

**WHY URBANIZATION AND  
FLOURISHING INVESTMENT FAIL  
TO PROVIDE CARE AND  
SUPPORT SYSTEM TO HIV POSITIVE  
CHILDREN AND ADOLESCENTS?**

**THE CASE OF DUKEM, BISHOFTU AND MOJO  
TOWNS OF OROMIA-ETHIOPIA**

**MAKING LIFE WORTHY FOR HIV/AIDS POSITIVE AND  
VULNERABLE CHILDREN AND ADOLESCENTS**



**CENTER FOR DEVELOPMENT AND  
CAPACITY BUILDING (CDCB)**

**ADDIS ABABA (FINFINNE)  
JANUARY 2020**

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Addis Ababa, Ethiopia

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Addis Ababa (Finfinne)  
January 2020

# Acknowledgment

This case Study is developed with the financial support of ViiV Healthcare UK for which we are profoundly grateful. The research team's contribution starting from developing the methodology, data collection and write up is highly appreciated. Therefore, CDCB is grateful for all team members for their selfless contributions. We are highly grateful for all institutions' and individuals who supported us in Key informant interviews, focused Group Discussions and consultative workshops for their fruitful contributions. I am thankful for coalition for children Affected by AIDS, Positive Action for Children's Fund and ViiV Healthcare and their staffs for their comments, feedback and facilitation of all the communications.



**Amanuel Adinew**

Executive Director of CDCB

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# List of Acronyms

- CDCB** - Center for Development and Capacity Building
- CSA** - Central Statistical Agency
- DHEA** – Dawn of Hope Ethiopia Association
- EDHS**- Ethiopian Demographic and Health Survey
- EMDHS**-Ethiopian Mini Demographic and Health Survey
- FGD**- Focus Group Discussion
- HAPCO**- HIV/AIDS Prevention and Control Office
- HIV**- Human Immunodeficiency Virus
- KII**- Key Informant Interview
- LB**- Live Birth
- MDG**- Millennium Development Goal
- PACF/ViiV** - Positive Action for Child Fund/ViiV Healthcare
- PLHIV** - People Living with HIV
- PMTCT** - Prevention of Mother-to-Child Transmission

## Executive summary

*In Ethiopia HIV incidence is leveling off after declining over the last few years (EDHS, 2016). Prevention of Mother-to-Child Transmission (PMTCT) service uptake and retention is low; and mother to child transmission accounts for more than 90% of childhood HIV infections. 90% of women were failed to follow-up the treatment in the 18 months after delivery.*

*CDCB in partnership with Down of Hope Ethiopia is implementing a three year polite PMTCT project in Bishoftu, Dukem and Mojo town of Oromia-Ethiopia with the financial support of PACF/ViiV Healthcare. The towns are HIV hot spot areas located on national growth corridor and with dry port. It is area with larger number of industries; the towns are favorite tourist destinations, flourishing investments activities, with large number of commercial sex workers (either mobile or resident), and high influx of skilled, semi-skilled and unskilled youth population in search of jobs. It is with high formal and informal economic activities with high mobility people and vehicles (transport and long distance trucks).*

*This is the Best Practice Case Study of the project intended to generate evidences in an effort towards improving the lives of children affected by HIV/AIDS and vulnerable children, adolescents and youth in terms of their childhood development, care and support, awareness towards HIV/AIDS risks and PMTCT service uptake in Ethiopia. The document has employed primary and secondary data sources, in addition to reviewing of the project under implementation.*

*This document identified that there is no institutionalized care and support system in place at family, community and school levels. However, there are initiatives by individuals and groups focusing on vulnerable children including HIV positive children. There is widespread stigma and discrimination against Children/student living with HIV and from PLHIV family by their teachers, community and their peer groups. There is a network of children, adolescent and youth HIV positives but with no support. Due to the absence of care and support system in place, vulnerable children (either HIV positive or not) are highly exposed to HIV infections, child labor and abuses.*

*This case study shows the need for various interventions at different levels to address the challenges faced by vulnerable and HIV positive children, adolescents and youth in the study area. Successful interventions could also serve as reference at national level for areas of similar context. But one cannot undermine the fact that addressing poverty could positively contribute towards resolving these challenges. Creating institutional synergy through programmatic approach, designing new awareness creation strategy for the current urban-rural interaction and emerging new economic activities regarding the transmission of HIV/AIDS is crucial. Schools and family level care and support including psycho-social support are very important.*

# Part I

## 1.1 Background

Ethiopia is one of the Sub-Saharan African countries with poor nutritional status and a high fertility rate. Moreover, there are low levels of access to reproductive health and emergency obstetric services. Although Ethiopia is on the fast track to achieve its MGD 5a goal (350/100,000 LB) in reducing maternal mortality, it still experiences highest ratio of mothers' death in Africa (676/100,000 LB). This is also one of the highest maternal mortality ratios of the world (EMDHS, 2019).

According to a recent data, the prevalence of HIV in Ethiopia among women and men aged 15-49 is 0.9 percent. The prevalence is higher among women than men (CSA and ICF, 2018). The prevalence among men aged 15-49 is 0.6%, while for men whose ages range between 40 and 49, it is 1.6%. For Ethiopian women in the age category 15-49, the prevalence is 1.2% and among women aged 40-44 years it is 3%. The prevalence is seven times higher in urban areas than in rural areas (2.9 percent versus 0.4 percent). HIV prevalence is 3.6 percent among women in urban areas compared with 0.6 percent among women in rural areas. HIV prevalence in the seven regional states and two city administrations of the Federal Democratic Republic of Ethiopia is as follows: Gambella 4.8 %, followed by Addis Ababa 3.4%, Dire Dawa 2.5%, and Harari 2.4% (CSA and ICF, 2018).



**Figure 1 : Regional Consultation Workshop**

Recent studies show that the prevalence of HIV/AIDS is stabilizing in urban areas and increasing steadily in rural areas. In general, HIV incidence is leveling off after declining over the last few years (EDHS, 2016). Prevention of Mother-to-Child Transmission (PMTCT) service uptake and retention is low; and mother to child transmission accounts for more than 90% of childhood HIV infections. In 2011, 24% of HIV-positive mothers received antiretroviral (ARVs) drugs and more than 90% of women were failed to follow-up the treatment in the 18 months after delivery.

Three towns in three districts were selected for an assessment of the HIV prevalence rate. The three selected towns, namely Bishoftu, Dukem and Mojo, are found on the highways from Addis Ababa to Djibouti and Kenya. They are on the main route of Ethiopia's growth corridor with high traffic of heavy trucks from the Djibouti port to the hinterland. Mojo is where Ethiopia's dry port that serves as a hub for all heavy trucks coming from Djibouti port and all corners of the country transporting import and export goods is located.

Oromia Regional State is one of the regions of the Federal Democratic Republic of Ethiopia. It is the largest regional state both in terms of area and population. The region occupies central Ethiopia including Addis Ababa (Ffinnee) and stretches to the border of Kenya in the South. HIV prevalence in Oromia is significantly higher in urban than in rural areas in both sexes. In Oromia Regional State, according to Federal HIV/AIDs Prevention and Control Office (HAPCO) report (2014), the urban HIV prevalence rate was 2.3% compared to only 0.6% in rural areas. This represents a nearly four times higher HIV prevalence rate in urban areas. The 2016 Demographic and Health Survey (DHS) found a much wider gap in HIV prevalence between the urban and rural areas, 3.5% vs 0.5%. Available data thus point to the fact that the HIV epidemic in the region disproportionately affects the urban population with data depicting a generalized urban epidemic. On the other hand, rural Oromia is characterized by a low level and non-generalized HIV epidemic. The existing social and sexual networks, the high concentration of at-risk populations, high population mobility and urban poverty and the existence of the Addis Ababa City Administration in the center of the region, which has higher HIV prevalence than Oromia, are among the factors facilitating the spread of HIV in Oromia in general and in urban areas in particular.

According to a survey conducted by the Oromia Regional HIV/AIDs Prevention and Control Office (HAPCO Report 2014), the behaviors of truck drivers related to their vulnerability to HIV/AIDs were studied in purposely selected towns of Oromia including Dukem, Mojo, Bishoftu, Jimma, Shashemene and Adama. According to the study, truckers prefer to pass their leisure time and overnights in towns with relatively better services that include good hotels, bars, Khat/shisha corners, sex work venues, and secure parking lots. These major towns in Oromia, including Addis Ababa and peri-urban rural communities, with limited awareness about HIV/AIDs of the surrounding towns and cities interact with cities and towns daily; consequently, they are highly vulnerable to HIV/AIDs. There is also high influx of youth from every corner of the country, particularly from the rural areas, to these towns and cities in search of jobs. These youth prefer to reside in peri-urban areas where the house rent cost is relatively low.

This best practice case study document will be used as tool to promote the scaling up of the ongoing PMTCT project, provide evidence to influence policy and to help initiate institutional reforms regarding the lives of children affected by HIV/AIDs and vulnerable children, adolescents and youth in terms of their childhood development, care and support, awareness towards HIV/AIDs risks and PMTCT service uptake in Ethiopia in general and in Oromia in particular.

This study employed scientific research methodology and based on primary and secondary data sources in a given geographic areas, Dukem, Bishoftu and Mojo towns of Oromia Regional State. According to the HIV Prevention in Ethiopia Roadmap 2018-2020, the towns have been identified as the 200 high-burden districts (geographic priorities of HIV prevention response) of the country. The primary data were collected using various tools and instruments, while the secondary data mainly focused on the ongoing CDCB and Dawn of Hope PMTCT project documents, reports and other related literatures. This best practice document is divided into three major parts: part one deals with the introduction of the document, while part two discusses the challenges faced by HIV positive and vulnerable children in the project areas and the achievements of the ongoing CDCB and Dawn of Hope (DH) project. Finally, part three of this document talks about future areas of intervention and existing opportunities for project scaling up and expansion.

## 1.1. Objective of the Document

The objective of producing this best practice case study document on “Mobilizing HIV positive mothers and their babies for PMTCT services in Oromia Regional State of Ethiopia” with the financial support of PACF/ViiV Healthcare is for policy influencing and scaling up of the project to areas of similar context in the country. This document could also help generate evidences in an effort towards improving the lives of children affected by HIV/AIDS and vulnerable children, adolescents and youth in terms of their childhood development, care and support, awareness towards HIV/AIDS risks and PMTCT service uptake in Ethiopia in general and in Oromia in particular.

## 1.2. Methodology

This case study has employed both primary and secondary data sources. The primary data was collected using Focus Group Discussions (FGD), Key Informant Interviews (KII), open-ended questionnaires, observation and consultative workshops at district and regional government levels and the secondary data collection was conducted through review of project documents, reports and other related literatures.

First, a team comprising four experts two HIV/AIDS experts, one development/sociology expert, and one economist was established. The team then developed relevant tools and instruments for data collection (prepared questionnaires with open-ended questions, FGD and KII guideline questions). Eventually, the team travelled to the study area to collect primary data. Accordingly, seven FGDs were conducted involving local community, HIV positive children, adolescents and youth network leaders/members and local government representatives in the three towns of the study area. Key informant interviews were conducted with twenty individuals (including PLHIV association leaders and volunteers, education office experts, health workers who provide safe abortion service, pharmacist and police officers) in the study area. Based on the consent of the participants, all FGDs and KIIs were filmed and photographed to be documented. During the field visit observations were made at long vehicle stations, bars, night clubs, khat shops and shisha houses. Questionnaires with open-ended questions were administered at district education offices, health offices, finance and economic development offices, labor and social affairs offices, women and children affairs offices, trade and investment offices and culture and tourism offices.



**Figure 2: Focus Group Discussion**

CDCB and Dawn of Hope PMTCT project documents, M&E reports, relevant and related literatures were reviewed. The team then analyzed data collected from primary and secondary sources and produced the first draft of the research report. The first draft of the case study was presented at consultative workshop organized at local government level for the community and local government representatives of the study areas. The team has incorporated inputs, comments and suggestions from the consultative workshop conducted at local government level and produced the second draft of the case study. The second draft of the case study was presented to the regional level consultative workshop organized for experts and officials of stakeholders at regional level. Finally, the team incorporated comments and suggestions from the regional consultative workshops and produced the final draft of the case study for proofreading and publication as well. The study has also strictly pursued social research ethics and HIV/AIDS protocol.

### **1.3. Scope of the Case Study**

The study focuses on the three towns, namely Dukem, Bishoftu and Mojo, of Oromia Regional State of Ethiopia. The study also focuses on issues related to vulnerable and PLHIV children, adolescents and youth and the existing care and support system in the study area. The study was conducted from October to December 2019.

This Case study focuses on three towns in the central part of Ethiopia namely: Dukem, Bishoftu and Mojo located 37, 47 and 73km from the capital Addis Ababa (Finfinne) respectively. The towns are HIV hot spot areas due to various factors: they are located on growth corridor; there is a dry port; there are a lot of industries; the towns, particularly Bishoftu, are favorite tourist destinations.

Due to these economic activities and flourishing investments in the area, there are high influx of

## Part II

### 2.1 The Challenges of HIV Positive and Vulnerable Children in the Project Area

#### 2.1.1 Background of the Project Area

skilled, semi-skilled and unskilled youth population to the area in search of jobs. Large numbers of trucks enter and stay in these towns. There are many commercial sex workers, either mobile or resident, in the three towns. There are unregistered petty trades and vendors engaged in small business, some of which are exacerbating vulnerability to HIV infection. The high mobility in the area coupled with the weak recording and registering system in Ethiopia makes more accurate estimation of socio-economic data in the area more complex. Cognizant of this, CDCB in partnership with Dawn of Hope has initiated the PMTCT project, which has been implemented since January 2018. The study area is also where the rate of urbanization is very high, which could even be higher than the national 4.6 %.

Some of the basic issues of socio economic and demographic characteristic indicators that have direct or indirect relation with the prevalence of HIV/AIDS and factors worsening vulnerability of children, adolescents and youth to HIV infection in the study area are presented in the following tables.

**Table 1: Population of the towns**

No.	Towns	Population		
		Male	Female	Total
1	Dukem	32,511	34,000	66,511
2	Bishoftu	104,626	113,345	217,971
3	Mojo	35,004	38,180	73,184
<b>Grand Total</b>		<b>172,141</b>	<b>185,525</b>	<b>357,666</b>

**Table 2: Number of students in the towns**

No.	District	Gender	Number of students as per the schools			
			Elementary	High School	Preparatory	Total
1	Dukem	Male	5,069	873	311	6,253
		Female	5,639	1,218	289	7,146
		<b>Total</b>	<b>10,708</b>	<b>2,091</b>	<b>600</b>	<b>13,399</b>
2	Bishoftu	Male	18,425	4,099	1,670	24,194
		Female	15,021	3,156	1,651	19,828
		<b>Total</b>	<b>33,446</b>	<b>7,255</b>	<b>3,321</b>	<b>44,022</b>
3	Mojo	Male	4,842	1,589	430	6,861
		Female	5,558	1,894	487	7,939
		<b>Total</b>	<b>10,400</b>	<b>3,483</b>	<b>917</b>	<b>14,800</b>
<b>Grand Total</b>			<b>54,554</b>	<b>12,829</b>	<b>4,838</b>	<b>72,221</b>

**Table 3: Some of the major business activities in the towns**

No.	Variables	Dukem	Bishoftu	Mojo	Total
1	No. of factories	598	48	67	<b>713</b>
2	No. of hotels and restaurants	80	209	110	<b>399</b>
3	No. of resorts	-	11	-	<b>11</b>
4	No. of lodges	-	5	-	<b>5</b>
5	No. of commercial sex workers	900	750	661	<b>2,311</b>
6	No. of long vehicles stay per night	450	-	850	<b>1,300</b>

**Table 4: Number of employed youths**

No.	Districts	Permanent Employees	Daily/seasonal Employees	Total Employed
1	Dukem	46,000	12,000	<b>58,000</b>
2	Bishoftu	22,572	7,093	<b>29,665</b>
3	Mojo	1,535	6,162	<b>7,697</b>
<b>Grand Total</b>		<b>70,107</b>	<b>25,255</b>	<b>95,362</b>

**Table 5: Number of Unemployed Youth**

No.	Districts	Male	Female	Total
1	Dukem	14,732	14,983	<b>29,715</b>
2	Bishoftu	6,802	4,208	<b>11,010</b>
3	Mojo	2,000	2,001	<b>4001</b>
<b>Grand Total</b>		<b>23,534</b>	<b>21,192</b>	<b>44,726</b>

**Table 6: Number of PLHIV Children and Adolescents**

No.	Variable	Dukem			Bishoftu			Mojo		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
1	No. of PLHIVs	513	331	<b>844</b>	2,021	2,563	<b>4,584</b>	775	1,433	<b>2,208</b>
2	PLHIVs on ART	513	331	<b>844</b>	2,021	2,563	<b>4,584</b>	775	1,433	<b>2,208</b>
3	Children on ART	11	13	<b>24</b>	201	184	<b>385</b>	31	37	<b>68</b>

### 2.1.2 Situation Analysis

In Ethiopia the urban and rural prevalence rates of HIV/AIDS epidemic are estimated at 7.7 % and 0.9% respectively (EDHS, 2016). These study areas (the three towns) are characterized by the towns rapidly encroaching on rural areas. This could also result in higher prevalence rate than the current national average.

The three towns are found on the highways from Addis Ababa to Adama, Dire Dawa, Djibouti, and to Hawasa, Moyale, Kenya. They are on the route of the country's main growth corridor with high frequency and stations of heavy trucks from the ports to Mojo, the country's dry port and which is a hub for all heavy trucks coming from all corners of the country for transporting import and export goods.



**Figure 3 : District level Consultation Workshop**

The study area is also a major industrial zone of the country with lots of investment activities. Consequently, it attracts large number of unemployed youths from all parts of Ethiopia, mainly rural areas. There are also various business and economic activities including petty businesses that highly exacerbate the spread and prevalence of HIV/AIDS such as khat and shisha houses<sup>1</sup>, bars, and taverns where local alcoholic drinks such as *arekie*, *tej* and *tela* are sold; night clubs and hotels where there are commercial sex workers. Some of the business activities, for instance, khat and shisha houses, are categorized as illegal. However, those people who run such houses use other licenses of legal

1 Khat is a plant the leaf of which is consumed as stimulant in Ethiopia and its neighboring countries like; Somalia, Yemen , Kenya and some Arab countries; while shisha is smoked by the youth like a pipe; it also has a stimulating effect.

business activities like that of bars and coffee shops to operate those illegal businesses. We have also learned from the ongoing PMTCT project that poverty is one of the aggravating factors for the spread and prevalence of HIV/AIDS. Most HIV positive mothers are commercial sex workers and factory laborers.

The area demands special intervention mechanism and institutional synergy to combat HIV/AIDS given the peculiarity and complexity of the situation as compared to other areas of the country. Apparently, there is a reduction in stigma and discrimination compared to the situation ten years back, while public awareness about HIV/AIDS transmission is still low. Low-level of awareness coupled with high vulnerability to HIV/AIDS makes the communities in the study area to be at high risk for HIV infection.

Despite the situation prevailing in this area, there are ample opportunities like proximity to the capital, high potential for resource mobilization, the lesson from CDCB PMTCT project, the presence of active PLHIV associations and pioneering PLHIV positive adolescents/youth network in the country that could be used as springboards for the fight against the spread of the virus. There is a need to bring together and institutionalize the efforts of all these stakeholders.

### 2.1.3 Prevalence

Although the official data from the concerned government offices and associations of PLHIV in the respective towns shows only those registered for ART as indicated in Table 6, there are a wide gap between those who use ART and the estimated number of PLHIV residing in Oromia Regional State. According to Ethiopian National HIV Prevention Roadmap 2018-2020, the average prevalence rate is 0.9 % of the total population where the urban rate is seven times more than the national average as indicated in Table 7 below. Please also note that the regional prevalence rate 0.9% is used although these towns are categorized as highly at risk for HIV/AIDS infection as indicated in the situation analysis. This implies that the estimated PLHIV population in the study area could be higher than the estimated figure indicated in Table 7 below.

**Table 7: HIV/AIDS Prevalence Gap: Official Data VS Estimation**

No.	Variable	Dukem			Bishoftu			Mojo		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
1	Population	32,511	34,000	66,511	104,626	113,345	217,971	35,004	38,180	73,184
2	No. PLHIVS documented	513	331	844	2,021	2,563	4,584	775	1,433	2,208
3	Estimation	2,048	2,142	4,190	6,591	7,141	13,732	2,205	2,405	4,611
4	Gap	1,535	1,811	3,346	4,570	4,578	9,148	1,430	972	2,403
5	% undocumented to estimation prevalence	75%	85%	80%	69%	64%	67%	65%	40%	52%

The data indicated above in Table 7 shows the huge difference between the actual official data from respective government offices and PLHIV associations. Row 2 of Table 7 shows the official data of PLHIV, while row 3 shows the estimation calculated per the national prevalence rate times seven based on National HIV Prevention Roadmap 2018-2020. Row 4 shows the gap between the officially registered and estimated population of PLHIV in the respective towns. This implies that the gap between officially registered PLHIV population and the estimated PLHIV of Dukem, Bishoftu and Mojo is 80%, 67% and 52% respectively. It is important to remember here once again that the Oromia regional HIV prevalence rate is used to calculate the estimation while the area is known for having a population facing higher risk of HIV/AIDS transmission as indicated in the situation analysis of this document. Therefore, the gap between the estimation and the actual data could be much higher than what is depicted in Table 7.

Some of the factors contributing towards the discrepancy in data are attributed to: First, the PLHIV population registered for ART service is low due to the reluctance to disclose their status for fear of stigma and discrimination. As focus group discussions conducted with the local community (PLHIV Association members), the local government representatives and key informants revealed, only poor people who cannot afford the cost of travel outside their town receive medication and support while the relatively better off families and/or individuals are going to other cities like Adama and Addis Ababa for medication and treatment. Second, the care and support system for PLHIV population could be poor in the three towns as compared to other bigger cities. Third, perhaps people are not going out for testing to know their status because of low awareness about HIV, which is the worst-case scenario whereby the transmission of HIV/AIDS could be higher than expected. Fourth, the vulnerability of the area due to the complexity of the context could also contribute highly to the increase in the number of PLHIVs beyond what is officially known. Thus, given the aforementioned factors, the complexity and the vulnerability of the area to the transmission of HIV/AIDS makes the prevalence higher than expected.

### **2.1.4 Vulnerability**

The focus group discussion conducted with local community and local government representatives of the respective town confirmed that the population in the study area in general adolescent and youth in particular are highly vulnerable to HIV/AIDS. This is because of various factors such as presence of industries, flourishing investment activities, a dry port, high tourist flow, the fact that it is a hub for large number of trucks which result in high influx of job seeking youth and mobility of people.

Consequently, large number of hotels, bars, night clubs, khat and shisha houses are exposing the youth to widespread unprotected sexual relationships. Furthermore, “marriage convenience” is high among the predominantly young women and men working in factories as they share rooms temporarily to cope up with economic challenges, which expose them for unprotected sex and pregnancy. The key informant interview with health professionals of the respective towns confirmed that most of the women coming for abortion services are factory workers who got pregnant during such temporary relations. During their off-work hours since they are free from the reins of family control, the factory workers spend time going on a date with their boy or girl friend. There are also situations where some of them get involved in commercial sex business.

The result of key informant interview with health professionals of the respective areas also show that the profile of those going for abortion services are mainly unmarried youth and factory workers. The high abortion rate in the area also shows the prevalence of unprotected sexual relations among the youth. The interview conducted with the respective police officers in charge of criminal investigation and child and women’s right protection also shows the presence of many commercial sex workers in the three towns although it is difficult to know how many they are since they are not licensed, and they don’t disclose their

identity. The number is very high in Dukem town where street commercial sex workers are coming from Addis Ababa and other major cities of the country including Harar and Dire Dawa. The monthly income of daily laborers working in various industries ranges between 600 and 1000 birr per month, which makes it very difficult to cover their monthly expenses including house rent. The severe poverty that both the unemployed youth and youth employed as daily laborers face forces them to engage in commercial sex businesses.

While there are similarities among the three towns of the study areas, there are some peculiarities of each town regarding factors exacerbating susceptibility to the transmission of HIV/AIDS. For instance, in Dukem there are about 58,000 (Table 4) youth employed in industries (mainly in Eastern Industrial Zone owned and run by the Chinese) where the managers of the industries are not willing to raise their workers' awareness on HIV/AIDS and reproductive health issues. The data from the town's health office shows that the spread of HIV/AIDS is high among the commercial sex workers. Forty out of one hundred of them are HIV positive.

Commonly, there are also sexual relationships among the young factory workers and their Chinese and Indians supervisors. During the regional consultative workshop, representatives from investment, industry and social affairs bureaus confirmed that there is widespread sexual harassment within industries against women workers by their co-workers.

Although there is a need for further investigation, some high school students in the town are being forced to engage in unprotected sexual relationships. From the interview conducted with local health facility professionals and education sector experts, it was learned that most high school students especially those coming from the surrounding rural areas carry emergency pills in their bags. This could be because of unreported rape cases and uncontrolled sexual relations among the young school students.

Bishoftu is one of the country's tourist destinations because of its attractive lakes, resorts and international hotels. It is also a town where the headquarters of the national air force and huge military manufacturing industry is found. And as a result, there are many young soldiers and military personnel in the town. The focus group discussants and key informant interviewees of Bishoftu and Dukem confirmed that young three-wheeler taxi, which is widely known as *Bajaj*, drivers involve in unprotected sexual relations with their commuters, especially with high school students. They commonly use forests and the Bajaj itself for such sexual relations, which is seriously condemned by the local community. On average about 550 long distance vehicles are stationed daily in Mojo for loading and unloading import or export goods from or to the country's dry port. Some of the truckers sexually involve with commercial sex workers and young women in the town.

The focus group discussions and key informant interviews results show that there are widespread unprotected sexual relations among the youth population in the towns under study. In addition to the aforementioned factors, there are rampant abortion cases and high demand for emergency pills indicating the presence of high risk for HIV transmission. The interview made with drug stores at the respective towns shows that there is high demand for emergency pills by young school students and factory workers. The consumption for emergency pills is very high during the weekend and on Mondays; and its demand is increasing over the last few years. The abject poverty in the towns is also one of the key factors aggravating vulnerability of youth and adolescents. For instance, adolescents and youth are forced to work in factories after school time to support their family. The data from Mojo education office (Table 8) indicates that school dropout ratio is higher among students from grade 9-10 and 11-12, which are 4.5% and 3.86% respectively.

**Table8: School Dropout Ratio of Mojo Town**

S.N	Grade	Dropout Ratio
1	1-4	2.25%
2	5-8	1.34%
3	9-10	4.5%
4	11-12	3.86%

According to the key informant interview with Mojo town education and social affairs offices, there is higher dropout rate of grade 9-12 students because they are employed by industries and investors working in the area. Usually, the students first try to go to school and work at the factories during off-school hours. But later, when they realize that they cannot do both simultaneously, they decide to drop out of school work at the industries.

Above all, the study shows that there is a decline in public awareness on HIV/AIDS recently as compared to the situation five or ten years ago when there were extensive campaigns to combat the epidemic. The focus group discussions made with the local community members and local government representative confirmed that currently less attention is given to awareness creation on HIV/AIDS as compared to some years back. The key informant interviews conducted with PLHIV association leaders of the respective towns also reflected the same point of concern. The result of the PLHIV key informant interview shows that there were several partner organizations engaged in raising public awareness on HIV/AIDS in the towns five or ten years back as compared to today. During the regional consultative workshop, the issue of low public awareness towards HIV/AIDS was a top agenda where participants discussed that government leadership is not giving due attention to HIV/AIDS, because the government's concern is more on political issues than social issues.

## **2.2 Project Summary**

### **2.2.1 Project overview**

The project entitled "Mobilizing HIV positive mothers and their babies for PMTCT service (PMTCT/HIV)" is being implemented by CDCB and DHEA in Dukem, Bishoftu and Mojo towns in Oromia Regional State of Ethiopia, with the financial support of PACF/ViiV Healthcare since January 2018. The overall objective of the project is to enhance adherence of HIV positive pregnant mothers, new born babies and adolescents through strengthening care and support and follow up, fostering linkages between governments systems and community structure by establishing strong tracing follow up system.

### **2.2.2 Achievements**

Monitoring and evaluations undertaken during the project

implementation have so far revealed that the outputs and short-term outcomes were remarkably achieved. The project is providing a range of prevention, treatment and care and support services to women and infants, which include preventing HIV infections among women of reproductive age, preventing unwanted pregnancies among women living with HIV, and providing women living with HIV lifelong ART to maintain their health and prevent transmission during pregnancy, labor and breastfeeding. The project also supports safe childbirth practices and appropriate infant feeding, as well as providing ART for prevention and effective treatment of infants exposed to HIV after birth and during breastfeeding. The project further prevented new HIV infections among women of reproductive age, reduced unintended pregnancies, prevented the transmission of the virus from mother to baby during birth, provided treatment, care and support to women living with HIV and their children, provided emergency nutritional support to needy HIV positive, pregnant and lactating mothers.

**Table 9: Outputs Planned Vs Achieved**

No.	Outputs	Planned	Achieved	Percentages
1	Prevented transmission of virus from HIV+ mother to her baby	800	564	70%
2	Provided proper treatment, care and support to HIV+ mothers and their children	55	42	76%
3	Emergency nutritional support to needy and pregnant HIV+ mothers provided	200	232	116%

This is a remarkable achievement of this project which has been under implementation for the past two years. The remaining planned work will be done in the next one year. What has been achieved with regards to providing emergency nutritional support to needy and pregnant HIV positive mothers has been beyond the plan because local resource has been mobilized to address the challenge.

### 2.2.3 Challenges

The key challenge in the course of implementing the project:

- Weak coordination in government structures, and absence of programmatic approach to engage potential local partners (private sector and local community initiatives);
- Low public awareness towards the risk of HIV/AIDS compared to the high level of vulnerability in the project area;
- Financial limitation to reach out to other indirect target groups for PMTCT services;
- Weak capacity among health facilities in the localities;
- Limited capacity of community coalition care (3C's), religious leaders, Gada system;
- Weak documentation and registration of facts and figures by concerned authorities.

### 2.2.4 Lessons

The key lessons drawn from the implementation of the project so far:

- The issue of the health status and overall well-being of children, adolescents and youth who are living with HIV is overlooked by existing institutional and social structures;
- Huge potential for local resource mobilization in the area;
- Various local community initiatives that could be promoted to address the problem especially of HIV positive children, adolescents and youth networks.

## 2.3 Existing Support System

### 2.3.1 Community Level Care and Support

In this assessment and during the implementation of CDCP PMTCT project, it was learned that there is no institutionalized and programmatic approach to care and support system in place. There are some initiatives by individuals and groups in government sector offices that are facilitated by district women and children affairs offices in collaboration with education offices. Though these initiatives mainly focus on vulnerable children including HIV positive children, there is no special arrangement to support children living with HIV, which is the focus of this study.

As far as care and support system is concerned, there are differences among the towns of the study area. For instance, in Mojo and Bishoftu towns, women and children office in collaboration with education office mobilizes resource from government offices, the local community and the private sector to provide education materials and food items for vulnerable children (orphanages). Although the program is not for HIV positive children most of the beneficiaries are orphanages where children who lost their families because of HIV/AIDS reside and children who are dependent on their grandparents and relatives also benefit from the support.

There are instances where government sector offices sponsor individual vulnerable children and cover their education expenses on a regular basis. The two sector offices also mobilize resources from the private sector such as private schools and colleges who provide scholarships to the children and take care of their school fee, and education material expenses. Such initiatives are very limited given the extent of the problem. For example, in Mojo there are about 2500 vulnerable children while only 3 to 4 children are using such opportunities while they are almost nonexistent in other towns.

Recently, what is becoming common is organizing events to provide education materials during school opening time, but even such initiatives are inconsistent. The schools could have been the best places to provide necessary care and support for vulnerable HIV positive children. Although there are incidences at different schools where HIV positive students are subject to stigma and discrimination from their peers and their teachers as well, the school system do not have such

care and support system for children living with HIV. Students, who have HIV positive parents but who themselves are HIV negative, are also victims of such stigma and discrimination only because of their parents' status.

The role of NGOs including churches in providing care and support for children living with HIV is very limited. In Mojo and Bishoftu some NGOs are providing very limited support for vulnerable children in few localities of the towns. Given the extent of the problem and the number of vulnerable children in general and HIV positive children in particular the care and support provided by these NGOs is almost nonexistent.

Even though there are large number of private investors in the area, there is no formal care and support to vulnerable children Vis a Vis children living with HIV. While consulting PLHIV associations for the implementation of PMTC project in the respective towns, it was noted that there is willingness from private companies to support vulnerable or HIV positive children. However, there is no institutional framework to put a care and support system in place to mobilize support from the existing opportunities in the respective localities.

In general, due to the absence of care and support system in place, vulnerable children (either HIV positive or not) are highly exposed to a lot of challenges including child labor and abuse in their respective towns. The key informant interview conducted with police officers in charge of women and children rights shows that children from poor families, especially commercial sex workers are highly exposed to various challenges. This includes killing babies after birth (3 reported in Dukem in 2019), child rape by same or opposite sex (2in Dukem and1 in Mojo in 2019), and child trafficking (2 in Dukem in 2019). The rape (especially the same sex cases) are rarely reported to the police for fear of stigma and discrimination while child trafficking is more complex and operated in a clandestine way. In this towns, most commercial sex workers go out for business (commercial sex work) leaving their children at home sometimes without attendants. According to a Dukem town police officer in charge of women and children rights, there was an incident where a commercial sex worker left her two children at home without any attendant and lit a candle in case there would be a power blackout. The candle caused a fire accident and burnt the children with the house.

### **2.3.2 Family Level Care and Support**

Family level care and support for HIV positive children differs from family to family depending on the socio-economic status of the families. As indicated in the background of the study, most of the PLHIV living in the study area are poor, while those who are better off and well-to-do not want to disclose their status in their neighborhood. Most of the PLHIV in the area are female headed households. This is attributed to either divorce or death of their husband, which forces them to raise children as single mother. In some cases, since they cannot afford to pay house rent, they share a house and live as roommate with others. Female headed households are mainly either commercial sex workers or daily laborers, while men headed households are drivers, ex-army soldiers, laborers and farmers. The usual downsizing of the number of industrial workers and army members is also exacerbating factor for HIV transmission. This is a serious problem in Bishoftu, where the national air force and military industries are located.

There are also discordant families of HIV positive parents in which both HIV positive and negative children live together. In this study, child care and support in such families was assessed. Child development, care and support system could be challenging based on family background. Key informant interviews conducted with PLHIV association leaders of the respective towns revealed that they neither have the skill and knowledge to teach their association members about family care and support nor to provide psycho-social support. Stigma and discrimination at family level depends on HIV status differences of family members. One key informant said, "One of my sons, who has HIV, says, 'You do not like me because you let me contract HIV, while you did not do the same to my brother.' And he has developed

a negative attitude to me and his brother.”

The focused group discussion at Mojo and Bishoftu revealed that there are few families who do not give attention to their HIV positive child because they think his/her life is short. There are also family members who do not disclose the status of their children born with the virus until the age of 14 to 16 but give them the medication telling them that they have other health problems. We asked those families why they decline from telling their children about their HIV status even though they are old-enough to be told about it. All of them have similar reason, they fear that the child may develop negative attitude towards them and get frustrated in his/her life.

One of our key informants, a twenty-four years old lady born with the virus whose mother was a volunteer PLHIV working as a teacher on HIV/AIDS said, “I never experienced what other kids usually experience during their childhood. That was because my mother always kept me in Dawn of Hope compound where there were only adult women and men.” This was because her mother’s HIV status was known in her neighborhood and the community was not willing to accept the child and let her spend time with their kids. Consequently, her mother was forced to keep her in Dawn Hope Association of PLHIV compound where the association members spend their time. As there is stigma and discrimination against youth with the virus and children from HIV positive parents, it is difficult for them to get jobs. They cannot, for instance, be employed to work as a housemaid or a babysitter.

As indicated above, based on their socio-economic status, there are differences among families with regards to disclosing the status of their children at the right age and their psychological readiness. Poor families mostly share a room for dining and sleeping and they cannot hide while they take their ART medicine from their children. Hence, their children ask them about the medicine or most of the time they understand that it is ART medicine even if they are not told. But relatively better off families having private bedrooms can take ART medicines in the absence of their children and keep their status a secret.

There is a strong link between poverty and HIV transmission. For instance, poor mothers who cannot afford to give extra meal to their baby are forced for prolonged breastfeeding which exposes the baby for HIV infection. Most PLHIV association members suffer from food shortage and they do not take their medication as a result. Therefore, compared to their counterparts from relatively better off families, children from very poor families are at a very disadvantageous position regarding their childhood development, care and support, and are highly vulnerable to HIV/AIDS even though they are born HIV negative.

Stigma and discrimination towards children living with HIV sometimes starts from once own family. They encounter the same problem at school and in the community. All the focus group discussions made revealed that there is drastic change with regards to stigma and discrimination as compared to the situation ten years back. However, the problem is still rampant in the rural parts of the towns. Stigma and discrimination

against HIV positive children are still there at family, school and community levels. One of our focus group discussants, who is a PLHIV, told us that she had lost her parents because of the virus thirteen years ago. Following her parents' death, her brother and sister kicked her out of their house; and she ended up out on street when she was ten. She still remembers her horrible childhood life with agony.

### **2.3.3 School Level Care and Support**

PLHIV children face stigma and discrimination at schools if their status is known among their school mates. There are some incidents where students shouted "AIDS!... AIDS!... AIDS!" at HIV positive students. The critical challenge for teenage HIV positive Children and adolescents occurs when they fall in love with someone. One of our key informant interviewees, who is born with the virus, said that he fell in love with his classmate without disclosing his status for a long time, later on when he told her his status she has not only rejected him, but she also abused him saying, "I did not know that I was living with the Devil," and changed her classroom. He told us that his ex-girlfriend's reaction had terribly hurt him. He also recalls that the most critical moment was the time he was told that he was HIV positive at the age of fourteen when he was a grade nine student. Previously, from grade 1–8, he was one of the top three students in his class. He scored 94% in grade eight national exam. When he was informed about his status when he was a ninth grader, he was devastated. He became hopeless and stopped going to school. However, he realized that his overreaction would hurt his mother, who brought him up without a father giving him special care and attention. He decided to continue his education for the sake of his mother. Later, when he joined the HIV positive youth network, he became hopeful as he realized that he could live long so long as he properly takes his medication and gets medical follow-up and treatment. Currently he is the leader of the network.

### **2.3.4 HIV Positive Children, Adolescents and Youth Network**

The HIV positive Children, Adolescents and Youth Network is a new initiative in the study area where HIV positive children, adolescents and youth got together and formed a network with the support of Belaynesh Maru, a nurse who is working at a hospital in Bishoftu town. According to the Ethiopian NNEP+ (Network of Networks of PLHIV), this initiative is a pioneering one in the country. The focus group discussion held with the representatives of the network revealed that the network helped them create a platform where they freely discuss about their medication, challenges encountering them in family, at school and in the community. There are about two hundred members of the network residing in Bishoftu town and the surrounding rural areas. The network members usually meet once in a month. All members of the network may not be able to attend the regular monthly sessions due to lack of transportation cost, but almost all network members attend the yearly event, which includes different entertaining shows for PLHIV of different age categories.

The network serves the members as a get together- a family union, a place to find their life partner, and a platform to encourage those who are in depression, to counsel parents of their members to care for their PLHIV children. Although this platform is very instrumental to promote care and support system, raise awareness on HIV/AIDS, and fight stigma and discrimination at home, school and in the community, there are several challenges for its existence. The key challenges include lack of space for regular meeting, lack of finance to cover miscellaneous expenses and get technical support. The network's leaders have an ambition to legally register and operate, however the Ethiopian civil society proclamation does not allow children less than eighteen years old to be a member and founder of any association.

## Part III

### 3.1 Future areas of Intervention

This case study shows the need for various interventions at different levels to address the challenges faced by vulnerable and HIV positive children, adolescents and youth in the study area. Successful interventions could also serve as reference at national level for areas of similar context. But one cannot undermine the fact that addressing poverty could positively contribute towards resolving these challenges. In general, the major areas of intervention at different level can be categorized as:

#### 3.1.1 Establishing Institutional/Programmatic Approach

From the case study, we realized that there are ample opportunities at the local level to address the challenges. Nonetheless, due to lack of institutional or programmatic approach local initiatives and existing opportunities are not effective enough to the expected level. Therefore, designing or creating institutional synergy through programmatic approach could help in tackling the problem in more effective, efficient and sustainable manner. At school level, building the capacity of school clubs working on HIV/AIDS is important so that they could serve as platforms for awareness creation, fighting stigma and discrimination, and for enhancing care and support for HIV positive children, adolescent and youth in schools. The school HIV/AIDS clubs could also help in strengthening and expanding access to ART service, and in promoting friendly ART services for children, adolescents and youth at different corners.

The Ethiopian Federal Government and the Oromia Regional State have introduced HIV/AIDS mainstreaming guideline which is intended to engage all sectors and volunteer individuals and private investors to work towards HIV/AIDS prevention, care and support. Regional states in Ethiopia do have their context based mainstreaming approaches and the guideline is on how to implement the HIV multi-sector mainstreaming.

In Oromia the “Oromia Social Support Council” regulation number, “199/2010” was promulgated as a legal framework to the HIV/AIDS mainstreaming guideline. The regulation was endorsed by the regional council in 2019 to provide local level care and support program, where local values and norms are used to mobilize local resources from government sectors, private, local community and civil society organizations to provide care and support to PLHIV. The council has a coordinating team drawn from social sector offices and 21 members representing local government structure, local community leaders, private sector representatives, representatives of religious institutions and civic society representatives. It is a very worthwhile initiative to address the challenges of HIV/AIDS through mobilizing local resources. It is designed based on the analysis of the dwindling global resource (donors’ fund) on HIV/AIDS prevention and to use local resource as an alternative way out. However, during our focus group discussions

with the local government structures in the three towns of the study area, and during a local level consultative workshop, no one mentioned this initiative. However, at the regional level consultative workshop, representatives of the respective institutions talked about it. They believe that it is the best initiative to address the current challenges of HIV, while they expressed that fact that the leadership are not giving due attention to implement and communicate it to the leaders at the local level.

While the local government leaders and senior experts were expressing the local resource mobilization efforts of school materials for vulnerable children as their own initiative, the regional representative consider it as part of the regional program of HIV/AIDS mainstreaming guideline. This implies the need for further communication of the new scheme to the local structure. Furthermore, the fact that the council has large number of members (21 members) at various local and regional levels, its effectiveness is under question based on the past experiences of the ineffectiveness of committee-based approach.

### **3.1.2 At Community Level**

The study shows that there is positive change in communities' attitude of stigma and discrimination towards PLHIV as compared to the situation five or ten years ago. However, communities' awareness towards the transmission of HIV/AIDS is getting lower than what it was some years back. The high rate of urbanization and the consequent rural-urban exodus of youth in Ethiopia in general and in the study area in particular is creating a new form of urban-rural interaction. Thus, this could lead to the increase in the number of new HIV infections. Therefore, it is very important to engage in extensive awareness raising activities at various levels. For instance, conducting various awareness creation campaigns at industries, dry port stations, on streets, in hotels, at night clubs, shisha houses, khat shops, schools and market places, where rural communities can be reached, is very important to raise communities' awareness. The current urban-rural interaction is also a new strategy of awareness creation regarding the transmission of HIV/AIDS.

### **3.1.3 At Family Level**

From the case study we realized that there are differences among families because of differences in socio-economic and educational backgrounds. Due to such differences, the way they give care and support, the manner they handle the early childhood development of their children varies from family to family. The way each family discloses their own status and that of their children is also varies across families. There are efforts by PLHIV associations to have a protocol of disclosing parents' and children's status. However, there is no well-organized and standardized protocol that fits to different categories of family with varying socio-cultural backgrounds. Hence, developing standardized protocol for disclosing HIV status and for provision of psycho-social support at family level customized to different socio-cultural and economic categories and making it part of the counseling procedure is very important. As poverty is among the key driving forces that increase vulnerability to the transmission of HIV as well as the spread of the virus, working on initiatives that increase the income of PLHIV and vulnerable families through different income generating schemes is crucial.

### **3.1.4 Establishing and Promoting PLHIV Children, Adolescents and Youth Networks**

One of the overlooked opportunities in national agenda towards combating HIV/AIDS in general, and in the study area in particular is promoting the network of children, adolescents and youth living with HIV. Therefore, establishing, promoting and strengthening such networks is very important as they could serve as platforms for awareness raising, strong follow up of ART service, to encourage adolescents and youth for HIV testing, to promote family level care and support and to fight stigma and discrimination.

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