



# ETHIOPIAN ORPHAN HEALTH FOUNDATION

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## Annual Report 2010



## Foreword

As the Amharic proverb states, *Kes be kes enqullal beegrwa tihedalech*, or “Slowly but surely, the egg hatches and the chicken begins to learn how to walk.” Slowly but surely, we launched a community-based health and education program for orphans and other vulnerable children and their guardians in Gondar, Ethiopia. And, slowly but surely, our program transformed the lives of 91 children in one village while creating opportunities for them to grow, to learn, and to succeed.

I am delighted to present the Ethiopian Orphan Health Foundation’s first annual report. Our ability to make a difference in the lives of Ethiopia’s most vulnerable children was possible only because of your generous support.

In 2010, we trained four community health workers to provide home-based health education and four adolescents to facilitate discussions about HIV/AIDS, conducted 129 medical exams among children and their guardians, gave medicine to 90 children to treat intestinal worms and prevent eye infections, distributed school supplies to 88 children, provided 91 bed nets to children and their families, and conducted 50 peer-led health education sessions and 221 visits at home to deliver health education messages. We have empowered young people, decreased stigma and discrimination against these children, and have created opportunities in education for them to succeed and become productive members in society.

Our achievements are your achievements, and we thank you for working alongside us to reverse some of the most entrenched and pervasive forms of inequity in healthcare and education. You took a stand against injustice in health and education, and I hope you will help us assist more children this year to have, slowly but surely, an even greater impact in the lives of vulnerable children in Ethiopia and beyond.

I hope you enjoy reading our 2010 Annual Report. I look forward to hearing your feedback, comments, and ideas for future projects.

Yours sincerely and respectfully,



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## The Need

HIV continues to spread throughout sub-Saharan Africa despite progress in the treatment and prevention of HIV/AIDS. In 2009, an estimated 1.8 million individuals contracted HIV in the sub-Saharan Africa, which accounts for 70% of all new infections worldwide.<sup>1</sup> While the infection rate has decreased since the peak of the epidemic in the mid-1990s, 22.5 million people in the region are living with HIV/AIDS.<sup>1</sup>

A neglected consequence of the epidemic is that a generation of children have been orphaned and made vulnerable when their parents die. According to a survey completed in 2009, approximately 14.8 million children living in sub-Saharan Africa lost one or more of their parents from AIDS in 2009.<sup>1</sup> The crisis is particularly wide-spread in Ethiopia, which has an estimated 5.4 million orphans and a national HIV prevalence between 1.4% and 2.8%.<sup>2</sup> As the epidemic spreads, the number of orphans will continue to grow and impact how families and communities care for vulnerable children.



The lack of parental care perpetuates a viscous cycle of child vulnerability that fosters violations of basic human rights. Orphans commonly suffer from food insecurity, malnutrition, lack of protection and shelter, lack of access to healthcare, and poor access to education.<sup>3</sup> Concurrently, children face the arduous burden of caring for ill parents and relatives and suffer from emotional trauma when their parents die. The experience of living in poverty and being affected by HIV/AIDS negatively impacts children's physical and psychological development and undermines their coping mechanisms.<sup>4</sup> They are discriminated against at home, in school, in the community, and in health facilities. The maltreatment of children threatens to reverse the livelihoods of already poor and marginalized children in society.<sup>5</sup>

## The Ethiopian Orphan Health Foundation

The Ethiopian Orphan Health Foundation, a 501(c)(3) international non-profit organization, launched a health, education, and well-being program in October 2009 in Gondar, Ethiopia. To overcome violations in basic human rights experienced by children, a project was designed with the Organization for Social Services for AIDS (OSSA), an indigenous NGO, the community, and the local government in order to provide healthcare and education to orphans and vulnerable youth.

## Target Population

The project was implemented in Teda ward, a peri-urban area that is located 12 km south of Gondar Town in the Amhara region. HIV/AIDS became exacerbated in Teda when daily laborers and members from the military lived with local families, which increased transmission of HIV.



According to the Regional Health Bureau, Teda has a population of 4,404 people. Our program targets 91 children in Teda, of which 40 are female and 51 are male. Children were included in the program if they lost one or both of their parents, were living with their grandparents, or living with someone with a chronic illness.

## Project Objective

The objective of the project was to provide healthcare and health education to vulnerable children and their caregivers and to support educational materials for vulnerable children in Teda ward, Gondar District in Ethiopia.

## Our Model

The Ethiopian Orphan Health Foundation's key innovation has been the progress made in reversing the most entrenched and pervasive forms of inequity affecting children. We have institutionalized a process that delivers results for the most marginalized and disenfranchised individuals in the world. Importantly, we have adopted holistic and culturally-sensitive approaches to improving the well-being of both orphans and their caretakers. Orphans are the last individuals to feel included in society, but our project prioritizes their participation and gives them, for the first time, a powerful voice in catalyzing change in their community. With the support of the community, government, local leaders, and outside experts, orphans and vulnerable youth have become active participants—rather than beneficiaries—to reverse the inequities in healthcare.

## Project Description

### Objective 1

To educate vulnerable adolescents about HIV/AIDS and reproductive health through peer-led traditional Ethiopian coffee ceremonies

### Activities

#### *1.1 Situation analysis to assess the health and education needs of children*

The Executive Director conducted focused group discussions with children, their caretakers, health officials, and government leaders in Teda to assess children's knowledge about HIV/AIDS and reproductive health, their access to healthcare, and identify gaps in current health and education. With the involvement of government leaders and OSSA, the situation analysis was used to design the current project.

#### *1.2 Selection and training of peer educators for facilitating discussions about HIV/AIDS and reproductive health*

Four peer facilitators were selected by government leaders in Teda to receiving training to implement health education coffee ceremonies for adolescents. They received training from a



district health officer for three days about leading peer health discussions, creating a participatory environment, and discussing key child and adolescent health issues.

The following topics were covered during the training: anatomy and physiology of reproductive system, family planning, sexually transmitted infections and HIV/AIDS, reproductive health problems and vulnerability of youth groups, condoms and their importance, gender and HIV/AIDS, menstruation, and abortion.

#### *1.3 Implementation of peer-led coffee ceremonies to provide education about HIV/AIDS and reproductive health*

Coffee ceremonies are an integral part of the social and cultural life in Ethiopia. During the rituals, participants traditionally exchange news, sing songs, network, tell stories, gossip, discuss politics or catch up with friends. The idea to use traditional coffee ceremonies to deliver health education originated from the Executive Director witnessing the participatory and inclusive environment created by the ceremonies and wanting to create an open

environment for adolescents to discuss sensitive health issues. Over coffee, popcorn, and biscuits, facilitators initiate discussions about HIV/AIDS and reproductive health. Male and female adolescents discuss topics, and facilitators summarize the take home messages at the end. A nurse supervisor is available if peer facilitators cannot answer questions raised during discussions. Many youth enjoy the coffee ceremonies because they are sharing experiences, debating health topics, and learning from one another.

**Results:** Youth empowerment about HIV/AIDS and reproductive health

Youth have a better understanding about sexually transmitted infections, reproductive health, and how to use condoms after 50 total coffee ceremonies. In addition to the improved knowledge and awareness about sexual health topics, the cost-effective program has expanded to include more active forms of health education. The peer education program has incorporated dramas that feature local poems and music about HIV/AIDS, which empowers the youth to discover themselves, their friends, their community, and their world. The success of the peer education model can be attributed to the youth's ownership in all aspects of the program and that it addresses unmet needs in health education through a fun and accessible way of learning.



A forum has been institutionalized that allows the youth to communicate with their peers without hindrance, fosters self-confidence and youth leadership, and provides the health and logistical resources to sustain the program. Taboo topics are no longer muffled because adolescents feel confident discussing sexual health messages. Currently, 25 adolescents take part in each coffee ceremony, and we are looking to scale-up this program throughout the district. Supporting and expanding this peer-led coffee program throughout Ethiopia has the potential to improve the lives of many of the most vulnerable individuals in society.

**Objective 2:**

To provide medical care to vulnerable children and their family members

**Activities**

*2.1 Deworming children*

Intestinal parasites are the second most common illness in the village according to the Teda Health Center. Nearly 75% (51/68) of children were found to have intestinal parasites.

Albendazole (400mg) was distributed to 90 children by the health professionals, which treats

worms. Children and their guardians were provided information about the importance of deworming and the prevention of intestinal parasites.

### *2.2 Trachoma*

Since trachoma is prevalent in the area, we provided prophylaxis Tetracycline eye ointment to 90 children. During the distribution, community health workers (CHWs) reinforced messages about facial hygiene, how to reduce the risk of eye infections, and information about the signs and symptoms of trachoma.

### *2.3 Medical exam at the Teda Health Center*

Since vulnerable children and their caretakers are susceptible to communicable infections and lack the financial resources to seek treatment, we provided medical exams at no cost to all children and their guardians. Most children were found to have intestinal parasites and many personal hygiene issues.

### **Results:** Improved medical care for vulnerable children and their caregivers

Almost all (99%) of children were both de-wormed and received tetracycline eye ointment for



intestinal parasites and trachoma, respectively.

Medical examination of 79 children revealed that the main medical problems are intestinal parasites (78%), malaria (9%), conjunctivitis (4%), and reproductive tract infections (4%). Medical examination of 50 guardians of orphans revealed that the main medical problems are dyspepsia (upset stomach) (22%), intestinal parasites (18%), urinary tract infections (16%), malaria (14%), pneumonia (12%), and acute febrile illness (8%).

Considering orphans and their guardians are vulnerable to communicable diseases, medicines

were procured to treat diagnosed medical conditions. Overall, children had poor personal hygiene and nutritional support at the household level. Consequently, community health workers have provided health education about keeping the body and environment clean and healthy.

The Ethiopian Orphan Health Foundation is committed to reversing the most entrenched and pervasive inequities in healthcare. Injustice is persistent in a system where ill children and their guardians are unable to use health services due to financial and logical barriers. Our work raises awareness about the healthcare struggles facing vulnerable individuals and takes a stand against the injustice experienced by children.

### **Objective 3**

To deliver public health services and education through home visits by community health workers

#### **Activities**

##### *3.1 Training community health workers (CHWs)*

Four local CHWs were recruited by government leaders to provide health education to children and their families. CHWs were trained about the plight of orphans and vulnerable children, HIV/AIDS, reproductive and sexual health, malaria, diarrhea, nutrition, and the relationship between these issues and education. They were informed of their roles as leaders in the community, how to work with the nurse supervisor, and collaborate with the community. Training materials were organized from national technical guidelines in Ethiopia. The participants appreciated that the training was child-centered and pertinent to the healthcare needs of the population.

##### *3.2 Home visits by community health workers*

CHWs visit children's homes every week during their free time to provide health education about diarrhea, malaria, trachoma, hygiene, HIV/AIDS, and provide psycho-social support. CHWs have established a repertoire with the children, their families, and the community, which fosters healthy and sustainable relationships. CHWs usually begin their sessions by inquiring about children's progress in school. They educate children and family members based on the health needs in the household and check comprehension by asking questions. CHWs check the use of bed nets and provide supplementary education to the household members.



##### *3.3 Long-lasting bed nets for malaria prevention*

Given malaria is endemic in the region and the main cause of morbidity and mortality in Teda, malaria prevention is a critical activity. We provided long-lasting insecticide-treated bed nets to 91 children and their guardians. A practical demonstration session was conducted to show children and their guardians about how to properly use the bed nets. A health officer from the Teda Health Center provided information about malaria transmission, seasonal variation, prevention, and what actions should be taken when an individual is infected with malaria.



## Results

Community health workers have become important resources in the community in caring for and supporting orphans and vulnerable children. They made 221 visits to the homes of orphans and vulnerable children and provided education and counseling about HIV/AIDS, reproductive health, malaria, psycho-social support, hygiene, diarrheal diseases, and use of bed nets. Qualitative research reveals that children and their guardians have greater awareness about health issues.

A nurse supervises community health workers every week to discuss challenges and opportunities, the quality of health education, relationship between the community and the children, and how to improve the delivery of health education.

A monitoring and evaluation officer visited households in July 2010 to assess the utilization of long-lasting insecticide-treated nets. Nets were available in all households and caregivers reported using nets.

### **Objective 4:**

To support school uniforms and education materials of vulnerable children

### **Activity**

#### *3.1 Provision of school materials and uniforms*

School materials were distributed to 88 children, which included uniforms, exercise books, pens, and pencils. The materials were distributed by the government leaders, who emphasized the importance of staying in school.

**Results:** Improved education and reduced stigma

Children were stigmatized at school because their families could not afford uniforms. Now,



children feel less stigma and discrimination at school because they were provided uniforms and school materials. Furthermore, leaders reported that school dropout rates have decreased because of our efforts. Community health workers are collaborating with the local schools to institutionalize a system to identify and to respond to children who drop out of school. The effect of HIV/AIDS, illness, death, and suffering stunted

children’s learning and growth potential, but our program met the education gaps and created a supportive environment for children to thrive by eliminating one of the root causes of child vulnerability.

## **Lessons Learned**

We have learned many lessons while implementing a community-based program for vulnerable children.

1. In a community that continues to be affected by HIV/AIDS, we showed government leaders, teachers, health professionals, religious leaders, and children that change is possible in their community.
2. Coffee ceremonies are an innovative and effective forum to deliver health education about HIV/AIDS in Ethiopia. Our program upholds the right to health by mobilizing resources in a culturally-sensitive manner to help those in greatest need. There are many opportunities to scale-up peer-led coffee ceremonies to other areas in Gondar.
3. We consider children and their guardians as partners in reducing their own vulnerabilities as opposed to passive recipients. With the support of the community, government, local leaders, and outside experts, orphans and vulnerable youth become active participants—rather than beneficiaries—to reverse the inequities in healthcare.
4. Transferring decisions to youth about running the coffee sessions has facilitated its expansion. We provided coffee materials and training for peer education, and youth have been inspired by the initiative and consider it an important part of their learning. Peer education sessions have evolved from debates to local dramas, poems, and music because youth have complete ownership in the program.
5. We realized the importance of regular communication with community members and stakeholders about the project. We encountered resistance by some children who were not permitted to attend peer education sessions by their caregivers. We did not clearly communicate the project goals and objectives to children and their guardians at the beginning of the project. Therefore, we conduct quarterly meetings with all stakeholders to hear their views about the project and ensure that the project is meeting the needs of children.
6. Our implementation strategy does not alienate children in our program from other children in the community. Our focus has been to support vulnerable children and include other children during health education discussions. We wanted to avoid the perception that peer-led coffee ceremonies are only intended for orphans because we did not want to increase stigma among vulnerable children. Consequently, a child-focused implementation strategy has created an inclusive environment in the community, which decreased stigma and discrimination among children. Importantly,

programs that target the most vulnerable individuals must be mindful of entrenching societal stigma at the expense of providing human rights to those greatest in need.

7. Our health and education programs have reduced entrenched societal stigma in different ways. The coffee ceremony reduced the taboos associated with talking about HIV/AIDS and sexual health by creating a non-judgmental and inclusive discussion forum. The education program allowed children to not feel different at school because they had school materials and wore uniforms like other school children. Collectively, we learned that addressing children's health and education needs creates a synergy in stopping the exclusion of vulnerable children from society.
8. Listening to adolescent orphans' views about their health and sources of health education inspired us to deliver health education to children based on the individuals whom they trust and respect. Ethnographic research revealed that adolescents' concepts about health and health education are neglected in program design, yet have important implications for the content of health education, mode of delivery, and type of interaction between health agents and vulnerable children. We prioritized health education topics and channels based on active input from children.
9. The project has created innovative partnerships and networks between local NGOs, the local government, faith-based organizations, schools, health facilities, and government offices. Local resources are available and people and institutions are willing to help the poorest and most vulnerable members in a society. The various institutional stakeholders contributed different resources. Collectively, their response improves the sustainability of the program, maintains an active network of support for the most vulnerable individuals in society, and contributes to an environment in which youth empowerment is the norm.

## References

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