Report

WaterAid

Meeting the needs

For water and sanitation of people living with HIV/AIDS in Addis Ababa, Ethiopia

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WaterAid – water for life
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Overview

This research investigates the needs of people living with HIV/AIDS (PLWHA) in water and sanitation, their constraints on meeting these needs, and ideas for addressing them through water and sanitation programming by NGOs and government in Ethiopia.

The research was done by WaterAid, an international NGO, and Progynist, a national NGO, in Addis Ababa, Ethiopia in September-December 2005, and builds on an earlier piece of research undertaken by the same organizations. The research was prompted by the observation that the water and sanitation needs of PLWHA were not being addressed either by HIV/AIDS programming or by the water and sanitation sector, despite the high numbers of people affected by HIV and their particular needs for clean water and sanitation. Latest estimates, based on data collected in 2003, give national adult prevalence of HIV/AIDS in Ethiopia at 4.4%, with urban prevalence at 12 % and rural at 2.6%[1] About 1.5 million people were estimated to be living with the virus in 2003 (ibid).

For this research, 22 PLWHA and 20 randomly selected control respondents (of unknown HIV status) were interviewed using questionnaires. A further 22 people were consulted through focus group discussions.

Results confirmed those of the earlier research that the **needs** of the majority of PLWHA for water and sanitation increase, but their **access** may be reduced due to discrimination or sickness, so that their needs are not always met. Increased needs for water and latrines occur mainly during the symptomatic phase of HIV, due to the types of opportunistic diseases experienced as well as the medication required. For example, fever increases the need for bathing and washing, and diarrhoea and fever require drinking more water. Just over half of the HIV positive respondents, including two with no symptoms, were taking anti-retroviral treatment (ART), and needed to drink several litres of water per day to reduce side effects. During the pre-symptomatic phase some PLWHA use more water for washing to avoid infections, and one respondent boiled her drinking water. Increased latrine use was correlated with diarrhoea, which was experienced by two thirds of HIV positive respondents, compared with only one in ten control respondents (although control respondents may have under-reported diarrhoea as it is seen as an indicator of HIV).

Water and sanitation **problems** in the neighbourhood were a priority for most respondents, whether or not they were HIV positive, and most advocated more facilities for everyone. According to focus group discussions, water and sanitation ranked third after income and housing in terms of the problems and discrimination which PLWHA face. Problems include insufficient number of facilities, high cost of buying water from vendors and poor maintenance, especially of latrines, which increased the perceived risk of sickness.

Discrimination in water and sanitation use was experienced by more than one third of HIV positive sample respondents as well as by participants in the group discussions. Experiences ranged from excessive amounts of water being used to flush the pit latrine[2] after an HIV positive person has used it, to locking of taps, bathrooms or latrines. It is not limited to those using shared facilities. The minority who have private facilities faced some of the most extreme forms of discrimination from close family members, or private landlords.

Discrimination in water and sanitation is often part of a complex web of discrimination which also affects housing, employment, social life and medical services for PLWHA with varying levels of income. Choosing to be secret or open about one's HIV status does not necessarily affect the probability of discrimination. Secrecy is generally only successful during the pre-symptomatic phase, as any sign of sickness, including taking medication, visiting a health centre, or frequent use of the toilet, triggers suspicion of HIV positive status which in turn often leads to acts of discrimination. Being open seems to work best for those prepared to challenge discrimination, and for people who are already respected in the community. In general, discrimination depends on the attitudes of those with whom PLWHA interact, which can be influenced by education and counselling.

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[1] AIDS in Ethiopia 5th Report, Federal Ministry of Health, Ethiopia (2004)

[2] Most respondents had access to a pit latrine. Pit latrines are not normally flushed after each use, although they do need periodic cleaning. Although cleaning should not be discouraged, PLWHA view excessive flushing as a form of discrimination.

Despite numerous examples of discrimination described by HIV positive respondents, most of the control sample claimed not to be aware of discrimination in their neighbourhood and said that they would not mind sharing water points and latrines with people who were HIV positive.

In discussing recommended **solutions,** respondents felt that tackling discrimination through community counselling and mass media was as important as provision of more facilities. Although most HIV positive respondents felt that PLWHA needed their own latrine, they also recognized the problems of reaching HIV positive people who may not be tested, or may not wish to reveal their status, as well as the risks of increased stigma as a result of targeting. For this reason, improved facilities for the general population were preferred to targeted provision, both by HIV positive and control respondents. Targeting of the chronically sick or those who are open about their status was also suggested, although the first excludes pre-symptomatic PLWHA for whom improved water and sanitation could prolong their good health, while the second excludes the majority of PLWHA in Ethiopia who still prefer not to disclose their status.

Researchers' **recommendations** include integrating programming in water and sanitation with that in HIV/AIDS; dissemination of research results to the public, including via radio; involving PLWHA and their representatives in water and sanitation projects; and advocacy to tackle discrimination and improve access to water and sanitation facilities for PLWHA.

Contents

Acknowledgements

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Glossary

AIDS	Aquired Immunodeficiency Syndrome
GO	Government organization
HAPCO	HIV/AIDS Programme Coordinating Office
HBC	Home based care
HIV	Human Immunodeficiency Virus
NGO	Non-government organization
PLWHA	People Living with HIV/AIDS

1.0 Introduction

This research investigates the needs of people living with HIV/AIDS (PLWHA) in water and sanitation, their constraints on meeting these needs, and some ideas for addressing them through water and sanitation programming by NGOs and government.

The research was done by WaterAid, an international NGO, and Progynist, a national NGO, in Addis Ababa, Ethiopia in November-December 2005, and builds on an earlier piece of research undertaken by the same organizations. The research was prompted by the observation that the water and sanitation needs of PLWHA were not being addressed either by HIV/AIDS programming or by the water and sanitation sector, despite the high numbers of people affected. Latest estimates, based on data collected in 2003, give national adult prevalence of HIV/AIDS in Ethiopia at 4.4%, with urban prevalence at 12 % and rural at 2.6% (MOH, 2004) About 1.5 million people were estimated to be living with the virus in 2003 (ibid).

The earlier research, on linkages between HIV/AIDS and water, hygiene and sanitation in Addis Ababa, Ethiopia was undertaken in 2004 (Mamo and Frazer, 2004). 44 PLWHA were interviewed and some case study material was reported. The main finding was that PLWHAs and carers have increased needs for, but reduced access to clean water and sanitation facilities, compared with the rest of the population. A further finding was that a high proportion of PLWHAs suffer from diarrhoea. Both WaterAid and Progynist were interested in doing further research in this area, to assess the need for HIV targeted programming in the water and sanitation sector.

1.1 Goal

The GOAL of the research is to address the water and sanitation needs of PLWHA and those affected through improved water and sanitation and HIV/AIDS programming in Ethiopia.

1.2 Objective

The objective of the research is to test the hypothesis that PLWHA have increased needs for and reduced access to water and sanitation facilities, and that some modification of current programmes is therefore necessary.

Based on these objectives, the focus of the research is on:

1) the experiences and needs of PLWHA and their carers in water and sanitation;
2) how PLWHA are affected by discrimination in water and sanitation provision;
3) what PLWHA think could improve their situation;
4) the attitudes of those not yet affected towards the HIV infected.

1.3 Methodology

The research was undertaken in Lideta, one of 10 sub-cities in Addis Ababa. Information gathering methods included individual interviews with 22 PLWHA and 20 randomly selected controls, and focus group discussions with 22 participants. Respondents were drawn from a range of wealth groups and water and sanitation access situations, as well as covering different stages of HIV infection and sickness.

1.3.1 Individual interviews

22 PLWHA were interviewed using a questionnaire. They were selected from the beneficiaries of two different types of NGO working with PLWHA in Lideta sub-city: Progynist, a partner of WaterAid providing support to the poorest of the poor, which undertook the previous related research (Mamo and Frazer, 2004), and Dawn of Hope, an urban based voluntary association of PLWHA, which had no previous links with WaterAid. The second NGO was included to reduce potential bias from working only with WaterAid partners. The Dawn of Hope sample also increased the range of socio-economic status covered within the sample.

From Progynist, 10 people were randomly selected, from a total of 52 Progynist beneficiaries, and were interviewed at the Progynist health post. An additional two respondents were purposively selected for questionnaire testing, and subsequently included as respondents, giving a total of 12. At Dawn of Hope,

10 PLWHA were selected randomly from over 208 members[3] of Dawn of Hope, Lideta Branch office, and were interviewed at Lideta Dawn of Hope office.

A further 20 people were interviewed as a control sample. They were randomly selected from nearby kebeles[4], with assistance from kebele administration staff. 10 households were selected from a total of 600 located in Kebele 50, near the Progynist office, and 10 from Kebele 52 near Dawn of Hope office.

The questionnaires covered housing situation, experience with HIV, and water and sanitation access, problems and solutions. The main reason for using the control was to gauge attitudes of people not affected by HIV/AIDS towards water and sanitation provision for PLWHA. The earlier research was done only with PLWHA, and may have exaggerated discrimination.

> *'Discrimination starts with the person themselves. Fearing discrimination, they isolate themselves before they are rejected by others.'* Kuri from Progynist

1.3.2 Focus Group Discussions

Results of the interviews were presented to two groups which then discussed topics presented by the researchers. For the first meeting, Progynist staff together with one of the sample respondents, invited seven women and five men who met at Progynist health post. They included both PLWHA and those whose status was unknown to the researchers. For the discussion, they were divided into a **women's group** and a **men's group**. For the second meeting, a **mixed group** of four women and six men, all HIV positive, were invited by Dawn of Hope, Lideta staff, and met at Dawn of Hope office[5].

All groups were asked to discuss, then rank:

- Water and sanitation, compared with other problems faced by PLWHA;
- Problems in water and sanitation faced by PLWHA;
- Types of discrimination faced by PLWHA;
- Solutions in water and sanitation for PLWHA.

The ranking was done using piles of peanuts, with the size of the pile representing the importance and rank of what was represented. The number of peanuts in each pile was then counted by the researchers, providing a scoring mechanism which could be compared across groups. For example, when the women's group ranked problems faced by PLWHA, income and job loss received 163 peanuts, housing insecurity 97 peanuts, water and sanitation 66 peanuts and lack of electricity at night 37 peanuts.

The 22 PLWHA respondents are referred in the text as the **purposive sample**, and the remaining 20 as the **control sample**. The combined sample of 42 respondents is referred to as the **combined sample.** Focus group participants are referred to as **focus groups.**

[3] No attempt was made to draw proportional samples in relation to the membership size of the organizations. Given overall resource limitations this would have yielded a very small sample size from Progynist, the smaller organization.
[4] The kebele is the lowest unit of government in urban areas of Ethiopia.
[5] Only one facilitator was available, but the mixed group also allowed for comparison with separate gender groups.

2.0 Findings

2.1 Characteristics of the respondents

Care must be taken in interpreting the results since neither the purposive nor the control samples fully represent the wider populations from which they are drawn. From the total population of PLWHA, respondents were selected from those who have tested positive and who seek benefits from an NGO, and are therefore likely to be poor. Similarly, focus group participants were mostly related to Progynist and Dawn of Hope NGOs.

Although control households were randomly selected, individuals interviewed were those present in the household, predominantly women, the elderly and the unemployed. If several members were present, the head of household was interviewed.

2.1.1 Gender

For the combined sample 32 women were interviewed and 10 men. The proportions were similar for the purposive sample of PLWHA and for the control, but for different reasons.

The purposive sample, randomly selected from among NGO beneficiaries, comprised 16 women and six men PLWHA, reflecting not only the higher proportion of beneficiaries of the NGOs who are women, but also higher national incidence of HIV among women. Estimates for 2003 are 5% for women and 3.8% for men (MOH, 2004). Incidence is also higher for women in Africa as a whole.

The control sample comprised 16 women and four men, reflecting the tendency for men to go out, while women stay home. For the focus groups, equal numbers of women and men were invited.

2.1.2 Marital Status

Only three out of 22 respondents of the purposive sample of PLWHA were currently married. Five were single, six divorced (one divorced wife died) and 1 separated. Seven (almost one third) were widowed, of whom 5 lost their spouse to AIDS.

A higher proportion of the control sample respondents were married (45%), while fewer were single, widowed or divorced.

2.1 3 Age

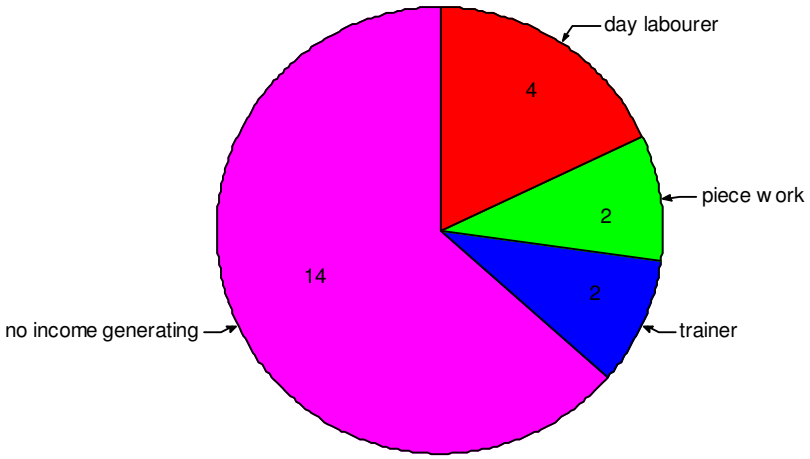
The purposive sample was younger than the control sample. This is partly because PLWHA tend to be younger, and partly because, in the control sample, household heads were interviewed, if present. Over 80% of the purposive sample was under 40 years old, compared with only 40% of the control sample. Awareness of and opinions about HIV/AIDS may be correlated with age, so different results might have been obtained from a younger control sample.

2.1 4 Employment

Just over half of all respondents had no current income generating activity, including 13 purposive and nine control respondents. Of those employed, control respondents tended to be employed in the formal sector (seven out of 11 cases) while purposive respondents were employed in the informal sector, including day labouring and piece work (six out of nine employed purposive respondents). The correlation is even stronger when the income of other family members is included. Twelve out of 20 control respondents' family members work in the formal sector (private or government), compared with only two from the 22 in the purposive sample, both of whom were employed by Dawn of Hope NGO working in HIV training. Five purposive respondents relied on donations, compared only one of the control sample.

Eight out of 22 purposive sample PLWHA lost previous employment due to sickness (six cases) and / or discrimination (four cases).

Figure 1: Current Income Source
Purposive Sample Only
(n=22)



2.1 5 Housing situation

Almost 70% of all respondents (both purposive and control) live in kebele rented accommodation, and there is no difference in percentage between the two samples. But control sample respondents not in kebele accommodation all owned their own houses, whereas none of the purposive respondents did. Two were in private rentals, one is living with parents, one is a lodger, and one lives at a church. One purposive respondent is currently homeless, thrown out of family accommodation once her HIV status became known.

Control sample respondents had been living in their present accommodation for longer than purposive respondents. Whereas purposive respondents had lived in their current homes for between one and ten years, control sample respondents had lived between eight and 60 years in the same accommodation. This may reflect the insecurity of tenure experienced by PLWHA, as at least five purposive respondents had been thrown out of previous accommodation. It may also reflect the better socio-economic status of the control sample, with five being house owners.

Half of all respondents from the combined sample disliked the neighbourhood where they were living, while a third liked it. The most frequently mentioned problems were related to water and sanitation, mentioned by just over one quarter of all respondents. This could have been influenced by the respondents knowing that the researchers were from WaterAid. Other problems mentioned included overcrowding and lack of employment. Six of the 20 control respondents, but none of the purposive respondents, had moved in to the area for work. Most respondents moved into the area because family lived there (10 cases), or on marriage (7 cases), or they were born there (7cases). Five had moved in because the kebele allocated a residence to them.

2.1 6 Access to food and nutrition

There is a sharp contrast in access to food and nutrition between the purposive and control samples, reflecting the better socio-economic status of the controls. Two thirds of the purposive sample of PLWHA reported problems getting enough food compared with only one out of the 20 control respondents. Nearly all of the control sample respondents eat three times a day, whereas a quarter of the purposive sample respondents eat only twice a day. Access to adequate nutrition was limited even for the control sample. Only eight out of the combined sample of 42 respondents reported adequate nutrition, indicating a varied diet, and of these, seven were control respondents. Thirty-six out of the 42 respondents reported what they had eaten the previous day. Eight control respondents reported a varied diet, while the remainder, including all purposive sample respondents, had eaten only injera (pancakes) with pulses or vegetables.

2.1.7 Summary description of respondents

Most interviewed respondents live in kebele rented accommodation. Purposive sample respondents tended to be poorer than the control sample, and this is reflected in their employment status, their lack of privately owned houses, and poorer food access. Within the purposive sample, Progynist beneficiaries were generally poorer than Dawn of Hope respondents, reflecting the selection criteria of

Progynist who work with the poorest. Focus group participants were from similar socio-economic status as the purposive sample[6], but personal data were not collected.

The different socio-economic status of the samples results from the sampling methodology, as the purposive sample was drawn from NGOs working with the poor. ***It cannot be concluded from this research that PLWHA are poorer than the general population.***

2.2 Experience with HIV/AIDS

2.2.1 Reason for getting an HIV test

The purposive sample was selected from people who had tested positive for HIV. Of the 22 respondents,15 got tested because they were sick and one because her husband was sick. Five were tested for visa application, while one tested on a friend's advice[7]. Two thirds had tested between two and four years previous to the interview, and the earliest test date was ten years previously (two respondents).

Interestingly, seven of the 20 control respondents, randomly selected from the local population, had also tested for HIV, and four of these revealed their status as negative. Five had tested because they wanted to know their status, one was sick, and one tested for visa application[8].

2.2.2 Incidence of HIV within households

It is striking that a high proportion of purposive respondents had family members who suffered from or had died from HIV/AIDS. From the 22 purposive respondents, six reported at least one living relative, spouse or ex-partner with HIV. Two of these are married to PLWHA, and another ran away from his wife, whom he suspects is positive, on learning his own status. Two had had previous relationships with PLWHA, and two have siblings living with the virus. Four respondents have HIV positive children living with them, while six others have children who have not been tested. Half of the respondents (11) mentioned relatives who had died of AIDS, and of these, six had lost one relative, four had lost two and one had lost three.

2.2.3 Sickness

Purposive sample of PLWHA

Most purposive sample respondents suffered occasional sickness (10 respondents) or chronic sickness (five respondents). Six respondents had no current symptoms, and only one was bedridden. Diarrhoea was the most common symptom experienced by 14 respondents (65%), 11 of whom never got diarrhoea before they tested positive for HIV. TB was the second most common sickness, and 11 (50%) had had it at least once, while three had it at the time of the interview. Other symptoms included skin infection (four cases), weakness (two cases), body pains and paralysis (one case each). The incidence of typhoid had not increased with HIV. Eight purposive respondents had ever had typhoid, of whom four had it since testing positive.

Control sample

There was little overlap in the types of sicknesses experienced by the control sample respondents. Almost two thirds had no current symptoms, while 11 mentioned occasional or chronic sicknesses such as diabetes, hypertension, gastritis and kidney problems. Many of these were elderly. Only two said they had ever had diarrhoea, while four had had typhoid.

Incidence of diarrhoea and typhoid in the family and neighbourhood

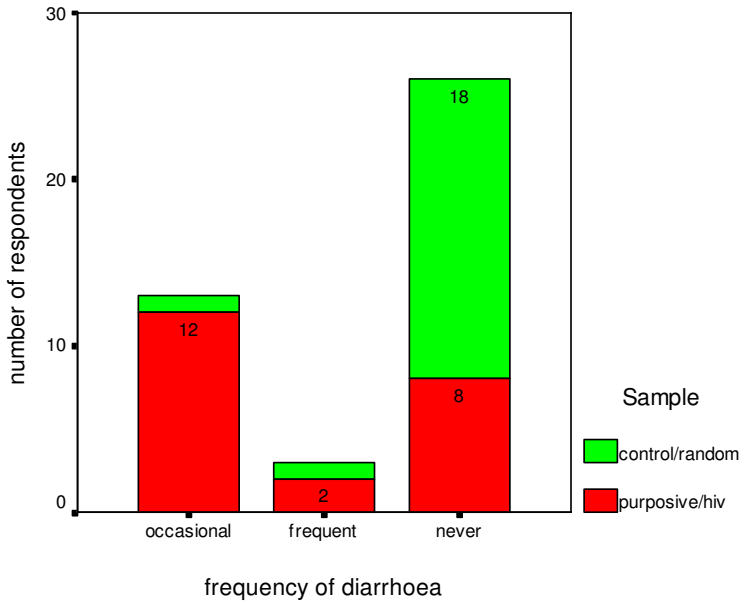
Since diarrhoea and typhoid are related to water and sanitation, respondents were asked about incidence in the family and neighbourhood. Reported incidence was low, with only six respondents (five purposive and one control) reporting family members who had ever had diarrhoea, and eight (three purposive and five controls) reporting family members who had ever had typhoid. Estimates for the neighbourhood are higher with almost 40% of all respondents (and 60% of purposive respondents)

[6] Some focus group participants were also sample respondents.
[7] According to national statistics for 2003, the incidence of HIV among those testing because they were sick is 47%, while for those testing for visa purposes it is 4.7% (MOH, 2004).
[8] Only a small proportion of the estimated 12% of the adult population in urban areas of Ethiopia gets tested and receives treatment. It is estimated that only 6% of AIDS cases sought health institution services and were reported in 2003 (MOH, 2004).

reporting diarrhoea and a slightly higher percentage reporting typhoid in their neighbourhoods. At least two respondents mentioned earlier typhoid outbreaks in their areas.

It is interesting that reported incidence of typhoid is higher than that of diarrhoea, and quoted incidence of diarrhoea is higher for purposive respondents than for controls. According to opinions voiced during the focus group discussions, frequent visits to the latrine and diarrhoea can lead people to suspect HIV/AIDS, and to initiate acts of discrimination. 12 out of 20 control respondents (60%) said they believed PLWHA had more frequent diarrhoea than others. If diarrhoea is considered by the community as an indicator of HIV, this may have influenced control respondents to under-report incidence for themselves, their family and their neighbourhoods.

Figure 2: Incidence of diarrhoea
Comparison of purposive and control samples
(n=42)



2.2 4 Use of ART and other medication

Twelve of the purposive respondents (55%) were taking ART, which they obtain free from government hospitals. The majority (nine) were members of Dawn of Hope, with only three Progynist beneficiaries taking ART. Many of those on ART said their health had improved, but only four out of the 12 had no current symptoms. Two had never had any symptoms, yet were on ART.

Of the 12 taking ART, 11 currently take no other medication, while one is undergoing treatment for TB. Of the 10 HIV positive respondents not on ART seven are taking medication including for TB, painkillers and antibiotics.

None of the interviewed PLWHA pays for medication. They get it free from government hospitals or from NGOs including Progynist. But most of the control sample respondents do pay for medication which they need from the pharmacy.

Focus group participants said that PLWHA did not always get the medication which they needed. They sited two reasons for this. Some PLWHA were afraid to visit health centres or take medication as people would suspect their HIV status (see Box 1).

Box 1: Fear of stigma constrains use of medication
W believes that the woman she lives with already suspects her status, but she is afraid that if this is confirmed then she will be thrown out and become homeless. For this reason she is not taking ARV, fearing that this will identify her as a positive person. Her neighbours ask questions even when she takes antibiotics and painkillers. They already suspect her status and won't drink coffee with her. She even avoids having the Progynist's social worker visit her. More than anything she is afraid to be identified as a positive person.

The other reason sited was that PLWHA experience discrimination from government medical services. This was mentioned by all three of the focus groups and by at least one sample respondent. Medical professionals were 'fed up' with AIDS cases or regarded them as 'lost causes' and did not bother to do proper diagnosis or prescriptions.

Box 2: Poor medical attention
An HIV positive patient went to the hospital as she was sick. The doctor gave her paracetamol, but her condition became worse and worse. She went back to the doctor and asked to be checked for typhoid. Eventually she was tested and typhoid was confirmed.

2.2.5 Home Based Care

20 out of the 22 purposive respondents have needed or are currently receiving home based care. 11 receive home based care from an NGO (seven from Progynist and four from Dawn of Hope). Four of these also get help from family and friends, while nine receive HBC from family members only. None of the control respondents needed home based care.

2.2.6 Who knows about their status?

In 9 out of 22 cases in the purposive sample, everyone in the neighbourhood knows about their status, although in at least two of these cases close family members told people without the consent of the respondent.

Box 3: Betrayal
A woman confided her HIV status to her best friend, intending it to be kept secret from other people. Their children used to play together as friends. One day, she gave water for the two children to drink. But her best friend's son said that his mother had told him not to drink water in her house. This made her feel betrayed by her best friend.

Two respondents are open to the public and are employed by Dawn of Hope (together with their husbands) to give training in education and home based care. Progynist beneficiaries do not have this opportunity and appear less willing to reveal their status or to tackle discrimination, with one notable exception. He is an iddir chair who told selected members of the iddir his status and changed the by-laws to support the chronically sick.

Other respondents told only selected family members and / or friends about their status, and are anxious to keep it a secret from others. The desire to keep the status secret is understandable given levels of discrimination. At least two fear they will lose their residence if others in the household know their status. Participants in the focus groups had different opinions about whether PLWHA should be open about their status, with some arguing that discrimination would increase, while others saying that being open led to psychological and emotional freedom, and enabled the person to get better care and support. But gaining these benefits may require tackling discrimination first.

Box 4: increased discrimination after revealing HIV status
BB revealed his HIV status publicly, and this has made it almost impossible for him to find permanent accommodation. Whenever he tries to rent a house the owners throw him out the moment they know who he is. He feels ashamed to reveal the number of times he has faced this problem. He says he often transports his personal belongings to his office and spends the night in his friend's house.

Information from the control sample confirms the finding that few reveal their status. Control respondents were asked about incidence of HIV in their neighbourhoods. Only one mentioned 'many cases', while a further six knew of one or two cases. Five mentioned 'suspected cases' where people were sick or had died but they were not sure if it was HIV/AIDS. Eight respondents said they did not know of any cases. Control respondents may have under-reported incidence in their neighbourhood, due to fear of any association with HIV/AIDS, or from not wanting to acknowledge the problem or reveal their neighbours.

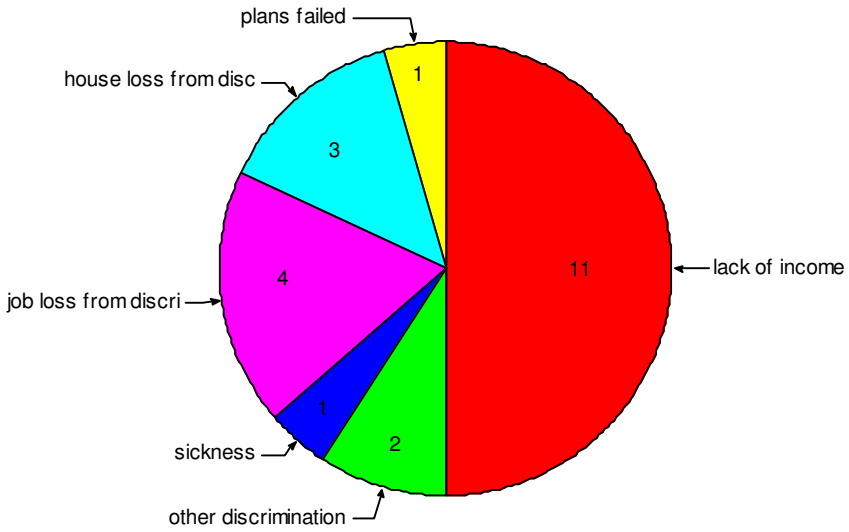
'People get sick in our village but none of them frankly tell what their real problem is.'

2. 3 Problems faced due to HIV status

2.3.1 Views of the sample respondents

The majority of purposive sample respondents cited lack of income (10 cases) or job loss (three cases) as the biggest problem they had faced since becoming HIV positive. Other problems included housing (3 cases), failed plans (3 cases) and stigma and sickness (one case each).

Figure 3: Biggest problem faced as a PLWHA
Purposive sample only
(n=22)



Water and sanitation were not identified as the biggest problem faced by any of the 22 purposive respondents, although many of them mentioned water and sanitation related problems during the interview. Further information on this was provided by the focus group discussions, and is presented in the section on Water and Sanitation.

2.3.2 Views of focus group participants

Whereas sample respondents were asked to specify the single biggest problem which they faced, participants in focus groups were asked to discuss, then rank, all problems faced by PLWHA. For the ranking, peanuts were divided into piles representing each problem (see Methodology section for details).

The three groups agreed on the types of problems faced by PLWHA with all three groups mentioning employment, housing, and water and sanitation. However the rankings varied, depending on the personal experiences of the participants. The women's group agreed most closely with the sample respondents, with employment / income ranked first. The men's group ranked water and sanitation first, arguing that good health was a prerequisite for tackling other problems. The mixed group had housing as the first problem, as several participants had personally experienced housing problems. Ranking orders are presented in the following table.

Table 1: Ranking order for Problems faced by PLWHA

Problem area:	Women's group	Men's group	Mixed group
Employment/income	1	2	2
Housing	2	3	1
Water and sanitation	3	1	3

Other problems mentioned in the discussion, included discrimination in electricity (lights switched off at night when people are sick); discrimination against children whose parents are HIV positive or have died of HIV/AIDS; and demoralization through insults, discrimination and people giving them a bad reputation.

2.3.4 Discrimination

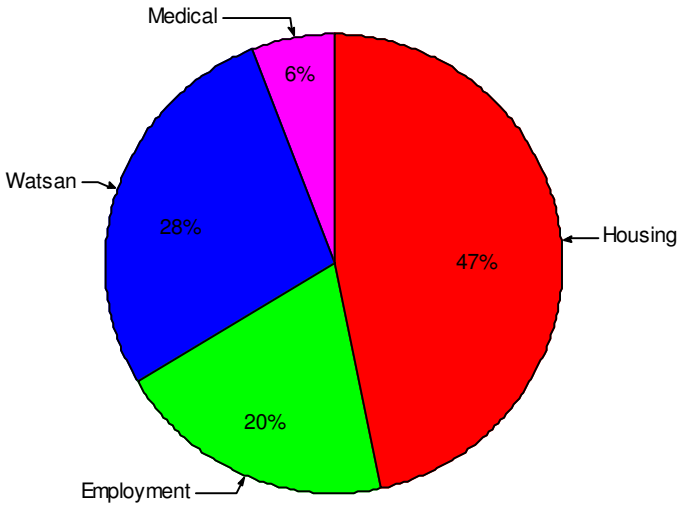
Most of the problems faced by PLWHA which were mentioned by respondents are related to discrimination. PLWHA experience complex webs of discrimination affecting housing, water and sanitation, social life, childcare, employment and access to medical services. In order to tackle discrimination in the water and sanitation sector (described in more detail in the following section) it is important to understand the broader context of discrimination and its determinants. For these reasons, the issue of discrimination is explored here in some depth.

Both purposive respondents and focus group participants were asked directly about personal experience of discrimination. From the sample survey, 14 out of 22 purposive respondents (almost two thirds) experienced discrimination and of these eight (over one third) experienced discrimination in access to water and sanitation facilities. Many informants had experienced multiple forms of discrimination affecting housing, employment, social life, childcare, water and sanitation and medical services.

But information from the control sample suggests that the general public is either not aware of, or not prepared to acknowledge discrimination of PLWHA. When asked about discrimination in their neighbourhood, only one of the 20 control sample respondents admitted that there was discrimination, while 12 (60%) said there was none, and the remaining seven said they did not know if there was or not, as they did not know any cases of HIV.

During focus group discussions participants discussed and then ranked different areas where PLWHA are affected by discrimination. Results for the three groups were very similar, with all three ranking housing first. Both the women's and men's groups ranked water and sanitation second, and employment third, while the order was reversed for the mixed group. Only the mixed group included the medical profession in their ranking, although the women's group also discussed this issue. The combined results of the ranking for the three groups are presented below[9]. These are strikingly similar to those for 'problems faced by PLWHA', suggesting that discrimination dominates PLWHA's perception of their problems.

Figure 4: Forms of Discrimination Experienced by PLWHA
Focus Group Discussions (n=22)



[9] The combined ranking was calculated by estimating the average percentage for the three groups, of peanuts allocated to each type of discrimination.

> "Once the status of people is known by other people they will try to force them out of the place where they are living. Families hide the patients in a room and facilitate their death. Most of the patients have no income that will enable them to rent a house so some of them remain homeless. Sometimes the owner of the house increases the rent of the house to make people leave the house".

Housing problems mentioned included insecurity of tenure in private rental rooms (which few respondents have due to low income); and discrimination within the family home. PLWHA are isolated within the family home and mistreated. Forms of mistreatment include insults, lack of home based care, denying access to food, demoralization, and hiding them from visitors.

Box 5: Living with the family dog

"I was sick with HIV/AIDS. When my parents heard the news they got mad. They didn't want other people to know about my situation, or to view them as the parents of a daughter with HIV/AIDS. So they locked me in a small room where they kept the dog. They were giving me food with the dog. Finally I escaped and went to 'Entoto Mariam' church".

At least five out of 22 respondents in the sample survey were thrown out of their current accommodation, sometimes violently, and participants in focus groups had had similar experiences. At least two participants in the research are homeless.

Box 6: Homeless due to HIV

FD divorced her husband 14 years ago and she and her daughter moved in with her mother and younger sister. After some time, her sister became suspicious and told her to get tested for HIV, but she refused. (In fact, she had already tested positive but was afraid to reveal her status). This made her sister nervous and she chased her out from the house hitting her. Now she is homeless, while her daughter is still living with her family. She has taken her family to court. Now she spends the night time baking Injera pancakes for people. She does not dare to tell her employer her status as she thinks she would lose the job. They also do not know that she is homeless. She sleeps and uses water and latrine facilities at her workplace. She is also doing embroidery, and is trying to enrol in a government HAPCO small enterprise scheme.

Leaving the city for the rural family home may not solve the housing problem, as the following case illustrates.

Box 7: Return to the village?

A daily labourer was found to be infected by the HIV virus. He was not able to survive in Addis Ababa city alone, so he moved to his parent's house in the rural area. There he showed the result of his HIV test to his parents and uncles. Finally the whole household including his mother asked him to leave the house. The uncle was also mad with him and, threatened to kill him. So he was forced to return to Addis Ababa.

Those living in kebele rented accommodation appear less vulnerable to discrimination in housing. This is because official government policy protects people to some extent. Despite this, however, in one case a PLWHA had one of his two kebele rented rooms allocated to another person, while in another case a neighbour tried to force a PLWHA to move out. In the latter case the kebele officials warned the neighbour against such behaviour. There is no such protection in private rental situations.

Box 8: Separate housing for PLWHA?

According to focus group participants, in Lideta sub-city the kebele has provided housing for PLWHA. However, no provision has been made for water and sanitation facilities, so residents are forced to pollute the nearby river. There is also no electricity. The area is avoided by others and the residents experience discrimination. Although they would prefer to live within the general community they cannot find any other housing (Kuri, personal communication).

Discrimination in the Neighbourhood

> "Once neighbours and iddir members know a person's status they will discriminate against the person in their social relationships. They don't go to those people's homes even if they get sick. They also discriminate against orphans or children who have positive parents. They don't invite them on different social occasions".

Whereas 16 out of 20 control sample respondents said that they had good or intimate relations with neighbours, this was the case with only eight of the 22 purposive respondents, while nine had poor relations with neighbours due to their HIV positive status. Few respondents received any kind of support from their iddir or church.

> **Box 9: Discrimination in the iddir**
> One woman described discrimination in her iddir. The main role of women in the iddir is to prepare food and drinks for people who come for the mourning ceremony. But when it is her turn to accomplish the task people don't feel comfortable and this makes her feel demoralized.

Some of the most painful experiences involve the children of PLWHA.

> **Box 10: no-one to help this child?**
> DA has the HIV virus, and the whole neighbourhood became aware of her status because her mother told them. DA has a baby boy and everyone in the neighbourhood forbad their children to play with him. One day he fell down on the ground and hit his forehead and it swelled up. Nobody was there to pick him up, and massage his forehead. When his grand mother asked the people surrounding him they said if they had touched his body they would have got the virus. Because of these attitudes, the mother eventually gave her son away to a humanitarian organization. The family lost about four members due to the virus, and following this some people call the family 'Dawn of Hope Association'.

Neighbourhoods are not always united in their attitude to PLWHA, as this case study from the control sample shows:

> **Box 11: The neighbours are not all bad**
> "HIV/AIDS is not common in the surrounding neighbourhood. I do know of one case. This girl was living with her mother in our neighbourhood. After the death of her mother she started to live alone. Suddenly she became sick. Her neighbours were bothering her so she left the area and went to another locality. But the surrounding people turned against those who had chased the sick girl out, and they brought her back here. Later, she became chronically sick and we called for the Red Cross. They took her to the hospital. Now we have no information about where she is and her status".

Discrimination in the Workplace

Three purposive sample respondents and several focus group participants lost previous occupations due to discrimination or fear of discrimination. Occupations such as cooking and selling food, washing clothes or selling fruit fail once potential customers suspect HIV. Focus group participants mentioned that employees had started to ask for medical reports including HIV tests for jobs such as waitressing, and even for government jobs.

> "I applied for government jobs on two occasions, but I was asked to present my medical certificate. I believe I lost those job opportunities because of my HIV status".

Box 12 :Jobless and homeless
One man used to be a driver, living in the home of his employer. But when he became an AIDS patient they told him to leave both the job and the house. He was very disappointed about this, so he started to threaten them. The people then sued him and he went to jail for several months.

Discrimination in Government Health Facilities

It is striking that medical services were mentioned by the focus groups largely in relation to discrimination by medical professionals. Problems related to being sick barely featured in the discussion. The lack of care given to HIV patients by doctors who are 'bored' with HIV cases has been mentioned in Section 2.2.4 above. Fear appears to be another factor encouraging discrimination, for example, in the case of a nurse, who wore five pairs of gloves when helping to deliver one respondent's baby. Confidentiality appears to be a further casualty of discrimination, as the following case illustrates.

Box 13: Where do the doctor's loyalties lie?
A woman who is living with the HIV virus, used to work in a super market. She became pregnant, and was seeing a doctor for regular check-ups. After she gave birth to her baby she resumed her job in the same supermarket. One day her doctor came to the supermarket. Unfortunately for her, he was a close friend of the owner. "Did you know that that girl has HIV?" he asked. The owner immediately asked her to leave the job, and told the other workers not to wear her uniform without washing it with strong detergent. Now she is jobless.

Discrimination and revealing one's status

There is no clear relationship between who knows about a person's HIV status and whether they experience discrimination. Of the 14 sample respondents experiencing discrimination six were open about their status, while the others were trying to keep their status secret. Conversely, of the eight who experience no discrimination, three are open about their status, while four successfully keep it secret from the general neighbourhood.

Sickness, including visiting health centres, taking medication and frequent use of the latrine, all led people to suspect a person's status before they revealed it.

Box 14: Discrimination both before and after declaring HIV status
Previously, EM was living with her parents, together with her second husband, who is also positive and her baby son (from her first husband). She was not open about her status, but the neighbours discriminated against her in many ways, as they suspected she was positive, due to her frequent sickness. They locked the toilet, and poured water and detergent in the toilet when she used it. They spoiled her wet clothes after she had washed them, and they even went to the extent of attempting to throw her baby in the river. They also tried to attack her with a knife. The case went to the court and one of the women was sent to jail for two months. After that EM left the place and rented a house in a very remote area where people didn't know her story. Finally she got a Kebele house in Lideta sub city. Now she is open about her status, and works for Dawn of Hope as a trainer. But she still experiences discrimination. Her new neighbours don't want to be with her. They don't want to go to her house even when she is sick. One day she invited them for the sixth birthday party of her son but no one attended the party which made her feel very frustrated.

The discrimination imposed on PLWHA makes her hate people who regard themselves as free of HIV, and makes her think of revenge on other people. She said if she can't get financial support for herself and especially for her son she will go to the bars and she will become a prostitute.

Positive experience of change over time

Some participants in the research believed that discrimination was less than previously due to education, although more education was needed. Earlier mass media coverage of HIV used scare tactics to encourage people to protect themselves. The effect was to increase discrimination. Now

personal testimonies to encourage positive living are also used. Counselling services provided by some NGOs have also been effective, as the following case shows:

Box 15: Counselling helps reduce discrimination
MA used to face many experiences of discrimination. Her neighbours forbade her to take a bath in their bath room. Her baby was forbidden to play with other age mates. When she took 'too much' time in the toilet people complained and asked her to leave the toilet soon. Her younger brother as well as her mother sometimes insulted her in the household. Then Progynist social workers called her mother and brother for counselling. Her relationship with her family and neighbourhood has now changed. The situation is getting better since they received education from Progynist.

2.4 Water and Sanitation

2.4.1 Access to water and sanitation for sample survey respondents

Both purposive and control respondents were asked about their access to water and sanitation facilities. The majority of the combined sample either has private connections or buy from vendors and only a minority use communal facilities (see Figure 5).

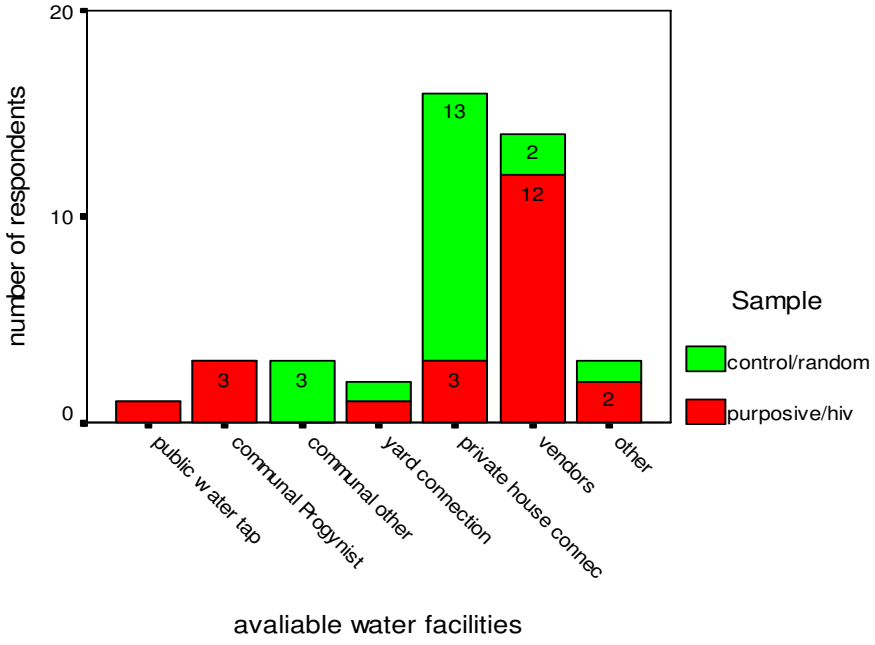
Comparing the two samples, the majority of those with private connections were from the control sample, whereas most of those buying from vendors were from the purposive sample. Buying from vendors can be the most expensive option, and often indicates the lack of nearby communal facilities.

There was little difference between the two samples in the proportion using communal facilities, but those from the purposive sample used a Progynist facility whereas the control sample used other communal facilities.

A few respondents use other water facilities, with one of the purposive sample respondents getting water at her workplace as she is homeless, while another uses holy water from Entoto Mariam church where she lives[10].

Those buying from vendors could not say how many households shared the same source, but those using communal taps quoted between 20 and 30 households per tap (4 reported cases).

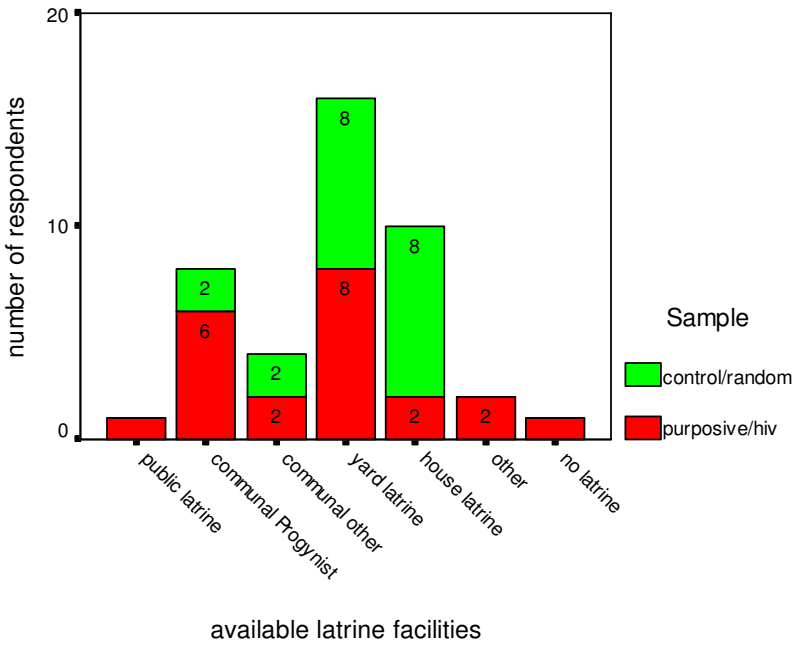
Figure 5: Available water facilities
Combined sample
(n=42)



[10] About 2000 PLWHA live as a community at the church, using the holy water as their only form of medication, as well as for other purposes. Unfortunately, there are no latrine facilities.

A higher proportion of respondents use shared latrines than shared water supplies, and only 10 respondents from the combined sample (just under one quarter) have a latrine in their home. Eight out of the ten were from the control sample. 16 respondents have a latrine in their yard (eight from each sample), and 12 use communal latrines (two thirds of these are from the purposive sample). In the purposive sample there is one respondent who uses a public latrine, two who have no access to a latrine at all, while another uses one at her workplace as she is homeless. For those using shared latrines, the number of households using one latrine ranged from two to 50, with 15 respondents quoting between three and six households per latrine. The high number of people sharing some latrines means that people may have to queue. A few respondents said they could afford a private water connection or toilet but did not have the space to install one.

Figure 6: Available latrine facilities
Combined sample (n=42)



Time taken to reach WATSAN facilities

Half of all sample respondents in the combined sample of 42 took less than a minute to reach their water source, and 11 took less than two minutes. The maximum time taken was ten minutes (1 case). Almost two thirds of the combined sample took less than a minute to reach the latrine, and a further 8 were within two minutes. The furthest case was 15 minutes to a public latrine.

Whereas those with private or yard connection had water available 24 hours per day (19 cases), those buying from vendors or using communal water points did not (23 cases). The most common time period for these water sources was 12 hours per day (11 cases), with a further six having access for eight hours. Six respondents had access between one and six hours per day. Since most of those using vendors were from the purposive sample they also experienced the shorter water access periods.

Use and Cost of water and sanitation

29 out of the total of 42 respondents were able to say how many buckets of water the household used per day. Most of those who could not estimate had private house connections, although a few with such connections could still estimate consumption in buckets. The number of buckets quoted ranged from ½ a bucket (two respondents) to six (one respondent). The most common number of buckets used per household per day was two or three. The number of buckets per member of the household ranged from one tenth of a bucket (one case) to three buckets (one case) with the most common number being one bucket per person (10 cases).

Of 21 respondents paying by the bucket, the cost per bucket ranged from 5 to 25 cents with most paying 10 or 15 cents per bucket. Out of 14 who paid on a monthly basis (those with private connections) most paid between 3 and 25 birr per month. The cost of water per person per day ranged from 0.03 to 0.28 birr, and was similar for households paying per bucket or per month. However, those

having private connections and paying monthly did not record quantities used. They may have been using more water than those paying by the bucket. Several respondents did not know the cost of water as another household member paid, while one received water from a neighbour at no cost.

Of nine respondents able to estimate the cost of emptying the latrine, eight pay between five and 20 birr per year, while one pays five bir a month (60 birr per year) into a collective fund.

Are people satisfied with their water and sanitation facilities?

Just under two thirds (62%) of the combined sample were not satisfied with their water and sanitation facilities. The proportion was higher for the purposive sample (over three quarters) than for the control sample (just under half). Control sample respondents had better access to water and sanitation than the purposive sample, largely due to their better socio-economic status. Discrimination and sickness can further limit access for PLWHA, as described in the following section.

Water and sanitation facilities shared between households were a source of conflict between neighbours in at least two cases.

2.4.2 Problems faced by PLWHA in water and sanitation

Participants in the focus groups were asked to discuss problems faced by PLWHA in water and sanitation. There was broad agreement between the three focus groups.

Problems with water

The lack of sufficient water points emerged as a key issue. This applies to the general public but is more of a problem for sick people. Since communal water points are too far, sick people tend to buy from vendors at a higher cost. Communal points charge from 5-10 cents, whereas vendors charge from 10 to 25 cents. This means that switching from communal water points to vendors may double the cost of water. An additional problem for the sick is that communal water taps tend to be opened early in the morning when the temperature is cold, exacerbating respiratory sickness. Taps may close around 10:00 am or earlier. This is also the time of day when people need to visit the health centres. Weakness due to sickness may also make it hard for PLWHA to carry the water.

Discrimination was also mentioned by all groups, although it was not considered to be as bad as for latrines. Examples included locking of taps especially in private rented accommodation.

Problems with latrines

Again the most pressing problem was the shortage of latrines. This means that people have to queue, even when sick, maintenance is inadequate, increasing the risk of some diseases, and toilets need frequent emptying which is costly. Sick people resort to using a potty if they cannot get to the latrine. Discrimination was common in private rentals, but also occurred with shared yard latrines. Frequent visits to the latrine leads people to suspect HIV status, and thus to discriminate.

Comparing severity of problems of water with that of latrines, the men's group and the mixed group ranked latrines before water, whereas the women's group ranked water first, perhaps because it is generally women who collect the water. It was agreed by all three groups that discrimination was worse in latrines than water.

2.4.3 Increased needs for and reduced access to water and sanitation for PLWHA

This research confirmed findings of Mamo and Frazer (2004) that PLWHA have increased needs for, but reduced access to water and sanitation.

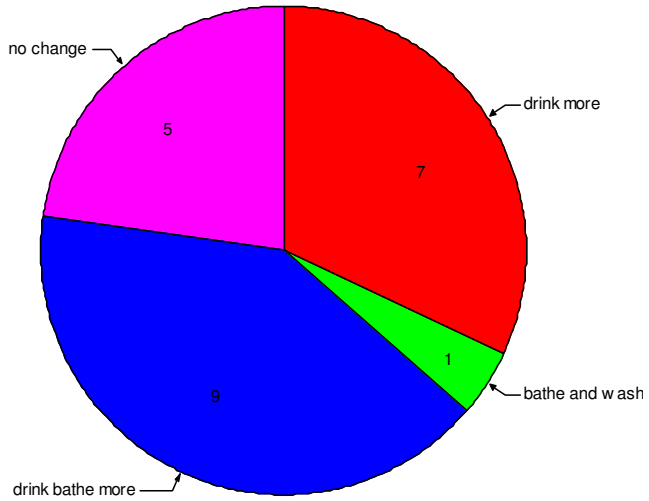
Increased need for water

According to the focus groups, PLWHA need more water because of sicknesses they experience and medication they take. Common sicknesses for PLWHA which increase water consumption include skin infection, fever and diarrhoea. Water is also used to wash household items and bedding, and for frequent bathing to protect PLWHA from sickness. Thirdly, those taking ART need to drink more water to reduce side effects.

Sample respondents supported these findings. Just over three quarters of the purposive respondents (17 of the 22) said that their water consumption had increased since they tested positive, and of these, 4 said that it had greatly increased. The increase was due to drinking more (7 cases), bathing and

washing more (1 case) or both drinking and bathing (9 cases). This is illustrated in the following pie chart.

Figure 7: Why has water consumption changed with HIV/AIDS?
Purposive Sample only (22 cases)



In seven cases the increased consumption led to the respondent buying more water, and six out of the seven were able to estimate the increased number of buckets used per day. Five increased consumption by one bucket, and one by two buckets per day. For three people this represented a doubling of daily household consumption.

Increased need for latrines

Focus groups said PLWHA's need for latrines increased because of frequent diarrhoea, and women mentioned other discharges due to various infections.

From the sample survey, almost three quarters of purposive respondents (16 out of 22) said that their need for a latrine increased since they were HIV positive, and three of these said it had greatly increased. Only two of those whose need had increased had access to a private latrine. Most used a communal or yard latrine (12 cases), but two of those whose need had greatly increased had no latrine access at all.

13 out of the 16 whose need increased currently suffered occasional or frequent diarrhoea.

Over half of control sample respondents (11 out of 20) thought that PLWHA would have increased need for water and sanitation, and 12 thought that PLWHA had more frequent diarrhoea than others. Most claimed to have heard this from the media, rather than from personal experience.

Changes in access to water

From the sample survey, six respondents said their access to water decreased since they tested positive. Five cases were due to sicknesses, with only one due to discrimination. However, other respondents and focus group participants had experienced discrimination, sometimes in their previous accommodation, so the sample results may underestimate the general situation.

Changes in access to latrines

Six respondents said access to latrines had decreased since they tested positive. Three cases were due to sickness and three to discrimination. Focus group participants also mentioned sickness and discrimination limiting access to water and latrines.

Box 16: Queuing for the Latrine when sick
AM and her husband are both HIV positive. Her husband has frequent diarrhoea which does not respond to medication. His access to use the latrine is reduced as he has to queue for long hours to use the toilet even when he suffers from diarrhoea.

Box 17: Distant toilet leads to using a potty when sick
AG suffers from frequent diarrhoea, even though she drinks boiled water. But she feels she cannot use the toilet, as it is too far away. The nearest kebele toilet takes 6 minutes for her to walk to. It is also dirty, with 30 households sharing the same toilet. So AG has to resort to using a potty in the house, which her daughter and husband then take to the latrine. AG pays 12 birr every two month when the latrine gets full.

About two thirds of control respondents did not know if PLWHA experienced reduced access to water and latrines, while about one third thought they did.

2.4.4 Discrimination in Water and Sanitation Provision

Discrimination in water and sanitation access ranged from being locked out of the toilet or bathroom, to the relatively mild experience of having excessive amounts of water thrown in the toilet after respondents had used it (see footnote 2).

Discrimination in water Use

Discrimination in water use is experienced in collection from the tap, use of receptacles, washing of clothes and locking of the bathroom. The impression is that people who behave in this way believe that HIV can be spread through sharing of taps, water receptacles and washing lines, as well as through contact with the clothes of an HIV positive person.

Box 18: Discrimination in water collection
One of the participants gets her water from a communal water point. After she collects water from the tap people wash the tap. They also don't want to put their water container next to hers. Neighbours don't like to lend her bottles, glasses and containers. This is the problem faced by many PLWHA.

Box 19: discrimination in relation to washing of clothes.
One woman, living with HIV, washed her clothes and hung them outside in the sun. When she went outside to see if the clothes were dry she found them strewn about on the dirty ground. Next time, she waited outside until the clothes dried. The neighbours reacted by not hanging their clothes on the same washing line, afraid that the virus might be transmitted through it.

Discrimination in latrine use

Both sample respondents and focus group participants claimed that discrimination is worse in latrine use than water because people believe that the larine can transfer the virus from a sick person to a healthy one.

Box 19 : Locked out of the latrine
MG used to stay in private rented accommodation. As soon as he started to visit the latrine frequently, they suspected him of having the HIV virus and they locked him out from the toilet and the water tap. They washed the ground where he walked to the toilet, and made him pay extra money for the water he was using.

DT is also forbidden by her ex husband and his relatives to use the latrine in her residence, so she is forced to go to her uncle's house to use the latrine.

2.4.5 Respondents' views on sharing water points and latrines

Discrimination was also explored through asking respondents their views on sharing facilities with others. Most respondents felt neutral about sharing water facilities, but opinions on sharing latrines varied.

Most of the 22 purposive sample respondents felt neutral (13 cases) or happy (seven cases) about sharing latrines with other HIV positive people. Five felt unhappy about sharing with those who were not tested positive.

Most of the purposive sample believed that those who had not tested positive would feel uncomfortable or unhappy about sharing latrines with HIV positive people, and only one thought they would feel neutral. By contrast, four fifths of the control sample claimed to feel neutral about sharing latrines with HIV positive people, with only four respondents admitting to feeling uncomfortable. Two respondents pointed out that they may already be sharing with positive people, since most hide their status. This gap between perception of PLWHA and others about sharing with HIV positive people may reflect the tendency of PLWHA to 'discriminate against themselves', that is, to anticipate discrimination before it occurs. On the other hand, the control sample, who claimed to lack much personal experience of HIV, may have been eager to provide the 'correct' answer.

Focus group participants were not asked directly about their attitudes towards sharing facilities. However, the preferred solution to water and sanitation provision for PLWHA was to increase facilities for the general public, implying that they do not mind sharing.

2.5 Respondents' views on water and sanitation requirements for the general population in their neighbourhood

Both purposive and control respondents were asked about problems they had living in their area. Two thirds of the combined sample mentioned water and sanitation related problems, and just over a quarter mentioned this as the main problem. There was no difference between purposive and control samples. Most felt they could not do anything about the water and sanitation problems mentioned, although one respondent allows neighbours to use his private toilet, while another tries to teach the community about how to keep themselves and the environment clean.

All respondents were asked to make recommendations for water and sanitation provision for the general population in their locality. Two thirds thought that more water points were needed, while three quarters thought more latrines were needed. Only 5% thought no change was needed for latrines, compared with 15% for water points. 7% thought improved maintenance was sufficient for water provision, and 12% for latrines. Most of those advocating no change or only improved maintenance were from the control sample.

In terms of types of facility, communal water points were recommended more often than private, whereas private latrines were recommended slightly more often than communal ones, especially by the purposive sample. Those recommending communal facilities recognized the shortage of resources and space for private facilities.

2.6 Respondents' recommendations for PLWHA in water and sanitation

2.6.1 Views of sample survey respondents

Respondents from both purposive and control samples were asked what they thought should be done for PLWHA in water and sanitation. This question was interpreted to refer to provision of physical facilities, rather than to education or tackling discrimination.

Overall, (combining the two samples) just over half recommended private provision of latrine or latrine and water for PLWHA. In most cases this was based on the perceived needs of PLWHA, although for a few control respondents it was rather due to a reluctance to share facilities. The remainder recommended the same provision for PLWHA as for others. Most argued that separate provision would increase discrimination, although some of the control sample thought that PLWHA did not need individual facilities, especially in the case of water provision.

Individual provision of facilities was more popular with the purposive sample, with three quarters recommending private provision either of latrines only or of water and latrines, and only one quarter arguing for the same provision as everyone else. By contrast, more than half of the control sample argued for the same provision as everyone else.

2.6.2 Views of focus group participants

The three focus groups had similar views on solutions to water and sanitation problems for PLWHA. All three discussed both the need for education against discrimination and the need for improved provision of facilities, arguing that neither alone could address the whole problem. Two groups (women's and mixed) thought that both education and provision of facilities should get equal weight, while the third (men's) group prioritized education to tackle discrimination over provision of facilities.

Education against Discrimination

Two groups (men's and mixed) thought that educational programmes should be delivered via the mass media, since it can reach everyone in the community. The women's group, however, said that the mass media had been used for several years, but had not achieved the desired results in bringing about behavioural change. In fact, all groups agreed that earlier mass media had used scare tactics making people afraid not only of the disease but of the people with HIV, and this had increased discrimination.

The mixed group argued for the use of personal testimony as well as medical information to tackle discrimination more effectively. The physician can give scientific explanations about how the virus is transmitted and how to protect oneself from the virus, whereas the personal testimonies would teach the public about discrimination and about positive living, by showing that living with the virus doesn't mean giving up hope.

The women's group thought that community based education was more effective, as it could relate more directly to people's situation and experiences. For example, an organization like Progynist has a closer relationship with the public and gives people confidence in their work so they can play a bigger role in changing public opinion on the issue.

Provision of Facilities

All focus groups agreed that PLWHA should not be targeted with separate facilities, since this would increase discrimination. It was also considered to be impractical given that many people either do not know their status, or are not willing to reveal their status. The men's group thought that provision for the chronically sick would be a second best option, since it would miss those who were not yet sick. Similarly, provision for those who are open would miss the majority of PLWHA who do not wish to reveal their status.

The option of having facilities available to PLWHA at central locations, for example at Dawn of Hope offices or Progynist health post, was popular. It was argued that this would not attract discrimination as facilities would be located outside the neighbourhood. Maintenance could be organized by the users, who would pay. However, sick people would find it hard to reach these locations.

The preference for improved facilities for everyone, rather than targeting of PLWHA contrasts with results from individual respondents in the sample survey, many of whom suggested individual provision for PLWHA. The result from the focus group was based on more comprehensive discussion of the practical problems of individual provision.

3 Recommendations

1. Disseminate the key messages of this research to GOs, NGOs, UN agencies and participating communities, both within Ethiopia and internationally, to stimulate action in tackling discrimination against PLWHA in water and sanitation;
2. Work with media, especially radio, to disseminate key messages from the research, backed up by reliable medical information;
3. Coordinate with UN agencies and NGOs working in HIV/AIDS and in water and sanitation on how to integrate programming in the two areas, building on their experiences. Encourage the development of working groups for this purpose;
4. Involve PLWHA and their representatives in water and sanitation projects, and encourage other agencies to do the same;
5. Use the research to Integrate HIV/AIDS messages into WaterAids's hygiene promotion work and their provision of water and sanitation;
6. Support Progynist in tackling the needs of PLWHA for water and sanitation;
7. Ensure that all existing and new water and sanitation facility provision by WaterAid and Progynist includes education on HIV/AIDS in order to tackle discrimination and achieve equity in access. Suggest to other organizations that they do the same;
8. Liaise with government agencies, including HAPCO and other relevant sections within the Ministry of Health, the Ministry for Water Resources, and AAWSSA on how to incorporate the research findings into national policies on water and sanitation and into the National HIV/AIDS response. This could include continued priority for vulnerable groups, including PLWHA, and legal provision for victims of discrimination.
9. Funding allocated to HIV/AIDS should be reviewed to ensure inclusion of water and sanitation related issues.
10. Continue to advocate for improved water and sanitation coverage, as this is likely to reduce discrimination in access.

References

Federal Ministry of Health (2004) *AIDS in Ethiopia 5th Report*
Mamo K and Frazer O (2004) *Making the Links: Mapping the relationship between water, hygiene and sanitation, and HIV/AIDS: a joint think-piece* WaterAid and Progynist, Ethiopia

Report

Meeting the Needs

for water and sanitation of People Living with HIV/AIDS in Addis Ababa, Ethiopia

A WaterAid report written by:

Priscilla Magrath, Consultant and
Mahider Tesfu, WaterAid Research Officer

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