ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

THE EFFECT OF HIV/AIDS ON CHILDREN: THE CASE OF ADDIS ABABA

BY
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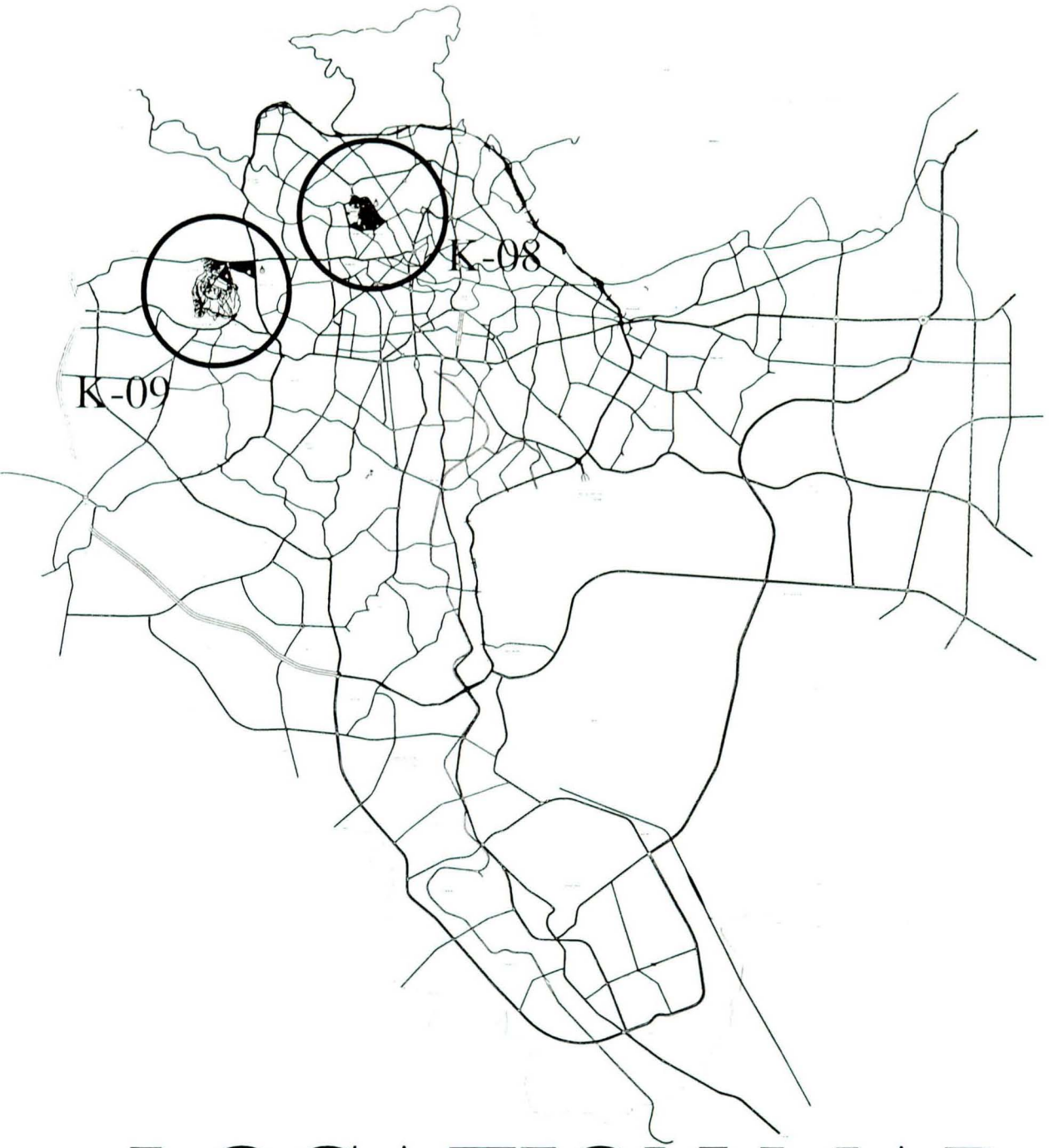
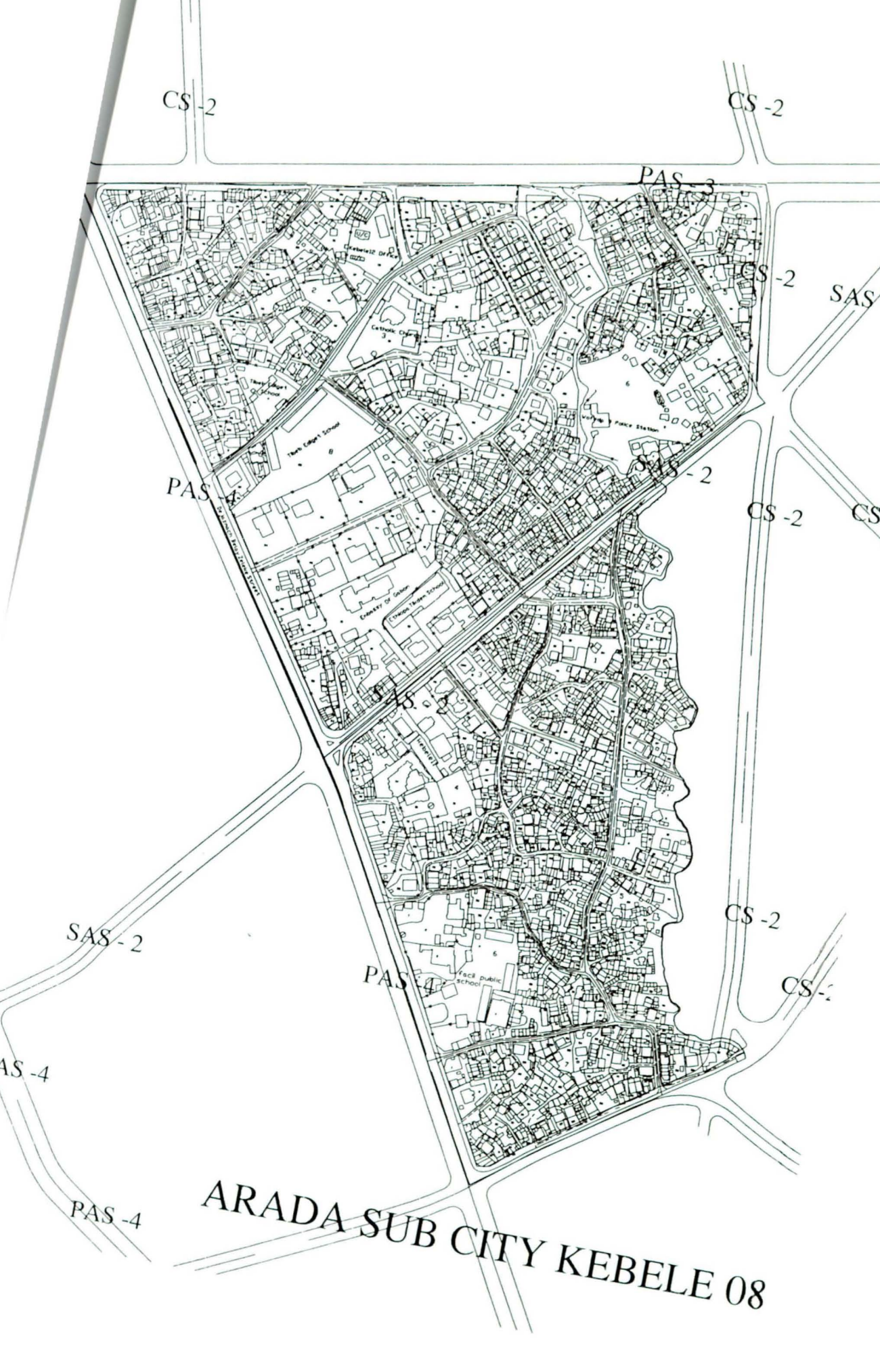


LOCATION MAP

ADDIS ABABA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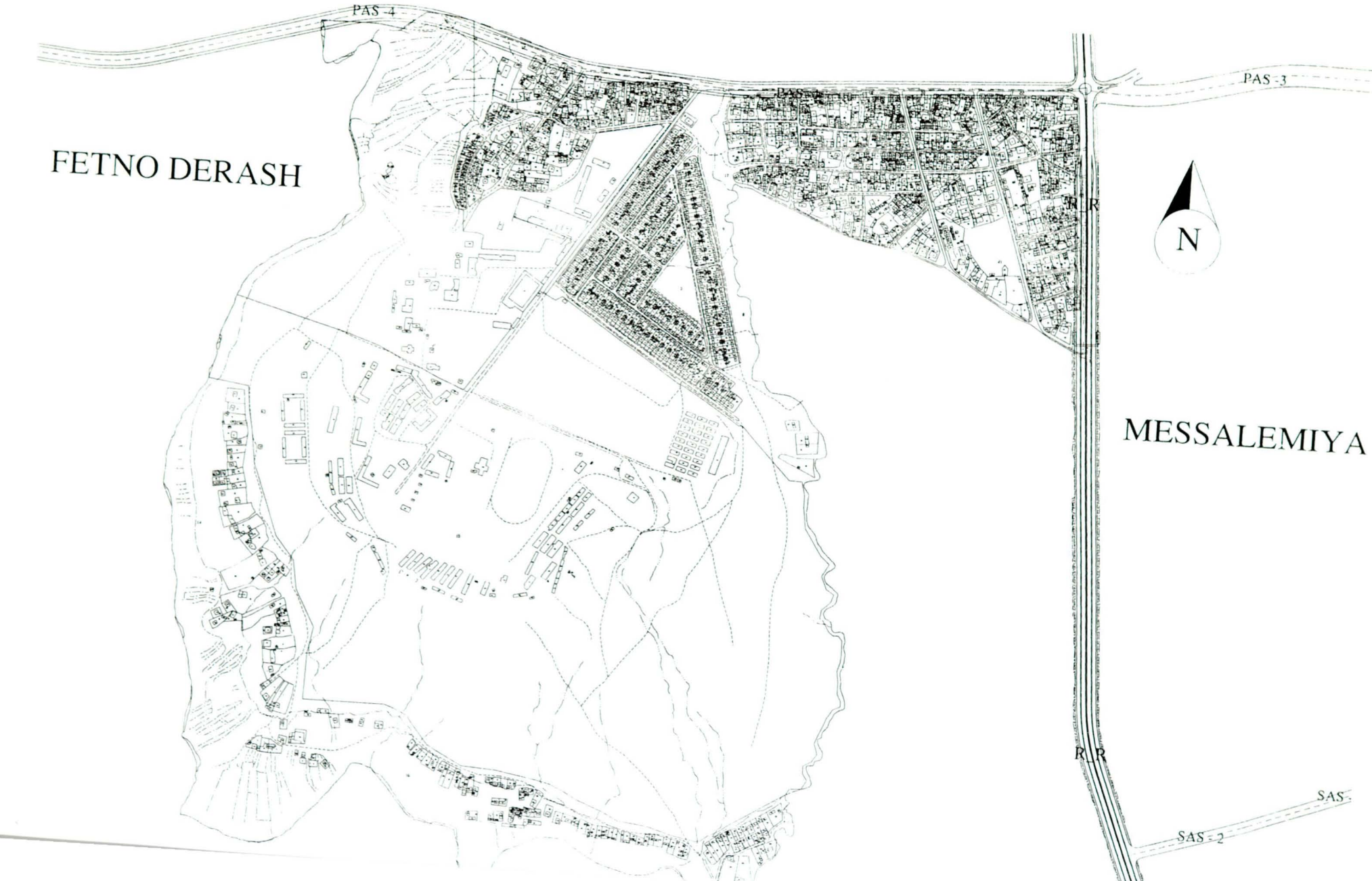
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ACRONYMS

AACAHB	Addis Ababa City Administration Health Bureau
AIDS	Acquired Immuno Deficiency Syndrome
CBO	Community Based Organization
CHGA	African Centre for Gender and Development
CSA	Central Statistics Authority
DFID	Department for International Development (UK)
EEC	European Economic Commission
FAO	Food and Agricultural Organization
FHI	Family Health International
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HIV	Human Immuno Deficiency Virus
ICASO	International Council of AIDS Service Organizations
ILO	International Labor Organization
IMF	International Monetary Fund
JICA	Japan International Cooperation Agency
MOE	Ministry of Education
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
MTCT	Mother-to-Child Transmission
NGO	Non-Governmental Organization
OHCHR	Office of the UN High Commissioner for Human Rights
OVC	Orphans Vulnerable Children
PLWHA	People Living with HIV/AIDS
SCA	Save the Children Alliance
SCA	Save the Children Alliance
SIDA	Swedish International Development Agency
STD	Sexually Transmitted Disease
STI	Sexually Transmission Infection
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Culture Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

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ABSTRACT

This study attempts to explain how the living conditions of children in Semen Mazegaja and Kolfe areas of Addis Ababa are affected and how they cope with the situation. In the process, it tries to identify factors affecting the coping of AIDS affected children with their inflicted problems. Social capital and available care options are among the factors identified. Our knowledge of these children, considering the effects of HIV/AIDS as well as the strategies and factors (social capital, traditions of orphan care, external agency based interventions, etc.) used to cope with their situation, enables us to understand their needs and priorities as well as potential indigenous aspects that work for their wellbeing.

The findings of the fieldwork, in which different research methods were applied, reveal that various and interrelated problems are inflicted upon AIDS affected children as the result of HIV/AIDS. However, AIDS affected children of different age, gender, orphan status, residence settings, household economic status, and family social network strength enjoyed social capital unequally, and faced different problems with different severity. These children employed different strategies, but not in all cases, to cope with their problems, in which community resources, individual learnt experiences, economic activities of the community, and the children's social capital were the basis for the various coping strategies respective to the strategies employed.

The other outcome of the study is that the local tradition of orphan care, particularly the tradition of fostering orphans primarily within the extended family proved to be essential in assisting AIDS orphans with their various needs. Although the impacts of HIV/AIDS weakened the social capital of the communities under study both at the household and community level, AIDS orphans from households with strong social capital operating through their relationships with extended kin, community members, and informal and formal community organizations were able to receive care as well as pool resources.

Moreover, the investigation showed that external agency based interventions, although their numerous limitations and difficulties were identified, were of assistance to AIDS

affected children they selected. The intervention agencies the researcher identified utilized the social capital of the community for they provided community based support, in which AIDS orphans in households with stronger social capital benefited more from the services provided. In general, the findings fit with the conceptual framework upon which the research is based.

CHAPTER ONE

INTRODUCTION

The wrath of some human catastrophes is distinctly felt in the beginning: natural disasters such as earthquakes, volcanoes, tsunamis, drought, and so on; technological disasters like the nuclear meltdown in Ukraine; political disasters like the genocide in Rwanda; biological disasters like the Ebola virus in Democratic Republic of Congo. But others begin slowly and quietly, their full impact masked until they become too large and too complex to be addressed as the case of HIV/AIDS.

The focus of the media has been on the instant impact of disasters rather than on that of catastrophes with a slow impact. Public health officials' concern has been on the prevention of HIV transmission while researchers, physicians, and service organizations focus on people who are ill and dying of HIV/AIDS. HIV/AIDS in relation to children has been seen in the context of mother to child transmission and pediatrics, which is only part of the problem they encounter.

The impact of HIV/AIDS on children is seen most dramatically in the wave of AIDS orphans, currently to be 15 million as projected in 2003 for Africa (Stine, 2003: 373). Ethiopia being one of the Sub-Saharan countries holds a major share of the orphan problem.

The trend of HIV/AIDS orphaning is so high that the traditional protective network of the extended family in Ethiopia, apparent in Addis Ababa, is reaching its saturation point. The epidemic is also killing adults that are contributing to the wellbeing of children's livelihood. Many teachers, health workers and other adults on whom children rely are also dying. Moreover, because of the time lag between HIV infection and death from AIDS, the crisis will worsen for at least the next decade. Keeping in mind the social consequences of the orphan crisis, the problems the orphans themselves encounter ought to be given priority.

The concept of orphan is a cultural construct, thus its definition varies across societies. United Nations Programme on HIV/AIDS (UNAIDS) reports orphans as children who have lost their mothers or both parents, and limits its estimates to children below age 15. On the other hand, the United Nations Convention on the Rights of the Child defines children as girls and boys below the age of 18, unless the age of adulthood is reached under national law. For the purpose of this research, girls and boys under the age of 18 are referred as children and a child who has lost either or both parents is referred as an orphan.

This study aims to investigate into the emotional, economic, and social effects of HIV/AIDS on children. The study also aims to understand the opportunities and obstacles children face in coping with their situation especially in view of the contributions and weaknesses of currently available care options in caring for children affected by HIV/AIDS in urban Ethiopia. The study aims further to look for successful experiences, if possible, indicate solutions to the problems. Due to the time limited to the study, samples will be limited to two areas, whereby the central and outskirts of Addis Ababa will be used.

1.1. Statement of the Problem

The HIV/AIDS pandemic has disrupted and will progressively disrupt the demographic structure of many societies leaving orphans among the most affected groups. Orphans are often referred to the silent legacy of AIDS. Until 2002, 13.2 Million children in Africa lost one or both parents due to the AIDS epidemic before the age of 15. Though many AIDS orphans are deceased, many more are living with or without HIV/AIDS, of which 95% currently live in Africa. MOH's sixth Report indicates that, in 2005, there were 744,088 AIDS orphans in Ethiopia, In 2003, 63.6% of AIDS orphans were estimated to live in urban areas. It was estimated that in 2005 the biggest metropolis, Addis Ababa, held 109,130 AIDS orphans. Making matters worse, it has been projected that the number of children orphaned by AIDS will rise dramatically in the next ten to twenty years. (UNAIDS, 2000: 27-8/ MOH, 2003/ MOH, 2006)

Orphans are not only affected indirectly by HIV/AIDS; some are also infected. To date over 90% of all children, infected through mother to child transmission, live in Sub-Sahara Africa. From 1995 through 2002, on average 600,000 children were born with HIV infection annually, meaning about 1600 per day. Out of these, in 2002, 87% lived in sub-Saharan Africa. Moreover, it has been estimated that 38% of the children in the southern and eastern African countries could be orphaned because of parental HIV/AIDS by the year 2010. (Stine, 2003: 374). Whether in real or relative terms, the proportion of orphans in the overall population is more critical than plain numbers.

Orphans are part of all societies. The orphan phenomenon has been and will always be experienced by all societies. In rich countries institutions are available that are capable to take in orphans. In poorer countries, orphans are routinely taken in by their extended families. The extended family in Ethiopia has been serving as traditional safety net for orphans. Many argue that orphans growing up in countries disrupted by the epidemic are more likely to cope if they can live in surroundings that are familiar, stable and as nurturing as possible. The consensus in this regard is that orphans should be cared for in

family units through extended family networks, foster families, and adoption. At the very least, siblings should not be separated. (Barnett and Whiteside, 2003: 196)

However, AIDS is generating orphans at such a high speed that the traditional coping mechanisms seem to be collapsing. (Ibid) Many families and communities are already impoverished and have difficulties to support themselves, let alone care for additional children. A question often asked is, to what extent do non-kin take care of children when the resources of the extended family are exhausted. Even if the extended family is supported by the state, the community or other institutions, such support can only serve as part of the solution in regards to the massive scale of the AIDS orphaning.

In response to the large numbers of orphans generated by AIDS, some calls are made, demanding an increase in institutional care for orphans as an alternative solution. However, in Ethiopia it was estimated that, in the year 2000, to keep a child in an orphanage costs between US$ 300 and US$ 500 a year, over three times the national per capita/ income per person (UNAIDS, 2000).

So far, authors such as Barnett and Whiteside (2003) have given much emphasis to social break down, cultural collapse and other costs to wider society due to the prevalence of HIV/AIDS and increasing orphans. Nevertheless, great concern has to be given to the effects of HIV/AIDS on the wellbeing of children and those who are deprived of their childhood. And, the fact that some of those HIV/AIDS orphans have lost their lives not even living beyond early adulthood has to be given due consideration. Though some have to face this tragic fact, orphans remain among the most affected and vulnerable groups running greater risks of many kinds.

Poor households affected by AIDS become poorer when able and productive household members are affected or die. The consequences of an adult death are manifested in the changed life chances of the child, even though only 30% of children born to infected mothers have will be infected in turn (Essex et al., 2002: 15). The time and energy a mother can devote to her children, the conditions at home, her material resources, her

skills and knowledge determine a child's passage from childhood to maturity socially, physically, and emotionally.

Keeping in mind the various effects of HIV/AIDS, its impact of poor nutrition, poor care, and poor or little schooling affect children in interrelation. Children from AIDS affected households tend to be poorer and less well nourished and have therefore a greater chance of being stunted or wasted. Stunting has long-term effects. The ability of children to benefit from education and to function socially and economically later in their lives will be affected by their poor physical condition, their compromised immune system, and defected mental functioning. (Barnett and Whiteside, 2003: 201-202)

When a child is taken into another household, the problems are worsened as the child is not one of their own given the tradition of caring for orphaned children within the extended family. Community based care appear to be the most cost efficient where poverty prevails in HIV/AIDS stricken communities. However, where there is no appropriate resource allocation the basic needs of children may not be effectively met. Besides, children may be subject to abuse and ill-treatment where effective monitoring mechanisms are not available. (Ibid: 208-209)

HIV/AIDS affected and infected children are struggling with the aforementioned problems or other uninvestigated problems. Amidst such situation, the impact of HIV/AIDS on the wider society and the wider future consequence of HIV/AIDS orphaning are given more concern by authors and in earlier and some current efforts to mitigate the prevalence of AIDS orphans. However, the direct and indirect problems of children's livelihood caused by HIV/AIDS has to be given priority and should be researched further giving due consideration for children's point of view in order to improve the care options provided in order to avert the foreseen breakdown of family and social structures they tend to seek refuge to. Thus, the research questions of this study are:

- What happens to girls and boys who, due to HIV/AIDS, lose one or both parents?

- How are their living conditions (school, social contacts, economy, health etc) affected?
- How do they cope with the situation?

1.2. Objective of the Study

1.2.1. General Objective

The general objective of this study is to understand what happens to children in Addis Ababa whose lives directly or indirectly are affected by HIV/AIDS and how they cope with the situation.

1.2.2. Specific Objectives

- To explore the nature of psychological, physical, economic, cultural, and social problems of children exerted by HIV/AIDS
- To investigate the impact of current care options and external interventions provided to children affected by HIV/AIDS
- To identify relevant and successful coping mechanisms applied by children and propose ways of inducing these mechanisms

1.3. Significance of the Study

Traditionally anthropological research has been conducted in rural settings. Nowadays more anthropological studies are emerging in urban contexts. In Ethiopia, most anthropological studies are still conducted in rural areas but my argument in this study is that we should also use anthropological methods to study urban problems. Thus, in this study I shall use anthropological methods to investigate the problems of HIV/AIDS affected and infected children in Addis Ababa.

Researchers have given a special attention to the inevitable social structure following the highly increasing numbers of AIDS orphans. While emphasis is given to the projection of

the saturating and collapsing social structure, and violence, the everyday problems of these children are laid aside. This study, therefore, maintains in-depth understanding of their problems in order to search for solutions, keeping in mind that it is one way of preventing the chaos of the wider society.

Furthermore, the study will contribute its findings to existing researches. In addition to understanding the level and nature of these children's problems, in order to find solutions, the gaps of existing care options will be identified, and relevant and helpful coping mechanisms from the experience of the children themselves will be learnt.

1.4. Research Methods

The research basically employs qualitative research methods and assesses both primary and secondary sources. A quantitative research method was also applied to support qualitative research findings as backgrounds to the communities under study. The fieldwork of the study took place between the beginning of February and the end of June. In order to examine the issue, the following strategies of qualitative research methods were applied in *Kolfe* and *Semen Mazegaja* areas in Addis Ababa, which were considered for this study because of their high prevalence rates of HIV/AIDS as inferred from the Sixth Report of MOH:

- Participant Observation

  Participant observation was applied in the daily work of external care providers maintaining possible invisibility. The difficulties, strength, and weakness of existing care options were observed. In the process, the interactions between the children and the care providers and the responses of the children will be observed and the effect of these relationships in a constructive or harmful outcome was analyzed. Participant observation of children in their homes and observation at 'Woizero Kelemework' and Meserete Idget Schools was made in 'Semen Mazegaja' and 'Kolfe' areas respectively. It was possible to observe their daily lives by tutoring them at their homes and through observations in the classrooms and at the playgrounds of these schools.

- Interview

  Detailed in-depth interviews were held with individuals from different groups;

- Orphans and vulnerable children of HIV/AIDS both on and off the streets were interviewed
- Parents and guardians of orphans, related and unrelated to the orphans, were interviewed
- Concerned government and non government officials were interviewed
- A chairperson of a Community Based Organization was interviewed
- Active community members were interviewed
- School teachers from different schools of the sample area were interviewed

- Group Interview

  Group interview was identified to be necessary in order to find out about the support networks of children. It was held with orphans living with guardians. The interview was conducted using cards on which the orphans state their responses.

- Focus Group Discussion

  Focus group discussions were separately held with 5 to 8 boys and girls aged seven to sixteen, mothers, and women guardians of orphans.

- Diaries

  Twenty orphans in guardian households were made to record a diary of their daily activities in detail for a month. In addition other twenty orphans in guardian households were made to record the types of food they eat at each meal with the respective time of feeding for a month. These diaries were utilized in order to fill in for the gap for settings of the children's daily lives that were difficult to observe.

- Case study

  Case studies of children affected and infected by HIV/AIDS are included to enrich the study and comprehend the modus operand.

The quantitative research method is applied via structured questionnaires in both 'Semen Mazegaja' and 'Kolfe' areas. In 'Kolfe' area, Kolfe Keranio Sub-city Kebele 09 (the old

Woreda 24 Kebele 09), and in 'Semen Mazegaja' area, Arada Sub-city Kebele 08 (the old Woreda 09 Kebele 11 & 12), were selected with purposive sampling. The following assumptions were made to determine the minimum sample size required for the study: a 50% proportion, a 95% confidence interval and a ± 5% deviation from the population, which is considered as infinite population. 184 and 200 sample households are selected from Kolfe Keranio Sub-city Keble 09 and Arada Sub-city Kebele 08 respectively. Stratified systematic sampling method is used to identify the sample households. The households in each Kebele are stratified based on ownership of housing units; self owned, Kebele owned, and owned by Agency for Rented Houses.

Based on the above sampling criteria, the data collection instrument used is a pre-tested standardized questionnaire, and data collectors were assigned. The data collectors were trained with basic survey methods prior to the data collection. Respondents were informed about the purpose of the study and their consent was considered. Members of households knowledgeable about their respective household were selected to be respondents.

Following the data collection, data editing and coding was carried out. Responses of the structured questionnaire were given codes. The data were entered using Microsoft Excel 2003. In order to reduce data entry error, all data have been reentered and verified for accuracy. Then, all required tables were generated using SPSS version 10 and 14. Finally, analysis was made using appropriate statistical methods based on the generated tables and results. Descriptive and analytical methods were employed in the presentation and analysis of data.

In the process of understanding multiple conditions that work against or enable children affected and infected by HIV/AIDS in overcoming problems inflicted on them by the epidemic, selected demographic and economic variables of the selected households were considered in the questionnaires, which would serve as background information that support the qualitative findings of the fieldwork.

CHAPTER TWO

Literature Review

2.1 HIV/AIDS in Ethiopia

Ethiopia is identified as one of the countries to detect the HIV virus among the population, in 1984, at the early stage of its discovery. However, HIV/AIDS surveillance activities began five years after its detection in the country. Since then the HIV epidemic has been steadily increasing in the country to an alarming prevalence. In 2000, Ethiopia was among the highly affected countries, ranking with number of reported people living with HIV in the world next to India and South Africa. The total number of people living with HIV as estimated by (MOH, 2006) was 1.5 million in the year 2005. In 2003 it was estimated that children aged below 15 years living with HIV/AIDS were 96,000, and the adult HIV/AIDS prevalence for women was estimated to be 5% whereas it was 3.8% for men. This prevalence is projected to be 5.7% and 4.4% for women and men respectively by the year 2008.

Various social, cultural, and economic factors are stated to be responsible for the spread of the virus. So far known risk factors, according (MOH, 2004), are sexually transmitted infections, multiple sexual partners and harmful traditional practices, of which multiple sexual intercourse is the most contributors for the transmission of the virus. And, mother to child transmission contributes to the second highest number of new HIV infections to heterosexual transmission each year. (MOH, 2004)

The prevalence of children born and infected with HIV/AIDS and children orphaned by AIDS as well as the extent of the problems exerted upon them are related to the adult HIV/AIDS prevalence. The adult HIV prevalence in the country is 4.4%. The prevalence is far greater in urban areas than rural areas – 12.6 in urban and 2.6% in rural areas. However, the highest prevalence rates are concentrated among the 15-24 age groups. Within the 15-24 age groups, prevalence among females is three times greater than among males, due to social and biological reasons.

Far more children are orphaned by AIDS than infected to HIV. Though significant numbers of children are infected, most are orphaned themselves. The cumulative number of AIDS orphans aged 0-17 years in the country is estimated to be 744,100. Of this total number of AIDS Orphans, 529,777 are maternal, 464,506 paternal, and 250,195 double orphans. Furthermore, there are indications that the number of AIDS orphans in Ethiopia would increase at an alarming rate. Accordingly, by the year 2010, the estimated number of AIDS orphans will reach 43% of all orphans. (MOLSA, 2003/MOH, 2006)

The alarming spread of the epidemic is disrupting the country's efforts in social and economic development, for it is taking its toll on large segment of the population, especially the potential age group for development both in rural and urban areas. In 2001, 16.8% of the adult and youth population was estimated to be infected by HIV/AIDS. In 2005, it is estimated that there were 134,450 AIDS deaths (368 deaths per day) in the country, of which 20,929 were children. Moreover, according to FHI (2002), from 1986 up to 2000, the cumulative numbers of deaths of AIDS were estimated to be 1.2 million, and are projected to be 5.2 million by the year 2014. Out of the estimated 5.2 million AIDS deaths in the country, 554,000 will be in Addis Ababa. Furthermore, around 17% of the adult population of the city is already infected, a rate of infection higher than most parts of the country. This significant number of deaths projected and adult infection rate estimated in the capital city reveals unfortunate social wellbeing prediction for the crowdedly populated metropolitans. (MOH, 2002/ MOH, 2006)

However, according to UNAIDS press release (2004), the prevalence of HIV had declined in 2003 from a peak of 24% in mid 1990's to 11%. HIV prevalence in most cases declines when increasing number of people living with HIV/AIDS die of it, offsetting the prevalence rate as well as creating behavioral change among people witnessing the consequences. In the case of Addis Ababa, the level of decrease in HIV prevalence is not only as the result of the aforementioned cause, prevention efforts that have been made have a stake in the decrease as well.

2.2. The Overall Impact of AIDS

A. Economic Impact

African Context

It may be felt obvious that HIV/AIDS affects the economy of a county at all levels; individual, household, community, and macro level. However, how an assessment of an economic impact is considered may provide answers to questions such as: what percentage of its GNP should a government spend on combating AIDS?; and how should governments and international donor agencies balance their efforts in combating AIDS against other social investments such as infrastructure development, education and the like? Amar et al. in Essex et al. (2002) considered static and dynamic effects of AIDS in assessing its economic impact. Static assessments concentrate on the overall costs of AIDS for an economy at a given time. Whereas, dynamic assessments concentrate on significant changes of key economic variables in time paths – GNP, savings, unemployment, food production, household formation, and so on. These considerations are also useful for planning by enterprises, families, and communities.

The complex interaction between the various consequences of the costs and losses makes quantifying the precise economic costs of the disease difficult. However, it is necessary to assess the major losses and their interrelated consequences and assume the trends resulting on the national economy.

The multi-sectoral impact of HIV/AIDS makes economic growth virtually impossible for developing countries. A negative impact on agriculture, particularly for developing countries, is directly related to the major share of their macro-economic performance as well as the wellbeing at the household and individual level; Africa's agricultural sector is essential for the wellbeing of the countries as well as the continent for it accounts for 24% of the Gross Domestic Product, 40% of the foreign exchange, and 70% of the employment. The agriculture sector suffers from the impact of HIV/AIDS as it hampers the agricultural production activity, reducing the time spent on agriculture with its prolonged illnesses and claiming the lives of agricultural workers. According to UNAIDS/WHO (2003), AIDS will take its toll on more than 20% of the African

agricultural workforce by the year 2020. Along with the deterioration of the economy of most affected countries, AIDS affected households are likely to experience more the suffering of severe poverty than non-affected households; income and production output of affected households is reduced losing productive family members or caretakers for the sick and additional expense being imposed on the households for medical and other services such as funerals. (UNAIDS/WHO, 2003)

The growth impact of AIDS, as measured by life expectancy at birth, in the absence of feasible mitigating factors, half a century of advance in development may be expected to be wiped out. AIDS significantly increases child mortality in countries with high prevalence of the epidemic. Its impact on the increase of child mortality in countries with high mortality rates in countries highly affected by the epidemic that have significantly reduced child mortality resulting from other causes. This situation reflects the down growth path, many countries especially sub-Sahara African countries, are imposed to follow regarding human development. (Essex et al., 2002/ Philipos. 2002)

Ethiopian Context

Countries with high prevalence rates in Sub-Sahara Africa are experiencing a tremendous macroeconomic impact as a result of HIV/AIDS. They are losing an average between 1% and 2% of their annual economic growth. Preliminary result of a model developed in 2000 by UNAIDS on the macroeconomic impact of AIDS shows that the impact for Ethiopia is slightly lower than the average for this region. It estimates the loss in GDP growth per capita as a result of HIV/AIDS to be 0.6% by 2010 (UNAIDS/ECA, 2000)

HIV/AIDS is having a real economic impact at the household level. It is compromising wealth of households with costs incurred on the household as the result of the epidemic exceeding the household income. A 1993 study of 25 households found that the average cost of treatment, funeral and mourning is several times the average income; the average income was found to be 270-620 Birr compared to mean expenditures on treatment of 1930 Birr and on funeral of 327 Birr. This situation is exacerbated by the reduced time spent on agricultural activities for more than 80% of the Ethiopian population. (Ibid)

It was found out that, through a survey carried out in 1994, the mean numbers of hours per week in agricultures per households was 33.6 hours in non AIDS afflicted households as compared with between 11.6 and 16.4 hours in those that were afflicted. The reduction effect on household labor time also has a major impact on the macro-economy with its negative effect on agricultural production. (Ibid)

The epidemic reduces the growth rate of the labor force in general, as it primarily takes its toll on the working age population. It is estimated that, by the year 2020, Ethiopia will lose 10% of its labor force to HIV/AIDS. The epidemic hampers the economic growth of the country treating the workforce of all sectors, keeping in mind the agricultural sector. The resulting effects on government revenue and expenditure will significantly weaken the capacity to escalate an effective response, or make progress towards the development of every sector, in turn affecting all levels of society. (Essex et al., 2002/ UNAIDS/WHO, 2003)

HIV/AIDS macroeconomic impact could also be attributed to its economic impact on education. A model developed by UNAIDS and UNICEF in 2000, reveals that increasing mortality rates due to AIDS in Ethiopia have led to discontinuity in teaching. Many students are losing or having a change in their teachers due to illnesses or death of a teacher as a result of HIV/AIDS. The model shows that, of around 4.3 million primary school students, 51,000 would have lost a teacher to AIDS in 1999. (UNAIDS/ECA, 2000)

The economic impact of HIV/AIDS on the health sector is reflected by the increase in demand for treatment as a result of the epidemic. The health sector is dealing with hospitals where an increasing percentage of beds are occupied by patients with AIDS related illnesses. In the year 1999, bed occupancy due to AIDS was predicted to increase from 5% in 1994 to 51% by the year 2004 (AACHB, 1999). According to a projection by UNICEF (1999), by the year 2005, one third of all government spending on health sector in Ethiopia is expected to be for treatment related to HIV/AIDS. Yet there lays a significant resource gap to cope with the health care needs of the country. The annual

cost of scaling-up activities nationwide is estimated at USD$ 112 million to US$ 156 million.

B. Impact on Households

HIV/AIDS inflicts both AIDS affected and non-affected households with its social and economic impacts, but differing extent of problems may be felt by the two kinds of households. The effects among households in highly affected developing countries are more pronounced. The economic impact of the epidemic on households can be understood within the perspective of declining gross domestic products within these countries, for the most part of which parades the macroeconomic effects of AIDS largely. (Essex et al., 2002)

Households' wellbeing is in part a function of local economies, political leadership, formal and informal education opportunity, and social and health service systems that increasingly use community based approaches. All of these are adversely impacted by the unusually high death rate among women and men, parents or not, in local areas. Thus, community function may be impaired affecting both AIDS affected and non-affected households. The wealth of households, particularly of AIDS affected households, compromised for the epidemic is highly taking the lives of prime age adults. Amidst disturbed functioning of the community, the costs related to illness and deaths of the family members are posing more severe problems upon AIDS affected households. Apart form the economic impact felt by non-AIDS affected households due to the macroeconomic impact of AIDS, the wealth of these households is depleting as a result of answering the need of relatives affected by AIDS. Thus, the economic safety net provided by families and communities is being further weakened in addition to the alarming increase in the number of AIDS orphans. The ability of these families is becoming less to contribute in cash, in needed materials or in the provision of work to the affected households. Furthermore, as the number of AIDS affected households falling from poverty into destitution increases, the amount of relief that can be provide per destitute household decreases. (ibid)

An important aspect of the impact felt by families is the change in the household structure following loss of parents. Households are consequently forced to be dissolute, reconstituted, reordered, and disrupted in the pattern of mentoring and care and support guided by the household head. The distresses of these situations are obviously imposed on the orphans generated in these households (Bicego et al., 2003).

C. Impact on Population

An important aspect through which HIV/AIDS disrupts the wellbeing of societies is its impact on population. Due to its effect, the population size of highly affected countries is and will significantly decrease, unfortunately, distorting their demographic structures. Unless the efforts combating AIDS are dramatically strengthened, according to UNAIDS (2004), by the year 2025, 38 African countries, including Ethiopia, will have populations which will be 14% smaller than predicted in the absence of AIDS. Worse, the seven countries with HIV/AIDS prevalence exceeding 20% will have projected populations more than one-third smaller due to the epidemic (UNAIDS, 2004).

The impact of HIV/AIDS is unevenly distributed throughout national populations. It primarily affects young adults, particularly women. This means, the epidemic is dramatically altering heavily affected countries' demographic structures, and life expectancy in many countries has declined as a result of it. AIDS is producing a new demographic structure "the population chimney", instead of the regular "population pyramid". (Essex et al., 2002)

Ten to fifteen years after the age at which people become sexually active, when those infected with HIV early in their sexually active lives begin to die; distortion of the pyramid occurs forming "the population chimney". The population of women beyond the early 20's and men beyond their early 30's will shrink in affected countries leading to fewer middle-aged people. In addition, the population of children has and will further decrease because of HIV related child mortality, premature maternal death, and reduced fertility. (UNAIDS. 2004/ Essex et al. 2002).

The aforementioned demographic impact on population structure means that, if current prevalence rates continue and there is no large scale treatment program, in the sub-Sahara Africa's worst affected countries, up to 60% of today's 15 years olds die before reaching age 60. The mortality rates for 15-19 years olds living with HIV in developing countries are now up to 20 times greater than those in industrialized countries. This is attributed to the stark differences in access to treatments of the disease. (UNAIDS. 2004).

Developing countries had extended life expectancy significantly until recent years. However, the average life expectancy of 38 countries, including Ethiopia, has dramatically declined primarily due to the impact of AIDS. The average life expectancy of a person born between 1995 and 2000 in countries where HIV prevalence exceeds 20% is now 49 years – 13 years less than with the absence of AIDS. Significant decrease in life expectancy or shortage in prime-age adults will have worse effects for next generations of families, especially for orphans and the elderly. Increasingly, more orphans will grow up in households headed by elderly or adolescent-care-givers instead of being cared for by aunts and uncles. Significant number of orphans will be obliged to be heads of households or resort to streetism. Many households will be large, taking in orphans from more than one family. Many households in an extended family will be headed by elderly relatives. However, the elderly population will continuously decrease as adults over 60 are not replaced because of the depletion of middle-aged population as the result of AIDS. The loss of prime age relatives does not only impoverish their immediate families but the whole extended family network for they are also an important providers of material and financial support to their extended relatives, apart from being potential care givers (UNAIDS, 2004/ Essex et al., 2002).

D. Impact on Women

The impact of AIDS on women and girls is severe, particularly in countries such as Ethiopia where the dominant mode of HIV transmission is heterosexual sex and social service provision is minimal. The burden of care usually falls on women and girls. A mother is more likely than a father to continue caring for their children after a spouse's death and a woman is more willing take in orphans. They also carry the burden of caring

result of HIV/AIDS, prolonged serious illness of parents including other family members and death of the bread winner in a family often have detrimental economic consequences for children because of high treatment costs, funeral costs, loss of income, and often loss of family property as a result of property grabbling. When a poor household's source of income dries vital assets are often sold off to desperately fulfill the household needs even if the sale will jeopardize the household's long term development. Orphaned households' income status is worse than those with seriously ill parents. The situation for children in child-headed households is particularly dire (Essex et al., 2002).

Reduction or loss of household income has more consequences for children beyond material needs. Children will become unable to get adequate food, will poorly attend school or will be forced to dropout, will have reduced access to health services, and will have increased vulnerability to HIV infection and other diseases. These children, mostly those without adult care, in order to realize their basic needs, will resort to unhealthy situations; migration, prostitution, theft, beggary, exploitative child labor etc. (Jackson, 2002).

ii. Education

A household impoverished by HIV/AIDS will have little or no money to cover education costs such as fees, school uniforms, textbooks, etc. Where there is little money available it is used to cover treatment costs for HIV/AIDS related illnesses of a family member. When a parent or both parents die the financial barriers for children's schooling gets heightened. According to Desai (1992) in Bicego et al. (2003), orphans have lower educational attainment than children whose parents are both living, and double orphans have the lowest educational attainment. Furthermore, for single orphans there is a differential impact according to whether the mother or father died. The death of a mother will affect the child through childcare and would affect initial enrolment in school more. The death of a father will affect the child more through financial resources and would therefore affect continuation in school to a greater extent. However, observations made by Ainsworth and Filmer (2001) in Bicego et al (2003) illustrate that the degree of under-enrolment varied from country to country with orphans not always having lower

enrolment outcomes. In addition, according to Barnett and Whiteside (2003), in a recent analysis of 23 countries, 21 of which are in Africa, it was found that double orphan hood affected school enrolment in most but not all countries.

The opportunity cost of schooling for children in households affected by HIV/AIDS becomes very high compared to other non-affected poor households. In households with parents weakened by HIV related illnesses, a child, usually a girl, may need to takeover household and care giving chores taking the time for schooling and studying let alone the ill parent/s unable to help their children with homework and supervision. The children's performance and achievement will be negatively affected both in the short and long terms. When families need to generate cash, boys who have more earning power may also be removed form school. (Barnett and Whiteside, 2003)

In a household where parents are too ill to care for the child and the income for food has become limited, malnutrition may follow and affects school performance or leads to other health problems. As a result, the child may be kept at home due to its own ill health.

At times of parental sickness and death siblings usually develop psychological trauma. The psychological traumas are also associated with ostracism, discrimination, and stigmatism suffered by children as a result of infection or HIV/AIDS in the family coupled with a fear that they may also be infected, making children unhappy in the school environment and often less likely to attend. According to a study made on the psychological impact of HIV/AIDS, it was found out that school performance of children is negatively affected by HIV/AIDS due unresolved psychological traumas (UNAIDS, 2001/Essex et al. 2002).

iii. Health

Child morbidity and the quality of parenting are closely correlated. According to a study in West Africa fostered children had higher mortality rates than other children, usually as a result of poorer care, malnutrition, and reduced access to modern medicine. Ill parents of HIV/AIDS may not be able to take care of their children. Elderly and children heading

households, in particular, may be uninformed about good nutrition, oral rehydration treatment for diarrhea, or about the symptoms of serious illness.

A family's ability to feed its members is highly interfered by the epidemic. Along the reduction of income the epidemic results in, reduction of agricultural production in AIDS affected household is distinguished. This situation attributes to more malnourished and most likely to be stunted orphans and children in AIDS affected households than non affected children. However, malnutrition in orphans may result from the effects of parental illness and household death on child rearing practices rather than from shortage of food (Essex et al., 2002).

iv. Mental Health

The severe social and economic effects of AIDS on children in developing countries such as Ethiopia overshadow concerns about psychological consequences of the epidemic. In addition, psychological effects are less obvious and often unnoticed or neglected. A child's changed behavior may be neglected as a temporary disorder that will pass rather than as an indicator of a psychological trauma with possible long-term implications. However, the effects on a child's mental health and the ability to cope resulting from parental illness and death are complex and depend upon the child's development, culture, and resilience (Humuliza, 1999).

Children in AIDS affected households suffer from sequential trauma associated with continuous traumatic stress syndrome. Many children suffer multiple losses—a father, mother, siblings, and other relatives. Separation of siblings is also a major factor for psychological distress among orphans. In addition, because of sibling dispersion and migration, many children lose friends, familiar surroundings, their hopes for the future, and their remaining childhoods. (Essex et al., 2002)

A child's psychological reaction and health related to parental illness depends to a large extent upon the status of the parents. Signs of a parent's depression, guilt, anger, or fear may be reflected in children as a changed behavior. A study made in Zambia found out

that during parental illness, children become worried and sad, more likely become solitary, appear miserable or distressed, become fearful of new situations, try to help more in the home, and stop playing so as to stay nearby. Furthermore, in a study made in Uganda, children expressed feelings of hopelessness or anger when their parents became sick and feared that their parents would die. Most who were orphaned were depressed and had lower expectations of the future; expectation to get a job, to be married, to have children etc. They were found to internalize behavior changes such as depression, anxiety, and decreased self-esteem, rather than to reveal acting out or sociopath behavior. It was also found out that loss of a mother is more distressing than loss of a father (Ibid).

The trauma and stress resulting from the illness and death of a parent are further heightened by stigmatization commonly based on orphan status, discrimination, ostracism, dropping out of school, moving away from friends, and putting up with increasing load of household chores. Consequently, children experiencing such situations will become subject to adverse mental health problems (Naerland, 1993/ Ntozi, 1997).

The aforementioned psychological problems stress the importance of provision of support to children in such situations in ways that go beyond traditional psychological interventions. In Africa, no longitudinal research has been carried out on the psychological impact of the epidemic. But continuous traumatic stress, even of a mild form, among children in developed countries is found to have long-term developmental consequences. If long term effects are similar in Africa, with the increasing rate of children being orphaned, adults with chronic traumatic stress syndromes may be produced, and a second generation of problems may occur including alcohol and drug abuse, sever depression, violent behavior, suicide, and purposive HIV transmission (Essex et al. 2002). Thus, possible long-term negative consequences on society and unpredictable societal changes have to be considered and the necessary interventions to help children overcome psychological problems have to be timely made.

v. Child Labor and Migration

Among many factors, economic factors and loss of care givers are common factors that drive decisions of HIV/AIDS affected families and orphans to migrate. Rural to urban migration often occurs when mothers are widowed and migrate with their children to towns in search of work or partners. In contrast, serious illness often leads to urban to rural relocation with a pattern so called going-home-to-die. AIDS affected households and individuals often relocate within the urban or rural setting. Children from child-headed households are significantly more likely to move within a two years period than children from adult headed households. Such intra-rural and intra-urban relocation of orphans is observed to be to poorer neighborhoods (Essex et al., 2002/ Ntozi, 1997).

A survey made by the Central Statistics Authority in 2001, revealed an increase in the number of working children: some 40 percent of the children moving to urban areas were under the age of fourteen, and most are from poverty and AIDS afflicted households. AIDS affected adolescents and children as young as seven years old often migrate to generate income, to towns to work as domestic servants, or, adolescents, to more affluent farms working as agricultural laborers. Some of those involved in domestic work are employed by relatives with a promise of better privileges. According to a rapid assessment carried out by UNICEF-Ethiopia Street Children Program, domestic servant children were paid monthly, at wages ranging as low as US$ 1.20 per month. The children working for relatives were not given monthly wages, but were instead promised money to visit their families in the villages.

The number of street children has increased as the result of the epidemic. UNICEF in 1993 had estimated the number of street children including those returning to their families by night in the capital to be 40,000. Currently, most of the children who live on the streets or street hawking by day to earn a living are either orphans or vulnerable children. According to the aforementioned rapid assessment, 80 percent of the street children interviewed in Addis Ababa were supporting their families, while 14 percent were orphans who fully supported their siblings and themselves. Particularly, street girls

are subject to sexual and physical abuse. Most of the street girls survive the streets by engaging in commercial sex work.

2.3. Response to the Impact of the Epidemic

A. Available Care Options

Identification of available care option facilitates for better understanding of the problems of AIDS affected children as well as how these children cope with their situation. There are various care options that are and could be provided to children made vulnerable and orphaned as the result of HIV/AIDS. In fact, the care options, to be discussed later, have been serving destitute and orphaned children due to other causes before and after the impact of HIV/AIDS.

Possible and available care options are stated and described as follows:

> *Institutional/residential care: A group living arrangement for children in which care is provided by remunerated adults who would not be regarded as traditional caregivers within the wider society. It covers a wider variety of care that includes not only institutions, but also homes, schools, hospital units, correctional and training facilities, and settings where children may be admitted that do not technically qualify, etc. The term residential care is preferable and is often interchangeable with "institution".* (Tolfree, 1995)
>
> *Alternative care: Care designed to avoid an institutional atmosphere; ideally, placement within a family unit that is monitored and supported by the surrounding community.* (Ibid)
>
> *Community based care: Children are cared for by responsible adults within their own communities and within a family or family-like setting. Community leaders or organizations take responsibility for children and oversee their care and wellbeing in aspects; legal, psychological, educational, material needs etc.* (Ibid)

Group care: Small family groupings of children within a larger institution. Households of children within a compound of such houses, set apart from the surrounding community, under the care of an adult caretaker in households scattered throughout the community (small group care). These placement homes become part of the neighborhood and afford children access to local leaders, adult role model, and the everyday life other children in the area experience. (Ibid)

Adoption: This involves a child being taken in to the care of adults other than their parents. It is done on a permanent basis and the child legally becomes the child of those parents. The term adoption is usually only applied where the people 'adopting' the child are not relatives. Once a child is adopted, the state usually stops being financially responsible for the child. (ibid)

Fostering: This is also involves a child being taken into the care of adults other than their parents. It is usually a temporary arrangement and the state retains financial responsibility for the child. It is a formal/ legal arrangement and usually involves non-related adults. In many cases, people foster large number of children. These 'foster homes' are essentially small institutions (Ibid). *However, the term 'fostering' is also used in this paper for taking-in of orphans by the extended families.*

In addition, in most of sub-Sahara African countries, where the governments are struggling to get out of the deep poverty they are in, financial responsibility for fostering families is given less attention and is practically impossible with the scale of the orphan problem in each country as the result of HIV/AIDS. Foster homes and group care are not yet identified in practice in Ethiopia (ibid, 2003/ Bagnoud, 2000).

i. Residential/Institutional Care

Save the children estimates that 8 million children live in institutions world wide and the number is growing. Though, institutional care, where available, cares for orphans slipping through the stressing community based support, yet, there is a great deal of evidence that institutions are not a good way of providing care for children. In developed countries alternative care options are being considered and many residential care institutions have closed. In developing countries, however, institutions are thriving and developing where new institutions are being built. For example, save the children reports that the number of orphanages in Liberia grew from 4 in 1989 to 117 by the year 2001 (Tolfree, 2003).

There are many reasons for the rise in institutional care in developing countries that are very less associated with finding solutions for the growing orphan problem. For example, there is the desire in certain societies to control children and to prevent them from being a nuisance. Many institutions set up for 'street children' are based largely on these desires rather than the best interests of children. There is also the wide spread belief that institutions are the best or the only way to care for children. Examples of this include India, China, Eastern Europe and countries of the former Soviet Union where this view is widely held. Political and public support for childcare institutions is another reason. Many institutions in developing countries are supported by local political figures. This is because they are seen as a worthy cause by the general public. In addition, the general publics in developed countries have similar views. This means that child care institutions in developing countries are able to raise funds relatively easily. Cultural barriers to adoption and fostering also play a role. In many societies, there are cultural beliefs which make it difficult for a family to adopt or foster a child who is not related to them. Institutions may also represent an 'easy' option for social workers. Administrative, legal and financial issues may make it easier for a social worker to place in vulnerable child in an institution rather than trying to support them in their extended family or community. Moral and religious values are also a factor. Many institutions are run by religious organizations who seek to promote particular values and beliefs. These beliefs may include the view that certain environments are not suitable for raising children. An

example of this is an institution run by a religious organization aimed only at children of commercial sex workers in India (ibid, 1995).

Many studies conducted around the world revealed that residential/institutional care is an extremely poor way of providing care for children and young people. A problem often stated is that residential care prepares children and young people poorly for adult lives as it places little evidence on teaching them skills they need. Besides, children in these institutions often lack interpersonal skills. Some may develop anti-social forms of behavior. In addition, they fail to develop their own cultural identify. They may feel alienated from their community. They often lack networks of friends and relatives and may lack the social skills needed to develop these adults who grew up in institutions from an 'under class' in some societies. Institutions also may promote stigma and discrimination. Children in such institutions may be seen as 'different' from other children and stigmatizes as a result. Levels of physical care above and beyond those in the community may also promote stigma. (Ibid)

Children and young people rarely have the opportunity to participate in decisions that affect them in residential care. Much residential care fails to meet the requirements of the convention on the rights of the child; a convention most countries of the world including Ethiopia have agreed upon and adopted, though some anthropologists criticize the convention that it is based on western conceptualization of children. Furthermore children and young people in institutions are more vulnerable to physical and sexual abuse. (Ibid)

Institutions only provide care for a very small proportion of orphans and other vulnerable children. Amidst the increasing number of orphans and vulnerable children as a result of HIV/AIDS, institutions will never have the capacity to provide care for these children due to the cost such institutions demand. The cost of providing care in institutions is extremely high. The cost of building and establishment can be enormous in addition to providing care for children in such settings where community resource is not shared. Save the children estimates that the cost of providing care for children in an institution

can be twelve times the cost of caring for that child in the community. Institutions have been described as a 'magnet' of resources. They undermine community care for orphans and other vulnerable children by consuming resources that might be available for support to community care. In addition, institutions attract children and young people to them for financial reasons. The higher physical standards of care may be attractive to poor communities. Financial resources available through the institution to support a child may relieve the financial burden on the family or community. Consequently, many children may end up in institutions when they could be well-cared-for in communities. For example, Save the Children reports that 85% of the children in institutions in Uganda had traceable relatives. (Ibid)

In addition to many problems residential care are fraught with, they are identified to lack vision, and lack viable programs due to shortage of skilled human resource in providing childcare. Based on evidences such as these, many countries have agreed that no new childcare institutions should be built. However, there continues to be wide spread public and political support for these institutions. A few organizations are moving away from providing institutional care to supporting community-based methods of care. (Ibid)

Childcare institutions, however, will continue to exist and operate for the foreseeable future. And, however undesirable residential care might be, there are children who need institutional care. Institutional child care provides a timely response for emergencies and is addressing the needs of large number of children besides saving lives and providing direly needed protection. Nevertheless, some people argue that this should be available as a last resort for children where no other form of care is available. (CHGA, 2004)

If their existence is allowed to continue they should be run to agreed standards to improve services provided for children in their care. Thus, some principles are proposed by concerned parties who refute institutions existence, but aware of their inevitable existence in the near future.

The proposed principles are as follows:

- *No new child care institutions should be built. Current institutions should not expand their residential facilities.*

- *Institutional facilities should be adapted to provide services other than residential care. These might include day care facilities and educational services.*

- *Guidelines and rules for residential care should be adopted by organizations and countries. These should always have the bet interests of the child at their center. Institutions should develop links with their communities and extended families, care should be provided at a level appropriate to the surrounding community. It should seek to provide as close to a family structure as possible. Children should be allowed to participate in all decisions which affect them.*

- *Organizations with experience of providing institutional care should move towards community-based models of care. Resistance from staff, donors and children will need to be overcome. Practical steps include visits to birth places, family tracing and payment for foster care. Experience from Ethiopia shows that it may be bet to try to reunite children under 15with their extended families while trying to assist those over 15 to prepare for independent living. (*Tolfree, 1995*)*

ii. Child family Reunification

Organizations working with children such as the Ethiopian Orthodox Church, Pestalozi Children Village, Radda Barner and the Jerusalem Association Children's Home have been reuniting abandoned children with their parents and reunifying orphans with their relatives while the children are cared for in institutions or at home. Tracing of parents or relatives is done first in a well planned manner, however, time-consuming that may be. Once their parents are traced, they could be reunited with them. Reunification must

however, be based on the willingness of both the children and their traced family members. However, orphans who have no relatives traced or have unwilling relatives to provide the care, still, have to resort to other care options available[1].

iii. Adoption

Adoption is the other alternative child care mechanism. There are many types of adoption; cultural, local, inter-country and so on. However, the most widely practiced of all documented adoptions in Ethiopia since the 1960s has been inter-country adoption. The ministry of labor and social Affairs (MOLSA) has been facilitating the adoption of children by couples and agents from Western Europe, the USA, and Australia[1]. According to MOLSA, a child must meet one of the following and the last criteria to be eligible for adoption:

- *A child must be an orphan*
- *The child must have been abandoned by his/her parents*
- *A child's parents must be terminally ill*
- *Child's parents must have disappeared; and*
- *Child must to be within the prescribed age limit as per the Director issued by MOLSA.*

The prospective parents, too, have to have a verification of their economic status, marital status, health and morality and furnish recommendation papers as regards of their character[1].

The process is quite lengthy and costly. Once the children have been taken abroad, follow-up work to have a first hand look into the actual circumstances they are in has not been carried out yet. In addition, AIDS orphans are unlikely to benefit from this child

[1] National Workshop on Orphans and Vulnerable Children affected by HIV/AIDS, Nazareth, December 13-15, 2001, Save the Children Alliance/ UNICEF

care option. However, if encouraged, adoption by local couples may enable AIDS orphans to benefit from adoption[1].

iv. Community Based Childcare

Community based childcare is a model where orphans are mainly cared for within the extended family and the community. The extended family has long been summoned as the African solution to the orphan crisis. Families cope with relative's death by ensuring that orphans receive care from a substitute caregiver. The extended family support network functions through changes in household composition; relatives move in to households to care for children who survive their parents, or orphans move into households of one or more relatives in response to the overwhelming demands of the epidemic. (CHGA, 2004)

Most of African extended families' sense of duty and responsibility in the past was almost without limit. Orphans were taken in even when a family did not have sufficient resources to care for its existing members. This was the basis for the statement that traditionally, "there is no such thing as an orphan in Africa". Paradoxically, Africa is home to 95% of the children orphaned by AIDS. But, the African extended family has proved to be effective in absorbing millions of orphans and vulnerable children. Its effectiveness has contributed to complacency of external agencies concerning the orphan crisis (Essex et al., 2002/ UNAIDS/WHO, 1999).

The predominant care option for orphans in highly AIDS affected communities in Africa remains to be the extended family. Members of the extended family are responsible for the protection of the vulnerable, the care of the poor and the sick, and transmission of social values. Extended families involve a large network of connections among people representing varying degrees of relationship including multiple generations and reciprocal relations (Jackson, 2002).

[1] National Workshop on Orphans and Vulnerable Children affected by HIV/AIDS, Nazareth, December 13-15, 2001, Save the Children Alliance/ UNICEF

The strength of the extended family in taking in orphans and vulnerable children is reflected by various factors. Purposive fostering is practiced by some societies, whereby children are fostered outside the natal family; in cultures where purposive fostering is practiced, the relatives who have the right to claim a child have an obligation to foster that child at times of crisis. Where contracts with relatives are maintained, orphans are more likely to be fostered. Conversely, orphaned children of migrant workers and commercial sex workers, groups that often have little contract with relatives, are at risk of being abandoned. The other factor is that, where traditional bride price and widow inheritance are practiced, orphan inheritance is common. (Essex et al., 2002)

The traditional community based care model is becoming saturated, overwhelmed, and weakened by a combination of the high increase in the number of orphans, a significant decrease in the number of prime-age caregivers, and a change to the social structure that underpins the traditional safety net. Prior to the impact of HIV/AIDS, changes such as labor migration, the cash economy, demographic change, formal education, and urbanization have weakened the extended families. In general, where traditional values are maintained such as in rural communities, the extended family safety net is better preserved, whereas in more urbanized communities it is weakened. (ibid)

Furthermore, as the impact of HIV/AIDS led to the ever increasing number of orphans and household impoverishment, the extended families' capacity to serve as a social safety net is becoming saturated. The mechanism that keeps families and households from destitution in many AIDS affected communities comprises material relief, labor, and emotional support provided by community members. A common response to economic crisis that result from disasters such as bereavement, all community members are obliged to participate and contribute towards funeral costs. The death of prime-age caregivers as a result of AIDS coupled with the adverse impact upon communities and families as a result of the widespread and progressive economic impact of AIDS is overwhelming the capacity of the traditional safety net (ibid).

The combination of the aforementioned three factors means many orphans leak through the overstressed safety net. They fall under the care of the poor and the elderly, especially to women. According to a study made on five highly AIDS affected African countries, from around one quarter of orphans in Niger to over one half of orphans in Zimbabwe live in households headed by grandparents. This situation is actually one of mutual support with increasingly frail grand parents being cared for by grand children. Children as the result of the weakened traditional safety net, often end up in a variety of vulnerable situations. Children as young as 11 or 12 years old are left to live by themselves often heading the household. Rising numbers of orphaned children living on the street, working children, and children dropping out of school to provide care giving or labor are all indicators of stress on the safety net (Bicego et al., 2003 / Essex et al., 2002).

Orphans cared in the community by prime caregivers also fall into some vulnerable situations; sexual and physical abuse, exploitation of their labor, etc. Orphan girls are particularly vulnerable to these situations. In situations where children are living outside of family-care, most countries including Ethiopia have laws that allow the state to have legal responsibility of the child. The state has to ensure that the child under care is not abused or exploited. However, since most forms of community care are informal and not recognized by law, it is difficult for the state to place children under its care[1].

At present, External Agency based interventions of international and local NGOs, the government, and the like have considered the strength and advantage of community based childcare in their efforts against the epidemic, and are working to improve its difficulties limitations in the care and support process. In various communities of Addis Ababa, the support provided for AIDS orphans by external interventionists is facilitated through guardians and community based organizations such as *Iddirs* and other associations[1].

[1] National Workshop on Orphans and Vulnerable Children affected by HIV/AIDS, Nazareth, December 13-15, 2001, Save the Children Alliance/ UNICEF

B. Efforts

i. International Level

In order to understand the current scale of problems exerted by HIV/AIDS, it is important to assess efforts made to mitigate AIDS at all levels. The three critical cornerstones of AIDS policy are effective prevention, care and long term mitigation of impact of HIV/AIDS. In most developing countries the scale of response, however, remains below what is required for the aforementioned cornerstones of AIDS policy, primarily, due to inadequate international and local funding, weak political response within countries, and too little human resource mobilization in a context of continuing stigma, discrimination and abuse of human rights. It is suggested that the broad development framework should incorporate HIV/AIDS within different sectors. Three concerns stand out above all others regarding international and national policy on HIV and AIDS. First, mass international and national response is required. Second, the response must be based on within a solid human rights framework. Third, HIV/AIDS must be viewed as an incremental development crisis, and the response must be genuinely multi-sectoral at all levels and take a long term perspective (Jackson, 2002).

Responses made by many countries, early in the epidemic, were restrictive and discriminatory. The Universal Declaration of Human Rights and other binding treaties on civil rights, the rights of women, the right of children, and others, to which many countries are signatories, are becoming taken seriously. Charters, conventions and declarations have formed broad internationally agreed goals for incremental achievement. However, little or no international sanction is made against failure to achieve human rights in most areas. (ibid)

The second International Consultation on HIV/AIDS and Human Rights in September 1996 drew up 12 international guidelines that form a broad basis for international policy around HIV/AIDS. The guidelines relate to three areas:

- Improving the accountability and multi sectoral response of governments.
- Wide-ranging law reform and legal import services around discrimination, privacy, criminal law, public health, and the specific needs of vulnerable groups such as women, children, sex workers, prisoners and others.
- Helping build an effective and ethical response in the community and the private sector. (OHCRC, 1996/UNAIDS, 1998)

In regards to children the United Nations Convention on the Rights of the Child (UNCRC) enshrines guidelines within which countries should develop national laws and policies that affect children. Key provisions of the UNCRC relevant to national responses to the AIDS epidemic, among other concerns, include:

- Article 3: includes the provision that the best interests of the child shall be a primary consideration in matters concerning children
- Article 5: recognizes the responsibility of the extended family, community or legal guardians to provide for children in a manner consistent with their evolving capacities
- Article 8: addresses the right of children to preserve their own identity, including their name and family relations
- Article 12: recognizes children's rights to be heard in any proceedings that concern them
- Article 18: recognizes the responsibility of the State to support parents and legal guardians in their child-rearing responsibilities and to develop services for the care of children
- Article 19: concerns the protection of children from abuse, neglect, maltreatment or exploitation
- Article 20: concerns the responsibility of the State to provide special protection for children deprived of their family environment
- Article 21: addresses safeguards around adoption

- Article 24: recognizes the right of children to the highest standard of health and access to health services
- Article 25: concerns the periodic review of the situation of any child placed in care
- Article 27: recognizes the right of children to an adequate standard of living
- Article 28: concerns the right of all children to education
- Article 32: addresses the protection of children from economic exploitation
- Article 34: asserts the right of children to protection from sexual exploitation and abuse (CYFWO, 2004)

In addition to policy makers, these provisions can assist child rights advocates, service providers and communities in their efforts to ensure that AIDS affected children's rights and needs are maintained.

Usually in collaboration with UNAIDS, various international resolutions, declarations, recommendations and commitments continue to be made around HIV/AIDS by the UN, governments, and other development partners committing to scale up funding, promote human rights, increase openness, and to expand responses for HIV prevention, care, and long term mitigation (Jackson, 2002).

The following part discusses the key partners involved and major initiatives set to mobilize resources and put words into action. The initial lead agency on AIDS was WHO, that had defined AIDS as a health concern, only later as a concern for development. In recognition for the need for multi-sectoral and multi-disciplinary response, UNAIDS, the joint program on HIV/AIDS, was established. UNAIDS aims to bring together the diverse UN response to the epidemic to assist governments develop national responses based on respect for human rights. UNAIDS and the cosponsors also work increasingly with the entire non-government sector, ranging from CBOs to the private sector. The initial cosponsors of UNAIDS when it became operational in 1996 were: UNICEF, WHO, UNDP, UNFPA, UNESCO, and World Bank (Ibid).

UNDP with a primary focus on poverty reduction and human development has long had an HIV/AIDS development program which focuses on human rights, stigma and discrimination. It has also supported the development of support networks of people living with HIV/AIDS, and declaration of human rights. The other cosponsor of UNAIDS, UNESCO, has focused particularly on the impact of AIDS on education and on prevention programs to in-and-out-of-school youth. And, UNICEF with its right-based focus on children recognizes AIDS as the most critical issue for children in much of Africa. Among other efforts, UNICEF led on preventing transmission to infants through voluntary counseling and testing in antenatal care settings and accessing antiretroviral, as well as policy development and support around obstetric and infant feeding practice. WHO on the other hand remains the lead organization on HIV and AIDS surveillance, care, treatment and related medical concerns. Somewhat with different position from other cosponsors, the World Bank is the major international financial lender to governments. With respect to AIDS, it has commissioned extensive research into the macro, sectoral, and micro-socioeconomic costs of the epidemic, amongst other efforts (Ibid).

Many other international, regional and national organizations, too many to enumerate, collaborate closely with UNAIDS, and the cosponsors in various ways. Bilateral donors and other government agencies for example, SIDA, ICASO, and USAID, have also undertaken restructuring and changed their development focus to incorporate HIV/AIDS, increasingly recognizing that they can not address the epidemic sufficiently form their health desks alone. Funding for AIDS is also expanding from the private sector, including major pharmaceutical companies.

Organizations and networks of PLWHA are playing a special role at all levels from international policy to individual and community support. PLWHA representatives have been particularly impressive and legitimate spokespeople for human rights and policy issues around HIV/AIDS. Furthermore, UNAIDS (1999) pointed out that involving PLWHA in providing a basis for partnership, mutual respect and understanding breaks

down simplistic concepts of 'service givers' that is the person who is not HIV-positive, and 'service giver', the person who is (ibid).

Many international NGOs such as Save the Children UK and USA, Help age International, Action Aid etc. are also increasingly involved in AIDS, some making it their integral part of their wider development or relief focus (ibid).

The G8, the foremost powerful nations of the world, meeting in Okinawa in 2000 made a commitment to set up what has become known as the Global Fund to fight HIV/AIDS, Tuberculosis, and Malaria (GFATM). The Global Fund has gained wide international acceptance with its aim to strengthen national and international responses to these diseases. In the first round submission of country applications, in March 2002, nearly 70% of all submissions, the majority being for HIV/AIDS, were from sub-Saharan Africa. Ethiopia, however, had received a lower award. Global funding in general has increased from roughly US$ 2.1 billion 2001 to an estimated US$ 6.1 billion in 2004, of which the Global Fund contributes to more than 80% (UNAIDS, 2004/UNFPA, 2001).

Despite, some signs of progress in the international endeavor, funds for the epidemic are still far too low than it deserves, and there is still high prevalence level of the epidemic worldwide. If the coverage is not highly accelerated, two to three million people will die every year for the next two years and increasing (UNAIDS, 2004).

ii. Local Level

Governments, especially developing Sub-Saharan countries, cannot tackle alone a development crisis on AIDS' scale, but they are critical leaders and partners in the response to the epidemic. Governments need to act with urgency and scale of response required, and set legal and policy framework to orientate and coordinate the response and to ensure services are mobilized from internal and international sources. The NGO or Private sector will not provide certain public goods that require government to commit part of its own budget and mobilize external resources. Delate (2000) notes that the

critical role of government includes: developing effective frameworks that ensure a coordinated, participatory, transparent and accountable responses to HIV/AIDS; encouraging the involvement of all ranges of non-governmental organizations and groups; safeguard the rights of people living with HIV and those affected by HIV by making changes to public health legislation, criminal and anti-discrimination laws; and creating a supportive and enabling environment for women, children and other vulnerable populations. (Jackson, 2002)

Many African countries have developed national polices around AIDS concerning discrimination, employment and other areas most in the context of national strategic plan on HIV/AIDS. According to UNAIDS/ ECA (2000), 16 African countries including Ethiopia by the end of 2000, had a high level national structure responsible for leading or coordinating the response to HIV/AIDS. Most started with national AIDS programs based in health ministries, but while often retaining these structures, they have now developed national structures with a much wider mandate than health services and public health. Some have developed sectoral policies, of which health policy has generally been the most widely developed. Military policy follows, and work place and educational policy are the next most frequently cited areas. In addition, strategies and priorities for vulnerable children and orphans are set by many countries, though not formulated as national policies.

In Ethiopia, a national HIV/AIDS policy is formulated in August 1998, and documentation is written both in English and in Amharic. The general National HIV/AIDS Policy covers all sectors. None of the specific sectors, however, has its own HIV/AIDS policy. Although each sector in Ethiopia does not have its own HIV/AIDS policy, the Health policy, the Education and Training policy, Developmental Social Welfare policy, among other sectoral policies incept in their general objectives and aim to address issues concerning vulnerable groups, especially children and women, and include persons affected or living with HIV/AIDS in their specific provisions. (MOH, 2003)

The developmental social welfare policy gives special attention to the welfare situation of vulnerable groups, especially children. The policy has strategies on numerous major issues directly concerned with the welfare situation of children. The policy considers community based approach as the best way to implement prevention, rehabilitation and developmental programs. The Ministry of Labor and Social Affairs (MOLSA) asserts that the policy is designed to coordinate the efforts of governmental as well as non-governmental organizations, civic societies, and individuals in the efforts to mitigate and eventually reverse social problems of vulnerable children. (MOLSA, 1996)

The main objective of developmental social welfare policy is "the creation of an environment conducive to promote a healthy life and sustainable development of vulnerable groups". The policy articulates the following centers of attention that may be beneficial to children afflicted by HIV/AIDS:

- *Ensuring children's all-round and harmonious development through extending appropriate and comprehensive care and services*
- *Facilitating conditions to enable children develop a sense of identity and belongingness and grow up to be self-confident citizens*
- *Making all efforts to implement international and regional conventions and legal instruments concerning the rights of the children*
- *Provision of the necessary support and incentives to the effort in the expansion of child development-oriented daycare centers, kindergartens*
- *Support to any effort that is being made towards the establishment and operation of child welfare and development organization and services by appropriate government organs, communities, non-government agencies, voluntary associations and individuals*
- *Making every effort to create an environment conducive to addressing problems of children in especially difficult circumstances*
- *Facilitating conditions that will enable orphaned and abandoned children to get the assistance they need and eventually be self-sufficient*
- *Making all efforts to provide protection against child abuse and neglect*

(ibid)

Community participation, partnership and coordination, programs and services, social welfare related laws, and advocacy and awareness-raising are among the major strategies adopted by the policy to effectively implement programs and to primarily address the problems of the vulnerable groups and marginalized sections of society. Inception of the aforementioned impressive focus areas and strategies is a major step in government concern and involvement. However, according to Dr. Bulti Gutema from the Ministry, although attempts are being made to make the policy known to the public, the organizational structure which enables concerned organizations and institutions to address the problem and look for alternative ways together with the community is still lacking. (MOLSA, 1996/ SCA, 2001)

The Convention on the Rights of the Child was ratified in Ethiopia on December 9, 1991, and proclaimed in the 'Negarit Gazetta' (a local newspaper) on January 30 1992. Different measures have been taken at Federal and Regional levels to realize the commitments promised since the ratification of the convention. The convention is translated into different languages of the country to make its basic principles known to the public. However, although no impact assessment is made on how the translated copies are utilized, according to various operational researches, the commitments so far demonstrated by all concerned parties to translate and promote the convention into tangible reality are far from expectation. (SCA, 2001)

MOLSA has incorporated the principles of the Convention on the Rights of the Child. However, in line within its mandate, it is confined to policy issues, research and creating enabling environments to empower the regional bureaus and nationally based associations to provide adequate services for its own target groups. The ministry is not expected to involve in direct implementation of activities at the grass roots level as these activities are relegated to regional bureaus. A number of orphanages used to be administered by the Ministry before they were handed over to regional bureaus. However, the Ministry engages itself in the processing of adoption services to orphaned and vulnerable children. Concerning orphans and vulnerable children, the Ministry

facilitates special protection supports in the form of community support, family support, sponsorship, and reunification programs. (ibid)

The Ministry has prepared operational guidelines on CRC and on inter-country adoption, and has prepared different alternative childcare guidelines in order to facilitate various programs provided to OVC. Furthermore, the Ministry had participated in different activities prior to the establishment of the National HIV/AIDS Council being a member of the UN-AIDS Team group. In addition, it had participated in the process of the realization of the National Council. It is still the advisory board to the council. (ibid)

In regards to health, the health policy gives special attention to the health needs of the family, especially children and women. No. 8.3.1 of the Health Policy ensures children's rights to enjoy the highest attainable standard of health, which is in accordance with article 24 of the CRC. However, the health services available in Ethiopia fail to give adequate health services anticipated by both the policy and the convention. (MOH, 1993)

The ministry works with various associations and facilitates different programs such as primary health care, resource mobilization, prevention, surveillance and care for mother and child etc. It supports civil societies and non-governmental organizations. It is also a member of the National Secretariat concerned with the provision of care and support to PLWHA. Moreover, the Ministry advocates on policy reviews and changes through a committee. (SCA, 2001)

In regards to education, the CRC treats education, in Article 29 as a means that should be directed towards the development of a child's talents, mental and physical ability and personality. According to the Ministry of Education, the education policy is designed to enable school age children acquire basic knowledge, skill and attitudes necessary for enhancing development. Although the Ministry does not have a program that deals with children affected by HIV/AIDS, it has a general objective of providing education to all children, and elementary education is given for free, enabling OVC to take advantage. Nevertheless, currently, more than 50% of school-age children are out of school due to

various challenges. By the year 2015, the Ministry plans to give free education to all children. (MOE, 1994)

In addition, the Constitution of the Federal Democratic Republic of Ethiopia, considers children as groups needing special attention, and states Articles in favor of children. It recognizes the principle of the best interests of the child in all areas of their concern. For example, in a section of the rights of the child in the Constitution, Article 36 fully devotes to the cause of children; it states that every child has the right to life, name and nationality, to know and be cared for by his/her parents or legal guardians, not to be subject to exploitative labor practices, neither to be required nor permitted to perform work which is hazardous to his/her education, health, or wellbeing, to be free of corporal punishment or inhumane treatment in schools and other institutions responsible for the care of the children. Moreover, according to Article 90 of the Constitution, policies shall aim to provide all Ethiopians access to social welfare services to the extent the country's capability permits. (SCA, 2001)

In Ethiopia the foremost non-governmental agencies working with the government are bilateral NGOs such as DFID, EEC, JICA, USAID etc. Since the early nineties, they have been working with the Federal Government forming partnerships. The partnerships have been working on sectoral development programs, which are believed to play a vital role in the development process of the country as well as the welfare of children. The programs mainly include development of the educational sector, health sector, and infrastructure. Besides, these organizations have been extending their efforts in combating HIV/AIDS through allocating funds to and building the capacities of organizations working at the grassroots level, including those working with OVC. Most international NGOs too, are working in partnership with grassroots implementer organizations, associations etc., restraining themselves from direct implementation, in belief that implementer parties close to the community yield better results. (van Diesen and Walker, 1999)

At the grassroots level, few international NGOs, most of the local NGOs, Community Based Organizations such as Iqubs and Iddirs, other associations, support groups, and clubs are identified to work with orphans and vulnerable children. Most of the children who are cared for are children orphaned and made vulnerable as the result of HIV/AIDS. According to organization profiles of 11 sample NGOs and CBOs in Addis Ababa by Selamawit (2005), the following major provisions were made to OVC:

- Community based support
- Basic necessities - food and shelter
- Educational materials, school uniforms, school fees, skill training
- Health care service
- Recreational service
- Counseling and guidance
- Tutorial service
- Group home provision
- Institutional care
- Home based care
- Prevention and control of HIV/AIDS
- Promoting rights of AIDS orphans
- Legal service, and
- HIV/AIDS education

In order to scale-up the protection of children from various forms of abuse and exploitation, the Police Commission has been working with non-governmental organizations working with Orphaned and Vulnerable Children. In 2001, Child Protection Unit Program was operational in ten Woreda Police Stations in Addis Ababa. Five other units have also been established in three regional cities. The unit has members from the police, social workers, and volunteers. The program does not directly address the problems of HIV/AIDS. However, it has provided substantial support especially to OVC. It deals with those who are afflicted by HIV/AIDS among other children orphaned and made vulnerable due to other causes in instances when children are sexually abused,

AIDS orphans are left without a caregiver, AIDS orphans' legal rights are denied by care takers, displaced children need referral to rehabilitation centers and places where they can get help, and police patrol is carried out in the places where street children spend the night (SCA, 2001).

The step taken by the police is an impressive step in the efforts to protect children orphaned and made vulnerable as the result of AIDS. However, problems such as lack of a legal entity that follows up cases of AIDS orphans in regards to their inheritance and other legal rights, difficulties to undertake mandatory test for sexual abusers for HIV/AIDS, absence of free medical checkup for both sexual abusers and victims etc. are obstacles in the endeavors of protecting children's rights. (ibid)

2.4. Theoretical Framework

Social Capital: Assistance to Children Affected by HIV/AIDS

According to Hunter (2003), the many streams that come under the auspices of the broad concept of social capital show its 'many-headed' nature.

> It is seen as a public good that is under-invested in the communitarian tradition. For Coleman (1988), it is close to a private good. While for Portes 1998; Portes & Landolt 1996 it assumes a resemblance to a club good. Woolcock (2001) documents how social capital has been re-invented many times in many different guises. Clearly, social capital is a multifaceted concept that opens the possibility of understanding social problems and rationalizing policy action at a number of levels.
>
> (Hunter, 2003)

Social Capital Theory, according to Bordieu (1993) and Coleman (1988), can be defined broadly as networks of social relations which are characterized by norms of trust and reciprocity and which lead to mutually beneficial outcomes (Hunter, 2003). According to Putnam, from his study and comparison between North Italy (economic growth and democracy) and South Italy (where the Mafia rules), social capital is incorporated in the

trust people feel vis-à-vis each other and the social, economic and political systems in which they are involved. Trust can develop if people often meet and can do things together. Through all interactions, the citizens will learn to trust each other. They become interdependent in the sense that "if I do what I am supposed to do for you, you will also do for me what is expected from", a kind of balanced reciprocity. When this goes on for a long time – several generations – trust develops (Putnam, 1993).

According to Woolcock (2000), social capital arising from social networks has been classified into three types: bonding, bridging, and linking. Bonding social capital is said to exist in dense or closed networks (e.g. among immediate family and friends), and helps people to 'get by' in life on a daily basis. Bridging social capital involves overlapping networks that may make resources accessible across various networks. 'Linking' social capital is a concept that involves social relationships with those in authority or positions of power, which is also useful for securing resources. (Hunter, 2003)

In understanding the effect of HIV/AIDS on children and these children coping with their situation, this paper attempts to understand the role of social capital at the individual, family, and community level in relation to children's wellbeing. Coleman, the forefather of social capital theory, defines social capital:

> ... *a particular kind of resource available to an actor, comprising a variety of entities which contains two elements: they all consist of some aspect of social structures, and they facilitate certain actions of actors ... within the structure.* (Coleman, 1988: 98)

Therefore, it is through the interplay of the individual and the group that social capital can be created and actualized, thereby potentially increasing one's well-being. It should be noted, that well-being can be defined by any of a number of indicators. (Bassani, 2003)

In his later work, Coleman defines social capital more specifically in terms of children:

> *What I mean by social capital in the raising of children are the norms, the social networks, and the relationships between adults and children that are of value for the child's growing up. Social capital exists within the family, but also outside the family.* (Coleman, 1990: 334)

Although he stated that the vital relationships, through which social capital is built, exist between children and family members as well as with adults outside the family, an important relationship that Coleman did not discuss is that between peers and siblings, both of which have impacts on the child's well-being. (Bassani, 2003)

One can distinguish between the structural and cultural aspects of social capital. Connections or networks are seen as structural whereas the cultural aspects of social capital are defined in terms of the norms, manners and customs related to these networks. While this distinction offers the prospect for refining the conceptualization, it is also necessary to be clear whether social capital is the 'property' of individuals or is a collective good, by definition available to every citizen. Whether, the view of social capital is either collective or individual in nature is heavily influenced by disciplinary perspectives. Woolcock (2001: 12), a sociologist with the World Bank, claims that whereas human capital resides in individuals, social capital resides in relationships. (Hunter, 2003)

Another approach has been to advocate a leaner conceptualization of social capital that focuses on sources of social capital (i.e. networks). Before providing a theoretical framework for this paper, it is important to outline briefly the various streams of thought in social capital theory.

Woolcock (2000) describe several conceptualizations of social capital. The *communitarian* perspective equates social capital with such local organizations as clubs, associations, and civic groups. (Hunter, 2003).

The *networks* view of social capital stresses the 'importance of vertical as well as horizontal associations between people and of relations within and among such organizational entities as community groups and firms' (Ibid).

The *institutional* view of social capital emphasizes the role of political, legal and institutional environment in determining the vitality of community networks and civil society (Ibid). (Hunter, 2003) asserts that there is still a role for institutional factors to explain the efficacy of social networks in achieving certain goals even if certain macro aspects of social capital are drained off under the banner of 'social capabilities'.

Woolcock (2000) advocate a *synergy* view that combines the *institutional* and *network* approaches to social capital. They dismiss the difficulties in reconciling the macro and micro aspects of these two largely competing views of social capital. They suggest that the central task for policy analysis is to show how to transform situations where a community's social capital substitutes for weak, hostile, or indifferent formal institutions into situations in which both realms complement one another. Nevertheless, Hunter (2003) criticized this view for being easier said than done, while being a laudable goal. (Hunter, 2003)

Coming back to the approach of linear conceptualization of social capital, we find Portes' (1998) four (sociological) sources of social capital. (see Fig. 1). *Value introjection* is a source of social capital that comes from shared values or cultural beliefs. An example of this source is what Hunter (2003) described as a commonality, the importance of kin among the heterogeneous Aboriginals. *Bounded solidarity* is another source of social capital springing from like people being in like circumstances. The third source of social capital mentioned by Portes is *the reciprocity of exchanges*. The final source of social capital mentioned by Portes is that of *enforceable trust*. This is the mechanism that *trust* maintains the reciprocal obligations and social norms existing within a community. (ibid)

Fig. 1. A sociological perspective on the dynamics of social capital

Source: (Hunter (2003), adapted from Portes. 1998: 8).

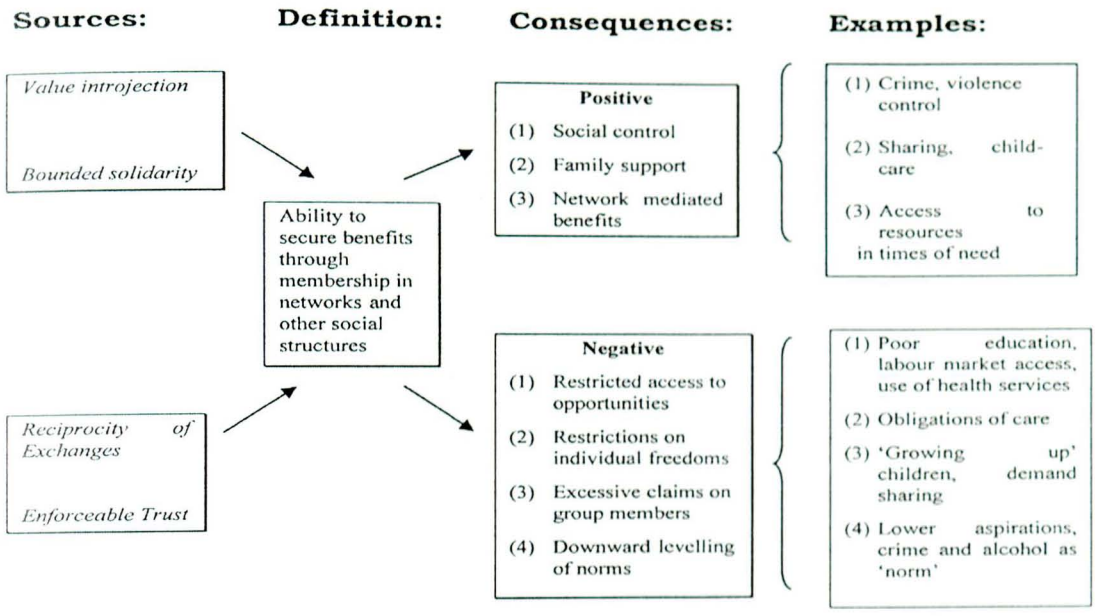

Fig. 1 also documents both the positive and negative consequences of social capital. The first positive effect of social capital is its impact on social control, often found in bounded solidarity or enforceable trust. Here, the community acts as an informal disciplinary mechanism that maintains social control through the threat of community action. The second positive effect of social capital is that it is a source of family support. Sharing is recognized as a direct means of family support by cushioning the impact of financial constraints through the distribution of collective resources (monetary and non-monetary). The final positive effect of social capital is that it secures network-mediated benefits beyond the immediate family. In addition, Portes' review teases out the four major negative consequences of social capital. They are the exclusion of outsiders, excessive claims on group members, restrictions on the freedom of individuals, and the downward leveling of norms (ibid). I hold that this approach may support in the purpose of this paper in understanding how social capital at the community level helps AIDS affected children in coping up with their problems, however, it fails short in explaining clearly how individuals within the same social network utilize social capital differently.

Later, the concept of social capital has been used for individuals. This strand was developed by especially Bourdieu. The understanding is that some individuals have more social capital than others do. This refers to their position in the society's social structure. According to Lin (2001), providing a summary of the formation and utilization of social capital, within society an uneven distribution of social capital develops through the combination of individual (one's position in society) and group (shared assets that are accessed via participation in social networks) capital. This formula accounts for the disproportion of social capital between individuals, for social capital is uniquely constructed based on the specific circumstances. It is important to indicate here that inequality is a fundamental component of the theory. (Bassani, 2003)

According to Bassani (2003), within a child's social network, he or she may attain social capital directly or indirectly via an adult or his or her peers. The younger the child, the more likely that he or she will depend on indirect forms of social capital which are brought into the child's social networks by adults, for children do not have the social or economic resources that are essential for the creation of social networks. As children enter into adolescence, they are exposed to more social networks due to their own social exploration of their community and peers. Peers play a fundamental role in accessing forms of social capital, for children learn and are socialized by peers in addition to the adults in the networks to which they belong. As stated previously, social capital can indirectly be passed through to the child via adults who are intimately tied to the child, such as parents, family members, and teachers. (Ibid)

Lin (2001) distinguishes three basic levels of social networks that the child may develop in: the micro, mezzo, and macro. The child and his or her family comprise the micro level network; the family can also be viewed as one of the five mezzo networks that influence the child's well-being, as it interacts with other families in its mezzo level network, which consists of the community, the school, parental work, and leisure networks. Holding together the mezzo sphere are the macro networks, which include government, tradition, and media. These three levels of social networks are intricately intertwined and interdependent on one another. Bassani (2003) states that these three basic levels of theorization always exist irrespective of the country or culture that the child is born into.

Due to time and page limitations I leave this argument to contests with further research, and this paper will focus more on social networks that exist between children themselves, children and their parents, other family members, the community, the school, and other networks of their parents. It will look at how children's networks at the household and community level, and the networks of their parents be it relatives or non-relatives assist them in coping with problems inflicted by HIV/AIDS, and relate the problems faced by orphans with their social capitals that are unequally utilized and distributed among them.

Taking the discussion to the focal point of the paper's issue, social capital at different levels can have impacts in mitigating the effects of HIV/AIDS on children. On the contrary, social capital can be weakened by the impacts of HIV/AIDS in assisting community members with their felt problems. The illness and death of household members can disrupt a household's links to their extended family and the larger community. In areas where cultural practices limit women's participation in formal organizations outside the home, the death of a male breadwinner can seriously impair a household's ability to access community resources or even receive family support. Nonetheless, studies indicate that households affected by HIV/AIDS draw their support primarily from family, neighbors, community institutions and informal organizations (Mutangadura et al. 1999). Thus, the social capital of households operating through their relationships with extended kin and the community is critical to their ability to recover from the illness and/or death of a household member due to HIV/AIDS. The social capital linkages that support AIDS affected and infected children and that can be affected by HIV/AIDS include; relationships with extended family members, linkages to formal and informal community organizations (social support groups), community labor sharing for housework and/or child care, extended family and/or community willingness to foster orphaned children, community willingness to support educational and nutritional needs of orphaned children (school fees, uniforms, supplemental feeding, etc.) (Shannon, 2003)

Likewise, a community's level of social capital can have major impacts on mitigating the effects of HIV/AIDS. Communities with high levels of social capital can provide affected households with a variety of social support activities that permits families to adjust to the

illness or loss of members. Conversely, communities with low levels of social trust and solidarity can leave households and families to fend for themselves or even to isolate and ostracize those households afflicted with HIV/AIDS. The strength of social ties, social trust and relationships within a community, the sense of collective responsibility and common outlook, all influence a community's willingness and ability to organize and support affected households. In view of the epidemic, some communities have provided a variety of support and mitigation activities. Some have organized community-based childcare, including cooperative day care and nutrition centers to permit women to work outside the home. Others have provided nutritional and educational support to orphans, home care and visitation programmes for orphans and HIV/AIDS patients, apprenticeship projects in marketable skills for orphaned adolescents, labor sharing arrangements and credit schemes for funeral benefits, among other activities (Mutangadura and Jackson, 1999). With increasing prevalence of HIV/AIDS in a community, the question arises as to how long even those communities with substantial social capital can continue to offer such support to affected individuals, families and households. The impact of HIV/AIDS also weakens the social capital at the community level. Among the social capital effects within a community as the result of HIV/AIDS are:

- Change/disruption of kinship and extended family ties in the community
- Change/disruption of formal and informal organizations in the community
- Changes/disruption in labor-sharing arrangements
- Increase in demand for community care for sick and dying members
- Increase in demand on community social support and self-help organizations
- Increase in demand for child fosterage within the community
- Increase in demand for child care within the community
- Community disintegration (breakdown in socialization, cultural transmission (Shannon, 2003)

CHAPTER THREE

3. Background of the Studied Areas

3.1. Background of Arada Sub-city, Kebele 08

Kebele 08 is one of the seventeen Kebeles administered under Arada Sub-city. It is situated in the northern part of Addis Ababa commonly known as "Semen Mazegaja", approximately two and a half kilometers away from an area known as "Giorgis" where high urban activity is observed. According to the 1994 census report Kebele 08's total population size was projected to be 17452 by the year 2004, of which more than half, 9450, are females. The report also indicates that there are 2543 households, of which most are women headed households.

According to the archive of the Kebele Administration, there are 2312 housing units in the Kebele, of which 1386 (60%) are Kebele owned with monthly rent ranging from Birr 1 up to Birr 100, 692 (29.9%) are privately owned, 104 (4.4%) are owned by Rental Houses Administration, and 128 (5.5%) are commercial facilities, of which some are used for both commercial and residential purposes.

In regards to access to education, the results of the survey reveal that there are four preschools, two elementary schools, and one high school in the Kebele. The preschools and one of the elementary schools incur monthly school fees ranging from Birr 30 up to Birr 100. Two of these preschools are privately owned and the other two are owned by Catholic Missionaries. The elementary school with monthly tuition fees is a public school, and the other elementary school and the high school are government owned only with an annual registration fee of 20 Birr. There are 448 pre students, 2499 elementary students, and 1951 high school students in the Kebele. The archive of the Arada Sub-city reveals that there are thirteen high schools with 13209 students in the whole Sub-city.

According to the Report on Welfare Monitoring Survey, 2000, 95.3% of households in Addis Ababa can get health assistance in a distance of less than 5 kilometers. In the

Arada Sub-city there are three government owned health centers, one private clinic, two government owned hospitals, and four government owned health posts.

3.2. Background of Kolfe Keranio Sub-city, Kebele 09

Kebele 09 is one of the sixteen Kebeles administered under Kolfe Keraino Sub-city. It is situated in the outskirt of the northwestern part of Addis Ababa in an area commonly known as "Kolfe". According to the 1994 census report Kebele 09's total population size was projected to be 17,854 by 2004, of which 8408 are females. The report also indicates that there are 2543 households.

The archive of the Kebele Administration reveals that there are 2458 housing units in the Kebele, of which 474 (19.3%) are Kebele owned with monthly rent ranging from 1 Birr, 744 (30.3%) are private owned, 356 (143.5%) are owned by Rental Houses Administration, 73 (2.96%) are commercial facilities, of which some are used for both commercial and residential purposes, 316 (18.34%) are unregistered houses, and 316 (12.85%) are in the Federal Police Training Camp. The camp residents are not included in the sample because of their temporary residence status. Alike Kebele 08 of Arada Sub-city, most of the housing units in the Kebele are observed to be in a dilapidated condition and lack basic facilities such as toilet, waste disposal system, kitchen etc.

Education access wise, there are four preschools, and two elementary schools in the Kebele, and two government high schools and missionary high school outside the Kebele and in the Sub-city. The preschools and one of the elementary schools incur monthly school fees ranging from Birr 30 up to Birr 100. Three of these preschools are privately owned and the other one is owned by Catholic Missionaries. One of the elementary schools is a public school. The aforementioned preschools and primary schools incur monthly tuition fees, similar with Kebele 08 of Arada Sub-city, ranging from 30-100 Birr. The other elementary school and the high schools are government owned only with an annual registration fee of 20 Birr. And, there are a total of 484 preschool and 7301 elementary school students.

3.3. Demographic Structure, Education, Employment, and Income of Sample Households

Survey was carried out on selected sample households of both Kebele 08 in Arada Sub-city and Kebele 09 in Kolfe-Keranio Sub-city in order to appraise relevant information about the people and households in both communities that would serve as background information for further findings as per the objectives of the study. Thus, demographic social and economic indicators of the households relevant to understanding the status of the communities where AIDS affected children and orphans may face problems and cope with the problems.

3.3.1. Arada Sub-city Kebele 08

A. Age and Sex Composition

Of the total sample households, table 1 indicates that 56.7% are female while the remaining 43.3% are male. About 7% are children under 10 years of age and 1% is infants 1 and below years old, where as about 26.6% are children below 18 years old which could be obtained computing the cumulative percentage for the age groups below 18 years. The youth between 19 and 24 years old account for 18.3%. Within the age group 25 – 35 and 36 – 55, women account for the majority 51.8% and 66.8% respectively. On the other hand the elderly above 55 years old account for 9.4% of the sample population, of which, 47.6% are women.

Table1. Sex and Age Composition of the Sample Households

	Sex				Total		
	Male		Female				
	Count	Row %	Count	Row %	Count	Row %	Col%
<= 1	3	27.3%	8	72.7%	11	100.0%	1.0%
2 - 10	34	49.3%	35	50.7%	69	100.0%	6.2%
11 - 18	99	45.6%	118	54.4%	217	100.0%	19.4%
19 - 24	77	37.6%	128	62.4%	205	100.0%	18.3%
25 - 35	150	48.2%	161	51.8%	311	100.0%	27.8%
36 - 55	67	33.2%	135	66.8%	202	100.0%	18.0%
56+	55	52.4%	50	47.6%	105	100.0%	9.4%
Total	485	43.3%	635	56.7%	1120	100.0%	100.0%

B. Family Size of the Sample Households

As can be seen from the table below, the majority of the sample households have a family size between 3 to 7 persons, the mode being 6 persons accounting for 16.2 % of the sample households. In some households, the number of household members goes up to 12 to 14 persons.

Table 2. Number of people in a household

Number of People in a Household	Frequency	Percent
1	5	2.5
2	11	5.5
3	25	12.6
4	29	14.6
5	30	15.2
6	32	16.2
7	27	13.6
8	16	8.1
9	9	4.5
10	4	2.0
11	6	3.0
12	2	1.0
14	2	1.0
Total	198	100.0

C. Marital Status

In regards to marital status, the following results were obtained.

Table 3. Marital Status of the Sample Households

	Marital Status	
	Count	%
Single	646	62.8%
Married	289	28.1%
Divorced	25	2.4%
Partner Deceased	69	6.7%

Based on the findings from the survey, marital status was computed only for members of the sample households above 9 years old. As can be seen from the table about 28% of members of the households are married while the majorities 62.8% remain single. Those who are divorced account for 2.4% of the sample population where as the widowed account for 6.7%. This figure is noteworthy compared to the total married population, indicating the significant number of orphans and evident vulnerability for the households

especially for orphans in these households due to losing a parent.

Table 4. Age and Marital status of the sample house holds.

		Marital Status								Total	
		Single		Married		Divorced		Widowed			
		Count	%	Count	%	Count	%	Count	%	Count	%
AGE	10-18	218	33.7%	4	1.4%	1	4.0%			223	21.7%
	19-25	234	36.2%	19	6.6%	2	8.0%	1	1.4%	256	24.9%
	26-35	171	26.5%	66	22.8%	6	24.0%	4	5.8%	247	24.0%
	36-45	20	3.1%	64	22.1%	8	32.0%	19	27.5%	111	10.8%
	46-60	3	.5%	97	33.6%	4	16.0%	31	44.9%	135	13.1%
	61-75			36	12.5%	4	16.0%	13	18.8%	53	5.2%
	76-<			3	1.0%			1	1.4%	4	.4%
Total		646	100.0%	289	100.0%	25	100.0%	69	100.0%	1029	100.0%

The results of the survey reveal the existence of child marriage in the community. Married children represent 1.4% of the married population, which is noteworthy. Moreover, there is moderate increase in the numbers of married persons with the age group 19 – 25, followed by more increasing shift of the numbers of married persons within the successive age groups. Likewise, divorce increases gradually along the successive increasing age groups up to age group 46 – 60 where the number decreases. Widowhood is evidenced to be the highest among the age group 46 – 60 followed by the age groups 36 – 45 and 61 – 75.

D. Headship structure of the sample house holds.

Table 5. Age, sex and headship structure of the sample households

Age	Dependents in Households						Heads of Households					
	Male		Female		Group Total		Male		Female		Group Total	
	Count	% Col.	Count	% Col	Count	% Col	Count	% Col	Count	% Col	Count	% Col
10-18	103	31.2%	122	24.9%	255	27.5%	1	.8%	3	2.8%	4	1.7%
19-25	95	28.8%	155	31.7%	250	30.5%	7	5.6%	5	4.6%	12	5.2%
26-35	102	30.9%	107	21.9%	209	25.5%	25	20.0%	20	18.5%	45	19.3%
36-45	15	4.5%	45	9.2%	60	7.3%	27	21.6%	27	25.0%	54	23.2%
46-60	8	2.4%	52	10.6%	60	7.3%	38	30.4%	38	35.2%	76	32.6%
61-75	7	2.1%	7	1.4%	14	1.7%	25	20.0%	14	13.0%	39	16.7%
76-<	-	-	1	.2%	1	.1%	2	1.6%	1	.9%	3	1.3%
Total	330	100%	489	100%	819	100%	125	100%	108	100%	233	100%
% Row	(40.3%)		(59.7%)		(100%)		(53.6%)		(46.4%)		(100%)	
					819						233	Total
					(77.9%)						(22.1%)	1052 (100%)

Members of households computed for headship structure were those above 10 years old, basing from the results of the survey. Headship is determined, according to this survey, by one's parental role in care-taking as well as in resource control in the household. As indicated in the table, of the total sample households considered only 22.14% are heads of their households, which signifies more than 77% prevalence of dependents. Of the 22.14% of heads of households, 46.35% are females. Head of household children aged below 18 years account to 1.5% of their age group and 1.7% of the total heads of households, 75% of the child heads of households being girls. On the other hand, elderly heads of households aged above 60 years old account to 18% of the total household heads.

E. Educational status

Educational status of members of the sample house holds by age and sex

Keeping in mind the proper age for school enrollment being 5 years, only members of the sample households above five years old were considered eligible and were selected for computation of educational status.

Results of table 6 reveal that 12.9% of the sample population represents those who are never enrolled in any level schooling. Of these proportions the 77.5% are girls and women. However, the table indicates that completion of grades above grade 1 up to grade 12 among women and girls out weighs that of men and boys in each grade strata. On the contrary, in regards to tertiary level education; certificate, diploma, and degree, men are the majority completers than women, accounting for 60.0%, 55.6%, and 81.3% in each respective tertiary education level.

Table 6. Educational status of the members of the sample house holds by age

		AGE								Sex		
		5-9	10-18	19-25	26-35	36-45	46-60	61-75	76-<	Male	Female	Total
		%	%	%	%	%	%	%	%	%	%	%
Highest grade completed	K.G	13.6%	.4%							66.7%	33.3%	.8%
	No level completed	15.9%	4.8%	3.8%	6.3%	21.9%	36.8%	35.8%	75.0%	22.5%	77.5%	12.9%
	Grade 1-3	52.3%	10.1%	2.7%	4.7%	3.5%	10.3%	18.9%	25.0%	36.5%	63.5%	8.7%
	Grade 4-6	18.2%	30.3%	9.2%	7.1%	21.1%	16.2%	20.8%		46.9%	53.1%	15.9%
	Grade 7-9		30.7%	25.2%	19.3%	14.9%	16.2%	11.3%		42.4%	57.6%	20.8%
	Grade 10-12		23.7%	51.9%	49.6%	31.6%	17.6%	7.5%		47.8%	52.2%	34.5%
	Certificate			2.3%	3.1%	.9%				60.0%	40.0%	1.4%
	Diploma			3.1%	7.9%	4.4%	.7%			55.6%	44.4%	3.3%
	Degree			1.9%	2.0%	1.8%	.7%	5.7%		81.3%	18.8%	1.5%
	Postgraduate						1.5%			50.0%	50.0%	.2%
Table Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	43.4%	56.6%	100.0%

When we look at school enrolment of children between 5 to 9 and 10 to 18 years old, 15.9% and 4.8% of the children in their respective age group have never enrolled to any educational level. The high prevalence of non-enrollment among children aged between 5 and 9 years and the decrease in the number among the age group 10 to 18 indicates the wide existence of late age school enrollment. However, from the age group 10 -18 along the successive age groups the number of persons never enrolled in any education level increases. Moreover, the result for children above ten years old whose highest grade completed is grade 1 to 3 and KG, accounting for 10.1% and 0.4% of their age group respectively, indicate below the appropriate age-grade-level within the age group.

F. Economic Activity of members of the sample house holds

Unemployment Rate

Unemployment rate in this survey is defined as the percentage of unemployed to the total economically active persons. And persons of ages 26 up to 60 years old are considered economically active for the survey's purpose. Each member of the sample households is considered employed if he/she was engaged in productive work during most of the last 12 months, and unemployed if he/she was not working even if he/she had work. (CSA. 1999)

Employment by age and sex

Table 7. Employment by age and sex

	Employment											
	Employed						Unemployed					
	Male		Female		Group Total		Male		Female		Group Total	
	Count	Row %	Count	Row %	Count	Row %	Count	Row %	Count	Row %	Count	Row %
7`-9			2	6.9%	2	6.9%	13	44.8%	14	48.3%	27	93.1%
10-18	2	.9%	3	1.3%	5	2.2%	102	44.5%	122	53.3%	224	97.8%
19-25	22	8.4%	20	7.6%	42	16.0%	80	30.5%	140	53.4%	220	84.0%
26-35	55	21.7%	36	14.2%	91	35.8%	72	28.3%	91	35.8%	163	64.2%
36-45	31	27.2%	21	18.4%	52	45.6%	11	9.6%	51	44.7%	62	54.4%
46-60	30	22.1%	16	11.8%	46	33.8%	16	11.8%	74	54.4%	90	66.2%
61-75	11	20.8%	2	3.8%	13	24.5%	21	39.6%	19	35.8%	40	75.5%
76-<							2	50.0%	2	50.0%	4	100.0%
Total	151	14.0%	100	9.3%	251	23.2%	317	29.3%	513	47.5%	830	76.8%

If the unemployed number of people is computed from the above table for the economically active population; ages 26 up to 60 years, the total unemployment rate for this Kebele is 62.5%. Of those unemployed, 68.5% are women. These figures are very high compared to the total unemployment rate of Addis Ababa, 37.7%, indicating the area among areas with the highest unemployment rates in the Capital (CSA, 1999). Besides, the result gives an initial indication of the gender differentiation of domestic and non-domestic role of members of the sample households, which more men are engaged in income generating activities than women.

The data for children engaged in employment show that a significant proportion of children aged between 7 and 9 years and between 10 and 18 years are employed accounting for 6.9% and 2.2% respectively of their respective age group. If employment for both age groups together (7 to 18 years old) is computed, 2.7% of the children are employed, without including street children. Of these employed children, 5/7 are girls.

Type of Employment	Age
	10 -18
	Col %
Self employed (formal)	14.3%
Self employed (informal)	14.3%
Employed by private formal sector	14.3%
Employed by private informal sector	
Employed by public sector	
Employed by NGO	
Employed as household servant	57.1%
Unpaid family worker	
Others	
Total	100.0%

Table 8. Type of employment, children

As can be observed from the table, 57.14% of the employed children, 7 to 18 years old are employed as household servants being residents. The rest 28.6% are self-employed in the formal sector and informal sector accounting for 14.3% with equal proportions in both sectors. Moreover, the other 14.3 % are employed by the private formal sector.

G. Income of the sample households:

Table 9. Monthly income of the households

Income of Households	Frequency	Percent	Cumulative Percent
<= 50	25	14.7	14.7
51 – 150	48	28.2	42.9
151 – 300	46	27.1	70.0
301 – 500	26	15.3	85.3
501 – 750	11	6.5	91.8
751 – 1000	11	6.5	98.2
1001 - 2000	1	.6	98.8
2001 - 2464	1	.6	99.4
2501 - 3000	1	.6	100.0
Total	170	100.0	

	N	Minimum	Maximum	Std. Deviation
Household Income	170	10	3000	349.372

There is a wide range in monthly income of the sample households; 2990, the minimum being 10 birr per month and the maximum being 3000 birr per month. The majority of the households (70%) earn monthly incomes less than 300 birr per month. Those who earn

below 150 birr per month account for 42.9%, inclusively, those who earn below 50 birr per month account for 14.7%. On the other hand, of the 30% of households who earn above three hundred birr per month, 15.3% of the households earn monthly incomes between three hundred and five hundred birr. Thus, those who earn above 500 birr per month account for only 14.7%.

3.3.2. Kolfe-Keranio Sub-city Kebele 09

A. Age and sex composition

As can be seen in table 10, 52.6% of the total sample household members are women and girls while the remaining 47.4% are men and boys. If the results of the table are further computed to include together children below 18 years old, it turns out that about 39.4% are children up to 18 years old, of which 52.2% are girls. Furthermore, the youth between 19 to 25 and 26 to 35 years old account for 23.0% and 19.5% respectively, whereas approximately 3% are elderly, 61 years old and above.

Table10. Sex and Age Composition of the Sample Households

	Female		Male		Total		
Age	Count	Row %	Count	Row %	Count	Row %	Col %
<-1	12	50.0%	12	50.0%	24	100%	2.2%
2-9	75	50.3%	74	49.7%	149	100%	13.7%
10-18	137	53.5%	119	46.5%	256	100%	23.5%
19-25	144	57.4%	107	42.6%	251	100%	23.0%
26-35	105	49.5%	107	50.5%	212	100%	19.5%
36-45	37	45.7%	44	54.3%	81	100%	7.4%
46-60	47	56.6%	36	43.4%	83	100%	7.6%
61-75	12	44.4%	15	55.6%	27	100%	2.5%
76-<	4	66.7%	2	33.3%	6	100%	.6%
Total	573	52.6%	516	47.4%	1089	100%	100%

B. Family size of the sample households

The average number of people in a household is around six people with a 2.4 standard deviation. The majority of the sample households have a family size between 3 to 8 people, the mode being 5 people accounting for 18.5 % of the households. In some households, it goes up to14 persons.

Table 11. Number of people in a household

Number of People in a Household	Frequency	Percent	Cumulative Percent
1	2	1.1	1.1
2	8	4.3	5.4
3	18	9.8	15.2
4	25	13.6	28.8
5	34	18.5	47.3
6	30	16.3	63.6
7	22	12.0	75.5
8	21	11.4	87.0
9	9	4.9	91.8
10	8	4.3	96.2
11	3	1.6	97.8
12	1	.5	98.4
13	2	1.1	99.5
14	1	.5	100.0
Total	184	100.0	

C. Marital Status of Sample Households

Based on the findings from the survey, marital status was computed only for members of the sample households above 9 years old.

Table 12. Marital Status of the Sample Households

Marital Status	Frequency	Percent
Single	560	61.1
Married	293	32.0
Divorced	15	1.6
Partner Deceased	48	5.2
Total	916	100.0

Likewise, Kebele 08 it is indicated that there is a significant proportion (5.2%) of persons whose partners are deceased compared to the total married population, which indicates high level of orphan hood. However, compared to the results of Kebele 08, there are fewer divorcees that account for only 1.6%.

Table 13. Age and Marital status of the sample house holds.

	Marital Status								Total	
	Single		Married		Divorced		Widowed			
Age	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %
10-18	249	44.5%	5	1.7%			2	4.2%	256	27.9%
19-25	212	37.9%	33	11.3%	3	20.0%	3	6.3%	251	27.4%
26-35	88	15.7%	115	39.2%	5	33.3%	4	8.3%	212	23.1%
36-45	8	1.4%	65	22.2%	1	6.7%	7	14.6%	81	8.8%
46-60	2	.4%	57	19.5%	4	26.7%	20	41.7%	83	9.1%
61-75	1	.2%	16	5.5%	2	13.3%	8	16.7%	27	2.9%
76-<			2	.7%			4	8.3%	6	.7%
Total	560	100%	293	100%	15	100%	48	100%	916	100%

As can be seen from the above table, married children aged up to 18 years account to 2.7% of their age group. Moreover, there is a significant increase of married persons among the successive age groups starting from the age group 19 -25 up to the age group 26 – 35, and it starts on decreasing among the age group 36 – 45 and keeps decreasing among the successive age groups. Remarkably, widowhood is witnessed in all age groups.

D. Headship structure of the sample house holds.

Age, sex and headship structure of the sample households

Headship, according to this survey, is determined by one's parental role in care taking as well as in resource control in the household.

Table 14. Age, sex and headship structure of the sample households

	Dependents in Households				Heads of Households				Total	
	Female		Male		Female		Male			
Age	Count	Col %	Count	Col %	Count	Col %	Count	Col %	Count	Col %
10-18	135	32.0%	117	38.4%	2	3.1%	2	1.6%	256	27.9%
19-25	140	33.2%	98	32.1%	4	6.3%	9	7.2%	251	27.4%
26-35	98	23.2%	71	23.3%	7	10.9%	36	28.8%	212	23.1%
36-45	20	4.7%	10	3.3%	17	26.6%	34	27.2%	81	8.8%
46-60	23	5.5%	7	2.3%	24	37.5%	29	23.2%	83	9.1%
61-75	4	.9%	1	.3%	8	12.5%	14	11.2%	27	2.9%
76-<	2	.5%	1	.3%	2	3.1%	1	.8%	6	.7%
Total	422	100%	305	100%	64	100%	125	100%	916	100%

Based on the finding of the survey, members of households considered for the headship structure computation were those above 10 years old. As indicated in the table, of the total sample households computed 20.6% are heads of their households, which signifies more than 79% of dependents. Of the heads of households, 33.86% are women and girls. However, among heads of households, balance of proportions is witnessed between the sexes along the age groups, except for the age group 26 – 35 (10.9% are female and 28.8% are male). Moreover, about 1.6% of the children up to 18 years old are heads of households, where as, 13.2% of the total household heads are the elderly aged above 60 years. The table indicates that the majority of the dependents are found for both sexes in the age groups 10 – 18, 19 – 25, and 26 – 35 with more of equal proportions.

E. Educational status

Educational status of the members of the sample households by age and sex

Keeping in mind the proper age for school enrollment being 5 years, only members of the sample households above five years old were considered eligible and were selected for computation of educational status. Table 15 indicates that 14.9% of the sample population computed for education status represents those who are not enrolled in any level of education. Of these proportion girls and women are minority accounting for 29.8%.

Table 15. Educational status of the members of the sample house holds by age

		AGE								
		5-9	10-18	19-25	26-35	36-45	46-60	61-75	76-<	Total
		Col %	Col %	Col %	Col %	Col %	Col %	Col %	Col %	Col %
highest grade completed	K.G	22.2%								2.2%
	No level completed	20.2%	6.3%	8.4%	10.4%	19.8%	44.6%	48.1%	100.0%	14.9%
	Grade 1-3	49.5%	12.9%	6.8%	7.1%	1.2%	14.5%	11.1%		12.8%
	Grade 4-6	7.1%	35.9%	12.0%	12.3%	18.5%	9.6%	22.2%		18.1%
	Grade 7-9	1.0%	31.7%	20.7%	17.9%	22.2%	16.9%	7.4%		20.0%
	Grade 10-12		13.3%	39.0%	40.1%	22.2%	8.4%	7.4%		24.0%
	Certificate			4.8%	.5%	1.2%	1.2%			1.5%
	Diploma			7.2%	7.5%	11.1%	3.6%	3.7%		4.8%
	Degree			.8%	1.4%	1.2%	1.2%			.7%
	Postgraduate			.4%	2.8%	2.5%				1.0%
Table Total		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

When we look at school enrolment of children between 5 to 18 years old, 7% of the children from the sample households have never enrolled to any educational institutions. Moreover, of the children between the ages 5 to 9 and 10 -18 those who have never enrolled account for 20.2% and 6.3% respectively. This increase in enrolment at a later age for children is an indicator of late age school enrollment. Similarly with Kebele 08, the high prevalence of non-enrollment among children aged between 5 and 9 years and the decrease in the number among the age group 10 to 18 indicates the wide existence of late age school enrollment. However, from the age group 10 -18 along the successive age groups the number of persons never enrolled in any education level increases. Moreover, the result for children above ten years old whose highest grade completed is grade 1 to 3, accounting for 12.9% of their age, indicates below the appropriate age-grade-level within the age group.

F. Economic Activity of members of the sample house holds

Employment

Table 16. Employment by age and sex

Age	Employment												Total
	Employed						Unemployed						
	Female		Male		Group Total		Female		Male		Group Total		
	Count	Row %	Count	Row %	Count	Row %	Count	Row %	Count	Row %	Count	Row %	Count
7`-9	1	1.7%			1	1.7%	25	43.1%	32	55.2%	57	98.3%	58
10-18	8	3.1%	4	1.6%	12	4.7%	129	50.4%	115	44.9%	244	95.3%	256
19-25	28	11.2%	30	12.0%	58	23.1%	116	46.2%	77	30.7%	193	76.9%	251
26-35	30	14.2%	75	35.4%	105	49.5%	75	35.4%	32	15.1%	107	50.5%	212
36-45	22	27.2%	39	48.1%	61	75.3%	15	18.5%	5	6.2%	20	24.7%	81
46-60	13	15.7%	29	34.9%	42	50.6%	34	41.0%	7	8.4%	41	49.4%	83
61-75			11	40.7%	11	40.7%	12	44.4%	4	14.8%	16	59.3%	27
76-<			1	16.7%	1	16.7%	4	66.7%	1	16.7%	5	83.3%	6
Total	102	10.5%	189	19.4%	291	29.9%	410	42.1%	273	28.0%	683	70.1%	974

If the unemployed number of people is computed from the above table for the economically active population; ages 26 up to 60 years, the total unemployment rate for this Kebele is 44.6%, higher than the total unemployment rate for Addis Ababa, 37.7%, likewise Kebele 08. Of the unemployed, 60% are women (CSA, 1999).

Employment of the sample population is further classified by age. The elderly aged 61 years and above whom are employed account for 39.3%. Out of the ordinary, fewer youth between the ages 19 to 25, accounting for 23.1% of their age group, are employed compared to that of the elderly. Furthermore, it can be computed from the results of the table that a significant number of children between the ages 7 to 18 years old are employed accounting for 4.1% of their age group, without including street children. Of these employed children 9/13 are girls.

Type of Employment	Age
	7-18
	Col %
Self employed (formal)	
Self employed (informal)	75.0%
Employed by private formal sector	
Employed by private informal sector	
Employed by public sector	
Employed by NGO	
Employed as household servant	23%
Unpaid family worker	8.3%
Others	
Total	100.0%

Table 17. Type of employment, children

As can be seen from Table 17, 75% of the employed children aged 7 to 18 years are self employed in the formal sector, and the rest 23 and 8.3 percent are employed as house hold servants being residents and as unpaid family workers respectively.

G. Income of the sample households:

Table 18. Average monthly income of the households

Household Monthly Income	Frequency	Percent	Cumulative Percent
<= 50	7	4.0	4.0
51 - 150	51	29.5	33.5
151 - 300	66	38.2	71.7
301 - 500	29	16.8	88.4
501 - 750	12	6.9	95.4
751 - 1000	5	2.9	98.3
1001 - 2000	3	1.7	100.0
Total	173	100.0	

	Number of Respondents	Minimum	Maximum	Std. Deviation
Monthly income in Birr	173	30	2000	251.21

According to CSA (2001), Households with an annual income less than 2000 Birr are classified as low income households, whereas households with an annual income between 2000 and 12,599 Birr and more than 12,600 Birr are classified as medium and high income households respectively.

There is a wide range in monthly income of the sample households, 1970, the minimum being 30 birr per month and the maximum being 2000 birr per month. The majority of the households (71.7%) earn monthly incomes less than three hundred birr per. Those who earn below 150 birr per month account for 33.5%, inclusively, those who earn below fifty birr per month account for 4.0%. On the other hand, of the 29.3% of households who earn above three hundred birr per month, 16.8% of the households earn monthly incomes between three hundred and five hundred birr. Thus, those who earn above 500 birr per month account for only 11.6%.

CHAPTER FOUR

4. Major Problems AIDS Affected Children and Orphans Face

In both communities where the study is carried out, children living with HIV/AIDS, children living with parents who are ill of HIV/AIDS, and mostly orphaned children due to AIDS were the HIV/AIDS affected children that researcher came across during the study. These children were identified to inhabit different settings; households of natal parents, single natal parent households, guardian households, child headed households, and the street. Most of the fostered AIDS orphans identified were double orphans living with single and women guardians. Various problems inflicted upon AIDS affected children with different living settings, orphan statuses, livelihood conditions, ages, gender and so on were found out.

4.1 Emotional Wellbeing

A range of emotional problems were identified to be experienced by HIV/AIDS affected children among those who participated in the study as the results of different problems imposed on them by the epidemic. Some of the major problems identified were loss of a parent, lack of love and attention, suffering from illnesses, fear of death, and fear of the hospital environment when hospitalized among some.

Children living with parent(s) ill of HIV/AIDS feel the anxiety of caring for a sick parent and fear of the death of a parent. Upon the death of a parent, they go through the state of bereavement and distress. An eight years old orphaned boy who is brought from Metehara and fostered by a 66 years old unrelated woman guardian expresses "*...at times when I think of my late mother, I would not sleep at night easily. When I sleep I would be troubled with nightmares that wake me up several times a night and difficult to get back to sleep each time I wake up*" (the case of Woineshet on page 117 further portrays the emotional problem children in such situations may go through). The distress of orphans further extends when they are fostered into households where they lack the love and attention they are used to on top of lack of emotional support while bereaving for the loss of their parent(s).

Orphans that were ill-treated by guardians and those who were recurrently ill of HIV/AIDS and who suspected or knew the cause their illness were observed to be lonesome, and the children and their guardians revealed that they lack personal and social interaction. These children isolated themselves at school and in the neighborhoods, did not spend most of their time with friends, and did not play much. A 14 years old orphan boy who had run away to his grandmother from his guardian aunt in 'Semen Mazegaja' describes his feeling: *"...everybody except my grandmother hates me"*. A guardian also described about her fostered nephew Behailu, an eight years old orphan boy who used to get recurrently ill of HIV/AIDS:

"When Behailu's mother died I brought him from the countryside to raise him. ... I never mentioned to him the cause of his illnesses. I give him a bath wearing gloves. But, I do the same thing with my daughter too not to make Behailu suspicious of my act and become aware of his disease and feel different. Yet, he asks me 'Why do I get sick? What is my sickness? My sickness is as Tizita's (a child he knows to be ill of AIDS), I am sick of AIDS. Is it not?' I think he related his mother's death and his sickness from what he watches on TV. He is very silent and lonely at home. He does not play at home or want to go out play with boys in the neighborhood. He sits at a spot alone and never leaves the spot unless I call him. Even, he is not encouraged to play while sitting alone. His skin rush is easily noticeable. I think he is ashamed of his appearance. He complains not to go to school explaining that he does not like anyone at school, and rather prefers to stay at home. But he is very good in education. ...while he was hospitalized when his blood was to be drawn, he had repeatedly refused by asking me 'what do they want to do with my blood'. ...he was afraid to be tested for HIV."

While I was conducting fieldwork, unfortunately, Behailu passed away shortly after being admitted to hospital. A teacher at Maria Rosa Kindergarten also described that orphans from very poor homes are usually silent, lack confidence, and isolate themselves from other children in the kindergarten.

Some of the orphans encountered in both communities were separated from their siblings when fostered into another household. Most of such orphans who participated in the study mentioned that they miss their brothers and sisters. It was surprising to find out that these orphans had no contact with their siblings though they were fostered by relatives. However, according to the children and their guardians, the reasons described for the loss of contact with siblings were: the orphan was fostered from the countryside, the other siblings are fostered by relatives in the rural areas, the guardian does not have close interaction with relatives caring for the other siblings, the guardian does not know the whereabouts of the other siblings, and the guardian does not initiate or encourage the orphan to establish contact.

Separated orphans from siblings devoid of contact, depending on their age of separation from their siblings, comfort in the fostering household, and duration of separation, tend to cope with the separation. To take a case in point, *Selamawit, a 13 years old orphan girl was fostered at age seven. She has a good relationship with her custodian aunt; in fact she tells that she loves her aunt. She has not had any contact with her sisters. However she says that she is used to being separated with her sisters, and glad to live with her aunt.*

Most of the orphans who participated in the study, especially those in destitute living conditions, lacked hope in their present situation as well as for their future. They were not optimistic about their life. Even if orphaned children are provided with material needs, they reflect that they are conscious of their loss of parental love and support that demoralizes them in having aspiration and self-initiation in achieving a better life. Orphans with deteriorated livelihood after parental loss and orphans that maintained better livelihood and have good relationship with guardians stated likewise that nothing would be the same as before unless their orphan hood were reverted. AIDS orphans' hope is also shattered with the destitute livelihood they live through. A seven years old orphan on the breadline also expressed to his mother "*Look at other people... we are living a fake life. It would have been better if we were dead*".

Feeling of insecurity was the other emotional problem experienced by the AIDS orphans in both communities. The orphans were often worried about their fate and of their siblings. In a focus group discussion of guardians and parents they mentioned that the children under their care usually worry about the death of parents or a guardian from their former experiences of losing a parent, and worry about their future care. A single mother living with HIV/AIDS mentioned that her children ask her *"... are you going to die...who will raise us if you die?"* Similarly, an elder guardian stated that whenever she falls ill, the child cries in fear of losing her. Another guardian also mentioned that the child asks her if she is going to die like his parents. Some of the orphaned boys living with guardians also felt unsecured unlike the guardians' children. These orphans mentioned that they were afraid of demanding their various needs to their guardians. The reason they commonly stated for their fright was that they would be driven out of the household. Some of these orphans also described that they are very cautious not to make faults and try to be appreciated by their guardians, because the guardians warn them of expulsion from the house whenever they find fault with the children.

4.2. Income

The effect of HIV/AIDS on household income is highly felt by AIDS affected households upon the illness and death of the breadwinner. In most cases, the breadwinners were husbands. The most destitute of the AIDS affected children encountered were AIDS orphans living in child headed households, with a single mother, and on the streets. Except for some of the street orphans, these orphans mentioned that their livelihood before they lost their parent(s) was better. Such households with economically active older siblings and other adult relatives were identified to earn better income. Maternal orphans living with a parent were also observed to be in a financially better position than that of paternal orphans.

Single mothers and fathers who go through illnesses of AIDS were encountered during the study. Since, they were the sole breadwinner of their households, the households experienced decrease of household income as the result of the decrease and absence of

economic activity among the parents. These households were already low-income households before affected by the epidemic, in most cases without extra resource for health costs. The parents in almost all cases preferred to allocate their meager resources to the usual household expenses rather than for their own health treatment, they sought only treatments free of charge. They described at interviews that they recurrently become ill, some of whom had become bedridden before accessing Anti Retroviral drugs given for free. Even some of the parents were observed to be bedridden when the study was carried out. However, parents in these households sought health treatment for siblings whenever possible; whether they discovered the child's HIV status or not. Thus, prolonged parental illness in the communities studied did not compromise household income through treatment costs, exceptional to the findings of Essex et al. (2002). The financial impact of the epidemic was mainly imposed among these households through decrease or absence of economic activity as the result of parental illness and treatment costs for the siblings.

Most of the fostering households encountered were low-income households headed by single women. In the midst of income constraint, these households are stressed by additional costs for taking in an orphan; available resources are shared among the children and the fostered orphans. On the other hand, in some cases where guardians were exploiting the orphans of labor, their labor substitutes paid house servants, who would otherwise be hired and incur expense to the households. A guardian who fostered her 13 years old niece and with two children below eight years old described about her niece, *"...Selamawit is never troublesome. She is a clever student. On top of this, she properly does the household chores. ... these days house servants are not available and have become expensive. Had she not been assisting me it would have been difficult for me."*

Income is stated as the major reason attributed by the AIDS affected children, their parents, and guardians to most of the problems the children face, such as lack of material needs, cloth, education materials, inadequate food, reduced access to health services, labor exploitation, and streetism.

4.3. Child Labor on the Streets and Streetism

While conducting fieldwork on the streets of 'Semen Mazegaja' and 'Kolfe', I came across numerous AIDS affected children who depended on the streets for their livelihoods. Several of these children were earning a living on the streets to support themselves and their households, and return to their households to spend the night. The major reasons stated by these children for resorting to the streets were decline in household income and unfulfilled material needs as the result of HIV/AIDS. The other children I encountered were more dependent on the streets, which served them as their homes and survival grounds. In their cases, they were forced to lead a street life due to the difficulties and incidences that arise in their HIV/AIDS affected living conditions such as household destitution, lack of shelter, conflicts in households, and so on.

Migrated AIDS orphans that were accompanied to the city and abandoned by an adult relative, mostly from Wolaita and Gurage zones of southern Ethiopia, were among children who earn their living on the streets. These children were usually engaged in more than one type of piecework constantly and dwell in a shelter they rent in a group with friends who similarly migrated. In addition, AIDS orphans living with a parent and in child headed households, mostly boys, had to engage in piecework and other income generating activities in order to fulfill their own needs and assist their impoverished households as a result of losing a bread winner family member(s). A reason for the tendency of boys to engage in non-domestic income generating activities more than girls is the gender differentiation of work in households. In a household where there are girls and boys at ages conceptualized as able to work, the boys go out to earn income unless the income they provide fails to fulfill the household needs. According to guardians and children at focus group discussions, they revealed that girls are expected to fulfill household chores and boys have to earn income when the need arises. On-street working AIDS orphans with households were observed engaging in shoe shining, carrying, seeking customers and collecting fair for taxis, street hawking, beggary, and theft (pick pocketing usually at bus stops and 'Gulit' market places).

These orphans stated that they prefer the streets to generate income though they face difficulties, because income-generating options within their neighborhoods are limited and rare. The little cash younger orphans generate is sometimes mugged. Street hawkers sell their goods from street to street avoiding Kebele regulation officers and the police. When they are caught, their goods are confiscated and they are physically abused. Most of these children often eat for lunch what they could get on the streets from their daily income. The food they buy on the street is less nutritious and inadequate compared to what they could have gotten at their homes had they been able to allocate the cost to home cooking. Even they miss lunch at times of insufficient earnings. However, most of these children were better off in fulfilling certain basic needs than some orphans fostered in the community and most orphans in child headed households encountered during the study.

The education of on-street working orphans is compromised with their livelihood conditions that necessitated fulltime engagement income generating activities. The on-street working orphans who participated in the study had dropped out of school or were forced to enroll to night shift schools; some had to discontinue schooling before changing to night shift. Some of these children used to work half days and go to half-day shift elementary schools. However, during the study they were forced to drop out of these schools due to the transformation of all half-day shift schools in both communities to full day schools.

One of the reasons for street AIDS orphans to go out to the streets is eviction from their households. Among the street children I came across during the study, there were AIDS orphans that were evicted by their parents and fostering guardians due to conflict. Two parents of such orphans, willing to participate in the study, both claimed that their children were violent, rebellious against house rules, and uncontrollable. Guardians that evicted orphans under their care stated their response for reaching to such a decision as follows: the child's behavior was uncontrollably violent; the behavior of the child could not be entertained within the limited resource of the household; and the child became a bad influence for their siblings. Nevertheless, most of the evicted orphans including those

from the households of the interviewed guardians maintained that they often came in conflict with their guardians because they were abused and discriminated. There were also orphans that ran away to the streets fostering from households due to physical abuse by guardians and other adult members of the household.

Loss of shelter is the other reason for AIDS orphans to resort to streetism. Double orphans who used to live with their late parent in a shelter rented from private proprietors had become unable to pay rent and maintain their shelter. Orphans in such situation, where they did not have close or any ties with their relatives and their relatives and community members were unwilling to take them in, did not spot any option but surviving on the streets. Among the street children who participated in the study, those without relative ties were siblings of commercial sex workers who had migrated from rural areas and town of the provinces. According to migrated commercial sex workers in 'Semen Mazegaja', they do not have frequent contact with relatives because of the distance from their home towns and villages in addition to not having any relative in the city. Besides, once they bear a child most of them seize their contact with relatives back home, or if they financially support their extended family, they maintain their contact but never mention about having a child because, as a commercial sex worker described it similarly with others' responses: *"back home (the countryside), it is a shame to have a child out of wedlock"*.

On the other hand, AIDS orphans in child headed households who live in a rented house from the Kebele Administration are forced to lose their shelter in certain cases. Though I came across with a couple of child headed households that maintained their Kebele rented house with unpaid rent deposit, there were cases of street orphans whose shelters were transferred to other tenants. Monthly rents of houses administered by the Kebele are cheaper, below 100 Birr up to one Birr, which made them to be highly demanded. Since orphans, alike the aforementioned cases of street orphans, are usually unable to pay their rents and unrepresented to bring their cases to concerned authorities, transfer of their shelters to other inhabitants is easier for Kebele officials.

AIDS orphans are also made to lead a street life as a result of property grabbling where they lose their shelter. In the cases identified at "Semen Mazegaja", orphans were disinherited by relatives abusing technicalities within the legal framework rather than openly denying orphans their inheritance or taking the matter to court. Primarily, a relative takes the legal guardianship with the agreement of a family council made up of other relatives of the orphan(s). Thus, the guardian becomes legally authorized to dispose off the orphan(s)' inherited property if the necessity arises in order to allocate the income from the sale to the needs of the orphan(s). In the case of "Amare", a 14 years old orphan, his father's brother who was his legal guardian took him into his household when he sold the orphan's inherited house. After living in his uncle's care for four and a half years, he was driven out of the household due to conflict with his uncle. Consequently, he resorted to streetism, otherwise would have used his late parents' house at least for shelter. Likewise, in the case of "Absera", a 16 year old orphan, and his little sister "Meseret", their legal guardian (father's brother) had promised them to provide them a better care under his foster in his household in "Wonji" when he sold their late parents' house. However, as soon as he disposed off their property, he abandoned them at a mini hotel he had stayed in. Fortunately, "Meseret" was taken in by their aunt, but she did not open her door to "Absera" who leads a street life. He does not blame his aunt for not taking him in, instead he mentioned that she is poor to care for both his sister and him.

Orphans living on the streets are marginalized groups of society and among the most vulnerable children in the studied communities. They face wide-ranging problems accompanied with the hardships of surviving on the streets. The street orphans that were observed during the study are vulnerable to physical and sexual abuse, HIV infection and other illnesses, drop out of school, lack shelter, and engage in unhealthy and risky practices to fulfill their daily needs. It was observed that most of these children often practice beggary as the easiest option to generate quick cash. Except for the few children engaged in piece work and petty trade, those involved in beggary were observed and revealed that they do not have the intent to save their earnings and shift towards other sustainable income generating activities or look forward to piecework, though they face difficulties of police chase and physical abuse while begging, especially at traffic lights.

However, they seldom engage in piecework involving labor at times of failure to generate income through beggary. In such situations, few have mentioned that they also seek for conducive circumstances for stealing, amidst the risk of the consequences of capture.

Street girls including those engaged in commercial sex work face sexual abuse. They responded that they are victims of rape usually where they sleep at night by groups of street gangs, pedestrians, and the police. Two rape victims that were identified during the study mentioned that they did not report their case to the authorities. One of these girls responded, *"There is no use in reporting it to the police, they do not protect us on the streets"*. Besides, according to the Arada Wereda Police, there were no rape cases reported by street children for the last two years. These girls face difficulties of spotting a permanent shelter because they have to move constantly from shelter to shelter in order to escape from obsessive sexual offenders who attack them at their shelters.

Some of the street orphans in both communities mentioned that they recurrently fall ill. They were able to describe their illnesses only with the symptoms, because they never sought medical attention for reasons that will be discussed later. They are also vulnerable to HIV infection due to lack of awareness, low access to contraceptives, sexual abuse of girls, and child prostitution. Though no street orphan who took the test for HIV was identified, it is probable that some are infected through mother to child or sexual transmission. I had come across with few sexually active street orphans who were informed of HIV/AIDS and most of the modes of its transmission, but unaware of prevention methods of its transmission. Besides, the majority of the sexually active street orphans encountered were fully aware of the transmission and prevention of HIV/AIDS, but do not use contraceptives during sexual intercourse, according to their responses, due to lack of access to contraceptives, their attitude towards unsafe sex, and their risky behaviors associated with street life. The major reasons for these are the facts that these children have not been part of direct interventions of HIV/AIDS prevention, lack hope for a better future, and the life they lead on the streets present them with risky circumstances.

The preferable option of shelter by street children is halls that charge fifty cents up to one Birr per person for a night. These halls do not provide blanket or mattress; the children have to use their own rags. However, all of the interviewed street children mentioned that they rarely use such shelters, only when they spare money after getting food. Otherwise, they usually sleep with groups of friends at street corners, which expose them to hardships and threats such as physical and sexual abuse, discomfort and illness of cold weather, and so on.

4.4. Child Prostitution

Orphan girls living on the streets of "Semen Mazegaja" as young as 12years were observed to resort to commercial sex work as an option of survival and overcoming their income difficulties. However, it is not only girls living on the streets that engage in commercial sex work, girls in child headed households were observed to be part of it, in order to fulfill theirs and their siblings' needs. Girls living with their parents and in guardians' households were also identified to be engaged in the practice, mostly influenced with peers already engaged in the practice; tempted with the materials their peers bought after engaging in commercial sex work.

Except for a girl I came across with whose guardian was aware of the girl's practice, most of these girls' parents and guardians were unaware of their practice. According to their responses, they were able to engage in the practice without the knowledge of their guardians and parents because most of them perform at the evening and some sneak out at night. I have also come across girls evicted by parents who found out about the girls practicing sex work. A girl whose guardian was aware about her practice mentioned that her guardian does not express her awareness about her practice and never mentioned about the practice in the household or elsewhere because it is taboo among the community. However, she collects the contribution of the girl from the income she generates due to the destitute situation of the household.

The girls that perform prostitution only during the evenings look for customers on streets. The rest of the girl commercial sex workers are engaged on streets and at bars located at a

red light corner in 'Semen Mazegaja' area known as 'Datsun Sefer'. These girls, as other girls living on the streets, are also physically and sexually abused, but mostly by customers. They are denied of the fee for their service, taking advantage of their status of a girl. In some cases, they become unable to negotiate the use of condoms with customers that force them to have unsafe sex, which could be considered as rape.

4.5. Migration/relocation

In both communities where the study took place, 'Semen Mazegaja' and 'Kolfe', migration and relocation of AIDS orphans is evident. Upon the death of parents or during illness of a remaining parent anticipating inevitable death, orphans are migrating to Addis Ababa to be fostered by relatives and friends of the parents. On the other hand, there was a case of a household in 'Kolfe' that moved to the countryside during the fieldwork. A mother living with HIV/AIDS took her two children to a village where her mother lives (unfortunately, I was not able to find out why she decided to move because she left suddenly). Relatives also bring orphans from the countryside with the notion that children could be financially independent if they work in the city. In all the cases identified the accompanying relative abandon them as soon as they are brought to the city or the work they would be engaged in is arranged. Such orphans are engaged in shoe shining, house serving, street hawking, etc. or lead a street life.

The case of Genzebe: *genzebe is an eight years old orphan who is fostered by a 66 years old woman called Aneni. Genzebe used to live with his mother in 'Metehara'. His mother used to work in the sugarcane farms of the sugar factory in Metehara. She and Woizero Aneni knew each other working at the farms. Genzebe does not know his father, Wro. Aneni tells that she knew him, but he died of AIDS. When Genzebe's mother fell ill, she took her son and went to Dembidolo where she stayed for four years. In august 2006, she passed away from her illness, leaving a will that Genzebe should be taken to be raised by Wro. Aneni who had moved to Addis Ababa by then. However, the man who accompanied Genzebe from Dembidolo managed to find out their address at Metehara. This year*

Genzebe has not enrolled to school because he came to Addis after school began, his guardian says that he will join next year.

Most of the AIDS orphans fostered in both communities were relocated from other areas of Addis Ababa, since relatives in the urban context of Addis Ababa rarely dwell in the same neighborhood, and most of these orphans are fostered by relatives. There were also orphans that runaway from a guardian's household in another area of the city to the communities under study and vice versa. Death of a guardian is the other factor identified to force orphans to be relocated. Few were relocated in such conditions more than once. Many of the orphans in guardian households revealed that, when fostered into a new household and in a new neighborhood, they become ill at ease with unfamiliar living conditions and arrangements within their new households and with unacquainted peers in the neighborhood and at school.

Significant number of street children came across in both areas were from households of other areas of the city. Thus, it is possible to deduct that there may be orphans who went out to the street of other areas from households of these communities, though such cases of orphans were not spotted. In fact, in addition to relocation to the streets of other areas, streetism by itself has to be regarded as relocation from one's household.

4.6. Education

AIDS Affected children often fail to benefit with education to various extents depending on specific living conditions and circumstances. In the communities where the study was carried out, commonly, low attainment in education and dropping out of school are problems inflicted upon children regarding education as the result of HIV/AIDS.

Orphans in child headed households were observed to lack guidance and support regarding their studies at home and follow up at school when the need of a guardian's present arises. They lacked initiation for schooling and perception of the benefits from education due to absence of an adult and a parental figure that encourages them or serves

as a raw model. Regular absenteeism and tardiness were common among orphans in these households prominently due to lack of parental care, in imposing bed time and waking them up in the morning as well as imposing the necessity to go to school. The fact that these orphans are forced to fulfill adult roles is also responsible for their absenteeism. Cases of orphans, particularly boys, as young as seven years old were observed to engage in income generating activities. Elder girls of such households are forced to stay at home in order to care for infants and other siblings who need homecare. Nearly all of the orphans I encountered with an adult role were either expelled from school or dropped out of school, except for a 12 years old orphan girl at 'Semen Mazegaja' called Helen whose infant sister is cared for by her neighbor during school time.

Orphans expelled from a school, particularly those in child headed households, face difficulties to join another school. Such cases I encountered in the communities resulted due to refusal of schools to accept expelled students, careless loss of academic credential papers, and absence of another school in convenient proximity. These children are left with night shift schools, which are easier to be admitted to but charge school fee. However, in most of the cases I came across with, orphans in child headed households are reluctant to look for admittance in other schools when expelled from their school.

Orphans living with a parent ill of HIV/AIDS and paternal orphans living with unemployed mothers were identified facing difficulties in schooling; decrease in school performance, absenteeism, and dropping out of school. Those with an ill parent needed to sacrifice their time for attending school and studying providing care for their parent. The stressful experience in these households also affects their performance in education. As described by a 12 years old orphan in such household named Aynalem, *"... I try to compensate for the lesson I miss by copying from my friends' notes and studying hard when I get spare time, but I got lower grades because I worry very much about lots of things..."* Moreover, most of the orphans who were inflicted with emotional problems were observed to benefit less in education. They lose interest of follow up and competing in their studies as well as of schooling. School age orphans encountered during the study

with emotional problems had declined in school achievements in comparison to each of these orphans' prior school results.

AIDS affected children in such households and elsewhere that are forced to engage in income generating activities in order to provide their households and themselves face difficulties in the aforementioned aspects of schooling.

The case of Murad: *Murad is a nine years old orphan boy in 'Kolfe' who lives with his aunt. His aunt is widowed with two siblings younger than Murad. She took Murad in her household when his single mother died before three years. She earns income from selling vegetables, coal and 'chat' in front of her gate. She asserts that the income she earns alone is not enough to sustain her household. She also mentioned that she has registered Murad at the Kebele in order to get support from an NGO. Yet he is not given any support, the Kebele HIV/AIDS desk official has promised them to be supported with WFP's food provision on August 2006. Unfortunately, the orphan is forced to dropout of school this year in order to provide income to the household. It was the aunt who proposed that he should work and what he would work. He is engaged in shoe shining and street hawking. He earns five to ten Birr daily, of which he daily puts four Birr at an 'Iqub' with other children in similar jobs and gives to his aunt the rest of his daily income as well as the money he collects from the 'equb'. When I asked him, "was it necessary to dropout of school?" he replied, "I have to work in order to pay rent and buy food for us." I had also asked him, "Wouldn't you be able to work after school hours". He described, "Customers for shoe shining are available only in the morning, and I will sell cigarettes and chewing gums in the afternoon."*

Night schools served such children as a convenient option to learn while engaged in work. However, only AIDS affected children who afford to pay the fees and value the benefit of education or those who are imposed to enroll by adults are identified to enroll in night schools. Besides, cases of orphans working as household servants were encountered whom their employers denied them of night schooling. To take a case as an example, *Kedija is an eleven years old orphan who is taken by an NGO from a household where she worked as a servant and made to be fostered by a volunteer guardian. A social*

worker stated that she is a double orphan and was brought from the rural area of Gurage Zone. However, Kedija does not remember her parents and how and when she came to Addis Ababa. Before a year, while she was working as a household servant the NGO selected her to benefit from food, education, and health support. However, her employers refused to let her enroll to school reasoning that she is needed at the household during the day and the night. It was then that she was made to be fostered by a volunteer guardian.

Lack of school fees, uniforms, and stationeries, are the other difficulties of schooling experienced by most of the AIDS affected children except for few children from better off households and that receive education material support from NGOs and individuals. Regarding school enrollment and academic performance, orphans particularly boys under foster care were better than AIDS affected children in all the aforementioned living conditions. However, girls in foster care were observed and mentioned that they spend after school hours and weekends with household chores. In addition, most cases of orphans under foster care and children living with a parent who were experiencing emotional problems had low performance in education during the study, of which some significantly decreased from prior good performance.

Nearly half of the AIDS affected children who participated in the study were below their appropriate age grade level. Late age start and discontinuity of schooling are the factors responsible for low age-grade-level cases encountered during the study. Migrated and relocated orphans were forced to discontinue schooling mostly upon fostering; due to arrival to fostering households after the beginning of an academic year. Negligence of parents and guardians to register a child timely at the beginning of an academic year is evidenced, contributing to late start among school age children and prolonged discontinuity of fostered orphans. Cases of orphans, especially HIV infected children, that were subject to late start and discontinuity due to illnesses were also encountered. In addition, repeating of grades and dropping out of school for economic (financial) reasons and joining back at provision of support were the other reasons identified for discontinuity and low age grade level among AIDS affected children.

AIDS affected children that were participating in the study that go to 'Woizero Kelemua' and 'Meserete Idget' elementary and junior high schools at "Semen Mazegaja" and 'Kolfe" respectively, were observed at classrooms, playgrounds, and going back from school. These children were reserved from obligatory as well as voluntary school activities. Their participation in the learning process in classrooms was minimal. They were reserved from extracurricular activities held in the schools during the study, such as club activities and art and sport competitions made for both boys and girls; foot ball, volleyball, painting, paper art, HIV/AIDS club, media club, and literature club. Loss of interest for such activities was the common response of these children for not participating in extracurricular activities. However, many orphan boys stated that they are interested to engage in soccer competitions, but they were not able to be chosen by soccer captains. This may be related to the finding from the observations of their relations with classmates. Girls were observed to have a group of few numbers of friends and boys had one or more groups of large numbers of friends. AIDS orphans, especially boys, were observed to be never among those who were influential and who acted as leaders of their group. In addition, both orphan girls and boys never appeared to be models for other students in the classrooms as well as in the school compound. Students who appeared as models were class monitors, academically good students particularly those who stood first in ranking, club leaders (also academically good), best sport players and captains, and physically strong boys in each batch who proved their strength with numerous fights.

is mentioned in former parts of this topic that AIDS orphans face various difficulties with schooling due to different difficult circumstances resulting from HIV/AIDS. eachers and school directors, in most cases, were inconsiderate of their problems when ey fail to carryout their expected roles as students in cases of failing to do home-take-signments, being unable to answer to questions in the classroom, tardiness, senteeism, argument with a teacher, and demonstrating unacceptable practices. To ention examples of acceptable practices: an orphan girl in the 2nd grade of Woizero elemua school was physically punished for playing with her friends as liquor ("Areke") ller, which she brought as a game from her observation of her mother selling at home.

an orphan boy in the same grade was also physically punished for asking a girl in his classroom to demonstrate with him the sexual intercourse of his guardians he witnessed t home perceiving it as a game. Most of the orphans who failed to cope with the xpectations and obligations of their school never raised their problems at home as xcuses to the teachers. However, teachers and school directors were observed not taking nto consideration what the circumstances of as student outside the school and in the ousehold might be while making decisions against deviant students. Often, such ecisions were academically detrimental to the AIDS affected children; instead of medial measures and preventive steps, decisions were rushed to expulsion and unishments that exacerbate the problem.

he Case of Andualem: *Andualem is a ten years old orphan who lives with his twelve ears old brother Yonas heading their household. Their late mother used to earn a living om commercial sex work. Their house is single roomed, situated along a red light rner road and used to serve their mother as a brothel. Now their house is partitioned to two rooms and the children rent one of the rooms to commercial sex workers. In the 004-2005 academic years, when their mother passed away, Andualem was in fourth ade and Yonas was in sixth grade. Their school results show that their education sults highly decreased starting from then mainly due to lack of follow up at home. arting from December 2004, they were supported by an NGO with food, education aterials, health costs, and sanitation materials. At the end of the school year Yonas was ade to repeat a grade and Andualem was expelled from school because of misbehavior d absence from class for numerous days. Since the street in front of their house is busy rough out the whole night, most of the time they stay outside on the streets until dnight with bigger boys and sleep in the morning instead of going to school, with none wake them up. At the beginning of the next academic year a community worker of the GO supporting them called Emebet looked for another school to register Andualem. dualem was refused to be accepted by the first school the community worker applied near the community for reasons of not accepting expelled students. She tried another hool pleading the school director to accept the child where he was fortunately cepted. However, Andualem had lost his 4th grade credentials given to him by his*

ormer school. Thus, the new school registered him to attend again in the 1st grade. Currently, both of them have completely stopped going to school and spend their time laying on the street with other boys. They mentioned that they have no interest for education. Even after they attended counseling sessions and when the NGO notified them that the support would stop unless they continue education, they refused to go back to school. ...

.7. Food /Nutrition

Upon the death of a breadwinner or a prime care provider of a household, decrease in the uantity, quality, and number of meals per day was evident. Child headed households, ouseholds of orphans living with unemployed mothers and single women guardians, and treet orphans faced difficulties to provide adequate food on the table due to lack of ncome. Orphans in child headed households and in households with a seriously ill parent ften experience shortage of food and cooking fuels. These orphans described that days ney eat less than three meals a day are numerous.

n addition, to difficulties of getting adequate food, orphans in child headed households, articularly households of young boys, face difficulty of preparing the food they are able o get. The case of two orphan brothers depicts such conditions in child headed ouseholds: *Yonas, (12 years old) and Andualem (10 years old) are brothers heading heir own household. They live in a narrow room, which is one side of the two partitioned ooms. They rent the other side of the room as a brothel for commercial sex workers. The floor tells that it has not been broomed for long. At the left corner of the room here lies a double bed, their mother had bought them, made of welded metal very small or their size with very dirty blanket. In front of it are a kerosene stove, food plates, cups, nd a cooking dish. They do not have a stove to make injera. Yonas describes, "Our aunt sed to live with us after my mother died. She used to cook for us from the income she ollects from renting the next room. However, I made sent away by reporting to Ato. ohannes at the Kebele because she used to hit us always. Then our neighbor, 'Emama silat', started to give us care buying and cooking food from the income we get. She also sed to make us injera at her home. But we quarreled with her because she did not use to*

us money when we needed to buy some things, instead she used to tell us that she saving the spare money for us. Now we receive wheat, oil, and soap from an anization, but Emama Tsilat has quit taking care for us. ...Emebet (a community ker for the NGO that supports them) had taken the wheat to a mill and prepared flour 'kinche', and showed me how to cook 'kinche' and porridge..." When I visited their ne I took a look at two sacks of wheat that were not grinded and infested. I guessed n the amount of the wheat that they did not make use of it. I asked them when the at was infested and whether they use the wheat or not. Yonas was not aware of the station of the wheat, he took a look inside the sacks and replied "it must be infested ntly. Emebet had told me to grind the wheat at the mill, but we eat at a hotel. (Yonas his brother daily collect 15 Birr from the rent) ...we eat 'atkilt beyeaynetu' and aroni for seven birr. When we run short of money we buy and eat 'paste'(a road side k). Before yesterday, the girl who rented our room left for the countryside. Now we ot have any money. ...Yesterday we ate 'paste'. Today we have not eaten anything". t day I visited them around two o'clock in the afternoon, they were playing on the ets with friends.

other cases of orphans with problems of food due to lack of care related to parental faced had problems that resulted from negligence and abuse by guardians and givers. Orphans who acted out against the abuse they experience in the household who conflicted with their abusive guardians were able to freely discuss their eriences while participating in the study. These orphans described abusive practices affected them in relation to food as well as in other aspects, which will be discussed . To be specific to problems of food, Begasi, a 12 years old orphan fostered by his in 'Semen Mazegaja' described that sometimes he is served with little amount of at lunch and dinner where there is adequate food prepared. He was afraid to ask his for more food until he dared to ask one day. His aunt refused to add more and ally insulted him of insatiation that led him to argue with her ending up in a quarrel. e, a fourteen years old orphan fostered by her uncle in 'Kolfe' also described that n she is found faulty or misbehaving, one of the punishments the wife of her uncle ses on her is missing a meal.

wise most of the orphans in guardian households responded, Genzebe a 10 years old an fostered by a woman, friend of his late mother, had mentioned that he does not any problem regarding food. He was one of the orphans I tutored at their homes ıg weekends and after school hours in order to observe their situation at home. ever, one Saturday his guardian told me that he would not be able to study then use he had to do a household chore.

next day, he mentioned that he had to finish washing clothes before lunch in order to ; the clothes dry in the afternoon, or else he would not eat lunch until he finishes ıing. He had finished his task on time that day, but he mentioned that he became re of this rule from such prior punishments he faced. However, he does not perceive ı experiences as abuse or problems; instead, he took them as a rule of the household. hermore, there are orphans who had other kinds of abusive experiences but did not al their experiences due to scare and discomforts to talk about the actions of their dians related to being dependents of their guardians. Taking such cases as a premise, ave a room for the possibility that there may be orphans in guardian households, ng those who mentioned to have no problems, who experience abuse that affects their ition but who are unwilling to expose their problems.

ıans experience food problems where they lack the attention a caring mother gives to ibling. The experience of two maternal orphan brothers is an example of problems of related to lack of parental care and negligence: Kaleb and Sintayehu are orphan ıers of eleven and nine years old respectively. They lost their mother to AIDS. Their r is employed at an electric power station in Kombolcha where he was transferred to re two years. He hired a house servant for the children and sends to the servant ey every month to fulfill the household needs. The elder child Kaleb describes, "The ınt delays our lunch and dinner for hours, and the food she cooks is not tasty. She is the food sometimes gives us a stomachache. She cooks one type of food once and ıs eat it for up to three days. She also refuses to give us food when we are hungry at

ıertime. ...I had told my father when he came last time, but he did not send her
y."

majority of orphans in guardian households had mentioned during interviews that always have food on the table, ever when financial difficulties arise in the ;ehold. However, some guardians who had reported of their difficulty in getting food ıe Kebele and a local NGO were silent about their food problems in front of other ·dians in a focus group discussion. Then I interested a guardian whom a community ker of the NGO confirmed of her report. She mentioned that she would not discuss ıt the food problem in the house because it is shameful to make public such condition . home. Keeping in mind the possibility of the aforementioned orphans to share the :eption of shameful secrecy of lack of food, twenty orphans in guardian households e made to record a diary of their daily activities in detail for a month. And other nty orphans in guardian households were made to record the types of food they eat at ı meal with the respective time of feeding for a month. I also chose to observe what ıans who carry lunch boxes at school eat, because observation at their homes during ltime would make them uncomfortable except for orphans I tutored at home.

ırned out that all of these orphans participating in the study ate at least three times a . The types of foods commonly consumed by these children were vegetables and ns that poor households could afford. Most orphans consumed varieties of grains and etables with different nutrition composition with 'injera' on each meal, and few others yed the varieties with successive single type meals. These orphans mentioned that the ity of the food they consume in their current households has not worsened from the ity they used to get in their late parents households; they did not complain of the food get an the guardian household. Though most of their guardians are poor, this may be use of the similar economic status of the households of their late parents and that of guardians'.

findings of the research conducted in both communities of 'Semen Mazegaja' and fe' reveal that AIDS orphans and children in AIDS affected households are exposed id are made venerable to illnesses and are debilitated to maintain good health as the t of HIV/AIDS. The impact of HIV AIDS has also influenced the health care access ther children in non-AIDS affected households. The AIDS affected children who : exposed and experienced illnesses lacked proper care, access to health treatment, eness of their health status, proper and adequate nutrition, or were infected of HIV. dren infected of HIV/AIDS, orphans in child headed households, and street orphans : commonly identified to have recurrent or serious illnesses.

rdians and children who participated in the study stated that illnesses such as stomach :, diarrhea, headache and coughing are minor heath problems often self cured at home that do not necessitate to seek health care services unless the illnesses are prolonged. wever, this attitude makes children vulnerable to severity of their health condition, e time would be wasted for early treatment on the onset of illnesses. These illnesses ld also be the symptoms of other serious illnesses. Orphans who had been seriously ill sought medical care mentioned that headache, diarrhea, or coughing were the ptoms for their illnesses. Though they had such experiences, these children and their dians maintained their perception of such illness as minor and need-not-seek medical tion.

ng the sudden home visits of orphans in guardian households I conducted with munity workers of an NGO who were intending to monitor the household conditions e orphans, I came across with an orphan who had been ill for more than a week and ner orphan for five days. Both of these orphans' guardians were reluctant to seek cal care even though the NGO provides them with health care cost coverage. One of uardians responded to why the child was not taken to a medical care saying, "He ecover soon. He had recovered at home from this illness before." The other guardian d to this question, "I was hoping day after day that he would get well by the day."

ırding to a social worker, there were two cases of HIV infected children who were at home while they were seriously ill. One of the children was an orphan living with ıardian who kept him to die at home. The guardian thought of seeking medical care lnesses of AIDS as hopeless based on her information that HIV AIDS is incurable. may be due to the guardian's lack of awareness about optimistic life with 'AIDS. The other child lived with his single mother. According to the informant, the ıer kept the child at home because she was fearful of the stigma that may result after sing the then Child's health condition and the cause of his illness. She thought that g him to a health care center would reveal her secret. Fortunate for both children, a ıl worker was able to intervene in getting the children access to medical care, both ren were alive and the orphan living with a guardian was in good health during the work period of the study.

ne across with very few guardians who knew about the HIV status of their fostered ans. In most cases, guardians made the orphans in their care to take the test for HIV ı they were hospitalized for serious illnesses. The other cases encountered were dians who made their foster orphans test out of their awareness about the cause for death of the parents, and guardians who were told by the late parents who had ucted the test for their siblings. However, most of the guardians do not know the status of the AIDS orphans in their care. Some of these guardians mentioned that keep in mind that there is higher probability for the orphans to test positive for HIV, hey prefer not to know about their status. They also acknowledged that they are ortable this way and the common reasons stated were: they fear of the bad news if hild test positive for HIV; they fear that they will reduce their care if they know that hild has been infected with HIV; they guess that the child is not infected of HIV ıse of the Childs age when parents died or because the child has lived for a long d in the fostering family with good health.

ever, guardians' lack of awareness about the HIV status of the fostered orphans ively affects health conditions of the orphans. Keeping in mind higher probability of

:r to child transmission of HIV among AIDS orphans, most of these guardians were ,ed not giving the attention and care a child living with HIV necessitates. As ɔned above, most of the HIV infected orphans under the care of guardians had ıe seriously ill before their HIV status was discovered whose health conditions have otherwise been better had their guardians known about their HIV status Though there were cases of a guardian and a parent who were reluctant to seek al attention once they found out their child's HIV infection, most parents and the ans who were aware of their child's HIV positive status were observed being ıtious than those who were unaware. Besides, taking precautions such as proper on, timely treatments for minor illnesses, and so on prevents or prolongs the nce of serious illness of AIDS among the orphans living with HIV.

eterrent health consequences of unawareness of one's HIV status are also apparent ld headed orphan households and AIDS affected street children. Furthermore, ıs in child headed households and AIDS affected street children were observed and ɔed that they often do not seek or get treatment services for illnesses. These ıs in both living conditions particularly those below fifteen years of age ,let alone ıess of one's HIV status, were unaware of the significance of their health situation llness, and lacked the indigenous knowledge and resources to nurse their illnesses ıe or elsewhere they inhibited. In the case of the street orphans even if they were nurse their illness, the street environment made it difficult to do so. Besides, most orphans I encountered during the study in both living conditions especially the er children, lacked the information to how to access health care services within each; where to go, the availability of the service, how to get free service etc. The ɔrphans who were informed about free health services were unable to obtain 'free paper' from the Kebele because they are not registered at any Kebele, since they live in a registered residence.

t orphan in Kolfe, who barely knows his age (looks like below ten years old) was r by a car on a street. The driver had escaped immediately after the car accident. strian who witnessed the event reported to and brought two traffic police men on

on a nearby street. As soon as they arrived, they took the child to Tikur Anbessa *ɔital. The child was bleeding from his ears. However, the child needed to be* *ɪtered and pay examination fee at the reception desk of the hospital. In the process* *·eceptionist demanded one of the police officers' identification cards in order to let* *·hild get examination, but the officer refused stating that it is not necessary since they* *·epresentatives of the law. The receptionist complained, "They always refuse to give* *ɪeir I.D cards in order not to be held responsible for anything". After long arguments* *her staff interfered and let the child receive emergency care, however the police* *ers left without giving their I.D cards. The child was able to get emergency medical* *and was appointed to neurosurgical examination after four days. The doctor who* *· him the emergency care acknowledged to me that his injury was serious. I was able* *eet the street orphan two days after his appointment date. However, he did not visit* *ɪospital though I had given him money for transportation. He mentioned that he spent* *noney I gave him before he could go to the hospital. From what I understood, he was* *ɔtant to seek medical attention or he did not understand the seriousness of his injury.*

ɣ orphans living in guardian households were observed with poor hygiene during the le period of fieldwork. They wore very dirty uniforms and clothes. According to the lren, the most frequent period of taking a shower mentioned was a week and the est was three weeks, and most of them mentioned two weeks. Few of these orphans ved soap from NGOs. The responses of the children for long period of taking shower ; lack of comfortable toilet; they do not take shower out of their freewill and no one ses it on them; their guardians do not buy them water in order to wash frequently Their responses reflect that the orphans lack proper care from their guardians and hygiene is not given priority within the financial constraints of their households.

ɪcial difficulty in accessing health care services is commonly stated by the AIDS ɛed children, parents, and guardians who participated in the study. Most of these ts and guardians do not have "free service paper". They mentioned that the ucracy of the Kebele administration in obtaining the paper is difficult as in proving financial incapability to afford a medical service. Almost all of the parents and

lians, particularly single woman headed households, mentioned that they could not d to buy medicines prescribed during medical consultations in most cases. Besides, were significant number of guardians and parents who mentioned that they face :ulty to afford the medical consultation fee at government health centers, which is heapest payment available; two birr per consultation.

)s intervening in the communities covered the health care costs including medicine : of few households in both communities. For some households it is fully covered for others health care costs up to 20 birr or 10% of their health care costs is covered nonth. Guardians and parents in these households acknowledged that this support has ed them a lot, however, they stated that they are usually unable to pay for medicine ; even if it will be refunded by the organization. Those parents and guardians who are ally refunded for medical costs mentioned that though the support is helpful, they me unable to benefit from the support when the partial costs they have to cover are fordable.

other difficulty commonly shared between most of the guardians and parents is the sportation cost to access health care. They mentioned that in most circumstances they ate as much money as possible from their little income in order to use the cheapest ic transportation, 'Anbessa Public Transportation'. However, they become short of ey when the child has to be repeatedly followed up at a health center or when the is referred to the pediatric clinic at 'Tikur Anbessa Hospital' which is far from both munities and which often necessities two visits, first to get an appointment date for kup and second to have a medical consultation. They also mentioned that they face ulty of transportation during emergency incidences. They have to resort to the more nsive taxi services at such incidences, because 'Anbessa' buses do not frequently e at bus stops.

st all of the AIDS affected children encountered in both communities, if referred to nly government pediatric clinics at 'Tikur Anbessa' and 'Yekatit 12' hospitals, do ave any options because they do not afford the costs at private clinics and hospitals.

of the guardians whose fostered child had been referred to 'Tikur Anbessa tal' recalled the very long time periods they had to wait until the child is admitted upy a bed, the shortest by an orphan was one month and the longest was two years. ding to Dr. Bethelehem at the Pediatric Department of Tikur Anbessa Hospital, at erage 100 children visit the pediatric clinic of the hospital every day. She noted that spital is far unequipped with the demand, for example, an oxygen tank that is sed to be used by a child is shared between seven children. I also observed the ric clinic overcrowded with patient children. The corridor of the pediatric check up is crowded with children lying on benches with glucose bags tied to the ceiling, and with oxygen aid. The corridor looked very dirty with bad smell coming from a in the corridor used by other outpatients and caretakers of the children who have rowded the corridor. A resident doctor of the clinic described that the pediatric is full and the children who are being treated on benches have to wait for discharges week depending on their cases of diagnostics.

Discrimination and Stigma

neral, the AIDS affected children that revealed the stigma and discrimination they ience indicated that it is less experienced within the community than at the hold level. The most describers of such experiences were children above ten years Among the children who described their experiences, orphans living with guardians hat they were less loved, less given attention, less tolerated, physically punished and given more work in the household than the siblings of the guardians. There also a couple of cases of orphans verbally abused by members of their foster hold. The aforementioned abuses were also described by maternal orphans living a stepmother. There were also maternal orphans who described mistreatment by stic servants.

onal needs of orphans who were still experiencing bereavement of death of parents neglected by guardians. Even discussion of the late parents of orphans was uraged in most of such households. Orphans who were distressed with parental

ths and shocked with new living situations and arrangements were often accused of ıblemaking by guardians. In the case of most orphans above ten years old in this ation in the community studied, they complained of the mistreatments and abuses to r guardians sometimes violently and inappropriately. However, the guardians ressed that orphans in their care should be grateful for the care and support they are vided with. Complaint of orphans, with such conceptions and with tension resulting n household resource sharing by orphans, made guardians feel unappreciated and ctant to provide care. Such misunderstanding between guardians and orphans in few ntified cases initiated further abuse by the guardians and other adult household mbers:

b is a 14 years old Aids orphan boy who is fostered by his aunt. All of his aunt's ings are older than him. The household's source of income is the siblings' earnings, daughter sends money from Beirut and the other two daughters work in Addis Ababa. b describes, "When Selamawit moved to another house, she made me move each of furniture alone from our house up to 'Yohannes' (approximately one kilometer). mawit and Sosina both always beat me brutally for every reason they get." Right r an incident of beatings he ran away to his grand mother at Merkato. His dmother lives alone in poverty, financially unable to support him. Since he moved y from his school, he also faces difficulty of transportation. However, his dmother is willing to take him in and he was also comfortable to stay with her. An O that supports him, after checking her household condition and recognizing his culty of schooling, decided to arrange his return back to his aunt's household. ing the reconciliation process, he mentioned his good relationship with his aunt, and unt revealed that he is a good boy but she does not have the power to restrain her ghters from beating him. The siblings accused him of stealing (out of suspicion from ittle money Sosina lost in one incident) and being 'durye' (behavior of a vagabond). ever, after reconciling Eyob with the siblings he was made to return to his aunt's ehold, though he firmly refused to return. Few weeks after returning, he described in nterview, "still, Sosina beats me. Even my aunt has started beating me and to make lo tough tasks."

ar worsening abusive experience upon returning to a guardian household in ciliation was mentioned by a street child (boy, 12 years old): "*before I began living e streets I used to live with my uncle. When I quarreled with him, I had run away to her uncle. But, my uncle told me that he was unable to support me and took me back first uncle in reconciliation. After returning back, he frequently quarreled with me ng me each time we quarreled...*"

discussing about the problems regarding food orphans experience in abusive ian households, it also depicted a form of the discrimination they experience. The wing briefly stated cases of orphans who described their discriminative and abusive iences may further elaborate the problem.

rphan in 'Semen Mazegaja' who was emotionally affected by the verbal abuse ibes the discrimination and stigmatization he experienced. *Michael is a 10 years old n boy who was taken into his aunt's household when his parents died. When his ing aunt died, his other aunt took him in her household. However, he described that verbally abused by his guardian and her sibling with an Amharic insult 'gefi' (a g which contextually means 'death imposer'). They insulted the child from the fear e will cause another death in the family. The insult made him feel responsible for ath of his parents as well as his aunt.*

was also a case of double orphans who suffered the discrimination and stigma from hbor based on their status as 'AIDS orphans', which could be an example of such ences of orphans outside the household. *Tsehaynesh and Bethelehem are orphans hild headed household. Bethelehem is an 11 years old girl and Tsehaynesh is a 13 old girl heading the household. They live in a compound with many Kebele rented s. A woman in one of their neighbors, according the other neighbors, used to have e with the girls' late parents. This woman forbids the orphans to use a toilet shared en the two households. They were also forbidden to use the hangers for drying s, also shared between all the households in the compound due to the limited space compound. They feel that they were discriminated because of being orphans.*

aynesh mentions, "she forbade us to use the toilet and the hangers because our ır and mother are not here with us, she would not have forbidden us if they were with They also mentioned that she insults them repeatedly by saying "asadagi delew" (which means 'spoiled')... "Your mother had been contaminating us with ʒ keeping it secret". However, the girls were able to bring their case to Kebele orities that made the girls to exchange shelter with other households who rented house from the Kebele. A social worker who was involved with the Kebele orities mentioned that while she was arguing with the woman, the woman had ght up that she also suspects the girls of being infected with HIV and for this reason loes not want to share toilet with them.

chapter depicts the various and interrelated problems inflicted upon AIDS affected lren. Furthermore, it reflected that the impact of HIV/AIDS weakens social capital at ıousehold and community level. AIDS affected children were observed to have weak ıl capital that would have helped them to 'get by' in life on a daily basis and make ırces accessible across various networks in mitigating the effects of the epidemic. had lost and become unable to utilize their family, community, and other social orks in order to receive resources and supports due to parental loss, sibling ersion, migration and relocation, streetism and so on.

dition, it is learned from the findings that children of different ages, gender, orphan s, residence settings, household economic status, and family social network strength the benefit of social capital unequally, and experienced different problems with rent severity. For example, orphans of commercial sex workers had no kinship ties to ve support; street children and orphans in child headed households were mostly e to gain family or adult support, whereas single orphans and adopted orphans were off in receiving emotional and material support and they faced less severe ems.

CHAPTER FIVE

Coping up with HIV/AIDS Inflicted Problems

. Coping Strategies of AIDS Affected Children and Orphans

haned and Vulnerable children owing to HIV/AIDS, boys and girls of different ages, loy a number of different strategies in order to address the daily problems they face. ir reactions and coping strategies to their problems differ according to their gender, income level, household care, and age precedence among siblings.

re is great similarity in some of the strategies applied between the children in 'Semen egaja' and 'Kolfe' with their respective gender, age, living conditions, and birth r. Among the fostered children who participated in the study, the younger children w nine years old were observed to be least able to overcome the difficult situations face in the household. The youngest children reacted with crying when they are hly treated and when they feel that their guardian treated them less than the other ings. However, guardians often punished the children for crying. Some of the children tioned that they endure maltreatments of guardians in silence because it only gets se. An eight years old orphan was made by his guardian to consider the lack of love, reatment, and other felt discriminatory practices as arising from his own fault. He tioned, *"She does not like me, she beats me very much, and when I fight with Abush sibling) she beats only me. ... she does that because I am not her son, but if I were d at school and trouble-free she would have treated me well".* These children rarely plain or cry because they took lessons from their previous reactions to attract tion such as complaints and crying that resulted in physical punishments. They were rved competing with the other siblings in their household to appear as "good" and ver" as the favored siblings, to win the love and attention of their guardian(s).

of the time, hunger has been a daunting problem these children face. Particularly, are unable to be fed at home when they become hungry between the regular meal s; breakfast, lunch, and dinner. During such times, some of these orphans mentioned hey wander around house to house within their compound hoping to be fed by luck.

e who are allowed to go out of their compound or without tight control go to nearby
:s of peers or adults they know. Some go to nearby kiosks and wait for shoppers to
ı pity on them or ask the shoppers to buy them cookies or bread. Some of those who
ıroblems of bringing food to school manage to get food from other students who
a lunchbox. A teacher at Maria Rosa Kindergarten described, *"Some of the orphans*
ve free education come to school with out a lunch box or bring foods strange to
students such as injera rinsed with water. Most of the time we give them the food
students leave over. They also ask a student and share the breakfast (around 10
:k) and lunch with the student."

th communities, AIDS affected and orphaned children over the age of ten, were
in employing various coping strategies to overcome discrimination, avoid
hold disputes, and fulfill basic and additional material needs. While responding to
diate needs and problems, most of these children have dropped out of school, faced
consequences in the fostering household, and some engage in criminal activities.

nes when the orphans become victims of conflicts in the household, according to
iews with the children, boys go out to play in the neighborhood with friends and
visit their friends to have a chat in order to ease their stressed emotions. Boys and
anguished of household disputes, abuse, and maltreatment were observed to run
to another relative of their choice (see the case of Eyob at page 97). However, in
o cases of orphan boys encountered where the relative they ran to was unwilling or
e to let them stay, they realized going back to the fostering household as their
. Thus, one of the boys asked his relative to reconcile him with his foster parent
cating forgiveness and the other boy's relative forced him to go back in
iliation.

ding to observations and interview with A Kebele Official, Many orphan boys sue
uardians to the Kebele for abuse. The orphans whose guardians were giving care
m in the orphans' house were able to evict the guardian. The orphans who were
d in households that receive support of items from an NGO were able to make the

le officials intervene for better outcome. However, the official mentioned that he rred to abstain from intervening because guardians' knowledge of the suit will only unhealthy consequences for the orphans, for example eviction, since the guardians ot forced to take in or keep their fostered orphans and it is difficult to find a place for hildren in any institutional care.

ıe children who were often obliged to carryout household chores, girls were found to y accept chores as their duty and cope with the chores better than boys. All of the an girls interviewed mentioned that household chores are the task of women and , though some mentioned that there is no shame in boys carrying out chores. Some of : girls also revealed their perception that all girls in Addis Ababa carryout chores. findings from interviews with guardians also surfaces that they conceptualize ehold chores as the duty of girls and women. The interviewed girls who were aned at, the least, eight years old were used to carrying out chores at their parents' eholds. The girls who spent most of their spare time with chores never complained ıe chores during the interviews even when it took their time for studying. An orphan (Selamawit, 13 years old) who lives with her aunt and who achieves good results at ol described, *"I finish all my tasks in the house and study... it only takes the time for tudies when I become lazy to do the tasks and play"*.

findings of the study indicated that street orphans, mostly girls, face assault and al abuse among the other difficulties, which are discussed in detail in chapter four. street girls make other street boys their boyfriends who serve them as protection physical abuse and rape. An orphan street girl mentioned, *"I was raped by street s... now that I have a boyfriend other boys (street boys) do not bother me."* In cases eet girls who are engaged in commercial sex relationships they establish with boys of protection as well as economic. According to a child commercial sex worker, are girls in commercial sex who have bigger boyfriends and boys without a sexual onship who protect them from sexual and physical assaults on the street and share come the girls daily earn. She also mentioned, *"I work alone. ...I might face assault*

working on the streets, but boys that protect you sometimes beat you and take all ıoney you earn."

ɜ affected boys and girls, according to interviews and observations, engage in rent kinds of activities to get food or to generate income in order to buy food and l material needs for themselves, their guardians, their ill parents, and their siblings. ng the boys and girls who were identified to be engaged in income generating ities, some work fulltime and others are engaged after school and at weekends. ıg fieldwork, girls with destitute livelihoods were observed to engage in fulltime and ime paid domestic work, work as waitress in a cafeteria, as a parking lot attendant or hewing gum, napkins, cigarettes, nuts etc. on the streets in order to overcome their and their households' income difficulties. Domestic work served the girls as a place ve as well. However, girls were observed to engage in far fewer types of income rating activities compared to that of boys. Some of the girls who had dropped out of ol to engage in full time work have continued their education at night shifts; they ioned that they mange to save from their expenses and pay for the tuition. Among girls, those who were engaged in fulltime paid domestic work mentioned that they ed the permission of their employers to go to night school in addition to the money chool fee. Most of the fulltime domestic servant orphan girls whom I encountered enquired their employers to go to night school, however, they were unable to get permission.

ıe other hand, the AIDS affected boys who were observed to be engaged in income ating activities mentioned that the opportunity for them to be hired by employers are. According to the findings of the interviews and observations, the strategy boys ly employed was engaging in any piecework they come across in the neighborhood ler to remove themselves away from their difficult circumstances: They carry loads taxi drop-inns, from a mill, and within the neighbor hood. They go errands for bors and other households in the community in exchange for little cash. Boys as as seven years old were observed to wander around their neighborhood looking for o be parked and request the drivers to wipe or watch over their car for little cash.

e were also two brothers in a child headed household, one nine years old and the twelve years old, who were observed to rent out bicycles for commissions from the ne they handover to the owner. However, the boys who employ the aforementioned ities mentioned that the respective piecework they carryout, though helpful, are not able often and the income earned from such activities is usually not enough for three s a day or other material needs of the children's households.

ermore, orphans and children in AIDS affected households, according to vations and interviews, employ different strategies to acquire food with the little ne they generate or for free. Among these children, there were also boys and girls, y the girls were never engaged in income generating activities. Boys and girls that friends from economically better families were encountered, who mentioned that sometimes eat with their friends at their homes when they become hungry. Some of boys also mentioned that they collect use-and-throw cans and bottles from their ls' households to sell it to 'korkoroyalew' (buyers of throwaways).

lings, funerals, memorial services, festivities of associations, and other festivities in community serve boys as sources of food. The boys go in crushes for food to services and festivities when invited guests leave. They mentioned that funerals and ings usually benefit them for three days at most. According to interviews and vations, I found out that, Orphan and street boys in "Semen Mazegaja" go to private ls in proximity to the community for leftover food from students leaving the school ound after school hours. In such events, orphans from a child headed households observed to appear with all their brothers. These orphans mentioned that they come er with their brothers in order to scramble as much food as they can get for their ssive meals amidst fierce competition with other children. They also mentioned that children who scramble with them too come together with their family members and s. Moreover, few orphans, boys and girls, acknowledged that they are regular nts of leftovers from the restaurants and hotels in the area. They receive the rs and share it with their household members, but they mentioned that when there

ore leftover than they receive, there are other orphans whom the restaurants and s seldom feed.

:t orphans were observed scavenging for food from public garbage disposals in the nunity. They described that they look for something to eat in the garbage only at desperate times, because leftover food is rarely found in the disposals, if lucky, they find some from garbage disposed from foreigners' houses. This may be because of raditional and religious belief practiced in the communities that throwing away food nful or the belief that it brings poverty to the household. During informal interviews two adults in 'Kolfe', one Muslim and the other Orthodox Christian, mentioned that ver food in their households is consumed again by household members or given to the needy, and they have never thrown away leftover food. They replied to why do not dispose leftover food:

"throwing away food is 'haram' (sinful)"

ause it has 'toor' (an awful deed that will bring about an equal repercussion to the)"

:over, during interviews, some boys described that when they generate little money equate to buy food from ordinary markets, some resort to alternative markets they identified. They buy moderately spoiled fruits from 'Gulit's (open market of petty rs). Those in "Semen Mazegaja" also buy from fruit sellers, at evenings, unspoiled that would spoil by the morning. In both communities, they buy "pastés" (fried ks) that lasted for more than a day from cafeterias and roadside snack sellers.

other strategy of AIDS affected children in fulfilling their needs is exploiting their ort networks. Orphans and children in AIDS affected households that participated in udy revealed and were observed utilizing the support of their network of individuals fill their basic and material needs. According to the findings of the group interview these children (discussed in detail in the next part), their support networks were gs, friends, relatives, and unrelated adults within the community and outside the nunity with empathetic relationship and good rapport with the children. Relatives

unrelated adults supported some of the children in kind and money, some regularly
others seldom. Sometimes, the children themselves also approach them for support.
children explained that they do not consider asking for money form such individuals
gging, instead, they characterize such practice with a term, "Qifela".

Support Networks of HIV/AIDS affected Children and Orphans

stance from support networks of children is identified during the fieldwork as a
ng strategy noteworthy and often employed by orphans and children in HIV/AIDS
ted households of the communities where the research took place. Boys and girls
een the ages eight and sixteen years were individually asked to write down all the
le they like, then all the people who have supported them. Then they were asked to
bine their list of people and put them in order of importance to their lives. Then they
asked to explain why they chose each person and one over the other.

rding to the results and descriptions of the participants, most of these children in
communities tended to heavily rely on supportive older siblings for their material
motional needs. Consequently, they relied on aunts, uncles, grand parents, and adult
ns who live with the children and with whom they have regular contacts. When
networks are unable to provide support or difficulty arose with their relationship
resort to friends for emotional support, and to selected friends for material support.
children exclusively relied on their Godfather and non-related adults with whom
have a close relationship, while most orphans heading a household highly depended
eir friends and adults they knew. Few have also mentioned their guardians to be the
supportive.

had more frequent contacts than girls had with friends. Girls met with their friends
y at school; they were observed to usually stay at home. Their support relationship
their friends was usually of emotional. When they met their friends, they were
ved spending most of the time chatting sitting at school and on their way to and
to school that served them to discuss their problems emotionally supporting each
Most of these girls explained that it is their friends that soothe them when they feel

ıled. Boys on the other hand spent most of the time they had with friends with ng games at school and in their neighborhood. They spent little time discussing their ınal issues. However, some of these boys replied to what they do when they feel ıled, angry, or sad, that they go out to play with friends. Mostly older boys and girls, ly above 12 years old, assisted each other's material needs.

children had weak relationship with relatives outside their households. An orphan ibed such relationship, *"I don't have a relative of any use"*. In most cases, their ct with such relatives was absent, where some of the children did not know them. guardians as well as parents maintained closer networks of few unrelated people, ly within the community. In such cases, social capital that comes form bounded arity (like people being in like circumstances) and the reciprocity of exchange was nt.

rding to the list the children made, nearly all the children who participated in the had small networks of people, not more than four persons excluding friends, except couple of children who stated that their relationship with relatives was stronger. In ds to material support, they revealed that the support each individual within a rt network provides is little, and most of the children approach two or more duals within their support network in order to fulfill a certain material need.

be learnt from the findings of this chapter that HIV/AIDS affected children of ent ages and gender utilize different, in some cases similar, strategies to cope with daily problems. Respective to the coping strategies the children utilized, community ces, individual learnt experiences, economic activities of the community, and the en's social capital were the basis for the different coping mechanisms the children In regards to their social capital, they utilized their social capital operating through elationships with their immediate family members and relatives in their households, s, and community members. The strength of their social capital in terms of the er of individuals in their support networks largely depended on the networks of arents, in accordance with Woolcock's concept of bridging social capital. Most of

children were able to rely on bonding social capital that existed in their networks with nediate family and friends, whereas only few had strong bridging social capital. wever, the network and trust children established with their friends significantly ped them to cope with their emotional and material problems, where children of erent gender and age differently used their support networks of individuals for their erent needs and problems.

CHAPTER SIX

Care Options as Mitigating Factors

1. Traditions of Care for Orphaned Children in the Studied Areas of ddis Ababa

rphan hood is not a recent phenomenon in Addis Ababa or elsewhere in Ethiopia. In oth communities, "Semen Mazegaja" and "Kolfe", where the study was carried out, the sidents are of diverse ethnic groups; predominantly Amhara, Oromo, and Gurage. The ouseholds that participated in the study come from patrilineal societies. According to o elderly from both communities, traditionally, children who lost their father to death ere supported by the extended family within their mother's household through pporting their mother, and children who lost their mother to death were cared for by eir father marrying another wife or were given to their grandparents of either their other's side or father's side being financially supported by their father. Primarily their her's brothers and father's father took in double orphans, though their wives play a gger role in caring for the children practically. Or else, other members of the extended mily took care for them. Guardians were known to the children prior to being orphaned cause relatives lived in close proximity and network of blood ties were strong. Caring a child was shared between the biological parents and the extended family.

dult participants from both communities commented that it was generally easier to care orphans before orphan crisis of AIDS. The extended family was more able to provide e for the then fewer orphans; there were fewer deaths of members from the extended nily and of parents. Orphans were made to forget their orphan status with equal care ong other siblings maintaining full integration with siblings. Orphans too young to nember their parents considered their guardians as their biological parents.

rrently, the traditional link between the concept of parenting and the kinship structure becoming inconsiderable. Orphans in both studied communities are mainly cared for hin the extended family, but usually taken in by mother's sisters and father's sisters. is may be due to negative attitude developed towards the care for orphans by women

ith affinal relationship and the desire among women to take in an orphan more than that men; a guardian explained, *"I prefer for my child to be cared for by a government stitution next to his grand mothers. ...If the government would not take him, I would efer his widowed aunts because his brother and sister will certainly marry".* rthermore, with the weakening networks of blood ties coupled with prevailing poverty the households amidst increasing numbers of orphans, taking in of orphans has pped off gradually, which indicates that HIV/AIDS weakens social capital at the mmunity level besides at the household level. During a focus group discussion with six thers and a woman guardian at Kolfe, they were asked their order of preference of the ople for the care of an orphan. All of them mentioned that it is best for any child to live th both parents, and they preferred that an orphan should live with the mother than the her except for a parent who mentioned that grandmothers care for an orphan better n a father.

e participants were discussing about their preferences for an orphan depicting it with fact on the ground and were talking about their own children. Consequently, the ther's mother and father's mother of the child were equally the second choice for four the participants: one of the parents mentioned, *"I believe that orphans that live with nd parents are usually not hurt. Why, they raise them well because they are stitutes of their siblings".* One of the rests of participants mentioned her friend as her ond choice. The other participant stated that she prefers her children or any child to e by itself once the parents are deceased. Government institutions were the third choice three of the participants, where as two participants mentioned sisters of the child and a ticipant stated brothers and sisters equally. Two of the participants that chose ernment institutions revealed that they do not have other preferences than they have ntioned so far. Two participants that respectively chose sisters and brothers and sisters ntioned government institutions as their fourth choice. One of these two participants ntioned, *"Even if the government will not take my children, leave out aunt and uncle".* the other hand, the other participant chose other relatives equally with brothers and ers of the child as her fourth choice if a government institution is not available to take child. A parent who chose sisters as her third choice stated the mother's sister, the

thers' sister, government institutions, and the parent's brothers consecutively as her urth up to seventh choice to care for an orphan. She mentioned, *"Since men only ovide money I prefer the government than uncles to take care of my children. ... if it is ly for money, at least they will not be exploited."*

able 19. Preference of Participants for Orphan Care

Order of reference	Participants' Preference for the Care of an Orphan						
	P1	P2	P3	P4	P5	P6	P7
1st	M then F	M - F	M - F	M – F	M - F	M - F	M - MM, FM
2nd	A Friend	-	MM, FM	MM,FM	MM, FM	MM, FM	F
3rd	Government	-	Z	Z	B, Z	Government	Government
4th	-		MZ	Government	Government	-	Other relatives equally with B and Z
5th	-		FZ	-	Non relatives, Neighbors		-
6th	-		Government	-	-	-	-
7th	-		MB,FB	-	-	-	-

= participant, M = Mother, F = father, Z = sister, B = brother, MM = mother's other, FM = father's mother, MZ = mother's sister, FZ = father's sister

he participants, while discussing about their preferences for orphan care, recurrently entioned that what a child needs foremost is love.

ferred from the above findings, the participants have weak social capital in the ructural aspects (connections and networks) in regards to their relationships with latives. However, social capital in its cultural aspects among the extended family is actically prevalent where most of the AIDS orphans in the communities under study are lopted by their extended family.

1.1 Impact of the Traditional Care for Orphans

most all of the orphans in households who participated in the study in both mmunities were either fostered by relatives or remained with siblings. Only few hans were cared for by unrelated guardians. The majority of these fostered orphans re cared for by their mother's sister then by father's sister, followed by those fostered grand parents. Remarkably, nearly all of the women guardians encountered were her divorced or widowed. Orphans fostered by uncles were hardly ever spotted. The gnitude of orphans in child headed households could be observed to be considerable in th communities. Parents and guardians talked about institutional care among their ference for childcare, but orphans taken in by such care from both communities could t be traced.

e livelihoods of orphans depended upon the resources of fostering families, often rce, and the assets and resources of their biological parents that remain after their ath. Orphans in child headed households who own assets transferred by their parents, ugh very few, are observed to be better off than other orphans in such households; for ample, those who own their shelter do not worry about rental fees, in addition, were nerating income from renting rooms. It was also found out, those few orphans fostered more contented households, on top of material needs being realized, achieved well in ucation relative to their capacity and revealed that they did not feel any kind of crimination or abuse imposed by guardians. There were also orphans fostered in poor useholds who stated their guardians foremost when they were asked to mention the st important persons in their lives.

findings of the study surface that nearly all orphans taken in for care by guardians ve primarily gained the benefit of shelter and education, otherwise who may have been the streets with all its vulnerabilities or dropped out of school in destitute situations h their siblings, alike orphans easily identified in both communities who slipped ugh the traditional care for orphans. Although more than a few orphans described se and discrimination by guardians, there were others who expressed the love and ntion they acquire from their guardians and who portrayed the destitution they

erienced before taken in by their guardians. The responses of these orphans during rviews reveal that they were emotionally supported and guided according to the ms and values of their respective communities. These children, while discussing about r stories of the past, went on talking about their future dreams appreciating their sent living conditions where they were not led to talk about it. Their responses reflect they commonly shared self-confidence, were able to imagine for a future career with nse of possibility for self-reliance and helping out their community and country in the rviews conducted with them:

zgebu, 8 years old, orphan boy in 'Kolfe') "I live with my aunt. My father died at the front. My mother used to be sick very often. Now I do not know the whereabouts of mother, even whether she is dead or alive. Before my aunt began to raise me, I had y problems. ...but now my life has changed. I could attend my classes without hering about my food. If my aunt were not there for me, I might have suffered a lot or n go out to the streets. My aunt will support me and encourage me until I complete cation and become self-dependent. I want to be a pilot when I complete twelfth grade, support my family and serve my country and people. "

fact that most orphans are fostered by guardians off the streets has made them easily ssible to external agency-driven interventions. Fostering households have proved to important mechanisms for such interventions in the efforts to provide support for hans in more effective and culturally appropriate manner. A social worker nowledged that orphans in guardian household benefit from the provided supports far er than those in child headed households, guardians are the primary implementers of supports the NGO provides. He also mentioned that guardians made it easy to itor the progress of the orphans, unlike that in child headed households; *"for mple, we face difficulty to identify orphans in child headed households that have loped bad behaviors or those who need counseling"*. They have also served for cing the costs in providing care by these interventions, making more AIDS orphans fit from the available provisions.

nmunity based organizations, particularly the 'Iddir', that served for the emotional port and material relief during death of a family member, based on the findings from responses of an 'Iddir' chairman and an orphan who benefited from the service, are y helpful for orphans without any relatives upon parental death. An 'Iddir' at 'Kolfe', ording to a social worker and my observations, has become an important agent for ernal interventions in outsourcing orphans with worst problems, in mobilizing mmunity members to care and provide support for orphans and for awareness grams, and in avoiding administrative costs for intervention projects that would be ected to grass root level implementation.

general, the social capital of households operating through their relationships with ended kin, community members, and formal and informal community organizations is ical to the wellbeing of AIDS affected and infected children, and in particular, for DS orphans in order not to slip through the traditional orphan care.

. External Agency-driven Interventions

re are in total seven Non Governmental Organizations providing care and support for hans and Vulnerable Children as the result of HIV/AIDS in 'Semen Mazegaja', of ch four are indigenous development organizations and the other three are faith-based anizations. All of these organizations provide their services also to orphans and nerable children due to other causes, in order to prevent stigmatization and rimination among those affected by AIDS. The names of these organizations with r respective provisions are stated as follows:

nt Clara' is an international faith based organization that has built a junior elementary ool in the community. The organization enrolls orphans and vulnerable children and few street children in its school and finds sponsors for each child to cover school and health treatment costs. According to Sr. Etaferahu, health treatment costs rred by these children have been fully covered until 2006. Then on, only 10% of their ment costs are reimbursed by the organization. Currently, there are 440 OVC nsored through this organization.

ria Rosa' is the other international faith based organization in this community. It has t a kindergarten where it charges relatively cheaper school fee and gives free :ation opportunity for few OVC. It also gives the opportunity to go to public schools overing the school fees for some of these OVC in the kindergarten, selected based on r destitution, until they graduate from high school. The organization is providing)ort to 60 OVC, of which 30 are currently in the kindergarten and the other 30 are)lled in elementary and junior education at other schools. It also provides stationery :rials annually and school uniforms twice a year for the OVC in the kindergarten and kfast and lunch services at school days for some of these orphans.

:ryone', 'Hiwot HIV Support', 'Abebech Gobena', 'Compasion', and 'Mesecrete stos' are indigenous NGOs, the later two being faith based, that provide support to C in 'Semen Mazegaja' area, except for 'Abebech Gobena' that gives support to only ians of any cause. The number of OVC supported and the types of support provided he organizations are presented in the following table:

e 20. Number of OVC and Types of Support Provided by NGOs in Semen Mazegaja

e of NGO	No. of OVC during the study	Description of supports provided
ryone'	25	- school fee, stationery, school uniforms, tutorial sessions - food & sanitation material provision (wheat, oil, and soap) - health care cost coverage (not exceeding 20 Birr/ month) - counseling service - child to parent reunification
ot HIV Support'	30	- food provision (wheat and oil)
bech Gobena'	180	- food provision (wheat and oil) - school fee, stationery, school uniforms - health care cost coverage (10%) - life skill training (for adolescents) - home based care for HIV infected children
npasion'	45	- school fee, stationery, school uniforms - health care cost coverage (100%)
serete Kiristos'	250	- school fee, stationery, school uniforms - food & sanitation material provision (Teff, wheat, oil, and soap) - health care cost coverage (100%) - life skill training

Kolfe" there are in total four NGOs that give support to OVC in the community, ely; Save the Children USA, Hiwot HIV/AIDS, Tesfa Limat, and Everyone. In tion, The Global Fund gives support services through the Kebele's HIV/AIDS Desk. the Children USA utilizes an "Iddir" in the community to implement its support

am. The types of supports given by these organizations and the number of OVC ɔrted in the community are presented in the following table.

: 21. Number of OVC and Types of Support Provided by NGOs in Kolfe

e of NGO	No. of OVC during the study	Description of supports provided
/one	24	- school fee, stationery, school uniforms, tutorial sessions - food & sanitation material provision (wheat, oil, and soap) - health care cost coverage (not exceeding 20 Birr/ month) - counseling service - child to parent reunification
ɔt HIV AIDS	-	- food provision (wheat and oil) - school fee - health care cost coverage (100%)
ı Limat	1300	- food provision (wheat and oil) - school fee, stationery, school uniforms - cloth (for holidays) - life skill training (adolescents)
the Children	-	- school fee, stationery, school uniforms - food provision (wheat and oil)
al Fund	1600	- financial support - stationery - food provision (wheat and sometimes Teff) - cloth provision (irregularly)

ans and Children who get support from external interventions in both communities better off in most aspects in relation to the types of supports provided to them. rding to the results of the interviews, except for those OVC whose food support was

d by guardians and some limitations of the supports, that will be discussed later, the support they received has been beneficial to the children in supplementing food quacies they used to experience. According to parents and the observation of two ins living with HIV/AIDS, this support has been helpful, particularly for children with HIV/AIDS, in maintaining their health.

esponses of the interviewed orphans reveal that, these food supports together with ational supports have allowed especially the most destitute of the OVC to leave id their worries about working for food or school expenses and become able to fit from education. All of the school age children under the support of the external ventions are currently enrolled in school. Some of these had dropped out of school in to generate income, and others in destitute situations mentioned that they would been forced to be removed from school without the support they are provided by the nal interventions.

alem Tadesse, orphan girl, 12 years old, 4th grade student) "When my mother passed I began living with my grand mother. I dropped out of school and became a servant estic servant). ... I was seven years old when I became a servant. Because my dmother had nothing to support me with, I had no other option than being a servant. er I joined 'Everyone' (NGO), my life has changed. I have stated again to live with randmother and continue education. The organization covers everything and helps n my studies. I am glad about all the supports I get from the organization. All of the orts are very helpful for my life. Especially their counseling service and their advice a great place in my life. ...I need "Everyone's" care and support until I complete ation and have my own better income. In addition, I have a dream to help others."

les the offering of schooling opportunities to these OVC, the interventions' policy food support is provided to only those OVC that will go and stay in school has ibuted to school enrollment among these children. Orphans who participated in seling and tutorial sessions have described that they now enjoy going to school and rstand their studies better than before, particularly identifying tutorial sessions as a

factor. They repeatedly mentioned that they liked the tutorial and counseling . Schoolteachers of these students commented that their class participation and nent was improving from day to day. There were a couple of cases of school ; that benefited from the tutorials to cope up with the studies where they left off, g to a tutor, who used to measure way below their level of education at the initial utorial sessions. Based on the findings from the observations at school, the n materials and school uniforms the OVC receive have also helped them to be t at school, develop interest for learning and follow their studies properly.

ng to the counselors in the communities, the OVC have developed self- ce, overcome their stresses, and become optimists of their future, partially as the better school achievements, successful counseling, and the sense of importance eloped from being considered for support.

e of Woineshet: *Woineshet is a 13 years old girl who used to live with her single and her little sister. Woineshet was nine years old when her mother became en of AIDS. For she was the eldest sibling, she nursed her mother at home for wo years. Unfortunately, her mother passed away when she was eleven. Since headed the household with her little sister, getting care and support from an while after losing her mother. A counselor of the NGO explained that she used to ted from her friends and other members of the community, she had lost interest oling and was repeatedly absent from school, she used to daydream and loudly herself, and she had tried to commit suicide twice. He also mentioned that she de to have these problems because of the stress she developed while caring for g mother and bereaving for her death. However, In addition to material support O provided, she began attending progressive counseling sessions. A core group d of community members began to recurrently visit her at home. After benefiting e psychosocial support for more than a year, she now has achieved marked . Currently, she attends school regularly and has improved her school results. bserved to socialize with her peers and community members in the core group. nselor stated that though it is impossible to conclude that she has fully recovered,*

her condition has improved very much currently because of the integrated psychosocial support she received from the organization and the community members.

There were cases of interventions for child headed households in providing shelter in cooperation with the Kebele. In addition, rents of these and some other child headed households are covered by an organization, 'Everyone', in both communities. Such interventions have prevented the orphans from resorting to streetism and sibling dispersion. Besides, few of the street children targeted in the child reunification program of the NGO, Everyone, have been reunified with their families and were staying with their families when the study was carried out.

The strength of the social capital at the households that adopted orphans – bonding social capital – is determinant to the wellbeing of AIDS orphans and to the external interventions achieving their objectives. According to social workers and project officers of NGOs working in 'Semen Mazegaja', guardians who have empathy and good relationship with their adopted orphan children were very helpful for orphans to benefit from the supports external agencies provide.

6.2.1. Limitations and Difficulties of External Agency-based Interventions

Very few orphans and vulnerable children as the result of AIDS are provided care and support compared to their magnitude in both communities. Besides, the OVC who are being supported comment that the support provided per individual is inadequate. To be specific, the food and health supports, though very helpful, could not fully meet the needs of those destitute OVC who cannot supplement the gaps themselves. These OVC whose health care costs are only partially covered could not benefit from the support. Even when health care costs are fully covered, the OVC face a difficulty in utilizing the support due to the technical procedure applied by all the organizations; health care costs incurred by the OVC are refunded by a project based on receipt evidences. According to some guardians, in most cases, they are unable to pay initially for such reimbursable costs. Large numbers of the OVC supported by some of the organizations are provided with one or two types of supports incomplete for coping up from their problems. Highly

destitute OVC in such situations, on top of being unable to effectively benefit from the limited types of support, they slip through the selection for further support by other organizations since they are identified as "the supported".

Shortage in funding is a problem commonly forwarded by the NGOs in both communities. In addition to shortage in the total resource pooled into the country for mitigating the problems of OVC, most of the local NGOs do not have the capacity to raise funds in potential donor countries. Therefore, the funds are allocated through international NGOs, which have their own administration costs that decrease the final amount that reaches the OVC. Furthermore, many local NGOs that each support few OVC in a small urban area is observed, which incur more administration costs than incurred by a single organization that supports the total number of OVC these NGOs support altogether.

Discontinuity of support services due to lack of funding, mentioned by project officers, is the other limitation of the interventions through local NGOs. Where such limitation is apparent to local NGOs, based on the fieldwork findings, activities that may serve for the sustainability of the supports such as empowerment of household members in income generating activities, mobilizing and empowering community based organizations to mobilize resources within the community, etc. are not undertaken. Support items such as food, school fees, and health costs are considered as relief by partner NGOs that allocate fund to the local NGOs, and local NGOs are observed to carry out only activities that require evaluation and report submission by partner organizations. For implementation of activities that are considered as relief is not expected to be sustainable and organizations that only provide relief are not held accountable by fund allocating NGOs, sustainability activities for such supports are not carried out.

Orphan households were observed to become victims of dependency syndrome; they have become dependent on the supports provided to them. They lacked the sense of responsibility in alleviating their own problems, rather waited for external help.

Guardians of orphans and other members of orphan households were called for a participatory planning meeting of a project design on Income Generating Activities for Self-reliance initiated while I was conducting fieldwork. However, most of them did not appear to the meeting. According to the responses of those who participated in the meeting and interviews made to those who did not appear, they insisted on being part of receiving only support items of relief nature that are continuously provided. They openly revealed their desire not to involve in income generating activities, some giving various reasons to show their inability. Some described their fear that the supports will discontinue as soon as they become part of the income-generating scheme. They were dubious to the possibility of generating an income. As such, they were much comfortable with the support items they receive. A guardian mentioned *"I will never be able generate an income exceeding the support I am receiving"*.

The needs of the OVC are diverse and relative to the specific problems faced by each child. As discussed in detail in chapter four, OVC face different kinds of problems with different extent and levels of diversity depending on their age, gender, and extent of destitution. However, the support items provided by the NGOs in both communities were found out to be limited, relatively giving more attention to food and education support. Most of the organizations were unable to be flexible in addressing specific and severe problems of OVC that were not included in their support programs. For instance, Helen Lema, an orphan girl head of a household could not constantly attend school in order to care for her infant sister in the household though education support was provided to her. Support items that address problems commonly faced by the OVC, such as legal protection, counseling, tutorial services are also not included by the NGOs, except for an NGO that provides counseling and tutorial services for only 25 and 24 OVC in each community. There were around 1600 OVC that registered seeking external support at the HIV/AIDS Desk of Kebele 09 and an official at the HIV/AIDS Desk of Kebele 08 asserted that the OVC they registered by then were around 1000. In addition to the insignificant number of the OVC included in the care and support program of the NGOs compared to the magnitude of the problem in both communities, those who benefit from

ounseling services are very small even compared to the number of OVC supported by
GOs.

s the findings of the study reveal, the major reason for the aforementioned problems is
at the decision in the type of support to be provided is top down; the decision on the
pes of supports a fund would be allocated for is initially decided by the top donor
ganizations. According to project officers of two NGOs, the funding procedures of
nor organizations do not allow the funding of a project proposal based on a baseline
rvey with specific flexible activities or with important activities different from the
tention of the donor organization. Likewise, NGOs that encounter problems that need
xible activities apart from their project proposals would be held accountable by donor
ganizations, which were discouraging for such attempts. On the other hand, there were
ntroversies between guardians of orphans with diverse problems and the NGOs
plementing support provisions. Guardians, without the information about the
ganizations' financial capability and objectives, frequently demanded for the alleviation
all their diverse problems at once. Such behaviors had made it difficult for the NGOs
work with such guardians in order to gradually assist with the problems of orphans
der their care.

rthermore, there were limitations and difficulties in the selection process of OVC. The
dus operandi stated by the NGOs is that representatives of community members
gether with Kebele officials participate in selecting the OVC as per the selection
teria stated in each project proposal. However, there were biases in the selection
ong both the representatives of community members and Kebele officials. The Kebele
icials were observed giving priority only to those OVC registered to receive support
first come first serve basis. According to informants from guardians, Kebele officials
e priority to those they have acquaintance with. Community representatives, in some
es, were also biased with what they explicitly observe about a household's condition.
useholds fostering orphans pretended to appear destitute to the community in order to
selected as beneficiaries. Complaints of such pretense to NGOs and the Kebele
inistration were common from neighbors providing evidences about financial

ellness of pretending households. A social worker mentioned that he was able to prove
'o of such complaints that they were true.

)on the commencement of implementation of care and support projects, I was able to
tness that numerous selected beneficiaries become unavailable. In the cases observed,
e reasons identified for such a difficulty were the mobility of selected households,
ocation of orphans to another fostering household, and unawareness of community
embers of the whereabouts of these target groups.

ie most common difficulty in meeting the ends of the supports provided was the misuse
provided food items by guardians. Though, according to a social worker, there were
ocations of the services intended for the OVC to the guardians' own use, most
ardians often mentioned that the food item provided is unsuitable for their daily use.
e staple food of the community being 'Teff', the food item provided by almost all
GOs was wheat. Thus, the guardians sell it or trade it in exchange for Teff. In addition,
ers sold the food item to fulfill the material needs of the household. Many OVC also
mmented that they did not like the food item FAMEX (a processed nutrition food
mplex).

)reover, abuses in the orphan households have also prevented health and education
)ports from genuinely benefiting the OVC. As discussed in detail in chapter four,
ises the OVC experience such as denial of health care, lack of moral support,
:upation with exploitation of labor, and lack of tutorial support contributed to the OVC
t were observed responding less to the provided services.

:ording to a social worker and interviews with guardians and parents revealed that
han girls, in order to fulfill their material needs, were easily influenced by peers to
age in child prostitution, easily took opportunities of marriage, and flee with
friends. Orphans dropping out of the support services in such cases were difficult for
lementers to intervene and achieve results.

/iding supports to street children was also a difficulty encountered by the NGOs due nobile nature of street children. Most of the OVC on the streets who were involved in :hild reunification program in both areas were unable to benefit as intended. Most of e children on the streets did not know the whereabouts of their parents. Thus tracing · parents was a failure. Those who went out to the streets from the studied munities, almost all of those who participated in the study mentioned that they rted to the streets due to unmet needs in the household or conflicts with dians/parents. In some cases, the orphans refused to go back confirming their ıtion better than that in their household. In other cases, the guardians were unwilling ıke them back in. There were seemingly successful interventions as in the street lren going back to their households. However, few stayed in. According to guardians, :hildren repeatedly clash with their parents with violent and worsening behaviors and tices they brought into their households from the streets. On the other hand, rding to the children, the common reasons they stated were; they were subject to ;ical abuse, their basic needs such as food and cloth were unmet, or they had no lom except for quarrels.

case of Seleshi: *Seleshi is a 13 year old orphaned boy. He used to live with his single her and his elder brother Sisay who is fourteen years old. They used to reside in a al home from a private proprietor. When their mother passed away from AIDS they forced lead their lives by themselves. However, they did not manage to pay their e rent after a little while. Thus, they were evicted and began to live in the Kebele pound making a shelter with plastic sheet at a spot the Kebele chairperson allowed to use out of his goodwill. Eventually both of them dropped out of school, and they most of their time on the streets trying to get food and returned to their shelter to the night. The Kebele chairperson assisted them also to be supported by an NGO. the reunification program of the NGO, their biological father was located and their fication was arranged. Seleshi moved into his father's household, but Sisay refused ve in asserting, "Instead of moving into a person's house I do not know I better stay I am and receive the food support of the NGO." Nevertheless, the NGO quit rting Sisay because of his refusal to go to school. Seleshi, staying with his father for*

a while, ran away from home. The father and social workers of the NGO tried to look for him, but were unable to find him. The father mentioned, "... it is his brother who mislead him to run away to him, only to lead a vagrant street life." Approximately after a month, I bumped into the elder brother around 'Giorgis' area and I was able to meet Seleshi by assuring Sisay that I meant no trouble. *Sileshi stated that he ran away from his father's home because he preferred to live with his brother. Though he faces difficulties living on the streets and his material needs were met better in his father's household, he described that he is used to living on the streets and prefers not to be separated from his brother.*

NCLUSION

major findings of this study surface that HIV/AIDS is a multifaceted problem; al, economic, social, cultural, political, and human rights. The study emphasized on ajor problems AIDS affected children face in 'Semen Mazegaja' and 'Kolfe'. The gs revealed that AIDS affected children face wide ranging and interrelated ems as the result of HIV/AIDS. The major problems identified were lack of basic sities, health care, psychological and emotional support, education, discrimination igma, child labor, streetism and child prostitution. In addition, it is learned from the gs that children of different ages, gender, orphan status, household economic status, mily's strength of links with social networks experienced different problems with ng severity.

ther emphasis of the study was children coping up with HIV/AIDS inflicted ems. Thus, the study took a closer look at the different strategies these children yed in order to cope with the difficult circumstances they find themselves in. It was stood that children of different ages and gender employed different kinds of coping gies, and the coping strategies employed were founded on the strength of their link heir social networks, individual lived and learnt experiences, economic activity of community, and community resources. Furthermore, the study looked into the dual support networks they utilized in overcoming their problems. The children's rt network with relatives was identified to be dependent on the strength of the ties s maintained with relatives. Only relatives within the same households of the en and those who had frequent contacts with their households served as support rks for the children. However, siblings and friends were identified as the prominent rt networks of the children. The study revealed that the children's individual rt networks were of assistance for their material as well as emotional needs.

rmore, the study looked at the role of care options within the communities in ting the problems of AIDS affected and infected children. The practice of fostering xternal agency based interventions were the care options identified in the unities. Most AIDS orphans were identified to be fostered by the extended family,

stly by widowed and divorced women. However, the study revealed that parents' ıtionship with relatives was weak and their preference for orphan care opts out ıtives, particularly married consanguine relatives and uncles. The reason they stated ; that orphans will be prone to mistreatment and abuse, and they will not get love, ch they need most. However, the fact that most of the AIDS orphans in the ımunity are adopted by the extended family because of the values and cultural beliefs ıdopting one's orphan relative shows the strong social capital between relatives in its ural aspect, which goes in accordance to Portes' source of social capital that comes n value interjection.

eover, the findings of the study revealed that the minimal presence and low capability ıstitutional infrastructures to act on the behalf of the community and the increasingly overished and overwhelmed traditional safety net impede AIDS affected children ı coping with inflicted problems. It was found out that external agency based rventions were available to insignificant numbers of orphans and vulnerable children ıpared to the magnitude of AIDS affected children in both communities where the y took place. However, the strong social capital at the community level – the itional values and norms of fostering and orphan care shared among community ıbers – were identified to be indispensable for the wellbeing of orphans and to rnal interventions in achieving their objectives. Additionally, households of adopted ıans with strong bonding social capital were of significant assistance to external ıcies in their endeavor. Supportive guardian care was spotted to be fundamental for ans to benefit from supports external agencies provided. On the other hand, fostering eholds with ease of access to resources were found out to be fertile grounds for ans in their care in meeting basic and material needs other orphans in low-income eholds had difficulties to meet.

gards to the care options in mitigating the problems of AIDS orphans, the study also ed at the limitations and difficulties of external agency based interventions. The ıgs of the study indicated that the interventions offered limited types of supports that less significant for the desired outcomes for orphans coping with many interrelated ems, lacked flexibility towards addressing the specific needs of orphans with

tional problems, and resulted in discontinuity of support services. The reasons fied through the study for these limitations were insufficiency of funds pooled to at the HIV/AIDS problem in the country, low capacity of the NGOs the unities in raising funds as well as in staffing, and lack of decision making by menting NGOs regarding the flow of the support from the top level. Furthermore, ndings of the study indicated that numerous NGOs were providing their services to rphans and vulnerable children, which the administration cost incurred by each of numerous NGOs multiplied by their numbers, each supporting few children, has a ion effect on the resource intended to reach the "beneficiaries".

dition, the study indicated that socio-cultural factors were noteworthy for the lties external interventions undergone in achieving their objectives. The difficulties ied were; lack of sense of ownership of the problem among some members of the unities, powerlessness and vulnerability of the women who were the most cers of orphans, mobility of guardian households and relocation of orphans, ty of street orphans, and withdrawal of orphans from support services mainly due r influence.

first, external agency based interventions ought to consider the importance of social in order to prevent the problems inflicted upon children as the result of HIV/AIDS nable children cope with these problems. Thus, interventions should emphasize on building the human capital of children, strengthening the networks of children ousehold members at the household level, with relatives, at the community level ommunity members and indigenous associations, and with external support es. In this regard, programs should utilize the strength of communities' social in meeting their objectives, and policies and programs should be designed eaming activities that work to revive the values and norms of community rs towards caring for orphans and boost the trust between community members ir social networks in order to strengthen and mobilize the social capital of the nity.

ond, support efforts must be principally community driven and owned, or at least be ımunity supported with external assistance, in order for care and coping strategies be ainable overtime, be able to assist large and highly increasing numbers of orphans ı exceptional need, and be culturally acceptable.

:d, the problems of AIDS affected children must be understood in terms of a elopment problem. Thus, childcare support efforts should be conceptualized as an y point to the community laying foundation for further community development grams and should be taken as an effective prevention strategy aiming to meet the g-term need for adequate orphan care, instead of a single concern of childcare that ıld become a temporary effort.

rth, external agencies along with Community Based Organizations must design and lement programs that work towards developing attitudes of fostering, adopting and ɔer care of orphans in general, particularly HIV infected orphans, among community nbers. Thus, the care of orphans amidst the alarming increase of the number of ıans and shortage of resources for external support would be effective and efficient ɔugh community-based support where there are highly willing and caring community nbers taking in orphans. In addition, support efforts for children that need special ntion must be intensified; efforts that address the problems of street children such as d reunification programs must be intensified, and efforts must emphasize on placing ndoned children and AIDS orphans without adult care and mistreated children in dential care or other alternative care options temporarily until adoptive families are ıtified.

ı, support efforts must pool in more funds to combat the orphan crisis and take into ɔunt the multiple developmental needs of children, not just their basic physical needs, supports of integrated type that address the multifarious problems of AIDS affected lren must be provided. These multifarious problems must be understood and tified by all concerned parties, particularly by guardians and parents. For instance, to

se one specific problem, psychological problems of AIDS affected children, which are en overlooked, must be given special attention.

xth, support efforts have to be mainstreamed along different sectors. In regards to the uation on the ground, pediatric health care must be developed, and schools must take o account the difficulties of AIDS affected children in order to allow such children fectively benefit from education.

venth, the economic capacity of guardians and parents should be strengthened through ome generating schemes, credit facilitation, provision of skill training and education. r the findings revealed that women are the prominent caretakers of AIDS orphans, ivities of social and economic empowerment of women should be intensively carried

Bibliography

agnoud, F., Association Francois-Xavier, Mulugeta Gebru, and Rebecca Atnafu. 2000. *Ethiopia: Transitioning from institutional care of orphans to community based care: The experience of Ethiopia's Jerusalem Association Children's Homes.* Retrieved October 2005, from www.ovcsupport.net/sw488.asp

arnett, T. and Whiteside, A. 2003. *Aids in the 21st Century.* New York: Palgrave Mc Millan

assani, C. 2003. *Social Capital Theory in the Context of Japanese Children.* electronic journal of contemporary Japanese studies, Article 1, 2003

icego, G., Rustein, S., Johnson K. 2003. *Dimensions of the Emerging Orphan Crisis in Sub-Saharan Africa.* Journal of Social Science and Medicine, 56, p. 1235-1247

entral Statistics Authority (CSA), Federal Democratic Republic of Ethiopia 1999. *The 1994 Population and Housing Census of Ethiopia: Results for Addis Ababa, Volume II Analytical Report.* Addis Ababa: CSA April 1999

HGA. 2004. *Impact of HIV/AIDS on gender, orphans and vulnerable children, Discussion Outcomes of CHGA Interactive Cameroon, November, 2004.* African Centre for Gender and Development (CHGA), Economic Commission for Africa (ECA).

ıildren Youth and Family Welfare Organization (CYFWO). 2004. *Convention on the Rights of the Child*, English and Amharic text. Addis Ababa: Save the Children Sweden

ɔleman, J. 1988. *The Creation and Destruction of Social Capital.* Journal of Law, Ethics & Public Policy, 3, p. 375-404.

_____. 1990. *Foundations of Social Theory.* Cambridge, Mass: Harvard University Press.

SA. 2001. Ethiopian Child Labor Survey Report. Addis Ababa: CSA/Addis Ababa

_____. *Report on the year 2000 Welfare Monitoring Survey, Vol.1, 251 Statistical Bulletin*: Addis Ababa. CSA April 2001

elate, R. 2000. *HIV/AIDS: Developing a national strategy with a human rights approach* in Southern African journal of International Affairs: Article 7(2):89-105

sex, Mboup, Kanki, Marlink, Tlou. 2002. *Aids in Africa*, Second Edition. New York: Kluwer academic/ Plenum Publishers.

H-Ethiopia. 2002. *Needs Assessment of PLWHA in Addis Ababa*. Addis Ababa

muliza. 1999. *Manual: Psycho-social support for orphans.* Basel: Terre Des Hommes.

nter, B.H. 2003. *Taming the Social Capital Hydra? Indigenous Poverty, Social Capital Theory and Measurement*. Canberra: *Centre for Aboriginal Economic Policy Research Discussion Paper No. 205*, (CAEPR), ANU.

kson, H. 2002. *AIDS in Africa: Continent in Crisis*. Harare: SAfAIDS.

n, N. 2001. *Social Capital: A Theory of Social Structure and Action*. Cambridge, UK: Cambridge University Press.

nistry of Education (MOE). 1994. *Federal Democratic Republic of Ethiopia, Education policy*. Addis Ababa: MOE

nistry of Health (MOH). 1993. *Health Policy of the Transitional Government of Ethiopia.* Addis Ababa: MOH

_____. 2002. *HIV/AIDS Behavioral Surveillance Survey.* Addis Ababa: Central Printing Press.

_____. 2003. *Fifth Report.* Addis Ababa: MOH, Disease Prevention and Control Department.

_____. 2004. *AIDS in Ethiopia*. Addis Ababa: Chamber Printing House.

_____. 2006. *Sixth Report.* Addis Ababa: MOH, Disease Prevention and Control Department.

nistry of Labor and Social Affairs (MOLSA). 1996. *The Developmental Social Welfare Policy*. Addis Ababa: MOLSA

_____. 2003. *Survey on the Prevalence and Characteristics of AIDS Orphans in Ethiopia*. Addis Ababa

tangadura, G., Mukurazita, D. and Jackson, H. 1999. *A review of household and community coping responses to the HIV/AIDS epidemic in the rural areas of sub-Saharan Africa*, UNAIDS Best Practice Paper, June 1999.

land, V. 1993. *AIDS-learning to be more helpful*. Kampala: Redd Barna

i, J. 1997. *Widowhood, remarriage and migration during the HIV/AIDS epidemic in Uganda*. Health Transit Rev. 7:125-144

RC. 1996. *Policy and Human Rights*. chapter in Jackson, "H. AIDS in Africa: Continent in Crisis". Harare: SAfAIDS.

ipos Petros. 2002. *The Impact of AIDS on Development: The Case of Addis Ababa*. Addis Ababa: Addis Ababa University.

iam, R. 1993. *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton, N.J.: Princeton University Press.

_____. 1995. *Bowling alone: America's declining social capital*. Journal of Democracy, 6 (1): 65–78.

e the Children Alliance (SCA). 2001. *Report on the First Consultative Meeting on Orphans and Vulnerable, Policy and Practice Review*. Addis Ababa: May, 2001

A/ UNICEF. 2001. *National Workshop on Orphans and Vulnerable Children affected by HIV/AIDS*: Nazareth, December 13-15, 2001. Save the Children Alliance/ UNICEF

amawit Yosef. 2005. *Impact of HIV/AIDS on AIDS Orphans with special emphasis on Social Capital*. Addis Ababa: Addis Ababa University.

nnon, C. 2003. Measuring Impacts of HIV/AIDS on Rural Livelihoods and Food Security. Sustainable Development Department (SD), Food and Agriculture of the United Nations (FAO). Retrieved November 2005, from www.fao.org/2003/PE0102a2_en.htm.

ie, G.J. 2003. *Aids update 2003*. New Jersey: Pearer Education, Inc. Upp, Dadalb River.

ree, D. 1995. *Roofs and Roots: The care of separated children in the developing world*. London: Save the Children UK.

_____. 2003. *Community Based Care for Separated Children*. Save the Children Sweeden. Retrieved October 2005, from www.ovcsupport.net/sw488.asp

ouzis, D. and du Guerny, J. 1999. *Sustainable Agricultural/Rural Development and Vulnerability to the AIDS Epidemic*: FAO/UNAIDS Joint Publication, UNAIDS Best Practice Collection. December 1999.

UNAIDS. 1998. in 'Policy and Human rights' a chapter in Jackson, H. *AIDS in Africa: Continent in Crisis*. Harare: SAfAIDS.

_____. 1999. *Guide to the Strategic Planning Process for a National Response to HIV/AIDS, Key Material*. Geneva: UNAIDS Best Practice Collection.

_____. 2000. *AIDS epidemic Report.* December 2000.

_____. 2001. *Investing in Our Future: Psychosocial Support for Children Affected by HIV/AIDS: A Case Study in Zimbabwe and the United Republic of Tanzania.* Geneva: UNAIDS

_____. 2004. *Report on the Global AIDS Epidemic.*

UNAIDS/ECA. 2000. *AIDS in Africa, Country by Country,* publication prepared for the Africa Development Forum *2000: AIDS: the Greatest Leadership Challenge,* Addis Ababa. Geneva: UNAIDS and ECA

UNAIDS/WHO. 1999. *AIDS Epidemic Update*. Geneva: UNAIDS

_____. 2003. *AIDS Epidemic Update: Global Summary of the HIV/AIDS Epidemic.*

UNFPA. 2001, *Global AIDS and Health Fund, UNFPA Briefing*. New York.

UNICEF. 1999. *Children Orphaned by AIDS: Front-Line Responses from Eastern and Southern Africa*

USAID. 2002. *HIV/AIDS in Ethiopia*. Addis Ababa: TVT Associates.

van Diesen, A. and Walker, K. 1999. *The Changing Face of Aid to Ethiopia – past experience and emerging issues in British and EC aid.* Christian Aid. Retrieved October 2005, from www.christian-aid.org.uk/indepth/fulllist.htm

Woolcock, M. 2000. *Managing Risk, Shocks, and Opportunities in Developing Economies: The role of Social Capital.* In Gustav Ranis, ed., *Dimensions of Development*. New Haven, Conn.: Yale Center for International and Area Studies.

Worden, JW. 1996. *Children and Grief.* New York: Guilford Publications,

Survey Questionnaire of _____Sub city Kebele_____

(*Please inform the respondent that they should not give names if they don't want to and the confidentiality of the survey is maintained)*

List of households	Relation of members	Residence status	sex	Age	Marital status
"Numbered" household members	Head =1 Spouse =2 Son or daughter of head & spouse =3 Son or daughter of head =4 Son or daughter of spouse =5 Mother or father of head and spouse =6 Other relatives =7 Non relative =8	Resident present =1 Resident absent =2 Visitor =3	MALE=1 FEMALE=2	How many years old? *Below 1 month=00*	10 years and above Single =1 Married =2 Divorced =3 Widowed =4

List of households	Headship	Educational status	Economic status		
"Numbered" household members	Who is the bread winner of the house hold? Mark "x"	Highest grade completed (formal education) no level completed =1 Grade 1-3 =2 Grade 4-6 =3 Grade 7-9 =4 Grade 10-12 =5 Certificate =6 Diploma =7 Degree =8 Postgraduate =9 If not completed the above three mark "x"	(Employment) Do you work? Yes=1 No=2 *Unemployed refers to those stopped working during most of the last 12 months*	If "No" , reason for not working Unemployed =1 Student =2 Domestic service =3 Pensioner =4 Too old =5 Handicap/Disabled =6 Other reasons, *specify* =7	What is the household's average monthly income?

Surveyor's name and signature

Surveyor's name and

DECLARATION

I, the undersigned, declare that this is my work and that all sources of material used for the thesis have been duly acknowledged.

Name: Awan Abdulwasie

Signature: _____

Date: December 12-2006

This thesis has been submitted with my full approval as an advisor.

Hirut Terefe (PhD) _____