Running Head: SITUATIONAL ANALYSIS OF ORPHANS AND VULNERABLE CHILDREN

Situational Analysis of Orphans and Vulnerable Children: The Case of Bahir Dar Town, Northwest Ethiopia

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A Thesis Submitted to the Research and Graduate Programs of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Social Work (MSW)

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June 2006
Addis Ababa, Ethiopia

Acknowledgements

First and fore most, I would like to praise the Almighty God for blessing me with the strength to go on.

Then, I would like to extend my splendid and profound gratitude to my thesis advisor Professor Nathan L. Linsk, a visiting professor from University of Illinois Chicago, Jane Adams College of Social Work, who generously devoted his time and professional knowledge to keep me in the right track through his guidance and suggestion. I also appreciate his patience in correcting and providing critical inputs my draft through the preparation of this thesis. I am also grateful to all participants of the study and organizations for their cooperation and support in the research.

Next, my heart felt gratitude goes to my family, especially my mother, and colleagues Arega, Yohannes, Dessalegne, Anteneh, Gizew, Girma, Derbie, Girmaye, Alemu, Tamerat, Assaye, Ababaye, Biruk, Melkachew who were there for me whenever I needed their support. My thanks also go to Dr. Alemayehu Mekonnen and Professor Habtamu Wondimu for their professional support in this study.

Finally, I would like to thank all my classmates, professors, and the staffs at the Graduate School of Social Work, AAU.

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ABSTRACT

The purpose of this study was to analyze and present the current situations of Orphans and Vulnerable Children (OVC) in BahirDar town. OVC were the unit of analysis for the study. Exploratory research design was employed. The data was gathered from OVC, caregivers, organizations working with children and community leaders, and FGD and IDIs methods was used to gather data. The findings of the study show the problems OVC becomes a great concern or threat for communities. HIV/AIDS was identified as number one factor for the increasing number of OVC. These children faced problems of food, clothes, access to school, medical care, stigma/neglect, improper inheritance of properties and psychosocial problems. OVC's accessibility for education was considered as their main needs. Community members were aware of the situation of OVC but they view OVC as the responsibility of their families, NGOs or government. Some Non-Governmental Organizations (NGO) and Faith Based Organizations (FBO) were undertaking the support of OVC. More input at community level is needed for the safety nets of OVC. Local government and community leaders need to ensure children are getting their rights to education. Foster families need assistance to learn how to cope with more dependents and how to settle bereaved children through family life skill training. There is an increased need for grass root community action to curb the pandemic. The different players have different roles but currently there is too much reliance on NGOs. The challenge is to find low cost intervention which communities themselves can start. Communities need to advocate against cultural and social practices that are spreading HIV in their community.

1. BACKGROUND OF THE STUDY

1.1 Why we are concerned about Orphans and Vulnerable Children?

International concern about the consequences of OVC has been rising as the HIV/AIDS epidemic has spread. International concern about the situation of Children living in Especially Difficult Circumstances (CEDC) such as OVC has been rising sharply in the last two decades. This appears to be the result of awareness, in many countries, of the devastating social consequences of HIV/AIDS. Increasing numbers of children are living in households where adults are sick or dying, children are losing their mothers and fathers more frequently than before, and some children are growing up without adequate adult care and supervision. Losing economically active young adults is devastating for families, communities and nations. The subsequent opportunities available to children who lose one or both parents must inevitably be affected. It is often said that young people are the future of a country, and it is clear that a childhood with limited opportunities will restrict the development of the individual. This has repercussions for their community and their country (UNAIDS 2004).

According to Children on the Brink, 2004 more than 143 million children in 93 developing countries have lost one or both parents by the end of 2003. Many of these deaths are results of HIV infection. Accordingly, 15 million children under the age of 18 had lost one or both parents to AIDS, with 78% in sub-Saharan African. In sub-Saharan Africa, 11 million children are orphaned by HIV/AIDS of more than 34 million orphans. The numbers of orphans in most sub-Saharan Africa countries are increasing exponentially because the infection is still rising as adults continue to succumb to the pandemic.

Among the sub-Saharan African countries, Ethiopia is one, which is most highly affected by the epidemic. In Ethiopia, 1.5 million people are living with HIV/AIDS, of which

96,000 are children below the age of 15. The Rapid Country Response Analysis of Ethiopia done by POLICY project/Future Groups in 2004 shows that Ethiopia houses the largest population of children orphaned by AIDS in Africa, i.e. 4.6 million children are estimated to be orphans of diverse cases of which; 1.2 million children are AIDS orphans. According to Ministry of Labour and Social Affairs (MOLSA) in Ethiopia, the number of OVC has been rising sharply from time to time due to in part to AIDS, as well as persistent and severe poverty, chronic food insecurity, war, drought, malnutrition, poor enforcement of children and women's rights, and other factors. Death of parent(s), rural- urban migration looking for job, dropping out of school, family disintegration, and the environmental (peer, community) influence are also the major causes for OVC being in the streets and increasing their vulnerability (MoLSA, 2004).

Mainly the burden of care of these OVC falls on extended families who themselves often need care and support, or impoverished relatives struggling to meet their own children's needs. This shows the inadequacy of the support that comes from the extended families because the families themselves do not have enough to feed extra mouths. As HIV/AIDS Prevention Control Office (HAPCO) on the strategic framework document indicates the magnitude of the problem at large, the general level of poverty and the growing demand for care and support of OVC in Ethiopia have weakened social cohesion and traditional care and support mechanisms through extended families, which causes leaving many OVC without fulfilling their basic needs (HAPCO, 2004).

A comprehensive care and support intervention like health services/medical care, educational assistance, shelter, legal and psychosocial support for these OVC and their families, should be scaled-up in a sustainable way to address the problems they face. By

considering this, government agencies, NGOs, international aid organizations, FBOs, communities and the like have a stake in ensuring the protection and well-being of OVC. Literature indicated that, although various organizations at International, National and Community levels tried to intervene to mitigate the multidimensional problems of OVC, the programmatic coverage of the existing efforts in Ethiopia is insufficient. This is because the support system of OVC in Ethiopia are not assessment based, comprehensive and coordinated, community based and are not based on the needs and priorities of the OVC (HAPCO, 2004).

This protection and care system of OVC in Ethiopia implies the need for devising direction on how to scale up comprehensive, well-targeted, cost-effective, community-based and sustainable approaches to mitigate the multi-faceted problems of OVC and to address their necessities. One critical step for providing such direction is to undertake a situational analysis that becomes an integral and on going activity for the well-being of children. This is because situational analysis of OVC is necessary before a plan for meaningful interventions to solve their problems and restore their hope for a meaningful future. It also articulates the magnitude and impact of the OVC situation in a given society and brings out all the ramifications and complexities compounding the problem. Furthermore, it provides clarity on what the real issues are and a basis for appropriate responses for OVC (FHI, 2005).

Therefore, the purpose of this study was to analyze and provide an understanding of the present situation of OVC in BahirDar town of Amhara Regional State. The study also attempts to explore and suggest appropriate social work interventions to address problems OVC are facing in the study area.

1.2 Situational Analysis-Definition

Situational analyses is a process of gathering and analyzing information to guide planning and action, in this case planning and action to direct help and support to the most needy OVC. As Family Health International (FHI) verifies situational analysis provides a synopsis of a particular situation at a given point in time that can be useful to different audiences for a variety of purposes, including; policy and strategy development, advocacy, social mobilization information exchange, stakeholder coordination, collaboration, and program design (FHI, 2005). Situation analysis differs from need assessment in such away that, need assessment is a narrower concept in that it basically assesses what problems that exist and what needs to be added or scaled up to address them. Situation analysis is broader in scope in that it identifies priority problems in a complex situation and considers the underlying dynamics with a view toward identifying potential points of intervention (Williamson, Cox and Johnston, 2004).

Conducting a situation analysis as a broadly inclusive, highly participatory process provides a vital opportunity to bring together key participants-those already engaged and those who will need to be engaged. The information gathered and analyzed through this process is used to facilitate the process of planning systematic, strategic, and integrated responses that successfully address the problems of OVC. It also provides valuable information that can serve as a basis for making difficult choices about how to direct resources to benefit the most seriously affected children, families, and communities (FHI, 2005).

In the context of OVC, situation analysis involves gathering information about the causes of and consequences for OVC, the way individual households and communities, NGOs, FBOs, etc, are responding, relevant policies which exist to protect OVC and any

programs or interventions which underway or planned. It concludes by analyzing the information gathered, identifying priority intervention programs and making specific recommendations for action for OVC (Williamson, Cox and Johnston, 2004).

1.3 Objectives of the Study

The general objective of the study is to understand and present the current situation of OVC in BahirDar town.

1.4 Specific Objectives of the Study

1. To understand and describe how the community defined OVC locally
2. To assess the magnitude of the problem of OVC in BahirDar town
3. To assess the foremost factors contributing to the presence of OVC in the study area
4. To gather information which helps to describe the impact of HIV/AIDS on Children, Families and Communities
5. To identify the major problems that OVC are facing and their main perceived needs
6. To assess government agencies, GOs, NGOs, family's and communities' response towards OVC in terms of the availability and accessibility of services including education, health, social and psychological services to OVC
7. To recommend possible and feasible social work interventions which curbs the problems of OVC and enhances their well-being

1.5 Research Questions

To attain the above stated objectives, the study attempted to answer the following research questions concerning the situation of OVC in the study area.

1. How does the community in the town define OVC locally?
2. What are the foremost factors contributing to the presence of OVC in the study area?
3. What are the impacts of HIV/AIDS on children, families and communities?
4. What are the major problems that OVC are facing and their main perceived needs?
5. What are the responses of families, communities, local government agencies, NGOS and FBOs for OVC?
6. What social work interventions are in place to curb the multifaceted problems of OVC?

1.6 Significance of the Study

Different researchers have tried to assess the situation of HIV/AIDS in Ethiopia, but the impact of HIV/AIDS on children is beginning to be explored. Since the study articulates the current situation of OVC and brings out all the ramifications and complexities compounding the problem, it is hoped that the study may help various organizations that are working in favor of OVC in the study area to develop shared understanding of the situations of OVC, which will help them to make sound decisions to plan and target resources on the unmet needs of OVC. The result of the study may also help those organizations working on OVC more effectively, efficiently mobilize, and use internal and external resources to develop strong, community based and sustainable programmatic responses to meet the needs of OVC in sustainable ways. Furthermore, it is hoped that the results of this study may provide some

information on the present situation of OVC in the study area for those who are interested to conduct further investigation on the issue under discussion.

Finally, since relevant and feasible recommendations and comments on the existing policy, strategies, programs, services and practices specific to the OVC are forwarded for concerned organizations which will help to enhance the wellbeing of OVC, all concerned government agencies, NGOs, CBOs, religious institutions, the academic community, and associations working with OVC and OVC themselves may benefit from this study.

1.7 Limitation of the Study

Studies on the situation of a particular segment of population in principle need to be the participation of all stakeholders working on that population starting from the beginning to the end. In addition, more samples should be taken as a participant of analysis to make conclusions about the situation of the study population. However, resource constraints such as time and financial limits the number of participants in the study area to be included in this study as respondents. A very small number of OVC are also selected to conduct the study and as a very vulnerable group of children, street children living on the street have not been included in the sample group. Because of the existing stigma attached to the persons infected and affected by HIV/AIDS, some heads of households in which OVC who were identified were not willing to provide information on the cause of the death of parents. Therefore, the analysis was made based on the response of those heads of households who provided the necessary data.

1.8 Operational Definition of Terms

Child: - a person whose age is 18 or below

Orphan: - a child aged 18 or below who has lost parent(s), regardless of how they died

AIDS Orphan: - a child aged 18 or below who has lost parent(s) who died by AIDS

Vulnerable Child: - a child who is living under difficult circumstances, which include children living with HIV, infected parent(s), with sick parents, children in child headed households, children who lead households, etc

Household: - person or a group of persons who live within the same dwelling and share a common source of food

Head of households: - a member of a household who economically supports or manages the household

Child Headed Households:- a household in which a person aged 18 or below is responsible for making day-to- day decisions for a group of persons who live within the same dwelling and share a common source of food, whether siblings or not

Guardian/Caregiver:- a person who regularly or voluntarily assist a household, in terms of household chores advice, giving medical, psychological and spiritual support whose members are siblings or not

2. LITERATURE REVIEW

2.1 Review of International Literature on Children

The Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) describe the standards to which those responsible for the upbringing of children should do. According to the convention and the charter, children

are entitled to special care and protection, and should grow up in a family environment, in an atmosphere of happiness, love and understanding. Actions affecting children should always take the best interests of the child first; there should be no discrimination between children; special protection to the most vulnerable or needy must be provided, as all children have the right to survival and development; and the child has the right to have views considered and to participate in decisions affecting them, according to age and maturity. It is recognized that, in all countries in the world, there are children living in especially difficult circumstances and that such children need special consideration. The state is expected to provide special protection for children who are deprived of a family environment.

The Declaration of Commitment from the United Nation (UN) General Assembly Special Session on HIV/AIDS in 2001 (UNGASS) identifies children orphaned and affected by HIV/AIDS as needing special assistance. There is a commitment to strengthen the capacity of governments, communities and families to support such children, including provision of counseling and psycho-social support, ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; and to protect OVC from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance's (United Nations Special Session on HIV/AIDS, 2001).

The UNGASS on Children in 2002, which resulted in "A World Fit for Children", a document, which sets out the goals and strategies, which member countries should incorporate in National Plans of Action. These goals and strategies are derived from the CRC and the Millennium Development Goals (MDGs), which focuses on eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering

women, reducing child mortality, improving maternal health, combating HIV/AIDS, and the like (United Nations Special Session on Children, 2002).

Generally, international literature on OVC emphasizes the scale of the problem of OVC seen largely because of HIV/AIDS. As such, it is seen to threaten both individual child development and national development. The responses needed vary among communities and countries, as the impact depends on many local factors. For interventions to be effective, it is essential to understand these factors, and for the organizations involved to work collaboratively. They need a shared understanding of the problems that OVC are facing and the most appropriate response. It is for this reason that many countries have commissioned a situation analysis concerning OVC.

2.2 Review of the Existing Ethiopian Literature on Children

The 1998 Central Statistics Authority (CSA) population and housing census report shows that children under the age of 18 account for about 52% of the total population of Ethiopia. In relation to the socio-economic conditions of children in Ethiopia, a study, which covers all regions of Ethiopia, focuses on the general situation of children 5-17 years-old was conducted in 2001 by CSA. The study found that only 38% of the children are attending schools, 85% of the children are engaged in some kind of productive and household activities and 33% of children combine schooling and work. Regarding the health situation of children, the study shows that the health status of Ethiopian children is extremely poor; the life expectancy at birth is low, 54 years; the infant, Under-Five and child mortality rate that is 113, 188 and 85 per 1,000 live births are high respectively, indicating the poor level of care they receive, and the unmet rights of Ethiopian children to survival and good health.

The literature shows that in Ethiopia, compared to other children, the socio-economic and psychological situations of CEDC, such as OVC, street children and children who are working and living in hazardous conditions, are more likely to be facing multifaceted social, economical, legal and psychological problems. They have poor nutrition and health, lack educational opportunities and drop out of school, lack love, care and attention, experience stigma and discrimination, experience exploitation and abuse, lack emotional support to deal with grief and trauma and experience long-term psychological problems (MoLSA, 2004).

Generally literature on Ethiopian children shows that large number of Ethiopian children are suffering from the ills of poverty and illiteracy such as living in extremely poor situations, suffering and dying from various diseases, not in school, working in hazardous conditions, exposed to various physical and sexual abuses, are trafficked, and are orphaned and/or infected by HIV/AIDS.

2.3 Review of Existing Ethiopian Laws and Policies Regarding Children

Ethiopia has adopted laws that protect children against the violation of their fundamental rights. The adopted laws guarantee access to information, education, health services, and other social services ensuring their rights of inheritance, and protect them against sexual abuse. These laws are found in the constitution of Federal Democratic Republic of Ethiopia (FDRE), the Revised Family Code of Ethiopia, the Penal and Civil Code of Ethiopia, and other legal instruments, such as the International Convention on the Rights of the children, and other relevant applicable international instruments.

In addition to adopted laws that protect children against the violation of their fundamental rights, the development social welfare policy (1996), which has been formulated to feature development, prevention and rehabilitation of a social condition, provides priority

concern for CEDC. In this policy, child welfare is one of the areas of focus. The policy states that appropriate and comprehensive care and services shall be extended to children so as to ensure their all round and harmonious development; conditions that will enable orphaned and abandoned children to get the assistance they need and to eventually be self sufficient shall be facilitated among other provisions (MoLSA, 1996).

In sum, Ethiopia has plenty of laws and policies regarding children on paper. Ethiopia is the first to adopt and sign international laws, but the problem is the enforcement of laws and policies. Adopted laws and formulated policies do not have strategies and guidelines for how they are implemented. Furthermore, at the community level laws and polices are not known to protect the rights of children. The communities, even enforcing bodies such as judges and police, are not aware of the existing laws and policies to protect children. In general, there are plenty of laws and polices that protect children against the violation of their fundamental rights, but all are on paper, while there is a problem of enforcement.

2.4 Overview of HIV/AIDS Epidemic in Ethiopia

Ethiopia is among the countries hardest hit by the HIV/AIDS pandemic. Even though it is difficult to get recent data, according to MOH, the national adult HIV prevalence in 2003 is estimated to be 4.4% of which 12.6% is urban and 2.6% rural. The 2003 HIV prevalence is higher among women (5%) than men (3.8%), and is higher in the urban (12.6%) than in the rural population (2.6%). The 2003 estimate of PLWHA is 1.5 million and out of these 96,000 are children under 15 years (MoH, 2004).

The cumulative number of AIDS cases in the country by mid 2003 was estimated at 147,000. It is estimated that there were 197,000 new infections, 98,000 new AIDS cases (46% male and 54% female) and 90,000 AIDS deaths in the adult population in 2003. AIDS

accounts for an estimated 30% of all young adult deaths and is expected to bring about a significant reduction in life expectancy. In the same year, a total of 128,000 pregnant women and an estimated 35,000 new born were living with the virus. Among children aged 0-14 years, there were 35,000 new HIV infections, 25,000 new AIDS cases and 25,000 AIDS deaths. A total of 4.6 million children under17 are estimated to be orphans for various reasons, of which 539,000 were orphaned due to AIDS. The trend of the HIV epidemic from 1982-2003 suggests three key points: a continuing gradual rise in national prevalence (3.2% for 1995, 4.1% for 2001, 4.2% for 2002 and 4.4% for 2003); an urban epidemic that has peaked at high prevalence levels; and a very gradual but steady rise in HIV prevalence in rural Ethiopia (MoH, 2004).

2.5 National Response to the HIV/AIDS Epidemic in Ethiopia

By recognizing its multidimensional impacts on individuals, families, communities and nations, the response to the AIDS epidemic in Ethiopia is a collective effort of the government, multilateral and bilateral donors, national and international NGOs, CBOs, FBOs, the private sector, associations of People Living With HIV/AIDS (PLWHAs) and individuals.

The government of Ethiopia developed the National Policy on HIV/AIDS in 1998 and the Strategic Framework for the National Response to HIV/AIDS (2001-2005) guided the national response to the epidemic. The overall objective of the Policy and Strategic Framework was to guide the implementation of successful programs to prevent the spread of the disease, decrease vulnerability of individuals and communities to HIV/AIDS, to care for those living with HIV/AIDS and to reduce the adverse socio-economic consequences of the epidemic. The response to the epidemic was designed to address both the direct causes as well as the underlying factors influencing the course of the epidemic.

An important development that took place in 2005 concerns, i.e. the FDRE launched the Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response (2004-2008), along with the free Anti-Retroviral Treatment Program. This Strategic Plan is based on guiding principles such as: multi-sectoralism, empowerment, shared sense of urgency, gender sensitivity, involvement of PLWHA, result oriented interventions and best use of resources in terms of allocation, harmonization, efficiency and accountability. Several guidelines and manuals on different intervention areas and policy-related issues have been developed and made operational.

In brief, significant progress has been made to curb the epidemic such as: Ethiopia has developed and implemented a national multi-sectoral AIDS strategy and the strategy has been revised and updated, national multi-sectoral strategic plans have been developed and revised to incorporate current developments, HIV/AIDS has been integrated into the country's general development plan, a functional national multi-sectoral HIV/AIDS coordination body exists in the form of HAPCO and the impact of HIV/AIDS on the socio-economic status of the country had been evaluated.

2.6 Conceptual Framework for Vulnerability, Human Rights and Protection, Care and Support of OVC

According to Children on the Brink, 2004 increasing number of children has been made vulnerable by the impact of HIV/AIDS. This vulnerability is due to poverty, hunger, armed conflict and harmful child labour practices, among other threats, all of which fuel and is fuelled by the epidemic. In countries affected most, parents, relatives, teachers, health care workers and others essential to the survival, development and protection of children are dying in unprecedented numbers. Millions of children are living with sick and dying parents or in

poor households that take in orphans. Children are profoundly affected as their parents fall sick and die, setting them on a long trail of painful experiences often characterized by: economic hardship, lack of love, attention and affection, withdrawal from school, psychological distress, loss of inheritance, increased abuse and risk of HIV Infection, malnutrition and illness, stigma, discrimination and isolation.

Concerning human rights principles of children, globally CRC is the principle framework to guide action on behalf of children. As such, it is the single most important reference point concerning OVC. The United Nations Convention on the Rights of the Child and other relevant human rights instruments guide all actions in support of OVC, in the recognition that development is the realization of a set of universally applicable, inalienable rights. This approach recognizes that children are both rights holders and participants; they are not merely the recipients of services or the beneficiaries of protective measures. CRC affirms that the family has primary responsibility to protect and care for the child, and that governments have the responsibility to protect, preserve and support the child-family relationship. The underlying values or guiding principles of the convention such as, best interests of the child, non-discrimination, right to survival, well-being and development and respect for the view of the child, influence the way each right is fulfilled and serve as a constant reference for the implementation and monitoring of all efforts to fulfill and protect children's rights(UNAIDS,2004).

According to UNAIDS, 2004 the HIV/AIDS epidemic is a massive and rapidly mounting disaster for children. With rates of HIV infection on the rise in many regions of the world, this crisis for children will persist for decades, even as prevention and treatment programme are expanded. The reaction of families and communities to the plight of these

children has been compassionate and remarkably resilient. However, shift of attention and efforts can help alleviate the suffering that many of them still face and provide brighter prospects for their future. To this end, a broad range of stakeholders from all sectors of society collaborated to produce the framework for the protection, care and support of OVC. These are (a) strengthen the capacity of families to protect and care for OVC by prolonging the lives of parents and providing economic, psychosocial and other support; (b) mobilize and support community-based responses, (c) ensure access for OVC to essential services, including education, health care, birth registration and others, (d) ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to communities, and (e) raise awareness at all levels through advocacy and social mobilization to create supportive environment for children and families affected by HIV/AIDS.

3. RESEARCH DESIGN AND METHODOLOGY

3.1 Research Design

A community based cross-sectional exploratory study design was employed to undertake this study. The study employed participatory research approach principles. In this study OVC, their caregivers, community leaders; and government agencies, NGOs and FBOs who were working closely with OVC participated. The study mainly employed a qualitative study method; however, quantitative data are gathered by reviewing literatures related to the situation of OVC.

3.2 Study Area

This study was conducted in BahirDar town, which is one of the major towns of Ethiopia and the capital of Amhara Regional State. BahirDar is located 570 km northwest of

Addis Ababa. BahirDar, which literally means “by the sea side,” is situated on the southern shore of Lake Tana, the source of the Blue Nile River. Currently the town is divided into ten kebele administrative districts. According to the 1994 CSA population and housing census report the total population number of the town were 94,140 (CSA, 1995).

BahirDar is one of the most rapidly growing towns in Ethiopia and rural-urban migration has led to rapid growth in urban populations, which has far exceeded the capacities of the government, and other actors in providing social services. As a result, large section of the population live in non-formal, or squatter settlements characterized by unplanned and low quality housing, lack of basic amenities, including health care, education, water and sanitation and high level of insecurity. Unemployment, poverty, social exclusion and deviance characterize the life of the majority of population living in the town (Amare Sewenet, 2005).

BahirDar exceeds the usual Ethiopian situation of HIV/AIDS prevalence. Based on government surveillance data, MOH estimates the adult HIV infection rate of the town was 13%, 20.8%, 23.4% and 20.8% in 1998, 2000, 2002, and 2003 respectively, which shows the prevalence of the pandemic is increasing from time to time in BahirDar town (MOH, 2004). The town hosts large number of OVC due to death of parent(s) in part to AIDS, as well as persistent and severe poverty, chronic food insecurity, rural-urban migration looking for job, dropping out of school, displacement of families, family disintegration, abuse and neglect by parents, lack of educational opportunity and other factors. According to Save the Children Federation data, the estimated number of OVC in the town exceeds 37,604. Moreover, the number of OVC supported by various philanthropic organizations is increasing and out of

those children who are supported by the organizations those who are registered to get care and support is beyond the capacity of the organizations (Save the Children Federation, 2004).

The study area is selected purposively based on: my work experiences and observation in the study site; the absence of information which shows the situation of OVC, because the supports provided by service providers for OVC were not assessment based, on the best interests of OVC or were not based on the problems and priorities of the OVC; high levels of HIV/AIDS prevalence in the town, which is one of the foremost factors for the presence of OVC; and the number of OVC in the town increases steadily from time to time.

3.3 Study Participants

OVC below 18 years-old were the main unit of analysis for study. Caregivers of the sampled OVC, government agencies, NGOs, CBOs and FBOs working with OVC, service providers and opinion leaders were also the subjects of the study.

3.4 Sample Size Determination and Sampling Procedure

All ten kebeles of the town were represented in the study and non probability sampling method, mainly purposive sampling, was used to choose the subjects of the study. To determine the sample size of the main subjects of the study, OVC, the list of all OVC who were the members of BahirDar town OVC association were taken as a sampling frame. From this sampling frame, the chairperson of OVC association selected three from each kebele for a total of 30 OVC (16 female and 14 male) purposively. The selection criteria included: OVC 7-18 years-old, OVC living with caregiver, knowledgeable about the situations or experiences being studied and their willingness to participate in the study.

After obtaining verbal consent from each OVC to participate in the study, the heads of households of caregivers of the selected OVC were informed and asked their permission to participate in the study. To gain perspectives, reflections, and observations from the respondents on the situation of OVC, government agencies, NGOs, CBOs and FBOs closely working with OVC, and community leaders included in this study were selected purposely based on the criteria that their main focus of working is related to children in general, and OVC in particular; and based on their knowledge of the situation of OVC. Based on the above stated criteria, two government offices; one local NGO; two FBOs were taken for the sample. The heads, experts or project coordinators of these organizations were key informants to obtain data on the situation of OVC in the study area. Community leaders who were participating in the FGD were selected from Kebele administrators and *Idirs* or associations by the help of BahirDar town HAPCO.

As shown from table1 below, a total of 125 respondents participated in the study. 65 participants participated in Individual In-Depth Interview (IDIs) (30, OVC, 30 caregivers, two experts from government office, one local NGO project coordinator, and two FBOs project coordinators) and 60 participants participated in Focus Group Discussion (FGD) (21 OVC, 19 caregivers, and 20 community leaders).

Table 1:- Summary of Distribution of Respondents Participated In IDIs and FGD

Category of Respondents	OVC	Care givers	GOs	NGOs	FBOs	Community leaders	Total
Individual In-Depth Interview (IDIs)	30	30	2	1	2	-	65
Focus Group Discussion (FGD)	21	19	-	-	-	20	60
Total	**51**	**49**	**2**	**1**	**2**	**20**	**125**

3.5 Sources of Data

The source of data for this study comprised both primary and secondary sources of information. Primary data were collected by using various data collection instruments or tools. To supplement the primary data, available relevant secondary sources were reviewed and embodied in the analysis to enrich the study.

3.6 Data Collection Techniques

Different data collection techniques were employed to collect data on the current situation of OVC in the study area. To collect information on the magnitude or prevalence of OVC, to determine psychosocial, socio-economic and other indicators of OVC, to assess the foremost factors contributing to the presence of OVC in the study area, to identify the major problems that OVC were facing and their main perceived needs, to gather information on the impacts of HIV/AIDS on children, families and communities and to assess the responses of the concerned bodies towards the problems that OVC were facing structured, semi-structured and open ended questionnaires and interview guidelines were developed.

The instruments were developed based on the adoption of already existing instruments on FHI frameworks and resource guide to conduct a participatory situational analysis of OVC affected by HIV/AIDS (FHI, 2005). The instruments were first developed in English and then translated to the local language (Amharic). To ensure the easily understandable nature of instruments and to make corrections of misleading and unclear questions, if any, pre-testing of questions was done prior to the actual data collection by undertaking the interviews and discussions in similar settings. Qualitative data collecting techniques (IDIs, FGD, and Observation), were applied to collect data from OVC,

caregivers, government agencies, NGOs, CBOs, FBOs working with OVC, service providers and community leaders on the situation of OVC.

In-depth Interview (IDIs)

In-depth interviews were conducted with 30 OVC, 30 caregivers and with five key-informants of government agencies, NGOs, and FBOs. The main thematic areas covered during IDIs with OVC includes: background information about OVC, educational background, food intake, problems they face and their perceived needs, psychosocial issues, relation with communities, OVC feelings on late mother/father and emotional well-being of OVC; where as background information about caregivers, housing conditions, household economic status and source of livelihood for households, access to social services, perception of caregivers on HIV/AIDS, their relation ship with OVC they are caring for, psychosocial issues and emotional well-being of OVC were the main thematic issues covered during IDIs with caregivers.

The main thematic issues covered with key informant of organizations include: Name of organizations, objective of organization, title/position of the key informant within the organization, how the organization defines OVC, the magnitude of OVC and major factors contribute for the presence of OVC, the extent of HIV/AIDS and its impact on children, families and communities, major problems and needs of OVC, services provided for OVC by the organization and policy issues related to OVC.

Focus Group Discussion (FGD)

Focus Group Discussions following selected themes was conducted with OVC, caregivers and community leaders. Six (two with each category) FGD were conducted. Each

focus group comprised of between 9-11 participants and cognizance was taken of gender and age in grouping participants.

Major discussion guidelines with OVC include: the major problems and needs of OVC, their relationship with their guardians, the attitude of families and communities towards OVC, how and with whom they deal during facing problems, their worries and their future plans and situation of living before and after their parent(s). Discussion guidelines with caregivers included: perception of caregivers on the changing nature of care and support for OVC before and now, the magnitude of OVC and major factors contribute for the presence of OVC, the extent of HIV/AIDS and its impact on children, families and communities, major problems and needs of OVC, the problems they are facing, the responses of GOs, NGOs, FBOs and CBOs and adequacy of the services.

Main discussion guidelines with community members include, how the communities define and describe OVC, the magnitude of OVC and major factors contribute for the presence of OVC, the extent of HIV/AIDS and its impact on children, families and communities, major problems and needs of OVC, the attitude of communities towards OVC, the concern of communities on OVC and their responses towards OVC.

Observation

During the collection of data, personal observation was undertaken on some issues such as on the housing conditions of the caregivers and clothing of OVC to produce contextual descriptions about the study population's daily life events and to confirm information gathered by other methods. The observation data contributed to a more accurate context that makes it possible to interpret the meaning of analysis variables or indicators.

Secondary Source of Data

Review of relevant documents, mainly books, journals, reports, institutional records and government policy documents, was undertaken to gather secondary data on OVC. The information generated using this method helps to supplement data gathered using primary data sources.

3.7 Management of Data collection and Data Analysis

The study team comprised of two, the researcher and one assistant who has a graduate degree in sociology and social\administration with relevant experiences working with OVC, HIV/AIDS and in using qualitative tools. The assistant assisted freely during the FGD as note-taker. Discussion was held with the assistant on contents of the instruments and on the clarity of questions. Qualitative information collected through IDIs, FGD and observation were recorded on paper first and then again written manually based on the frequency of the responses in each question. Secondly, the data were organized and summarized thematically and presented in descriptive manner by using content analysis methods.

3.8 Consent and Ethical Consideration during Data Collection and Analysis

Because of the stigma and human rights issues around HIV/AIDS, the highest ethical standard was upheld during data collection and analysis. This is because study participants may experience psychological, social, physical or economical harm during the process of data collection or after dissemination of study results. During data collection, the study was undertaken with informed verbal consent obtained from the respondents. Children were only interviewed or allowed to participate in a FGD after informed and supported by parental

permission. When the caregiver consented to the interview, but the child refused to give consent, the interviewer was not proceeding with the interview and that child did not participate in the FGD. After informed consent was obtained from the participants, the interview and FGD was conducted in a scheduled place and time to avoid distraction, maintain confidentiality and privacy during interview and discussion. To protect the identity of respondents, the names of participants including young children in the report were not mentioned or presented by pseudonyms.

4. CHARACTERISTICS OF RESPONDENTS OF THE STUDY

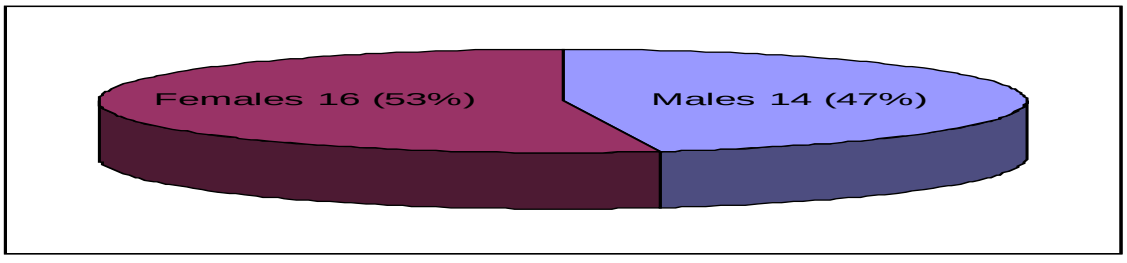
As indicated in the methodology section, different data sources were utilized and different categories of individuals were included in the study. In this section, the characteristics of each respondent are presented.

4. 1 Characteristics of OVC

Sex of Orphans and Vulnerable Children

The first characteristic of OVC examined was their sex distribution. As shown from figure1 below, from the total 30 OVC, the majority (53%) were females and 14 (47%) were males.

Figure 1: Sex Distribution of Orphans and Vulnerable Children



Age of Orphans and Vulnerable Children

The second characteristic of OVC examined was their age. As shown from table 2 below from the total 30 OVC, 17 (56.7%) of OVC were between 7-12 years-old and 7 (23.3%) were between 13-15 years-old while the remaining 6 (20%) were between 16-18 years-old.

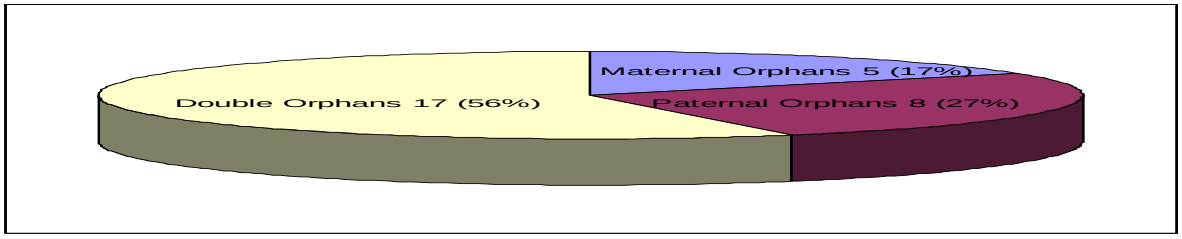
Table 2:- Age Distribution of Orphans and Vulnerable Children

Age of OVC	Frequency	Percentage
7-9	5	16.7
10-12	12	40.0
13-15	7	23.3
16-18	6	20.0
Total	**30**	**100.0**

Category of Orphans and Vulnerable Children

The third explored characteristic of OVC was their orphan category. As shown from figure2 below from the total 30 OVC, 17 (56 %) had lost both of their biological parents (double orphans), 8 (27%) of OVC lost their biological fathers (paternal orphans) and the remaining, 5 (17%) lost their biological mothers (maternal orphans).

Figure 2: Category of Orphans and Vulnerable Children



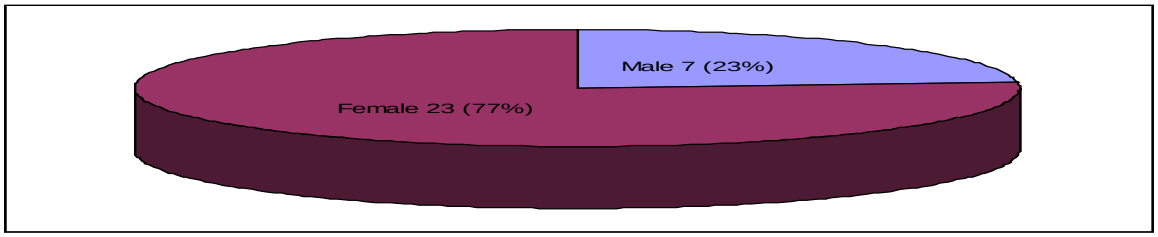
4.2 Socio-Demographic Characteristics of Caregivers/Heads of Households of OVC

The second categories of respondents were the heads of households of the caregivers. To understand, analyze and present the current situation of OVC primarily the familial environment in which OVC were living or the families who were custody/caregivers was examined. The explored characteristics of the caregivers were presented below.

Sex of the Caregivers

The first examined characteristic of caregivers was their sex distribution. As shown from figure 3 below, from the total 30 caregivers, 23 (77%) were females while 7 (23%) were males.

Figure 3: Sex Distribution of Caregivers of OVC



Age of Caregivers

The second characteristic of caregivers examined was their age. As shown from table 3 below, from the total 30 caregivers, 17(56.6%) caregivers were above 55 years-old, 9 (30.1%) were between 41-55 years-old who are pretty old, 2 (6.6%) were between 31-40 years-old while the remaining 2 (6.7%) were between 15-18 years-old, becoming heads of households at a young age.

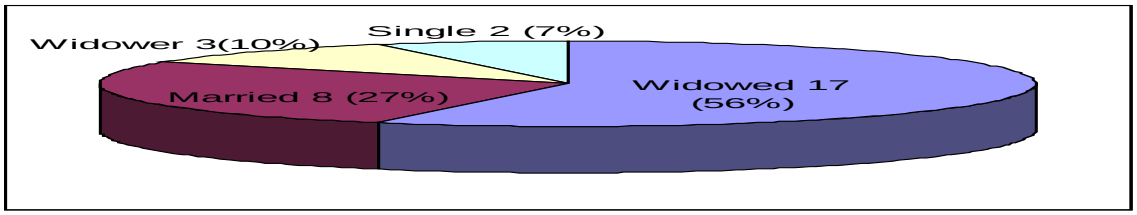
Table 3:- Age Distribution Guardians of OVC

Age of Guardians	Frequency	Percentage
15-20	2	6.7
31-35	1	3. 3
36-40	1	3. 3
41-45	2	6. 7
46-50	2	6. 7
51-55	5	16. 7
56-60	7	23. 3
Above 60	10	33. 3
Total	**30**	**100.0**

Marital Status of Caregivers

Regarding the marital status of caregivers, as shown from figure 4 below, from the total 30 caregivers, 20 (66%) of caregivers had been married but currently lost their spouse due to various cases including HIV/AIDS.17(56%) were widowed (lost their husbands) and 3 (10%) were widowers (lost their wives). 8(27%) of caregivers were married including 4 women and 4 men, and the remaining 2 (7%) of caregivers were single; both of these were females.

Figure 4: Marital Status of Caregivers



Educational Status of Caregivers

Another examined familial characteristic of caregivers of OVC was their educational level. As shown from table 4 below, 11 (36.7%) of caregivers were illiterate (cannot read and write), 9 (30.0%) of caregivers simply can read and write (but not attended formal school), 5 (16.6%) of caregivers completed grade 1-4, and 3 (10%) and 2 (6.7%) of caregivers completed grade 5-8 and 9-12 respectively. None of caregivers had training beyond grade 12.

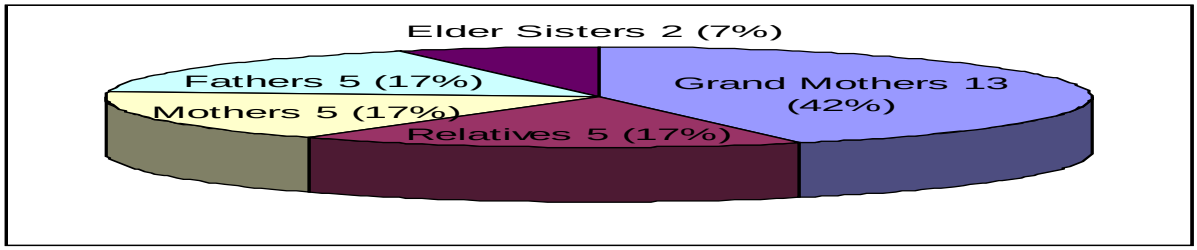
Table 4:- Educational Status of Caregivers

Educational Status of Guardians	Number	Percentage
Illiterate	11	36.7
Literate(Can read and write)	9	30.0
1-4 Grade	5	16.6
5-8 Grade	3	10.0
9-12 Grade	2	6. 7
Total	**30**	**100.0**

Custody of Orphans and Vulnerable Children

Regarding the relationship between OVC and their caregivers, as shown from figure5 below, from the total 30 OVC, 10 (34%) of OVC live with their remaining parent, 13 (42%) of OVC live with grand mothers, 5 (17%) of OVC live with other relatives, mainly with their uncles and aunts, and 2 (7%) of OVC live with their older sisters.

Figure 5: Custody of Orphans and Vulnerable Children



Family Size in the Households of Guardians/Caregivers of OVC

Another familial characteristic examined was the family size of the households of caregivers. As shown from table 5 below, the family size in the households ranges from 5-11. 22 (73.3%) of caregivers have family size that ranges from 7-9, 4 (13.4%) of caregivers have family size between 5-6 and the remaining 4 (13.3%) of caregivers have family size ranges from 10- 11 in their households. In addition to this, an attempt was made to examine the number of OVC within each household and as it is shown on table 5, the number of OVC in households ranges from 2-9. In terms of percentage of household members ranges from 33.3% (minimum) to 81.1% (maximum) in the households of the caregivers of OVC.

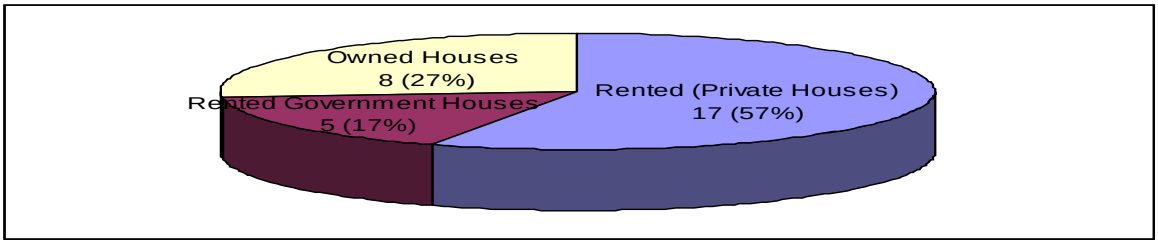
Table 5:- Family Size in the Households of Caregivers

Family Size in the HH	Frequency	Percent		Number of OVC in HH	Frequency	Percent	Number of OVC in HH by %
5	2	6.7		2	2	6.7	40.0
6	2	6.7		2	2	6.7	33.3
7	6	20.0		3	4	13.3	42.9
8	8	26.6		4	6	20.0	50.0
9	8	26.7		4	7	23.3	44.4
10	3	10.0		4	8	26.7	40.0
11	1	3.3		9	1	3.3	81.9

Housing Condition

The housing condition of the heads of the households of OVC was another variable through which the familial situation was investigated. In this regard, the heads of the households were interviewed whether the houses they are residing currently were their own or not. As shown from figure 6 below, from the total number of 30 heads of the households, 17(57%) of caregivers are living in privately owned rented houses, 5 (17%) heads of the households are living in government (kebele) rented houses and 8 (27%) of heads of the households are living in their own house.

Figure 6: Housing Condition of Caregivers



While conducting interviews with the heads of the households regarding the housing condition, observations focused on the number of rooms, and the materials in which the walls and the roofs of the house were made from. Regarding the materials in which the walls and

roofs of the house were made, the majority of the walls were made from mud and the roofs have no ceilings. Regarding the number of rooms, a very small number of houses have two to three rooms, while the majority of the houses have a single room, which is used as both sleeping room and kitchen.

Availability of Household Facilities

The availability of housing facilities of the heads of the households was investigated. Housing facilitates such as availability of potable water, availability of toilet, source of light, source of energy used to cook food and access to radio and television sets were assessed by interviewing the heads of households. Concerning the availability of potable water, the majority of the respondents do not have their own private piped water and they bought water from *bono water* –meaning communal piped water points opened in the morning and at the evening for a very short times; otherwise they bought water from private owned piped water. For cooking food, washing their bodies and other purposes the heads of the households used river waters. The data on the availability of a toilet show that the majority of the heads of the households use common or public toilets, which were opened during the daytime only, and very small numbers have no toilets and they use forests as a toilet. Regarding access to television sets and radio, almost all heads of households have neither television sets nor radio or tape recorders.

Family Income and Their Livelihood

Family income was the final variable to assess the familial situation of OVC. The monthly incomes of the heads of the households of OVC were examined by asking the heads of the households to tell or estimate the total monthly income that they earned. Therefore, the

data presented was based on the amount of monthly income reported or estimated by the heads of the households. Accordingly, 10 (33.3%) of the respondents earn a monthly income of less or equal to 100.00 Birr, which makes them fall below the poverty line. On the other hand, there were only 4 (13.3%) of the respondents who earn a monthly income of more than 500.00 Birr and 16 (46.7%) of the respondents earn a monthly income with a range of 101.00-500.00 Birr. For the majority of heads of households, the major sources of income were pensions, monthly financial support from NGOs, sporadic financial support from relatives, friends, neighbors and the income earned from daily work of the family member including OVC.

4.3 Local Government Agencies, NGOs, FBOs and CBOs

Local government agencies, NGOs, FBOs and CBOs that were working closely with OVC were included in the study. From many government agencies, NGOs and FBOs, two government offices, one local NGO and two FBOs who were providing support for OVC were taken as samples and heads/experts, project coordinators of these organizations were taken as key informants to collect data on the situation OVC and their organizations responses towards the problems OVC were facing.

Samples were taken from community based organizations such as *Idirs* (locally established associations for the sake of funeral and burial purposes) and Anti-AIDS Associations that were working mainly with OVC. The community leaders of those community based organizations working on HIV/AIDS prevention, control, and the provision of care and support for OVC participated in FGD.

5. FINDINGS OF THE STUDY

In these parts of the paper, the major findings of the study are presented in a systematic way of reminding the specific objectives of the study and accordingly presenting the findings of the study.

5.1 The Definition and Description Given by the Community for OVC

The first specific objective of the study was to understand and describe how the community in the town defined OVC locally. In this line of search, the local definitions given by the participants of the study who are participated in the FGD and IDIs are presented below.

5.1.1. Definition of Orphan and Vulnerable Children

Definition of "an orphan"

The local definition given by all the participants of the study who were participated in the FGD and IDIs was unanimous. Informants spontaneously defined an orphan as "a child below 18 years-old who has lost one or both biological parent(s)." However, some informants, especially community leaders defined an orphan as "a child below 18 years-old who has lost his/her father." The logic behind this definition according to them was, if the child is left with just a mother, it is as if they have no parents since it is assumed a woman left on her own will struggle to provide basic needs. The terminologies used in local languages to define an orphan was *Yemute Legie*- to mean a child who lost both his/her biological parents, or *Asadagie Yellow* (for boys) *Asadagie Yelelat* (for girls) was also mentioned- to mean a child who has lost both of his/her biological parents or a child who have no parent(s) to take care of his/her due to the death of their parent(s).

Definition of "Vulnerable Children"

Participants in the study defined vulnerable child as "a child below 18 years-old who is living in a very difficult situation or hard life and missing many of his/her basic needs (food, health care, clothing, shelter and education) due to various reasons." Informants most frequently identified vulnerable children as those children who have been abandoned by one or both parents (babies/children who are left in public places), children living in the street, children who are living with HIV positive parent(s), children who are living with child headed households and old grandparent(s). The terminologies used in local languages to describe vulnerable children were *Chigeragna Legoche* or *Lechiger Yetegaletu Legoche*- to mean children who have no parent(s) who cares for and prone to multifaceted problems.

Generally, the community defined OVC as a child below 18 years-old who has lost one or both parent(s), living in a very difficult situation and missing many of his/her basic needs (food, health care, clothing, shelter and education), and prone to various vulnerability situations.

5.2 The Magnitude of OVC in BahirDar Town

The second specific objective of the study was to assess the magnitude of the problem in BahirDar town. Accordingly, data were collected from the participants how respondents were noticed the prevalence of OVC in the town or in their communities using FGD and IDIs.

Regarding the magnitude of the problem of OVC in the study area, all the participants of the study confirmed that the magnitude of OVC in the town had reached alarming levels as evidenced by large number of OVC in their communities and the number of OVC currently supported by organizations and registered in the waiting list to get support. All caregivers,

community leaders and key informants mentioned that the community members of the town were too concerned about how the number of OVC is escalating "every day." Although nothing had been carried out by government bodies or other concerned bodies to register OVC in the town, from the participants' daily experiences and observation, they estimated that there were "thousands" of OVC in their community in particular and in the town in general. Government officials, community leaders and representatives of NGOs pointed out that they were paying scant attention to development activities since they were tackling the immediate problems OVC in the town.

A key informant from the social sector government office explained that the magnitude of the problems of OVC in the town was so great that at the time when NGOs were submitting project proposals to implement other developmental activities or provide other social services in the town, they were advised and sometimes forced to incorporate the program support for OVC in their project proposals. Another key informant from a local NGO explained that putting numbers on the problem of OVC in the town is impossible and difficult even to estimate because each day at least 40-50 OVC were reported and registered in their organizations to get assistance. According to him, there are many children who were registered and found in the waiting list to get assistance, but due to financial constraints they are not able to assist them on time. Further, he pointed out within a single household on the average 3-5 OVC were reported and registered to seek assistance, but the organizations were forced to provide assistance only for one with maximum two orphan or vulnerable children within that family due to limits on the capacity of the organization. The urgency of the problem of OVC in the town given their limited NGO financial resources, most of the

charitable organizations provide assistance beyond their plan by increasing the numbers by 20-25 OVC per year by sharing the annual budgets of OVC with the grater numbers of OVC.

The participants of the FGD of *Idirs* mentioned that due to the increasing number of OVC in their community and by considering this as their concern or a major threat to the community, the majority of the *Idirs* were on the way to change their by-laws to incorporate the issue of HIV/AIDS prevention and control programs and to provide support for OVC. Some of the *Idir* leaders who participated in FGD even mentioned that they were already changing their *Idirs* by-laws and started to implement activities in HIV/AIDS prevention and control programs and providing support for OVC. The *Idirs* were incorporating into their by-laws that each *Idir* member contributed one Birr per month and deposited in a separate account to implement the activities of HIV/AIDS prevention and control programs and to assist OVC.

BahirDar town HAPCO project coordinator stated that even if there is no registration or reliable data of OVC in the town, from the report of NGOs and other organizations that provide support for OVC, the number of OVC in the town are getting higher from time to time. As shown from table 6 below from the 2006 report of HAPCO which shows the number of OVC supported by various organizations and found in the waiting list, it is possible to conclude that the problem or the magnitude of OVC in the town are rampant and severe.

Table 6:- Number of OVC Supported by Service Providing Agencies

Year	Number of OVC Supported	Number of OVC in the waiting list	Total
2003	4,874	1,678	6, 552
2004	6,908	2,560	9,468
2005	7,011	4,671	11,682
2006	9,180	4,987	14,167

SOURCE; BahirDar HAPCO, 2003, 2004, 2005, 2006 Report

5.3 Factors Contributing to the Presence of OVC in BahirDar Town

The third specific objective of the study was to identify or assess the foremost factors contributing for the presence of OVC in BahirDar town. In relation to this, all respondents described the death of one or both parent(s) due to AIDS, as ”the biggest factor”, the “number one cause” bring into being OVC in the town. Besides AIDS, informants mentioned other diseases such as malaria, typhoid and tuberculosis (TB) and accidents as a causative factor contributing for the increasing number of OVC.

According to the respondents, other than children losing their parents due to death by AIDS and other causative factors, there are also other factors which result in a child becoming vulnerable. Other major causative factors mentioned by the respondents include: unplanned (teenage) pregnancies, unplanned pregnancies amongst women engaged in prostitution, desertion of young pregnant girls by boy friends, poor parenting style, sickness of caregivers, family breakdown and rural-urban migration of children for various reasons. In addition the weakening of family ties due to migration for search of jobs and more individualistic life styles and tribal customs such as polygamy and informal marriage, all creates an environment in which vulnerable children are being produced.

Respondents also identified the more general socio-economic environment prevailing these days as the main contributor to many of the circumstances that make children vulnerable. In summary although the factors listed above are reasons why OVC result, the causes are rooted in poverty, specifically insufficient income, limited employment opportunities and unemployment, large families with limited means of income to support them, limited general education and low levels of knowledge of sexual and reproductive health, parenting, family planning and life skills.

5.4 Extent of HIV/AIDS and Its Impact on Children, Families and Communities

The fourth specific objective of this study was to gather information, which helps to describe the extent of HIV/AIDS, factors fueling the spread of the pandemic, and the impact of HIV/AIDS on children, families and communities in the town.

In relation to the extent of HIV/AIDS, all the participants of the study unanimously agreed that the pattern of HIV/AIDS epidemic in the town was getting worse and worse over time. Some of the indicators forwarded by respondents for the mounting pattern of the epidemic in the town were the number of people who are HIV positive and registered with Down of Hope (an association established by persons living with HIV/AIDS) has increasing from year to year; the number of PLWHAs who were supported by philanthropic organizations and found in the waiting list in need of support were increasing from time to time; many of the hospital beds were being occupied by HIV/AIDS patients; the number of PLWHAs who are in need of Antiretroviral Treatment (ART) were increasing; the number of AIDS orphans were increasing; and many PLWHAs were found bedridden sick with chronic illnesses with symptoms like weight loss, diarrhea and skin rash. Death rates and sickness were rising from time to time.

Regarding the factors that contribute to the spread of HIV/AIDS in the town, almost all respondents pointed out that poverty is the root factor fueling the spread of HIV/AIDS. They explained that there were no adequate employment opportunities created to involve the majority of the residents who are unemployed and underemployed. The conditions are being aggravated due to rural-urban migration to the town from neighboring semi-urban and rural areas searching for jobs. They mentioned that the majority of the residents and rural-urban migrants have no job, which made them feel hopeless and forces girls, to engage in

prostitution activities as an employment opportunity to help themselves and their parents, which increases their vulnerability to contracting HIV/AIDS.

Another determinant factor mentioned by the majority of respondents, which causes the spread of HIV/AIDS was the ever increasing and expansion of chat, red-light houses and illegal video houses. They pointed out that due to unemployment opportunities and absence of recreational and entertainment places in the town, the majority of unemployed youths spend their time and visit *chat* houses and illegal video houses (which show pornographic films). According to respondents, after chewing *chat*, to avoid the problem of sleep disturbance there is a trend called *chebsie or mirkana mesiberia*-drinking too much alcohol, which predisposes and motivates them to have unhealthy sexual intercourse soon after with prostitutes. The same is true for illegal video film attendants. After they (youth) have attended pornographic films, the majority of them go to prostitutes to test what they were watching in the film, which exposes them to risky sexual behaviors.

The majority of respondents mentioned the lack of political commitment and community ownership to fight against the pandemic. Respondents pointed out that mainly HIV/AIDS prevention and control programs and support scheme were undertaken by some NGOs in on-off way. According to them, both preventive and curative programs were undertaken inconsistently by NGOs, and when the program of those NGOs are phase-out or stopped for various reasons, all started programs come to an end; neither government offices nor communities take over already started activities, which inhibits behavior change. An expert from a government office pointed out that one of the determinant factors for the spread of the pandemic in the town was lack of political commitment of political leaders of the town administration. According to the expert during annual budget allocation for sector offices, the

town administrators allocate "zero" budget for offices working on HIV/AIDS prevention and control program.

HIV/AIDS-related stigma and discrimination was also pointed out as a factor to the spread of HIV/AIDS. The majority of respondents mentioned stigmatizing and discrimination against the PLWHAs, which inhibits individual's commitments to have HIV-testing, increases the secrecy of their status and jeopardizes the prevention efforts, which all these in turn facilitates the spread of HIV/AIDS. Furthermore, neglect and lack of viable economic opportunities for widows whose spouses died of AIDS was mentioned by participants as a major contributing factor to the spread of HIV/AIDS. Because of this, some widows were resorting to prostitution in order to take care of their families. The neglect of OVC by their families and communities was forcing them especially girls or young women to engage in prostitution, having sexual relationships with older men in return for financial support or to enter into early marriage to escape poverty and to help their siblings.

Regarding the impact of HIV/AIDS on children, families and communities, all participants of the study unanimously said that AIDS had devastated children, households and communities in the town. They explained that the disease was seriously affecting the whole community, mainly the youth, which is the productive segment of the country. Concerning the impact of HIV/AIDS on children, a17 year-old double orphan who lived with his grandmother stated “before the death of my parents I was in school, I lived in good situation. I was thinking only about education and my parents encouraged me to attend school. Now I am working as a shoe shiner, my classmates are attending school. My elder sister is engaged in prostitution in another town. My two smaller brothers are living in rural areas with our uncle; we have no chance to meet together.” Another 16 year-old female double orphan child stated “before my

parents' death I was in school, but now I dropped out of school and started to sell lottery to feed myself and my older grandmother." She added "my older brother also withdrew from school and he was engaged in daily works before his death during Ethio-Ertrea war."

Some examples were mentioned during IDIs with caregivers about how the epidemic has had impact on families. For example, a 34 year-old widowed woman who lost her husband by AIDS and cares for five orphans stated "my husband was employed and earned 1,700.00 Birr per month. When he alive we were lived in good situations, all our children were attending school, our house was full of facilities, we were on the process to build our own house,…after his death every thing changed, his employer stopped his salary immediately after his death, we started to sell goods, our children withdrew from school, the owner of the house expelled us from the house, we started to search for rented house, but the communities refused us because they hearing that my husband died of AIDS…. Now the children (boys) are engaged in day works while the girls are working in bars."

Regarding the impact of the pandemic on communities, one community leader who participated in FGD stated "in our community in each day at least one or two persons dies and there is a funeral ceremony." He further added "now a day it is common in this town that most of the community members spend their time in burial and funeral ceremonies and the majority of *Idirs* money is spent for the these ceremonies." Another community leader stated "before the money of the *Idir* was used for other purposes but now a days it is for burial ceremony only….most of *Idirs* are left without money….as a result of this we are on the process to change our *Idir's* by-laws to stop allocating money for burial and funeral ceremonies, and instead to prevent the pandemic and provide care and support for PLWHAs before death and OVC after the death of their parent(s)".

Generally, the increasing incidence of HIV/AIDS and its adverse impact on children, families and communities in the town becomes a major concern for the communities in the study area. The factors contributing heavily to the spread and impact of AIDS in the town were poverty; unemployment and underemployment; lack of recreation places particularly for youth; rural-urban migration; expansion of chat, red light and illegal video houses; lack of political commitment and lack of ownership of the community to fight against HIV/AIDS, secrecy, HIV/AIDS-related stigma and discrimination, and low Information Education and Communication (IEC) and Behavior Change Communication (BCC) intervention.

5.5 Major Problems of OVC and Their Main Perceived Needs

As indicated in the objective part of the study, the fifth objective of this study was to identify the major problems that OVC were facing and their main perceived needs. To make the findings of these two interrelated variables clear, the results of the findings were presented separately.

5.5.1 Major Problems that OVC are facing

Regarding the problems that OVC are facing, children themselves, caregivers, key informants and community leaders listed a range of problems that OVC are facing. These problems were transcribed manually based on the frequency of the responses and the organized and summarized problems were presented below in descriptive manner in order of their severity starting from the severest one.

Food Insecurity/Nutrition Problems: The first problem most OVC and their caregivers mentioned was the problem of getting food. In securing information on meeting the basic needs particularly the availability of food and feeding patterns, OVC and their caregivers

were repeatedly and commonly mentioned the problem of getting food or food insecurity as their main problem. Concerning children's own perception on the food fairness of distribution and adequacy of food, though almost all OVC eat two or less meals per day, the majority of OVC indicated that they were not well fed, do not get sufficient food and they do not have well balanced diets.

Regarding the perceived fair distribution of food in their homes, some OVC reported that the distribution of food in the households is not fair, and they get less food than the biological children of their caregivers. In this regard, a 12 year-old boy stated "the children's of my caregiver eat together with their parent, but I am allowed to eat the left over foods." Another female orphan child stated "I am always waiting left over foods of my caregiver's children to get food; after they eat I am forced to eat their children's left over foods."

Findings from FGD held with caregivers, community leaders and key informants support the contention that OVC do not get sufficient food. The participants reached a consensus that OVC do not have well-balanced and sufficient food. Regarding this issue, a guardian of three orphans stated "orphans whom I take care of eat two times per day if possible otherwise one times per day, I have no option to feed them properly, our source of food is the limited monthly financial support from NGOs and the income coming from OVC themselves through daily works which limits them to feed properly." A community leader and hotel owner participated in FGD stated "during lunch and dinner time, most OVC in the community always come to the hotel for searching of leftover foods and they take out of leftover foods constantly." He further added, "due to the increasing number of such OVC, from day to day we were forced to register them and take the leftover foods in accordance with their registration order."

Health Problems: The second major problem raised by OVC was health problems. With regard to the health status of OVC, it was found that the majority of OVC were repeatedly sick. Children, especially double orphans, reported the incidence of their sickness was increased after the death of their parents. Their caregivers who participated in the study also affirmed the bad health status of OVC. All caregivers commonly agreed that OVC who they care for were sick/ill repeatedly. Some of the reported health problems that OVC were facing repeatedly include fever, cough, diarrhea, loss of weight, headache, malaria, vomiting, tonsillitis, insomnia and loss of appetite.

Regarding the type of health service institutions OVC visit or seek medical assistance from during illness, the majority of sick OVC sought medical service from government health institutions. According to them, despite the availability of contiguous health institutions, they have problems such as insufficient medicines, shortage of drugs, high treatment costs (for them), nepotism and discrimination of health staffs, unnecessary procedures and limited capacity of health institutions which have limited them from seeking treatment there.

The study also attempted to assess whether the ill-OVC were provided with the necessary medical assistance or treatment, and the data shows that the ill-OVC did not get necessary medical assistance due to financial constraints. To explain how financial constraint limits them to get medical assistance, a 67 year-old guardian woman who cares for three OVC said “when a child is sick, I normally borrow money from my friends to go to health institution, otherwise the child would die, but sometimes there is nowhere to borrow and so, I don’t even go there.” Another older guardian who cares for four OVC said “even though I Know that traditional medical treatment is not effective, I sometimes forced to seek medical

treatment for ill-OVC on traditional healers with a very low cost due to financial constraint to seek medical treatment from health institutions."

My name is Eskedar [pseudonym]. I am 21 year-old. I am keeping my two young siblings. Our mother died in August 1997, after a year our dad died. We were facing many problems. Among these, our serious problem is medical fees. If any one of us falls sick, I find it difficult to do anything because by that time I may have no money. It is a very big problem keeping my sister and brother at home while she/he is ill. I cannot take him/her to the health institution to medical treatment because I do not have money to pay for medical scheme and for the prescribed medicine. I have the only option to go to traditional healer's house or praying to God at home without medical treatment to seek medical treatment from health institutions.(Interviewed orphan child head of household stated how financial constraint affects her and siblings to seek proper medical treatment).

Clothing Problem: The third problem mentioned by OVC and their caregivers was the problem of clothing. The majority of OVC reported that they are not clothed properly or they did not have sufficient clothing to protect themselves from cold and rain. During IDIs and FGD held with OVC, observation of their clothing conditions proved that almost all OVC were wearing torn and dirty clothes. Mainly school uniforms and nightclothes were mentioned as major clothing problems.

Educational Problems: Another critical problem raised by OVC and their caregivers was the problem of inaccessibility of OVC to school. Even though currently all OVC participated in this study attending schools by the help of NGOs, the majority of OVC and caregivers argued, after the death of their parent(s) the probability of most OVC continuing their education is low. The majority of OVC dropped from their education. The probability of dropout of school increases for double orphans than single orphans. OVC and their caregivers generally confirmed that financial constraint or economic problem is a crucial factor for

dropping out school, which hinders caregivers to fulfill the required educational materials and school uniforms. Although, all caregivers repeatedly identify education as one of the greatest needs for OVC, they reiterated that they were not able to get money to pay school fees, buy educational materials and school uniforms.

My name is Hayat [pseudonym]. I am 15 year-old. We are six in the family. The first-born is 20 year-old, she is female and stopped school in grade 9, the second is a boy aged 17, he stopped school in Grade 7, and the third is I. I dropped school in grade 6. After me is my young brother aged 12; he stopped school in grade 5 recently because of lack of money. We all dropped our school due to financial constraint. Then the last two girls' one is aged 11 and is in grade 3 and there is a grade 1-girl child. The last two girls go to school with great suffering with little help from NGO. Before the death of our parents, we all were going to school. (Interviewed orphan girl stated on educational situation of her and siblings).

Stigma and Discrimination/Neglect: Another problem that most OVC are suffering was stigma against and discrimination within the households and communities. All participants of the study pointed out that stigma and discrimination were most definitely an issue in their community towards PLWHAs and OVC.

The respondents revealed that OVC are discriminated against, stigmatized and ostracized by families in the household, peers and communities, because it was believed that OVC may have HIV/AIDS just as their parents did. A female household head participated in FGD stated that some community member isolate, discriminate against and neglect OVC. This is because some people assume that orphans were suspected to have HIV and they can transmit to their children. Therefore, they didn't permit their children to play with OVC. Another community leader participated in FGD stated that in our community if a child loses his or her parent(s), the communities discriminate against and stigmatize him/her, because the

community members thinks that the child is a disease victor. Nobody wants to get close to that child because the community thinks the child will transmit the virus to them.

Most OVC pointed out that although there is stigma against them and discrimination within the communities, the stigma and discrimination at the household level is severe and has a great impact on them. A male orphan participant of FGD indicated that ”living with other a people in a new home is not easy; I do not feel at ease, I feel inferior; my guardian’s children insult me, ordered me to do household chores.” Another orphan who is living with his uncle mentioned that “his uncle’s wife discriminates against him in such away that when she buys clothes for her own children but nothing for me, when she advised her children to study but she ordered me to do household chores, when her children eat together with them, I am waiting till they finished to eat the leftover food.”

Child Labour Exploitation: Another problem that OVC faced was child labour exploitation at household and community levels. All OVC mentioned that following the death of their parent(s) all of them were forced to engage in any economic activities. This shows that the death of their parents increases the probability of OVC to engage in economic activities. Some of the activities that OVC are engaged in on a daily basis include: bartender, shoe shining and repair, petty trading, selling sugarcane and chewing gum, daily labour, selling lottery and *qollo*, housemaids, washing others’ cloths, caring and loading and washing bicycles.

To find out the level of child exploitation, the study examined the time they spend per day and amount of money they earned. Accordingly, it was found that almost all OVC spends a minimum of 8 hours per day and on the average most OVC earned 3-5 Birr per day. What worries them most was not their engagement in economic activities and the long working

hours, but what worries OVC most is that all the money they earned in whatever activities they are engaging in is taken over by their caregivers; they have no authorization to use the money they earned. A 14 year-old double orphan engaged in shoe shining and repair activity stated "I always give the money I earned to my aunt; even I can't buy a bread to eat when I am hungry." He added "even, if there is variation in the amount of money I earn from day to day, my aunt suspect me that I am just hiding some of the money and she withholds food." Another 15 years double orphan girl said, "I am working as a waiter, but I don't know how much my monthly salary is? Only my uncle knows, even I have no right to buy educational materials with the money I earned from this work."

Some OVC mentioned that their labour exploitation not only happened at household level, but also at the community level. An orphan who was working in caring and loading activities stated "some times people ordered me to carry their goods and they paid what they want to pay, even there are some persons who never pay. What can I do? I cry and start my usual work again for survival."

Problems Related to Inheritances: Another problem OVC facing was the problem of proper inheritance of properties after the death of their parent(s). Most OVC raised problems related to the inheritance of properties of the deceased parent. Based on data collected from OVC, caregivers and community leaders with regard to the inheritance of properties, the inheritance of properties left after the death of parents is categorized into two. The first category is at the time when one of the parents dies and the second is at the time when both of the parents died. In the first case, the other parent inherits the whole property and manages it and in the second case, if there is an older brother or sister they can inherit, control and administer the property. If there is none, close relatives can take advantage of it.

Most OVC pointed out that the problem happens after the property of their deceased parent is inherited either to the remaining parent or elder brothers/sisters and relatives. Some single orphans mentioned that after the death of one of their parents, the other parent inherits and administers all the property. After some time, a widow/widower re-marries and the whole property remained with the married couples. When a conflict exists between the step-father/step-mother, orphans remained without any property and they are forced to be expelled from home or started to live with relatives.

The problem of inheritance becomes a serious issue when the child has lost both of their parents. At this time some of older brothers or sisters and relatives that inherit properties sold or transferred to their own property and after some time they expelled their siblings from their house (in case of relatives) and their older brothers or sisters who inherit their parent's property start to engage his/her own business by changing their place of work and by hiding themselves from their siblings. OVC then go to closer relatives or in to the street as a solution. A 12 year-old living with her grandmother stated "our older brother took all the properties of our parents and after some time started to live in another town. We left without anything to pay for house rents and to eat. At this time, the owner of the house evacuates us from the house and we (her self and her two brothers) started to live on the street by begging. After we suffer a lot our grandmother takes care of us."

Caregivers, OVC and community leaders raised the issue of legal mechanisms of protecting property of the deceased families. Respondents indicated that there is a major disparity between the legal protection mechanisms that are said to be in place versus the reality faced by OVC and their caregivers. Regarding the legal realities faced by OVC and their caregivers in relation to property protection, almost all respondents pointed out that they

are not aware of the existence of legal mechanisms in place to protect the rights of OVC and their caregivers. A community leader who participated in FGD stated "there is no legal provision for OVC or their caregivers. Traditionally, if there is an older brother or sisters they can control the property, if there is not, close relatives can take advantage of it." A male head of households who takes care of two OVC stated "many adults, including me, don't know the legal rights that could protect the properties of orphans and children after the death of parents." OVC also indicated that they were unaware of any legal mechanism available to protect their legal rights on their parent's property. A 16 year-old boy stated "I don't know the legal rights and mechanisms on how the properties of our deceased parent are inherited; only the community leaders know how it is inherited. Even I don't know where I can make claims problems occurred on this issue."

Problems Related to Psychosocial Aspects of OVC

Child-Caregiver Relationship: Regarding the relationship between OVC and their caregivers, qualitative data obtained from OVC, their caregivers, community leaders and key informants indicated that mainly the relationship between OVC and their caregivers was characterized by a lack of love and care. Based on the information emerging from OVC, it is apparent that there is better care and love when children are living with their grandmothers than those living with other relatives. Most OVC stressed that the treatment they got from their caregivers varies accordingly with their custody type; those OVC who were living with their grandparents and elder sisters were receiving better care and love than those OVC who were living with their relatives. The majority of OVC lived with other relatives (uncles and aunts) expressed their feeling that they were not receiving adequate love and care from their

caregivers. They didn't receive the same care and love as the biological children of their caregivers.

Some OVC themselves best expressed this situation of unequal treatment of their caregivers. An interviewed girl said "my uncle's wife is not good for me, especially when I was going to school. As a result of this I dropped out of school but her children are at school." During IDIs some caregivers also stated that OVC they the care for don't get the same love and care that they received from their parents. A head of households expressed "I can never be like a mother to my nephew."

The situation varies across households regarding whether OVC are able to talk to their caregivers for advice when OVC faces problems. Most OVC feel it is better for them to keep their problems to themselves rather than telling their caregivers and seeking solutions from their caregivers. Some OVC prefers crying, sleeping and playing with other children to relieve from the stress than seeking advice from their caregivers. A 16 year-old girl pointed out that even if she asks her guardian for advice and support, so many times she didn't have a response. Another 17 year-old child lived with her aunt stated "my guardian's response when asked for advice is brutal. Some times she gives positive feedback but most of the time she is angry, insult and demoralized me when I ask her about some issues."

Perception of OVC Situation during their Parent's Illness*:* OVC were asked about their feelings when their parents were ill. Almost all OVC stated their psychosocial experience during their parent's illness was mostly characterized as full of fear for the future. Most of them were not sure and don't know where they will live, who will support and care for them, and what they will eat. Most OVC pointed out that during their parents' illness; their parents were not interested in raising issues related to their children's future.

The perception of OVC during their parent's illness becomes severe for those OVC who lost both parents. Most double orphan children pointed out that, at the time when one of their parents were sick they relied upon the remaining parent, but when the remaining parent was sick, their future becomes dark and severe. A 15 year-old double orphan stated “after two years of my mother’s death, my father was sick and sleep in hospital for two months, at this time my bright future becomes dark and I feel hopelessness.” Another 16 year-old female double orphan stated “at the time when the only remaining parent (mother) was sick and become bedridden, what comes in my mind is those children who are living on the street and I would be like them after the death of my mother.”

The OVC perception of their situation after their parent(s) death was also explored in this study. The psychosocial situation of almost all OVC after the death of their parents was characterized as full of worry, fear and uncertainty after the death of their parents more than it was during their parents’ illness. Just as they were fearful of their future when their parents’ were sick and dying, they also faced more fear and developed a sense of hopelessness after their parents' death. They fear what will happen in their living situation after the death of their parents, some fear that they may have HIV transmitted from their parent, others fear dropping out of school, health situation, and some children indicated that they have lost their hope for their life and now they feel hopelessness.

In relation to the feelings of OVC on late mother/father, almost all OVC mentioned that they miss their parents tremendously, especially the care and love that they received from their parents. Although most parents did not leave much behind after their death, small items remain with their children as reminders such as photographs, clothes and some kitchen utensils. According to the response of OVC, these items have importance for them after the

death of their parents. An orphan girl stated “I am very happy when I eat my food by the plate that my mother always used during her illness and always when I eat with that material, I remember the situations of my mother in the hospital.” Another girl said “my mother left me her picture when she was dead. The picture is with me now and when the children in the house were playing with their parents, I will go to my bed and see my mother's photo.”

The Emotional Well-Being of OVC after Their Parents’ Death: From the data obtained from the respondents, the emotional wellbeing of OVC was characterized as full of psychological problems. The majority of OVC face psychological problems such as feeling of hopelessness, fearfulness, unhappiness, scary dreams/nightmares, fighting with other children in school and out of school, isolation/loneliness, worried, aggression, frustration, anger and running away from home.

The respondents, mainly key informants, have pointed out that these emotional problems coupled with lack of love and care from their caregivers have forced most children to leave their guardian’s home and started to live street life, which leads them to engage in unhealthy behaviors as in theft, drug addiction, dropping out of school and prostitution. A 16 year-old girl stated “I took care of mother when she was ill in hospital. Because of this, I dropped out of school. Now I am living with my uncle but his wife and children have not positive attitude to me. When things become bitter at home, I started to think to run away from home and started to live street life or engaging in prostitution like others do.”

5.5.2 The Main Perceived Needs of OVC

Besides the problems that OVC were facing, the main perceived needs of OVC were discussed mainly with OVC and their caregivers. Even though, food insecurity was mentioned by most OVC as their primary problem, both OVC and their caregivers simultaneously most commonly identified that helping OVC to attend school (fee for school fees, uniforms, shoes, books), was mentioned as their primary needs. Next to education they mentioned, basic needs such as food, clothes and medicine; love, compassion, understanding from caregivers and advice and counseling (about loss of parents, studying and problem solving). Children and caregivers in the study made it clear that they valued education highly and were desperate to attend school, often making great sacrifices to achieve this goal. They see education generally and attending school specifically as a salvation for many of their problems. All OVC emphasized the importance of education to ease the multifaceted problems they and their families are facing currently.

In support of this, a 12 year-old and 5th grade student stated that "now I want only help to complete my school. I am just resisting so many challenges to complete my education because it is the only hope for me in my future life." A guardian who cares for a girl orphan stated "a child who I care for thinks about her education and she thinks about her studies because she wants to be an educated woman… if I can't fulfill school materials, she collect firewood and sell it to get money to buy educational materials."

In general, the main problems that OVC facing in their daily lives include: missing basic needs like food and clothes; held back and dropout of school; inadequate health care/not receiving appropriate treatment; missing love, compassion, understanding and loneliness; various types of abuses and neglect, stigma and discrimination; and problem of

inheritance. Education is pointed out as main perceived needs not only for OVC but also for their caregivers; this is because education is considered as a principal determinant of their future.

5.6 Current Program Responses to OVC

The sixth objective of the study was to asses the responses of families, communities, government agencies, NGOs, and FBOs towards the problems that OVC were facing in terms of the availability and accessibility of services including education, health and psychosocial services. To achieve this objective data was collected from GOs, NGOs and FBOs. These organizations were selected purposely based on their focus of work on OVC. The heads and/or project coordinators of the selected organizations were selected as key informants and IDIs were conducted with them regarding the situations and the responses of organizations towards the problems that OVC are facing. The names of organizations and key informants were not mentioned here to keep the confidentialities of the organizations and respondents.

5.6.1 Local Government Response to OVC

To collect data on the situations of OVC and to understand the responses of government towards the problems that OVC were facing, among many government agencies working with children in the town, two social service government agencies were selected based on their focus of work on children. Two experts, one from each government office, were selected as key informants.

Related to information on the prevalence and situation of OVC, the key informants mentioned that none of the organizations neither government nor NGOs, have actual data on OVC in the town. They pointed out that the only mechanism of gathering data on the

prevalence of OVC in the town is annual reports of organizations that provides support for OVC. From the reports of these organizations the number of OVC is increasing in the town from year to year. They also mentioned that neither government organizations nor NGOs have any information on the current situation, mainly on the problems and needs of OVC. Further, they added every organization provides support for OVC as they would like to assist; their provisions were not assessment based or based on the needs of OVC. The key informants pointed out that in the future these two government offices have plans to gather information on the prevalence and situations of OVC in collaboration with other governments and NGOs working in the town.

According to the key informants, the local government offices play facilitation and coordination roles rather than direct provision of support for OVC. As it is shown from table 7 below some of the activities mentioned by key informants include awareness raising on polices and conventions related to children, providing training on child rights and support, community mobilization and coordinating the activities related to children implemented by philanthropic organizations.

Table 7:- Summary of Responses of government agencies towards OVC

Types of Activities Implemented by GOs
Education on HIV/AIDS to raise awareness within communities
Provide information for professionals on current situation of HIV/AIDS and its impact
Development and dissemination of IEC materials on HIV/AIDS
Educating on National HIV/AIDS policy and CRC to raise awareness
Establishing town administration AIDS council and kebele Anti-AIDS committee
Establish children clubs at schools and establishing OVC Association
Providing educational materials once per year in collaboration with UNICEF
Coordinating and monitoring the activities of service giving organizations
Advocacy work on OVC and organizing workshops and seminars on OVC
Fund solicitation from National HAPCO and UNICEF

5.6.2 Local NGOs and FBOs Response to OVC

In BahirDar town there are many NGOs working on HIV/AIDS prevention and control and in providing support for OVC and PLWHAs. From these NGOs, one local NGO was selected purposely as an example because the organization's main program focuses on HIV/AIDS, and the organization's history of working for a long period in the provision of support for OVC. Two FBOs were taken as a sample purposively because their program focus is on providing support for OVC, caregivers and PLWHAs. The project coordinators of these organizations were taken as key informants to gather data on the general situations of OVC and to identify the responses of their organizations to address the problems that OVC were facing.

The key informants mentioned that the organizations started to work on HIV/AIDS prevention and control program by considering the alarming spreading of HIV/AIDS and the adverse impact the pandemic brings at national, community, family and individual level. The key informants pointed out that OVC and their caregivers, PLWHAs and the general communities were the beneficiaries of the service rendered by organizations. The program of the organizations includes: providing socio-economic support for OVC and PLWHAs; counseling services for PLWHAs, their families, OVC and their caregivers; building and supporting community based efforts to respond to AIDS epidemic and providing community based support; and promoting positive attitude towards OVC and PLWHAs.

The organizations are working closely with town administration HAPCO, BOLSA, and CBOs to select the beneficiaries and monitor and evaluate the program. The organizations with stakeholders employ criteria to select OVC such as, medically certified double or single orphans due to HIV/AIDS; children below 18 years-old; proved to have no sufficient income

or support from elsewhere; and double orphans of any case with no income and/or poor caregivers /families. Table 8 below shows some of the services provided by the organization for OVC and other beneficiaries of the program, include socio-economic, psychosocial support, Income Generating Activities (IGA) and referral services.

Table 8:- Summary of types of services provided by NGOs and FBOs for OVC

Service provided by NGOs and FBOs
Provision of financial support for food, health, shelter and the like
Provision of educational materials support (exercise book, school uniform, etc)
Provision of educational services (tutorial)
Provision of counseling and spiritual support
Provision of material support (clothes, blanket, and night clothes)
Provision of sanitation materials
Provision of library, indoor and out-game services
Provision of skill and vocational training
Referral services (for other services)

5.6.3 Response of Families and Communities towards OVC

Families and communities responses towards OVC were also examined. The families' treatment of the children, disciplining methods of the family, and the attitude of the community towards OVC were explored. The findings show that most of the OVC were not content with the support they were receiving form their caregivers and communities.

Regarding the treatment of OVC by their caregivers, the study found that most OVC were being subjected to inhuman treatment by their caregivers who were looking after them. Many of OVC were physically and emotionally abused especially when their closest relatives or caregivers in the household was not at home. According to them, the caregivers, through employing a variety of cunning strategies, were denying them access to food and assigning them to do heavy tasks. A double orphan child aged 13 said “my stepmother often sends me to fetch water when we are about to eat food and by the time I return she and her children would have finished eating all the foods.” Some OVC mentioned that their relatives who care for

them openly or subtly accused them of worsening their economic problems. An orphan boy aged 14 who has living with his uncle said "my uncle and his children often describe the good life they used to live before I moved in to their household and by so doing it becomes very clear to me that I am the source of their suffering as the household now struggles to make ends meet…They do not openly accuse me of causing their suffering but the stories make me very much uncomfortable."

The OVC who were ill-treated by their caregivers were in a quandary, as they did not know what causes of action to take to stop their further dehumanization. According to OVC, however, despite their displeasure in looking after OVC, some caregivers still did not want to let other relatives looking after OVC, as they feared being labeled as a cold-hearted by the community and relatives. They were masquerading as kind-hearted persons to get respect in the community. Furthermore, OVC said these caregivers were always quick to tell people that they were taking care for their late relatives' orphans despite mistreating the children. Some OVC said when other relatives offered to take them; the callous caregivers claimed that they were all living harmoniously as a family. One 14 year-old orphaned boy said "so what does my uncle who is openly hostile to me want from me by refusing to give me permission to go and stay with my aunt who have been offering to look after me?"

Another issue explored in relation to familial response towards OVC was the disciplinary methods employed by caregivers. In this regard, the majority of OVC indicated that mostly their caregivers use abusive forms of discipline such as scolding, insulting, physical punishment (beating), ignoring, ordering to do jobs and denied of food (withholding food) rather than using constructive forms of discipline methods such as advice.

Concerning the attitude and response of communities towards OVC in the study area, it is found that almost all of community members participated in the study was aware of the problems and situations OVC and their caregivers were facing, but they were not in a position of assisting them due to various reasons. The erosion of the social values, especially the need to assist members of the extended family, further exacerbated the situation. In relation to this, a guardian of nine orphans (coming from three families) stated "people no longer feel compelled to assist OVC as they argue that is burdensome to assist others when you can not adequately for their own children." Another caregiver of five orphans stated "many of us who are caring for OVC have ran short of ideas on how we fulfill basic needs like food, clothes, health, education….Not only communities and government, but also God has abandoned us."

Most community leaders who participated in FGD confirmed that OVC, especially AIDS-orphans, were socially isolated. A community leader who participated in FGD stated "since there is a misconception in the community that AIDS orphans can transmit the virus to them and their children, people including me find it very difficult to help and adopt OVC." Some community members indicated that some of the households in the communities are concerned about the conditions that OVC are facing but they do not assist them because they too are poor. According to them most of the households in their communities is poverty-stricken which makes it difficult for them to assist others. A woman who participated in FGD said "I am concerned about the situation of neighboring OVC but I don't materially or financially assist them because I am poor which makes it difficult for me to assist them."

5.6.4 The Adequacy of the Services Offered for OVC

The adequacy of the services rendered to OVC was also explored in this study. The data gathered from respondents, mainly OVC and their caregivers, shows that in spite of the

efforts made by various organizations, the services rendered for OVC were not adequate. In relation to this a guardian of three orphans stated "the services provided by NGOs were not adequate, but something is better than nothing." Another guardian mentioned that the services were not only inadequate but also not provided in a sustainable manner. A project coordinator of an NGO supported the idea forwarded by caregivers by stating that "our organization recognizes that the services provided for OVC were not satisfactory, but we can't do anything from the resource constraints we have and from the magnitude of OVC in this town."

Respondents, mainly key informants, were asked about the obstacles which inhibit rendering adequate support for OVC. The major recurring reasons identified by the respondents were financial constraints followed by lack of coordination efforts among organizations. Unable to identify problems and needs of OVC, lack of reliable information on the situation of OVC, lack of education, advocacy work, commitment and ownership were also mentioned by the respondents as a hindrance factor to provide adequate support for OVC.

6. DISCUSSION

This situational analysis of OVC in BahirDar town, the capital of Amhara Regional State, is the first attempt in the region of its kind. The study attempted to assess how the community define and describe OVC; the magnitude of the problem; factors contributing for the presence of OVC; impacts of HIV/AIDS on children, families and communities; the problems and perceived needs of OVC and the responses of various organizations towards the problems of OVC. This situational analysis shows the presence of many OVC in the study area, who have lost one or both parents, and others who are living in vulnerable circumstances. These children are likely to suffer food insecurity, poor health, educational deprivation, stigma

and discrimination, exploitation, problems related to inheritances, inadequate love and care, and other psychosocial problems. Pre-existing economic constraints combined with their caregivers' circumstances jeopardize their health, education, their well-being and safety. It is hoped that the findings will be useful for planning improved and coordinated interventions for OVC, thinking about policy and legal reforms and commencement further detailed research on this issue.

This part of the paper discusses the major finding results of the study and implications of the findings in relation to other similar studies.

Socio-Demographic Characteristics of Caregivers

The findings demonstrate that above three-quarter (77%) of the heads of households were women headed families with 77.3% above 50 years-old. Given that the average life expectancy at birth for Ethiopian is 46 year-old, this data indicate that theses women who care for the majority of OVC are heading towards the late years of their life span. The large numbers of women headed households demonstrate that women are still providing the bulk of care and support for OVC in the town. The gender of the heads of the households is an important issue to look at. Female-headed households generally assume care of more OVC than male-headed households do. As a result, female headed households with OVC have the highest dependency ratios (UNICEF, 2003).

The result of the study also indicates that second in line of responses to take in an orphaned child are grandmothers. Data collected from around the globe indicates that as a result of the increasing number of OVC and the shrinking of potential caregivers, OVC tend to live in bigger households headed by much older relatives (Foster and Williamson, 2000). Although grandparents may provide a secure and loving environment that helps children to

socialize, they may have difficulties responding to children's psychological, legal, economic and basic needs (World Bank, 2003). Grandparents may also be old, tired, and quite possibly to be sick. They usually face strong economic hardships with very little external support. The future care of the children living in a grandparent's home is in jeopardy as the current generation of grandparents will die. Anticipating permanent planning or some kind of alternative support before their death is required, in order to avoid OVC to be sent from one home to another.

The data from this study indicate that aunts and uncles are as likely to take in an OVC as a sibling with around 17% of OVC living with these members of their extended family. These households most likely also have their own children, and great tension is frequent when they add more dependents in to their family structure. Qualitative data from OVC indicate that the OVC experience is most difficult in the home of an aunt and uncle. They do not receive equal treatment in comparison to the biological children of the household; they are forced to dropout from school and work to bring income to the household; and they sometimes suffer stigma and discrimination from their cousins. This implies that family units have to consider whether they have the capacity to absorb and care for OVC. Rather than automatically accepting extra children, family members may argue that others are better placed to care for them (UNICEF, 2003).

About 36.7% of household heads interviewed for this study never attended school. Only 30% received informal education and 16.7% received formal education (from grade 1-4), which both indicates high numbers of caregivers were not receiving education and the literacy rates among them were also low. This affects OVC in terms of household economic status.

The income potential is less for those without education or who are illiterate leaving households reliant upon petty trade, and other daily work jobs.

Data on the economic and livelihood situation of OVC households show that monthly financial support of NGOs and other private lucrative work as their main source of income. A significant number of households also claim to have no sources of income and those that do average below 100 Birr per month (about 9 USD). The implications of these results indicate that household caring for OVC are living in or very near abject poverty. The majority of orphans are living with a surviving parent or grand parent. Others are absorbed in to the extended family system or older siblings. Almost all vulnerable children are living with one parent or other family ties. Whether the household contains orphans or vulnerable children, the economic status of that household in both cases was poor. They are struggling under the financial strain of caring for an orphan or vulnerable children and failing to provide or fulfill their needs.

Definition and Descriptions Used by the Community for OVC

The findings revealed that communities defined and describe an orphan as a child below 18 years-old who has lost one or both parents due to various reasons; and vulnerable child as a child who is less than 18 years-old whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights. Taking the definition and description of CRC as terms of reference to define and describe OVC, the result of the findings shows that communities in the study area were aware and have better understanding on the situation of OVC, which paves the way for child right advocates like social workers and others to mobilize the community to devise community based support for OVC. The distinction made by some

informants that OVC are those children without both parents, not just one, has implications for single parent households in an environment where policy exists to help double OVC as a priority.

OVC who are runaways from home and started to live on the street children are amongst the most vulnerable of vulnerable children. They start out believing that life on the streets, making their own way, will be better than life at home. In reality, they face great hardships and risks-lack of food and medical and physical abuse. In addition, there is a general negative attitude of communities to the presence of street children in their communities, regarding them as children with deviant behavior, as troublemakers or thieves. Without some intervention by others, they have little or no chance to return home (if that is the best solution) or to secure any reasonable kind of livelihood.

The Magnitude of the Problem and Factors Contributing For the Presence of OVC

The findings of the study on the magnitude of OVC shows that the problem of OVC in the study area was rampant and severe and the death of parent(s) due to AIDS is mentioned as the number one cause or the biggest factor for the presence and increasing number of OVC. This implies, if HIV prevalence indicates that an area is already hit, or is going to be hit, by AIDS related deaths and AIDS related deaths are the main reason for the presence of OVC. It follows that areas, which have a high HIV prevalence are also likely to be areas significant for OVC.

HIV prevalence is a key predictor for future AIDS deaths and therefore future OVC. The presence of OVC in a community today is a possible indicator that HIV has been around for some years back in that community. This becomes stronger if socio-demographic and economic factors are also considered i.e. the local features of the area that are likely to be

encouraging the spread of HIV like prostitution. Based on information from the studies on developing strategies and policies for support of HIV/AIDS infected and affected children (Hunters and Williamson, 1997), which suggests orphan-hood peaks approximately 7-10 years after sero prevalence, it would seem that there has been long-term HIV prevalence in BahirDar town as shown by the presence and increasing number of OVC.

The increasing of HIV prevalence figures obtained from antenatal clinic surveillance in BahirDar town (13% in 11998, 20.8% in 2000, 23.4% in 2002 and 20.8% in 2003) and the increasing number of OVC supports the finding of the study and the popular assumption that the prevalence of OVC is positively correlated with HIV infection (MOH, 2004). The above findings relating sero-prevalence also implies that OVC problem will continue for many years to come. Moreover, the finding of the study implies for GOs, NGOs, CBOs, FBOs and all community members that more comprehensive, community based and continuity interventions should be designed to slowdown the spread of HIV, in turn to reducing AIDS deaths and the subsequent impacts of the pandemic on children.

Extent of HIV/AIDS and Its Impact on Children, Families and Communities

The qualitative findings of the study show that the pattern of HIV/AIDS epidemic in the town is getting worse and worse from time to time. As it is indicated in the finding part, there were indicators (qualitative) that show the increasing pattern of the epidemic in the town. The finding of the study also revealed the major factors contributed for the spread of the pandemic in the town were poverty, unemployment, lack of political commitments, lack of community ownership, AIDS related stigma and discrimination, women's inability to negotiate safe sex and absence of female condom, lack of recreational centers, the absence of youth friendly VCT services, and expansion or ever increasing of chat and red-light houses.

The findings of the study shows children are profoundly affected as their parents fall sick and die, setting them on a long trail of painful experiences often characterized by economic hardship; malnutrition and illness; withdrawal from school; lack of love, attention and affection; psychological distress; loss of inheritance; increased abuse and risk of HIV infection; and stigma, discrimination and isolation. The impact of AIDS on families and communities are also stated in the way, parents, adult relatives, teachers, health care workers and others essential to the survival, development and protection of children are dying in unprecedented numbers. Millions of children are living with sick and dying parents or in poor households that take in OVC. Families and communities are also taking care of OVC willingly or unwillingly which increases another burden in the household. The finding also implies the general level of poverty and the growing demand for care and support of OVC in community have weakened social cohesion and traditional care and support mechanisms through extended families, which causes leaving many children without fulfilling their basic needs and vulnerable to other psychosocial problems

The findings of the study on the extent of HIV/AIDS and the sero prevalence of the epidemic supports the findings that HIV/AIDS was the major contributing factor for the increasing number of OVC currently and also in the future. Concerning factors which aggravates the spread of HIV/AIDS in the town implies that poverty is a root cause for the spread of the pandemic, which brings another factor which fuels the spread of the epidemic (the major factor contributes for the presence of OVC). Within this succession, the finding of the result implies the vicious circle of poverty, HIV/AIDS, presence of OVC and the impact of HIV/AIDS on children, families and communities. This implies the need for devising

strategies; programs and activities which focus on poverty reduction in parallel with preventing and providing support for infected and affected persons.

Problems of OVC and Their Perceived Needs

The loss of a parent(s), apart from the psychological trauma, signals a significant life change for many children. Thus, initially they may be split up from their siblings. They may enter a household much less economically secure than their previous one. They may enter a hostile household experiencing resentment or discrimination from other family members. If they have lost a mother, their father may re-marry and a stepmother can develop a very negative attitude towards the children of her new husband.

Due to the prevailing poor conditions of the families in which many OVC are living, OVC in general are lacking many basic needs. However, the discrimination existing within some families between biological children and others can make the problems more acute for OVC. They are, therefore, more likely to go hungry, miss out on schooling, be over-worked, be abused, punished or not be heard or listened to. Thus OVC, at the very least, need equality within the new family in terms of basic rights and access to the family's resources, schooling, health care, etc. In addition to that, OVC need extra help in adjusting to a new family or new environment and special consideration and understanding by new families and community members to cope with the trauma of losing their parents and their changing circumstances. This suggests some investment, information, education and training for caregivers and community members on how OVC can be supported psychologically. Where children are abused within the household, the need is for effective networks at community level to counsel those children and their caregiver and, in extreme cases, provide an alternative home for them.

Access to education is definitely as one of the major issues raised by all OVC and their caregivers as their basic needs in this study. Children and their caregivers saw it as hope, perhaps the only hope, for their future well-being. The sense of membership and belonging, afforded by a school community, is a chance for these children to secure support networks in the absence of parents and other sympathetic adults in their lives.

As a general backdrop, the situation in Ethiopia as far as access to schools is categorized into two. The first is primary level which is characterized mainly by free education system (there is no fee for school) which encourages and provides more school access and opportunities for children. The second is secondary and tertiary levels, in which the free education system is abolished. At this level families are expected to pay for school uniform, materials such as books and additional charges usually for building maintenance and other purposes (up to 150 Birr) which are beyond the reach of many families. At this level access to education becomes a challenge and threat for children.

The issue of school uniforms was mentioned so many times in this study as a barrier to enabling children to attend school, there is clearly a debate as to whether the lack of a uniform should be such a key issue. A lack of acceptable clothes, school materials and hygienic conditions at home i.e. just the availability of soap to wash, can be major disincentives to children to attend school, especially if teachers or fellow pupils ridicule them. Therefore, school principals and teachers have a key role to make generally be sympathetic to the problems and needs of OVC.

Many children are denied schooling because the families cannot afford to send them in the first instance (or to continue their education), because some children are barred or discouraged from attending by teachers or peers or because the families simply do not want to

send them. The abolition of school fees at primary level helps to alleviate some of the financial burden for families, although the issues of school materials and uniforms remain a threat for families starting from secondary level. A key point to emphasize is that many children in poorer families, not just OVC, fail to get their needs met in order to attend school. The key difference however is that when money is scarce and only some children in the family can be sent to school, the OVC are very often the ones left behind. However sometimes children and OVC in particular do not go to school because their parents or guardians do not value education. This may be because the parents/caregivers themselves did not receive education. Often it is because the parent/caregivers want the child/orphan as an extra labourer for the household, either working around the house or community or going out to earn money.

A final point is that the widespread provision of free primary education to all children could be perceived as a quick fix to the problems of OVC. Allowing access to schools is one of the easiest components of addressing children's needs so there is a risk that it will be promoted as having addressed the main problem faced by OVC. There is also the issue of quality of education to consider. With the expected increase in the number of pupils enrolling and attending, there will be increased pressure on infrastructure. Investments in education should have been undertaken by government and others, and more should be planned, all which should go some way towards solving against this risk.

Responses of CBOs, GOs and NGOs towards the Problems of OVC

Communities in the study area are found to be largely aware of the situation OVC and their caretakers are experiencing in meeting basic needs. They are also aware of the number of OVC resulting from deaths by AIDS, as AIDS deaths mostly not acknowledged or disclosed. Communities regard the issue of OVC as a family, NGOs and Government Issue, not an issue

of general concern is to that community. This is because there have always been OVC and they have always been absorbed by the extended family, so people think it is nothing new. Thus, because many people are unaware there is an almost total absence of community level initiatives to help these families. It was also evident that some people in communities do not value the idea of giving assistance other than in the sense of money or gifts in kind. This implies to a need to sensitize communities and discuss with them the value of different forms of support, which communities can offer to vulnerable families.

Furthermore, there is prevailing view among communities that government or NGOs, rather than communities, should take responsibility for OVC. This has certainly been encouraged by the interest of NGOs in OVC. Communities have observed people undertaking research or piloting interventions and they conclude that those people will take over the responsibility with ongoing interventions and funds to provide support for OVC and their caregivers. This fuels a lenient attitude. Some informants from NGOs and CBOs confirmed this by sayings that, at present, communities are just waiting for money to appear rather than creating their own solutions. This indicates that there is a real need to properly involve the community from the start in any plans for interventions; otherwise, the view that it is "someone else's issue" will prevail. More ideally, communities themselves should be encouraged and supported to come up with their own plans to assist OVC. Some communities seem to have taken the first step in recognizing the issue of OVC by revising their *Idirs* by-law to provide assistance for OVC. Some key informants mentioned that some local people are aware of families struggling, and are sympathetic, but are unable to assist because of their own hardships.

On the other side of the fence, the local government officers at community level do not appear to be of the view that these OVC are their responsibility. Government representatives would like their communities to be a lot more engaged on the issue of OVC but acknowledge that this will take a considerable amount of awareness raising and education. Thus, although they would like to get their communities involved, they are waiting for outside direction and support especially from donors. However, the local government leaders do not have access to funds and resources to undertake this kind of work which supports the idea that lack of political commitment as one of the barriers to tackle the pandemic in the town.

There is poor communication and low understanding between policy makers, service providers and beneficiaries. Both service providers and the beneficiaries at community level do not know even the existing pieces of laws and polices protecting the rights of children. In addition, there is considerable bureaucracy to get the services from service providers. For the beneficiaries, it appears to be like a lottery in that depending on how aware, proactive and motivated the local leaders are to act on their behalf, they may or may not win. An example of bureaucracy is in the case of exemptions from medical costs (to get free medication card), which have to be applied for through the layers of leaders-from bottom to top level. Even after they got the free medication card(if someone is lucky) passing through ups and downs, at the service provision level OVC sometimes find themselves faced with unexpected charges and some times hospital staff appears to make ad hoc decisions on what is and is not covered by the exemption.

To address these shortcomings, some NGOs and FBOS are undertaking marvelous work to directly help and support OVC and their caregivers. However, due to the limited geographical focus of these organizations support and community awareness activities are

limited to some selected kebeles. These organizations provide economical, psychosocial, and vocational and skill training for OVC in a very sporadic way. The services rendered for the beneficiaries are not based on the needs of them, but on the wish of the organization. For all organizations the provision of legal support for OVC and their caregivers are absolutely non-existent which shows the provided services are not comprehensive and supports the problems that most OVC and their caregivers are facing the problems of proper inheritances of properties. This implies for the importance of devising activities on legal provisions for OVC and their caregivers.

Coordination among these organizations has fluctuated over time and is strong among some organizations and weaker among others. An example of lack of coordination is reflected on the amount of financial support provided for OVC. Some organizations provide 75 Birr; others received 100 Birr while another organization provides 150 Birr per month per an orphan. This clearly implies lack of coordination among service providing agencies and the absence of guidelines on provision of support for infected and affected persons. The need for these organizations to work together and support more clients is increasing as the number of AIDS deaths rise and vulnerable children continue to be found on the streets.

The current capacity of all of these organizations is overstretched. Their future status is uncertain due to funding constraints, lack of other resources like vocational training centers and the need for staff capacity building and volunteer recruitment. Their source of funding mainly embarks on external donors which increases uncertainty for most organizations and their clients on the sustainability of the program. This implies that most service providing organizations in the study area are not acquainted with resources within the community to provide a sustainable community based interventions both for preventive and curative. NGOs

and especially international NGOs (who have access to more resources than local NGOs) have a crucial role in helping communities to understand, and come to terms with, the magnitude and longitude of the issue of orphaned children. Their role is to encourage and support communities to develop appropriate interventions to strengthen the capacity of families to care for their OVC.

7. CONCLUSION, RECOMMENDATION AND IMPLICATION FOR SOCIAL WORK PRACTICE

7.1 Conclusion

Taking the situational analysis of OVC as its central them, this study was conducted in BahirDar town, the capital of Amhara Regional State, northwest part of Ethiopia. The general objective of the study was to analyze, understand and present the current situation of OVC in BahirDar town. Under this superseding objective, the study attempted to assess how the community define and describe OVC; the magnitude of the problem; factors contributing for the presence of OVC; extent of HIV/AIDS and impacts of HIV/AIDS on children, families and communities; the problems and perceived needs of OVC and the responses of various organizations towards the problems of OVC. In this section of the study the conclusions that are made based on the findings are presented below.

1. The findings of the study pertaining to the local terms community members used to define and describe OVC in the study area leads to the following conclusion. (a) The local language *Yemute Legie*- to mean a child who lost both his/her biological parents, meaning a child both of his/her biological parents were died, was used by the community members in the study area to define and describe orphans. (b) The local language *Chigeragna Legoche* or *Lechiger*

Yetegaletu Legoche- to mean children who have no parent(s) who cares for presently or in the future and prone to multifaceted problems. (c) Generally communities in the study area defined and described OVC as a child below 18 years-old who has lost one or both parent(s), living in a very living difficult situation and missing many of his/her basic needs (food, health care, cloth, shelter and education), and prone to various vulnerability situations.

2. The findings of the study with regard to the magnitude of the problem of OVC in the study area leads to the conclusion that the magnitude of the problem of OVC in the town is high or increasing from time to time as evidenced by the presence of large number of OVC in the communities, and the number of OVC currently supported by organizations and registered in the waiting list to get support.

3. The findings of the study in relation to the foremost factors contributing for the presence of OVC in the study area leads to develop the following conclusions. (a) The death of parent(s) due to AIDS is the biggest factor, or the number one cause for the presence and increasing number of OVC in the town. Besides AIDS, other diseases such as malaria, typhoid and tuberculosis (TB) and accidents are another causative factor contributing for the increasing number of OVC. (b)Unplanned pregnancies among teenagers and amongst women engaged in prostitution; desertion of young pregnant girls by boy friends; poor parenting style; sickness of caregivers; family breakdown; rural-urban migration of children for various reasons; the weakening of family ties due to migration for search of jobs and tribal customs such as polygamy and informal marriage are factors which also all creates an environment in which vulnerable children are being produced. (c) In a nutshell, although the factors listed above are reasons for the presence of OVC, the causes are rooted in poverty, particularly insufficient

income; limited employment opportunities and unemployment; and large families within a household with limited means of income.

4. The findings of the study pertaining to the extent of HIV/AIDS, factors fuelling the spread of the pandemic, and the adverse impacts of the pandemic on children, families and communities, in the study area result in the following conclusions. (a) HIV/AIDS prevalence in the study area is rampant. Factors contributing heavily to the spread of the epidemic are poverty; unemployment and underemployment; lack of recreation places; rural-urban migration; expansion of chat, red light and illegal video houses; lack of political commitment and absence community ownership, secrecy, HIV/AIDS-related stigma and discrimination, women's inability to negotiate about safe sex, absence of open discussion on sex and sexuality matters and low IEC/BCC intervention.(b) Children are profoundly affected as their parents fall sick and die, setting them on a long trail of painful experiences often characterized by economic hardship; malnutrition and illness; withdrawal from school; lack of love, attention and affection; psychological distress; loss of inheritance; increased abuse and risk of HIV infection; and stigma, discrimination and isolation. (c)The impact of AIDS on families and communities are stated in the way parents, adult relatives, teachers, health care workers and others essential to the survival, development and protection of children are dying in unprecedented numbers. Millions of children were living with sick and dying parents or in poor households that take in OVC. Families and communities are also taking care of OVC which increases another burden in the household. The finding also indicate the general level of poverty and the growing demand support of OVC in community have weakened social cohesion and traditional care and support mechanisms through extended families. (d) Poverty,

the extent of HIV/AIDS and the adverse impacts of the pandemic on children, families and communities create a vicious circle.

5. Concerning the problems that OVC were facing and their main perceived needs, the findings of the study brings about the following conclusion.(a) food insecurity (nutrition problem), inaccessibility to proper medical treatment, clothing problems (mainly school uniform and night clothes), inaccessibility and dropout of school, stigma and discrimination/neglect at household and community level, labour exploitation and improper inheritance of the deceased property are major problems that OVC are facing. Most OVC also facing psychological problems such as feeling of hopelessness, fearfulness, depression, unhappiness, scary dreams/nightmares, isolation/loneliness, worry, aggression, frustration, anger and desertion.(b) Accessibility of schooling and attending schooling was the most recurrent perceived needs of all OVC and their caregivers. All OVC considered education as their main determinant factors for their future bright hope.

6. The findings of the study with regard to the responses of families, communities, government, NGOs and FBOs help to develop the following conclusions. (a) Extended families, mainly grandparents, aunts and uncles remained caregivers of OVC after the death of parent(s). (b) The majority of the communities were aware of about the general situation of OVC and caregivers, but failed to assist or support them mainly due to either the economic hardship communities are also facing or considered the issue of OVC as the concern of families, NGOs or government. (c) Governmental organizations have failed to provide any type of services for OVC. (d) NGOs and FBOs are taking initiatives to provide support for OVC, their caregivers and some times PLWHAs. They provide economical, psychological,

social, spiritual and skill training assistance for OVC and their caregivers. But, legal support which is one of the main components of the support system is absolutely non-existent. (e) The services rendered for OVC are not need based, comprehensive, adequate and provided intermittently.

7.2 Recommendations

Based on findings and conclusions of the study the following recommendations are suggested.

1. As evidenced from the high prevalence of HIV/AIDS and the accompanying economic and social impacts of the epidemic, the relevance of the existing HIV/AIDS policy towards both to prevent and control the epidemic and alleviating the plight problems of is questionable. This also shows that the current HIV/AIDS policy fails to both to curb the pandemic and to address the issues of OVC adequately. Thus, immediate attention and action should be given and undertaken to the revision of the policy to curb the pandemic. There should be also strategies, which enable communities to talk more openly about HIV/AIDS. This can dispel myths, raise awareness, and engender compassion. In addition, community and culturally based HIV/AIDS prevention strategies should be devised, and paralleled with the prevention of the epidemic; community level poverty reduction strategies through creating employment opportunities should be designed.

2. The protection of OVC should be ensured through improved policy and legislation. There should be national policy and strategy on OVC to address their issues and needs adequately. There is also need to revise the existing legislation in light of the emerging problems associated with HIV/AIDS related stigma and discrimination. Awareness of community

should be developed, particularly women and children should be empowered, to enable them observe the existing legal provisions that are enacted to protect women and children. The level of awareness and capacity of legal enforcing agencies should be strengthened to ensure the observance of the various welfare rights of OVC.

3. A supportive environment for OVC and their families should be created by raising awareness through advocacy and social mobilization. OVC are frequently victims of stigma and discrimination, hostility, isolation and human rights violations. To this end, all stakeholders should have to play a role in awareness raising and social mobilization to build a more supportive environment. Intensive advocacy work should be carried out at national, regional and local level to sensitize concerned government officials, opinion leaders, religious leaders and others to enable them understand, appreciate and develop commitment towards OVC. Building broad collaboration among key stakeholders in all sectors should also be considered. To meet the needs of OVC there have to be broad networks and targeting advocacy at all levels including national, regional, and local to involve government, civil society, NGOs and FBOs in a shared initiatives for community action.

4. The care and coping capacities of families and communities should be strengthened. The first line of responses to the needs of OVC comes from extended families. Strengthening the capacity of families and communities to fill the widening gaps in the safety net traditionally provided by the extended family may be the most cost effective, efficient and sustainable way of assisting OVC.

5. There should be the involvement of children and OVC as part of the solution. Children are not simply a passive, powerless target group to be aided, but capable actors and important

resources to engage in a community response to OVC problem and HIV/AIDS. OVC should be aware of their rights and encouraged to take actions to ensure the observance of their rights. They should participate in meetings focused on identification of issues that affect OVC, and in advocacy and policy formulation, including in program planning, implementation and evaluation related to OVC.

6. Succession planning should be expanded and supported. There is an urgent need to significantly expand activities geared to helping parents plan for their children's future. These includes in disclosing their illness, comforting children in their grief, making a will and other arrangements, such as identifying a appropriate caretakers and seeing the preparation and passing of legal documents. Planning in advance will help parents ensure a better future for their children and alleviate a major source of emotional distress and other psychological problems.

7. Access of essential services for OVC should be ensured. For the maximum well-being of OVC need to have access to essential services including health care, nutrition, clothing, psychosocial, education and others. Specially, the main perceived needs of OVC, access to school, should be ensured. This is because education plays a vital role in the well-being of children. It offers them a chance for their future. Furthermore, the rendering services should be assessment based, comprehensive and provided in uninterrupted way. Service providers should address the legal service supports of OVC and their caregivers. Linking the rendering support and prevention also considered. OVC are themselves at high risk of HIV infection due to economic hardships and loss of parental care and protection. For this reason alone, care programs should include a strong prevention component targeting children.

8. Further detailed, comprehensive, participatory research should be done in collaborations with all concerned bodies to assess the overall situation of OVC in the study area and to respond accordingly.

Implications for Social Work Practice

This situational analysis of OVC shows the presence of many OVC, who have lost one or both parents and others who are living in vulnerable circumstances. These children are likely to suffer food insecurity, poor health, educational deprivation, stigma and discrimination, exploitation, problems related to inheritances, inadequate love and care, and other psychosocial problems. Pre-existing economic constraints combined with their caregivers' circumstances jeopardize their health, education, their well-being and safety. The findings of the study have a great implication for social work practices in the area policy formulation, advocacy, community mobilization, empowerment, service provision, and assessment and research areas both for in preventive and curative program.

REFERENCES

Amare Sewenet (2005). Analysis of Impacts of HIV/AIDS on Proximal Determinants of Fertility: The case of Bahirdar city, AA, Ethiopia, AAU, (MA Thesis)

BahirDar Town HIV/AIDS Prevention and Control Office reports of 2003, 2004, 2005 and 2006. BahirDar, Ethiopia

Central Statistics Authority (1995). *Population and Housing Census, Country Level*: Results of Amhara Region. AA, Ethiopia

Central Statistics Authority (1998). *Population and Housing Census, Country Level*. AA, Ethiopia

Central Statistics Authority (2001). *Demographic and Health Survey 2000.* AA, Ethiopia

Central Statistics Authority (2001). *Ethiopia -Child Labour Survey Report.* AA: Ethiopia
Civil Code (1960). AA, Ethiopia

Family Health International (2005). *A framework and Resource Guide for Conducting a Participatory Situation Analysis of Orphans and Vulnerable Children Affected by Affected by HIV/AIDS.* Arlington, USA

Federal Democratic Republic of Ethiopia (1995). *The Constitution of Federal Democratic Republic of Ethiopia.* AA, Ethiopia

Federal Democratic Republic of Ethiopia (1998). *Policy on HIV/AIDS.* AA, Ethiopia

Federal Democratic Republic of Ethiopia (2000). *The Revised Family Code, Proclamation No. 1/2000.* AA, Ethiopia

Foster G. & J.Wiliamson (2000). *A review of current literature of the impact of HIV/AIDS on children in sub-Saharan Africa.* AIDS 2000 Year in Review, vol.14, No.3

HIV/AIDS Prevention and Control Office (2004). *Ethiopian strategic Plan (2004-20080 for Intensifying Multi-Sectoral HIV/AIDS Response*. AA, Ethiopia

Hunter S. & J. Williamson (1997). Developing Strategies and Policies for support of HIV/AIDS infected and affected children, draft report for USAID

International Save the Children Federation (2004).Positive Change: Children, Communities and Care (Pc3) program, Project proposal submitted to USAID

John Williamson, Adrienne Cox & Beverly Johnston (2004. *A Framework and Resource Guide for Conducting situational Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS*. Arlington, USA

Joint United Nations Program on HIV/AIDS (2004). *Children on the Brink 2004*: A Joint Report of New Orphan Estimates and a Framework for Action, Washington, D.C, USA

Joint United Nations Program on HIV/AIDS (2004). *The Framework for the protection, care and support of orphans and vulnerable children living in the world of HIV/AIDS.* NY.USA

Ministry Of Health (2001). *Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2001- 2005.* AA, Ethiopia.

Ministry of Health (2001). *Strategic Framework for the National Response to HIV/AIDS in Ethiopia for2001-2005.* AA, Ethiopia

Ministry of Health (2004). *AIDS in Ethiopia 5th edition:* Background, Projections, Impacts and Interventions. AA, Ethiopia

Ministry of Labour and Social Affairs (1996). *Developmental Social Welfare Policy.* AA, Ethiopia

Ministry of Labour and Social Affairs (2003). *Survey on the Prevalence of and Characteristics of AIDS Orphans in Ethiopia.* AA, Ethiopia

Ministry of Labour and Social Affairs (2004).*Ethiopia's National Plan of Action for Children (2003-2010 and beyond).* AA, Ethiopia

Organization of African Unity (1990). *African Charter on the Rights and Welfare of the Child.* AA, Ethiopia.

Penal Code of Ethiopia (1957). AA, Ethiopia

POLICY Project/The Future Groups (2004). Rapid Country Response Analysis: Ethiopia, draft Report. AA, Ethiopia

United Nations (1989). *The Convention on the Rights of the Child.* NY.USA

United Nations (2002). Report of the AdHoc Committee of the Whole of the 27th Special Session of the General Assembly: *A World Fit for Children.* NY, USA

United Nations children's Fund (2003). *Africa's Orphaned Generations.* NY, USA

United Nations Special Session on HIV/AIDS (2001). *The Declaration of Commitment General Assembly Special Session on HIV/AIDS.* NY, USA

World Bank (2003). *Orphans in sub-Saharan Countries: a Framework for Public Action.* NY, USA

ANNEXES

Annex I

Verbal Consent Form for Participants of the Study

Introduction

My name is Gardachew Tiruneh. I am from graduate school of social work at AAU. I am currently collecting data regarding the present situation of orphans and vulnerable children to understand the current situation of OVC in BahirDar town. As part of my assessment, I am talking to a wide cross section of people in the town. I would use the information for fulfill my thesis requirement and to present information to help those concerned bodies to plan activities that will address the identified needs of orphans and vulnerable children.

Confidentiality and consent

I may ask some personal questions that some people find difficult to answer. I am not going to talk to any one about what you tell me. Your answers are completely confidential. Your name will not be written on this form and will ever be used in connection with any of the information you tell me. You don't have to answer any question that you don't want to answer, and you may end this interview at any time you want. However, your honest answer to these questions will help me better understand the present situation of OVC in this town. I would greatly appreciate your help in responding to this study. The interview will take 45minutes to an hour. Would you be willing to participate?

Signature if interviewer_____

(Respondents have given certifying that informed consent verbally)

Annex II

INTERVIEW GUIDE FOR ORPHANS AND OTHER VULNERABLE CHILDREN

I. BACKGROUND INFORMATION

1. Sex [male] [Female]
2. Age_____
3. Ethnicity_____
4. Religion _____
5. Type of respondent

   A. Maternal orphan B. Paternal orphan C. Double orphan

   D. Street children E. Others (specify) _____

II. EDUCATIONAL BACKGROUND

1. Are you currently in school? [Yes] [No]
2. What school do you go to? _____

   (Record answers to be government, private, community school)
3. What grade are you in? _____
4. What are the reasons for not currently in school?

   A._____

   B._____

   C._____

III. FOOD INTAKE

1. How many meals do you usually have per day? (Write the number)_____
2. What is the usual meal like? (List all the food item) _____
3. Did you eat any thing yesterday? [Yes] [No]
4. What did you eat yesterday during morning, lunch and dinner?

   Morning_____ Lunch_____Dinner_____

IV. PSYCHOSOCIAL ISSUES

I. Background Information on Father

1. Is your father alive? _____. **If yes, skip to Q 11**
2. When did he die? _____
3. What do you think the cause of his death? _____
4. After your father died, what did you do to help your self feel better?

   A. Talked to friend B. cried C. Talked with relative D. pray E. Nothing

   F. Others (specify) _____
5. Did your father discuss his health condition with you before died? _____

   If yes, skip to Q 8

6. Did any one else discuss this with you? [Yes] [No]

7. With whom you did discuss with about the health condition or death of your father? _____

8. What has changed in your daily life / circumstances / and soon since your father died? **DON'T** read the list of response. **CIRCLE** if respondents mention the response. And, **PROBE** to get further answer.

A. my school attendance has declined B. dropout of school

C. I have to do more chores D. I have to care my smaller children

E. We have less food/ money as a family F. No shelter

G. I have less food/clothes as an individual H. Nothing at all

I. Others_____

9. How has the loss of your father affected the way you feel about life?

DON'T read the list of response. **CIRCLE** if respondents mention the response. And **PROBE** to get further answer.

A. Sad, Unhappy B. Sorrowful C. Worried D. Angry

E. Scared F. Isolated, alone G. Resolute, determined

H. Others (Specify) _____

10. What do you miss most about your father? **Skip to Q 16 after this response.**

_____

11. Are you living with your father right now? [Yes] [No]

12. Why don't live with him? _____

13. Do you ever visit your father? _____

14. How often do you visit your father? _____

15. If you don't visit him, please state briefly why you didn't visit your father?

A. _____

B._____

C. _____

II. Background information on Mother

16. Is your Mother alive? _____. **If yes, skip to Q 26**

17. When did she die? _____

18. What do you think the cause of her death? _____

19. After your Mother died, what did you do to help your self-feel better?

A. Talked to friend B. cried C. Talked with relative D. Pray E. Nothing

F. Others (specify) _____

20. Did your Mother discuss her health condition with you before died?

[Yes] [No] **If yes, skip to Q 23**

21. Did any one else discuss this with you? [Yes] [No]

22. With whom you did discuss with about the health condition or death of your mother?

23. What has changed in your daily life / circumstances / and so on since your Mother died? **DON'T** read the list of response. **CIRCLE** if the response is mentioned by respondents. And **PROBE** to get further answer.

A. my school attendance has declined B. dropout of school

C. I have to do more chores D. I have to care my smaller children

E. We have less food/ money as a family F. No shelter

G. I have less food/clothes as an individual H. Nothing at all

I. Others_____

24. How has the loss of your Mother affected the way you feel about life?

DON'T read the list of response. **CIRCLE** if respondents mention the response. And PROBE to get further answer.

A. Sad, Unhappy B. Sorrowful C. Worried D. Angry

E. Scared F. Isolated, alone G. Resolute, determined

H. No feeling (Neutral) I. Others (Specify) _____

25. What do you miss most about your Mother? **Skip to Part V after this response**._____

26. Are you living with your Mother right now? [Yes] [No]

27. Why don't live with her? _____

28. Do you ever visit your Mother? [Yes] [No]

29. How often do you visit your Mother? _____

30. If you don't visit her, please state briefly why you didn't visit your Mother?

A. _____

B._____

C. _____

V. OVC GUARDIANS/ CARE GIVERS RELATION SHIP

1. With whom you are living right now? (What is the relation ship to your guardian or caregiver)? _____

2. How long did you live in this household? _____

3. What do you do when you have a problem in the household you lived now?

A. Talk to some body B. Cry C. Ignore it D. Pray

E. Nothing (keep it my self) F. Others (specify) _____

4. Who is the first person you talk to when you have a problem or worry? **If the response is no one/ keep it my self skip to Q 6.**

5. If this person is not available to talk to, who is the next person you go to when you have a problem? ___

6. Before _____ began to care of you, how often did you see him/ her?

A. Lived in the same house hold, all the time B. a few times a week

C. A few times a month D. Rarely

E. Never

7. Before _____ began to take care of you, how well do you know him/her?

A. Very well B. A little bit C. Not at all

8. Before _____ began to take care of you, how well do you like him/her?

A. Very well B. A little bit C. Not at all

9. When _____ **FIRST** began to care for you, how did you feel about the new household? **DON'T** read the list of response. **CIRCLE** if the response is mentioned by respondents. And **PROBE** to get further answer.

A. Sad, Unhappy B. Worried C. Angry D. Scared E. Isolated, alone F. Comforted G. Happy H. No feeling (neutral)

I. Others_____

10. What is different about your life since you moved in to this household?

11. How has living with this guardian in his/her household affected the way you feel about life? **DON'T** read the list of response. **CIRCLE** if the response is mentioned by respondents. And **PROBE** to get further answer.

A. Sad, Unhappy B. Worried C. Angry

D. Scared E. Isolated, alone F. Resolute, determined

G. Comforted determined H. Happy contented I. No feeling (neutral)

J. Others_____

12. What would like your _____ to do more of?

13. What would like _____ to do less of?

14. Do you think that adults treat OVC differently from other children?

[Yes] [No] **If No, skip to Q 18.**

15. If yes, how do they treat OVC differently? **DON'T** read the list of response. **CIRCLE** if the response is mentioned by respondents. And **PROBE** to get further answer.

A. Favoring those with parents B. Support provided not equal

C. Mistreat OVC D. Treat OVC kindly

E. Favor OVC F. Love given to OVC is Conditional

G. OVC has to work for things H. others_____

16. Do you treat you this way? [Yes] [No] **If No, skip to Q 18**

17. If yes, how does this make feel?

A. Sad, Unhappy B. Sorrowful C. Worried D. Angry

E. Scared F. Isolated, alone G. Comforted H. Happy

I. Others_____

18. Does your guardian treat you better; the same or worse in relation to his/her own children?

A. Better B. Same C. worse D. No own biological children

19. Does your guardian treat you better; the same or compared to other children you found when you moved in to this house hold?

A. Better B. Same C. worse D. No other children in the house hold

22. How does such treatment make you feel? _____

23. What are the major problems you are facing being an orphan/ vulnerable children?

A. _____

B._____

C. _____

24. What are the major needs do you want to meet?

A. _____

B._____

C. _____

VI. CHILDREN'S FEELINGS ON LATE MOTHER/ FATHER

1. What major things are you not able to do now which do you liked doing when your father or mother was alive?

2. is there any thing still bothering you about your parent(s) death? _____

3. If yes, what are these things?

1. _____

2. _____

3. _____

4. Do you have any special personal items of your father/ mother?

[Yes] [No] **If No, skip to Q 8.**

5. What are those items that you have?

A. Photos B. Cloths C. Jewelry D. letters

E. Others (specify) _____

6. When did you look at these things? _____

7. How do you feel when you look at these things?

A. Content B. Happy C. Warm D. Sad E. Angry F. Others_____

8. Do you wish that you could have some of these things?

[Yes] [No]

9. Why do you wish to have those Items? _____

VII. HIV/AIDS ISSUES AND RELATION SHIPS IN THE HOUSEHOLDS

1. Do you think parents/guardians should talk about their health condition with their children? A. Yes B. May be C. No

2. If Yes or may be, why? _____

3. If No, why? _____

4. Can you tell me about the health problems that your parent (s) had before they died? If the respondent(S) mentioned or identify case of HIV/AIDS**, Proceed to Q 5, If not proceed to Q 6.**

5. Do you think parents with HIV/AIDS should talk about their health condition with their children? A. Yes B. May be C. No

- If Yes or may be, why? _____
- If No, why? _____

6. How many children of the same father and mother or other children lived with you in your parents' home before moving to this house hold?

Boys_____

Girls_____

7. How many of these children live with you now in the same household?

Boys_____

Girls_____

8. Do you visit your brothers and sisters or other children who used to live with you but now live away from this home? [Yes] [No]

9. How do you feel about being separated from your brothers and sisters and other children? _____

10. How do you get you moved in to this household? _____

11. How do you get along with other children in this household? _____

12. How do you get along with your guardian? _____

13. How do you feel living in this home? _____

14. Why you feel this way? _____

XIII. EMOTIONAL WELL-BEING CHECK LIST

Using the following scale, please rate each item and record the response in number on the space next to that item.

1. Very Often 2. Often 3. Sometimes 4. Rarely 5. Never

_____ 1. How often would you say that you have scary dreams or nightmares?

_____ 2. How often would you say that you ever feel unhappy?

_____ 3. How often would you say that you ever get in to fights with other Children?

_____4. How often would you say that you prefer to alone, instead of playing With other children?

_____5. How often would you say that you ever feel worried?

_____6. How often would you say that you ever feel frustrated easily when Something doesn't go your way?

_____7. How often would you say that you ever become very happy?

_____8. How often would you say that you ever feel angry?

_____8. How often would you say that you ever feel afraid of new situation?

_____9. How often do you feel hopeful?

_____11. How often would you say that you ever feel like running away from home in the last 6 months?

12. How many times in the last 6 months have you actually run away from home?

13. Tell me something about your life that makes you happy?

14. Who would you admire most? (Indicate the name of the person admitted and profession)_____

Annex III

INTERVIEW GUIDE FOR HEADS OF THE HOUSEHOLDS OF OVC

I. BACKGROUND INFORMATION

1. Sex [male] [Female]

2. Age_____

3. Educational status_____

4. Marital status_____

5. Ethnicity_____

II. HOUSEHOLD ECONOMIC STATUS

1. What are the sources of income earned for the household?

   A._____

   B. _____

2. How much money did the household earn monthly from the above mentioned sources of income?

3. Do you think that the monthly income/ money earned enough to meet the needs of the household? [Yes] [No]

4. If No, what other mechanisms does the family have to meet the needs of the families in the household?

   A._____

   B. _____

   C. _____

5. Yesterday how many meals did the family eat? (Write the number of meals they eat)_____

6. What did you eat for those meals yesterday? (List all food items)_____

7. Do you own this house or rent?

   A. Own B. Rent C. Non-payment tenant D. Others_____

8. Total number of rooms in the main household occupied by the household? (Observe and record the number of rooms)_____

9. What material is the roof of the hose and wall of the house made of?

(Observe and record) Roof_____ Wall_____

10. What is the source of light for the house? _____

11. What do use to cook your food? _____

12. Where do you get your drinking water? _____

13. Where do you use latrines? _____

14. Where do take shower or bathing? _____

III. GENERAL LIVELIHOOD ISSUES AND HOUSEHOLD ACCESS TO SUPPORT SERVICES

1. What is the source of income to the household to meet the needs of the family?

   A._____

   B. _____

2. Are you receiving any form of assistance from outside your household for the care of OVC? [Yes] [No]

3. If yes, what kind of assistance do you have received to care OVC and who provided the assistance?

A._____ From_____

B. _____ From_____

C._____ From_____

4. How regular the support is provided?

A. Once a week D. Once in Six months

B. Once a month E. Once a year

C. Quarterly F. Others (specify) _____

5. How you spread the assistance you get from others?

A. For OVC only

B. For all children in the household

C. For all family members in the household

D. Others (Specify) _____

6 In the last one year, have you received any type of classes or training?

[Yes] [No}

7. What type of training did you received and who provided the training?

A._____ From_____

B. _____ From_____

C._____ From_____

8. Is there a Committee of "Orphan and Vulnerable Children" in this community/town? [Yes] [No}

9. If yes, what does this committee do?

A._____

B. _____

C._____ _____

10. How helpful has this committee been in providing support to families with orphans and vulnerable children? _____

IV. PERCEPTION OF GUARDIANS ON HIV/AIDS AND RELATED ISSUES

1. Have you seen an increase in the number if OVC living in this community/ town? [Yes] [No]

2. What are the main reasons that children are being Orphan and are Vulnerable in this town/community?

A._____

B. _____

C. _____

3. Do you have seen an increase in the number of families taking care of OVC in this community/ your neighborhood? [Yes] [No]

4. Have you seen an increase in the number of People Living with HIV/AIDS in this town/ community?

[Yes] [No]

5. What are the main factors for the spread of HIV/AIDS in this town?

A._____

B. _____

C. _____

6. What you suggest to reduce the spread of HIV/AIDS in this town?

A._____

B. _____

C. _____

7. What are the biggest concern facing your community with regard to HIV/AIDS?

A._____

B. _____

C. _____

8. What are the main problems that OVC you have taken in are facing?

A._____

B. _____

C. _____

9. What are the main needs of Orphans and other vulnerable Children you have taken in?

A._____

B. _____

C. _____

10**.** What are the main concerns that you have for OVC you have taken in?

A._____

B. _____

C. _____

V. RELATION SHIP IN THE HOUSEHOLD

1. How many children are live in this household? (Write the number)

Boys_____ Girls_____

2. How many children whose parent(s) have died or whose parent(s) are a live but are in need live with you? (Write the number)

Boys_____ Girls_____

VI. PSYCHOSOCIAL ISSUES

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

2. Are there any conflict between the children you have taken in and your own children? [Yes] [No]

3. What are the common causes for this conflict?

A. _____

B._____

C._____

4. What do you do about the children (OVC) and your own children during conflicts?

A. _____

B._____

C._____

5. How well the children you have taken in get along with one another?

(For families who have taken in more than one OVC)

6. With whom do the children do you have taken in spend most of their time?

A. _____

B._____

C._____

7. With whom do the children do you have taken in usually talk with when they are worried or have a problem?

A. _____

B._____

C._____

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

9. How often have you talked with the children about their deceased parent (s)?

10. Have either of the parent(s) of the children you are taken in been seriously ill? [Yes] [No]

11. How has the illness or death of their parent (s) affected the children's daily life? 12. How has the illness or death of their parent (s) affected the way the children feel about life?

VI. EMOTIONAL WELL-BEING CHECK LIST

Using the following scale, please rate each item and record the response in number on the space next to that item.

1. Very Often 2. Often 3. Sometimes 4. Rarely 5. Never

_____1. How often do the children you have taken in have scary dreams or night dreams?

_____2. How often do the children do you have taken in feel unhappy or sad?

_____3. How often do the children do you have taken in ever get in to fights with other children?

_____4. How often do the children do you have taken in prefer to alone, instead of playing with other children?

_____5. How often do the children do you have taken in refuse or resist going to school?

_____6. How often do the children do you have taken act disobediently at school?

____ 7. How often do the children do you have taken act disobediently at home?

_____8. How often do the children do you have taken in attack children?

_____9. How often do the children do you have taken in feel worried?

_____10. How often do the children do you have taken in feel frustrated easily?

_____11. How often do the children do you have taken in feel afraid of new situation?

13. How many times in the last 6 months has one of the children you have taken in run away from home?_____

14. Is there anything about these children that makes them feel differently from other children in the household? [Yes] [No}

15. If yes, what is it?

A. _____

B. _____

C._____

VII. CHILD HEADED HOUSEHOLDS (ONLY FOR HOUSEHOLD HEADS AGE 18 AND BELOW)

1. When did you assume the responsibility of being the heads of this household?

2. How many biological brothers and sisters (who have the same mother and father as you) are you looking after in this house hold?

Boys_____ Girls_____

3. How many other children who do not have the same mother and father as you are taking care of?

Boys_____ Girls_____

4. Are any members of the family earning income? _____

5. What types of work?

A. _____

B._____

C._____

6. If you depend on the support from relatives other institutions how regular is the support? 7. If you depend on the support from relatives other institutions how is the support? 8. What is the nature of the support you receive?

A. _____

B._____

C._____

9. What do you see as the greatest challenge of heads of house holds?

_____

Annex IV

INTERVIEW GUIDE FOR KEY INFORMANTS

1. Name of the organization_____
2. Type of organizations_____
3. Date of establishment_____
4. Name of interviewed person/position_____

   Telephone_____
5. what is/are the objectives of the organization
   a) _____
   b) _____
   c) _____

6. Does your organization work related to Orphans and vulnerable Children?

   Yes [___] No [___]

7. If your organization supports OVC, how does your organization define OVC? Where this definition does comes from?

8. Have you noticed in this town an increase in the number of OVC?
   - How big is the problem of OVC now?
   - What are the major causes of the increment of OVC in this town? (Probe the impact of HIV/AIDS).

9. Do you think the spread of HIV/AIDS in this town is increased or decreased?
   - What are the major reasons for the spread of HIV/AIDS in this town?
   - How can be the spread of the pandemic reduced?
   - How do you think that HIV will affect the people in this town/community

10. What are the major problems facing OVC in this community? Probe:
    a. Support needs(food, clothing, shelter, education)
    b. Care needs (medical, counseling)
    c. Stigma and discrimination

12. What type of assistances/ services does your organization provide to OVC?
    - Food [___]
    - Clothing [___]
    - Financial [___]
    - Education [___]
    - School fee & other related costs [___]
    - Health care [___]
    - Counseling [___]
    - Training (IGA) [___]
    - Others (specify)_____

13. Does your organization have access to legal services for children and their families under your case? Yes [___] No [___]

14. Do you think that the existing care and support is adequate and sustainable? How can the existing care are improved

15. Complete the following table estimating the number of beneficiaries supported by your organization to know whether the number of children who are in need are increasing or decreasing.

Year of services	Number of Beneficiaries		
	Female	Male	Total
2003			
2004			
2005			
2006			

16. What type of assistances/ services does your organization provide to OVC care givers/guardians?

1. _____
2. _____
3. _____
4. _____

17. What are the sources of funding to the organization to provide care and support for OVC? Please include any community contribution?

a) _____
b) _____
c) _____

18. What problems your organization is facing in relation to providing care and support for OVC?

Annex V

INTERVIEW GUIDE FOR USE WITH GOVERNMENT OFFICES

- Name of Respondents_____
- Title/position_____
- Office_____

1. Who in this town is regarded as an Orphan and Vulnerable Children?
    - What categories of children are in greatest need of support in this town?
    - How do families in this town provide care for the needs of orphans (e.g., parental care, shelter, education, clothing, health care)?
    - How do communities in this town provide for the needs of needy children?
    - Where does the definition of an orphan come from (e.g., national legal definition, developed by town)?
2. Have you noticed in this town an increment of OVC?
    - How big is the problem of OVC?
    - What are the major causes of the increment of OVC in this town? (Probe the impact of HIV/AIDS)
3. What are the major problems facing OVC in this community? Probe:
    - Support needs(food, clothing, shelter, education)
    - Care needs (medical, counseling)
4. Do you think HIV/AIDS has affected the situation of orphans and children in need in this town?
    - In what ways has HIV/AIDS affected the situation of orphans and children in need in this town?
5. Do you think the spread of HIV/AIDS in this town is increased or decreased?
    - What are the major reasons for the spread of HIV/AIDS in this town?
    - How can be the spread of the pandemic reduced?
    - How do you think that HIV will affect the people in this town/community
6. What are the specific policies of the government regarding children in these categories? Are these written policies? (Request copies where available).
    - Is there a specific policy for orphans, children affected by AIDS, or needy children? If not, are there plans for one in the future?
    - What efforts and measures are in place to ensure effective implementation and monitoring of existing policies?
7. What programs does your office have in place to support OVC? (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?
8. What are the limitations of these programs? Explore how limitations can be addressed (i.e., adequacy, coverage, and sustainability).
9. What problems the office is facing with regard to OVC?

Annex VI

FGD GUIDE WITH CHILDREN AGES 13–18 YEARS

Number of participants Male_____ Female_____

1. What are the major problems you are facing?

2. What are your major needs that you want to meet? Probe

- To meet your basic needs who helped you.
- Where do these helps come from?
- How regular and adequate is the support?

3. What has changed for you since the death of your parent(s)?

4. What was discussed with you concerning what would become of you after your parents died?

- How helpful was that discussion?
- If there were no discussion, what would you have wanted to happen?
- Which plans were adhered to and which were not?

5. For those of you whose parents were sick before they died, what did they discuss with you with regard to their health condition?

• What was the cause of their death(s)?

• What still bothers you about your parent(s)/guardian(s) dying?

• What new roles did you have to take up during your mother/father's illness?

6. What did you do that made you feel better before your parents died and after they died? (Typical responses include: I visited them in the hospital or wherever they were; I cooked his or her food; I prayed for him or her)

• What things were there that you wanted to do for your sick parent that you were stopped from doing?

• If the respondent answers "Nothing," ask, "What do you think children can do to make themselves feel better?"

• What do you do now when you experience this pain?

Do you cry or talk to a friend, caregiver, and priest/pastor/church elder; seek solace in alcohol; use drugs; have sex?

7. What do you do when you have a problem?

• Who do you talk to? What problems do you talk about?

• How do you feel after you have talked to these people?

8. What worries do you have about life? How often do you worry about life?

9. What do you plan to be when you grow up?

Annex VII

FGD GUIDE FOR USE WITH HEADS OF HOUSEHOLDSOF OVC

Number of participants Male_____ Female_____

1. Compared to you your grand parent's time, what has changed regarding care of each other and children? How is it different today? Probe:

• What practices found in your grandparents' time are still in place?

• What practices that supported orphans or children in need those are no longer in place would be helpful if they were revitalized?

2. Have you noticed more vulnerable children or orphans in this town/community?

    • What do you think are some of the reasons for the increase or decrease in the number of orphans and vulnerable children in this town/ community?

    • What effect do you think that HIV has had on the well-being of children? (Ask this question only if it has not been mentioned earlier).

3. Do you think the spread of HIV/AIDS in this town is increased or decreased?

- What are the major reasons for the spread of HIV/AIDS in this town?
- How can be the spread of the pandemic reduced?
- How do you think that HIV will affect the people in this town/community?

4. What were your reasons for taking in the children you are caring for?

5. What problems do you face in looking after orphans and vulnerable children?

6. What are the major problems that OVC are facing?

7. What do you think are the best ways to take care of vulnerable children and orphans? Probe:

    • Who should be responsible? (Immediate or extended family; adoption group; foster care family; institution)

8. Who takes care of children in need and orphans in your community, other than people such as you? Probe:

    • Is existing care adequate and Sustainable?

    • What other help is available? List known resources

    (e.g., communities, churches, clinics, projects, government structures)

9. Recognizing that communities are the front line for caring and supporting orphans and vulnerable children, do you have any ideas about how we can increase the capacity and numbers of community members to take responsibility for orphans and vulnerable children?

10. Do you want to add some thing before we conclude and close our session?

Annex VIII

FGD GUIDES FOR USE WITH COMMUNITY LEADERS

Number of participants Male_____ Female_____

1. Who in this community is regarded as an Orphans and Vulnerable Children?

(Explore child's age, dead parent's sex)

2. How did families and communities take care of each other, especially orphans and children in need, during your grandparent's time?

- Which of these practices are still in place?
- Among the practices that are no longer in place, which would be helpful if they were reintroduced?

3. Have you noticed in this community an increase in the number of OVC?

- Why is so?
- How big is the problem of OVC now in BahirDar town?
- What are the major causes of the incensement of OVC in this town? (Probe the impact of HIV/AIDS)?

4. Do you think the spread of HIV/AIDS in this town/community is increased or decreased?

- What are the major reasons for the spread of HIV/AIDS in this town?
- How can be the spread of the pandemic reduced?
- How do you think that HIV will affect the people in this town/community?

6. What are the major problems facing OVC in this community? Probe:

- Support needs(food, clothing, shelter, education)
- Care needs (medical, counseling)

7. What are the major concerns of the community to OVC?

- What are the options available in this community for the care and support of OVC?
- What contributions is the family making toward the care and support of orphans and children in need? How can we increase and sustain the capacity of the families to do so?
- What contributions is the community making toward the care and support of orphans and children in need? How can we increase and sustain the capacity of the community to do so?
- How you would like to be involved in providing care and support for orphans/ children in need? Probe:
- Which option do you think the best? Probe (Immediate and extended families, Adoption, Supported by NGOs, Foster care, Institutional care, etc)
- Do you think that the existing cares and support provided by families and communities are adequate and sustainable? How can the existing care be improved? Probe (by community, government, individuals and families, NGOs

8. Do you have any thing to add before we conclude and close our session?

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 this thesis have been acknowledged.

Name of student: Gardachew Tiruneh Ejigu

Signature _____

Date _____

Advisor: Professor Nathan L.Linsk

Signature_____

Date_____