and 5 % as shown in table 1.2.

Table 1.2 Precision Level or Margin of Error of Some Selected Variables

No.	Variable	No. of respondents	Margin of error in %
1	Do you own a land for agriculture	678	2
2	Have you ever heard of HIV/AIDS	739	2
3	Do you know the cause of HIV/AIDS	734	2
4	What is cause of HIV/AIDS	508	4
5	Do you have more than one sex partner	702	3
6	Your relationship with somebody HIV positive	252	5
7	If a person has HIV/AIDS, how will the income be affected	634	2.5
8	If a person has HIV/AIDS, how will the agriculture be affected	629	2.5
9	If a person has HIV/AIDS, how will the community be affected	473	4.5
10	If a person has HIV/AIDS, how will it affect the occupation	677	4

This indicates that the precision of the obtained survey result is high. For example about seventy percentages of the respondents reported that they know the causes of HIV/AIDS with plus or minus 2 % margin of error at 95 % level of confidence. This term simply means that if the survey were conducted 100 times, the percentage who say 'they know the causes of HIV/AIDS' will range between 68 and 72 % most (95 %) of the time.

1.8 SIGNIFICANCE OF THE STUDY

Although many countries tried to reduce the prevalence rate of HIV/AIDS, the epidemic has a severe negative impact on the different sectors of the economy and social and cultural conditions of a country. Mere implementation and evaluation of administrative and policy actions may have positive outcomes in reducing the impact of the epidemic. The anticipated result of such evaluation is believed to be of a paramount importance to the concerned national authorities in that it enables them to take the necessary administrative and policy actions to correct observed weaknesses and shape better operational plans. The results of the study can also be used by national policy makers to introduce appropriate policies for the prevention and control of HIV/AIDS and minimize the adverse impact of the epidemic. Moreover, the findings of the survey may help the international community to learn from the Ethiopian experience.

CHAPTER TWO - LITERATURE REVIEW

2.1 BACKGROUND

The global epidemic of HIV/AIDS is rapidly becoming the worst infectious disease catastrophe recorded in history, surpassing the 14th century bubonic plague and the 1917 influenza epidemic which killed around 20 million people.* During the early years when the disease was first discovered, researches were mainly concentrating on the end result, namely, AIDS, but were unaware of and missed out an entire and crucial stage leading to the development of AIDS following the initial infection. As a matter of fact, more concentration should have been given to the infection causing HIV rather than to AIDS, which, as found out later, is the final stage of HIV infection. The human toll and suffering due to HIV & AIDS is already enormous. Over the past quarter of a century HIV/AIDS has become an increasing global phenomenon, and AIDS was regarded primarily as a health issue. Today, however, it is widely accepted to be a debilitating force affecting all social and economic aspects of the human life thus delaying or reversing the economic development of affected countries. To make matters worse, the HIV/AIDS pandemic affects attach the most productive age groups which are not only the majority of the working force but also who cater for a large number of dependents.

* Publication of the population Reference Brochure Vol No1. 2002

2.1.1 Global

Since AIDS was first diagnosed in 1981 there were 20 million deaths as a direct result of the disease, and today in 2005 the number of HIV-positive persons is estimated to be about 39.1 million and this is an increase of more than one million over the figure of 2004. In 2003, almost five million people became newly infected with HIV which is the largest number in any one year since the beginning of the epidemic. The scale and impact of the epidemic varies from region to region. Some countries are more affected than others, and even within countries, there are usually wide variations in infection levels between different provinces, states or districts. The impact of AIDS is felt first by the individuals, then their families, and eventually it ripples outwards towards firms, business enterprises and then to the macro-economy of the country.

The HIV/AIDS epidemic has placed stress on the individual, family, community and the nation at large. The implications of the rising rates of morbidity and mortality are not only that HIV/AIDS is changing the demographic structure of the household but also that of the community and the nation as a whole. More importantly, it is becoming increasingly apparent that HIV/AIDS is having an adverse impact on the livelihood of rural households. The HIV prevalence is continuing to rise as more individuals are steadily joining the pool of people living with HIV. In countries hard hit by the pandemic, morbidity and mortality have risen and are expected to continue rising. Table 2.1 below illustrates the total estimate of adults and children living with HIV/AIDS (UN AIDS, 2004)*

* UN AIDS

Table 2.1 Global summary of the HIV and AIDS epidemic (December 2004)*

Global Summary of the HIV and AIDS epidemic, December 2004		
Number of People living with HIV in 2004	Total Adult Women Children under 15 years	39.1 million (35.9 - 11.3 million) 37.2 million (33.8 - 41.7 million) 17.6 million (16.3 - 19.5 million) 2.2 million (2.0-2.6 million
People newly infected with HIV in 2004	Total Adult Children under 15 years	1.9 million (4.3 - 6.4 million) 2.3 million (3.7 - 5.7 million) 640,000 (570,000 - 750,000)
AIDS deaths in 2004	Total Adult Children under 15 years	3.1 million (28-35 million) 2.6 million (2.3 - 2.9 million) 510,000 (400,000 - 600,000)

* UNAIDS 2004 A comparative review has been made on the number of women and men living with HIV/AIDS in certain African counties and it was found that the ratio of women to men ranges from 20 to 10 in S. Africa, and 45 to 10 in Kenya and Mali. In general, there is a great variation in the HIV/AIDS prevalence rate among Sub-Saharan countries and that there is no such thing as the "African" epidemic,

Table 2.2 - Adults and children estimated to be living with HIV as of end 2005

Region	People living with HIV	People newly infected in 2005	Prevalence (percent of adults infected)	Deaths due to AIDS in 2005
World	40,300,000	4,900,000	1.1	3,100,000
Sub-Saharan Africa	25,800,000	3,200,000	7.2	2,400,000
N.Africa/Middle East	510,000	67,000	0.2	58,000
South/Southeast Asia	7,400,000	990,000	0.7	480,000
East Asia	870,000	140,000	0.1	41,000
Oceania	74,000	8,200	0.5	3,600
Latin America	1,800,000	200,000	0.6	66,000
Caribbean	300,000	30,000	1.6	24,000
Eastern Europe/Central Asia	1,600,000	270,000	0.9	62,000
Western/Central Europe	720,000	22,000	0.3	12,000
North America	1,200,000	43,000	0.7	18,000

2.1.2 AIDS in Africa

During the period between 1981 to the end of 2003, there have been 20 million deaths due to AIDS while in 2004 around five million adults and children have become infected with the virus. Africa is affected by HIV/AIDS far more than any other continent. Latest statistics show that over 29 million of the 42 million people in the world with HIV are in Africa. However, the vast majority of people living with HIV/AIDS in Sub-Saharan Africa, do not have access to antiretroviral drugs. The estimated US$20 billion would provide antiretroviral therapy to just over six million people (over four million of which are in sub-Saharan Africa). Support for

22 million orphans, HIV voluntary counseling and testing for 100 million adults, school-based AIDS education for 900 million students and peer counseling services for 60 million young people not in school. About 43% of these resources will be needed in sub-Saharan Africa, 28% in Asia, 17% in Latin America and the Caribbean, 9% in Eastern Europe, and 1% in North Africa and the Near East. The Table below provides a Global summary of the HIV/AIDS epidemic:*

2.1.3 AIDS in Sub - Saharan Africa

Sub-Saharan Africa is by far the worst affected area in the world by the AIDS epidemic. Nearly two-thirds of the world's HIV-positive people live in sub-Saharan Africa, which constitutes about 10% of the world's population, but accounts for over 60% of all people living with HIV. In 2005 an estimated 3.1 million adults and children have become infected with the HIV virus thus bringing the total number of people living with HIV/AIDS in Sub-Saharan Africa by the end of that year to 25.8 million. Sub-Saharan Africa, Eastern Europe and Asia, account for 95% of new HIV infections in 2005.

The main cause for the rapid spread of the HIV epidemic in Sub-Saharan Africa is predominantly poverty, and unless and until poverty is significantly reduced, there will be no or little progress either in reducing transmission of the virus or enhancing the capacity to effectively cope with the inevitable socio-economic consequences. Women, in particular, are at great risk of infection. For instance, as of December 2005, women accounted for 57% of all people living with the HIV virus globally and for

* UN AID's July 2004 The report on the Global HIV/AIDS epidemic

57% in Sub-Saharan Africa.* Women in general, including young girls, bear the burden of the impact of the epidemic as they are more likely to take care of the sick; to lose jobs, income and schooling as a result of illness and to face stigma and discrimination. A comparative survey had been made on the ratio of women to men who are living with HIV/AIDS in certain African countries. The findings of the study indicated that ratio of women to men ranged from 20%: 10% in South Africa to 45%: 10% in Kenya and Mali. In general, there is a great variation in the HIV/AIDS prevalence rate among Sub-Sahara African Countries and that there is no such thing as "African" epidemic.

Accordingly, in six of these countries, adult HIV prevalence rate is below 2%, while in six other countries it is reported to be over 20%.† Seven Southern African Countries have adult prevalence rates of above 17% with Botswana and Swaziland having more than 35%. South Africa is the most affected of all in the region, and it is forecasted that the epidemic would reduce the economic growth rate of the country by 0.3-0.4% annually. By 2010, it is estimated that the GDP would be 17% lower than it would have been without AIDS and knocking off about US$ 22 billion from the country's economy.‡

Even in a diamond rich Botswana, the country with the highest per capita GDP in Africa, AIDS is expected to slice off 20% off the government budget, erode development gains, and bring about 13% reduction in the income of the poorest households in the next 10 years.

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* Botswana, Central African Republic, Lesotho, Malawi, Mozambiqu4e, Namibia, South Africa, Swaziland, Zambia, United Republic of Tanzania.

† Data by province Sources: Ministry of Health (Mozambique); Department of Health (South Africa); Ministry of Health and Child welfare (Zimbabwe); Ministry of Health (Keneya); Ministry of Health (Unite Republic of Tanzania); Ghana Health Service (Ghana); Centers for Disease Cntrol and Prevention (CDC) - GAP- Cote d'Ivoire (Cote d'Ivoire); Conseil National de Lutte Contre SIDA (Senegal); Adapted from Asamoah-Odei, et al. HIV prevalence and trends in sub-saharan Africa ; no decline and large subregional differences. Lancet, 2004 (Botswana, Ethiopia, Uganda and Nigeria).

‡ Marcus Hacker, 'The economic Consequences of HIV/AIDS in Southern Africa, IMF working paper, WP/02/38, February, 2002

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Population - based surveys can help fill in more details in the picture of the epidemic. Findings from 34 such surveys conducted among mining and manufacturing workers in southern Africa were recently published and indicate a suggestive picture of the spread of HIV among wage-income workers. These surveys which were conducted during the years 2000/2001, reported HIV prevalence rates of 24.6%, 14.5% and 17.9% among workers in Botswana, South Africa and Zambia, respectively.* Workers in the mining sector had the highest levels of infection and from among these the unskilled and uneducated individuals were infected at a much higher rate. In spite of all this, some countries that are facing the wrath of AIDS in certain African countries have taken the challenge face-to-face and are gradually overcoming the catastrophe slowly but surely, mainly as a result of a strong commitment and concerted and determined actions. The following countries may be cited as good examples.

a) Uganda

The downward trend is most firmly established in Uganda, which saw HIV national prevalence decline steeply from 13% in the early 1990s and subsequently remaining at 41% by the end of 2003.† This was the most notable, but by no means, the only example.

b) Kenya

Recent data suggest that Kenya could be on a similar path, where data collected from antenatal clinics show HIV prevalence falling from 13.6% in 1997/1998 to 9.4% in 2002 and then staying largely unchanged in 2003.‡

* National Aids Coordinating Agency, Botswana, 2005
† Ministry of Health, Uganda, 2003
‡ Wawer et al, 2005

c) Burundi

Figures for Burundi also suggest a decline in HIV prevalence, but this is based on limited data, namely, only from six clinics.*

d) Ethiopia

The epidemic in Ethiopia is most severe in urban areas, including the capital Addis Ababa. However, there are encouraging signs that the declining trend among pregnant women in the capital (1st detected in 1997) is continuing. By 2003, HIV adult prevalence in Addis Ababa had fallen to 11% less than half the level it had reached in the mid – 1990s.

Overall, in 10 antenatal clinics in the capital, Addis Ababa, the median prevalence rate dropped from 13.7% in 1997/1998 to 11.8% in 1999/2000, and has remained at about 12% since then.†

Meanwhile, a clearer picture is emerging on the epidemic in Eritrea, where the most detailed round of HIV sentinel surveillance to date has fixed prevalence at 2.4% in 2003‡ Overall, HIV prevalence in the country appears to be stabilizing. However, infection levels vary considerably, highlighting a need to intensity and to refine the focus of prevention efforts. Along the southern coastal strip of the country prevalence reached 7.2%, and was more than three times as high in urban as in rural areas.§ Prevalence was highest among young unmarried women in urban areas (7.5%), most of whom had partners in the military. Women working in bars, hotels or as housemaids appeared to be particularly vulnerable to infection.

* Minstere de la sante publique, Mozmbique 2004
† Consortium of Reproductive Health Associations in Ethiopia, special report - 2005
‡ Federal Ministry of Health, Ethiopia 2004
§ UN AIDS 2004 Report

In West Africa, HIV prevalence is much lower with no country having a prevalence rate above 10% and most having prevalence rates ranging from 1 to 5%. Adult prevalence in countries in Central and East Africa falls somewhere between these two groups, ranging from 4% to 13%.

2.1.4 AIDS in Ethiopia

Ethiopia, is a country with long standing rich tradition, cultures and diversity of people but is backward in terms of socioeconomic, health services coverage and technological advances. Health indicators/parameters such as infant and maternal mortality, and mortality from HIV & other communicable diseases, malnutrition and the average life expectancy, place Ethiopia among the least privileged nations in the world. The most recent UNFPA report on population growth in Ethiopia reveals a grim picture. UNFPA warned that the population of Ethiopia, which is currently about 72.4 million, is growing at an annual rate of 2.7%. Table 2.3 depicts the population, total Fertility Rate (TFR), Infant Mortality Rate (IMR) of selected regions in comparison with Ethiopia.

Table 2.3 - Total Fertility Rate (TFR) and Infant Morality Rate (IMR)[*]

Country	*Population in Millions (Mid 2005)*	*TFR %*	*IMR %*
1. World	6,396	2.8	56
2.Developing countries	1,206	1.6	7
3.Africa	885	5.1	90
4.Sub-Saharan Africa	733	5.6	96
5.Ethiopia	72.4	5.9	105

[*] UNFPA Report 2004

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At this rate, the population of Ethiopia could reach 170 million in less than 30 years and the government is faced with a dilemma – should it focus on controlling the HIV/AIDS epidemic or the population explosion?

According to the Association of Reproductive Health Services Providers, about 3.2 million women in Ethiopia do not have access to family planning services (Ethiopian Herald 2004) Ethiopia has a very high fertility rate in comparison with other countries which have one third of both the fertility rate and population size (Table 1.3) and this puts infant and maternal mortality at a great risk for lack of adequate family planning and reproductive health services. The promotion and expansion of reproductive health and family planning services would be the only option to reduce both IMR and MMR, which in turn, would significantly contribute towards the control and prevention of HIV/AIDS
(Ethiopian Herald. Daily Newspaper, 2 January 2004*)

In Ethiopia, the first evidence of HIV infection was detected in 1984, while the first AIDS cases were reported in hospitals of Addis Ababa in 1986. Although HIV serological surveys using a representative sample has not been undertaken since, projection of data from the then available studies in different population groups show that about 2.5 million adult Ethiopians were possibly affected with HIV/AIDS by December 1997, which translates to an adult prevalence rate of 7.4%. (as of 2004 Dec. prevalence rate was 4.4%).† The English weekly newspaper *Nation*, reported that in 2004 HIV/AIDS has claimed over 100,000 lives in Ethiopia. According to the report, 115,000 Ethiopians have died due to AIDS-related illnesses in 2004 alone and 1.5 million people are estimated to be living with the virus (ENA 2005).

* The English daily Dec. 10, 2004
† Ministry of Health Report 2004

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Even though the cure is elusive, we have learned a crucial lesson about what works best in preventing new infections and improving the quality and care for people living with HIV. There have been some major developments, including the use of antiretroviral medicines. Ethiopia has begun distribution of free anti-retroviral drugs to people living with the virus to reduce AIDS-related deaths. The drugs are funded by the Global Fund and the US government, and will be distributed to the patients in 20 hospitals and 30 health centers throughout the country. The program aims to give the drug free of charge to about 15,000 people in 2005 and this figure is expected to increase to 210,000 in the next five years (ENA 2005). The Ethiopian government believes that access to the drugs by all people living with HIV/AIDS will save 78,000 deaths per year and reduce the number of AIDS orphans from 600,000 to 332,000 by 2008 in the country. (UN AIDs 2004, UN AIDS 2005, CDC Ethiopia, 2005)*

Efforts made to control the spread of HIV/AIDS have resulted in the reduction of adult prevalence rate from 7.4% in 1997 to 4.4% in December 2004 (HAPCO, 2005).† These are indeed heartening developments but the figure is still to high and this underscores the need to redouble and extend these efforts.

Though there is a decline in the prevalence rates, efforts to score better results should continue. In a study conducted by Sanders et al in Addis Ababa about the causes of 17,519 deaths, were retrospectively reviewed, and complete data were available for 6342 (47%) females and 7269 (53%) males. During 1987-2001, the '25-49' versus '5-14' group all-cause mortality ratio increased by 8.5% per calendar year. A total of 5101

* Federal Ministry of Health Ethiopia, 2004, UN AIDS / WHO 2005 (UNAIDS, 2004)
† HAPCO 2005 Ethiopian HIV/AIDS National Response 2001-2005 HAPCO, June 2005.

deaths were recorded in the prospective surveillance. Crude mortality rates were 9.5/1000 per year (men) and 7.1/1000 per year (women). Comparing with 1984, the deaths are 5 times as many for men and 5.3-times as many in women in the age group of 35-39 years, attributing the increase in mortality in ages 15-60 to HIV in the period 1984-2001. Ethiopian men and women have a probability of 18.8 and 17.8%, respectively, of dying of HIV before age 60. This study depicts that burials have increased significantly among the '25-49', versus the '5-14' group, during the period 1987-2001. This trend, and a five-time higher mortality in 2001 than in 1984 in those aged 35-39 years demonstrate a severe impact of HIV on mortality.

It is a disturbing fact that in a country whose economy is already burdened by rampant poverty, HIV/AIDS epidemic and a high infant mortality rate the problem is farther compounded by lack of funds, and even if funds were available, the inappropriate and inefficient distribution and utilization system of these funds make them equally worthless to fight AIDS. Although funding has greatly increased over the past few years it has not been always effectively utilized. Table 2.4 gives a comparative view of the current scenario of certain parameters of Ethiopia in relation to other regions and countries of the world.

Table 2.4 - Comparative selected; health indicators (mid 2004)*

Country	*Population in Millions (Mid2004)*	Birth rate/1000	Death rate/1000	percent Of population with AIDS		Life Expectancy	
				Male	Female	Male	Female
1. World	6,396	21	9	1.0	1.1	65	69
2.Developing countries	1,206	11	10	0.4	0.5	72	80
3.Less developing countries	5190	24	8	1.4	1.4	63	67
4.United States	293.6	14	8	0.6	0.6	75	80
5.Africa	885	38	14	6.3	6.2	51	54
6.Sub-Saharan Africa	733	41	16	7.6	7.5	48	50
7.Northern Africa	191	26	7	0.5	0.5	66	69
8.West Africa	263	42	15	4.5	4.3	50	51
8.Eastern Africa	270	41	18	7.9	7.6	44	47
9.Ethiopia	72.4	41	18	4.1	4.4	45	47
10.Eriteria	4.4	39	13	2.8	2.7	52	55

A brief overview of the history of the health policy and the National AIDS Policy that followed after the epidemic outbreak reveals that a comprehensive Health Services Policy was adopted first towards the end

* Source: UNAIDS FACTS sheet 2004

of the Imperial period through initiatives from the World Health Organization (WHO). However, the downfall of the regime precluded the possibility of putting this scheme to the test. In recent times, the country has experienced severe man-made and natural calamities and political instability that have caused untold sufferings to the people. The Dergue regime that came into power in the mid-seventies formulated a more elaborate health policy that gave priority to the prevention and control of diseases, health services and promotion of self-reliance and community involvement in rural areas. But in practice the totalitarian political system lacked the necessary commitment and leadership qualities to address and maintain active popular participation in translating the formulated policy into practice. In addition, the bulk of the national resources was committed to the pursuit of war throughout the life of the regime, which left little for development activities in any sector. Therefore, in health as in most other sectors, in the two previous regimes, there was no meeting ground between declaration of intent and demonstrable performance. Furthermore, the health administration apparatus contributed its own share to the perpetuation of backwardness in health development because, like the rest of the tightly centralized bureaucracy, it was unresponsive, self-serving and impervious to change.

A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all had strong support from the top political leaders. This support is critical for several reasons.

a) It sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts.

b) It facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority.

c) It signals to individuals and community organizations involved in the AIDS programmes that their efforts are appreciated and valued, and

d) It ensures that the programme will receive an appropriate share of national and international donor resources to fund important programmes.

Perhaps the most important role of the government in the fight against AIDS is to ensure an open and supportive environment for effective programmes. Governments need to make AIDS a national priority not only on paper but also implemented in full and reviewed periodically. By stimulating and supporting a broad multi-sectoral approach that includes all segments of the society, governments can create the conditions in which prevention, care and mitigation programmes can succeed and protect the country's future development prospects.

The Ethiopian government after having come to reality with the types of harm that AIDS would cause to the population in terms of diminishing the quality and quantity of the labour force; leading to social and economic crisis in the country, along with the inevitable psychological impact, established a national HIV/AIDS control programme administered under the Ministry of Health (MOH). Accordingly, staff from the MOH, assisted by experts from the Global programme on AIDS, developed a Short and Medium term plans in March and May 1987, respectively

The First Medium Term plan (MTP-1) focused on public awareness establishment of laboratory services, surveillance of HIV & training of workers.

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The Second Medium Term Plan (1992-1996) (MTP-II) was designed in December 1991 based on the experience gained from MTP-1. The major emphasis of MTP-II was to stop the spread of HIV using a multi-sectoral approach.

In 1997, a national HIV/AIDS policy was developed through consultation with partners and national stakeholders, and was later presented to the Council of Ministers in August 1998 and was ratified with certain amendments. During 1999-2002 much progress has been made in the areas of political and financial mobilization and in the development of National Strategic Plans. However, countries must focus on the implementation of programmes that would take into account the poverty factor and try to fight poverty in order to eradicate HIV.

Some political, health and other leaders are normally involved directly in HIV/AIDS programme implementation, But if political, governmental, non- governmental, religious, business, education & other regional leaders are not directly involved in the implementation of HIV/AIDS prevention programme, they should be involved as much as they can by way of advocacy on awareness creation in the community. If the leaders of all parts of Ethiopia discharge their share of responsibility, this epidemic can be turned around. Evidence from Uganda suggests that appropriate information on the spread or diffusion of the virus throughout the population the magnitude, the nature of the disease, methods of transmission, the fatal consequences and means of protection from HIV/AIDS are key to achieving wide spread changes. Consequently, the government then introduced the following National HIV/AIDS policy.

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GENERAL POLICY:

The overall objective of the policy is to provide a suitable environment for the prevention and control of HIV/AIDS in the country.

SPECIFIC OBJECTIVES

- To establish effective HIV/AIDS prevention and control strategies in order to curb the spread of the epidemic.
- To promote a broad multi-sectoral response to the HIV/AIDS epidemic, coordination of the activities of different sectors and the mobilization of resources for the control of the epidemic.
- To encourage government sectors, non-governmental organizations, private sectors and communities to take appropriate measures in order to alleviate the social and economic impact of HIV/AIDS.
- To promote proper institutional, home and community-based health care and psychological support for people living with HIV/AIDS, orphans and surviving dependents.
- To safeguard the human rights of people living with HIV/AIDS and avoid discrimination against them.
- To empower women, youth and other vulnerable groups to take action to protect themselves against HIV/AIDS.
- To promote and encourage research activities targeted towards preventive, curative, and rehabilitative aspects of HIV/AIDS.

The National AIDS Policy along with the general strategies can be highlighted as follows:

- Promote IEC by utilizing all possible media, materials and methods
- Encourage faithful sexual relationships- Fidelity
- Promote the use of condoms in high risk places
- Minimize other unsafe practices such as risky traditional practices and sharing of needles.

- Ensure safe medical practices to protect patients and health service providers.
- Provide diagnosis and treatment for sexually transmitted diseases
- Protect the human rights of people.

As yet, little or no statistics exist on the profound effects of the virus in Ethiopia, which makes it even harder to establish accurate development strategies, but according to the United Nations Development Programme (UNDP), strategies must address the threat of an economic meltdown caused by AIDS. UNDP reported that little research has been done to study the impact of AIDS on sustainable development plans. Barbara Toggler in charge of HIV/AIDS at UNDP, Ethiopia, states that the consequences of HIV/AIDS need to be incorporated into economic strategies and particularly poverty reduction strategies. She further added that discussions on the implications of HIV/AIDS among development experts and policy makers have been extremely limited, and that both national and global development targets and goals have been formulated without taking into account the added challenges resulting from sharp increases in AIDS-related adult mortality. In Ethiopia, concern is now mounting that AIDS could blow off course the much-heralded poverty reduction strategy on which the future development of the country is planned.

Central to these activities are programmes that address poverty today so as to facilitate future socio-economic development. Prime Minister Meles Zenawi* has called on the National AIDS Council to put together a team to ensure that the Poverty Reduction Strategy Paper (PRSP) takes this into account. "HIV/AIDS now poses the foremost threat to Ethiopia's development", the National AIDS Council of Ethiopia states "AIDS may be

* The Ethiopian Herald, 1 June 2004

costing Ethiopia significantly in its economic growth every year, further reducing the scope for poverty reduction. If it continues unchecked, HIV/AIDS will alter the country's development by retarding growth, continued the Council. Unless the intergenerational effects of HIV are addressed now it would be only unjustified optimism to assume that Africa in general and Ethiopia in particular might become a pole of development in the succeeding decades as Uganda and now Kenya have proven.

According to the Ethiopian Herald it estimated that 2,500,000 people are infected (Ethiopian Herald June 10, 2004). Latest statistics confirm that in 2004, 4.4% of adult populations of Ethiopia have been living with HIV as against 7.4 % in 1997. According to HAPCO/Ethiopia* in 2007 about 1.32 million people (45% male and 55% female) live with HIV/AIDS (PLWHA). This results in a prevalence rate of 3.5% (3% among males and 4% among females; 10.5% urban and 1.9% rural areas) for the total estimated population of 73 million. Though population growth steadily increased this is a good sign (declining effect) mostly attributed to ART Despite these signs of progress, there are still huge challenges in turning the tide of this epidemic. UNICEF† has identified HIV/AIDS problem as one of the major health problems of Ethiopia (UNICEF, 2004). Due to this emerging problem identified by various organizations and the government, the Honorable Prime Minister, Mr. Meles Zenawi, emphasized the importance and urgency for curbing the spread & control of HIV and population explosion when he spoke in an international meeting in 2003.‡ Though several international and national agencies are coming forward to develop and help in the management of AIDS/HIV in Ethiopia, effective strategies are not being adopted by the government to

* HAPCO - AIDS Report Ethiopia, 2007
† UNICEF Report 2004
‡ International meeting to mitigate AIDS, 16 June 2000, Addis Ababa, Ethiopia

enable the people, particularly those in rural areas to get maximum benefit rural areas. Statistics in relation to the rural areas are inadequate and one cannot come to a definite strategic plan from bits and pieces of health indicators. To fight AIDS, a complete data analysis and compilation is required.

According to the reports of the East Gojjam Zonal Health Department, Planning and Programming Services Section, since 1990 E.C, out of 2587 persons of various illnesses 279 (11%) were diagnosed to be HIV-positive. But in 1993 E.C, of 167 patients (males-98: females-69) of various illnesses, 78 (males-46: females-32) i.e. 47% were found to be HIV-positive. In 2002, of 198 persons (males-107: females-91) who were voluntarily tested for HIV 60 (30.4%); were found to be HIV-positive, in 6 months gap, thus making HIV a major health hazard in the zone.

In the study area namely, **Misrak Gojjam Zone,** statistics are not fully representative, but available data by a survey conducted by the Ethiopian AID* in January 2002, shows that no knowledge about AIDS for men was 8.7% and 18.9% for women, which is very low. This lack of knowledge about the HIV/AIDS is enough to cause maximum damage to the family & community, which can lead to a chain of adverse reactions thus affecting the country at large. Table 2.5 illustrates the knowledge of the respondents about HIV/AIDS in Misrak Gojjam zone

Table 2.5 – Percentage of respondents' knowledge about HIV/AIDS (Year 2005)

S/NO		MEN	WOMEN
1.	Not heard of HIV	8.7	18.9
2.	Does not know how to avoid HIV	3.0	4.2
3.	Abstinence from sex prevents HIV	49.5	44.2
4.	Use of condoms	39.4	26.4
5.	Avoid use of injection	36.0	28.9

* Baseline survey of Misrek Gojjam by Ethiopian Aid, 2003

2.1.5 Impact of the AIDS policy on the target area

The focus of the policy is on the prevention of the spread of the disease; on promoting safe sexual practices and providing appropriate care to the affected and their families through information, education and communication (IEC). By interpreting results of the above Table, one can see the short comings in this region. The 91.3 % and 81.1 % of men and women who reported knowledge of about HIV/AIDS should not lead us to believe that the pandemic is under control. Rather we should seriously be concerned about the 8.7 % men and 18.9 % women who do not know about HIV/AIDS. To be noted here is the difference between the knowledge and the mode of prevention of HIV being a deficit of 18.9 % for women and 8.70 % for men. This is not a chance to be taken as this deficit can lead to a chain of reactions and is likely to increase the prevalence and incidence rates. Similarly, this is representative for all the other factors above. One can come to the conclusion that though various efforts have been undertaken, a totality has not been reached and IEC has not been accomplished, thus paving a way for HIV/AIDS to peep and ready to cause devastating effects on the individual. Some steps that should be taken include:

a. Relevant education after initial pretest assessment
b. Implementation and periodic review of policies and programmes that address the rural areas and inter-relationships between poverty and development;
c. Coordination between governmental and NGOs based on the findings
d. Post assessment test
e. Dissemination of findings available to even the common man and to actually put in place those activities that can make a difference in the outcomes of development programmes.

f. Communication strategies should also be well designed to include all stake holders, i.e. government & non-government organizations, health sectors and the common man.

It has been shown that the impact of HIV/AIDS is not only on the individual but also on the family, community, as well as on the economic and agricultural sectors to mention a few. The highlights of the impact on HIV/AIDS are given below.

2.2 GENERAL IMPACTS OF HIV/AIDS

In all countries, the family, which consists of a grouping of related members living under one roof sharing common property, goal, customs and practices, is the basic unit of a social institution. Families form communities which ultimately form the nation. In many countries which are characterized by high HIV/AIDS prevalence, the problem is not only limited to health threat to the individual; it is also a social and economic threat to families and communities. These impacts are particularly devastating to developing countries because of the nature of the disease, which is characterized by the following adverse effects.

a) It kills mainly young and middle aged adults in their most productive years.
b) It increases health care costs and is 100% fatal
c) It reduces productivity for many more years to come.
d) It causes rising absenteeism and high employee turnover thereby incurring high east due to the need for recruiting and training new personnel.

The impacts of HIV/AIDS are multi-faceted and the major effects are summarized as follows:

2.2.1 Economic Impact

The overall effects of HIV/AIDS on the society are measured by the loss of growth of GNP or loss of in development points in the Human Development Index used by the UNDP.

Household surveys conducted in the African and Asian continents (Cote d'Ivoire, Tanzania, Thailand) reported that the effect of the HIV/AIDS epidemic is devastating and that families living with the virus have a substantial income reduction ranging from 40% to 60% (UN AIDS 2004). This loss has been made up for by spending from savings, if any, by borrowing, selling houses, valuables, livestock and reduction of consumption. In Ethiopia, a study on 25 AIDS - afflicted rural families reported that the average cost of medical treatment, funeral and mourning amounted to several times the average household income.

A case study in Zambia and the Democratic Republic of Congo shows that company managers have been investing more in training workers to handle two or more tasks or they hire two or three workers for on single job on the expectation that at least one of them will die sooner or later.*

The rising cost of labour is not the only issue of worry; the epidemic is also decreasing the demand for goods and services in developing markets. To make matters worse, the virus often strikes the only breadwinner and the family, is then forced to spend its meager savings, if any, on medical treatment for the victim and is left impoverished in the process.

A similar study conducted in Cote d'Ivoire revealed that income in affected households was half that of the average non-affected household, mainly due to the illness of other members which also incur additional

* Minstere de la sante Republiaue du Congo, 2004

costs. Furthermore, some members of the household divert more of their time and effort away from their usual income generating activities.

The effects of HIV/AIDS on the family, children and community are summarized in Table 2.6 below.

Table 2.6 - Effects of HIV/AIDS on the community

Potential impacts of AIDS on families	Impact of AIDS on children	Community stresses
Loss of members, grief - Impoverishment - Change in family composition and in roles played by adults and children - Loss of labour - Forced migration - Dissolution - Stress - Inability to parent and care for children - Loss of income for medical care and education - Demoralization - Long-term pathologies (increased depressive behaviour in children) - Number of multi-generational households lack of middle generation will increase.	- Loss of family and identity - Depression - Reduced well being - Increased malnutrition, starvation - Failure to immunize or provide health care - Loss of health status - Increased demands for child labour - Loss of schooling/educational opportunities - Loss of inheritance - Forced migration - Homelessness, vagrancy, crime - Increased street living - Exposure to HIV infection	Reduced labour - Increased poverty - Inability to maintain infrastructure - Loss of skilled labour, including health workers and teachers - Loss of agricultural inputs and labour - Reduced access to health care - Elevated morbidity and mortality - Psychological stress and breakdown - Inability to marshal resources for community-wide funding schemes or insurance

Prosper Poubouta from the African Union reported that the virus has destroyed an entire productive generation and added that the AIDS pandemic had reversed recent development gains in Ethiopia and across the continent (Netsanet, T. 2002).* He emphasized that AIDS has the potential to create severe economic impacts in many African countries. According to a report by a Botswana Institute of Development Analysis, AIDS could reduce GDP growth rate by 0.5% to 2.6% a year in several African Countries and that when AIDS is coupled with poverty, the humanitarian problem becomes an economic crisis as well. In South Africa the epidemic is projected to reduce economic growth rate by 0.3% to 4% lower than it would have been without AIDS†

2.2.2 Social Impacts

The social impacts of HIV/AIDS involve dissolution, or partial dissolution of families whereby children are sent away to live with relatives; a spouse or a child migrates to earn income, and some times upon the death of a spouse, the widow widower may have to move to their husband's brother.

Rural households are often more acutely affected than urban families. They suffer loss of productive labour on the farm; loss of income, food reserves savings and assets that are diverted to cover health care and funeral costs. Educational opportunities are reduced as children withdraw from schools either to take care of the sick or to engage in income generating activities or because they cannot afford to pay for their education. This in turn decreases the level of literacy, reduces in the number of skilled laborers, which ultimately leads to economic crisis.

* Netsanet Tesfaye on, Dr. Girchew Mamo, ACDI/VOCA – Ethiopia, 2002
† - Mostly of Agriculture, Public Relations Department
- African - Asian Agricultures Aganst AIDS, Banigkob, Thailand 2002

In addition, poverty has always been a driving force of epidemics, and the HIV epidemic is no exception. The epidemic causes migration, separation of families, poor education which especially in developing countries, leads to prostitution, which catalyzes the rapid spread of the virus. AIDS exacerbates and prolongs poverty while poverty increases vulnerability to HIV/AIDS. This relationship between AIDS and poverty has a considerable negative impact on households and hence on communities.

2.2.3 Agriculture Impacts

Agriculture is the largest sector in most African economies accounting for a large portion of production and employment. The great majority of the population in countries most affected by HIV/AIDS lives in rural areas. Farming and other rural occupations provide livelihood for more than 70% of the population. (Demeke, 1993)* It is therefore expected that the HIV/AIDS epidemic will cause serious damages to the agriculture sector, particularly in those countries where production is labour intensive. AIDS has a fatal impact on individuals in developing countries where it kills young and middle-aged adults in their most productive years, thereby severely impairing productivity. Agriculture is a dynamic, integrated and interdependent production system, which, to be successful, relies on close linkages with other components operating through a network of interrelated sub-sectors, institutions and rural households at every level of activity.

The efficiency and effectiveness of each sub-sector, institution and household depends, to a large extent, on the capacity of other components of the system. If this capacity is eroded through HIV, then the system's ability to function will be drastically reduced.

* Mulatu Demeke, (1993) The Potential Impact of HIV/AIDS on the Rural Sector of Ethiopia 1993

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In Ethiopia the male head of household is responsible for special tasks, such as oxen cultivation, harvesting, thrusting and farm management. One study reported that the effect of death by AIDS varied from region to region. For instance, in Nazareth area, it would have the most severe effects on harvesting *teff*.* In Afar, on digging holes for transplanting enset plants; in Bahirdar on ploughing millet fields and in Yirgalem on picking coffee. Women are generally responsible for other tasks such as leveling, farm fields and doing household duties. The death of a wife due to AIDS can make it difficult for other members of the household to carry out these tasks in addition to caring for other members including children. The death of a family member leads to reduction in savings and investment. The stock of food grain can be depleted, livestock sold to provide food for mourners as well as to cover other expenses. Such loss of production assets will make it very difficult for future survival.

A study conducted in Ethiopia showed that agricultural labour force time fell from 33.6 hours per week in non-afflicted households to between 11 and 16 hours per week in afflicted households, and is expected to have an every greater impact in the future† (Black Michaud, 1997) According to estimates by FAO, in 27 most affected countries in Africa, 7 million agricultural workers died from AIDS between 1985 and 2000, and 16 million more deaths are likely to occur in the following two decades.‡ In 12 countries, including 10 most affected African countries, reduction in labour force ranging from 10% to 26% are anticipated. Namibia is expected to suffer the most in terms of loss of labour force by 2020 when its labour force is expected by 26% followed by Botswana. In a study conducted by the Ethiopian AID in Misrak Gojjam, Ethiopia, the following findings were reported.

* A grain used as staple food in Ethiopia
† Black- Michaud, 1997
‡ FAO

25% of the communities owned only one hectare of farmland; 30% had two hectares and 40 did not want tot disclose the information.

A report from the zonal department of agriculture showed that the average size of farmland owned by a farm household was 1.5 hectares.* Considering the population size in rural Misrak Gojjam, a farmland size of 1.5 hectares is very small. Furthermore, the presence of HIV- positive people in the area will further reduce productivity leaving families in desperate situations.

A study which was earlier carried out by Ethiopian Aid (EA) in June 2005 indicated that the limited availability of land is not adequate for the production of enough crops. The upcoming younger generation needs to be accommodated on the available farmland and this further reduces land available for cultivation.†

The evidence with respect to the impact of HIV/AIDS on agriculture remains scattered and incomplete. Most studies cover small areas, and many do not include a control group from households not affected by HIV/AIDS. Moreover, little is known about the effect of the epidemic over a long period of time. Nonetheless, available evidence demonstrates that HIV/AIDS is having a crushing effect on agricultural production and the economic viability of AIDS- affected households in diverse areas of Africa, as well as commercial agricultural enterprises.

The following will give a summary of the impact of HIV/AIDS on agriculture HIV/AIDS:

- Primarily affects the most productive age group (15-49 years) which is the main breadwinning group responsible for raising families, supporting dependents such as the elderly and children.

* Msrake Gojjam, Agriculture office, 2004
† Ethiopian Aid, Evaluation Report, June 2005

- Causes absenteeism due to protracted illnesses and leads to loss of labour force due to AIDS and AIDS-related diseases, thus leading to reduction of land under cultivation; declining yields and reduced food production as well as food insecurity.
- It leads to loss of knowledge of traditional farming methods due to the untimely death of experienced family members before passing on their know- how to subsequent generations.

2.2.4 Impact on the Health Sector

Most developing countries face serious shortage of health care facilities and the HIV/AIDS pandemic aggravates the situation by considerably increasing the number of health service seekers, and significant number of hospital beds will be occupied by AIDS patients.

The majority of the population in developing countries is poor and cannot afford to pay for medical services in private health service providers. Government health care facilities will therefore be overcrowded by service seekers and this will adversely affect the health budget of the government health care facilities, leading to shortage of hospital beds, medicines, medical equipment and other important supplies.

2.2.5 Impact on the Education Sector

HIV/AIDS has a very serious impact on the education sector. The death of a breadwinner in a family will affect the income of the family. This may lead to children withdrawing from school for lack of financial support to buy materials necessary for their school. In addition, when adults fall sick the children are asked to withdraw from school to take care of the sick or to get engaged in income generating activities. Death of school teachers due to AIDS negatively impacts the quality of education which is crucial for the production of qualified professionals and skilled laborers.

2.2.6 Other Impacts

Impacts of HIV/AIDS on other areas have also been observed. The transport sector is especially vulnerable to AIDS and is also crucial for the prevention of AIDS. Building and maintaining transport infrastructure involves deploying teams of men away from their families often for extended periods of time, thereby increasing the likelihood of multiple sexual partners. A survey on bus and truck drivers in Cameroon reported that they spent an average of 14 days away from home on each trip and that 68% of them had sex during their most recent trip and 25% had sex every night they were away*

The mining sector is a key source of foreign exchange for many countries, and is carried out at sites far from population centers forcing workers to live apart from their families for extended periods of time. Consequently, they often resort to commercial sex. Many of them become infected with HIV and spread the virus to their spouses and the community when they eventually return home.

Highly qualified mining engineers cannot be daily replaced and a severe AIDS epidemic can seriously threaten the mining industry.

Developing water resources and hydroelectric projects in arid regions requires highly skilled engineers and constant maintenance. The loss of even a small number of highly trained engineers can plan an entire water and electrical systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend several nights away from their families.

* AIDS Analysis Africa, 1994

CHAPTER THREE - DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS OF RESPONDENTS

3.1 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The development study has conducted a survey on the impact of HIV/AIDS on the well being of the rural population of three Woreda of East Gojjam namely: Hulet Eju Enesie, Gozamin and Shebel Berenta. This chapter presents information on the demographic and other background characteristics as age, sex, religion, education, occupation, ethnic group, marital status,...etc. These and other information collected by this survey is intended to provide evidence on socio-economic situations of the rural population, knowledge, awareness and understanding the multifaceted impacts of HIV/AIDS on social, economy and other areas. The findings are intended to assist recommendation and advocacy for an alternative action, if necessary, or suggest strengthening the ongoing programs by identifying areas where there are weaknesses.

3.1.1 Distribution of Respondents by Age, Sex, Religion and Education

Table 3.1 presents the distribution of respondents by demographic characteristics such as age, sex, religion and education. The percentage distribution of the respondents by age group in Table 3.1 shows that seventy four percent of respondents fall between ages 26 to 45 years, which are age groups containing sexually active persons. The proportions of respondents who were interviewed by sex reveal that slightly more than 80 % of male and about twenty percent for female. Relatively more female were represented in Gozamin Woreda as compared to Hulet Eju Enesie and Shebel Berenta Woredas.

DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS OF RESPONDENTS

The survey results in Table 3.1 also show that almost all respondents are followers of the Ethiopian Orthodox Christian religion. As shown in Table 3.1, generally more than 93 % of the respondents reported to have completed primary school or were non-literate. The proportions of respondents who have educational background beyond primary school are less than 5 %. Similarly, the percentage of those who had primary school education ranges from 24.3 % in Gozamin to 47.6 % in Hulet Eju Enesie.

Table 3. 1 Distribution of Respondents by Age, Sex, Religion and Education and by Woreda

Demographic Characteristics	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Age								
<18	1	0.1	-	-	-	-	-	-
18-25	64	8.6	-	-	-	-	-	-
26-35	275	36.9	-	-	-	-	-	-
36-45	276	37.0	-	-	-	-	-	-
46-60	115	15.4	-	-	-	-	-	-
>60	14	1.9	-	-	-	-	-	-
Sex								
Male	601	80.7	286	74.9	254	88.2	61	81.3
Female	144	19.3	06	25.1	34	11.8	14	18.7
Religion								
Orthodox	732	98.3	382	100.0	284	98.6	66	88.0
Muslim	13	1.7			4	1.4	9	12.0
Educational status								
Degree holder	2	0.3	2	0.5				
Diploma holder	1	0.1	1	0.3				
High school	30	4.0	22	5.8	5	1.7	3	4.1
Primary	260	35.0	93	24.3	137	47.6	30	41.1
No education	450	60.6	264	69.1	146	50.7	40	54.8

3.1.2 Distribution of Respondents by Occupation, Ethnic Group and Marital Status

As expected, in rural areas of the country 90 % of the respondents are farmers. The percentages are slightly lower (87.4 %) in Gozamin as compared to the remaining two Woredas.

Table 3.2 also shows that all the respondents in the three Woreda belong to thr Amhara Ethnic group. Similarly, more than 8 % of respondents have reported as currently married. The percentages of currently married are higher (92.7) in Hulet Eju Enesie in contrast to other Woredas.

Table 3. 2 Distribution of Respondents by Occupation, Ethnic Group and Education and by Woreda

Demographic Characteristics	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Occupation								
Farmer	667	88.5	334	87.4	264	91.7	69	92.0
Student	13	1.7	10	2.6	2	0.7	1	1.3
No particular job	17	2.3	17	4.5				
Others	48	6.4	21	5.5	22	7.6	5	6.7
Ethnic Group								
Amhara	745	100.0	382	100.0	288	100.0	75	100.0
Marital Status								
Currently married	669	89.8	339	88.7	267	92.7	03	84.0
Widowed	15	2.0	5	1.3	7	2.4	3	4.0
Divorced	26	3.5	16	4.2	7	2.4	3	4.0
Separated	26	3.5	17	4.5	5	1.7	4	5.3
Living with but not married	4	0.5	2	0.5	1	0.3	1	1.3
Never married	5	0.7	3	0.8	1	0.3	1	1.3

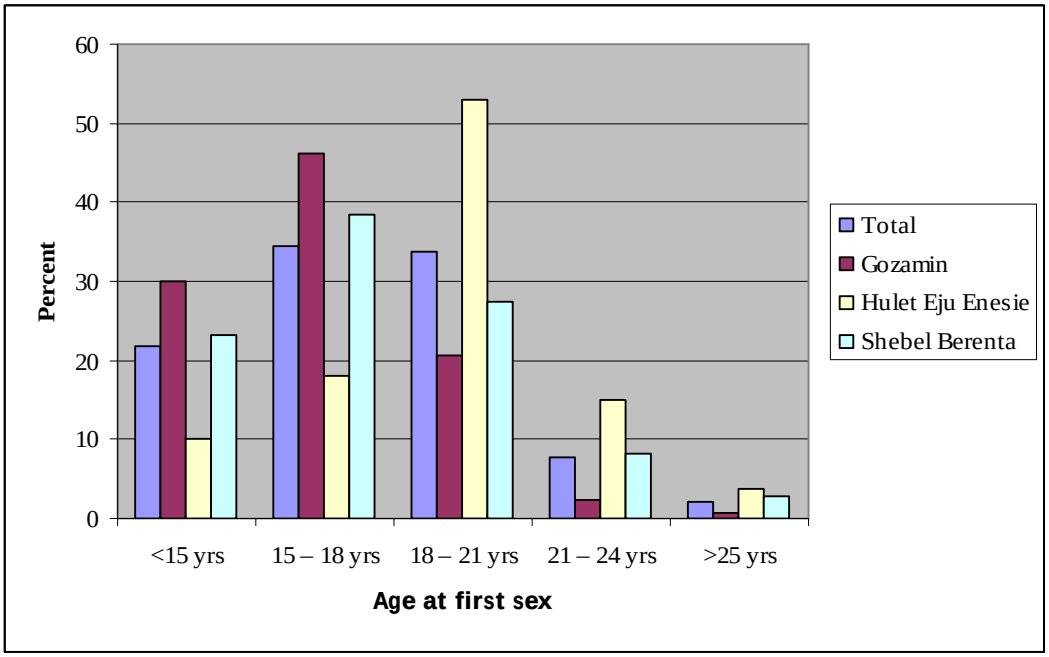
3.1.3 Distribution of Respondents by Number of Marriages, Age at first sex and First Sex Partner

Table 3.3 also shows of the sampled respondents who are ever married. 27.4 % or less are reported to have been married only once. The remaining vast majority are married more than two times. This may suggest that remarriage is almost common phenomenon in these three rural Woredas. Especially, this time when the spread of the infections of HIV/AIDS are expanding remarriage may increase the risk of having HIV/AIDS infection unless care is taken by both partners.

Table 3. 3 Distribution of Respondents by Number of marriages and First sex partner

Demographic Characteristics	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Number of marriages								
One	154	20.8	67	17.7	67	23.3	20	27.4
Two	237	32.1	110	29.0	103	35.9	24	32.9
More than two	348	47.1	202	53.3	117	40.8	29	39.7
At what age did have first have sex								
<15 yrs	160	21.7	114	30.1	29	10.1	17	23.3
15 – 18 yrs	255	34.5	175	46.2	52	18.1	28	38.4
18 – 21 yrs	250	33.8	78	20.6	152	53.0	20	27.4
21 – 24 yrs	58	7.8	9	2.4	43	15.0	6	8.2
>25 yrs	16	2.2	3	0.8	11	3.8	2	2.7
With whom did have sex with first								
Person whom he/she was going to marry	670	93.1	329	89.4	274	98.2	67	91.8
Prostitute	43	6.0	32	8.7	5	1.8	6	8.2
Student	6	0.8	6	1.6				

Figure 3. 1 Graphical presentation of Age at first sex



The data in the Table 3.3 and figure 3.1 shows that 30.1 % respondents in Gozamin, 10.1 % in Hulet Eju Enesie and 23.3 % in Shebel Berenta reported to have had sex before the age 15, whereas more than sixty percent (except in Hulet Eju Enesie (28.2 %) had their first sex at or below the age of 15, before the legally Permitted minimum age for marriage, which is 18 years. However, more than half of the population in Hulet Eju Enesie had their first sex between 18 years to 21 years.

As shown in Table 3.3 about ninety percent or more had the first sexual intercourse with the person he/she was going to marry, despite the fact that most respondent started having sex at early ages. This may suggest that engagement in sexual activity before marriage is not common in these rural Woredas. However, 8.7% of the population in Gozamin reported to have had the first sex with the prostitutes. This Woreda is closer to Debra Marcos town, the capital of East Gojjam Zone. May be this proximity to the town, where commercial sex workers are available,

might have given them greater chance of having sex with these commercial sex workers.

3.2 SOCIO ECONOMIC CHARACTERISTICS OF RESPONDENTS

This chapter presents information on socio-economic characteristics of the sampled population focusing mainly on the type of employment, possession of livestock, status of agricultural, land ownership, size of land owned, type of cultivated crops, ...etc.

3.2.1 Type of Employment, Possession of livestock and Land for Agriculture

Table 3.4 presents the type of employment of the respondents from three Woredas. More than 90 % of the populations are self-employed except in Shebel Berenta Woreda where the proportions are slightly less than 90%.

Table 3.4 also shows that the percentages of the population who own any livestock range from 48.0%-88.7%. In terms of the possession of livestock the percentages for residents of Gozamin Woreda are significantly lower as compared to the remaining two Woredas. Unlike this, the percentages of the possession of land for agriculture are almost the same. More than 90 % of the population unanimously reported that they have land for agriculture.

Table 3. 4 Percentage Distribution of Respondents by Employment Status, Possession of Livestock and Land for Agriculture and Woreda

Employment status/possession of Livestock and Land for Agriculture	Total		**Woreda**					
			Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Self Employed	689	92.6	345	90.6	277	96.2	67	89.3
Salaried	20	2.7	15	3.9	2	0.7	3	4.0
Daily Wage Earner	16	2.2	7	1.8	4	1.4	5	6.7
Student	8	1.1	5	1.3	3	1.0	-	-
Others	11	1.5	9	2.4	2	0.7	-	-
Own any Livestock								
Yes	518	70.0	337	88.7	145	50.9	36	48.0
No	222	30.0	43	11.3	140	49.1	39	52.0
Own land For Agriculture								
Yes	678	91.5	345	90.8	263	92.0	70	93.3
No	63	8.5	35	9.2	23	8.0	5	6.7

3.2.2 Adequacy of Land for Agriculture and Status of Cultivating of Domestic and Cash Crops

Respondents were asked whether the land they own is sufficient for agriculture; whether they produce crops for home consumption and produce as cash crops. The survey results are presented in Table 3.5. There are significant differences in terms of landholding size by Woredas. As shown in Table 3.5 twenty-seven percent in Shebel Berenta and more than half (56.3%) in Hulet Eju Enesie Woreda have one hectare or less. The corresponding figure for Gozamin Woreda is 38.6 %.

DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS OF RESPONDENTS

More than three in ten respondents in Shebel Berenta Woreda have more than two hectares, while in Gozamin and Hulet Eju Enessie, the percentages are 12.6 % and 6.6 % respectively. Nevertheless, about ten percent of respondents in Gozamin and Hulet Eju Enesie have adecquate land for agriculture.

Table 3.5 Percentage Distribution of Respondents by Land holding size, Sufficiency of Land for Agriculture and whether they Cultivate Crop for domestic use, cash crops in the Woredas

Demographic Data	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
Land holding size	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
0.1-0.5ha	100	13.6	44	11.8	50	17.5	6	8.0
0.5ha-1.0ha	225	30.7	100	26.86	111	38.8	14	18.7
1.01-1.5ha	144	19.6	82	22.0	55	19.2	7	9.3
1.51-2.0ha	112	15.3	64	17.2	28	9.8	20	26.7
Above 2ha	89	12.1	47	12.6	19	6.6	23	30.7
none	64	8.7	36	9.7	23	8.0	5	6.7
Is the land enough for agriculture								
Yes	170	25.3	111	32.8	53	20.1	6	8.6
No	500	74.7	227	67.2	211	79.9	64	91.4
Do you cultivate for home use only								
Yes	368	51.5	152	41.0	188	69.6	28	38.4
No	346	48.5	219	59.0	82	30.4	45	61.6
Do you cultivate any cash crops								
Yes	678	94.7	340	91.4	269	99.3	69	94.5
No	38	5.3	32	8.6	2	0.7	4	5.5

Table 3.5 and figure 3.2 also shows that more than 30 % of the respondents in Gozamin Woreda have enough land for agriculture whereas the figure is only about 20 % for Hulet Eju Enesie. Though relatively a larger percentage of respondents in Shebel Berenta Woreda reported to have more than two hectares, 92.0 % explained that the and was not adequate enough for agriculture. This could probably the case if the fertility of the soil in Shebel Berenta is comparatively more depleted or for other reasons.

Figure 3.2 Chart showing the land holding size of the respondents

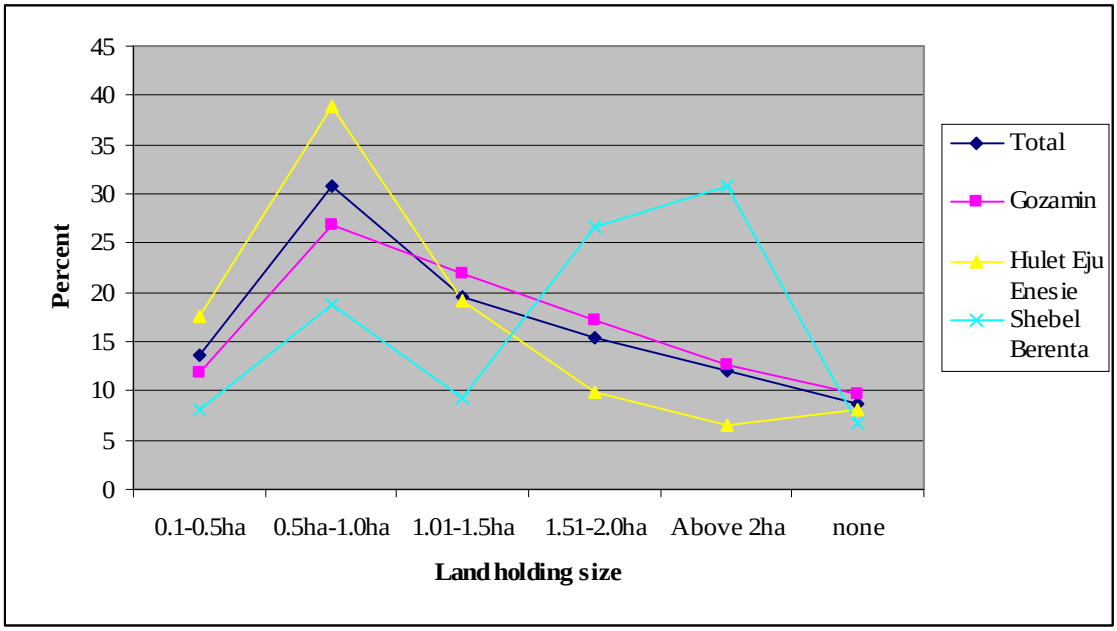


Table 3.5 shows that the percentage of respondents who cultivate crops for home consumption only markedly vary from Woreda to Worada. About 70 % of respondents in Hulet Eju Enesie Woreda cultivate crops for home consumption only. The percentages for Shebel Berenta and Gozamin are 38.4% and 41.0 % respectively.

As shown in Table 3.5 people cultivate crops more for cash than for consumption in all Woredas. More than 90 % respondents reported to have been cultivating some types of cash crops.

3.2.3 Sufficiency of Production, Food Shortage and Reason for Shortage Food

Respondents were asked about the sufficiency of their produce for domestic consumption, for consumption and sale, whether they have ever faced food shortage, estimated degree of food shortage and reasons for it. The survey results are presented in Table 3.6. Slightly more than one quarter of residents in Gozamin and Hulet Eju Enesie Woreda reported that the products from their farms are not enough for their consumption. A similar patterns is also observed in the percentage of respondents who reported the product is not enough for both consumption and sale.

Table 3.6 and figure 3.3 present information on status of food shortage, estimated amount of food shortage, and reasons for food shortage. More than 70 % of the respondents in Gozamin and Hulet Eju Enesie Woredas and nearly all in Shebel Berenta Woreda have faced food shortage some time in the past.

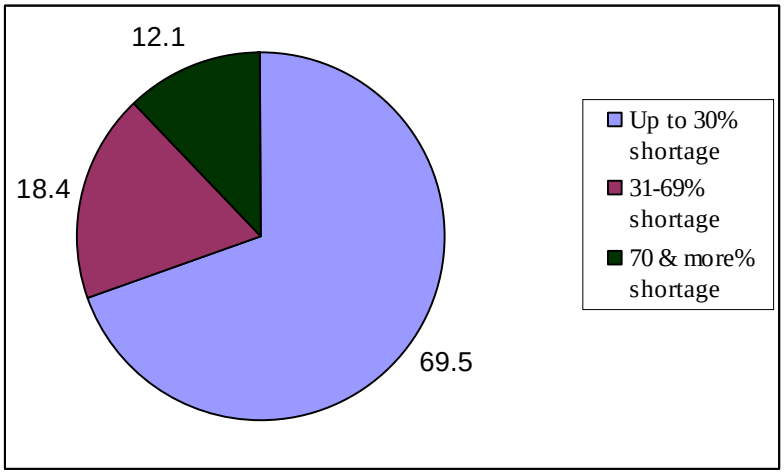
According to the survey results 93.7 % of the respondents in Hulet Eju Enesie and 72.9 % in Shebel Berenta reported food shortage of 30 % or less. However, in Gozamin Woreda slightly more than half reported to have food shortage of 30 % or less. Regarding the estimated degree of food shortage about seventy percent estimated their food shortage had been upto 30 % in short supply.

As shown in Table 3.6 the main reason for food shortage is lack of adequate production. The percentages range from 50.0 % in Shebel Berenta to 82.3 % in Gozamin Woreda. The second reason cited for the shortage food is drought. A significantly larger percentage (43.2 %) of respondents in Shebel Berenta, as compared to others, reported drought as a second reason for food shortage.

Table 3.6 Percentage Distribution of Respondents by food Shortage and Reasons for the food shortage and by Woreda

	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
Is the product from your farm enough for your consumption	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Yes	181	25.4	96	25.8	74	27.4	11	15.3
No	533	74.6	276	74.2	196	72.6	61	84.7
Is it enough for both consumption and sale								
Yes	82	11.5	56	15.1	23	91.5	3	4.2
No	631	88.5	315	84.9	247	8.5	69	95.8
Have you faced any food shortage								
Yes	565	78.0	302	79.9	193	71.2	70	93.3
No	159	22.0	76	20.1	78	28.8	5	67
percentage estimate of food shortage								
Up to 30% shortage	386	69.5	157	53.2	178	93.7	51	72.0
31-69% shortage	102	18.4	17	26.1	9	4.7	16	22.9
70 & morepercent shortage	67	12.1	61	20.7	3	1.6	3	4.3

Figure 3.3 Chart showing percentage estimate of food shortage of respondents



3.2.4 Production at one time and Average Monthly Income

Table 3.7 presents the amount of production at one harvest time and the average monthly income of the respondents. More than 90 % of respondents in Shebel Berenta produce below 10 quintals at one harvest time. In Gozamin and Hulet Eju Enesie 51.5 % and 53.3 % respectively, produce below 10 quintals at one harsest time. More than 30 % in the latter Woreda produce 10-20 quintals at one harvest time.

Table 3.7 Percentage Distribution of Respondents by amount of Production at one harvest time, estimated monthly Income and Woreda

Amount of Production /Monthly Income	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Production at one time								
<10 qt	381	56.5	185	51.5	131	53.3	65	94.2
10-20 qt	204	30.3	120	33.4	80	32.5	4	5.8
20.5-30 qt	51	7.6	25	7.0	26	10.6	-	-
30.5-40 qt	12	1.8	7	1.9	5	2.0	-	-
40.5-50 qt	7	1.0	5	1.4	2	0.8	-	-
> 50 qt	19	2.8	17	4.7	2	0.8	-	-
Estimated monthly Income								
<250 birr	578	83.6	306	87.7	233	81.2	39	70.9
250-500 birr	90	13.0	27	7.7	47	16.4	16	29.1
500-750 birr	14	2.0	8	2.3	65	2.1	-	-
750-100 Birr	2	0.3	1	0.3	1	0.3	-	-
>1000 Birr	6	0.9	6	1.7	-	-	-	-

Table 3.7 also shows that on the average 83.6 % of the respondents are earning a monthly income of less than 250. In general, nearly all of the respondents have an estimated monthly income of 500 Birr or less.

3.2.5 Health Status and Type of Illness

Respondents were asked whether they are in a good health or not during the interview period, and if no the type of illness they are suffering from. Table 3.8 presents information on health status and types of illness.

DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS OF RESPONDENTS

As shown in Table 3.8 more than half of the respondents in Gozamin and Hulet Eju Enesie and slightly less than half (48.0 %) in Shebel Berenta reported that there are not in good health during the interview period. Accordingly, of those who had a health problem 59.5 % in Gozamin and 47.9 % in Hulet Eju Enesie reported to have been suffering from malaria. About 19 % of respondents in Hulet Eju Enesie Woreda reported that they are HIV/AIDS patients

Table 3. 8 Percentage Distribution of Respondents by Health Status and Type of Illness during the Interview Period

Health situation	Woreda					
	Gozamin		Hulet Eju Enesie		Shebel Berenta	
	%	No	%	No	%	No
Health status						
Yes	47	180	48.3	139	52.0	39
No	57.8	201	56.7	149	48.0	36
Type of Illness						
Malaria	59.9	109	47.9	69	21.4	6
HIV/AIDS	1.1	2	18.8	27	25.00	7
General Weakness	12.6	23	6.6	8	14.3	4
Flu	12.6	23	26.4	38	28.6	8
Other (TB)	13.7	25	1.4	2	10.7	3

CHAPTER FOUR - *ANALYSIS OF THE DETERMINANTS AND IMPACT OF HIV/AIDS*

4.1 HIV/AIDS AND AWARENESS OF ITS IMPACTS

HIV/AIDS epidemic is a global concern of every country in the world particularly, in Africa where the spread of HIV/AIDS is increasing in most countries and by the fact that the victims of the epidemic are the young population who are productive is becoming a serious challenge for the region. Coupled with other socio-economic problems such as poverty, high fertility rate, low literacy rate,... etc that are prevailing in most of the countries in the region HIV/AIDS is aggravating the situation

Information on the level of awareness and attitudes of the society towards the HIV/AIDS patients and other related issues are very important in assisting policy makers and planners in monitoring and evaluating the impacts of the campaign launched against HIV/AIDS. In this regard, information on awareness of HIV/AIDS and other related issues were collected in this survey.

4.1.1 Awareness, Sources of Information and Knowledge of HIV/AIDS

Table 4.1 presents information on awareness, sources of information and knowledge about HIV/AIDS. Accordingly, ninety-five percent of all the respondents have heard about HIV/AIDS at some time or another. There are small differences between Woredas concerning level of awareness of HIV/AIDS. Regarding the sources of information about HIV/AIDS Table 4.1. also shows that on the average, 44.6 % had heard about HIV/AIDS from Health Institutions. Similarly 56.3 % of respondents in Gozamin and 38.6 % in Shebel Berenta had heard about HIV/AIDS from the

health institutions while relatively larger percentage (38.8 %) in Hulet Eju Enesie reported to have heard about HIV/AIDS from the mass media, mainly radio. Generally, the results in Table 4.1 show that Health care facilities (Hospitals, health centers the mass media and public meetings) are the major sources of information about HIV/AIDS for the respondents of these three Woredas.

Table 4.1 also shows that more than 90% the rural respondents know about HIV/AIDS. The knowledge about HIV/AIDS is highest among the respondents of Shebel Barenta (93.1 %)

Table 4.1 Percentage Distribution of Respondents by Awareness, Source of Information, Knowledge of HIV/ADS and by Woreda

Awareness/Knowledge	Woreda					
	Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%
Aware about HIV/AIDS						
Yes	365	96.8	268	93.4	71	94.7
No	12	3.2	19	6.6	4	5.3
Source of Information						
Health Institutions	206	56.3	81	30.2	2.7	38.6
Orally/Village	47	12.8	39	14.6	7	10.0
Radio/Mass media	38	10.4	104	38.8	12	17.1
Church	9	2.5	4	1.5	-	-
Edir	7	1.9	-	-	-	-
Public meetings	51	13.9	36	13.4	14	20.0
School/training	8	2.2	4	1.5	10	14.3
Knowledge about HIV/AIDS						
Yes	33.2	87.6	248	86.4	67	93.1
No	4.7	12.4	39	13.6	5	6.9

4.1.2 Knowledge and Belief about the Causes of HIV/AIDS

Respondents were asked whether they knew what caused HIV/AIDS. Accordingly Table 4.2 presents information about the knowledge of the causes and means of transmission of HIV/AIDS. Above seventy Percentages of the respondents reported that they knew the causes of HIV/AIDS. There are differences in knowledge of the causes of HIV/AIDS among the Woredas. Relatively a larger percentage of respondents, in Shebel Berenta Woreda 88.9 % reported that they knew the causes of HIV/AIDS. The corresponding figures for Gozamin and Hulet Eju Enesie are 71.7 % and 61.6 % respectively.

As shown in the same table more than half of the respondents who know the cause of HIV/AIDS believe that the epidemic is caused by a virus. About 40 % or more reported that human beings are the causes of HIV/AIDS because they do not accept professiona advice on the prevention of the disease.

Table 4.2 Percentage Distribution of Respondents by Knowledge and belief about the causes of HIV/AIDS.

Knowledge/Causes of HIV/AIDS	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
Know what causes HIV/AIDS	No	%	No	%	No	%	No	%
Yes	510	69.5	271	71.7	175	61.6	64	88.9
No	224	30.5	107	28.3	109	38.4	8	11.1
Causes of HIV/AIDS								
Man	218	42.9	123	44.9	72	41.1	23	39.0
Virus	286	56.3	151	55.1	101	57.7	34	57.6
Do not know	4	0.8	-	-	2	1.1	2	3.4

4.1.3 Knowledge and Ways of HIV/AIDS Transmission

Table 4.3 shows that knowledge about HIV/AIDS transmission is very high although there are differences between Woredas. On the average, however, more than four in five respondents reported that they knew how HIV/AIDS is transmitted. The percentages range from 90.1 % in Shebel Berenta to 85.4 % in Hulet Eju Enesie Woreda.

Regarding the means of HIV/AIDS transmission Table 4.3 also shows that respondents believe that sexual intercourse is the main route of HIV/AIDS transmission. There are significant differences in the percentages between Woredas, which range from 69.4 % in Hulet Eju Enesie to 36.8 in Gozamin. Generally, nearly all respondents in Hulet Eju Enesie Woreda and about 90 % respondents of Gozamin and Shebel Berenta Woreda believe that sexual intercourse, blood transfusion from infected people and sharing needles/razor blades with infected people are the main routes of HIV/AIDS transmission.

Table 4.3 Percentage Distributions of Respondents by Knowledge and ways of HIV/AIDS Transmission.

Knowledge and Ways of HIV/AIDS Transmission	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Know how HIV/AIDS is transmitted								
Yes	635	86.2	326	86.0	245	85.4	64	90.1
No	102	13.8	53	14.0	42	14.6	7	9.9
Ways of HIV/AIDS transmission								
Sexual transmission	511	44.2	301	36.8	170	69.4	40	43.0
Blood transfusion from infected people	273	23.6	231	28.2	20	8.2	22	23.7
Sharing needles/Razor blades with infected	215	18.6	145	17.7	51	20.8	19	20.4
Mother to Child during Pregnancy	107	9.3	94	11.5	3	1.2	10	10.8
Breast milk	32	2.8	30	3.7	-	-	2	2.2
Others*	19	1.6	18	1.9	1	0.4	-	-

4.1.4 Knowledge and Methods of HIV/AIDS Prevention

Table 4.4 presents information on the respondents' opinion whether HIV/AIDS can be prevented and methods of preventing it. The survey results indicated that almost all respondents (about 96 %) believe that HIV/AIDS can be prevented. As shown in the Table, relatively larger percentages of respondents in Hulet Eju Enesie Woreda think that HIV/AIDS can be prevented.

Table 4.4 also shows that all of the respondents believe that having one sex partner only, abstaining from sex and using condoms are the most

* Others include kissing/touching, sharing meals, cups and spoon, using the same toilet/toilet facilities -- etc

important ways to prevent HIV/AIDS. There are significant differences in the knowledge of methods of preventing HIV/AIDS.

Table 4.4 Percentage Distributions of Respondents by Knowledge and Ways of Preventing HIV/AIDS and Woreda.

Knowledge and Ways of Preventing HIV/AIDS	Woreda							
			Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Can HIV/AIDS be prevented								
Yes	706	96.2	358	95.5	278	97.2	70	95.9
No	28	3.8	17	4.5	8	2.8	3	4.1
Ways of Preventing HIV/AIDS								
Usage of condoms	222	21.4	168	24.7	40	13.8	14	20.6
Having one partner only	569	54.9	325	47.9	208	71.7	36	52.9
Abstaining from sex	245	23.6	185	27.2	42	14.5	18	26.5
Others	1	0.1	1	0.1	-	-	-	-

4.1.5 Perception of Illnesses that are caused because of HIV/AIDS

Respondents were asked about illnesses that are caused by and associated with HIV/AIDS. Table 4.5 shows that 74.6 % believe that TB is the disease that is most commonly associated with or caused by HIV/AIDS. Similarly, 10.1 % reported diarrhea as illness which is caused by HIV/AIDS although there are differences among the Woredas. More than 70 % of the respondents in Gozamin and Hulet Eju Enesie described TB as an that is associated with HIV/AIDS, while the corresponding figure for Shebel Berenta is 60.6 %.

Table 4.5 Percentage Distribution of Respondents by perception of the type of illness caused because of HIV/AIDS and Woreda

Type of Illness reported to be caused by HIV/AIDS	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
TB	421	74.6	246	77.1	155	73.1	20	60.8
Diarrhea	57	10.1	47	14.7	10	4.7	-	-
Cough	28	5.0	22	6.9	6	2.8	-	-
Don't Know	44	7.8	4	1.3	31	14.6	9	27.3
Others	14	2.5	-	-	10	4.7	4	12.8

4.1.6 Knowledge and Sources of Information about Anti-retroviral

Respondents were asked whether they knew about anti-retroviral drugs that are used to prolong the life of HIV/AIDS patients and the sources of the information. Table 4.6 shows about half (47.9 %) of the respondents knew that there are drugs that prolong the life of HIV/AIDS patients. The knowledge about anti-retroviral drugs is higher among respondents in Hulet Eju Enesie Woreda (74.2 %) as compared to those in Gozamin (65.0 %) and Shebel Berenta (57.4 %).

Table 4.6 Percentage Distribution of Respondents by Knowledge and Source of Information about Drugs that prolong life for HIV/AIDS Patients

Knowledge/Source of Information	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Know about Anti-retroviral Drugs								
Yes	495	47.9	243	65.0	213	74.2	39	57.4
No	234	32.1	131	35.0	74	25.8	29	42.6
Source of Information about Drugs								
Health Station/Hospital/ Clinic	239	49.7	158	65.8	70	34.3	11	29.7
Radio/Mass media	169	34.8	47	19.6	105	51.5	17	45.9
Orally/Village	41	8.5	15	6.3	22	10.8	4	10.8
Others	12	6.6	20	8.4	7	3.5	5	13.5

Table 4.6 also shows that health institutions, mass media and oral communication in villages are the most important sources of information on anti-retroviral drugs. There are differences among Woreda regarding sources of information. Significantly more than half (65.8) of respondents in Gozamin have heard about drugs from health institutions, while those in Hulet Eju Enesie and Shebel Berenta have heard about the drugs from mass media mainly the radio.

4.1.7 Knowledge of a Place for HIV/AIDS Test

Table 4.7 presents the percentage distribution of respondents who knew where to get a test for HIV/AIDS. As shown in the Table the knowledge is very high and, around 80 % of the respondents knew where a test for

HIV/AIDS can be taken. Only less than 15 percent of the respondents do not know where to get the test for HIV/AIDS except respondents in Shebel Berenta Woreda.

Table 4.7 Percentage Distribution of Respondents by Knowledge of a place for HIV/AIDS Test

Woreda	Know a place for HIV/AIDS Test					
	Yes		No		Do not Know	
	No	%	No	%	No	%
Total	612	86.2	95	13.2	3	0.4
Gozamin	326	87.2	48	12.8	-	-
Hulet Eju Enesie	228	87.0	31	11.8	3	1.1
Shebel Berenta	58	78.0	16	21.6	-	-

4.1.8 Respondents' Sexual Behaviours

Unprotected sex is likely to increase the risk of exposure to HIV/AIDS infection. Respondents were asked a number of questions about their sexual behaviours in order to assess the risk behaviour associated with unprotected/unsafe sex. Table 4.8 shows that about 84 % or more had their first sex after marriage. This may suggest that sex before marriage is less common among rural dwellers. As shown in the Table, of those who had sex before marriage more than 75 % had unprotected sex. In addition, 18.9 % of respondents in Gozamin Woreda and 14.1 % in Hulet eju Enesie reported to have more than one sex partner.

Table 4.8 also shows that the majority of the respondents who had more than one partner had unprotected sex. Differences among the Woredas are very wide, i.e. 95 % in Hulet Eju Enesie and 53.1 % in Gozamin.

Table 4.8 Percentage Distribution of Respondents by Sexual Behaviour and Woreda

Respondents Sexual Behaviour	Total		Woreda					
	No	%	No	%	No	%	No	%
Had first Sex After Marriage								
Yes	630	85.7	314	83.7	246	86.0	70	94.6
No	105	14.3	61	16.3	40	14.0	4	5.4
Unprotected Sex Before Marriage								
Yes	18	18.4	8	14.0	9	23.7	1	33.3
No	80	81.6	49	86.0	29	76.3	2	66.7
Have more than one Sex partner								
Yes	115	16.4	65	18.9	40	14.1	10	13.5
No	587	83.6	279	81.1	244	85.9	64	86.5
Had unprotected Sex (> one partner)								
Yes	34	30.1	30	46.9	2	5.0	2	22.2
No	79	69.9	34	53.1	38	95.0	7	77.8

4.1.9 Respondents HIV/AIDS Status and Testing for HIV/AIDS

Respondents were asked a number of questions about their status of HIV/AIDS, and their perception of the risk of contracting HIV/AIDS, whether they have been tested for HIV/AIDS and, if not, their willingness to be tested. The results of the survey are presented in Table 4.9. The overwhelming majority of the respondents in Hulet Eju Enesie and Gozamin Woreda believe that they have no HIV/AIDS. The corresponding figure for respondents of Shebel Berenta Woreda is comparatively lower (65.7 %).

SUMMARY

The perceutage of respondents who were not willing to give answer to the question about their HIV/AIDS status ranges form 30 % in Shebel Berenta to 19.3 % in Gozamin. This may suggest that there is strong fear among respondents to describe about their status of HIV/AIDS.

As shown in Table 4.9 more than 90 % respondents in Gozamin and Shebel Berenta, and nearly all respondents in Hulet Eju Enesie believe that they are not at risk of contracting HIV virus. Table 4.9 also shows that at least ninety five percent of the respondents have not been tested for HIV/AIDS. In this regard, there is no difference among the three Woredas. However, more than 75 % of the respondents are willing to be tested for HIV/AIDS.

Table 4.9 Percentage Distribution of Respondents who have HIV/AIDS, Believed at risk of developing HIV/AIDS and Testing for HIV/AIDS by and Woreda

Status / Testing For HIV/AIDS	Total		**Woreda**					
	No	%	No	%	No	%	No	%
Have HIV/AIDS								
Yes	10	1.4	3	0.8	4	1.4	3	4.5
No	612	83.4	303	79.9	265	92.0	44	65.7
No answer	112	15.2	73	19.3	19	6.6	23	29.9
At risk of Developing HIV/AIDS								
Yes	34	4.7	26	7.2	3	1.0	5	6.8
No	684	94.9	331	91.9	385	99.0	68	93.2
Don't know	3	0.4	3	0.8	-	-	-	-
Tested for HIV/AIDS								
Yes	33	4.4	17	4.5	12	4.2	4	5.3
No	711	95.6	364	95.5	275	95.8	71	94.7
Willing to be Tested								
Yes	586	82.0	277	75.7	246	88.8	63	87.5
No	129	18.0	89	24.3	31	11.2	9	12.5

Table 4.9 also shows that the percentages of respondents in Hulet Eju Enesie and Shebel Berenta Woreda who knew someone who has HIV/AIDS are very low. However, in Gozamin Woreda 43.8 % knew someone who has HIV/AIDS. This could probably be due to the fact that Gozamin is a Woreda found nearest to Debra Marcos town, the capital of East Gojjam Zone and hence the respondents of this Woreda might have greater chance to know someone living with HIV/AIDS

4.1.10 Knowledge and Relation ship with PLWHA

In this survey respondents were asked whether they knew anyone who has the HIV virus in his blood, and if so, if they were willing to establish friendship/ relationship with them Table 4.10 shows that slightly greater than one quarter (26.3 %) of the respondents knew some one who is living with HIV/AIDS. Residents of Gozamin Woreda seem to have greater chance (43.8 %) to know someone who has the HIV virus in his blood.

Table 4.10 also shows that among those who knew someone who has the HIV virus in his blood only less than have good relationship with them. Regarding their willingness to be friendly with PLWHA, less than 50 % of the respondents believe that they can establish friendship with persons who have the virus in their blood. Relatively larger percentages of respondents (57.6 %) in Hulet Eju Enesie expressed that they can establish friendship with PLWHAs as compared to respondents in other Woredas.

Table 4.10 Distributions Respondents who know some one with HIV/AIDS and Relationships with PLWHA by Woreda.

Knowledge/Friendship	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Know any one who has HIV/AIDS								
Yes	144	26.3	167	43.8	20	6.9	7	10.1
No	544	73.7	214	56.2	268	93.1	62	89.9
Relationship with somebody who has HIV/AIDS								
Good relationship	95	37.7	81	38.6	13	33.3	1	33.3
Not good relationship	138	54.8	110	52.4	26	66.7	2	66.7
Willing' to be friendly with person having HIV/AIDS								
Yes	344	46.3	148	38.9	166	57.6	30	40.0
No	399	57.3	238	61.1	122	42.4	45	60

4.1.11 Attitude toward People Living With HIV/AIDS /PLWHA/

Respondents were asked whether they are willing to a) care for and eat with persons with HIV/AIDS, b) stay away or isolate some one, who is close to them and whom they know has HIV/AIDS. Lack of care and isolation of PLWHA by close friends or relatives can cause a serious moral and psychological distress to the patients. Information on the attitudes of a community towards PLWHA is therefore, very important in assessing the extent of stigma and discrimination associated with HIV/AIDS.

SUMMARY

Table 4.11 shows that more than half (57.3 %) of the respondents are willing to care for a person with HIV/AIDS. Respondents in Gozamin Woreda are more willing to take care for PLWHA. Table 4.11 also shows that about half of the respondents reported that they are willing to eat with PLWHA. The percentage of respondents who think they can eat with PLWHA vary among the Woredas being, slightly more than 50 % in Hulet Eju Enesie and Shebel Berenta.

As shown in Table 4.11 52 % stated that if some one close to them has HIV/AIDS they will stay away or isolate him/her. In Shebel Berenta Woreda much higher percentage (62.2 %) of respondents, expressed their unwillingness to live with PLWHA.

Regarding friendship with PLWHA, less than half of the respondents (46.3 %) were willing to be friendly with PLWHA. A relatively higher percentage of the respondents (57.6 %) in Hulet Eju Enesie expressed their willingness to establish friendship with PLWHA as compared to the percentages observed for other Woredas.

Table 4.11 Percentage Distribution of Respondents who want to take care, eat and live with PLWHA by Woreda.

Attitudes toward PLWHAs	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Willing to take care for PLWHA								
Yes	423	57.3	191	50.1	190	66.9	42	57.5
No	315	42.7	190	49.9	94	33.1	31	42.5
Willing to eat with PLWHA								
Yes	369	49.8	180	47.2	148	51.9	41	54.7
No	372	50.2	201	52.8	137	48.1	34	45.3
Willing to stay away or isolate PLWHA								
Yes	385	52.2	183	48.2	156	54.9	46	62.2
No	383	47.8	197	51.8	128	45.1	28	37.8

4.1.12 Perception of the Problems that are caused by HIV/AIDS

Respondents were asked about problems caused due to HIV/AIDS and who/which group will be affected by HIV/AIDS. Table 4.12 shows that more than 90 % mentioned poverty, family, suffering of health deterioration and TB are problems that are caused by HIV/AIDS. There are slight differences in the percentages among the Woreda, ranging from 98.1 % in Gozamin to 92.2 % in Hulet Eju Enesie Woreda. Regarding societal/economical groups that will be affected most, Table 4.12 also shows that respondents of the target areas unanimously described family, income and agriculture will be the most affected groups by HIV/AIDS. About 75 % of respondents in Hulet Eju Enesie believe that family will be affected most by the HIV/AIDS epidemic.

Table 4.12 Percentage Distribution of Respondents by perception of problems caused and groups that will be affected by HIV/AIDS and Woreda.

Problem caused/Groups affected by HIV/AIDS	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Problem caused								
TB	268	25.5	193	29.1	39	14.6	36	36.0
Poverty	384	36.5	241	36.3	110	41.0	33	27.5
Family suffers/health deteriorates								
Others	10	1.0	5	0.8	3	1.1	2	1.7
Don't know	31	2.9	7	1.1	18	6.7	6	5.0
Groups affected by HIV/AIDS								
Family	561	38.5	294	28.5	221	74.4	46	35.7
Income	254	17.4	214	20.8	17	5.7	28	17.8
Agriculture	249	17.1	212	20.6	18	6.1	19	14.7
Community	204	14.0	174	16.9	10	3.4	20	15.5
Country	185	12.7	133	12.9	31	10.4	21	16.3

4.1.13 Opinion on how HIV/AIDS affects Different Socio-Economic Groups

Respondents were also asked a number of questions on how the income, agriculture, community and the state be affected if the breadwinner of the family has HIV/AIDS. This information will be useful to assess the devastating social, economical and demographic consequences of HIV/AIDS. Table 4.13 shows that unanimously almost all respondents believe that if a person has HIV/AIDS the family will be affected by lack of money, which is leading to poverty and from loss of loved one. Similarly, all respondents suggested that if a person has HIV/AIDS, unable to work and medical expense are serious challenges that affect the income.

Table 4.13 also shows that all respondents have a firm belief that agriculture, the dominant means of livelihood, will be affected because a person with HIV/AIDS would be unable to work. All Woredas have the same views on this issue.

As shown in Table 4.13 if a person has HIV/AIDS 25 % of the believe that the community will be affected most likely by social problem associated with HIV/AIDS. About 25 % also suggested that poverty is likely to affect the community. There are variations between Woredas, in this regard. Respondents in Hulet Eju Enesie and Shebel Berenta believe that poverty is the most likely negative effect on the community while respondents in Gozamin believe that social problems are the most likely ones.

More than half of the respondents (except in Hulet Eju Enesie) suggested that the community and state will be affected by poverty caused due to the HIV infections. They also believe that decreased production and loss

of people in the productive age groups caused by HIV/AIDS epidemic will be serious challenges to the community and development of country.

Table 4.13 Percentage Distribution of Respondents by Opinion on How HIV/AIDS will affect Different Socio-Economic Groups

Perceptions of Ways How HIV/AIDS affects Socio-Economic Groups	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
How Family will be affected								
Lack of money	424	50.3	252	51.3	132	48.2	40	51.3
Loss of Loved one	417	49.5	239	48.7	140	51.1	38	48.7
Others	2	0.2	-	-	2	0.7	-	-
How Income will be affected								
Unable to work	564	890	310	86.4	230	95.8	24	68.6
Medical Expense	70	11.0	49	13.6	10	4.2	11	31.4
How Agriculture will be affected								
Unable to work	629	100.0	357	100.	236	100.0	36	100.0
How Community will be affected								
Unable to work	55	11.6	33	14.0	22	16.7	1	3.2
Medical Expense	32	6.8	15	6.4	16	7.8	-	-
Social problem	189	40.0	107	45.3	73	35.4	9	29.0
Stigma	83	17.5	64	27.1	12	5.8	7	22.6
Poverty	114	24.1	17	7.2	83	40.3	14	45.2
How Community and Country will be affected								
Productive age group will be affected	101	22.2	30	14.0	62	29.8	9	28.1
Production Decreased	110	24.2	50	23.4	55	26.4	5	15.6
Poverty	143	53.5	134	62.6	91	43.8	18	56.3

4.1.14 Perceptions ways how HIV/AIDS Affects Occupation, Agriculture and the Community Development.

Respondents were asked questions on how occupation, agriculture and the development of community will be affected by HIV/AIDS. This information is useful for assessing the rural community's awareness about multifaceted effects of HIV/AIDS. The survey results are presented in Table 4.14. Fifty six percent of the respondents reported that if a person has HIV/AIDS a decrease in productivity will have major effects on occupation. The views of the respondents vary in this regard ranging from 57.9 % in Hulet Eju Enesie Woreda to 43.8 % in Shebel Berenta.

At least 40 % of the respondents suggested that decrease in household income is the most serious the effect of HIV/AIDS on occupation. Table 4.14 shows that respondents think that agriculture will be affected most as a result of decreased manpower because of HIV/AIDS. About one quarter of the respondents feel that decreased productivity and less income are the effects of HIV/AIDS on agriculture. There are certain differences among the Woredas, though the patterns are the same as observed for occupation.

Regarding the effect of HIV/AIDS on the development of community results on Table 4.14 show that more than half of the respondents believe that poverty will be a serious challenge. Almost equal percentage of the respondents mentioned that social problem and decreased manpower are also likely to affect development of the community.

Table 4.14 Percentage Distributions of Respondents by Perception of Ways How HIV/AIDS affects Occupation, Agriculture and the Development of Community.

Ways how HIV/AIDS Affect Different Areas	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
How Occupation will be affected								
Decreased productivity	517	56.0	338	56.1	158	57.9	21	43.8
Loss Income	404	437	264	43.8	113	41.4	22	56.2
Others	3	0.3	1	0.2	2	0.7	-	-
How Agriculture will be affected								
Decreased man power	483	48.7	302	44.9	159	58.9	22	41.4
Decreased Productivity	269	27.1	201	29.9	55	20.4	13	10.3
Less income	240	24.2	170	25.3	56	20.7	14	13.8
How Community Development will be affected								
Social problem	69	21.6	35	19.6	26	23.4	8	27.6
Decreased manpower	70	21.9	38	21.2	24	21.6	8	27.6
Poverty	180	56.4	106	59.2	61	55.0	13	44.8

4.1.15 Knowledge of HIV/AIDS and Orphan hood

Respondents were asked whether they personally know someone who died of AIDS and children who had been orphaned as a direct result. Accordingly, the results in Table 4.15 show that slightly less than half personally knew someone who died of AIDS. The percentages seem to vary among the Woredas and range from 56 % in Gozamin to 38 % in Hulet Eju Enesie. Similarly the same percentages of respondents reported that they know children who had been orphaned due to AIDS.

Table 4.15 Percentage Distributions of Respondents who know some one Died of AIDS and Children Orphaned Due to AIDS and by Woreda.

Knowledge of AIDS and Orphaned Children	Woreda							
	Total		Gozamin		Hulet Eju Enesie		Shebel Berenta	
	No	%	No	%	No	%	No	%
Know some one died of AIDS								
Yes	348	47.7	212	55.6	110	38.2	26	43.3
No	369	50.6	161	42.3	175	60.8	33	55.0
Do not Know	12	1.6	8	2.1	3	1.0	1	1.7
Know Children Orphaned Due to AIDS								
Yes	344	47.3	210	55.1	110	38.2	24	40.7
No	370	50.8	163	42.8	172	59.7	35	59.3
Do not Know	14	1.9	8	2.1	6	2.1	-	

4.2 FEEDBACK OBTAINED FROM AIDS PATIENTS

4.2.1 Livelihood of the patients

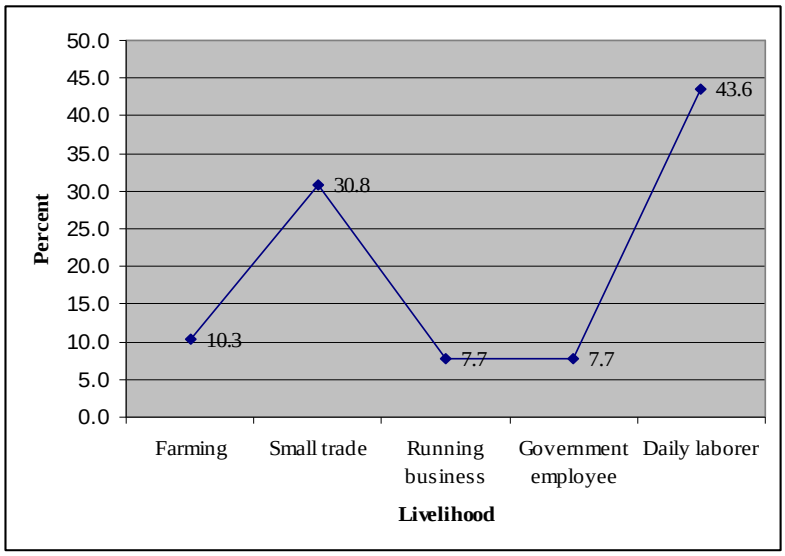
Data on the livelihood of AIDS patients have been collected by interviewing the patients themselves and the results are given in Table 4.10 All of the patients interviewed are head of the household or the breadwinners of the family.

According to these results, 43.6 % of the patients are daily labourers, while 30.8 % earn their livelihood by small trade Farming accounts for 10.3 % and the remaining are running other small businesses or are government employees. (Fig. 4.1)

Table 4.16 Percentage distribution of the livelihood of patients

Livelihood	No.	%
Farming	4	10.3
Small trade	12	30.8
Running a business	3	7.7
Government employee	3	7.7
Daily laborer	17	43.6

Figure 4.1 Graphical presentation of the livelihood of patients



4.2.2 Status of AIDS patients and their family

Data on the health and marital status of the patients; health status of the spouse and school attendance of children were collected from the interviewed AIDS patients and presented in Table 4.17.

The Table shows that most of the patients (87.2 %) are currently active and only 12.8 % of the interviewed patients are bed-ridden. The marital status of a great majority of patients covered by the survey is married. Around 40 % of the patients reported their spouses were not alive. Out of those spouses who were alive, two thirds were tested for HIV and 93.3 % of those tested for HIV/AIDS were found to be HIV positive. Around 80 % of the respondents reported they have children. 58.1% of the children of

AIDS patients interviewed were not going to school. The reasons given for stopping going to school are given in Table 4.18 Inability to afford the cost of school is the main reason reported by respondents for dropping out of school. Some of the respondents have also reported children that they withdrew from school to look after their sick relatives.

Table 4.17 Percentage distributions shows the status of AIDS patients and their family

Status of the patient/his family	YES		NO	
	No.	%	No.	%
Active or bed-ridden				
Active	34	87.2		
Bed-ridden	5	12.8		
Married	38	97.4	1	2.6
Spouse alive	23	60.5	15	39.5
Tested for HIV	15	65.2	8	34.8
HIV positive	14	93.3	1	6.7
Have any children	31	81.6	7	18.4
All children go to school	13	41.9	18	58.1

Table 4.18 Percentage distribution of reasons for not going to school

Reasons	Yes	
	No.	%
Not school age children	3	13.6
Due to poverty	2	9.1
Due to financial problems	3	13.6
Don't have child	1	4.5
Couldn't afford school cost	11	50
Children looking after me (patient)	2	9.1

4.2.3 Care taker and medical service

AIDS patients interviewed were asked as to who was taking care of them while they are in bed and who pays for their medication, and the findings

are shown in Tables 4.19 and 4.20. As shown in Table 4.19 and figure 4.2, the burden of taking cares of the patients is on children. About 43 % of the patients responded that they are taken care by their children while they are ill in bed. Patient relatives and spouses are reported by 28.6 and 22.9 % of the respondents, respectively.

The survey result presented in table 4.20 shows all of the interviewed patients reported that they go to health care facilities to get medical treatment. About half of the respondents said that the expenses for their medication are covered by the government. Those who cover the expense by themselves are 35.9 % and only for 12.8 % of them the medical treatment expense is covered by NGOs.

Table 4.19 Percentage distribution of care takers while the patients are ill in bed

Care-taker	No.	%
Spouse	8	22.9
Children	15	42.9
Relatives	10	28.6
Neighbors	2	5.7

Figure 4.2 Graphical presentation of care taker of patients

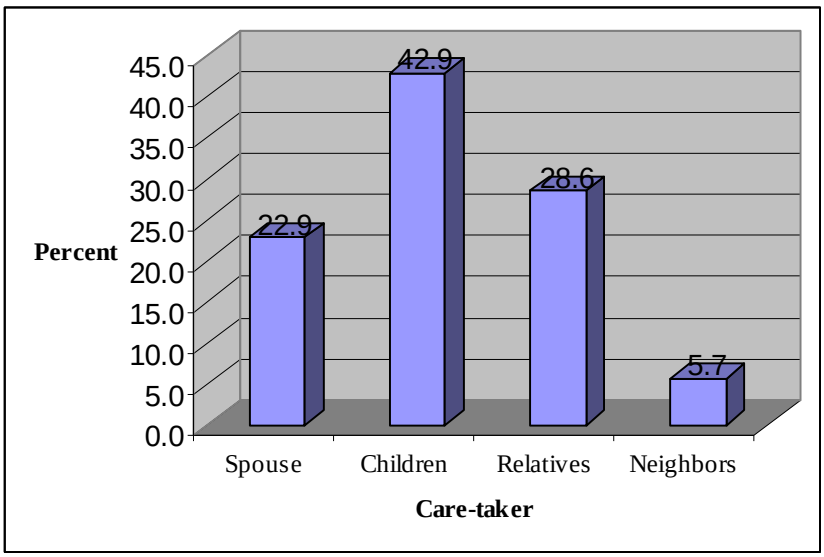
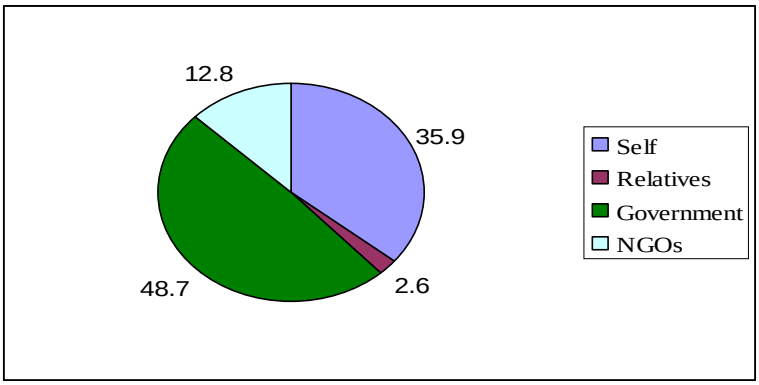


Table 4.20 Percentage distribution of persons paying for medication

Expense covered by	Yes	
	No.	%
Go to health care facilities	39	100.0
Who pay for medication		
Self	14	35.9
Relatives	1	2.6
Government	19	48.7
NGOs	5	12.8

Figure 4.3 Chart shows who pays medical expenses for AIDS patients



4.2.4 Negative consequences of AIDS on the patients' family

AIDS patient who are economically inactive or bed-ridden during the survey were asked who replaced them as the head of the household and the result indicated that 40 % of them have no replacement and 40 % were replaced by their relatives. In addition, the survey result showed that most (80 %) of the replacements do not adequately provide for the needs of the family.

As indicated in Table 4.21, 56.4 % of the patients were reported to have experienced serious hunger and poverty which was the most serious major negative consequences of AIDS on their family. The major (28.2 %) negative consequence reported was, children resorting to street life or migration elsewhere. Other negative impacts including expulsion from the rented houses and children forced to engage in labor work (child laboru).

Table 4.21 Percentage distribution of respondents by negative consequences of lack of care and support.

Consequences	Yes	
	No.	%
Serious hunger & poverty	22	56.4
Forced to leave the rented house	1	2.6
Children resort to street life or migrate elsewhere	11	28.2
Just waiting for my death	3	7.7
Children forced to be employed in domestic works	2	5.1

4.2.5 Participation of NGOs in care and support for AIDS patients and AIDS orphans

To assess the extent of care and support provided by NGOs for AIDS patients and AIDS orphans; existence of such type of NGOs in the survey area and type of service they provide the NGOs (Ethiopian Aid and Agri Sservice) were interviewed and the result is presented in Table 4.22. The existence of NGOs providing care support to the victims was reported by nearly half the respondents. The result shows the major service provided by NGOs in the area is mainly financial support. A few of the respondents reported home-based care, counseling and nutritional support provided by NGOs.

Table 4.22 Percentage distribution of respondents by types of support provided by NGOs to AIDS patients and AIDS orphans

	Yes		No	
	No.	%	No.	%
NGOs provide care and support	21	53.8	18	46.2
Kind of care and support				
Home-based care	3	14.3		
Counseling	2	9.5		
Nutritional support	1	4.8		
Financial support	15	71.4		

4.2.6 Attitude of some target groups towards AIDS patients and AIDS orphans

In order to know the extent of discrimination or stigma towards AIDS patients, AIDS patients were asked the attitude of AIDS patient family members, relatives, neighbors, health service providers and community at large towards them.

Results of the survey shown in Table 4.23 indicate that all patients included in the survey reported that the attitude of family members and health service providers are friendly. Nearly half of the respondents reported relatives and neighbors have friendly attitude toward them. The result shows over 75 % of the community at large have negative attitude towards AIDS patients.

Table 4.23 Percentage distribution shows attitude of different target groups towards AIDS patients and AIDS orphans

Groups	Friendly		Unfriendly	
	No.	%	No.	%
Family members	39	100.0		
Relatives	23	59.0	16	41.0
Neighbors	20	51.3	19	48.7
Health service providers	39	100.0		
Community at large	9	23.1	30	76.9

4.2.7 Negative impacts of being an AIDS patient

AIDS patients were asked to list the negative impacts that their family faced as a result of them being an AIDS patients. The result of the survey as shown in Table 4.24 indicates that the major impact is being unable to afford food and house rent expenses. Other impacts faced are

discrimination, feeling lonely, lack of care-takers, worry about the fate of their children, etc.

Table 4.24 Percentage distribution shows negative impacts of being AIDS patient on the patients' family

Impacts	Yes	
	No.	%
My income drastically reduced and couldn't afford food and house rent expenses	39	60.8
Discrimination and feeling lonely	9	14.1
Worry for fate of children worry for the fate of children	6	9.4
Lack of care-takers (who look after me)	5	7.8
Lack of medical expense	3	4.7
Others	2	3.2

4.3 RESULTS OBTAINED FROM FAMILY MEMBERS OF THE DECEASED

4.3.1 Respondents' relationship to the deceased person

All members of the deceased family included and covered by the survey reported that the deceased person was the breadwinner of the family. As shown in Table 4.25, below, 46.9 % of the respondents are spouses of the deceased, other relatives and friends accounting for 25 % of which 18.8 % are children.

Table 4.25 Percentage distribution of respondents by relationship the to deceased

Relationship	No.	%
Spouse	15	46.9
Child	6	18.8
Mother	3	9.4
Others	8	25.0

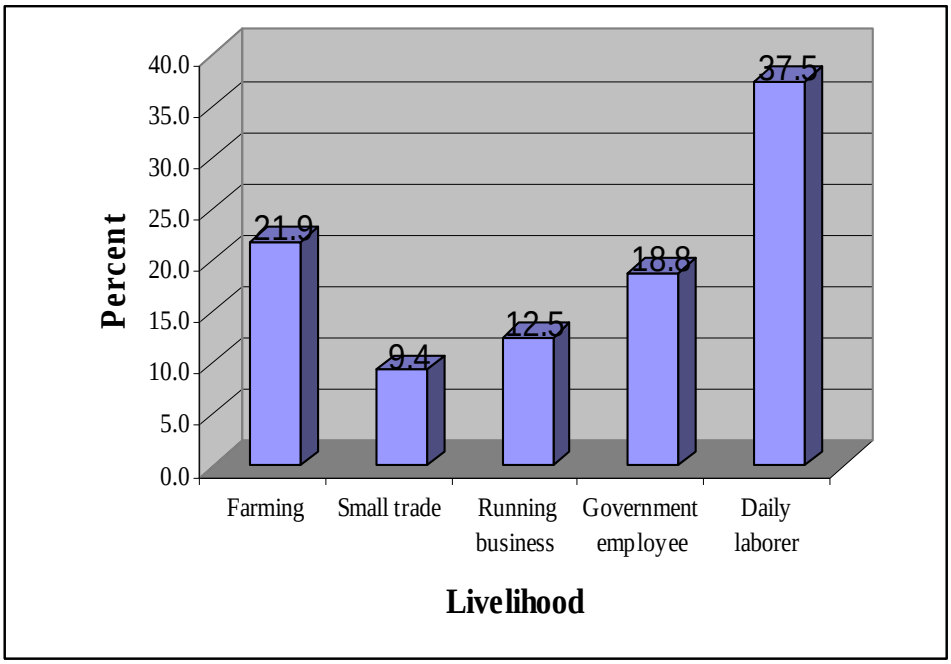
4.3.2 Livelihood of the deceased

Results on the livelihood of the AIDS deceased persons compiled from the survey are given in Table 4.26. accordingly 37.5 % of them were daily form labourers, 21.9 % were farmers and 18.8 % were government employees. The remaining were small traders or run small businesses.

Table 4.26 Percentage distribution of the livelihood of the deceased

Livelihood	No.	%
Farming	7	21.9
Small trade	3	9.4
Running business	4	12.5
Government employee	6	18.8
Daily laborer	12	37.5

Figure 4.4 Graphical presentation of the livelihood of the deceased



4.3.3 Previous status of the AIDS deceased and school participation of the deceased children

The survey result of the deceased person's marital status, number of child and whether the students are currently going to school is presented in Table 4.27. The results show that all of the AIDS deceased persons covered by the survey were married and have children.

The survey result indicates that 75 % of children of the deceased do not go to school and the main reason given was that the income of the family was suddenly reduced significantly that the children were not able to pay school expenses and were therefore forced to drop out of school.

Table 4.27 Percentage distribution showing the previous status of the deceased and school participation of the deceased children

1. Status of the deceased	Yes		No	
	No.	%	No.	%
Was married	32	100.0		
Have child	32	100.0		
All children go to school	8	25.0	24	75.0
2. Reason for not going to school				
• Family income reduced due to loss of breadwinner	17	70.8		
• Discontinued education Because he/she is AIDS orphan	4	16.7		
Others	3	12.5		

4.3.4 Living condition of the deceased before he/she became AIDS patient

Respondents were asked to rate the living conditions of the deceased before he/she became AIDS patient and the result is shown in figure 4.5 and Table 4.28. Only 31.2 % of the living conditions of the deceased were rated as poor. The remaining were rated to be good (21.9 5 and fair (46.9 %) before he/she because AIDS patient.

The family of the deceased family were also asked whether they had adequate amount of food after the death of the patient and the result is shown in Table 4.28. According to this 90.6 % of the respondents reported that they did not have enough food after the death of the patient.

The availability of food and the living condition of the family of the deceased before and after he/she because AIDS patient as well as after the dearth of the patient was examined and the results are given in Table 4.28 with its "Chi Square Test"

The cross-tabulation result shows that all of the families which previously had fair or poor living condition do not have enough food after the head of the household became AIDS patient. Out of families which had living conditions before the breadwinner become AIDS patient, 57 % of did not have enough food after the head of the family became AIDS patient or died. This is a clear indication of the negative economic impact of AIDS on the AIDS patient and on members of this family after his/her death.

Table 4.28 Percentage distribution of respondents by living conditions before and after becoming AIDS patients

	Yes		No	
	No.	%	No.	%
Living Conditions				
Good	7	21.9	-	-
Fair	15	46.9	-	-
Poor	10	31.2	-	-
Have enough food after death of patient	3	9.4	29	90.6

Figure 4.5 Chart showing the living conditions of the deceased before becoming AIDS patient

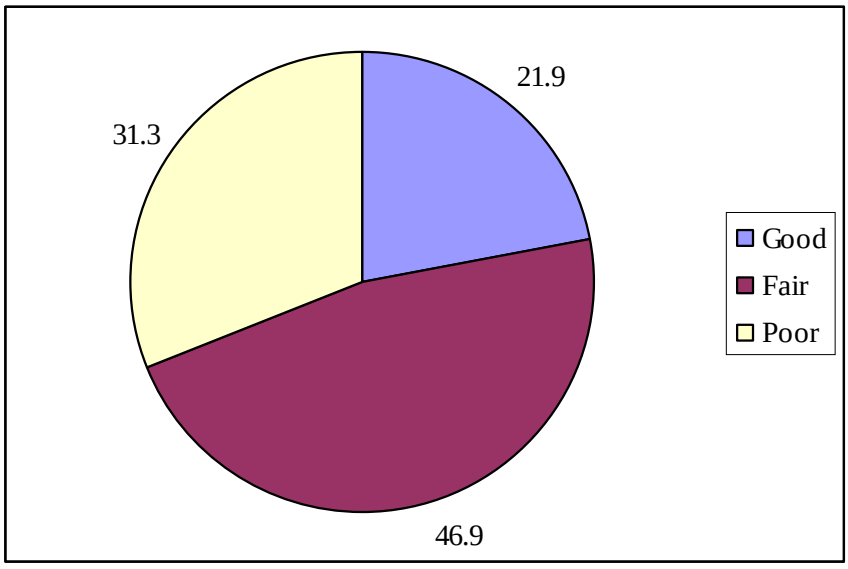


Table 4.29 Cross tabulation of the deceased family food situation after the death of AIDS patient and Living conditions before become AIDS patient

			Living conditions before became AIDS patients			Total
			Good	Fair	Poor	
Does the family have Enough food after the Death of AIDS patient	Yes	No.	3			3
		%	42.9			9.4
	No	No.	4	15	10	29
		%	57.1	100.0	100.0	90.6
Total		No.	7	15	10	32
		%	100.0	100.0	100.0	100.0

Chi-Square test of the cross tabulation result

	Value	df	Assump. Sig. (2-sided)	
Pearson Chi-Square	11.82	2	0.00271	

4.3.5 Health status of the spouse of the deceased

During the survey an attempt was made to assess the health status of the spouses of the deceased as presented in the table 4.30. Cross-tabulation of the spouse health status with the living conditions of the AIDS victim before he/she became patient is also done and the result is given in Table 4.31 together with the Chi-Square tests result.

As it is observed in Table 4.30, 81.2 % of spouses of the deceased were still alive while 18.8 % of them died eventually. The great majority 88.5% of the spouses of the deceased were tested for HIV/AIDS and found to be HIV-positive. About two thirds of the HIV positive spouse are getting medical treatment and 34.2 % of them the respondents were asked there would be someone to take care of the family in the event of death of the spouse. 88.5 % of the respondents reported that there is no one.

The cross-tabulation between the living conditions of the family before the head of the household became AIDS patients and the health conditions of the spouse was done and the result is given in Table 4.31 together with Chi-Square test. The result shows most of the spouses previously had poor living conditions died. In addition, spouses from previously fair living conditions were not getting medical treatment. The survey result indicates that all of the spouses who previously had good living conditions are alive and are getting medical treatment as well. The survey results show persons with poor living conditions are more vulnerable than others, lack of medical treatment, medication, lack of nutritious food, or both.

Table 4.30 Percentage distributions shows the health status of the spouse of the deceased

Status of the deceased spouse	Yes		No	
	No.	%	No.	%
Alive	26	81.2	6	18.8
Tested for HIV/AIDS	23	88.5	3	11.5
HIV positive	23	100.0		
Get medical treatment	15	65.2	8	34.2
If spouse dies, are other members of the family who can take care of the family	3	11.5	23	88.5

Table 4.31 Cross-tabulation results of living conditions of the family before the head became AIDS patient against the deceased spouse health conditions

			the spouse alive		the spouse get medical treatment	
			Yes	No	Yes	No
Living conditions of the family before the head became AIDS patients	Good	No.	7		4	
		%	26.9		56.7	
	Fair	No.	15		10	5
		%	57.7		66.7	62.5
	Poor	No.	4	6	1	3
		%	15.4	100	6.6	37.5
Total			26	6	15	8

Chi-Square Tests				
Pearson Chi-Square Result	Value	df	Asymp. Sig. (2-sided)	
Spouse alive	16.25	2	0.0003	
Spouse get medical treatment	4.999	2	0.0821	

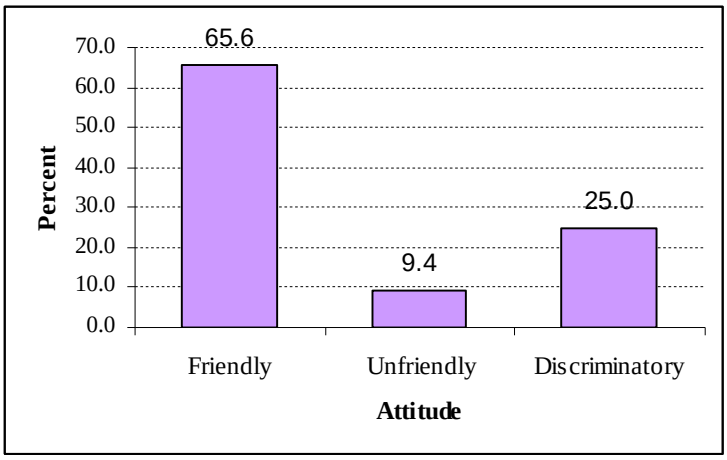
4.3.6 Attitude of the community towards PLWHA AIDS patients and AIDS orphans

Information on the attitude of the community towards PLWHA, AIDS patients and AIDS orphans was collected by the survey and the report is given in Table 4.32 and graphically presented in figure 4.6. From both tabular and graphic presentations, the survey result shows that 65.6 % of the community have positive attitude towards PLWHA, AIDS patients and AIDS orphans. The result also shows that about 25 %? Of the community have negative or discriminatory attitude towards PLWHA AIDS patients and AIDS orphans.

Table 4.32 Percentage distribution of respondents the attitudes of the community towards PLWHA, AIDS patients and AIDS orphans

Attitude	No.	%
Friendly	21	65.6
Unfriendly	3	9.4
Discriminatory	8	25.0

Figure 4. 6 Graphical presentation of the attitude of the community towards PLWHA AIDS patients and AIDS orphans



4.3.7 Negative consequences on the deceased family as a result of the death of the AIDS patient

In order to see the negative consequences of AIDS, the deceased families were asked to list the negative consequences they faced as a result of the death of the AIDS patient. The summary of the result is presented in Table 4.33 below. The Table shows that major impact is economic one including lack of food, cloth, money and poverty. Other negative social consequences like discrimination, lack of treatment and care-taker, school children dropping out of school and migration are also reported by the respondents.

Table 4.33 Percentage distribution of respondents by major negative consequences on the death of the AIDS patient

Consequences	No.	%
Lack of treatment from the family	9	28.1
Lack of food, cloth ,money and starvation	26	81.3
Poverty	3	9.4
Discrimination	3	9.4
Migration	3	9.4
Children dropping out & school	3	9.4
Loss of job	3	9.4
Lack of somebody to take care of them	3	9.4

4.4 EMPIRICAL ANALYSIS SUING A CROSS REGIONAL DATA

In order to determine quantitative and perhaps more precise relationship between the major determinants/factors and impact on HIV/AIDS it is necessary to specify and estimate a model linking them.

HIV/AIDS determinants equation:-

Ln HIV/AIDS = Bo + B_1 Ln PO + B_2 Ln IL + B_3 LnAW + B_4 Ln US + B_5 Ln NSP+ e

HIV/AIDS – Acquired Immune Deficiency Syndrome
PO–measures the level of poverty (household income)
IL – measures level of illiteracy
AW –measures the level of awareness
US – Unprotected sex
NSP – Number of sex partners
e – Error term – Stochastic disturbance term

The independent variables capture some structural characteristics of the region and are related to economic policy, which can be adjusted by policy makers in order to assess the impact of HIV/AIDS on the community. .

The three randomly selected sample regions/ weredas in the rural part of Ethiopia, east Gojjam include Gozamin, Hulet Eju Enesie and Shebel Berenta. For most of the variables, the values represent the average of the period in percentage. The expected sign for the level of awareness is negative, while the expected results for the other variables poverty, illiteracy, unprotected sex and number of sex partners is positive.

4.7.1 Econometric Results

The purpose of the empirical analysis is to see the direct effect of the major determinants/factors that affect HIV/AIDS using cross section regression with three regions/weredas of east Gojjam.

As shown in table 4.34, all variables except one are correctly signed. The estimation results show that poverty has a positive relationship with HIV/AIDS. This means that the higher the level of poverty, the greater the impact on HIV/AIDS. As expected, high level of poverty implies less income which is directly related to HIV/AIDS.

The other variable which affects HIV/AIDS significantly is the level of illiteracy. As expected the level of illiteracy has a positive effect on HIV/AIDS. The implication is that as the level of illiteracy increase, household income declines having positive impact on HIV/AIDS.

The regression in the table 4.34 below shows that the effect of awareness level is negative as expected. This implies that as the level of awareness on the transmission and preventive mechanisms increase, the impact on HIV/AIDS declines. This is due to the fact that people will be aware of the modes of transmission and preventive mechanisms of HIV/AIDS. The estimation results show that unprotected sex has positive effect on HIV/AIDS. As the level of unprotected sex increases, its impact on HIV/AIDS will also increase.

The signs indicating the effect of the above variables included in our regression of the determinants of HIV/AIDS are almost consistent to what has been predicted by theory. And it is almost similar to many of the empirical studies conducted so far on the determinants of HIV/AIDS.

An exception to the above statement is the effect of NSP on HIV/AIDS, which is negative. This result is completely contradictory to the theoretical prediction and it might have something to do with our data being cross sectional. Most of the variation in the data is across regions, reflecting conditions that change slowly and are static. The outcome may also be the result of measurement errors or the way we defined the variable NSP in this model.

Table 4.34 Estimates of the determinants of HIV/AIDS

Explanatory Variables	HIV/AIDS Determinants Coefficients	t
Ln PO	0.71	1.03
Ln IL	0.76	1.
Ln AW	-0.58	-0.71
Ln US	0.07	0.07
Ln NSP	-0.47	-0.53
Constant	-16.01	-0.81

No of Observations	3
F(5,10)	3.5
R Squared	0.61

Table 4.35 Precision level or margin of error of some selected variables.

No.	Variable	No. of respondents	Margin of error in %
1	Do you own a land for agriculture	678	2
2	Have you ever heard of HIV/AIDS	739	2
3	Do you know the cause of HIV/AIDS	734	2
4	What is cause of HIV/AIDS	508	4
5	Do you have more than one sex partner	702	3
6	Your relationship with somebody HIV positive	252	5
7	If a person has HIV/AIDS, how will the income be affected	634	2.5
8	If a person has HIV/AIDS, how will the agriculture be affected	629	2.5
9	If a person has HIV/AIDS, how will the community be affected	473	4.5
10	If a person has HIV/AIDS, how will it affect the occupation	677	4

This indicates that the precision of the obtained survey result is high. For example about seventy percent of the respondents reported that they know the causes of HIV/AIDS with plus or minus 2 % margin of error at 95 % level of confidence. This term simply means that if the survey were conducted 100 times, the percentage who say 'they know the causes of HIV/AIDS' will range between 68 and 72 % most (95 %) of the time.

QUALITATIVE ANALYSIS

4.5 FOCUS GROUP DISCUSSION AND FREQUENTLY ASKED QUESTION OUTCOMES

Focus group discussions were held with knowledgeable persons, elders, community leaders, etc. in the study area. Questions raised for discussions were HIV/AIDS knowledge, attitude and practice. In addition, questions frequently raised about HIV/AIDS were discussed.

According to the result obtained from the focus group discussions, there is a mixed perception of the community about HIV/AIDS. The majority of the interviewees responded by stating that the community considers HIV/AIDS as God curse to evil doing of human beings or consider it as a disease which is only common in urban areas.

Detailed discussions were conducted with the knowledgeable persons on the impacts of HIV/AIIDS. AIDS victims are usually youths or persons in the productive age group and loss of such a productive group has a great impact on the agricultural production and development of the economy. The other economic impacts mentioned are shift of labour from production activities to caring activities of patients and cause absenteeism. The social impacts of HIV/AIDS listed during the discussions are, increase in the number of orphans stigma or discrimination, migration of victim families to the urban areas or elsewhere and overcrowding in health care facilities leading to shortage in hospital beds.

Participants in focus group discussions were also asked how they can help HIV/AIDS victims as individuals and/or members of the community. Most of them reported that they are willing to help them by counseling and caring services. They also explained that are willing to

supply the victims' needs by contributing money and providing some basic necessities.

The very alarming and damaging situation was also revealed during focus group discussions. Most of the participants never dared to disclose what they knew about HIV/AIDS in individuals or families. The society perceives HIV/AIDS in a way that leprosy was perceived in old times namely a disease inherited and running through certain families or ethnic groups. The stigma is so immense that if someone or a medical person reveals the case to a third party he will be threatened or assaulted by the family of the victim. This indicates that an aggressive campaign must be introduced to increase the awareness level of the society that HIV/AIDS is just an acquired disease and not a disease affecting only certain individuals or sects. The clergy and the church should be highly deployed for such a campaign. If everybody keeps quite about the disease, the pandemic will silently spread among the society and defeat all efforts that are being taken to curb the spread of the disease.

Some participants of the focus group discussions from the health sector revealed that the stigma effect is so strong that PLWHA are reluctant to seek and receive assistance openly in the facilities available for such services. Many prefer to come during evenings when no body is around. At one instance, the HIV section of Ethiopian Aid had to open a backdoor entrance for the patients. A coordinated action must be streamlined involving all stakeholders to remove such unfounded perception from the minds of the community members.

4.6 RESULTS OF IN-DEPTH INTERVIEW WITH WOREDA HEALTH OFFICERS AND HEALTH CARE FACILITIES OFFICERS

Both the health care facilities and Woreda health officers reported that the number of deaths due to HIV/AIDS has been increasing in the Woredas covered by the survey. In all Woredas, the results of the in-depth interviews indicate that government health care facilities provide the PLWHA with medical services for opportunistic diseases. Out of five government health facilities interviewed, four of them reported that they provide antiretroviral drugs for AIDS patients while the other one did not.

Regarding loss of health professionals due to AIDS, only one Woreda reported that it lost some of its health professionals to AIDS. Most of the interviewed health officers agreed that the awareness creation programs in the survey area are not well organized. Despite this, however, some of them reported that they have observed some behavioral changes in the communities with regard to safe sexual practices.

Five health care facilities (hospitals, health centers and clinics) were asked whether there were any NGOs providing care and support services to AIDS patients, PLWHA and AIDS orphans. The officials reported that there are only two NGOs in the area to provide care and support services.

As reported by the health officials, the attitude of health professionals towards PLWHA and AIDS patients is positive or friendly. However, the attitude of the community towards the AIDS patients and PLWHA as reported by half the respondents is negative or discriminatory. The remaining half were reported to be either indifferent or friendly.

Health facility providers were also asked the prevalence of HIV/AIDS but most of them stated that they have not compiled such data. Only one hospital, Motta hospital, reported the HIV/AIDS prevalence rates to be

6.8 %, 13.8 % and 8.0 % in 2003, 2004 and 2005, respectively. According to Motta and Goncha Woreda health office reports the prevalence rate has been steadily increasing. Report form Motta hospital shows that approximately 20 % of the beds in the hospital are occupied by AIDS patients. According to the hospital report this is having a negative impact on other patients who are unable to get the required, since the beds are occupied by the AIDS patients.

The major negative impacts of HIV/AIDS on the community as reported by health facilities and Woreda health officials are:

- Loss of the most productive age group
- Increase in the number of orphan children
- Increase in the number of patients and overcrowding of the health facilities
- Decrease in economic development of the country
- Old age group and children left without care takers
- Shift of labor from production sector to care taker
- Increase in absenteeism
- Threat to the survival of the generation

4.7 RESULTS OF IN-DEPTH INTERVIEW WITH WOREDA EDUCATION OFFICERS AND SCHOOL DIRECTORS

The in-depth interviews were conducted with school directors and Woreda Education officers to find out the impact of HIV/AIDS on the education program. Results obtained from school directors and Woreda health officers for some of the questions are independently analyzed to see the difference in opinion between the two groups.

In Motta, Bichena and Goncha Woredas, a large number of school dropouts was reported between 2003 to 2005. According to these respondents the reasons children for dropping out of school and are

poverty, illness and loss of parents due to AIDS. A large number of school dropouts in Motta and Goncha primary schools were reported to be due to lack of finance as a result of the death of their parents by AIDS. 360 children are reported to have dropped out.

Almost all education officers reported the number of AIDS orphans has been increasing over the past three years. All school directors explained that there are no NGOs in the area who help AIDS orphans to continue their education. The Woreda Education Office report, however, shows that there are NGOs in the area to help AIDS orphans to continue their education. This may be because school directors have less direct contacts with the NGOs then the Woreda Education Office.

All respondents reported the death of teachers in their schools/Woreda, as a result of HIV/AIDS. The death figures as reported by the interviewed school directors range from 2 to 5 teachers per school. The death figures reported by each Woreda range from 15 to 18 per Woreda per year. Most of the school directors and Woreda Education Officers reported the number of teachers dying due to AIDS has been steadily increasing over the past few years.

The impacts of the death of teachers' on the education program as explained by the respondents is summarized as follows:

- Learning-teaching process and education quality is seriously affected
- Loss of educated and skilled man-power
- The implementation of educational capacity building program is hampered
- Affects teachers/student ratio and hence the quality of education
- Negatively affects education coverage

4.8 Impact of HIV/AIDS

In many of the countries which are characterized by high HIV/AIDS prevalence, the impact is not only limited to the health threat of an individual, but also to the socio economic and political threats of the community and the nation at large. The impacts are devastating characterized by the following adverse effects. As per the National AIDS Council of Ethiopia, HIV/AIDS poses the foremost threat to Ethiopia's development by costing the country significantly in its economic growth, reducing the scope for poverty alleviation and retarding the country's development. United Nations Children's Fund (UNICEF) has also identified HIV/AIDS as one of the major health problems in Ethiopia. These multifaceted impacts of HIV/AIDS are summarized as follows.

4.8.1 Economic Impact of HIV/AIDS

The overall economic impact of HIV/AIDS on the society is measured by rate of economic growth and household income/ Gross National Product (GNP).

Household surveys conducted in most African and Asian countries show that household income declined from 60% to 40% in those families where there is at least one infected person by the virus. For instance, a study in Cote d'Ivoire reveal that income in affected households is half the average non affected household mainly due to illness caused by HIV/AIDS which also incur additional cost Members of affected households divert more of time and effort away from the usual income generating activities helping out members living with the virus. In most cases this loss is made up by reducing consumption, borrowing, spending from savings, selling assets such as houses, livestock and other valuables. In countries like Ethiopia,

afflicted rural families reported that the average cost of medical treatment, funeral and mourning amounted to several times the average household income. In general, food reserves saving and households are diverted to cover health care and funeral costs. According to the survey results, most respondents of east Gojjam suggested that if household is affected by HIV/AIDS, he is unable to work and faced with huge medical expenses affecting the level of family income.

The epidemic has also impact on decreasing the demand for goods and services resulting in rising cost of labor. It affects the labor force in particular the productive group of the population reversing the development gains and economic growth of the country. For instance, in South Africa and Botswana, the epidemic is projected to reduce the economic growth rate from 4 to 0.3% and from 2.6 to 0.5% respectively.

As per the survey results, the economic impact of HIV/AIDS is very high in that children replace the breadwinner of the family and provide inadequate food, income and other needs of the family. Some of the negative impacts of HIV/AIDS on the victim's family as reported by the respondents are inability to pay for food and rent and care givers and children are obliged to be street dwellers. Moreover, the standard of living as a result of deceased members of the family due to AIDS declines indicating negative impact of the pandemic on the economic wellbeing of the society.

As per the survey results 90% of the respondents in the three weredas mentioned that HIV/AIDS has a very big impact on the socio economic and cultural factors of the region's population. For instance, high level of poverty, family suffering, decreased manpower and productivity, social problem and poverty, loss of income, deterioration of the health,

agricultural and educational sectors are the major outcomes of high prevalence of HIV/AIDS. Large percentage of respondents mentioned that social problem and decreased manpower are most likely to affect the development of the community.

4.8.1.1 Impact on the agricultural sector

The HIV/AIDS epidemic causes serious damages to the agriculture sector, particularly in countries where agricultural production is labor intensive. AIDS has a fatal impact on individuals in developing countries i.e.: the death of young and middle-aged adults in their most productive years, thereby severely impairing productivity. For instance, according to the estimates by Food and Agricultural Organization (FAO), in 27 most affected countries in Africa, 7 million agricultural workers died from AIDS between 1985 and 2000, and 16 million more deaths are likely to occur in the following two decades. Agriculture as a dynamic, integrated and interdependent production system relies on close linkages and network of interrelated sub-sectors, institutions and rural households at every level of activity. The efficiency and effectiveness of each sub-sector, institution and household depends, to a large extent, on the capacity of other components of the system such as the labor force. If this capacity is eroded through HIV, then the system's ability to function will be drastically reduced.

The death of a family member because of HIV/AIDS leads to a reduction in saving and investment, depletion of stock of food grain, sell of livestock to provide food for mourners as well as cover up of other expenses. Moreover, a study conducted by the Ethiopian Aid (EA) in June 2005 indicated that the limited availability of land is not adequate for the production of enough crops leading to food insecurity and poverty thereby increasing the vulnerability to HIV/AIDS. Moreover, most

respondents in the three weredas suggested that a decrease in productivity because of HIV/AIDS may have a major effect on occupation and hence on the level of income and on the agricultural sector.

The impact of HIV/AIDS on agriculture is summarized as:

- Absenteeism caused by HIV-related illnesses and the loss of labor from AIDS-related may lead to the reduction of the area of land under cultivation and declining yields resulting in food reduction and food insecurity;
- The loss of labor may also lead to declines in crop variety and to changes in cropping systems, particularly a change from more labor-intensive systems to less labor intensive systems. A shift away from labor-intensive crops may result in a less varied and less nutritious diet, or switching from export crops to food crops;
- The reduction in labor supply through the loss of workers to HIV/AIDS and the time spent by household members in caring for sick relatives at crucial periods of planting and harvesting could significantly reduce the size of the harvest, affecting food production;
- The HIV/AIDS epidemic may also affect the traditional copping mechanisms that are often found in rural areas;
- The cost of HIV/AIDS is largely borne by rural communities. Many HIV-infected urban dwellers return to their village of origin when they fall ill. Rural households (particularly women) provide most of the care for AIDS patients. In addition, food, medical care costs and funeral expenses are primary borne by families;
- It leads to loss of knowledge of traditional farming methods due to the unexpected death of experienced family members before passing their know-how to subsequent generations;

With regard to Ethiopia, the agricultural labor force time fell from 33.6 hours per week in non-afflicted households to between 11 and 16 hours per week in afflicted households, and is expected to have an every greater impact on the sector.

4.8.1.2 Impact on the health Sector

Most developing countries like Ethiopia are faced with serious shortage of health care centers and facilities. The HIV/AIDS pandemic aggravates this situation by increasing the number of health service seekers and the demand for hospitals by AIDS patients. Since the majority of the population in developing countries come from lower class bracket and can not afford to pay for medical services in private hospitals, government health care centers will be crowded by service seekers. This in turn adversely affects the government expenditure on the health sector leading to shortage of hospital beds, medicines, medical equipment and other important supplies.

As per the survey results, about one third of HIV infected people in three weredas do not get medical treatment. This absence of medical treatment leads disintegration and migration of family members, reduction of food, shelter and income and that children are forced to be involved in income generating activities instead of attending school.

Moreover, a number of diseases are caused by the HIV epidemic. About 75% and 10% of the respondents reported that TB and diarrhea are the most commonly associated illnesses with HIV/AIDS respectively. In some hospitals and health care centers in the three weredas, 20% of the beds are occupied by AIDS patients. The survey result also shows that the growing number of AIDS patients in the sampled areas leads to the

occupation of significant number of hospital beds by AIDS patients and short age of medical facilities.

4.8.1.3 Impact on the education sector

HIV/AIDS has indirect impact on the education sector. The death of the breadwinner as a result of HIV/AIDS leads to the withdrawal of children from children because of lack of financial support to buy materials necessary for their school. In addition, children are forced to drop out from school and be engaged in income generating activities to take care of affected members of the family. Death of qualified and competent staff due to AIDS negatively affects the quality of education.

As per the survey results, 40% of the patients lost their spouses as a result of HIV/AIDS and the burden of looking after the patients fall on children. For this reason about 60% of the AIDS patients' children do not attend school and are forced to withdraw from schools. The finding of the FGD and the in-depth interview with the relevant education and health institutions , the number of teachers dying due to AIDS and the number of school drop outs increased substantially as a result of HIV/AIDS.

Moreover, the percentage of respondents who had been orphaned due to AIDS among the three weredas ranges from 38 percent in Hulet Eju Enesie to 56 percent in Gozamin.

4.8.1.4 Social impacts of HIV/AIDS

The social impact of HIV/AIDS involves migration of members of the family to make a living, death of a relative and psychological impact on the society. The epidemic causes loss of productive labor, separation of families, poor education which especially in developing countries, leads to prostitution and catalyzes the rapid spread of the virus. The

relationship between AIDS and poverty has a considerable negative impact on a nation in that AIDS exacerbates poverty while poverty increases vulnerability to HIV/AIDS.

4.8.2 CULTURAL NORMS AND PRACTICE WITHIN RURAL COMMUNITIES

Once the HIV virus is present within a rural community, the following cultural and social practices may contribute to its spread among members of the community.

1. Marriage:

   Various forms exist, such as early marriage (girls as young as 10 to 12 years old); remarriages of divorces and widows. More than 75 % of the respondents in the study area reported having had two or more remarriages.

2. Multiple sex partners:

   The practice of multiple sex partners (extramarital affairs) is in common in urban as well as in rural areas. The survey result shows that about seventy % have unprotected sex in extramarital sex affairs.

3. Marketing related risks (Alcohol consumption):

Certain aspects of agricultural marketing may play a major role in fueling the rural epidemic. Marketing involves much movement of sellers and buyers both into and out of rural areas, on journeys that may be completed within a day or two. Weekly rural markets in East Gojjam are a major social gatherings, drawing people together, to buy and sell consumable commodities. Market days are often occasions for recreation, even if there was no business to conduct, and are acknowledged as an opportunity to meet secret lovers. Drinking on a market days is a common and long established tradition and often leads to casual unprotected sex.

CHAPTER FIVE - SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

5.1 SUMMARY

Based on the findings of the survey and identifying areas where there are weaknesses to mitigate the effects of HIV/AIDS on the community, the following preliminary summarized recommendations are suggested.

- As far as creating awareness among the society is concerned, communication and education strategies should be well designed to include all stakeholders i.e.: governmental and non governmental organizations, health sectors at national and regional levels. There is also a need to review periodically policies and programmes addressing HIV/AIDS in rural areas and its interrelationships between poverty and development and disseminate the findings so as to make a difference in the outcome of development programmes.
- Poverty reduction strategies should incorporate HIV/AIDS related issues. These strategies are effective methods for controlling the spread of HIV/AIDS.
- Government and non-governmental organizations should be responsible for disseminating the appropriate information to the public, and particularly to the youth about the transmission and prevention methods of the virus, with emphasis on abstinence and premarital and unprotected sex.
- The government should give due attention to the urban as well as the rural communities. Rural development programs should be designed in such a way that they incorporate HIV/AIDS related issues. Moreover, since health services in most of these rural areas

are very scantly and ill-equipped both from the point of view of manpower, medical equipment, medicines and other basic facilities, serious intervention methods need to be urgently taken in rural areas.

- Development strategies need to address the threats of socio economic, political and cultural problems caused as a result of AIDS. In other words, the implications of national policies of countries on HIV/AIDS should take into account the challenges resulting from sharp increases of AIDS related deaths. The consequences of HIV/AIDS need to be incorporated into economic strategies and particularly poverty reduction strategies.
- Promote optimal translation of earlier commitments of leaders to resource provision, social mobilization and sustainable programming of poverty alleviation and reduction of the transmission of HIV/AIDS.
- Develop processes and procedures that would ensure a higher degree of political will to be translated into policies and strategies to control the impact of the pandemic based on concrete and valuable plan of operations
- Develop internal and external resource mobilization mechanisms for the prevention, care and treatment of the diseases in question and sustainable allocation of budgetary resources to combat the epidemics
- Mobilise civil societies to redirect national and international policies and programmes to address the compelling and evolving implications of the HIV/AIDS epidemic so that it does not further reverse human and social capital development. To achieve the stated goal, the people and government should take ownership of the responsibility and commit resources to responding to

challenges of HIV/AIDS in the context of human and social capital development. Building on its comparative advantage, and consistent with the overall mandate of generating global frameworks for joint action, institutions in the international community, will provide catalysing resources and guiding tenets for the urgency this epidemic calls for.

- Strengthen macro-level public and private sector capacity to HIV/AIDS in the context of development. This will focus inter alia on National Framework for HIV/AIDS Private sector (profit and not-for-profit) programs, and care for the affected and infected.
- Strengthen the use of social capital (religious groups, civil society organizations, NGOs, parastatals and professional associations) in responding to HIV/AIDS peril. Nothing else will have more impact than massive behavioural change within the population to stop the spread of this epidemic. Specific tools for exploiting the social capital in favor of the program will include, inter alia, participatory training for social capital development, participatory planning and implementation, community monitoring and evaluation through participatory action research and local resource mobilization for prevention, care and mitigation.
- Identify, generate and disseminate best practice on HIV and development, whose foundation will be policy dialogue and research, identification, networking and documentation and dissemination of best practice. This assists in mainstreaming HIV/AIDS programs in Regional States, Weredas and local communities.
- Strengthen the capacity of the national research organizations and international institutions to work towards an intensified and

expanded research program into the virus, the epidemic and its impact on society and polity.

The response to the epidemic must be based on a commitment to ensure that solutions to the challenges of HIV/AIDS and development arise from an enhanced capacity of individuals, families, communities and national institutions to understand the nature of the epidemic in their own contexts. This will ultimately empower us all to take charge of their own well being, building on the strength of local knowledge and values and of an enabling environment at national and international levels, which fosters and supports local initiatives. Ethiopia must learn from other lower income countries, because there is evidence of a trend towards stabilization of the epidemic. This is being attributed to a number of factors. These include:

- Effective and broad-based community responses involving NGOs, CSOs, CBOs, and the entrepreneurial community with the main aim of engaging communities and theirs members as citizens of a political society.
- Political will and engagement which supports a broad political, economic and social governance based response involving a wide spectrum of society and key governmental organizations and ministries
- An effective ethical, legal and human rights framework which addresses fear, stigma, denial, shame, discrimination through various means of networking and developing communities of practice.
- Finally, while effective prevention activities must remain central to a national response, there is now a need - in heavily affected

communities – for policies and programs (actions) which address the impact of the epidemic on individuals and their families (especially the poor). There is a need to address the effects on communities and productive sectors. The scale of the challenge to be addressed has changed in highly affected countries and integrated programs are now essential if the threat to social and economic systems is to be overcome.

- Address and create awareness about HIV/AIDS in adequate scope and depth. These key strategies can be elaborated along several distinct axis or "dimensions" including; the political and policy environment, thematic strategies, geographic strategies and institutional strengthening strategies. Within each arena, the national and regional co-ordination will require stakeholder to undertake the following measures. First, it is to increase their action on and resource allocation to elements of the response to HIV/AIDS, which fall under their respective mission and mandate and in which they hold a competitive and comparative advantage. Secondly, it is to seek, apply and evaluate effective ways to collaborate and co-operate with other partners towards a united response to HIV/AIDS. Finally, it is to uphold the ultimate aim of national, and regional Intensified Action co-ordination, which, in particular in the context of HIV/AIDS is to promote human development, and national, and regional self-reliance for the Intensified Action. These will be achieved through the following outputs and actionable program areas in the short, medium and long term.
- Develop technical capacity for national and regional information management coordination to receive/collect, collate, analyze and

interpret data on HIV/AIDS and formulate prevention and mitigation plans that can be incorporated in the development plan.

- Enhance capacity to respond to socio-economic development crisis and become more responsive and effective to HIV/ by undertaking in-depth analysis of inter-sectoral needs and encouraging government and popular participation in the capacity building.
- Co-ordinating and mobilizing technical resources and improved mechanisms for rapid use by national programmes. These include support for development and implementation of national strategy done by mapping and with emphasis on current pools of dedicated or transferable skills.
- Develop more effective use of existing co-ordination mechanisms and initiatives to serve as a platform for advocacy and improved co-ordination. These include mechanisms and identification of cross-border issues, which require sub-regional perspectives, and the development of mechanisms for addressing them.
- Strengthen and develop coordination mechanisms between regional organisations and resources and propose mechanisms for making resources rapidly available to national programmes and identify mechanisms for addressing other areas where sub-regional action adds value to national programmes.
- Devise a drug policy for HIV/AIDS and a resource management and commitment.
- There must be willingness by regional organizations and other external agencies to act flexibly and to complement one another based on comparative and competitive advantage, and maximum reliance on existing organizational entities without the creation of additional bureaucratic structures. At national and regional level

the aim of the national HIV/AIDS policy should be to ensure maximum impact at country level through support for national programs. The co-ordination mechanism at international level will be to support country and sub-regional initiatives and to take forward international actions that will further enable effective local responses.

- Enable environment for multi sectoral and democratic action and resource mobilization and strengthen the status of women in order to reduce their vulnerability to HIV/AIDS.

- Protection of vulnerable populations: to protect the rights of vulnerable populations, including children affected by HIV/AIDS. A supportive political and policy environment is critical to the development of an effective national, response. This includes (1) promoting self-reliance to cope with the epidemic. (2) Increasing the realization of the magnitude of the HIV/AIDS in communities while simultaneously working to reducing the stigma associated with HIV/AIDS. (3) Directly addressing vulnerability to HIV/AIDS through short and medium term social and economic reforms, and (4) Strengthen those sectors most relevant to responses to the HIV/AIDS.
- Strengthen the capacities of institutions and local levels to lead and coordinate HIV/AIDS to mobilize partners within civil society, and to execute their responsibilities to ensure the care of the poorest and other highly vulnerable groups Advocacy and information sharing and networking
- Support organizational development of national NGOs
- Status of women: to strengthen the status of women in order to reduce their vulnerability to HIV/AIDS, TB and STDs.
- Ensure greater involvement of people in the Intensified Action

- Local empowerment: to empower NGOs to participate actively in designing and implementing parts of the national, sub-regional and regional Intensified Action
- Supporting major key stakeholders in civil society to strengthen their leadership, technical and programming capacities in the Intensified Action co-ordination
- Strengthening advocacy and program efforts within the international, sub-regional and regional partners focused on HIV/AIDS, TB and STDs seeking a strategic mix of functional approaches
- Promote resource mobilization, policy dialogue, technical collaboration, and national and international political mobilization, external resources: to harness external resources better and to increase the efficiency of planning for and implementation of externally financed HIV/AIDS, TB and STDs activities.
- Encourage highest-level government commitment to confront HIV/AIDS, which demonstrates commitment in order to mobilize for action and to see this commitment reflected in increased allocation of resources.
- Raise awareness of the status of the HIV/AIDS and its current and potential socio-economic impact and insert crisis considerations more fully and prominently into the development agenda
- Working with national authorities and civil societies to reduce the impact of HIV/AIDS and interrupting the cycle of HIV/AIDS
- Reaching out to and involving highly vulnerable populations in targeted programs and cross-cutting issues of gender, human rights and participation.
- Impact mitigation: to support policies and programs that reduce the negative socioeconomic impact of HIV/AIDS on production

systems, public services, and households including allocation of adequate farm land.

The aims and activities is to support these elements of success on a large scale, so that successful responses to HIV/AIDS can be multiplied rapidly across the nation. This will create a policy and social environment conducive to successful action by developing strong commitment to confronting HIV/AIDS at the highest levels of government which includes raising awareness of the status of the epidemics and its devastating impacts, empowering communities, NGOs, local governments and the private sector and inserting the epidemics' considerations more fully into the national programms. It is also protecting the rights of vulnerable populations through organising and implementing a multi sectoral response and developing policies and plans that mitigate the impact of the epidemics on key national, sub-regional and regional sectors, institutions and services.

5.2 RECOMMENDATIONS - POSSIBLE ACTION PLAN TO MITIGATE HIV/AIDS

In order to prevent the negative impact of HIV/AIDS on the community, mechanisms tested and proved in certain circumstance are recommended for managing and coordinating programmes. In the following, a framework structure is presented for the recommendations where the matrix represents the role of stakeholders such as government, donors and NGOs and CSOs in the prevention of HIV/AIDS. The response to the epidemic must be based on a commitment to ensure that solutions to the challenges of HIV/AIDS and development arise from an enhanced capacity of individuals, families, communities and national institutions to understand the nature of the epidemic in their own contexts. This will ultimately empower us all to take charge of their own well being, building on the strength of local knowledge and values and of an enabling environment at national and international levels, which fosters and supports local initiatives. Ethiopia must learn from other lower income countries, because there is evidence of a trend towards stabilization of the epidemic. This is being attributed to a number of factors. These include:

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- An effective ethical, legal and human rights framework which addresses fear, stigma, denial, shame, discrimination through various means of networking and developing communities of practice.
- Finally, while effective prevention activities must remain central to a national response, there is now a need - in heavily affected communities – for policies and programs (actions) which address the impact of the epidemic on individuals and their families (especially the poor). There is a need to address the effects on communities and productive sectors. The scale of the challenge to be addressed has changed in highly affected countries and integrated programs are now essential if the threat to social and economic systems is to be overcome.
- Address and create awareness about HIV/AIDS in adequate scope and depth. These key strategies can be elaborated along several distinct axis or "dimensions" including; the political and policy environment, thematic strategies, geographic strategies and institutional strengthening strategies. Within each arena, the national and regional co-ordination will require stakeholder to undertake the following measures. First, it is to increase their action on and resource allocation to elements of the response to HIV/AIDS, which fall under their respective mission and mandate and in which they hold a competitive and comparative advantage. Secondly, it is to seek, apply and evaluate effective ways to collaborate and co-operate with other partners towards a united response to HIV/AIDS. Finally, it is to uphold the ultimate aim of national, and regional Intensified Action co-ordination, which, in particular in the context of HIV/AIDS is to promote human development, and national, and regional self-reliance for the

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- Develop more effective use of existing co-ordination mechanisms and initiatives to serve as a platform for advocacy and improved co-ordination. These include mechanisms and identification of cross-border issues, which require sub-regional perspectives, and the development of mechanisms for addressing them.
- Strengthen and develop coordination mechanisms between regional organisations and resources and propose mechanisms for making resources rapidly available to national programmes and identify mechanisms for addressing other areas where sub-regional action adds value to national programmes.
- Devise a drug policy for HIV/AIDS and a resource management and commitment.

- There must be willingness by regional organizations and other external agencies to act flexibly and to complement one another based on comparative and competitive advantage, and maximum reliance on existing organizational entities without the creation of additional bureaucratic structures. At national and regional level the aim of the national HIV/AIDS policy should be to ensure maximum impact at country level through support for national programs. The co-ordination mechanism at international level will be to support country and sub-regional initiatives and to take forward international actions that will further enable effective local responses.
- Enable environment for multi sectoral and democratic action and resource mobilization and strengthen the status of women in order to reduce their vulnerability to HIV/AIDS.

- Protection of vulnerable populations: to protect the rights of vulnerable populations, including children affected by HIV/AIDS. A supportive political and policy environment is critical to the development of an effective national, response. This includes (1) promoting self-reliance to cope with the epidemic. (2) Increasing the realization of the magnitude of the HIV/AIDS in communities while simultaneously working to reducing the stigma associated with HIV/AIDS. (3) Directly addressing vulnerability to HIV/AIDS through short and medium term social and economic reforms, and (4) Strengthen those sectors most relevant to responses to the HIV/AIDS.
- Strengthen the capacities of institutions and local levels to lead and coordinate HIV/AIDS to mobilize partners within civil society, and to execute their responsibilities to ensure the care of the poorest and other highly vulnerable groups Advocacy and information sharing and networking

- Support organizational development of national NGOs
- Status of women: to strengthen the status of women in order to reduce their vulnerability to HIV/AIDS, TB and STDs.
- Ensure greater involvement of people in the Intensified Action
- Local empowerment: to empower NGOs to participate actively in designing and implementing parts of the national, sub-regional and regional Intensified Action
- Supporting major key stakeholders in civil society to strengthen their leadership, technical and programming capacities in the Intensified Action co-ordination
- Strengthening advocacy and program efforts within the international, sub-regional and regional partners focused on HIV/AIDS, TB and STDs seeking a strategic mix of functional approaches
- Promote resource mobilization, policy dialogue, technical collaboration, and national and international political mobilization, external resources: to harness external resources better and to increase the efficiency of planning for and implementation of externally financed HIV/AIDS, TB and STDs activities.
- Encourage highest-level government commitment to confront HIV/AIDS, which demonstrates commitment in order to mobilize for action and to see this commitment reflected in increased allocation of resources.
- Raise awareness of the status of the HIV/AIDS and its current and potential socio-economic impact and insert crisis considerations more fully and prominently into the development agenda
- Working with national authorities and civil societies to reduce the impact of HIV/AIDS and interrupting the cycle of HIV/AIDS

- Reaching out to and involving highly vulnerable populations in targeted programs and cross-cutting issues of gender, human rights and participation.
- Impact mitigation: to support policies and programs that reduce the negative socioeconomic impact of HIV/AIDS on production systems, public services, and households including allocation of adequate farm land.

The aims and activities is to support these elements of success on a large scale, so that successful responses to HIV/AIDS can be multiplied rapidly across the nation. This will create a policy and social environment conducive to successful action by developing strong commitment to confronting HIV/AIDS at the highest levels of government which includes raising awareness of the status of the epidemics and its devastating impacts, empowering communities, NGOs, local governments and the private sector and inserting the epidemics' considerations more fully into the national programms. It is also protecting the rights of vulnerable populations through organising and implementing a multi sectoral response and developing policies and plans that mitigate the impact of the epidemics on key national, sub-regional and regional sectors, institutions and services.

5.3 CONCLUDING RECOMMENDATION SPECIFIC FOR THE STUDY DREA

The serious negative impacts of HIV/AIDS in the three Woredas are clearly demonstrated. So far the impacts on the rural areas have been given little attention but the findings of this study are more than enough to prompt all concerned to focus on this destructive pandemic. The time has passed when HIV/AIDS used to be considered to be only a health problem, but it has now become evident that there is no sphere of human activity that is not affected by it. The conclusion given below are therefore made with a multidisciplinary approach;

- In spite of the AIDS pandemic the Ethiopian population has been growing at a rate of 2.7 % per year as a result of which the share of farming land per person has been diminishing daily. The young adults, who are the majority of the work force are neither employed nor can produce adequate crops for their livelihood because of shortage of farming land. The government has therefore to:
    - Adopt appropriate population and land policies in order to curb population explosion and provide the farmers with adequate farmland.
    - Establish nodal towns to settle the majority of the unemployed youth in agriculture and also create industrial or commercial enterprises thereby shifting the population from the century old subsistence agricultural practices to modern and/or small scale industrial production. This would reduce the shortage of farming land and the active and productive labour force will be fully occupied in production rather than spending their time in consuming local alcoholic beverages and be engaged in unsafe sexual practices thereby further spreading the deadly virus.

SUMMARY

Resettlement of farmers in less densely populated fertile parts of the country has been going on for sometime but more needs to be done in this regard. People must be convinced and in-couraged to voluntarily move to these areas. This being in the best interest of the people the use of forced resettlement may even be considered as an option.

Poverty reduction strategies are other important measures that need to be taken seriously and given priority. There is no doubt that poverty reduction strategies are effective methods for controlling the spread of HIV/AIDS because HIV/AIDS flourishes in an impoverished environment.

Findings of this survey have shown that the people are reluctant to take voluntary counseling and testing for HIV/AIDS. The awareness creation programmes on VCT should therefore be conducted in a more aggressive manner. Free testing and counseling centers should be made available at accessible locations both in the rural and urban areas.

The provision of appropriate information is the right of the citizen, and the government as well as NGOs and all other stakeholders should see to it that the public, and particularly the youth should be provided with appropriate information about the transmission and prevention methods of the virus, with an emphases on abstinence and premarital and unprotected sex. Traditional early marriage practices should be discouraged and the existing legislation should be strictly.

The youth is a very adventurous group of people and may not take pieces of advice seriously and free or easy access of condoms should be the best alternative for this stubborn group. Social marketing schemes at market centers in the best venue to reach-out the population.

SUMMARY

As mentioned earlier, rural communities, so far have not been given due attention with regard to the prevention and central of HIV/AIDS mainly because it is believed that only people in urban areas are exposed to the virus. Results of this study have shown it to be otherwise. Serious intervention methods need to be urgently taken in these rural areas where the pandemic can cause more serious consequences than in urban areas because health services in most of these rural areas are very scantly and ill-equipped both from the point of view of manpower, medical equipment, medicines and other basic facilities. Mobile clinics should be seriously considered for proper mitigation of the problem in the rural areas.

More over misconceptions were wide spread in rural areas. Some people believes that AIDS attacks only those who are cursed by God because they refused to obey His rule. The media, the clergy, government authorities should address misconceptions to enhance behavioural change.

Awareness creation programmes have been going on regularly, particularly in urban areas. Unfortunately, the results scored have much to be desired. Findings of this study have shown that although the people know most of the facts about the dangers of HIV/AIDS, there has been very little behavioural change. People shill practice extramarital sex, they stile frequently visit commercial sex workers.

These awareness creation programmes should not be limited to public meetings or distribution of IEC materials but should be supplemented by monitoring and evaluation activities to record improvements in behavioural change or the lack of it.

SUMMARY

What is awareness if action is not taken? As the survey indicated almost over 97% are aware of the HIV/AIDS disease and all evils associated with it like stigma, displacement, unemployment etc. Real action to control the situation must be in place and the availability and access to advice, medicine and support has to be coordinated. A one stop shopping system approach must be introduced. The people are clearly saying **"what we hear is not enough. Come help us**".

The results of the study have shown that people, who by the nature of their work are obliged to stay from home for an extended period of time are highly vulnerable to the virus. Such people need to be advised to reduce unnecessary staying away from home to the very minimum.

Another important intervention method for improving the lives of PLWHA is the provision of antiretroviral drugs, which have shown their effectiveness in reducing morbidity and mortality and also in helping the patients to have a reasonably good health condition and conduct better livelihoods.

Even a more fundamental and lasting strategy is a strong political commitment by the government. Uganda is cited as the champion in reversing the devastating effects of the HIV/AIDS pandemic. The main reason for the success of Uganda has been proven to be strong and serious political commitment on the part of the government. The example of Uganda mast be adopted by all countries affected by HIV/AIDS.

One of the worst consequences of the pandemic is the creation of a large number of children with out parents and with neither help nor hope. The problem is more felt in developing countries where the large majority of the communities are impoverished themselves that for them to come to

the rescue of the orphans is unthinkable. The government and NGOs should, therefore, make efforts to set up orphanages in different highly effected parts of the country to care for and support the ever-increasing number of orphans. Micro Credit facilities should be encouraged to create access to borrowing and the creation of sustainable income for people affected by HIV/AIDS. Failure to do that would result in producing impoverished and uneducated citizens who would be burdens to the already destitute communities, with no sustainable healthy livelihood in sight.

The contribution of school teachers to the production of skilled manpower for development programs is self evident. Training professional teachers requires very long process. The loss of one teacher to AIDS means a loss a professional who cannot be replaced easily or quickly, particularly in rural areas. Efforts should, therefore, be made to enable them lead decent and responsible lives by providing them with salaries that may match their sacrificial services. Such incentives, in addition to improving their income, may include assisting them to own their own houses, free education and medication for themselves and their family members.

The negative impacts experienced by PLWHA are not limited to material social and economic hardships. The effects of discrimination and stigma leave unforgettable scars in the lives of the victims. The other dangerous of stigma is very alarming. When HIV carriers are excluded from society they will find ways to retaliate by spreading the disease as revenge. The government and NGOs may promote antidiscrimination and anti-stigmatization attitudes. Results of the study have clearly shown that although the people believe that discrimination and stigmatization are wrong, unfair and unethical, they are still reluctant to put them in

practice. Popular beliefs and tradition have their strong share in this. The introduction of appropriate legislation by the government alone cannot be enough. The proper implementation of the legislation should be carefully and methodically monitored to see whether any changes in attitude have been produced.

The government should see to it that the people strictly adhere to the laws and law breakers should be dealt with and severely penalized to ensure compliance

Annex

IMPACT OF HIV/AIDS IN THE WELL-BEING OF THE RURAL POPULATION IN SELECTED WOREDAS (DISTRICTS) IN EAST GOJJAM, AMHARA, ETHIOPIA.

(HULETIJU ENESSIE; GOZAMIN; SHEBEL BERENTA)

PhD Thesis Outline

Development Studies

St Clements U. British West Indies

By Yeshiwas Bekele/ ETHIOPIA

1.0 BACKGROUND OF THE STUDY, WHY CONDUCT SUCH A STUDY, METHODOLOGY AND APPROACHES

The researcher of this dissertation has his roots and background in the deep rural structure of Gojjam as a whole. I was born from parents of modest stature. Apparently my father is from DAMOT and Agew descent in the North-West part of Gojjam. My mother is both from Dega Damot and in her father's side she rightly claims to have her roots in all East Gojjam, Enessie, Bichena, Enemay, Gozamin, etc. This apparently makes me a full Gojjame. In addition, during my up-bringing I have enjoyed the life of the beautiful rural Gojjam everywhere where my family moved from one place to another as our father, Dejazmach Bekele Kasa, was serving as Governor in most parts of Gojjam.

The wisdom of family life, a large family sometimes involving 100 or more members is a social school of education, which later influenced my life. For a brief period I joined my grandfather (from my mother's side) Dejazmach Almaw Worqneh and also had a chance to experience an Ethiopian Urban life in Addis. I stress here that I mentioned Ethiopian

urban life, because even the urban centers in the country could not categorically be classified as urban. Urban centers are, to date, nodal settlements in Ethiopia. Later we moved to Sidamo, south Ethiopia, where my grand father served as governor and had the chance to acquaint my self with the beautiful Sidama people and their glorious culture.

Until I completed Elementary School, in Finoteselam, Gojjam, the only student to pass the national exam out of 33, to join the few high schools in Addis, I have enjoyed living in rural Gojjam. The rural Gojjam then was so fertile, social agendas were dealt by traditional means; life was more or less beautiful. The environment was so protected, rivers, lakes, forests were heavens for the inhabitants then.

After completing my education in Regional Planning in Germany, and Construction Management in the USA, I luckily started working for the Integrated Rural Development Project (CADU) in Arsi another naturally rich province in southern Ethiopia where my adult encounter with the beautiful and innocent peasant population left a mark on my life which influenced my commitment to work in development.

Immediately after the peoples revolution started in 1974 (This was high-jacked by non commissioned hooligan military Juntas) I was appointed to be governor of Bahir Dar Province, where I contributed both to the city's modern development efforts and the well-being of the rural population at large. Then I was appointed as Chief Executive and later as 1st Deputy Mayor of Addis Ababa. Prior to being appointed as Governor of Bahir Dar, I worked in the Municipalities Head Office, Ministry of Interior, then directly responsible for over 200 municipalities in the country. Here I really had the opportunity to get an in-depth knowledge in the working mechanism of the urban structure of the country. As

explained above I could claim to have urban/ rural direct experience, which is a unique opportunity to be involved in programmes affecting the inhabitants at decision-making levels.

I had also tested the ups and downs in life. In 1984 I was abducted by over 20 murder squad members of the then communist Junta and spent time in prison, initially at the Bermuda prison. After I was transferred to the main prison I was elected to advice in technical and development issues. Hear I started raising funds for constructing wards for women prisoners with babies, assembly halls and even a stadium. During prison time I considered my captivity as an act of hooligan gang act and never gave up on life. Imagine thousands were just perishing and killed in cold blooded murder by the state which was supposed to protect them!

My commitment to work in development was actually strengthened then. Immediately after the fall of the communist Junta in 1991 I was reinstated and served as 1st Deputy Mayor for Addis Ababa, the capital city. When appointments were done on ethnical proportions I was not discouraged and immediately got involved in Non Governmental development activities. Since 1995, I am heading the Ethiopian Aid, now a leading indigenous NGO and 'WASS' Development Enterprise, a development and consulting firm in good standing. Imagine, I have the green card to live and work in the US but still my choice is to be with my people.

It is because of my involvement with Ethiopian Aid that I started development projects in areas where my ROOTS started, and had the chance to revisit the rural part of Gojjam after 20yrs. During the last 20-30yrs the environment has been totally deteriorated, food production has decreased and even what is produced required much efforts and labor involving expenses beyond the capacity of the farmers, population has

alarmingly increased, as a result, the living condition of the peasant population has totally collapsed. In addition, the malaria epidemic has even changed its character and now attack everywhere including the highlands. This coupled with the HIV/AIDS endemic has totally made life in the rural parts unbearable and some even wonder why **God** created them to face such situations.

Ethiopian Aid, supported by Government policy, is trying to help the people by implementing integrated development endeavors. While implementing such projects and guided by a detailed baseline survey indicators growth or improvement could not vividly and positively be registered. The main reason being the population pressure which diminishes the farm land size for each family and the HIV/AIDS endemic which affects the direct living conditions of everybody.

All these factors have again motivated me to continue my commitment, to work in development for my fellow citizens in Gojjam, to conduct this research in the hope that the finding may help to mitigate the root causes of all evils associated with poverty and especially the HIV/AIDS epidemic and its effects in the **well-being** of the rural population.

SURVEY AREA

The research focuses in three Woredas (Districts) namely:

		M	F	Total
Huleteju Enessie	Representing the Highland (Dega) >2400m.a.s.l.	127,213	12,657	251,123
Gozamin	Representing the Mid land (Woina Dega) 1500-2400m.a.s.l.	119,366	120,506	239,869
Shebel Berenta	Representing the low land (Kola) <1500m.a.s.l.	47,137	40,568	96,705
	Total Population			**587,697**

Huleteju Enessie (High land); Gozamin (Middle land) and Shebel Berenta (Low land). From our previous other studies these three Woredas (Districts) could easily represent the region as a whole.

METHODOLOGY AND APPROACHES TO THE RESEARCH

The following chapters, sections and annexes will be incorporated.

The research was started in late 2003 and so far it is outlined after the preliminary research but to be yet enriched with additional research.

Annex

INTRODUCTION

The introduction will discuss HIV/AIDS at a Global, Regional, and Country and in particular to the case in Ethiopia and the study focus region of the study.

HIV/AIDS EFFECTS AND SITUATIONS

- GLOBAL OUTLOOK
- AIDS IN AFRICA
- COUNTRY FOCUS
  - KENYA
  - BURUNDI
  - ETHIOPIA
- HIV/AIDS IN SUB-SAHARAN AFRICA

- HIV/AIDS IN ETHIOPIA
  - GENERAL
  - POLICY - HIV/AIDS
  - POPULATION POLICY
  - HEALTH POLICY
  - PHS RESULTS, ETC.
- IMPACT OF HIV/AIDS ON THE FAMILY AND ECONOMY - ETHIOPIA
  - HEALTH
  - TRANSPORT
  - EDUCATION
  - INFRASTRUCTURE SERVICE
  - IMPACT ON AGRICULTURE
  - EFFORTS SO FAR AND THE RESULT GAINED (POSITIVE/ NEGATIVE)

Annex

PROBLEM STATEMENT

The people are faced with choices of life and death! Without major actions, renewed commitment and global efforts the situation may treat the existence of the productive population. But we are researching to recommend an alternative action which is people centered based an innovative approaches.

4.1 The objectives:

- Assess the demographic variables of the adults
- Assess Reproductive Health and Family Planning practices
- Correlate the impact of HIV on RH/FP practices
- Determine the **impact** of HIV on the Socio Economic and life style practices
- Correlate the impact of HIV with the demographic data
- Determine quantitative/ qualitative facts on the Impact of HIV on the well-being of the rural population.
- Assess Farm-land size, production etc to PLWHA and to those not affected.

RESEARCH (SURVEY) METHODOLOGY

RESEARCH DESIGN

The research design that is expected to be followed will be the **Cross-Sectional Descriptive Research Design.**

SAMPLING METHOD

Stratified random sampling - This is selected as the population is not homogenous. Sample size will be 60%.

SETTING FOR THE STUDY

The three selected Woredas as mentioned above will be the base for the study (research).

DATA COLLECTION

Trained personnel will be deployed using questionnaire for both Men and Women in Reproductive Age Group. Prior to the main study a pilot study will be conducted to test the validity and reliability of the tool. Focus Group Discussion (FGD) will be held for QUALITATIVE ANALYSIS.

DATA ANALYSIS

The data will be analyzed by both qualitative and quantitative method using **inferential** of differential statistics using latest technology. Data entry using IMPS, (Integrated Micro Computer Processing System) SPSS (Statistical Package for the Social Sciences) for data analysis.

DATA INTERPRETATION

The data after analysis shall be discussed and interpreted with illustration through tables, diagrams, charts and graphs as deemed relevant. Precision of survey results Random Sampling – margin of error and the confidence level between 2-5 %.

RECOMMENDATIONS

After the completion of the main study, useful and practical recommendation shall be made based upon the findings. This will be

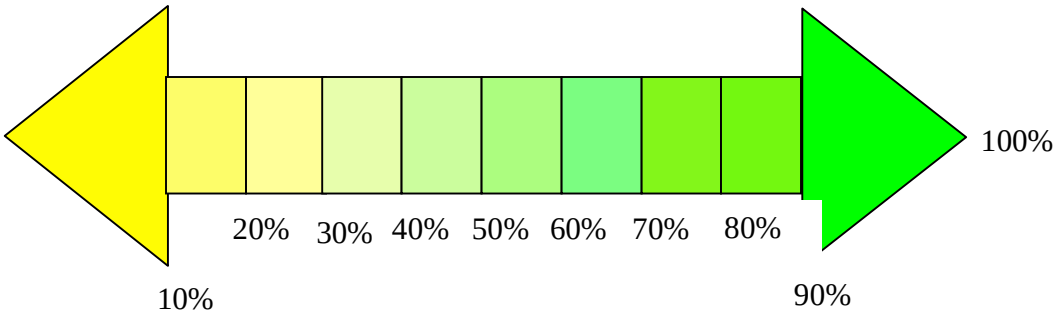
communicated to the Regional, National, Global bodies which may require facts for **Action** to solve the problems.

N.B. The research is totally designed following the guidebook - REAL WORLD RESEARCH - 2ND EDITION - 2002 - BLACKWELL PUBLISHERS.

2.0 GUIDE TO THE QUESTIONNAIRE

This questionnaire is not to be handed to the subject, but to be conducted as an interview tool by the data collector. Conduct the interview by utilizing this questionnaire to the rural population with regards in determining the impact of HIV on the rural population. Collect the data as applicable sequentially FROM SECTION I TO SECTION III.

In the socio Economic Data of question number 6 “Is the product from your farm enough for your consumption”, the interviewer is requested to use the below diagram to interpret the percentage of the crop production by the farmer and also can be utilized for question numbers 6,10,13.



Using the systematic random sampling, from each Woredas the n~~th~~ Kebele is selected and in population the n^{th} person is selected. From each Kebele 1-2% OF THE POPULATION IS TAKEN AS THE REPRESENTATIVE SAMPLE SIZE.

Total Number of Kebele 5

Use the population formula for selection of Kebele:

1) Gozamin 42/5=8 (Every eighth (8th) Kebele + Every Kebele select 8th house.)
2) Shebel Berenta= 18/5 = 3 (Every third (3) Kebele + Every Kebele select 3rd house)

3) Hulet Eju Enessie = 47/5 = 9 (Every 9th Kebele in every Kebele select 9th house)
4) List of households in each Kebele

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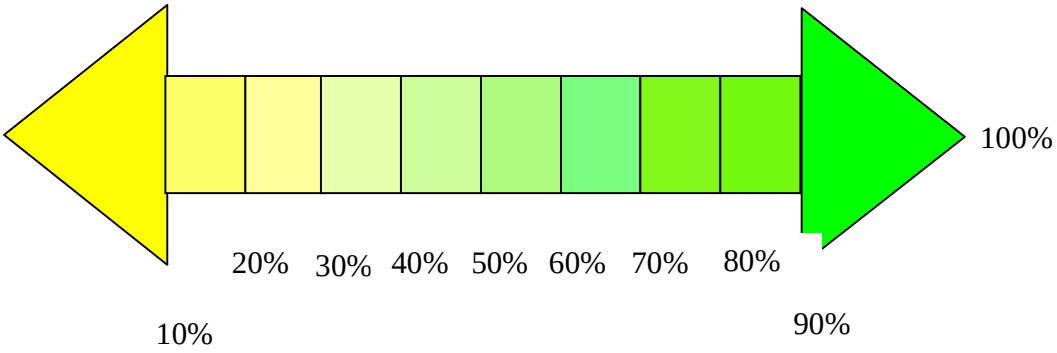

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Annex

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Annex

DEVELOPMENT STUDIES ¾Y'-MTƒ Ø"ƒ

3.0 QUESTIONAIRE ON THE IMPACT OF HIV/AIDS ON THE WELL-BEING OF THE RURAL POPULATION IN GOJJAM –

(Huleteju Enessie; Gozamin; Shebel Berenta)

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3.1 SECTION I-DEMOGRAPHIC DATA ¾e'-l´w G<'@

1. **Name:**
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2. **Date of Birth/Age**:
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3. **Sex:**
   ï _____

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4. **Religion**
   a) Orthodox ☐
   b) Protestant ☐
   c) Muslim ☐
   d) Others…….(Specify) ☐

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   G. *`„Ê¡e ☐
   K. –a,e"ƒ ☐
   N. S<eK=U ☐
   S. K?L----------(ÃÓKì<)

5. **Address:**
   ›É^h: _____

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6. **Educational Status**
   a) Degree Holder. ☐
   b) Diploma Holder ☐

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c) High School ☐

d) Primary ☐

e) No education ☐

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7. Occupation

1) Farmer ☐

2) Student ☐

3) No particular job ☐

4) Others……..Specify ☐

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8. Ethnic Group

a) Amhara b) Oromo

a) Guraghe d) Tigre

e) Argoba f) Others……..(specify)

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9. Marital Status

a) Currently Married
b) Widowed
c) Divorced
d) Separated
e) Living with but not married
f) Never Married

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10. Number of Marriages till date

a) One ☐
b) Two ☐
c) More than two ☐

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K. G<Kƒ Ñ>²? ☐
N. ŸG<Kƒ Ñ>²? uLÃ ☐

11. How many children do you have

a) 1 ☐
b) 2 ☐
c) 3 ☐
d) More than 3 ☐

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G. 1 ☐
K. 2 ☐
N. 3 ☐

S. Ÿ 3 uLÃ ☐

12. At what age did you first have sex?

a) < 15 yrs ☐

b) 15-18 yrs ☐

c) 18-21 yrs ☐

d) 21-24 yrs ☐

e) >25 yrs. ☐

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a. <15 ›Sƒ ☐

K. 15-18 ›Sƒ ☐

N. 18-21 ›Sƒ ☐

S. 21-24 ›Sƒ ☐

W. >25 ›Sƒ ☐

13. Who did you have sex with first

a) Person whom he/she was going to marry ☐

b) Others…..(specify) ☐

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3.2 SECTION II SOCIO ECONOMIC DATA TIu^©" ›=¢•TÁ© S[Í

1. Are you

a) Self employed ☐
b) Salaried ☐
c) A daily wage earner ☐
d) Student ☐
e) Unemployed ☐
f) Others..(specify) ☐

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[. K?L ---------- ÃÓKì<

b) Do you own any animals; Yes. ☐ No. ☐
¾ÓM- ¾J'< ”edƒ ›K-ƒ; G. ›- K. ›Ã ☐ ☐

---

c) What animals and How many.

1.	Oxen	☐	g. Calves	☐
2.	Bulls	☐	h. Camels	☐
3.	Cows	☐	i. Sheep	☐
4.	Horses	☐	j Goat	☐
5.	Donkeys'	☐	k. Others Specify	☐
6.	Chicken	☐		

U" ›Ã'ƒ ”edƒ ›K-ƒ ulØ` e"ƒ;

h. u_ K. ¨Ãð"
N. LU S. ð[e
W. ›IÁ [. Êa
g. ØÍ k. ÓSM
u. uÓ }. õ¾M
†. K?L----------ÃÓKì<

d) Do you own a Land for agriculture? Yes. ☐ No. ☐

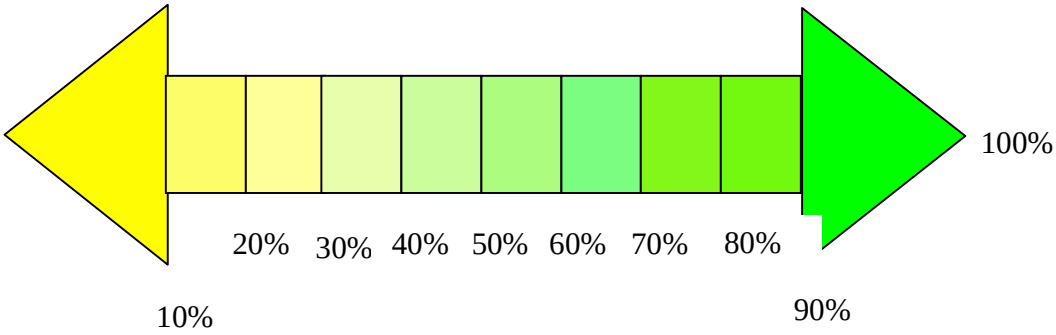
¾Ö`h S_ƒ vKu?ƒ'-ƒ; G.›- K. ›Ã

e) How much land do you have …….(specify)

U" ÁIM S_ƒ ›K-ƒ; SÖ'<" ÃÓKi<

f) Is the land enough for cultivation? Yes. No.

ÁK-ƒ S_ƒ KÖ`h um "¨<; ›- ›Ã



g) Do you cultivate for home use only? Yes. No.

Ku?ƒ ¨<eØ õÐÖ w‰ ¾T>un U`ƒ "¨< ¾T>ÁS`~ƒ; ›- ›Ã

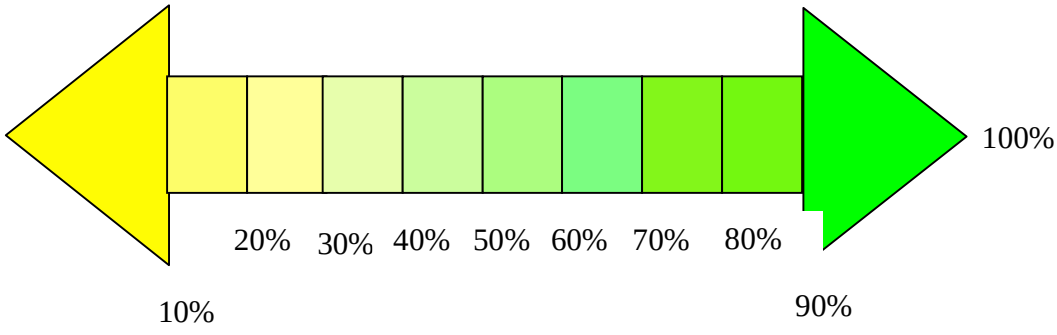
h) Do you cultivate any cash crops Yes. No.

¾cwM U`„‹ ÁS`ÖK<; ›- ›Ã

i) Is the product from your farm enough for your consumption Yes. No.

ŸS_ƒ-ŸT>ÁÑ–<ƒ ¾U`ƒ SÖ" Ku?}cw- õÐÖ um "¨< wK¨< ÃÑUÖK<;

G.›- K. ›Ã



j) Is it enough for both consumption and sale? Yes. ☐ No. ☐

U`ƒ- Ÿu?}cw- õÐ u}ÚT] KiÁßU ÃunM wK¨< ÁevK<;

›- ☐ ›Ã ☐

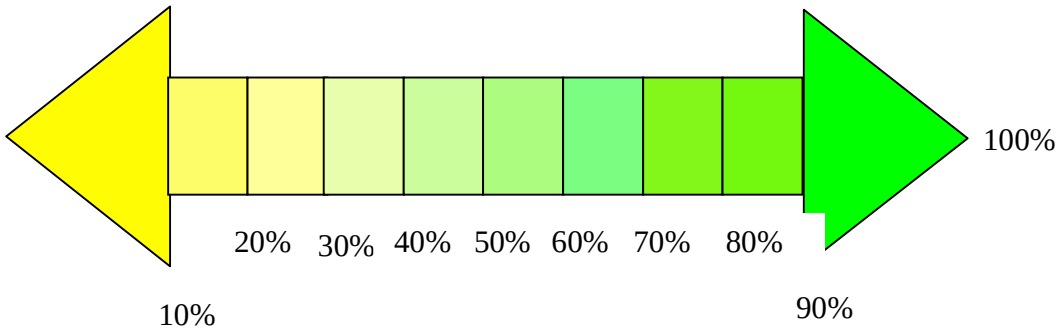
---

k) Have you faced any food shortage? Yes. ☐ No. ☐

¾UÓw ØÛ[ƒ ›ÒØV-ƒ Á¨<nM; ›- ›Ã ☐ ☐

l) How much estimate of food shortage did you face? ……(specify)

U" ÁIM ¾UÓw ØÛ[ƒ ›Kw-ƒ;



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m) Did you face food shortage due to

a. Drought Yes ☐ No ☐
b. Inadequate production Yes ☐ No ☐
c. Insufficient labour due to HiV/AIDS Yes ☐ No ☐

¾UÓw ØÛ[ƒ ¾ÑÖS-ƒ uU" U¡"Áƒ '"<;

a. É`p ›- ›Ã ☐ ☐
K. um U`ƒ vKTÓ–ƒ ›- ›Ã ☐ ☐
N. um ¾c¨< Ñ<Muƒ u›?‹ ›Ã y=/›?Ée U¡"Áƒ vKS•\
›- ☐ ›Ã ☐

---

n) How much do you harvest at one time?……(specify)

u›"É Ñ>²? U" ÁIM ÁS`K< ; ----------ÃÓKì<

---

o) How much do you earn per day / week / month. ……..(Specify)

uk" /udU"ƒ/ u¨` U" ÁIM Ñu= ÁÑ—K<; ----------ÃÓKì<

---

p) What is your total income per month?

a. Less than Br.250
b. Br.250-500
c. Br.500-750
d. Br.750-1000
e. Above 1000

u¨` ¾T>ÁÑ–<ƒ ¾Ñu= SÖ" U" ÁIM ¨<;

a. Ÿ 25® w` Á"dM
K. Ÿ 25® - 5®® w`
N. Ÿ5®® - 75® w`
S. Ÿ 75® -1®®® w`
W. Ÿ1®® w` uLÃ

---

q) Are you in good health? Yes.☐ No. ☐

uØ\ ¾Ö?"ƒ G<'@ LÃ ¨< ÁK<ƒ; G. ›- K. ›Ã ☐ ☐

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r) If "NO" What illness do you have

a) Malaria ☐
b) HIV/AIDS ☐
c) General Weakness ☐
d) Flu ☐
e) Others ☐

SMe- #›Ã$ ŸJ' U" ›Ã'ƒ ui ¨< ÁKw-ƒ;

a. ¨v
K. ›?‹ ›Ã y= /›?Ée
N. É"U ÃcT-M
S. Ñ<"ó"
W. K?L----------(ÃÓKì<)

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3.3 SECTION III- HIV RELATED QUESTIONS

¡õM 3 Ÿ›?‹ ›Ã y=/›?Ée Ò` ¾}ÁÁ²< ØÁo-‹

S/NO lØ`	QUESTIONS ØÁo	Yes ›-	No ›ÃÅKU	N.A SMe ¾KU
1	Have you ever heard of HIV/AIDS eK ›?‹ ›Ã y= /›?Ée cU}¨< Á¨<nK<;			
2	From where did you hear of HIV/AIDS eK ›?‹ ›Ã y= /›?Ée Ÿ¾ƒ cS<;			
3	Do you know what is HIV/AIDS ›?‹ ›Ã y= /›?Ée U” □”ÅJ’ Á¨<nK<;			
4.	Do you know the cause of HIV/AIDS u›?‹ ›Ã y= /›?Ée KSÁ´ ¾T>ÁÒMÖ< ’Ña‹” Á¨<nK<;			
5	What is the causes of HIV/AIDS a) Man b) Virus / Germ/micro-organism c) Don’t know ¾›?‹ ›Ã y= /›?Ée U¡”Á„‹ U”É” “†¨<; G. c¨< K. zÃ[e /Ë`U N. ›L¨<pU			
6	Do you know how HIV/AIDS is transmitted ›?‹ ›Ãy= /›?Ée □”Èƒ □”ÅT>}LKõ Á¨<nKK<;			

S/NO lØ`	QUESTIONS ØÁo	Yes ›-	No ›ÃÅKU	N.A SMe ¾KU
7	Mention some ways that HIV/AIDS can be transmitted **(DON'T READ OUT)** a) Sexual transmission b) Blood transfusion from infected people c) Multiple users of needles by infected people d) Mother to child through pregnancy e) Kissing / touching f) Sharing meals, cups and spoon g) Using the same toilet, Toileting articles h) Swimming pools i) Breast milk j) Coughing, sneezing k) Others…… (specify) ›?‹ ›Ãy= /›?Ée ¾T>}LKõv†¨<" S"ÑÊ‹ ÃÓKì< G. uÓw[eÒ Ó"–<'ƒ K. uzÃ[c< ¾}Á² ÅU c=KÑc" N. eK U ¾J'< 'Ña‹" uSªªe (KUdK? ULß S`ô) S. Ÿ "ƒ ¨Å î"e W. uSddU" uS""ƒ [. UÓw ›"É LÃ uSwLƒ" ¾SSÑuÁ n-‹" uSªªe g. u›"É SìÇÍ u?ƒ uÒ^ uSÖkU k. ¾Sª— eõ^-‹ uÒ^ uSÖkU u. Ÿ "ƒ Ö<ƒ ¨Å MÏ }. udM ' uTe'Öe ' uƒ"ói †. K?L ---------- (ÃÓKì<)			
8	Do you think HIV/AIDS can be prevented ›?‹ ›Ã y=/›?Ée" SŸLŸM Ã‰LM wK¨< ÁevK<;			

S/NO lØ`	QUESTIONS ØÁo	Yes ›-	No ›Ã	N.A SMe ¾KU
9	How do you think that one can prevent HIV/AIDS: **(DON'T READ OUT)** a) Usage of condoms b) Having one partner only c) Abstinence from sex. d) Others……...(Specify) ›"É c¨< ›?‹ ›Ã y=/›?Ée" "È*ƒ* SŸLŸM Ã‹LM; G. ¢"ÊU uSÖkU K. ›"É K ›"É uS¨c" N. Ÿ¨c=w uS kw S. K?L ----------ÃÓKì<			
10	What other illnesses are caused because of HIV/AIDS **(DON'T READ OUT)** 1) T.B 2) Others ….. (Specify) u›?‹ ›Ã y= /›?Ée U¡"Á*ƒ* ¾T>Ÿc~ K?KA‹ ui-‹ "T" "†¨<; G. d"v 'k`d K. K?L----------ÃÓKì<			
11	Do you know that a drug is available to prolong life for a HIV/AIDS person? u›?‹ ›Ãy= /›?Ée ¾}Á²" c¨< ÉT@ K=Á^´U ¾T>‹M SÉG'>*ƒ* "ÇK Á¨<nK<;			
12	Where did you hear of this drug. eK²=I SÉN'>*ƒ* Ÿ¾*ƒ* cS<;			
13	Do you know of any way to find out if a person has HIV or not u›?‹ ›Ã y= /›?Ée ¾}Á²" c¨< KÃ}¨< ¾T>Á¨<lu*ƒ* S"ÑÉ ›K-*ƒ*;			

S/NO lØ`	QUESTIONS ØÁo	Yes ›-	No ›Ã	N.A SMe ¾KU
14	Do you know of the various ways a person can be tested for HIV **(DON'T READ OUT)** a) Blood test b) Sputum test c) Death d) Presence of T.B e) Physical Changes f) Others …..(Specify) ›"É c¨< ›?‹ ›Ã y=/ ›?Ée uÅS< "ÇK "Èƒ K=¨p Ã‹LM; G. ¾ÅU U`S^ K. ¾›¡ (U^p) U`S^ N. uVƒ S. ud"v ui Ÿ}Á² W. uc¨<'ƒ K¨<Ø [. K?L----------ÃÓKì<			
15	Do you know where one can have this test done? ¾ÅU U`S^ ¾ƒ TÉ[Ó "ÇKw-ƒ ÁK<nK<;			
16	Did you first have sex after marriage? KSËS]Á Ñ>²? ¾Ów[eÒ Ó"–<'ƒ ¾ðìS<ƒ ŸÒw‰ u%EL ¨<;			
17	If "No" Did you have protected sex then? SMe- #›Ã$ ŸJ' Ów[eÒ Ó"–<'~" c=ðîS< Ø"no ›É`Ñªm;			
18	Do you have more than 1(one) sex partner? Ÿ›"É uLÃ ¾¨c=w ÕÅ— ›K-ƒ;			
19	If "Yes" Do you have protected sex?			

	SMe-#›-$ ŸJ' Ø"no ÁK¨< Ó"–<'ƒ "¨< ¾T>ðîS<ƒ;			
20	Do you have HIV/AIDS? ›?‹ ›Ã y= /›?Ée uÅU- ¨<eØ ›Kw-ƒ;			
S/NO lØ`	QUESTIONS ØÁo	Yes ›-	No ›Ã	N.A SMe ¾KU
21	Are you at risk of developing HIV/AIDS. K›?‹ ›Ã y= /›?Ée u×U ¾}ÒKÖ< '-ƒ;			
22	Have you been tested? U`S^ ›É`Ñ¨< Á¨<nK<;			
23	If "NO" are you willing to undergo a test? SMe-#›Ã$ ŸJ' Ÿ›G<" u%EL U`S^ KTÉ[Ó ðnÅ— '-ƒ;			
24	Do you know anyone who has HIV/AIDS? ›?‹ ›Ã y= /›?Ée uÅS< ÁKuƒ c¨< Á¨<nK<;			
25	If "Yes" relationship……..(specify) SMe-#›-$ ŸJ' ÁL‡ Ó"–<'ƒ u=ÑMì<;			
26	Will you be friendly with a person having HIV/AIDS? ›?‹ ›Ã y= /›?Ée uÅS< "Kuƒ c¨< Ò` Ø\ ¾J' TIu^© Ó"–<'ƒ ¾T>•`-ƒ ÃSeM-M;			
27	Will you take care of a person with HIV/AIDS? u›?‹ ›Ã y=/›?Ée ¾}Á²" c¨< "¡w"u? ÁÅ`Ñ<KM;			
28	Will you eat with a person with HIV/AIDS? u›?‹ ›Ã y= /›?Ée Ÿ}Á² c¨< Ò` uÒ^ ÃSÑvK<;			
29	If someone close to you has HIV/AIDS will you stay away OR isolate him? Ÿ›ÖÑw- ÁK c¨< u›?‹ ›Ã y= /›?Ée u=Á´ ›w[¨<ƒ ÃJ"K<; ¨Ãe Ã`lM;			

S/NO lØ`	QUESTIONS ØÁo	Yes ›-	No ›ÃÅKU	N.A SMe ¾KU
30	What are the problems caused due to AIDS **(DON'T READ OUT)** a) T.B b) Poverty c) Family suffers and health deteriorates e) others .(specify) u›?‹ ›Ã y=/ ›?Ée U¡"Áƒ K=Ÿc~ ¾T><K< ‹Óa‹ T" "†¨< G. d"v 'k`d K. `Gw N. ¾u?}cw ‹Ó`" ¾Ö?" S¨¡ S. K?L ----------ÃÓKì<			
31	If one has HIV/AIDS, what are the possible areas it is likely to affect and how are they affected? **(DON'T READ OUT)** a) Family b) Income c) Agriculture d) Community e) Country f) Others ---------- (specify) u›"É c¨< ›?‹ ›Ã y=/ ›?Ée SÁ´ U¡"Áƒ Ñ<Çƒ K=Å`evt¨< ¾T><KK< T" T" "†¨<; G. u?}cw K. Ñu= N. `h S. TIu[cw W. GÑ` [. K?L----------ÃÓKì<			
32	If a person has HIV/AIDS, how will the family suffer /be affected? **(DON'T READ OUT)** a) Lack of money leading to poverty b) Loss of loved one c) Others ….(specify)			

	›”É c¨< u›?‹ ›Ã y=/ ›?Ée u=Á´ uu?}cu< LÃ U” ÃðÖ`u¤M; G. ¾Ñ”²w ¤Ø[ƒ Ÿ³U vhÑ` ¤`Gw; K. T>eƒ“/vM” uSVƒ S’Öp N. K?L----------ÃÓKì<			
S/NO lØ`	QUESTIONS ØÁo	Yes ›-	No ›Ã	N.A SMe ¾KU
33	If a person has HIV/AIDS, how will the income be affected **(DON’T READ OUT)** ----------(specify) ›”É c¨< uzÃ[c< u=Á´ Ñu=¨<” ¤”Èƒ ÃÑ<ÇªM;			
34	If a person has HIV/AIDS, how will the agriculture be affected **(DON’T READ OUT)** ----------(specify) ›?‹ ›Ã y= /›?Ée ¤`h” ¤”Èƒ K=ÑAÇ Ã‹LM;			
35	If a person has HIV/AIDS, how will the community be affected **(DON’T READ OUT)** ----------(specify) ›?‹ ›Ã y=/›?Ée uTlu[cw LÃ ¾T>ÁeŸƒK¨< }¤•¤ U”É” ”¨<; (SMc<” ›ƒ“Ñ`)			
36	If a person has HIV/AIDS, how will the Community & country be affected **(DON’T READ OUT).** ----------(specify) ›?‹ ›Ã y=/›?Ée uTlu[cw ¤“ u›”É ›Ñ` ¤ÉÑƒ LÃ ¾T>ÁeŸƒK¨< }¤•¤ U”É” ”¨<; (SMc<” ›ƒ“Ñ`)			
37	If a person has HIV/AIDS how will it affect the occupation **(DON’T READ OUT)** a) Decreased productivity b) Less income c) Others ›”É c¨< uzÃ[c< u=Á´ e^¨<” ¤”Èƒ ÃÑ<ÇªM; G. ¾U`ƒ SÖ” Sk’e			

	K. ¾Ñu= SÖ" T'e N. K?L----------ÃÓKì<			
S/NO lØ`	QUESTIONS ØÁo	Yes ›-	No ›Ã	N.A SMe ¾KU
38	How will HIV/AIDS affect the agriculture **(DON'T READ OUT)** a) Decreased manpower b) Decreased productivity c) Less Income d) Others…… (specify) ›?‹ ›Ã y= /›?Ée `h" "È*ƒ* K=ÑAÇ Ã‹LM; G. ¾c¨< GÃM Ø[*ƒ* TeŸ}M K. ¾U`*ƒ* SÖ" T'e N. ¾Ñu= SÖ" T'e S. K?L----------ÃÓKì<			
39	Do you think having HIV/AIDS will affect the development of the country ›?‹ ›Ã y=/›?Ée u›"É ›Ñ` ÉÑ*ƒ* LÃ ¾T>ÁeŸ*ƒ*K¨< }î• U"É" '¨<; (SMc<" ›*ƒ*"Ñ`)			
40	If "Yes" how **(DON'T READ OUT)** a) Decrease number of skilled people b) Decrease productivity c) More expenditure on health with less income d) Others ……. Specify #›-$ "K< "È*ƒ*; G. ¾}T[" ¾c¨< GÃM uSk'e K. U`T'*ƒ* Sk'e N. u*ƒ*"i Ñu= LÃ w²< ¨Û KÖ?" uT¨<×*ƒ* S. K?L----------ÃÓKì<			

3.4 QUESTIONNAIRE FOR FOCUSED GROUP DISCUSSION

[ªm ÓKcx‹" L"}} u<É" ¾T>k`w ØÁo

1. What do you think is perception of the community to HIV AIDS?

   Tlu[cu< eK ›?‹ ›Ã y=/›?Ée ÁK¨< ›SK"Ÿƒ U"É" "¨<;

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2. Do they know how HIV/AIDS is transmitted?

   ›?‹ ›Ã y=/›?Ée ["Èƒ ["ÅT>}LKõ Á¨<nK<;

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3. In the wareda do they know how one can prevent HIV/AIDS transmission?

   u¨[Ç ¨<eØ ›?‹ ›Ã y=/›?Ée" ["Èƒ SŸLŸM ["ÇKv†¨< Á¨<nK<;

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4. Haw is this wareda , does the community know the treatment for AIDS?

   u¨[Ç ¨<eØ u›?‹ ›Ã y=/›?Ée ¾}Á²" c¨< ["Èƒ S"ŸvŸw (S`Çƒ) ["ÇKv†¨< Á¨<nK<;

---

5. In your worda, what is the impact of HIV/AIDS? What is your opinion?

   u¨[Ç- ¨<eØ ›?‹ ›Ã y=/›?Ée ÁeŸ}K¨< }î• U"É" "¨<; ›e}Á¾ƒ- U"É" "¨<;

6. How can you help as individuals and community?

   1.
   2.
   3.
   4.
   5.
   6.

   uÓMU J' uÒ^ K=ÁÅ`Ñ<ƒ ¾T><K<ƒ ÉÒõ U"É" "¨<;

   1.
   2.
   3.
   4.
   5.
   6.

3.5 FREQUENTLY ASKED QUESTIONS
u}ÅÒÒT> ¾T>Ö¾l ØÁo-‹

i. How and where did AIDS originate?

›?Ée ”È*ƒ* “ Ÿ¾*ƒ* S×;

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ii. Why is Africa, of all the regions in the world, the hardest hit?

›õ]" KU” u›?‹ ›Ã y=/›?Ée Ÿõ}— }Öm J'‹;

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iii. Why is HIV worse in some parts of Ethiopia than in others, although no region in the country is free from HIV?

U”U ”ŸD” uG<K<U ¾›=*ƒ*ÄåÁ ¡MKA‹ ¾›?‹ ›Ã y=/›?Ée }Öm u=•`U KU” ›”Æ ¡MM ŸK?L¨< ¡MM uuKÖ G<'@ w²< }Öm-‹ •*ƒ*;

---

iv. Have we succeeded in getting a cure for AIDS?

¾›?‹ ›Ã y=/›?Ée” SÉG'>*ƒ* uTÓ–*ƒ* }d¡„M“M;

---

v. It is said that the most important mechanisms for transmitting the virus ate heterosexual intercourse, prenatal transmission and blood transfusions. How important ate other means of transmitting the virus, such as circumcision, homosexuality, sharing shaving instruments, dental instruments, mosquitoes, Kissing, etc?

K›?‹ ›Ã y=/›?Ée ¾T>ÁÒMÖ<” ª“ ª“ 'Ña‹ ¾Ów[eÒ Ó”–<'*ƒ*' Ÿ“*ƒ* ¨Å MÏ ”Ç=G<U ¾ÅU ´¨<¨<` Ÿ›”É c¨< ¨Å K?L c¨< “†¨< }wLDM:: ¾}k\*ƒ*e 'Ña‹ KUdK? Ó`³*ƒ*' ¾}SddÃ ï ¾Ów[eÒ Ó”–<'*ƒ*' eK U 'Ña‹” uÒ^ SÖkU' ¾Ø`e SS`S]Á Sd]Á-‹' ¾¨v *ƒ*™˜ “ SddU ›?‹ ›Ã y=/›?Ée” ¾Te}LKõ GÃL†¨< U” ÁIM ”¨< wK¨< ÃÑU K<;

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vi. Why do some people (e.g. some prostitute) escape HIV infection despite constant exposure and lack of protection?

›”Ç”É c-‹ (KUdK? c?}— ›Ç]-‹) K›?‹ ›Ã y= ›?Ée u×U }ÒMÖ¨< dK KU”É¨¨< ŸzÃ[c< ’í ¾J’<ƒ;

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vii. Why do some HIV-positive mothers transmit the virus to their newborn children while others do not?

KU” ›”Ç”É u›?‹ ›Ãy=/›?Ée ¾}Á²< ’õcÖ<a‹ zÃ[c<” ¨Å MÐ‰†¨< Áe}LMóK< K?KA‡e KU” ›Áe}LMñU;

viii. Why can’t the government test everybody for HIV infection?

S”Óeƒ KU” G<K<”U c¨< ¾›?‹ ›Ã y=/›?Ée U`S^ ›ÁeÅ`ÓU;

---

ix. Why not quarantine those who are infected with HIV?

KU” u›?‹ ›Ã y=/›?Ée ¾}Á²< c-‹” ðîV ›“ÑL†¨<U;

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x. Despite education campaigns and increased condom use, HIV is till increasing. Why aren’t these programmes effective?

U”U ”ŸD” eK ›?‹ ›Ã y=/ ›?Ée w²< ƒUl`ƒ u=cØU “ ¾¢”ÊU }ÖnT>-‹ lØ` u=ÚU`U ui¨< Ó” uŸõ}— lØ` ¾}eóó ÃÑ—
M:: ’²=I ¾T>cÖ< ƒUl`„‹ KU” ¾}ðKÑ¨<” ÁIM K=ÖpS< ›M‰K<U;

3.6 QUESTIONNAIRE FOR AIDS PATIENTS WHO ARE HEADS OF HOUSEHOLDS

1. Kebele_____ Woreda _____ Zone _____ Region _____
2. What have you been doing to earn your living
   a) Farming b) Small trade c) Running a business
   d) Government employee e) daily laborer
3. Are you the head of the household (bread winner) of the family? Yes No
4. If Yes, were you able to adequately provide for the needs of your family before you fell ill? Yes No
5. When did you come to know that you are HIV -Positive?
   a) _____ Months b) _____ years
6. Are you still active or are you bed-ridden? a) Active b) Bed-ridden
7. If you are bed-ridden, who has replaced you as head of the household?
   a) Spouse b) Eldest son c) Eldest daughter d) Relative e) Others
8. What does your replacement do to provide for the family?

   _____

   _____

9. Does he/she adequately provide for the needs of the family? Yes No
10. If No, what are the negative consequences on your family?

    _____

    _____

    _____

11. Who takes care of you while you are ill in bed?
    a) Spouse b) Children c) Relatives d) Neighbors e) Home-based care takers
12. Do you go the health care facilities to get medical treatment?
13. If Yes, who pays for your medication?
    a) Self b) Relatives c) Government d) NGOs

14. If No, why don't you go to these facilities to seek medical assistance?

_____

_____

15. Are there any NGOs who provide care and support to AIDS patients and AIDS orphans in the area? Yes No
16. If Yes, what kind of care and support do they provide?
    a) Home-based care b) Counseling c) Nutritional support
    d) Medical support e) Others
17. Are you married? Yes No
18. If Yes, is your spouse alive? Yes No
19. If Yes, has he/she been tested for HIV? Yes No
20. If he/she has been tested, is he/she HIV-positive? Yes No
21. Do you have any children? Yes No
22. If Yes, do they all go to school? Yes No
23. If No, why? Please explain in detail

_____

_____

_____

24. What have been the attitudes of the following target groups towards AIDS patient and AIDS orphans?
    a) Family members Friendly Unifrendly
    b) Relatives Friendly Unifrendly
    c) Neighbors Friendly Unifrendly
    d) Health service Providers Friendly Unifrendly
    e) Community at large Friendly Unifrendly
25. What are the major negative impacts that your family had to face as a result of your being an AIDS patient?

_____

_____

_____

3.7 QUESTIONNAIRE FOR THE FAMILY MEMBERS OR RELATIVES OF DECEASED AIDS PATIENTS

1. Kebele_____ Woreda _____ Zone _____ Region _____
2. How are you related to the deceased?
   a) Spouse b) Child c) Father d) Mother e) Others
3. Was the deceased the bread winner of the family? Yes No
4. If Yes, what was he/she doing to earn his/her living?
   a) Farming b) Small trade c) Running business d) Government employee
   e) Daily laborer g) Unemployed
5. Is the deceased married? Yes No
6. If Yes, do they have any children? Yes No
7. If Yes, do all the children go to school? Yes No
8. If No, why?
   a) School too far away b) family is poor
   c) Discontinued education because he/she is AIDS orphan d) Others
9. How do you rate his living conditions before he/she became AIDS patients?
   a) Good b) Fair c) Poor
10. Does the family have enough food after the death of the patient? Yes No
11. Is the spouse of the deceased alive? Yes No
12. If Yes, has he/she been tested for HIV/AIDS? Yes No
13. If Yes, is he/she been tested for HIV/AIDS? Yes No
14. If Yes, is he/she getting medical treatment?
15. If No, why?

_____

_____

_____

_____

_____

_____

16. What is the attitude of the community towards PLWHA, AIDS patients and AIDS orphans?

    a) Friendly b) Unfriendly c) Discriminatory

17. If the spouse dies, are there family members or relatives who can take care of the family?

    Yes No

18. Could you list the negative consequences on the family as a result of the death of the

    AIDS Patient

    _____

    _____

    _____

    _____

    _____

3.8 QUESTIONNAIRE FOR THE HEAD OF THE WOREDA HEALTH OFFICE AND HEAD OF THE HEALTH CARE FACILITY

(HEALTH POST, HEALTH STATION, HEALTH CENTRE, HOSPITAL)

1. Kebele_____ Woreda _____ Zone _____ Region _____
2. How many health care facilities are there in the Woreda? _____
   a) Health posts _____
   b) Health station, if any, _____
   c) Health centers _____
   d) Hospitals _____
3. What has been the prevalence of HIV/AIDS in the Woreda over the last three years?
   a) 1995 (EC) _____%
   b) 1996 (EC) _____%
   c) 1997 (EC) _____%
4. In your opinion, is the number of deaths due to HIV/AIDS increasing or decreasing?
   a) Increasing b) Decreasing
5. Do government health care facilities provide PLWHA with medical services for opportunistic diseases? Yes No
6. Do you provide antiretroviral drugs for AIDS patients? Yes No
7. Approximately, what % of the beds in your health facility/ Woreda are occupied by AIDS patients? _____ %
8. What impact does this have on the medical services to other patients?

   _____

   _____
9. Have you lost some of your professional (health) employees due to AIDS? Yes No
10. If Yes, how many? _____

11. Do you believe that this reduction in the number of health professionals would seriously affect the health programme of the Woreda/health care facility? Yes No
12. Do you think that awareness creation programmes on HIV/AIDS are organized adequately? Yes No
13. If Yes, have you observed any behavioural changes in the communities with regard to safe sexual practices? Yes No
14. Are there any NGOs providing care and support for the following groups?
    a) AIDS patients Yes No
    b) PLWHA Yes No
    c) AIDS orphans Yes No
15. What is the attitude of your health professionals towards PLWHA and AIDS patients?
    a) Friendly b) Indifferent c) Discriminatory
16. What is the attitude of the community towards AIDS patients and PLWHA?
    a) Unfriendly b) Indifferent c) Discriminatory
17. Do you have additional comments on the negative impacts of HIV/AIDS on the community?

    _____

    _____

    _____

3.9 QUESTIONNAIRE FOR THE HEAD OF THE WOREDA EDUCATION OFFICE AND SCHOOL DIRECTORS

1. Kebele _____ Woreda _____ Zone _____ Region _____
2. How many primary and secondary schools are there in this Woreda?
   Primary _____ Secondary _____
3. Can you give us an estimation of the total number of student dropouts in the Woreda/ year school over the last three years (EC)? _____
   a) 1995 _____ b) 1996 _____ c) 1997 _____
4. What are the major causes for these dropouts?
   a) Illness b) Loss of parents due to AIDS c) Poverty d) Others
5. Could you give us an estimate of the number of dropouts as a result of loss of one or both parents due to AIDS? _____
6. Do you think that number of AIDS orphans has been increasing over the past three years?
   Yes No
7. Are there any NGOs in the Woreda who help AIDS orphans to continue their education?
   Yes No
8. Are there any teachers in this Woreda/School who have lost their lives as a result of AIDS? Yes No
9. If Yes, could you give us an approximate number of deaths in the Woreda/School?
   _____
10. In your opinion, is the number of teachers dying due to AIDS increasing or decreasing?
    a) Increasing b) Decreasing

11. What are the impacts of these deaths on the education programme of the Woreda/School?

_____

_____

_____

12. Do you any additional comments on the negative impacts of HIV/AIDS on the education programme of your Woreda/School?

_____

_____

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ETHIOPIA
ERITREA
Red Sea
YEMEN
Aksum
Mekele
Simien Mountains National Park
Ras Dashen 4620m
Gulf of Aden
Gondar
SUDAN
Lake Tana
Lalibela
DJIBOUTI
Bahar Dar
Debre Markos
Debre Libanos
Dire Dawa
SOMALIA
Addis Ababa
Awash National Park
Gambela
Lake Abiata
Lake Shala
Lake Langano
ETHIOPIA
Ogaden Desert
Gambela National Park
Rift Valley Lakes
Bale Mountains National Park
Lake Abaya
Omo National Park
Lake Chamo
Mago National Park
KENYA
Moyale
0 200 km
0 120 mi
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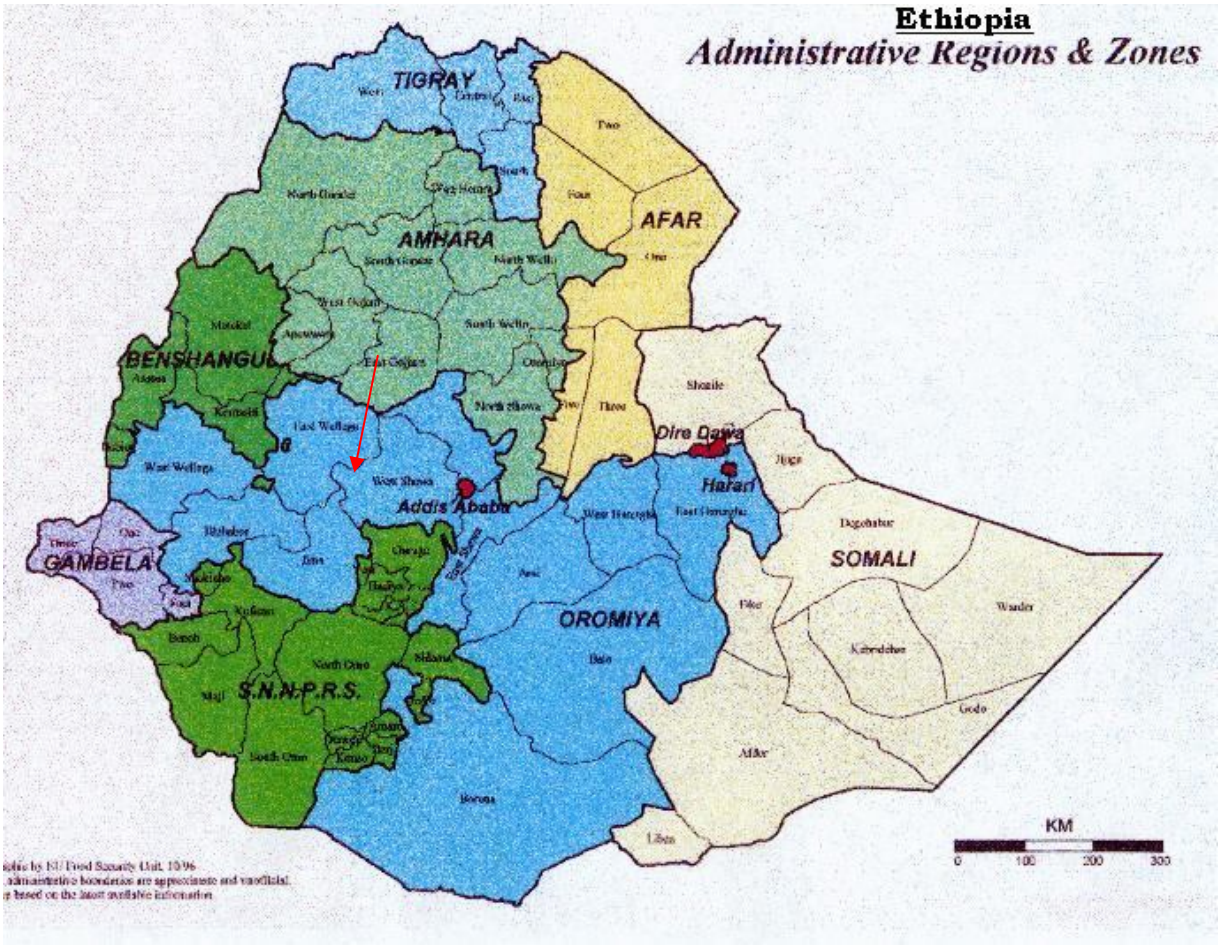
Ethiopia
Administrative Regions & Zones
TIGRAY
AFAR
AMHARA
BENSHANGUL
GAMBELA
S.N.N.P.R.S.
OROMIYA
SOMALI
Addis Ababa
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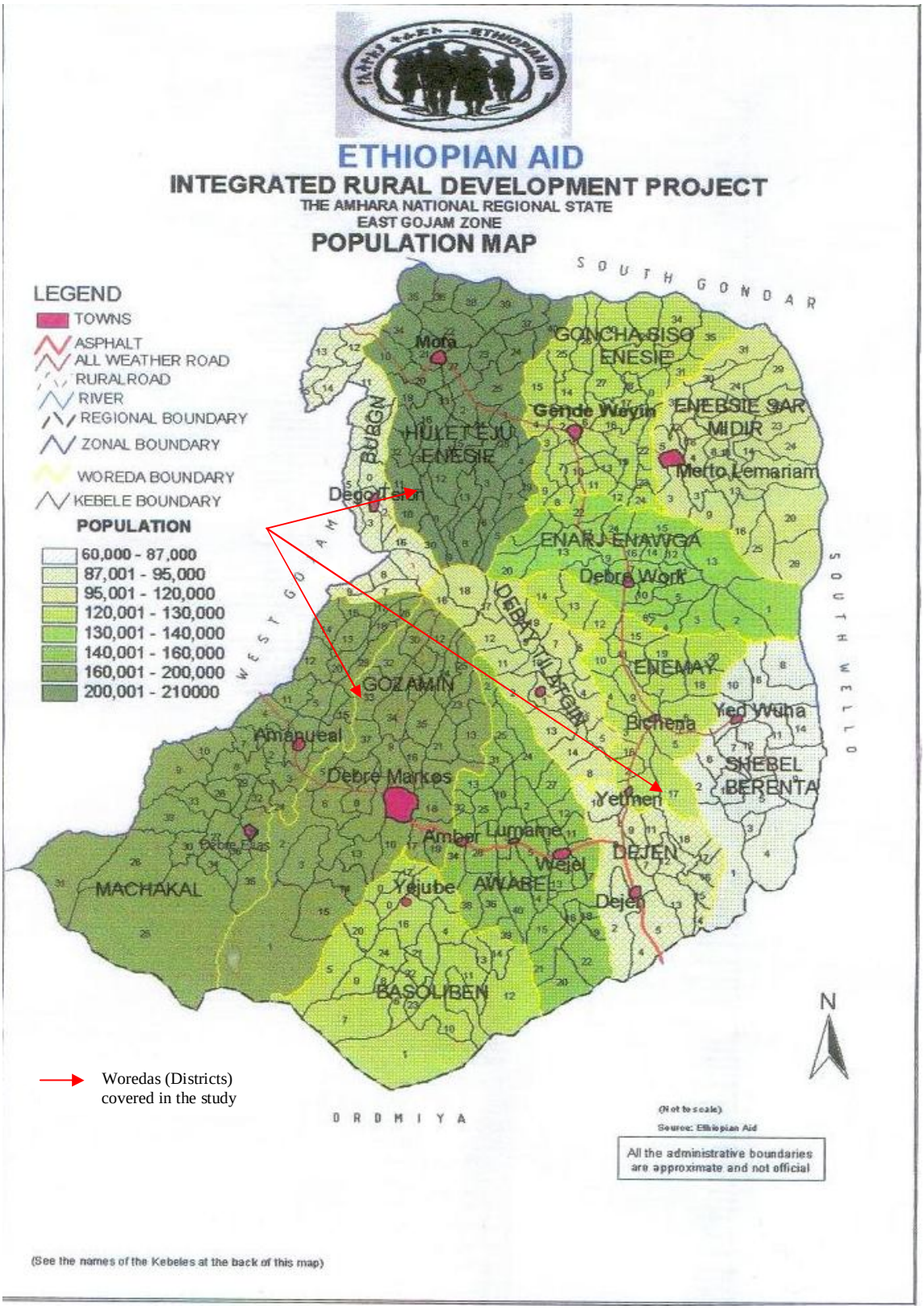
ETHIOPIAN AID
INTEGRATED RURAL DEVELOPMENT PROJECT
THE AMHARA NATIONAL REGIONAL STATE
EAST GOJAM ZONE
POPULATION MAP
LEGEND
TOWNS
ASPHALT
ALL WEATHER ROAD
RURALROAD
RIVER
REGIONAL BOUNDARY
ZONAL BOUNDARY
WOREDA BOUNDARY
KEBELE BOUNDARY
POPULATION
60,000 - 87,000
87,001 - 95,000
95,001 - 120,000
120,001 - 130,000
130,001 - 140,000
140,001 - 160,000
160,001 - 200,000
200,001 - 210000
SOUTH GONDAR
WEST GOJAM
SOUTH WELLO
ORDMIYA
Mota
GONCHA SISO ENESIE
Gende Wuyin
ENEBSIE SAR MIDIR
Metto Lemariam
HULETEJU ENESIE
BURGN
Degot Leon
ENARJ ENAWGA
Debre Work
DEBAY TILILIGN
GOZAMIN
ENEMAY
Yed Wuha
Bichena
Amanuel
Debre Markos
SHEBEL BERENTA
Yetmen
Amber Lumame
Debre Elias
DEJEN
Wejel
MACHAKAL
Yejube
AWABEL
Dejen
BASOLIBEN
N
Woredas (Districts) covered in the study
(Not to scale)
Source: Ethiopian Aid
All the administrative boundaries are approximate and not official
(See the names of the Kebeles at the back of this map)