

**NEEDS, PROBLEMS, AND RESPONSES TO THE  
SITUATION OF AIDS ORPHANS AND OTHER  
VULNERABLE CHILDREN (OVC) : THE CASE OF  
LIDETA SUB-CITY KEBELE 01/18**

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## **Acronyms**

AIDS- Acquired Immune Deficiency Syndrome

ANC- Antenatal Care

ART- Antiretroviral Therapy

CBO- Community Based Organization

HIV- Human Immuno Deficiency Virus

MOH- Ministry of Health

MOLSA- Ministry of Labour and Social Affairs

NGO- Non-Governmental Organization

OVC- Orphan and Other Vulnerable Children

UN- United Nations

UNAIDS- Joint United Nations Program on HIV/AIDS

UNICEF- United Nations Children's Education Fund

USAID- United States Agency for International Development

WHO- World Health Organization

## **ABSTRACT**

**Background:** This study was conducted in Addis Ababa city Administration, Lideta Sub-City, Kebele 01/18. One of the concerns in this study was to provide a relatively complete and reliable picture of the situation of OVC in kebele 01/18, focusing on the magnitude, characteristics, causes and consequences. The study was also attempted to show the impact of OVC on families, households and communities.

**Objective:** Understand and realize the situation of OVC at household level in Kebele 01/18 and thereby improve the environment that is supportive for the care and protection needs of children and families affected by HIV/AIDS is the general objective of this study.

**Methods:** The study utilized both qualitative and quantitative techniques to gather relevant information. Different categories of respondents, which were the units from which information was collected, had participated in this study. The total subjects of the study were 90. Data was collected using a structured, semi structured and unstructured questionnaire for different categories of respondents.

**Results:** A total of 50 heads of OVC households and 25 OVC age 10 and above participated in the study. In the study, it was found that the majority (82%) of the heads of OVC households were female while the remaining (18 %) were male. Investigation of the living arrangement of orphans revealed that the majority of them live within the extended family system. Each adult headed households care for approximately 2 OVC while child headed households care for three children.

A considerable proportion (26%) of OVC households depend on support from NGOs, begging and house rent for livelihoods. The study showed that the average income of the OVC households is Birr 157.40. The majority (58 %) of the households the members have contributed nothing to the income of the household.

The study also showed that 62 percent of the OVC households have at least three meals per day irrespective of quality and quantity. However, 30 percent of the households reported that they were less likely to have access to such categories/ frequencies (breakfast, lunch and dinner) of meals. The majority, 80 % (58 and 22 %) of the respondents viewed their living standards as extremely poor and lives below average as compared with their neighbors.

Most of the households surveyed had access to potable water and latrine. But, most of them do not have these services in their dwellings. Except few (12%), majority of heads of OVC households have faced problems like family trouble as a result of taking in these OVC.

The health care system and provision of schools seems sufficient for a large number of the families. At present, the majority (80%) of them are reported that they are in school. However, most of the children were totally absent or missed the first period of the class, perform low and do not pay attention to their education.

Respondents from each institution agreed that the magnitude of OVC in the sub-city, in the Kebele and schools is increasing though difficult to pinpoint the exact number. The institutions also identified the major gaps in the implementation of OVC program and proposed solutions. In general, they observed that families and communities are the first line of response to the epidemic concerning orphan care.

**Conclusion and Recommendation:** Strengthening capacities of families and communities, providing counseling services to affected children and their care givers, and looking for possibilities to reunite OVC like street children with their relatives are some of the recommendation of this study.

## **Chapter 1: INTRODUCTION**

### **1.1. Background of the Problem**

This study was conducted in Addis Ababa city Administration, Lideta Sub-City, Kebele 01/18 (the former kebele18 and kebele 01 merged and considered as one). In the Kebele 01/18, there are about 480 orphans and other vulnerable children (OVC) that are registered and supported by the local NGOS named, Love for Children, Handicap National, Good neighbours Ethiopia, Genet Church, and Rescue the child and youth. These NGOS work to fulfil the basic rights and well-being of these orphans and other vulnerable children. The registration made by the Kebele to identify only needy children shows that there were about 480 OVC who are living with sick parents (infected by HIV/AIDS), alone, residing with neighbours, aunts, grand mothers, brothers, etc. These show that the OVC in the kebele constitute 2.3 percent of the total children under the age of 18. The OVC in the Kebele are largely depending on the support of NGOS for survival. Tragically, the number of OVC in this Kebele is continuing to rise in the years ahead, due to the high proportion of adults already living with HIV/AIDS (Kebele Report).

The people in the Kebele are similar in religion, language and economic background. The mainstay of the people is petty trade and daily menial jobs. Two main dominant religions, Orthodox Christianity and Muslim, are practiced and the majority of the people use Amharic language as a media of communication. The ethnic background of the people is heterogeneous and the dominant ones include Amharas and Oromo.

The reports of the organizations indicate that HIV/ AIDS are the major cause for children to be orphan and vulnerable. These OVC are highly depending on NGOS for survival. On the other hand, care givers are children below the age of 18 or old people who

are economically poor. The number of families headed by child, and old people in the Kebele is increasing.

These children suffer manifold bereavement through the loss of fathers and mothers. It is apparent that the impact of AIDS on children can lead to continuous traumatic stress syndrome.

It is difficult to say much about the efforts made to address the issue of these AIDS induced orphans and other vulnerable children. What is known much about is the problems faced by these children and a piecemeal support by both government and NGOs involved in the area. The prevailing experience/programs focused more on raising the awareness of students on HIV/AIDS, support tutorial classes, guaranteeing the economic security of the care givers and traditional associations, like "Idir" (burial associations). On top of that most programs lack integration and are characterized by duplication of efforts.

In general the above information suggests that OVC households in kebele 01/18 are living outside of their familial environment and face environmental, physical and social hazards. One of the concerns in this study was to provide a relatively complete and reliable picture of the situation of OVC in kebele 01/18, focusing on the magnitude, characteristics, causes and consequences. The study was also attempted to assess the impact of OVC on families, households and communities level. In addition to this, the resources, responses and initiatives of the community, individuals, and other service providers available to assist OVC was researched and strategies that give insight into the problem and nature of OVC for social workers intervention was drawn.

These were the general issues investigated in this study. The specific research questions were improved on the basis of the existing situations as indicated here below.

- A. What the situation of OVC looks like at house hold level in Kebele 01/18? In this regard the conditions of livelihood, education, health, psychosocial state, food, and availability of services to orphans and other vulnerable children were assessed.
- B. Who are the care givers for OVC at household level?
- C. Do OVC households have access to services like information, income generation and other basic needs?
- D. What positive and negative effect of OVC on families, households and communities prevail?
- E. What intervention strategies will be employed to promote the positive aspects and minimize the negative impacts?
- F. As a response to the increasing burden of OVC local NGOs have been supporting these households. The programs of these NGOS aimed to address the needs of OVC households through partnership with the traditional associations and Kebele in which they operate. What are the responses and initiatives that prevail in the kebele and what are some gaps, challenges and opportunities in response to orphans in the Kebele?

## **1.2. Operational Definitions**

**Caregiver:** for the purpose of this study caregiver is any person other than a father or mother who provides care to a child or children who are not their biological children and live together in one house. Older sibling that cares to a child or children also regarded as care giver in this study.

**Household:** The term 'household' has different meaning depending on the context it is referred to. For the purpose of this study the definition adopted by the central statistical

Authority to conduct the 2000 welfare monitoring survey is adopted. Accordingly, it refers to a person or a group of persons, irrespective of whether related or not, who normally live together in the same housing unit or group of housing units who have cooking arrangements.

**Head of household:** is a person who economically supports or manages the household for reasons of age or respect, is considered as head by members of the household or declares himself as head of a household. Head of a household could be male or female.

**Idirs:** In this study Idirs refers to a community burial and support associations rendering services to orphans and vulnerable children.

**Kebele:** In this study Kebele refers to the smallest administrative unit under the sub city of Addis Ababa administration providing services and support to orphan and vulnerable children.

**Orphans:** In this study orphan refers to children of under 18 years of age and who have lost one or both parents to AIDS.

**Vulnerable Children:** In this study it refers to those children dependent on people living with HIV/AIDS, are HIV infected or at high risk of infection

### **1.3. Objective of the Study**

#### **1.3.1. General Objectives**

The general objective of the study is to understand and realize the situation of OVC at household level in Kebele 01/18 and thereby improve the environment that is supportive for the care and protection needs of children and families affected by HIV/AIDS.

#### **1.3.2. Specific Objectives**

**1.3.2.1.** Identify the general socio-economic characteristics of OVC households by sex, age, income, education, family size, religion, ethnic group, health, and relationship with OVC.

**1.3.2.2.** Identify the needs of OVC households and their perception towards the communities' intervention in fulfilling the emotional and financial needs of OVC households.

**1.3.2.3.** Identify major problems faced by OVC at household, at school and community level

**1.3.2.4.** Assess the intervention strategies/ services to OVC and identify gaps and challenges

**1.3.2.5.** Identify the impacts of orphaning on families, households and communities.

**1.3.2.6.** Come up with viable and workable recommendations that help for social work interventions.

## **Chapter 2: LITERATURE REVIEW**

The existence of orphans and other vulnerable children is not a new phenomenon in the world. World History shows that there were a considerable number of orphans immediately after the Second World War. However, children who lost one or both parents of HIV/AIDS are not the same as those who lost their parents by other cases. This is for the reason that a child whose mother or father has HIV begins to experience loss, sorrow and suffering long before the parent's death. In addition to this, once AIDS has claimed the mother or the father, the probability to lose the remaining parent is very high. Because of this and other reasons defining the concept of orphans, showing the linkage and trend, identifying the needs and problems, and setting up the appropriate responses became multifaceted and complex. In the part that follows this will be entertained from the available literatures perspectives.

### **2.1. Trend in Defining the Concept of OVC**

The term OVC has been coined in light of the high number of children affected by the AIDS epidemic. It has been argued (Boler,T. Carrol,K, 2003 ) that in high prevalence countries, all children are already affected by the epidemic. According to these authors, using the term by itself is not a prerequisite as far as the merits of creating a specific category of children who are affected by the AIDS epidemic, are to track the welfare of these children, and to aid the targeting of interventions. Although the definition of an orphan in relation to HIV/AIDS varies from country to country, the main variables are Age – children up to 15 or up to 18 years; and Parental loss – mother, father, or both parents.

The term orphan varies from one cultural and socioeconomic context to another and therefore tends to differ between countries. On the UNAIDS publication of 1999, orphan is defined as “a child who loses his/her mother to AIDS before reaching the age of 15 years”.

The rationale for using ages under 15 is statistical and methodological, linked to the age categories used in most Demographic and Health Surveys, as these are a primary source of information (Smart, 2003). Most orphan estimates are for children under 15 years old. Data from child health surveys is normally based on children less than 15 years. Data on children 15-17 years is usually presented together with adult data in the 15-49 year category.

Regarding parental status, most estimates and models define an orphan as a child whose mother has died. The rationale behind the inclusion of maternal orphan is that maternal demographic data is more easily obtained and in surveys, biological mothers are more easily related to their children than fathers. In addition to this, it is believed that the impact of HIV/AIDS on orphans is more serious on those who lost their mothers for she is the primary caregiver. However, this is argued that loss of a father may have greater socio-economic impact than loss of a mother particularly in developing countries. In general, because of exclusion of paternal orphans and children aged 15-17 year old the total number of orphans is underestimated by 45-70% and 25-35% respectively.

In considering this gap some agencies have sought to improve upon the UNAIDS definition. US AID therefore defines AIDS orphans as children who have lost their mothers or fathers or both parents as a result of death from AIDS. Similarly, The UNAIDS Reference Group on Estimates, Modeling, and Projections defines a child orphaned by HIV/AIDS as a child, less than 15 years of age, who has lost at least one parent to AIDS. Even though improvements made in including paternal orphans' exclusion of children aged 15- 17 remains unchanged until 2003 in most of the publications.

At present in a joint publication of UNAIDS UNICEF, and USAID- *Children on the Brink 2004* – defined the term orphan in the following way and used it for statistical purposes in estimating subpopulations of orphans.

*“Maternal orphans are children under age 18 whose mothers, and perhaps fathers, have died (includes double orphans).*

*Paternal orphans are children under age 18 whose fathers, and perhaps mothers, have died (includes double orphans).*

*Double orphans are children under 18 whose mothers and fathers have died.*

*Total orphans are children under age 18 whose mothers or fathers (or both) have died. The total number of orphans is equal to the sum of maternal orphans and paternal orphans, minus double orphans (because they are counted in both the maternal and paternal categories)” (UNAIDS et al p-6)*

In terms of vulnerability, there are two types of usage is observed in literatures. Some used is to describe only those children dependent on people living with HIV/AIDS and HIV/infected and/ or at high risk of infection while others include street children, unaccompanied children, internally displaced children and refugees.

In the Ethiopian context, the Child, Youth and Welfare Organization defined orphans in 1992 as those “less than 18 years of age who have lost both parents, regardless of how they died”. Similarly, vulnerable children are defined in the same document as “children with insufficient family support”.

This has become the standard reference for definitions and estimates related to OVC in studies conducted recently in Ethiopia to determine the prevalence and characteristics of OVC by Non governmental organizations like Save the children alliance (Save the children Alliance, 2001). However, the National survey conducted in 2003 by the Ministry of labor and Social affairs in collaboration with the Italian cooperation and UNICEF adopted the definitions of UNAIDS, WHO and UNICEF of 1999 for its operational definitions.

Using the UN AIDS definition for Ethiopia, AIDS orphans are projected to have increased from 620,000 in 2000 to 1.8 million by 2009 (MOLSA,2000 p.8). Leaving aside the problems of definitions and estimates, the number of AIDS orphans in the country does not appear to be well documented, let alone providing estimate based on guesswork.

The definition of orphan hood is significant in relation to child development. Loss of a parent in early childhood, at school age and in early or late adolescence affects children differently, both psychologically and developmentally. Defining orphans as children under 15 years detracts attention from the needs of older adolescents including the sexual and economic exploitation of adolescent girls. Research is needed to identify the implications of different age and parental-status definitions in terms of willingness to respond, resource allocation decisions, programs selected and their implementation.

For the purpose of this study, an AIDS orphan refers to a child under age 18 either or both of whose parents have died of AIDS.

## **2.2. Linkage between OVC and HIV/AIDS**

The present problem of orphan and vulnerable children is largely associated with HIV/AIDS. According to the estimates of UNAIDS, some 2% of children were orphans in developing countries before the advent of HIV/AIDS. However, this proportion was increased in 2003 to 12.3 percent of all children in some countries of sub-Saharan Africa. There were 43 million orphans in the region, an increase of more than one-third since 1990. Worldwide, it was a 3 percent increase in the number of orphans since 1990 (UNAIDS, UNICEF, USAID, 2004).

It is also estimated that in high fertility countries in Eastern Africa, for every mother dying of AIDS three children become orphans (Lous, Elemendors, 1992). According to

statistical publication of UNAIDS released in July 2004, more than 50 millions children aged 0-17 are expected to become orphans from all causes. Out of these, 36.8 % will be AIDS bereaved orphans in Sub Saharan Africa during the 2010s (UNAIDS et al, 2004). The following figure portrays orphan estimates since 1990 and prediction in 2010 in Sub Saharan Africa.

**Table 2.1: Total Number of Orphans for Sub-Saharan African Country**

Year	All Children 0-17 (thosands)	Total Orphans as a percent of all children	Total number of orphans	Total number of orphans due to AIDS	Orphans due to AIDS as % of all orphans
1990	260,000	10.9	28,400,000	550,000	1.9
1995	290,000	11.2	35,500,000	3,000,000	9.2
2000	330,000	11.9	39,200,000	8,500,000	21.7
2003	350,000	12.3	43,400,000	12,300,000	28.3
2010	400,000	12.5	50,000,000	18,400,000	36.8

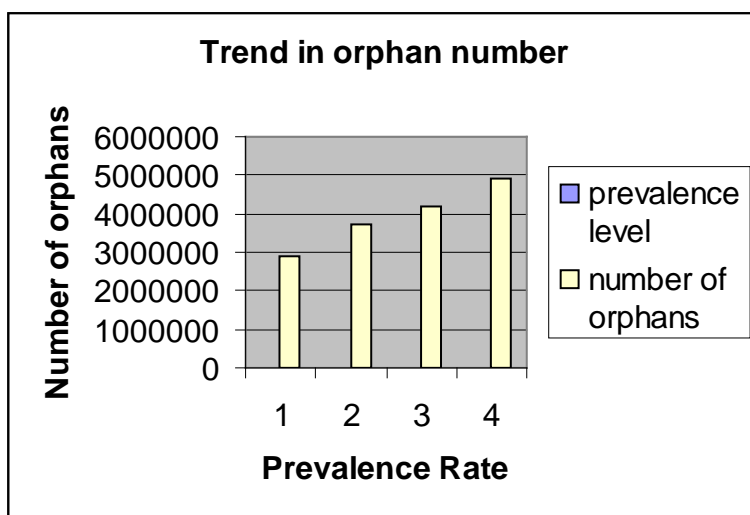
*Source: Children on the Brink (July,2004)*

According to the data obtained from Children on the Brink, Ethiopia also houses the third largest population of orphan by AIDS in sub Saharan Africa, next to Nigeria and Congo Democratic Republic. A total of 3.9 million children under 17 in the country were estimated to be orphans for different reasons, of which 720,000 were due to AIDS. In the same document it is predicted that Ethiopia will have an estimated orphans of 4.7 million which is 11% of all number of orphans ages 0-17 in year 2010 (UNAIDS, UNICEF and USAID, 2004). This means that 9.4 % of orphans in Sub-Saharan Africa will be found in Ethiopia in year 2010.

The level of prevalence rate has directly connected with the number of orphans. Countries with high prevalence rate have been characterized by high numbers of orphans. Increase in the number of AIDS orphans is connected with high level of HIV prevalence

rates. The trend in Ethiopia can be seen from the following chart 1 considering the national prevalence level of 1.6 %, 3.9 %, 4.1% and 4.1 % for years 1990, 1995, 2000 and 2003 respectively.

**Figure 1: Relationship of Prevalence Rate and the Number of Orphans**



*Source: Computed on the basis of the data obtained from AIDS in Ethiopia (Ministry of health,2004 ) and Children in the Brink,2004 .*

In fact there is the assumption that the current initiatives of ART has a potential impact in reducing mortality and prolonging the life expectancy of AIDS patients which in turn reduces the number of AIDS orphans. It is estimated that 100 % coverage of ART would lead to 332,000 fewer AIDS orphans by 2008 (MOH,2004).

### **2.3. Needs and Problems of OVC**

Since 1988, the wider implications of the AIDS epidemic have been increasingly evident at all levels. By selectively killing people in the most economically productive age groups (15-49 yrs) the epidemic is creating two highly vulnerable groups of survivors (the elderly and young orphans) who have lost their principal source of support. AIDS orphans

may suffer discrimination as well as fewer life opportunities because they will not have access to adequate nutrition, basic health care, housing and clothing and other amenities usually provided by parents.

Children may experience reduction in their quality of life when their mother goes to provide home care for an HIV/AIDS-affected relative or because of transfers of money to a sick relative's household. On top of that as parents and family members become ill, children take on more responsibility to earn an income, produce food and care for family members. These children do not only suffer during their parent's illness but in the long run they will be orphaned.

According to the review made by UNICEF, in the 20 sub-Saharan African countries, children between the age of 5 to 14 who had lost one or both parents were less likely to attend school and more likely to work for more than 40 hours a week.

In Ethiopia the school attendance rate for children 10-14 years of age is 34% for single orphans and 26 % for double orphans as compared to 43% for non orphans ( MOLSA, UNICEF ,UNAIDS, 2003).

National level data comparing orphans with other children on the basis of indicators of well-being such as the satisfaction of basic material needs by their families, malnutrition, food insecurity, psychological, health, the incidence of early sexual involvement, connection with adult caregiver, property dispossession and others are absent. However, a national situation analysis conducted in all the country's regions in 2002, which did not have such comparative figures, indicated that many orphaned children had difficulties in obtaining their daily meals, proper clothing and school uniforms, supplies and fees which led to higher drop out rates (MOLSA et al, 2003).

The study conducted by the Ministry of Labour and Social Affairs in 2003 made comparisons with regard to food, clothing, and education of non AIDS orphans and AIDS orphans. The study found out that more non-AIDS orphans (59.4%) were well fed compared to AIDS orphans (50.9%). In relation to clothing, the study attempted to find out the adequacy of clothing. In this regard, it was found out that more than half (55.3%) of the AIDS orphans reported that they were not clothed properly as opposed to 48.6% of non AIDS orphan children. Alongside the perceived adequacy of clothing, comparison was made on education of non AIDS and AIDS orphans. It was found that both groups of orphan children dropped out of school following the death of their mothers, however, greater numbers of non AIDS orphans (17.7%) dropped out of schooling following their mothers' death compared to AIDS orphans (11.9%). This study also shows that AIDS orphans unable to sustain their own livelihood are expelled from their parental residences following the deaths of their parents. Most AIDS orphans live with poor relatives who are often unable to provide for the physical, educational, and health needs of the child.

Children in an HIV/ AIDS affected household begin to suffer even before a parent or care giver has died. When parents are sick, almost all household resources are spent on medication in the hope for survival. The remaining resources are then spent on rituals practiced at the death of a family member. A number of interrelated factors take their toll on the children: grief over the death of parent, fear about the future, separation from siblings, distress about economic circumstances, and HIV/AIDS- related discrimination, isolation and loss of inheritance. Children affected by HIV are at serious risk of exploitation, including physical and sexual abuse. Those forced to live on the streets may turn to prostitution and crime as a means to survive. Therefore, although most of these children are born free of HIV, they are highly vulnerable to infection. The traditional safety net for orphans and other

vulnerable children-the extended family- has come under huge strain as a result of the loss of many breadwinners and caregivers. (**Joint UN programs, a, b, c, 2004**).

#### **2.4. Situation of OVC and HIV/AIDS in Addis Ababa**

In Ethiopia, AIDS orphans in the total child population in the major cities are 14.69% (MOLSA 2003). In 2003 alone, it was estimated that 568,000 children lost one or both parents due to AIDS (MOH, 2004). This shows that Ethiopia is one of the countries with high number of OVC in the world. Out of different regions of the country, Addis Ababa was one of the regions among those with the highest prevalence of HIV. According to MOH (2004) HIV prevalence at urban sites in 2003 was 12.6 %. Addis Ababa, in the same year, has the HIV prevalence rate that ranges from 10.9-15.1% at ANC sites. The prevalence rate from 1989-2002 at ANC sites were between 11.2-21.2 % Though these data of prevalence rate have different meanings, it indicates that there are a considerable number of deaths that affects the lives of the children.

## **Chapter 3: RESEARCH DESIGN AND METHODOLOGY**

### **3.1. Short Description of the Study Area**

Two merged Kebeles/sites in Addis Ababa were selected for the study. The sites are former Kebele 01 and 18 that were merged in the recent administrative set up of Addis Ababa city. These two sites were selected because of the availability of OVC in the program of NGO's where the researcher of this study was assigned during his first field placement and because of the relationship the researcher had developed to the OVC households.

### **3.2. Research Design**

Since the objective of the study is to understand and realize the situation of OVC at household level, it is explanatory and descriptive. It is descriptive because the general socio-economic characteristics of OVC households by sex, age group, income, education, family size, religion, ethnic group, health, and the like were established.

And it is an explanatory study in which the needs and communities perception of OVC households and impacts of orphaning on families, households and communities were examined. Therefore, the nature of the study led the researcher to use both quantitative and qualitative data collection techniques. The quantitative method used was simple statistics such as means, averages and percentages in order to understand demographic and socioeconomic characteristics of the study subjects. The following methods of data collection were used: In-depth interviews using structured questionnaire (survey method) for the sample OVC households and, semi-structured interview for key informants like Government Officials, Kebele leaders, Representatives of community based organizations and Heads of NGOS and Observation methods for issues related with housing and other facilities.

### **Sampling Techniques**

According to the information obtained from the Kebele, there were about 302 OVC households that were registered and provided with support during the initial time of the survey. In the sample design an attempt was made to make sure that all OVC households were adequately represented and that random sampling is employed at every stage of sampling. In general the following steps and principles were followed in the sample design and selection of the households:

- a) As a first step a list of heads of households were prepared and arranged in accordance with the housing number given by the Kebele. It was in ascending order.
- b) Those households without a house number were given an arbitrary number considering the house as next to its neighbors. For instance, if the unregistered house is next to the registered house with number 250, then it was given as house # 250-1 for the purpose of this study. OVC households residing in the Shelters were also considered as part of this study and were treated similarly.
- c) For households that are headed by a child the elder orphan was taken as a respondent. Following these steps, 50 head of households were selected using random numbers among the lists provided by Kebele and involved in the study. 25 orphans and Vulnerable Children age ten and above from the same OVC households were also included in the study using quota sampling.

The data were collected from March 23- April 5, 2006 through interviewing 50 households and 25 OVC. The date and time of administration of the instruments were decided in consultation with participants of the study. The Kebele office assigned one person who facilitated such technical arrangements.

## **Study Population**

Different categories of respondents, which were the units from which information was collected, had participated in this study. The use of these different categories of study population is to obtain more insight information from the study subjects. The categories of the study population are the following.

### **Head of Households, Orphans and other Vulnerable Children**

Primary data was collected using structured and semi-structured questionnaires. Therefore, a sample of 50 heads of OVC households was selected using random sampling method. Besides, 25 orphans age 10 and above from same households were interviewed. The members in the OVC households were the caregiver, or the surviving parent (HIV/AIDS infected) or an OVC who is member of the family age 10 and above or head of the household.

### **The Government, Kebele, Schools, CBO and the NGO**

Government employee, Kebele workers, and heads of NGOS and representatives of schools and community based organizations were taken as source of data. The employees and heads of NGOS, CBOS and Schools were selected based on their relevance to objectives of the study. These are: Lideta sub city HIV/AIDS Prevention and Control Office; Kebele administrations of 01/18 of the Lideta sub city; Lideta Selam School and Meskerem “And” School; Genet Church and Love for Children ;and members of Lideta Selam and Andinet Meredaja Idirs.

### **Units of Analysis**

The units of analysis used are OVC households affected by HIV/AIDS

## **Sample Size**

The total subjects of the study were 90. These are 50 households and 25 orphans, 2 key informant from 2 NGOS, 1 representative from the Lideta sub-city HIV/AIDS Prevention and Control Office, 2 persons from the kebele Administration where the study was conducted, and 5 randomly selected individuals from the community based organization and 5 representatives of elementary schools were interviewed using structured and semi-structured questionnaire.

### **3.3. Data Collection Instruments**

The methods used to collect the data include in-depth interview using structured and semi-structured questionnaire and key informant interviews. All categories of data collection was conducted in Amharic after translating the questions from English to Amharic. Then again the Amharic version responses were translated into English for analysis.

#### **Instruments**

##### **Structured Questionnaire for OVC Household**

This instrument was designed and administered to obtain a rich and considerable amount of quantitative and qualitative data from both OVC households and orphans and vulnerable children. For this purpose, fully structured questionnaire for 50 OVC households were developed in order to collect data using survey method. It has different parts and was developed to collect data on the socioeconomic status of the households. The questionnaire has 6 main parts. These were background characteristics of the household; economic status and livelihood; availability of basic facilities and services within the household; view of OVC household towards the community; Psychosocial issues and available intervention services/coverage.

### **Structured Questionnaire for Orphans and other Vulnerable Children**

AIDS orphans and other vulnerable children age 10 and above were included in the study as a source of data. Similar to the households, OVC were selected from the same Kebele and house that were understudy. Elder child in the household were represented in the study. In the case where the child in the same household was unable to respond due to age and other factors the child in next households was taken until reached 25. Structured questionnaire was developed to collect data from 25 OVC. The main parts included were about the living arrangement; educational situation; access to basic needs; problems they have and responses to their needs and problems.

### **Unstructured Questionnaire for the Service Providers NGO**

This tool was used to interview heads of two NGOS out of five as the key informant. Questions raised was about the main activities of the project in the prevention, control, and support for OVC; kinds of support being given to the OVC; the characteristics of the clients; identification of the gaps in the process of OVC program and so on.

### **Semi-structured Questionnaire for the Sub City's Head of HIV/AIDS Prevention and Control Office**

The semi-structured questionnaire was developed in order to collect data from the sub city's HIV/AIDS Prevention and Control Office. The main part of this questionnaire comprises inquiring information about who is regarded as an orphan, families and communities response to OVC and impact of HIV/AIDS on children in need. The involvement of the office in the efforts to mitigate the problem of OVC such as identifying the ongoing programs and implementation of policies; what should be the role of the government, NGOs, Religious institutions and the community; with regard to the main problems of OVC households affected by the epidemic.

### **Semi-structured Questionnaire for the Selected Kebele Representatives**

Semi structured questionnaire was developed to the sample kebele representatives in order to collect data about the problems of OVC, as well as the population's characteristics. For example questions such as involvement of the kebeles in supporting OVC households; the main livelihood sources of the sample population; main problems of affected households as well as orphans and the like were posed in this questionnaire.

### **Unstructured Questionnaire for Community-based Caregivers**

Caregivers like Idir were also used as a source of data in the data collection process. The issues included in the questionnaire were about the type of assistance to OVC households and the community perception towards these households and the problems they have been facing due to existence of such problem.

### **Unstructured Questionnaire for Two Schools in the Kebele**

Schools were also used as a source of data in the data collection process. The issues included in the questionnaire were about the assistance provided to OVC through schools, impact of having OVC in the overall school systems, problems the OVC have in general and their relationship with peers was collected.

### **Direct Observation**

The researcher was made observation in most of the households during the survey as well as during the time of data collection from the selected cases. Direct observation was made on the informants' housing condition like number of rooms, materials used to construct houses, their access to different facilities such as water and toilet, and so on.

## **Literature Search and Review**

Both published and unpublished literature related to OVC was searched with the aim of understanding the situation of OVC at all levels.

## **Data Collection**

Primary and secondary data were collected for this study. Secondary data were collected from literature and documents such as NGO reports, Kebele records, etc. Primary data were collected from households, orphans and vulnerable children, government agencies, head of NGOS, and caregivers using the above indicated instruments (structured and unstructured questionnaire, semi-structured questionnaire, and direct observation).

### **3.4. Data Analysis**

The primary step in analyzing the quantitative data was checking the questionnaire for consistency and error. Accordingly, those that contain unrealistic or incomplete data were excluded. The answers for open ended questions were counted and responses were grouped into few discrete categories and tallied accordingly. Similarly, qualitative information were organized into categories and systematically displayed.

### **3.5. Delimitation**

The scope of the study is delimited to an urban area and deal with orphan and vulnerable children found at household levels and supported through the Kebele. The study focuses on the needs, problems and responses provided to them. In a baseline survey made by MOLSA (2003), these types of children (living as a household member) constitute 18 % of OVC in the country.

### **3. 6. Ethical Considerations**

The following ethical issues were taken care of during the research process:

3.6.1. Surviving parents, guardians and other participants of the research were asked to give their informed consent orally before filling out the questionnaire or conducting any discussion.

3.6.2. Since minors can not give informed consent, permission was asked from their surviving parents or caregivers.

3.6.3. Information obtained from and pertaining to children remain confidential to protect children from any harm

## Chapter 4: RESULTS OF THE STUDY

This chapter contains three main sections. Section I provides findings of the survey on OVC households. Some figures which further elaborate the survey findings of this section are provided as annexes. Section II presents findings of the survey on orphan and vulnerable children; while section III, presents the discussions made with different organizations regarding the existing programs and responses.

### Section 1: OVC Households

#### 4.1. Personal and Family Situation of OVC Households

As indicated in the objectives of the study, the first characteristics of the households examined in the study were, sex, age, family size, marital status, level of education, religion, ethnic group and relationship of head of household with OVC. The detailed information with regard to each variable is described as follows.

##### *Age and Sex of the head of the Households*

**Table 4.1.1: Age and Sex of the head of the household**

Age group	S E X				Total	
	Male		Female		No.	%
	No.	%	No.	%		
< 18	4	8	6	12	10	20
18-29	2	4	4	8	6	12
30-39	1	2	6	12	7	14
40-49	0	0	7	14	7	14
50-59	1	2	4	8	5	10
60 and above	1	2	14	28	15	30
Missing	0	0	0	0	0	0
Mean age	29.2	-	45.1	-	42.3	
<b>Total</b>	<b>9</b>	<b>18</b>	<b>41</b>	<b>82</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

As shown in table 4.1.1 above the characteristics examined were sex and age of the head of OVC households under the study. In the study it was found that the majority (82%) of the respondents were female while the remaining (18 %) were male. Among the sample

respondents, 20% head of OVC households were children below the age of 18 while 30% of them were above the age of 60. These both age groups (below 18 and above 60) constitute 50 % of the respondents. The remaining 50 % of household heads lies between age 18 and 59 years. The mean age of OVC household heads in the study site is 42.3%.

The issue why more women are OVC heads of households than men require a clarification. There may be many factors for this as described by the respondents. Most of the grand- mothers of children were widowed and lost their husbands due to war in the previous regime. Even, it was confirmed that the deceased mothers (lost their fathers due to war) became vulnerable to HIV/AIDS in their endeavors to support the family economy. It was also reported that some of the children orphaned were born out of wedlock and left with grandparents from the beginning.

*Family Size of the OVC households*

**Table 4.1.2: Family Size**

Family Size	Children (age 18 and below)		Adults (age 19 and above)	
	No	%	No	%
1-3	37	74	42	84
4-6	8	16	8	16
7-9	5	10	-	-
10 and above	-	-	-	-
<b>Total</b>	<b>50</b>	<b>100</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

In the survey family size of the respondents were studied. Accordingly, it was found out that the OVC households have family size of children that range between 1 and 9 and family size of adults that range between 1 and 6.

The majority of the studied households (74 percent) have children aged 18 and below as a family member that ranges from 1to 3. The second largest (16 percent) have 4 to 6 children as family members while the rest (10 percent) have children 7 to 9. Similarly, 84

percent of households have adults aged 19 and above as family members that range from 1-3 family size while 16 percent households have adult family members that range from 4-6 family size.

With regard to family size attempt was also made to look into the total number of OVC at studied households. This can be shown in the following table 4.1.3.

**Table 4.1.3: Distribution of OVC by Household Type**

Number of OVC at household	Household type				Total	
	Adult headed		Child headed		No	%
	No	%	No	%		
one	22	44	1	2	23	46
two	14	28	4	8	18	36
Three	2	4	4	8	6	12
Four	0	0	0	0	0	0
Five	2	4	0	0	2	4
Six	0	0	0	0	0	0
seven	0	0	1	2	1	2
Total number of OVC	66		28		94	
Mean dependency Ratio	1.7		2.8		1.9	
<b>Total</b>	<b>40</b>	<b>80</b>	<b>10</b>	<b>20</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

(Note: Total number of OVC is obtained by multiplying number of OVC at household level by each household type)

As shown in table 4.1.3 above the majority, 46 % of the households have supported one OVC while 36 % have supported 2 OVC in their houses. The rest, 12 %, 4% and 2% of the studied households have 3, 5 and 7 OVC at household level respectively. All in all there are a total of 94 orphans and vulnerable children in the fifty studied households. The mean dependency ratio (total number of OVC divided by head of households) for adult headed and child headed households shows that 1.7 and 2.8 respectively. This means that for each adult heads of household there are approximately 2 children who must be supported. Similarly in the child headed households there are approximately three children that must be supported given that child headed households play similar role with adults in handling the family under

their custody. Therefore, the dependency ratios for households that are taking care of orphans are higher for child headed households as compared to other households headed by adults under study.

*Marital status of head of OVC households*

**Table 4.1.4: Marital Status of head of OVC households**

Marital status	Total	
	N	%
Married	13	26
Unmarried/single	14	28
Separated	1	2
Divorced	3	6
Widowed	19	38
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

Table 4.1.4 shows marital status of OVC household heads. The majority, 38 percent are widowed, 28 % are single, and 26% are married. The rest 6% and 2% are divorced and separated respectively.

*Level of Education of heads of OVC households*

**Table 4.1.5: Level of Education heads of OVC households**

Educational Status	Total	
	No	%
Illiterate	20	40
Read and write	9	18
Grade 1-4 (first cycle)	2	4
Grade 5-8 (second Cycle)	12	24
Secondary school	7	14
Others	-	-
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

*Note: Ethiopian education system splits primary level education, grade 1-8 into two which is known as first primary cycle (grade 1-4) and second primary cycle(grade 5-8).*

Educational level of the respondents is quite low as shown in the table 4.1.5 above. About 58 percent of the respondents (40% illiterate & 18% read and write) reported that they had no formal education while 28 percent( 4% first cycle and 24% second cycle) had primary school, that is, first and second primary cycles only. The rest 14 percent had secondary school education. There were no respondents with education above secondary school among the respondents.

*Religion of heads of OVC households*

**Table 4.1.6: Religion of heads of OVC households**

Religion	Total	
	No	%
Orthodox	45	90
Protestant	2	4
Muslim	3	6
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

As shown in table 4.1.6 above majority, 90 percent of the respondents are followers of orthodox religion while the rest 6 and 4 percent are followers of Muslim and protestant religions respectively.

*Ethnic Group of heads of OVC households*

**Table 4.1.7: Ethnic Group of OVC households**

Ethnic Group	Total	
	No	%
Amhara	26	52
Oromo	18	36
Tigre	2	4
Wolaita	1	2
Gurage	2	4
Harare	1	2
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

More than half (52%) of the respondents are Amhara followed by Oromo (36%). The rest are from the various other ethnic groups as shown in table 4.1.7 above.

*Relationship of head of household to Orphans and Vulnerable Children***Table 4.1.8: Distribution of the Relationship of Head of Household to Orphans**

Relationship of head of household to the OVC	Total	
	No	%
Mother	2	4
Father	1	2
Grandparents	18	36
Child headed/Siblings/	10	20
Other relative/relatives	15	30
Unrelated	4	8
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

In terms of the relationship of the head of the household to the child, data in table 4.1.8 suggest that 36 percent AIDS orphans and vulnerable children live with their grand parents followed by other relatives like uncle, aunt, cousins, etc. However, a significant number (20 %) of them live with their siblings in a child headed households. About 8 percent of them also live with non relatives like neighbors and benevolent individuals particularly with childless families.

Table 4.1.8 above also provides information on who actually is the caregiver. One sees from the table that these people are mainly members of the extended family and that only a few people or groups are part of the general care providers.

#### **4.2. Household Economic Status and Livelihood**

Under this section income and expenditure of the respondents was discussed. In the income part issues related with sources of income of head of the household, other members of the households contribution to the income, estimated average monthly income, frequency of meals per day, and household economic status as compared with others was examined. Likewise, the expenditure of the households on food before and after the arrival of the child was looked at.

**4.2.1. Income:***Sources of Income***Table 4.2.1.1: Sources of Income of heads of OVC households**

Sources	S E X				Total	
	Male		Female		No.	%
	No.	%	No.	%		
No source of income	0	0	0	0	-	0.0
Civil servant	2	4	2	4	4	8
Trading	0	0	9	18	9	18
Daily labor work	6	12	5	10	11	22
Relatives	0	0	3	6	3	6
Pension	1	2	9	18	10	20
Other	0	0	13	26	13	26
<b>Total</b>	<b>9</b>	<b>18</b>	<b>41</b>	<b>82</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

Sources of income of the respondents were the other variable through which the situation of OVC households was investigated. The distribution of sources of income showed that civil servant, trade, daily labourer, relatives, pension and other sources specified as major sources of income. The highest numbers, 26 percent of the respondents earn their income from other sources that include support from NGOs, begging and house rent. Those who got support from NGO's reported that they have received Birr 60 on permanent basis in the form of retirement fund from one religious affiliated organization which the respondents named it "Yebrihan Lijoch". Besides, the second largest group, 22 percent have got income in working as daily labourer (porter, baking Injera for rich family, construction, etc). The third group of the respondents, 20 percent have got their own or deceased family pension. The fourth group, 18 percent engages in various trades such as selling local drinks (*Tela and Araki*), selling *Enjera*, *changing cents*, renting beds, selling distaff, etc. The remaining 8 and

6 percent got income in working as a civil servant and support from relatives particularly working children. Details have been shown in the above table 4.2.1.1.

*Number of household members earned money*

**Table 4.2.1.2: Household Members Sources of Income**

<b>Household members Sources of Income</b>	<b>Total</b>	
	<b>No</b>	<b>%</b>
Regular Employment	2	4
Piece work	19	38
Nothing	29	58
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

The study attempted to explore the sources of income of other household members apart from the head of the household as described in table 4.2.1.2 above. It was reported that in the majority (58 %) of the households the members have contributed nothing to the income of the household. That is, they did not engage in works that produce income to the household. On the other hand, in the remaining 42% percent of the household, considerable members have contributed to the household income. Out of those, 38 % of them contributes to the household income from piecework (daily laborer, housemaid, barber, taxi helper, and shoe shiner) while 4% from regular employment.

*Estimated Average monthly income of the household***Table 4.2.1.3: Monthly Income of the Head of the Household**

Average Monthly Income	S E X				Total	
	Male		Female		No.	%
	No.	%	No.	%		
≤ 100	1	2	28	56	29	58
100-200	0	0	9	18	9	18
201-300	5	10	4	8	9	18
301-400	1	2	0	0	1	2
401-500	0	0	0	0	-	0
501-600	2	4	0	0	2	4
Average Income	Birr 198.80		Birr 149.51		Birr 157.40	
<b>Total</b>	<b>9</b>	<b>18</b>	<b>41</b>	<b>82</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

Estimated average monthly income of the OVC household was collected by asking the heads of household to tell how much the family income was. Another fact that was considered here is that support given by service giving organizations including the government and extra income produced by all family members. Accordingly, as shown in table 4.2.1.3 above more than half (58%) of the respondents earn a monthly income of less or equal to Birr 100. The other 36 % have got an average of monthly income that ranges from Birr 101- 300. The rest 4% and 2% have got an average monthly income that ranges between 501-600 and 301-400 respectively. There is no respondent that falls between the ranges of Birr 401-500. The average income for male respondents is Birr 198.80 while for female equals to Birr 149.51. In general, Birr 157.40 is the average income of the respondents.

*Frequency of meals/ day for all household members***Table 4.2.1.4: Frequency of Meals Per day for all Household Members**

Frequency	Total	
	No	%
3 times a day	31	62
2 times a day	4	8
Once a day	-	0
Others (as available)	15	30
<b>Total</b>	<b>50</b>	<b>100</b>

Frequency of meals per day irrespective of quality and quantity for all household members of the respondents was assessed in order to know OVC s access to food. As shown in table 4.2.1.4 above it was found that 62 percent of the households have at least three meals per day. The type of meals may be bread, roasted grain or *Injera* (stable food of Ethiopians) with *Shiro* (Ethiopian sauce made from peas, vetch or horse beans) depending on the income. However, 30 percent of the households reported that they were less likely to have access to such categories/ frequencies (breakfast, lunch and dinner) of meals. They responded that they eat food as available depending on their daily income. There are days bypassed without eating. The rest 8 percent reported that they have at least two meals per day.

*Household economic status compared with other household***Table 4.2.1.5: Household Economic Status Compared with Others**

Status	Total	
	No	%
Better	3	6
Above Average	0	0
Average	7	14
Below average	11	22
Poor	29	58
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field Survey*

Comparison of the economic status of the households with others, particularly with neighbors living around was made by asking heads of the households on how they view their living standards as compared to others. Therefore, the data presented in table 4.2.1.5 here above was the opinion of the heads of the OVC households. Accordingly, the majority, 58 percent of the respondents viewed their living standards as extremely poor while 22 percent viewed as below average. The rest 14 percent analyzed their economic status as average. On the other hand it was only 6 percent that viewed their living as better even above average.

#### **4.2.2. Expenditure:**

Practically bringing in additional members to the household has an impact on the economy of the family for it raises the expenditure. This holds untrue for some OVC households under study. This is because most of the caregivers are dependent family members of the household that live together with the deceased parents and were not responsible to manage the household economy. On the other hand some of the orphans have been living with the parents from the beginning and do not exactly know the expenditure in terms of finance. Therefore, the query was made on the increase and decrease of expenditure on food before and after the arrival of the child is shown in table 4.2.2.1 below. As observed 44 % of the households studied do not know the change on the expenditure while 40 % said that there is a trend of increase of expenditure on food. The remaining 16 % of the households reported that the expenditure remains stable and fully utilized for food.

*Monthly expenditure on food after the arrival of the child***Table 4.2.2.1: Monthly Expenditure on Food after the Arrival of the Child**

Monthly Expenditure on food	Total	
	No.	%
Increased	20	40
Stable (same as before)	8	16
Decreased	0	0
Do not know	22	44
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey***4.3. Availability of Facilities and Services**

Under availability of facilities five main factors were considered. These were access to and availability of water, toilet, access to health services, access to electricity and housing condition.

*Source of access to water***Table 4.3.1: Source of Access to Water**

Source of water	Total	
	No	%
Tap water in the dwellings	9	18
Public/communal tap (BONO)	29	58
Tap water from the houses of neighbors	12	24
Other	0	0
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

Most of the households surveyed had access to potable water. The largest group of households (58 percent) gets water from communal tap known as “BONO” while (24 percent) gets water buying from the nearby residents/ neighbors. The rest 18 percent of the households have a tap water in their dwellings. The detail information can be seen in the above table 4.3.1.

*Access to toilet***Table 4.3.2: Access to Toilet**

	Households Total	
	No	%
<b>Do you have toilet?</b>		
Yes	40	80
No	10	20
<b>Kind of toilet facility</b>		
Flush toilet, private	0	0
Flush toilet, communal	0	0
Pit latrine, private	5	10
Pit latrine, communal	35	70
No facility	10	20
<b>If no facility, how do you use toilet</b>		
Public toilet in different places, In hotels around and		
Use festal/plastic and throw it somewhere	19/20	95
Open area	1/20	5

*Source: Field survey*

The survey data shows that 80 percent of the households have access to toilets, while 20 percent do not have access to any kind of toilet. Most of the households (70 percent) have communal pit latrine that was constructed by non governmental organizations. Only 10 percent of the households have private pit latrine. No one has private or communal flush toilet among the respondents. Those respondents who said they have no toilet (20 %) use different places such as hotels and public toilets. There are also practices where some members of the households use plastic bags and throw it somewhere. Only 1 person reported that s/he uses open area.

*Access to health services***4.3.3. Access to Health Services**

All of the respondents (100 percent) use Government owned Hospital and health center. They use a health center located in the Kebele 01/18.

They were asked whether they were satisfied with the service they get or not. Almost all of the respondents replied that they were satisfied with the services provided to them. The respondents explained that the doctors treat them very well and refer to the hospitals if the case is serious. All of them have confirmed that they have got health services free of charge. The only requirement to get the service free of charge is produce the paper that certify them they are poor. This certification is easily obtained from the Kebele. As informed by the sub city, this type of health service is a privilege provided by the government to all citizens incapable to pay for.

*Access to source of energy*

**Table 4.3.4: Access to Source of Energy**

Source of energy for cooking	Total	
	No	%
Electricity only	-	0
Wood only	6	12
Charcoal only	3	6
Kerosene only	3	6
Wood and Kerosene	21	42
Charcoal and Kerosene	14	28
Do not cook	3	6
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

Almost all of the respondents have electric power in their dwellings. As reported they use electricity only to get light from. As shown in the above table 4.3.4, for cooking, the majority 42 percent use wood and kerosene while 28 percent use charcoal and Kerosene. The rest 12 %, 6%, and 6% use wood or charcoal or kerosene only for cooking food respectively. The rest 6% reported that they do not cook food at home.

### 4.3.5. Housing Condition

**Table 4.3.5.1: Housing Condition**

Live in (Ownership of Houses)	Total	
	No	%
Own houses	2	4
Rented from Kebele	38	76
Rented from Private	3	6
Dependent	2	4
Other (specify)	5	10
<b>Total</b>	<b>50</b>	<b>100</b>

*Source: Field survey*

As shown in table 4.3.5.1 above, of the OVC households, the majorities (76 percent) live in houses rented from the Kebele, Government owned houses. Only 4 percent of the respondents own houses privately. Six percent of the respondents live in houses rented from private while four percent are dependent on some one like close relative or friends and ten percent live in a shelter for their previous houses were demolished by the government to substitute them with condominiums.

**Table 4.3.5.2: Size and number of rooms of the households**

Size of the household	Number of rooms in the house			Total
	one	two	three	
1		1		1
2	1	2		3
3	10	3	2	15
4	8	3		11
5	4	3		7
6		2		2
7	2	2	1	5
8		2	2	4
9		2		2
<b>Total (No)</b>	<b>25</b>	<b>20</b>	<b>5</b>	<b>50</b>
<b>Total (%)</b>	<b>50</b>	<b>40</b>	<b>10</b>	<b>100</b>

Concerning the size of the households and number of rooms, the data shows that 25 respondents (50 %) with family size ranging from 2-7 live in a single room while 20 respondents (40%) with family size ranging from 1-9 live in a two room house. The

remaining 5 respondents (10 %) with family size three, seven and eight live in a three room houses. The above table 4, 3.5.2 depicts the detail information.

#### 4.4. View of OVC Households towards the Community

The majorities 90 % of the households surveyed lived in this community for years ranging from 10 – 60 years and do not anticipate moving from this community in the next 2-3 years. The rest 10 % lived in this area for years ranging from 7 months to 8 years. The OVC households were asked about their opinion towards the community which themselves are the part. The following table 4.4.1 shows the statements in which the respondents were agreed and disagreed about their community.

**Table 4.4.1: Respondents Opinion about the Community**

Statements	Agree		Disagree		Total	
	No	%	No	%	No	%
This is a supportive community for OVC households.	45	90	5	10	50	100
People in the community do not share the same values. (Some are supportive and some are not)	50	100	0	0	50	100
People in the community support in fulfilling emotional needs of OVC	50	100	0	0	50	100
People in the community support in fulfilling financial needs of OVC	0	0	50	100	50	100
People in the community are protecting OVC girls from being harassed	35	70	15	30	50	100
People in the community show love and care for OVC.	45	90	5	10	50	100
People in the community appreciate/ encourage you for your assistance to OVC	49	98	1	2	50	100

As shown in table 4.4.1 above 90 % of them believe that their community is supportive for OVC households. But, 10% of the households disagree with this statement. Those who disagree with the statements said that the community particularly neighbors remind the children in discussing the kindness of the deceased parents, use their labors

freely, and do not cooperate them to watch television. Almost 100 % agreed that people in the community do not share the same values (Some are supportive and some are not). Similarly, 100 % of the respondents agreed that the community members are intervene in fulfilling emotional support to OVC. However, all of them agreed that people in the community are not fulfilling the financial support to OVC households due to abject poverty in the area.

With regard to protection of girl child 70 % of them agreed that the community are protecting girls from being harassed. 90 % of the participants of the survey revealed that people in the community show love and care for the OVC households. Most of them confirmed that the neighbors share both sorrow and happiness. Though not go further from the leap service, 98 % of the respondents agreed that people in the community appreciate and encourage them for their assistance to orphans. The rest 2% disagreed with the statement. The reasons given for the disagreement is that “upbringing a child does not need appreciation or encouragement of others for it is natural to do so”.

#### **4.5. Psycho-Social Issues**

Under this section of the survey opinion of the head of OVC households was taken to look into the present life situation of OVC. In this regard the participants were asked about the feelings of children, incidence of conflicts, affiliation of children in terms of spending time, knowledge about death and causes of death of parents and measures taken by the guardians to handle or guide the behavior of the OVC and the reasons, difficulty and feelings in dealing with OVC from the guardian/caregiver perspectives.

##### ***Causes and methods used to resolve conflict***

The majority, 50 % of household heads indicate that they perceived that the OVC living with them are happy or somewhat happy while 30 % and 14 % reported that the

orphans resided with them are somewhat unhappy, less happy and Very unhappy, sad respectively. The remaining 6% did not respond to the question. It should also be noted that very few households have taken in orphans and some are already have acquaintance with the guardian and so it is not possible to make too many inferences on the psychosocial condition of orphans based on the quantitative data alone. This is because the information obtained is from the perspectives of OVC household and more of comprehensive. It also requires further discussion on each issue like what did children feel about the loss of parent, about the services provided to them, about care of their guardians, etc. In addition to this there is a need to discuss with children living with them to understand the perspective from the side of children.

The respondents were also asked about the occurrence of conflicts between the children they have taken in and other children. Accordingly, 80 % of them confirmed that there is an incidence of conflict of which 62.5 % have taken place with others, the guardian. In fact, 20 % of the heads revealed that the conflict occurred among the siblings themselves while conflicts with other children in the household and neighbors reported 12.5 % and 5% respectively. The common causes of conflict were other causes (57.5) such as failure to fulfill the transportation needs, pocket money, and purchase of clothes during holiday, etc., which the children were familiar before the death of the parents. In search of attention (25%), related with housework (12.5 %) and jealousy (5 %) were reported as common causes of conflict. With regard to frequency of conflict the respondents reported that difficult to keep in mind when it happened. But, all of them confirmed that the conflict has happened every other day. The majority of them (62.5%) were talking (discuss the matter) with the children while 25% scold the children to resolve the problems. However, 12.5 % of them

used physical punishment to resolve the problem. For details of the response refer Table 4.5.1 of the report indicated here below.

**Table 4.5.1: Feeling, Causes and methods used to resolve conflict**

	Households Total	
	No	%
<b>Feeling of an orphan child</b>		
Happy, Happier	25	50
The same (sometimes happy, sometimes not)	0	0
Somewhat unhappy, less happy	15	30
Very unhappy, sad	7	14
No Response	3	6
<b>Incidence of Conflict</b>		
Yes	40	80
No	10	20
<b>Incidence of Conflict with</b>		
Their brothers and sisters	8	20
Other children in the household	5	12.5
Neighborhood children	2	5
School mate	0	0
Others (care givers/guardians)	25	62.5
<b>Common causes of conflict</b>		
House work	5	12.5
Jealousy	2	5
Fighting over snacks	0	0
Wanting attention	10	25
Ownership of clothes	0	0
Ownership of household items	0	0
Others	23	57.5
<b>Frequency of Conflict</b>		
Daily	0	0
Every other day	40	100
Once a week	0	0
Once a month	0	0
Others	0	0
<b>Methods of Conflict Resolution</b>		
Scold the children	10	25
Punish the children	5	12.5
Talk with the children	25	62.5
Separate them	0	0
Consult with the school	0	0
Others	0	0

*Source: Field Survey*

**Attachment of Children**

Table 4.5.2 below shows that the majority 40 % of the OVC spent most of their time with guardians followed by friends (26%) and own brothers and sisters (20%). Also, it was observed by the respondents that 14 % spent their time with step-foster siblings. Similarly, 48 % of the respondents said that the OVC were frequently talking with guardians while 26 % said with own brothers and sisters. The rest of the respondents distributed among care giver husband/wife (10%), friends (10%), relative (4%) and step-foster-siblings (biological children of the caregiver) (2%).

**Table 4.5.2: Attachment of Children**

	Households Total	
	No	%
<b>With whom OVC spent their time</b>		
Care giver	20	40
Care giver husband or wife	0	0
Relatives	0	0
Step- foster- siblings	7	14
Own brother and sister	10	20
Friends, cousins, other children	13	26
No one, keeps to him or herself	0	0
Other	0	0
<b>With whom OVC talk frequently</b>		
Guardian	24	48
Guardian husband	5	10
Relative	2	4
Step-foster-siblings	1	2
Own brother and sister	13	26
Friends	5	10
Adult relative	0	0
School teacher	0	0
Religious leaders	0	0
No one, keeps to him or herself	0	0

*Source: Field survey*

***Knowledge about death and causes of death of parents***

Respondents were asked to report whether the OVC know the cause of death of their parents, talk about deceased parents and frequency of talking in the past six months about the deceased parents. As shown in table 4.5.3 below 60% of the households confirmed that the children know cause of death of their parent/s while 40% of the respondents confirmed that the children did not know the cause of death of their parent/s due to age at the time of death of their parents. In addition to this, most of the respondents believed that telling the cause and even the death itself did not have due importance for the future life of a child. Among those who responded that the children know the cause of death of their parents, 80% of confirmed that the children raised the issue and discussed with them particularly whenever the guardians failed to fulfill their needs such as covering transport cost, clothing for holidays, etc. In 46.7 % of the households at least they remember and talked about the deceased parent/s on daily basis while 33.3 % households did not remember the frequencies. There are also 16.7 % households that talked only once in the past six months about the deceased parents. Concerning the illness of the parent/s of the children, 90% of the households revealed that they were seriously sick while 10% said that the parents were not seriously sick. Respondents were also asked on the effect of the sickness and death of the parents on the life of the child. The majority, 42% of them observed that school attendance of the children was declined/stopped while 32% said that it affected the children and the family in reducing the food and the money. About 20 % of the respondents mentioned other factors that the children deprived of love and affection they should get from them.

**Table 4.5.3: knowledge about death and causes of death of parents**

	Households Total	
	No	%
<b>Do OVC know cause of death?</b>		
Yes	30	60
No	20	40
<b>Talk about deceased parents</b>		
Yes	30	60
No	20	40
<b>With whom they talk about death of parent/s</b>		
Guardian	24	80
Guardian husband/wife	0	0
Relative	0	0
Step-, foster-siblings	5	16.7
Own brothers and sisters	1	3.3
Friends, cousins, other children	0	0
Some other adult relative not living with them	0	0
School teacher	0	0
Religious leaders	0	0
Others	0	0
<b>Frequency of talking in the past six months</b>		
<b>About deceased parents</b>		
Daily	14	46.7
Weekly	1	3.3
Monthly	0	0
Only one time	5	16.7
Others	0	0
Missed (don't remember)	10	33.3
<b>Severity of illness (Seriously ill or not)</b>		
Yes	45	90
No	5	10
<b>Effect of the sickness or death of a parent/s</b>		
<b>On the child</b>		
School attendance has declined/stopped	21	42
Grades have worsened	0	0
More house or field work	2	4
Take care of small children	1	2
Take care of a living parent	0	0
Less food/money as a family	16	32
Not affected their life circumstances	0	0
Other (love and affection)	10	20

**Source: Field Survey**

***Reasons for, difficulty and feelings in dealing with OVC***

The extended family system remains to be the major survival support for orphaned children living in the study area. However, what motivates these individuals to take care of these children particularly under this tense socio-economic situation is very important. As shown in table 4.5.4 of annex 1, 74 % of the households revealed that they are responsible as a customary practice to take care of a child lost his/her parent, 20 % of them said that it was because of absence of alternatives while 6% said acquaintance with the deceased parents and kindness. In this regard, some of the respondents particularly relatives said that they forget the grief and felt that as if they got their deceased child, brother, sister, etc. Meaning, they considered the children as replacement.

Respondents were also asked the major difficulty they have faced in taking in other children. Of the total households, 50% of the respondents reported that things get hard financially and there is less food to go around, 28% reported that the children can't go to school, guardians faced health problem and have no time to rest, 12% reported that they have faced nothing while 10 % reported that other causes like family disturbances. This latter case was also confirmed by the respondents selected from the Kebele. According to the kebele respondents, mostly women decided to take in the child of their deceased relatives with out the consent of their husbands and children. As a result, many families entered into conflict and reached to the extent of divorce. There are also many cases where the child (orphan child) runaway from such kind of family and join the street life.

In general, the respondents under this study feel good (40%) and fair (60%) in supporting the children. With regard to the general feeling about future survival, 60% reported fair while 40 % reported that generally well. In response to the future support required, 60% emphasized medical care, food and clothing, 24 % Clothing, medical care

and school fee, 12% some one with whom they talk, and 4% Clothing, school fee, training or education to the children.

#### **4.6. Intervention Coverage**

It is understood that the OVC households require various types of services to cope with the circumstances they are in. These services are rendered by many actors like government, NGO, faith based organizations, Community Based Organizations (CBO) and benevolent individuals. Therefore, under this section of the survey issues related with such responses like psychosocial, income generation, HIV/AIDS prevention, food, and legal rights were considered.

#### **Psychosocial**

One of the issues explored in terms of psychosocial is that identifying the place where they can go whenever they have a problem and need advice. As shown in table 4.6.1 below, the majority, 64 percent do have a person or a place to go for advice. As responded 30 percent consulted household members, 20 percent of them visited Kebele HIV/AIDS workers, 10 percent friends, 10 percent neighbors, and 4 percent relatives for advice to solve the problems they have. The rest 36 percent have no one to go for advice.

In the Kebele, it was noticed that there are volunteers that can provide a variety of services, such as helping with households or providing referrals. The OVC households were requested whether such volunteers were assigned to their household in the past three months and provided them services related with medication, counseling, health education, income generation, etc. Almost all of them confirmed that except registration for the food assistance they had never got such services. In fact, 36 percent said that volunteers were visited their homes and provided them with home based care service package consisted of provision of gloves, other sanitary materials, health education, etc before the death of AIDS patients. The

services immediately ended when a person with the AIDS died. This issue was raised with the head of the NGO and Kebele officials why do the services discontinued following the death of parents. Both reported that the problem is more of related with the budget and interest of the donors. Some donors do not want to go further to include the family of the deceased. Details of the results were shown in table 4.6.1 below.

**Table 4.6.1: Psychosocial**

	Households Total	
	No	%
<b>Do OVC households have a person to consult?</b>		
Yes	32	64
No	18	36
<b>Persons consulted</b>		
Household members	15	30
HIV/AIDS Desk workers in Kebele	10	20
Neighbors	5	10
Friends	5	10
Relatives	2	4
No one	18	36
<b>Frequency of consultancy in the past three Months</b>		
One time	12	24
Two times	10	20
Three times	10	20
None	18	36
<b>Volunteers assigned to provide services</b>		
Yes	18	36
No	32	64
<b>Frequency of visits made in the past three Months</b>		
One time	6	12
Two time	5	10
Three time	7	14
Nothing	32	64
<b>Types of assistance provided by volunteers</b>		
None	32	64
Medical care	0	0
Medical care to children	0	0
Counseling to adults	0	1
Counseling to children	0	0
Advocate for children's rights	0	0
Health education	14	28
Income generation	0	0
Food assistance	3	6
Support in household chores	1	2
Others	0	0

*Source: Field Survey*

### **Income Generation**

Training with the intention of increasing the income of the household was not given to OVC households. The Kebele also confirmed that the NGOs working in the area do not have the training package except provision of services like fulfilling educational materials, provision of grain, finance and clothing. Table 4.6.2 below depicts the fact.

**Table 4.6.2: Income Generation**

	<b>Households Total</b>	
	<b>No</b>	<b>%</b>
<b>Has any one received training to increase income?</b>		
Yes	0	0
No	50	100

### **HIV/AIDS Prevention**

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*Source: Field Survey*

The majority (98%) of the respondents have heard about HIV/AIDS. However, except 20 percent the majority 80 percent got information on how to protect themselves from HIV/ AIDS in the last 3 months. Those who know how to protect themselves have got information from Radio/TV (20%), health center (52%), from family members (6%) and Kebele /school (22%). Details of the result can be shown in table 4.6.3 below.

**Table 4.6.3: HIV/AIDS Prevention**

	Households Total	
	No	%
<b>Have heard how to protect from HIV/AIDS</b>		
Yes	49	98
NO	1	2
<b>Have received information on how to protect from getting HIV/AIDS</b>		
Yes	40	80
No	10	20
<b>Source of Information</b>		
Radio/TV	10	20
Health center	26	52
Family (discussion on the issue)	3	6
Kebele/School	11	22

*Source: Field Survey*

## **Food**

The respondents were also asked whether they have got food assistance from outside sources like religious institutions, NGOs, relatives and Idir. Out of the total respondents 60 percent of them said that they did not receive food assistance while 40 % of them confirmed that they have received wheat, Teff, supplementary nutritional food and edible oil from NGOs (Love for children, Yebrihan Lijoch and Korea) and church named “Gunet”. The details are indicated here under in table 4.6.4.

**Table 4.6.4: Food**

	Households Total	
	No	%
<b>Received food assistance outside of the household</b>		
Yes	20	40
No	30	60
<b>Organizations providing food assistance</b>		
Church(Gunet )	3	6
Mosque	0	0
Idir	0	0
Relatives	0	0
NGO		
• love for children	13	26
• Korea	2	4
• Yebrihan Lijoch	2	4
Others	0	0
Not received/ no contact	30	60
<b>Types of food assistance provided</b>		
Wheat and oil	15	30
Supplementary food (FAFA)	2	4
Teff	3	6
Nothing	30	60

*Source: Field Survey*

### Legal Rights

Knowledge of the respondents about legal rights of children was the other variable that was considered under this study. Accordingly, as indicated in table 4.6.5 below, majority (70 %) of them have knowledge that the Children have right to safety, health, education, right to inheritance and other rights like rights to speak. The respondents have also indicated that exploitative labor such as serving as a domestic worker with low payment is the major instance in which the rights of these OVC children have been violated.

**Table 4.6.5: Legal rights**

	Households Total	
	No	%
<b>Knowledge about child rights</b>		
Children have no right	0	0
Children have right to safety, health, education	20	40
Right to inheritance	10	20
Right to free from physical and sexual abuse		
Others (rights to speak)	5	10
Don't know	15	30
<b>Instances child rights have been violated</b>		
Property grabbing	8	16
Exploitative labor	40	80
Sexual abuse	0	0
Physical abuse	0	0
Violence	0	0
Banned from attending school	2	4
Others	0	0

*Source: Field Survey*

## Section 2: Orphan and Vulnerable Children

### 4.7. Background Characteristics of OVC

#### *Age and Sex Distribution*

**Table 4.7.1: Age and Sex Distribution of OVC**

Age	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
10-14	9	36	4	16	13	52
15-18	6	24	6	24	12	48
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

A total of 25 OVC age 10 and above were taken as part of the study. These children were selected among the OVC households under study. Among the 25 children interviewed 60 percent were males and 40 percent were females. Among the children 52 percent were between the ages 10 and 14 years while 48 percent were between the ages of 15-18. Details can be shown in the above table 4.7.1.

#### *Level of Education*

**Table 4.7.2: Educational Status of OVC**

Education Status	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
No formal Education	0	0	0	0	0	0
Grade 1-8	13	52	9	36	22	88
Grade 9-12	2	8	1	4	3	12
12 and above	0	0	0	0	0	0
Others	0	0	0	0	0	0
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

As shown in table 4.7.2 above 88 percent of the children of both sexes attained grade 1-8 while the rest 12 percent in grade 9-12. Although the majority of orphans discontinued their education following the death of parents, at present, the majority (80%) of them are

reported that they are in school. Only 20 percent of the respondents discontinued their education at present (refer table 4.7.3 below).

*Current status of Education*

**Table 4.7.3: Current Status of Education**

Currently in school	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Yes	12	48	8	32	20	80
No	3	12	2	8	5	20
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

*Living arrangement*

**Table 4.7.4: Living Arrangement**

Responsible to care for a child	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Father	0	0	0	0	0	0
Mother	1	4	0	0	1	4
self	1	4	0	0	1	4
grandmother	4	16	5	20	9	36
grandfather	0	0	0	0	0	0
aunt	4	16	2	8	6	24
uncle	0	0	0	0	0	0
Elder brother	1	4	1	4	2	8
Elder sister	2	8	1	4	3	12
neighbor	1	4	0	0	1	4
Parents friends	0	0	1	4	1	4
others	1	4	0	0	1	4
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

As discussed under table 4.7.1 above, a total of 25 OVC aged 10-18 years were included as part of this study. The detailed percentage distribution of the living arrangement of this group of children is shown in table 4.7.4 above. The distribution shows that 36 % with grand parents, 24 % with aunt, 12 % with elder sister and 8% with elder brothers. The rest 20 % were equally distributed among mother, self, neighbor, parents and others like

cousin. Except one child who is paternal orphan and living with his mother, the rest 96 percent in this group reported that they are orphans living with members of extended family and non relatives. It is obvious that following the death of their parents' orphans often suffer from several psychosocial problems such as stress, depression, discrimination and neglect. Therefore, orphans acquaintance with responsible person for care and support is important factor that helps them to rehabilitate from tragic death of their parents. Although the majority knew their present caregivers/guardians before they started living with them there was only one child (4 %) who did not know his present guardian (Table 4.7.5 below). This is particularly the case for an orphan living with others (cousin) that is thought to be distant relative. Regarding this child a discussion was made with his guardian what initiated the woman to take care of this child whom she didn't know before. As she reported, she brought him from the rural area for the boy lost both his parents by AIDS. She said:

*“He doesn't have relatives in the area. I am the only distant relative living in Addis Ababa. I am his relative through his maternal line. Once I went to visit my families in the rural area and found him working as shepherded in one of farmer's house. I was sad with what happened on that of his family. I brought him here with the view of his future. At least he gets educational and other support from government and non government organizations here in Addis Ababa. I thought that if I were left him in that rural area he could die. Now, he continued his education and we got food grain every two months. Even I myself benefited from the support let alone him”*

**Table 4.7.5: Previous Acquaintance with Present Care Giver**

Acquaintance with present care giver	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Yes	14	56	10	40	24	96
No	1	4	0	0	1	4
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

## 4.8. Basic Needs

### 4.8.1. Food

It was discussed under section one of this chapter with OVC heads of households regarding the frequency of meals per day irrespective of quality and quantity (table 4.2.1.4). Although majorities of them are living in abject poverty, 62 percent of the households confirmed that they have at least three meals per day. Similar question was posed to these OVC whether the food they have got is sufficient as compared to the lives they had with the deceased parents in terms of quality and quantity. As shown in table 4.8.1.1 below, 56 percent said that they have got sufficient food while the rest 44 percent responded that they are not. But, as compared to their previous life they had with the deceased parents, 84 percent reported that the supply of food is decreasing. Only 4 or 20 percent of the respondents said that there is no change both in quality and quantity of food (table 4.8.1.2 below). 52.4 percent of the respondents perceived that the food supply is decreasing both in terms of quality and quantity while 47.6 percent perceived that it decreased only in quality (Table 4.8.1.3 below).

**Table 4.8.1.1: Feeding Well/ Sufficient Food**

Feeding well	Sex				Total	
	Male		Female		No	%
	No	%	No	%		
Yes	9	36	5	20	13	56
No	6	24	5	20	12	44
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

**Table 4.8.1.2: Comparison of Food Supply Before and After Death of Parent/s**

Supply of food	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Decreased	12	48	9	36	21	84
Increased	0	0	0	0	0	0
Not Changed	3	12	1	4	4	16
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

**Table 4.8.1.3: Perceived Trend of Decrease**

Conditions of decrease	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Decreased in quality	6	28.5	4	19	10	47.6
Decreased in quantity	0	0	0	0	0	0
Decreased in both quantity and quality	6	28.5	5	24	11	52.4
<b>Total</b>	<b>12</b>	<b>57</b>	<b>9</b>	<b>43</b>	<b>21</b>	<b>100</b>

*Source: Field Survey*

#### 4.8.2. Clothing

As shown in table 4.8.2.1, 4.8.2.2 and 4.8.2.3 below, the majority of the children (68%) reported that they did not get adequate clothing. 84 percent of them said that the supply of clothing is decreased after the death of parents. Majority, 85.7 percent said that the decrease is both in quantity and quality. The rest 32 % reported that they have got adequate clothing, 12%no change as compared to their previous life and 14.3% revealed that there is a decrease in quality.

**Table 4.8.2.1: Adequacy of Clothing**

Adequacy of clothing	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Yes	6	24	2	8	8	32
No	9	36	8	32	17	68
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

**Table 4.8.2.2: Comparison of Supply Clothing before and After Death of Parent/s**

Supply of Clothing	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Decreased	13	52	8	32	21	84
Increased	1	4	0	0	1	4
Not Changed	1	4	2	8	3	12
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

**Table 4.8.2.3: Perceived Trend of Decrease**

Conditions of decrease	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Decreased in quality	3	14.3	0	0	3	14.3
Decreased in quantity	0	0	0	0	0	0
Decreased in both quantity and quality	10	47.6	8	38.1	18	85.7
<b>Total</b>	<b>13</b>	<b>61.9</b>	<b>8</b>	<b>38.1</b>	<b>21</b>	<b>100</b>

*Source: Field Survey*

#### 4.8.3. Health Care

A major issue with regard to healthcare services is its adequacy. Among OVC interviewed as shown in table 4.8.3.1 below, 80 percent revealed that they have got adequate health care services while 20 percent they did not. The respondents also compared the health care services before and after the death of parent/s. As shown in table 4.8.3.2 below, 52 percent confirmed that it is increased while 24 percent said decreased. The rest, 24 percent said that there is no change.

**Table 4.8.3.1: Adequacy of Health Care Services**

Sufficient health care	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Yes	13	52	7	28	20	80
No	2	8	3	12	5	20
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

*Source: Field Survey*

**Table 4.8.3.2: Comparison of Health Care Services Before and After Death of Parent/s**

Comparison of health care	Sex				Total	
	Male		Female			
	No	%	No	%	No	%
Decreased	3	12	3	12	6	24
Increased	9	28	4	16	13	52
Not Changed	3	12	3	12	6	24
<b>Total</b>	<b>15</b>	<b>60</b>	<b>10</b>	<b>40</b>	<b>25</b>	<b>100</b>

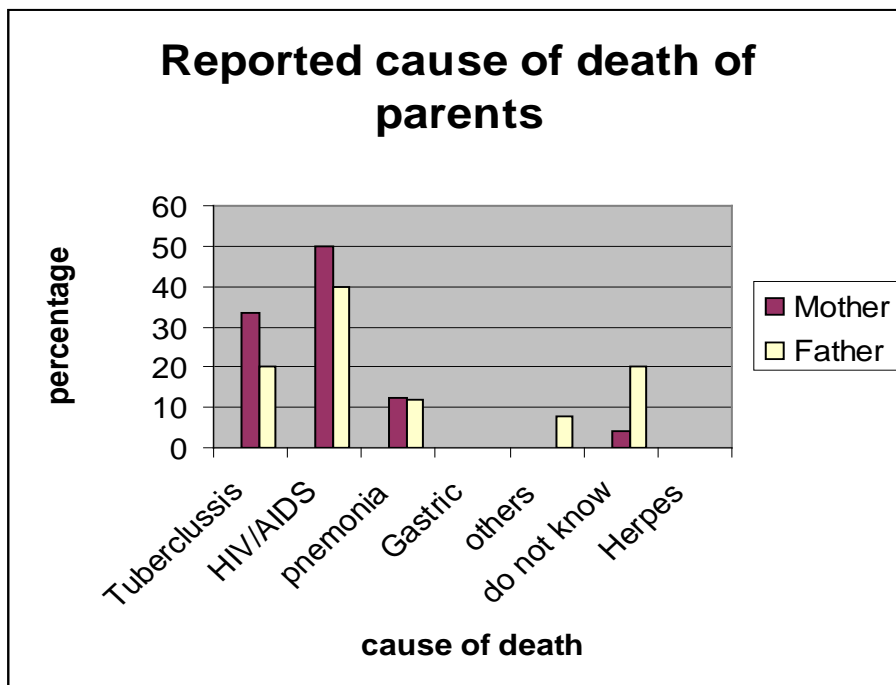
*Source: Field Survey*

#### 4.9 Reported Causes of Death of Parents

The respondents were asked to report who was deceased in the household and the possible cause of death of their parents. This can be shown in the following tables (4.9.1 and 4.9.2) and Figure 2 below.

**Table 4.9.1: Person Deceased in the Household**

Deceased in the household	Total	
	No	%
Mother only	0	0
Father only	1	4
Both father and mother	24	96
Brother	0	0
Sister	0	0
<b>Total</b>	<b>25</b>	<b>100</b>

**Figure 2: Reported Cause of Death of Parents****Table 4.9.2: Reported Cause of Death of Parents**

Cause of death/ health problem	Parents			
	Mother		Father	
	No	%	No	%
Tuberculosis	8	33.3	5	20
HIV/AIDS	12	50	10	40
Cold/pneumonia	3	12.5	3	12
Gastric	0	0	0	0
others	0	0	2	8
Do not know	1	4.2	5	20
Herpes	0	0	0	0
<b>Total</b>	<b>24</b>	<b>100</b>	<b>10</b>	<b>100</b>

*Source: Field Survey*

As shown in table 4.9.2 above, the most frequently mentioned causes of death for the mothers were HIV/AIDS (50%), tuberculosis (33.3 %), and pneumonia which is commonly known by non medical individuals cold (12.5 %). The rest, 4.2 % reported that they don't know the cause of death of their mothers. The corresponding proportions of these causes for the father were 40 %, 20 %, and 12% respectively. The remaining 20 % don't know the

cause of death of their fathers while 8 % reported that the cause of death of the fathers were others like war and accident.

These data, though very crude as it was based on opinion of the respondents, point to the fact that the major cause of death of parents of these children was predominantly related to HIV/AIDS. It has been well established that tuberculosis and pneumonia were amongst the commonest opportunistic diseases in HIV infected individuals.

### **Section 3: Organization and Community Reaction**

Under this section of the findings both magnitude and trends of children from the perspectives of the organizations and community, existing responses of care and support activities; effects of orphaning on different institutions like schools and Kebele were explored. To this effect, one representatives from Lideta sub-city HIV/AIDS Desk Office, two employees of Kebele HIV/AIDS, five members of Meskerem and Lideta Selam schools, two heads of NGOS and five members of Idir were contacted. Responses provided for issues raised were presented here below.

#### **4.10. Magnitude and Trends of OVC**

Respondents from each institution were asked to give their ideas about the magnitude and trends for children affected and infected by HIV/AIDS. Almost all of them agreed that the numbers were difficult to pinpoint, as the officials lacked accurate numbers or lacked data that was disaggregated by age or sex. However, they were confident that the trend of OVC in the sub-city, in the Kebele and schools is increasing.

The information available at each institution level largely reflects the number of OVC registered to get support from the organizations. For instance, the Kebele record at the end of April 2006 shows that there were about 340 OVC in the Kebele who got assistance through them from two organizations (Love for children supports 242, Gunet church supports 98). During this interviewing about 140 additional children were registered and waiting for support. This raised the number of children to be supported to 480.

The sub city confirmed that certain groups particularly those children whose parents and relatives are economically well and uninformed to the available services were excluded. The office acknowledges that getting the actual number of OVC and reporting remains a big

challenge. Besides, there is no well established system and manpower in place. As discussed, there were only two individuals to coordinate all issues related with HIV/AIDS in 18 Kebeles found under the administration of Lideta Sub-city.

The respondents from the organizations were also asked to describe the reasons for the increasing trend of OVC in the area. All of them linked it with the high prevalence rate of HIV/AIDS.

The reasons for high prevalence rate of HIV/AIDS in the Kebele were associated with abject poverty prevailed in the area and the current move of people from all Kebeles of the sub city to a temporary shelter built by the government and situated in the Kebele 01/18. In the areas where people were dislocated due to the current initiatives of construction of condominium houses the people living with HIV/AIDS have been given priority of getting the shelters that were fully made (the wall and the roof) from corrugated Iron sheets and situated in the Kebele. It is hoped that those who resided in these shelters will be transferred to condominium houses as soon as the construction work is over.

#### **4.11. Responses to the OVC**

There are some sporadic initiatives to support orphans and vulnerable children in the study area. Some of the institutions that provide support to orphans and vulnerable children in the study area include family, health institution, religious organizations, Idirs (burial associations), Lideta sub-city, Kebele administration, and NGOs. Some of the initiatives in the Kebele include educational support programs, psychosocial support programs, health programs, nutritional support programs, livelihood programs, and advocacy and awareness building.

The sub city that comprises 17 Kebeles plays the role of monitoring and coordinating activities through its delegates assigned in the two Kebeles. Under each Kebele the sub city has two employees working with all issues related with HIV/AIDS. The sub city has been following up activities implemented in each kebele on the basis of the guideline prepared. As informed, there is no policy on OVC. But, the government has developed a guideline that can be used by all stakeholders involved in support and care for OVC. The sub-city believes that the available response to the orphan crisis is growing, but it lacks urgency, remains unfocused and is limited in scope.

The Kebele under the study has been engaged in various activities related with OVC. The major activities include identifying eligible children for support, screening volunteers, facilitate the provision of health care, distribute grains together with NGOs and follow up the situation of children in the Kebele. The respondents in the Kebele also identified some of the problems related to the impact of orphaning on the community. Among others, family disagreement is the major one. Mostly, the husbands and the children of the caregivers do not want to welcome these orphans for it affects their lives in many ways like food shortage, sleeping place, and night clothes. There are so many cases where the kebele interferes and resolved the problem. Stigma and discrimination reported to be amongst the many problems that are faced by some of the orphans in such households.

In general, they observed that families and communities are the first line of response to the epidemic concerning orphan care. They have reacted with compassion absorbing orphans mainly within the extended family system.

## **Non Governmental Organizations**

### **1. Love for Children:**

It is a local NGO that provides services related with education, psychosocial support, advocacy and awareness raising. It depends on International Organization for funding OVC programs in the Kebele. It supports 242 OVC with food grain through the Kebele and provides other services through schools and volunteers. It also works with street children and poor mothers. This NGO has five technical staffs directly involved in the program implementation of OVC with background of Sociologist, Nurse and home economics. Under the education program, this NGO provides school uniform, cover school fees for limited number of children. This NGO did not have programs related with children aged 0-5. Psychosocial support programs like peer education, life skill training, and home visiting were also part of their programs designed for OVC. The organization also provides health related services like hygiene and sanitation, HIV prevention awareness raising, and reproductive health education. With regard to nutritional support programs they distributed only grain to OVC households in the Kebele.

The organization has identified three major gaps in the process of OVC program implementation that includes limitation of budget, targeting beneficiaries and failure to sustain some of the programs due to absence of community participation and limited capacity in terms of size and professional competence. The organization also proposed that building the capacity of the staff, involve community members, Idir leaders along with Kebele officials particularly in the selection of children entitled for support are important factors to address all problems of OVC.

## **2. Genet Church**

It is a faith based organization that runs child sponsorship project within the area under study. Its program is not only intended for HIV/AIDS orphans and vulnerable children and limited within that Kebele. The organization supports 350 children from poor families including children affected and infected with HIV/AIDS. The organization provides five types of services to OVC households and others. The types of the programs/services include educational support, health program, nutritional support, advocacy and awareness raising and others like maintenance of house and provisions of furniture. The organization covers school fees for 107 children, school uniform for 350 children and tutorial support for 147 children. It also provides spiritual counseling for all children under the program. The organization has three technical staffs directly involved in the program that are with background in accounting and “social work” as reported. The organization confirmed that there is a problem of man power in terms of size and relevance of profession. In addition to this delay in the release of budget is the other problem the organization confronted to implement the programs. The organization depends on child sponsorship as sources of fund.

The two NGOS, love for children and Genet church, did not directly address or targeted OVC. For instance, under the education program there is a tutorial support provided to girls who are academically lagging behind others. The uniform support is not also meant for OVC.

### **Schools**

Two elementary schools, Lideta Selam and Meskerem Anid (1-8<sup>th</sup> grade) were selected and discussion was made with five persons with age range 21- 45 years old. The discussants were 3 male and 2 female teachers. Three of the teachers were directly

responsible to run programs related with HIV/AIDS within the school while two are heads of schools.

Although not supported with official records the number of OVC in the schools is increasing from time to time. In fact all the OVC in the school are not belonging to the study Kebele for the schools serve other adjacent Kebeles. Both schools have been providing the following services along with formal activities of the school to OVC: Provision of uniform, educational materials support, tutorial support for girls, HIV/AIDS education, and counseling services. The financial sources for school support are NGOs working in the area. There is also a budget support from Sub-city education office. Discussion was made on the availability of selection criteria. Both schools do not have written form of eligibility criteria. However, they do have a certain standard commonly understood by all teachers and school administration for selection. Some of the common understandings include loss of parents, physical observation ( not well clothed, underfed, etc) and teachers report on the situation of a child's relation, educational performance and observation related with stress and depression. Such later information on a child is easily obtained for the system from grade one to four is self contained (a system where one teacher is expected to teach all subjects and stayed with children from grade one to four). In addition to this respondents were requested the changing roles of schools due to the presence of these children. Both schools identified the followings as impact appeared due to the presence of OVC.

- **The erratic school attendance of pupils/ absenteeism:** This is an increasing trend observed in the past years. The majority of these children are either totally absent or missed the first period of the class intended for the day.
- **Low educational performance of the majority of children:** The majority of the students perform low. As a result tutorial classes that are unusual in the educational

systems of the schools are arranged together with NGOS. In fact almost all students whose performance is very low and teachers involved benefited from the tutorial program.

- **Increased in the drop out rate of schools:** due to absence of responsible adult and problems related with food the majority of the students do not pay attention to their education and hence the majority of them dropped out or repeat classes.
- **Introduction of new extracurricular activities:** New roles of schools and teachers like running clubs related with HIV/AIDS, sexual and reproductive-health education, etc have been introduced as part of the school activities.
- **The transformation of schools into welfare institutions.** Schools are engaged in delivering uniforms, educational materials, and finance. They have been occupied with activities of soliciting fund. The respondents also said that many persons in relation to OVC come to schools either to support or to study the situation. On top of that, the school community also started initiating welfare activities.
- **Discipline:** Under normal circumstance, students are requested to bring their parents whenever they violate the school rules and regulations. Now a day, this can become a problem for some of the students. Even those who have parents occasionally started reporting that they lost both parents to escape from the school disciplinary measures.

### **Idir**

Five individuals that represent two Idirs were contacted. All individuals are male with age range of 52-65. In the Kebele there are about 15 Idirs (Burial association). Out of this only members from two Idirs were purposely selected with the assumption that this community based organizations (CBO) are implementing program related with orphan support in the study area. In principle this CBO is formed to organize funeral ceremonies

and help the family of the deceased. It also has a good death registration system and track-record of the deaths of its members and their relatives. Of note, Idirs are actively involved in HIV/AIDS prevention care and support activities in some parts of the country. However, the Idirs members contacted for the purpose of this study did not have programs related with orphans and vulnerable children. As discussed, they know that the association is quite appropriate to take up the task. But, due to financial problem they do not yet started programs related with such children. The existing practice is that the relationship with the member/s of the Idirs discontinued immediately after the death of the member/s.

## **Chapter 5: DISCUSSION OF THE MAJOR FINDINGS**

In this study the needs, problems and responses to the situation of AIDS orphans and other vulnerable children were assessed. From the study it was found that the needs and problems of OVC households are multifaceted and complicated.

A large proportion of guardians that take care of these OVC in the community under study are either too young or too old to care adequately for the children's material or psychological needs. The study shows that 50 % of the guardians are below age 18 and above age 60 (table 4.1.1). There are cases of exceptional stress that include grand parents who are left with the offspring of their deceased children; young surviving siblings caring for younger brothers and sisters; and orphaned children experience the death of a second set of elderly or sickly foster parents.

The extended family support network systems plays the role of caring for either through changes in household composition, with relatives moving in to households to care for survivors or orphans moving out into one or more relatives' households. These orphaned children are forced to live either with foster parents, grandparents, and other relatives or live alone in child-headed households. New heads of family are brought into being due to AIDS. Child headed families in the study area constitutes 20% (table 4.1.8). The majority of the orphans were placed into a household with large family size and living in single or two rooms. The study found that 90 % (table 4.3.5.1) of the respondents live in a single and two room houses.

As the study shows the highest numbers of the respondents earn their income from other sources that include support from NGOs, begging and house rent. It implies that the already poor families and communities that need support for them have been taking care of the orphans. Households with orphans are more likely to become poorer because of the

increased dependents. In the studied households adults are sustaining an average of two orphans (table 4.1.3). In the other way taking in a child has an impact on the households in terms of space (rooms) and share of income of the already poor households.

The World Bank estimates of per capita income for Ethiopia is an even lower of \$ US 100-110. One third of the population must struggle to make do with less than \$1 per day which is Birr 8.83 with current exchange rate during this study. Considering the average income of the OVC household, which is Birr 157.40 per month (table 4.2.1.3) and the approximate number of two OVC that must be supported by the household (table 4.1.3) it can be said that this children are living in an absolute poverty situation at the time of this survey, meaning that were unable to secure even the basic minimum needs for survival when dividing Birr 157.40/30days/3 household members (including head of the household and excluding other members) that equals to Birr 1.75 per day per person.

In terms of facilities, most of households surveyed had access to potable water and toilet services. However, majorities of the households do not have tap water and toilet in their dwellings. The largest group, 82 % gets tap water from communal tap and neighbors. Similarly, 70 % of OVC households use communal pit latrine (Table 4.3.1 and Table 4.3.2). Both orphaned and vulnerable children in this study suffer from a lack of basic needs such as clothing and food in their new household environment. Nearly 68 % of the orphans reported that they have problems of clothing both for the day and the night. They did not have shoes, blankets, clothes rather than uniform for schools. Similarly, 56 % of orphans and vulnerable children confirmed that they have got food from both their guardians and service giving organizations though the quality and quantity of food is reduced too much as compared with their previous life they had with deceased parents. The rest 44 % confirmed that they did not get sufficient food. It was found that 62 percent (table 4.2.1.4) of the households have at

least three meals per day. The type of meals may be bread, roasted grain or *Injera* (*staple food of Ethiopians*) with *Shiro* (Ethiopian sauce made from peas, vetch or horse beans) depending on the income. In the same context 30 percent of the households reported that they were less likely to have access to such categories/ frequencies of meals (breakfast, lunch and dinner). They responded that they eat food as available depending on their daily income. There are days bypassed without eating. One may question the quality of the data collected through the sample survey such as this one since some of the responses may be subjected to misreporting due to children's and caregivers expectations of some kind of assistance. However, examination of the information collected from organizations involved supported most of these findings. There is always a mismatch between the number of children and the available resources. In addition to this for most of the organizations are largely depending on the external resources to execute their projects, the programs that have been designed towards supporting the orphans and vulnerable children are more of the reflection of the interest of the donors and not the need of the orphans. Hence, problems related with clothing are noticeable and no organizations have an interest to support in this regard. The health care system and provision of schools seems sufficient for a large number of the families. Participation of the organizations in these particular areas is generally good. However, most of the children were totally absent or missed the first period of the class, perform low and do not pay attention to their education and hence the majority of them dropped out or repeat classes. This in turn has an impact on the education system in general and necessitates the schools to engage in other extra services like soliciting of fund, counseling and sexual and reproductive-health education.

The most common unmet needs of these OVC households are food and clothes. This might be attributed to absence of a system and organization that directly involved in the

service provisions of feeding and clothing. The existing trend is distribution of grain to OVC households.

Similarly, the psychological welfare of the children in this study depends in many ways on both the composition of the household and the community they are in. Orphaned children may find their environment unpredictable and constantly changing. Following the death of their parents' orphans often suffer from several psychosocial problems such as stress, depression, discrimination and neglect. To confront the situation they need some kind of support either from the community, caregivers or the organizations working for them and with them. In this regard it is possible to say that the children did not get the appropriate support. In the study area, all the organizations do not have the counseling programs intended for both the caregivers and OVC. Some caregivers did not discuss about the cause of death and even the death of parents. Although people in the community are not in a position of fulfilling the financial support to OVC households due to abject poverty at least they show love and care for the OVC households. Most of them confirmed that the neighbors share both sorrow and happiness. In fact, in the schools contacted they tried to provide counseling with untrained teachers in relation to their education. Some of the organizations have programs of visiting homes of people living with HIV/voluntary services through trained volunteers. However this program of volunteers is not extended to assess the needs of OVC and their guardians.

Different patterns of coping mechanisms exist within families depending on whether the father or the mother is sick or dies. The extended family system remains to be the major survival support for orphaned children in the study area as clearly shown in the sample survey. Nearly, 92 % including child headed (table 4.1.8) were residing with their relatives. As discussed with Kebele, some of the families sold the wheat grain and edible oil given to

them and tried to purchase cheap grains like maize to feed all family members. In addition to this, some of the households used the money they got from sale of support to run the petty trades in the area. In addition to this some of the children engaged in activities that produce additional income to the family.

## **Chapter 6: CONCLUSION AND RECOMMENDATION**

This study has an important contribution in filling some literature gaps available in the areas of orphan and vulnerable children. From the major discussions made orphan and vulnerable children have many problems related with shelter, food, and clothing. The study revealed that the extended family remains the principal support for orphaned children in the study area. However, this traditional system that exists for a long period of time is being overstretched in the light of the ever-increasing number of orphans as well as the very limited economic abilities of the community. The emergence of the new child headed households is an implication of such results rather than urbanization that result in heterogeneous community. The existing interventions in support of orphans and vulnerable children are not yet well developed in the study area. One is, because of the existing traditional family structure that absorbs these children and the other is scarcity of resources and limitation of capacity to design and implement a viable program to meet the demands of these children.

For the purpose of this paper attempt will be made to recommend some points that pave way for social work practices on the basis of this research findings. It is believed that these recommendations are practical to Addis Ababa in general and to the study area in particular. Therefore, the followings will be recommended:

**6. 1. Strengthening the care and coping capacities of families and communities (fostering):** The first line of response to the needs of children affected by HIV/AIDS comes from extended families. Strengthening the capacity of communities to fill the widening gaps in the safety net traditionally provided by the extended family may be the most efficient, cost effective, and sustainable way of assisting orphans and other vulnerable children. This has to be strengthened through financial and training of various sorts. Families and communities

also play a crucial role in identifying children who are most in need, both those affected by HIV/AIDS and other vulnerable children. In the culture of the majority of the population, upbringing children of relatives is common practice. The existing practice in this regard showed that most orphans are residing with their grand parents, uncles and aunts. Strengthening this practice allows children to be better integrated into society than they would be had they placed in an institution.

**6.2. Emphasizing community care rather than Institutional care:** Article 36 of the Ethiopian constitution emphasized institutionalization. It says that “the state shall accord special protection to orphans and shall encourage the establishment of institutions which ensure and promote their adoption and their welfare, and education.” In fact in the absence of alternatives it might be a good solution. However, institutionalization of children in orphanages and other facilities is not a desirable solution to the impacts of HIV/AIDS. This is due to the magnitude of the problem that demands huge construction funds and manpower to manage the programs. Apart from this, resources expended to fund institutional care for a single child can assist a considerable number of children if used effectively to support a community based initiative. The institutionalization of children separates them from families and communities and often delays childhood development. In almost all communities deeply affected by the HIV/AIDS pandemic, there is some form of community responses emerging here and there by benevolent individuals. This initiative requires strengthening, continuous support, and more systematic mobilization. In order to establish and sustain real change, it is critical to expand the community’s direct involvement in the decisions that will impact the lives of its members, and to develop the organization strength of local committees, structures and community based organizations (religious institutions, Idir (funeral association), etc). Therefore, mobilizing communities and strengthening community capacity for care and

support is the foundation for sustainable responses to the needs of children infected and affected by HIV/AIDS.

**6.3. Providing Psychosocial support to affected children and their care Givers:** The psychological needs of children and their care givers continue to be one of the most neglected areas of support. Psychological support can be rendered using group approaches, peer support and individual counseling. When parents or caregivers become ill, children drop out from school in order to work and earn income and support the families. They also care for sick family members. In most of the areas children are struggling to survive on their own in a child headed households, while others are forced to live on the street. Orphan children are socially marked. They experience social isolation and discrimination as people suspect, through association, that they are also HIV positive. In the findings, it is found that the OVC households do not have a place to go for counseling or advice. Therefore, providing counseling services in home and school environment is found essential.

**6.4. Strengthening Young people's life and survival skill:** In the absence of parental guidance and support, adolescents and young people are forced to take on responsibilities for which they may not prepare. Training young people to cope with such demands is essential. Vocational training and apprenticeship are also key to enhance their ability to generate income as well as to play adult role.

**6.5. Ensuring protection of orphans and other vulnerable children through improved policy and legislation:** Appropriate government policies are essential to protect orphans and other vulnerable children and their families. These policies must contain clauses to prohibit discrimination in access to medical services, education, employment, and housing, and protect the inheritance rights of orphans.

**6.6. Family tracing:** This will serve certain groups of OVC like street children, orphans who have relatives in the other parts of the country, etc. Introducing such type of program helps to overcome the problem of children particularly of some of child headed.

**6.7. Independent living homes:** Child heading families are emerging due to HIV/AIDS. These children do not want to be under the care of adult relatives for they are already started living independently due to death of parents. From the theory of developmental stages, according to Erik Erickson, a child is trying to determine his/her own identity at this age. He/she is separating emotionally from his parents and from other adults. Since majority of them are young enough to live independently, it is important to provide care and support for this group of children.

**6.8. Including the issue of OVC as a development Agenda:** The implication of having many orphans and vulnerable children is obvious for those involved in implementation of various development agenda. The government offices found at each level, community based organizations, local NGOs should be incorporated the issue of OVC as part of their development program.

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## Annex 1. Questionnaire

### Addis Ababa University Graduate School of Social Work

#### I. Interview Guide to be used with head of OVC household

**Introduction:** Good morning/afternoon. “My name is....I am a social work student at Addis Ababa University. I am interviewing people here in Lideta area in Kebele 01/18 in order to find out about the situation of OVC.” We would like to discuss issues both with you and one of the children living with you.

**Confidentiality and Consent:** “I am going to ask you some very personal questions that some people find difficult to answer. Your answers are completely confidential. Your name and household members will not be written on this form unless willing, and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand the circumstances that many people are living with, and we will use the information to create better support programs. We would greatly appreciate your help in responding to this survey. The survey will take about an hour to ask the questions. Are you willing to discuss with me? (If No, thank them for their time and explain that you can not interview them)

#### Part 1: Background Questions for Guardians/ Parents of OVC

##### A. Respondent Identification

1. Interview Code \_\_\_\_\_
2. Region \_\_\_\_\_ Sub-City \_\_\_\_\_ Kebele \_\_\_\_\_
3. Sex of the Respondent: \_\_\_\_\_

**Note: The interviewer shall complete question No. 1, 2, and 3 without asking the respondent.**

Name of the household (ask for consent ) \_\_\_\_\_

Duration of stay in the area/Kebele \_\_\_\_\_ (in years)

Date of Interview: \_\_\_\_\_

**B. Personal and family situation**

4. How many people usually live in your household? \_\_\_\_\_ No. of adults (19 and above) \_\_\_\_\_

Please indicate the relationship and approximate age of adults who live in your household:

Adult No.	Relationship to head		
_____	<u>Of household (HHH)</u>	<u>Sex</u>	<u>Age</u>
Adult # 1	_____	_____	_____
Adult # 2	_____	_____	_____
Adult # 3	_____	_____	_____
Adult # 4	_____	_____	_____

Please indicate the relationship and approximate age of Children who live in your household:

Child No.	Relationship to head		
_____	<u>Of household (HHH)</u>	<u>Sex</u>	<u>Age</u>
Child # 1	_____	_____	_____
Child # 2	_____	_____	_____
Child # 3	_____	_____	_____
Child # 4	_____	_____	_____

5. **Age of the respondent:** \_\_\_\_\_

6. **Marital status:** (1) Married (2) unmarried (3) Separated (4) Divorced (5) Widowed

7. **Level of Education:** (1) Do not have basic education (2) Read and write (3) 1<sup>st</sup> Primary Cycle (1-4) (4) Second primary level (5-8 ) (5) High school (9-10) (6) other (specify) \_\_\_\_\_

8. **Religion:** (1) No religion (2) Orthodox (3) Catholic (4) Protestant (5) Muslim (6) Traditional (7) other (specify) \_\_\_\_\_

9. **Ethnic group:** \_\_\_\_\_

## Part II. Household Economic status and livelihood

### Income:

10. **Sources of Income:-** (1) No source of income (2) Civil servant (2) Trading (3) Daily labor work (4) Relatives (5) Pension (6) Other (specify)\_\_\_\_\_
11. **Other household members earned money (number):** from regular employment: \_\_\_\_\_ From piece work:\_\_\_\_\_
12. **Estimated Average monthly income of the household earned by all members of the household:** \_\_\_\_\_(write amount)
13. **Frequency of meals/ day for all household members :** (1) at least three times a day (2) at least two times a day (3) at least once a day (4) Others (specify)\_\_\_\_\_
14. **Household economic status compared with other household (Probe for opinion):** (1) Better (2) above average (3) Average (4) Below average (5) Poor

### Expenditure:

15. How much was your monthly expenditure for food before you take in the child?  
Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; more than 701 =5; I am living with my parents =7
16. How much is your monthly expenditure for food at present?  
Below Birr 100 = 1; 101-300 =2; 301-500 =3; 501-700 =4; more than 701 =5; it is the amount I receive from NGO =6;  
(Probe if the head of the household felt the trend (increase or decrease or same ) of monthly expenditure on food )

## Part III. Availability of facilities and services

17. What is your source of access to water?  
Tap water in the dwelling = 1, Public/communal tap = 2, Tap water from neighbours = 3, Other =4
18. Do you have toilet?  
Yes =1; No =2
19. If the response for question 18 is yes, what kind of toilet facility is used by the family?  
Flush toilet private =1, Flush toilet, communal =2, Pit latrine private =3, Pit latrine communal =4

20. If your response to question 18 is no, how do you use toilet?  
Public toilet in different places =1; in hotels around =2; open area =3; use festal/plastic and throw it some where =4
21. Where do you get health services?  
From government hospitals/clinics = 1, From private = 2, From traditional healers = 3;  
1&2 =4
22. Are you satisfied with the health services you are getting?  
Yes = 1, No = 2
23. If the answer for question 22 is no, why?  
It is unaffordable = 1, It is Poor quality =2, Doctors do not treat properly = 3, all = 4; the queue is boring =5
24. Do you have electric power in the dwelling?  
Yes = 1, No = 2; Other =3
25. What do you use for cooking?  
Electricity = 1, wood = 2, Charcoal = 3, Kerosene = 4, 2 and 4 =5; 3 and 4 = 6; do not cook =7
26. Do you own or rent this house?  
Own =1, Rent= 2
27. If rented, from whom?  
Rented from kebele=1, Rented from private=2 , Dependent= 3, other=4 (please specify)  
\_\_\_\_\_
28. If rented, how much is paid monthly? \_\_\_\_\_
29. Number of rooms of the house:- (1) one (2) two (3) three (4) four (5) more than four
30. Record main material the house made from (*ask only if you are not sure*)
- Material of the floor:\_\_\_\_\_
  - Material of the wall:\_\_\_\_\_
  - Material of the roof:\_\_\_\_\_

**Part IV: View of OVC households towards the Community**

31. How long have you lived in this community?  
< 1 year =1, 1-5 years=2, 6 years or more=3, all my life=4

32. Do you anticipate moving from this community in the next 2-3 years?

Yes=1, No=2

33. If yes, why ? \_\_\_\_\_

\_\_\_\_\_

34. Do you agree or disagree with the following statements? (probe the reason if disagree with the statements)

- This is a supportive community for OVC households. Agree=1, Disagree=2
- People in the community do not share the same values. (Some are supportive and some are not) Agree=1, disagree=2
- People in the community are intervene in fulfilling emotional support to OVC  
agree=1, Disagree=2
- People in the community are intervene in fulfilling financial support to OVC  
agree=1, Disagree=2
- People in the community are protecting OVC girls from being harassed  
Agree=1, Disagree=2
- People in the community show love and care for OVC.  
Agree=1, Disagree=2
- People in the community appreciate/encourage you for your assistance to OVC  
Agree=1, Disagree=2

35. If your household needed help, like with money or food, are there people beyond this household, besides relatives, from whom you could get assistance?

Yes=1, May be=2, No=3 don't know=4

#### **Part V: Psycho-social issues**

**Note:** (For families, who have not taken in other children, ask about their own children.)

36. How happy are the children you have taken in, compared to other children their same age?

Happy, happier=1, The same, sometimes happy, sometimes not=2, Somewhat unhappy, less happy =3 Very unhappy, sad=4

37. Are there any major conflicts between the children you have taken in and other children?

Yes=1, No=2

38. Who do they have these conflicts with?

Their brothers and sisters=1, other children in the household=2, Neighborhood children=3, their school mates=4, other=5\_\_\_\_\_

39. What are the common causes for these conflicts?(DO NOT read the list. Circle 1 if item is mentioned.

Probe: "Anything else?"

House work=1, Jealousy=2, Fighting over snacks=3, wanting attention=4, Ownership of clothes=5, Ownership of household items=6, other=7\_\_\_\_\_

40. How often do these conflicts happen?

Daily=1, every other day=2, Once a week=3, Once a month=4,  
Other=5\_\_\_\_\_

41. What do you do about them? (DO NOT read the list. Circle 1 if item is mentioned.

Probe: "Anything else?"

Scold the children=1, Punish the children=2, Talk with the children=3, Separate them=3,  
Consult with the school=4, Other=5\_\_\_\_\_

42. How well do the children you have taken in get along with your own children?

Very well=1, Somewhat well=2, Somewhat poorly=3, Very poorly=4, Do NOT have biological children=5

43. With whom do the children you have taken in spend most of their time? (Relationship to child),

The guardian=1, The guardian's husband/wife/=2, relative=3, Step- Foster-siblings=4,  
Friends, cousins, other children=5, own biological brothers and sisters= 6 no one, keeps to him or herself=7, Other/specify:\_\_\_\_\_

44. With whom do the children you have taken in usually talk with when they are worried or have a problem? (Relationship to child)

The guardian=1, The guardian's husband/wife/=2, relative=3, Step-, Foster-siblings=4,  
Their own brothers or sisters =5, Friends, cousins, other children=6, Some other adult relative not living with them=7, School teacher=8, religious leaders=9, No one, keeps to him or herself =10, Other==11:\_\_\_\_\_

**Note: Ask the following only if one or more parents have deceased. If both parents are alive, skip to 52**

45. Do the children who you have taken in know what caused their parent (s)' death?

Yes=1, No=2

46. Do they ever talk with anyone about their deceased parent (s)?

Yes=1, No=2

47. When they do talk about their parent (s), who do they talk with?

The guardian=1, The guardian's husband/wife/=2, relative=3, Step-, Foster-siblings=3,

Their own brothers or sisters =4, Friends, cousins, other children =5, Some other adult relative not living with them=6, School teacher=7, Religious leaders=8,

Other=9: \_\_\_\_\_

48. Have you ever talked with the children about the death of their parent(s)?

Yes=1, No=2

49. How often in the previous 6 months have you talked with the children about their deceased parent(s)?

Daily=1, Weekly=2, Monthly=3, Only one time=4, Other=5: \_\_\_\_\_

50. When was the last time you talked with the children about their deceased parent(s)?

Today=1, Yesterday=2, This week=3, Last week=4, Two weeks ago=5, Last month=6  
More than a month ago=7

51. Has either of the parents been seriously ill? (If neither parent has died nor been seriously ill, skip)

Yes=1, No=2

52. How has the illness or death of their parent(s) effected the children's daily life

(circumstances, etc.) if at all? DO NOT read the list. Circle 1 if item is mentioned.

Their school attendance has declined/stopped=1, their grades have worsened=2, they do more house or field work=3, they have to take care of smaller children =4, they have to take care of a living parent=5

We have less food/money as a family=6, it has not affected their life circumstances=7,  
other=8: \_\_\_\_\_

53. What is difficult about taking in other children?

It gets hard financially=1, There is less food to go around=2, some children can't go to school=3, I have no time to rest=4, Too much pressure=5, Health problem of guardian =6, Other=7: \_\_\_\_\_

What motivated you to take in the child ? \_\_\_\_\_

54. How do you generally feel about your current situation?

Generally good=1, fair=2, Not good=3

55. How do you generally feel about your future especially about your options for survival going forward?

Generally good=1, fair=2, Not good=3

56. What kind of help/support do you need?

Medical care=1, Food=2, Support for the children's school fees=3, Clothing=4, Someone to talk with=5, Someone to watch the kids for me from time to time=6, Training or education=7, Other=8: \_\_\_\_\_

## **Part VI: Intervention coverage**

### **A. Psychosocial**

57. Do you have a person that you feel you can go to when you have a problem and need advice?

Yes=1, No=2

58. Who do you consult for advice with problems? \_\_\_\_\_

59. How often have you sought advice in the past 3 months when you had a problem? \_\_\_\_\_

60. In the Kebele, volunteer care givers can provide a variety of different services, such as helping with household tasks or providing referrals. Has a volunteer caregiver been assigned to your household?

Yes=1, No=2

61. If yes, how often in the past 3 months has the volunteer caregiver visited your household ? \_\_\_\_\_

62. What type of assistance does/did the volunteer caregiver provide to your household?  
None=1, medical care=2, medical care to children=3, counseling to adults=4, counseling to children =5, advocate for children's rights=6, health education=7, income generation=8, food assistance=9, household chores=10, others (specify)\_\_\_\_\_
63. Of the types of assistance you identified, which one has been the most helpful to you and/or your household?  
None=1, medical care=2, medical care to children=3, counseling to adults=4, counseling to children =5, advocate for children's rights=6, health education=7, income generation=8, food assistance=9, household chores=10, others (specify)\_\_\_\_\_

### **B. Income Generation**

64. Has anyone in this household ever received training with the intention of increasing the income of the household?  
Yes=1, no=2
65. If yes, who participate in the training?\_\_\_\_\_
66. What types of training has been provided?\_\_\_\_\_
67. Who provided the training? (Please mention the name)\_\_\_\_\_
68. Has participation in the training led to any increase in income for the household?  
Yes=1, No=2
69. Does the person who received the training continue to use the skills learned in the training? Yes=1, No=2

### **C. HIV/AIDS Prevention**

70. Have you ever heard about how to protect yourself from getting HIV/AIDS?  
Yes=1, No=2
71. Have you received any information about how to protect yourself from getting HIV/AIDS in the last 3 months?  
Yes=1, No=2
72. If yes, from whom/where?\_\_\_\_\_

### **D. Food**

73. Has anyone from outside of your household assisted your household by giving you food?  
Yes=1, No=2

74. If yes, who provided you with food assistance? (Circle all that apply)

Church=1, Mosque=2, Idir=2, Relatives( indicate)=3, NGO (name it)=4, others(specify)

\_\_\_\_\_

75. What type of food assistance have you received? \_\_\_\_\_

76. How many times did your household receive food assistance in the past 3 months?\_\_

\_\_\_\_\_

### **E. Legal Rights**

77. Under the law, children have some basic rights, can you think of some examples of rights that children have? (do not read out choices- circle all that are mentioned)

Children have no right=, Right to safety=2, right to health (food and free from disease)=3, right to education=4, right to inheritance=5, right to be free from physical and sexual abuse=6, Others (specify)\_\_\_\_\_ =7, don't know=8

78. What are instances where a child's rights have been violated or ignored? (do not read out choices-circle all that are mentioned)

Property grabbing=1, exploitative labour=2, sexual abuse=3, physical abuse=4, violence=5, banned from attending school=6, other, specify=7\_\_\_\_\_

### **II. Interview Guide to be used with Child residing in the Household aged 10 and above**

1. Age

10-14 = 2; 15-18 =3

2. Sex

Male = 1, Female = 2

3. Level of education

No formal education =1, 1-8=2, 9-12=3, 12+=4; Other/specify \_\_\_\_\_

4. Are you in school currently?

Yes = 1, No = 2; Other/specify \_\_\_\_\_

5. If your answer for the above question is no, why?

Drop out because could not pay school fees = 1, Could not afford to buy uniforms and learning materials = 2, To care for the sick family member =3,

To care for younger siblings = 4, Fear of stigma in school = 5,

Other/specify = 6\_\_\_\_\_

6. Your housing condition?

Privately owned=1, Rented from Kebel=2, Rented from private individual =3, Shared house with others =4; Other/specify =5 \_\_\_\_\_

7. Who is responsible to care for you now?

Father=1, mother=2, Self=3, grandmother=4, Grandfather=5, aunt=6, uncle =7, elder brother=8, elder sister=9, Neighbors=10, Parent's friends=11, other/specify=12\_\_\_\_\_

Do you know your present guardian before the death of your parent/s

Yes=1, No=2

8. What is source of income/what does your caregiver do for a living?

Civil servant =2; sale Tela/Enjera/Araki/rent bed etc. =2; house maid =3; driver =4; assistant for driver =5; daily laborer =6; sex worker =7; waitress in Bar/hotel, etc. =8; Pensioned = 9; No job = 10; Other =11

How much is your monthly income?

Below 100 Birr =1; 100-300 =2; 301-500 =3; 501-700 =4; 701-900 =5; 901-1000 =6;

Greater than 1000 Birr =7; Do not know = 8

9. Who was deceased in the household?

Mother=1, Father=2, Both=3, Brother =4, Sister =5, 2 & 5 = 6; 2&4 = 7;

1&4 =8; 3&5 = 9

10. If your response for the above question is mother, when did she die?

Before one year =1, Before 2 years = 2, Before 3 years = 3, Before 4 years = 4, Before 5 years = 5, Before 6 years=6, Before 7 years=7, Before 8 years =8, before 9 years =9; before more than 10 years =10

What was her health problem?

Tuberculosis =1; HIV/AIDS =2; Cold =3;Gastric =4;other =5 do not know =6; Herpes= 7

11. If your response for question No. 10 is father, when did he die?

Before one year =1, Before 2 years = 2, Before 3 years = 3, Before 4 years = 4, Before 5 years = 5, Before 6 years=6, Before 7 years=7, Before 8 years =8, before 9 years =9; before more than 10 years =10

What was his health problem?

Tuberculosis =1; HIV/AIDS =2; Cold =3; Gastric =4; other =5; do not know =6

12. If your response for question 10 is brother, how old was he?

below 5 =1; 5-10 = 2; 11-14 =3; 15-19 =4; 20-24 =5; older than 24 =6

when did he die?

Before one year =1, Before 2 years = 2, Before 3 years = 3, Before 4 years = 4, Before 5 years = 5, Before 6 years=6, Before 7 years=7, Before 8 years =8, before 9 years =9;

before more than 10 years =10

what was his health problem?

Tuberculosis =1; HIV/AIDS =2; Cold =3; Gastric =4; other =5; do not know =6

13. If your response for question 10 is sister, how old was she?

below 5 =1; 5-10 = 2; 11-14 =3; 15-19 =4; 20-24 =5; older than 24 =6

when did she die?

Before one year =1, Before 2 years = 2, Before 3 years = 3, Before 4 years = 4, Before 5 years = 5, Before 6 years=6, Before 7 years=7, Before 8 years =8, before 9 years =9;

before more than 10 years =10

what was her health problem?

Tuberculosis =1; HIV/AIDS =2; Cold =3; Gastric =4; other =5; do not know =6

14. What are the major problems you are facing at present?

Financial = 1, Lack of family love =2, Housing = 3, stigma and discrimination = 4, 1 &3 = 5; no problem =6; 2&4 =7; 1&2 =8; 1,2&3= 9

15. What was your parent's income before being affected by HIV/AIDS?

Less than Birr 100= 1, Birr 101-200 = 2, Birr 201-600 = 3, Birr 601-1000 = 4; Birr >1000 = 5, Daily laborer =6; not known = 7

16. Do you get sufficient food? (do you feel that you are well fed)

Yes = 1, No. =2;

As compared with before death of parent/s, does the supply of food decrease, increase or has not changed?

Decreased =1; Increased =2; Not changed = 3

If it is decreased, how?

By quantity = 1, By quality = 2, 1&2 = 3

17. How do you get your food ?  
by working to feed my self=1; Supported by agencies=2; provided by family members=3;  
begging=4; Others (specify)\_\_\_\_\_
18. Do you get sufficient clothing? ( ask for both day and night clothing)  
Yes = 1, No. =2;  
As compared with before death of parent/s, does the supply of clothing decrease, increase  
or has not changed?  
Decreased =1; Increased =2; Not changed = 3  
If it is decreased, how?  
By quantity = 1, By quality = 2, 1&2 = 3
19. Do you get sufficient health care?  
Yes = 1, No. =2;  
As compared with before death of parent/s, does the health care decrease, increase or has  
not changed?  
Decreased =1; Increased =2; Not changed = 3
20. Are you engaged in income generating activities?  
Yes =1, No = 2
21. If your answer for the above question is yes, why?  
There is no income after parents death = 1, Income is not enough to cope with = 2,  
Caregiver needed me to work = 3, Responsibility for siblings = 4, 1, 2, and 4 = 5
22. Do you get assistance from government?  
Yes =1, No = 2
23. If your response to question no. 22 is yes, what kind of assistance do you get?  
Financial =1; Home base care =2; Medical assistance =3; Assistance in kind (such as food  
and clothing) =4; Other, specify =5
24. If you get financial assistance from government, how much is it?  
50 Birr =1; 75 Birr =2; 100 Birr =3; 150 Birr =4; 200 Birr =5; more than 200=6
25. Do you get assistance from NGO?  
Yes =1, No = 2

26. If your response to question no. 29 is yes, what kind of assistance do you get?

Financial =1; Home base care =2; Medical assistance =3; Assistance in kind (such as food and clothing) =4; Other, specify =5; 1& 4 =6

27. If you get financial assistance from NGO, how much do you get?

50 Birr =1; 75 Birr =2; 100 Birr =3; 150 Birr =4; 200 Birr =5; more than 200=6

28. Do you get assistance from neighbors?

Yes =1, No = 2

29. If your response for question 28 is yes, what kind of assistance do you get?

Financial =1; Home base care =2; Medical assistance =3; Assistance in kind (such as food and clothing) =4; Other, specify =5

30. Is your family member of Iddir?

Yes =1, No = 2

31. If your response for the above question is yes, do you get assistance from Iddir?

Yes = 1; No = 2

32. If your response to the above question is yes, what kind of assistance?

Financial assistance = 1; Assistance in kind such as food and clothing = 2; Payment for housing = 3; For medical =4; Other/specify = 5

33. If your response for the above question is financial assistance, how much do you get?

Less than 100 Birr = 1; 101-200 = 2; 201-300 = 3; 301-400 = 4; 401-500= 5

>500 =6 ; Other/specify

34. AIDS orphans are said more likely to be abused and engaged in deviant acts and behaviors, is it true?

Yes = 1, No. =2

35. If your answer for the above question is yes, what is the reason?

Due to lack of income as a coping mechanism/means of survival = 1

Due to lack of parents care = 2

Due to social exclusion and discrimination = 3

Due to lack of social welfare system in the country = 4

All = 5; 1 & 2 = 6

### **III. Organizations**

#### **3.1. In-Depth Interview Guide for Use with Government Officials**

Explain the purpose of the study

Name of Respondent \_\_\_\_\_ Title \_\_\_\_\_

1. Who is regarded as an orphan by your organization? Explore for children's age, dead parent's sex, and so on.
2. Where does the definition of an orphan come from (e.g., national legal definition, developed by the organization)?
3. Who is regarded as a needy child?
4. How do families respond to the needs of orphans and other vulnerable children in this community (e.g., parental care, shelter, education, clothing, health care)?
6. Has this always been the practice or has it changed? If it has changed, what do you think has caused the change?
7. Do you think HIV/AIDS has affected the situation of orphans and children in need?
8. In what ways has HIV/AIDS affected the situation of orphans and children in need?
9. What other categories of children are in greatest need of support in this sub-city? (e.g., street children, child beggars, and child prostitutes). Explore the reasons for each category mentioned.
10. What are the specific policies of the state government regarding children in these categories? Are these written policies? (Request copies where available). Note when policies were enacted.
11. Is there a specific policy for OVC, or needy children? If not, are there plans in the future?
12. What efforts and measures are in place to ensure effective implementation and monitoring of existing policies?

13. What programs does your organization have in place to support these children? (Explore for the type and location of programs, categories of children, age range of beneficiaries, and criteria for selection). Is there any collaboration with NGOs/charitable organizations?
14. What are the successes of these programs?
15. What are the limitations of these programs?
16. Explore how limitations can be addressed (i.e., adequacy, coverage, and sustainability).
17. What contribution can your organization make to address issues affecting orphans and other vulnerable children in this sub city?
18. What assistance would your organization need to address issues related to each of these categories of children? Explore specific areas (e.g., planning, technical support, capacity-building, logistics, and funding).
19. What should be the role of the government, NGOS, religious institutions and the community; with regard to the main problems of OVC households affected by the epidemic?

Thank you,

### **3.2. Questions posed to Kebele 01/18 employees working with OVC**

1. What is the size of the population in the kebele?
2. What are the major means of livelihood of the people in this area?
3. How many OVC are there in the kebele? What is the trend looks like ? (increase/decrease)
4. What is the role of the kebele in the prevention and control of HIV/AIDS?
5. When did it start working on HIV/AIDS?
6. Does the kebele give assistance to HIV/AIDS affected households, individuals and orphans?
7. If the answer for the above question is yes, what kind of support do you give and what are the basis to be eligible for support?
8. Are there HIV/AIDS affected individuals who disclose themselves and request assistance in the kebele?
9. If the answer for the above question is yes, how many applied?
10. What should be the role of the government in caring for OVC ?
11. What should be the role of the religious institutions in caring for OVC ?

12. What should be the role of the community based organizations such as Iddirs and Eqqubs in supporting this group of children?
13. What should be the role of NGOs the protection and care of OVC?
14. Do you have a guideline to follow up the programmes intended for OVC (ask for copy) ?
15. What are the major problems of the Kebele, which hinders its activities?
16. Does the existence of OVC have an impact on the community? (please mention if any)
17. What do you propose to overcome the problems of OVC in the Kebele
18. Additional Comment if any?

Thank You

### **3.3. Institutional/Organizational Questionnaire**

Purpose of the Information; the purpose of the information collection is to map out programs and services that address the needs of orphans and vulnerable children (OVC) and use it in the study to be conduct impartial fulfillment of Masters in Social Work.

The information that will be collected through this questionnaire will be summarized and reported in general terms.

Your organization is chosen to participate in the study because of your involvement in the support of OVC. So, I am trying to learn more about how your organization is operating in delivering services to OVC.

The survey is a confidential exercise and therefore, particular information will not be disclosed in the final report. Please be comfortable to provide accurate information to the best of your knowledge.

1. Background Information

Name of the organization \_\_\_\_\_

Type of organization: \_\_\_\_\_

Location: Sub City \_\_\_\_\_ Kebele \_\_\_\_\_ Telephone \_\_\_\_\_

Contact person: \_\_\_\_\_

2. Operational Definition and population of OVC

Orphan: \_\_\_\_\_

\_\_\_\_\_

Vulnerable Children: \_\_\_\_\_

\_\_\_\_\_

Estimated number of OVC: Male: \_\_\_\_\_ Female: \_\_\_\_\_

3. Programs or services or activities to OVC (circle all that is appropriate)

Educational Support=1,  
 early childhood development=2,  
 Psycosocial support programmes=3,  
 health program=4,  
 nutritional support programmes=5,  
 livelihood programmes=6,  
 advocacy and awareness raising=7,  
 housing and shelter=8,  
 other (specify) \_\_\_\_\_

4. Sources of funding (please indicate all type of funding organizations in 2005) for OVC programmes

1. INGO 2. LNGO 3. community contribution 4. Eth. Government 5. Child sponsorship 6. Private donor from Ethiopia 7. Private donor from abroad 8. membership contribution 9. others (specify) \_\_\_\_\_

5. Technical staffs directly involved in the implementation of OVC program/service (exclude management and support staff) by sex and professional background: Total \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_

Profession:(please list down) \_\_\_\_\_

6. Age category of OVC supported by your organization

No.	Age category	Male	Female	Total
1	0-5 years			
2	6-9 years			
3	10-14 years			
4	15-18 years			
5	Above 18			
	Total			

7. Services and Activities provided to OVC in Kebele 01/18 (please indicate number of beneficiaries in the past 6 months)

Total OVC

	Male	Female	Total
I. Educational support programmes			
School fees			
School uniform/clothing			
School feeding			
Tutorial support			
Non formal basic education			
Others (identify and write)			
II. Early childhood development (0-5 years)			
Sanitation			
feeding			

clothing			
Nursery schooling			
Day care services			
III. Psychosocial support programs			
counseling			
Peer education			
Life skills training (apparent ship)			
Home visiting			
Spiritual support			
Succession planning (memory book writing and will writing)			
Recreational support			
Family reunification			
Other psychosocial support (specify and writer)			
IV health program			
Vaccination			
medication			
Hygiene and sanitation			
ARV treatment			
CVT			
HIV prevention awareness raising			
RH education			
Other (specific and writ)			
V. nutritional support program			
Vitamin A support			
Supplementary food			
Food ration (safety net)			
Other (specific and writ)			
VI. livelihood programs			
Income generating activates			
Micro finance(credit and savings)			
Vocational/ skill training(apparent ship)			
Employment opportunity creation(placement)			
Agricultural input supply			
Financial support for subsistence			
Others (specify and writ)			
VII. advocacy and awareness building			
Legal support to children's legal right			
Awareness creation on child rights			
Children inheritance protection			
Interagency referral system/ networking			
Other (specify and writ)			
VIII. other support programs			
Habitat support/housing			
Promotion of adoption			

Street shelter			
clothing			
Library and resource center			
Other support program			

8. serves/program gap

8.1 list the major three gaps in the process of OVC programs/service implementation

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

8.2 What are the main /root cause for the aforementioned gaps?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

8.3 alternative solution to over come that gaps?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**3.4 Questions posed to Schools**

Introduce purpose of the study

Register age and sex of participants

1. Have you ever noticed the presence of OVC in the school?
2. If yes, what is the trend looks like ? (increase/decrease)
3. Does your school provide assistance to these OVC? ( please ask for sources and types of assistance provided)
4. Would you provide me with eligibility Criteria ? (ask for copy if written)
5. Did you face problems in assisting these children? If yes, what were the problems and how do you overcome it ?
6. What are the main problems you have observed regarding these children pertaining to the following?
  - Educational performance
  - Peer relationship, playing
  - Respecting school Discipline
  - Compared to other pupils in school
7. What impacts (positive and negative) were observed on the teaching –learning process of the school due to existence of OVC in the school?

8. What impacts (positive and negative) were observed on the children who have parents due to existence of OVC in the school?
9. Do you have long and short term plan to address the problem of these children at school level? If you have already started implementing the program, please describe the types of the activities.
10. What are the best practices and challenges you have observed in implementing such programs
11. If you have comments.

Thank You

### **Declaration**

This thesis is my original work and has not been presented for a degree in any other University, and that all sources of material used for the thesis have been duly acknowledged.

Name of student: \_\_\_\_\_ Signature: \_\_\_\_\_

Name of Advisor: \_\_\_\_\_ Signature \_\_\_\_\_