PSYCHOSOCIAL CARE AND SERVICES FOR HIV/AIDS ORPHANS IN AHOPE AND KIDANE MEHRET CHILDREN'S HOMES ADDIS ABABA

M.A Thesis Research

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ACRONYMS AND ABBEREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
DHS	Ethiopian Demographic Health Survey
CBO	Community Based Organizations
CDP	Child Development Program
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FGD	Focus Group Discussion
GO	Government organization
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Viruses
IEC	Information, Education and Communication
MoWA	Ministry of Women's Affairs
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PSS	Psychosocial Support
SOS	Save Our Souls
UNCRC	United Nations Convention on the Rights of the Child
UNESCO	United Nations Educational Scientific and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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DEDICATION

I dedicate this thesis to my wife Lensa Gemechu together with our children's for supporting me with affection, love and for her dedication in the success of this thesis.

TABLE OF CONTENTS

LIST OF PHOTO

Table / Photo **Page**

Abstract

This study was initiated to understand psychosocial care and service for HIV/AIDS orphan children living in Addis Ababa orphanage. It was conducted in selected institution in Addis Ababa. A qualitative non-probability sampling approach was selected to conduct the research. In depth interviews and focus group discussions were employed with ten children caregivers and each focus group discussions had five members. Likewise, ten HIV/AIDS orphaned children were selected and interviewed in their living compound plus two focus group discussions were made with project staff and each group consisted of five participants. Observation method was also employed in this study where I observed the interaction between children and their caregivers. Data analysis was done using thematic analysis. The participants' views were based on the fact that the orphanage offers the basic needs such as food, clothing, shelter, health care and education. Only material support does not make children to develop fully. The psychological supports and parental love was less emphasized. It emerged during the study that HIV/AIDS orphan children were not receiving adequate parenting love, care and interaction with their respective caregivers. Caregivers seemed to lack adequate parenting roles as well as the necessary qualifications and skills to care for HIV/AIDS orphans. HIV/AIDS Orphans themselves, as a result of inadequate and insufficient caring skills, were not receiving adequate education and experience necessary to equip them with social, moral, cognitive and emotional skills. The finding of the present study revealed no access to grow up in a family environment, low interaction with their caregivers (lack of parental love) and lack of sufficient survival skill. Likewise, the studies showed that orphans spent more time with each other and lacked adult figure who could have trained them how to develop basic life skills.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Globally, of the more than 156 million children classified as orphans, around 17.3 million have lost one or both parents due to AIDS (UNICEF, 2017). According to the report of United Nations Children's Fund and the joint UN program, 132 million orphan children live in the continents of Africa, Asia and America. According to this report, out of 132 million orphan children there are 13 million children who have lost their mothers and fathers. Moreover, the report indicates 5% orphan children to be above the age of five year.

The HIV/AIDS pandemic has resulted in many children losing their parents or living with the disease. Children affected by HIV may experience poverty, homelessness, school drop-out, discrimination, loss of economic and social opportunity, and early death. UNICEEF and numerous international organizations adopted the broader definition of orphan as the AIDS pandemic began leading to the death of millions of parents worldwide, leaving an ever increasing number of children growing up without one or more parents. So the terminology of a "single orphan" – the loss of one parents – and a "double orphan" – the loss of both parents was born to convey this growing crisis (UNICEF and the joint UN program, 2005).

Conflicts/wars and HIV/AIDS, irrespective of their level of intensity, continue to rob children of their childhood, increase their vulnerability and risks and they are more likely to live a life of fear and insecurity.

Residential/orphanage/institutional care homes shall be used interchangeably to mean the same thing in this paper

AIDS is one of the main causes of orphan hood in Africa (UNAIDS, 2016). In 2016, it is estimated that globally, there were approximately 18 million children orphaned by AIDS (UNICEF, 2017).While it is difficult to differentiate HIV/AIDS-related orphan hood from other types, it can be inferred that, since HIV/AIDS is the leading cause of death, it is also the largest cause of orphan hood. The United Nations Children's Fund (UNICEF), the Joint United Nations Program on HIV/AIDS (UNAIDS) and the United States President's Emergency Plan for AIDS Relief reported that about 12% (12 million) of all orphans in sub-Saharan Africa are due to AIDS (UNICEF, UNAIDS & US PEPFAR 2017), identifying AIDS as the leading cause of orphan hood in sub-Saharan Africa.

More than 80% of AIDS orphans live in sub-Saharan Africa (UNAIDS, 2016). The loss of parents during childhood has far-reaching and lasting consequences on the development and well-being of AIDS orphans. Orphans are more likely to face malnutrition, have poor physical and mental health, experience educational disadvantages are exploited labour, and suffer from stigma and social exclusion. Within the global crisis of AIDS orphans, appropriate care and service arrangement for AIDS orphans remains an urgent and important issue, particularly in resource-poor countries and regions.

Ethiopian Orphans

As an effect of the poor conditions of this developing nation, Ethiopia struggles to care for millions of orphaned children. In Ethiopia, due to HIV/AIDS pandemic disease, many thousand children are living in residential homes. A UNICEF (2017) report states that in Ethiopia there are over 5 million orphans in a population of over 90 million. The 5 million means that 5 percent of the total population is an orphan including 1.5 million AIDS orphans. Orphans in Ethiopia are

defined as children under 18 whose both parents died, because of AIDS, untreated illnesses, hunger, and war.

Study conducted in Ethiopia explained how devastating the experience of losing a parent can be and stresses how important support and nurturing are in order for the AIDS orphan to survive the emotional and economic losses Bhargava, A. (2005). Though traditional Ethiopian kinship systems provide support for orphans, third-world conditions have overwhelmed this cultural safety network increasing the need for orphanage care. A great majority of Ethiopian orphans are placed in one of the nation's numerous orphanages. Many foreign aid organizations have established orphanages in Ethiopia to help relieve this nation's strain.

The provision of psychosocial care and service for AIDS orphan and those affected does not only constitute a human right obligation, but also remain vital to undertake effective prevention activities (Gilks et al., 2003). AIDS orphan experiences different needs and problems related to his or her status of HIV infection. These include a particular care needs that can be dealt with the formal health sector and support needs by counselors, community-based organizations, or support groups in the circle of informal health sector. This entails that AIDS orphan being reached through a fully comprehensive provision of psychosocial care and service throughout the early, late and terminal phases of the disease (Gilks et al., 2003).

In addition, such programs should necessarily involve those living with the virus in order to convince others that the disease is like other human health problems and by so doing enhance the fight against it (Green, 1994). The demand for care depletes household resources, but there are some ways in which house can be enabled to respond to the needs of HIV-positive family members; these include income generating activities, building family skills, facilitating

availability of close relatives to assist affected members, mobilization of material and spiritual support, etc (Gilks et al., 2003).

Care and service for orphaned children is one of the major challenges facing AIDS-affected communities especially in sub-Saharan Africa. Governments with limited budgets lack financial resources to invest in orphaned and vulnerable children and responsibility usually falls on extended families who are often living in poverty and struggle to adequately care for orphaned children. Some extended families are not able to provide adequate care resulting in alternative living arrangements such as, orphanages and child-headed households (Mavise, A. 2011). Creation of orphanages as an alternative means of child care which never existed in the mindset of this society has become the order of the day.

Orphanages are now considered by both children and adults in this community as a way through which a few lucky children are made to benefit from the emotional health and material needs. Most literature on institutional care for orphaned and vulnerable children is generally negative and institutionalization of children is discouraged.

In Western countries, institutionalization has lost popularity and the process of deinstitutionalization is ongoing where institutional care is being replaced with community-based care or foster care (Mulheir et al., 2017). Further researches on institutional care have also revealed that it was more expensive to care for children in residential homes than any other form of alternative care system (Williamson & Greenberg (2016). The General Assembly of the UN adopted a resolution on “Guidelines for the Alternative Care of Children” to encourage governments to support families to care for children, prevent separation and promote reintegration where alternative care was necessary (UN, 2015).

Care is a multi-sided concept which includes different activities and dimensions, like agents (those who provide care – state, institutions, individuals, and those who receive care: citizens, children, elderly, sick and disabled etc), occupations ("skilled" – provided by doctors and nurses, professional nannies, "semi-skilled" or "unskilled" – given by parents/mothers/fathers, children, unprofessional carers) etc. (Zimmerman, Litt, Bose 2014).

Another significant aspect of care is monetary or tangible provision. For example, care can accommodate a range of activities, besides highly intimate activities, like bathing, feeding, and nursing, and less intimate such as cooking, cleaning, shopping and general maintenance work, "it may also include wage earning or income generating activities necessary for provisioning". Furthermore, Parrenas (2011) argues that it is important to recognize providing for one's family as a part of mothering: female nurturing and caretaking in general.

According to research conducted in Ukrainian transnational families on care; parenting moral, emotional and material care are three main forms of care which are expected to enable reproduction in the family Parrenas (2011). Moral care provides disciplining and the socialization needed to raise decent moral citizens in society. Emotional care has a function to provide emotional security to the members of the family via expression of feelings of warmth and affection, and concern. Material care is meant to satisfy physical needs of dependents, including food, clothing, education or skill-training to ensure their future provisioning for the family. In different societies and cultures expectations of care, especially moral care, vary depending on ideological norms, particularly gender ideology, and the abilities and expectations of parents about the family's social reproduction (ibid.). Parrenas asks an important question "In transnational households, are parents able to provide all three basic forms of care?" (2011).

Currently, one of the main model of care arrangement for AIDS orphans are practiced in most developing countries, Institutional care, or orphanage, has been viewed by most as the least favorable of all possible options. Several studies that compared orphanage and foster care in the sub-Saharan regions reported that children in family-based foster care had better health outcomes than their counterparts in orphanages (Ford *et al.* 2017).

In addition, orphanages are often perceived as expensive to operate. However, some people counter-argue that because foster care cannot meet the needs of increasing numbers of children, orphanages with a good source of government or community support and external donations may be a viable option for AIDS orphan care. (Kidman *et al.* 2017). In South Africa research into models of care and the cost of this care for orphaned and vulnerable children is scarce (Smart, 2014).

Moreover, research on models of care of orphaned children in Zambia revealed a four-tier response to children's needs in the quest for upholding their rights. The family who must identify vulnerable children and orphans and provide the basic day to day needs of the children as well as emotional support, the community which must support both the children and their caretakers as well as act as a forum for lobbying authorities to assist in providing an effective response to their needs and rights, the churches/NGOs/CBOs who should co-ordinate all responses whilst also providing material support and support services. Finally the state must develop local infrastructure, empower state personnel, create an enabling environment at all levels, modify state services and facilitate funding for grassroots responses. (McKerrow, 1996:3).

Psychosocial care describes a continuum of care and service and aims at ensuring the social, emotional and psychological wellbeing of individuals, their families and communities. It may include a range of actions along the continuum: Love and affirmation, ensuring that the child's basic rights are realized (for example protection, nutrition, development, health care, and participation), listening and responding to the child in order to assist him or her to cope in times of difficulties such as coping with loss or exposure to frightening experiences, ensuring that the child is well connected socially to others and strengthening the life skills of the child. According to Refworld (2009), psychosocial care and service helps children to be motivated and feel that they are cared for, it leads them to forget that their parents passed away and helps than make right choice in their lives.

The core principles which underpin psychosocial care and service enhance the psychosocial well-being of children fall within a child rights perspective and include protection from harm, the best interests of the child, child participation, family-based care, social and community integration. Among special groups that requires psychosocial care and support is children living with HIV/AIDS.

How can we provide psychosocial care and service? Caregivers and family are the most important providers of psychosocial care and support because they offer children stability, safety, and a sense of belonging. Most OVC can overcome the difficulties they face in time if caregivers provide them with support. However, caregivers may need assistance in knowing how to provide psychosocial care and service for these children. Providing good psychosocial care comes down to good communication skills, both verbal and non-verbal.

HIV/AIDS care and service offered: to mitigate the effects of HIV/AIDS, institutions cater for only those orphans whose parents succumbed to HIV/AIDS. The institutions are usually different from other institutions in that ways and procedures of taking care of HIV/AIDS clients are followed.

Some of these centers offer an array of psychosocial care and services to these children. For instance, they allow occasional sponsored day trips, hold birthday singing sessions and other recreational based sessions. These are very important aspects of socialization. They cement peer relationship; bolster assertiveness and confidence among the children (Gibbons 2005). In very highly organized centers resource wise, they provide trips and outings especially during summer (Gibbons 2005). Children, for instance, may be taken to the pyramids, beach, zoo, museum and many more places. There is also educational entertainment as the institution access both public and private funding. This, therefore, makes the institutional environment habitable to an extent of calling it a home. Children can celebrate their birthdays and have parties. The home gives them a chance and sense to develop their identity and define who they are and what they represent in terms of values and the aspirations in the society they live in (Lutenbacher 2005).

According to the Standard Service Delivery Guideline for OVC Care and Support Programs of Ethiopia, there are seven core service components, including shelter and care, economic strengthening, legal protection, health care, psychosocial support, education and nutrition (Federal HIV/AIDS Prevention and Control Office (FHAPCO), 2017).

Use of Orphanages: To make sure that the poor residents of Ethiopia will receive extensive assistance, several orphanages where created in the different parts of the stated country to take care of the children and teenagers who do not have families or parents in Ethiopia. With the help

of these orphanages, several Ethiopian children change their destiny. The staffs who are working in these orphanages were trained to become special volunteers who are capable of providing the most basic needs of the poor and homeless individuals (ministry of women, children and youth affair office report, May 4, 2014).

Study conducted in SOS Children's Village Ethiopia, (Weinshet, 2014), social workers play a crucial role within institution but they faced challenges while providing care and service for orphan children. The major challenges are heavy workloads, scope of responsibilities, emotional burden/distress, constraints in meeting the needs of the children, time constraints & teamwork and lack of recognition by their organization. On other hand, a study conducted in Zimbabwe (Sarah et al, 2015) the orphans' wellbeing was satisfactory, ranging from good health status, well balanced emotional attributes, including having good meals, adequate shelter and good education.

The orphanages in Ethiopia are capable of providing food and well-structured shelter for the homeless children. These institutions have strong connections with the national government of Ethiopia and other nations. All of the financial assistance and relief goods that the other nations would like to give to the Ethiopian people are being distributed in the facilities of these institutions to make sure that those individuals who really need help will receive it.

On other hand UNICEF (2016) report on *Africa's Orphan hood and Vulnerable Generations,* stated that residential facilities were an appropriate primary response for orphans and the following reasons were advanced against institutionalization of orphan care:

- High turnover rates of staff which made it very difficult to sustain a caring environment
- High child-to-staff ratios that exacerbated the care deficit

- Difficulties in reintegration during the early childhood, due to community stigma
- Frequent failure to respond adequately to the psychological needs of children
- Higher cost compared to community-based care and greater challenges to scaling up
- Lack of government standards and monitoring of the care provided and
- Worse outcomes physically and mentally for children living in residential care facilities.

Impact of Orphanages: The orphanages in Ethiopia do not just provide the foods and shelters to the orphans and homeless individuals. These institutions conduct extensive support for all the poor families and individuals in Ethiopia. These institutions provide alternative education for the orphans and homeless children who are staying in their facilities. The main purpose of the presence of alternative education in the facilities of these institutions is to provide the homeless children and other poor individuals in Ethiopia with new opportunities that can make their lives better and more productive in the future.

The organizers of the orphanages in this country believe that education is the best solution for the increasing rate of poverty in their country. According to study conducted in Zimbabwe (Sarah et al, 2015) on impact of institutionalization of orphaned children on their wellbeing, the institutionalized orphans face the challenges of limited resources and lack of parental affection. The caregivers however played loco-parentis role.

1.2 Statement of the Problem

Unlike in the Ethiopia, there have always been HIV/AIDS orphans in Addis Ababa and different governmental and non-governmental organization has a place to care and support the children in institutional care. However, as a result of increased mortality due to HIV and AIDS related illnesses, accident, hunger and the number of orphan children is highly increased. Ethiopia has

registered one of the largest populations of orphan and vulnerable children in the world (UNICEF report, 2013). It goes without saying that HIV/AIDS is one of the major factors for the escalation of the number of orphans.

The impact of HIV/AIDS is unique because it kills children in their prime years and leaves them most vulnerable, and they deprives families and communities of the young and most productive people. HIV/AIDS is also deepening poverty, reversing human development achievements, worsening gender inequalities and eroding the capacity of government to provide essential services. When parents fall ill, children are often compelled to leave school to take care of the ailing parents or due to diminished resources to keep them in school. Those in school do not concentrate as they worry about what will befall their parents. Teachers are also infected and affected and as a result education of the children is affected. HIV/AIDS scares their minds and are left with traumatized memories of society's stigma towards them and many unanswered questions.

In this regard, HIV/AIDS pandemic has become a major concern as a major developmental problem having tremendous implications on the lives of children, families and the society at large. Children orphaned due to HIV/AIDS are those with broken families, beyond their control they are vulnerable to various kinds of survival and human rights problems.

Their problems are so complex, multi-dimensional and very serious and have been increasing in the sub-Saharan Africa. Ethiopia, as one of SSA country, is most seriously affected by the HIV/AIDS pandemic with the estimated number of AIDS orphans between 720,000 to 1,200,000. In view of the fact that HIV/AIDS is continuing to be a threat in the lives of many Ethiopia, it is expected that the magnitude of the problems associated with it may persist for

some time. Following the HIV/AIDS dilemma, children are not always told the truth about their parent's diagnosis and this fact creates different thoughts, feelings and actions and the psychosocial well-being of these orphans tends to be ignored by society (USAID, 2014). It is acknowledged that family members, generally the children's biological grandparents, often take orphans in and look after them, but they do not understand the various psychosocial effects that need to be addressed.

According to a study carried out by Tadele et *al.* (2010) on understanding institutional child care options for children in Ethiopia, it was found out that apart from lack of appropriate parental care, other factors such as HIV/AIDS, natural disasters, internal migration due to internal conflicts and biting poverty were the basic underlying challenges that children faced globally and particularly in Africa today. Children who have lost their parents to AIDS-related illnesses, and who are not supported in a caring family environment may be at a higher risk for: neglect, leading to a lack of access to basic rights, physical abuse, sexual abuse, exploitation (for example child labour), ill health requiring specialized care (e.g. children living with HIV), psychological stress, possibly leading to concentration difficulties, anxiety, depression, and post-traumatic stress disorder (Cluver et al.,2007), emotional difficulties manifested for example in relationship problems and learning difficulties.

Ethiopia ratified the UNCRC in 1991. Since then, the government has carried out numerous activities geared towards ensuring the protection and promotion of the rights and welfare of children. The Convention was qualified through a national legislation (Proclamation No 10/1992) and then translated to local languages for dissemination. Further, other conventions such as the African Charter on the Rights and Welfare of the Child (ratification proclamation

No283/ 2002) and ILO Convention 182 on the Worst Forms of Child Labor were ratified by the government.

The study explored the psychosocial care and service for HIV/AIDS orphan in an orphanage considering that orphanages have become one of the ways through which orphaned children are taken care of in Ethiopia today. Most researches have negatively reported on the quality of these institutions and have criticized the use of institutional care homes for not being appropriate in orphan care. Likewise, orphanages often meet the material needs of orphans much better than foster care, nonetheless as institutions they deprive orphans from autonomy and personal contact with their relatives Tadele et *al.* (2010). Generally, the study tried to explore and assess the psychosocial care and service for HIV/AIDS orphan children in A Hope Project and Kidane Mihiret orphanage in Addis Ababa.

1.3 Research Questions

The study has aimed to answer the following research questions:

1. What does the daily life experiences and living conditions of HIV/AIDS orphan children look like in an orphanage?
2. What are the psychosocial provisions available to orphan children in the orphanage?
3. How do children caregivers describe children psychosocial care and service in an orphanage?
4. How does the interaction among children, caregivers and others look like in an orphanage?

1.4 Objectives of the Study

1.4.1 General Objective

The general objectives of the study were to investigate psychosocial provision for HIV/AIDS orphan children in an orphanage.

1.4.2 Specific Objectives

The specific objectives of the study were:

1. To investigate HIV/AIDS orphan children daily life experiences and living conditions in an orphanage.
2. To understand psychosocial provision available to orphan children in the orphanage.
3. To investigate children caregivers perception about children psychosocial care and service in an orphanage.
4. To explore the situation of interactions between children and their caregivers in an orphanage.

1.5 Significance of the Study

The information will be used to create an understanding amongst professionals, like psychologists, social workers and healthcare professionals, with regard to the needs of HIV/ AIDS orphans so that appropriate care and support will be rendered to HIV/AIDS orphans children in orphanage.

The findings of this study will also assist policy makers to review policies aimed at enabling institutions to provide proper care and support for HIV/AIDS orphans beneficiaries. This study will attempt an in-depth understanding of the psychosocial care and service of these HIV/AIDS orphans and the result will help governmental and nongovernmental organization and society in

general on the path to a better understanding of the support needed to attain desirable levels of psychosocial well-being.

1.6 Delimitation of the study

The study was delimited to A Hope and Kidane Mihiret Children Home / Orphanage / because of resources and time limitation.

1.7 Operational Definitions

There can be different definition for one concept according to different individuals. So most of the time, concepts seems to be defined on the basis of the research problems.

- **Orphanages –** Facilities /care homes/ used to house children who are orphaned by HIV/AIDS.
- **HIV/AIDS Orphan** - A child who has lost one or both parents due to HIV/AIDS, with age range from 14-17 years old and who has lived for 4-10 years in orphanage.
- **Caregiver/taker** - a person, who has the primary responsibility for providing care and service to a child in a home.
- **Interaction** – Care and service giving and taking relations among the child, caregivers and others in A hope and Kidane Mihret children's home.
- **Psychosocial care and service** - A form of care and service given to enhance the mental, social, spiritual, and emotional behavior an orphanage in A Hope and Kidane Mihret.

CHAPTER TWO

RELATED LITERATURE REVIEW

Introduction

This literature review explores the following issues under the topics: literature on psychosocial care ad service, the nature of institutional care, context of residential care: a growing phenomenon, approaches of orphan care, forms of orphan care: institutional vs. alternatives, the situation of HIV/AIDS orphans worldwide, the situation of HIV/AIDS orphans in sub-Saharan Africa and in Ethiopia, psychological and social issues relating to HIV/AIDS orphans and uncertainty in life.

Moreover, the literature review explains the gaps in OVC policy, international OVC policy frameworks, country-level policy responses, policies study in Ethiopia, development of national OVC policy, theoretical framework, the concept of care, theories of childhood, Bowlby's attachment theory, attachment in an institutional setting, attachment outcomes of parents versus institutional caregivers, parent-child attachment and psychosocial outcomes and finally Erikson's view on psychosocial development.

2.1 Psychosocial Care ad Service

It was in the early 1960s that the term care in community found expression in policy formulation. According to this notion, the community is viewed as both a recipient and provider of care the increasing participation of individuals and voluntary groups in the community care is encouraged as a way of eliminating the distinction between patrons and clients and establishing strong partnership between them (Clarke, 2001). Care as a comprehensive and integrated process refer to the range of needs for wellbeing, which includes services such as providing counseling and psychological support, medical care, legal, and financial provisions (Esayas, 2004). In principle,

Home-Based and Care includes a full range of care and services, family counseling and health education, linkage of HIV care with prevention activities, formal and informal education, a formal referral system, and linkage with community health centers (Gilks et al., 2003). In fact, the needs of AIDS orphans are varied and the approaches to be more inclusive in providing care and support for family members (Liyu, 2001).

Compressive care and service aims at linking interdependent group of providers and services that can address the needs of AIDS orphans and their caregivers. A network of social and economic relations in the home and the work place helps to construct the care-giving roles whose provision encompasses the emotional aspects of managing feeling and establishing and maintaining relationships. Thus, the goal of providing care and service includes assessments, treatment, and education of people at risk and people already infected with HIV (Corless and Patrice, 2003). Since the diagnosis of the first AIDS cases in Ethiopia in 1986, a number of NGOs, faith–based institution, and civic societies in general have been involved in responding to the epidemic. At the begging, they were involved in IEC activities to inform people about the risk of HIV infection and to encourage them to adopt protective behaviors. Gradually, the provision of training, psychological support, care and counselling, and advocacy were added to existing programs (ActionAid, 2001). However, these interventions were inadequate in scale mainly owing to insufficient stakeholder involvement (Garbus, 2003).

In HIV/AIDS prevention and care activities, there is a need to cope with the stigma attached to the epidemic and to raise the standard of life of AIDS orphans through mitigation of its economic effects. In order to address the needs of AIDS patient, caregivers have to be given support like medical care for AIDS-related conditions, family education on AIDS, voluntary HIV testing, counseling, material support, and training (Gilford et., al. 2000). The provision of care and

service for AIDS orphans plays significant roles in HIV/AIDS prevention and control by bridging the gaps in addressing their basic needs and maximizing their ability to cope with infection and span of life. This helps HIV-positive people to avoid hopelessness and unsafe sexual behaviors. However, there a number of factor that impedes full-fledged care and service programs. Some of the major challenges includes caregivers' financial hardships, oppressive workload, over involvement with care receivers, inadequate support, fear of disclosure and isolation, and diminished ties with care recipients (D'Cruz, 2004).

Psychosocial care and service enhance wellbeing by providing meaning in life and enable the HIV-positive person to cope with the physiological and psychological difficulties of the disease (Anne, 2003). According to ActionAid Ethiopia, care and service are more appropriate in faith-based institution as they include spiritual and moral components (ActionAid, 2001). In dealing with HIV/AIDS and its impact at local level, place of worship within communities has taken some initiatives. These include advocacy, change in local community attitudes, speaking against prejudice, fund-raising, and organizing Home-Based Care (Tariku, 2001).

2.2 Nature of institutional care

It is not unusual for the care found in orphanages to differ from institution to institution in a country, or over a period of time in the same country or from one country to another. According to Gunnar (2016) institutions are classified into four levels, based on the quality of care they provide: (1) institutions characterized by global deprivation of the child's health, nutrition, stimulation, and relationship needs; (2) institutions with adequate health and nutrition support, but depriving the child's stimulation and relationship needs; (3) institutions that meet all needs except for stable, long term relationship with consistent caregiver and (4) institutional environment that provides for stable and consistent caregiving, but only deprives children of a

regular family life embedded in a regular social environment. Promoting such an institution might be considered the ultimate goal of some institutional intervention efforts (St. Petersburg-USA Orphanage Research Team, 2017). There are certain modal features of institutional care across countries and continents. These include: generally high child to caregiver ratios; caregivers with low wages and little education or training who work rotating shifts; regimented and non-individualized care; and a lack of psychological investment in the children (St. Petersburg-USA Orphanage Research Team, 2017). On other hand, the concept of residential care includes a wide variety of model across spectrum.

At the other end are small group homes, in which facilities attempt, more or less successfully, to replicate a nuclear family setting by providing children with the opportunity to develop a consistent relationship with one or more parental figures and a number of ‘ siblings’ of different age and sex. Together, the ‘family’ lives as a unit and prepares food, eats and undertakes house tasks as they would in an ordinary home. Between these two models lie facilities which combine different aspects of the two approaches, and can include places such as ‘children’s villages’. Globally, children living with or affected by HIV, like all children, are cared for in facilities which span the range of models, though no reliable data exist regarding the most common model of care.

The most common structural characteristics of orphanages are the number of children under the care of a single caregiver during their working hours. This is often high, ranging from 6 to 10 or more children per caregiver, including infants in the first year of life. Many different caregivers often serve the children. When vacations, staff turnover and other factors are considered,

children may be exposed to different caregivers over their first two years of life. The care they receive tends to be highly regimented.

Studies also find common characteristics in the quality of caregiver-child interactions that occur in institutions (St. Petersburg-USA Orphanage Research Team, 2017). These interactions often tend to be limited to the routine chores of the day, such as feeding, bathing and changing. Such chores are often done in a perfunctory, business-like manner with little social interaction. Caregivers tend not to respond to a crying child or to play with the children. Little warmth and sensitivity is afforded the children. One-on-one interaction is rare. And reciprocal verbal and nonverbal "conversation" is limited. Some institutions have been found to be globally deficient. In such institutions, not only are structural characteristics and caregiver-child interactions found wanting, they also fail to provide adequate medical care, nutrition, sanitation and safety. Other orphanages offer adequate medical care, nutrition and sanitation, but the nature of their structural characteristics and caregiver-child interactions cast them as social-emotionally depriving institutions.

Most of orphanages were initiated as a quick response to solve the problem of unaccompanied and orphan minors. Because of this situation many problems were faced by the home. According to assessment made by the ministry of women, children and youth affair, Ethiopia (2016), The assessment found the major problems: inadequate funding to support programs design for children, shortage of trained personnel, inadequate skill training that resulted in long care in orphanage and lack of long-term strategic planning. As a result of these and other problems, the children in the orphanages often elicit unwanted behavior like feeling of loneliness and

hopelessness, dependency on the adult population for all their needs, low self-esteem, and feeling of inferiority.

Likewise, regarding experience of the Ethiopian orphanage, there are some problems encountered like problems related to the formation and operation of the orphanage for instance, initiating the home without proper planning, lack of adequate source of fund, problem related to children under orphanage (keeping children over the age of 18 years, lack of individual attention from caretakers, feeling of considering properties of the center as personnel, unexpected need of children, pre-marital sexual practice among children and children engaged in illegal activities such as alcoholism and etc, problem related to the caretakers (lack of skill of workers to cope with frequent changing behavior of children, frequent change of caretakers and disagreement with the children and development of sexual relation between the male children and female caretakers and conflicts resulting from orphanage management and the children.(Sebsibe et al., (2014).

2.3 The Context of Residential Care: A Growing Phenomenon

While traditions of care in most parts of the world mean that the vast majority of the 153 million orphaned children worldwide - of whom roughly 17 million have lost one or both parents as a result of HIV- are cared for within extended family networks. Some are not absorbed into community and family structures (UNICEF 2012:103). Some end up in residential care, including in large scale institutions, despite the view widely shared by international agencies, governments, service providers, academics and others, that alternatives to such facilities should be developed, especially for children under three years. The precise number of children in such circumstances is unknown.

There is currently limited data on the linkages between HIV and residential care. It is generally agreed that the HIV pandemic has had devastating social and economic impacts, although the vast majority of orphaned children are cared for within families, the disease has seriously undermined the capacity of families and communities to support and care for their children. This is especially the case where HIV prevalence is high, most notably in Ethiopia. To illustrate, 13 per cent of children throughout the country are missing one or both parents. This represents an estimated 4.6 million children – 800,000 of whom were orphaned by HIV/AIDS. Despite huge improvements in access to HIV treatment, children affected by and living with HIV continue to be vulnerable to the loss of parental care. Whereas HIV- positive boys and girls were once placed in residential care and were expected to die, with the advent of treatment survival rates have increased dramatically and with them a concurrent increase in the need for care and placement requirements for children.

In some countries, especially those in Eastern Europe and Central Asia, residential care has long been an established solution for many families in distress. In 2011, it was estimated that 1.3 million children in this region were deprived of parental care, even though the vast majority had biological parents who were living. In 11 out of 17 countries studied, these numbers continue to climb. In regions, including southern Africa and parts of south and south East Asia, residential care for children is on the increase (Every Child, 2011).

Residential care is growing, in part as a result of successful appeals to support 'AIDS orphans' (Every Child, 2011). In another study in Zimbabwe, it was found that 36 new orphanages were built between 2008 and 2011 (Powell et al, 2011). The responses of governments, international agencies and others to HIV and AIDS are widely viewed as responsible for this proliferation of residential care.

2.4 Approaches of orphan care

Current approaches to dealing with orphan hood emphasize the role of families, communities, institutions and foster homes. In this section, four different approaches of orphan care are explored – familial, community-based, institutional and rights-based.

2.4.1 Familial care

It is an approach that provides an expanded view of how to work with children and families. Family-centered service is made up of a set of values, attitudes, and approaches to services for children with special needs and their families. Family-centered service recognizes that each family is unique; that the family is the constant in the child's life; and that they are the experts on the child's abilities and needs. The family works with service providers to make informed decisions about the care and services that the child receive.

The assumption in international social work and children's rights is that families are the best place for children's rights and well-being to be secured. The duty of a state is to support families in doing this by providing accessible social services and social protection (Articles 18, 26 and 27), as well as ensuring the integrity of the family (Articles 7, 8, 9 and 10). In sub-Saharan Africa, the extended family system has for generations met most of the basic needs of children and provided a protective social environment in which they could grow and develop. In periods of crisis, kinship systems have dictated various social, economic and religious obligations towards the family lineage, as well as the social and material rights of the parentless children within the lineage. Consequently, on the death of the biological parents, the continued care of a child within the extended family has been guaranteed (UNICEF, 2016).

2.4.2 Community-based care

Community-based care is an alternative for taking care of orphans in the contexts of poverty and impoverishment. The role of the state in the care of orphans in many parts of the world is minimal. Many African countries attempted to develop social welfare programs for disadvantaged social groups based on the Western, modern, welfare-state model. These programs were propelled by modernization theories that saw the increased institutionalization of poor children (orphans, abandoned children, street children etc.) in foster homes and large-scale orphanages. The period also witnessed the expansion of schools and modern educational institutions. However, a lack of resources and reductions in social spending associated with foreign debt and structural adjustment programmes significantly hindered these developments. With recurrent civil war and economic recession, and also increasing pressure from the state for taxes, organized charitable NGOs and institutions emerged. The functions of these NGOs have been to provide a home where infants are brought up, to serve as 'alternative actors' in welfare and development, and to 'save' the failed role of the state in child protection.

Community-based care refers to local, community-driven care arrangements carried out with different levels or degrees of community ownership and participation. Like care by or within extended families, it draws on the resources and strengths of communities in mobilizing resources and taking on the responsibility of administering them. The approach is also driven by the principle that care should be endogenous, participatory and needs-oriented, and that it should fulfil the basic needs of families and households (Friedmann 2008). Ansell (2016) identify three variants of community-based care for orphans and vulnerable children: care *within* the community (i.e. not in institutions); care organized *at* the community level, where service provision (e.g. food, education, health care) is coordinated through the use of already existing traditional community institutions, and religious-based and village-based committees; and

care *by* the community, where resources (time, labour, money) are mobilized from community members in order to support orphans. 'Empowerment' and 'participation' are unique features of community-based care, although as Skovdal et al. (2011) point out, they are both contested and are never straightforward approaches, since they problematically suggest the cooperation and cohesiveness of local community members and that there is an identifiable, stable community ready for participation (Ansell 2016).

2.4.3 Institutional care

Institutional care is understood to be any residential care where an institutional culture prevails. The size of the institution matters but is not the only defining feature. Children are isolated from the broader community and/or compelled to live together. Children here do not have sufficient control over their lives and over decisions which affect them. The requirements of the organization tend to take precedence over the children's individual needs. This usually includes large residential units (more than 10 children) but also smaller units with strict regimes, units for children who have committed minor offences, residential health facilities, and residential special schools (Mulheir G, 2017)

The traditional welfare provision for orphans outside families and the kinship system has been containment in institutions, largely financed through charitable donations (UNICEF, 2016). The level and quality of care provided in institutions differs from one institution to another, depending on the type of internal organization (family-based or conventional dormitories), the size of the family or other internal unit, internal equipment, the number of qualified staff, the working hours of care-givers and the type of relationship they have with the children, management style, the overall atmosphere within the institution and financial resources (Cahajic

et al. 2006). Although institutions are considered to be the last resort for the care of parentless children, they have a role to play in short-term, emergency placements for sibling groups (Sanou et al. 2009). According to study conducted in Addis Ababa, Kaliti Institutional Care Center (M.G. Kotecho & M.E. Adamek, 2016) under-use of existing resources, lack of training for caregivers, idleness of residents, lack of recreational areas, and inaccessibility of the compound for physically and visually impaired elders are the major challenges faced beneficiaries.

Perhaps an excellent example of institutional care for orphans where the strategy has been 'exported' from the West to the rest of the world is that of SOS Children's Villages. SOS children's village believed that traditional orphanages did not provide opportunities for the proper care and development of orphaned and homeless children. The underlying principles of SOS Children's Villages are conceptualized as the 'four pillars of the organization': 1) the 'village' in which orphan and/or destitute boys and girls can live together as 2) 'brothers and sisters' in 3) a 'family-like environment' with the care of 4) a 'mother' (SOS International 2017). Each village consists of a cluster of households (usually 10 to 15) in which orphans are placed under the care of an SOS mother, who acts as a substitute for the children's natural parents and who is supported by another non-professional woman, called the 'auntie'.

One advantage that SOS Children's Villages have over traditional orphanages is that they provide health, school and early childhood development services which are shared with local communities, so that the children may be better integrated into community life (SOS International 2017). However, SOS Villages are often criticized as lacking a male role model. Although the director is usually male and there are some visiting male specialists, it may not be sufficient to claim that the children have enough opportunity to interact with male members of the community.

2.4.4 Rights-based care

A child rights-based approach is a conceptual framework for the process of human development that is normatively based on international children's rights standards and operationally directed to promoting, protecting and fulfilling children's human rights. The tasks of the residential worker are complex, requiring many skills. Taking a rights-based approach to work is an important way to apply those skills in a proactive way. A rights-based approach is one where the worker has examined children's rights and tries to put them at the center of their practice; however, applying a rights-based approach has been met with some suspicion. Some would argue that the promotion of children's rights has added to tensions in residential care, and undermined practitioner morale (Kathleen Marshall, 2016).

The adverse impacts of orphan hood on children are complex and multifaceted. These complexities are linked with the wider economic, political and cultural contexts in which orphans find themselves, in much the same way as they are also compounded by the social construction of orphan hood. However, the construction of orphans as victims expounded by powerful media images and emotionally charged 'discourses of vulnerability' draws undue attention to what Meintjes and Bray (2008) describe as only a 'small tip of the iceberg'. Whereas orphans may be vulnerable victims, such constructions ignore their agency and resilience, while simultaneously neglecting the circumstances of a vast majority of children who live in poverty and economic marginality.

The 'orphan problem' throughout Africa is the consequence of deep-seated poverty and inequality, but it is also amplified by inappropriate global, donor-driven policies and programs that waste crucial resources at the expense of children's well-being. Despite increasing knowledge on multi-faceted nature of this issue, however, there is a tendency to shy away from

posing real questions, let alone to rise to the challenges. Many of the poverty-related hurdles that biological orphans face, such as a lack of access to food, education, medical care and sanitation facilities, are also shared with children who might be called 'social orphans', i.e. children who have been abandoned mainly due to poverty.

2.5 Forms of Orphan Care: Institutional vs. Alternatives

The number of orphans and their vulnerability is only part of the problem. The greater question is of what is being done to assist them. Professionals are constantly debating the most effective way to care for vulnerable children. Residential care has been linked to negative effects on children in several research studies (James, Zhang, & Landsverk, 2012). But there are also several studies that show the children themselves do not always have negative things to say about their experiences in residential care. In fact, many of those findings lean towards being more positive (Kendrick, 2013). This shows a hope for institutional care. Many are now looking at interventions for these institutions to implement that will cause the outcomes to both benefits the children and the system itself (Kendrick, 2013). Even with the new knowledge of interventions, some will stand by their stance that residential care is always harmful and should never be considered effective. Still, others are looking at the interventions and agreeing that with these interventions, residential care may be an effective solution to childcare.

Professionals who tend to stand by the abolition of institutionalization often do so with extreme passion and rightfully so, as there seems to be more empirical, quantitative data supporting the argument that residential care is detrimental to the child's wellbeing. Dozier.,et al (2012) even make the claim "we argue that institutional care is structurally and psychologically at odds with what young children need" (p. 2).

2.6 The Situation of HIV/AIDS Orphans Worldwide

An estimated 36.9 million people were living with HIV worldwide in 2017. Of these, 3.0 million were children and adolescents under 20 years of age and about 19.1 million were women and girls. Each day, approximately 4,900 people were newly infected with HIV and approximately 2,580 people died from AIDS related causes, mostly because of inadequate access to HIV prevention, care and treatment services (UNICEF report July, 2018). However, new HIV infections among children are declining rapidly – approximately 58% since 2000 – due to scaled-up efforts to prevent mother-to-child transmission. AIDS-related illnesses have been responsible for approximately 25 million deaths worldwide, and have generated profound demographic changes in the areas most heavily affected, examples ranging from dramatic decreases in life expectancy; increases in the number of orphans and increases in the number of child-headed households (UNAIDS 2015). Given the above statistics, it can be argued that HIV/AIDS is a threat to children and their families globally and that it will continue to be a threat for many years to come.

2.7 The Situation of HIV/AIDS Orphans in Sub-Saharan Africa

According to Global AIDS Monitoring 2018 and UNAIDS 2018 estimates, sub-Saharan Africa had the highest number of orphans under the age of 18, with an estimate of 56.5 million from all causes of death globally. About a quarter of all orphans, 11.6 million aged up to 17-years had lost one or both parents to AIDS-related deaths. The number of orphans in some sub-Saharan African countries exceeds half a million and in others, children who have been orphaned by AIDS comprise half or more of all orphans nationally. On other hand, the report indicates that there are three million children and adolescents living with HIV in 2017 nearly nine in ten live in sub-Saharan Africa. (UNAIDS 2017) report that 22 million adults (15 to 49-years of age) were living

with HIV in sub-Saharan Africa, which implies that this region will continue to have a high adult mortality rate due to AIDS. Similarly, other study conducted in Africa found that Sub-Saharan Africa is home to only about 13% of the global population, but it nearly 70% of people living with HIV (PLWHA) (Perpetua LumTanyi, 2018). Likewise, in Sub-Saharan Africa, for instance, about two million AIDS-related deaths are recorded annually and at least 13 million children have lost either one or both parents as a result of the pandemic (Perpetua LumTanyi, 2018).

2.8 The Situation of HIV/AIDS Orphans in Ethiopia

According to an estimate by the FHAPCO, 2017, there were on average 19,743 deaths every year, which left behind about 247,250 children orphaned. HIV/AIDS has seen a rapid spread all over Ethiopia, putting the lives of millions at risk directly or indirectly. Like many countries, Ethiopia's fight against HIV/AIDS is one of the few highly paid for projects by western donors, which includes the over US$2 billion contribution by the U.S. government through its program called PEPFAR. Data from FHAPCO, 2017 indicates that there are over 718,550 people living with HIV in Ethiopia alone, a little over 1.18% of the population. According to the globally accepted consensus, if the total number of HIV infected people in a given country exceeds the one per cent threshold of the population, that country is considered to be under category of 'outbreak of the virus.' The 2016 DHS reveals that around 56% of the women and 55% of the men among the surveyed household have never been tested for HIV, an indication of the current number of HIV positives in the country could be a lot more had all the population been tested. And, despite the existence of the large number of people living with HIV/AIDS, only 72% of them are thought to be aware that they are living with the virus; the remaining 28% think they are not infected.

When measuring the prevalence of HIV women tend to be more vulnerable than men. Of all the HIV positives in Ethiopia, 39% are men while women account for the remaining 61%, of which 25% of are commercial sex workers. Among the estimated four million residents thought to live in Addis Ababa HIV prevalence stands at a staggering 5% according to the FHAPCO (2017) data, which places the city on top of all regions in the country followed by Gambela (4%), Harar and Dire Dawa (2.9% each).

2.9 Psychological issues relating to HIV/AIDS orphans.

HIV/AIDS poses a unique challenge in terms of parental loss as there is a high likelihood that if one parent is HIV positive the other parent will also be HIV positive. As a result, children are faced with the possibility of losing both parents within a very short space of time. The situation is further worsened when the person caring for the children also dies due to AIDS, thereby causing the children to suffer multiple losses (UNAIDS, 2017). The children may also suffer further loss as they are separated from one another (UNAIDS, 2017). As a result of these traumatic events many children experience sadness, develop angry feelings towards others, blame themselves and worry about what the future holds for them as they face life on their own. All these negative experiences can cause children to develop serious emotional problems and lead them to engage in inappropriate behavior such as excessive use of substances, aggressive tendencies and even suicidal thoughts (Foster, 2014).

The present study shows that the orphans and vulnerable children in institutional homes are vulnerable to behavioral and emotional problems (Ravneet Kaur, 2018). Emotional and behavioral problems influence the child's overall development, specifically academic and social outcome as adults. The problems can present as defensiveness, sadness, having difficulty forming friendships with many children, frequent lying, crying, shouting, screaming, and

stealing, sometimes biting or pinching others and throwing things at others (Ravneet Kaur, 2018). According to study conducted in Myanmar (Myo Myo Mon, 2018), A greater number of HIV‐OVC were noted in the abnormal category with regard to hyperactivity and prosocial behaviors and the higher incidence of social and psychological consequences among HIV‐OVC call for more community support program and creation of job opportunities to minimize social impact in the affected families.

2.10 Social issues relating to HIV/AIDS orphans

Children orphaned by HIV/AIDS are influenced by various social factors, beginning with the onset of parental illness and continuing until the death of the parent/s. These social factors continue to influence orphaned children after their parent/s's death and have an impact on their development.

In the past orphaned children were cared for by family members. However, as St. Petersburg-USA Orphanage Research Team, 2016 noted, the overwhelming power of HIV/AIDS has crippled the extended family system's ability to assist one another with child rearing in times of need. As a result of this failure children are exposed to all forms of abuse, sexual exploitation, stigmatization and discrimination. Sub-Saharan Africa has been heavily impacted by the HIV/AIDS pandemic, resulting in major economic and social problems for orphans. When parents die the extended family assumes responsibility for the overwhelming majority of children orphaned by HIV/AIDS. This has an overwhelming effect on these families, to the point where they are finding it more and more difficult to manage. The sheer numbers of orphaned children needing to be sheltered and supported combined with the increasing numbers of the adult population becoming sick due to HIV/AIDS has a devastating impact on these families. Many of

these families are unable to provide for the children's essential needs which are crucial for every child's healthy development.

2.11 Uncertainty in life.

Both before and after the death of a parent, AIDS-affected children are exposed to a high degree of uncertainty. Unfortunately, it seems that the only thing that is certain to them is the eventual death of the loved one. Children are faced with many questions, which often are impossible to answer. Questions such as "How long will the sickness last?", "How will we afford medicine if my father is unable to work?", "Will my parent die?", "What will happen to me and my siblings once they die?", "Where will we live?" Such uncertainties pose a great challenge to secure a psychological base, essential to a child's development of a healthy and functional personality" (Dwaine, L.2000.)

After the death of their parents, AIDS orphans continue to face enormous uncertainties. If they are living with extended family members, they may be uncertain about their role within the existing family, and much of a burden they are placing upon the family. They may also be uncertain about their education, and whether the family will be able to pay the fees to send them to school. On the other extreme, some orphans either fall outside of the extended family safety net and end up as street children, or they become heads of households, where they are responsible for looking after their siblings and taking on the roles that their parents used to have. Such children often must face the everyday uncertainties of life on their own. (Fleshman, 2001).

The orphans are expected to forego their childhood and to assume the responsibilities of adults, which may include caring for younger siblings, growing their own food, and engaging in income generating activities. Often, these young children are poorly prepared for their new adult roles. For example in Namibia, children left with small livestock – chicken and goats – saw many of

their animals die, simply because they did not have the experience to care for them properly (UNAIDS 2000). A study carried out in Kenya found out that four out of five orphans who were farming in one rural area said they did not know where to go for information about food production. Such uncertainties can severely affect the psychological and physical health of these children, and hinder their opportunities to become loving, caring, socially developed individuals (UNAIDS, 2000).

2.12 Gaps in OVC Policy Frameworks

2.12.1 International OVC Policy Frameworks

In 1990, the World Declaration on the Survival, Protection, and Development of Children urged countries to develop NPAs for children. Since then, the Millennium Development Goals in 2000 and the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in 2001 have reaffirmed international commitment (Smart, 2003). World leaders agreed to develop national policies and strategies to serve the needs of children affected by HIV/AIDS by 2003 and to implement them by 2005. At the UNGASS Review in 2006, country leaders emphasized their focus on "children orphaned and affected by AIDS" (Cardoso, 2012).

As a result, two international frameworks for OVC policy emerged. First, the *Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS*, published by UNICEF in 2004, serves as the global consensus for OVC programming. In addition, the United Nations General Assembly adopted a resolution, *Guidelines for the Alternative Care of Children,* to guide country-level policy decisions on child protection and social welfare in response to emerging forms of alternative care for OVC. Although these frameworks have focused attention on the health and care arrangements of OVC, they do not address the psychosocial well-being of these children.

2.12.2 Country-Level Policy Responses

Nearly 50 countries are developing or implementing national responses for children affected by AIDS and other vulnerable groups. Thirty-two of these countries have endorsed a NPA, and many others have integrated OVC policy into sector plans for HIV/AIDS and Poverty Reduction Strategic Plans (Engle, 2008). Nevertheless, policy responses have been inconsistent across regions. Eastern, Southern, and sub-Saharan Africa, which have the highest OVC burdens, have made the most progress (Gulaid, 2016). Sixteen of 22 nations in Eastern and Southern Africa have begun developing a NPA, and 14 have begun implementation (Gulaid, 2016).

In sub-Saharan Africa, 29 of 35 countries have endorsed a NPA (Progress in the National Response to Orphans and other Vulnerable Children in sub-Saharan Africa: The OVC Policy and Planning Effort Index (OPPEI) 2007 Round Summary Report, 2008). On the other hand, progress on developing policy frameworks for OVC has been considerably slower in the rest of the world. So far, no nations in West Africa have implemented a NPA. Moreover in Asia and the Pacific, which has the highest number of orphans, and Latin America and the Caribbean, which has the second-highest HIV-prevalence in the world, only a few countries, such as Cambodia, China, and Guyana, have adopted comprehensive NPAs (Gulaid, 2016). Most nations in these regions have yet to formulate country-level policies to address their rising OVC burden.

2.13 Policies study in Ethiopia

2.13.1 Development of National OVC policy

Despite having one of the largest OVC populations in Africa, Ethiopia lacks a comprehensive national plan of action to address the needs of these children. Nevertheless, as a signatory of the UN Child Rights Convention and the African Charter on Rights and Welfare of Children, Ethiopia is beginning to consolidate and to prioritize the development of national OVC policies.

Prior to 2010, OVC programming was managed through the Network of Organizations working in Support of Orphans and Vulnerable Children. This loose coalition of government, non-governmental, and community-based organizations was created in 1998 to coordinate cross-sector efforts to benefit OVC (Chernet, 2001). Nevertheless, the services offered by network members were not standardized or made uniform in terms of quality and size. To address this issue, the MoWA and the FHAPCO developed the Standard Service Delivery Guidelines for OVC Care and Support Programs (2010). This document is thus far the most comprehensive national framework on OVC.

The Standard Service Delivery Guidelines document contains seven core service areas which are considered critical components of programming targeting OVC: shelter and care, economic strengthening of families, health care, psychosocial support, education, and food and nutrition. In addition, the guidelines specify "critical minimum activities" which are supposedly "doable by all service partners irrespective of financial and human resources". Finally, the document delineates the application of each core service at the child-level, community-level, and policy-level. Continuing with the psychosocial services example, the guidelines require providers to assess the psychosocial well-being of individual children, provide caregivers with guidance on how to counsel children, establish community support groups, and use the local education system to identify and counsel OVC.

2.14 Theoretical Framework

Flick (2009) conceptualizes theories and argued that theories are not representations of given facts, but versions or perspectives through which the world is seen.

2.14.1 The Concept of Care

According to Daly & Rake (2003), care is considered to be the activities and relations that involve the caring of the sick, the elderly and the dependent young. They further argued that it is a form of interpersonal relationship and social exigency or a necessary activity within the society. Daly & Rake (2003) further contend that the concept of care is rooted in relations of personal involvement and to some extent personal service. They stated that care has always been a subject of debate that focused on how social policies seek to manage the demand and supply of care. Barnett & Land, (2007) and Healy, (2008) on their part argued that care is a complex phenomenon and diverse, yet it is constitutive of togetherness that is excluding and charitable provisions that is disempowering. All in all, care can be said to have consisted of physical, emotional and intellectual processes that enabled human beings to maintain their livelihood and distinguish these activities from the economic ones. This inevitably raises the issue of gender roles in the care giving process in which Tronto (2004) argued that in all societies gender relations were shaped by the different care arrangements. She further contends that women were the greatest providers of care compared to men and that care regimes shaped gender regimes and vice-versa. According to Oleke*et al*. (2007), the relative vulnerability of orphan care varied considerably with the category of kin. They argued that societies that followed patrilineal kinship provided responsibility of care to orphans within the paternal kin who offered protection of children's rights to safety, support, belonging and inheritance. Although most studies revealed that economic hardship was found to be greater among orphans residing with maternal kin, it is believed that they experienced compassion, care, and involvement in the household activities and always felt being part of that family compared to their counterparts who resided with their paternal kin, argued Oleke *et al*.(2007).

Therefore, the concept of care was important in this study since orphaned children were bound to have faced multiple challenges while at the orphanage. I found it relevant to seek the views of orphaned children themselves in order to understand the linkage in the care giving arrangements between family, society and institutional systems. Thus, presenting the concept of care in this section was meant to understand the interaction that existed between the caregivers and orphaned children who resided in an orphanage. However, I found it useful to connect the concept of care to the theories of childhood in order to compliment the issues that the participants to this study might not have raised during the discussion on how they describe the care and service practices at the orphanage.

2.14.2 Theories of childhood

The notion of childhood has been discussed by several authors and most studies have revealed that this concept is constructed by adults and how children respond to adult notions of childhood. James and Prout (1997: p8) argued that children were active participants in the construction and determination of their own social lives, the lives of those around them and of the societies in which they lived. For this study, I will consider the fact that childhood and children's social relationship is important when studied in their own right; not just in respect to their social construction of their own social lives, but also the lives of those around them and the environment in which they lived.

2.14.3 Bowlby's Attachment Theory

The Attachment Theory proposed by Bowlby (1944) suggests that attachment constitutes the most thoroughly researched and developed body of knowledge regarding specific care-taking ingredients. Attachment refers to the nature of the relationship between caretaker and a child as

well as the resultant personality style demonstrated by the child later in life. Bowlbv (1944) in his article “Forty Four Affectionless Thieves, their Characters and Home Life” noted that children who have experienced maternal separation and deprivation frequently develop an affectionless personality and engage in delinquent behavior. He went on to conclude that failure of super-ego development in these cases follows a failure in the development of the capacity for the object love (Grusec and Kuczynski 1997).

He notes the significant role of parents in the development of the ego and the super-ego of their children from infancy to maturity. Bowlby notes that ego and super-ego development are inextricably bound up with the child’s primary human relationships; only when these are continuous and satisfactory can his ego and super-ego develop (Bowlby 1951). He notes that secure attachment patterns are associated with more cooperative, pro-social child behavior both in the context of child- parent relationship and with others.

Bowlby also refers to instincts as a major influence upon attachment. When children are put under residential care, their primary instincts are survival, to socially adjust and adapt to the new environment. According to Bowlby’s attachment theory, children who experiences parents as emotionally available, loving, and supportive of their mastery efforts will construct a working model of the self as lovable and competent. In contrast, children who experience attachment figures as rejecting, emotionally unavailable, insensitive and non-supportive, or inconsistent will construct a working model of the self that is unlovable, incompetent, and generally unworthy (Verschureren, Buyck, and Marcoen 2001). In addition, those who are securely attached will report more realistic or balanced self-concepts, reporting on both positive and negative characteristics, although typically more positive attributes are cited (Easter brooks & Abeles,

2000). That is, securely attached children have more *access* to both positive and negative self-attributes than do insecurely attached children, who often present an unrealistically positive account of their strengths in an attempt to mask underlying feelings of unworthiness.

Attachment is a crucial stage in a child's development. The attachment process sets the relationship process in motion. It is from the attachment process that all other skills of survival are developed in children. Children whose parents died due to HIV/AIDS were unable to care for them luckily only survived if they were taken in by other adults. When children do not have primary caregivers, as is the case for many institutionalized children, development is compromised.

The institutional caregivers face the mammoth task of creating an equal participatory base for all orphans in their respective families, those with different age and from different backgrounds. The behavior that we observe when a child is seeking closeness with a parent/caregiver is called attachment behavior. The theoretical basis of most of the attachment research is that secure attachment in infancy will predict good psycho-social outcomes in later years Maccoby, (2009).

2.14.4 The Short Comings of Institution

Institutional childcare facilities are often established with good intentions and believed that it is the best place to keep children in need. However, evidence revealed that family and community based forms of care are more likely to meet the needs of children (Kauffman &Bunkers, 2012). According to Csaky (2009), children who entered in to institutional care unit at a young age were physically, socially and emotionally underdeveloped. Furthermore, orphan children who are in the institution lack good interaction with their caregivers and outside society.

For orphans that grow in the institution, the feeling of being unwanted results into low self-esteem and difficulties in forming relationships with others. In some instances siblings being separated from each other and grown up in different place of institution as a consequence their relationship affected seriously (Branigan, *et al,* 2008). Furthermore, children who were brought up in institution marked as 'deviant' because they fail to practice survival skills, basic life skills and abide by society's rule. The study conducted in Zimbabwe orphanage showed that, even though all the different group of the study participants knew what socialization means, orphans were not receiving adequate interaction with the caregiver and the outside society (Sharara, 2012).

Since the caregivers in the orphanage lack of adequate parenting role as well as the necessary qualifications to care for the orphans they are deprived of receiving adequate survival skills and socialization. In addition, care providers are almost unable to provide and maintain attachment, care, and love for orphan children because of the high ratio of children to staff, the high frequency of staff turnover, and the nature of shift work. On top of that they failed to receive attention and an adult figure from which they develop a secure base on which all other relationships are built (Williamson, & Greenberg, 2010).

2.14.5 Attachment in an institutional setting

Caregiver behaviors with children tend to be perfunctory with little talking and even less conversation, little interaction outside of routine caretaking duties, minimum responsiveness to children's individual needs (such as crying), caregiver-directed rather than child-directed interactions when they do occur, and almost no attempt by caregivers to form relationships with children. (Petersburg - USA Orphanage Research Team, 2010).

Fuhrmann and Munchel, (2016*)* observed that a child in an orphanage has, on average, two caregivers a day, owing to staff shift changes throughout the day. At the same time, the caregivers themselves frequently change as a result of high staff turnover, with serious implications for children's growth and development. Sometimes the child's needs are met and sometimes they aren't. The child never knows what to expect. Because of change of caregivers, the large numbers of the children under the institutional caregivers with their different demands, institutional attachment process is at risk. McCall & Groak (2008*)* adds that the institutional caregivers may be virtual strangers to the children.

2.14.6 Attachment outcomes of parents versus institutional caregivers

Newman & Warren (2011) observed that children from authoritarian parents were found to be less confident and more reliant on others to have their needs met, and more at risk for psychosocial malfunctioning, such as somatic complaints, social withdrawal and anxiety disorders. They go on to say children of authoritative parents displayed confidence, self-esteem and can form social relationships. Permissive or avoidant parents, have avoidant children who exhibit different forms of social incompetence, they are often identified as the bullies by their peers and are hostile and aggressive (Mortimer, 2011).

According to Mc Call & Groak (2008*)*, institutional children have insecure attachment due to the child's movement from one caregiver to another. (Muhamed rahimov, 2010) reported that institutional orphans had disorganized attachments. Institutional infants have also been described as passive and quiet. A child with insecure attachment or an attachment disorder doesn't have the skills necessary to build meaningful relationships. Children with attachment disorders or attachment problems have difficulty connecting to others and managing their own emotions. This

results in a lack of trust and self-worth, a fear of getting close to anyone, anger, and a need to be in control. A child with an attachment disorder feels unsafe and alone.

2.14.7 Parent-child attachment and psychosocial outcomes

Parent-child attachment quality has been linked to a number of psychosocial outcomes in childhood. On the one hand, attachment security is associated with adaptive emotion regulation processes in childhood.

By childhood, secure children show less aggression and more cooperation in peer interactions and more appropriate, flexible emotional attunement and behaviors responses to a range social and environmental cues (Sroufe, 2005). These data highlight the long-term emotion regulation benefits associated with secure attachment patterns in infancy. Avoidant and ambivalent-resistant attachment are forms of attachment insecurity; both strategies are associated with less effective affect and stress regulation. By childhood, insecure children evidence other markers of affective deregulation. Avoidant children evidence less prosocial and more aggressive behavior toward peers (Bennett, 2004). whereas ambivalent children report more loneliness than do their secure counterparts. On the whole, insecure children endorse less positive affect, more depression, and more separation anxiety from their mothers (Bennett, 2004). They exhibit less perseverance in social interactions and competitive games, as well as greater emotional reactivity during a threat-based experimental paradigm. These data reflect the greater difficulties that insecure children face in their attempts to regulate affect and engage in interpersonal interactions.

Disorganized infants and children evidence various pronounced indices of affective deregulation. In childhood, disorganized children respond to their parents' frightened and frightening behavior through a range of controlling strategies including punitive and coercive bossiness or, alternately,

caregiving by directing, organizing, and entertaining the parent. Not surprisingly, compared to other attachment groups, disorganized mother child dyads display the lowest levels of cooperation and positive mutuality in a range of interactions. Over the course of childhood, the mother-child relationship remains a forum in which disorganized children evidence disrupted and deregulated ways of managing affect. Controlling/disorganized children also display elevated aggressiveness in peer interactions and more externalizing, internalizing, and dissociative symptoms than their organized counterparts and perform more poorly on mathematics and syllogistic reasoning tasks during childhood (Burns, N. and Groove, S.K. (2005).

2.14.8 Erikson's view on Psychosocial Development.

Erikson's theory covers the entire span of human development while at the same time acknowledging that individuals are independent beings. In Erikson's developmental theory each life stage is characterized by a psychosocial crisis that serves as a basis for development. The epigenetic principle plays a significant role in development. The emergence of the developmental crisis is determined by the person's genes at a specific age. In addition, the crises emerge in a set sequence. Each stage's development crisis must be handled during that stage in order to ensure the individual's overall development during that period (Meyer & Viljoen, 2008).

Erikson's theory of human development outlined eight stages of development. These eight stages cover the entire lifespan from childhood to adulthood. Although Erikson's theory of psychosocial development consists of eight stages only the first five stages will be explored within this study as they relate specifically to childhood development. These stages are referred to as basic Trust versus Mistrust, Autonomy versus Shame and doubt, Initiative versus Guilt, Industry versus Inferiority, and Identity versus Role confusion.

2.14.9 An Outline of Erikson's Theory of Psychosocial Development.

The first stage of Erikson's theory of psychosocial development is labeled Trust versus Mistrust. During this stage children are particularly vulnerable and rely on others for care, shelter and reassurance. When children's basic needs are met they develop trust in their environment. However, when their needs are not met they will lack trust. This means that children will develop a healthy balance between trust and mistrust if their needs are adequately provided for during this stage (Maddi, 1989).

It is important for children to develop a sense of balance in terms of trust, which will allow them to form close relationships with others, and mistrust, which will allow them to take care of themselves (Erikson, in Papalia et al., 2010). If this balance is accomplished children develop an optimistic view of life (Boeree, 2006). The first year of life is very important as it is during this period that the baby needs to form an attachment with a trusted mother figure in order to ensure healthy development. According to Erikson (1977), when a baby has developed social trust, he eats well, sleeps well and his bowels are relaxed. Trust remains very important in the early years of the child's life. Maternal caregivers can demonstrate this trusting relationship with their children by attending to the children's special needs in a caring and sensitive manner within their immediate environment.

Erikson's second stage of development is referred to as Autonomy versus Shame and doubt. According to Erikson (1980), this is a very critical period for the relationship between the mother and the child. The parent/s or caregiver/s' attitude towards the child will either have a negative or positive effect on the child. According to Erikson (1980) this stage is very significant for the relationship between feelings of warm personal attachment and extreme hatred, and mutual

assistance and determination. This stage also determines whether the child will be assertive or not. When children are able to restrain their feelings and actions without compromising their self-respect they develop a fixed sense of independence and self-importance. This stage is likely to be challenging for children in institutions as individual attention is not possible and the caregivers are already overwhelmed. These caregivers may criticize and try to control the children and even deny them the opportunity to assert themselves. Children may start to doubt their own ability to do things on their own and become overly dependent on others, thereby developing feelings of shame and doubt. This lack of independence may endanger all future development and result in incompetence.

Erikson's third stage of development is referred to as Initiative versus Guilt. The main focus points during this stage are the child's increasing ability to move around on his/her own. During this period children experience guilt regarding some of the ideas in their minds that they would like to explore (Meyer & Viljoen, 2008). This stage is likely to prove challenging for children orphaned by HIV/AIDS as they have no parents to imitate or with whom they can identify.

Erikson's forth stage of development is known as Industry versus Inferiority. During this stage children acquire skills relating to how to become productive members in their society by learning the ways of life appropriate to their society. Society's function during this stage is to ensure that space is provided for children to learn diligently and through teamwork (Meyer & Viljoen, 2008).

Erikson's fifth developmental stage is referred to as Identity versus Role confusion. The age of maturity is largely dependent on the child's way of life and the period of training needed for the person's chosen career. The discussion of Erikson's stages of psychosocial development

provides a clear overview of how children progress both psychologically and socially. This discussion of Erikson's theory of psychosocial development it seems clearly suggests that children orphaned by HIV/AIDS are likely to experience various difficulties with regards to their psychosocial development. This is likely to lead to difficulties in the way in which they relate to others in their environment (Thwala, 2008).

CHAPTER THREE

RESEARCH METHODOLOGY AND DESIGN

3.1 Research Methodology

This study used a qualitative methodology. According to Chisaka (2011) qualitative research focuses on studying phenomena in their natural setting, thus enabling the researcher to draw theoretical insights and conclusions from academic debate rather than positivism which tends to stay with theoretical positions which are then supported by the research data. It uses corroboration and triangulation to produce more in-depth and comprehensive information.

Because of its focus on natural settings, the qualitative research methodology was used to explore the psychosocial care and service in the institutions that were the sites of this study. Psychosocial care and service seem to be a complex subject which could not be answered by a simple yes or no, and as a result required the use of the qualitative methodology. According to Burns & Grove (2005), the qualitative paradigm allows both understanding-oriented and an action-oriented perspective to clarify the deeper causes behind a given problem and its consequences. This study allowed the researcher to use the qualitative understanding in interviewing people on psychosocial care and service for HIV/AIDS orphan children.

Qualitative data is subjective because they are perceptions of people in the environment. The data were used to describe the context, or the natural setting of the participants in the institutions, as well as the interactions of the different participants in the context. Subjectivity leads to difficulties in establishing reliability and validity (Baxter & Jack, 2008, *accessed on line 11 December 2009)*. In order to counteract subjectiveness, the researcher had to make sure that the study was trustworthy, through checking for auditability, credibility and fittingness as recommended by Denzim & Lincoln (2000). This was made possible by choosing the correct

environment for interviews like a non-threatening environment for all participants. This made it possible to use emic perspectives in a natural environment to get an in-depth understanding of the psychosocial care and service. As a researcher in the qualitative paradigm, I used open ended questions that provided direct quotations. A holistic approach of the institutional participants was used during the study. I made contact with participants after visiting the institutions and explained the need to carry out the research out the children, caregiver and staff.

According to the qualitative paradigm, the researcher is the primary data collection instrument under natural conditions. When doing a qualitative research, the investigator seeks to gain a total or complete picture of events, procedures and philosophies occurring in natural settings in order to make accurate situational decisions (Chisaka, 2011). Because of that it was difficult to prevent or detect researcher bias and therefore my role in the study had to be explained. I was a good listener, recorded the data accurately. I initiated writing early and included what was considered essential primary data in the final report. This resulted in interpreting the responses of the participants accurately. This also meant that I had to uphold the use of deontological and relational ethics during the study. Instead of taking sides by sympathizing with orphans or caregivers, I was empathetic and focused on researching about psychosocial care and service, without imposing my own meanings on the processes.

3.2 The Research Design

Burns & Groove (2005), describe a research design as the format and theoretical structure under which the study will be carried out. It includes the discussion of steps to be taken in order to safeguard the validity or authenticity of the findings. Burns & Groove (2005) describe the procedure as follows, after formulating the specific problem and thoroughly reviewing relevant literature, the researcher plans the study. For the purposes of this study, the researcher used

exploratory-descriptive research design to investigate psychosocial care and service for HIV/AIDS orphan children in an orphanage.

3.3 Study Area

Ethiopia is one of the African countries and Addis Ababa town serves as a capital city. Addis Ababa lies at an elevation of 2,200 metres (7,200 ft) and is a grassland biome, located at 9°1′48″N 38°44′24″E. Addis Ababa has 10 sub cities with a total population of 2,976,425. Bole sub city is the largest and Arada is the third smallest sub cities of the town. Moreover, all Ethiopian ethnic groups are represented in Addis Ababa because it is the capital of the country, the largest groups include the Amhara (67.04%), Oromo (19.00%), Gurage (16.34%), Tigrayan (5.18%). Languages spoken include Amharic (71.0%), Oromiffa (10.7%), Gurage (8.37%), Tigrinya (3.60%). The religions most believers in Addis Ababa is Ethiopian Orthodox with 74.7% of the population, while 16.2% are Muslim, 7.77% Protestant, and 0.48% Catholic. Different infrastructures were built to serve the people. Institutions like education sector, health, economic are found in the city (Addis Ababa municipality, 2016)

Addis Ababa city Map

Source: Addis Ababa city administration, May, 2019

3.4 Study Site

3.4.1 About A Hope Children's Home

Children's Home: The children came to AHOPE HIV+. AHOPE is place of giving and growing. The children at A HOPE are part of the entire A HOPE family and they live in one of two homes: Little AHOPE and Big AHOPE. Currently there are 95 children in these two homes. The homes are divided based on age which allows for more appropriate activities to take place at each home. Both homes are filled with caregivers/takers who ensure each child gets some individual attention which all children need. There is also a pediatrician, nurses, teachers, social workers/counselors and supervising and child-care workers are also part of the staff.

Little A Hope: The kid is range of age is from infancy to age eleven. These babies, toddlers and young children are loved and nurtured by a dedicated staff. The little ones have playtime, they learn to walk and to speak and they dance to fun music. They are also taught basic skills to ready them for school.

Big A HOPES:

Group Home: The Group Home program was developed as a means for our children between the ages of 11 and 17 which were the target groups for the study. The four Group Homes are smaller than Little AHOPE with 10 youngsters per home. The Group Homes are staffed by a Mother and Auntie like caregivers/takers who live in the home with the children. The focus of the Group Home program is to provide the children with a home environment and begin teaching basic independent living skills such as chores, helping with the cooking and following curfew.

Independent Living Program: The Independent Living Program is for those young adults over the age of 18 who are ready to take the skills they have learned and live independently of AHOPE. These young men and women will continue receiving supportive services, including

rent and counseling, but will be responsible for maintaining their own homes and managing their own budget.

Kolfe Keranio sub city, wereda 09, house no.1411

Source: Addis Ababa city administration, May, 2019

3.4.2 Kidane Mehret Children's Home/Orphanage/

‘’ Kidane Mehret Children’s Home’’ has been initiated to contribute to the effort being exerted to tackle the problem of Street children, HIV/AIDS orphans children’s and abandoned children. The project mainly targets those children deprived of the basic survival needs, love, care affection and guidance because either they have lost their parents or families or they are left without any one to look after them including those children affected and infected by the HIV/AIDS pandemic.

The project aims at creating a nurturing environment in which the children will grow up together as a unified family where they can experience love, friendship, discipline and regain their dignity. The center will also address the physiological (food, shelter, clothing and medical care) and psychological need as well as giving the children sound educational background in order to equip them with skills and empower them to sustain themselves when they reach the age of leaving the center and thus saving them from the vicious circle of poverty.

Under the general objectives that nurturing environment for the targeted children in order to make them productive, active and responsible citizen of the country, the institution basically provides institutional care and support for 160 children at a time, by way of fulfilling the basic survival needs which include food, shelters, cloth and medication, provide formal and informal education, provide life skill training, psychosocial support, counseling service ethics education, provide preventive education for HIV/AIDS infected and affected children, and provision of entertainment facilities. The institution admit the children to the center by using the stated admission criteria like birth to 18 years of age from Addis Ababa, Jimma and nearby place of Addis Ababa, abandoned children under 10 years of age, children s living with HIV/AIDS and street children.

Yeka sub city, wereda 05

Source: Addis Ababa city administration, May, 2019

3.5 Approaches

In conducting the study, qualitative approach was used as the approach will give high degree of flexibility to understanding the case in its qualitative nature. The qualitative approach was helped me in gathering subjective information and other related issues such as living conditions, health and welfare of the orphans and other related issues.

3.6 Population

Population is described by Yin (2001, *accessed on line 13 April 2010),* as the entire number of subjects under study which is the whole. Gall et al (2007) go on to say that; population in a study can be found in two types that is target population and accessible population. Target population includes all the members of a real or hypothetical set of people, events or objects to which researchers wish to generalize the results of their research (Burns & Groove, 2005). In this study the target population referred to persons in the two institutions. The total populations of children in both institutions were 255. Of these 160 is belongs to Kidane Mihret children's home and the rest is for AHope children's home. Moreover, total populations of caregivers were 26, of which 10 caregivers belong to AH and the rest is KM. i.e each caregivers consisted of 10 children in their home.

3.7 Sample

According to Burns & Grove, (2005) a sample is a subset of the population that is selected for a particular study. Gall et al (1996) say a sample is a part of a whole. Data are generally collected from a sample rather than the entire population because using a sample is more practical and less costly than collecting data from the entire population (Polit & Hungler, 2003, *accessed on line 8 August 2011).* However, as Patton (2002) pointed out that the sample can be a disadvantage if it does not reflect the characteristics, behaviors or beliefs of the population. The sample should then resemble the population. The sample was composed of HIV/AIDS children, caregivers and staff. The sample selection ensured gender sensitivity and equitable representation. I collected data through semi structured interviews with HIV/AIDS children & caregivers and focus group discussions with caregiver and staff.

The sample was drawn from A Hope Ethiopia and Kidane Mihiret Children Home/Orphanage/ in Addis Ababa, Kolfe Keranio and Yeka sub city**.** The sample constituted of 30 participants, which were 10 HIV/AIDS orphan children, 10 caregivers, and 10 staff for both institution.

Children's age ranges from 14-17 years old and living for 4-10 years in institution were involved in-depth interview. Key informant interview and discussions was conducted with caregivers whose age ranged 35 - 45 and who have more than five years of work experience in caring for children in orphanage. Similarly, discussion was conducted with staff (child-care co-workers) and they had more than two years of work experience in delivering professional service for children. The discussions made with caregivers and staffs have 5 members. Observation participant was conducted in the living compound of both orphanages. Moreover, observation was conducted in one month duration which is twice in a week on Saturday and Sunday. Finally, document review was conducted in institution in their respective office.

3.8 Sampling Procedure and Technique

Sampling is described by Polit & Hungler (2003) as the method of choosing participants or sample from the whole that have the chance of participating in the study. As stated by Adler (1987), as cited by Polit & Beck (2008) to achieve a systematic approach to data in qualitative studies two conditions should be met:

- First there must be a clear idea of the case to be investigated and
- Secondly there must be documentation of feasible techniques in the taking of samples of individuals, events or activities.

As a sampling method, purposive sampling was selected to conduct this research. Purposive sampling is used to select the sample on the basis of knowledge of the population, its elements

and the nature of the research and researchers find it convenient to target those particular samples that was identified as a useful indicators (Babbie,2001).

The justification for selecting purposive sampling method is that the data required for the study by nature seek someone with better understanding and wilful motivation. Eliciting sample respondents purposively facilitate the inclusion of those qualities and quality respondents and it is helpful to escape less important informants' inclusion in the sample which allows the resources to be used effectively. All participants (HIV/AIDS orphan children, caregivers and staff) in this study were found in institutions.

3.9 Sources of Data

Primary as well as secondary sources of data were used. The primary sources of data were HIV/AIDS orphan, children caregiver, project staff and observation and the secondary sources of data was documents review like official reports related to HIV/AIDS orphan, published and unpublished materials.

3.10 Data Collecting Instruments

After literature review, the researcher set out to do the study. The study was divided into three phases according to the different participants and instruments to be used for collecting data from the said participants. In phases one semi-structured interviews were used for both the HIV/AIDS orphan children and their caregivers in both institutions. Children caregiver and staff used focus group discussions in phase two. Moreover, observation and document review were used the third phases.

3.11 The researcher as an instrument

In qualitative studies, the researcher is the primary instrument of data collection. This meant that I had to clarify the role that was played by me so that the study would be valid and reliable. Yin (2001, *accessed on line 13 April 2010)* points out that the involvement of the researcher in collecting data in naturalistic setting raises a number of questions related to the validity, reliability and objectivity of the research findings. Two issues that seem to surface are that the presence of the investigator can alter the behavior of those being studied. Opinions and biases of the researcher can influence the interpretations assigned to the findings. In this study, I made attempts to maximize my presence, by prolonging my stay during the study and interviewed participants in privacy. Field notes were kept throughout the study. These notes consisted of:

- Participants' comments before and after group discussions.
- Tentative interpretations that were made by me during the data collection and analysis procedures.

3.12 Data Collection Procedures

The first step that I did was showing the legal letter to the officials of the institutions /orphanage/ and getting permission to collect data then giving an introduction about the objective of the research in order to get their willingness to collect the data. There were various techniques of data collection as stated (Patton, 2002; Gall et al, 1996; 2007). These are tools that are used for collecting information and data needed to generate themes to the problem under investigation.

3.13 Validity

According to Kumar, T. (2008) validity is the 'integrity of the conclusions that are generated from a piece of research' and reliability is believed to mean dependability of consistency' and that qualitative researchers' use a variety of techniques (interviews, participation, documents) to record their observations consistently' (Polit & Beck, 2004). Validity in qualitative data

techniques was reached through transcribing, corroborating and triangulating information from semi-structured interviews, focus group discussions and observation from different groups of participants.

In order to generate data, I made appointments with research participants through calling the orphanage coordinators and explaining the expected activities and procedures. The length of time taken was explained from 45 minute to 1 hour for interviews and 1 hour for focus group discussions. This length of time was for all participants and/but based on discussions. The other issue that was brought to the participants' attention was the issue of privacy and individualism especially with interviews. The researcher emphasized the importance of privacy and used the available rooms within the institution.

The HIV/AIDS orphan children interview were conducted in natural setting of their living compound, interviews of caregivers and focus group discussions of staff were held in institutional halls. Similarly, observation was conducted in the institutions compound. This was important as suggested by Patton (2002) that steps for data collection need to be clear, orderly and justified. No participant should be put in a threatening situation like holding focus group discussions with orphans in the staff office. The involvement of the staff and clarity on the steps to be followed during the study assisted in gaining maximum co-operation from all categories of participants.

3.14 Data Gathering Methods and Tools

The data required for this study was collected from both primary and secondary sources in line with the sampling method. For the study, key informant interview, focus group discussion and observation, was used to collect data. To do so, tools like interview guide and discussion guideline was used.

3.14.1 Key Informant Interview

The key informant's interview was conducted in the orphanage. In-depth semi-structured interviews were used to gather qualitative data from two institutions and both HIV/AIDS orphan children and their caregivers were participated. The semi structured interviews used open-ended questions concerning psychosocial care and service. These interviews allowed me as the researcher to probe and clarify answers as Yin (2001, *accessed on line 13 April 2010)* state that, skilled interviewing can follow up a respondent's answer to obtain more information and clarify vague statements. Furthermore, non-verbal as well as verbal cues were noted in the face to face interviews.

Nonverbal cues helped in identifying the key points in the interaction process. In the case of interviews with HIV/AIDS orphaned children, issues related to daily life experiences and living conditions of HIV/AIDS orphan children in an orphanage were focused. Likewise, interview made with children caregivers was mainly focused on psychosocial care and service offered for HIV/AIDS orphan children. This is in line with Patton (2002), who stated that in-depth interviewing should be repeated in face to face encounters between the researcher and the informants directed towards understanding informants' perspectives on their experiences or situations as expressed in own words. I had the opportunity to motivate the participants leading to higher response rate as noted by Berg (2001).

Christensen & James (2000) pointed out that conventional wisdom regarding best practices for interviewing children in a group setting required that:

- Children should be interviewed in restricted age groups as otherwise older children will dominate.

- Boys and girls should be interviewed separately since they have different communication styles and
- Groups should be small, with no more than eight children at maximum

After asserting the participant, the participant was asked by me to clarify answers when need arises. When notes from interviews were completed, I compiled the notes. The interviews ended when there was saturation of data as highlighted by Yin (2001, *accessed on line 13 April 2010).*

3.14.2 Focus Group Discussion

Focus group discussions are a special kind of group interview combined with techniques of qualitative analysis. Kumar, T. (2008) says the only difference between a focus group discussion and an in-depth interview is that the former is undertaken with a group and the latter with an individual. Focus group discussions (FGDs) are very important they do not discriminate those who can read and write and those who cannot read and write to express their opinions. They encourage participation by those who are shy or reluctant to be interviewed on their own since they can participate in the multitude Chisaka (2011).

The focus group discussions were conducted with children caregiver and staff. Age and gender of the participants was considered while grouping them for discussions. The focus group discussion was conducted in the form of discussion in identifying their sex to explore the psychosocial care and service of HIV/AIDS orphans. Focus group discussions explored the meaning of the findings that cannot be explained by use of statistics.

Criteria for selecting participants depended on the purpose of the investigation. Participants were selected purposively to represent a wide range of views of the issue. Participants were selected purposely based on their experience of providing care and service in the orphanages, number of

years lived in orphanages (years of received care), direct contact they have with beneficiaries. For the purposes of this study caregivers and staff who participated in focus group discussion were divided into two groups of 5 caregiver and 5 staff. Focus groups were made into small groups so that the caregivers and staff were controllable and facilitated smooth running of the discussion.

Once the participants were selected I brought them together for a discussion. Participants were allowed to use language that they were comfortable with. Questions which were prepared in advance were presented informally to the group. The order in which questions were presented to the group depended on how the discussions developed. New questions that arose during the discussion were addressed. The questions were asked by me who kept the discussion focused on the issues of interaction processes. As views were expressed, the researcher sought clarification, asked for agreement or disagreement on opinions that were expressed and probed for additional comments. I established and sustained rapport with the group, maintained a neutral role in asking questions, encouraged all participants to speak without letting any one person dominate the discussion.

Focus groups are usually recorded on audio tape. Audio is recommended over video recording because it is easier, less expensive and less noticeable to participants and therefore less reactive. In addition, audio recordings are also easier to transcribe for later analysis. Berg (2001) makes a point in relation to obtaining "suppressed discussion". The discussions were done using local languages where necessary for clarification.

3.15 Observation

Kumar, T. (2008) says that observation is purposeful, systematic and a selective way of watching interactions or phenomenon as it takes place. The main objective of using observation method in

this study was to understand the interaction between orphaned children and their caregivers likewise it helped me to assess how caregiver promote attachment skill (sleeping, feeding, bath room etc), moral skill (bible study, praying etc), social skill (playing game, cooking, washing etc) , cognitive skill (reading, making decision, doing homework etc) and emotional skill (difficulty in engaging in group discussion, family discussion etc). The key contents of the observation, was watching interactions of children with their caregivers.

3.16 Document Review

In this study, the document analyses included: official reports related to HIV/AIDS orphan and published and unpublished reading materials prepared on the study area.

3.17 Methods of Data Analysis

In the study I collected data mostly based on the purpose and objectives of the study. The accomplishments of data collection were accompanied by thematic analysis (the code which have similar characteristic were gathered together). The gathered data were analysed qualitatively parallel to data collection. Since qualitative data are generated from every day events in natural setting, meanings and interpretations were done parallel with data gathered.

3.18 Measures to ensure trustworthiness

Whilst verifiability of quantitative research is assessed in terms of its reliability and validity, qualitative research is accurately assessed according to trustworthiness through credibility, transferability, dependability and conformability (Baxter & Jack, 2008, *accessed on line 11 December 2009)*. In this study I used Guba's model for ensuring the trustworthiness of qualitative data. In this model, the following tactics were used: first, focus groups and semi structured interviews were used to triangulate the methods. Secondly, feedback from participants

was obtained about the meanings of sentences. The responses were circulated among participants so that they could confirm whether I had captured their views correctly. Thirdly, the researcher used an audio, and transcribed the data verbatim. Fourth, the raw data was analyzed and reliability was ensured with the assistance from the supervisor.

3.19 Ethical Considerations

Ethics is defined by Kumar, T. (2008) as "moral philosophy that deals with making judgments, good or bad, proper or improper, approval or disapproval and right or wrong". The purpose of observing ethics in this study was to protect the participants from harm. According to the guideline on *Ethical Approaches to Gathering Information from Children and Adolescence in Institutional Settings* Schenk *et al*. (2005) observed that researching on children raise ethical issues because of the nature of the subjects which can sometimes mean to be extremely sensitive and can likely affect the children's emotional health and feelings. Permission was obtained from the offices of selected orphanages. The objective of the study was clearly communicated in a language the study participants can understand. In addition, the rights of the study participants to withdraw from the study at any time were safeguarded. At the same time, the potential benefits and risks of participating in the study was explained to the study participants. To avoid intrusive interview for the child, the researcher established good rapport and used qualitative interview techniques, and the assistant data collector was well communicated before data collection.

3.20 Bias

Bias on the part of the research is unethical and Kumar, T. (2008) says that bias is a deliberate attempt to either hide what one has found in their study, or to highlight something disproportionately to its true existence. According to Burns & Groove (2005:727) biases distort the findings from the expected true picture. Potential sources of bias were dealt with through

- The interviews were conducted privately in a friendly environment that was free from any suggestion of victimisation (Polit & Beck 2004:37).
- Interviews were conducted by their mother tongue.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS OF FINDINGS

4.1 Data Presentation and Analysis Procedures

Data collected from the interviews, group discussions, observation and document review were analyzed by qualitative means as indicated by Mayring (2000, *accessed on line 2 November 2009)*. Qualitative data analysis contains reviewing, summarizing, generalizing and interpreting data in an appropriate and accurate way. The researcher used Constant Comparison Analysis (CCA), often called "coding system". Coding enables the researcher to locate and bring together similarly labeled data for examination and to retrieve data related to more than one label when wanting to consider patterns, connections, or distinctions between them. A set of categories, based on them or issues is developed for coding the discussion. Like most qualitative reports, the data consisted of extensive quotes from the participants that illustrated typical domain points in the discussions.

The approach used to analyze data was according to Yin (2001, *accessed on line 13 April 2010)*. The approach involves an interim analysis, which refers to the cyclical process whereby data collected are analyzed, prior to additional data collection. This approach was used throughout the study. Memoing was used which refers to reflective notes written by researchers recording ideas generated during data analysis (Berk, 2006). Individual interviews, focus group discussions, observation and document review were transcribed verbatim before data were analyzed.

4.1.1 Segmenting

Segmenting involved dividing the data into meaningful analytical units (Yin, 2001, *accessed on line 13 April 2010)*. This was done by carefully reading the transcribed data one line at a time, taking cognizance of the following questions:

- Is there a segment of the text which is important for this research?
- Does it differ in any way from the text that precedes or succeeds it?
- Where does the segment begin or end? Such segments (words, sentences or several sentences) were bracketed as a way of indicating their starting and ending points.

4.1.2 Coding

According to Patton (2002), codes are labels for assigning units of meaning to the descriptive or inferential information compiled during a study. Key words are attached to chunks of varying sizes, words, phrases, sentences, or whole paragraphs; these are referred to as "units of meaning". Coding is the process of marking these units of meaning with symbols; descriptive words or category names. In addition, face sheet codes which applied to single complete transcripts and group codes were assigned to enable me to search for group differences. Interview with children were coded as CI_1, Focus groups with caregivers were coded as FGD_1 Focus groups discussion with project key co-worker staff were coded as FGD_2 and observation were coded as OBS_1 and document review were coded as DR_1. Finally, A Hope orphanage coded as AH and Kidane Mihret orphanage coded as KM.

4.1.3. Identification of broad categories

The data from in depth interview, focus group discussions and document review were then sorted into the following broad categories: daily life experiences at the orphanage; psychosocial provisions and caregiver's and staff description about children psychosocial care and service. Moreover, the data from focus group discussion and observations were sorted into the following broad categories: caregiver interaction with children and how caregiver's promote survival skills: attachment skills, moral skills, social skills, cognitive skills and emotional skills. Themes that emerged from these categories were identified.

4.2. Findings of the study

4.2.1 Demographic data of participants

The study sought to find out the demographic information of the participants /caregivers/ which included age of caregiver, religion, ethnicity, level of education, marital status of caregiver and number of year work experience in the orphanage. The findings of the study are discussed in the below table.

Table 1: **Demographic information of the caregivers**

No	Participants personal information	Number of caregivers participated
1	**Age of caregiver**	
	35 - 39	2
	40-42	2
	43-45	6
	Total	**10**
2	**Religion**	
	Orthodox	8
	Muslim	0
	Protestant	2
	Other	0
	Total	**10**
3	**Ethnicity**	
	Amhara	5
	Gurage	3
	Oromo	1
	Tigre	1
	Total	**10**
4	**Education level**	
	Illiterate	0
	Certificate	2
	Primary education	6
	Secondary education	2
	Total	**10**
5	**Marital status of caregiver**	
	Divorced/separated	3
	Married	2
	Widowed	5
	Total	**10**

6	**Number of year work experience in the orphanage**	
	5-7	1
	8-9	4
	10-11	3
	More than 11 years	2
	Total	**10**

Source: own fieldwork, 2019.

As it indicated Table 1, all of the orphan caregiver was females. Majority of the female caregivers were widowed, separated or divorced and the rest few were married. The caregivers are Amhara and Gurage and the majority are Orthodox and Protestant religious followers. Moreover, majority of the caregivers educational status were categorized under primary education levels and followed by secondary and certificate. Likewise, the majority of caregivers age ranges from 43 to 45 years and followed by 40 to 42 years and finally 35 to 39 years of age.

The study revealed that older caregivers are also responsible for providing proper care and service for the orphan children and they are playing major care giving roles amidst a multitude of challenges that children manifest different unpleasant behavior in the orphanages. Similar study conducted in Ethiopia, Jimma town indicate that older caregivers with long year experience of the care and support play vital role and feel more proud of their contributions (Firafis et al., (2017).

4.3 Presentation of results

The analysis of this study was structured around four different themes. The next section discussed the findings of the study in detail on the issues raised by the participants upon which detailed account of their psychosocial care and service at the orphanage has been presented.

1. Daily life experiences of HIV/AIDS orphans children at the orphanage

In describing how their ordinary day life was at the orphanage, five key issues emerged which were categorized into activities such as housework, attending classes, participating in extra-curricular activities, life skill practice, counseling service and recreation and entertainment.

The AH participants informed me that it was the first time that they had been asked to talk about their daily life experiences at the orphanage since they had become AIDS orphans. Most participants (from both AH & KM) pointed out that housework activities involved preparation of breakfast and cooking food, dining, cleaning of the compound, washing the bathrooms as well as washing of clothes. Data from CI_1 reported that:

> *'' Each of us has own program, prepared by the counselor and mom, for preparing, breakfast and lunch (during summer season) and dinner (weekend time) in supporting mom and it is one of life skill practice for our future independent life''(data from AH)*

> *'' During breakfast or lunch, we all sat at the dining table and before we eat, one of us had to lead us into prayers first'' (data from KM)*

> *'' We are responsible for keeping our sleeping room, toilet and compounds clean in turn (based on the day assigned for each of us) since we always competed with other houses because there is monthly rewards that the project coordinator usually rewards the house that emerged best in terms of cleanliness every month''*(data from both AH & KM)

After conducting the interviews, I walked around both orphanage and observed that the sleeping room, toilet and compound in which the children lived were neat and the compounds were quite clean which implied that most children played a role in house work. Moreover, during document review (KM), one of data gathering tool, I saw that there was a document including their means of verification like photo and minutes that confirm as children /home/ were rewarded monthly basically based on their participation on cleaning sleeping room, toilet and compound in which

they lived.

Likewise, all the participants (from both AH & KM) revealed that they attended school based classes and home based tutorial classes and they participated on both classes in asking and responding to questions. Although some participants pointed out that besides attending classes and tutorial, they participated in reading story books provided in the home book shelf as well as revising notes. Likewise, they participated in group study and highly involved in educational question and answer competition and that sometimes they counseled fellow housemates who might be faced with some problems that were likely to hinder them from attending school based classes and home based tutorial classes and other programs.

Most participants (AH) revealed that whenever one of the housemates was sick or behaved in a'' strange manner‟, the caregivers reported the matter to the project counselor or coordinator for immediate action which included treatment or counseling. Nevertheless, I was not able to witness any incident of that kind during the study period at the orphanage. However, I was informed by the project coordinator and project counselor of the orphanage that some children especially those who highly suffered from psychological problems sometimes behaved ‘'very strangely‟ especially when they were just brought into the orphanage and children who exercised unpleasant behavior which is sometimes deviant behavior (behavior which is unique and not exercised by children in the orphanage).

They also reported that such children were treated in a ‘'special way‟ and offered psychosocial therapy, cognitive behavioral training and orientation by trained personnel as well as counseling in session manner since they suffered from trauma and stigma or other psychological problems due to the loss of both parents and either mother or father and experienced a very difficult life.

Concerning extracurricular activities, most participants (from both AH & KM) indicated that they participated in extracurricular activities like playing games such as football, table tennis, play cards, play station; while other participants said they were members of the children parliament, debating and drama clubs and yet some members said they preferred to go church, mosques and participated in environmental exploration and volunteering activities as part of their extracurricular activities. Data from CI_1, (AH) 16 years old girls stated that:

> *'' When the time for games approached, we all go for what each one of us prefer and enjoy most. As to me, I prefer going to the church because I would get psychological satisfaction and relief for my personal life''*

Similar study found out and confirmed that orphan children participated in different types of playing games such as football, netball, volleyball, spinning; harvesting and carrying maize from the garden to the school store in their daily activities (Tom Kabos Ogwang, 2011).

Another participant 17 years old boy reflected as:

> *'' Participating in volunteering activities helps me in developing a sense of humanity because I have got opportunity to visit Gergesonen old and mental health rehabilitation center in Addis Ababa that our counselor organized for us ''* (AH)

She also noted that during the extracurricular activities, almost all the children were engaged in some activity; while a few wait their turns and watched their friends play games like football or play station. However, I observed that the participants were participated on games such as football or play station were predominantly played and watched over by boys and girls respectively. However, for debating and drama clubs, the number of participants was very few (data from DR_1 of AH). When I tried to see issues related to children parliament, unfortunately I have got chance to observe while children participated in the child parliament, their monthly meeting and it was not as such well organized and also has not clearly defined responsibility that

they will discharged (data from OBS_1 of AH). Moreover, in one of my study sites, A hope children home, I saw that the children exercised their talents by involving in different club activities like preparing poem, drama, and dance and scout club.

Concerning counseling service related activities, those children who had psychological problem before and after they admitted to the orphanage got counseling service in daily basis through session in repetitive manner in both orphanages. The study revealed that few of the children felt sad, depressed, and in stress due to limited relationship with their relative outside orphanage and this particularly in Kidane Mihret children's home. Moreover, it revealed that children feel psychological disturbance because of family separation due to HIV/AIDS crisis. This basically happened not at a time of admission to the orphanage but when the children lived some times and grew in the orphanage. Data from CI_1, (KM) A 15 year old boy who lost her mother and father expressed her grief by saying:

> "*It has been eight years since I lost my parent due to HIV/AIDS crisis. After long time of their death, I understand the case as I have HIV/AIDS positive and started to suffered sadness and depressed in the orphanage.*

Likewise, the participants (AH & KM) indicated that they raised different question related to HIV/AIDS issues in association with ART (Anti-retroviral therapy), which is the children took this medicine on daily basis which is very important for survival. According the data from FGD_2 (of both AH & KM) they said that sometimes the children feel frustration because of the reason to take the medicine on daily basis and as a result they tried to hide the medicine under their tongue and majority of the children asked question frequently about ART (Anti-retroviral therapy) and personal identity. Data from CI_1, (of both AH) A 14 year's old girl who lost both

parents expressed as:

'' I have always a question that why I am here in the orphanage? Why I take the medicine daily? Who am I? from where this disease came to me? ''

As the study clearly indicated, there are children categorized under these psychological disturbances in the orphanage like depression, stress and sadness due to loss of their parents and they were confused because of different factors like accumulated unresolved identity crisis. Moreover, data from CI_1 (KM) reported that children suffer psychological problem like loneliness and depression due to parental related trauma and illness before they were admitted to the institution. They mention the reason of their psychological problem that they don't have person trust whom they share their feeling here in the orphanage. 16 years of old children stated that:

'' I feel loneliness because at the time of admission, we are 50 street children admitted to the orphanage including me and no feeling of loneliness at all unfortunately 49 of them left the orphanage due to the fact that they were unable to cope up with their addiction that they practiced before they were admitted to the institution.''

Data from CI_1 revealed that A Hope orphanage gave training related to addiction for children in repetitive manner due to the reason that those youth who are currently living in the community independently are exercising different addiction and therefore the training that the orphanage give seem to be preventive.

Another issue which emerged regarding the participants daily life experiences at the orphanage was recreation and entertainment. Some respondents of both orphanages pointed out that they enjoyed playing guitar or piano; while others said they participated in singing in the church or better still listened to the gospel music as well as meditated; a participant revealed that he

preferred listening to radios. Likewise, data from CI_1 of AH also revealed that children spent their spare time by listening to music and watching films.

- *In my free time, holiday, and weekend and out of school time, I prefer to listen to* gospel *music and watching films.*

This was corroborated with the OBS_1 of AH made by me during my stay in the field, indicted that some children were watching film, listening gospel music, praying and going to church. This implied that A Hope children's home encouraged children's active participation in the construction and determination of their own social lives.

It also emerged that some participants of AH were find of traditional and modern dances with 21^{th} century pop music which they said helped them to maintain their culture, keep modern style. This is basically helped the participants and they enjoyed interacting with friends in the A Hope orphanage so that they could share fun and joke as well as telling the already watched film story. One participant shared his view on this subject (CI_1 of AH) :

'' Participating in traditional and modern music is important for us in interacting with each other with our friends in the orphanage and it helps and make us to forget personal crisis like sadness and depression''

Moreover, according to data from FGD_2 of AH majority of the participants participated in program like coffee ceremony, happy birth day and annual tour that was held and prepared once a year that was organized by project staff. These programs supported the participants in showing their talents and in enhancing their self-confidence and communication skill. One 14 year's old participant said that, (CI_1 of AH):

'' I participated on coffee ceremony program and presented my talents in preparing poem, ***መነባነብ*** *in front of the audience, this helps me in enhancing my self-confidence (not to fear) and improved communication skill ''*

During my visit and data from OBS_1 of AH, I found children in some houses debating with each other and following modern style, currently named '' **ሙድ ይህዛሉ** ''on the already displayed talent on previous coffee ceremony program. Moreover, data from FGD_1 of both AH & KM revealed that children participated on weekly family discussions on different issues like children behavior, education and life skill practice. Regarding family discussions, the program is organized weekly and all children participated on the matter concerning them and children got chance to speak and share their idea on the topics under discussion.

The data from CI_1 (an experienced child of KM) and FGD_1 of AH, they told me that the discussions helps us/them to solve the problem of individual and group, equipped them skills on how to manage conflicts and other issues. Moreover, I was informed, that the children always told stories that they read from book and watched films and the story telling helped them to feel at home, easily interact with other children and their caregivers. The data from FGD_1 of AH indicated that she also participated in telling stories that, she shared from her personal history and experience as well as listened to the children's story especially after dinner and sometimes they sang both traditional and modern music before going to bed. The orphanage was to allow the children tell stories, share jokes and have fun with each other. By doing so, the orphanage provided the children with the opportunity to gain common sense knowledge through individual thoughts irrespective of the children's experiences.

Generally, during interview session with orphan children of both institutions, I observed that the orphan children's needs intervention in order to improve their communication skills.

2. Psychosocial provisions available to HIV/AIDS orphans children

All of the research participants of both orphanages were able to report some moral, emotional, spiritual, and social support from both institutions. This kind of support was narrated as psychosocial provision and vital to help them in their holistic development of their future life. Support in this sense took on the form of care-giving; taking care of specific needs such as health, food, shelter, clothing and school fees and treating the children as a member of the family.

2.1 Provision of basic needs

Most of the children (both AH & KM) reported that they felt so happy and led better life than before due to the basic services they received at the orphanages. They witnessed that they were able to access basic needs, such as food, clothing, shelter, medical care, education and pocket money. Similar study done in Ethiopia, Gonder revealed that orphan and vulnerable children in the orphanages accessed all the basic services necessary to sustain their lives (Sebsibe et al., (2014).

A 15 years old double orphaned boy who served for 9 years in the orphanage expressed his feeling by stating (CI_1 of KM):

"I feel good living here because we can now afford to have all the basic needs that we didn't have while in the village or on street... I feel blessed because I never had a dream to lead such a good life."

In contrast, A 16 year old single orphaned girl who lived for 4 years in the orphanage expressed the condition by saying (CI_1 of AH):

"The food is usually salty; the cloths are not smart and fit to wear… If I get any opportunity to leave this orphanage, I will never hesitate. For me, it is like a prison."

2.2 Medical care and support

Data from CI_1 of both AH & KM reported that the children got medical care and service in well-organized ways in which both medical checkup and medical treatments are included. Moreover, they had access to appropriate health care, including clinic and preventive therapy against common opportunistic infections at standard levels. Even when AR therapy may not be possible better access to treatment of opportunistic infections have been undertaken to prolong the lives of the children. Moreover, data from FGD_1 of both AH & KM the personal hygiene of children and sanitation of their living environment was well kept. To this end, they have regularly been attended by trained permanent nurses and had regular hospital visits & blood checkup.

2.3 Extracurricular activities and entertainments

Regarding to extracurricular activities and entertainment, data from both orphanages indicated that there were effectively organized in the orphanages as a supplementary to the formal school education. The children reported they refresh their mind by simple games, movies and trained on circus tricks. Moreover, the children in similar ways were actively engaged in art, culture and sports activities that enabled them socially integrated. Likewise, they also participated on yearly recreational trips to different recreational area like Sodere and Bishoftu resorts. While others would be very happy if they were members of debating and drama clubs, playing the guitar or the piano. One child stated that:(CI_1 of KM):

"*Every day after school, we have nothing to do and nowhere to go in our spare time. As the result of this most of us feel depressed. If there are activities organized to spend time, we will go for what each one of us enjoys most*."

Field observations at AH also revealed that children spent their spare time by wandering here and there around shelters without being engaged in any visible activities.

2.4 Education

The study revealed that all the children of both orphanages have been given the chance to continue attending regular schooling. In order to intensify their education in elementary and high schools, they have attended schooling in modest level of private and public schools. In addition, they have attended tutor classes in schools and have tutors at home. Moreover, they were supported by all staffs, volunteers and their attendants in studying at home and having them scheduled study program. 15 years boy orphaned child expressed his feeling as (CI_1):

If I hadn't got chance to be admitted here to orphanage, I wouldn't have got such support that helps me to attend my education and now I don't think about educational support than attending my education.(data from KM):

Moreover, on other child indicated her feeling as follows:

"*I feel so different ever since I started been getting support by the orphanage. They give us scholastic materials, paying school fees and school contribution. This has really helped me a lot and I think other children feel the same way as me". (data from AH):*

Furthermore, data from FGD_2 of AH stated as:

"All of the children have gaps in reading and numbering before they were admitted to the orphanage and after they were admitted to the orphanage, they showed us good progress in developing reading habit." (The counselor)

On other hand, data from FGD_1 of AH confirmed that feeling of shame to exist. Most children orphaned due to HIV/AIDS resist and want to stop going to school due to absence of their sibling nearby and they create unconvincing idea that they falsely reported as if they were sick. In addition, most of the children orphaned by HIV/AIDS were very old (their age and grade is not equivalent to each other) for their grades and the caregivers reported that this resulted in feelings of shame. This is illustrated by the following reflections from the participants:

'' A child could be 15 years old but still doing grade 5. This normally affects them at school and many are ashamed of the grades they are in''

2.5 Psychological and life skills education support

The study reveals that there are children from both orphanages who have low self-esteem, under developed life skills, learning disabilities, and disturbed social behavior in the orphanage. According to the data from FGD_2 of AH, there were actions taken like counseling both individually and in group and this helped them to identify their feelings and to enhance their capacity to cope with their new and difficult situation. According to them, such support helped them in their future individual life when they want to be reintegrated to the community.

Moreover, children of both orphanages reported that they also have participated on periodic coffee ceremonies program organized by them. The ceremonies have multipurpose which included recreation, education and motivations. They also celebrated their birth dates by inviting their favorites. The project had a plan to intensively use volunteers - like HIV positive volunteer educators, model artists of the children, peer groups and other appropriately selected interested volunteers. The annual interventions of such intervention have been scheduled by the psychologists and some of them together with the beneficiaries. 17 years old child expressed her feeling in such way (CI_1 of KM):

"When I am feeling sad about something, I confide with my school friends, but if I miss my mother I do not talk to my friends because they would ask me questions that I am not ready to answer about my mother".

Another child stated as (CI_1 of AH):

"Before I joined this orphanage, I usually felt sad due to lack of psychological support now here there is no problem. I am very happy with this life."

2.6 Social Interactions of children with the community

The study revealed that there is no organized program in both orphanages that primarily strengthens social interaction of children with the community than simply sending children to church and mosques. Moreover, both the orphanages staff believes that encouraging children to have school mates have paramount role in building social relationship. Similarly, that data from CI_1 of KM revealed that there is no well-organized program that they participated in community social events like holidays, contesting places, organized events (like festivals) and there is limited time to visit their extended family members. 14 years child said that: (data from CI_1 of KM):

"I have got chance to visit my extended family in Addis Ababa only for two days, less than a week because I think the orphanages rule and regulation in relation to this to strict. It is un thinkable to visit for those children who have extended family outside Addis Ababa."

Similar study done in Ghana indicated that orphans in institutionalized care lack dynamic social identities and matrilineal networks being potentially vulnerable to neglect and exploitation (Elaina Voyk, 2011).

The study revealed that the orphaned children had poor social life and communication with the people around them. The majority of the discussants expressed that the difficulty was mainly

related to the orphanages' rules of conduct and social skills. A 16 years old double orphaned boy who lived for 9 year in the orphanage explained it (CI_1 of AH):

"*I do not know how to interact with people in the community. I have no confidence to talk and walk with them because I am an orphan. I go to school but I do not talk with my classmates*…"

3 Children caregivers and other key coworkers' description about children psychosocial care and service.

Data from FGD_1 of AH indicated as follow:

"These HIV/AIDS orphaned children are well equipped with all basic needs and in most case are able to concentrate with their studies since they always feel cared and protected."

The data from FGD_2 of KM indicated that:

"Children are provided with the basic need which is really helping them to build their future. Psychosocial care and service enables the children to get love, support and care from the care givers and key coworkers. The orphanage coordinator.

This kind of psychosocial care and service help them to be motivated and feel that they are cared for, it leads them to forget that their parents had passed away and help to make the right choice in their lives. Similar study done in Nairobi, Kenya revealed that psychosocial support enables OVCs that have suffered HIV/AIDS to cope with the loss of their parents and encouraged then on how to live their present lives and adopt all necessary mechanism to be happy in life (Omwoyo Yobes Nyagaka, 2015).

The study shows that psychosocial care and service for HIV/AIDS orphaned children enables them to be well equipped in all life aspects: life skills, knowing the importance in the life, and it provide them with shelter food, education and health in their children homes.

The data from FGD_2 of AH indicated that:

The HIV/AIDS orphaned children got support like food, shelter, education and health in orphanage. The counselor.

Since most of these HIV/AIDS orphaned children are in big depression, psychosocial support helps them to have good self-esteem and spiritual encouragement in their lives. Hence they lead positive life. The data from FGD_1 and FGD_2 of both AH & KM helped the researcher (me) in understanding of psychosocial care and service programmes for orphaned and vulnerable children in the orphanage.

Data from FGD_1 of AH indicated as follows:

"*The vulnerable child is one who is living in difficult situation with high risks and his risks seriously affect their future growth and developments*." *The orphanages coordinator*

These children who are most affected are the ones who are below the age of 18 years. According to the FGD_1 of AH an orphan is one who has lost one or both parents and this child is vulnerable when they lack inadequate support from adults. Their situations are worsened when the child is HIV positive and they receive limited care. Similar study done in China indicated that the appropriate care arrangement for AIDS orphans should be evaluated within the specific social and cultural context where they live (Yan Hong et al., (2011).

Data from FGD_1 (representative of caregivers of KM) indicated that:

"*Psychosocial care and service programs need to take active measures to meet the general needs of children living with HIV/AIDS, including health, at every age level*."

Similar study done in Tanzania revealed that psychosocial support like food, clothing, shelter and education has a vital role in helping orphan children in restoring their sense of purpose and confidence in their life (Tumaini Richard Mgaya, (2014).

Data from FGD_1 of AH caregivers who have long years work experience in orphanage in care and service of orphan children reported that they are devoted and sacrifice a lot of things while supporting them. A caregiver who has more than 11 years' work experience stated the case as the following:

'' Although my effort and result obtained were not equivalent, Am happy and got pleasure for my journey in proving support because there are a few children who are currently in college and engaged in marriage ''

Similar study done in Jimma town indicated that the orphan caregivers derive psychological satisfactions from their moral right deeds. Caregivers with long year experience of giving the care and support feel more proud of their contributions (Firafis et al., (2017). Moreover, according to study done in Addis Ababa encouraging the orphan's individuality and autonomy and enhancing their self-esteem, and respect and care by adults were identified as the major themes that could promote orphan children's sense of well-being (Afework Tsegaye, (2013)

The study reveals that continuous counseling and guidance service helped the children in the orphanage in such ways that in developing good attitude towards themselves and good understanding about life together with life challenges. Similar study done revealed that psychosocial support enables OVCs that have suffered HIV/AIDS to share their problems and feelings freely since they have the same problem and they understand each other very well (Omwoyo Yobes Nyagaka, 2015).

Data from FGD_2 of AH indicated that:

"Counseling service is conducting in repetitive manner in the orphanage for all children particularly for those children who suffered psychological problem before and after they were admitted to the orphanage. (The Counselor)

Likewise, data from FGD_1 of AH indicated that children exercised age-based life skill in their daily life while living in the orphanage. This is basically to support them to cope up with challenges they face in their independent life program in the future. For instance they clean their bed room, bathroom and exercise home based activities like preparing breakfast at their free time and summertime.

"Practicing age-based life skill at all age levels helps the children to live positively and particularly for those children who live with HIV/AIDS primarily supports them to accept being positive and live positively like other children."

Data from FGD_2 (Social work) indicated that:

"Participation of children on entertainment and recreational activities like indoor and outdoor game is essential for them in developing good relationship among each other and with other."

4 Findings on the children interaction with their caregiver and how Caregivers promote children survival skills.

The data from FGD_1 and OBS_1 of both AH & KM, the following information is the participant's answers pertaining to the question: interaction between children and their caregivers and on how the caregivers promote children survival skills.

Data from OBS_1 of both AH & KM indicated that there is problem in attachment particularly lack of secure attachment and parental love in the orphanage. Similar study done in Ethiopia, Gonder town, revealed that the children in both Yenege Tesfa and Bridge of Hope orphanages reported that they suffered from stress, depression, and other emotional problems which were rooted in their lack of parental love from staff, particularly caregivers and the community (Molalign et al., (2014).

This is confirmed in my observation that while children play indoor types of game and the caregivers tried to order her in doing something and she refused, disobeyed and even she tried to insult her. I hear A 14 year girl child while communicating with her caregiver:

"You always order me than other children, why? I have a right to play with my friends, you are not my mother"(data CI_1 of AH)

Data from CI_1 of AH reported that we didn't learn skill related to problem solving skill because when conflict arises between caregivers and children and among children they simply reported to the orphanage coordinators and the coordinators intend to take measures and take some sort of punishment. We all know this and talk with each other but difficult to talk with her because if we talk to her, she may revenge as latter therefore we prefer silent.

Data from CI_1 of AH revealed that sometimes our caregivers make us fear and be tension by saying '' I will and leave this work because she has children who attend university and other engaged on job. This basically disturbs us psychologically. Moreover, data from CI_1 revealed that caregivers make discrimination (ማዳላት) among us; this happen when some conflict is made with her and this makes the interaction poor with her and loss of trust to her. On the contrary, data from FGD_1 of AH reported that children cover and not expose information of some of their issues particularly their unpleasant behavior among them, this make us our interaction low.

On other hand, the study revealed that as feeling of anger exist due to exposure to trauma during parental illness; the participants stated (FGD_1 of AH) that the children orphaned by HIV/AIDS living at both institutions were exposed to long periods of illness when their parents became sick. It seems that some of the children have not dealt with their loss completely. The results of the study show that orphaned children exposed to parental illness may develop psychological difficulties in their interactions with others as a result of past traumatic experiences. The data

from the participants (FGD_1 of AH) further revealed that exposure to prolonged illness sometimes results in the children experiencing feelings of anger, sadness and loss or lack of emotional control. Similar study done indicated that although their material needs (food, accommodation, education and health care) were well taken care of, they still faced some psychosocial challenges such as on-going mourning for lost parents and a longing to make contact with relatives (Priscillah Rukundo and Marguerite Daniel, 2017).

A 16 years old double orphaned girl who lived for 4 year in A Hope orphanage explained it: ($CI_{1)}$:

"I suffer a lot with my mother when she was sick before she died, after she died, I didn't forget each instance and this creates disturbance before and after they admitted to the orphanage."

Data from CI_1 of AH reported that they shared their personal issues to aunts than mother because aunts gave attention, time and play with them. The caregivers did not want to give them attention like her biological child who lives with us. Moreover, the caregivers are not as such open and we do not freely talk and play with them. A 16 years old orphan stated the case:

'' Our communication with aunts is so good that I consult them than mother because aunts understand me and share my happiness and feeling ''

Moreover, children of (DR_1 of KM) gave me permission to see their daily personal dairy. The information I got in relation to the interaction with their caregivers indicated that there is still some disagreement between them because the information listed on their personal dairy reveals that the caregivers do not want to develop good relationship with them and she simply provided service for them without parental love, concerning orphanage rule. According to study conducted

by in Africa Kenya, no attempt by caregivers to form relationships with children (Petersburg - USA Orphanage Research Team, 2010).

According to Bowlby's attachment theory children who experience attachment figures as rejecting, emotionally unavailable, insensitive and non-supportive, or inconsistent will construct a working model of the self that is unlovable, incompetent, and generally unworthy (Verschureren, Buyck, and Marcoen 2001).

Moreover, I have got chance to observe children (OBS_1 at AH) while playing football with their friends, who came from surrounding community, in the orphanage center and I observed that a group of children and conflict with each other and I heared words that clearly showed there is some hate and insult that the community children said to the orphanage children stated below:

'' You are stupid and you intentionally disturbing us''

On other hand, the orphan children replied that:

"People in the community and even children have no love for us. Instead, I observed them when they hate, insult and laugh at us. I do not know their reason; they even do not like the existence of the orphanage."

Furthermore, I observed some children ((OBS_1 at AH) who communicate with caregivers in good manner and they exercised some life skill practice together with their caregivers like eliminating dirty things from food items (ሚስር ጦልቀም etc) for preparing lunch for children. On other hand, there was a child who didn't wants to engage themselves in such like life skill activities but they sit around. From this one can understand the fact that there is some parental love for children from their caregivers and on contrary there is lack of parental love from caregivers' side for other children.

The majority of the children complained that they had a problem of communication (CI_1 of AH) they pointed out that the problem was usually related with continuous disturbance as a result of poor interaction with caregivers and due to scoring poor mark in education. In the CI_1, a 14 year old double orphaned girl expressed her problem of communication by saying:

> "*Usually I prefer silence than communicating with staff. The problem becomes raised due to poor educational performance in my class tests. The other thing is the caregiver and counselor has no love for me and they simply talk about education and others*…"

In contrast, a few of the children stated that they have good communication with their caregivers and counselor plus good educational performance A 37 year old caregiver who had served for 7 years in the orphanage said that: (data from FGD_1 of AH):

"I together with project counselor usually advise some of the children to have good communication skill and educational performance not to see these things carelessly. However, there is no change. This is their communication and school performance is still poor…"

On the contrary data from OBS_1 of KM revealed participants to this study indicated that they felt so happy being at orphanage because the relationship between children and their caregivers is so good that they received the love and care from them. Besides, receiving love and care from the caregivers and other staff at the orphanage, it created happiness for the children and the data from CI_1 of KM on the question, what interaction between you and your caregiver look like, indicate that the relationship that was created between them enhanced child mother attachment, but not for all children, which is very important for children development for their future. Most participants of KM expressed their happiness being at orphanage and expressed their feelings in relation to their relationship with their caregivers by stating that: (CI_1):

- *I feel good living here because I have good relationship with my caregivers so that I can ask her what I want and wish.*

- *Currently, I now feel good and have lots of courage and future hope because I have people like my caregivers was support me in preparing me future independent life.*

I observed how happily they attended classes, accomplished daily life activities like cleaning their bathroom, dining room, participating on life skill practice, obeying their caregivers and other staff and in generally discharging their responsibility in the orphanage.

Regarding the relationship among children, I observed that they were happy and they see each other brotherly and sisterly. Some of the participants stated as follows: (CI_1 of AH & KM):

- *We feel good because we see each other as sister and brother in the orphanage while living together.*

- *We feel good especially during holiday's celebration in the orphanage because we celebrate together so that we don't feel bad and alone.*

- *Various lifestyle or mood from diverse backgrounds sometimes leads to fights and quarrels which sometimes happen in the orphanage and few children don't like it.*

While moving and observing around the KM orphanage, I observed that a child was quite lonely and seated at the verandah of their houses while others plays and talk with their caregivers.

Another issue I observed in the orphanage (both of AH & KM) was the issues related to the extent or degree in which the project staff provided much care and service for the children. Most participants indicated that most of the project staff cared so much for them and made them feel ease.

This was confirmed by children saying:

- *I feel like I am living in biological family home with our brothers and sisters.*

- *I feels good because my caregiver is approachable in case of problems more than any other staff.*

Data from CI_1 of KM reported that our caregiver's advice us on the matters that we involve like life skill practices and responsibility we discharge in the orphanage especially when we wash cloth, clean bath room misbehave.

During my observation in the orphanages (AH), I observed that there are debates among children in relation to certain tasks like cleaning home, washing kitchen materials and cooking. Few of the children refused to do some activities and they justified that this activities does not belongs to them rather it is girls role like. Such issues indicated that there is some difference in understanding tasks to accomplish. This difference in understanding is basically derived from gender roles and culture. Some participant's categories activities like cooking and cleaning kitchen materials and room belong to girls. However, most of the participants especially girls strongly disagreed with the boy's statement on the categories of the activities and they said that they all are equal and there was need for them to share work equally irrespective of their gender. They further argued that they were in another environment different from their family homes and they have to abide by what the orphanage caregivers wanted them to do. All these argument is supported by participant and who stated that:

- *I feel good if an activity like cooking, cleaning kitchen materials and fetching water only belongs to girl.*

- *I am very happy with my caregivers because she teaches all of us how to do and practice life skill including different housework activities.*

The above participants responses was interpreted as a way through which children viewed how they were cared for by adults particularly their caregivers, how their social world was shaped and the meaning that the children often attach to the environment and the society in which they lived. The gender issues raised by these participants indicated that gender roles are shaped by the different care arrangements in different societies. For this particular case, the children within this locality viewed certain roles as gendered which implied that societal cultural beliefs and identities is deeply rooted in the children's mindsets irrespective of the environment in which they lived.

In response to the issue of care and service, the participants of KM indicated that they trusted their project staff that consisted of the caregivers, counselor's social workers, and project coordinators of the orphanage that they relate and sense them to their biological parents because of the manner in which the caregivers treated them at the orphanage. A report by UNICEF (2010) on *Africa's Orphan hood and Vulnerable Generations* stated that residential facilities were not an appropriate primary response for orphans‟ care due to the fact that these facilities were faced with numerous challenges. The findings of this research revealed that the children felt that they were treated well by their caregivers yet paradoxically these caregivers did not have any formal or professional training with regards to care of vulnerable children. On the other hand, the research also revealed that children at both orphanage appreciated care and service provided for them in the orphanage and were grateful that their future looked brighter than they had ever imagined.

4.1 Findings pertaining to question 1 on how the caregivers promote children attachment skill in the orphanage?

Data from FGD_1 of both AH & KM indicate that caregivers didn't know how to enhance

children attachment skill in details but they support children from their experience of parenting. Moreover, the children caregivers indicated that as some training was given for them on how to care for the orphans by project staff and outside trainers but the training was not as such significant and it is not frequently provided for them. On other hand, the caregivers reported that there are challenges like shortage of caregiver's due to frequent turnover of caregiver's i.e the number of children and caregivers is not equivalent.

Answering to the question on the parenting skills that institutional caregivers used on socializing orphans and the 5 caregivers from KM orphanage said parenting was based on Christian parenting and mission statements and 5 caregivers from AH orphanage reported that the parenting skill not based on Christian parenting rather they said that they were trained to look after the orphans and assist the orphans, and they were not trained to parenting orphans.

Similar study done in Zimbabwe, Africa revealed that according to caregiver's views in order to enhance children attachment skill, they primarily based on parenting which was based on Christian parenting and mission statements (Brandina, Mhondiwa Sharara **,** 2016).

Moreover, the study found that the caregivers of both orphanages didn't know about parenting styles, which is very important to promote children's attachment skills rather caregivers treated the children basically based on their experience they gained previously and some caregivers were harsh, some were good. Moreover, data form FGD_1 of AH revealed that the caregivers promoted children attachment skill in such way that they named and called the children by adding suffix on their name like ***'' Yee and Koo''***, this helped caregivers to increase the interaction between them and children and the children easily developed good relation to develop trust. Contrary to this,

data from CI_1 of AH revealed that most orphans described the relationship *as "*a maid and child relationship not mother-child relationship"

Data from FGD_2 of AH on the interaction between children and caregivers in relation to institutional caregiver's attachment skill revealed caregivers became "parents" to orphans. Caregivers fed, bathed, changed and assisted the orphans in the day to day activities and no other staff was involved in attachment process except caregivers. Project coordinator however said they enhanced attachment skills when allocating orphans to the families. Moreover, all orphanage community including children involved in socializing newly admitted children to the orphanages by preparing different program like coffee ceremony program. The following were remarks made by project counselor:

> *...the newly admitted orphan is attached to another orphan who has been lived for more than 5 years, have good behavior and have ability to socialize the comer ..."*

The response of both orphanages caregivers on how institutional caregivers socialized orphans with attachment skills, caregivers agreed that they sleep, feed, bath and wash clothes for orphans and they agreed how difficult it was to promote attachment skills in orphans given the temporary and permanent relationship caregivers have with orphans because children experience different behavior and have different background before they admitted to the orphanages. *The* caregivers' noted that (data from FGD_1 of KM):

> *...orphans are too many to be attached to..." "...it is difficult to get attached to any orphan...", "...Orphans should know that "...I am just a caregiver, not their real mother...".*

Data from CI_1 of KM on the interaction between children and caregivers in relation to institutional caregivers socialized orphans with attachment skills, majority of them revealed that

they achieved attachment skills by helping each other in doing daily household tasks, homework and sometimes playing games. One orphan said;

> *"...we help each other in our daily life here in the orphanage; we know each other very well so that we achieved attachment skill among each other.*

On other hand the study revealed that feelings of loss or sense of belonging exist. The data from FGD_1 of KM suggests that separation from biological siblings may result in children orphaned due to HIV/AIDS losing a sense of belonging as they have already lost their parents to the disease. The participants of both orphanages spoke about children's separation from their siblings in various ways. In a few cases, brothers have been separated from each other due to institution admission criteria that a child who has HIV positive got chance to be admitted to the institution and his respective brother didn't get chance to live together because of his health status (being HIV free).

"One child said that when his parents died, things were very difficult at home and he has got chance to be admitted to Kidane Mihiret institution and unfortunately his brother was HIV free and did not got chance to be admitted and still I doesn't know where he is''

Most of the children here don't know where their brothers and sisters are and they have no means of being with them.

4.2 Findings pertaining to question 2 on how the caregivers promote children moral skills in the orphanage?

The data from FGD_1 of both AH & KM reported that orphans were being socialized with moral skills in the orphanage. Socialization of moral skills was practiced through sending orphans to school and church, encourage orphans to study bible, praying and allowing orphans to watch television. All the programs that the orphan children practice to enhance their moral skill is

guided by prepared program. For instance, institutional timetables for bible study. One caregiver from FGD_1 of KM said:

…The institutions prepare program for orphan children in the orphanage from 3.30 to 4.30 local time for one hour per a week to teach and enhance their moral skill through inviting spiritual people from the church and other volunteers.

Moreover, the participants reported that there is a program that the orphan children participated in to promote their moral skill outside the orphanage. This program basically was coordinated by participation of all caregivers and we took the children to visiting areas of Addis Ababa like Macedonia elders and mental health center to visit them plus support them by engaging themselves in collecting money and material that basically support them. One orphan reported that (data from CI_1 of AH) :

"We all are happy for being involved in such like volunteer activities in helping such like people who are in difficult situation so that our moral skill will be increased".

Moreover, the response of caregivers (KM) on how to promote moral skill of children revealed that they have basically enhanced children's moral skill based on their experience and training taken that was organized by the institution. The training was focused on Christian values and ethics. Caregivers said;

"Some orphans children don't want to go to church and we the caregivers face challenges to enhance moral skill for such like children, instead we prefer to teach and encourage exercising Christian values and ethics in the orphanage and outside."

4.3 Findings pertaining to question 3 on how the caregivers promote children social skill in the orphanage?

Regarding development of social skills of children, data from FGD_1 of both AH & KM revealed that the caregivers use different strategy to promote children social skills. For instance, they send children to surrounding community to celebrate community holidays like Epiphany and true cross. Moreover, the caregivers used home based celebration like celebrating happy birthday with their friends who came from outside institution. This basically helped them to have intimate friends from the community children's.

Moreover, the caregivers enhance children social skill by taking children to community and help them to engage in environmental exploration. This is basically organized by project social worker and volunteers which helps the children to understand community culture and norms. This is very important for the children because when they start independent life. 39 work experience caregivers (KM) stated the case as the following:

'' *Institutional children have limited understanding and awareness about outside life challenges therefore such activities help them to increase their understanding about it and nothing is new for them when they start independent life in the community.''*

On other hand, data from FGD_2 of both AH & KM revealed that institutions used games, cooking, washing school, television and social gatherings (like weeding) to equip orphans with social skills. For instance, games helped orphans children to interact, entertain, and divert them from negative thoughts and promoted positive behavior among orphans. Project rule allowed the type of social gatherings to be attended, when and for how long in the orphanages. Older orphan children helped their caregivers to socialize their brothers and sisters to social skill because of the reason that the responsibility of their caregivers were many and it is expected from them to support their caregivers.

Furthermore, the children caregivers (AH) reported that orphans were socialized with social skills through social visits like educational visit and group discussions on matter they concern (best interest of the child). However, the caregiver didn't participate on all scheduled program related to social visit and gathering due to their work schedule and workload. Data from CI_1 of AH reported that children actively participated on social gathering and visits more than any other skill but they were so interested and happy if caregivers participated fully with them in such like accession. 15 age child express her feeling that:

> *"... My happiness is double if my caregivers were involved on social events that I prefer to participate but ..... She didn't and she justifies that as she has a lot of work and she persuades me by saying: I will prepare lunch for you until you return back."*

One orphan said;

> *...My caregiver teaches us through weekly family discussion about social skill and she encouraged me to go out and meet our friends, and attends community festival...*

On other hand, data from FGD_1 of AH indicate fear of stigmatization to exist. The participants' statements revealed that children orphaned by HIV/AIDS living at institution are in fear of stigmatization in many different contexts. These contexts include the home and school. For instance, children do not want to be visited by every people in the center and they did not want and allow even to post their ART and CD4 hospital appointment, types of medication they take daily in their living room and sleeping room. Furthermore, they strictly notified and communicate with staff key coworkers like counselors and caregivers not to share information about their status to home room teacher, unit leaders and other school community. The reason is that the counselor and social workers have frequent communication with school community that they are sometimes absent from the school due to their medical case and even the children didn't

want to write sick leave stating HIV case on sick leave format. This is due to the reason that they are in fear of stigmatization. The participants stated that the stigmatization of children orphaned by HIV/AIDS is a major problem that further intensifies the children's grieving process. Similar study reported that some of the HIV positive children experienced stigma (Priscillah Rukundo and Marguerite Daniel, 2017)

4.4 Findings pertaining to question 4 on how the caregivers promote children cognitive skill in the orphanage?

Caregivers (both AH & KM) responding to how they enhanced orphan children cognitive skill is that those children whose age are school age were attending school and they said that cognitive skills were taught through reading and writing, numbering. Moreover, the caregiver reported that those children whose ages are not reaching for school i.e the toddler exercised and enhanced their cognitive aspects through our support like using different age based games.

Furthermore, data from FGD_1 of both AH & KM reported that caregivers promoted children cognitive skills through educational rewarding through prepared education day program for children for their good academic performance so that project coordinator rewards them and his/her photo posted on the wall that other children take as a model. Likewise, caregivers (KM) support children in their education that at the time when they do their homework and particularly, for those children who have poor academic result in Amharic subject.

According to data from FGD_2 of both AH & KM the cognitive skill of orphan children were promoted using encouraging them to read, involving them in decision making on the matter they concern them, doing homework and media. Moreover, institutional coordinators were responsible for sending orphans to school, attending consultation days and assisting orphans with home-work.

Responding on how caregivers socialized orphans with cognitive skills, caregivers reported that cognitive skills were taught by sending orphans to school, orphans were assisted by home based tutorial teachers, friends and colleagues in doing home-work as it was difficult to assist orphans in subjects that the caregivers failed. Besides that, other orphans were not interested in school.

The study revealed that, Kidane Mihiret children home, has no counselor and social worker and the responsibility of both positions is performed by church sister. Likewise, there is no program that primarily stand for enhancing children talents than simply focusing on education (data from CI_1)

All orphans of school going age group had a chance to attend school; the young ones could start with preschool. One caregiver of AH said that; (data form FGD_1):

> *'' In addition to school based tutorial, teachers from home based tutorial teach orphans children using different study techniques like grouping them, question and answer competition and debating. And also there is educational support program that each children especially those children who failed in education supported by each staff. ''*

Other comments from caregivers included

> *'' We support orphans as much as we can, it is so hard when they failed in their education and orphan children's are not interested with school''*

On other hand, data from CI_1 of both AH & KM reported that we support each other while studying together at the home. One orphans said that:

> *'' We support each other and the good thing is our friends from outside can come and help us also.''*

4.5 Findings pertaining to question 4 on how the caregivers promote children Emotional skill in the orphanage?

Children caregivers (both AH & KM) reported on how orphan children are socialized with emotional skill through weekly family discussion on challenge they faced. On other hand, orphanage coordinator (AH) reported that orphan children's emotional skill were promoted using, counseling and guidance, holding group discussions on problematic issues, organizing training and experience sharing. According to orphanage coordinators the caregivers did counseling for orphan children based on their experience unless if the problem was beyond their capability, they reported to project counselor. The caregivers explained the issues as the following: (FGD_1 of AH)

> *"...the orphans sometimes present with a number of challenges in relation to their parental death and they complain to God why they are being HIV positive, for the case they did not know.*

However, the caregivers (both AH & KM) didn't have enough knowledge and understanding about how to promote emotional skill of orphan children in the institution. Similar study done indicated that caregivers socialized orphans with emotional skills, most caregivers had no knowledge on how to equip orphans with emotional skills (Brandina, Mhondiwa Sharara **,** 2016).

Other caregivers believed that they equip orphans through group discussions and games although they failed to explain how games can be used to emotionally train a childlike through role play, as few caregivers said,

"...it's difficult to teach and promote orphan children emotional skills; we tried our best via weekly family discussion and other group discussions and games..."

Similarly, the data from CI_1 (both AH & KM) about the emotional development indicated that they did not know how they were socialized with emotional skills. One orphan said,

"Emotional skills are acquired through playing play station, table tennis and other like watching television, drama but I think the counselor and social worker know better, they can tell you much on that ....please ask them..."

Generally, AH children's home is more related to the four nature of institutional care, stated by Gunnar (2016). Moreover, the study revealed that institutional caregivers were not playing an active role in socializing orphans with survival skills such as social, moral, cognitive and emotional skills. The discussion of Erikson's stages of psychosocial development generally provides a clear overview of how children progress both psychologically and socially. The Erikson's theory of psychosocial development clearly suggests that children orphaned by HIV/AIDS are likely to experience various difficulties with regards to their psychosocial development. This is likely to lead to difficulties in the way in which they relate to others in their environment (Thwala, 2008).

CHAPTER FIVE

DISCUSSION

5.1 Findings pertaining to question 1 on what does the daily life experiences and living conditions of HIV/AIDS orphan children look like in an orphanage?

A conductive environment that fulfills the basic needs of orphans: The fact that children in this study explained their daily life activities and participated in housework, attending classes, participated in extra-curricular activities, life skill practice, counseling service and entertained themselves was significant enough to state that they did appreciate the environment in which they lived. Most of them pointed out that before they were admitted to the orphanage, they lacked and didn't have most of the basic needs such as food, shelter, clothing, education, health care and entertainment service besides love and care which was very crucial for their development. Children participated on extracurricular activities like children parliament, playing games, to go church/mosques and participated in environmental exploration and volunteering activities.

On the contrary, children feel frustration because of the reason to take the medicine on daily basis and as a result they tried to hide the medicine under their tongue and majority of the children asked question frequently about ART (Anti-retroviral therapy) and personal identity. This instance is more related to identity crisis that Erik Erikson stated in his developmental stage, the emergence of the developmental crisis is determined by the person's genes at a specific age and the crises emerge in a set sequence. Likewise, the study clearly indicated, there are children categorized under these psychological disturbances in the orphanage like depression, stress and sadness due to loss of their parents and they confused because of different factors like accumulated unresolved identity crisis.

On other hand, some children participated in program organized in the orphanage. These programs supported the participants in showing their talent and in enhancing their self-confidence and communication skill. Orphaned children participated on family discussion that each home organized weekly so that orphaned children equipped with the skill like problem solving and decision making skill on matters they concern them. UN convention on the right of child stated that the fundamental principle of "the best interest of the child" as enshrined in the UN Convention on the Rights of the Child (1989) was observed in order to protect and promote the children's wellbeing. Article 12 of the UN Convention on the Rights of the Child (1989) clearly stated that:

> *Children and young adults have a right to be involved in decisions which affect them. This right extends from decisions affecting them as individuals, to decisions which affect them as a collectivity- an acknowledgement that they are social actors in their own lives*.

5.2 Findings pertaining to question 2 on what are the psychosocial provisions available to orphan children in the orphanage?

The participant of the study explained the psychosocial support that available for them in the orphanage. Gilborn et al.,(2006) conceptualizes psychosocial support and argued that it is an ongoing process of meeting physical, emotional, social, mental, and spiritual needs of a child all of which are essential elements for meaningful and positive human development.

All of the research participants were able to report some moral, emotional, spiritual, and social support from both institutions. This kind of support was narrated as psychosocial provision and vital to help them in their holistic development of their future life. Support in this sense took on the form of care-giving; taking care of specific needs. More specifically, list of psychosocial provisions available to orphan children includes provision of basic needs, medical care and

support, extracurricular activities and entertainments, education, psychological and life skills education support, social interactions of children with the community. Similar study done in Uganda revealed that the orphanage offers them the basic needs such as food, clothing, shelter, security, health care, education and spiritual guidance which they lacked while they were in their family homes after the death of their parents (Tom Kabos Ogwang, 2011). Likewise, similar study done in Ethiopia, Gonder revealed that orphan and vulnerable children in the orphanages accessed all the basic services necessary to sustain their lives (Sebsibe et al., (2014).

Regarding the social interactions of children with the community, the study revealed that the orphaned children had poor social life and communication with the people around them. The majority of the discussants expressed that the difficulty was mainly related to the orphanages' rules of conduct and social skills. Similar study done in Ghana indicated that orphans in institutionalized care lack dynamic social identities and matrilineal networks leaving potentially vulnerable to neglect and exploitation (Elaina Voyk, 2011).

The study revealed that the support that the HIV/AIDS orphan children received in the both orphanage brings positive changes in relation to health improvement (physical changes), educational performance, life skill practice and behavioral changes. According to Refworld (2009), psychosocial care is important in order to maintain a continuum of family and community-based care and support during and after humanitarian crises and to prevent immediate or long-term mental health disorders. The author argues that "Experiencing difficult or disturbing events can significantly impact the social and emotional wellbeing of a child. Exposure to violence or disaster, loss of, or separation from family members and friends, deterioration in living conditions and lack of access to services can all have immediate, as well

as long-term consequences for children, families and communities‟ balance, development and fulfillment.”

This kind of psychosocial care and service help them to be motivated and feel that they are cared for, it leads them to forget that their parents passed away and helps than make right choice in their lives. Similar study done revealed that psychosocial care enables OVCs that have suffered HIV/AIDS to cope with the loss of their parents and are encouraged on how to live their present lives and adopt all necessary mechanism to be happy in life (Omwoyo Yobes Nyagaka, 2015).

In Ethiopia, vulnerable child is a child who is less than 18 years of age and whose survival, care, and 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 lost (FHAPCO, 2010). Moreover, the number of children who are 18 years and below continues to grow due to increased cases of loss of one or both of their parents due to HIV/AIDs. Many other children live with chronically ill parents. Still others are living in abject poverty with very little food.

According to Psychosocial Care and Support Initiative, Children and Youth exposed to the devastating effects of poverty, conflict, HIV and AIDS are especially entitled to care for their emotional and social (psychosocial) wellbeing. Many have lost parents and family, experienced deprivation and abuse, been stigmatized, witnessed atrocities, and suffered overwhelming grief. All these factors have necessitated the need for psychosocial support for the orphans and vulnerable children in the community and the society as a whole. Through psychosocial interventions, the psychosocial needs of children are able to be addressed at the initial stages. Psychosocial care will therefore, enable orphans and vulnerable children to have better opportunities so as to develop to their full potential, it will also empower them to participate in

social life and develop self-confidence and self-reliant as they grow to maturity, combats discrimination among orphans and vulnerable children in the community by facilitating the integration of those groups who are suffering from discrimination as a result of HIV/AIDs and other vulnerabilities in the society. Similar study done in Tanzania revealed that psychosocial support and care like food, clothing, shelter and education has a vital role in helping orphan children in restoring their sense of purpose and confidence in their life (Tumaini Richard Mgaya, (2014).

5.3 Findings pertaining to question 3 on how do children caregivers and other key coworkers' describe children psychosocial care and service in an orphanage?

The research found out that most participants in this study positively explained the psychosocial care and service at the orphanage and argued that they were able to afford the basic needs that they lacked before they admitted to the orphanage.

The study indicated that the majority of the respondents agreed, psychosocial care and service has great impact in life of orphaned and vulnerable children in two orphanages and it brings significant developmental changes in relation to holistic issues that include physical, social, cognitive and emotional changes up on their life. The study further reported that before and at a time when they admitted to orphanage, HIV ADIS orphan children were living in circumstances with high risks and whose prospects for continued growth and development are seriously threatened. The study reported that now they are well equipped with all basic needs and in most case are able to concentrate with their studies since they always feel cared and protected.

Likewise, an HIV AIDS orphaned child is one who has lost one or both parents due to HIV AIDS epidemic and this child is vulnerable when they lack inadequate support from individual

adults. The study indicated that the situation of the children before they admitted to the institution are worsened when the child is HIV positive and they receive limited care from the society other than from parents and most importantly they are marginalized and discriminated against by the society. HIV/AIDS predominately attacks people in the society but the impact falls hard on orphaned and vulnerable children. When a parent/s dies of AIDS, the children are most likely to die even when the children are HIV negative. This is because of the social impact the children face due to the discrimination, vulnerability, lack of care and support would drive them to a state of hopelessness and the desire to live and better them. The caregivers reported that the psychosocial care and service enables the children to get love, holistic support, helped them to be motivated, feel that they are cared for it leads them to forget that their parents passed away and helped to make right choice in their lives.

The role the Ethiopian government with regard to supporting HIV/AIDS orphaned children is to protect and care for these children. This is done through continuous improved policy and legislation formulation. According to the Ministry of children and women affairs, most HIV AIDS orphaned children are protected by governments by creating government orphanage through channeling resources to the institution, creating good environment for local and international organization like A Hope and Kidane Mihret to have an orphanage to care HIV AIDS orphan children and by creating families strengthening program by channeling resources to the communities where those children come from.

In general, the benefits of psychosocial care and service for HIV/AIDS orphaned children that the institution provided for them brings changes on children lives and these services revolve around physical, material needs such as shelter, clothing and food. The emotional were incorporate the need for love, security, motivation, trust, sense of belonging, understanding and

guidance. The mental incorporate aspects such as formal education, information education and general life skills. The social were essential for integration into a community without feeling stigmatized or different; to develop a sense of belonging; form friendships and community ties; acceptance; identity; acknowledgement from peers and opportunities for social interaction. Spiritual needs include a belief in a higher being, which enables them to develop hope for their future. According to HOPE worldwide Africa (2006), this gives them hope to keep trying, to be courageous and to persevere. They can trust in the higher being to help them in difficult situations. According to the caregivers, to provide quality and standard service for target beneficiaries, in its nature, psychosocial care and service programs need staff team work to take active measures to meet the general needs of children living with HIV/AIDS, including health, at every age level."

5.4 Findings pertaining to question 4 on how is the interaction between children and their caregivers look like in an orphanage?

Developing a trusting relationship between caregivers and orphaned children: In response to the issue of care and service, the orphaned children indicated that they trusted project staff more or less who consisted of the orphanage caregivers, counselors, social workers and the coordinators of the orphanages that they likened and associated to their biological parents because of the manner in which the caregivers treated them at the orphanage.

Being abandoned and loss of parental care have a devastating impact on children's social development (Killian and Durrheim, 2008). This study also revealed that the majority of the HIV/AIDS orphaned children were socially isolated and had poor attachment to the people around them. It has been well documented that the HIV/AIDS orphaned children suffer from both disturbed social interactions as well as peer relationship problems (Zhao et al., 2007). The

reasons behind these could be the strict orphanages' rules of conduct which limit social interaction, create bad perceptions of people among the children, leading to lack of self-confidence and social skills. The other explanation could be that lack of parental love and care from people in the community and care providers could also ruin their moral values and beliefs affecting their smooth social interaction that leads to a friendly life. Similar study done in Ethiopia revealed that the children in the orphanage reported that they suffered from stress, depression, and other emotional problems which were rooted in their lack of parental love from staff, particularly caregivers and the community (Molalign et al., (2014). Furthermore, According to Bowlby's attachment theory children who experience attachment figures as rejecting, emotionally unavailable, insensitive and non-supportive, or inconsistent will construct a working model of the self that is unlovable, incompetent, and generally unworthy (Verschureren, Buyck, and Marcoen 2001).

A report by UNICEF (2016) report on *Africa's Orphan hood and Vulnerable Generations,* it stated that residential facilities were not an appropriate primary response for orphans care due to the fact that these facilities were faced with numerous challenges. The report list out the reasons against institutionalization of orphan care like: high turnover rates of staff, high child-to-staff ratios, difficulties in reintegration during the early childhood, frequent failure to respond adequately to the psychological needs of children, higher cost compared to community-based care and greater challenges to scaling up, lack of government standards and monitoring of the care provided and worse outcomes physically and mentally for children living in residential care facilities.

The findings of this research revealed that the children felt that they were treated and cared by their caregivers yet ironically these caregivers did not have any formal or professional training

than personal experience in regards to care and service of HIVAIDS orphan children. Though the researcher agree with some of the reasons advanced against institutionalization of children, the awareness of the children in this study dominated some of the negative statement advanced against orphanages which did not take into consideration the children's understanding. However, this issue was in line with Schenk, *et al*. (2005) views who suggested that collecting accurate and geographically specific information on children should be done in a manner which respected their rights in order to learn more about their circumstances and situation. The children in this particular case lacked the basic care necessary for their development like parental care and love (secured attachment) which was the primary purpose of this orphanage according to the orphanage coordinators.

On the other hand, the research also revealed that children at this orphanage appreciated the psychosocial care and service that they got from the orphanage. This is confirmed by the Standard Service Delivery Guideline for OVC Care and Support Programs of Ethiopia (Federal HIV/AIDS Prevention and Control Office (FHAPCO), 2017) revealed that the core service components, including shelter and care, legal protection, health care, psychosocial support, education and food and nutrition.

For this study, the creation of an orphanage which took care of the HIV/AIDS orphaned children who didn't got basic necessity and for those who were at challenge getting basic need, created an enabling environment in which the HIVAIDS orphaned children rediscovered their full potential and looked beyond their social world as argued by most participants. Childhood theory argued that children were active participants in the construction and determination of their own social lives, the lives of those around them and of the societies in which they lived. Moreover, Erikson

view on his psychosocial development stated that when children's basic needs are met they develop trust in their environment (Erikson 1980). Developing and enhancing good relationship between children and their caregivers, their family, their relative and further wider community network is important for shaping intervention. Secure attachment patterns are associated with more cooperative, pro-social child behavior both in the context of child- parent relationship and with others (Bowlby 1951).

The overall challenges of HIV/AIDS orphan children solved and at least minimized by taking into consideration factors such as trusting relationships, emotional support outside the family, self-esteem, encouragement of autonomy, hope, responsible risk taking, a sense of being lovable, and school achievement, belief in God and morality and unconditional love. Erikson agreed on his psychosocial development stage and revealed that each stage's development crisis must be handled during that stage in order to ensure the individual's overall development during that period (Meyer & Viljoen, 2008).

Regarding attachment skills, the all most all of caregivers from one study site said parenting was based on Christian parenting and mission statements and on contrary, other caregivers from other study site reported that the parenting skill not based on Christian parenting rather they said that we are trained to look after the orphans and assist the orphans, but we are not trained to parenting orphans. Similar study done in Zimbabwe, Africa agreed with the first statement that according to caregiver's views in order to enhance children attachment skill, they primarily based on parenting which was based on Christian parenting and mission statements (Brandina, Mhondiwa Sharara **,** 2016).

Regarding moral skills, caregivers was used strategy through sending orphans to school and church, encourage orphans to study bible, praying and allowing orphans to watch television. Moreover, caregivers motivate children to visit support center like Macedonia elders and mental health center and others. On contrary, the study revealed that as different delinquent behaviors exist while children practice the moral skills. The caregivers stated that few of the children orphaned by HIV/AIDS living at both children's home engage in delinquent behaviors such as stealing and habitual lying. Bowlbv (1944) in his article "Forty Four Affectionless Thieves, their Characters and Home Life" noted that children who have experienced maternal separation and deprivation frequently develop an affectionless personality and engage in delinquent behavior. Similarly, the focal points of Erikson's stage of development during initiative versus guilt are the child's increasing ability to move around on his/her own. During this period, children experience guilt regarding some of the ideas in their minds that they would like to explore (Meyer & Viljoen, 2008). This stage is likely to prove challenging for children orphaned by HIV/AIDS as they have no parents to imitate or with whom they can identify.

Regarding development of social skills of children, the caregivers motivate children to participate and celebrate on community holiday and engaged in environmental exploration visit. Contrary, participants' statements revealed that children orphaned by HIV/AIDS living at institution are in fear of stigmatization in many different contexts. These contexts include the home and school. For instance, children is not want to visited by every people in the center and they did not want and allow even to post their ART and CD4, hospital appointment, types of medication they take daily in their living room and sleeping room. Furthermore, they strictly notify and communicate staff key coworkers like counselors and caregivers not to share information about their status to home room teacher, unit leaders and other school community.

Responding on how caregivers socialized orphans with cognitive skills, caregivers reported that cognitive skills were taught by sending orphans to school, orphans were assisted by home based tutorial teachers, friends and colleagues in doing home-work as it was difficult to assist orphans in subjects that the caregivers failed. Besides that, other orphans were not interested in school. Cognitive skills seem to be very important in personal development for their future lives and create good environment in leading independent life for instance in getting better chance of being employed and having creative skill in creating their own jobs. Basically, for effective coping life challenges in the community for their future, the HIV AIDS orphan children needs basic survival skills that no one skill is more important than the other skills i.e all skills is required not only for study target group but also for all children in the orphanage.

Regarding, emotional skills, the caregivers reported on how orphan children socialized with emotional skill were through weekly family discussion on challenge they faced. However, the caregivers didn't have enough knowledge and understanding about how to promote emotional skill of orphan children in the institution. Similar study done indicated that caregivers socialized orphans with emotional skills, most caregivers had no knowledge on how to equip orphans with emotional skills (Brandina, Mhondiwa Sharara **,** 2016).

Generally, the data from the participant's in relation to institutional family interaction, it is not as such effective, lacks in providing the orphans adequately with the survival skills which in this study were interaction: moral, social, cognitive and emotional skills. The family members, especially caregivers who in this study stood as substitute mothers, they provided survival skill support for the children not based on professional aspects rather they basically focused on their experience of parenting even though they got training with limited time.

The study showed that regarding to interaction as a whole, the HIV/AIDS orphan children depend on each other more than the caregivers and project staff in the institution because there is no formal program prepared by the institutions in relation to enhancing children interaction and increasing children survival skills. The discussion of Erikson's stages of psychosocial development generally provides a clear overview of how children progress both psychologically and socially. The Erikson's theory of psychosocial development clearly suggests that children orphaned by HIV/AIDS are likely to experience various difficulties with regards to their psychosocial development. This is likely to lead to difficulties in the way in which they relate to others in their environment (Thwala, 2008).

CHAPTER SIX

SUMMARY, CONCLUSION AND IMPLICATIONS

6.1 SUMMARY OF THE STUDY

The study sought to explore and assess the psychosocial care and service for HIV/AIDS orphan children the case of A Hope Project and Kidane Mihret orphanage in Addis Ababa. A qualitative exploratory-descriptive research design was used. The study was guided by the following research questions: what does the daily life experiences and living conditions of HIV/AIDS orphan children look like in an orphanage, what are the psychosocial provisions available to orphan children in the orphanage, how do children caregivers describe children psychosocial care and service in an orphanage and how is the interaction between children and their caregivers look like in an orphanage.

A qualitative design guided the study and purposive sampling was used to select study participants. The sample was made up of 30 participants of which ten orphans, ten caregivers and ten staffs. Data were collected through in-depth interviews, focus group discussions (FGDs), observation and document review. Ethical considerations were also met through seeking permission and informed consent from caregivers, HIV/AIDS orphans children and key informants. Data were thematically categorized and analyzed.

The findings of the study showed that orphans involved in the study encounter problems related to psychosocial care and service in the orphanages particularly parental love and care. It emerged during the study that HIV/AIDS orphan children's were not receiving adequate parenting love and interaction with their respective caregivers. Caregivers seemed to lack adequate parenting roles as well as the necessary qualifications and skills to care for HIV/AIDS orphans rather they

used their previous parenting experience. HIV/AIDS Orphans themselves, as a result of inadequate and insufficient caring skills, were not receiving adequate education and experience necessary to equip them with survival skills, like social, moral, cognitive and emotional skills.

6.2 CONCLUSION

The HIV/AIDS orphan children shared their daily life experiences and living conditions in the orphanages. The fact that children in this study explained their daily life activities and participated in housework, attending classes, participated in extra-curricular activities, life skill practice, counseling service and entertained themselves was significant enough to state that they did appreciate the environment in which they lived. The respondents said their lives were much better because they were offered the basic needs necessary for life course adjustments at the orphanage which they lacked before they admitted to the orphanage and while they were under the care of relatives. The participants to this study also appreciated the work of project staff their support particularly in delivering care and service. The research revealed that orphaned children adapted to the environment in which they lived due to homogeneity of the challenges they faced during childhood, before they admitted to the orphanage and as such accepted a new life discourse to which they viewed themselves as brothers and sisters. Despite the negative assertions about orphanages as revealed by most studies, the participants in this study viewed their psychosocial care and service and living condition at the orphanage as normal‟ and were more grateful that they were able to afford the basic necessities of life despite the high risk factors they went through during childhood.

Even though children lacked love and poor interaction with their caregivers they positively explained and obtained psychosocial care in the institution in a form of “care-giving”, taking

care of specific needs. Such care encouraged and motivated them when they were confronted with challenges before they admitted to the institution, brings significant developmental changes in relation to holistic issues that include physical, social, cognitive and emotional changes up on their life. Moreover, it helped them to compare their situation before and after admission and choose to live positively. The study also concluded that the psychosocial care should be implemented to help HIV/AIDS orphan children to build a strong normal background. Lastly, The salient finding of the study revealed that HIV/AIDS orphan children does not adequately equipped with life-long survival skills which were social, moral, cognitive and emotional skills. There were gaps in terms of preparation of the caregivers for effectively discharging the parental roles to the orphans. Moreover, the finding shows that the orphanages solve some of orphan's basic needs such as materials need, schooling and health care. Only material support does not make children to develop fully. The psychological supports and parental love are neglected.

6.3 IMPLICATIONS

The implication related to developmental psychology, education, policy and future research will be discussed under.

6.3.1 Implications to Developmental Psychology

The study revealed that not having access to grow up in a family environment, low interaction with their caregivers (lack of parental love) and lack of sufficient life/survival skill affected the later life of orphaned individuals. According to Thomas, (2010), the environments where individuals are born and brought up predict their life in their later age. Individuals will have different religious and cultural backgrounds when they born and brought up in different social conditions. Therefore, to tackle the challenges of orphaned individuals at a grass root level, student like me can help orphaned children in the institution by providing basic survival skill,

equipped them with basic developmental process with its manifestation, work towards on the attachment process with their respective caregivers which create good interaction between them and restore family environment. Furthermore, I can help them through placement in the institution by facilitating the process of assistance for the families or provide sufficient training and experience sharing program on caregiver's parenting skill to keep vulnerable children in a loving family environment.

According to the employees of both institutions, the government and nongovernmental organization recognized the short coming of institution in attaining holistic need of orphans. Therefore, they categorized at a last option of the placement of children in the institution. They said that they are striving in equipping children caregivers with basic parental and survival skills through continuous training, experience sharing, and inviting professional individuals. Thus, I can encourage caregivers to develop their skills through program that the institutions organize for them. As orphans spent more time with each other, lack adult figure and they had minimal interaction with their caregivers they failed to develop basic life/survival skills. According to Thomas (2010), individuals' behavior is conditioned by their environment and life experiences. I together with other behavioral science professionals more concerned with child care and development and strive to end poor attachment between children and their caregivers, promote basic life /survival skills.

6.3.2 Implication for Education

The social work profession should be encouraged to take steps to ensure the interaction between children and their respective caregivers, life/survival skill practice as an integral part of social work education, increase research and scholarship on how to enhance positive relationship in a

very well-structured culturally competent practice among developmental psychologists. In addition social agencies should be encouraged to provide positive relationship, life/survival skill practice and child care and development within culturally competent in service training and opportunities for continuing education for agency based workers. Therefore, the current study has a positive implication for developmental psychology education in producing professional care practices and the need of ongoing education and training for all caregivers, counselors and social workers, with particular emphasis on promoting the importance of interaction and survival skill practice on orphaned children lives.

6.3.3 Implication for Policy

According to Federal Democratic Republic of Ethiopia Ministry of Women's Affairs (2009), it is the role of the government to regulate and supervise the provisions of alternative care to children and ensure the safety, well-being and development of the children who are receiving it. Therefore, the current study gives clue for the responsible body to supervise the application of the care and services for the children in the institution. Moreover, model or effective institutional care in the country should be scale up and adopt. Furthermore, conduct assessment and search volunteer families and mobilize communities to adopt HIV/AIDS orphaned children to their biological family. According to Federal Democratic Republic of Ethiopia Ministry of Women and Children's Affairs (2009), all actions of the child care institutions must be practiced in line with the principles of the best interests of the child, nondiscrimination, survival and development and participation of the children needing the service. Therefore, the present study may give clue to the responsible body in placing the children in need according to the best interest of the child and every action should be taken by considering and respecting their participation.

The research revealed that that the caregivers of both institution were not trained and lack of knowledge of parenting style. Therefore, it recommends the responsible body to set as principle to recruit trained caregivers or provide sufficient training and follow its application. The current study revealed that the care and service provided to children faced challenges: parental love, interaction and children life/survival skill is overlooked and couldn't get attention. Therefore, orphans face challenges to in relation to getting parental love and equipping them to basic survival skill. Hence, from the findings it is better that the policy makers review policies that promote children life/survival skill in the orphanages. There should also be extensive training of institutional caregivers to strengthen their parenting roles and responsibilities to make them support the children in the orphanage.

6.3.4 Implication for Future Research

Globally, the challenge of orphans while they were in the care unit has attracted the attention of the researchers. Orphans problems were not limited to institutional life were as they suffered before they admitted to the orphanage. On top of that they failed to lead independent life and not competent with the wider society. Therefore, the present study gives some clue for the researchers to recognize the current situation and challenges of HIV/AIDS orphan children and conduct the research on different aspects of their difficulties while they are in the orphanage. There are a number of areas in which researches on orphaned children's perspectives can be sought. One aspect could be to find out from the orphaned children who reside in an orphanage in an urban or city area and compare their views with those who lived in an orphanage in the rural area but in different locations. Another aspect for future studies would be to seek the views of the orphaned children who reside with their relatives (families) or community care homes or those who live in the foster care homes and analyze their views on how they explain their care

and service in the orphanage. Moreover, future research should be focus on rating the quality of care and service provided for the children in the institution either using already prepared national framework for OVC, care and service guideline, HAPCO, Ethiopia or using standardized rating scale via quantitative approach. I do hope that considerations will be made to redefine the concept of orphanages to suit the best interest of the vulnerable children as stipulated in the UNCRC.

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DECLARATION

First, I declare that this thesis is my bona fide work and that all sources of materials used for this thesis have been duly acknowledged. This thesis has been submitted in partial fulfillment of the requirements for M.A degree in Developmental Psychology in Addis Ababa University. I solemnly and certify that it has not been submitted to any other institution anywhere for the award of any academic degree, diploma, or certificate.

Name: _____

Signature: _____

Place: Addis Ababa University

Date of Submission: June, 2019

I hereby confirm that the thesis has been worked out under my supervision as a university advisor.

Name: _____

Signature: _____

Date: _____

APPENDICES

Appendix I

English and Amharic Version

Addis Ababa University

አዲስ አበባ ዩኒቨርሲቲ

College of Education and Behavioral Studies

የትምህርትና ስነ ባህሪይ ጥናት ኮለጅ

School of Psychology

ስነ ባህሪይ ትምህርት ክፍል

Confidential

Psychosocial Care and Service for HIV/AIDS orphan children in an orphanage in Addis Ababa.

የጥናቱ ርዕስና መዳረሻ

በአዲስ አበባ ከተማ በሚኙ ህፃናት ማሳደጊያ ተቋማት ውስጥ ወላጆቻቸውን በኤች አይ ቪ ኤድስ ያጡ ህፃናት ማበራዊ የስነ ልቦና ድጋፍና አገልግሎትምን እንደሚመስል የሚደረግ ጥናት

Verbal Consent Form for Participants of the Study

ወላጆቻቸውን በኤች አይ ቪ ኤድስ ያጡ ህፃናት ማበራዊ የስነ ልቦና ድጋፍና አገልግሎት ምን እንደሚመስል ለሚደረግ ጥናት የተዘጋጀ ቃለ መጠይቅ ፎርም

Introduction:
መግቢያ

Good morning/Evening/Afternoon Sir/Madam

My name is Firafis Dereje. I am from graduate school of Psychology at Addis Ababa University. I am currently collecting data regarding psychosocial care and service for HIV/AIDS orphan children inyour orphanage here inAddis Ababa.

As part of my investigation, I am talking to a wide cross section of people in this orphanage. The study is being undertaken between HIV/AIDS orphan children in the orphanage. It is in this regard you are selected to provide information, which can serve several purposes, especially guiding policy makers in designing programs for improving the wellbeing of HIV/AIDS orphan children in the orphanage.

የተከበራችሁ የዚህ ጥናት አካልና ተሳታፊዎች በቅድሚያ እንደምን አደራችሁ/ዋላችሁ

ስሜ ፊራፊስ ደረጀ ይባላል የመጣሁት ከአዲስ አበባ ዩኒቨርሲቲ የሳኮሎጅ ትምህርት ክፍል ነው።የመጣሁበት ምክንያት በአዲስ አበባ ውስጥ በሚገኙ የህፃናት ማሳደጊያ ተቋማት ብሎም በእናንተ ድርጅት ውስጥ ወላጆቻቸውን በሞት ያጡ ህፃናት ማበራዊየስነ ልቦና ድጋፍና አገልግሎት አሰጣጥ ምን እንደሚመስል ለማጥናትና መረጃዎችን ለመሰብሰብ ነው።ስለሆነም እናንተ የጥናቴ አካል እንደመሆናችሁ መጠን በተቋማችሁ ውስጥ ባሉ በተለያዩ የሙያ ዘርፎች የተሰማሩ ሰዎች ጋር ሰፊ ጉዳዮችን እንነጋገራለን። ይህ ጥናት ትኩረት እሚያደርገው ከላይ እንደተገለጸው ወላጆቻቸውን በሞት ያጡ ህፃናት ላይ ሲሆን በዚህ ዙሪያ ተቋማችሁ ለጥናቱ የሚሆኑ ማስረጃዎችና መረጃዎች ይገኙበታል በሚል እሳቤ ተመራጪ ሆኖዓል። ይህም ለጥናቱ የጎላ ጠቀሜታ ሲኖረው በተለይ ፖሊሲ አውጭዎች በኤች አይ ቪ ኤድስ ወላጆቻቸውን ያጡ ህፃናትን ደህንነትና አገልግሎት አሰጣጥ ላይ ትኩረት ሰጥተው እንዲሰሩ የጎላ ሚና ይኖረዋል ።

Confidentiality and consent

I may ask some personal questions that some people find difficult to answer. I am not going to talk to anyone 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 do not have to answer any question that you do not want to answer, and you may end this interview at any time you want. Your name will not appear on the questionnaire and even in the report. I would greatly appreciate your help in responding to this study. The interview will take 45 minutes to an hour. Would you be willing to participate?

(Ask respondent for any comments, clarifications or questions before starting the interview).

(Respondents have given certifying that informed consent verbally)

የጥናቱን ሚስጥር ጠባቂነትና ግልጽነት

አንዳንድ ግለሰብ ላይ ትኩረት ያደረጉ ጥያቄዎች ሊጠየቁ ይችላሉ ነገር ግን ግለሰቡ የተናገረውን ለማንም ሶስተኛ አካል ሚስጥሩ አይነገርም። በዚህ ቅጽ ስማችሁ ተጠቅሶ ከምሰጡት መልስ ጋር አይያያዝም ።መልስ መስጠት እማትፈልጉትን ጥያቄ ለመመለስ አትገደድም/ጅም። ይህንን ቃለ መጠይቅ በማንኛውም ሰዓት የማቋረጥ መብት አለህ/ሽ። ከዚህ በመነሳት ለምታደርጉልኝ ድጋፍና ለምትሰጡኝ ምላሽ በቅድሚያ አመሰግናለሁ ! የጥናቱ ተሳታፊዎች በፍቃደኝነት ላይ የተመሰረተ ቃለ መጠይቅ

መጠይቁ ከ 45 ደቂቃ እስከ 1 ሰዓት ሊወስድ ይችላል ለመሳተፍ ፈቃደኛ ነህ/ሽ?

General Information / አጠቃላይ መረጃዎች

Town /እምትኖርበት አካባቢ ከተማ ስም----------

Sub city/ዋና ከተማ----------

Woreda/ ወረዳ----------

Name of orphanage/እምትኖርበት/ሪበት ተቋም ----------

Date of the Interview/ቃለ-መጠይቅ የተደረገበት ቀን:_____

Start Time/መጠይቁ የተጀመረበት ሰዓት End Time/ያለቀበት ሰዓት--------

Demographic Characteristics

The demographic information related children caregiver includes: age of caregiver, religion, ethnicity, level of education, marital status of caregiver and number of year work experience in the orphanage.

1ኛ የጥናቱ ኩነቶችና መሰፈርቶች

ጥናቱ መረጃ ለሰብሰብ ትኩረት እሚያደርገው በአዲስ አበባ የህጻናት ማሳደጊያ ተቋማት ውስት ወላጆቻቸውን በሞት ያጡ ህፃናት ማበራዊየስነ ልቦና ድጋፍ አሰጣጥ ጋር ተያይዞ ሲሆን ሲሆን ኩነቶቹም፡-

For Children Caregivers / ለህጻናት ተንከባካቢዎች

1. What is your age bracket/እድሜ
    - 35 - 39 years [ ], 40-42 years [ ], 43-45 years [ ]

- 35-39 [ ] , 40-42 [ ], 43-45 [ ] , ሌላ[ ]

2. Religion/ሀይማኖት፡
   - Orthodox [ ], Muslim [ ], Protestant [ ], Other [ ]
   - አርቶዶክስ [ ] , ሙስሊም [ ], ፕሮቴስታንት [ ] ሌላ [ ]

3. Ethnicity/ብሄርህ ምንድን ነው?
   - Amhara [ ],Oromo [ ], Gurage [ ], Other [ ],
   - አማራ [ ], ኦሮሞ [ ], ጉራጌ [ ], ሙ.ሌላ [ ]

4. What is your educational level/የትምህርት ደረጃ
   - Illiterate [ ], Primary [ ], Secondary [ ], Certificate [ ], Diploma [ ], Degree [ ]
   - መሰረተ ትምህርት [ ], የመጀመሪያ ደረጃ ት/ቤት ያጠናቀቀ/ች [ ], ሁለተኛ ደረጃ ትምህርት ያጠነቀቀ/ች [ ] ሴርቲፊኬት [ ] ዲፕሎማ [ ] ዲግሪ [ ] ሌላ [ ]

5. Marital status of caregiver/የተንከባካቢዎች የጋብቻ ሁኔታ
   - Divorced [ ], Married [ ], Separated [ ], Widowed [ ],
   - የተፋቱ [ ] ያገቡ [ ] ተለይተው የሚኖሩ [ ] ብቻቸውን እሚኖሩ [ ]

6. Number of year work experience in the orphanage/በደርጅቱ አገልግሎት ዘመን ?
   - 5-7 years [ ], 8-9 years, [ ] 10-11 years, [ ]
   - 5-7 [ ] , 8-9 [ ], 10-11 [ ], ሌላ [ ]

A. Interview guideline for children caregiver / ለህጻናት ተንከባካቢ እናቶች የሚቀርቡ ቃለ-መጠይቆች

1. How do you see psychosocial care and service that you offered for HIV/AIDS orphan children? በተቋማችሁ ውስጥ ላሉ ህፃናት የሚሰጡ ማበራዊየስነ ልቦና ድጋፍና አገልግሎት አሰጣጥ እንዴት ታዩታላችሁ ?
2. What is the care giving and taking situation between you and children look like? ድጋፍና አገልግሎት ከመስጠትና ከመቀበል አንፃር በእናንተና በህፃናት መካከል ያለው መስተጋብር (የቅርርብ) ምን ይመስላል?

3. How do you explain the relationship between you and children? በህፃናቱና በእናንተ መካከል ያለውን ግንኙነት እንዴት ትገልፁታላችሁ?

B. Focus group discussion guideline for children caregiver/ለህጻናት ተንከባካቢ እናቶች የቡድን ውይይት ቃለ- መጠይቆች

የህፃናት ተንከባካቢ ሰራተኞች የህፃናትን ክህሎት እንዴትና በምን መንገድ እየገነቡ ይገኛሉ፡-

1. How do you promote orphan children attachment skill?
   ወላጆቻቸውን ያጡ ህፃናት ከተንከባካቢዎቻቸው ጋር ያላቸው ውህደት እንድጎለብት ምን እንዴት ትሰራላችሁ?

2. What role do you play to promote orphan children moral skills?
   የህፃናቱ ግብረገብነት ክህሎት እንዲጎለብት የእናንተ ሚና ምንድን ነው?

3. How do you promote orphan children social skills?
   ህፃናቱ የማህበራዊ ክህሎቶች እንዲዳብሩ በምን አይነት ዘዴ ታበረታቷቸዋላችሁ?

4. What role do you play to promote orphan children cognitive skills?
   የህፃናቱ የማሰብና የግንዛቤ ደረጃ እንዲያድግ የእናንተ ሚና ምንድን ነው?

5. How do you promote orphan children Emotional skill ?
   ህፃናቱ ተንካራ የስሜት ክህሎት እንዲኖራቸው እንዴት ትሰራላችሁ?

C. Interview guideline for HIV/AIDS orphan children/ለህፃናት የሚቀርቡ ቃለ መጠይቆች

1. Mention your name, where you come from and how long you have been here/በቅድሚያ ስምክን ንገረኝ/ሪኝና በአጭሩ ከየት እንደመጣህና በዚህ ማሳደጊያ ተቋም ለምን ያህል ጊዜ እንደቆየህ/ሽ ብታብራራልኝ/ሪልኝ?

2. How is your ordinary day like/የእለት ተለት እንቅስቃሴህን እነዴት ታሳልፋለህ/ሽ?

3. Can you tell me how you feel being in this place/ከዚህ ማሳደጊያ ተቋም በመሆንህ/ሽ

እሚሰማህን ስሜት ልትገልፅልኝ ትችላለህ/ሽ?

4. What is the interaction between you and your caregiver look like in line with care taking and giving/በአንተ/ች ተንከባካቢ አናቶች መካከል ያለውን ግንኙነት አገልግሎት ከመስጠትና ከመቀበል ጋር በዙሪያ ልታብራራልኝ/ሪልኝ ትችላለህ/ያለሽ?
5. Can you tell me what it is like to be here with your friends, caregivers and other staff/ ከዚህ ማሳደጊያ ስትኖር ከጓደኞችህ ከአሳዳጊዎችህና ከመሳሰሉት ሰራተኞች ጋር ያለው ሁኔታ ምን እንደሚመስል ልታብራራልኝ/ሪልኝ ትችላለህ/ሽ?
6. What kind of support is available here in the orphanage for you/በዚህ ማሳደጊያ ተቋም ምን አይነት ድጋፎችንና አገልግሎቶችን ታገኛለህ/ሽ?

D. Focus group discussion guideline for project staff (child-care co-workers)/

ለማሳደጊያ ተቋሙ ሰራተኞች የሚቀርቡ የቡድን ውይይት ቃለ መጠይቆች

1. How do you see psychosocial care and service that you offered for HIV/AIDS orphan children/ለህፃናቶቹ የምትሰጪቸው የስነልቦና ና ማህበራዊ ድጋፍ አገልግሎት እንዴትታዩታላችሁ?
2. What kinds of role and responsibility do you have and play in offering service for children in orphanage/በማሳደጊያ ተቋሙ ውስጥ አገልግሎት ከመስጠት ጋር ተያይዞ ያለህ/ሽ ሀላፊነት ምንድን ነው?
3. How do you describe care and service delivered for children in your position/አንተ/ች በምትሰራበት የስራ መደብ ለህፃናት የሚሰጡ ድጋፎችና አገልግሎቶች እንዴት ትገልፀዋለህ/ሽ?
4. How do you explain the relationship between children and their caregiver/በህፃናት ተንከባካቢ እናቶችና በህፃናት ያለውን ግንኙነት እንዴት ትገልፀዋለህ/ሽ?

E. Observation check list for understanding the interaction between children and their caregivers

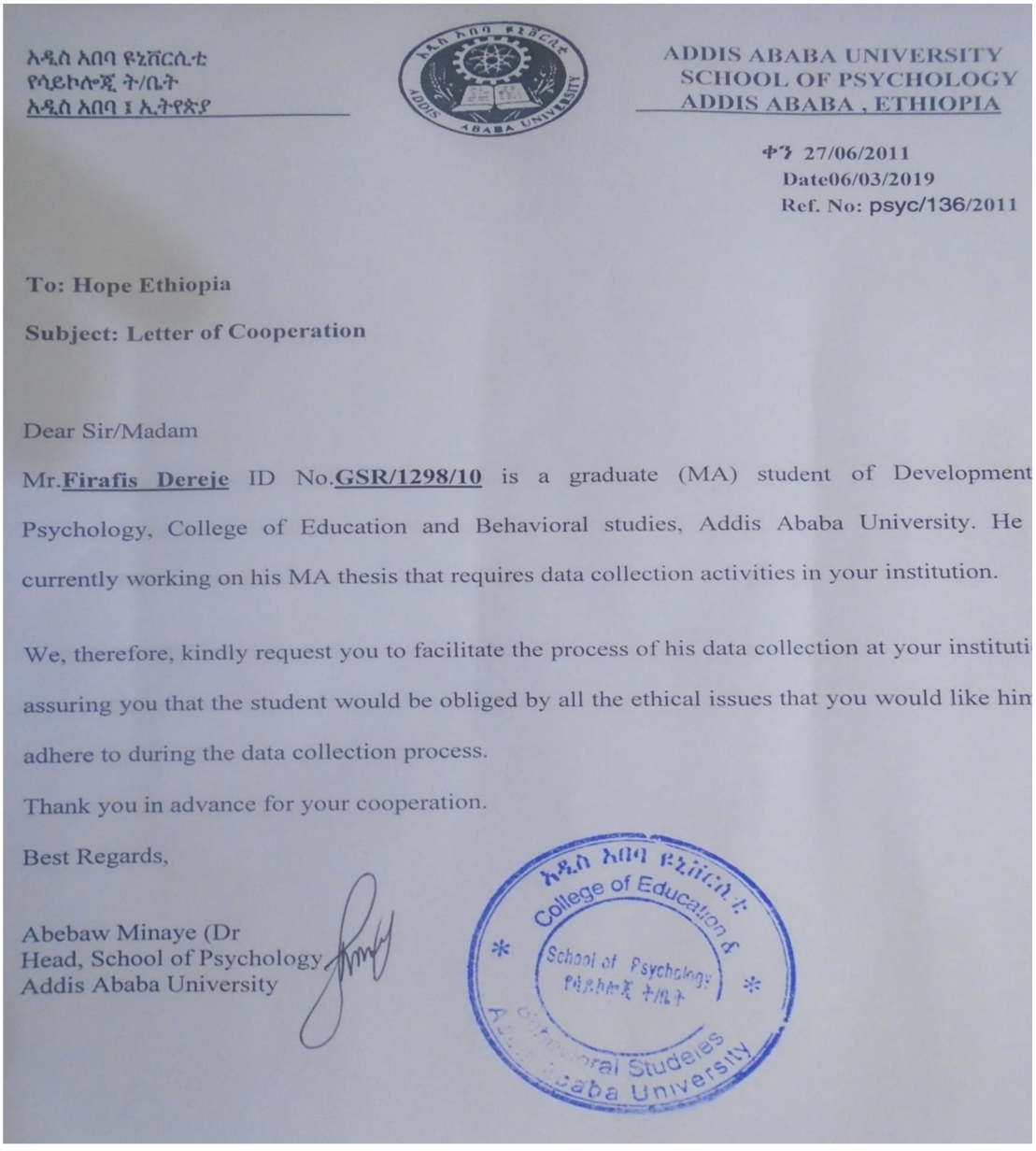
1. How children receive care and service from their respective caregivers which includes feeding, clothing, advising, giving love and protection, communication, sleeping, playing, dialogue, etc / ህፃናት በምን መንገድ ነው ከቅርብ ከተንከባካቢዎቻቸው ድጋፍና አገልግሎት እሚያገኙት? ለአብነት ያክል የአመጋገብ የአለባበስ ፍቅርን ምኝታ ጨዋታ ክርክርና ንግግሮችን ?

THANK YOU VERY MUCH FOR YOUR IDEAS AND TIME

ስለሰጡኝ ጊዜና ሐሳብ በጣም አመሰግናለሁ

Appendix II

Introductory letter from Addis Ababa University
College of Education and Behavioral Studies



አዲስ አበባ ዩኒቨርሲቲ
የሳይኮሎጂ ት/ቤት
አዲስ አበባ ፤ ኢትየጵያ

ADDIS ABABA UNIVERSITY
SCHOOL OF PSYCHOLOGY
ADDIS ABABA , ETHIOPIA

ቀን 27/06/2011
Date06/03/2019
Ref. No: psyc/136/2011

To: Hope Ethiopia

Subject: Letter of Cooperation

Dear Sir/Madam

Mr.**Firafis Dereje** ID No.**GSR/1298/10** is a graduate (MA) student of Development Psychology, College of Education and Behavioral studies, Addis Ababa University. He currently working on his MA thesis that requires data collection activities in your institution.

We, therefore, kindly request you to facilitate the process of his data collection at your institution assuring you that the student would be obliged by all the ethical issues that you would like him adhere to during the data collection process.

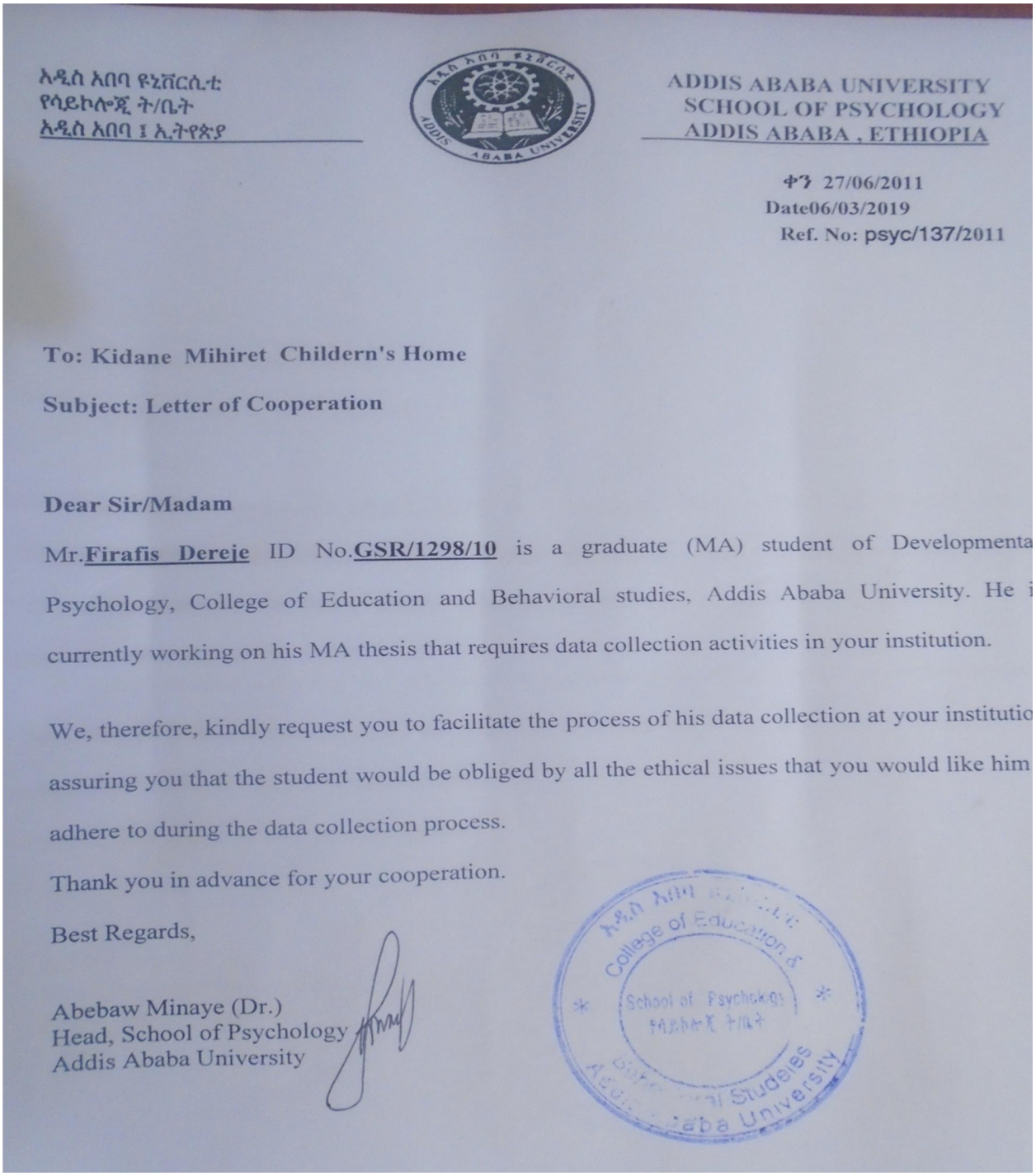
Thank you in advance for your cooperation.

Best Regards,

Abebaw Minaye (Dr
Head, School of Psychology
Addis Ababa University

አዲስ አበባ ዩኒቨርሲቲ
College of Education &
School of Psychology
የሳይኮሎጂ ት/ቤት
Behavioral Studies
Addis Ababa University

Scanned letter from CEBS, Department of Psychology, to AHope Ethiopia Orphanage



አዲስ አበባ ዩኒቨርሲቲ
የሳይኮሎጂ ት/ቤት
አዲስ አበባ ፤ ኢትየጵያ

ADDIS ABABA UNIVERSITY
SCHOOL OF PSYCHOLOGY
ADDIS ABABA , ETHIOPIA

ቀን 27/06/2011
Date06/03/2019
Ref. No: psyc/137/2011

To: Kidane Mihiret Childern's Home

Subject: Letter of Cooperation

Dear Sir/Madam

Mr.**Firafis Dereje** ID No.**GSR/1298/10** is a graduate (MA) student of Developmenta Psychology, College of Education and Behavioral studies, Addis Ababa University. He i currently working on his MA thesis that requires data collection activities in your institution.

We, therefore, kindly request you to facilitate the process of his data collection at your institutio assuring you that the student would be obliged by all the ethical issues that you would like him adhere to during the data collection process.

Thank you in advance for your cooperation.

Best Regards,

Abebaw Minaye (Dr.)
Head, School of Psychology
Addis Ababa University

College of Education & School of Psychology Studies Addis Ababa University

Scanned letter from CEBS, Department of Psychology, to Kidane Miheret Children's Home

Appendix III

Addis Ababa City Map

Source: Addis Ababa city administration, June, 2019