Exploring Effectiveness of Community Coalition Services for protection of Orphan and Vulnerable Children in Addis Ababa: The case of Keranyo area

By

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Declaration

I, Yeshewahareg Feyisa, hereby declare that this research project work entitled "Exploring Effectiveness of Community Coalition services for protection of Orphan and Vulnerable Children in Addis Ababa: The case of Keranyo area" is my original work and has not been used by others for any requirements in any other places and sources of materials used in this project have been duly acknowledged.

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Certification

This is to certify that this paper entitled, "Exploring Effectiveness of Community Coalition services for protection of Orphan and Vulnerable Children in Addis Ababa: The case of Keranyo area", is an original work prepared by Yeshewahareg Feyisa based on her field study in: Keranyo, Addis Ababa for the partial fulfillment of the requirements for the Degree of Masters in Social Work of the College of Social Science, Addis Ababa University. She has completed the work under my supervision and guidance and, thus, I duly approve this thesis to be submitted for defense.

Name……

Signature……..

Date: ……

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ACRONYMS

AHCDO: Action for Humanity Community Development Organization

AIDS: Acquired immunodeficiency syndromes

CC: Community Coalition

CCC: Community Care Coalition

CCG: Community Care Group

GO: Government Organization

HIV: Acquired immunodeficiency virus

HH: House Hold

NGO: Non-Governmental Organization

OVC: Orphans and vulnerable children

PLWHA: People Living with HIV/AIDS

UNCRC: United Nation Convention on the Right of Children

WCYAO: Women, Children and Youth Affair Office

WV: World Vision

Abstract

This study is aimed to assess the effectiveness of Community Coalition for protection of Orphan and Vulnerable Children in Addis Ababa, Kolfe Keranyo Sub city woreda 08. The study employed quantitative descriptive method to answer the basic questions. The participants were 116 care givers of Orphan and Vulnerable Children (OVC) who got service from Community Coalition established to serve OVC in Keranyo area. The selection of these participants was made by using systematic random sampling. Demographic and family structure questionnaire that contains questions on basic services given by the CC these are, Education, Health, Psychosocial, Legal and Socio-economic used to interview the respondents. Data were analyzed using descriptive statistical methods using percentage from frequency count to see general pattern of the outcome of services and cross tab Chi-square test to see the relationship of the independent and dependent variable. Both the percentage count and Chi-square test computation revealed that all type of supports given to the OVC and their guardian impact their wellbeing positively enhancing the children and care givers wellbeing with regard to their education, Health, Psychosocial legal and socio economically.

Key words: Community Coalition; Effectiveness of services; Orphan and Vulnerable Children; Services for OVC.

CHAPTER ONE

1. INTRODUCTION

1.1 Back ground

Children are more than one third of the population in most developing countries and half of all children in the world are deprived of at least one of their basic human needs. According to 2007 national census report 55.5% of Ethiopian population is constituted by children below the age of 18. Children are one of the most vulnerable groups in almost any population because of their physical and emotional dependence on adults and social status. Their vulnerability is greater in developing countries because of the higher incidence of poverty and fewer social protection mechanisms in place (Gabel, 2012).

As per the definition in the Ethiopian Federal Standard Guide Line for OVC service delivery, an orphan is defined as a child who is less than 18 years old and who has lost one or both parents, regardless of the cause of the loss. Orphans are different from other vulnerable children in that they have lost their parents. They are grieving. Grieving is a process, and some children never stop grieving (Datta, 2009). A vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights. Orphan and vulnerable children (OVC) are children that are susceptible to various types of physiological, psychological and social problems (Abashula et al., 2014). The causes of vulnerability and orphan-hood are mainly related to HIV/AIDS, food insecurity, poverty, conflict, natural disasters and infectious diseases (PEPFAR, 2012).

The impact of vulnerability and orphan-hood on the children are that they are at an increased risk of suffering from malnutrition, poor physical and mental health, as well as being at risk for stigmatization and exploitation. Orphans are at a high risk for contracting HIV themselves as a result of maternal transmission, prostitution, and sexual exploitation. Many orphans are forced to drop out of school for financial reasons and consequently this would hinder their future opportunities for jobs and economic growth. In addition, low educational achievement and delayed intellectual development due to malnutrition make orphan children to have significantly lower psychological wellbeing than non-orphans (Afework, 2013).

Like many developing countries in Ethiopia, especially in Addis Ababa many children are orphan and vulnerable and seek immediate support for their survival and growth despite less number of agencies (NGO, GO) compared to the need. Ministry of Women Children and Youth is government Authority mandated to coordinate the issue of children including OVC. The government and its development partners undertake several activities to respond to the complex issue related with OVC. Yet the responsibility of alleviating such problem is not merely of government or aid agencies however it should be also responsibility of communities where by the children live since the challenge of orphans and vulnerable children requires a concerted community effort and should not be left to individual, struggling, households (Germann et al., 2008).

Communities have their own means of managing crisis faced by their members. They have been supporting each other in time of difficulties such as during impoverishment, accidents, chronic problems, sickness and death of most important members of the family. Their support also extended to the family breakdown, disability, psychological and emotional

distress (Binega, 2014). One of the means by which communities respond to such problem is creation of coalition that focused in alleviating community problem.

Community coalitions have been defined in several ways and they are established and serve different purposes. Coalition refers to a group of citizens uniting on a common goal. Most definition share common features that community coalition are community endeavor or joint action that pool and activate local resources, facilitate citizens involvement for common problem solution. Also defined as intra-and inter-organizational alliance of individuals representing diverse organizations, factions, or constituencies who agree to work together in order to achieve a common goal. Coalitions by themselves are not a prevention strategy, but a means whereby a community can organize, plan, and deliver multi-level and multi-faceted prevention programs, policies, and practices (Center for Prevention Research and Development, 2006).

Community coalitions create collaborative capacity among diverse organizations, including health care providers, community groups, grassroots organizations, faith-based groups, universities, and government agencies. They help their communities to develop the capacity to build social capital that can be applied to several social issues. They are catalysts or agents of change at the local level, advocating for stronger policies (National Opinion Research Center, 2010).

In Ethiopia as well as in other countries community coalitions currently play a significant role in care and support of OVC. This involves visiting the most vulnerable children to provide emotional and material support; alerting authorities to urgent problems; planting low-maintenance crops and distributing the produce to vulnerable households; organizing

cooperative child care programs; raising funds for relief assistance to vulnerable individuals; encouraging care givers to send orphans to school; paying education costs for OVC; organizing community schools; working to prevent the spread of HIV; and providing skills training (Datta, 2009).

This research has been undertaken in one of most destitute localities of Addis Ababa named Keranyo where significant number of OVC live and there is community based organization established to support these OVC. The area is located in the West out skirt of Addis Ababa. It is under the administration of Kolfe Keranyo sub city woreda 08. Most of the residents of the area are people migrated from South Nations Nationalities and people Region (SNNPR) in search of economic opportunity in the City. Walking around the villages of the area can easily tell that the residents are poverty stricken that live in very crowded area where basic facilities such as sanitation, water lack. Upon their poverty stricken life many of households are headed by HIV positive, single headed mostly female and households where children are grown by siblings and other relatives.

According to the woreda WCYAO, few Non-governmental organizations had projects and ongoing projects to respond to the situation of the OVC through direct support to the children and indirect support for their caregivers. In addition to the NGOs, since 2009 community members have set up a coalition which represents different Iddirs. The main purpose of the coalition/ CBO is to give care and support for OVC in Keranyo with the initiation made by one of the NGO implementing in the area (AHCDO Strategic Plan, 2012). Hence this research is aimed at assessing the effectiveness of service delivery by this Community Coalition for targeted Orphan and Vulnerable Children in the area.

1.2. Statement of the problem

Every child need to grow in situation where the basic needs for their survival and growth fulfilled along with love, dignity, respect and peace as indicated in the UNCRC (UNCRC 1989). These basic needs are such as safe housing and environment, food and nutrition, health, education, legal protection, protection from danger and psychological support.

Literatures indicate that despite this fact, majority of children in the world mostly in sub-Saharan African countries are denied from getting these needs. Orphans (due to any case) and vulnerable children need especial attention by community, government, and its development partner as OVC might have poorer life chance than the other children if they are taken care by poorer relatives and because of the situations made them vulnerable put them at higher risk of neglect and abuse. According to Lachman and coauthors (2002), currently things are changing and Child protection has moved and is still moving from the welfare approach to a rights-based approach, that is, from charity to entitlement. The child became entitled to protection instead of being the recipient of charity.

Hence Children have the right to get protection and support mainly from the citizens' right duty bearer that is government and next from the community where they live in. Assistance for vulnerable children in communities has been carried out mainly by families, church-affiliated groups and other small organizations. Although their sustainability is not always assured, many small groups and organizations provide essential support and do excellent work. Successful programs reinforce their capacities, and do not try to replace them or remove children from the community (Kolker, 2008).

The needs of African children are great, particularly taking into account the HIV epidemic, other health issues and the poverty, food inadequacies, lack of social and health services that surround them. While a fully developed supportive environment may not be available, community strengths including shared family responsibility, local helping organizations, and existing social structures can support these children (Linsk et al., 2010) to realize their full growth and survival. In cases where community coalition set up to respond to the needs of OVC, they should function effectively to sustain their service and achieve their goal in the care and protection for children. Programs also should ensure that communities have the necessary support to take responsibility for addressing the needs of OVC (Federal Democratic Republic of Ethiopia Standard Service Delivery Guide for OVC, 2010).

Even though, there has been strong culture of caring for orphan in Ethiopia, the sick, and disabled and other needy members of the society by the nuclear and extended family members, communities and churches (Belay and Missaye, 2014), the growing number of orphans and vulnerable children coupled with the pressure of poverty on households is putting load to give proper care and support for the OVC. Significant contribution have been made in treatment, care and support of those infected and affected by HIV/AIDS by prioritizing community care coalition (Idir, Equb, Mahiber, etc.) as caregiver (Binega,2014). But still Children, who are vulnerable and particularly orphaned continued living in conditions where their basic needs unmet, their rights are violated, exposed to labor and sexual exploitation and abuse. Even though the country has a welfare policy that is broad and captures all the necessary tools (Save the Children UK, 2008), standard service delivery guideline for OVC, the role of the State in the care of orphans and other children in need in Ethiopia is minimal (Tatek and Aase, 2007) and also the limited resources available for governmental response affect

effectiveness of programs to address vulnerable children's needs, compounded by challenges in integration of social service and medical infrastructures and inadequate work forces in terms of numbers as well as education and professional opportunities (Linsk et al., 2010). Lack of skills, lack of trained human resources, and lack of material and financial resources and proliferation of ownership of the OVC's problems in the country are major impediments to render reasonable services or to effectively implement laws and policies in the country (Save the Children UK, 2008).

In such situation where government and its development partners lack full capacity to address the vast problem, communities can be ideal tool to address the problem of OVC in their area if few hands on made by government and development partners to strengthen them to act sustainably and effectively. The failure of indigenous institutions in providing services for OVC and maintaining social system increased the concern of community regarding the problems of OVC (Abashula et al., 2014). Understanding this fact currently in several urban and rural areas community mobilization is undertaken by Government and NGOs to respond to the situation of OVC. However, these community coalitions observed trembling to give effective services to meet the goal desired.

Several researches have been conducted on areas of community coalitions towards care and support of OVC both in Ethiopia and other countries (Binega, 2014, Abashula et al., 2014, Abebe, 2012, Abebe and Aase, 2007, Wube M., Horne J. C., Stuer F.,). But most of them focus on the formation of the coalitions, the challenges OVC face, types of vulnerabilities, implementation of support program, how to strengthen community actions and mobilization of resources by these community initiatives. Moreover, the researchers have been undertaken in the context of other countries and in other regions of the country where it differs from context

of Addis Ababa. Yet the effectiveness of the OVC protection by these community coalitions has not been investigated. Hence, this research will assess and explain the effectiveness of services given by community coalition in Kolfe Keranyo woreda 08 to protect OVC.

1.3. Significance of the study

The explanations of the finding have three main significances. The first, it enables the coalition to evaluate the outcome of its intervention on the wellbeing of the children and if it is in line with the government OVC service standard guideline. Secondly, it shows the gap to concerned stakeholders implying at which point to revise their strategies in working with community coalitions/organizations. Thirdly, it gives lessons for others like minded coalitions/initiatives that want to engage or already engaged in OVC support to make them a frontline actor in the actions taken to help OVC. And this research will fill the gap on understanding of Community coalitions service provision effectiveness dimensions for care and support of OVC in Ethiopian particularly in urban destitute area context.

As the finding of this study believed to reveal the level of outcomes of service provided on the wellbeing of children and their guardians, it indicates the impact, the gaps on the service with its reason and gives lesson for other like-minded coalition. It also helps the coalition that examined in this study to look whether it is meeting its objective. It enhances the understanding of government and non-government stakeholders the gaps, positive impact of community coalition for Orphan and Vulnerable Children and to look at their partnership modality with this coalition and indicate the way forward on how it needs to be strengthened.

1.4. Objective

1.4.1. General objective

This study will assess the effectiveness of essential services given by Community Coalition to improve wellbeing of OVC and their care givers.

1.4.2. Specific objective

- To asses services given by Community Coalition to Orphan and Vulnerable Children targeted in Keranyo area.
- To assess Educational, health, psychosocial and legal status of children benefiting from the community Coalition.
- To analyze the statistical association between essential services given to the children and their guardians and their life condition in relation to education, health, psychosocial and legal matters.

1.5. Scope of the study

This study has been be undertaken on the community coalition established to respond to the case of Orphan and vulnerable children in Addis Ababa Kolfe Keranyo sub city in woreda 08 which usually called Keranyo area. The study has been undertaken on service recipient of the coalition these are OVC and their care givers. It assessed effectiveness of services rendered by the coalition to improve the wellbeing of Orphan and Vulnerable Children and their care givers.

CHAPTER TWO

REVIEW OF RELATED LITERATURES

2.1. Children's Vulnerability and Orphan-hood Consequences

According to Gabel (2012) study, consequences related with orphan and vulnerable children are childhood poverty and prolonged stressful experiences which can have lifelong effects on children's physical, social, emotional and neurological development as well as on physical and mental wellbeing later in life. Inadequate investments in childhood increase the likelihood of poverty in adulthood, rob children of their right to achieve their potential, and perpetuate the intergenerational transmission of poverty.

These days, orphans, especially those who lose their parents to HIV/AIDS, suffer among other things from consequences such as having to care for sick and dying parents (without protective clothing) and younger siblings, as they become "parentized" themselves and lose out on their childhood; loss of income as parents are unable to work, become ill, and die; having to witness and endure parental death(s) and the associated emotional stress; stigma within the community if it is suspected or known that their parent died of AIDS (Lachman et al., 2002)

The other aspect of consequences comes as a result of being orphan and vulnerable child is the risk of violence and abuse. Two types of violence against children with potential for severe consequences include physical and sexual abuse. Reports of physical abuse consistently outnumber those of sexual abuse, and sexual abuse is more often reported among females than males. Particularly when such abuse is prolonged and repeated, include acute and severe outcomes such as death, injury, traumatic brain injury, as well as long-term developmental outcomes such as substance abuse, risky sexual behaviors, depression, and youth violence.

Given their deprived social circumstances and the unlikely possession of many protective factors to promote resiliency, the negative influence of childhood physical and sexual abuse may be heightened among those who have been orphaned (Lauren B. Zapataa et al., 2013).

The other dimension where orphans disadvantaged is education. Orphan-hood significantly reduces a child's chances of attending schooling and the effect is particularly strong in the case of double orphan-hood (Guarcello et al., 2004). Orphan and Vulnerable children in most cases fail to pass from grade to grade and also have less attachment to school which likely lead them to adverse condition of life (Tefera and Mulatie, 2014). In severe cases orphan and vulnerable children drop out from school due to lack of educational material (UNICEF, 2007).

In Ethiopia, securing daily food is a major problem for most orphan children. It is reported that 6.1% of them forced to beg in order to get their daily food (UNICEF, 2007). Similar to educational material, lack of food is one reason for orphan and vulnerable children to drop out school (Haile, 2008). Due to food insecurity they face stunting which is irreversible after two year age. Economic and social vulnerabilities are dimensions of the OVC that end up them with health, nutritional, education and other services lack coupled with child labor and trafficking, violence and addictive behaviors, mental health problem (Gabel 2012).

In terms of health care, OVC get healthcare less likely than non-orphan and this said to be related with stigma and discrimination, financial constraints and in some cases their guardians are desperate to bring them to health facilities as they assume that they don't get any benefit from the children in future (World Vision UK, 2011).

Supporting and strengthening community efforts to meet orphaned children's needs will contribute to their human development and eliminate the need for commercial sex in search for food or money. In this way, prevention of future HIV infection is also strengthened. However, the greatest challenge in relation to child protection and HIV/AIDS may not be just orphan hood but the other categories of vulnerability (street children, child labor, and early marriage) that such children may move in and out of as their life circumstances change. (Lachman et al., 2002).

2.2. Protection of Orphan and vulnerable Children and its challenges

According to Lachman and coauthors, protection of children from abuse and neglect already had a long history. This protection became an organized service in Europe in the 16th and 17th century with the establishment of orphanages and other children's homes by various groups of concerned citizens, often supported by churches. During the following centuries, these activities became better organized and were given a firm basis in child protection laws in the Western world, particularly at the end of the century. The driving force behind this development was the concern about the well-being of the child as a vulnerable individual. As such, children deserved our compassion and support. We had to save the child from the negative conditions they were living in. It was a moral often religiously motivated obligation, a matter of charity that should be supported with the necessary legal tools.

In the course of the 20th century, child protection has become a solidly institutionalized system in most societies, and the volunteers were gradually and to a large extent replaced by professionals. But this institutionalized and professionalized child protection system based on a welfare approach has changed considerably over the past 25 years which is moving from the

welfare approach to a rights-based approach, that is, from charity to entitlement. The child became entitled to protection instead of being the recipient of charity (Lachman et al., 2002).

Gabel (2012), argue that social protection is evolving in developing countries and it relates to the vulnerabilities of children. The paper presents also the different conceptual models for OVC protection and how they have changed, been influenced and challenged by the changing definition of poverty and the growth in transnational knowledge and policymaking.

According to the report by Kolker (2008), few of the challenges in OVC protection programming are national partners involved with OVC care are different from those working on prevention and treatment; services for OVC are usually delivered by small community and faith based groups with limited capacity and difficulty in scaling up; government ministries responsible for children and social welfare tend to be small, poorly funded, politically weak and also poorly staffed to fulfill the requirements expected by international partners; scaling up demands wider knowledge of, quantification of, and quality assurance for existing, usually disconnected, service providers for whom little national or international guidance exists and of which national and district governments may, in fact, be unaware. In addition most interventions are not adequately costed: many are taken for granted, with little recognition or reinforcement of the best practices.

In Ethiopia, the role of the State in the care of orphan and other children in need in is minimal. Consequently organized charitable NGOs and institutions have emerged to supplement the ‘failed’ role of the State even though they operate in accordance with different principles, have limited outreaching capacities, are partial, cost in-effective and sometimes do not reach the poorest of the poor. (Abebe and Aase, 2007).

2.3 Effectiveness of community based care for Orphan and Vulnerable Children

Community support for OVC and their families has been critical to protect children from the worst effects of HIV and AIDS (Datta, 2009).Community-based care is emphasized as the most sustainable and effective approach to support the 43.4million orphans in sub-Saharan Africa. Though community-based care is an ambiguous concept, it implies the importance of community engagement, commitment, and initiative in the care of orphans. There are a number of social, historical and cultural factors unique to each country that influences the care that community members provide to orphans. Community-based care needs to be approached with the recognition that a ‘‘community’’ is not necessarily cohesive or always benevolent (Thurman et al., 2008).

Community Coalitions are convenient actions to stimulate social resources in order to address problems that a single organization, service or group cannot autonomously solve or overcome (Vargas-Moniz,www.ecpa-online.eu). Even though they are not a prevention strategy by themselves; they are a means whereby a community can organize, plan, and deliver multi-level and multi-faceted prevention programs, policies, and practices (Thurman et al., 2008).

For coalitions to be effective, numerous internal factors such as formalization, planning, inclusiveness, leadership, resources, and ongoing professional development are essential. Numbers of evidence-based practices have been reported in the literature reviewed to guide the early stages of coalition development as they play great role for effectiveness of coalition practice. These are every community has a unique history and context that must be considered in the development and implementation of a coalition politics, economics, geography, leaders, and various sectors must all be considered. Coalitions should seek to bring people together across social, economic, and political ties to address common community interest; Diverse membership

contributes to collaborative endeavors, but participants must be on equal grounds to reduce hierarchy; More diverse sector representation and increased diversity of membership has been associated with better outcomes for policy change; members should represent broad and relevant community sectors (Center for Prevention Research and Development, 2006).

An assessment of the theories of community coalitions and a review of the body of literature on community coalitions and partnerships yielded six characteristics that can affect community coalition functioning and effectiveness. These characteristics include: leadership, membership, structure, operations and processes, strategic vision, and contextual factors. These characteristics can affect the development of community coalitions and their ability to achieve their goals and create change (U.S. Department of Health and Human Services, 2010).

2.4 Empirical studies on community coalition for Orphan and Vulnerable Children protection

A study in Rwanda by Thurman and coauthors (2008) on Barriers to the community support of orphans and vulnerable youth indicate that Orphans as a group are stereotyped as poorly behaved and benefiting unfairly from humanitarian assistance. Adults in the community feel unable to control orphans' behavior, and ambiguity exists about the role of non-parental adults in disciplining youth. Even adults who have stepped forward to volunteer to mentor youth-headed households view the responsibility for care of orphans to lie primarily with NGOs. In this environment, the support networks of orphans and vulnerable youth are inherently limited and many perceive serious marginalization.

A research undertaken by Germann S. and coworkers (2008) assessed communities in four African countries including Ethiopia, where an NGO named World Vision has supported community-led childcare initiatives of different types of community care groups (CCG)

directly involved in child care and community care coalitions (CCC) and focused on coordination and networking within different contexts. The findings indicate, that community led-child care established through strong community mobilization processes, well horizontally and vertically networked, are sustainable mechanisms for enhanced child well-being at the community level.

A paper that reviews the current evidence base on evaluations of community interventions for orphans and vulnerable children (OVC) in high HIV-prevalence African settings through various strategies within their communities(Schenk, 2009) suggest that although findings overall indicate the value of community interventions is effecting measurable improvements in child and family wellbeing, the quality and rigor of evidence is varied. A strategic research agenda is urgently needed to inform resource allocation and program management decisions. Immediate imperatives include building local technical capacity to conduct quantitative and qualitative evaluation research, and strengthening monitoring and evaluation systems to collect process and outcome data (including costing) on key support models. Donors and implementers must support the collection of sound empirical evidence to inform the development and scale-up of OVC programs.

A research in Nyanza province, Kenya (Datta, 2009) also assessed community intervention for Orphan and vulnerable children under the research title; *addressing the needs of orphans and vulnerable children: Strengthening ongoing community actions*. The main components of the work were: Assessed vulnerabilities of the children, types of community action and the challenge they face, roles played by state and non-state actors, types of vulnerabilities in the different context of the province and forms of community actions and motivating factors for their action and key recommendations to strengthen community action and

to address vulnerabilities of OVC. The research focused on how to best strengthen community action for OVC.

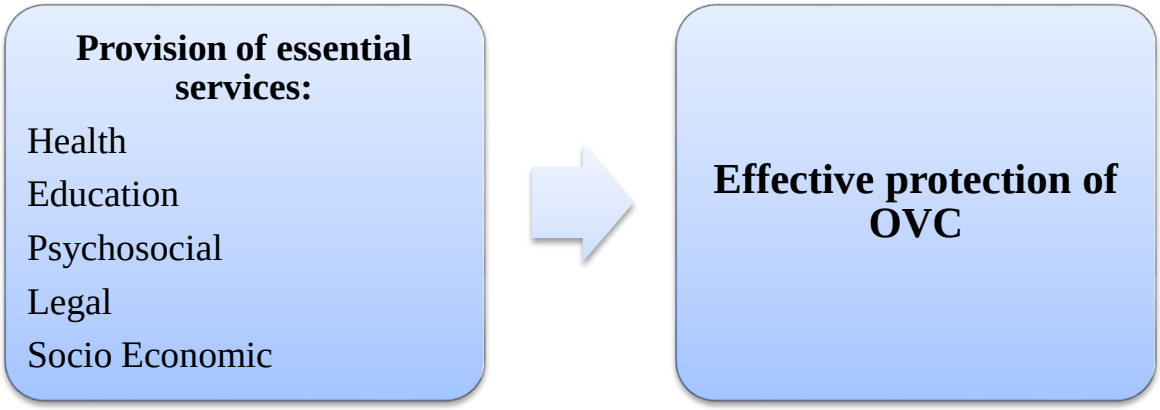
In Ethiopia, home and community based care given for PLHIV, orphans and vulnerable children through associations organized for burials (Idir) to reduce stigma and discrimination of PLHIV and vulnerable children, increase acceptance and use of voluntary testing and counseling for HIV, improve PLHIV health and well-being, improve household economic conditions of PLHIV, orphans and vulnerable children (M. Wube, C. J. Horne, F. Stuer, 2010).

CHAPTER THREE

CONCEPTUAL FRAME WORK AND CONCEPTUAL DEFINITION

3.1. Conceptual frame work

The National Standard Service Delivery Guidelines for OVC prepared by FDRE Ministry of Women, Children and Youth indicates that there are seven key service packages (Education, Health, Psychosocial, Food, Economic strengthening and Legal) that should be considered as a frame work when Governmental, Non-governmental, Community Based Organizations and any other institutions initiated to give support for orphan and vulnerable children (FDRE Standard Service Delivery Guidelines for orphans and vulnerable children's care and support programs, 2010). This framework is a tool used by all institutions to assess and evaluate interventions made for Orphan and Vulnerable Children across the country. Hence this research mainly bases on this frame work that set to ensure in addressing holistic need of OVC children. Hence the effectiveness of service rendered by the Community Coalition was assessed against these seven service elements by using Indicators set under each service package element.



3.2. Conceptual Definitions

In this research the independent variable is the service factors that encompasses Educational supports, Health care supports, psychosocial supports (Food, shelter and care, psychological), Legal supports and Economic strengthening support. The dependent variable is the effectiveness of the CC in improving the wellbeing of the children and their caregivers in terms of Educational outcome, Health condition, Food security, safety and security, Socio economic condition and psychological wellbeing.

3.2.1. OVC protection services

OVC protection services broadly defined as interventions that address the need to improve health, wellbeing and development of OVC (FDRE, SSDG for OVC, 2010). Services given basically address educational, health, food, shelter and care, psychological legal and economic strengthening support that are inculcated by serious of activities and steps in the implementation.

3.2.2. Effectiveness of the services

Effectiveness of the services is coalitions influenced positive changes on the wellbeing of the children and their care givers as well as reduce children vulnerability by bringing better condition of life with regard to education, health, psychological, safety, food security, legal protection and security and better socio economic status of Orphan and Vulnerable Children and their families. According to OVC protection service standard (Federal Democratic Republic of Ethiopia Standard Service Delivery Guide for OVC, 2010), the services said effective when Shelters are safe, warm and dry with access to water and sanitation i.e. latrines; when household assets (economic and social) are built to withstand shocks and household income source is sustained and diversified; when OVC have timely access to legal assistance

and legal issues are resolved according to the law and where the law does not protect OVC, change is advocated; when Child receives appropriate care for the identified needs; when Children are happy participating in activities and not isolated and children are interactive, confident and empowered to be decision- makers; when increase promotion rates among OVC through tutorial classes, summer programs and other supplementary educational support and enhance OVC performance at school through improvements in the quality of learning through facilitating tutorial services, improving class attendance; when it ensure that OVC have access to food and balanced and nutritious diet.

3.3. Research Questions

This research examines seven research questions and hypothesis that are formulated on the basis of the seven service packages as they serve as a bench mark to assess the effectiveness of services rendered to OVC. Therefore, the research was based on the following hypothesis and main research questions.

1. Do the supports that the community coalition provides on basic services such as educational, psychosocial, health, legal and socioeconomic are improving the wellbeing of OVC and their caregivers?
2. Do the community coalition is meeting its objective in protecting OVC?

3.4. Hypothesis

Hypothesis 1: Provision of essential services (Education, Health, Psychosocial, Legal and Socio economic) for OVC is effective means in ensuring the wellbeing of Orphan and Vulnerable children and their guardian.

Hypothesis 2: The Community coalition is meeting its objective in protecting orphan and vulnerable children

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1. Research design

The design of this study was descriptive quantitative as it was planned to describe whether or not the service rendered to Orphan and Vulnerable Children by Community Coalition is effective. Descriptive research design examines situations in order to establish what the norm is, i.e. what can be predicted to happen again under the same circumstances (Walliman, 2011).

The proposed research design includes randomly selected individuals of the same group, single occasion, survey method that has descriptive and correlational function. This research sought to determine if the independent Variables (Educational, Health, psychosocial, legal and economic strengthening supports) have impacted positive change (effective) on the wellbeing of OVC.

4.2. Study Area and Target Population

The study was conducted in Addis Ababa city Kolfe Keranyo sub city Woreda 8 Community called Keranyo. Kolfe Keranyo is one of the ten sub cities in Addis Ababa and Woreda 08 is one of sub administrative area in the sub city. Kolfe Keranyo Woreda 08 is located on the western part of Addis Ababa located at about 9.6km from the center of the city (CSA report, 2007). According to the Woreda Administration, currently more than forty thousand people live in the area. Regardless of government's and others' efforts, Keranyo area population remain in the worst situation of poverty. Socio economically, the area is populated by the poorest of poor. Most of the population in the area bases their livelihood on informal economic sector such as providing cooking and laundry services to individuals, retail petty trading of essential

food items, utensils and used clothes, working as daily laborers, collecting and selling Eucalyptus tree leaves for fire wood and other small income generating activities (ACHDO strategic plan, 2013).

The level of poverty is so abject that the PLWHAs and OVCs in the area lack the minimum basic well-being and development. The greater proportions of such children have already lost the parental care and protection and equal numbers of them are at the brink of losing such care and protection. Some of the PLWHAs and OVCs have lost their marriage partner and one or both of their parents respectively due to their passing away, some of them are abandoned by one or both of their parents, significant number of children run away from homes and family due to different social and economic problems, significant number of children come to this specific location from rural areas to live with their older siblings and relatives and search for better opportunities but upon reaching their destination face the fate of abandonment.

The survey participate 116 OVC caregivers who have been supported by the CC at least for one year. Generally, Keranyo area is selected as it is one of the destitute area in the city where significant number of orphan and vulnerable children live which at the same time also has Community Coalition (Community based organization) that established to respond to the situation of the OVC.

4.3. Sampling of study participant

Participants of the study selected from the list that displays the name of total population, which is master list of program beneficiaries. The names recorded on the list were heads of the family where OVC live. The beneficiary list was used as sampling framework where the total number of samples determined (selected) by using systematic simple random sampling as the study population was homogenous and finite. The sample size was determined using the general

formula that usually used in surveys that indicated below and online calculator using the link http://www.raosoft.com/samplesize.html.

$$n = \frac{Z^2}{\frac{4e^2+z^2}{N}} \qquad \frac{1.96^2=}{\frac{4*(0.05)^2 + 1.96^2}{165}} \qquad \frac{3.8416=}{\frac{4*\ 0.0025+3.8416}{165}} \qquad \frac{3.8416}{0.0333} \qquad \mathbf{n = 115.4}$$

Z is confidence level standard value 1.96

e is the margin of error 0.05

N is the total population

Total population (beneficiaries' families) is 165. Out of 165 families, 116 care givers of them were selected to be samples using the above formula and link. The online calculator gave 116 and the above formula gave 115.4. 116 taken as it would be better to have more sample size than less. From 165, 116 were selected using lottery method from the sampling frame.

To cross check responses of the caregiver which are specific to the children, 10% (n=12) children above age 8 were interviewed in addition to the caregivers. The children were selected purposely from previously selected 116 in order to get children which fit to this age category (above 8year).

4.4. Data collecting instrument

The instrument used to collect data in this survey is an interview questionnaire and check list for observation. An interview questioner prepared to collect data on basic demographic and family structure situation and services rendered to OVC and their caregivers on Education, Health, Psychosocial, Legal and Socio-economic. Research instrument mainly was informed by

national standard service delivery guideline for OVC developed by Ministry of Women Youth and Children in 2010. The rationale for using this guideline in the process of designing the questionnaire is based on the fact that the guideline contains a set of minimum conditions to serve OVC and their care givers to ensure wellbeing of the Orphan and vulnerable children.

The observation checklist includes situations that need to be observed with interview questions in order to complement and match the response given by participants. Participant observation helps the researcher to catch things or observe an event that the participant is not willing full or unable to tell (Kawulich, 2005). Observations made to crosscheck responses of questions that can be observed to ensure the fact and get more consistent data.

4.4.1. Demographic and family structure Questionnaire

The respondents were asked to provide information regarding their gender, age, literacy, grade level, parental status, marital status, head of HH, number of children living in the house with their age categories.

4.4.2. Indicators of minimum Service packages questioner

Questions and observation check list were prepared based on the government national standard guideline for OVC service package indicator prepared to be used by all institution engaged in OVC care and support. These standard services are health, education, food, psychosocial, shelter and care, legal and economic strengthening. Participants were asked to give their response around these seven packages to assess the service effectiveness of the CC.

4.5. Pilot testing

Pilot testing of the fitness of the questioner was administered on five respondents and made modification on the original questions. The test was administered in order to adjust the

questions after getting understanding on whether or not the questions are understandable by the respondents, if there are missing points in the questions and if there are questions that result repetitive response which result waste of effort. The pilot testing was under taken on individuals from the same population but different individuals who are not selected in samples and who are willing full to participate for piloting.

4.6. Inclusion criteria

Participants included in this research were OVC and their guardian who directly benefit or listed as beneficiary by the CC receiving service for at least one year. The reason for including participants who got service for more than a year is that beneficiaries who were getting service for less than one year do not enable us to conclude whether the service is effective or not.

4.7. Data collection procedure

After approaching the CC and obtained approval to conduct the research, the randomly selected children caregivers were approached through the CC. For the data collection, after obtaining informed consent from the OVC and their guardian, structured questionnaire was administered to interview them by including observations simultaneously.

4.8. Ethical Considerations

All participants in the data collection were requested for their informed consent having the agreement format to sign by both the researcher and the respondent. They were informed that all the information they provide will be used only for the study purpose and it will be kept confidential and anonymous. The data collection processes were undertaken by ensuring respect and dignity of every individual participating. The process of getting consent focused on

explaining the objective of the study, benefit of their participation, why they are selected in in this study and that their participation have no risk and harm and only for academic purpose.

Parental/guardians consent and permission was obtained for children participated in the study before the interview. The purpose of the study also explained for the children and it was conducted in private location which at the same time under observation of their care givers. Discussion with all respondents was undertaken in situation that ensures their privacy so that they could be more open to answer all questions freely.

4. 9. Data analysis

Two levels of data analysis (univariate and bivariate) was under taken. Univariate analysis was undertaken to understand the general pattern of demographic and family characteristics, and those of main outcome variables that include education, health, food, psychological, shelter and care, legal and socio-economic condition. Bivariate analysis was undertaken using Chi-square correlation to test the hypothesis by looking at the relationship between dependent and independent variables. These were education support and outcome on the children education, health supports and current health condition of both the children and their caregivers', psycho social support and out comes on psychosocial condition, legal support and legal status of the children, socio economic support and outcome of socio economic condition (health, education, food, legal, housing). Binary, nominal and ordinal data is best displayed in the form of tables or charts for further analysis. Thus, frequency or one-way tables, depicting information in a row or column is the simplest method for analyzing these data. They are often used as one of the exploratory procedures to review how different categories of values are distributed in the sample. The first step in analysis of Binary, nominal and ordinal data is construction of a bivariate cross-tabulation, which is sometimes also referred to as contingency

or a two-way table (Singh, 2007).As the types of data collected were categorical and ordinal, descriptive statistical measure that is frequency count made as univariate analysis for the categorical type data and mode as measure of central tendency for ordinal type of data. In addition to see the correlation between two independent variables Chi-square was used.

CHAPTER FIVE

RESULT

In this section the finding of the study presented mainly in line with the research questions. The results have been presented in two parts. The first part focused on description of demographic and family characteristics and analysis of single variables using descriptive statistics of frequency count and measure of central tendency mainly mode to understand the pattern of main variables. Here, the main variables given emphasis to answer the research questions were indicators of education status such us enrollment, Children learning as expected, access to school materials sufficiently, promotion from grade to grade, preparation of young children to work as an adult; Indicators of health such as health status of Children and their caregivers; Indicators of food security such as frequency of hunger times, meal frequency in a day, indicators of psychological status such as participation in school clubs, presence of worry on care givers side about children future life, know where to go if needed counseling, children safety feeling and happiness when playing with other children; Indicators of Shelter and care such as housing condition, sleeping place condition; Indicators of Legal such as presence of birth certificate, legal issue the children faced and solved; Indicators of socio economic status such as source of livelihood, frequency of work, self-reported comparison of affordability food, shelter, housing over time.

The second part presents correlation between the support given by community coalition and wellbeing status of OVC. On this correlation analysis section, cross tab Chi-square statistical tool applied to see the relationship between the support given by the CC and indicators that show impacts of main variables (Health, Education, Psychosocial, Legal and socio economic wellbeing)

5.1. Demographic characteristics and Family structure

The sex composition of the caregivers were 95.7% (N =111) Female and 4.3% (N=5) Male (Table 1). This shows that the sex composition of majority of primary care givers of OVC assisted by CC are Female and those who are male respondents were either who lost the mother of their children by death or divorced. The age of the children caregiver was found to be 5.2% (N= 6) between 18 and 30, 60.3% (N=70) between 31and 40 and 40.3% (N=32) between 41 and 50 and 6.9% (N=8) are above the age of 50. Regarding their literacy level out of total 116 respondents, 62.1% (N=72) are literate and 37.9% (N=44) are illiterate. This indicates majority of respondents/children care givers are young even though the number of granny headed care givers was very small. From total of 116 caregiver respondents, 36.2% (N=42) are married, 4.3% (N= %) single, 42.2% (N=49) widowed and 17.2% (N=20) Divorced. From the total 116 families 38.8% (N=45) are father headed, 49.1% (N=57) are mother headed, 2.6% (N=3) are sibling headed, 2.6% (N=3) are aunt/uncle headed and6.9% (N=8) are granny headed.

Regarding the orphan-hood type of the children, (table 1) showed that out of total respondents, 53 of them are orphan of which 94.3% (N=50) of them are single orphan or children who have lost one parent and 5.7% (N=3) are double orphan or children who have lost both parents. Concerning the children age category, out of 116 families 42.2% (N=49) of them replied that they have two children under 18, 27.6% (N=32) have three children under 18, 18.1% N=21) have four children under 18 and 9.5% (N=11) have greater than 4 children. 17.2% (N=20) of HH replied to have one child under-five and 6.9% (N=8) responded that they have two children under age of five.

Table1. Demographic Characteristic and Family structure

Variables		N	%
Sex	Male	5	4.3
	Female	111	95.7
	Total	116	100
Age	18 - 30	6	5.2
	31 - 40	70	60.3
	41 - 50	32	27.6
	>50	8	6.9
	Total	116	100
Literacy	Yes	72	62.1
	No	44	37.9
	Total	116	100
Marital status	Single	5	4.3
	Widowed	49	42.2
	Divorced	20	17.2
	Total	116	100
Single or double orphan Children taken care	Single	50	94.3
	Double	3	5.7
	Total	53	100.0

5.2. Educational status of the children

About 99.1% (N=115) of the respondents have enrolled children under their care in school and only 0.9% (N=1) do not enrolled children in school. Nearly all OVC in school age supported by CC have been enrolled in school.

Out of 116 respondents, 75% (N=87) responded that their children are growing and learning as expected, 13.8% (N=16) said that their children are growing and learning as expected partly and 11.2% (N=13) said that the children under their care are not growing as expected.

Regarding having sufficient school material, the findings suggest that 66.1% (N=76) of the respondents, who enrolled their children in school (N=115), said that children under their care are getting school materials sufficiently whereas 33.9% (N=39) said that children under their care are not getting school materials sufficiently.

Out of 116 respondents, 95.7% (N=110) of them said that children under their care are promoted from grade to grade and whereas 4.3% (N=5) are not.

Out of the respondents (N=31) who have young children under their care, 74.2% (N=23) said that they are getting preparation to work as an adult whereas 25.8% (N=8) of them said that their young children are not getting preparation to work as an adult.5

5.3. Health status of Children and their Guardians

Out of 116 respondents 75.9% (N=88) said that children under their care treated well when they fall ill whereas 24.1% (N=28) replied that the children get treated sometimes (Table 3).

From total respondents (N=116), 71.6% (N=83) of them said that there is no time that their children didn’t get medical service while they are in need whereas 28.4% (N=33) responded that there are occasions where their children didn’t get medical service while they are in need.

Regarding their current health status of both children and the caregivers, the most frequently given response for current health status of the children is “Good” whereas the most frequent response for the current health status of the caregivers is “Fair”.

Table2. Descriptive summery of Health status of the children

Variables		**N**	**%**
What happens when the children fall ill	Treated well	88	75.9
	Sometimes	28	24.1
	Total	**116**	**100.0**
Children needed medical service but did not receive	Yes	33	28.4
	No	83	71.6
	Total	**116**	**100.0**

Table3. Descriptive statistics of Health status of the Guardian

Health status of the guardian	
N	116
Mode	2

Level of scale for health status of the guardian: 1= Good, 2 = Fair, 3 = Bad

5.4 Children's status of Food Security

The survey on the food security aspect revealed that 75% (N=87) of the respondents responded that there are no times that children slept hungry in the past 4 weeks. 12.1% (N=14) of the respondents said that the children slept hungry twice in the past 4 weeks. 11.25 (N=13) responded that the children slept hungry only once in the past 4 weeks and 1.7% (N=2) of them responded that the children slept hungry three times in the past 4 weeks. All the respondents (100%, N=116) replied that there is no time that the children went whole day without food in past 4 weeks.

Concerning improvement in food consumption, 89.7% (N=104) of the respondents said that their food consumption has improved. 3.4% (N=4) of them said it has decreased and 6.9% (N=8) said that it is similar as compared to the time they first enrolled in the CC.

Their meal frequency result showed that 75.9% (N=88) from the total respondents eat twice daily and 24.1% (N=28) three times daily.

Table4. Descriptive summery on Children's Food Security status

Variables		N	%
Times children slept hungry within last 4 weeks	none	87	75.0
	once	13	11.2
	twice	14	12.1
	Three times	2	1.7
	Total	**116**	**100.0**
Days the children went whole day without food in last 4 weeks	0	116	100.0
Improvement in food consumption	Improved	104	89.7
	Decreased	4	3.4
	Same	8	6.9
	Total	116	100.0
Current meal frequency in a day	Twice	88	75.9
	Three times	28	24.1
	Total	**116**	**100.0**

5.5 Psychological status of the children

The Table below indicates the finding from outcome of psychological support. One of the indicators, children participation in school clubs, shows that from total respondents who have enrolled their children in school (N=115), 45.2% (N=52) responded that the children participate in school clubs, 33% (N=38) said that the children do not participate in school clubs and 21.7% (N=25) answered that they are not sure whether or not the children participate in school club activities.

Among total respondents (N=116), 54.3% (N=63) said that they worry about the future life of the children under their care whereas 45.7% (N=53) said that nothing worry them about the children future life.

From the total respondents (N=116), 97.4% (N=113) answered that children under their care tell their wish for future life whereas very few of them 2.6% (N=3) answered that the children didn't ever tell their future life wish.

Regarding caregivers worry about among the children there might be who want to hurt him/herself, 97.4% (N=113) said that they don't have worry about it while 2.6% (N=3) said they have worry.

From the total respondents asked (N=116) about their knowledge where to go if needed psychological or counseling support, 41.4% (N=48) said they know, 40.5% (N=47) replied they don't know and 18.1% (N=21) answered they are not sure where to go.

Regarding children feeling safe and secure among the total respondents (N=116), 76.7% (N=89) responded that the children under their care feel safe and secure, 11.2% (N=13) said they don't feel safe and secure and 12.1% (N=14) answered they are not sure if the children feel safe and secure.

The other psychological wellbeing indicator assessed was Children's happiness in playing with other children and among total respondents (N=116) 76.75 (N=89) said that the children under their care are happy in playing with other children, 11.2% (N=14) said the children are not happy in playing with other children and 12.1% (N=14) responded that they are not sure if the children are happy in playing with other children

On the subject of self-confidence of the children, the most frequently given response is "High" from the scales put as "High, Medium, and Low".

Table 5 Descriptive summary of OVC Psychological status

Variables		**N**	**%**
Children participate in school clubs	yes	52	45.2
	No	38	33.0
	Not sure	25	21.7
	Total	**115**	**100.0**
Have worry about the children future life	yes	63	54.3
	No	53	45.7
	Total	**116**	**100.0**
The child tell future wish for life	Yes	113	97.4
	No	3	2.6
	Total	**116**	**100.0**
have worry that among the children there is who want to hurt him/herself	yes	3	2.6
	No	113	97.4
	Total	**116**	**100.0**
Now know where to go if needed counseling	Yes	48	41.4
	No	47	40.5
	Not sure	21	18.1
	Total	**116**	**100.0**
The child feel safe and secure	Yes	89	76.7
	No	13	11.2
	Not Sure	14	12.1
	Total	**116**	**100.0**
Happy in playing with other children	Yes	89	76.7
	No	13	11.2
	Not Sure	14	12.1
	Total	**116**	**100.0**

5.6. Status of Shelter and care

Concerning status of shelter and care, the majority of respondents 87.9% (N=102) responded that their housing condition is moderately adequate and 12.1% (N=14) said that their house require repair.

Concerning the sleeping place of the children 95.7% (N=111) sleep on mattress and only 4.35 (N=5) sleep without mattress. All of the children 100% under the care of this study respondent have night clothes.

Regarding whether or not the sleeping place improved after they enrolled in the CC program, 98.35% (N=114) said it is improved, 0.9% (N=1) said not improved and 0.9% (N=1) said the same as before.

Table6. Descriptive status of Shelter and care

Variables		**N**	**%**
The housing condition	Moderate	102	87.9
	need repair	14	12.1
	Total	**116**	**100.0**
Children sleeping place	On mattress	111	95.7
	Without mattress	5	4.3
	Total	**116**	**100.0**
Children have night clothes	Yes	116	100.0
Children sleeping place improved after enrolled in the program	Yes	114	98.3
	No	1	.9
	Same	1	.9
	Total	**116**	**100.0**

5.7. Status of Children's Legal conditions

The finding on legal support outcome shown in the Table below revealed that all 100% of the children under the care of this study respondent have birth certificate and for all of them it was facilitated by the CC.

From the total respondents who are eligible for question "denied from getting service due to legal status" which was asked only orphan children caregivers (N=53), all 100% said not denied. Similarly all orphan children caregivers (N=53) responded that there is no legal problem

or right issue faced by the orphan children as a result of their orphan hood. Again all children caregivers (N=116) interviewed said that the children have an adult who stands up legally for them.

Concerning presence of anyone who will give support/facilitate for legal issues raised on the children, the majority 70.7% (N=82) replied that the children have someone who will give support/facilitate for legal issues raised on the children, 14.7% (N=17) said they don't have and 14.7% (N=17) responded that they are not sure whether they will get someone who will give support/facilitate for legal issues raised on the children.

Table 7 Descriptive summary of Legal status

Variables		**N**	**%**
The children have birth certificate	Yes	116	100.0
Who facilitated to get birth certificate	CC	116	100.0
Do the children are denied from getting service due to legal status	No	53	100
Legal problems or right issue the children faced	No	53	45.7
The children have an adult who stands up legally for him/her	Yes	116	100.0
Is there anyone who will give support/facilitate for legal issues raised on the children	Yes	82	70.7
	No	17	14.7
	Not sure	17	14.7
	Total	116	100.0

5.8 Socio economic status

Socio economic outcome mostly computed using their mode as most of them use ordinal type of scales. On the source of livelihood the finding illustrated in the chart below that source of livelihood for most of them is daily wage and the secondly main source of income is trade and very few (4.3%) from assistance obtained from neighbors and relatives.

Table8. Descriptive summary of Socio economic status

Variable		N	%
Frequency of work	Every day	82	70.7
	Sometimes	29	25.0
	NA	5	4.3
	Total	**116**	**100.0**

Table9. Descriptive statistics on Source of livelihood

Source of livelihood	
N	116
Mode	3

Label of scale for source of livelihood 1= trade, 2 = Salary, 3 = Daily wage, 4 = Assistance from relatives, Assistance from the CC

Table 10. Descriptive summery of socio economic status with measure of central tendency

	comparison of affordability of food expense over time	Comparison of affordability of health expense over time	Comparison of affordability of education expense over time	Comparison of Shelter over time	Agree with the statement of I can meet the needs of the children
N	116	116	116	116	116
Mode	1	1	1	1	3

Level of scale for comparisons: 1= Improved, 2 = Not improved,

Level of agreement on meeting needs of the children: 1 = strongly agree, 2 = Agree, 3 = Neutral, 4 = Dis agree, 5 = strongly disagree

5.9. Relationship between education support given by CC and Education status of the Children

The finding on impact of educational support such as access to educational material sufficiently, tutorial support and socio economic support for care givers on current children education status reject the null hypothesis. The finding shows that there is significant relationship between these supports and Children's learning is as expected, children performance, Children stay out of school to help family respectively. The significance level as indicated in the summery table *p= 0.039*, 0.000, 0.050 respectively. Consequently, the education support given by the CC improved children education status.

5.10. Relationship between Shelter support given by CC and Shelter condition

With regard to support of the CC on shelter and care, the supports were provision of sleeping materials and renovation of their houses. As indicated in the Table, the significance level for relationship between these supports and their housing condition is very high that is p = 0.000. In addition to direct support for shelter, the socio economic support given also has positive significant relationship with housing condition of the family and the significance level for this relationship was p = 0.024. Hence the supports given by community coalition on shelter as well as socio economically have improved their sleeping and housing condition.

5.11. Relationship between Socio economic support given by CC and Food security

Relationship of socio economic support that is access to credit computed with presence of food consumption improvement. The finding revealed that there is significant relationship between caregivers' access to credit service with their improvement in food consumption. As illustrated in the summary Table, the significance level is 0.015. That implies the socio economic support impacted their food security rejecting the null hypothesis.

5.12. Relationship of Socio economic support with children's Health status

The relationship between Socio economic support (access to credit service) and children's health status shows that there is significant positive relationship with significance level of 0.026. This tells that the socio economic improvement gained after socio economic support impacted the children health status.

5.13. Relationship of Socio economic support with children's care givers Psychological status

Here, care givers Psychological status related with the support was their confidence level about continues fulfilling needs of children under their care. The significance level of the relationship between socio economic supports with children's care givers Psychological status is 0.035. This shows socioeconomic status improvement of the care givers improved their level of confidence to take care of the children.

Table 11 Chi-Square Tests for relationship between support given by CC and status of children and their guardian

Correlated variables with Pearson Chi-square	Value	df	Asymp. Sig.
Correlation between CC support on Education and Children's Education status for Children learning as expected	6.501	2	.039
Correlation between CC support on Education and Children's Education status for Children Performance	58.799	2	.000*
Correlation between CC support on Education and Children's stay out of school to help family	5.993	2	.050
Correlation between CC support on Shelter and care and status of Children Shelter and care condition	81.580	1	.000**
Correlation between CC support on Socio Economic support and food security	5.971	1	.015

Correlation between CC support on Socio Economic support and health status of the children	4.938a	1	.026
Correlation between CC support on Socio Economic support and Housing condition	5.100	1	.024
Correlation between CC support on Socio Economic support and Vs level of agreement to full fill the children's future need	6.726	2	.035

Relationship is Significant at ≤0.05 level.

*The support given on education has perfect relationship with children performance on education proving that the null hypothesis is totally false.

**There is perfect relationship between Shelter and Care support given by the CC and Children Shelter and Care status indicating that the hypothesis is very true.

CHAPTER SIX

DISCUSSION

6.1. Demographic characteristics and family structure

Even though (Biemba G. et al., 2010) argue that the extended family remains the main form of support for OVC, eighty percent of children who are defined as orphans by the UNAIDS/UNICEF definition have a surviving parent putting much of the burden of care on women (JLICA, 2008). The later one is in line with this research finding that the main care givers were widow and divorced mother of the children. Care givers of the children were mostly widowed and second most were divorced. From widowed family majority of them were caregivers of single orphan children. In most families who got support from the CC, number of children was two though significant of them has three OVC per family. Children who raised by Sibling, Aunt/Uncle and granny totally makes 12.1% and which couldn't be undermined when coupled with the level of poverty they are living in.

From more than five million Ethiopian children considered to be orphaned or vulnerable, 77,000 (1.54%) was living in child-headed households (Belay Tefera and Missaye Mulatie, 2014). This is nearly in line with finding from family structure with regard to heads of house hold as the finding in this research was 2.6%

This shows that the CC gives service to mostly orphan children and to children raised by single due to divorce. This indicate, the recruitment criteria for OVC by the CC in the area appropriate as it addresses mostly the orphan and children raised by single care giver and of course those who are raised by both parents but OVC live in poorest of poor, illiterate family.

6.2 Education

The educational support such as tutorial, school material supplies has brought positive outcome on the performance of the children which include promotion from grade to grade and children school enrollment. This finding is similar with finding obtained from a comparative research under taken by World Vision on orphan and Non-orphan in five African countries including Ethiopia on action for OVC in Africa, the study shows many vulnerable children receiving support from Community Care coalition members seen to be doing well in school (World Vision UK, 2011).

Study conducted in Chilga Woreda (Tefera and Mulatie, 2014) indicates that OVC who do not get any support nearly half of OVC in the Woreda have ever failed to promote to next grade level at least once in their academic life and more than half of them had poor attachment with their school and never obtained recognition for their achievement. This capitalizes how the supports from community are important to address OVC challenges related to education.

Additionally, findings on OVC service impact illustrate that distribution of school materials may have impacts beyond educational outcomes and indirectly serve to enhance children's psychosocial well-being (Nyangara F. et al., 2009). Also research finding by (Chitiyoa M. et al., 2008) support my finding in that their research on providing *psychosocial support to special needs children indicates* that provision of school uniform support to OVC made the children not to miss school where as before the support children were missed from school afraid of being misfits in the classroom because they did not look good.

It is understood that even though primary education in our country is free of payment, many children remain unenrolled in school due to lack of school materials such as uniforms,

exercise book, pen, books, etc. OVC assisted by the CC except children in one family, all of them are enrolled in formal education. Children in one family who did not enroll in school reported that it was due to illness related with mental retardation which of course requires the effort of the CC to enroll these children in school that have special needs education. The research revealed that it was not only particular educational support that helped to show overall good educational outcome; however it was coupled with other support of CC such as health, Psychosocial and socio economic supports given. As indicated in the tables under the result section the relationship of educational support with children education status was significant in its positive impact that prove the hypothesis is true.

6.3. Health

The finding revealed that the health supports given to the children and their guardian has improved the health status of the children and their care giver. Even though the interview didn't inculcate question regarding HIV/AIDS status of the respondents, during interview session respondents who were HIV positive were frankly telling that they are HIV positive. They said that during their enrollment most of them were bedridden as well badly sick. But due to Home based care and referral services network availed by the coalition, majority of them revived from that situation and became productive person, able to grow their children.

Most literatures in relation to outcome of health service for OVC and their care givers focus mainly on provision of Home Based Care (HBC) services outcome. For instance a finding from research undertaken by Family Health International in 2009 indicates that outcomes of the HCBC program in five categories, including reduction in stigma and discrimination of PLHIV and OVC, increased acceptance and use of voluntary testing and counseling, improved PLHIV health and well-being, improved household economic conditions

of PLHIV, OVC, and other beneficiaries, and increased community support by Iddirs. The findings clearly show that the HCBC program has resulted in improved health status of clients and reduction of self-stigmatization, and PLHIV now communicate more openly with their families and neighbors. The HCBC program has increased awareness of and facilitated access to treatment. There has been a decrease in opportunistic infections, as PLHIV have understood the need for prompt care, and they take their medications in a timely fashion. Mortality has significantly decreased in the past several years because of facilitation of access to treatment and support for adherence to ARTs provided through the HCBC program. This is also in line with finding of this study that the health support given to OVC and their guardian bring significant change in their health status and livelihoods.

Not only for HIV positive, has it been understood that the CC has facilitated with government hospital free of payment medication. In addition to the above health supports, the improvement on socio economic condition of the caregivers in addition improved their health status as they get better nutrition than before enrolled in the CC program.

The improvement of health condition for guardian and children by itself has brought additional benefit such as livelihood improvement, better capacity to feel children's need and increased self-confidence of the care givers to take care of OVC under their care as illustrated in the chi-square test result summary table (Table 9). The finding proved that the hypothesis made on CC supports have positive impact on health and psychological status of the guardian.

6.4. Psychosocial

Psychosocial support for Children and their guardian included Food, Psychological, Shelter and care supports. The findings on each element discussed in the following sections.

6.4.1. Food

The finding of the study shown that, food security of the family has improved in that there is no day that the children went day and night without food and insignificant proportion of children slept hungry with four past weeks of the study. Yet, the meal frequency is not satisfactory as it was two times in a day even though the respondents reported that the situation was worse (i.e. once in a day and even there were days that they passed without any food) before they enrolled in the CC program. Additionally the ability of majority of families got food by buying not by aid itself shows the improvement of somehow affording food expense of course, in my understanding this relates mainly to the socio economic capacity improvement of the caregivers rather than direct food aid. Direct food aid was given to caregivers who were bedridden due to HIV and other illness until their health gets better. Therefore, the impact of food consumption improvement mainly came from the capacity improvement of socio economic condition. Study by Maraisa L.et al., (2014) in South Africa on Community-based mental health support for OVC support this research finding by indicating that there is relationship between improved food security and mental health outcomes with socio economic support such as Cash Transfer given to OVC families. Study by Datta (2009) compliments the study in that food support by Community help to sustain OVC in schools.

6.4.2. Psychological

Orphan and vulnerable children face different types of psychological disorders unlike other children. Among Psychological problems they face: anxiety, loss of self-esteem and confidence due to parental loos, stigma and vulnerability if the lost parents due to HIV, and depression. Children care giver also face psychological problems grief, fear, anger after the death of a relative. Grandparents, children looking after younger children and caregivers looking after

many children often find it difficult to cope and blame themselves for not being able to do enough. (International HIV/AIDS Alliance, 2003).

The finding from indicators of psychological wellbeing exposed that the counseling support, participation of the children in school club (supported by the CC) health condition of their guardian and other socio economic improvement, resulted good psychological wellbeing outcome. As illustrated in frequency tables and Chi-square correlation, there are no children reported to cause harm on them and majority of them are happy in playing with other Children and nearly all of the caregivers reported that children under their care express their future hope and wish as well their confidence revealed to be good. Therefore the holistic support provided by the CC contributed to better psychological wellbeing rejecting the null hypothesis.

6.4.3. Shelter and care

Adequate shelter and care is important to provide security and stability for all children and families. For children to feel and be safe, they need to know that where they live is protected from danger. This protection is often lacking for marginalized groups such as street children, children in conflict situations and other children living outside of family care (http:// WWW. OVC Support.net, 2015)**.**

Shelter and care support such as renovation of houses, provision of sleeping materials has also illustrated to bring improvement on the condition of the OVC as compared to the time before they enrolled in the CC program. As indicated in the finding, currently almost all children sleep on mattress and have night clothes. The housing condition for majority of them is medium even though most of them live in a house with only one room. This condition is

something that can be improved with their socio economic condition as it directly relates to the alarmingly increasing rent of house as most of them live in rented house.

6.5. Legal

The finding do not show as such the occurrence of legal and right issue raised against the children which couldn't let me know the significance of the CC intervention on the legal matter. However the presence of birth certificate (birth registration) for all children, which is part of legal document for the children, does not overlooked as it was a meaning full support of the CC to the OVC in contrast to in Ethiopia that birth registration practice is adopted only by few regional states and woredas. that According to the report by Save the children UK in 2008, as a result of the neglect of birth registration system in Ethiopia, protection of child rights like the right to have a name and nationality, the right to know parents and get their care, the right of the child to be protected against abuse and exploitation, the right of the child not to involve in armed conflict, the rights of children conflicting with the law, the right of access to social service, and he right to participate in the political life of the country are being affected.

In addition as illustrated in the chi-square analysis summery, the socio economic betterment of the care givers resulted that significant number of caregivers to report that they are able to facilitate legal support for the children under their care in case legal issues arise.

6.6. Socio-economic

Socio economic support such as livelihood training and access to credit service resulted improvement on the livelihood condition of children guardian. As indicated in the result part, comparison of the guardians' socio economic status in relation to affordability of food, health, shelter, legal and psychological with their status before enrolled in the CC, for most of them the

result show “improved”. The improvement of socio-economic condition resulted improvement on the overall better wellbeing of the children and their guardian. When it compared with others researchers work on this aspect, this finding is in line with research finding undertaken by MEASURE Evaluation on Effects of Programs Supporting Orphans and Vulnerable Children in Kenya and Tanzania in 2009. The finding indicated that socio economic support given to guardians associated with reduced food insecurity among participants and also provided cost-effective and viable economic opportunities to guardians, inevitably building their capacity to care for themselves and their children. In addition, the publication by *From Faith to Action* on Strengthening Family and Community care for OVC in Sub-Saharan Africa says, helping caregivers sustain livelihoods by enabling them help feed, clothe, and pay the school fees for the children in their care.

Summary

The objective of this study was to assess the effectiveness of essential services given by Community Coalition to ensure wellbeing of OVC and their care givers. Essential services element examined were; Health, Education, Psychosocial, Legal and Economic strengthening support. The magnitude of outcome indicators of essential services were analyzed using descriptive statistical analysis techniques these are frequency count and measure of central tendency (i.e. mode). Correlation of dependent and independent variables analyzed to see the relationship of the supports given and the current well-being status of the children and their guardian using Chi-square.

Finding from frequency count and measure of central tendency, with regard to OVC access to scholastic material and other Education supports, health services and treatments,

Psychosocial (food, psychological, shelter and care), Legal and economic strengthening for care givers shows that majority of them reported the outcomes of the supports have put them in better conditions.

The finding from Chi-square correlation to see the relationship of the supports given and the wellbeing status of OVC and their caregivers shown significant relationship of the support with their status that lead to the conclusion that the supports given by the community coalition with regard to essential services have impacted the wellbeing of Orphan and Vulnerable children and their guardians in Keranyo.

6.7. Limitation

One of the limitation of this study is the baseline information/status was not taken for program participants prior to exposing them for intervention. The other is as many of the indicators are adopted from National OVC standard service guideline; they are a difficult to be understood by the respondents and the researcher. In this research multiple regression analysis was not used because the focus of the research was to see only the relationship of dependent and independent variables and the research instruments were designed to understand this relationship.

CHAPTER SEVEN

SOCIAL WORK IMPLICATION, CONCLUSION AND RECOMMENDATION

7.1 Implication to Social work

This study has implication from practice, education and policy point of view.

Its implication on practice is that, the role of Community Coalition on improvement of situation of Orphan and Vulnerable children should be highly recognized by social workers. Hence, Social work professionals need to assist this segment of the society significantly.

With regard to education, Social work training institutions need to train more professionals may be not only at higher level but also by giving short term training for volunteers who committed to serve such coalitions with minimal knowledge they have.

From policy point of view, Social workers need to advocate for policy improvement and in creation of fertile ground to promote for such self-initiated coalitions and the creation of more association to relief the vast majority of OVC yet not looked by any one.

7.2. Conclusion

Based on the major findings of the study, the following conclusions are drawn:

- The OVC educational support outcome score of most indicators showed good result. This shows that the educational support has impacted children education positively even though significant change was not observed on their education performance.
- The health support also have brought better health situation for both the children and the guardian/parents.

- Shelter and care support given to the children brought better shelter and health condition both to the children and their guardian/parents.
- Food and economic support has brought improvement in the children's food security.
- Legal support together with socio economic support brought better legal status of the children and security.
- Psychological support accompanied with other supports such as health, resulted better psychological status for the children.
- Shelter and care support brought significant change in their housing and safety improvement.
- Economic strengthening contributed to the improvement of their food security, health status, education and shelter.

7.3. Recommendations

Currently the community coalition temporarily stopped giving service due to license related issue where by the process elongated by the concerned authority. As the finding from this research shows the existence of this community coalition has positive impact on the wellbeing of orphan and vulnerable children living at Keranyo with regard to their education, health, food, psychological, legal, children safety and socio economic conditions. Therefore, it is recommended that the concerned authority should think of the time taken for renewal of license so that the CC resumes its function.

The CC should work on better and effective approaches that could enhance the educational performance of the children. These might be such as creating linkages with schools and education office to arrange more tutorial session and supporting school clubs of the schools where most children learn in collaboration with schools assisting illiterate guardians/parents

to have basic adult education so that at least they can follow and assist their children educational performance.

Even though the sero (HIV) status was not included in the survey, the researcher recognized that most respondents whose health condition is on “Fair” status are HIV positive caregivers. Hence, the CC should give emphasis in facilitating more health service with regard to payment referral services and medicines from government health institution for those families whose health is affected by HIV.

The CC also expected to create linkage with legal service giving institutions both governmental and private, for easy facilitation of legal process to secure and protect the children’s rights in case issues arises particularly for those who are needy

The other important recommendation is the CC should prioritize the service it delivers to all recipients as “one fits to all” doesn’t work in such programs due to resource limitation and other factors related with the condition of the children.

The CC also needs to work with government and non-government organization to mobilize more resources from different funding agencies such as NGOs, Embassies in Addis, Private companies who are interested on charities and its Iddir’s members in order to address more number of OVC in Keranyo area.

This study focuses on only the effectiveness of the services given by Community Coalition in protection of OVC; it didn’t include the quality aspect. Hence, other research might need to extend this research by looking at the quality dimension of the service given to the children.

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Appendix–I

Questioner

Introduction

My name is Yeshewahareg Feyisa. I am master of social work student at Addis Ababa University. I am doing a survey research to learn about service effectiveness of community coalition (CC) for OVC in Keranyo area at Woreda 8. For this purposes your household has been chosen to participate in this study because you are believed to provide me important information. The survey is a confidential exercise and your name will not be disclosed anywhere. Please feel free to answer these questions as they will help in future strengthening of community effort to care for OVC and their guardian and help me to complete my study successfully. The interview will take about 20- 30 minutes. . Participation is absolutely voluntary and that you can stop at any time if you don't feel comfortable. Would you be willing to have a discussion with me?

1. Demographic data		
1.01	*OBSERVE:* Gender of respondent	1. Male 2. Female
1.02	Age of respondent *(If age is unknown, approximate through past events)*	1. 8 – 17 2. 18 – 30 3. 31 – 40 4. 41 – 50 5. Greater than 50
1.03	Ever attended school	1. Yes 2. No
1.04	If Q.1.03 is yes Level of school attended	1. Primary (1 -4) 2. Junior (5 – 8) 3. High school (9 – 12) 4. Tertiary level
1.05	What is your marital status	1. Married

		2. Single 3. Widowed 4. Divorced/ separated 99. . Other
1.06	Who is the head of this household?	1. Father 2. Mother 3. Siblings 99. Other specify _____
1.08	Do you own your home/rental or dependent?	1.own it 2. rental 3. dependant
1.09	If the answer is *own it*, Is the house legal?	1. Yes 2. No
1.10	For How long have you been receiving service from the CC	1. One year 2. Two year 3. Three year 4. More than three year
2. Family composition and characteristics		
2.01	How many adults 18 years or older live in this household?	1. 1 2. 2 3. 3 4. >3
2.02	How many children age 0-17 years old live in this household?	1. 1 2. 2 3. 3 4. 4 5. >5
2.03	How many children under 5 years old usually live in this household?	1. 1 2. 2

		3. 3 4. 4 5. >4
2.04	Who take care of children in this house?	1. Mother 2. Father 3. Both (mother & father) 4. Sibling 5. relative
2.05	Are you biological mother/father of all the children?	1. Yes 2. No
2.06	If no how many of the children are not yours (OVC whom you take care)	1. 0 2. 1 3. 2 4. 3 5. 4 6. 5
2.07	If the response for Q 2.04 is No, What is your relationship with the children/child?	1. Relative 2. Not relative
2.08	Are the children/child single orphaned or double orphaned?	1. Single 2. Double
2.09	Does biological mother of the child/children alive?	1. Yes 2. No
2.10	Does biological father of the child/children alive?	1. Yes 2. No
2.11	Does biological mother of the child/children is seriously sick?	1. Yes 2. No
2.12	Does biological father of the child/children seriously sick?	1. Yes 2. No
3.Socio economic		

3.01	What is source of livelihood for this HH?	1. Trade 2. Monthly salary 3. Daily wage 4. Assistance from relatives and neighbors 5. Assistance from the CC and other aid organizations
3.02	If the answer is 1,2,3 what is frequency of work	1. Every day 2. Sometimes
	Have you got livelihood related training facilitated by the CC	1. Yes 2. No
	Have you got access to credit	1. Yes 2. No
3.03	Able to pay for school related expenses	1. Yes 2. No 3. To limited capacity 4. NA
3.04	Comparison of affordability of food expenditure over time	1. Improved 2. Decreased 3. Same
3.05	Comparison of affordability of health care expenditure over time	1. Improved 2. Decreased 3. Same
3.06	Comparison of affordability of education over time	1. Improved 2. Decreased 4. NA
3.07	Comparison of shelter over time	1. Improved 2. Decreased
4.Education		
4.01	Do the children/Child enrolled in school	1. Yes 2. No 66. NA
4.02	If no why?	1. Not in school age 2. Unable to cover school expense 3. Due to child health problem 99. other specify
4.03	Is your child doing well – growing and learning as you would expect?	1. Yes 2. No 3. partly
4.04	If no why?	1. Due to inadequate nutrition

		2. Due to health problem 3. Due to lack of educational follow up from parents 4. Due to the child is has no motivation for education
4.05	How was the performance of the Children/child [ranking]? before you enrolled in the program	1. Low 2. Medium 3. High 4. NA
4.06	How is the performance of the Children/child [ranking] currently?	1. Low 2. Medium 3. High 66. NA
4.07	If low why?	1. Because not getting tutorial 2. Caregivers do not help them to study 3. The child/children do not have motivation to study 4. The child/children give priority to help family 99. Other specify
4.08	Did the child get tutorial	1. Yes 2. No
4.09	If yes who facilitated	1. School 2. CC 3. Government 4. My self 99. Other specify _____
4.10	Have you noticed change on the child's performance after the Tutorial	1. 1. Yes 2. No
4.11	Did the children/child got school materials like stationeries, uniforms, sup. Books sufficiently?	1. Yes 2. No

4.12	Who fulfil those needs	1. the guardians 2. The CC 3. Other agencies 4. Relatives/neighbors
4.13	If no why?	1. Care givers do not afford 2. The coalition do not provide regularly 99. Other specify
4.14	Do you think you can continue fulfilling educational materials adequately?	1. Most definitely 2. definitely 3. not sure
4.15	Do you have any worries about the child's performance or learning?	1. Yes 2. No
4.16	If yes what is that	1. Do not understand what is learning 2. His /her performance might decrease 3. Might quit her/his education 4. 99. Other
4.17	Is the child promoting to the next grade as expected?	1. Yes 2. No
4.18	How often must the child stay out of school to help family?	1. Never 2. Seldom 3. Most of the time
4.19	Is the young children/child getting the preparation needed to work at a job as an adult?	1. Yes 2. No 66. NA
5.Health		
5.01	How is the health status of the guardian	1. Good 2. Fair 3. Bad 4. Very bad
5.02	How is the health status of the	1. Good

	children/child	2. Fair 3. Bad 4. Very bad
5.03	How often do the children/child miss/ from school or work due to illness	1. Never 2. Seldom 3. Most of the time 66. NA
5.04	Do the children/child has chronic illness	1. Yes 2. No
5.05	If yes do he/she get proper treatment for it	1. Yes 2. No 3. Some times
5.06	Do the CC assisted you in getting treatments	1. Yes 2. No 3. Some times
5.07	What happens when the child/children falls ill?	1. Treated well 2. Left without treatment 3. Sometimes treated sometimes not
	Do the Children get treatment during illness	1. Yes 2. No
5.08	Are there times where any health services the child/children needed but did not receive	1. Yes 2. No
5.09	What was the reason	1. Due to un-affordability 2. Because the service was not available 3. Because there was no one to be with 4. Because the child refused 5. Because the guardian refused to be given 99. Other specify _____
6.Psychosocial (food, shelter & care, counselling/psychological support)		
6.1	**Food**	

6.1.1	How many times do the children/child slept hungry in last 4 weeks	1. 0 2. 1 3. 2 4. 3 5. More than 3
6.1.2	How many days do the children/child Went whole day and night without food in last 4 weeks	1. 0 2. 1 3. 2 4. 3 5. More than 3 days
6.1.3	How do this family get food	1. By buying 2. Aid from CC 3. Aid from other agencies 4. Support from relatives and neighbors 99. Other specify _____
6.1.4	Most often how many times do the family eat every day	1. 1 2. 2 3. 3. 4. More than 3 days
6.1.5	How often you do not get full due to less food available	1. Never 2. some time 3. most of the time
6.1.6	Is there improvement in food consumption of the children when compared with the time first you enrolled in the program?	1. Improved 2. Declined 3. Same
6.2	**Shelter and care**	
6.2.1	How many rooms are there in your hose	1. 1 2. 2 3. 3

		4. More than 4
6.2.2	Where do the children live **[needs observation**]	1. In the same house with the family 2. Separately in another room
6.2.3	Does the family house adequate or need repair	1. Adequate 2. Moderately adequate 3. Need repair
6.2.4	How was it before enrolled in the CC service	1. Same in poor condition 3. More better
6.2.5	How do the child/children sleep**[needs observation]**	1. Without any mattress 2. On mattress
6.2.6	Is the sleeping place enough for the children	1. Yes 2. No
6.2.7	Do the children has night clothing**[needs observation**	1. Yes 2. No
6.2.8	Do you think sleeping place improved after enrolled in the program	1. Yes 2. No 3. Same
6.2.9	Does the child work for anyone outside the household?	1. Yes 2. No 3. Sometimes
6..2.10	In what ways does the child work?	1. Not paid 2. paid
6.2.11	Do you or anyone else worry that the child or among the children may be sexually abused, raped, or touched by adults or older children?	1. No 2. Yes, I/we have doubt
6.2.12	[Observation]Does the child have scars or other signs of physical abuse, such as unexplained burns, bites, bruises, broken bones, or black eyes	1. Yes 2. No
6.3	**Psychological**	

6.3.1	Do you agree with a statement "I can meet the needs of the children in my care?	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree
6.3.2	Do you think the child feels safe and secure?	1. Yes 2. No 3. Not sure
6.3.3	Does the child/children seem happy playing with other children?	1. Yes 2. No 3. Not sure
6.3.4	Does the child or among the children do you worry any one he/she might want to hurt himself/herself or want to die?	1. Yes 2. No 3. Not sure
6.3.5	Does the child tell his goal/wish for his future life	1. Yes 2. No
6.3.6	Did ever the child or you get counselling service	1. Yes 2. No
6.3.7	From where	1. School 2. Aid agencies 3. CC 4. Relatives and neighbors 5. Government office
6.3.8	Do you know where to go if you need counselling service	1. Yes 2. No 3. Not sure
6.3.9	If the answer is yes, Where is that?	1. School 2. Aid agencies 3. CC 4. Relatives and neighbors 5. Government office 99. Other specify _____

6.3.19	Do the children participate in school extracurricular activity like clubs	1. Yes 2. No 3. Not sure 66. NA
6.3.20	How do you describe the self-confidence of the children?	1. Good 2. Fair 3. Bad 4. Very bad
6.3.21	Do you worry about this child future life?	1. Yes 2. No
6.3.22	What do you worry about for this child in the future?	1. Health 2. Educational attainment 3. Psychological well being 4. Socialization 5. Their growth 99. Other specify _____
7. Legal		
7.01	Does this child have birth registration or certificate?	1. Yes 2. No
7.02	Who facilitated to get it	1. CC 2. My self 3. Relative or neighbor 99. Other specify _____
7.03	If parents are not alive do the children have a will?	1. Yes 2. No
7.04	Has he/she been refused any services because of legal status?	1. Yes 2. No 3. Not sure
7.05	Do you know of any legal problems or right issues for this child, such as property grabbing?	1. Yes 2. No 3. Not sure
7.06	If yes, Did the CC assisted the	1. Yes 2. No 3. On process

	child/children to secure their rights	66. NA
7.07	Does this child have an adult who stands up for the child legally?	1. Yes 2. No
7.08	Is there anyone who will give legal issue support or facilitate if in need for the children/child matter	1. Yes 2. No 3. Not sure
7.09	Who is that	1. Relative or neighbor 2. Government 3. Aid agencies 4. The CC 5. I (Paid service) 99. Other specify _____

Do you have additional points to tell me that we didn't discuss?

Appendix - II

Observation Checklist

Education

1. School report card
2. Uniforms
3. Exercise books

Health

1. Health condition of both the guardian and the child/children
2. Physical appearance

Psychosocial

1. Emotional condition
2. Way of communication
3. Confidence and hope

Shelter and care

1. Housing condition
2. Sleeping place and night clothes
3. Children clothing
4. **Legal**

1. Birth certificate
2. Parents will if available

Appendix - III

Consent form to participate in the study

'Effectiveness of Community Coalition for protection of Orphan and Vulnerable Children in Addis Ababa: The case of Keranyo area

Addis Ababa University School of Social Work

Introduction

I am Yeshewahareg Feyisa a Master of Social Work student from Addis Ababa University School of Social Work. The purpose of the study is for the partial fulfillment of the Master's degree in social work. The aim of the study is to examine how the community coalition is effective in promoting child protection in Kolfe Keranyo woreda 08.

This study will not provide you any social, health related services or any financial payment. Participation is voluntary. If you are willing to participate in the study, I will interview you on the above-mentioned issues for about 20-30 minutes. All the information will be kept confidential and your name will be used anonymously. You have the right not to participate if you are not willing; you have the right to ask any question that is not clear or it is uncomfortable to you at any time. The interview will be conducted in a private setting that helps you to feel comfortable during the interview. I will ask you to talk about you and children under your care.

Risk will not be happen because of your participation in this study. If something happens because of your participation, I will take the responsibility and you can contact me by this phone

number 0911444570 any time you want and AAU School of Social Work by this phone number 011-1225954.

Agreement by the informant and the researcher

I have read this consent form, I have agreed to participate in this study, and my participation is voluntary.

I have received the copy of this form

Signature ---------- Date----------

I have discussed the proposed research with the informant and in my opinion; the informant understands the benefits and risks, the rights and other things mentioned above in this form. I think the informant is capable of freely consenting to participate in this research.

Signature---------- Date----------