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COORDINATION OF CARE FOR ORPHAN AND VULNERABLE CHILDREN IN NIFAS SILK LAFTO SUB CITY, ADDIS ABABA, ETHIOPIA

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Abstract

Purpose; The general objective of this study was to assess the provision of Coordination of care for orphan and vulnerable children (OVC) in the case Nifas Silk Lafto Sub city. The sub city was chosen based on the service provider's number in the sub city. According to Ethiopian SSDGL(2010); the basic needs of the OVCs are (7+1); (1) Shelter and care, (2)Food and Nutrition, (3) Health care , (4) Economic Empowerment , (5) Psychosocial Support, (6) Legal Protection and (7) Educational Support, the +1 is the most important component of OVC service provision which is Coordination of Care this component is all about coordinating different services for OVC by network building, resource mobilization and referral linkage to address the whole needs of the OVC. This is because a single sector may not provide all the identified needs of the OVC so Coordination of care is very important. This study assesses the provision of coordination of care for OVC in line with the Quality standards of OVC service provision set by the SSDGL (2010).

Method; the study used both qualitative and quantitative research methods for addressing the intended purpose. A total of 131 participants participated (114 for quantitative) and (17 for the .qualitative) One Sample t-test and One way ANOVA was conducted to analyze the quantitative data.

Result; the study result indicated that across the service providers in the study which are; Government WYCA, CCC and NGOs there is a statistically significant difference when comparing their mean score on the quality dimensions. There is capacity gap to perform all the quality standards. The CCCs needs more capacity building trainings and the government should support them more. The NGOs in the study scored more on the technical part of the scale and this shows that the coordination needs more functional network to utilize the existing professional resource.

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Acronyms

AIDS: Acquired Immune Deficiency Syndrome

ANOVA: Analysis of Variance

CBO: Community Based Organization

CCC: Community Care Coalition

CSO: Civil Society Organization

FBO: Faith Based Organization

FGD: Focus Group Discussion

HIV: Acquired immunodeficiency virus

KII: Key Informant Interview

MOLSA : Ministry of Labor and Social Affair

NGO: Non-Governmental Organization

OVC: Orphan and Vulnerable Children

SSDGL: Standard Service Delivery Guide Line

UNICEF: United Nations Children's Fund

UNAIDS: United Nations Joint Fund on HIV/ AIDS

USAID: United State Agency for International Development

WYCA: Women, Youth and Children Affairs

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CHAPTER ONE: INTRODUCTION

1.1 Background

The situation for children around the globe shows that millions of them have become vulnerable as a result of political, economic and socio-cultural conditions occurring in countries across the world. Global estimates indicate that about 145 million children have been orphaned and made vulnerable due to various causes Biemba, G., Jennifer Beard, Bram Brooks, Megan Breshman and David Flynn.(2010) In developing countries, it is the interrelated impacts of HIV/AIDS in particular and deepening poverty that most contribute to devastating consequences on being orphan and vulnerability of children.(UNICEF, 2006, 2008; Foster(2008). Out of the estimated 130 million Orphans and Vulnerable Children (OVC) in developing countries, sub-Saharan Africa region is most affected with about 12% of the OVC compared to 7% in Asia (Larson, 2010). In Sub Saharan Africa, many approaches were adopted in order to decrease the crises of OVC ;

(1.) Institutional–based,
(2.) Public service organization approach: social cash transfer for OVC and
(3.) Working class level approach; public service organization approach which is social cash transfer for OVC and service provision by family members, individuals, faith based organizations and local community based organizations.

According to the 2007 national census report, 55.5% of Ethiopian population is comprised of children below the age of 18.According to Foster, 2004; Adaro and Bassett, 2008; Alviarand Pearson, 2009); The high vulnerability rate of children and their guardian's demands coordinated care and support for all their unfulfilled needs. In the recent past, community-based responses which combine socio-economic contributions by the extended families, relatives, friends and neighbors within the local communities have been recognized as the most effective sources that enable to address coordinated care and support for OVCs and their caregivers (Foster, 2004; Kaare, 2005; UNICEF, 2008). This is mainly because of their ability to reach households in greatest need; respond rapidly to crisis; are cost efficient; address local needs using available local resources; draw from specialized knowledge of community members; and provide financial and psychosocial support (UNRISD, 2009).

1.2. Statements of the problem

Since basic needs of OVCs such as ; Safe housing and Environment, Food and Nutrition, Health, Education, Economic Wellbeing, Legal Protection and Psychosocial Support, (Ministry of Women's Affairs and Federal HIV/AIDS Prevention and Control, 2010) could not be addressed by a single sector, service providers needs to be coordinated. Coordinated care would reduce duplication of efforts, increase service coverage, effectiveness and efficiency. Coordination of care is considered as the guiding principle to deliver quality services for OVCs. Following this line of inquiry; the implementation of coordination of care needs to be investigated.

Although there has been strong culture of caring for orphan in Ethiopia, the sick, and disabled and other needy members of the society by the nuclear and extended family members, communities and FBOs (Belay and Missaye, 2014), the growing number of orphans and vulnerable children coupled with the pressure of poverty on households is putting load to give proper care and support for the OVC. Significant contribution have been made in treatment, care and support of those infected and affected by HIV/AIDS by prioritizing community care coalition (Idir, Equb, Mahiber, etc.) as caregiver (Binega,2014). But still Children, who are vulnerable and particularly orphaned continued living in conditions where their basic needs unmet, their rights are violated, exposed to labor and sexual exploitation and abuse.

All children of the glob need to grow in situation where the basic needs for their survival and growth should be fulfilled along with love, dignity, respect and peace as indicated in the UNCRC (UNCRC 1989). The basic needs required by all children are safe housing and environment, food and nutrition, health, education, economic wellbeing, legal protection, protection from danger and psychological support. On the issue under taken, different Literatures indicate that majority of children in the world especially in sub-Saharan African countries are denied from getting these basic needs.

Orphans and vulnerable children need special attention by community, government, and its development partner as OVC might have poorer life chance than the other children if they are taken care by poorer relatives and the situations made those vulnerable at higher risk of neglect and abuse. According to Lachman and coauthors (2002), currently things are changing and Child protection has moved and is still moving from the welfare approach to a rights-based approach,

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

Orphans and vulnerable children need special attention by community, government, and its development partner as they might have risk life chance than the other children since the situations may expose them to higher risk of neglect, abuse and marginalized or deprived of from the basic rights of children given by nature and the laws for their existence (FHI, 2005).

While a fully developed supportive environment may not be available, community strengths including shared family responsibility, local helping organizations, and existing social structures can support these children (Linsk et al., 2010). In cases where community care and support coalition are set up to respond to the needs of OVC, they should function effectively to sustain their service and achieve their goal in the care and protection for children. Programs also should ensure that communities have the necessary support to take responsibility for addressing the needs of OVC (Federal Democratic Republic of Ethiopia Standard Service Delivery Guide for OVC, 2010).

Until recent years before the Standard Service Delivery Guideline (SSDGL) of Ethiopia has been published On February, 2010; the service provision for OVC was not standardized and just the service providers provide the service which they can offer not what the OVCs need. The SSDGL introduced a system called coordination of care for providing support for OVC which addresses all the basic needs of the OVC. But still after the guideline was published and announced for the service providers; the OVC service provision across OVC service providers was not studied.

Therefore, in this particular research, the capacity of provision of coordinated care services and supports to orphans and vulnerable children, referral network strategy and linkages among child service provision stakeholders will be studied and analyzed. Most importantly, this particular

research will give a general insight about opportunities and challenges that exist within local structural settings in straggling of the crisis of OVC care and support in Nifas Silk Lafto Sub city.

1.3 Research Questions

The present study sought to answer the following questions.

- How is coordination of care for OVCs implemented across service providers?
- What are the challenges and opportunities faced during coordination of care provision?
- What is the impact brought about by coordination of care?

1.4 Objective of the Study

The general objective of the study is to assess the implementation of coordination of care for Orphan and Vulnerable Children in Nifas Silk Lafto Sub City.

The specific objectives are

- To **assess** the implementation of coordination of care across service providers.
- To **explore** the challenges and opportunities of coordination of care implementation.
- To **assess** the impact of coordination of care.

1.5 Significance of the study

The findings of this study will help in informing policy makers on policy design for filling the gaps of local actors in provision of care and support for OVCs and their guardians; it is also significant in alerting the progressing efforts of community participation as an important role for addressing local level development challenges and utilization of local resources.

1.6. Scope of the study

This study has been undertaken on the Evaluation of the provision of coordinated care and support for OVC by the local actors /Community Care Coalition established/, Women Youth and children Affairs and NGOs working on OVC care and support at Nifas silk Lafto Sub City Addis Ababa. The researcher has chosen this sub city based on the fact that large numbers of OVC service providers were registered.

CHAPTER TWO: LITERATURE REVIEW

This chapter presents review of literature that focused on the view of OVC, the concept of coordination of care services and supports; and the nature and scope of community based OVC care and support in connection to the roles and performing status of primary actors in the provision of care and support for OVC ; community care and support coalition. The chapter further discusses the theoretical concepts related with community participation in the coping of social problems.

2.1. Over view of Orphan and Vulnerable children

2.1.1 Definition of orphans

Review of the literature indicates that the definition of the term "orphan" differ s from one context to another based on ….the joint report, Children on the Brink 2004 (UNAIDS, UNICEF and USAID, 2004) makes distinction among the following categories of orphans:

- ✓ Maternal orphans - children under age 18 whose mothers have died;
- ✓ Paternal orphans - children under age 18 whose fathers have died; and
- ✓ Double orphans - children under 18 whose mothers and fathers have died.

Different countries define Orphan in different ways like for example ; in Botswana a child below 18 years who has lost one (single parents) or two (married couples) biological or adoptive parents is considered an orphan , in Uganda, a child below the age of 18 years who has lost one or both parents is considered an , in Rwanda a child who has lost one or both parents is considered an orphan.(Rose Smart, 2003), but In Ethiopia, it is commonly understood and legally defined that an orphan is a child who is less than 18 years old and who has lost one or both parents, regardless of the cause of the loss (SSDG, 2010).

2.1.2. Definition of Vulnerability

Since 'vulnerable children' is defined differently by different scholars, is has a complex sets of concept to define. This leads to have various definitions (Smart, 2003; Miller, 2007).According to Wakhweya et al., (2008), definition of child vulnerability is context specific since it is modified according to political, legal, cultural and economic contexts in particular settings.

Nevertheless, Miller (2007) considers 'vulnerable children' as children with ill parents or caregivers, children in poverty or conflict; and children without caregivers. This definition implies that 'vulnerability' is a concept that covers a wide range of children both orphans and non-orphans. According to (SSDG, 2010) , vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been threaten due to a particular condition, and who is found in a situation that has no access for the fulfillment of his or her rights.

2.2. Consequences of Vulnerability and Orphan-hood

OVCs are prone to multidimensional social psychological and economic problems. According to Gabel (2012) study, consequences related with orphan and vulnerable children are childhood poverty and prolonged stressful experiences which can have lifelong effects on children's physical, social, emotional and neurological development as well as on physical and mental wellbeing later in life. Inadequate investments in childhood increase the likelihood of poverty in adulthood, rob children of their right to achieve their potential, and perpetuate the intergenerational transmission of poverty. These days, orphans, especially those who lose their parents to HIV/AIDS, suffer among other things from consequences such as having to care for sick and dying parents (without protective clothing) and younger siblings, as they become "prenticed" themselves and lose out on their childhood; loss of income as parents are unable to work, become ill, and die; having to witness and endure parental death(s) and the associated emotional stress; stigma within the community if it is suspected or known that their parent died of AIDS, (Lachman et al., 2002)The other aspect of consequences comes as a result of being orphan and vulnerable child is the risk of violence and abuse. The other dimension where orphans disadvantaged is education. Orphan-hood significantly reduces a child's chances of attending schooling and the effect is particularly strong in the case of double orphan-hood (Guarcello et al., 2004). Orphan and Vulnerable children in most cases fail to pass from grade to grade and also have less attachment to school which likely leads them to adverse condition of life (Belay and Messay, 2014). In severe cases orphan and vulnerable children drop out from school due to lack of educational material (UNICEF, 2007).

In Ethiopia, securing daily food is a major problem for most orphan children. It is reported that 6.1% of them forced to beg in order to get their daily food (UNICEF, 2007). Similar to

educational material, lack of food is one reason for orphan and vulnerable children to drop out school (Haile, 2008). Due to food insecurity they face stunting which is irreversible after two year age. Economic and social vulnerabilities are dimensions of the OVC that end up them with health, nutritional, education and other services lack coupled with child labor and trafficking, violence and addictive behaviors, mental health problem (Gabel 2012).

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

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

2.3. Community based Responses on the provision of care and support for OVC

The problem of OVC in the sub-Saharan Africa has largely been attributed to the impact of HIV and AIDS pandemic on the socio-economic wellbeing of most households. To address this situation, community-based responses have been widely recognized as crucial especially in the provision of care and support for escalating number OVC (Ninan and Delion, 2008). That is why many OVC in sub Saharan Africa have received care and support from a broad spectrum of community organizations (Birdsall and Kelly, 2005; Mathambo and Richter, 2007). According to Attawell(2010), most of these responses can be generally grouped into Civil Society Organizations (CSO) and Government agencies. CSO is a wider group that comprise Community-Based Organization (CBO), Non-Governmental Organizations (NGO); Faith-Based Organizations (FBO) and indigenous community initiatives such as mutual support groups, neighborhood association, saving club, informal counseling groups, traditional

support mechanisms, faith-based congregations and self-help groups. The Government constitutes government staff, institutions and departments.

Compared to CBO, FBO, NGO and government agencies that are more formalized, the indigenous community initiatives are less formalized and usually built on traditional systems. Thus they are considered more efficient and sustainable in dealing with complex issues of children affected by HIV and AIDS (Mathambo and Richter, 2007). Since they are mostly initiated from within the community, their members are strategically positioned to understand severely affected households and the appropriate assistance required (Ninan and Delion, 2008).

Most indigenous OVC initiatives result from small groups of concerned individual such as extended families, neighbors or groups out to address a need within the community (Phiri et al., 2001; Foster, 2002). However, some emerge as a result of seeing and adapting to OVC activities of other communities while others result from community mobilization efforts of entities outside the community (IHA, 2002). They also operate on the principles of reciprocity, consensus-based decision making, volunteerism, local leadership, innovation; and self-reliance in resource mobilization (Foster, 2002; Ninan and Delion, 2008).

Community OVC initiatives offer a wide range of services. Attawellet al., (2010) gives five categories of the range of activities and services provided. They include: prevention, treatment, care and support, impact mitigation, and advocacy and networking. However, as noted in IHA (2002), the range of services an initiative provides depends on preferences and motivation of leaders and volunteers of the initiatives, local needs, local resources, and whether the initiative is located in an urban, peri-urban or rural setting.

Community OVC responses play both leading and supporting role depending on aspects considered important. Attawell (2010) argues that the responses play the leading role where such aspects as face-to-face interaction, knowledge of the community, and peer influence and support are considered important. Supportive role is played where the involvement of the government and other agencies is emphasized. Despite the potential of community OVC initiatives, they cannot be seen as alternative to the state because of various limitations. These include: resource constraints, limited outreach ,inadequate consultation and engagement of community

members, and dependency on external funding for sustainability. (Birdsall and Kelly 2005; Mathambo and Richter, 2007; Ninan and Delion, 2008).

When it comes to Ethiopia, the country has endorsed HIV AIDS prevention and control policy in 1998. At the national level, the OVC Task Force that constitutes international and national organizations has been established. United Nations Children's Fund (UNICEF) and Ministry of Labor Social Affairs (MOLSA) guide this Task Force and are responsible for endorsement of policy, strategy, and programs on OVC care and support appropriate to all levels and context. In addition, a representative from Save the Children US (SC/US) and Save the Children Sweden (SC/Sweden) are members of the Task Force.

Very recently, National standard service delivery guide line was developed by the Federal Democratic republic of Ethiopian Government Ministry of WYCA that enables to provide standardized services for OVC by all child welfare implementers.

2.4. Community care and support coalition

The community coalition care (CCC) groups of individuals and /or organizations at local level that join together for common purpose of expanding and improving the care for most vulnerable children and vulnerable members of the communities. The community coalition care brings together faith based organizations, government organizations, NGOs, CBOs and volunteers in identifying, monitoring, assisting and protecting of OVCs.

The basic roles of other NGOs are strengthening of this community care and support coalition. According to World vision (2006), the roles of World vision in Zambia are strengthening technical and structural capacity, financial and material support as well as advocacy for resource mobilization. In Ethiopia the involvement of community care and support coalition is a recent phenomenon for the provision of care and support for vulnerable groups of the society. According to the national and regional state training on the guiding manual of the Community care and support coalition (2012), there are three committees within the community care and support coalition structures. These include education and advocacy subcommittee, resource mobilization subcommittee, and documentation, selection and monitoring subcommittee. From this we can understand that there should be interdependent efforts of the three committees for

effective provision of care services and support for all vulnerable groups of the societies including OVC and their guardians.

2.5. Structural Functionalist Theory and Orphans

The functional perspective focuses on the way in which the families gratify the needs of their members and contribute to the social stability. Families have six paramount functions namely production, protection, socialization, regulation of social behavior, affection and companionship. Among these functions protection, socialization, affection and companionship have direct influence on children development (Chafer, 2006). The structural functional perspective gives emphasis on how the different roles that make the family unit functional maintain the family and ensure society's continuity. Bale and Parson (1955), who are the leading proponents of the structural functional perspective, tried to categorize the role of the family member in one family and how the absence of one parent, who is important to carry out the identified role for the sustainability of the family. Adult family tasks are best accomplished when spouse (married) carry out distinct and specialized roles such as instrumental roles that provide food and shelter, and expressive roles that provide emotional From the above insights, one can confirm that this theory gives more emphasize on keeping the stability of the society through the stated roles(functions) of the family on its members and how the existing system of extended family, community and guardians in NGOs affect directly or indirectly the life and academic status of orphan children. Supports for families, both roles sustain the family unit. Anything that interferes with these family tasks has been considered as dysfunctional because it jeopardizes the smooth function of the groups (Benokraitis, 2002:31).

2.6. Concepts on Coordination of care service and support for OVC

Coordination of care is defined as a child-focused process that adds to and coordinates existing services and manages child-wellness through advocacy, communication, education, identification of needs and referral to services and involves planning care for a child or family, monitoring that care, and making adjustment to the combination of services when needed, According to SSDGL(2010); coordination of care also be defined as a system of service programs and/or service providers that are linked through a referral network(s) that is (are) (preferably) formalized or non-formalized and in which referrals made and referrals completed

can be tracked and evaluated in a cost effective manner through efficient communication channels (Family Health International internal discussions, 2007. It is critical that care is coordinated for each child; there are many activities that must be carried out at the community, region, and system level, PEPFR(2008).

Coordinated care is the over-arching framework through which services would be delivered in an integrated manner so as to reduce duplication, fill service gaps and increase service coverage, program efficiency and effectiveness. In order to deliver quality services to OVC, coordination should occur at all levels, not just at service delivery point. Coordination of care is the critical integrative activity that assures that services have the desired impact.

Coordination care is not a service by itself but it is the vehicle through which all the other services are delivered to OVC. In order to ensure quality service provision, actors should be able to monitor children's/ households' receipt of necessary services through linkages and referrals. Coordinators of care will usually provide both direct care and referral for services. Effective coordination of care at the point of service delivery requires a great deal of coordination and information sharing at other levels.

Coordination of care can be defined as a child-focused process that augments and coordinates existing services and manages child-wellness through advocacy, communication, education, identification of needs and referral to services. This involves planning care for a child or family, monitoring that care, and making adjustment to the combination of services when needed. Coordinated care requires linkages with all sectors to ensure the appropriate mix of services for program beneficiaries.

Coordinated Care is selected to be the overall guiding principle through which services would be delivered in an integrated manner so as to reduce duplication, fill service gaps and increase service coverage and increase program efficiency and effectiveness. In order to deliver quality services to OVC, coordination should occur at all levels, not just at service delivery point. Coordination of care is the critical integrative activity that assures that services have the desired impact.

Coordinated care does not mean that programs should provide all the services. However, in order to ensure quality service provision, partners should be able to monitor children's/households'

receipt of necessary services through linkages and referrals. Moreover, it has to be noted that coordination of care is overarching to the other service areas & also needs strong information sharing mechanism, good level of cooperation, collective vision & long-term commitment.

These increasing needs of OVC and their care givers could not be addressed through the involvement of disintegrated systems of service provision models. Rather it should employ the joint efforts of different service providers like CBOs, NGOs, government sectors, the local community and private organization for effective and sustainable alleviation of the deep-rooted crisis that affects these vulnerable groups of the societies.

2.6.1. Principles of coordination of care

In order to provide quality coordinated care services and supports for OVC and their guardians, systems of coordination of care play irreplaceable roles. Effective coordination of care has the following principles PEPFR (2012).

- Requires linkages with all sectors to ensure the appropriate mix of services for program beneficiaries.
- Is an overall guiding principle, meaning that all services should be delivered in an integrated manner so as to reduce duplication, fill service gaps and increase service coverage and increase program efficiency and effectiveness
- Should occur at all levels, not just at service delivery point. Coordination of care is the critical integrative activity that assures that services have the desired impact.
- Needs strong information sharing mechanism, good level of cooperation, collective vision and long-term commitment.

Coordination of care services can be addressed to beneficiaries at different service delivery sites and community and structural/system levels since it needs collaboration efforts of all concerned bodies.

2.6.2. Coordination of Care at the Point of Service Delivery

At the child/household level, coordination of care involves assessing needs, planning care for a child or family, monitoring care, and making adjustments to the combination of services when needed. Coordinators of care will usually provide both direct care and referral for services that are required for the OVC. Regardless of whether the needed service is directly provided or arranged through referral, the responsible body should monitor all the services that the child is receiving on an ongoing basis(PEPFR, 2008).

2.6.3. Coordination of Care at the Community and System Level

Effective coordination of care at the point of service delivery requires a great deal of coordination and information sharing at other levels. The following activities must be carried out to enable coordinated care and referral at the household level, (PEPFR, 2008)

2.6.3.1. Community mobilization

Community mobilization is a deliberate, participatory process that involves local institutions, leaders and groups as well as other community members to organize for collective action toward a common purpose, (PEPFR, 2012). It is required to organize the resources (human and other) to design, lead, and implement activities related to OVC care at the local level. This usually involves forming committees at the village levels or empowering existing groups to address OVC issues. The process involves dialogue within the community to foster recognition and ownership of the problem, identification of community resources, setting priorities, and developing and implementing action plans. Community leadership from the outset facilitates success and sustainability of coordinated care. According to the guide Entitled coordinated quality care and standards for OVC services, (PEPFR 2012), community mobilization can be characterized by:

- Developing an ongoing dialogue between community members regarding OVC issues.
- Creating or strengthening community organizations aimed at improving OVC.
- Assisting in creating an environment in which individuals can empower themselves to address their own and their community's needs.

- Promoting community members' participation in ways that recognize diversity and equity, particularly of those who are most affected by the OVC issue.
- Working in partnership with community members in all phases of a project to create locally appropriate responses to OVC needs.
- Identifying and supporting the creative potential of communities to develop a variety of strategies and approaches to improve OVC status (even interventions that may not have been recommended by fund givers and other external actors).
- Assisting in linking communities with external resources (e.g., organizations, funding, and technical assistance.) to aid them in their efforts to improve OVC.
- Committing enough time to work with communities, or with a partner who works with them, to accomplish the intended goals.

In general Community care and support coalition (CCCs) can influence public opinion and decision-makers and make a big difference in the fight against OVC crisis. Though their contacts and advocacy, they can help needy children and families benefit from donations; access public services required by OVCs and their caregivers..

2.6.3.2. Community Asset Mapping

Community asset mapping is defined as a participatory planning process which engages community members in exploring the assets or resources that their community has, with the purpose of creating a concrete output a map that can be used for referrals and planning purposes.

Community asset mapping involves making an inventory of the support and opportunities that can be offered by individuals, civic associations, businesses and local institutions or it may be Natural resources (such as a forest, communal garden or lake) may also be included, PEFR(2012). Before establishments of functional referral system for the provision of coordinated quality care for OVC and their guardians, it is important to identify resources and gaps in the continuum of care at the local level. Information about what services are available, who is eligible, and how services are accessed (registration procedures, criteria, etc.) must be gathered and relayed to the service providers who will coordinate care at the household level. Care coordinators, in turn, can then educate caretakers about available services. PEPFR (2008). This shows us that all locally available assets (resources) should be depicted on the map along

with their respective location sites that can ease the works of the community care and support coalition for making referral activities towards the service delivery organization or individuals.

2.6.3.3. Referral Network building

Referral networking refers to the development of a web of relationships among implementing partners, civil society organizations, government agencies, donors, and experts in universities and the private sector. Network building involves meetings, sharing of information, and joint efforts to make policy and to plan, implement, monitor, and evaluate programs. From this it is important to note that coordination of care is a joint responsibility of the community, government, civil society, and implementing agencies. Each of these will have different organizational strengths, technical capabilities, and resources, (PEPFR, 2008)

2.6.3.4. Resource mobilization

Before defining and explaining what resource mobilization is it is important to define the word resource? In most common use, resource means an economic factor which can be used to accomplish a goal, or a means to undertake or achieve a desired outcome such as assets, materials, or capital. According to PEPFR (2014), resources could be defined as materials, and services that help to fulfill OVC/families and the organizational needs. These include cash (money), human skills, time contributions and services of volunteers, equipment and materials.

Since the local communities are the sources of all resources available for provision of care and support for the vulnerable groups of the society, we can explain it in the context of the community. Local resources in the community are usually identified during the community assets mapping exercises, a participatory process which engages community members in exploring the assets or resources that their community has, with the purpose of creating a concrete map that can be used for referrals and planning purpose. The resources within the community can be financial or non-financial. (PEPFR,2014)

Resource mobilization can be defined as the process of identifying and obtaining resources for an organization/project or program. According to PEPFR (2014), it is a process of raising support to facilitate the wellbeing of OVC and their families. It involves identifying resources, expansion of relations with resource providers and mobilizing the skills, knowledge and capacity

in the community for proper use of resources for the intended purpose. Local/community resource mobilization is participatory and involves local institutions, leaders and groups as well as other community members to organize collective action towards a common purpose in the related to addressing the needs of OVC and families.

In order to address the huge crisis of OVC and other vulnerable members of the community, mobilization and utilization of local resource mobilization is important especially in countries affected by the pandemic HIV/AIDS. Since resource mobilization process within the community may be recent strategy in some country, it may be difficult and required collaborated efforts of concerned bodies.

In connection to this, Citizens, institutions, businesses, and other concerned bodies within the community can take greater ownership of activities that directly contribute to the positive development of their communities. In addition to this, long-term relationships with other institutions and organizations can be created that provide a better base for future work. Mobilizing local resources can also increase the sustainability of community initiatives as local supporters are more likely to continue supporting HVC and families than external donors. (PEFR,2014).The community Coalition care should bring people and resource together across social, economic, and political ties to address common community interest; Diverse membership contributes to collaborative endeavors, but participants must be on equal grounds to reduce hierarchy; More diverse sector representation and increased diversity of membership has been associated with better outcomes for policy change; members should represent broad and relevant community sectors (Center for Prevention Research and Development, 2006).

The same to other countries of sub Saharan Africa, the community care and support coalition is the acknowledged responsible body or agent that can mobilize and provide care and support directly or indirectly to OVC and other vulnerably groups even if it is a recent phenomenon.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 The research setting

The research is selected Nifas Silk lafto sub city which is a sub city with a large number of OVC service providers in the area and the research is a case study of that sub city service providers.

3.2 Study design

This study has employed a mixed research design. In the qualitative assessment, In-depth interviews and Focus group discussions (FGD) have been conducted.

For the quantitative component, across-sectional survey that involved WYCA, NGOs and Community Care Coalitions in the sub city has been employed.

3.3 Sampling Techniques and Selection of participants

Four Woreda Administrations (Woreda 01, 03, 05and 07) were randomly selected using a lottery method out of the total 12Woredas.Pertinentstakeholdersand organizations including NGOs, CCCs and from Government institution (that is, women, children and youth affair office) were involved. The research has collected data from 131 participants both qualitative and quantitative components of the study.

3.4 Data collection procedure

Quantitative data has been collected using questionnaires that had been translated into Amharic. Respondents for quantitative data were**, 19** CCC members, **21** individuals representing Women, Children &Youth Affairs (WCYA) offices at Woreda level relevant persons and persons representing sub city, **3** persons representing CBOs and **71** individuals representing NGOs working on OVCs which makes the total number of respondents **114**.

Qualitative data were collected using four FGDs with three **3**CCC members from each Woreda with total number of CCCs **12**. In-depth interview was conducted with two **2** sub city WYCA and one **1** Addis Ababa Town WYCA in order to explore shared perceptions and lived experiences.

An interview guide schedule has been compiled by the researcher. The interviews were face to face and each took approximately 30-45minutes in length.

3.5 Data Analysis

Quantitative Data: First the quantitative data was conducted using SPSS. The data collected through questionnaire are presented using graphs and frequency distribution tables. The results are interpreted using statistical measures such as percentiles, mean, and standard deviation.

Qualitative Data: The information collected through interviews and focus group discussion were transcribed and categorized into themes systematically. Transcribed data were read and re-read to define themes and sub-themes and organize them according to objectives of the study.

3.6 Data Quality control

Whatever procedure for collecting data is selected, it should always be examined critically to assess the extent and the likely hood for it to be reliable and valid. The researcher took three major steps to make the collected data valid and reliable. The first step was pilot testing the questionnaires and the interview guides. The second measure was using different data collecting instruments: interviews, questionnaire, and focus group discussion, to collect data. The–third measure was the use of various respondents: Non-Governmental Organization (NGO), Women Youth and Child Affair and Community Care Coalition (CCC) Members (triangulation of respondents).

3.7. Ethical Consideration

Participation of respondents was strictly on a voluntary basis. Participants were fully informed as to the purpose of the study and consented verbally. Measures were taken to ensure the respect, dignity and freedom of each individual participating and to assure confidentiality in the study. Participants were informed that the information they provide would be kept confidential and would not be disclosed to anyone else.

CHAPTER FOUR: FINDINGS

This chapter has three major themes based on the research questions and appeared categories of the data. The first theme explains the quantitative data of coordination of care implementation in accordance with the quality dimensions of the Standard Service delivery Guideline (SSDG) for the provision of coordinated care and support for OVCs in line with the qualitative data gathered, The second theme entertains OVC service provider's coordination and cooperation opportunity and faced challenges. The third theme of the data presentation involved the value added by coordinating care and support for service provision.

The participants were given questionnaire that was extracted from the standard service delivery guideline for OVC service provides in order to evaluate the quality dimensions of the coordinated care service provision.

The questionnaire is presented in the form of likert scale with26 items. The scale comprises of 11 subscales which examine the quality dimensions of coordination of care.

For the purpose of identifying the existing approach of execution of coordination of care by service providers, to identify its effect and analyze its impact; various respondents were asked some questions regarding Coordination of care for orphan children. The respondents were people of ages 18 to 64, and of various professions incorporated in this study in order to identify the viewpoints of people in several related occupations related to the field of study as an idea source through their responses for the questions prepared related to the study.

4.1. Socio-demographic characteristics of study participants

Table 1: Socio-Demographic Profiles of respondents (N=114)

Socio-Demographic Variables	Levels	Frequency	Percentage
Sex	Male	35	30.7
	Female	79	69.3
Age	18-19 years	11	9.6
	20-25 years	28	24.6
	26-39 years	66	57.9
	40-64 years	9	7.9
Job	Government office	3	2.6
	Women and children affairs	19	16.7
	Community care coalition member	18	15.8
	Non-governmental organization	71	62.3
	Other (CBOs)	3	2.6

As we can see from Table 1 above, 66 (57.9%) of the respondents of the questionnaire are between the ages of 26 to 39, 28(24.6%) of the respondents are in the age between 20-25, 11(9.6%) of the respondents are between the age of18-19 and 9(7.9%) of the respondents are in the age between 40-64.

4.1.1. Coordination of care implementation in accordance with the quality dimensions of the Standard Service Delivery Guideline

The participants were given questionnaire that was extracted from the standard service delivery guideline for OVC service provides in order to evaluate the quality dimensions of the coordinated care service provision.

For the purpose of identifying the existing approach of execution of coordination of care by service providers, to identify its effect and analyze its impact; various respondents were asked some questions regarding Coordination of care for orphan children. The respondents were people

of ages 18 to 64, and of various professions incorporated in this study in order to identify the viewpoints of people in several related occupations related to the field of study as an idea source through their responses for the questions prepared related to the study.

4.1.2. The status of coordination of care implementation by service providers

Table 2: Descriptive Statistics of Overall service provision and the Sub Scales within it

NB: Subscales with only one item had been analyzed using item by item analysis the other sub scales with more than one item had been analyzed using a one sample t-test in order to compare the means.

Variables	N	Items	Min	Max	Mean	SD
Overall Coordination of care	114	26	38.00	92.00	63.50	14.48
Access	114	2	2.00	7.00	3.96	1.67
Effectiveness	114	3	3.00	12.00	7.02	2.67
Technical Performance	114	3	4.00	10.00	7.09	1.79
Efficiency	114	2	3.00	9.00	4.86	1.29
Continuity	114	4	4.00	16.00	9.27	2.83
Appropriateness	114	2	2.00	9.00	5.30	2.12
Sustainability	114	4	4.00	17.00	10.39	3.19
Innovation	114	3	3.00	12.00	8.11	2.53

Descriptive statistics was computed for the overall status of coordination of care and sub scales (specific parameters). The mean score of overall coordination of care was lower compared with the expected average score (M=63.5, SD=14.48).

Table 3: Implementation of the coordination of care with a closer look at its specific standards

Components of coordination of care	**Test Value = 65**					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
General coordination of care	-1.106	113	.271	-1.50000	-4.1859	1.1859
Test Value =5						
Access	-6.699	113	.000	-1.04386	-1.3526	-.7351
Test Value =7.5						
Effectiveness	-1.893	113	.061	-.47368	-.9695	.0222
			Test Value =7.5			
Technical Performance	-2.456	113	.056	-.41228	-.7449	-.0797
Test Value =5						
Efficiency	-1.239	113	.218	-.14912	-.3875	.0892
Test Value =10						
Continuity	-2.738	113	.077	-.72807	-1.2548	-.2013
Test Value =5						
Appropriateness	1.549	113	.124	.30702	-.0857	.6998
Test Value =10						
Sustainability	1.293	113	.198	.38596	-.2052	.9771
Test Value =7.5						
Innovation	2.595	113	.011	.61404	.1452	1.0829

As can be observed in the table above, one sample t-test was employed to examine the quality of service provision (coordination of care) for orphan and vulnerable children. The test was made both for the overall coordination of care and each of the standards (sub-scales) within the general measure. As indicated earlier, the tool that evaluates quality of coordination of care consisted of 26 items measured in five point likert scale. Therefore, it is determined that a score below or equal to the average mean score was determined to be the standard value. That is the maximum point that an individual can score is 130 (5*26items). Therefore, the average score in this case is 65 (by adding all the subscales average score we get 65). Hence, the mean score of overall coordination of care was compared against the number "65".As can be depicted from the one sample t-test summary sheet above, the services provided for OVC in general are found to be lower and did not qualify when viewed against the set standards (MD=-1.5, p=.124).

The same was applied for the sub-scales to determine which of the standards are implemented properly and which ones are neglected components by service providers. As you can understand from the above summary sheet, the mean scores of these components were compared against standard number using one sample t-test (depending on the number of items each sub-scale has). To make it a bit clear, the mean score of each component was compared with an expected average score. For example, "effectiveness" is standard measure that is set out to be one indicator of quality coordination of care. This specific component has three items measured in a five point likert scale, where higher values indicate better coordination of care and lower scores indicating poor coordination of care. In this case, the maximum expected score (better coordination) is 15 (5*3items). Whereas, the minimum expected score is 3 (1*3items) and the average score is 7.5 (15/2). Hence, the observed score is compared against the expected average score (7.5) using one sample t-test. Based on this statistical computation, it can be said that almost all the scores lie around the average score, which leads to the conclusion that service providers are better off in none of the standards.

Table 4: The status of Coordination of Care in terms of safety, collaborative atmosphere and participation (N=114)

Subscale	Items	Responses				
		SA	AG	UD	DA	SD
Safety	The services provided ensure confidentiality & child sensitive assessments	55	33	14	11	1
Collaborative Atmosphere	Non-competitive atmosphere is fostered.	14	43	39	14	4
Participation	Procedures are in place to provide feedback on service provision.	14	34	17	16	33

As indicated in the aforementioned pages, MOWCYA (Ministry of Women, children, youth Affairs) has outlined core standards of service provision for orphan and vulnerable children to be implemented by service providers. These are minimum set standards against which service providers are evaluated. Of these parameters, one outline that services provided for OVC need to be as confidential as possible. Accordingly, in this study respondents were asked as to how the services they provide comply with this core standard. As can be depicted from the table presented above, majority of the organizations working with OVC (77%, n=88) ensure that the services provided are confidential &and conduct child sensitive assessments to provide appropriate services. Ensuring a collaborative atmosphere is also another criterion to be implemented by service providers. In relation to this, this study founded that about half of the organizations working with OVC (50%, n=57) provide the service in non-competitive manner. Moreover, it is not more than 42% (n=48) of service providers who put procedures in place to receive feedback about service provision from service recipients and stakeholders.

4.1.3. The status of Coordination of care across service providers

It is worth doing to inspect which service providers are worse off/better off in implementing the core guidelines of coordination of care. Inspecting this and related issues would have a paramount importance where exactly efforts have to be exerted than accusing everyone involved. In an effort to examine whether or not coordination of care differs across service providers, one-way analysis of variance (ANOVA) was employed as follows.

Table5. Comparison of the Status of Overall Coordination of Care across Service Providers

Service Provider	**N**	**Mean**	**SD**	**F**	**p**
Government Office	3	59.0	0.000	3.08	0.019
Women and Children Affairs	19	55.63	9.33		
Community Care Coalition	18	67.4	17.7		
None Governmental Organizations	71	65.42	14.34		
Other (CBOs)	3	49.0	0.000		
Total	114	63.5	14.5		

	Sum of Squares	df	MS	F	Sig.
Between Groups	2402.477	4	600.619	3.08	.019
Within Groups	21274.023	110	195.175		
Total	23676.500	114			

The one way ANOVA result showed that the quality of coordination of care varies across different service providers, F (4,110) =3.08, p=.019. Accordingly, a post hoc test was carried out to identify which of the service providers are better off in implementing coordination of care. Before running the post hoc analysis, the test of homogeneity of variances was checked to determine which post hoc tests to use. Accordingly, the Levene‘s test of homogeneity of variances clearly indicated that the variances of coordination of care across the four groups of service providers was not equal, F (3, 109) = 3.88, p = .029. Therefore, Games-Howell test was employed, as the assumption of homogeneity of variance is violated. Games-Howell test showed that service providers in Community Care Coalitions better implemented coordination of care compared with Government organizations, Non Governmental organizations and Other CBOs who participated in this research.

4.1.4. Qualitative data on the quality of coordinated care for OVCs

Interview and key informant interviews were employed to get additional information for the quantitative data and also to cross check the consistency of the qualitative and quantitative data on the provision of coordination of care.

The data will be presented in themes which were organized based on the questionnaire subscales

- **Coordination of care in the lens of 'safety'**

Interview respondents answered that; *"we used to give service for students in schools and the students become stigmatized and confirmed that they are the beneficiaries of the project and sometimes some children got bullied for being beneficiary of a project or a program."* **Interview participant NGO**

"*The beneficiary selection and need assessment process proceeds with the CCC members and in coordination with other CBOs for example with Idirs. The members went to the beneficiaries home in order to check their living status and identify the very need.* " **key informant CCC member**

"*Our beneficiaries are those who are living in our sub city with lower income, Orphans, Child headed households, children with bed render parent, poorest of the poorest and also who are strugglers and whom we provide training and life skill training for the OVCs the trainings we gave had been age appropriate and consider the time and place which is safe to provide the service."* ***Key informant*** **Sub city WYCA.**

"*Our project beneficiary's service provision is conducted based on the need of the beneficiary assessed by the woreda WYCA and we provide our offer for the woreda and the woreda will give us the beneficiaries who are illegible for our offer. If the services are school material; we provide them at the schools, and if the services are economic empowerment or fund we provide them with the woreda representatives."* **Interview participant NGO**

- **Coordination of care in the lens of ' ACCESS'**

Access in this context refers to availability of information to the OVCs on how and where to get the service, to engage government resources (money, physical and human) and availability of capacity for coordination in order to meet demand.

FGD discussants discussed that *"most of the services provided for OVCs include; shelter and care, health service, economic empowerment, psychosocial support, legal support, food and nutrition, education support. First of all the CCC has its own beneficiary selection criteria and know all the beneficiaries need but not all in a recorded document. The beneficiaries profile are not fully stored with the disaggregation of gender and need. We just know them so we do what we do with out the documentation. When NGOs and other CBOs ask for project beneficiaries, we then assess the needs of the beneficiaries and provide their profile for the donor. The information on how and where to get what service is not mostly listed or accessible but sometimes we have some listed asset maps."*

"CCCs work in collaboration with the government or respective WYCA to get available resources but our capacity for the provision of coordinated care for OVCs needs more capacity building trainings. Additionally, the CCC members have other commitments as an individual so for us to give a more valuable service we need to be equipped with capacity whether from government or from NGOs.

- **Coordination of care in the lens of 'Effectiveness'**

Effectiveness here refers to the objectives of coordination of care are being met which is stakeholder involvement in planning for OVCs and the services are responsive for the whole child.

"The beneficiary's needs are assessed and then referred to the available donor then if the beneficiary has other need which cannot be addressed by the donor we also refer them for other service provider to help them get the services they need. Before some years, we used to find some beneficiaries getting same service from different providers which are service duplication now we are trying to minimize this problem." **Interview participant woreda WYCA**

- **Coordination of care in the lens of Technical Performance**

"*We are the front liner when it comes to OVC service provision and we do our best for the children but still we need capacity building trainings and more follow up und professional advice***." CCC member FGD discussant**

"*Plans are developed for providing support for our beneficiaries by first assessing the beneficiary's needs, analyzing their actual situation and planning the appropriate care.*" **Interview participant Sub city WYCA**

"*Our CCC members have good capacity on identifying needy beneficiaries, prioritized their needs and referring the beneficiaries for donors. Moreover, we provide support for the CCC by our experts in the field.* **Interview participant Woreda WYCA**

"*We have capacity building programs for stakeholders first by assessing their technical gap and then planning training and professional assistance because after all we work for humanity use need assessment for our planning projects.*" **Interview participant NGO**

- **Coordination of care in the lens of Efficiency**

"Service provision for OVCs needs more functional collaboration with multiple service providers in order to address the basic needs of the child. In our context we work together with NGOs interested in our woreda and we have GO-NGO forum which gets together NGOS and GOs in the area to evaluate our work, to get feedback and plan future collaborative works." **Interview Participant Woreda WYCA**

"We mobilize resources from different service providers and provide it to our beneficiaries. The work we do here is very transparent." **FGD discussant CCC member**

- **Coordination of care in the lens of Continuity**

"*The sub city has network with different service providers with in the sub city. The network helps us to assess and refer beneficiaries to the service providers easily. NGOs provide service for beneficiaries through us*." **Interview participant Sub city WYCA Expert**

"*There was a project called Yekokeb Birhan before five years back from now and the project has given us training about collaborating with different stakeholders and signing Memorandum of understanding (MOU) to address the needs of the beneficiaries, using existing structures when providing services for beneficiaries . Since then we have been collaborating with stake holders and tried to give whole service for the beneficiaries as much as possible. The project work*

closely with us and through us." Now we do have network with respective stakeholders but it is not as functional as it should be." **FGD discussants CCC members**

- **Coordination of care in the lens of Collaborative Atmosphere**

"The provision of service for OVCs needs more than one service provider to address the assessed needs of the beneficiary taking that concept in our mind we have assessed the needs of the OVCs and then look for service provider after getting one provider, we then refer the child for another service to get the remaining service he/she needed." **CCC member interview participant**

"*We get many requests from the woredas and sub city WYCAs to support some beneficiaries on a specific service but we do not have the capacity to provide service for every request they made because we have donors and the project activities most strictly needs to be followed. But on the services we have planned for we do provide service for them. We even have quarterly plan to capacitate the government WYCA professional and CCCs in the area."* **Interview participant from NGO**

"We have a good relationship with the stakeholders in our area and the forum which connects stakeholders to monitor their work and plan together for what has been the situation." **Woreda WYCA**

- **Coordination of care in the lens of Appropriateness**

Most of the interview participants stressed that;

"The services we provide for our beneficiaries consider the needs of the children and prioritize their immediate need."

- **Coordination of care in the lens of Participation**

The FGD discussants were asked if they check the service feedback from the beneficiaries and participate the beneficiaries when planning care for them; *"after we assess the needs of the beneficiaries we just plan the care by ourselves the beneficiaries do not participate in the care planning or service planning. The service provision should have been better for the beneficiaries if they had participated in the designing of care for themselves but the practice says otherwise. Even community should be also included in the care plan (service plan)."*

- **Coordination of care in the lens of Sustainability**

"For the service provision process we begin from the existing structures which are government structure, CCC, CBOs and the like to get the service deliver appropriately and yet using of existing structures is one of our sustainability strategy used for the project." **Interview Respondent NGO**

"Staff turnover has been a really challenging work for the sector because many staffs were trained on capacity building trainings but after some time they will leave the sector and the sector faces challenge to train the new staff and update." **Interview respondent Woreda WYCA**

"The network created with relevant stakeholders helped us to sustain the services for the beneficiaries and I feel like more work is needed for the sustainability of the services because some networks are not functioning at the time." **Interview Respondent WYCA**

- **Coordination of care in the lens of Innovation**

"*Some of the approaches we use for service provision are flexible based on a situation because service provision mostly involves more than one provider." Wise resource utilization is very important."*

4.2. Challenges faced during the implementation of coordination of care

Different challenges and constraints are accounted for low levels provision of coordinated care and support for OVC at Nifas Silk Lafto sub city. According to the information gathered from the key informants, the main constraints for provision of coordinated care and support to OVC is the low commitment and capacity of the CCC towards the problems and needs of OVC in the community. In connection to this, the information showed that most of the members of the CCC have no payment from the government. As a result they are primarily engaged in their own business rather than working for the needs of OVC.

The other challenge is lack of coordination among the three sub-committees as they carried out their duties and responsibilities this is further complicated by their wrong belief that OVC care and support is a responsibility of only Sub citys' women and child affair head. This implied that there is lack of awareness on the issues of OVC by most of them.

The next serious constraint is lack of trust of the community on the roles of CCC who mobilized resources for providing care and support for OVC. The key informants from the Sub city CCC narrated that, *when we requested money from the community, they ignored their contribution through the CCC. Because they openly said that this is the systematic means of accumulating money for the members of the CCC by the names of these OVC. As a result members of the community prefer to provide responses for OVC by themselves regardless of the involvement of the CCC*.

According to the information gathered from Sub city CCC, the higher levels CCC members did not have significant roles in supporting the kebele CCC for coordinating services in the sub city. The woreda CCC need result based support for mobilizing the community in order to create awareness regarding to coordinated responses to problems of OVC.

Poor documentation of OVC profile in each woreda is another determinant factor that affects provision of coordinated care and support for OVC at the Sub city. Neglecting of street children by the members of the woreda CCC is believed to be one of the constraints in the provision of care and support in the Sub city. Regarding to this the Sub City child protection officer said, *most of the street children are vulnerable to abuse than others in the Sub City. When cases are reported to the police office, the office is tried to collaborate with the Sub city WYCA to manage the cases especially when health care is needed. But the Sub city WYCA is not interested in treating the child because the WYCAs are limited their duties only for OVCs who are the residence of their Sub city*. From this, it is clear that the Sub City provides care and support services only for those OVC who are registered as residences of specific Sub City.

Dependency syndrome is one of the other serious challenge for the provision of care and support for OVCs in the Sub City.

The last challenge is overburden of the CCC on different non programmed campaigns implemented at the whole sub city. The key informants and focus group discussants informed that always throughout the year, the CCC members have spent little time for coordinating, mobilizing and providing OVC care and support in the Sub City.

4.2.1. Opportunities that enable the provision of coordinated care

Similar to mentioning a number of constraints and challenges in providing coordinated care and support for OVC, the focus group discussants and key informants also explained some of the opportunities that can available for OVC care and support in the sub city. Mentioned among them wer the existence of community-based organizations and their interest to engage in providing care and support for OVCs. Iddirs are served as one of the key stakeholders on the issues of child care and support equivalent to other service providers identified in the sub city.

The other opportunity that was mentioned by the key informant and focus group participants were of the efforts of different project donors in the provision of care and support for OVC in the Sub City. These organizations have engaged in addressing the needs of OVC in the areas of education, psychosocial support, health care, food and nutrition, child safety/legal/ shelter and care and economic strengthening activities during their project life periods. The helping culture developed by the community is another last but not least opportunity for providing OVC response in the Sub City. The key informants and focus group participants believed that the community of Nifas Silk Lafto Sub City is good at making efforts to address the needs of OVCs in their neighbors through their own way regardless of the involvements of the CCC. But their awareness on the roles of CCC is limited so that they suspect the CCC to contribute the cash for OVC care and support.

4.3 The Impact Brought by Coordination of Care

The discussants of the focus group discussion discussed that documentation of beneficiaries profile and beneficiaries need assessment is one of the impacts brought by Coordination of care.

"*In our case, before coordination of care introduced we did not assess our beneficiaries need we just used to provide the service on hand wither its needed by the beneficiary or not"*Sub city 07 CCC member.

The Focus Group Discussants and key informants added that "*The concept of Coordination of Care introduced many key service delivery strategies like;* ***Referral network*** *which means one service provider should have network with other service provider in order to provide whole service needed by the beneficiaries for example if one service provider provides education*

material for its beneficiaries and the beneficiaries also need economic empowerment or medical care the organization will refer the beneficiary to other service providers which provide the service needed. The other concept is ***Need Assessment and Care Plan*** *which means assessing the need of beneficiaries before providing any service then after the needed service is assessed, Care plan will be developed the care plan shows which beneficiary needs what service so that it will save time and decrease service duplication. When service provider comes; the WYCA provides the profiles of the beneficiaries which needs the service providers offer. But this is mostly in theory because as we see the reality due to the multi job description of the CCC and WYCA even though the theory is known the reality is not as such often.* ***Resource Mobilization*** *here the service providers especially around the government side and idirs used to do it before this concept introduced and now first assess our community assets or possible providers and then start the resource mobilization by signing memorandum of understanding with the providers."*

The key informants and FGD discussants added that, *the main duties and responsibility of education and advocacy subcommittee of the CCC is creating awareness to the wider societies related to HIV/ AIDS, Child protection and support, contributing money as a membership partners, identification of service providers and make linkages for effective and sustainable coordinated child care and support, but no more efforts are made to mobilize the community for OVC responses as there are little/no coordination among the members of the CCC. Most of the time, the Sub city CCC members have no sufficient time that enable them doing long periods of time for effective OVC care and support. In addition to this, the members have others house hold duties others than voluntarily service rendering activities for these Vulnerable members of the society. Moreover they still stick on previously used disintegrated systems of educating the people of the local community towards OVC responses. But the level of community awareness to the problems of orphan and vulnerable children is relatively high due to their religious impacts; however, the communities help the OVCs by their own ways than collaborating with the CCC as they don't have trust on the roles of the CCC. So the efforts of the CCC in the creation of awareness to unify the society are minimal and needs further collaborative and structure based*

4.3.1. Identification and linkages of OVC

But the selection of OVCs for these services was initiated by the service provider organization than the CCC, The key informants from the Sub city CCC said that, There are OVCs in all Woredas being selected by the CCC and waiting for service providing organizations. *Some private organization supported the OVC during the special occasions, like religious holidays and beginning of Ethiopian New Year.*

4.3.2. Resource Mobilization and Service provision for OVC

According to the information gathered from the key informants and FGD discussants, there is ways for resource mobilization by improving the awareness of the communities toward a responses for OVC. Similarly when there are resources collected from the community, it follows the action of distributing it for the beneficiaries based of the data verified by the documentation and selection subcommittee. Regarding to mobilizing resources, the CCC of the study have mobilized financial resources from the community, NGOs, Governments and private organization for OVC responses. The main strategy used by the CCC to collect financial resources is selling legally published tickets which cost two birr for individual members of the community, monthly fee from members and requesting organizations by formal letters.

The key informants from the members of the CCC explained that, there is a good start and *the communities have awareness towards responses to OVC care and support, but few of them prefer to help the OVC by their own ways than through the established governmental structure. These parts of the communities have no trust on the CCC as they suspect it is a means designed for exploiting the members of the community in the names of OVCs and other vulnerable groups. In addition to this, there is also overlapping of requesting resources from the same organizations by different CCC that made them unwilling offer it to neither of these CCCs.*

CHAPTER FIVE: DISCUSSION

Introduction

This study conducted on the purpose of assessing the implementation of coordination of care by service providers' for Orphan and Vulnerable Children (OVCs) in the case of Nifas silk lafto Sub city. This discussion will focus on the research questions and over all data gathered to answer them.

5.1. Implementation of Coordination of Care by Service providers

Coordination of Care is a very significant component for OVC service provision. The needs of OVCs may not be fulfilled by a single body it needs more coordination and collaboration with different possible service providers. When providing service for a whole need of a beneficiary or OVCs in this case there is a need to have up to date information on how and where to get the information and service.

The quantitative data presented in the previous section revealed that the provision of coordination of care by service providers needs improvement. One of the objectives of this study was to assess how well coordination of care for orphan and vulnerable children is implemented by service providers. Accordingly, an assessment tool consisting of 26 items organized under eleven sub-scales is used. The tool was developed by Ministry of Women, Children and Youth Affairs to evaluate the quality of coordination of care by service providers for Orphan and vulnerable children. More specifically, the tool was designed to evaluate the status of coordination of care in terms these parameters; safety, access, effectiveness, efficiency, technical performance, continuity, collaborative atmosphere, appropriateness, participation, sustainability and innovation. Descriptive statistics was computed for the overall status of coordination of care and sub scales (specific parameters). The mean score of overall coordination of care was lower compared with the expected average score (M=63.5, SD=14.48).

The CCC member respondents scored relatively more on most subscales on the survey. On the qualitative data the CCC members had the chance to further explain their idea and experience on the coordination of care for OVCs. They have mostly discussed that the service provision for OVCs in their area is facilitated by the WYCA and by the CCC and NGOs. The services

provision to be more quality they need capacity building trainings and some platforms to mobilize resources. The CCC has the role of identifying OVCs in their area and assessing the identified OVCs needs in order to plan care. The mean score for CCC were (67.4) SD (17.7).

The government and WYCA representatives scored more on the subscales like Continuity which gives more emphasis on networking and long term commitment. The mean score for GOs were (59.0) SD (0.000).The government works to have more updated and flexible system when it comes to Coordination of Care for OVCs. The current situation is not as such satisfactory .The quality standards were very important disaggregation of the angle from where to see the services provided.

The NGO representatives score more on the subscales like Technical performance, Innovation and participation. The mean score for NGOs were (65.42) SD (14.34). The data gathered from the NGOs through qualitative information were more on techniques and capacity building. The NGOs have more technical capacity and they share their capacity by providing trainings and professional advice for government and CBOs who are interested.

In general from the results and discussion above one can understand the specialties of the service providers but as in coordination of care only one actor ca not fulfill the needs of the beneficiaries so it is confirmed that more work needs to be done to strengthen existing networks and establish new ones also in order to get the quality service intended.

5.2. The Challenges and Opportunities during the implementation of coordination of care for OVCs

5.2.1. Challenges faced during implementation of coordination of care for OVCs

Different challenges and constraints are accounted for low levels provision of coordinated care and support for OVC at Nifas Silk Lafto sub city. Lack of trust on the roles of CCC is directly associated with minimal levels knowledge of the community towards responses of OVC made by the government, COS, NGO and other responsible body. There is another justification for the ignorance of the community towards OVC care and support through Sub city CCC; the communities have requested contribution of money for different developmental purposes by the Sub city administrators. Another challenge is lack of coordinated monitoring and supportive

actions taken by the sub city. The information gathered from most focus group discussants shows that some numbers of care givers of OVCs prefer to be supported life long period by NGOs for unlimited times. The basic justification they used for this argument is by narrating activities of income generating activities supported by NGOs in the Sub City. While the NGOs provided basic skill training and matching funds for the care givers that helps them to run their own business activities, the care givers used the money for another temporary house hold expenses. But they want another support repeatedly throughout their life from child care and support providers.

Most focus group discussants believed that absence of verified documents of OVC in the sub city leads to service duplication and wastage of resources since the same services are provided to specific groups of OVCs from different service providers. That means the Sub city CCC referred one OVC into different service providers (may be CBOs, GOs, NGOs) which provide the same service for children. This is because the CCC members didn't have documents which may show who have gotten care and support from which organizations in the Sub city.

Most of the time, they are engaged on leading and coordinating political and other developmental responsibilities. This in turn affects the care and support provision for OVC. This shows that there is no significant working habit of integrating different activities at all levels of the Sub City which in turn helps to address the needs of OVCs in the Sub City.

5.2.2. Opportunities for implementing Coordination of care for OVCs

One of the most exemplary is the efforts and commitment of Iddirs to support OVC with educational materials and food support by employing participation of their members. Iddirs of the Sub City also organized themselves in to a General Iddirs Board which could help create additional capacity for mobilizing their members and build better financial sources used for cares and supports for OVCs. In addition to engaging in providing direct care and support for OVC, NGOs working at the Sub City have involved at the areas of building the performance capacity of governmental sectors and Sub city to bring sustainable means of serving the vulnerable groups in the Sub City through the provision of technical trainings regarding to OVC care and support and material supports. In general the information gathered show s that there are so many good

opportunity for providing sustainable care and support for OVC if community mobilization and referral linkages used properly by the actors of OVC care and support organs of the sub city.

5.3. Impact Brought by Coordination of Care

Mobilizing the wider community into the common goals for addressing the needs of OVC is not a simple business. It demands the creation of awareness to the local community for the long run care and support for people existed in trouble specially children under vulnerable to multi faced socioeconomic problems. Similarly the Federal Democratic Republic Government of Ethiopia was aimed at establishing the CCC to support the OVC and other parts of the community who need care and support from the society. Educating and awareness creation duty is attributed to education and advocacy subcommittee of the CCC in Ethiopia in general.

According to the information gathered by the researcher from key informants and FGD discussants, the CCC at each Sub city of the Sub city was established around 2014 with the total members of 20 persons. Since then, they tried to mobilize the community for addressing the basic needs of OVCs by awareness creation through wider community events.

In order to provide effective coordinated care and support for OVC in the given area, it is crucial to have verified OVC data on the hands of the CCC and WYCA. According to the information obtained from Sub city WCYA head and members of the CCC of Sub city, the CCC have identified OVCs when required by other service providers based on the criteria designed by the Federal Democratic Republic Government of Ethiopia through the SSDG.

Even though the CCC is working together with child service providers regarding to OVC selection and linkages, still they used traditional methods and ways than effective and short cut systems. The identification and selection process was often carried out as an urgent and campaign like activity/ task. Such kind of doing things resulted in service duplication as well as less coverage in the addressing of ever-growing needs of support by the OVC. Most FGD discussants elaborated that, the CCC tried to select and link OVCs to CBOs, NGOs, and other private organization, but there are problems in the selection process; Some OVCs were supported by more than one service providers for the same services while others were remain in trouble.

The linkages with these organizations were conducted through formal letter systems of communication which is routine and complicate than making agreements on memorandum of Understanding that can simplify linkages and service provisions. The facts from key informants shows that little or no efforts done on negotiation with different organization for OVC responses except when the service providers required the CCC to select these children from each Woredas.

Local resources mobilization is very important for addressing sustainable and effective OVC cares and supports in coordinated manner. The best ways for facilitating community resource mobilization and linkages for coordinated care and support to OVC is utilization of the social, economic and political structures existing within the community. Mobilizing sufficient resources is highly depend on the functioning of creating awareness and mobilizing the community through advocacy, transmission messages, preparing public conferences for the wider community.

In addition to the above components of the coordination of care and support, many participants of this study suggest that coordination of care and support initiatives laid the basis for sustainability of the OVC service provision. Most of them also suggest the need to intensify coordination of care by building the capacity of CCCs. Besides, it is important to note the value of such a strategy by ensuring ownership and close follow up of government partners. Coordination of care was found to be core component of OVC service provision. It is considered as a strategy to provide holistic support to OVC with mobilization of support and referral networks with likeminded institutions. Coordination of Care intends to sustain care and support to OVC. As it is documented in this study, government, NGOs and CCCs operating at community level, private sectors engaged in for-profit business and individual members of the community were found to be key stakeholders engaged in provision of support to OVC. The coordination of care has enabled the service providers to benefit from resources available at different levels. While coordination at *Sub city* level helped to avoid duplication of efforts and to leverage on local opportunities, coordination at *woreda* level helped to mobilize resources from community members, private organizations and CSOs operating in the *woredas* to better serve OVC and sustain interventions. Particular capacity concerns were flagged at CSOs and government level where continued staff turnover remains to take away those with required capacity for Coordination of care for OVC service provision.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

6.1.1. How is Coordination of Care implemented by service providers?

Although most of the respondents in this study believed that many good works are being undertaken and mostly the work performed is pre planned, still there is some work to be done in order to achieve and reach higher levels of success by seeing some of the results of key quality dimensions.

Most people living in the study area also have a doubt that most of the money, materials and other resources gathered in the name of the vulnerable and orphan kids will not be provided to the kids. So most people refrain from giving money or resources to institutions due to transparency issues. In short they think people in those institutions will pocket the resources rather than providing them to those in need. So most of them do not support institutions while the ones that do want to do it individually by themselves where they guarantee how and where their money and resources are applied. So this shows that still some work must be done to convince those people into supporting those institutions by showing a solid visual change that can persuade them. Such change could be for example like notifying how many children are under the program, making public how much resources and money gathered from local residents, supporting institutions etc. and showing how much is left, where were children under those programs and where they are currently, etc to convince their trust and build a constant reliable source of income probably making them registered supporters for this cause and making the whole process official. As we all know Ethiopians are always willing to give and support the ones that are in need and in worse conditions. This is one of our best cultures which makes us who we are and this good culture should not be altered due to some immoral and dishonest people who want to profit from such institutions (if there are). So if the institutions involved in the support and care of orphan and vulnerable children are doing what they say are doing then they should provide accountable and transparent systems of checks and balance to gain the trust of the vast majority of the people. Only then are they able to create a sustainable system of

support for those children in a steady and continuous way since this kind of support is not applied for some time and stop when we feel like it or we don't have the resources to continue. When we get the vast majority of people behind this cause the support they provide will be steady and will allow institutions to create a system on a firm ground which will not be dependent in people and slight fluctuations in resources.

6.1.2. Challenges and Opportunities during coordination of care

On assessing the main challenges that determined the provision of coordinated response for OVC in the Sub City; the study investigated many constraints/ challenges that affect sustainable provisions of care and support for the targeted beneficiaries. This included lack of commitments and coordination of the members of CCC /in advocacy, community mobilization, resource mobilization/, lack of trust of the community due to limitation of awareness, lack of result base supportive systems by the responsible bodies, poor documentation of the CCC which accounts service duplication, neglecting of homeless street children by the CCC, dependency syndromes of the beneficiaries.

The fourth objective of the study revealed the main opportunities that can be used as a back bone for providing sustainable responses for the needs of young promising OVCs living in the sub city. These opportunities included the relative concentration of manufacturing industries used as sources of job opportunities if linkage and coordination will be made, the participation of Iddirs, NGOs, GOs, the community, the technical and vocational college, the university and other stakeholders for addressing sustainable OVCs responses through direct support and capacity buildings.

6.1.3. The Impact Brought by Coordination of care

As an impact; coordination of care concept brings light for service providers on how to mobilize local resource and how to give whole service to a child by creating network and referral system but still the logic of coordination of care is understood by the service providers and not enough effort is done to really get what is desired. In some cases the implementation is somewhat good relatively the journey of coordination of care has been started and will progress if the service providers get capacity building trainings and more strong system of coordination of care at grass root level.

6.2. Recommendations

1. Community mobilization should be conducted through different wide media messages systems /example; FM radio, community events, public meeting, etc…/ for facilitating resource mobilization and coordinating care and support in the town.
2. Result based monitoring and supportive super vision should be conducted at all levels of the government lines to bring sustainable systems for community care and support.
3. The CCC should employ effective and formal referral systems with community care and support providers.
4. The CCC should identify locally available resources, draw sketch maps and service directories, and make memorandum of understanding with service provider organizations for facilitating provision of coordinated care and support for the beneficiaries.
5. The higher governmental responsible body should cascade capacity building programs for CCCs on technical and material aspects.
6. The Sub city responsible body should support and strengthens the referral networks established among OVC care and support providers; NGOs, GOs.
7. Religious institutions should be intensively participated in the areas of OVC care and support.
8. Effective awareness creation systems should be employed to minimize dependency syndromes of the beneficiaries
9. Further research should be conducted on the technical performance and capacity of the service providers.

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Appendix

Research questionnaires, interview and FGDs

My name is Elham Yesuf; I come from Addis Ababa University. I am here to study the provision of Coordinated Care and Support for Orphan and Vulnerable Children for the purpose of fulfilling Masters Degree in Social Psychology. Please try to give your genuine answer there is no right or wrong answer. Thank you for your cooperation.

Annex 1: Questions for WYCA, NGO, CCC, others

Appendix A (1) Addis Ababa University College of Education and Behavioral Studies School of Psychology Questionnaire (to be filled by OVC Service Providers)English Version

The purpose of this questionnaire is to collect data necessary to carry out a research on "Evaluating the provision of Coordinated Care and Support for OVCS the case of NIfas Silk Lafto Sub city in Addis Ababa." The information you provide will be kept confidential and used only for research purpose. Your identity will not be disclosed to another party and no one will identify your response. Hence, you are kindly requested to complete the form set forth carefully. Thank you in advance for your co-operation.

No	Items	Categories
1	Sex	A. Male B. Female
2	Age	A. 18– 19 B. 20– 25 C. 26-39
3	Where do you Work	A. Government Organization C. Non-Government Organization B. Community Based Organization

Evaluating the quality of Coordination of care for OVCs

Instruction: Below are listed statements describing the dimensions of quality matrix for coordination of care. Please read the statements carefully and indicate the extent to which you agree or disagree with each statement by putting 'X' mark in the boxes that represents your opinion.

Response Key: 1 = Strongly Agree

2 = Agree

3 = Undecided

4 = Disagree

5 = Strongly Disagree

No	Items	1	2	3	4	5
	Question under safety category					
1	The services provided ensure confidentiality and child sensitive assessments.					
Questions under Access category						
2	Government resources (money, physical, human) are engaged.					
3	Undertook service mapping (Ensure information is available on where & how to access child friendly services.					
Questions under Effectiveness category						
4	Ensured services are responsive to the needs of the whole child.					
5	Stakeholders are involved in planning care for OVCs.					
6	Established Objectives are being met.					
Questions under Technical Performance						
7	Problems of double counting are resolved.					
8	Ensured that Joint planning is dynamic not static.					
9	Staffs are trained regarding child-Centered assessment so that services are based on need not organizational offerings.					
Questions under Efficiency						
10	There is no duplication of Effort.					
11	Resources utilization is transparent and mobilized.					
Questions under Continuity						
12	Coordination is a long term Commitment.					

13	Networking is Established, Nurtured and Functional.					
14	Systems are formed and functioning across stakeholders.					
15	Care plans for individual children are completed and followed.					
Questions under Collaborative Atmosphere						
16	Non-competitive atmosphere is fostered.					
Questions under Appropriateness						
17	Child friendly services are ensured.					
18	Services are responsive to gender, age, and special needs of children.					
Questions under Participation						
19	Procedures are in place to provide feedback on service provision.					
Questions under Sustainability						
20	Existing Community Structures are used.					
21	Plan developed for reduction in external resources.					
22	A range of Multi sector stakeholders are engaged in planning, implementation and monitoring.					
23	Capacity building is a priority.					
Questions under Innovation						
24	Creative use of resources is fostered.					
25	Approach to coordination is flexible and responsive to community changes.					
26	Forums are conducted periodically to stimulate and encourage new ways to coordinated is in place.					

Annex II: Interview questions for FGD participants CCC members

Males ---------- Females ---------------

1. What is the status of coordination of care and support for OVC in the sub citys?

2. Who are involved in the provision of care and support for OVC in the sub citys? (What kinds of service, involvements of the community, referral linkages, resource mobilization……)

3. What are the major challenges and opportunities identified for the provision of coordinated care and support in the sub citys?

4. What mechanisms should be taken to with stand challenges of child care and support?

5. What is the impact of provision of coordinated care and support for OVC?

6. Do the communities have potentials for providing coordinated care and support for OVC?

Annex IV: Interview questions for women and youth affair office

1. responsibly --
2. What are the major causes of child vulnerability in the sub city?
3. What are the stakeholders that provided care and support for OVC?
4. What are the advantages of coordinating care and support for OVC?
5. What looks like the participation of the community, GOs, NGO in the provision of care and support for OVC in the sub city?
6. Is there any capacity building support provided for the CCC by the concerned body?
7. Are there referral systems established for the provision of coordinated care and support for OVC?
8. Are there referral network workshops adapted among OVC service providers?
9. How do you see the functionality of CCC in the provision of care and support for OVC?
10. What strategies should be adapted to provide sustainable care and support for OVC in the sub city?
11. What is the impact brought by implementing coordinated care for OVC?