

**HIV/AIDS AND ITS IMPACTS ON THE TRADITIONAL
SUPPORT NETWORKS OF THE ELDERLY: THE CASE
OF ARADA SUB CITY IN ADDIS ABABA**

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Running head: HIV/AIDS AND ITS IMPACTS

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Elderly: The Case of Arada Sub City In Addis Ababa

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ABSTRACT

The purpose of this study is to assess and analyze the consequences HIV/AIDS on the traditional support networks of the elderly in Arada sub-city. The study focuses on

assessing the impact of HIV/AIDS on the traditional support networks of the elderly; problems, aggravating factors and coping mechanisms of older people; and policy responses and the existing practices to address problems of older people. The methodology of the study was qualitative where primary and secondary sources of data were used. To collect the necessary data, the researcher employed key informant interview, focus group discussion, semi-structured interview, observation, in-depth interview and document analysis as major techniques. In this regard, interview guides, topical outlines, and observation checklists have been used. In the course of analysis, family care giving, community care and support through its institutions, supports of religious institutions, alms giving, and sporadic initiatives by associations and private enterprises have been identified as traditional support networks of the elderly. Lack of basic needs; financial constraints; age related health problems; psychosocial stress and trauma; social exclusions; etc are the major problems of older people. Whereas, poverty, lack attention, absence of social security, death of children from AIDS, the myths and misconception related to aging and lack of elderly-targeted programs are the identified aggravating factors. HIV/AIDS is affecting the traditional support networks of the elderly in a variety of ways. It was concluded that though it is difficult to figure out the number of older people infected/affected by the epidemic. HIV/AIDS is changing the roles of the elderly from being the recipient of care to providers of care and support. In this regard, the researcher suggests a number of relevant areas of social work practice to address problems of the elderly. Accordingly, policy responses; advocacy and awareness raising to maintain the traditional support networks, and designing and implementing participatory older people-focused relevant social work interventions at micro, mezzo and macro levels are recommended.

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1 1. INTRODUCTION

1.3 1.1 General background

HIV/AIDS has become the leading cause of death in the world, continuing to be a global social and economic problem that causes further threats to the very fabric of our society. As one of the development crises, the HIV/AIDS epidemic is fast spreading all over the world. According to Botchwey (2000), HIV/AIDS is the biggest development challenge that the world has ever confronted; a disease, which is noted as “unique in its devastating impact on the social, economic and demographic foundations of development, which has adverse effects on a nation’s progress (UNAIDS, 2000)

In most cases, the unusual, high numbers of adult deaths and the burden of sickness place heavy demands on older people, which in turn affect the formal and informal coping mechanisms of affected families. The increasing number of older men and women are therefore struggling to absorb the multiple impacts of HIV/AIDS on their families, households and communities. Consequently, many old men and women are facing the task of providing care and support for themselves, their sick adult children as well as their orphaned grandchildren just at the time when their incomes are decreasing (HelpAge, 2005; May, 2003; James, 2004).

It is believed that due to the impact of AIDS epidemic, poor countries will continue to face an increasing number of AIDS induced deaths and the resulting orphan-hood. HIV/AIDS has large social, psychological, economic and demographic impacts on both individuals, families, communities and society, thus leading to painful stress, disability, death of adult parents and children, and the resulting orphan-hood. In order to mitigate these problems, the government of Ethiopia adopted a national policy on AIDS in 1998 and a national strategic framework in the year 2001 by acknowledging that HIV/AIDS is

not only a health problem but also a development challenge (MOH, 2000; National AIDS Council, 2001).

According to Rajulton and Ravanera (2001), the family plays an important role in the provision of care and support to its older relatives who can no longer take care of themselves. Similarly, in Ethiopia, older persons are traditionally respected and integrated within the extended family structure so that they are not seen as burdens. They are also regarded as figures of authority and teachers of customary law. Conversely, children are regarded as insurance for latter life because they are assumed to provide the necessary care and support for their parents in old age (MOLSA, 2003; Rehabilitation Agency, 1996). However, this is no longer the case because the family is undergoing changes. For example, the traditional values of children providing care and support to the elderly is declining as the family unit experiences changes due to HIV/AIDS infecting and killing of younger adults.

Available research reports (e.g. MOLSA & HelpAge, 2000; HelpAge, 2003; May 2003) indicate that older people in most African societies are vulnerable groups because of poverty, lifetime hardships, malnutrition and high susceptibility to chronic diseases. These same reports indicate that the AIDS epidemic is now posing an additional burden on them, i.e. in their old age, when they may require support and expect to be looked after, they have to take on the role of caring for others, in most cases without even the necessary resources. Moreover, older people are facing lack of social, economic and psychological supports combined with poor access to health and education services.

The negative consequence of HIV/AIDS could be at the time in life when older adults expect support from their family; they end up having to provide support to others instead and possibly have to sacrifice their own well-being. These changes have affected the long- term care of older persons such that a reversal of role in the provision of care has

emerged. Consequently, older-persons find themselves taking care of their orphan grandchildren. Conversely, the young orphans provide care to their ageing grand parents in the absence of an adult of normal parenting age (Zimmer and Dayton, 2003; May, 2003; James, 2004).

According to MOLSA (2003) in Ethiopia, the long-term care of older persons is left to the immediate family members irrespective of their social and financial ability to give their ageing relatives. However, HIV/AIDS has brought a lot of hardships and uncertainties for older persons. For instance, it has put the burden of caring persons living with the HIV/AIDS on older people, especially on grandmothers and the young children. Young children also take care of their grandparents when sick they nurse them often without physical, emotional or psychological readiness.

This shows that AIDS has become and continues to be a major hazard threatening the social and economic aspects of the country due to its dreadful effects on individuals, families, and the society. Thus, this study attempts to investigate the consequences of HIV/AIDS on the traditional support mechanisms older persons in Arada sub-city, assess the existing practices to address problems of the elderly, and then suggest some recommendations based on the findings.

1.4 1.2 Significance of the study

HIV/AIDS and its devastating impacts such as premature deaths, orphan-hood, lack of caregivers to the elderly, etc., are so complex and present serious development challenges. Thus, this study seeks to develop greater understanding on these and the study helps to map out some social work interventions, which would ameliorate HIV/AIDS induced problems of older persons.

Different researchers have tried to assess the situation of HIV/AIDS in Ethiopia, but its impact on the traditional support networks of the elderly has not been adequately

assessed. As the focus of this study is to identify the consequences of the epidemic on the traditional support networks of the elderly, the results of this study may provide some information for those who are interested to conduct further investigation on the issue under discussion.

In countries like Ethiopia, where there is scanty information available on the multidimensional impacts of HIV/AIDS, this study may give an insight on the major problems facing older persons due to the pandemic. Moreover, the suggestions forwarded on the existing policy issues and practices based on the findings of the study may indicate relevant social work interventions to government organizations, NGOs, religious institutions, community based organizations and associations working with the elderly.

1.5 1.3 Statement of the problem

HIV/AIDS and its devastating impacts like parental death and the induced orphanhood are serious development challenges. The concern of who and how older persons will be cared for are also major problems because of the current demographic transitions brought by HIV/AIDS infections and related deaths. In Ethiopia, families are expected to provide care for their older relatives. Unfortunately, young adults who are expected to look after the aged are the most vulnerable groups to HIV/AIDS infections (MOLSA and HelpAge, 2003). Moreover, the effect of HIV/AIDS is indirectly changing the role older people from being provided for to providers of care and support to other segments of the population.

Even though the crisis of HIV/AIDS is a global problem, its impacts are much more severe in resource constrained countries like ours, where there is high population growth with poor health infrastructures, low education coverage, scanty information on the causes and consequences of the pandemic and poor social security system. The main traditional support mechanism of the elderly, i.e., family care giving is declining due to

industrialization and urbanization, which favour nuclear family to extended family structure. By and large, HIV/AIDS and its induced hazards have complicated the survival of older persons though it has not been adequately studied (MOLSA, 2003).

The multi-faceted social, economic and psychological problems facing the elderly made them the most vulnerable groups of the community. In Addis Ababa, older people are living in different situations. There, are few older persons who get pension fees; there are also non-pensioners, those under government institutional care, in NGO day care centres, the destitute and those within the extended family structure. There is still considerable number of older persons under community support. However, the existing practices to address problems of the elderly are below satisfactory (MOLSA, 2003).

As HIV/AIDS mainly affects younger adults, it has a profound impact on older persons because the burden to care for the sick is left to them and young children, who take this burden at the time they need to be cared for themselves. Therefore, the purpose of this study is to investigate and analyze the consequences of HIV/AIDS on the traditional support network of the elderly in Arada sub-city of Addis Ababa. It examines how the epidemic affects the existing roles of the elderly and generates new roles of older persons; review the current policy supports to maintain the traditional support networks; and assess the existing practices to address HIV/AIDS induced problems of older persons. It is also intended to explore and suggest appropriate social work interventions, which would address problems facing the elderly in the area of study.

1.6 1.4 Objectives of the study

The over all objective of the study is to assess, investigate and analyze the consequences of HIV/AIDS on the traditional support networks of the elderly in Arada sub-city of Addis Ababa. More specifically, it is set out to:

- 1) Assess and analyze the impacts of HIV/AIDS on the traditional support mechanisms of the elderly.
- 2) Determine the presence of changes in roles between traditional care providers and recipients.
- 3) Identify the major problems of older persons and the coping mechanisms, which are being used.
- 4) Assess some of the roles of the government, NGOs, the family and the community in providing care and support to older persons.
- 5) Recommend appropriate and feasible social work interventions that would minimize HIV/AIDS induced problems of the elderly.

1.7 1.5 Research questions

To attain the stated objectives, this study attempts to give responses to the following research questions.

- 1) What are the impacts of HIV/AIDS on the traditional support mechanisms of the elderly?
- 2) What are the problems of older people due to the pandemic? And what coping mechanisms are used currently?
- 3) What policy support exists to maintain traditional support mechanisms of older persons?
- 4) What social work interventions are needed to mitigate the impacts of HIV/AIDS on the well-being of older persons?

1.8 1.6 Operational definitions

For the sake of clarity and consistency in the study, the following definitions are used.

Traditional support mechanisms of the elderly: include the informal caregiving network, which is made of family members and close relatives, the community and institutions.

Impact: can be direct and indirect or tangible and intangible. Accordingly, direct impacts refers to those consequences directly affecting individual older persons, caregivers or family members due to HIV/AIDS induced problems like health problems, income loss,

lack of access to basic needs and services, etc. Indirect impacts are those impacts affecting the community or institutions by making them to shoulder the burden of caregiving to older persons and other persons who are affected by the HIV/AIDS pandemic.

Caregiver: is a member of a household, extended family or community member who is giving social, economic, and/or psychological care and support and/or personal care and assistance to the elderly.

Care receiver: An older person who is unable to secure the basic needs and services by oneself and is dependent on another person for such.

Extended family: is a network of family structure or relatives that comprises grandparents, parents and their children who either share a common residence or not but maintain close ties among each member of the family.

Elderly: refers to persons who are age 60 and over.

1.9 1.7 Conceptual framework

During the pre-HIV/AIDS era, adult children were carers of their ageing parents and other older relatives. Nevertheless, with the onset of the HIV/AIDS pandemic, the traditional support network of older person has been changed (Stephen and Christianson, 1996). The pandemic has driven older persons into the role of breadwinners and second shift parents for their orphaned grandchildren. Orphans have also been forced to take care of their ageing grandparents without assistance from adult family members. This shows the adverse effects of the pandemic on the informal caregiving under the extended family structure.

There is a growing concern that older people across Africa are being adversely affected by the AIDS epidemic (Zimmer and Dayton, 2003). Although they may be less likely to infect themselves, as a group of survivors, they may be especially affected if an

offspring suffers or dies from HIV/AIDS. That is, when an offspring contracts HIV/AIDS, the older adult may become the caregiver of the infected child, and later the caregiver to orphaned grandchildren that may create financial, social, health and psychological burdens. According to Albert and Cartel (cited in Zimmer and Dayton, 2003), living arrangements of older societies reflect lifetime strategies aimed at securing housing, material goods and other items necessary to ensure physical and emotional well-being. The adverse consequence of HIV/AIDS could be that at the time in life when older adults expect support from their families, they end up having to provide support to others instead and possibly have to sacrifice their own well-being.

This indicates that the understanding of caregiving cannot be limited to the situations of care recipients but need to include other components such as family situations, social networking and economic conditions, to mention just a few. Informal care giving under the family system is a task, which HIV/AIDS infection and related deaths has complicated. Therefore, this study strives to identify the major consequences of HIV/AIDS on the support mechanisms of older persons, coping mechanisms being used and suggest relevant social work practices to address the aforementioned problem.

As we can see in the following framework, the impact of HIV/AIDS on the traditional support network of the elderly is multifaceted. Morbidity and mortality have sever burdens on the affected families and older people are more vulnerable than adult family members due to lack of access to resources and services. Economically, HIV/AIDS has direct impacts including cost of medical treatment and frequent illness; cost for funerals; loss of income due to the death of a family member, etc. Moreover, it has social, psychological and healthy related impacts on the welfare of older people through influencing their health and traditional support networks. On the other hand, when there is

high attention to the prevention and control of the epidemic and provision of services to PLWHA, development endeavours will be compromised.

2 2. LITERATURE REVIEW

2.3 2.1 Definition of the Term Old Age

3 Different countries and writers define old age differently. Some use chronological age, others health and functional age and the rest use retirement age to define old age. For example, the UN defines older persons as those aged 60 years and above. This definition has gained acceptance of many countries. However, in the African context, the formal retirement age falls between 45 and 65 years (Nhongo, 2004; MOLSA, 2003).

In Ethiopia, older people often refer to major historical events such as war, drought or famine to tell their age due to inadequate birth registration system and other vital statistics as well. As a result, people in Ethiopia use different variables to make out whether a person is old or not. For instance, change in hair color, difficulty in hearing, health problems, having grandchildren and ceasing giving birth (reaching menopause) are considered as traditional indicators of being old. However, these are quite subjective and may not really indicate "old age" because these variables could happen to someone due to various environmental factors other than age. Nevertheless, the formal retirement age in Ethiopia is 60, which goes along the UN definition (MOLSA, 2003).

3.3 2.2 Overview of Ageing in the World

The world is aging due to the decline in mortality and fertility, improvement of medical science, expansion of education, and the advancement in science and technology (Kosberg and Garcia, 1996). Although modernization and advancements in science and technology in the health sector enable people to live longer across, it has also adverse effects on the well-being of older people through changing the traditional support networks, particularly in developing countries like Ethiopia.

An ageing population is a resource, but it will become a burden to communities and societies unless policies, programs and projects are focused on the needs and capacities of older people. In most developing countries, older people are considered as signs of accumulated knowledge, skills, generosity, and even graciousness and beauty. Thus, the growth in number of older people should not be considered as a crisis for governments, as it can be planned for (HelpAge, 2004).

Ageing is the result of a combination of declining mortality (increase in life expectancy) and declining fertility; leading to structural changes in the age-structure of the population. The term ageing of population refers to changes in the age structure when the weight of the adults and the elderly is higher in the total population in general than the weight of the young population (UN, 2004).

According to projections, the population aged 60 years and over is increasing rapidly across the world. In 1950, it was 200 million, representing only 8% of the total world population, escalated by 75%, and reached to 350 million in 1975 and then increased to 630 million in 2002. Older people will arrive at 1.2 billion in 2025 and 2 billion in 2050 (HelpAge, 2004). The population of older people is growing faster than the rest of the population at the rate of 2% per year, but will jump to a growth rate of 2.8% between 2025 and 2030.

According to HelpAge (2004), the average annual growth rate of the population age 60 years and over in developing regions is 2.5 per cent, which is almost three times that of the developed ones (0.9 per cent). Still, in 2045-2050, the growth rate in the developing regions (2 per cent) is projected to be ten times as high as in the developed regions (0.2 per cent). In developing countries, the growth rate of the older population is projected to continue increasing at least until the end of the coming half-century.

Table 1: Number of population aged 60 years and above, in millions
(In the world, developed and developing regions, 1950-2025).

Region	1950	In %	1975	In %	2000	In %	2025	In %
World total	214	100	346	100	590	100	1.21b	100
Developed regions	95	44	166	48	230	39	315	28
Developing regions	119	56	180	52	360	61	806	72

Source: MOLSA and HelpAge (2000 p.12).

In 2005, Africa is home to some 47 million people aged 60 and over, most of whom live in rural areas. The over 60's and particularly the over 80's- represent the fastest-growing population group on the continent. Africa's older population is set to increase by 50 per cent between 2000 and 2015 and by nearly 5 fold by 2050. Thirty per cent of households in Sub-Saharan Africa are headed by a person aged 55 and over, 68 per cent of these include at least one child under the age of 15 (HelpAge, 2005).

The growth in life expectancy offers new opportunities but it also creates challenges for the future. Particularly, in the developing world, populations are now ageing at an unprecedented speed, while most of their poor still live in poverty. Thus, the population ageing occurring in the developing world is not accompanied by real socio-economic development; consequently, large segments of the population continue to live at the margin. Furthermore, the traditional forms of care and support available to older

generations until recently are under threat (Kalache, 1991 cited in Rajulton and Ravanera, 2001). This is not because families no longer care, but is the result of social changes that include urbanization, geographic spread, the trend towards nuclear families and the participation of women in the workforce (Kalache, 1994 in Victoria, 2002).

Throughout the twentieth century, the proportion of people aged 60 and older has increased in all countries of the world. This trend started earlier in the industrialized countries, but countries in the developing world are experiencing the same changes in population structure. The convening of the *World Assembly on Ageing in Vienna* in 1982 was an acknowledgement of the fact that ageing could no longer be viewed as a phenomenon of the Western world. The Assembly provided, for the first time, a forum where both developed and developing countries could exchange ideas and information on their experience of the ageing process (Sen, 1994 cited in Nhongo, 2004). It was evident from the demographic changes taking place that the ageing process was occurring at an unprecedented rate in most developing countries. From a demographic point of view, ageing has two facets. First, it manifests an increase in the relative proportion of people over the age of 60 out of the total population; and second, it takes the form of increased longevity.

3.4 2.3 The Situation of HIV/AIDS in Ethiopia

Ethiopia is one of the sub-Saharan African countries characterized by absolute poverty with economic, social, political, and natural challenges. In addition, it is also known for terrifying prevalence and alarming spread of HIV/AIDS. This spread worsens the burden of the population as the great majority of the population are exposed to a variety of infectious and parasitic diseases coupled with malnutrition and very low health service coverage, i.e. below 45%, with wide disparities between rural and urban areas and from region to region (World Council of Churches, 2003).

In Ethiopia, HIV infections were first identified in 1984, and the first AIDS cases were reported by 1986. Since then, the number of infections has been increasing to the extent that almost everybody is affected directly/indirectly by the epidemic. It is spreading alarmingly and infected about 1,475,000 out of which (658,000 males and 817,000 females) in the country (MOH, 2004). In 1989, the HIV prevalence among adults population is estimated to be 2.7%, in 1997 it increased to 7.1 %, and 7.3 in 2000, but it was 4.4 % in 2004, of which 12.6 % in urban and 2.6% in rural areas.

However, this decrease in percentage may not indicate that HIV/AIDS infection has been reduced in Ethiopia because there are various factors that may contribute to the low reported incidences. For example, the infected people may not show any of the symptoms of AIDS related illness; people are already sick and dying from AIDS but the family and communities may be in a state of denial and maintaining a state of secrecy; the infected people may not go to the health institutions; prevalence rates is very low in rural communities; etc (Aster, 2004).

HIV/AIDS is more pronounced in adult age group (15-49), one out of every six adults is estimated to be infected (UNAIDS, 2004). According to World Council of Churches (2003) report, 91% of the reported AIDS cases in Ethiopia were in the age group between 15-49 years. Similarly, the government report indicates that 90% of AIDS cases occur to adults whose ages ranging 20 to 49 (MOH, 1998). The death of this economically active segment of the population leaves the country with long lasting development challenges unless the epidemic is curbed soon.

AIDS accounts 30% of the adult deaths that happened in Ethiopia in the year 2003 (MOH, 2004). This same report shows that the cumulative number of AIDS deaths is estimated to increase from about 350,000 in 1998 to 6 million by 2014. It is true that the adult group is the social and economic basis of the family and the society

and the death of this segment of the population has negative impacts on the overall economic output and health care, which in turn severely affected family insurance that further contributes in leaving many children with out parents and the elderly without caregivers.

During the early years of the epidemic, HIV/AIDS was regarded as almost exclusively as a health problem; however, its longer existence revealed its multifaceted impact and considered as a development problem. Besides to claiming the lives of human beings and increasing the number of orphans, AIDS has brought complex and multifaceted problems to human development and a change in the demographic, social, economic and political structures (Family Health International, 2001). Equally, the impact of HIV/AIDS in Ethiopia are broadly categorized as demographic, social, economic, agriculture, health care, education, impact on households and communities.

In line with the global concern and demand for response to curb the devastating impact of HIV/AIDS on human and social capital development, the Ethiopian government has developed important policy and strategic instruments. Accordingly, a national task force was established in 1985, and following it, in 1987 the National AIDS/STD Control Program (NACP) was established at department level within the Ministry of Health. It is responsible for directing and coordinating the implementation of the National AIDS Control Programs (World Council of Churches, 2003). In effect, two medium term prevention and mitigation strategies were implemented in the years 1987-1996 (MOH, 2000). The First Medium Term Plan (MTP-1) focused on public awareness, establishment of laboratory services, and surveillance of the HIV/AIDS prevalence and training of health workers. The Second Medium Term Plan (1992-1996), put emphasis on interventions to control the spread of HIV and adopted a multi-sectoral approach to mobilize national efforts against AIDS through decentralization of AIDS/STDs

prevention and control activities at team level under the Ministry of Health, which was responsible for the coordination of the national and regional endeavours.

A National AIDS Council, which comprises members drawn from sectoral ministries, regional states, NGOs, religious institutions, the civil society and associations of PLWHA, was established in 2000 to intensify and coordinate the multi-sectoral responses to the epidemic. Moreover, a five-year (2001-2005) strategic framework has been formulated and a new five-year strategic plan for increasing multi-sectoral HIV/AIDS response was approved by the council of ministers (World Council of Churches, 2003).

3.5 2.4 The Consequences of HIV/AIDS

The impact of HIV/AIDS may differ across countries, communities, households, families and individuals depending on the level of development and the existing coping mechanisms. To this effect, poor countries and their population are most vulnerable due to various social, economic and political problems. The impact of HIV/AIDS in resource poor countries, like Ethiopia is multidimensional, among others the main ones are demographic, social, economic, gender-related and its impact on the elderly.

Since its emergence in the early 1980s, HIV/AIDS has spread at an alarming rate worldwide with the number of new infections rising each year. According to UNAIDS (2004), since the beginning of the epidemic, more than 20 million people have died in the world. For instance, in 2003 sub-Saharan African countries estimated 2.2 million people deaths, which accounts 75% of the 3 million global AIDS deaths in that particular year. There were also 3.5 million new HIV/AIDS infections in sub-Saharan Africa in 2002 out of the 5 million worldwide (UNAIDS, 2004)). Furthermore, more than 21.8 million people who have died from HIV/AIDS since the start of the epidemic are from Africa. Consequently, AIDS deaths have left over 8 million orphans in sub-Saharan Africa.

These high rates of HIV/AIDS incidence make the disease the leading cause of death in Africa (UNAIDS/WHO, 2000). The UN report indicates that in seven African countries where HIV prevalence is higher, the average life expectancy of persons born between the years 1995-2000 is 49 years, which is 13 years lower than in the absence of AIDS.

As the majority of people living with HIV/AIDS in Africa are between the ages of 15-49, which is the productive age group, it weakens the economy by squeezing productivity, adding various costs, diverting resources, and depleting knowledge and skills. This shows that HIV/AIDS has negative impacts on all sectors of development, which the African countries are attempting to achieve.

With regard to the health sector, HIV/AIDS is bringing additional pressures on the poor health infrastructures of the highly affected sub-Saharan African countries. According to Aster (2004), in sub-Saharan African countries, AIDS patients occupy about half of the hospital beds. This in turn has a negative impact on the health services to be provided for non-HIV patients including older persons since it creates problems of reducing their chance of recovery when they are forced to be admitted only at the later stages of illness.

3.6 2.5 The Consequences of HIV/AIDS on the Living Arrangements of the Elderly

Rajulton and Ravanera (2001) explain that in most developing countries, older people are typically the poorest members of society and live far below the poverty line whilst the cycle of poverty is hard to break for anyone, the challenges are even greater for older people as societies ignore their needs and fail to recognize their potentials.

Similarly, Kazeze (2005) describes that the African elderly have encountered with poor health, lack of basic education, no access to information, the negative impact of AIDS and much more. The lack of income security makes older people vulnerable and

open to neglect and abuse. The problem of income increasingly affects people as they get older because in old age, there will be reduced ability to work since working abilities are highly dependent on good physiological conditions.

It is widely believed that the AIDS epidemic has the potential to alter living arrangements and in effect, the support mechanisms of older adults (VanLandighan M., Knodel J., Im-em W., and Saengtienchai C. (2000). Yet, it is difficult to predict the extent of such changes, since a health event of this magnitude has rarely been experienced. Merli and Palloni (cited in James, 2004) equate the HIV/AIDS epidemic with the European Black Plague and suggest that the changes in household arrangements that will take place in Africa may be of a similar scope. They further justify that adults in their prime years (ages 15 to 49) are most likely to contract HIV/AIDS; and because it is fatal, victims often leave behind dependent children and older parents who need care and support. HIV/AIDS has multifaceted impacts on the welfare of older people. In support of this, HelpAge (2001:57) describes that:

HIV/AIDS is having a devastating but under-reported economic, social, health and psychological impacts on older women and men. They are caregivers for the sick and AIDS orphans. Older people may be infected as they take care of orphans, relatives and parents who have HIV/AIDS, as well as serving as traditional birth attendants and healers. This may be due to the fact they are unable to buy protective devices, they may not know the modes of transmission, or other related reasons.

Yet, efforts to fight the epidemic exclude older men and women though the epidemic has slowly changed their roles from being provided for to providers of basic needs, medical care, and education to orphaned grand children (UN, 2002).

Sub-Saharan Africa is highly affected by HIV/AIDS and this has both direct and indirect impacts on older people (HelpAge, 2003). For example, out of the global total 13.2 million orphans, 12.1 million existed in Sub-Saharan Africa, under the care of older family members, mostly older women (HelpAge, 2003). In African countries, AIDS is generating a vast majority of orphans to the extent that the family support

structures cannot cope. Here the traditional support mechanisms are changing, as more adults are dying to AIDS and related illness. The already African poor families and communities need support to themselves let alone take care of the orphans. Consequently, grandparents are becoming caregivers to AIDS orphans at the time they need care and support for themselves (Nhongo, 2004). The caring role exposes older people to the risk of HIV as they come into direct and unprotected contact with opportunistic infections and body fluids of those who are sick. Thus, caregiving places a great burden on older people. The physical and emotional pressures placed on them by HIV/AIDS puts their general health at risk.

A lot has been discussed on the effects of the pandemic on sexually active age groups. Unfortunately, very little has been done to explore its effects on older people (HelpAge, 2001). HIV/AIDS has devastating but under-reported economic, social, health and psychological impacts on older women and men. They are carers of these orphaned or ill from HIV/AIDS, and are themselves at risk of infection from the virus. The main effect of population ageing and HIV/AIDS is the burden they place on older people in terms of filling the gap left by other segments of the population in providing care and support to other family members. At a time in their lives when they might normally have expected to be recipients of care and support, many older people are caring for the sick, the dying, and AIDS orphaned grand children (UNAIDS, 2004).

Even though the impact of HIV/AIDS is revealed in the daily routines of communities, families and households as well as on different sectors of the country, the impacts of HIV/AIDS on the traditional support networks of the elderly in Ethiopia is not adequately assessed. As the epidemic affects productive segments of the population, it results in absence of care and support to children and the elderly; decline in income and savings; increased expenditures for health care; diversion of development resources

towards prevention and control efforts; etc. For example, in 2003 Ethiopia had received from the World Bank and Global Fund US \$59.7 million and \$55.4 million respectively for the prevention and control of HIV/AIDS. This shows that the response to HIV/AIDS has forced poor countries like ours and potential donors to divert their resources towards the epidemic. This indicates the negative consequences of the epidemic on the poverty reduction endeavours of Ethiopia.

3.7 2.6 The Family as the Primary Caregiver for the Aged

The family was regarded as the safety net for older persons and other vulnerable groups: orphans, the elderly, the disabled etc., and those were taken care of by their adult children and relatives; however, this is changing slowly. Available research findings indicate that HIV/AIDS related deaths have had negative impacts on the traditional support mechanisms of the elderly. The effects have not only on the actual caregiving but almost in all spheres of life for older persons. Unfortunately, while the traditional support network is gradually being reversed, governments and NGOs are doing a little to address the problems of older persons despite a number of concerns have been raised on various reports (Stephen and Christianson, 1996; HelpAge, 2003).

A study conducted by the World Health Organization (WHO) in the mid-1989 examined, from an international perspective, the important issues of providing support to the elderly. This study questions and dispels many of the myths perpetuated by the modernization school, which has been so influential in assessing the needs of the elderly in both developed and developing countries. The study shows that the family played a central but very varied role in supporting the elderly. It illustrates that there was a considerable diversity in the experience of ageing owing to different levels of socioeconomic and socio-demographic developments. Nevertheless, the cases presented in the study also show that, in the absence of other forms of support (e.g. pension

schemes), older people continue to be economically active, particularly in the rural areas. This same research finding indicate that from information based on rural areas, there are strong indications that a much higher proportion of older people are in the labour force in developing countries than in industrialized countries (Rajulton and Ravanera, 2001). The other key issue that requires further exploration is the role of the extended family structure in fulfilling the necessary living costs of older persons and facilitating the role of the aged in childcare and socialization.

Similarly, Apt (1992) places the role of the family in the care of the elderly in the context of the political economy of a country (Ghana), particularly in relation to poverty and uneven development. She further points out that the majority of the population (69 per cent in 1984) continued to live in rural areas. On the other hand, Phillips (cited Maeda, 2003) describes the experience of Hong Kong as an example of the provision of care and accommodation for the elderly in a newly industrialized area. This author shows that Hong Kong has embarked upon a comprehensive and integrated service for its elderly population, with a mixture of public and private enterprise. The developments in Hong Kong have been pragmatic responses to the integration of traditional support for the elderly because of rapid social changes over the past decades, in effect various forms of residential, day care, and community-based services are provided to the elderly. .

However, Nhongo (2004) discusses that the role of older people in the African household has changed significantly over time. Traditionally, their role was to advise, direct and guide their families and societies in various practices, ceremonies and rituals that ensured their survival, existence and continuity. Besides, they were involved in the socialization of youngsters, family and community members in the attainment and passing on of indigenous knowledge, values and norms. But the advent of formal education coupled with the advancement of science and technology, which has resulted in

modern way of life, meant a change in the roles played by older people. By and large, the onset of HIV/AIDS has added another dimension to the whole scenario, i.e. its devastating impact coupled with the effects of population ageing, means that older people are becoming the responsible bodies to the survival of an increasing number of AIDS orphaned grandchildren and those adults sick from AIDS. The elderly play this difficult role with no resources at their disposal, with a variety of age-related health problems, and inadequate recognition for their efforts (Kolosa, 2004).

The significant role played by the family in Africa has been exhaustively presented by Apt (1999), who points out that historically, African communities had well-articulated caring structures that preserved the quality of life for older people, but this was linked to the low chance of the survival of large numbers of older persons. This same writer further observes that migration and urbanization have both separately and jointly been pinpointed as contributing to the destabilization of the value that in the past sustained older persons in a closely-knit age-integrated African society. Such a practice had implications for the way that older people were perceived within both the family and community structures.

For instance, the majority of older people in Ethiopia live in their respective families and communities because the family has traditionally been responsible for the care and support of older relatives. In effect, the extended family unit has historically been the social safety net providing more than 90% of care to the aged as a result high fertility is valued because children are expected to provide labour to their immediate family and they are primary carers of their ageing parents (MOLSA, 2003)

3.8 2.7 Social Welfare and Older People in Ethiopia

According to MOLSA (1982), social welfare has been engrained in Ethiopian culture through its social, religious and traditional institutions to address the daily

challenges of the poor through mutual aids. These sorts of mutual aids have been widely accepted and practiced in different forms of religious institutions, community based organizations, and voluntary associations. Various informal associations through which people joined in their respective communities with the purpose of providing members including their dependents with material assistances in the events of economic misfortunes had a long history in Ethiopia. Those sorts of mutual aids have continued to function even after the advent of urbanization and industrialization. However, although there is no way to deny the contributions of these informal systems in tackling the socio-economic insecurity, the traditional support mechanisms were below satisfactory when viewed from the number of needy people in the country (Solomon, 1998).

The successful but informal functioning of traditional community-based organizations such as: 'Iddir', 'Mahiber', 'Senbete', 'Meredaja', etc are attributed to the common people's capacity to organize their own welfare systems for the sense of social and economic responsiveness. Particularly, in rural areas, when an old man/woman is incapable of supporting himself/ herself, and does not have families nearby, it is the responsibility of the community and its traditional institutions to take care of him/her. It has also been manifested in a limited extent even in urban centers (Rehabilitation Agency, 1996). This shows that these traditional support networks have been the main social welfare systems for the provision of care and support to the elderly for historical times in Ethiopia.

As Tenagne (1989) describes giving care and support to the elderly in the Ethiopian traditional way of life has been the responsibility of the extended family, i.e. kinship relation and mutual help have been the dominant systems of supporting the elderly. The family provides personal care and even shares a home when older persons are unable to live alone. Children are assumed as major supporters of their parents and grandparents,

particularly when these members of a family are old enough to care themselves. Consequently, older people rely first and foremost on their respective family members for the necessary care and support be it personal, in cash or in kind so that elders were confident enough that their extended family members would support and take care of them in time of old age. In return, they were contributing their respective families playing the roles of socializing children; giving advice to the youth and adults; mediating conflicts among family members and the community; leading rituals, ceremonies; etc.

In Ethiopia, the need of older people is catered through the extended family system, which is a two or three generation held together by kinship or marriage ties. Thus, it is the socially and culturally recognized responsibility of the family to take care of all its members including its elderly (MOLSA & HelpAge, 2000). Hence, the family is the major provider of care and support to the elderly and plays the most significant role in preventing older people from living in poverty. However, it has become a common phenomenon to observe changes in the family structure particularly in urban centres due to urbanization, modernization, migration, poverty, and changes in life style, which in turn results in the prevalence of nuclear family structure. These all contributed to the gradual decline of the traditional support mechanisms of the family.

However, older people are still considered as core to the Ethiopian society so that they are given due respect, deliberation and concern to their well-being. In most cases, they are community leaders and accorded high esteem as well as prestige. The national report presented at the world assembly on ageing summarises the range of responsibilities of older people in traditional Ethiopian societies in such a way that older people play the roles of “teaching moral values; disciplining children; serving as religious preceptors and leaders of courts; arbitrating disputing parties; advising the youth & adults; carrying forward the country’s oral literatures and folklores” (MOLSA & HelpAge, 2000 p.21).

In addition, the elderly play a great role in the socialization of children and grandchildren at the household level as well as act as advisors and administrators of daily routines in the respective communities.

3.9

3.10 2.8 Global, Regional and National Instruments on Welfare of the Elderly

4 Planning, organizing, implementing and facilitating social work interventions require policy support. Without a clear policy it will be very difficult to mobilize the necessary resources to address a given social problem. In this regard, attempt was made to review some of the existing international, regional and national instruments of ageing.

5 Accordingly, the dramatic increase in the number of older people throughout the world is becoming a greater challenge to the social and economic development of every country. However, this ageing of the population has not given adequate attention (except in the informal sector), until 1982, where the international community recognized the need to call worldwide attention to the problem of ageing and decided to convene the World Assembly on Ageing in 1982. Since then, member States started to give attention to ageing and the UN organizations such as WHO, ILO, FAO, ESCO, UNFPA, etc have developed programs on ageing in their respective activities (MOLSA & HelpAge, 2000).

According to Nusberg (1993), ageing policy as part of social policy is concerned with measures designed to promote the well-being of the elderly at all levels. Thus, the ultimate goal of ageing policy should be to strengthen the continued functioning of older persons as full participants in all social and economic spheres of life. To this end, many

countries have realized the social, cultural and economic contributions of older people in their respective national development, consequently most of them started to design various policies, strategies and programs to address problems of older people.

5.3.1 2.8.1 International Instruments

There are three age-specific international instruments adopted to protect the rights and welfare of the elderly. These are the UN Plan of Action on Ageing – 1982; UN Principles for Older Persons – 1991; and UN Proclamation on Ageing – 1992.

The Vienna International Plan of Action on Ageing, which was adopted in 1982, is the first global instrument on ageing. It aimed at strengthening the capacity of governments and the civil society to accept population ageing as critical issue and address the development challenges and dependency needs of older persons (UN, 1982). It consists of various recommendations for actions that include issues like research; data collection and analysis; education and training; health and nutrition; housing and the environment; family and social welfare; protection of elderly consumers; and income security and employment

After the endorsement of the plan of action, the UN principle for older persons was adopted by the general assembly in 1991. It contains five categories of principles, i.e. independence, participation, care, self-fulfilment and dignity (HelpAge, 2001). After ten years of the endorsement of the International Plan of Action on Ageing, another international instrument, the UN Proclamation on Ageing was adopted. It primarily urges the international community to promote the implementation of the plan of action; disseminate the UN principles of older persons; to enhance intra and inter-regional cooperation, and exchange of resources for the implementation of elderly policies, programs, and projects (UN, 1992).

Since then, the plan of action together with its recommendations progressively promoted a worldwide attention on various issues related to ageing. To this end, a considerable progress has been made to address the multi-dimensional problems and needs of older persons. For instance, within the UN itself a series of activities were performed among which the following are the major ones.

- On December 14, 1999, the UN general assembly decided to celebrate 1 October, as “International Day of Older Persons” worldwide. (UN resolution 45-106).
- On 16 December 1991, the “*U N principles for older persons*” were adopted.
- The UN general assembly also resolved to implement the global action on ageing to extend to the year 2001.
- The second UN general assembly on ageing was held in Madrid, Spain (8-12 September 2002), and adopted two instruments namely, "Political Declaration" and "Madrid International Plan of Action on Ageing".
- The former has 19 articles, which entail the general commitment that member States made to implement the plan of action through various ways (MOLSA & HelpAge, 2000).

5.3.2 2.8.2 Regional Instruments on Ageing

In 2001, OAU developed a draft policy framework and plan of action on ageing with the aim to guide the then OAU (the current AU) make any policy/ programs designating, formulation, implementation, monitoring and evaluation in relation to the needs of older persons. The aim of the draft policy framework and plan of action is to guide AU member states any policy or program designing, implementation, monitoring and evaluation in relation to the needs of older persons. The designing of the policy framework and plan of action was based on the outcome of the Experts meeting held in Kampala, Uganda a year before the review key ageing issues in Africa. It has also

recognized that even if international instruments: the UN Principles of Older Persons and the International Plan of Action exist to safeguard the rights of the elderly, the relevance of more context specific approaches, policies and programmes to govern ageing issues in Africa was considered.

The policy recommendation and plan of action evolves around rights; information and co-ordination; poverty; health; food and nutrition; housing and living environment; the family setting; social welfare; employment and income security; crises, emergencies and epidemics; ageing and migration; education and training; and gender.

African states agree on ageing and HIV/AIDS policies in a meeting held to develop the African Union Policy Framework and Plan of Action on Ageing in 2002. In the meeting, poverty; older people's rights; HIV/AIDS and gender; the urgent need to protect, support and educate older people in relation to HIV/AIDS were the main issues of discussion. Specifically, the need to allocate more resources to support growing numbers of older people caring for the sick, looking after orphans, and sustaining families and communities (HelpAge, International 2001).

5.3.3 2.8.3 National Instruments of Older People in Ethiopia

The government recognition to problems of older people in Ethiopia dates back to the reign of Emperor Haile Selasse, on which, the emperor took the first initiative to give support to the handicapped and destitute older persons. Consequently, the Haile Selasse I Foundation established with the intention to organize, motivate and strengthen other institutions, day care centers and elderly homes to enable them provide charity to the poor and destitute older people.

Later, the development of Imperial Order No 70/63 resulted in the establishment of the former Rehabilitation Agency. Its aim was to help and organize the destitute elderly and other vulnerable groups (Rehabilitation Agency, 1996). The then Imperial Order used

to encourage churches, missionaries, community-based organizations, and voluntary associations to engage in welfare and rehabilitation programs. During that time, the services provided for older persons were in two approaches: subsidies to older people while they stay within their families and admitting the elderly in to the institutional homes for the aged. (Rehabilitation Agency, 1996).

According to MOLSA (1982), there were about forty voluntary social welfare institutions in the country; many of these were in Addis Ababa with or without branch offices in other administrative regions. Some of the major activities that were carried out by these institutions include rehabilitation of the physically and mentally handicapped persons; supports to the aged and destitute; community care centers; medication for the sick & the needy; and other related activities.

After the 1974, these institutions were reorganized and came under the government body called the Rehabilitation Agency for the Disabled. It was responsible for the provision of basic needs to the aged who could no longer be self-supporting and those who were left without their families (Tenagne, 1989). In addition, it was providing institutional care services in two “Old People’s Homes” in the then two regions and subsidies were also given in two centers of the agency. The services given include food, clothing, shelter, medical care, sorts of work therapy and related services (Tenagne, 1989).

During the military regime, as Ethiopia was under the communist principles, the government was supposed to run everything because private undertaking was discouraged. To this effect, most of the social welfare programs were nationalized; missionaries and other charity organizations were dismissed; and every thing was under the command economy. The then programs such as villages or ‘Ambas’ of different nature like Children Amba, Jegnoch Amba, and elderly care centers were the mere responsibilities of the government. Among others, Yetnora (East Gojjam) was the most prominent Amba (care

center) for the elderly. Moreover, peasants' associations and urban dwellers associations were formed at rural and urban areas respectively and used to give different care & support services to the elderly in their respective localities (Rehabilitation Agency, 1996).

With regard to the existing government response, the recognition given to problems of the elderly is shown under article 41, sub-article-5 of the constitution and it says that "the state shall, within available means, allocate resources to provide rehabilitation & assistance to the physically and mentally disabled, the elderly, and children who are left without parents or guardian" (FDRE Constitution, 1995 p.41)

Based on the constitution, the Ministry of Labour and Social Affairs (MOLSA) developed a Developmental Social Welfare Policy, which includes issues of the elderly in 1996. However, available reports including the government ones show that though issues of the elderly is included in the national constitution and developmental social welfare policy, there is still not any program or intervention strategies designed to implement what have been stated in these documents. To this effect, the concerned bodies have not adequately addressed the socio-economic and other problems of the elderly. It is also further justified that not only the absence of independent elderly welfare policy, but also issues of older persons have not yet mainstreamed in to sectoral development endeavors (MOLSA, 2003; HelpAge, 2001).

When these efforts are viewed from the number of older persons and their multidimensional problems, the services being provided are inadequate as compared to the needy older people because though there are above three million persons age 80 and over, it is only nearly half a million people are entitled for pension benefits. All the rest are under either the extended family support, community care and support or begging on the streets and in churchyards to sustain their lives (MOLSA, 2003). The following table shows the number of older people in Ethiopia.

Table 2: Ethiopian older population by age group, sex, and residence

Age	Urban			Rural			Total		
	Male	Femal	Total	Male	Femal	Total	Male	Female	Total
60 – 64	78,729	85,824	164,553	480,774	453,27	934,04	559,503	539,097	1,098.
65 – 69	56,993	65,967	122,9	360,8	329,85	690,71	417,848	395,822	813.6
70 – 74	37,057	44,748	81,80	251,0	223,06	474,15	288,147	267,817	555.9
75 +	37,844	48,517	86,36	271,5	225,82	497,36	309,386	274,344	583.7
Total	210623	245056	455679	1364261	1232024	2596285	1574884	1477080	305196

Source: Statistical Authority Abstract (2001).

In the table above, the overwhelming majority of older population (85%) is living in rural areas of the country, where the socio-economic problems are prevalent in comparison to the problem of older people who live in urban areas. However, according to Helpge/Ethiopia's report of June 2001, the number of urban elderly shows remarkable increase as they are moving from rural areas to towns in search of food, clothing, medication, better work, etc that would sustain their lives.

According to the Central Statistics Authority 1994 census report, cited in (HelpAge, 2001), the population of older people is increasing dramatically in Ethiopia and it is predicted that their number will rise to 9,576,670 in 2025. The same document goes on stating that among the elderly in Ethiopia, only half a million are entitled for pension benefit. The rest, especially those who live in the rural areas are solely dependent on subsistence farming and some cottage industries. Nevertheless, one has to keep in mind that a considerable number of others live without any income depending on the care and support provided by the extended family structures, religious institutions, and community based organizations. Still others sustain their lives begging on the streets.

When we come to the situation of older persons in Addis Ababa, it is common to see the elderly begging on the streets, in churchyards, around market places, and even within villages. In support of this, MOLSA (2003) report indicates that the number of

older persons begging on the streets and in churchyards is increasing from time to time. This is because those who cannot get care and support in their respective localities in the countryside move to urban centres including Addis Ababa. Apart from poverty, family abuse and neglect; the rapid urbanization that cause youngsters go away from parents searching for better life; drought; war and displacement; the death of caregivers etc are major causative factors for older persons' rural-urban migration. After their arrival, very few of them may get supports of humanitarian service providers. The rest, who could not get such accesses, would join either the street life, live along the roadsides, or in churchyards involving in begging (MOLSA & HelpAge, 2000).

Moreover, on top of the economic pressure exerted upon them, the existing age-related discriminations from development activities like credit and saving schemes coupled with community misconceptions against ageism play a part in not recognizing their contributions to overall development endeavours. As elsewhere in the world, women live longer than men in Ethiopia and are more likely to be alone and poor in old age. Thus, the social and economic problems are more complicated for women than men in many regards. From the above mentioned facts, one can easily understand how these valuable segments of population are suffering from severe poverty at the age that they were to be given care and support.

5.4 2.9 The Existing Practices to Address Problems of Older Persons

The pension scheme is the only social security provision in Ethiopia. It is even limited to workers in the civil service, military and industries. The elderly in the rural areas, others who engage in the informal economy and those who are out of the civil service are not entitled to any form of social security including the pension scheme. To this effect, though the number of older persons with age 60 and above is more than three

million, there are merely half a million pensioners in Ethiopia (MOLSA, 2003). On the other hand, even those who are entitled to the pension scheme do not get adequate amounts of money to support themselves and their families. For this reason, most of them have been encountered with a variety of social and economic problems. This indicates the need for establishing supports systems to mitigate problems the elderly in their later lives.

With regard to the existing services, the government is providing services to the elderly in three forms. These are (1) institutional care for older persons in its three homes for the aged, (2) it used to provide financial assistance in the form of subsidies to only 250 families, and (3) it provides technical and material supports to organizations and associations working with the elderly (MOLSA, 2003).

Table 3: Organizations working with the elderly in Addis Ababa

Name of the organization	Type	Services delivery	Approach
Social Security Authority	Gov't	Provision of social security funds	-----
St. George Church Older People Welfare Society**	NGO	Provision of food, clothing, medication, and home-based support services	Family based
Every One**	NGO	Financial support, counselling services, elderly experience sharing sessions, home based support	Day care and family based
Association for Support and Development of Destitute Old persons	NGO	Financial, clothing, health care, housing maintenance, counselling	Community based
Community Based Integrated Sustainable Development Organization(CBISDO)	NGO	Food, clothing, medication, shelter and recreation, Income generating schemes for the able bodied elderly	Community based
Daughters of Charity (DOC)	NGO	Medical treatment; housing utensils; setting up income generating scheme for both the elderly and their grand children	Community based
Enredada Elderly Association	NGO	Food, clothing, housing maintenance and health care	Community based
Health Service and Social Security for the Elderly	NGO	Ensure economic & social security, and health of the elderly	Community based
HelpAge International-Ethiopia	NGO	Financial support for organizations working with the elderly; advocacy on the rights of the elderly, etc	Community based
Integrated Holistic Approach Urban development Project	NGO	Food, clothing, medication, shelter and recreation; Income generating schemes	Community based
Kaliti Home for the Aged	Gov't	Food, clothing, shelter and health care	Institutional
Kana Family and community Development Association	NGO	Health care, Utensils and loan scheme	Community based
Medhin Social Service Centre	NGO	Food, clothing, housing maintenance, income generating scheme	Community based
Missionaries of Charity			Community

	NGO	Food, Clothing and Shelter	based and institutional
Ministry of Labour and Social Affairs (MOLSA) **	Gov't	Advocacy, research, formulation, implementation and follow-up of laws	Community based and

Source: Ministry of Labour and Social Affairs (20054) **- Organizations included in the study;

Currently, there are also some services run by NGOs, particularly in Addis Ababa. Most of the services are provided in three approaches, i.e. family based, community-based and institutionalized services. Table 3 shows the organizations and services provided to older people in Addis Ababa.

6 3. RESEARCH DESIGN AND METHODOLOGY

7

This is a descriptive study. For the sample, different organizations that comprise government, NGOs, religious institution and association were intentionally selected based on their appropriateness to deal with issues of the elderly. In the study, both quantitative and qualitative research methods were employed. However, the quantitative method part was used for very few data related to the socio-demographic characteristics of the respondents, hence; the study mainly employed qualitative methodology.

7.3 3.1 *The rationale for adopting qualitative research method*

There are a number of reasons for choosing qualitative research method for this study. Firstly, qualitative research is considered as an appropriate methodology for researchers whose research questions lead them towards inductive or ‘data driven’ approach, i.e. to look at the existing situation and try to make sense by analyzing themes and patterns. Secondly, qualitative research is said to suit a research project in which descriptions and explanations (rather than prediction based on causes and effects), are sought when it is not possible or feasible to manipulate the potential causes of behaviour,

and when variables are not easily identified or too embedded in the phenomenon to be extracted in the study (Henderson, 1994; Pope and Mays, 1999). Thus, the qualitative research method is well suited to assess, examine and analyze complex social phenomenon like the consequences of HIV/AIDS on the traditional support network of the elderly. As a result, qualitative research method was used as the main approach in this study.

7.4 3.2 Sources of data

The main sources of data for this study are two in kind; these are primary and secondary sources of information.

Primary sources: It consists of different categories of respondents drawn from various organizations. These include: representatives of the Federal, City and Sub-city level Labour and Social Affairs Organizations; the kebele HIV/AIDS prevention and control desks; representatives of non-governmental organizations working with the elderly; leader of a church; older persons who are beneficiaries of NGOs and religious institutions; elderly under the extended family support system; caregivers of older persons; and the destitute elderly.

Secondary sources: To supplement the primary data, policy documents, different books written on the elderly, workshop proceedings on ageing, African Union Policy Framework and Plan of Action on Ageing, research reports, written reports, and project documents of selected institutions that are working with elderly were consulted. In addition, other available literature, both published and unpublished were also reviewed and embodied in the analysis to enrich the study.

7.5 3.3 Sampling technique

Due to the complex nature of the problem under study and the difficulty of easily accessing older persons through the survey method, qualitative research approach was used. Non-probability, purposive sampling, was used to select respondents.

7.6 3.4 Study population

In this study, different categories of respondents participated. The main purpose of the use of different groups of respondents was to triangulate the collected data and thereby to obtain more insightful information on the problem under study. The categories of the study population are described hereunder. The total number of respondents included in the study is 68. This was done taking the financial and material constraints in to consideration.

Key Informants: Informants were selected from relevant organizations of the public sector including the Ministry of Labour and Social Affairs, city and sub-city labour and social affairs offices, and the Kebele HIV/AIDS prevention and control desk. Key informants were also selected from four NGOs and associations working with the elderly. Moreover, leader of a church was included in the study. The researcher selected the respondents based on their knowledge and experiences on the issue under investigation. In this regard, it was the responsible officials of the organizations included in the study, who identified these informants in their respective organizations.

Focus Group Discussants: All the FGD participants were older persons who are under different living conditions. These include elderly under the extended family structure, those who live alone in church compounds, the homeless older persons, elderly caring AIDS orphans, the destitute older people, and older persons who get care and support from government organizations, NGOs, or associations.

Caregivers: Caregivers were also selected from two organizations that provide care and support to the elderly. Others were also chosen from extended family structures, which provide the necessary care and support to the aged family members.

Cases: In this study, four older persons were selected based on their participation and explanations in the focus group discussions held with the elderly in different settings. This writer tried to represent each case as older persons under the extended family support system, those caring AIDS orphans, those who live alone, and the destitute older persons who use begging as sole means of survival.

7.7 3.5 Methods of data collection

In this study, six types of data collection techniques were utilized to triangulate data and increase the breadth of information. In this regard, methodological and data triangulations were used employing different methods and using various sources of data respectively. The methods of data collection include; key informant interview; focus group discussion; observation; in-depth interview; semi-structured interview; and document analysis. *In this regard, interview guides, topical outlines, and observation checklists have been used. These tools are presented at appendix I.* All these methods were conducted in Amharic after translating the English version of the tools.

Key informant interview: It was conducted with government officers, representatives of NGOs, associations and religious institution. Totally 10 informants were interviewed.

Focus Group Discussion: It was the most important method of data collection in this study. All the discussants were older persons aged 60 years and over who are in different living conditions: elderly under family support, beggars, beneficiaries of NGOs, heads of households, those caring AIDS orphans, and others who are caregivers to the sick and PLWHA. The invitation of participants from diverse living condition was ultimately to increase the breadth of information collected. In running the FGD, older men and women were discussed in separated groups and hence there were four FGDs, out of which two

were for men and the rest were their counterparts. Forty-four persons participated in the FGD, of those 20 were men and the rest were women.

Semi-structured interview: It was conducted with home-based caregivers of organization working with the elderly and caregivers of older persons under the family unit

In-depth interview: Interviews were made with four older persons. In this regard, the researcher himself managed all the interviews. During the focus group discussions a note taker from MSW students assisted this author.

7.8 3.6 Data collection process

With regard to the data collection process, the researcher had primarily contacted officials of the sample organizations as to how and when to make discussions with the respondents. This was a good opportunity to review and consult the available documents in the respective organizations pertinent to the study. Then, the administration of the data collection instruments was realized. The researcher collected all the relevant data in months of March and April, 2006. The researcher has successfully completed the fieldwork through higher dedication and enthusiasm of individuals working at the organizations included in the study.

7.9 3.7 Data analysis

The process of data entry was begun soon after the completion of the fieldwork. In fact, the study mainly employed qualitative method to collect the relevant data for achieving the stated objectives, but for some of the closed-ended and structured questions related to the socio-demographic characteristics of the respondents basic descriptive statistics was used to compute the corresponding descriptive analysis.

By employing qualitative methodology, the field notes were first checked for accuracy and completeness, then coded and recorded according to the themes of the study. Then, the data were typed by using word processor, and then it was sorted and categorized

in to major themes for content analysis- the major analysis for qualitative data. The content analysis was made by describing the major findings of the fieldwork, as per the themes of the study.

7.10 3.8 Ethical Considerations

The advisor and the School of Social Work primarily approved this thesis proposal. In addition, the researcher followed logical procedures in every stages of data collection. Most importantly, the subjects of the study were introduced about the purpose of the study, then informed verbal consent from all the respondents and the concerned bodies of all the organizations covered by the this study was obtained to discuss with and interview them on the problem under consideration. In addition, all the respondents were told that their responses are completely confidential. Their name will not be written on the report and will ever be used in connection with any of the information they told me .

Moreover, the respondents were informed that they have full right to discontinue or refuse in participating in the study. However, providing well organized and detail orientation on the ultimate objective of the study was used as a proactive remedy for the aforementioned problem not to happen.

7.11 3.9 Description of the study setting

The study is delimited to cover only two kebeles of the Arada sub-city, in Addis Ababa. This was so because the sub-city is most known resort and center of attention to the elderly since it is a center of major political, cultural, religious and business institutions that are set up and carried out. In this locality, a number of vulnerable older persons including beggars are abundantly seen due to the above physical characteristics that have been serving as centers of resources for beggars. Thus, the researcher selected this locality and picked up only two kebeles, (Kebele 03/09 and O1/15) to make the assessment as comprehensive as possible.

Arada sub-city is located nearly in the middle of the city and organized in three administrative and municipal strata (City, Sub-city and Kebele) based on the recently amended Charter Proclamation No. 361/2002 adopted by the Federal government. It is one of the ten sub-cities established by Proclamation No. 1/2003; it covers the former districts of 1, 2, 9, 13, and 14. It encompasses most of the place known before the Italian invasion as the Ras Makonnen Sefer with the Arat kilo, Amist kilo, Sidist kilo, and Serategna Sefer as well as the specific locality known as Arada and its surroundings of Gedam Sefer and Piazza (Arada sub-city administration, 2004).

The Arada locality, after which the sub-city is named, is one of the oldest parts of the Addis Ababa City where the major political, cultural, religious and business institutions are set up and carried out. These religious and cultural heritages confer on the sub-city physical characteristics that have made it a center of attraction for the destitute elderly. Specially, the Churches provide vast resource for the destitute. Deciding to conduct this study based on the mostly known resorts and centers of attention of the elderly, the researcher selected Arada sub-city where vulnerable older persons including beggars are abundantly seen due to the above physical characteristics, which are serving as centers of resources for beggars. To make the assessment specific, the researcher picked up two kebeles: Kebele 03/09 and Kebele 01/15.

According to the National Population and Housing Census of 1994, out of the total 2, 112, 737 population of Addis Ababa, the proportion of the population aged 60 years and above was 4.1 percent. (You may see the details in the tables 4 and 5 below).

Table 4: The five years elderly population projection of Addis Ababa (1995-2000)

Age group	Total population (both sexes)					
	1995	1996	1997	1998	1999	2000
60-64	32,364	33,613	34,912	36,260	37,661	39,116
65-69	20,778	21,581	22,415	23,281	24,180	25,114
70-74	15,780	16,389	17,022	17,680	18,382	19,072
75+	21,007	21,819	22,663	23,537	24,447	25,391
Total	89,929	93,402	97,012	100,758	104,650	108,630

Source: The 1994 Population and Housing Census of Ethiopia (cited in CSA, 2005).

8 Table 5: Total population of Addis Ababa and Arada sub-city

Population of Addis Ababa			Population of the Arada sub-city		
Sex	In number	In percent	Sex	In number	In percent
Male	1, 023, 4652	48.44	Male	103, 638	47.95
female	1, 089, 285	51.56	Female	113, 458	52.05
total	2, 112, 737	100	Total	217 , 096	100

Source: Central Statistics Authority (2005).

8.3 3.10 Limitations of the study

Obviously, research studies are encountered with financial and time constraints. This study also did not escape from these constraints. Particularly, lack of comprehensive data on the situation of older people in Addis Ababa has been the greatest challenge that the researcher has encountered. Besides, there were financial and time constraints to collect all the necessary data and to deal with in-depth. Furthermore, as the methodology of the study is mainly qualitative and the respondents were selected based on purposive (non-probability) sampling technique, it may be difficult to generalize about all older people of Addis Ababa city based on the findings.

9 4. FINDINGS OF THE STUDY

10 This section deals with the presentation of data obtained from primary and secondary sources through different techniques of data collection. .

10.3 4.1 Characteristics of the respondents

Table 6 below shows the sex composition, age structure, level of education, and work experiences of the respondents. In addition, it indicates the older persons' family size, marital status, sources of income, housing condition, social networking, and other issues related to their living arrangements were included under this section with the intension to show the socio-economic conditions of the elderly included in the study.

As indicated in the table the total number of respondents is 68, out of which 32 were men where as 36 were their counterparts. When we look at age structure, 54.4 % of the respondents were age 60 and over. Concerning their level of education, 4.41% are illiterate whereas 32.35% of them are with only primary education. In the same table, item five indicates marital status of older persons included in the study. Accordingly, 12.06%, 31.03%, 24.13%, and 32.75% were single, married, separated / divorced, and widowed respectively. As could be seen from item six of the same table, the family size of the majority of the respondents ranges from 0-4. However, there is also considerable number of older persons (17) whose family size is above five.

As shown in the same table, the main means of livelihood for older persons include begging, petty trade, pension benefit, family support, community support, religious institutions, support, government support, NGOs support, daily labours, and involvement in cottage industries. Regarding their housing condition, it was reported that thirty-three elderly are living in rented houses; six older persons live in their own houses, and nine are homeless.

Table 6: Characteristics of the respondents

No	Items	Key Informants	FGD participants	Cases	Care givers	Total (in percent)
1	Sex:					
	a. male	6	20	2	4	32 (47.05)
	b. female	4	24	2	6	36 (52.95)
	Total	10	44	4	10	68 (100)
2	Age:					
	a. 21-40	7	--	...	8	15 (22.05)
	b. 41-59	2	9	2	13 (19.11)
	c. 60 and above	1	32	4	--	37 (54.41)
	d. No response	----	3	...	--	3 (4.41)
	Total	10	44	4	10	68 (100)
3	Level of education:					
	a. illiterate	---	26	2	2	30 (44.11)
	b. primary education	---	18	2	2	22 (32.35)
	c. secondary education	2	...	---	4	6 (8.82)
	d. 12+2	3	---	2	5 (7.35)
	Total	10	44	4	10	68 (100)

4	Marital status:					
	a. single		1	1	5	7 (12.06)
	b. married		15	1	2	18 (31.03)
	c. separated / divorced		9	2	3	14 (24.13)
	d. widowed		19	--	--	19 (32.75)
	Total		44	4	10	58 (100)
5	Family size:					
	a. 0-4		29	2		
	b. 5-9		13	2		
	c. 10 and above		2	---		
	Total		44	4		
6	Means of survival:					
	a. begging		14	1		
	b. petty trade		26	1		
	c. pension benefit		2	1		
	d. family support		4	1		
	e. community support		--	1		
	f. religious institutions' support		30	2		
	g. NGOs support		13	2		
	h. daily labours		25	3		
	i. cottage industry		8	1		
7	Housing condition:					
	a. rented house		30	3		
	b. private house		6	--		
	c. homeless		8	1		
	Total		44	4		
8	Involvement in CBOs					
	a. participant		24	1		
	b. non-participant		18	3		
	c. no response		6	--		
	Total		44	4		

N. B: For item 6 totals is not added up due to repeated frequency.

10.4 4.2 Organizations included in the study

In the study, government organizations, non-governmental organizations, associations of the elderly and religious institution working with older people were included.

10.5 4.3 Categories of older persons in Arada sub-city

Respondents categorized older people residing in Arada sub-city based on two ways: socio-economic conditions and chronological age. However, most of the discussants and informants agreed on socio-economic condition as determinant factor for categorization. However, only an informant tried to categorize the elderly based on

chronological age, accordingly, he grouped them as young-old and old-old. Nonetheless, based on the information obtained from the majority of the respondents, the elderly were grouped as follows:

Destitute older persons: refers to older persons who live on the streets, in churchyards, roadsides or in open spaces who use begging as the main means of survival.

Disabled elderly: includes older people who are impaired naturally or due to a variety of calamities so that they are not in a position to fulfil their basic needs by themselves. They often get support from their immediate families, close relatives, communities, religious institutions or NGOs.

Frail older persons: this category encompasses very old men and women who are unable even to walk or work due to their being old. They are mostly bedridden and with a difficulty to detect even who their family member is. These are older person who cannot perform any work.

Rich older persons: includes the elderly who are relatively in a better socio-economic status due to their life-time accumulated wealth. In relation to this, discussants and informants reported the presence of well to do older people who have cars, villa houses, business enterprises, and other private holdings.

Pensioners: older people who had been either in the civil or military services for which they became beneficiaries of the pension scheme.

10.6 4.4 Traditional support mechanisms of the elderly

The first objective of the study is to assess and analyze the impacts of HIV/AIDS on the traditional support mechanisms of the elderly and thereby to determine the presence of change in roles between traditional caregivers and receivers. To attain this objective, it is highly relevant to explore the existing support networks and then assess the consequences of the HIV/AIDS on these. Accordingly, key informants, FGD participants,

caregivers and cases reported family caregiving, community care and support, supports of religious institutions, alms giving, and the social and economic supports among neighbourhoods and companions during both happiness and grief as major traditional support networks. In this regard, attempt was made first to describe the traditional support networks and then show consequences of HIV/AIDS on these traditional support mechanisms.

Family Caregiving: The extended family structure is the first and most important agent that caters the needs of older persons in Arada sub-city. Reportedly, the family is the major provider of care and support to older persons and plays the most significant role in preventing the elderly from living in poverty. Particularly, informants mentioned that children and grandchildren are the major supporters of parents and grandparents, especially when these family members are too old and weak to care for themselves. They further explained that older people rely first on their family members for the necessary care such as food, clothing, shelter and financial assistances.

As far as family caregiving is concerned, FGD participants were not in a position to reach at a consensus because, while a few of them were arguing for, the rest majorities were against the aforementioned idea. Because, most of the discussants indicate family supports as a typical characteristic of rural households, but not common in Addis Ababa. At the same time, they were too much suspicious on the presence of family support to older persons, particularly in Arada sub- city. Moreover, it was reported that there is a greater tendency among the present urban youth to live independently abandoning the dependents be it the elderly or other family members except their offspring.

However, few of the discussants argued strongly on the availability of older persons in good conditions through the necessary care and support of their children and close relatives. They raised a number of older persons living under the extended family

structure in their respective localities. Though these two parties did not agree on these two extreme cases, they reached at a consensus on the presence of a considerable number abandoned older persons begging on the streets and in churchyards. Therefore, if those older persons are not migrants/displaced from different parts of the country, the likelihood of being abandoned by their respective family members is higher.

Community care and support: The second most important traditional support network of the elderly worth mentioning here is community care and assistance. According to the respondents, community support system through institutions like Iddirs, Mahibers, Meredajas, Debos, etc are social and economic support mechanisms of older persons and the disabled who have no immediate family responsible for caring. These community based organizations have also been the main indigenous support networks of Ethiopians during draught, famine, economic misfortunes and other man made and natural calamities.

Nevertheless, it was also mentioned that the community support system to the elderly is declining due to various reasons. For instance, activities such as constructing houses; repairing the damaged houses; provision of food, clothing and financial assistance; and other related services to the abandoned older persons had been carried out by the respective peasants' and urban dwellers' associations in rural localities and urban centers respectively during the Derg regime. Now, they said, "let alone such organized care and supports, the sporadic assistance has gradually been eroded due to the attention given to PLWHA and AIDS orphans". However, few discussants affirmed the presence of community care and assistance to the destitute elderly

10.6.1 Alms giving and supports of religious institutions: *Giving alms to the destitute elderly is the major traditional support mechanisms for those who have nothing to eat, no way to go, and no alternative means of survival. According to informants from government agencies, the sub-city under study is located at the center of Addis Ababa,*

where a number of Ethiopian Orthodox Churches are setup, which in turn is meant to attract many destitute elderly due to the vast number of pilgrims who come to the churches practice workshop and on their way extend generous hands to destitute older persons by offering alms.

As indicated before, the Arada locality is one of the oldest parts of the Addis Ababa in and around which the key political, cultural, religious and business enterprises are set up. This situation has created concentration of destitute elderly around the churches and the near by streets who engage in begging. The abandoned elderly, persons with disabilities, destitute orphans, street children and the unemployed poor beg for alms in and around worship sites, markets, and other public places. Begging is the major way of survival not only for the destitute elderly but also for street children and mothers. Among the FGD discussants and cases, there were some older persons whose sole means of livelihood has been begging. Therefore, Alms giving has been one major traditional support mechanism of older persons in the area under study.

Sporadic initiatives of NGOs and voluntary associations: The sporadic assistance of NGOs, voluntary associations and private enterprises in the form of food and clothing is the other traditional means of supporting older persons in the sub-city. These organizations provide food to the elderly in major holidays such as New Year, Ethiopian Meskel, Christmas, Epiphany, Easter, etc. It was also reported that the presence of few individuals who provide shelter to the homeless older persons. As reported, the provision of food and clothing for these segments of the population is very sporadic and not continuous.

10.7 4.5 The impacts of HIV/AIDS on the traditional support networks of the elderly

10.8 The first objective of this study is to assess and analyze the impacts of HIV/AIDS on the traditional support mechanisms of the elderly. In this regard, respondents were requested to point out the impacts of the epidemic on the support mechanisms, aggravating factors, and their living conditions to have a better understanding on the issue under discussion. Accordingly, there are different factors that adversely affect the traditional support networks, which in turn aggravate problems of older people. Reportedly, the first and most determinant factor affecting their support mechanisms is HIV/ AIDS followed by poverty, urbanization and modernization, which in turn affect the extended family structure and other informal ways of helping the elderly.

Respondents mentioned that even without HIV/AIDS, most people in Arada sub-city are very poor and when the effect of the epidemic is added, their living situation worsened. Besides, the ever-increasing cost of living, lack of attention and the absence of older people's involvement in credit schemes were also mentioned as aggravating factors of their problems. On the other hand, the information obtained from the respondents show that older adults in Arada sub-city live in a variety of living conditions. Accordingly, there are older persons who live alone in churchyards, on the streets or in plastic sheets along roadsides. There are also a considerable number of older persons who live under the extended family system, where 3-4 generations live under the same roof. The rest live in co-residence to sustain their lives with the meagre income they obtain.

10.8.1 4.5.1 The living conditions of older people in the study area

Living arrangements are influenced by different factors such as, marital status, economic well-being, health status, family size, kinship patterns, the value placed on living independently or with family members, the availability of social and economic support, the housing conditions, etc (Rajulton & Ravanera, 2001). Similarly, older persons included in the study have different living conditions. Accordingly, there are few childless older persons who live alone, others have children but live alone, and still others have children in the countryside but have no any relation with them. Still a considerable number older men and women live under the extended family structure. The rest are in the situation of co residence with persons with out any kinship ties or marriage relationships simply sharing a house to reduce house rents.

However, there are also persons whose living condition is relatively better as compared to others. These include persons who have private homes; those who receive pension benefits; live in rented home but get the necessary support in the form of remittance; and those who engage in petty trades to make money.

Similarly, key informants and caregivers affirmed the presence of different categories of older persons in the study area. Accordingly, there are rich older persons, there are also older persons who are in the 'medium social class' - considering their sources of income. There are also a considerable number of poor old persons who engage in petty trades, under extended family support, and others who get assistance from the government or NGOs in cash or in kind. The rest, perhaps the majority of older persons are the frail, migrated, displaced or isolated older men and women who live on the streets using begging as the main means of survival.

10.8.2 4.5.2 Older persons' perception on HIV/AIDS

When the issue of HIV/AIDS was raised during the focus group discussion, some of the discussants started to cry, their eyes were in tears. The facilitator asked discussants

to know their reasons for crying. One discussant warmly reported the death of her two children from AIDS in effect she is caring her four orphan grandchildren, out of which a child is living with the virus. Reportedly, all these children are double orphans since they lost both parents.

According to their responses, they did not have any idea few years ago, but now, they are well aware of how the virus is transmitted. However, three of the discussants considered AIDS as ‘punishments of God’ for people’s sins as ultimate cause. They further indicated, “Unless we abide by commandments of Moses, the disease will continue devastating mankind. They tried to link this case to that of the period of biblical Noah, during which the earth had been eroded by the hot water”. Nevertheless, others limited the scope of the discussion from spiritual issues and tried to justify on the modes of transmission and prevention mechanisms and its impact. With regard to the impacts, they mentioned; children and the elderly become without caregivers; increasing the number of orphans; diversion of government attention from development to HIV/AIDS prevention and control; loss of productive man-power; abandonment of children due to the death of parents, etc.

Older persons are groups of survivors who are affected if an offspring suffers or dies from HIV/AIDS. For example, when an offspring contracts HIV/AIDS, the older adult mainly women may become the caregiver of the infected child, and later to orphaned grandchildren. Likewise, FGD participants reported the presence of older women providing care and support to PLWHA and AIDS orphaned grand children. In this regard, two participants raised their own cases. The first one is a 65 years old woman rearing four grandchildren whose parents deceased from AIDS. The other is a 67 years old woman providing care to three grandchildren. Consequently, they further replied that they have encountered with financial and psychological burdens.

The problems older persons caring for orphans were found to be more difficult. For instance, a case for the in-depth interview conducted, is 60 years old woman caring four AIDS orphans. One of the orphans is mentally ill and the other is physically disabled. She has no income except the support obtained from St. George Welfare Association and another local NGO. In addition, two children are provided with clothes, stationeries and school fees. The old woman said,

My main problem is food and clothing for the children. They are growing fast and need food and clothes repeatedly. There are also out schoolchildren who need support to attend their schooling. Moreover, the two disabled children are not also mentally stable. She added life is becoming very miserable so that I prefer dying to living in such a miserable life.

There were also FGO participants who are caring their grandchildren born while their daughters had been at secondary school. They said that teenagers start sexual relationships with their male counterparts and if they bear a child, they will become school dropouts and at the same time may leave their homes. To this effect, they may join street life, sex work, or other menial jobs. Likewise, an older man caring for two grand children said:

I had two daughters attending their secondary school education. Three years before, the elder got conceived and bore male baby. It was a greater shock for the family. Not only this, the worst followed, i.e. my younger daughter became seriously sick, and we took her to the health center but it was difficult to cure her. Then she was taken to hospital. The case identified, and it was an attempt of abortion. She also bore a child after couples of months. This situation created serious conflict in the family. At the end, both the siblings joined the life of prostitution. Now, we do not know even where they exist.

He further reported, “We have to struggle looking after these kids. We receive nothing from the government, NGOs, or CBOs. We, grandparents have to work not only for ourselves but for the survival of grandchildren”. Reportedly, the other most pressing challenge facing older persons is the stigma and discrimination associated to the death of their offsprings. If neighbourhoods or members of the community, where older persons live, are aware of the cause of death is related to AIDS, there will be discrimination of

both older persons and orphaned children. In relation to this, an informant disclosed a case; he said:

There was an older woman co-residing with her daughter who had two children. After the death of her daughter to AIDS, however, the owner of the house refused their being there as a result the older women along with her orphaned grand children went out of that house and rented a kebele house appealing the case to the kebele administration.

Another informant replied that if house renters know the death of their clients to AIDS, they would automatically force the survivors, i.e. children and other family members to leave their house. This shows that leave alone providing care and support to PLWHA and orphaned children, there is stigma and discrimination among house renters and other community members including even relatives.

On the other hand, a few of the FGD participants, caregivers and key informants reported the presence of grandparents who had cared for their children and grandchildren at some time in the past, and in many instances who are receiving care and support from their children and grandchildren in return either through remittances if they are a broad, or through the provision of food, clothing, shelter and care living with in the near by communities. For instance, a 70 years old man reported “I am in good living condition through the necessary care and support of my children and grandchildren. I have two children in abroad. I have also others here in Addis Ababa. I have no problem, long live to them!”

However, many discussants took the above case as exceptional because, they further justified, in the past both in rural and urban areas, children and grandchildren used to provide care and support to the old relatives. But now, particularly in urban areas like Addis Ababa, the situation has changed. Both children and grandchildren prefer living independently to live with in their respective families.

They further argued with the justification that due to urbanization and modernization, which favours nuclear family to the extended family system, employed children living with in their respective families are sometimes considered as backwards. Besides, the ever-increasing cost of living here in Addis may not allow children and grandchildren to provide financial supports to the elderly. It is, mostly exacerbated by the multidimensional impacts of HIV/AIDS, which mainly constrained the adult segment of the population.

Key informants were also requested to indicate the impacts of HIV/AIDS on the living arrangements of older people in the study area. Accordingly, based on their experiences they raised a number of ways in which AIDS could affect the living situation of the elderly. Of these, firstly it could reduce the supply of adult children with whom to live, thus it reduces the likelihood of living together and helping each other. Secondly, it increases the number of grandchildren who require care and support, there by increasing the tendency of older persons to co reside with grandchildren. Third, for those who live with grandchildren, the epidemic could change the balance from co residence to the immediate responsible persons to care for grandchildren whose parents died of AIDS, to this effect, older persons are taking the roles providing the necessary care and support to orphaned grandchildren and they are playing the child rearing role within their extended families structure

They further reported that in many communities of Arada sub-cities, older people, particularly older women are responsible to the care and upbringing of their children and grandchildren. Apart from this, while caring for the sick, most of the elderly use all the available resources to fulfil the costs of treatment and medication coupled with the costs of feeding, clothing, transportation and other necessities. Moreover, many older people in Arada sub city are caring for PLWHA, the dying and AIDS orphaned grandchildren.

They are providing financial, social, psychological and other necessary care and supports to those groups.

According to the informants, many people including the elderly are migrating from rural areas to Addis Ababa assuming that the city is more convenient for a living. To this end, for instance, all the cases and most of the FGD participants are those who came from different parts of the country to the city. However, when they reach at the city, they have found different situations from what they expected it to be, in effect as most of them have no where to go, women were forced to work as housemaids. But later, most of them found it difficult to continue in that work since it was under their expectation.

10.9 4.6 Problems of older persons

Older persons are facing a number of problems. By and large, the multidimensional impact of HIV/AIDS, for example, the death of the breadwinner has devastating impact upon families and households. Survivors including older persons suffer from the resultant social, economic, psychological and emotional problems. The elderly themselves, key informants, and caregivers described economic, social and psychological problems as the major challenges facing older people in the study area.

Economic or financial problems: The economic problems emanated from loss of income; inability to work due to physiological problems, lack of caregivers due to the death of adult children and grandchildren from AIDS; absence of social security provisions, etc were problems felt by almost all of the FGD participants, key informants and caregivers. On the other hand, poverty, lack of attention, absence of social security, etc were identified as major causative factors hindering older persons from access to basic survival needs: the shortage food, clothing, shelter, and education and health services.

All older persons who participated in the FGDs and in-depth interviews reported financial constraints as their major problem affecting their families. They explained,

financial constraints in turn leads to other problems including inability to pay house rents, utilities and facilities being used; inability to participate in community-based organizations due to lack of money for membership fees; the burden of caring the sick and rearing AIDS orphans with the inadequate income; inability to cover school fees to the school-age children, etc.

Social problems: Focus group discussion participants, caregivers, and informants of NGOs raised a number of social problems facing the elderly. These include age-related health problems and the inaccessibility of health services; absence of policy support to maintain traditional support mechanisms; inadequate attention given to the elderly with regard to the care and support roles that are bestowed up on them due to HIV/AIDS; the decline in support networks; absence of targeted programs to support older persons caring PLWHA and orphans; disability due to the effects of long-term diseases that occurred during their childhood, and early adulthood; absence of older people involvement in development endeavours; absence of social security provision for older persons (except the pension benefit of civil servants and the military); the prevailing misconception and negative attitudes towards aging; no access to information, education and communication..

Key informants from government organization mentioned absence of targeted programs to support older persons caring PLWHA and AIDS orphans; the decline of family and community support to the elderly; lack of caregivers due to the death of adult children and grandchildren from AIDS; inability of children and grandchildren to support their older relatives due to poverty and unemployment; and limited capacity of the existing services and facilities as major problems facing the elderly.

Psychological problems: According to the responses of FGD participants and caregivers, older persons are facing different psychological problems such as: the grief and trauma at the loss of children and grandchildren before their times, despair, depression,

fear of dying, loneliness, lack of needed services, anxiety of their future survival when the breadwinners die, absence of caregivers and other related problems.

Among others, depression was frequently mentioned as the most common problem among older adults because of the biological changes associated to aging, lifestyle changes, bereavement and physical illness, which in turn cause pain and fear of becoming disabled. Moreover, discrimination among communities and societies compounded these problems.

10.10 4.7 Coping mechanisms of older people

As indicated above, older persons encountered a number of problems. Of these, the multidimensional impact of HIV/AIDS, for example, the death of the breadwinner has devastating impact upon families and households. Survivors including older persons suffer from the resultant social, economic, psychological and emotional problems. Due to these and other serious challenges, older persons and other family members use various coping strategies. Accordingly, respondents reported the following as common coping mechanisms.

10.10.1 Selling assets/properties: *Reportedly, the most common coping mechanism of older persons and other HIV/AIDS affected families is withdrawing saving and selling assets. As mentioned by the respondents, families often make their saving choices in relation to the perception of risk and life expectancy, if a person knows he/she get infected with HIV, and would not have hope for the future, he/she is unlikely to save money. On the other hand, persons would not think about future, in cases when the pain and suffering generated by the illness and death of relatives happen in the family.*

Similarly, discussants replied that withdrawing saving if available and taking on more debt is usually the main options of the family that struggle to pay for medical

treatment or funeral costs. Then as debts mount, assets such as radio, tape recorder, televisions, household furniture, women ornaments like gold necklace and rings are sold and used as source of income. Similarly, there was considerable number of older persons who sold their properties to survive among the FGD participants. The assets sold include houses, household furniture, equipment, utensils, and both men's and women's ornaments.

10.10.2 Asking assistance from relatives, neighbourhoods and communities: *Receiving help in cash and in kind from relatives, neighbours, and community members, associations and organizations is also an important coping strategy for older persons and households facing an adult death. However, it is only possible if the aforementioned parties are relatively better off. Discussants further confirmed the presence of only limited families, associations and organizations that provide supports to the abandoned and destitute elderly in Arada sub-city, as compared to PLWHA and AIDS orphans in the same locality.*

10.10.3 Changing living arrangements: *As one or both parents die to AIDS or other diseases, the capacity of the family to remain intact, particularly when the breadwinner die will be too difficult if not impossible, consequently, relatives and intimate friends of the affected family may take in individual child when the resources are available to do so. It is common that grandparents, particularly grandmothers seem to take over the roles and responsibilities of parenting the orphans. There are also a situation where no able bodied adult available to provide resources and maintain member of the family together. This leads to the dissolution of the family unit in effect it may become child-headed, female-headed, or elderly-headed household.*

10.10.4 Involvement in cottage industries and petty trade: *Some FGD participants mentioned their involvement in cottage industries such as weaving, spinning, knitting, embroidery, metalwork, carpentry, pottery, tannery, horn making, rug and tapestry, and the production of household utensils as means of making money. Others also reported their engagement in petty trades including preparation and selling of food, local drinks, and retail sale of beverages as well as household consumable goods as means of earning money. Apart from these, a number other alternative means were identified*

by FGD participants, caregivers, and cases as coping mechanisms of older persons. These are: begging on the streets, in church yards, in open markets, bus stations, in door-to-door situation across communities; co residing with persons without any relations simply to reduce the cost of house rents; selling private houses, properties and other undertakings; collecting and selling firewood from the nearby forests; preparing and selling local drinks and foods, particularly older women; participating in petty trades and retail sales; renting and/or selling ones own home; engaging in daily labours such as guarding private shops and restaurants, child keeping and related activities, etc. However, it is only those older persons with relatively better physiological condition who carryout these activities because, they justified, and all the aforementioned activities need labour.

In addition, older persons to get relief from psychosocial problems like stress, trauma, depression, frustration, loneliness, anxiety and other related problems also use drinking and discussing with peers to get out of these problems. Furthermore, participating in church programs, development activities and leadership roles in CBOs (e.g. Iddir, Mahiber, Iquib, etc) and other voluntary associations were also suggested as activities of older persons, which have both individual and communal significances.

A few informants from NGOs working with the elderly reported another measure that older persons rarely take it as a remedy to get out of their problems, that is, doing nothing. These discussants mentioned that the first but rare coping mechanisms of older persons from HIV/AIDS affected families is just to sit and see what will happen next. This is because they have already passed through severe financial, psychological and social constraints and traumatic conditions due to the death of a breadwinner or their children from AIDS, it becomes too difficult for them to respond it in any meaningful ways so that responding to the problem becomes beyond their capacity. Here, destructive measures like isolating one self, committing suicide, etc are the harmful last resorts.

10.11 4.8 Policy responses to address problems of the elderly

The African state are urged to use the Madrid International Plan Action (MIPAA) and the AU Policy Framework and Plan of Action on Ageing to guide the development and implementation of national policies for order persons and to include issues of the elderly in HIV/AIDS policies. The AU policy framework and plant action, particularly has a section on the traditional support mechanisms of older people, i.e. the family. This section strongly recommends actions that call for the development of policies, which aim at repositioning the family to respond the problems of older persons.

It calls for the identification and contributions of the traditional support mechanisms, norms and values in providing care and support to the elderly. The AU policy framework further explains on the impacts of HIV/AIDS on older person. Hence, it states the need to ensure polices, programs and projects relating to HIV/AIDS recognize that older people are the main care providers for those who are sick and orphaned grandchildren. To thin end, it recommends the need to harmonize different policies that address diverse groups within the family setting which will be complimentary to each other and can address problems of the whole family rather than a segment of a family (Nhongo, 2004; Kazeze, 2005)

With regard to Ethiopia, it is vital to begin with the constitution. Accordingly, the FDRE constitution Article 451 (5) states that the government provides care and support to the mentally ill, elderly and orphans as the economic condition of the country allows. However, there are no programs or guidelines that indicate how to implement the aforementioned general statement. The other point worth mentioning here is that Ethiopia has ratified the UN resolution made from the derivatives of the Vienna Plan of Action to celebrate, '*International Day of Older Persons*' since 1990 and it was a focal point in the UN program on ageing to mark 1999 International Year Older Persons. Moreover, the

adoption of a national social policy in 1994, and the formulation of a Developmental Social Welfare Policy (DSWP), in 1996 that consists of UN principles of older persons is also the other attempt since the endorsement of the Vienna Plan Action.

Even though the presence of these policy documents is undeniable, most of the key informants, FGD participants, caregivers and cases replied that there have never been considerable practical interventions to address the problems of older persons by the government except paper work. However, few of the respondents reported the existing government efforts by raising typical cases. Of these, the Kaliti elderly institutional care center, financial subsidies to few older persons, being a signatory of different UN conventions were reported as positive attempts.

Nevertheless, it is only recently (in 2005), almost ten years after the endorsement of the policy that Ministry of Labour and Social Affairs attempted to develop the draft National Action Plan which serves as a guide to implement the policy and other directives (Draft National Action Plan for the Elderly, 2005). On the other hand, whatever support is available in the country, in relation to mitigating problems of the elderly, they are not carried out in a coordinated manner. There are few elderly homes run by the government and elderly focused activities here and there by non-governmental organizations and other civil societies (like elderly associations). But, compared to the magnitude and complexity of the problem in the country, the attempts are not satisfactory.

Key informants from NGOs further replied that unless appropriate and context specific programs, strategies and guidelines are designed and implemented, the mere presence of policy document does not make sense as far as the problems of older persons is concerned. Similarly, the majority of FGD participants and cases strongly questioned the presence of government attention to problems of the elderly. They further justified the

existing problem taking examples, i.e. the police officers often force the homeless destitute older persons not to stay on the streets, let alone giving attention to their problems.

As far as mainstreaming issues of older persons in development endeavours is concerned, it is high time to assess the existing policies specific to the elderly. In spite of the fact that Ethiopia is confronted with a wide range of social and economic problems, and poverty is being considered as the underlying cause to these problems, social welfare and social service are below satisfactory. To this effect, poverty reduction has been at the core of the overall development agenda in recent years.

The development and implementation of poverty reduction strategy is expected to bring development actors round a common overriding agenda, i.e. poverty reduction and in effect development. However, though the government often advocates that the poverty reduction strategic paper (PRSP) has developed in a highly participatory, organized and structured manner, a considerable number of respondents opposed this assertion. Instead, they emphasized the negligence and denial of older persons' participation in development endeavours. Few of them stated to the extent that older persons have not yet considered as productive citizens.

The other policy relevant to raise here is the Developmental Social Welfare Policy (DSWP). According to MOLSA (2003), being aware of the negative implications of the absence of social welfare policy, on the basis of the 1994 national social policy, Ethiopia adopted the DSWP in 1996. Although the policy aimed at promoting basic social welfare services to all Ethiopians, it has particular targets among which older persons in need of care and support are the ones whose welfare is assumed to be maintained through community participation has been a strategic area of the policy

Consequently, the policy indicates six major interventions capable of improving the welfare older people. Many of the stated intervention strategies emphasize how to maintain and reinforce community based services. Nevertheless, it fails to indicate the traditional support networks of the elderly and as to how to maintain them.

However, family and community care and support systems have historically been the major social security systems of older persons in Ethiopia. Unfortunately, the ways of strengthening and maintaining these traditional support mechanisms of older persons are not adequately mentioned in the policy document, as it should be. However, it tries to indicate that lack of family support and absence a comprehensive social security system as the underlying course of old-age poverty. But, as the traditional support networks have been the major means of sustaining older persons for long period in the Ethiopian context, elderly related development programs, policies and strategies need to incorporate the indigenous coping mechanisms so as to maintain these for generations.

Nevertheless, the need for policy intervention to address problems of the elderly is discussed in a number of documents such as: the Madrid international Plan of Action on Ageing; the African Union Policy Framework and Plan Action on Ageing; the Millennium Declaration; the Declaration of the World Summit for Social Development; New Partnership for African Development; the AU Plan of Action on Poverty Alleviation and Employment Promotion; and other international, regional and national development plans. However, issue of the elderly was not included in the first poverty reduction strategy paper of Ethiopia. Later on, a pilot project has initiated and is still in progress to include older people in the poverty reduction strategy paper (HelpAge, 2003).

10.12 4.9 The existing practices to address problems of older people

Objective four of the study requires assessing responses of the government, NGOs, CBOs, the family and the community in addressing problems of older persons.

Accordingly, there are only two NGOs that run elderly-targeted services: Every ONE and St. George Church Welfare Association. The former is an indigenous non- governmental organization committed to address problems of the elderly who have lost their supporters and carrying multiple burdens at a time of ever decreasing resources. The organization believes that older persons have become the primary care givers for their children and grand children who are infected and affected by the HIV/AIDS epidemic.

In an effort to overcome the problems of older persons, Every ONE is assisting 60 elderly in 3 different sites. Its program is carried out on small-scale capacity building and care giving. The elderly are engaged in light skill trainings like cotton spinning and making traditional utensils. There is also a traditional coffee ceremony held weekly during which older persons get together and are encouraged to discuss on different issues related to their life courses. Moreover, older persons share their wisdom and experiences with Every ONE's supported children through monthly educational tale activities. To this effect, these older persons are paid birr 50 per month for their contributions.

Similarly, St. George Welfare Association is a religious association established in 1962 and is aimed at providing basic necessities to the abandoned destitute older persons. At present, the association runs its programs in Addis Ababa and Debre Libanos, at Agat Medihanealem center. It has total 124 beneficiaries who are provided with basic needs, food, clothing and medical care. It also renders elderly home maintenance services, home-based care and covers funeral costs when the beneficiaries are passed away.

Having these in mind, discussants and informants were requested to comment on the available services to the elderly. Consequently, informants from the government organization reported that there is no significant service being rendered to the elderly, particularly those who reside in the sub-city. They further explained that though the number of abandoned and destitute elderly residing in the sub-city is much higher as

compared to those in other parts of Addis Ababa, there has never been even significant attempt, let alone actual practices observed as far as the welfare of older persons is concerned. Reportedly, apart from fundraising with the name of older persons, NGOs, CBOs, voluntary associations and even older persons and pensioners' associations, could not address problems of the elderly. Nevertheless, the most important but often not recognized and unreported traditional support mechanisms of older persons, as they mentioned, is the most survival means of the elderly is alms giving and the care and support provided by the extended family system

When we look at the responses of the FGD participants regarding the existing services specific to the elderly, they confirmed the existing supports from NGOs and religious institutions, particularly the Ethiopian Orthodox Church. But, they said that the services being provided are inadequate as compared to the number of abandoned older persons in the sub-city. However, they strongly criticized the government's neglect and absence of attention to the elderly. One discussant said:

we are citizens that protect our homeland from invaders; we are meant for the existing generation; we have life long wisdom and experiences, which may benefit the youth and the society at large; unfortunately, being old, we are the most forgotten, neglected and abandoned segment of the population. Our basic and constitutional rights are violated."

10.13

10.14 4.10 Case report

To have a clear understanding on the consequences of HIV/AIDS on the traditional support mechanisms of the elderly, in-depth interviews were conducted with four older persons who are in different living conditions including the one under the extended family support, a beggar, head of a household caring AIDS orphaned grandchildren, and an older man living alone. The information obtained from each case is presented

separately but discussion was made along with the information obtained from other respondents.

Case-I

I am living along with my child. The household comprises six members including my child, his wife, three children, and me. We get electric light, pipe water and toilet services from the neighbours paying some money. I had three children, but two had passed. As a result, the responsibility of caring me is solely levied on this child. I hate being a dependent, however, now in this situation. My child has job, but his wife does not have. As a result, there is not enough source of money for our survival. The number of family member is increasing so does the cost of living. I do not get any assistance from the government, NGOs, CBOs, or private organization. But, I get health services from the government health center free of charge but some times, we buy medicines from private pharmacies when they are not available in the government ones.

HIV/AIDS has diverse impacts on the living condition of older adults including me. For example, a number of adults passed away leaving their children; older persons are becoming carers of orphans and other family members; there are older persons doing tiresome and odd jobs at the time of getting the necessary care and support from their children; the elderly are also the primary caregivers of their infected children and grandchildren; the frail and bed-ridden elderly are dying from lack of food and supports

Case-II

I am living in a plastic sheet begging on the streets and in churchyards. I do not have any relative here in Addis Ababa. I have stayed in this condition for five years. I do not get any support from government, NGOs, CBOs, religious institutions or relatives. I live with my wife but no children.

I have encountered with many problems leading this miserable life here in Addis Ababa. Of these, the problem of shelter is the most urgent followed by my health problem. I suffer from asthma, arthritis, hypertension, and age related physical weaknesses. The other problems are lack of adequate food, clothing, and medication followed by financial constraints to have access to the necessary utilities and facilities. I am also worrying about the existing disease, which I do not want to call it in name. My daughter is working in a private hotel. She is high school graduate but unemployed in effect she joined that life.

Case- III

I lost two children from AIDS. Now I am caring four grandchildren. One is a secondary school completer, the rest are still attending their education. Both the deceased children had jobs; unfortunately, they were not entitled to the pension scheme because their years of experience are below 10 years. We even did not get provident fund. I am head of the family, which comprises five members including me. The living situation of the family is worsening from time to time due to the decline in income.

I am old enough to perform activities as I did before, but I am still doing some activities such as baking Injera for sale; preparing and selling local drinks; collecting and selling firewood; and other jobs to make money. I am also getting assistances from St. George Welfare Association. I get 12 kg Teff powder and ½ liter food oil per month; clothing (complete clothes, blanket, toga, a pair of shoes, etc., annually from the organization. In addition, two grandchildren who are attending their education get supports like school fees, stationeries and school uniforms from one non-governmental organization. However, all the supports we are getting are inadequate. We get health services from the church clinic. We live in an ordinary house donated from a private individual. Lack of adequate food, clothing and shelter; health problems (hearing, visual, and other physiological problems); absence of family support; absence of government attention, lack of support from humanitarian organizations are just to mention a few of my problems.

Case-IV

I am living alone in a house within St. George Church compound. I have no means of income except the support I receive from St. George Welfare Association. I get food items, clothing and health services from this association.

Now, I am old enough to carry out activities as I did so far in effect, my survival is solely dependent on the supports of the association.

My major problems are lack of adequate food, clothing and shelter; age-related health problems (hearing, visual, and other physiological problems); absence of family support; lack of support from humanitarian organizations is just to mention a few. However, there are many homeless older persons on the streets, in churchyards, in open spaces, under the tree, in plastic sheets who cannot move, hear, see, or communicate due to various man made and natural problems. Hence, I am relatively better.

11

12.5. DISCUSSION OF THE MAJOR FINDINGS

In this section, discussion was made on the major findings that are relevant to attain the stated research objectives.

12.3 5.1 The impact HIV/AIDS on the traditional support networks of older persons

HIV/AIDS has large social, economic, psychological, demographic and related impacts on both individuals, families, communities and societies, thus leading to the death of adults, children and other segment of the population. It is also believed that due to the AIDS epidemic, poor countries like Ethiopia will continue to face an increasing number of AIDS induced deaths and the resultant elderly and children without caregivers. Consequently, it weakens the coping mechanisms of communities, deteriorates the traditional support networks and aggravates poverty (UNAIDS, 2000).

Its impacts on family caregiving: Available literatures indicate that the family provides important resources that sustain the well-being of all its members who are at different age groups. Providing and receiving supports among family members is a lifetime activity, which has sustained historical times in Ethiopia. However, the family care and support system has gradually changed due to the socio-economic and cultural changes brought about by urbanization, industrialization, and globalization (Kazeze, 2005).

There have been different discourses on the demographic changes infertility and morality and their impacts on the family structure (Rajulton and Ravanera, 2001). These same writers indicate that in spite of the dramatic changes in the family of today and of the gloomy forecasts of the future by some studies, we see the support systems still working in different societies as it was in the past. In supports this, the “attachment theory” argues that there is and will always be a strong sense of responsibility and commitment that adult children have towards their aging parents and vice versa. On the other hand, the “support bank theory”, the well-known insurance hypothesis states that parents invest in their children, which investment is available to be withdrawn in the later life, i.e. during their old age (Rajulton and Ravanera, 2001).

Similarly, the findings indicate that the extended family structure that has historically been the main caregivers of older persons is being under a great problem due to the prevalence of HIV/AIDS and related deaths, i.e. adult children who are expected to care and support are at high risk of the epidemic. Adults’ death to AIDS leads to family break down that in turn endangers the elderly and children.

According to May (2003), in developed countries fast aging populating receive support in the form of pensions, social security schemes, and health care systems. In Ethiopia, however, the family has been the primary and often the only basis of support, but it is under serious challenge. As findings of the study confirmed, older persons are the major caregivers to the sick and AIDS induced orphans.

It is also found from literatures that most Ethiopian parents have large families partly to ensure supports by their adult children in their old age, but the existing situation is not in away what it should be, because the family which has been the primary care giver is being eroded due to urbanization, modernization, poverty coupled with the devastating negative consequences of HIV/AIDS.

HIV/AIDS is affecting family care giving in a number of ways. First, it deteriorates family income, when a member contracts the virus thus increases health costs and alters the pattern of expenditure. As time goes, the infected adult will be unable to work hence income loss happens. The illness and death of the breadwinner follow, which in turn results in change in the family structure. Consequently, older persons will shoulder the burden of caregiving to the sick and orphaned grandchildren at the time they need the necessary care and support from their adult children.

In support of this, informants confirmed the presence of a number of older persons who are providing care and support to their sick children as well as the abandoned orphaned grandchildren in the sub-city. There are also indications that a higher level of stress, fear and trauma caused by the epidemic may be compromising the caring relationships between close relatives and family members. The findings also indicate the presence of compromising of the caring relation between and within families caused by stress associated with the disease. To this effect, a 60-year-old woman caring for four AIDS orphaned grandchildren said “the grandchildren are crying and I am crying, we don’t get any support except St. George Church Welfare Association; no one cares for anyone else”.

Another older man pointed out “I live alone in St. George Church compound, but if there was another person with me, I would not live there. So, my usual praise goes to God who doesn’t allow me to have a child because others with children do not get the necessary care and supports expected of them as children”.

On the other hand, the AIDS epidemic has an extensive impact on older people through their involvement in the living and care-taking arrangements of their infected adult children. The majority of the respondents confirmed that older persons, usually mothers, are the main caregivers to PLWHA and orphaned grandchildren in the sub-city.

In developing countries like Ethiopia, institutional and others forms of formal care and financial support for persons with AIDS are quite limited as compared to the U.S or other developed nations. Thus, AIDS victims are heavily dependent on the informal system, especially family care and support. In addition, exchange of services and material assistances between parents and children as well as grand children, including co residence with adult children constitute the most dominant traditional support system for older persons (MOLSA, 2003). Within this system, under normal conditions, there is a kind of give and take situation, i.e. older parents used to provide the necessary care and support to children who in turn are expected to provide care to them in their old age. To this end, children have historically be considered as assets in the Ethiopian families. But, now, the death of adults to the AIDS epidemic is greatly affecting this traditional support network. It is worth mentioning here to raise the case of one discussant, i.e. a 65 years old man said, *“I had five children of which two were died. The rest are living out of Addis Ababa. However, I get nothing from them. If this is the significance of the child, why had I suffered rearing them? I would prefer to be childless so long as I get nothing in return”*. The majority of the discussants also confirmed the presence of a considerable number of children and grand children who do not support their older relatives.

Moreover, the information obtained from key informants affirmed the presence of older persons neglect by their respective able bodied family members for various reasons such as the ever increasing cost of living, inadequate income, underemployment, unemployment, miss conceptions of modernization- preference to live independently without carting the elderly, poverty and related factors. This implies the negative effects of social and economic situations on the traditional family care and support given to the elderly. To this effect, socio-economic factors and HIV/AIDS are changing the roles of older persons from being looked after to caring others, especially grandchildren after

their parents have died to AIDS. Consequently, older persons are losing the necessary care and support expected of their respective families and thus they have become the most abandoned than ever before.

Consequences of AIDS on community care and support: Although it is difficult to figure out the number of older persons who have suffered from AIDS, a greater number of elderly are being affected by the epidemic indirectly through their relationships with younger adults living with the virus. The epidemic can affect non-infected older persons through its impacts on families, communities and the society.

To this end, the findings indicate the presence of adverse effects of HIV/AIDS on community caregiving. The major impact is that as HIV/AIDS contracts the productive labour force, it results in reduction in productivity, thus leading decreased income among community members, which in turn deteriorates the participation of individuals in community based organizations such as Inddir, Mahiber, Iquib, senbete, etc due to their inability to pay membership fees, as their income get reduced.

As the number of CBOs participants' reduces, the likelihood of limiting their areas of focuses will be higher, to which their involvement will be merely on funeral services. Consequently, the informal support systems of the destitute elderly, i.e. communities care and support through these institutions have either reduced or totally ceased. This implies that the indigenous community insurance system for older persons, which has existed for historical times is being threatened.

On the other hand, as the impacts HIV/AIDS at the family level increases the numbers of orphans, this will in turn create burden on the extended families and communities. For instance, the UNAIDS (2000) report estimates that there were about 990, 000 AIDS orphans in Ethiopia at the end of 2001; whereas the MOH projected the number of orphans to escalate to 2.5 million by 2004. In this regard, the findings indicate

that due to the presence of huge number orphans and vulnerable children in Addis Ababa that caters the attention of the government, NGOs, communities and religious institutions, the attention given to older persons is below satisfactory. Currently, even community based organizations and religious institutions are providing care and supports in different ways to PLWHA and orphans, which was not the case for long period.

This attempt in turn has significant impacts on the care and support to be provided for the needy older persons. Furthermore, the existing greater emphasis given to the HIV/AIDS prevention and control efforts has another impact on the welfare of older persons. To this end, the respondents were claiming their being neglected due to the emphasis given to HIV/AIDS and the adult segment of the population.

It was also confirmed by most of the respondents that traditionally, neighbours, Iddirs, Mahibers and other community based voluntary associations have contributed to support older persons by providing basic necessities, materials and financial assistances, repairing damaged houses, cleaning houses, fulfilling materials for funeral services, etc. However, the trend has gradually changed due to the emergence of other vulnerable groups such as PLWHA, AIDS orphans, street children, and other persons under difficult circumstances. To put in a nutshell, in spite of the existing change in family and community caregiving, we see a considerable number of family and community support systems to the elderly still working in the sub-city though not as it was.

Impacts on care and supports of religious institutions: Like community caregiving, churches, mosques and monasteries have historically been the main means of sustenance for the abandoned and destitute older persons. The majority of the respondents pointed out that religious institutions have great but often unreported contributions in maintaining the welfare of persons under difficult circumstances through

mobilizing followers and community members to support the helpless elderly, persons with disabilities and the destitute children and older persons with what they have.

It was also found out from the assessment that persons with disabilities, the elderly, destitute orphans and the unemployed poor beg for alms in and around worship sites, market places, and other public places. They beg by taking the advantage of the religious doctrine, which considers that showing pity for the destitute by giving alms. In addition, this situation has been acknowledged and taken as normal by the religious institutions themselves and communities. Though it is difficult to indicate the extent, respondents reported the presence of reduction in alms giving to the destitute due to various reasons. Among others, poverty, increasing cost of living and multidimensional impact HIV/AIDS were mentioned as potential reasons for the case to exist.

12.4 5.2 Problems of older people

Older persons are facing various problems related to social, economic, psychological, emotional, and related challenges due to a variety of reasons associated to changes in the traditional support mechanisms, which include decline in family caregiving, community care and support, the supports of religious institutions, and mutual care and support among neighbourhoods, companions and close relatives.

As indicated before, the family has been the primary caregivers of older persons in the Ethiopian tradition. However, although there is still mutual love and support between the family and the elderly, social and economic problems are adversely affecting the family to function its responsibilities of caregiving, as it should be. In support of this, Assefa (cited in MOLSA and HelpAge, 2000) noted that in traditional societies, including Ethiopia, the family support system has stayed long. Now, he further argues, the trend is changing because the family setting is being nucleated and the traditionally respected role of the elderly is declining.

Data collected from the respondents also indicate that family care giving is declining due to a variety of reasons, out which the impacts of HIV/AIDS is the first and most determinant factor that aggravates the challenges of older persons. Poverty and unemployment were also suggested as causative factors for the declining of family care giving. Older persons included in the study reported the presence of neglect among their children and grandchildren due to the prevailing myths and misconception of the youth towards supporting their older relatives. The youth are developing negative attitudes to the extent that extended family structure is a sign of backwardness.

Apart from these, urbanization and industrialization coupled with the ever-increasing cost of living is also affecting family caregiving to the elderly. In support of this, Henslin (1991) noted that developing countries are witnessing higher rate of urbanizations that leads to people's preference of nuclear family to the extended family structure. To this end, old people become isolated, feel lonely and they despair.

Similarly, interview reposes show that communities are developing negative attitudes regarding older persons' contributions to the society, and their valuable contributions are being under estimated. This denial and neglect of their lifetime contributions leads to social devaluation, which in turn makes it difficult for the aged to have valued self-image. It was also frequently mentioned that the existing social and economic situations favour the young, which may create intergenerational conflicts because heavy reliance on children and the youth will produce negative impacts on older persons' emotional well-being.

All the aforementioned factors have adverse effects on the social, psychological and emotional well-being of the elderly. Once, they were heads of the family, leaders of the community, owners of wealth, arbitrators of conflicts, teachers of customary law, had the capacity to generate income, supporters of persons' under difficult circumstances, etc.

Getting old is often accompanied by loss of independence, deterioration in physical well-being, and a sense of being out of life, long-painful illness, and decrease in general physical and psychological well-being, etc (Rehabilitation Agency, 1996) .This shows that the neglect and abuse associated to the prevailing misconception of communities, particularly the younger generation leads to not only the decline in family and community caregiving, but the psycho social problems of the elderly.

Lack of basic needs was reported as the most urgent need of older persons followed by age-related health problems; various psychosocial problems associated to the death of their children and grandchildren before their times; inaccessibility of the health services; inability to afford house rents, utilities and facilities; absence of social security provisions except the pension scheme; lack of attention from the government, NGOs, CBOs, and other stakeholders; and absence of older persons-targeted programs to address the problems of older people were reported as major problems of the elderly in the area understudy.

These problems are consequences of multiple causalities related to poverty, HIV/AIDS, the prevailing negative attitudes and misconceptions towards aging, inadequate policy support, lack of attention, etc, which need the courage and commitments of all individuals, families, communities, and the society at large to maintain the traditional support mechanisms of the elderly which have historically been the major insurance systems of older adults.

In this regard, an informant from government organization mentioned, “working for older people is doing for the self, because children of today will be elderly of tomorrow. Getting old is a natural biological process where every one will arrive at so long as he/she is lucky enough”. This quotation clearly indicates that preparing favourable environment

for the elderly is just working for ones later life because the relevant care and support network established today has determinant impacts for ones future lives.

12.5 5.3 Policy responses to problems of older people

An overall national development policies, goals and priority areas affect the development of any program or project. Thus, the formulation and implementation of an aging policy is instrumental either to maintain or promote the existing traditional support mechanisms, which are highly relevant to secure the welfare of elderly, promote the roles of older people in development endeavours, increase solidarity between generations as well as to prevent social exclusion of older persons (Nusberg, 1993). All these necessitates policy supports, however, responses of the informants, discussants, and care givers claimed lack of government attention to problems of the elderly as a causative factor to multidimensional problems of older persons.

On the other hand, the presence of elderly issues in the national constitution, social policy and developmental social welfare policy as well as being a signatory to the international and regional instruments of aging may indicate the government's recognition to problems of this segment of the population. However, either being a signatory or the mere presence of policy document does not make sense when viewed from the magnitude of problems of older people.

Moreover, both the international and regional instruments of aging recommend states to mainstream issues of the elderly in all development endeavours and thereby take actions accordingly. When we look at the case of Ethiopia, let alone mainstreaming issues of older persons in sectoral development endeavours, there is no program or guideline prepared to implement even what has been said in the existing developmental social welfare policy. However, in this regard the informant from a government agency

reported that the Ministry of Labour and Social Affairs has finished its preparation to formulate national plan of action on aging, but it is not yet endorsed.

Different authorities suggest various factors to the inadequate policy responses to problems of the elderly. Government authorities pointed out financial and human resource constraints as main reasons. However, older persons, respondents from NGOs and associations frequently mentioned lack of government attention as a determinant causative factor for the existing socio-economic problems of older persons. The rest forwarded poverty as the main obstacle for the unmet needs of the elderly.

An aging population is a resource, but it will become burden to societies unless development endeavours do not include issues of the elderly. This fits to the situation of Ethiopia because let alone mainstreaming the issue in development programs, there is no considerable efforts as to how maintain the traditional support networks of older people.

136. CONCLUSIONS AND RECOMMENDATIONS

This section consists of conclusions drawn based on the findings and recommendations, which are taught relevant social work practices to minimize problems of older people.

13.3 6.1 CONCLUSIONS

The main traditional support mechanisms of the elderly are family caregiving; community care and support through its institutions (Iddir, Mahiber, Meredaja, etc); alms

giving; supports of religious institutions; social and economic support networks among closer relatives, neighbourhoods, and companions; and sporadic initiatives by NGOs, associations, and private enterprises.

The international and regional instruments of the elderly recommend that national policies need to incorporate issues of aging and appropriate support mechanisms of older people in to the mainstream of social and economic plans. Policies for employment, education, health, transport and social welfare should take in to account the needs of older people. However, as available literature and findings of this study confirmed, policy responses to the problem of the elderly here in Addis Ababa is below satisfactory.

Older persons included in the study are residing in different living arrangements: some live alone; the majority live in rented houses; others under the extended family structure and the rest, considerable number of the elderly live in plastic sheets, on the streets and in churchyards. This shows that older persons in the study area are in poor living conditions.

The findings indicate that HIV/AIDS is changing the roles of traditional care provider and recipients through affecting the family, community, and religious institutions care and support systems, which have been sustained for historical times. Nevertheless, it is hardly possible to talk about the presence of reversal of roles between traditional caregivers and receivers because there are still these support systems though not as they should be as viewed from the magnitude of problems of older adults in the study area

The reviewed literature and interview responses reveal that a part from the adverse impact of HIV/AIDS, urbanization and modernization has affected family care giving to the elderly, which has historically been the main traditional support network, due to people's preference of nuclear family to extended family structure.

A detailed analysis of the collected data show that community caregiving to older people through its institutions (Iddir, Mahiber, Meredaja ,etc) is declining due to the attention given to development activities, PLWHA, AIDS orphans and other needy segments of the population.

Religious institutions have also been the main sustenance of the destitute elderly in Arada locality. Nevertheless, the existing situation shows that these organizations are also changing their attention to development activities, caring bed-ridden PLWHA as well as AIDS orphans. Thus, if these changes in areas focuses had not been at the expense of the supports to be provided for the destitute elderly, the attention given to the aforementioned issues is significant.

In the Arada sub-city, there are only two NGOs, which provide food, clothing, medication, money for accommodation, and home-based care services to the elderly. The total number of older persons getting these services is only 150. The initiative of these organizations is timely and relevant for the survival of these elderly. However, when the service delivery is viewed against the number of needy older people residing in that locality, it is considerably below satisfactory

The findings of the study indicate that inadequate food, clothing and shelter; inaccessibility to education and health services; lack of caregivers; age-related health problems; absence of social welfare provision; psychological stress and trauma associated to death of their children and grandchildren; lack of elderly-targeted projects, etc as major problems facing older people.

Poverty, the death of younger generation from AIDSS, lack of social security, lack of recognition, the substitution of extended family structure by nuclear family, and the prevailing myths and negative attitudes of the youth to the aged, were reported as aggravating factors of older people.

The UN principles of older persons: independence, participation, care, self-fulfilment and dignity are instruments to mainstream issues of older persons in various development programs. Even though Ethiopia is a signatory to the UN conventions to aging, the existing efforts are below satisfactory even to fulfil the first principle (participation), which calls older persons to have access to food, shelter, clothing, water, health care, education, training, income generation opportunities and living in safe environments.

An aging population is a resource, but it will become burden to societies unless development endeavours do not include issues of the elderly. This fits to the situation of Ethiopia because let alone mainstreaming the issue in development policies and programs, there is no considerable efforts to implement elderly issues indicated in the national Developmental Social Welfare Policy.

As available literatures and interview responses confirmed that in Ethiopia, the socio-economic realities and family structures are changing. Conversely, the roles of older persons in the family, communities and societies are also changing. Largely, the traditional support networks of the elderly, which have historically been the main informal insurance system of later life, are declining due to poverty, urbanization and modernization, HIV/AIDS, and its induced orphan-hood.

13.4 6.2 RECOMMENDATIONS

Social work has the flexibility to intervene in several areas that can significantly improve the existing resources, which can contribute to the process of successful ageing. Whether this flexibility resides in counselling; educating and disseminating information; connecting the elderly to community programs; accessing the necessary services; enabling older persons participate in sectoral programs; and other relevant interventions, which would address problems of older adults, relevant social work practice is by far the

most significant and timely. Thus, social worker could play a number of roles in this regard.

Older people are expected to have life-long experiences on how to overcome several problems facing them and other segments of the population. Thus, it needs a social work practice to develop and support older persons-focused peer counselling and experience sharing sessions on the coping mechanisms of the multidimensional problems facing them. Thus, appropriate social work practice, which would enable the elderly to solve their own problems by themselves through sharing their life-long indigenous knowledge, skills and experiences.

Many older people in Arada sub-city play important roles in their households and communities doing house works, minding properties, socializing and caring for children, arbitrating social and economic conflicts, teaching customary laws and oral traditions, transmitting lifetime accumulated knowledge, skills and experiences to the youth or acting as educators and counsellors. These contributions need to be recognized, respected and rewarded in terms of economic returns. Hence, a strength-based social work intervention on the traditional support networks is highly relevant to maintain these valuable roles of the elderly and address their major problems accordingly.

To maintain the welfare older people and to promote the integration and collaboration of efforts among the government, NGOs, CBOs, associations, religious institutions, and other stakeholders, designing relevant elderly welfare programs and plan of actions that would clearly show the duties and responsibilities of all the concerned bodies is timely to address problems of the elderly. In this regard, the government should take the initiative to save the lives of thousands of destitute older persons begging on the streets. .

As problems of the elderly are multi-faceted in nature and magnitude, so are the solutions that require social work interventions at micro, mezzo and macro levels. Thus, wherever the level of intervention is and whatever the relevant practice may be, social workers could play pivotal roles in creating enabling environment to start up family and community-based interventions, which would strengthen and maintain the valuable traditional support networks of the elderly.

The consequences of HIV/AIDS on older people are multifaceted that need different interventions. Hence, the government, NGOs, CBOs, religious institutions, voluntary associations, and other stakeholders should recognize that older people are caring for the increasing numbers PLWHA and orphans at a time they should be cared. Therefore, all these stakeholders need to incorporate issues of older people into their HIV/AIDS prevention and control endeavours because failure to invest in older people will adversely affect not only the elderly but also others they care for.

The African Union Policy Framework and Plan of Action on Aging recommends the need for development of policies that aim to reposition the family setting which respond to problems of the elderly. In this regard, decline in family caregiving is one of the findings of the study. Thus, it is highly relevant to conduct further research that explore the existing traditional support mechanisms and design strategies, which maintain these valuable support networks. .

Older people are becoming the primary caregivers of PLWHA, and orphaned grandchildren. Hence, it is necessary to initiate and strengthen community-based care and support mechanisms of older people who are caring HIV/AIDS infected and affected families.

There is also a need of much more careful research documenting the impacts of the HIV/AIDS epidemic on older people in Ethiopia, which would enable better understand the problem and to respond accordingly.

Considering the caring roles and responsibilities bestowed upon older people due to the HIV/AIDS, older people should be targeted in the HIV/AIDS awareness campaigns in effect they can reduce their own risk of infection, will be able to provide better care for PL WHA , and their psychological stress and trauma associated to the decease may get reduced.

It is also necessary to organize and implement awareness raising programs through the mass media to enable the society understand and maintain the traditional support mechanisms of the elderly, which have sustained for historical times.

Population aging is a resource, not a burden. Therefore, social workers should create enabling environment to start up community-based support to the needy older persons and work towards strengthening the existing traditional support mechanisms of the elderly.

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23 APPENDICES

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25 Appendix-I

**Addis Ababa University
Graduate School of Social Work**

HIV/AIDS and Its Impacts on the Traditional Support Networks of Elderly: The Case of Arada Sub-City, in Addis Ababa

(Interview Guides, Observation Checklists and Discussion Guides)

Introduction

The questions are prepared to collect information and write MSW thesis on the impacts of HIV/AIDS on the traditional support networks of the elderly, with specific emphasis to the case of Arada sub-city in Addis Ababa. The purpose of the study is to assess, investigate and analyze the impacts of HIV/AIDS on the traditional support mechanisms of older persons. Moreover, it is intended to assess the existing policy supports and available practices to address problems of older persons in Addis Ababa and forward appropriate and feasible social work interventions, which would minimize HIV/AIDS, induced problems of older persons in the study area.

In order to attain the stated objectives, collecting relevant and genuine data is highly significant. In this regard, questionnaires, interview guides, discussion guides and observation checklists are prepared to the respective respondents. Accordingly, this paper consists of six sections. These are:

- Section one: Interview guides prepared for older-persons (Individual cases)
- Section two: Questions and discussion guides prepared for key informants
- Section three: Discussion guides for FGD participants.
- Section four: Questions to be posed to care givers/ providers
- Section five: Observation checklists
- Section six: Documents to be analysed

Section One: Interview Guide Prepared for Older Persons
(Individual Cases)

Direction: For each of the following questions, you are requested to provide short, precise and true statements. It is your right to refuse or discontinue from participating in this study. Finally, I would like to promise you that all your responses would be kept confidential and used only for the purpose of this study.

I Bio-data

Code number of the interviewee.....Sex.....Age.....Level of education.....
Marital status.....Physiological condition.....Occupation.....

II. Family situation:

- 1 Family structure: Extended... Nuclear... Your status in the family.....
2. Age structure, size and sex composition of the family

Age structure	Male	Female	Total	No of dependents	No of independents
Below 15 years					
15--40 years					
41-59 years				z	
60 years & over					

3. Would you indicate the dependent and independent members of your family?
4. Who is the head of your family?
5. Has there been a change in your family size, age structure and sex composition in the last 5/10 years? If yes, please explain it.
6. Who is the breadwinner of the family?
7. Is there any one who provide care and support for you? If yes, who is your care giver?
8. Is there any one who receives care from you? If yes, for whom do you care for?
9. Was there a deceased person in your family? If yes, please respond to the following questions: (9.1) Who was deceased? (9.2) When did the person die?
 (9.3) For how long had the deceased person been sick?
 (9.4) Do you know the causes of his/her death? If yes, please explain it.
 (9.5) What do you think you have missed a lot due to the death of that family member?
 (9.6) What problems have you and other family members encountered due to his/ her death?
 (9.5) What coping mechanisms have been utilized to ameliorate the problems?

III. Household Income and Expenditure

1. What are the sources of income for your family?
2. Do you get assistance in cash, in kind, or in other ways other than your income? If yes, please respond to the following questions:
 - From whom do you get assistance/support? GOs, NGOs, CBOs, religious institutions, the local community or others?
 - What kind of assistance have you received so far?
 - What are the major care and support services you are receiving?
 - May you tell me as to how you are managing to survive with the existing situations?
3. How much did you spend for education?
4. Are you a member of any community based organization? If yes, to which you belong? (1) Iddir (2) Mahiber (3) Iquib (3) Debbo (4) Meredaja (5) If any,
5. How much do you give to these organizations? And to what extent does it affect your income/ expenditure?
6. Why do you need to participate in these organizations? Please explain the pros and cons of your membership?
7. Who contributes a lot to the expenditure or income of your household? Why?
8. To what extent does the death of a family member in your household affect the income/ expenditure?
9. Has there been a change in income/ expenditure of your family in the last five years? If yes, to what extent has it increased/ decreased and why?
10. If you have any additional comments on the issues discussed, you may add.

IV. Availability and adequacy of services and utilities

1. Where do you get the health services? (1) Public health institutions (2) Private health institutions (3) From traditional healers (4) Holy water (5) If any.....
2. Have you satisfied with the health services you are getting? If yes, to what extent? If not why?
3. Of the following utilities indicate what you have and not.
 - (1) Electric power supply (3) Telephone (5) Bathrooms
 - (2) Clean water (5) Toilet (6) If any, please mention it.
4. What do you comment on the adequacy and quality of these services and utilities?
5. How do you compare and contrast the facilities and services that older persons get with other members of the community?
6. Which group of older persons are highly at risk due to absence/ shortage of basic needs, services, facilities and utilities
7. Has the prevalence of HIV/AIDS any impacts in getting the above mentioned services and utilities? If yes, how and to what extent has it affected.
8. What should be the roles of the following agents to address the problems of older persons in your community?
 - (1) the government (5) the business community
 - (2). NGOs (6) the family unit
 - (3) CBOs (7) Older persons themselves
 - (4) Religious institutions (8) Associations

V. Issues related to the impacts of HIV/AIDS on the traditional support

networks of older persons

- 1 Can you tell me what you know about HIV/AIDS?
- 2 Who are the most vulnerable segments of the population to HIV/AIDS? Why?
3. What are the major survival problems that older persons are facing in the era of AIDS?
4. Is there any problem that you have encountered due to the pandemic? If yes, please indicate how & to what extent does it affect you and your family?
5. What problems have you encountered so far in providing care and support for HIV/AIDS infected/ affected persons in your family? What do you think you have missed alot due to the impacts of HIV/AIDS in your family?
6. What are the impacts of HIV/AIDS on the traditional support mechanisms of older persons here at Addis Ababa?
 - Family care giving under the extended family structures
 - Care and support given by religious institutions
 - On community care and support through Iddirs, Mahiobers. Iquibs, etc.
 - Government care and support systems
 - Alms giving, and others if any.
7. In your opinion, what are the negative consequences of HIV/AIDS on older persons?
8. Has HIV/AIDS resulted in a change in the roles of older persons? If yes, how and to what extent?
9. What is the attitude and perceptions of the community towards AIDS affected and infected individuals and families?
10. What is the attitude and perceptions of the community towards older persons?
11. Has HIV/AIDS resulted in a change in the roles of older-persons? If yes, how and to what extent?
12. What coping mechanisms have you used sofar to mitigate your problems?
13. What is the attitude and perceptions of families and communities towards care & support giving to teh needy older-persons?
- 14 How do you assess the attentions of the government, NGOs, CBOs, religious institutions and other stakeholders given to older people as compaired to other Segment of the population?
15. If you have any comments regarding the welfare of elderly ingeneral and traditional support mechanisms (on policay issues, programs, the existing practices, etc) , you may add.

Section Two: Questions and Discussion Guides prepared for Key Informants

Direction: For each of the following questions, you are requested to provide precise and true response. It is your right to refuse or discontinue from participating in this study. Finally, I would like to promise you that all your responses will be kept confidential and used only for the purpose of this study.

- I. Bio-data:** Code number of the interviewee.....Sex...Age... Current position
- Academic background: Field of study..... Level of education.....
- Service in the current position in years.....Total service in years....

II. Background information:

- 1 .Name of the organization/ association.....Location.....Year of establishment?
2. Why did the organization get established? The purpose, goals and objectives of it.
3. May you tell me the historical development of the organization/ association?
- 4.What are your organizations' areas of focus? Why?
5. Who are the target groups of your organization? And why?
6. How did your organization select target beneficiaries/ clients? Indicate the selection criteria being used.
7. May you indicate the population size, age structure and poverty situation of the clients?
8. What are the major strategies and intervention modalities of your organization to address the problems of elderly?
9. What are the services provided by your organization?
(9.1) Preventive activities (9.2) Rehabilitative services (9.3) Development-oriented ones
10. Do you think new emergencies of clients have affected the objectives and activities of the organization? If yes, how do you manage it/? If not, why not?
12. Is there referral service of clients in your organization? If yes, please explain how and with whom?

III. Issues related to the impacts of HIV/AIDS on the support mechanisms of elderly

1. What categories of older people exist in Addis Ababa, specifically in Arada sub-city?
2. Among the existing groups of older persons, who are at high risk due to lack of basic needs; education & health services; facilities and utilities?
3. What are the urgent needs/ problems of those older people ? Indicate in rank order.
4. What are the major problems facing elderly in Addis Ababa? And what are the aggravating factors of these problems?
5. What roles does the organization play in the prevention and control of HIV/AIDS ?
6. Does the organization provide any support to HIV/AIDS affected/ infected individuals, households, and groups? If yes, what supports are being provided to those groups?
7. What are the impacts of HIV/AIDS on the welfare of elderly here in Addis Ababa?
8. What are the traditional support mechanisms of older people in Addis Ababa?
9. Does HIV/AIDS have any impacts on the traditional support networks of elderly? If yes, what are the consequences of HIV/AIDS on the traditional support mechanisms of older people with specific reference to those living in Arada sub-city of Addis Ababa? Please explain in detail.
10. What are the major factors that affect the informal care and support mechanisms of older persons in Ethiopia in general and specifically in Addis Ababa?
E.g.: Family care giving under extended family structure Community care and support
Care and support by religious institutions Alms giving Government support systems
11. What policy support exists to maintain the traditional support mechanisms of older persons in Addis Ababa? in Ethiopia?
12. Specify the type of policies exist for older people on the aforementioned issues.
13. Has HIV/AIDS and related deaths resulted in a reversal of roles between traditional care

- E.g.: The roles between older persons and their offsprings in Arada sub-city.
8. What do you suggest to make older persons and your life better?
 9. What is the attitude and perceptions of individuals, families & communities toward older persons and traditional care & supports provided for them?
 10. When a breadwinner or other family member gets infected/ affected by HIV/AIDS, what are the major problems that a household / family will face?

Section Four: Questions posed to care givers and other family members

I. Socio-demographic information

1. Code number of the respondent.....Sex.....Age.....Level of education.....
Marital status.....Type of occupation, if anySource of income....
2. Who is head of the household?.....
3. Indicate the age structure, sex composition and size of the family

Age structure	Male	Female	Total	Number of dependents	Number of independents
Below 15 years					
15-20 years					
21-40 years					
41-59 years					
60 years & above					

4. Which one of the following group of older people do you feel are most vulnerable to various social and economic problems? (Please indicate in rank order)

- (4.1) Older persons under extended family structures
(1) not at risk (2) somewhat at risk (3) medium risk (4) at high risk
- (4.2) HIV/AIDS infected elderly
(1) not at risk (2) somewhat at risk (3) medium risk (4) at high risk
- (4.3) Older-persons who are heads of the household s
(1) not at risk (2) somewhat at risk (3) medium risk (4) at high risk
- (4.4) Older persons within HIV/AIDS affected elderly
(1) not at risk (2) somewhat at risk (3) medium risk (4) at high risk
- (4.5) Abandoned elderly
(1) not at risk (2) somewhat at risk (3) medium risk (4) at high risk
- (4.6) Elderly in institutional and /or day care centers
(1) not at risk (2) somewhat at risk (3) medium risk (4) at high risk
- (4.7) The destitute (beggars)
(1) not at risk (2) somewhat at risk (3) medium risk (4) at high risk
- (4.8) If any, please indicate

.....

6. Which one is the major survival problems of older people ? (Please indicate in rank ordering)

- (1) Absence of basic needs (3) No access to education and health services
- (2) Lack of income for survival (4) Lack of social security provision

(5) If any, specify.....

II. Questions regarding HIV/AIDS and its impacts on older-persons

1. What do you know about the causes and consequences of HIV/AIDS?
2. Who are the most vulnerable segment of the population due to the impacts of HIV/AIDS? And why?

.....
.....

3. What are the major survival problems and aggravating factors of older people in the era of HIV/AIDS?

.....
.....

4. Is there any problem that you have encountered due to the pandemic? If yes, please explain as to how & to what extent has it affected you and your family?

.....
.....

5. What problems have you encountered so far in providing care and support for HIV/AIDS infected and/or affected persons in your family? What do you think you have missed a lot due to the death of your family member from AIDS?

6. What do you feel about the impacts of HIV/AIDS on the traditional support mechanisms of older persons here in Addis Ababa?

- Family care giving under the extended family structure
- Care and support given by religious institutions
- On community care and support through Iddirs, Mahiobers. Iquibs, Merdajas, and other community social networks, etc
- Alms giving and others if any.

7. In your opinion, what are the negative consequences of HIV/AIDS on older persons?

8. Has HIV/AIDS resulted in a change in the roles of older persons? If yes, how and to what extent?

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.....

9. What is the attitude or perceptions of individuals and the local communities towards AIDS affected and infected individuals and families?

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11. What ways have you used so far to relieve or solve your problems?

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.....

12. What are the major factors aggravating your problem caring for older people?(Please indicate your response in rank ordering)

13. What coping mechanisms have you used so far to address these problems? (Please indicate your responses by rank ordering)
14. In your opinion, which one of the following strategies of providing care and support for older-persons and care givers is the most appropriate? (Please indicate your response in rank ordering)
- (1) Providing individual support in their residential setting
 - (3) Providing informally without considering the traditional support mechanisms
 - (3) Providing care & support formally by established programs through organizations, which target older persons.
 - (4) Providing care & support through established institutional and/or day care centers
 - (5) Providing home based care and support
 - (6) If any other than these, please specify.....
15. Which traditional support mechanism of the elderly is highly affected by HIV/AIDS? (Please indicate your responses in rank ordering)
- (1) Family care giving under the extended family structure
 - (2) Community support systems through Iddirs, Iquibs, Mahibers, etc
 - (3) Care and support provided by NGOs
 - (4) Government support systems
 - (5) Alms giving
 - (6) Home based care and support
 - (7) Others specify.....

16. What are some of the existing roles & functions of individuals, communities, NGOs, CBOs, religious institutions, the local government and other stakeholders to provide Care and support to older-persons?

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17. How do you assess the contributions of individuals, communities, religious institutions NGOs and the local public institutions in providing care and support AIDS affected & infected individuals and families?

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18. How do you view the problems of older persons looking AIDS orphans in your community?

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19. How do elderly themselves, care-givers, extended families, and the local community cope with the impacts and burdens associated to HIV/AIDS?

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.....
20. What should be the roles of the following agents to address the problems of older-persons and care givers?

- | | |
|-------------------------------|------------------------|
| • The government | The family setting |
| • Associations & Trade unions | NGOs |
| • International donors | CBOs |
| • Elderly themselves | Religious institutions |

21. If you have any additional comments, which are related to HIV/AIDS and its impacts on the traditional support networks of elderly, you can mention.

Section Five: Observation Checklists

Observation, as data collection tool will be used to have a look at the following situations:

- 1.Housing conditions of some older-persons.
- 2.Living arrangements of the sample cases.
- 3.Social interactions and activities of individual cases in their respective localities
- 4.The care and support services provided for older persons in government organizations, NGOs, CBOs, religious institutions or other stakeholders.
- 5.Income generating activities, which some older persons are engaged in.
- 6.The participation of some older persons in vocational trainings, if any.
- 7.And other conditions/ situations, which will be deemed necessary to the study will be observed and embodied in the analysis to enrich the study.

Section Six: Document Analysis

Apart from different literatures, the following documents will be reviewed and embodied in teh analysis to enrich teh study.

- Developmental Social Welfare Plociy of Ethiopia
- The national strategic plans and policy frameworks on social security and ageing if available.
- The Addis Ababa City social welfare strategic plans, and policy frameworks, if any.
- The African Union Plicy Framework and Plan of Action on Ageing.
- The United Nations Conventions and Declarations on Ageing, etc.

25.3.1.1

25.3.1.2 Appendix- II

25.3.1.3

25.3.1.4 Verbal Consent Form for Participants of the Study

My name is Mussie Tezazu. I am from the Graduate School of Social Work at Addis Ababa University. I am currently collecting data for my Thesis Project entitled “HIV/AIDS and Its Impacts on the Traditional Support Networks of the Elderly: The Case of Arada sub-city in Addis Ababa.” As part of my assessment, I am talking to a wide cross section of people in the sub-city. I will use the information for the fulfilment the thesis requirement and if necessary, the report may be submitted to concerned bodies, which would use the information to plan relevant interventions that would address problems of the elderly.

Confidentiality and consent

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

Signature if interviewer_____

(Respondents have given informed consent verbally)

DECLARATION

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

Name of the student: **Mussie Tezazu Asmare**

Signature _____

Date _____

Advisor: **Professor Nathan L. Linsk**

Signature_____

Date_____