Assessment & Evaluation of Care and Support Services for PLHA at Shambu Hospital in Horro Guduru District, North-Western Ethiopia

MSW Dissertation Research Project Proposal (MSWP -001)

Prepared By

Abebe Mamo
Enrollment No. 1051140

Project Supervisor

Sebsib Belay (Mr)

Indira Gandhi National Open University

School of Social Work

April, 2013
Addis Ababa, Ethiopia

DECLARATION

I here by declare that the dissertation entitled "**ASSESSMENT AND EVALUATION OF CARE AND SUPPORT SERVICES FOR PLHA AT SHAMBU HOSPITAL IN HORRO GUDURU DISTRICT, NORTH-WESTERN ETHIOPIA"** submitted by me for the partial fulfillment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirement for any other programme of study. I also declare that no chapter of this manuscript in whole or in part is lifted and in corporate in this report from any earlier work done by me or others.

Place: **Addis Ababa, Ethiopia**

Date: **May 15, 2013**

Signature: _____

Enrolment No. : **ID1051140**

Name: **Abebe Mamo Seyoum**

Address: **Addis Ababa, Ethiopia**

CERTIFICATE

This is to certify that Mr./Miss/Mrs **ABEBE MAMO SEYOUM**

Student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for his /her project work for the Course **MSWP-001.**

His /Her Project Work entitled

"**ASSESSMENT AND EVALUATION OF CARE AND SUPPORT SERVICES FOR PLHA AT SHAMBU HOSPITAL IN HORRO GUDURU DISTRICT, NORTH-WESTERN ETHIOPIA"**

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

Place: **Addis Ababa, Ethiopia** Signature _____

Date: Name: **Sebsib Belay (Mr.)**

Address of the Supervisor: **Addis Ababa, Ethiopia**

Phone No. : _____

TABLE OF CONTENTS

Content **Page**

PRORORMA FOR SUBMISSION OF MSW PROJECT PROPOSAL FOR APPROVAL FROMACADEMIC COUNSELLOR AT STUDY CENTRE

Enrolment No. : **ID1051140**

Date of Submission: ……

Name of the study centre: ……

Name of the guide: ……..

Title of the project: **Assessment And Evaluation of Care and Support Services for PLHA at Shambu Hospital in Horro Guduru District, North-Western Ethiopia**

Signature of the student: …….....

Approved/not approved

Signature: …… Name & Address of the student: ……

Name & Address of Guide: …… …….....

…….. ……

……. Date: ……

Appendix IV: List of NGOs in Shambu Town, Horo Guduru Wollege Zone, North-western Ethiopia March, 2013

S.N.	Name of NGO's	Type of NGO	Area of service/program
1	CU-ICAP-Ethiopia	INGO	ART technical support
2	Save the Children-Food by prescriptions	INGO	Nutritional Support for HFT sever and Moderate malnutrition ART client's and technical support
3	HST	INGO	Salary and training for ART Data clerks
5	MSH(Management Science for Health) and SCMS (Supply chain management system)	INGO	Technical support
6.	Lamin-Lamif	Local NGO	Socioeconomic support for PLWHA

ACKNOWLEDGMENT

I would like to acknowledge my supervisor Mr. Sebsib Belay for his advising me in writing this thesis.

My heart appreciation also goes to Indira Gandhi National Open University, School of social work for providing me the proposal guideline and references.

I also wish to acknowledge the contribution of the Shambu Hospital staffs in the development of this research thesis.

Lastly but not least, I would like to thank the study participants in providing me the required data that the studies attempt to see.

ACRONYMS AND ABBREVIATION

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral
CU-ICAP	Colombia University- International care for AIDS program
DHD	District Health Desk
HIV	Human Immune Virus
IEC	Information Education and Communication
M & E	Monitoring and Evaluation
MoH	Ministry of Health
NGOs	Non-governmental organizations
OI	Opportunistic Infection
PLHA	Peoples Living HIV AIDS
RHB	Regional Health Bureau
TB	Tuberculosis
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

LIST OF TABLES

List of Tables **Page**

LIST OF FIGURES

List of Figure **Page**

ABSTRACT

In the timeline features, some of the most important developments in the history of HIV/AIDS in Africa can be considered. These events are divided into five categories as follows: spread of HIV/ AIDS, science and prevention, treatment, global action, and national event. The human immune-deficiency virus (HIV) has created an enormous challenge worldwide. Although HIV/AIDS is a global epidemic, some countries are more afflicted than others, Sub-Saharan Africa being the hardest hit.

The human immune-deficiency virus (HIV) is a virus that destroys parts of the body's immune system. HIV is the cause of AIDS. HIV-positive means the person has been tested and the test result shows that the HIV virus is present in his/her body. Acquired Immune Deficiency Syndrome (AIDS) is a group of diseases caused by HIV.

The study was aims at assessing and evaluating Shambu Hospital's interventions for providing care and support to People living with HIV/AIDS using cross-sectional data (beginning from 2007 to 2012) in Horo Guduru District of Wollega Zone in North-western Ethiopia. The data were collected from 60 respondents using semi-structured questioner. It was analyzed using SPSS version 20 and from the data frequency, percentage and cross tabulation was computed.

The result of the study indicated that a total of 60 respondents were interviewed for the study. Majority 38(63.3%) of the respondents were female and the rests were male. The educational background of the respondents were 9(15.0%) illiterate, 9(15.0%) able to read and write, 7(11.7%) 1-4, 10(16.7%) 5-8, 9(15.0%) grade 9-10, 5(8.3%) grade 11-12, 7(11.7%) certificate holder and the rests 4(6.7%) were more than diploma holder

Even if the hospital have some constraints in providing HIV/AIDS care and support, High number of the respondents were very satisfied by over all ART services at the Hospital while small number neither satisfied nor unsatisfied respectively. Hence Majority the respondents rate or evaluate the ART services as very good, among this 16 were male 32 were female. Similarly, 11(18.3%) rates the ART services as good and 1(1.7%) rates as neither good nor bad.

CHAPTER ONE

INTRODUCTION

In the timeline features, some of the most important developments in the history of HIV/AIDS in Africa can be considered. These events are divided into five categories as follows: spread of HIV/ AIDS, science and prevention, treatment, global action, and national event. The human immune-deficiency virus (HIV) has created an enormous challenge worldwide. Although HIV/AIDS is a global epidemic, some countries are more afflicted than others, Sub-Saharan Africa being the hardest hit.

The human immune-deficiency virus (HIV) is a virus that destroys parts of the body's immune system. HIV is the cause of AIDS. HIV-positive means the person has been tested and the test result shows that the HIV virus is present in his/her body. Acquired Immune Deficiency Syndrome (AIDS) is a group of diseases caused by HIV.

There is also multi-faceted perceived impact of HIV/AIDS on different aspects of society. Since recognition of the syndrome, HIV has infected and contributed to the death of million people. More of these people, including people living with HIV/AIDS (PLHA) are in Sub-Saharan Africa, where AIDS is the leading cause of death. A few countries in this Region such as South African and East African countries are cases in point. In these countries, HIV/AIDS has already reached an epidemic or pandemic status based on the data on rate of adult HIV prevalence, reduced life expectancy, changes in population structure and ever-worsening poverty conditions, and aggravating socio-economic and gender inequalities, deteriorating state of food insecurity, frustrated development efforts, increase in the number of orphans and vulnerable children, severe social stigma and discrimination, but to mention some of the complex and adverse effects. On top of this, HIV/AIDS increases significantly the amount of time off work and school due to illness, care of the sick and burial attendance.

The impacts of the epidemic have not been limited to causing illness and deaths to infected individual, and strains on the health sector. The consequences are also strongly felt by affected households, communities, educational establishments, manufacturing and service giving industries, and national economics as a whole (UNAIDS, 2008).

In response, concerned states, organizations and professionals, including the Government of Ethiopia have come up with three major responses. These are biomedical, social and structural responses. The structural response consists of care, support and treatment services, including ART. Thus, antiretroviral therapy (ART) has become an integral part of the continuum of HIV care.

People living with HIV/AIDS (PLHA) is a general term for all people infected with HIV, whether or not they are showing any symptoms of infection. The needs of people and households infected and affected by HIV/AIDS (e.g. PLHA, orphan and vulnerable children and their families) are comprehensive and need to be addressed as a package either at health institutions or through community supported home-based care services. These services should be provided in a continuum and directed at strengthening the respective clients in different contexts. People living with HIV/AIDS, particularly need comprehensive care, support and treatment services such as Antiretroviral drugs (ARVs). These are treatments that aim to slow, or stop the virus multiplying, or increasing in the body – Antiretroviral Therapy (ART).

At the United Nations General Assembly Special Session on HIV/AIDS, held in June 2001, the global community cited ART as a key component of effective HIV/AIDS programmes. In their Declaration of Commitment, heads of state from 189 countries affirmed that "prevention, care, support and treatment for those infected and affected by HIV/AIDS are mutually reinforcing elements of an effective response and must be integrated in a comprehensive approach to combat the epidemic."

While the moral imperative to provide the best possible treatment for people with AIDS-related disease is widely recognized, national governments and donors have been reluctant to enter into this endeavour. They cite numerous concerns, ranging from the cost of ARVs to the capacity of health care delivery systems in the developing world to the ability of patients to adhere to lifelong treatment regimens. However, the cost of antiretroviral drugs continues to decrease and ARVs are now available through private channels in almost all countries in the world. Drug manufacturers lower the prices of antiretroviral drugs for resource-poor countries (Sharma, 2003). WHO similarly launches the "3 by 5" initiative to widen access to AIDS treatment in developing countries (Kapp, 2003). On the contrary, the above-mentioned concerns remain and

both ministries of health and the international donor communities need guidance on how to develop and implement appropriate and effective HIV/AIDS treatment programmes.

A successful treatment programme is the result of the synergy among a large number of components. In an ideal situation, appropriate drugs with few or no side effects are accessible and affordable to those who need them. Those who need the drugs seek and adhere to treatment freely and without fear of stigmatization or discrimination, and health care workers monitor treatment and adapt regimens to suit individual patients. Even though impressive progress has been made in many of these areas of HIV/AIDS care, support and treatment, numerous challenges and questions remain.

1.1 Need for Study

Components related to comprehensive care include: clinical management and direct physical care to PLHA and his/her family; education (for health workers, family, neighbours, volunteers, etc.); involvement of the PLHA; counselling (social, spiritual and emotional support); Voluntary HIV Counselling and Testing (VCT) and follow-up; adequate resources (medicines, medical supplies, linen, food, clothing, shelter, and money); advocacy and legal aid; prevention strategies; care for the caregivers; protection and infection control; strategies to promote acceptance of PLHA, and to reduce stigma and isolation in institutions and communities.

Although many countries will not have adequate resources to address all these components, each country can be working toward comprehensive care. There are also sites in the continuum of care. These sites are home care, community and district hospital care. Home care is care given to sick people in their homes. This might include people caring for themselves, or care given by family, friends, neighbours, health and social service workers and others. Such care can be physical, psychosocial, spiritual and palliative. Community care is care given by people within the community. This care might be given by nurses, midwives, trained volunteers, community health or TB workers, traditional healers, non-governmental organizations (NGOs), local leaders, teachers, youth groups, lay or religious leaders etc. Health centre care is given to sick people in a community health centre by nurses, midwives, counsellors, social workers, traditional healers,

volunteers and other staff. District hospital care is given to sick people by doctors, nurses, counsellors, social workers, education services, and legal aid.

There are further basic principles in a continuum of care (e.g. listen to the person with HIV/AIDS and his/her family, and enable them to plan for the future. Steps in linking services across the continuum include: assess the level and type of need; developing strong referral systems; staff and training; wider involvement; ongoing counselling, not just before and after HIV testing; care at home; care costs; and programme monitoring.

Providing antiretroviral therapy (ART) as a component of comprehensive HIV/AIDS care is rapidly becoming a reality in some countries and is becoming a distinct possibility in many other developing countries. However, many questions about the most effective, equitable, and cost effective remain. Above all, the question about balanced implementation of such programs has not yet addressed. Therefore, it becomes important to study what the people living with HIV/AIDS (PLHAs) are benefiting from district hospital care and support services.

1.2 Statement of the Problem

The human immuno-deficiency virus (HIV) has created an enormous challenge worldwide. The multi-faceted aspects of HIV/AIDS-related impact continue to be manifested in every country and region of the world, creating major barriers to preventing the further spread of the infection, alleviating its impact and providing appropriate care, support and treatment (UNAIDS, 2005, pp. 1-44). It is therefore necessary to address HIV-related impact at individual level to achieve public health goals and overcome the pandemic.

Responses to multi-faceted impact of HIV and AIDS can be placed along a continuum of prevention, care and treatment and the negative effects of stigma and discrimination can be seen on each of these aspects of the response. Highly Active Antiretroviral Therapy (HAART) was the breakthrough in the industrialized world, leading to the reduction of mortality and the improvement of quality of life of PLHA. Thus, antiretroviral therapy (ART) has become an integral part of the continuum of HIV care.

Since recognition of the pandemic, HIV has infected close to one million people due to acquired immune-deficiency syndrome (AIDS) in Ethiopia. About 1,216,908 people living with HIV/AIDS (PLHAs) are currently residing the country and 580,910 of them are getting ARV drugs at different ART sites, where AIDS is one of the leading causes of mortality. Thus, Ethiopia is among the countries most heavily affected by the HIV epidemic. Since then, more than 750, 000 PLHA have been in need of antiretroviral treatment since 1998, and of this population, about 2% can afford to pay for ARVs and healthcare services, and a total of 18,073 people from all walks of life died of AIDS (MoH, 2011).

In response to those multi-dimensional problems, the Government of Ethiopia has taken measures to reduce the risk of transmission of HIV and to mitigate the impact of the HIV epidemic on society at different levels. Several policies are in place to support the implementation and scaling up of the national response, including the National HIV/AIDS Policy, the National Strategic Framework on the Prevention and Control of HIV/AIDS, and the Supply and Use of Anti-Retroviral Drugs Policy. Based on these policies and the recommendations of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), The Government of Ethiopia launched its ART initiative in 2003. The country is now preparing to rapidly scale up its ART Programme.

In Ethiopia, The National ART Programme is based on such guiding principles as: ART, which is comprehensive services; the chronic care model will be applied to deliver ART; treatment and clinical procedures will conform with the National ARV Treatment Guidelines, which are based on international standards and best practices; greater involvement of PLHA will be encouraged; equitable universal access will be strongly promoted; national prevention strategies will be emphasized; the National ART Programme will strengthen the national health care system; efforts will be made to ensure sustainability; only one National ART Implementation Guideline will be followed; public-private partnership will be encouraged and promoted; and national and international networking will be valued and supported (MoH, 2005, p.2).

Thus ART, which is comprehensive services, is an integral part of the HIV continuum of care. The goal of the National ART Programme has been implemented as a safe, effective and

equitable programme as part of an HIV continuum of care. The efficient provisions of ART services to the needy PLHA in Ethiopia has been carried out by different organizations, professionals and committees at different levels such as national, regional, district, facility as well as community levels. The ART Programme Management and Coordination are in effect at all organizational levels and integrated into the existing health care systems in the country.

At district level, the district health desk (DHD) is the major government organization which is coordinating the ART Programme at that level. The DHD assists in implementing the Programme by linking facilities, kebeles, and the community. The ART services are also being provided to the needy at facility level. The facilities' primary role is to provide ART services, including referring PLHA to local community support groups. They are supported by the Hospital and Health Centre HIV/AIDS Committee to perform the tasks such as to develop an ART work plan, to prepare site for accreditation, assure that access to ART is in line with national guidelines, to institute weekly meetings, to review ART clinical monitoring data, to act without delay on emergent corrective measures, to submit Monitoring and Evaluation (M & E) to regional ART task force via appropriate channel, to assure integration of ART with other services, to assure logistics system, to coordinate capacity building, and to assure that all staff participate in ART (MoH, 2005).

At the facility level (e.g. hospitals), it has a primary role to provide ART services, including referring PLHA to local community support groups. They are also charged with patient care monitoring, and data collection, analysis, action, and reporting to the District Health Department (DHD) or Regional Health Bureau (RHB). They are supported by the Hospital and Health Centre HIV/AIDS Committee to perform the tasks. These include: facility director; physicians; nurses; pharmacist/ pharmacy technician/ druggist; laboratory technicians; counsellors; matron; and PLHA. Most importantly, all health personnel should be trained in ART provisions.

These personnel have the following responsibilities: to develop an ART work plan; prepare site for accreditation; assure that access to ART is in line with national guidelines; institute weekly meetings; review ART clinical monitoring data; act without delay on emergent corrective measures; submit M&E to regional ART task force via appropriate channel; assure integration of

ART with other services; assure logistics system; coordinate capacity building; and assure that all staff participate in ART.

In this context, ART services are provided to the PLHA clients by Health Centre HIV/AIDS Committee members that are composed of physicians/health officers; nurses; laboratory technicians; pharmacy technicians/druggist; counsellors; and PLHA. The Committee members are strictly required to establish referral system to and from the community; to serve as an entry point for ART care and to provide referral to the hospital; to provide technical support to sub cities and Kebeles; to assist in establishing the community care monitoring system; to assist in analyzing and reporting community care data; and to assume hospitals' responsibilities in areas, where hospitals do not exist. MoH (2005, p. 8) states,

> A successful implementation of ART Programme at all levels requires appropriate and standardized structures, processes, measurements, and monitoring. This entails: strictly following national ART policies, guidelines and protocols, using clinical tools and monitoring, establishing minimum requirements for facility accreditation, enforcing standard operating procedures, standardizing training curricula and materials, and developing and applying standardized health management information system.

People living with HIV/AIDS in Horo Guduru District of Wollega Zone in North-western Ethiopia have been suffering from HIV/AIDS-related problems. Thus, this research tries to contextualize care and support which have been provided to the PLHA, to navigate the deep waters and challenges posed in the context of HIV/AIDS- related multi-dimensional issues in order to evaluate these services and to identify Shambu Hospital's efforts, strengths and constraints in providing the strictly required care and support services for PLHA who have been its clients beginning from 2007 to 2012. Thus, this research intends to look into how they have been intervening to mitigate the multi-faceted impact of the problems.

1.3 Objective of the Study

This study aims at assessing and evaluating Shambu Hospital's interventions for providing care and support to People living with HIV/AIDS using cross-sectional data (beginning from 2007 to 2012) in Horo Guduru District of Wollega Zone in North-western Ethiopia. It specifically intends to:

- assess care and support services for people living with HIV/AIDS in Shambu Hospital in Horo Guduru District;
- evaluate care and support services in the Shambu Hospital; and
- Identify the Hospital's efforts, strengths and constraints in providing care and support services for PLHA who have been clients of the Shambu Hospital since 2007.

1.4 Operational Definition of Concepts

- **Care**: - the services rendered by members of the health professions for the benefit of HIV/AIDS patient. (Source: Guidelines, *Federal HIV/AIDS Prevention and Control Office, March 2008*)
- **Illiterate**: Having little or no formal education.
  (Source: *http://www.thefreedictionary.com/illiterate)*
- **Opportunistic infection:** An infection by a micro-organism that normally does not cause disease but becomes pathogenic when the body's immune system is impaired and unable to fight off infection. (Source: http://*www.thefreedictionary.com*)
- **Palliative care**: is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (Source: *http://www.who.int/cancer/palliative/definition/en/*)

1.5 Limitations of the Study

The results explored from study may not represent other hospitals because the constraints and strengths that this Hospital has may not exist in other hospitals. Besides, the sample size for this study was not calculated statistically and then not representative of the target population. Therefore, the results of this study could not used for the purpose of generalization for other hospitals in the zone or region. In addition, this study was not designed to deeply investigate the Hospital.

1.6 Organization of the Thesis

The MSW Dissertation has six chapters. Chapter One introduces to the need for study, statement of the problem, objectives of the study, operational definitions of concepts, and limitations of the study. The Second Chapter presents review of related literature, and discusses about conceptual/theoretical framework of the study, clinical care service, psychological support, socio-economic support, involvement of PLHAs and their families and respect for human right and legal needs. Chapter Three is on study design and methods. Specifically, it describes the study area, study design and methods, universe of the study, sampling method, tools and procedures of data collection, data processing and analysis, and ethical issues. The Fourth Chapter dwells on data analysis and interpretation. Chapter Five presents discussion which highlights those major findings in the light of the results of those previous relevant studies conducted elsewhere in the world. Finally, the thesis puts together those interpreted and discussed findings in order to draw conclusions and to recommend suggestions for action or practice.

CHAPTER TWO

LITERATURE REVIEW

2.1 Conceptual/Theoretical Framework

Care and support model incorporates interventions for PLHAs. Care and support for PLWHA is also to enable them live a positive or meaningful life. These are practical (in cash and/or kind), physical, emotional and spiritual of the patients, their care givers and families (including treatment of opportunistic infections). Medical treatment and nutritional support are equally important. Of all these, spiritual care tends to help most as it enables them enjoy relative peace of mind while drawing closer to God Almighty (WHO, 2007).

Providing care to people living with HIV/AIDS and to their families requires a broad range of services that include not only clinical care focusing on diagnosis and treatment but also supportive and complementary services to ensure that adequate nutrition, psychological, social and daily living sup-port are available. Efforts to prevent HIV transmission also need to be strengthened whenever opportunities arise, according to the same document.

In order to provide caring service for PLHAs, it is imperative to treat and to support them. Regarding adequate treatment service, there should be anti-retroviral therapy (ART), opportunistic infections, food (dietary intake), housing facilities, clothing materials, soap, toothpaste, etc. treatments. The treatment also includes pocket money and diagnostic testing. There have to be adequate support services, such as psychological, guidance, counselling, rights and legal, spiritual, income generating activities, community, and social inclusion. Therefore, both adequate care and support services contribute to sustainability of healthy living people for a sustainable healthy life (see Figure 1).

Comprehensive HIV/AIDS care and support services must include inter-related treatment services. These are clinical care for everyone, psychological support, socioeconomic support, involvement of people living with HIV/AIDS and their families and respect for human rights and legal needs.

2.2 Clinical Care for Everyone

Everyone should receive clinical care regardless of gender and age. Services include counselling and testing for diagnostic purposes (including dedicated programs of voluntary counselling and testing); prophylaxis of opportunistic infections; management of HIV/AIDS-related illnesses; control of tuberculosis and management of sexually transmitted infections; management of HIV disease with antiretroviral combination therapy; palliative care; access to drugs related to HIV/AIDS, including drugs for opportunistic infections, cancer related to HIV/AIDS and antiretroviral drugs; interventions to reduce the mother-to-child transmission of HIV; support systems such as functioning laboratories and drug management systems; nutritional support; health education measures; adequate universal precautions in clinical settings; and post exposure prophylaxis.

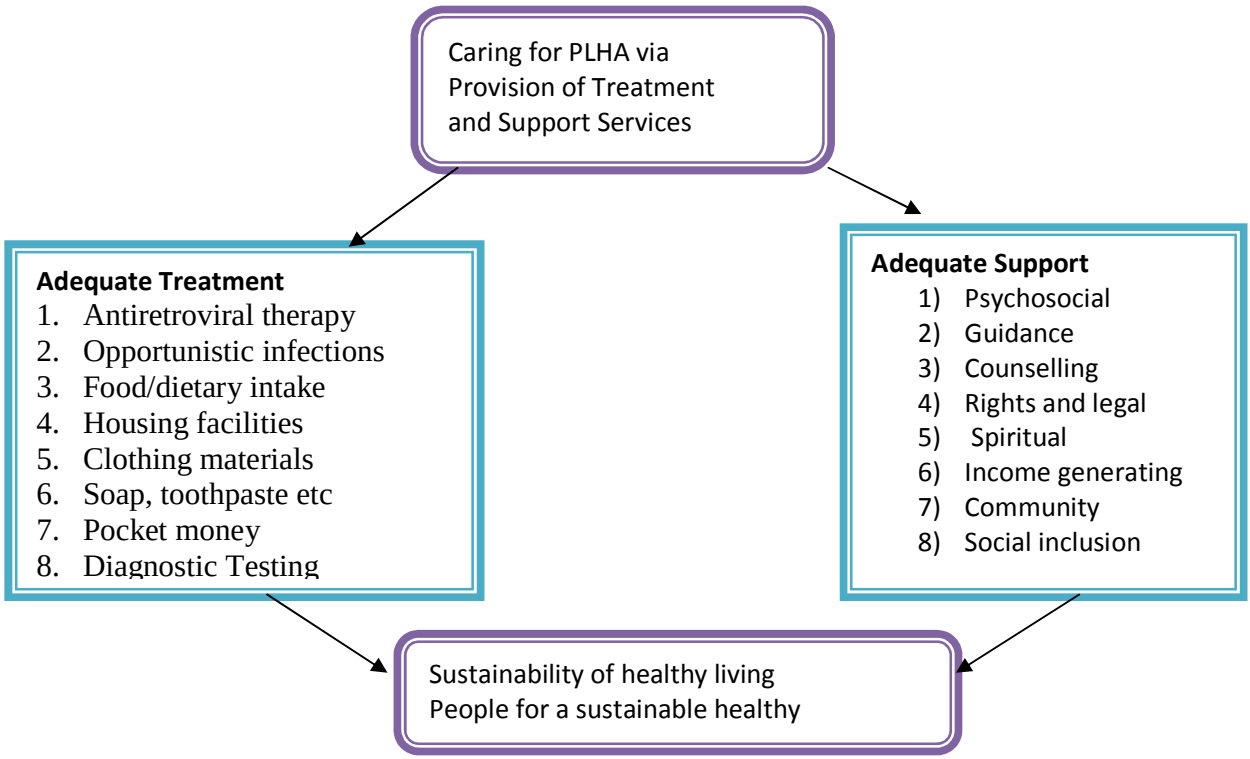


Figure 1. Conceptual Scheme for Sustainability in HIV/AIDS Care and Support for the PLWHA

Source: Guidelines, *Federal HIV/AIDS Prevention and Control Office, March 2008*)

2.3 Psychological Support

Psychological support includes initial and follow-up counselling services to meet the emotional and spiritual needs of people living with HIV/AIDS and their families and to assist in disclosure, including psychosocial support through support groups (post-test clubs) and other peer, volunteer or outreach approaches within communities.

2.4 Socioeconomic Support

Material and social support is needed within communities to ensure that nutritional and daily living needs are met. Various options include micro-credit schemes; housing; food support; helping hands in the household; health insurance schemes that include HIV/AIDS care and treatment; and planning and support for orphans and vulnerable children in households and communities (WHO, 2004).

At the heart of social aspects of HIV/AIDS, PLWHA have various needs that, if gotten could make them feel relatively comfortable with their conditions. Diam and Angono (2001) argued that the basic needs of PLWHA in Senegal and around the world are provision of support and aids to them. This requires receiving, interviewing, listening attentively to and visiting them at homes and hospitals, giving them medical care, especially by treating their opportunistic infections and supplying them with food materials. Other assistance for empowering PLWHA is to expose them to income-generating activities, like agricultural production (Okoruwa, Onwurah, & Saka, 2008). At the level of Nigeria's National Health Service and Community Act of 1990, governmental legislation has outlined areas of concerns in care management under community health. This policy initiative include: services that: flexibly and sensitively respond to the needs of individual and career, unfold a multitude of options to consumers, intervene in fostering independence and centre on those with great needs.

2.5 Involvement of People Living with HIV/AIDS and their Families

People need to be involved in the planning and delivery of comprehensive care to ensure that HIV/AIDS care, treatment and support program intended for them address their needs, reinforce adherence, prevention and care, promote health-seeking behaviour and respect their human rights (WHO, 2004).

2.6 Respects for Human Rights and Legal Needs

Services are needed that address stigma and discrimination in health facilities, in communities and in the workplace and promote equal access to care. This should also include succession planning and protection of property. All strategic plans of national AIDS program should reflect this comprehensive approach to HIV/AIDS care, which should be promoted by public and nongovernmental health program and institutions. “Each service in this comprehensive approach reinforces and is linked to other services in a continuum of care that begins when a person learns of his or her HIV status and is offered for the duration of the illness comprehensive care and support that also addresses the holistic needs of people living with HIV/AIDS and their family members (WHO).

Lichtenstein (2003, 2008) argues that fear of stigma, discrimination and risk to contract STIs, like HIV/AIDS have limited the interests of many, especially older African American women in participating in care and support activities for patients in some areas located in the Southern part of America. Maman and others (2009) added that stigma and discrimination are influenced by people’s fear of transmission, their perceived dangers of and suffering from HIV/AIDS and vulnerability to death, including burden associated with provision of care services to PLHA, but these are likely to be lessen by the amount of access to treatment, care and support that each positive person has and the socioeconomic power of each PLHA.

CHAPTER THREE
STUDY DESIGN AND METHODS

3.1 Description of the Study

Horro Guduru Wollega Zone is located in Oromiya region, in Western Ethiopia about 315km from Addis Ababa. The total populations of the zone was 676450 among these 338876 were male and 337574 were females. The capital town of zone is Shambu town and also there are other administrative towns in the zone.

The climate of the areas has three zones: 'dega' (high land zone, 2400m above sea level), with annual mean temperatures ranging from 10 to $16c^0$, 'Weynadega' a middle zone, 1500-2400m, with annual mean temperatures from $16\text{-}29c^0$, and 'kola' or hot low lands, below 1500m , with temperature $23\text{-}33c^0$. Majority of the population live in rural areas, subsisting mainly on small scale agricultural production mainly Teff, Maize, Wheat, Beryl and oil seeds.

The populations of the zone also mainly depends on animal production like Cows, Sheep, Goats, Horse, Mule and hen in addition to agricultural production.

In this zone there are two dams for hydroelectric power supply namely Fincha and Amarti-Nashe. The power they generate is more than 180 MW. Also Fincha Sugar factory which produces Sugar and ethanol from its Molasses is found in the zone. This factory uses the excess water from hydroelectric power for irrigation of Sugar plantation. The dams also serve for Fish's production.

The most dominant ethnic groups were Oromo followed by Amhara. The major religious groups are Christian (orthodox and protestant) and Muslim.

Administratively, the zone is divided into nine (9) districts and one administrative town. In the zone there is 1 District hospital, 45 health centres, and 175 health posts serving the catchments populations of the zones. Shambu Hospital is the only Hospital found in zone. It is supported by Governments, International non-Governmental Organization and local non-Governmental Organization s. Also the services provided for PLWHA were supported by four non-Governmental Organizations.

3.2 Study Design and Methods

This study used non-experimental study design. Both quantitative and qualitative research approaches were also used in this study. In quantitative research approach, descriptive sample survey was used through the use of interview schedule. Under qualitative research approach, the researcher employed semi-structured interviews with key informants, individual in-depth interviews with two PLHAs from both sexes, observations of the Hospital's relevant settings and documentary analyses of pertinent documents in different resource centres. By so doing, the researcher also identified relevant categories of themes and contents, quoting and paraphrasing pieces of information drawn through extensive and intensive literature reviews.

3.3 Universe of the Study

The study included all people living with HIV/AIDS in Horo Guduru District of Wollega Administration Zone, North-western Ethiopia. However, the sample population or target population was composed of all people living with HIV/AIDS who had been provided with ART at the Shambu Hospital since 2007. There are about 800 people living with HIV/ADS who are clients of the ART Programme of the Shambu Hospital taking antiretroviral drugs since then. Therefore, it was appropriate to conduct study on ART services which had been provided to these clients at the Hospital.

3.4 Sampling Method

In the study, the researcher proposed to take a sample size of 60 people that were selected and drawn among a total of 800 people living with HIV/AIDS. Sampling method proposed were non-probability sampling, specifically purposive sampling. The researcher selected this sampling method due to proximity of the health institution and cost effectiveness. Generally, as much as possible, the researcher collected data from different categories of the clients who had been residing in all kebeles of the town in Horo Guduru District.

3.5 Data Collection: Tools and Procedures

The main tools of data collection in the study were interview schedule or structured questionnaire for descriptive sample survey study in order to collect data from the sample of people living with HIV/AIDS. The interview schedule shall mostly contain closed-ended questions though some open-ended and mixed questions were also included. The interview schedules were prepared by English language and then translated to local language which is Afan Oromo. In qualitative research methods, the researcher used interview guide for conducting semi-structured interviews with key informants and in-depth interviews. The questions in the interview guide were formulated by keeping in mind the objectives of the study. In order to conduct direct observations or non-participant observations, the researcher employed observation schedule to generate qualitative data on those issues which may be difficult to be collected reliably by way of interviews. In addition, the researcher also conducted documentary analyses using documentary analysis checklist.

3.6 Data Processing and Analysis

The completed interview schedules or structured questionnaires were scrutinized, verified, edited and arranged serially. The quantitative data collected could be processed and analyzed manually and on the computer by using SPSS software in order to generate outputs in the form of frequency distribution tables, charts, bi-charts, graphs, measures of central tendency, and measures of dispersion statistical techniques in the light of the objectives of the study and the nature of variables in the study. In what follows, both quantitative data and qualitative data were used in their appropriate parts while writing up the thesis.

3.7 Ethical Issues

Ethical issues were considered at all stages of data collection. Firstly, a formal letter was written to Shambu Hospital by School of Graduate Studies of St. Mary's University College in collaboration with IGNOU and then the written permission was taken to the Hospital. Verbal consents were obtained from each respondent and they were informed as the information they provided were not exposed to others – remain confidential. The researcher also avoided of biases in all process of accomplishment of the research as much as possible.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

This chapter is dedicated to the presentation of the results from the research. It has been categorized into four main parts. The first part deals with a distribution of respondents according to certain selected background variables through the questionnaire survey. The main background variables are care and support services. They include sex, age, marital status, educational status, religious affiliation, disability status, causes of disability, residence types, time of knowing one's HIV status, mechanisms of knowing one's HIV status, reactions after knowing one's HIV-positive, ways of getting convinced to live positively, current occupational status, and monthly income. The second part looks at available care and support services at Shambu Hospital. The next part presents and discusses about human resources. The last part is devoted to the effects, strengths and constraints in effectively providing comprehensive care and support for PLHA clients in Horo Guduru District.

4.1 Background Characteristics of Respondents

A total of 60 respondents participated in the study. As shown in Table 1, about two-third 38(63.3%) of the respondents were females and the rest (36.7%) were males. Those people living with HIV/AIDS who have been ART clients at Shambu Hospital are mostly females. Regarding their educational status, the findings of the study indicate a mixed picture. The educational background of the respondents were relatively got concentrated at primary second cycle (grades 5 to 8) in which this educational level accounted for 16.7%.

The dominant religion of the study subjects were Orthodox Christianity, 33(55.0%), followed by Protestant Christianity which accounted for 18(30.0%), Muslims 7(11.7%) and Catholic Christianity, 2(3.3%) in that given order. Similarly, when one sees the marital status of them, more than half (55.0%) of them were found to be single/never married, but those were found to be married accounted for 30.0%. More than one-quarter (26.7%) of the respondents' ages were found to be between 30 and 34 years. The mean age of the respondents' ages was also 36.9 years with standard deviation of 12.3 years. Therefore, the clients of the Hospital are mostly female older adults. In addition, there is variability in the age distribution of the respondents which, in turn, results in heterogeneous subjects.

The PLHA clients of the Shambu Hospital mostly reside in conventional type of houses. As to the house type of the study participants, about 50(83.3%) were found to be conventional type, while the rests were conventional attached housing type which accounted for 10.0%.

Table 4. 1 Distribution of Respondents by Sex, Age, Marital Status, Religion, Educational Status, and House/Residence Type in Shambu Hospital, 2013

Variable	Category	Frequency (n)	%
Sex	Male	22	36.7
	Female	38	63.3
	Total	**60**	**100.0**
Educational background	Illiterate	9	15.0
	Able to read and write	9	15.0
	1-4	7	11.7
	5-8	10	16.7
	9-10	9	15.0
	11-12	5	8.3
	Certificate holder	7	11.7
	Others	4	6.7
	Total	**60**	**100.0**
Religion	Orthodox	33	55.0
	Protestant	18	30.0
	Muslim	7	11.7
	Catholic	2	3.3
	Total	**60**	**100.0**
Marital status	Single	33	55.0
	Married	18	30.0
	Divorced	7	11.7
	Separated	2	3.3
	Total	**60**	**100.0**

Age category	<15	2	3.3
	15-19	3	5.0
	20-24	2	3.3
	25-29	7	11.7
	30-34	16	26.7
	35-39	9	15.0
	40-44	6	10.0
	45-49	5	8.3
	>=50	10	16.7
	Total	**60**	**100.0**
House type	Conventional	50	83.3
	Conventional attached	6	10.0
	Hotel	1	1.7
	Others	3	5.0
	Total	**60**	**100.0**

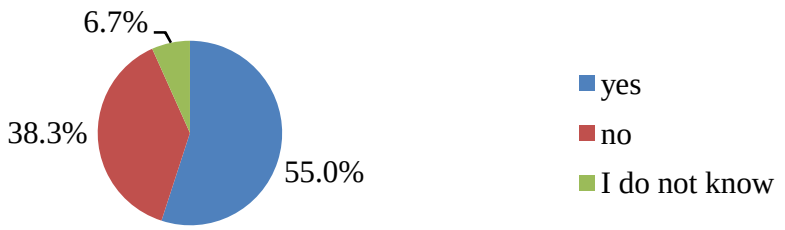
SOURCE: Own field survey, 2013

4.2 Care and Support Services

Although all of the respondents had known the practice of ART services at the Hospital, only about fifty-two percent of the respondents thought that all people living with HIV had been in need anti-retroviral therapy (ART) at the Institute, while 13.3% thought that because they had not been in need of the ART. Surprisingly, a total of 21(35.0%) of them were found to be without any idea on the treatment.

As far as access to IEC materials on HIV-positive living and ART were concerned, more than half (55.0%) of them responded that they had had access to IEC materials. However, 23(38.3%) had not had access to those materials and 4(6.7%) were found to be without any awareness of the availability of IEC materials (Figure 1).

Fig.2. Showing percentage of respondents access to IEC material Horo Guduru Wollega zone, Shambu, March, 2013.



SOURCE: Results of own study, 2013

Thirty- nine (65.0%) of respondents thought that there had been essential drugs available in the Hospital for ART services and 21(35%) were found not to be aware of whether drugs had been available or not. In order to effectively provide the required care and support services for PLHAs at the Hospital, the majority 43(71.7%) of the respondents were found to be aware of laboratory tests had been available in the Hospital. Thus, Shambu Hospital has already made avail essential drugs for ART services to be provided to the PLHA clients since 2007.

The majority 58(96.7%) of study subjects answered that as viral load counts had not been available at the health facility which, in turn, affected to qualify the PLHAs for ART. Similarly, fifty-five percent of them argued that because blood sample had not been sent to nearby health facility. Moreover, 27(45.0%) of the subjects in the study said that blood had not been sent to the nearby facility for viral load counts. Therefore, the viral load counts are being performed at Shambu Hospital.

A significant majority, 55(93.2%) of the respondents were found to be in the opinion of CD4 counts as they had been done at the Hospital and the rest of them responded that the counts had not been not done at the health facility. In addition, 16(26.7%), 10(16.7%% and 34(56.7%) thought that syringes and needles had been re-used, had not been re-used, and had not been aware of the practice respectively (Table 2).

Table 4.2 Respondents Opinion about availability of Facilities with Tests and Services for delivering ARVs, Opportunistic Infections, Care and Support Services at the Hospital Level, March 2013

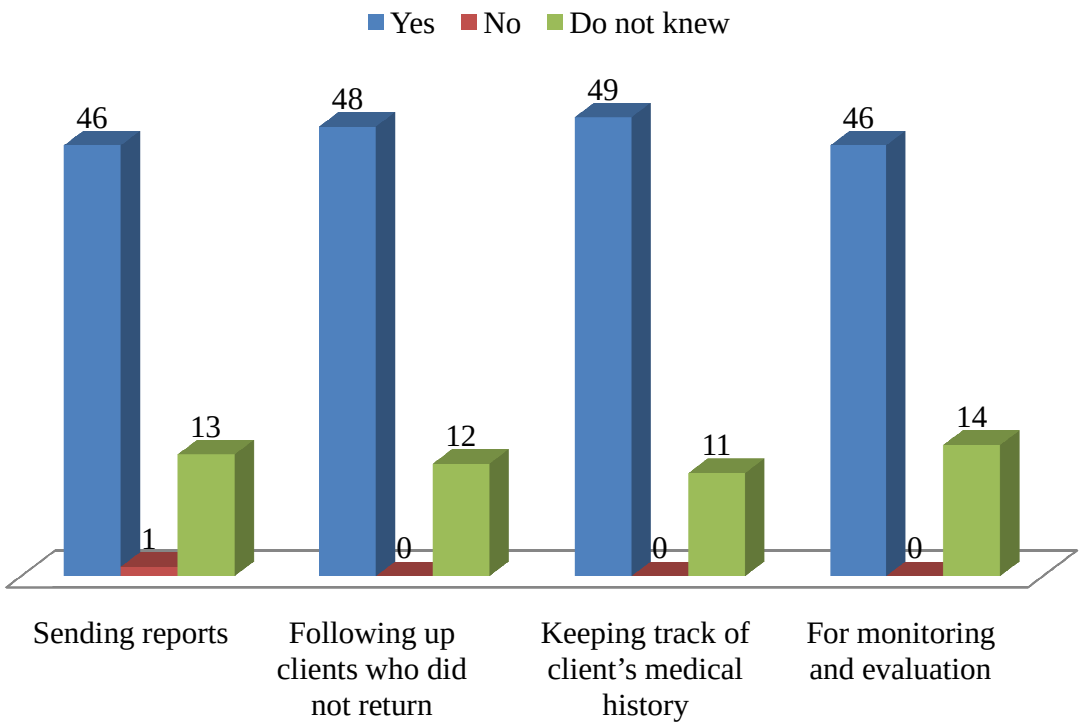
Items	Yes [n [n(%)]	No [n [n(%)]	I do not knew] [n(%)]
Viral load counts due at the facility	2(3.3%)	58(96.7%)	0(0.0%)
Blood sent away to nearby facility	27(45.0%)	33(55.0%)	0(0.0%)
CD4 counts done at the facility	55(93.2%)	4(6.8%)	0(0.0%)
Blood sent away to a nearby for CD4 counts	8(13.3%)	6(10.0%)	0(0.0%)
Re-use of syringes and needles	16(26.7%)	10(16.7%)	34(56.7%)

SOURCE: Own survey results, 2013

Concerning the uses of records by the facility managers at the Hospital were concerned, the majority 46(76.7%), 48(80.0%), 49(81.7%) and 46(76.7m%) of the sample clients expressed that the medical records had been sending reports, following up of the clients who did not return to the Institute, had been keeping client's medical history to use for monitoring and evaluation of the care and support services respectively (Figure 2).

The study revealed that the dominant Sex category in ART care and support services according to the respondent's belief were female 51(85.0%). Similarly, the dominant 51(85.0%) age category that, the care and support providers' age is found dominantly were 30-34 years followed by age 35-39 which were 5(8.3%). Also the rest age categories 20-24 were 2(3.3%) and 25-29 age were 2(3.3%).

Fig 3. Showing respondent answerer about the use of records by the facility managers at the hospital (n=60) Horo Guduru Wollega zone, Shambu, March, 2013.



SOURCE: Compiled by the author, 2013

The PLHA clients who are presently attending the ART at Shambu Hospital believe that the HIV/AIDS Committee members and health professionals have already got trained in the ART services. Nevertheless, the respondents confirm that they have not yet trained in the proper provisions of ART. Regarding the respondents' belief about the Hospital's HIV/AIDS committees, 41(75.0%) of them believed that they had been trained, while 5(8.3%) and 14(23.3%) believed that the committees were not trained and had not even known respectively. Thus, the present HIV/AIDS Committee members who are working in the Hospital have been trained in ART. The findings of the study also showed that 45(75.0%) respondents had thought health professionals got trained in ART services, but 15(25.0%) of them had not known whether the providers were trained or not. The majority 42(70.0%) respondents had ever attended in ART training when they became providers of the ART services, while 4(6.7%) had not attended and

even 14(23.3%) of them had not managed to remember the training. Generally, those committee members who have already reached at primary education second cycle and secondary education first cycle are got trained in proper provisions of ART.

Table 4.3 Educational Status of Respondents by Ever attended ART Training, March 2013.

Educational level	Ever attend ART training					
	Yes		No		Do not remember	
	f	%	f	%	f	%
Illiterate	5	11.91	0	0.00	4	28.57
Able to read and write	4	9.52	2	50.00	3	21.43
1-4	4	9.52	0	0.00	3	21.43
5-8	7	16.67	1	25.00	2	14.29
9-10	7	16.67	0	0.00	2	14.29
11-12	4	9.52	1	25.00	0	0.00
Certificate holder	7	16.67	0	0.00	0	0.00
Others	4	9.52	0	0.00	0	0.00
Total	**42**	**100.00**	**4**	**100.00**	**14**	**100.00**

SOURCE: Own study findings, 2013

The clients of ART are most satisfied by the services provided at the health facility. High number 44(73.3%) of the respondents were found to be very satisfied by overall ART services at the Hospital, while small number 15(25.0%), and 1(1.7%) were satisfied and neither satisfied nor unsatisfied in that order. Hence, about 48(80.0%) the respondents rated or evaluated the ART services as very good; among this, 16 respondents were males, and 32 were females. Similarly, 11(18.3%) rated the ART services as good and 1(1.7%) rated as neither good nor bad (table 4.). Therefore, Shambu Hospital is providing very good ART services to its PLHA clients.

Table 4.4 Relationship between Sex of the Subjects by their Evaluation Rate ART Services, March 2013

Sex	Evaluate or rate ART services						Total	
	Very good		Good		Neither good nor bad			
	f	%	f	%	f	%	f	%
Male	16	26.67	5	8.33	1	1.67	22	36.6
Female	32	53.33	6	10.00	0	0.00	38	63.33
Total	**48**	**80.00**	**11**	**18.33**	**1**	**1.67**	**60**	**100.00**

SOURCE: Own survey, 2013

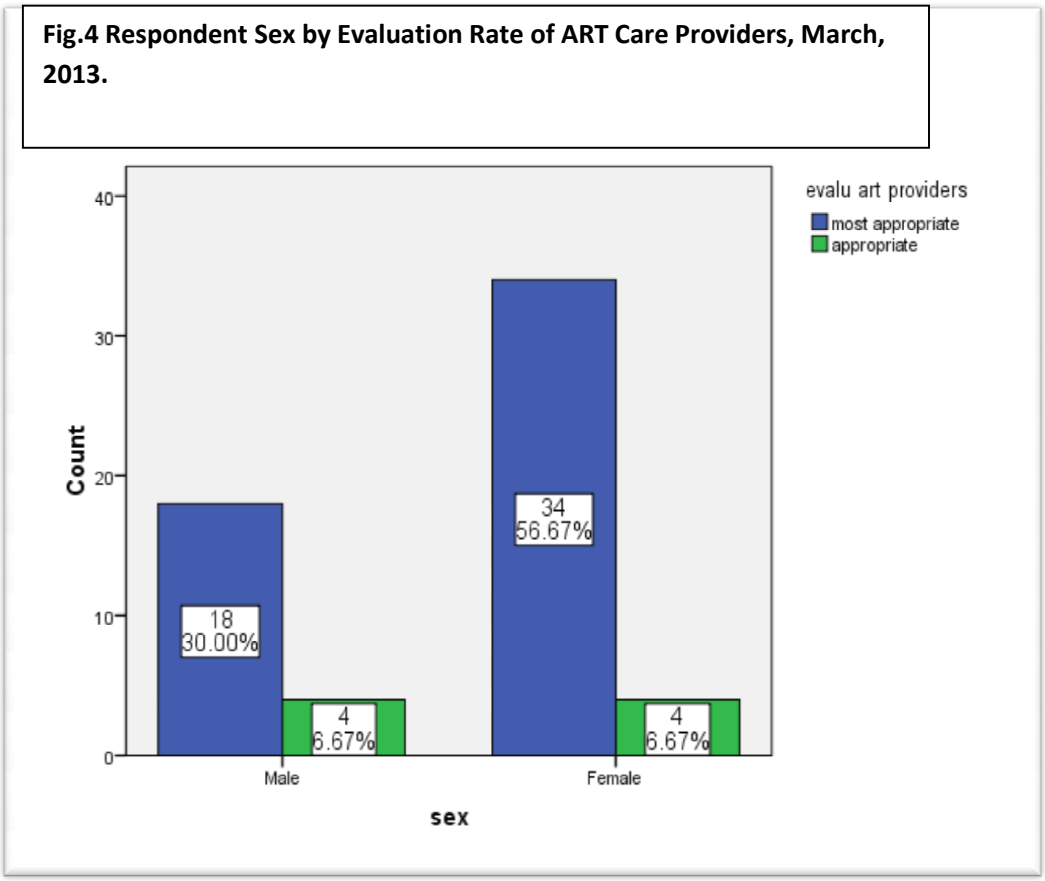
Likewise, the study subjects also evaluated the ART provider's examination(s), diagnosis and treatment for each of their health complaint as most appropriate 52(86.7%) and appropriate 8(13.3%).When one could see this by sex category, high number of both males (18) and females (34) had evaluated ART providers as most appropriate (Figure. 3).

4.3 Hospital's Efforts, Strengths and Constraints in providing Care and Support Services

Most of the respondents' opinions on efforts of the Hospital ART providers were investigated. They are convincing the issues that they serve, good adherence, good counselling, and very good support on relative diseases beyond HIV/AIDS. Regarding strengths of care and support provisions for PLHA at the Hospital, there were services on drug dispensing, laboratory, ANC follow-up, malnutrition and services on counselling and screening service for TB treatment and management.

The constraints on the part of the Hospital in effectively providing comprehensive care and support services were found to be scarcity of man power in drug dispensing; and scarcity of a few drugs (like Cotrimoxazol syrup), shortage of money to support for those clients on ART for providing food support; helping hands in the household and spiritual support giver(s).

Fig.4 Respondent Sex by Evaluation Rate of ART Care Providers, March, 2013.



SOURCE: Own study results, 2013

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

This study indicated that all of the respondents had known the practice of ART services at the Hospital. This practice was found to be similar to what had been stated in the Guidelines. The Guidelines indicate that those types of services which have been provided to support PLHA clients. Everyone should receive clinical care regardless of gender and age. Services include counselling and testing for diagnostic purposes (including dedicated programs of voluntary counselling and testing); prophylaxis of opportunistic infections; management of HIV/AIDS-related illnesses; control of tuberculosis and management of sexually transmitted infections; management of HIV disease with antiretroviral combination therapy; palliative care; access to drugs related to HIV/AIDS, including drugs for opportunistic infections, cancer related to HIV/AIDS and antiretroviral drugs; interventions to reduce the mother-to-child transmission of HIV; support systems such as functioning laboratories and drug management systems; nutritional support; health education measures; adequate universal precautions in clinical settings; and post exposure prophylaxis.

Even though the ART Guidelines are indicating that all clients who are living with HIV need ART service, the findings of the study have come up with mixed picture on the issues under investigation. This study revealed that only about 31(51.7%) respondents had thought that all people living with HIV need anti-retroviral therapy (ART) at the Hospital, while 8(13.3%) thought as they had not been in need ART and 21(35.0%) of them were found to be without any idea on the service.

In the same framework, the study also revealed that there had been constraints of basic resources (such as money and man power) for socio-economic supports of peoples living with HIV/AIDS. Unlike this, at the heart of social aspects of HIV/AIDS, PLHA clients have various needs that, if they manage to secure them could make them feel relatively comfortable with their existing conditions. Diam and Angono (2001) argue that the basic needs of PLHAs in Senegal and around the world have been provisions of supports and aids to them. This requires receiving,

interviewing, listening attentively to and visiting them at their respective homes and hospitals, giving them medical care, especially by treating their opportunistic infections and supplying them with food materials. Other assistance for empowering PLHAs is to expose them to income-generating activities, like agricultural production (Okoruwa, Onwurah, & Saka, 2008). At the level of Nigeria's National Health Service and Community Act of 1990, governmental legislation has outlined areas of concerns in care management under community health. This policy initiative include services which are flexibly and sensitively respond to the needs of individual and career, unfold a multitude of options to consumers, intervene in fostering independence and centre around those with great needs.

The study further identified the nutritional service provided for the clients at Shambu Hospital. The Hospital was serving the clients that had had malnutrition (both moderate and severe malnutrition) by providing pulpy nuts. Besides, some scholars have identified that, in providing care to people living with HIV/AIDS and to their families requires a broad range of services that include not only clinical care focusing on diagnosis and treatment but also supportive and complementary services to ensure that adequate nutrition, psychological, social and daily living supports are available. Generally, efforts to prevent HIV transmission also need to be strengthened whenever opportunities arise (WHO, 2004). This statement concurs with the findings of the study as the majority of key informants, FGD participants and documentary analyses clearly justified in the study District.

5.2 Conclusions

This thesis has been arguing that proper care and support services provided to PLHA clients has to consider the socio-demographic, sensitive issues related to getting infected with HIV and individuals' reactions upon getting informed their HIV positivity status; available care and support services and available number, quality and professional composition of the service providers at district hospital level; and concerted efforts, as well as strengths contribute a lot. In addition, constraints on the part of the Hospital and its various stakeholders have already lent their hands in influencing the ART services at the Hospital.

The PLHA clients at Shambu Hospital are single/never married females in the age category of 30-34 years who have already attended second cycle of primary education of the current

regime's education system. These clients are also residing in conventional housing units in Horo Guduru town, North-western Ethiopia.

As all of the PLHA clients have known the practice of ART services at Shambu Hospital, almost half of them are in need of the ART and also have access to IEC materials. In addition, the clients are aware of the availability of essential drugs, including laboratory tests. Moreover, services related to viral load counts are available at the health facility and CD_4 counts which are very important to determine whether or not to prescribe ART to a specific client are carried out.

The managers of the health facility are sending medical reports to different network partners, but no practice of feedback from them. Consequently, the Hospital's Officials cannot effectively perform M & E of the care and support services.

In Shambu Hospital, the HIV/AIDS Committee members who are providing ART care and support services for PLHA clients have already got trained in proper provisions of ART services. The clients of the Treatment in Shambu Hospital are most satisfied by the services provided. Therefore, the ART services which are provided in the Hospital are viewed as very good. This is because ART providers' medical examinations, diagnostics and treatments for each type of health compliant of the PLHA client as most appropriate. These are cumulative and concerted results of the Committee members and the Officials of the Hospital's efforts and strengths in those matters.

Against these backdrops, there are some constraints on the part of different stakeholders at different levels in effectively providing comprehensive care and support services due to scarcity of well-trained manpower in drug dispensing and that of few drugs (like Cotrimoxazol syrup) and shortage of financial resource for properly providing food support, helping hands in the housh9old chores and spiritual support providers at Shambu hospital in Horo Guduru town.

5.3 Recommendations

Based on those major findings and conclusions drawn from them, the researcher forwards suggestions for action or practice and for further study. As the study revealed, there are some points that the Hospital should consider in the future. These are:

- Shambu Hospital and NGOs which are supporting the Hospital should consider equal access to IEC material for all HIV/AIDS patients and ART clients by giving due attention to their socio-demographic and other relevant characteristics.
- The Hospital should create awareness for all people living with HIV/AIDS who have been getting care and support services from the health facility about the services it provides.
- Since there is shortage of trained manpower in the health facility, all concerned officials and stakeholders at different levels should hold consultative meetings and decide to employ and fulfill the required manpower at Pharmacy Department of the Hospital.
- The Hospital should avail and have to ensure all necessary drugs for ART (e.g. Cotrimoxazol syrup) in its stock at any time.
- It should also consider how to create awareness of the materials serving the clients, for example about syringes.
- All concerned Officials and other stakeholders of the Hospital should keeping on strengthening the efforts and their strengths already put in place and toil against those constraints which have been preventing them to effectively carry out ART care and support services at the health facility.
- As the current study was completed using a non-experimental study design, cross-sectional sample survey of the quantitative research approach and complemented by some of the qualitative research methods using social work perspective, a similar study should be planned within the same school that uses an adequate, representative sample size and a longitudinal research method to determine if changes, as well as adherence to the ART over time become perceptible among the PLHA clients of Shambu Hospital in Horo Guduru town.

REFERENCES

Campbell, C., et al. (2005). Understanding and challenging HIV/AIDS stigma. *In HIVAN Community Booklet Series*. Natal, Durban: Centre for HIV/AIDS Networking (HIVAN), University of Kwa-Zulu.

Diam, P., & Angono, A. Z. (2001). *Income-generating activities: An experiment in Senegal. Voices from Africa: NGO Responses to HIV/AIDS, Issue 10*. Geneva: NGLS Publication.

Fleck, F. (2003). WHO issues global alert after grim report on HIV/AIDS. *BMJ*, 327: 698.

International HIV/AIDS Alliance. (2007). Understanding and challenging HIV stigma: Module D&E. Retrieved from http://www.aidsalliance.org/graphics/secretariat/publications. 3stigma D&E. PDF.

Kalichman, S.C., et al. (2005). Development of a brief scale to measure AIDS-related stigma in South Africa. *AIDS and Behaviour*, 9(2), 135-143.

Kapp, C. (2003). AIDS campaign signals new WHO priorities and approach. *The Lancet*, 362: 1900-1901.

Lichtenstein, B. (2008). Exemplary elders: Stigma, stereotypes and sexually transmitted infections among older African Americans. *Current Sociology*, 56(1), 99-114.

Link, B.G., & Phelan, C. G. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.

Mawar, N., Sahay, S., Pandit, A., & Jahajan, U. (2005). The third phase of HIV pandemic; social consequences of HIV/AIDS stigma and discrimination and future needs. *Indian Journal of Medical Research*, 122, 471-484.

MoH. (2005). *Guidelines for implementation of antiretroviral therapy in Ethiopia*. Addis Ababa: Commercial Printing Enterprise.

____. (2011). *Health and health related indicators*. Addis Ababa: Policy Planning Directorate Office, Ministry of Health.

Okoruwa, V. O., Onwurah, B. C., & Saka, J. O. (2008). Food demand among HIV households in North Central, Nigeria. *European Journal of Social Sciences*, 5(4), 91-98.

Smith, R.A., & Morrison, D. (2006). The impact of stigma, experience, and group referent on HIV risk assessments and HIV testing intentions in Namibia. *Soc. Sci. and Med*, 63, 2649-2660.

UNAIDS. (2005). *HIV related stigma, discrimination and human rights violations: Case studies of successful programs.* Geneva: UNAIDS/WHO. Pp. 1- 44.

WHO. (2004).*National AIDS programmes: a guide to monitoring and evaluating HIV/AIDS care and support*. Geneva: WHO. Pp. 4-6.

____. (2007a). *Module 9. People living with HIV/AIDS.* . Geneva: WHO. P. 4.

____. (2007b). *Reducing HIV stigma and discrimination: A critical part of national AIDS programmes*. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS). Pp. 1-32.

____. (2007c). *Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector*. Geneva: world Health Organization (WHO).

APPENDICES

Appendix I: Interview Schedule (English version)

St. Mary's University College

School of Graduate Studies

The objective of this study was to assess and evaluate care and support services for PLHA at Shambu Hospital in Horro Guduru District North-Western Ethiopia. So, you are kindly requested to participate in the study which will identify limitation and constraints in the hospital. Your answer will be contributed for success of the study.

I. Background Data

1. Sex of the respondent: 1. Male 2. Female
2. Age of the respondent: _____ Years
3. Educational status of the respondent: 1. Illiterate 2. Able to read and write 3. Primary first cycle education (1-4) 4. Primary second cycle education (5-8) 5. Secondary first cycle education (9-10) 6. Secondary second cycle education/preparatory (Grade 11-12) 7. Certificate Holder 8. BA/BSc/BEd/UB holder 9. MA/MSc/Med/UM holder 10.Other(please specify)_____
4. What is your religious affiliation? 1. Orthodox Christian 2. Protestant 3. Muslim. 4. Catholic 5. Other (please specify) _____
5. What is your marital status?
   1. Single (never married)
   2. Married
   3. Divorced
   4. Separated
   5. Widower
   6. Living together as husband and spouse
6. Do you have any type of disability?
   1= yes 2= No

6.1 If "yes", please specify your physical disability_____

6.2 If “yes”, What is /are the cause(s) of your disability?_____

7. In which type of house are you living?

   1= Conventional (house residence or separated)

   2= Conventional house (attached)

   3= Hotel (hostel)

   4=Orphanage

   5=Boarding School /University/college dormitory

   6= Homeless

   7= Other (please specify) _____

8. When did you know your HIV sero- positive status _____E.C?
9. How did you know your HIV sero- positive status?_____
10. What were your reactions when you know your HIV sero-positive status? _____
11. How did you get convinced to live positively? _____ - _____
12. What is your current occupation? _____
13. Your monthly income in ETB_____

Part II. Care and support services

1. Do you know the practice of ART services at Shambu Hospital?

   1= Yes 2=No 3=I do not know

2. What was your CD4 count when you started getting ART at the hospital?_____
3. Which of the following types of comprehensive care and support have you been getting at the hospital?

   1=Anti-retroviral therapy (ART)

   2= Voluntary HIV Counseling and Testing

   3=Control and management of STIs

   4= Prophylaxis for certain opportunistic infection (OIs)

   5=Treatment for TB

   6=Palliative care

   7= other(please specify)_____

4. Do you think that all people living with HIV need anti-retroviral therapy(ART) at the hospital?

   1=Yes 2=No 3=I have no Idea

5. In your opinion, which of the factors are taken into account to qualify HV- Positive People for ART at the Hospital?

   1= The CD4 Count

   2= Viral loads

   3= Evidence of HIV- related disease

   4= A combination of this factors

   5= others (please specify) _____

6. Do you have access to IEC material on HIV-positive living, ART, etc?

   1=Yes 2 = No 3= I do not know

7. Please indicate the types of facilities with signs or posters advertising ART care and support services.

ART services	Location of sign or Poster			
	Inside	Outside	Both	Facilities with sign

8. Which of the following essential equipment is available for providing care and support services for PLHA?
9. Do you think that essential drugs available in the hospital for ART services?

   1= yes 2=No 3= I do not know

9.1. If “yes” to Q No. 9, then please tell me the essential drugs

10.In order to effectively provide the required care and support for PLHA at the Hospital, are there laboratory tests? 1=Yes 2=No 3=I do not know

10.1 Would you mind telling me about the types of the laboratory test available?

_____

_____

_____

11. What types of facilities with tests and services are available for delivering ARVs and opportunistic infections care and Support at the Hospital level?

    11.1. Viral load counts due at the facility? 1=Yes 2=No

    11.2. Blood sent away to nearby facility? 1=Yes 2=No

    11.3. CD4 counts done at the facility? 1=Yes 2=No

    11.4. Blood sent away to a nearby for CD4 counts? 1=Yes 2=No 3=I do not know

    11.5. In your opinion, are there instances indicating the re-use of syringes and needles? 1=Yes 2=No 3=I do not know

12. Which of the following care and support facilities have commodity management books/records?

	Yes	**No**
12.1 Equipment		
12.2 Register of medicines		
12.3 Register of contraceptives		
12.4 Reusable commodities		
12.5 Other(s)		

13. Which of the following care and support facilities have client record systems?

Record systems	Yes	No	Remark
13.1 Record system in use 13.2 Type of system a. Logbook b. Facility –retained card c. Both client and Facility –retained cards d. Other(s)			

14. Indicate the use of records by the facility managers at the hospital.

14.1 sending reports 1=Yes 2=No 3=Do not know

14.2 Following up clients who did not return 1=Yes 2=No 3=do not know

14.3 keeping track of client's medical history 1=Yes 2=No 3=Do not know

14.4 For monitoring and evaluation 1=Yes 2=No 3=D0 not know

15. Please clearly tell me about the types of care and support available for PLHA or at the Hospital

1=_____

2=_____

3=_____

4=_____

5=_____

6=_____

7=_____

III. **Human Resources**

1 .What is the dominant Sex category in ART care and support services?

1=Male 2=Female

2. In which age category, the care and support providers' age is found?

1=15-19 2=20-24 3=25-29 4=30-34 5=35-39 6=40-44 7=45 +

3. At district/District level, which are the district HIV/AIDS committee members? (Multiple responses is possible)

1= District health office representative

2= District Hospital office representative

3=Health center

4=PLHA

5= NGOs' representative

6= Private health sector (representative)

4. What are the responsibilities of the district level health desk office regarding ART care and support services?(Multiple response is possible)

1= Assists in implementing the ART program by linking facilities, kebeles and the local community

2= Supports ART activities at the local community level

3= Encourages community mobilizations among NGOs', CBOs, CSOs and FBOs

4= responds to facility needs (Shambu hospital need)

5= Reports, Monitoring and evaluation data to the Oromia region health bureau

6=Gets support from the district HIV /AIDS committee

5. Hospital HIV/AIDS committee members include

1= Facility Director 2= Physicians 3= Nurses 4= Pharmacist / Pharmacy technician/druggist 5= Lab. Technicians 6= Counselors 7= matron

6. Among the hospital HIV/AIDS committee members, do you think that all of the personnel got trained in ART?

1= yes 2=No 3=Do not know

7. Do you think that the health professionals at ART services got trained?

1= yes 2=No 3=Do not know

8. Have you ever attend in ART training?

   1= yes 2=No 3=Do not remember

9. Are you satisfied by over all ART services at the Hospital?

   1= very satisfied 2= satisfied
   3= neither satisfied nor unsatisfied 4=unsatisfied 5=very unsatisfied

10. What is/are your experiences about and/or views on general ART services?

    _____
    _____
    _____

11. About which topics did you discuss during your interaction with the ART providers?

    _____
    _____
    _____

12. How do you evaluate or rate the ART services at the Hospital?

    1=very god 2=good
    3= neither good nor bad 4 = bad 5= very bad

13. What were your health complaints during last 12 months

    _____
    _____
    _____

14. What types of illness symptoms did you experiences during the last 12 months?

    _____
    _____
    _____

15. How do you evaluate the ART provider's examination(s), diagnosis and treatment for each of your health complaint?

    1= Most appropriate 2= Appropriate
    3= neither appropriate nor inappropriate
    4= inappropriate 5= Most inappropriate

16. What is/are your experiences with and views on those services provided?

_____
_____
_____
_____

IV. Efforts, strengths and constraints

1. In your opinion, what five major efforts have the Hospital ART providers made to the level of your satisfaction?

_____
_____
_____
_____
_____
_____

2. What are the five major strengths of care and support provisions for PLHA at Shambu Hospital?

_____
_____
_____
_____
_____-
_____

3. What are the five major constraints in effectively providing comprehensive care and support for the PLHA clients?

_____
_____
_____
_____
_____
_____

Thank you!

ANPPENDIX II: OBSERVATION CHECKLIST

	Area observed	
1	Counsellor Introduce him/herself to the patient, giving his/her name and position	Yes/No
2	Review information on the patient's **HCC Registration Form**, gathering additional socio-demographic data as needed.	Done Not done
3	Assess the patient's **knowledge of HIV/AIDS**.	Adequately assessed Not adequately assessed Not done at all
4	**Educate on HIV** and correct misconceptions as needed:{Tick area covered}	How HIV attack our body immune system. Different routes of HIV transmission. Difference b/n HIV and AIDS. Healthy living practices (e.g., good nutrition, exercise, rest, social support, positive attitude toward life).
5	**Discuss ART.{Tick the part covered)**	The goals of therapy: suppress the virus and improve the immune system; it is not a cure. The reasons for combination therapy. The importance of adherence to the medication regimen. General side effects of ARVs and how to manage them.
6	Difficulties or potential barriers to keeping medical appointments, taking the medications and adhering to the medications were identified.	Identified Not identified
7	To overcome identified difficulties or barriers. Discussion for possible interventions or referrals to care and support services was done	Done Not done

8	Scheduling an appointment for the second counselling session, to include a family member/friend to whom the patient has disclosed his/her HIV-positive status and who will agree to attend the remaining counselling sessions.	Done Not done
9	Completing the appointment card and giving to the patient.	Done Not done
10	Complete the Pre-ART Counselling Form and file it in the patient's medical record.	Done Not done
11	Revision of the topics discussed during the previous counselling session:	Done Not done
12	The role of social support in ART adherence: The roles of the family member/friend were discussed.	Done Not done
13	Review of barriers to adherence: Do they still exist? Are there new ones?	Adequately assessed Not adequately assessed Not done at all
14	Defining interventions to overcome remaining barriers to adherence.	Done Not done
15	Patient asked if s/he has any questions or concerns	Not done
16	Scheduled the third counselling session and complete the appointment card.	Done Not done
17	Completing the Pre-ART Counselling Form and file it in the patient's medical record.	Done Not done

APPENDIX III: OBSERVATION CHECKLIST AFTER STARTING ART

S.N	Point to be observed/checked	
1	Patient had checked for any **side effects** using a list of possible side effects	Adequately assess Not adequately assessed Not done at all
2	**Referring patient to MD/HO** if the side effect(s) is (are) not being managed at home and is (are) interfering with the patient's quality of life and medication adherence	Done Not done
3	**Review each medication**: name, dose, schedule, possible side effects and how to manage them.	Done Not done
4	Patient were asked if s/he has any questions or concerns about the medications, how to take them or the possible side effects	Done Not done
5	For the patient that has no difficulties with medication adherence: scheduled the next counselling visit on the same day as the patient's next visit with the MD/HO (two weeks after starting ART	Done Not done Not encountered
6	If the patient is having difficulties taking the ARVs and is not adhering: discuss strategies to overcome the barriers and schedule a visit for intensive follow-up within the next 48 hours.	Done Not done Not encountered
7	Completing the Pre-ART Counselling Form and file it in the patient's medical record.	Done Not done

Annex V: Thesis Proposal