Addis Ababa University
School of Graduate studies

The Psychosocial Problems of Orphan and Vulnerable Children, and the Responses of Service Providing Organizations: The Case of Arada Sub City, Addis Ababa

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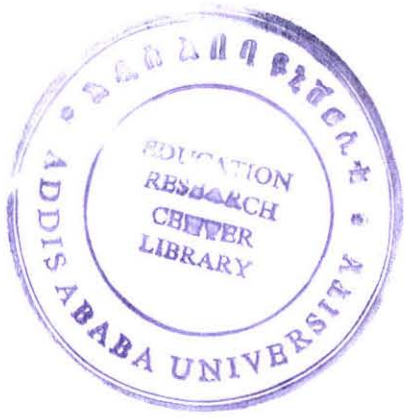
A Thesis Submitted to the School of Graduate Studies of the Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Social Psychology

Desalegn Takele



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By:

Desalegn Takele

Approved by Board of Examiners

Tekle Fendis	
Chairman, Department of Graduate Committee	**Signature**
Belay Tefera	
Advisor	**Signature**
Tamirie A	
Examiner, Internal	**Signature**
Girma Lemma	
Examiner, External	**Signature**

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List of Abbreviations and Acronyms

CBOs:	Community Based Organizations
CRC:	Convention on the Rights of the Child
CSA:	Central Statistics Authority
FBOs:	Faith Based Organizations
FHI:	Family Health International
GOs:	Government Organizations
GOE:	Government of Ethiopia
HAPCO:	HIV/AIDS Prevention and Control Office
MOH:	Ministry of Health
MOLSA:	Ministry of Labor and Social Affairs
NAC:	National HIV/AIDS Council
NGOs:	Non Governmental Organizations
OVC:	Orphans and Vulnerable Children
PEPFAR:	President's Emergency Plan for AIDS Relief
RAAAP:	Rapid Analysis and Action Plan
UNAIDS:	Joint United Nations Program on HIV/AIDS
USAID	United States Aid International Development

Abstract

The main purpose of this study was to find out the psychosocial problems of orphans and vulnerable children (OVC) and the responses of service providers to the problems of OVC in Addis Ababa, Arada Sub City.

Eighty eight OVC, 40 guardians from the sampled OVC and 4 Service providing organizations, who were directly involved in the care and support of OVC, were used as data sources. The OVC were selected from two organizations. Purposeful and available sampling methods were used to select the respondents. The instruments used for collecting the data were questionnaires and interviews.

Results of the study showed that OVC face different psychosocial problems. Socially, they were subjected to various problems like isolation, displacement and separation, early school drop out, lack of attention, and mistreatment by guardians. Psychologically, many of them suffer from deprivation of parental care and support, and experience a range of negative psychological and emotional problems such as having scary dreams, unhappiness, being afraid of new situations, difficulties falling asleep, fights with other children, feelings of loneliness, worry, frustrations, anger, difficulty in making friends, feelings of hopelessness and lower self-esteem. OVC's accessibility for education was considered as their main needs. OVC used pray, ignorance, talking to somebody and crying as the major coping strategies to cope with their problems. Guardians were aware of the situation of OVC, but they had low perceptions to the psychosocial problems of OVC. The types of care and support provisions were mainly financial and material; food and educational, and the responses of service providers towards the psychosocial problems of OVC were generally very limited. The main challenges that the service providing organizations encountered in OVC care and support especially in psychosocial support were lack of clear guideline, meager organizational strategies and program design, funding constraints, shortage of human resources and low awareness on OVC psychosocial issues at all levels.

It is recommended that, early intervention is needed to prevent adverse effects on children's long-term development. Strengthening the capacity of families and communities is desired to care for children. Psychological and social support systems are also needed to enhance the psychosocial well being of OVC. More over, creating awareness at all levels of the community to the psychosocial problems of OVC is a critical measure to ease the psychosocial problems of OVC.

I. INTRODUCTION

1.1 Background

Ethiopia has been severely challenged by decades of conflict, food insecurity and abject poverty. Children in particular have been profoundly affected and are one of the most vulnerable segments of the Ethiopian society. Children under the age of 18 accounts for about 52 % of the total population of Ethiopia. From this, 44% are below 15 years old while 8% are 15-18 years old (CSA, 2005).

From this proportion of children, large numbers of children suffer from the ills of poverty and illiteracy. They are also victims of several harmful traditional practices such as early marriage, female genital mutilation, physical punishment, and labor exploitation. There is high infant and child mortality rate, i.e.112 and 84.5 per 1,000 live births respectively. Children in Ethiopia have less access to school. According to the UNICEF (2003)'s report, the net primary school enrolment /attendance of children was 30% and the percentage of primary school entrants who reached grade 5 is 51%. Children in Ethiopia also suffer poor health situation owing to inadequate access to clean water, sanitation facilities and nutrition. Several studies have also shown that most children in Ethiopia are engaged in various productive and household chores and activities which are characterized by lacking access to occupational safety, working for long hours, paid very low wages, and a work environment which is dangerous to their health (CSA, 2005).

Generally, several literature indicate that large number of Ethiopian children are suffering from the ills of poverty and illiteracy such as living in extremely poor situation, suffering and dying from various diseases, not in school, working in hazardous conditions, exposed to various physical and sexual abuses, are trafficked, and are orphaned and/or infected by HIV/AIDS (CSA, 1998).

Compared to other children, the psychosocial and socio-economic situations of children in especially difficult circumstances, like orphans and other vulnerable children (OVC) are more likely to be multifaceted and complex in Ethiopia. Studies conducted by

Ministry of Labor and Social Affairs (MOLSA) and others indicate that there are about 1.2 million HIV/AIDS orphans in Ethiopia, and the number would be rise to 1.8 million in 2010. Generally, the study indicated that AIDS orphans in Ethiopia are facing multifaceted social, economical, legal and psychological problems. They have poor nutrition and health, lack educational opportunities and drop out of school, lack love, care and attention, experience stigma and discrimination, experience exploitation and abuse, lack emotional support to deal with grief and trauma, experience long-term psychological problems, take drugs and other substances and become involved in crime and vulnerable to HIV/AIDS infection (MOLSA, 2004).

Addis Ababa, the capital city of Ethiopia, is one of the administrative regions of Ethiopia, which is highly affected by HIV/AIDS pandemic. According to the 2004 Surveillance Report of Ministry of Health (MOH), the prevalence of HIV/AIDS in Addis Ababa was 14.6%. The report also indicates that the current number of AIDS orphans in Addis Ababa is estimated to be over 79,000. Like other parts of Ethiopia, AIDS orphans in Addis Ababa are also facing multifaceted social, economical, legal and psychological problems.

To address these mutifaceted problems especially the pschosocial problems that OVC are facing and to change or improve the situation for survival, development and welfare of OVC, GOs, NGOs, CBOs, FBOs, donor countries, international organizations, civil societies, the private sector and the community at large would have to be mobilized for action. While there are a number of programs that address the material needs of orphans and vulnerable children, there is less emphasis on helping children cope with the trauma associated with witnessing the deaths of family members. There is also lack of adequate local researches on the responses of service providing organizations for the psychosocial needs of OVC. For this reason, assessing and understanding the major psychosocial problems of OVC and the response of service providers (GOs, NGOs, CBOs, FBOs) in a given area is important.

Therefore, this study attempts to explore the psychosocial problems of orphans and vulnerable children and the responses of service providing organizations to the problems of OVC in Addis Ababa of Arada sub city.

1.2 Statement of the Problem

Although HIV/AIDS has reached almost every part of the world, no other region has been harder hit than Sub-Saharan African countries, which homes nearly three quarters of the world's people living with HIV/AIDS.

According to the report of United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF) and UNAIDS; 15 million children under the age of 18 had lost one or both parents to AIDS, with the majority (78%) in sub-Saharan African by the end of 2003. In sub- Saharan Africa, there are more than 34 million Orphans of which 11 million of them are orphaned by HIV/AIDS. The number of Orphans in most sub-Saharan Africa countries is increasing exponentially because the infection is still rising as adults continue to succumb to the pandemic (UNAIDS, UNICEF and USAID, 2004).

Among the sub-Saharan African countries, Ethiopia is the one, which is severely hit by HIV/AIDS pandemic. In Ethiopia 1.5 million people are living with HIV/AIDS, of which 96,000 are children under the age of 15. Ethiopia houses the second largest population of children orphaned by AIDS in sub-Saharan Africa, next to Nigria. 4.6 million Children are estimated to be orphans because of different reasons of which, 1.2 million children are AIDS orphans. Ethiopia's high number of orphan are due in part to AIDS, persistent and severe poverty, poor performance of children and women's rights, chronic food security, conflict, war, malnutrition and other diseases (POLICY project/ The Futures Groups, 2004).

Generally, the magnitude of the problem at large, the general level of poverty and the growing demand for care and support of OVC in Ethiopia leave many children without fulfilling their basic needs and vulnerable them to other psychosocial problems (HAPCO, 2004).

A comprehensive care and support interventions like health services/medical care, educational assistance, shelter, socio-economic strengthen, legal and psychosocial support for orphan and vulnerable children and their families should be scaled-up in a sustainable way to address the social, economical, legal and psychological needs of OVC. By considering this, Government organizations, NGOs, International aid organizations, religious bodies, the private sector and the community groups and the like have a stake in ensuring the protection and well-being of OVC. Literatures indicated that, although various organizations at International, National and Community level tried to intervene to mitigate the multidimensional problems of OVC, the programmatic coverage of the existing efforts in Ethiopia is insufficient. This is because the care and support system of OVC in Ethiopia are not assessment based, comprehensive and coordinated, and are not based on the needs and priorities of the OVC.

Moreover, studies conducted by UNICEF (2003) also indicate that in many regions of the country, psychosocial care for OVC is the most neglected dimension of OVC care and support provided. In support of this idea, the International HIV/AIDS Alliance Organization in its' report (2003) revcals that most programs regarding orphans and vulnerable children in Africa focus on material support and meeting children's physical needs. Relatively few programs consider the psychosocial effects on children of having HIV, caring for a sick parent, living in a household affected by HIV/AIDS or losing one or both parents.

To alleviate and address the multi-faceted problems of OVC especially the psychosocial part, one of the critical steps is to undertake such type of study. Therefore, the aim of this study is to explore the psychosocial problems that orphans and other vulnerable children (OVC) are facing in Arada sub city of Addis Ababa. The study also attempts to examine the major responses of service providing organizations (GOs, NGOs, CBOs, FBOs) towards the psychosocial problems of OVC and suggests appropriate psychosocial interventions to address problems of orphans and vulnerable children (OVC) in the study area.

1.3 Objectives

The general objective of the study is to explore the problems and experiences of orphan and vulnerable children (OVC) and service providing organizations responses to the psychosocial problems of OVC in Arada sub city of Addis Ababa. Specifically, the study has the following objectives:

1. To examine the social interaction and conditions of OVC in the house hold.
2. To find out the major psychological & emotional experiences/problems that OVC are facing.
3. To assess guardians perceptions regarding the psychosocial problems of OVC.
4. To investigate the coping mechanisms adopted by OVC for their psychosocial well being.
5. To assess service providing organizations' responses towards psychosocial problems and needs of OVC in terms the availability and quality of services and
6. To recommend feasible psychosocial interventions which minimizes the psychosocial problems of OVC and enhances the well-being of OVC

1.4 Research Questions

To attain the above stated objectives, the study attempts to answer the following research questions concerning the psychosocial problems of orphans and vulnerable children, and the responses of service providers on the problem in the study area:

1. What are the social interactions and conditions of OVC in the household?
2. What are the major psychological & emotional problems that OVC are facing?
3. What are the perceptions of guardians regarding the problems of OVC?
4. What are the coping mechanisms adopted by OVC for their psychosocial well being?
5. What are the responses of service providers (GOs, NGOs, FBOs and CBOs) for the psychosocial problems and needs of OVC?
6. What psychosocial interventions are in place to mitigate the problems of orphans and vulnerable children?

1.5 Delimitation

The study was conducted on 88 OVC, 40 guardians/caregivers and 4 service providers' organizations in Arada Sub city of Addis Ababa. The study also tried to explore merely the psychosocial effect of HIV/AIDS on OVC. Though HIV/AIDS has other possible impacts like economic, health and educational impacts, these were not being addressed in the study due to the constraints such as time, money, and materials.

1.6 Limitations

Although the researcher tried to administer the study, shortage of time to make detailed and continuous observations of the issue understudy, to take limited number of participants in the study area, financial constraints, lack of interest to respond to the interview questions by some guardians, and lack of willingness by some organizations to take hold of the OVC in the study were some of the major problems faced.

1.7 Operational Definitions

Child: A person whose age is below 18 years as put in the Convention on the Rights of Children

Orphan: A child who has lost one or both parents due to HIV/AIDS, as these were my eligible respondents to attain the objectives stated.

Vulnerable Child: A child aged below 18 years who is either HIV positive or has lost one or both parents because of HIV/AIDS and lives without adequate adult support (e.g., in a household with chronically ill parents, a household headed by a grandparent, and/or a household headed by other relatives or foster parent, neighbor and a child).

Guardian/Caregiver: A person (grandparent, parent, foster parent or relatives), who took the responsibility of looking after a child who lost one or both parents due to HIV/AIDS.

Service provider organizations: Organizations (GO, NGO, FBO, CBO), which provide care and support for OVC and their families

Psychosocial problems: Problems which are both psychological and social affecting orphans and vulnerable children's emotional well-being and social conditions as a result of losing parent(s) due to HIV/AIDS, as reported by children and their guardians.

1.8 Significance

Different researchers have tried to assess the situation of HIV/AIDS in Ethiopia, but the psychosocial impact of HIV/AIDS on children is often overlooked. Furthermore, while there are a number of programs that address the material needs of orphans and vulnerable children, there is less emphasis on helping children cope with the trauma associated with witnessing the deaths of family members. Since, the study articulates the psychosocial problems of OVC and the responses of service provider organizations on the issue, it is hoped that various organizations that are working in favor of orphans and vulnerable children in the study area will develop shared understanding of the psychosocial conditions that OVC are facing which helps them to make sound decision, plan and target resources on their unmet needs. The result of the study will help those organizations working on OVC to develop strong programmatic responses to meet the psychosocial needs of OVC in more organized way. Further more, it is hoped that the results of this study may provide some information on the present psychosocial problems of OVC for those who are interested to conduct further investigation on the issue under discussion.

Finally, since relevant and feasible recommendations and comments on the existing strategies, program responses, services & practices specific to the OVC will be forwarded for concerned organizations which help to enhance the well-being of OVC, all the concerned government organizations, non-governmental organizations, religious institutions, community based organizations, the academic community, and associations working with the OVC, families and OVC may benefit from this study.

II. REVIEW OF RELATED LITERATURE

2.1 The Prevalence of Orphans and vulnerable children

Although HIV/AIDS has reached almost every part of the world, no other region has been highly hit than sub-Saharan African, which hosts nearly three quarters of the world's people living with HIV/AIDS. According to the Joint Nations program on HIV/AIDS (UNAIDS), nearly 40 million people in the world are currently living with HIV/AIDS, of which nearly 2.2 million are children below the age of 15. Of all regions of the world, sub-Saharan African remains the most affected regions with 25.4 million people living with HIV/AIDS of which 1.9 million are children under the age of 15. The pandemic is not only causing so many deaths, but it is also rendering many children parentless (UNAIDS, 2004).

According to the report of the United States Agency for International Development (USAID), the United Nations Children's Fund (UNICEF) and UNAIDS; 15 million children under the age of 18 had lost one or both parents to AIDS, with the majority (78%) in sub-Saharan African by the end of 2003. In sub- Saharan Africa, there are more than 34 million orphans, of which 11 million of them are orphaned by HIV/AIDS. The numbers of Orphans in most sub-Saharan Africa countries are increasing exponentially because the infection is still rising and due to adults continue succumb to the pandemic (UNAIDS, UNNICEF and USAID, 2004).

Among the sub-Saharan African countries, Ethiopia is the one, which is highly affected by HIV/AIDS pandemic. In Ethiopia, 1.5 million people are living with HIV/AIDS, of which 96,000 are children under the age of 15. Ethiopia houses the second largest population of children orphaned by AIDS in sub-Saharan Africa next to Nigeria. In Ethiopia, 4.6 million children are estimated to be orphans of different reasons of which, 1.2 million children are AIDS orphans and the number would rise to 1.8 million in 2010 (POLICY project/ The Futures Groups, 2004).

According to Ministry of Health (MOH, 2004) report on the main indicators of national and regional HIV/AIDS related indicators, the total number of orphans and vulnerable

children in Addis Ababa is above 150,000 of which, 79,000 children are AIDS orphans (MOH, 2004).

2.2 The Impact of HIV/AIDS on Children

Because HIV/AIDS predominantly attacks people of childbearing age, the impact this is having on children, extended families, and communities is devastating. If a parent dies of AIDS, the child is three times more likely to die even though he or she is HIV negative. Besides increased risk of death children whose parents have died due to HIV/AIDS also face stigmatization and rejection, and often suffer from emotional distress, malnutrition, a lack of health care, poor or no access to education, and often most importantly, lack of love and care. They are also at high risk for labor exploitation, sex trafficking, homelessness, and exposure to HIV. Extended families and communities in highly affected areas are often hard –pressed to care for all the children. In communities hard hit by the double hammer of HIV/AIDS and poverty, there are millions of children who are not orphans, but who have been made more vulnerable by HIV/AIDS. For example, children whose parents are infected with HIV/AIDS might not receive the care and support they require, and may instead become their parents' caregivers, often dropping out of school and becoming the breadwinner. Research indicates that these children, caring for sick and dying parents, are the most vulnerable of all (PEPFAR, 2006).

A recent survey conducted by MOLSA, Italian Cooperation and UNICEF, on the prevalence and characteristics of AIDS orphans in Ethiopia, indicates that the impacts of AIDS on children are both multifaceted and complex. AIDS orphans endure overwhelmingly and largely unmitigated losses; living as they do in societies already weakened by underdevelopment, poverty and the AIDS pandemic itself. This is particularly true in sub-Saharan Africa, where few social support systems exist outside of families and where basic social services are largely inadequate (MOLSA, 2003).

Neither words nor statistics can adequately capture the human tragedy of children grieving for dying or dead parents, stigmatized by society through association with HIV/AIDS, plunged into economic crisis and insecurity by their parents' death and struggling without service or support systems in improvised communities. Children suffer

from psychosocial distress and increasing material hardship due to AIDS. They may be pressed into service to care for dying parents, required to drop out of school to help with farm or household work, experience-declining access to food, housing, clothing, and health services. Many are at risk of exclusion, discrimination and stigmatization.

The survey also stated that the mean score for emotional adjustment of AIDS orphans was lower than that of non-AIDS orphans. Accordingly, the lower level of emotional adjustment was reflected in degrees of unhappiness or worry, lower level of patience, fatigue and depression, feeling hopelessness and pessimistic, avoiding people, and disturbing others. The findings of the survey suggest that AIDS orphans have a higher probability of developing social adjustment problems when compared to non-AIDS orphans (Ibid).

In general, the psychological impact of HIV/AIDS on children is often overlooked. Not only do many children who live in heavily affected areas contend with the death of one or both parents, but also they also frequently face the death of younger siblings, aunts, uncles and other relatives. While there are a number of programs that address the material needs of orphans and vulnerable children, there is less emphasis on helping children cope with the trauma associated with witnessing the deaths of family members. The additional burden of caring for terminally ill relatives may send children into shock leaving many of them with unanswered questions about their own mortality and future (Salaam, 2005).

2.2.1 Psychological Impact of HIV/AIDS on Children

According to the study in South Africa on the impact of HIV/AIDS on children, the viable social and economical impact of AIDS on children often hides the less visible but severe psychological consequences children experience due to the impact of AIDS in their lives. Psychosocial needs are frequently overlooked because many adults lack basic skills in recognizing children's psychological reactions. Children affected by AIDS not only experience stigma but also provide terminal care to dying parents.

Furthermore, they suffer multiple bereavement through the loss of fathers, mothers, siblings, aunts and other relatives. In addition to direct losses caused by death, they

experience loss of familiar surrounding, friends and schooling, and can loss hope for the future due to the consequent migration or the slide from poverty into destitution. It is also apparent that the impact of AIDS on children can lead to continuous traumatic stress syndrome. During childhood, when minds, bodies, values and personalities are being formed, such unresolved trauma is capable of inflicting life long damage and distortion on human development. With the scenario that up to 35% of all children might be orphans in several southern Africa countries by 2010, failure to support children's to overcome such trauma might cause dysfunctional societies, jeopardizing years of investment into national development (Stefan, 2002).

A child whose mother or father is HIV positive begins to experience loss, sorrow, and suffering long before parent(s) death. Moreover, since HIV is transmitted mainly by unsafe sexual intercourse between couples, once HIV is claimed the mother or the father; the children are far more apt to lose the remaining parent. This causes children find themselves trust in the role and responsibilities of mother or father or both; doing the household chores, looking after siblings, farming and caring for the ill or the dying parent (s), experiencing stress that would even exhaust even adults.

Since HIV infection progress from initial infection to mild HIV related illness to the life threatening illness children can live with long periods of uncertainty intermittent crisis, as both parents slowly get sick and die. Because of the unavailability of effective relief for pain and related symptoms in developing countries, like Ethiopia, children who live through their parent's pain and illness frequently suffer from depression, stress and anxiety. Many children lose every thing that once offered them comfort, security and hope for the future. AIDS orphans witnessed the prolonged illness and death of one or more family members and suffer mental distress as a result. According to the study carried out in Ethiopia by Save the Children Denmark, some of the psychosocial challenges faced by AIDS orphans are loss of family, stress, depression, lack of health care, lack of schooling, early entry into paid and unpaid labor, loss of inheritance early marriage, exposure to abuse and increased risk of HIV/AIDS (Save the Children Denmark, 2002).

According to the International HIV/AIDS Alliance (2003)'s publication report, the psychosocial impact on children of living in families affected by HIV/AIDS will lead to stress, often characterized by: anxiety, loss of self-esteem and confidence, stigma and discrimination and depression (International HIV/AIDS Alliance, 2003).

Children affected by HIV/AIDS can show grief even before their parent (or parents) dies, and after their death may act in a way that seems strange. Adults often believe that children will forget their parents after a few months. In many cultures, there is little understanding of children's grief or of how grief is expressed by children of different ages. Adults often find it too difficult to cope with their own grief to be able to help the children deal with theirs. It can be difficult for children to acknowledge and talk about their strong feelings concerning a parent's illness or death. Even if they are able to express these feelings, often no one has time to listen.
Different literatures also indicate that common feelings experienced by children when they lose their parents include guilt, anger and sadness (Ibid).

2.2.2 The Social Impact of AIDS on Children

Initially the social impact of HIV/AIDS often causes families and communities to be paralyzed, a response that is linked to the fear of the unknown new situation in communities where traditional coping patterns give no easy answers to the problems. Fear is followed by stigmatization of the affected individuals & families. Family/house hold and community patterns can change as a result of and traditional society safety nets start to adapt to the new crisis in an attempt to mitigate the negative impact.

The extended family was the traditional social safety net in most of African countries including Ethiopia. Over the past decades, poverty in general and the magnitude of the problem of orphans and other vulnerable Children weakened extended family networks. The combined social impact of AIDS such as the care for terminal ill family members, increased number of orphans to look after with reduced number of prime-age caregivers has put the extended family safety net under great stress. As a result, many orphans slip through that traditional society security net.

Although recognizing that AIDS puts families under incredible stress, most families in southern Africa are still providing some level of care for affected children. Therefore extended families must be seen as the front- line response to large –scale care and support of children affected by AIDS. Some studies suggest that most families agreeing to take in foster children from the extended family were living below the poverty line, whilst wealthier relatives maintained minimal links with orphans apart from some financial support (Stefan, 2002).

The number of orphans and other vulnerable children (OVC) mainly due to AIDS in Ethiopia is growing and mainly the burden of their care falls on extended families who themselves often need care and support, or impoverished relatives struggling to meet their own children's needs. This shows that the inadequacy of the support that comes from the extended families because the families themselves do not have enough to feed extra mouths. Generally, the magnitude of the problem at large, the general level of poverty and the growing demand for care and support of OVC in Ethiopia have weakened social cohesion and traditional care and support mechanisms through extended families, which causes leaving many children without fulfilling their basic needs and vulnerable them to other psychosocial problems (HAPCO, 2004).

One of the first visible impacts of prolonged parental illness on children can be that their education is disrupted due to a lack of financial resources and the children's increased responsibility for household and care giving chores. Even for orphans that continue with schooling, their performance is often lower than for non-orphans peers. The epidemic also takes its toll on the quality of education as the numbers of teachers are reduced due to AIDS- related mortality rates (MOLSA, 2003).

In line with this, a study conducted by MOLSA (2003) stated that AIDS seems to have a negative impact on children's socializations with respect to their identity, understanding and participation. Children affected by AIDS may feel a sense of alienation, stigmatization and isolation. The health and nutritional status of orphans compared with non-orphans is lower. This is a matter of concern, as not only it is a child rights violation

but also as childhood, malnutrition is associated with reduced productivity in later life (Stefan, 2002).

2.2.3 Psychosocial Impact of HIV/AIDS on Caregivers

Caregivers can also have psychological problems – for example, grief, fear, and anger– after the death of a relative. If severe, such psychological problems can also have an effect on the children they are looking after. Caregivers looking after many children often find it difficult to cope and blame themselves for not being able to do enough, even though they must also deal with their own grief and sadness.

Many struggle to meet their children's needs – for food, clothes and schooling, looking after them when they are sick and giving them love and attention – in conditions of financial hardship and with little practical, medical or social support. Sometimes they are also struggling with the fact that the children in their care have HIV and may soon die. Often their contribution is not recognized, and they may suffer some of the following psychosocial effects as a result: Depression, grief and feelings of helplessness, withdrawal and isolation, despair and loss of hope for the future, anxiety, frustration, confusion. (International HIV/AIDS Alliance, 2003)

2.3 Needs of Orphans and Vulnerable Children

Needs of orphans are the same as the general needs of children, except in the areas of skills. Orphans may require skills at an early age in order to cope with additional responsibilities that they assume. These needs are best given according to the age categories of children as shown below.

Table 1: Needs of orphans and vulnerable children by age category

0-5 years: Early Childhood Development	6-14 years: Primary School Children	15-18 years: Secondary/Tertiary Education/Youth out of school
• Immunization • Nutrition/breastfeeding • Stimulation/psychosocial care • Basic health care • Shelter and clothing • Guidance, pre-school education • Protection; Behavior formation	• Education • Shelter/clothing • Food • Health • Guidance and counseling • Behavior formation • Stimulation, psychosocial support • Reproductive health education • AIDS/HIV education • Life survival skills • Protection	• Basic needs (education/health/food/shelter) • Reproductive health/HIV/AIDS education • Protection (legal protection/property inheritance) • Behavior change • Career guidance/counseling • Vocational training/entrepreneurial training • Income generating activities • Socio-economic reintegration

Source: Seroney & Pfahler (2004)

The national NGO Mary Joy AID organization conducted a focus group discussion with orphans to determine major perceived needs. Their responses reveal a complex and often uncertain and frightening daily existence, with food shortages their constant number one concern and needs. This was followed by lack of clothing and bedding, overwhelming grief and poor medical care. The following table shows the most serious concerns and needs as directly reported by Ethiopia's OVC.

Table 2: - Mary Joy AID Orphans Focus Group Discussion Responses on their major perceived needs

OVC Problems and Challenges	Ranking of Problems and Their needs
Food shortages	1
Lack of clothes	2
Grief caused by death of parents	3
Lack of adequate medical care	4
Lack of educational materials and uniforms, guidance and counseling skills	5
Inability to pay rent or maintain house	6
Anger, hopelessness, anxiety and other psychological problems and Lack of adequate parental love and family	7
Labor abuse or undertaking activities beyond their capacities	9
Lack of adequate community support	10
Absence of adequate policy and legal protection	11
Stigma and isolation	12
Problems related to inheritance and property rights	13
Vulnerable to street life and other related problems	14

Source: Rapid Country Response Analysis: Ethiopia, 2004/2005 POLICY Project/ the Futures Group

Concerning OVC and care takers' needs, during the OVC Rapid Assessment and Action Plan process, researchers interviewed orphans, caregivers, NGO staff, local officials/leaders and anti-AIDS club members to ascertain what kind of support they needed to provide better care to AIDS orphans. Based on the result of the study, caregivers listed severe poverty as their number one priority issue, and described how chronic poverty was making it difficult for them to properly care for AIDS orphans. Caregivers were also concerned about providing better support emotionally fragile orphans whose loneliness, sadness and depression was only made worse by stigma and abuse in the community and in schools. Their needs include material and financial support, and support for engaging in income generating activities. Orphans, on the other hand, reported needing tutorials, credit, and assistance with finding employment. They

report that current forms of assistance are commonly fragmented, limited in scope, and often interrupted (unsustainable).

All respondents said much more work needed to be done to expand advocacy for AIDS orphans, including community sensitization to children's rights and the effects of stigma. Improved psychosocial and financial support to caregivers was also underlined as key strategies for improving OVC care. (Cited in POLICY project/ The Futures Groups, 2004).

2.4 Essential Elements of Support for OVC

According to Seroney & Pfahler (2004), the essential elements of a comprehensive OVC support program from a societal perspective are the following:

Policy and Law: – Appropriate government policies are essential to prohibit discrimination of access to medical services, education, employment, housing, and protection to the inheritance rights of widows and orphans. Formulation and revision of policies and laws should fully consider the challenges that are faced by people living with HIV/AIDS, children and their families.

Medical Care: – For optimal well being of orphans and other vulnerable children, they and their guardians must have access to appropriate clinical and preventive health care; nutrition support; palliative care and complimentary home-based care, and complete and relevant information.

Socio-Economic Support: - While it is important to meet the immediate threats to well-being (loss of income, education access, shelter, nutrition and other essential necessities), the foundations for long-term health and well-being should be considered right from the beginning. Communities must be able to identify children and households in most need, prioritize their needs, and use local and external resources to increase their well-being and strengthen community safety nets. Special attention should be paid to child-headed households, families with young children headed by the elderly; families with young children headed by adolescents, and abandoned newborns. Micro-finance programs have shown good potential for increasing economic resilience among poor households in a sustainable, cost-effective manner.

Psychosocial Support: – Before, during and after death of parents or guardians, orphans and vulnerable children need support to come to terms with effect of changes in parents' emotional and physical state; sense of loss, grief, hopelessness, fear and anxiety. Psychosocial support is important to avoid or prevent the long-term effects, which include psychosomatic disorders, chronic depression, low self-esteem, underdeveloped life skills, learning disabilities, and disturbed social behavior.

Education: – Education plays a vital role in the well being of children. It not only offers them a chance for their future but also provides developmental stimuli. Ways to improve access to education should include accelerating actions to ensure that universal education is available to all children; negotiating with schools to allow the most needy children access to education; and educating staff and students about HIV/AIDS. Educational activities need to be linked to other interventions such as nutrition and psychological support and to develop a holistic program that influences a child's ability to attend school and maximize the benefits of education.

Human Rights: – Human rights-based approaches in programming are essential for the success of HIV prevention and care programs, including those for OVC.

Governments, NGOs and other service providers have committed themselves to respecting, protecting, facilitating and fulfilling human rights by ratifying human rights treaties, e.g., Convention on the Rights of the Child (CRC) (Seroney & Pfahler, 2004).

2.5 Child Right Principles, Strategies and HIV/AIDS

The United Nations Convention on the Rights of the Child and other relevant human rights instruments guide all actions in support of orphans and vulnerable children, in the recognition that development is the realization of a set of universally applicable, inalienable rights. This approach recognizes that children are both rights holders and participants; they are not merely the recipients of services or the beneficiaries of protective measures.

The Convention on the Rights of the Child affirms that the family has primary responsibility to protect and care for the child, and that governments have the responsibility to protect, preserve and support the child-family relationship. The

Convention also specifies the responsibility of the State to provide special protection for a child who is deprived of his or her family environment (UN, 1990).

Child Right Principles

According to the United Nations CRC, the underlying values – or 'guiding principles' – of the Convention, which influence the way each right is fulfilled and serve as a constant reference for the implementation and monitoring of all efforts to fulfill and protect children's rights are: Best interests of the child, Non-discrimination, Right to survival, well-being and development, and Respect for the view of the child (Ibid).

Key Strategies for the Protection and Care and Support OVC

According to the framework developed by UNAIDS (2004) for the protection, care and support of OVC living in a world with HIV/AIDS, the five strategies outlined below are intended to target key action areas and provide operational guidance to governments and other stakeholders as they respond to the needs of orphans and vulnerable children. These strategies are to be implemented hand in hand with efforts to prevent the further spread of HIV, the loss of parents to AIDS and other causes of child vulnerability. The strategies are:

1. Strengthen the capacity of families to protect and care for orphans and vulnerable children by prolonging the lives of parents and providing economic, psychosocial and other support.
2. Mobilize and support community-based responses.
3. Ensure access for orphans and vulnerable children to essential services, including education, health care, birth registration and others.
4. Ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to families and communities.
5. Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS (UNAIDS 2004).

2.6 Brief Overview of Current Responses or Programs for OVC

2.6.1 Government Response to OVC

A national task force on HIV/AIDS was established in 1985. Two medium term prevention and control plans were designed and implemented between 1987 and 1996. With the increasing rate of infection and the worsening of its impacts, the government of Ethiopia has developed a national policy on HIV/AIDS. The policy is designed to guide the implementation of programs to prevent the spread of HIV, to care for AIDS patients and to reduce the adverse socioeconomic consequences of the pandemic.

The policy calls for information, educational and communications programs to inform the population about the risks of HIV infections and to encourage people to adopt protective behaviors. The Ministry of Health takes the lead in providing materials, guidance and support, but it is indicated that the community at large must assume the responsibility for carrying out the program through mass organizations, professional associations, religious groups, government agencies, and non governmental organizations.

The national HIV/AIDS prevention and control secretariat was also established in April 2000 the head of which is the president of the federal democratic republic of Ethiopia. Following this, in June 2001 a strategic frame work for the national response to HIV/AIDS in Ethiopia (2001 – 2005) was formulated. The strategic framework has ten components.

The strategic framework also lays out the institutional arrangements through which the strategies are implemented. The national HIV/AIDS council (NAC) is the federal level bureau, which is composed of members of the government, sector ministries, religious organizations, non-government organizations, the private sectors, and people living with the virus. Under the NAC, there are the national HIV/AIDS secretariat, national advisory board, and national review board each entrusted with different responsibilities. The NAC has structures going down to regional, woreda and kebele levels.

The framework emphasizes that HIV/AIDS is not only a health issues but also developmental and security issues, and calls for a multi – sectoral approach and the

inputs of all stakeholders. It also reiterates the importance of monitoring and evaluation and lists down strategies for effective and proper implementation.

Though both the policy and the strategic framework realize that the growing number of AIDS orphans is a serious concern, none of them incorporate measures that should be taken to alleviate the problems (MOLSA, 2003).

Besides, the (draft) Ethiopia OVC RAAAP Action Plan found that given the government's restricted resources, health and education programs are prioritized over social welfare programs (which are considered a more appropriate concern for NGOs rather than government). There is, therefore, no national government social safety net program for OVC and families affected by AIDS. While child-headed households have on occasion been targeted for food aid and data collection, it is by no means routine.

The most common form of government support to AIDS orphans is regular financial assistance to help meet basic needs and pay for school expenses. HAPCO and the Ministry of Labor and Social Affairs are the main distributors of this aid in various parts of the country. The government also provides some health care, institutional support to orphanages, and some assistance with education. Data supporting these initiatives, however, are difficult to come by and the exact number of AIDS orphans benefiting from these government services is difficult to pinpoint (MOLSA, 2004).

Furthermore, according to a 2004 *Country Index of Effort for Orphans and other Children Made Vulnerable by HIV/AIDS*, conducted by the Futures Group for USAID:

- The government of Ethiopia (GOE) had not yet adopted a policy specifically on OVC.
- The GOE has a National Action Plan in place for OVC made vulnerable by HIV/AIDS but there is no multisectoral coordinating structure to implement it. This plan does not yet estimate cost of implementation, specify funding and other resources, prioritize services and interventions according to urgency and need, or provide clear guidance to all ministries, NGOs and other stakeholders. (POLICY project/ The Futures Groups, 2004).

2.6.2 Community Response

Ethiopia's families, communities and NGOs are the frontline of defense for its millions of orphans, including1.2 million orphans due to AIDS. With little or no financial support from the GOE, families and communities are being forced to spend down their own meager earnings to support a swelling population of emotionally traumatized infants and children. Literatures indicated that this short-term remedy is beginning to fail as more and more families plunge deeper into poverty and community agencies are unable to meet orphan demands for food, clothing, shelter, education and psychosocial support.

With regard to local OVC Care giving Structures, *Iddirs* or *Afoacha* are community burial and support associations that have become important local structures facilitating the flow of services to OVC. Traditionally, *Iddirs* and A*foacha's* primary function has been to support families with funerals and burials. With the advent of the AIDS pandemic, however, their roles have shifted to include the support of vulnerable households, specifically widows and children. Today, *Iddirs* and *Afoacha* have expanded to provide counseling, home-based care, food support, income-generation activities, and small loans to members. These activities are often carried out through sub-*Iddirs*, largely consisting of women.

In urban areas, *Mehabers*, groups that are largely faith based (when members are all of the Orthodox faith), exist beside *Iddirs.* The *Mehabers* bring members together monthly to engage in social and community issues, sometimes raising funds for specific identified purposes. In rural areas, *Mehabers* are generally absorbed within the *Iddirs,* which have a stronger faith-based element. In Muslim communities, *Jamaa* are groups similar to *Mehabers* that also engage in social gatherings. *Iddirs* and *Afoacha* play a variety of roles within communities, and these roles will be expanded further to include more intentional care and support efforts for those affected by the pandemic, including OVC and caregivers (POLICY project/ The Futures Groups, 2004).

2.6.3 Faith-Based Organizations (FBOs) Response

According to the (draft) Ethiopia OVC RAAAP Action Plan, many religious institutions provide assistance to OVC in the form of regular allowances through sponsorships and community endeavors. Today, the few church-sponsored orphanage programs that do exist are being dismantled and other types of programs are in need of support in order to build the kind of capacity that would support an expanded national response. Although most of religious institutions tried to provide care and support to orphans in Ethiopia, their care and support package for OVC were limited and minimum (POLICY project/ The Futures Groups, 2004).

2.6.4 Non- Governmental Organizations (NGOs) Response

Both International and National Non-Governmental Organizations plays a vital role in providing care and support for OVC and their families or guardians/ care givers in addition to their roles played in the prevention and control of the pandemic. Literatures indicated that the contribution of these international and national NGOs in providing care and support is considerable but it is not comprehensive and has low coverage.

An important study by UNICEF in 2003, *Mapping of Care and Support Interventions in Dilla, Jimma, Gondar and Dire Dawa,* revealed that in at least these four regions, OVC care and service delivery is operating at a crippling level. Some of the major findings from the UNICEF Mapping study include:

- Psychosocial care for OVC is the most neglected dimension of the care provided to OVC in the four study regions. Counseling to caregivers is almost non-existent.
- Coordinating bodies at the regional and district level were understaffed, under-funded and lacking in the technical expertise necessary to carry out complex logistical operations.
- The absence of a national OVC framework and operational manuals for delivering care and support to orphans has resulted in erratic service delivery.
- No criteria exist to identify and select eligible beneficiaries for care and support.
- The absence of a clearly defined minimum quality of care package for OVC and home-based care services has resulted in erratic and potentially conflicting care and support service delivery.

- Local community involvement in OVC care is almost insignificant in the four areas studied. The scope and degree of the OVC issue is not fully appreciated by key actors at both the coordinating and implementing level. (UNICEF Mapping Document cited in POLICY project/ The Futures Groups, 2004)

Furthermore, the (draft) 2004 Ethiopia OVC RAAAP Action Plan reveals similar findings. Major gaps include the absence of a national OVC policy, an inability to bring existing policies into operation, pervasive poor coordinating mechanisms, and insufficient legal protections for orphans. The report states that governmental and NGO assistance to OVC is "limited, fragmented and discontinuous." NGOs characterize their work as having "lack of guidelines standardizing support for OVC, deficiencies in providing psychosocial care for children, and absence of effective forums and networks. Nationally, representative data on the well-being of OVC is lacking." (MOLSA, 2004).

III. METHODS AND PROCEDURES

In this chapter, the methods used in the study are described. The sampling procedures and its variant forms together with their rational have also been presented. The description of the tools and techniques, methods used to analysis data and ethical consideration during data collection are also discussed.

3.1 Study Design

A descriptive survey research method was employed for this study. In this study OVC, their guardians/caregivers, representatives of GOs, CBOs, NGOs and FBOs participated. The study employed mainly quantitative research method to make description and analysis of the existing psychosocial status of OVC, and qualitative research method was also used to analysis the perception of guardians to the situation of OVC and the responses of the selected service provider organizations on the problem under study.

3.2 Sources of Data

The source of data for this study comprised of both primary and secondary sources of information. Primary data were collected by using various data collection instruments or tools. To supplement the primary data, available relevant secondary sources from different sources were reviewed & embodied in to enrich the study.

3.3 Participants

Eighty-eight Orphan and Vulnerable Children between 11-18 years old, 40 caregivers from the sampled OVC and 4 representatives from the service provider organizations, which give care and support to OVC, were the participants of the study.

3.4 Procedures

Data for this research were obtained from different sources. They were obtained from OVC, guardians of OVC and representatives of service provider organizations who give care and support for OVC. A total of eighty-eight OVC, 40 guardians of OVC and 4 representatives of the organizations, which provide care and support to OVC participated in the study.

Purposive and available sampling technique was used to choose the subjects of the study. To determine the sample size of the participants of the study, OVC, the list of all OVC (1337) who are beneficiaries of the two organizations (NGO & FBO) were taken as a sampling frame. From this sampling frame, with the help of the organizations, 88 OVC selected (48 female and 40 male) purposively on such variables as OVC who get care and support service provisions, aged 11-18, and their willingness to participate in the study was the criteria to select orphan and vulnerable children.

For the interview, 40 available OVC guardians from the sampled OVC, and 4 key informants from the selected four service provider organizations were purposely selected based on their knowledge and experience to OVC care and support as respondents.

3.5 Consent and Ethical Consideration during Data Collection and Analysis

Because of the nature of the problem, the stigma and human rights, & issues surround HIV/AIDS; the highest ethical standards were upheld during data collection and analysis. This is because study participants may experience psychological, social, physical or economical harm during the process of data collection or afterwards through dissemination of the study results. By considering this, the study was undertaken informed verbal consent obtained from the respondents. Children were only allowed to participate in the study when supported by parental or caregivers' permission. When the caregiver consented, but the child refused to give consent, the researcher was not proceeding with the process and that child did not participate. After informed consent was obtained from the participants, the process of data collection was conducted in a scheduled place and time to avoid distraction and to maintain confidentiality and privacy. To protect the identity of respondents, the names of participants and organizations are not mentioned.

3.6 Instruments

To obtain reliable and objective information, data were collected through different data collection methods. For this purpose questionnaire, interview and personal observation guidelines were developed. The instruments were developed by adopting the already

existing instruments of FHI OVC psychosocial survey (FHI, 2003). The instruments were first modified in English (by the author) and then translated to the local language-Amharic by a language expert to make it easily understandable to the respondents. To ensure the easily understandable nature of instruments and to make corrections of misleading and unclear questions, if any, a pilot study was done a few days before to the actual data collection from 8 OVC, 2 Guardians of OVC and 1 service provider organization representative in similar settings. The pre-test helped the researcher in modification of questions and dropping of irrelevant questions.

I. ***Questionnaire***: - this part contains close and open-ended questions. The quantitative assessment of the psycho- social issues was carried out among 11 to18 years' old children who are orphaned or vulnerable and living within parent's/guardians' households in the selected sub city area, where the selected organizations are currently operating. The study utilized three data collectors to administer the questionnaires. Topics that covered in the 11-18 year olds questionnaire were: demographics characteristics, psychosocial and related issues.

II. ***Structured and semi-structured interview:*** These were used to collect data from the guardians of OVC and the representatives of the organizations. Most of the interview items prepared for the caregivers were structured. Whereas for the representatives of the organizations, semi-structured interview items were prepared.

III. ***Observation:*** In the process of data collection, the researcher observed resources/services available, and the physical and emotional conditions of OVC. The observation data contributed to a more accurate context that makes it possible to interpret the meaning of analysis variables or indicators.

3.7 Data Organization and Analysis

The collected data is organized in line with the objective of the research. In this process both quantitative, primary descriptive method, i.e. percentage and qualitative analytic procedures were used. The qualitative information collected through interview and observation were organized and summarized thematically and presented in descriptive manner in the analysis and discussion part of this research.

IV. FINDINGS AND DATA PRESENTATION

This chapter deals with the findings and presentation of data gathered from OVC, guardians and service providing organizations. Based on the responses obtained from the sample respondents, the findings of the data are presented along with each table.

4.1 Results from OVC Respondents

Table 3: -Socio- Demographic information of OVC Respondents

Socio demographic variables		**Number**	**Percent**	
Age	11-14	50	56.8%	
	15-18	38	44.2%	
	Total	88	100%	
Sex	Male	40	45.5%	
	Female	48	54.5%	
	Total	88	100%	
Parental situation				
Maternal orphan	Male	2		
	Female	4		
	Total	6	6.8%	
Paternal orphan	Male	4		
	Female	8		
	Total	12	13.6%	
Double orphan	Male	34		
	Female	36		
	Total	70	79.6%	
Grand total	Male	40	45.5%	
	Female	48	54.5%	
	Total	88	100%	
Education				
Whether OVC ever attended school?				
Yes		68	77.3%	
No		20	22.7%	
Reason for not attending school				
Death of parents		5	25.0%	
Financial problem		15	75.0%	
Currently attend school				
Yes		78	88.6%	
No		10	11.4%	
Reason for not currently attending school				
Death of parents		2	20%	
Financial problem/		6	60%	
Illness		2	20%	

Type of schools attended			
Government	56	71.8%	
Private/community	22	28.2%	
Current grade level			
1-8	44	56.4 %	
9-12	34	43.6%	

4.1.1 Socio Demographic Characteristics of Respondents (OVC)

Regarding the socio - demographic information of OVC as it shown in Table 3, a total of 88 OVC from the ages 11 - 18 were asked of which 54.5% were female and 45.5% male. Of the total 88 respondents, 79.6% were double orphans, 13.6% were paternal and 6.8% were maternal orphans. The average age of the respondents was 14.

In relation to their educational background, when asked if they had ever attended school 77.3% of the OVC indicated that they had attended and 22.6% had never. Of those that never attended school, the following reasons were given: 25% cited their parents/guardian death, and 75% mentioned that they had financial problems.

Findings from the study also showed that majority of the children 88.6% were attending school at the time of the study. Concerning the type of school they attended Government schools were attended by 71.8% of the OVC and Community/private schools by 28.2% children. The highest educational levels attained by most OVC were primary 56.4% and secondary 43.6%.

4.1.2 Psychosocial Conditions of OVC

To examine the social interaction & conditions of OVC in the household and find out the major psychological & emotional experiences or problems that orphans and other vulnerable children are facing, data were collected from the respondents (OVC) in terms of their relationship and living condition, feelings about siblings' separation, Communications in the household, children's feelings and life changes after the death of parents and their emotional well being. The results of the findings were presented as follows.

Table 4: - Household relationships and living condition of OVC

Socio Demographic variables	Number	Percent	
Current relationship with guardians			
Mother	4	4.5%	
Father	2	2.3%	
Aunt/uncle	20	22.7%	
Grand parent	34	38.6%	
Sister/brother	18	20.5%	
Neighbors and others	10	11.4%	
Total	88	100%	
How OVC acquainted with guardian before moving in /how well do OVC know their guardians prior to moving in			
Very Well	62	70.5%	
A little bit	12	13.6%	
Not at all	8	9%	
I don't know	6	6.8%	
Treatment by guardian			
Roughly	14	16%	
Fairly	20	22.7%	
Caringly	48	54.5%	
Other (I don't know…)	6	6.8%	
Treatment by other children in the Household			
Roughly	22	25%	
Fairly	24	27.3%	
Caringly	28	31.8%	
Other (I don't know…)	14	16%	
Extent of happiness of OVC in current home/How happy/unhappy living in this household			
Sad/unhappy, Sorrowful, Worried, Scared, Isolated/alone	48	54.5%	
Happy/contented, Comforted …	74	84%	
Other (I don't know…)	4	4.5%	
What should be done/improved by guardians			
Materials support (food, clothes, ..etc)	26	29.5%	
Educational support (school fees ..etc)	38	43.2%	
Emotional support	20	22.7%	
Nothing	4	4.5%	

Concerning OVC current relationship with guardians, OVC were asked how they were related to their guardian, 4.5% of the children responded that their guardian was their mother, 2.3% said that it was their father, another 38.6% stated that it was their grandparent, 22.7% said their aunt/uncle, 20.5% their own brothers/sisters.

Regarding the question on how well did the children know their current guardian before to live with them, about two thirds (70.5%) reported that they had known their guardians *very well* prior to staying with them. Of note is the fact that 9% of the OVC did not know their guardians at all, while 13.6% of the OVC reported that they had known their guardians a little prior to staying with them.

Regarding on how guardians and the other children treated OVC in the household, more than half (54.5%) of the OVC reported that their guardians treated them *caringly*, while 22.7% and 16% of the OVC reported that they were being treated *fairly* and *roughly respectively*. On the question how guardians treated OVC in relation to their own children, less than a third 63% reported that they were treated better and the *same*, and 17% said they were treated *worse* compared to the biological children. The rest of OVC reported that our guardians do not have their own children. Regarding treatment by other children in the household, again more than a quarter (31.8%) revealed that being treated caring, 27.3% fairly and only 25% said they were treated roughly.

On the question of level of satisfaction with their living conditions, 84% of the OVC felt happy, contented and/or comforted about living in their current household. Fifty four per cent reported that they feel sad/unhappy, sorrowful, worried, and/or isolated/alone. An open ended question was also asked for OVC in relation to their life changes since moving into the new household, and almost half of the orphans 50% reported that nothing had changed in their life since moving into the new household while more than a quarter 32% reported that they had less food/clothes as an individual, and their school grades had declined or worsened.

With respect to the expectation of OVC that the guardians should provide or improve, as shown in the above table the majority of OVC expected that their guardians should provide or improve on the provision of material things such as food, clothes and school fees while 23% of OVC expected that their guardians should also provide emotional support.

Table 5: - Children's feelings about siblings' separation

Socio Demographic variables	Number	Percent	
Do you visit your brothers /sisters or the other children who used to live with you but now live away from this home?			
Yes	34	38.6%	
No	40	45.4%	
Other (e.g. live together)	14	16%	
Feelings of Being Separated From Brothers, Sisters & Other Children			
Sad/unhappy, Sorrowful, Worried, Scared, Isolated/alone	94	106.5%	
Happy/contented, Comforted, Resolute	8	9%	
Other	26	29.5%	
Perception of how OVC thinks siblings feel about separated			
Sad/unhappy, Sorrowful, Worried, Scared, Isolated/alone	62	70.5%	
Happy/contented, Comforted, Resolute	12	13.6%	
Other	32	36.4%	
How they spend their free time			
Being with friends& playing Football, other sports, physical activity	46	52.2%	
Games non-physical	6	6.8%	
Go to church	20	23%	
Being with family	4	4.5	
Reading	30	34%	
Taking drugs			
Other (working household chores)	4	4.5%	

On the question of visiting their brothers/sisters who lived away from current home, about 38.6% of the children who lived elsewhere reported that they visited their brothers and sisters while 45.4% did not. And 16 % of them said that they live together with their brothers and sisters and they don't have their own brothers and sisters.

Regarding OVC feelings of being separated from brothers, sisters & other children and perception of how OVC thinks siblings feel about separated, of those who do not live together with their brothers and sisters almost all of the children reported that they feel (106.5%) sad/ unhappy, sorrowful, worried, scared and/or isolated/alone about being separated from their brothers, sisters and other children. And, almost 70.5% of the OVC's perceived that other brothers, sisters and other children also feel sad, unhappy, Sorrowful, and/or worried about being separated as well.

On the question how OVC spent their free time, Fifty two percent of the OVC spent their free time playing with friends football, other sports and any other physical activity, 34% spent their free time reading, 23% going to church, 5% spent their time being with family and 5% spent their time working household chores.

Table 6: - OVC Communication in the Household

Socio Demographic variables	Number	Percent	
Did your parents ever discuss their health condition with you before they died?			
Yes	16	18.2%	
No	60	68.2%	
Other (I don't remember)	12	13.6%	
Do you think parents/guardians should talk about their health condition with their children/dependants?			
Yes	76	86.4%	
No			
Maybe or in some cases	12	13.6%	
Reason why parents should talk about their health condition with their children			
They know the truth why parent died	22	25%	
They know what to do if parents die	18	20.4%	
They can prepare emotionally	20	23%	
They can prepare practically	28	31.8%	

Orphans and vulnerable children were asked regarding their parents' openness about their health condition, less than a quarter (18.2%) of the OVC reported that their parents had discussed their illness with them before they die, while the majority of OVC (68.2%) reported that their parents had not discussed their illness with them before they die.

An assessment was also made regarding OVC perception whether their parents should talk or not about their health condition with their children and why, almost two thirds of the children (85.4%) believe that their parents/guardians should discuss their health condition with them because they wanted to know why their parents died (25%). Other reasons were they needed to prepare themselves emotionally (23%), so that they know what to do when their parents die (20.4%), and that they can prepare practically (31.8%). While 13.6% of the respondents believed that their parents/guardians should discuss their health condition in some cases.

Table 7: - Children's feelings and life changes after the death of parents

Psychosocial Demographic variables	Number	Percent	
Perception of causes of parental death			
HIV/AIDS related death (TB, long illness)	50	56.8%	
Malaria	2	2.3%	
I don't know	34	38.6%	
Other	2	2.3%	
Total	88	100%	
How parental death affected the way the child feels about life			
Sad/unhappy, Sorrowful, Worried, Scared, Isolated/alone	138	156.8%	
Happy/contented, Comforted, Resolute	8	9%	
Other (I don't know)	6	6.8%	
Whether OVC still bothered by parents(s)' death			
Yes	54	61.4%	
No	34	38.6%	
Things bothering OVC due to parents' death			
Death of parents & reason for their death	18	33.3%	
Lack of material support (clothing, food, school fees)	12	22.2%	
Lack of emotional support (love, care…)	12	22.2%	
Loneliness, frustration	8	14.8%	
Stigma & discrimination	4	7.4%	
How OVC's life changed since parental death			
My school attendance has declined/stopped	2	2.3%	
My grades have worsened	18	20.4%	
I have to do more household chores	8	9%	
I have less food/clothes as an individual	12	13.6%	
Started school late	6	6.8%	
No shelter	4	4.5%	
I have to take care of smaller children	8	9%	
I have to take care of my parent	2	2.3%	
We have less food/money as a family	18	20.4%	
Nothing at all	28	32%	
Other (I don't know)	6	6.8%	
Whether OVC was left with any personal items by parents/property inheritance			
Yes	30	34%	
No	24	27.2%	
I don't know nothing	34	38.8%	
How OVC feels when they look at items			
Sad/unhappy, Angry	18	60%	
Happy/contented, Comforted, Resolute	12	40%	

According to the findings of the study, the majority of OVC stated that their parents' were deceased (79%). When they were asked what they thought was the cause of their parents death, 56.8% stated HIV/AIDS & related, other causes cited were malaria (2.3%), others (2.3%), and the rest of the respondents stated that they don't know the causes of their parent(s) death (38.6%).

When they were asked how the loss of their parents had affected their feeling about life, as shown in the above table the majority (156.8%) of the children said they were sad/unhappy, sorrowful, and/or worried by their parent(s) death.

In addition to their feeling, OVC were also asked whether they still bothered by parent(s) death and things bothering them due to parent(s) death. More than half (61.4%) of OVC reported that they were still bothered by their parents' death at the time of the study, the major things bothering them were death of parents (33.3%), lack of material support (clothing, food, school fees) (22.2%), Lack of emotional support (love, care...)(22.2%), stigma & discrimination (7.4%), and loneliness problem (14.8%).

The death of a parent can be a trying experience for children. The child often undergoes emotional and social change. OVC were also asked about their life change following the death of parent(s). Almost 32% of the OVC reported that nothing changed, while 20.4% of the respondent stated that their grades have worsened, 9% said that they did more household chores, 14% said that they got less food/clothes as an individual, 5% said that No shelter, 9% said that to take care of my parent.

Regarding whether OVC were left with any personal items by parents, the majority of the respondents (39%) did know nothing whether any personal items left for them or not by their late parent/guardian. Of those who were in possession of some special personal items from their late parents (34%), had various feelings stirred up within them when they looked at the items. Accordingly the majority (60 %) felt saddened, and/or angry while others felt happy, warm and/or contented (40%).

Table 8: - Psychological issues (emotions and experiences) as reported by OVC

Psychological Issues	Ratings	Responses	
		Number	Percent
Scary dreams/nightmares	Often	24	27.2%
	Sometimes	40	45.4%
	Never	20	23%
	Don't Know	4	4.5%
Feelings of unhappiness	Often	38	43%
	Sometimes	36	41%
	Never	14	16%
Fights with other children	Often	16	18.2%
	Sometimes	48	54.5%
	Never	22	25%
	Don't Know	2	2.3%
Feelings of loneliness or prefer to be alone	Often	26	29.6%
	Sometimes	30	34%
	Never	32	36.4%
Feelings of worry	Often	26	29.6%
	Sometimes	38	43.2%
	Never	24	27.2%
Frustrations	Often	22	25%
	Sometimes	46	52%
	Never	20	23%
Feeling happy	Often	44	50%
	Sometimes	36	41%
	Never	8	9%
Feelings of anger	Often	22	25%
	Sometimes	52	59%
	Never	14	16%
Fear of novel/new situations	Often	8	9%
	Sometimes	54	61.4%
	Never	24	27.3%
	Don't Know	2	2.3%
Trouble falling sleep	Often	14	16%
	Sometimes	40	45.4%
	Never	32	36.3%
	Don't Know	2	2.3%
Difficulty in making friends	Often	14	16%
	Sometimes	20	22.7%
	Never	52	59%
	Don't Know	2	2.3%
Feeling s of being hopeful	Often	42	47.7%
	Sometimes	28	31.8%
	Never	16	18.2%
	Don't Know	2	2.3%

Feelings of running away from home	Often	8	9%
	Sometimes	16	18.2%
	Never	54	61.3%
	Don't Know	10	11.4%
Refusal to eat at meal times	Often	14	16%
	Sometimes	36	41%
	Never	38	43%

As shown in table 8, a series of questions aimed at checking the emotional well-being of the respondents were asked. Each of the questions was set up to measure a range of possible psychological experiences from "Never" to "Often".

According to the responses of the respondents, 45.4% and 27.2% of them stated that they sometimes and often had scary dreams or nightmares while 41% and 43% of them were also confirmed that they sometimes and often unhappy respectively.

One manifestation of a child's emotional frustration may be fighting. The children in the study were asked how often they got into fights with other children. More than half (55%) of the OVC reported that they got into fights sometimes, with 18% often getting into fights. The children were also asked how often they preferred to be alone and had problems of making friends. About, 34% sometimes had loneliness problems while 30% often encountered loneliness. On the other hand, just fewer than a quarter (22%) of the respondents sometimes had problems making friends with 16% citing that they often had such problems of making friends.

Worry was most predominant among orphans and vulnerable children who had lost their parents. In this regard, close to three quarters (73%) of the OVC reported that they had sometimes or often worried. Regarding the questions what kind of things did they worry about, Children were mostly worried about death of parents (17%), about school learning (16%), their future life (14%), their loneliness (8%), and the rest were worried over nothing (20%), and didn't know what they worry about (25%).

On the other hand, almost half (50%) of the children reported they often felt happy and 41% indicated they sometimes felt happy. Their major reasons for feeling happy included living with relatives (23%), playing with friends (27%), learning their education (20%) going to church (12%) and I don't know (18%)

Concerning their feelings of frustration, anger, like running away from home, and how often they feel hopeful, seventy seven percent of the respondents were sometimes or often easily frustrated while 84% sometimes or often became very angry. Just under 30% felt like running away from home sometimes or often. More than two third (70%) of the OVC reported that they were sometimes or often afraid of getting into new situations, while 18% of the respondents never felt hopeful about the future. Regarding the question what made them felt hopeful, education was the most commonly cited source of being hopeful, followed by faith in God, and guardian's motivation.

As to the questions how often they had trouble falling asleep and refuse eating at meal times, about 61% of them sometimes or often, had trouble of sleeping, while close to 57% sometimes or often had appetite problems at meal times.

When asked what was something that the OVC like to do to be happy, almost 23 % stated I don't know, 20% going to school, 18% playing with friends, 11% going to church, and 8% reading.

4.1.3 Coping mechanisms of OVC

Table 9: - Coping strategies during parent(s)'illness & after death of parent(s)

Variables	Number	Percent	
What do you do usually when confronted with a problem			
Talk to somebody	35	39.8%	
Cry	12	13.6%	
I tried to Ignore it	28	31.8%	
Pray	27	30.7%	
Nothing (keep it to myself)	6	6.8%	
Who do you talk to when you have a problem or a worry?			
Guardian & Guardian's husband/wife/relative	28	31.8%	
Child's brothers/sisters	12	13.6%	
Friends, other children	13	14.7%	
No one, keep to myself	29	33%	
Other (Step- foster-siblings, uncle wife…)	6	6.8%	

The OVC were asked questions that addressed as to how they overcome some of their problems, what they usually did when they had problems and the people they talked to when they had problems. Table 9 shows some of the reported coping strategies. As seen

in the above table, 39.8% usually talked to someone, 31.8% of them said that they tried to ignore the problem, 30.7% of the OVC stated that they tried to pray, 13.6% of them cried, or/and 7% of them keep it to themselves when they were having a problem.

When asked about the first person the OVC talked to when they had a problem, about 33 % 0f the OVC reported that they keep to themselves rather than to talked to someone, 32% of the OVC talked to their Guardian & Guardian's husband/wife/relative, and equally important 14% of the OVC reported that they talked to their brothers/sisters as well as their friends.

4.1.4 OVC Access to Support Service

Table 10: OVC Access to Support Service

Socio demographic variables	**Number**	**Percent**	
Are you receiving any form of assistance from outside the family for your well-being?			
Yes	84	95.4%	
No			
I Don't Know	4	4.6%	
If you receive support (from organizations) how regular is the support			
Daily			
Once a week			
Once a month	70	79.5%	
Once in 3 months			
I Don't Know	18	20.5%	
Types/kinds of assistance received			
Financial assistance	18	20.4%	
Food Assistance	76	86.4%	
Education (School fee & other related costs)	52	59%	
Health Care	6	6.8%	
Clothing	8	9%	
Psychosocial support/counseling	10	11.4%	
Training (IGA)			
I don't Know	4	4.6%	
Do you think the support you receive adequate to meet the daily life of yours			
Enough	22	25%	
Non – enough	66	75%	
What kind of support do you need to bring life changes			
Educational support	32	36.4%	
Financial support	11	12.5%	
Food support	20	22.7%	
Psychosocial support	21	23.9%	
Nothing	4	4.5%	

As shown the above table, 95.4% of the OVC responded that they received support from institutions while 4.5% they don't know whether received or not. OVC were also asked how regular is the support, the majority of OVC 79.5% reported that they received support monthly while 20.5 % indicated that they don't know the regularity of the support.

With regard to the type of support that was reportedly received by OVC, the most commonly cited was food 86.5%, followed by educational support 59%, financial support 20.4%, psychosocial/counseling support 11.4%, clothing support (9%), and/or health care support (6.8%).

The adequacy of the services rendered OVC was also explored in this study. The majority of OVC (75%) mentioned that the service rendered for them were not adequate, because they received only 25 kilo white, one liter oil per month and few school materials biannual.

On the question what kind of support they need to bring life changes, the majority cited educational support 36.4%, followed by food 23.9% and psychosocial support 22.7%.

4.2 Findings from Guardians

In this section of the paper the Socio- Demographic information of Guardians, Perception of guardians about OVC situations and related issues are presented.

Table 11: -Socio- Demographic information of Guardians Respondents

Socio demographic variables		**Number**	**Percent**	
Sex	Male	4	10%	
	Female	36	90%	
	Total	40	100%	
Age	Below 18	2	5%	
	19 – 64	36	90%	
	65 & above	2	5%	
	Total	40	100%	
Marital status				
Single		4	10%	
Married		12	30%	
Divorced		10	25%	
Widowed/widower		14	35%	
Total		40	100%	
Whether attended formal school				
Yes		26	65%	
No		14	35%	
Highest level of school completed				
Primary		18	69.2%	
Secondary		6	23.1%	
College/university		2	7.6%	
Not attended formal schooling		14	35%	

Socio demographic characteristics of respondents (Guardians)

Regarding guardians, as shown in the above table, approximately the overall mean age was 41.5 years. Ten percent of the guardians were below 18 years and above 65 years. The majority of guardians 90% were in the 19 – 64 years age group. The sex distribution of those who responded in their capacity as guardians of OVC was predominantly female 90% with a ratio of almost nine females to one male. Almost 35% of the guardians of OVC were windowed, while slightly over a quarter 30% were married, 25% and 10% of the guardians of OVC were divorced and single respectively.

Regarding OVC guardians' educational level, more than 65% of the guardians had attended formal schooling while about 35% of the OVC guardians had no attended formal schooling. Of those guardians who had attended formal schooling, 69.2% of them had attended primary school, while 23.1% and 7.6%of them had attended secondary education and higher education respectively.

Household composition and reason for taking OVC

Data gathered from guardians on the number of children in the family, the average number of children per household aged 18 and below was five for both males and females. To examine the number of OVC with in each house hold, the number of OVC in the households ranges from 1 to 5. Of the guardians who had taken an OVC into their household, just Over a half (55%) mentioned the death of the parents of the OVC as the main reason for taking in these children. slightly above a quarter (30%) mentioned the fact that they have the only relative for taking the children, with only 15% citing "I am a parent" of the children as the reason for their taking them in.

Impact of HIV/AIDS on household following taking in OVC

From the assessment of the impact on the guardians' house holds after taking in OVC, shortage of food, shortage of money for educational and medical issues and increased financial expenditure on food were mentioned by the majority of the guardians, respectively, as the major impact on the house hold. Very few guardians reported that they lost their marriage since the OVC had been incorporated into the household.

Table 12: -Perception of guardians about OVC situations and related issues

Psychosocial Demographic variables	Number	Percent	
Have you seen an increase in the number of orphans and vulnerable children living in your neighborhoods			
Yes	27	67.5%	
No	13	32.5%	
Have you seen an increase in the number of families taking care of OVC in your neighborhoods			
Yes	26	65%	
No	12	30%	
I don't know	2	5%	
Main reasons that children are being OVC in the area			
HIV/AIDS	30	75%	
Accidental deaths	2	5%	
Tuberculosis	2	5%	
Other (I don't know)	6	15%	
Main needs for OVC			
Financial support	22	55%	
Food support	26	65%	
Educational support	24	60%	
Skills training	4	10%	
Medical support	8	20%	
Socio-emotional support	6	15%	
Other	2	5%	
Problems child may be facing			
Financial support	16	40%	
Food support	20	50%	
Educational support	18	45%	
Skills training	4	10%	
Medical support	8	20%	
Socio-emotional support	12	30%	
Other (shelter)	2	5%	

Perceptions of guardians about OVC situations

Guardians were asked whether they had noticed an increase in the number of OVC and families taking care of them in the past six months prior to the survey. The majority of guardians reported having seen increases in OVC living in the neighborhood 67.5%, while families taking care of OVC 65%.

On causes of orphan hood, the majority of respondents 75% singled out HIV/AIDS as their perceived main reason, followed by "I don't know" 15%, tuberculosis 5% and 5% believed it was due to accidental deaths.

The main needs of OVC from their guardians' perspective were food 65%, educational support 60% and/or financial support 55%. Some of the other needs mentioned were socio emotional support 20% and medical support 15%.

Regarding the guardians perception on the major problems for OVC they had taken in were food cited by 50%, educational support cited by 45%, financial support cited by 40% and/or socio emotional support cited by 30%. Concerning the major socio emotional problems of OVC facing as perceived by 20% guardians. They pointed out that OVC have problems of unhappiness, worry, lower level of patience/aggressiveness/, depression, feelings of hopelessness and pessimistic, avoiding people, disturbing others, loss of self esteem & confidence, anxiety, and/or stigma & discrimination.

Table 13: Guardians Perceptions of Appropriate Communication with OVC

Socio Demographic variables	Number	Percent	
Did you discuss sex with their children			
Yes	29	72.5%	
No	11	27.5%	
Did you discuss HIV/AIDS with their children			
Yes	28	70%	
No	12	30%	
Did you discuss sex and HIV within the family			
Yes	31	77.5%	
No	9	22.5%	
Did you believe that children need to talk about these issues			
Yes	38	95%	
No	2	5%	

HIV/AIDS and related issues Communication within the Household

Respondents were asked a series of questions aimed at establishing the extent of communication within their household, particularly with regards to discussion on sex and HIV/AIDS. Out of the total respondents, less than three quarters (72.5%) talked to children about sex. Almost a similar number of respondents indicated that they talked to the children in their household about HIV/AIDS. They were also asked whether they

talked about these issues in their families, 77.5 % of the respondents agreed. Correspondingly, almost 95% of the respondents to this particular matter felt the need that children should know about issues of sex and HIV/AIDS.

Table 14: - General livelihood issues and household access to support services

Socio demographic variables	**Number**	**Percent**	
Do you (the family) have any source of income for your family			
Yes	14	35%	
No	26	65%	
Ways of making ends meet			
Formal salary	12	30%	
Informal income	26	65%	
Support from relatives	2	5%	
Are you receiving any form of assistance from outside the family for the well-being OVC			
Yes	40	100%	
No			
Types/kinds of assistance received			
Financial assistance	4	10%	
Food Assistance	38	95%	
Education (School fee & other related costs)	28	70%	
Health Care			
Clothing			
Psychosocial support/counseling	4	10%	
Training (IGA)	8	20%	
Do you think the support you receive enough to meet the daily life of the family			
Enough	8	20%	
Non – enough	32	80%	

General livelihood issues and household access to support services

As shown the above table, 65% of the guardians reported that they had no their own source of income for their family, while 35% said that they had. Guardians were also asked on how they managed to make ends meet in their households. The majority of respondents stated informal income as the main source of household income (65%). Only 30% cited formal salary as their main source of income and another mentioned that donation and support from relatives.

Regarding the question whether they received any form of support from out side of the family for the well being of OVC, almost all of the guardians indicated that they received support from institutions monthly. With regard to the nature of support that was

reportedly received by guardians, the most commonly cited was food 95%, followed by educational support 70%, Training (IGA) 20%, psychosocial/counseling support 10% and/or financial support 10%.

The adequacy of the services rendered to guardians for OVC was also explored in this study. The majority of guardians mentioned that the service rendered for them were not adequate (80%), as they reasoned out " we get only 25 kilo of white and 1 liter of oil per month for the family.

4.3 Findings from Service Providing Organization

4.3.1 Current Program Responses of Service Provider Organization

In this section the background information of the service providing organizations and their current program responses to wards OVC are presented.

Table 15: - Back ground information of Service providing organizations and their responses to the situation OVC

Type of organization	No of OVC supported	No of OVC sampled	Type of service provided	Who provide the psychosocial service
Government organization	2000	--	Food, school material, psychosocial/counseling support	Trained volunteers
NGO	1074	69	Food, school material, health care, psychosocial/counseling support	Trained volunteers
FBO	263	19	Food, clothing, educational including school material, health care, skill training, psychosocial /counseling support	Professionals as well as trained volunteers
CBO	The number is not know exactly	---	Food, clothing, health care, school material & psychosocial support	Trained volunteers
Total		88		

To asses the responses of service providing organizations towards the psychosocial problems that OVC were facing in terms of the availability and accessibility of different services, data was collected from the above four different service providing organizations accordingly.

General Information

As indicated in the above table, Different service providing organizations that were working closely with OVC were included in the study. From many service provider organizations, one from each (Government organization, NGO, FBO, and CBO) organizations who providing care and support for OVC were taken as samples and experts, project coordinators and leaders of these organizations were as key informants to

collect data on the situation of OVC and their organizations responses towards the problems OVC were facing especially the psychosocial problems. As previously indicated the sampled organizations were selected purposely based on their focus and experience of work on OVC care and support. The OVC were selected from two organizations that are willing to take hold of the selected OVC. The names of organization and key informants were not mentioned here to keep the confidentialities of the organizations and respondents.

The objectives of the organizations are to prevent and control the prevalence of HIV/AIDS through different intervention mechanisms; one is provide care and support for those children who have lost one or both parents by HIV/AIDS.

In assessing the prevalence of OVC and what the representatives of organization are thought the main causes of orphan hood in the area. Almost all of the key informants reported that the prevalence of OVC in the study area is high. On what they thought were causes of orphan hood, the majority of key informants single out HIV/AIDS as the main reason for OVC, followed by poverty.

Type of Services they provide

The service providing organizations were asked to report on the types of care and support that they were implementing in support of OVC. From the analysis of responses provided by key informants, 7 different types of interventions were identified. Such interventions as reported by key informants include: food support, school material or educational support, clothing support, health care support, skill training, legal support, and psychosocial /counseling support (See the above table 15).

When this data is analyzed by the type of services they provide, the major share of interventions goes to material support (food and nutritional, school material/educational, clothing, health care support) respectively, followed by skill training, legal and psychosocial support which received low attention from service providing organizations at lesser extent.

Regarding the questions what type of psychosocial support they provided and who provided the service, the majority of the respondents reported that individual and group counseling, play therapy; except one service provider i.e. FBO, the rest of them provided the psychosocial support by trained volunteers through home to home visit. In addition to the researcher's observation, the majority of them believed that they do not have independent counseling centers to provide the necessary support to OVC.

Related to information on the type of psychosocial services they provided to OVC guardians, the key informant from all organization mentioned that there is no specific services provided for guardians' related to psychosocial, while two coordinators from organizations (FBO, NGO) pointed out that they only provide training in relation to HIV/AIDS & skill training. However the key informants stated that in the future they have the plan to provide the necessary counseling services and training related to psychosocial issues to OVC guardians in collaboration with other organizations who working on children.

Major program gaps:

As part of the data collection process, leaders/coordinators of OVC service giving organizations were asked to report on and describe the major problems encountered in the course of providing the service they provide especially the psychosocial service. Based on their responses and the findings described above, the major OVC service gaps are broken down into the following key issues. These include: the gap between the demand and supply of OVC services, absence of clear guideline, poor organizational strategies and program design, funding constraints, shortage of human resources, and low awareness on OVC psychosocial issues at all levels, and/or absence of strong networking. As they reported, these gaps are interwoven and often one is the cause of for, or the effect of the other.

Adequacy of the Services Offered for OVC

The adequacy of the services offered to OVC was also explored in this study. The data gathered from the key informants show that or as they reported, the services they rendered for OVC were not adequate and comprehensive, "because we can't do any thing from the resource constraints we have".

At the end, respondents were asked regarding their views to the best ways to take care of OVC issues regarding to the long-term psychosocial support to deal with their emotional pain surrounding the death their parents, the key informants were mentioned the following suggested solution as the best ways to support the OVC in the long-term basis. These are: control the prevalence rate of HIV/AIDS, provide psychosocial training to OVC guardians, provide life skill training for OVC, provide essential services to OVC, strengthen the counseling services, create awareness to the psychosocial problems of OVC at all levels, assess and identify the major needs of OVC before provide the support, create referral linkages and networking with different organization working in support OVC.

V. DISCUSSION

The study attempted to explore the psychosocial problems of OVC and the responses of service providing organizations towards the problems of OVC in Addis Ababa of Arada sub city.

In this part of the study, the major findings obtained using different data collection tools from the participants are discussed in relation to different research questions. The discussion part of the study attempted to focuses on the social interaction & conditions of OVC in the household, the major psychological & emotional experiences/problems that orphans and other vulnerable children are facing, guardians/caregivers perceptions regarding the problems of OVC, coping mechanisms of OVC, and service providers responses towards psychosocial problems and main perceived needs of orphans and vulnerable Children

Socio demographic characteristics of OVC

The sex distribution of OVC aged between 11-18 years in the study area was with slightly more females than males. As the finding of the study indicated, fathers were twice more likely to die than mothers is in line with other findings, which showed that there were more paternal orphans than maternal orphans (e.g. UNAIDS, 2004). The fact that the study also show that nearly 80% of the OVC had lost both parents means that a high proportion of the OVC in the study area have been deprived of parental care of support and such OVC in the end may turn out to be more vulnerable to psychosocial stressors of morbidity than those with either parent alive. They may therefore deserve special targeting by intervention programs.

In relation to the educational status of OVC, the findings of the study indicate that the majority of the OVC had attended and are still in school, while the fact that 23% and 11% of them reported that they had not and still not currently in school because of parental death and financial problem. Of course it is encouraging that the majority of the OVC attended their education, but service providing organizations should take note that some of the OVC were not attending school at the time of the study and they should therefore

design interventions programs to address problems that are usually associated with early school drop-out.

These finding also agree with previous findings (e.g. Salaam, 2005) which revealed that children whose both parents are die with HIV/AIDS might not receive the care and support they require, and may be frequently absent or tardy from school, find it hard to concentrate or unable to assume school-related expenses, such as school fees, uniforms, books and other school supplies (Salaam, 2005).

The Social Interaction & Conditions of OVC

The findings demonstrated that most of the OVC had their grandparents as guardians. Others had their mother and father, an aunt and an uncle. This may suggest that the traditional safety nets and family ties are still playing a pivotal role in the study area, as evidenced by the large proportion of OVC living with grand parents, parents and close relatives. However, notable is the fact that mothers constitute by far the largest proportion of guardians of OVC in the study area. This may also show that the burden of care and support lies more heavily on mothers than fathers. Therefore service provider organization should put in place strategies that support women in their care giving role.

Generally, the treatment of OVC by their guardians was good as reported by around 54.5% of the OVC questioned, and it is heartening to note that less than a two third (63%) reported that they are treated the same as the guardian's biological children & other children who were already in the household when the OVC moved in. It is important to note that about (16%) of the OVC reported that their guardians treated them badly compared to their biological children &other children already in the household. The results of the study also indicate that almost a quarter (23%) of the OVC revealed that other children in the household treated them badly. This may show that a number of guardians and guardians' biological children or other children already in the household merit some attention from those service provider organizations concerned with the importance of treatment and issues of child rights and neglect, which leads to social adjustment and psychological problems.

Considering that being an orphan was one of the indices for vulnerability in our study, it is encouraging that almost two thirds of the orphan reported that they felt happy about

living in their current household & that almost half reported that nothing much had changed in their lives since moving into the new household. This may also indicate that family ties are still playing a pivotal role in helping orphanhood children.

Concerning the number of brothers and sisters and other children living with in the same household, the results of the study which show that up to 84% of OVC had been separated from their brothers/sisters, while 16 % of the OVC had been living with in the same house hold; highlighting the problem of displacement and separation. Of those children who lived away from current home, 45 % of them did not visit their brothers and sisters. Accordingly, the findings of the study indicate that almost all the OVC feel sad/ unhappy, sorrowful, worried, scared and/or isolated/alone about being separated from their brothers, sisters and other children. This may indicate that displacement and separation may very well be risk factors for psychosocial vulnerability. Therefore this calls for the strengthening of family and community safety nets that allow orphans to stay together with their siblings in their original house hold or, at the very least, move with their siblings if they are to be absorbed into other households. The above finding goes with the findings of Rusakaniko.S & et al. (2006), which revealed separation of siblings traumatizing and cause social and emotional insatiability leading to loosing family ties and possible identity crisis.

The study has shown that the majority of OVC engaged in different recreation activities that brought them into social contact with other children, implying that stigma and discrimination were not major problems among children in the study area.

OVC were asked regarding their parents openness about their health condition. The study has shown that the majority of OVC reported that their parents had not discussed their illness with them before they die, while the majority of the OVC were of the opinion that parents should talk about their illness with their children. While on one hand children feel talking would help them in a variety of ways, such as helping them to know the truth why parents died, prepare emotionally and practically for the parents(s)' death. This implies that parents seem reticent to open up about their illness. Therefore, it is important and

necessary that program interventions should undertaken activities to motivate parents to talk about their health conditions during their sickness to their children to protect them form different psychosocial reactions after their death.

Generally, displacement and separation, isolation, lack of communication and attention, and maltreatment are some of the social problems OVC are facing. In addition to the tragedy of losing their parents and the insecurity living condition, they suffer from psychological and emotional problems because of the maltreatment, reticent less of parents and siblings separation. In accordance with this idea, a study conducted by MOLSA (2003) stated that AIDS seems to have a negative impact on children's socializations with respect to their identity, understanding and participation. Children affected by AIDS may feel a sense of alienation, stigmatization and isolation. This is a matter of concern, as not only it is a child rights violation but also as childhood, it is associated with reduced productivity in later life (Stefan, 2002).

The major psychological & emotional experiences/problems of OVC

Children experiences of psychological problems cannot be separated from the wider context of their lives. Since HIV infection progress from initial infection to mild HIV related illness to the life threatening illness children can live with long periods of uncertainty intermittent crisis, as both parents slowly get sick and die.

Hence, parental death appears to have long-term negative psychological effects on most children. In line with this the findings of the study indicated that, a significant proportion of the OVC took in the study reported experiencing a range of negative psychological and emotions problems such as they often and some times having scary dreams, feeling unhappy, being afraid of new situations, difficulties falling asleep, fights with other children, feelings of loneliness or prefer to be alone, feelings of worry, feelings of frustrations, feelings of anger, difficulty in making friends, feelings of hopelessnes and refusal to eat at meal times. Although these indices of psychosocial morbidity may not be as conspicuous as psychotic symptoms, they are nevertheless important, as they are disturbing. They are important because they are indicators of hidden psychological morbidity & they are disturbing when one considers that about a fifth of the OVC reported experiencing them often enough. This should clearly serve as a red flag that

prompts all those concerned with the welfare of OVC in the study area to take note of the significant psychosocial burden with which their charges are dealing.

Regarding OVC feelings and life changes after death of parents, the findings of the study showed that, about 57% of the OVC thought that the cause of their parental death was HIV/AIDS, more than half (61%) of the OVC were still bothered by their parent(s) death. In addition to this, the majority of OVC indicated that their life and feeling about life changed or affected due to parent(s) death. These indicate that the death of parent(s) can be a traumatic experience for children and they might need assistance in coping and dealing with their problems.

These findings also almost consists with the previous study carried out in Ethiopia by Save the Children Denmark (2002) and Belay and Belay (2005), which showed that because of death of parents children can go through some trying experiences and their life also changes.

Guardians/Caregivers Perceptions Regarding the Problems of OVC

Regarding the guardians perception on the situation of OVC, the findings of the study revealed that, the majority of guardians perceived that the number of OVC in the study area was increasing and the death of parent(s) due to AIDS is mentioned as the biggest factor for the presence and increasing number of OVC. This implies that, guardians of OVC have adequate awareness on the prevalence of HIV/AIDS is high and AIDS related deaths are the main reason for the presence of OVC in the study area. This finding confide with Belay and Belay (2005) psychosocial survey on OVC in Addis Ababa and Gondar, which revealed that there is an increase trend in the number of orphaned children in most areas of the country and HIV/AIDS as a prime cause for the rise in the number of OVC.

Concerning the guardians perception on the impact of HIV/AIDS in the household, the majority of guardians reported shortages of money and food, as well as increased financial expenditure after taking in OVC is a clear sign that the taking in of OVC has significant impacts on the guardians household, most likely due to an increase in the dependency burden on the guardians. It is not surprising that the major reasons cited by guardians for taking in OVC were the death of OVC's parents. These indicate guardians

of OVC perceive that HIV/AIDS has created a great impact on families who looking after OVC, besides the increasing number of OVC in the study area. Interventions thus need to be put in place to mitigate against these impacts.

The finding of guardians in the study also demonstrated that, the main needs of the OVC as perceived and reported by their guardians were food (65%), educational support (60%), financial support (55%), socio emotional support (20%) and medical support (15%). These are the same as the main concerns that the guardians had with respect to the OVC they had taken in. Regarding the guardians perception on the major problems for OVC they had taken in were food cited by 50%, educational support cited by 45%, financial support cited by 40% and socio emotional support cited by 30%. This indicates that except few, the majority of guardians have low perception and lack basic skills in recognizing children's psychosocial reactions/needs. This finding is in line with International HIV/AIDS Alliance Report (2003), which revealed that in many cultures there is little understanding of children's psychosocial problems by caregivers. The report also indicates that the viable social and economic impact of AIDS on children often hides the less visible but severe psychological consequences children experience due to the impact of AIDS in their lives. Thus, implementation of interventions should be targeting the whole areas of needs, concerns and problems OVC for their all rounded well being, especially the psychosocial.

As demonstrated by the nature of responses by guardians to questions on communication with household on sex and HIV/AIDS issues there appeared to be reasonably good communication.

While it is true that the majority of respondents believed that children should know about sex, HIV/AIDS and related issues, it is interesting to note that fewer guardians actually not to talk to their children about such issues. Thus, although their attitudes towards educating OVC on sex, HIV/AIDS and related issues are positive, such positive attitudes do not necessary translate into free discourse on these issues between guardians and their charges, underscores attentions by intervention programs.

Only about a quarter of the guardians reported that they had told the OVC the cause of their parents' death. Probable reason could be related to stigma surrounding HIV and AIDS, now this could affect the child concerned psychologically.

In general, we can conclude that the majority of the guardians perceived that the prevalence of HIV/AIDS and the presence of OVC in the study area widespread. Guardians' also have positive attitudes towards educating OVC on sex, HIV/AIDS and related issues. They also perceived that HIV/AIDS has created many impacts on children and their families and because of parental death many children facing different material and psychosocial problems.

Coping Strategies of OVC

OVC are vulnerable to different psychological problems unless they get caring and understanding families. If families who can create conducive and supportive environment take in these OVC, they may accept the reality and resilience. In relation to this the findings of the study indicate that the majority of children talked to their guardians and relatives when they had a problem. It is encouraging to note that the majority of OVC did not bottle things up but rather talked to somebody. However, there were about 33 % of the children who did not talk to anybody they keep to themselves when they had a problem. For children in this age ranges that are unable to talk to someone about their problem may mean that they do not trust others in solving their problem.

Regarding the mechanisms they utilized when confronted with a problem the findings of the study also showed that, the majority of the OVC interchangeably used pray, ignorance, talk to some body and cried as the major coping strategies to confront their problems.

OVC Access to Support Service

Regarding OVC access to support services, the majority of OVC indicate that they received support from institutions monthly. Concerning the nature/kind of support they received the majority of the OVC cited food and educational material supports are the major supports they get. Only 11.4 % of the OVC got psychosocial support. This indicate

that the major services of the service provider organizations goes to material support rather than psychosocial, which give lower attention for psychological and social support. The majority of the OVC also reported that the service they got from institutions was inadequate, and they also reported that they need educational, psychosocial and food support for their well-being. This attributed to the service provider organizations give attention for comprehensive support, especially for educational and psychosocial support needs of OVC.

Current Program Responses of Service Providing Organizations on the Psychosocial Conditions of OVC

The findings from the service providing organizations on the situation of OVC demonstrate that HIV/AIDS pandemic is killing a lot of people and the prevalence of OVC in the study area is on the increase, as indicated by the large proportion of the respondents. They also reported that HIV/AIDS, together with poverty, were the major causes of Orphan hood. This could be attributed to the fact that the problem of HIV/AIDS was getting worse in the study area, with most of the respondents reporting. How ever, it is encouraging that there are a number of service provider organizations, which largely aware of the situation of OVC in the study area and staring to provide care and support service in support of OVC.

When analyzed the type of services the service providing organizations provided to OVC, the findings of the study show that the major share of interventions goes to material support, followed by health care, legal and psychosocial support, which received low attention from service providing organizations at lesser extent. This may indicate that the type of care and support they provide is not compressive and focus on material needs. In support of this finding, the International HIV/AIDS Alliance organization in its' report (2003) revealed that most programs regarding orphans and vulnerable children in Africa focus on material support and meeting children's physical needs. Relatively few programs consider the psychosocial effects on children of having HIV, caring for a sick parent, living in a household affected by HIV/AIDS or losing one or both parents.

Regarding the type of psychosocial support they provided to OVC and their guardians, as understand in the findings of the study, the majority (75%) of the organizations do not provide the necessary and formal psychosocial support to their beneficiaries. This is because the majority of the service provider organizations who included in the study did not have counseling centers and trained professionals to provide the support. This may imply that the psychosocial support for OVC and their guardians is the most neglected and give low attention by service providing organizations. The finding of this study agree with studies conducted by UNICEF (2003) indicate that in many regions of the country, psychosocial care for OVC is the most neglected dimension of OVC care and support provided.

On the other side, the majority of the respondents admitted that the services they rendered for OVC were not adequate and they have major program gaps due to the demand and supply of OVC services, absence of clear guideline, poor organizational strategies and program design, funding constraints, shortage of human resources, and low awareness on OVC psychosocial issues at all levels, absence of strong networking. These may indicate that there is poor communication and coordination between grant makers and service provider organizations. It also implies that most service providing organizations in the study area are not acquainted with resources within the community to provide a sustainable community based intervention for both preventive and curative. Therefore, as key informants suggested, service providing organizations has many expected roles to encourage and support communities to design appropriate interventions on the problems of OVC, to strengthen the capacities of families to care for their OVC, to create referral linkages and networking with different organizations working in support OVC, to create awareness to the psychosocial problems of OVC at all levels, to assess and identify the major needs of OVC before providing the support, and control the prevalence rate of HIV/AIDS.

VI. CONCLUSIONS AND RECOMMENDATION

6.1 Conclusions

This study tried to explore some aspects of the psychosocial problems of OVC, and the responses of service providing organizations on the problems of OVC in the case of Arada sub city, Addis Ababa. Data were collected from 88 OVC, 40 guardians who look after the selected O VC a nd 4 representatives from the organizations who provide care and support for OVC. Using questionnaire, interview and personal observation guides data were collected from the above participants. Under the above superseding objective, the study attempted to describe the impacts of HIV/AIDS on children and their families, to find out the social and psychological conditions of OVC, to assess guardians/caregivers perceptions regarding the problems of OVC, to investigate the coping mechanisms adopted by OVC for their well being and to assess the responses of service providing organizations to wards the problems of OVC. In this section based on the findings of the study the following conclusions could be presented.

The findings of the study with regard to the prevalence and impact of HIV/AIDS on OVC in the study area leads to the conclusion that the magnitude of the problem of OVC in the area is high or increasing from time to time as evidenced by the presence of large number of OVC in the study area due to death of parents by HIV/AIDS, as the biggest factor.
The results of the study also indicate that besides increased numbers of children, whose parents have died due to HIV/AIDS, HIV/AIDS has also created economical, social and psychological impacts in the house hold in which OVC lived in. Extended families in the study areas are also often hard –pressed to care for all the children, which increases another burden in the household.

The psychosocial problems of OVC begin long before their parents die. Children suffer the emotional effects of seeing their parent's illness and also more vulnerable to psychosocial problems because of parental death. Concerning the social adjustment and psychological problems that OVC were facing the findings of the study brings about the following conclusions.

- As identified by the study, lack of attention and communication, maltreatment, displacement and separation from siblings and familiar environment, being abused, low dropping out of schools, and feelings of alienation and isolation are some of the social problems that OVC are facing.
- The results of the study also revealed that, because of parental death a significant proportion of the OVC took in the study are often experiencing a range of negative psychological and emotions experiences like depression, grief, feelings of loneliness or prefer to be alone, feelings of worry, feelings of frustrations, feelings of anger, feelings of hopelessness, lowered self esteem, which have a great influence on their overall development and well-being.
- Moreover as identified by the study, the death of a parent can be a trying experience for children. The child often undergoes emotional and social change. The life of OVC changed following the death of parents. Hence, it was found that, most of OVC have declined their school performance, do more household chores, they got less food and clothes, take care of small children and difficulties to fulfill school fees and supplies, which can have a direct impact on the child's psychosocial development and feelings about life.

The findings of the study with regard to the guardians' perception on the problems of OVC in the study area leads to the conclusion that guardians perceived that the prevalence of OVC in the study area was rampant and severe and the death of parent(s) due to AIDS is the number one cause or the biggest factor for the presence and increasing number of OVC. Guardians of OVC also perceived that the main problems that OVC facing are food, educational support and financial problems, nevertheless they have low awareness to the psychosocial needs/problems of OVC.

Praying, ignorance, talk to some body, and crying were the main copping mechanisms taken up by most OVC when they confront a problem after the death of parents.

The findings of the study with regard to the responses of service providing organizations towards the psychosocial problems of OVC help to develop the following conclusions. Service provider organizations are taking initiatives to provide care and support for OVC and their families. But, they focus on material support and meeting children's physical

needs. They provide food and nutritional support, school material or/and educational support, clothing support, health care support, skill training, legal support, and psychosocial /counseling support. But, as identified by the study the psychosocial support for OVC and their guardians, which is one of the main components of the support system, is the most neglected and gives low attention by service provider organizations.

6.2 Recommendations

Based on the findings and the conclusions drawn, the following recommendations are made:

- As evidenced from the fact that there were more paternal orphans than maternal orphans, and mothers constitute by far the largest proportion of guardians of OVC in the study area. Service providing organizations should put in place strategies that support women in their care -giving role as well as to encourage males to actively participate in care giving.
- Intervention programs should addresses the problems of that are usually associated with early school drop out. About twelfths of the OVC were not attending school at the time of the study.
- There is a need to encourage service providing organizations to channel resources towards strengthening the family unit as means of providing safety nets for OVC. In this regard, children should be assisted to remain with in the home when their parents die.
- Early intervention can prevent adverse effects on children's long-term development. It is important to prepare children for parental death, and to identify and help children with psychosocial and emotional needs before they develop serious problems. Interventions addressing the psychosocial issues of children should begin during the parent's illness. Therefore, intervention programs should encourage parents to be open and truthful, and to talk about their illness and possible death with children, to help prepare them to cope with grief and loss, provide counseling services for children in and out of school and for parents and

train guardians, and teachers to recognize the early signs of developmental, psychological and emotional problems in children.

- Addressing children's needs for psychosocial and emotional support is as important as addressing their physical needs for food, shelter and clothes. In this regard, Intervention programs should be capture comprehensive care and support approach and raise community awareness about the importance of psychosocial and emotional support for children.
- Strengthen the capacity of families and communities. Families and communities are the most important resource for providing children with psychosocial and emotional support. Programs should focus on strengthening the capacity of families and communities to care for children, rather than targeting children directly. Thus, intervention programs should strengthen the capacity of families to meet their own livelihood needs, and help guardians to give children psychosocial and emotional support. Possible actions include: helping guardians to understand stages of childhood development in locally and culturally meaningful terms, offering training in parenting and communication skills, developing strategies to support and encourage the social integration of children who are withdrawn, depressed or aggressive, helping children to deal with stigma, discrimination and rejection, and encourage guardians to make children feel special and loved; for example, mark children's birthdays with cards, gifts or a special meal.
- It is also important to provide psychosocial and emotional support for guardians such as grandparents and others, to help them cope with their own grief, fears, stress, and worries about the future and to enable them to give children the best possible care.
- Considering the above intervention strategy, the service providing organizations should encourage, support, guide and counsel children to accept the reality and cope with the social adjustment and psychological problems associated with the perceived threats of parental loss (help children to help themselves), enable them to understand their rights and being understand by their guardians too, train qualified home-based care providers to provide psychological and emotional support during home visits, train their staff in counseling skills and facilitate

access to family and individual counseling services where possible, to asses their potential, assets and liability for helping OVC and their guardians, strengthening the capacity of families and communities to care for children, endow with comprehensive care and support approach, mobilize and support community-based responses, to create referral linkages and networking with different organizations working in support OVC, and raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS.

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APPENDICES

Addis Ababa University

School of Graduate studies

Department of Psychology

Questionnaire for OVC

I. : BACKGROUND INFORMATION

1. Age of the respondent ----------
2. Sex of the respondent 1. Male 2. Female
3. Type of the respondent
   1. Maternal orphan
   2. Paternal orphan
   3. Double orphan
   4. Other (specify) ----------

II. EDUCATIONAL BACK GROUND

4. Have you ever been in school?

   1. Yes 2. No

5. If No, Why have you never been to school?

   1. Death of parents
   2. Death of guardian(s)
   3. Financial problems
   4. Illness
   5. Lack of school space
   6. Lack of support
   7. Don't like school
   8. Other _____
   9. Don't know

6. Are you currently in school?

   a. Yes
   b. No

7. What school do you go to?
   1. Government 2. Private, or Community School

8. What grade are you in? _____

9. If you are not currently in school, State the reasons for not currently attending school

   1. Death of Parent (s)
   2. Death of Guardian(s)
   3. Drop out
   4. Failed exams
   5. Financial problems
   6. Got a job
   7. Illness
   8. Lack of school space
   9. Lack of support
   10. Pregnancy
   11. Other_____
   12. DON'T KNOW

III. PSYCHOSOCIAL ISSUES

a) Household Relationships and living conditions of OVC

1. What is the kin relationship to your guardian?
   1. Mother
   2. Father
   4. Aunt
   5. Uncle
   6. Grandmother
   7. Grandfather
   8. Sister
   9. Brother
   10. Neighbor
   11. Cousin
   12. Other----------
   13. Don't know

2. Before the guardian began to take care of you, how well did you know him/her?

   1. Very Well
   2. A little bit
   3. Not at all
   4. Not Applicable
   5. Other_____
   6. Don't know, don't remember

3. Does your guardian treat you better, the same or worse in relation to his own children?
   1. Better
   2. Same
   3. Worse
   4. No own biological children
   5. Other_____

4. How are you treated?
   1. Roughly
   2. Fairly
   3. Caringly
   4. Other----------

5. How are the other children in the household treated?
   1. Roughly
   2. Fairly
   3. Caringly
   4. Other----------

6. How does such treatment make you feel?(multiple answers possible)
   1. Sad, unhappy
   2. Sorrowful
   3. Worried
   4. Angry
   5. Scared
   6. Isolated, alone
   7. Resolute, determined
   8. Comforted, relieved
   9. Happy, contented
   10. Other----------

7. How has living with this guardian in his/her household affected the way you feel about life? (multiple answers possible)

   Sad, unhappy
   Sorrowful
   Worried
   Angry
   Scared
   Isolated, alone
   Resolute, determined
   Comforted, relieved
   Happy, contented
   Other----------

8. What is different about your life since you moved into this household? (*Do not read the response. Multiple answers are possible AND, always probe a minimum of 3 times to get further answers)*
   My school attendance has declined or stopped
   My grades have worsened
   I have to do more chores
   I have to take care of smaller children
   We have less food/ money as a family
   I have less food/ clothes as an individual
   Nothing
   Other _____
   Not at all
9. What would you like your guardian to do more of?

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b) Child feelings about siblings separation

10. How many children lived with you in your parents' /guardian's home before moving?
    Boys----------
    Girls----------
    Other_____
11. How many have the same parents as yourself?
    Boys----------
    Girls----------
    Other_____
12. How many brothers /sisters or the other children live with you now in the same household?
    Boys_____
    Girls_____
    Other_____
13. Do you visit your brothers /sisters or the other children who used to live with you but now live away from this home?
    YES
    NO
    Other_____
14. How do you feel about being separated from your brothers/ sisters or other children? (*Do not read the response. Multiple answers are possible AND, always probe a minimum of 3 times to get further answers)*
    Sad, unhappy
    Sorrowful
    Worried
    Angry
    Scared
    Isolated, alone
    Resolute, determined
    Comforted, relieved
    Happy, contented
    Other----------
15. How do you think your brothers, sisters or other children feel about being separated? (*Do not read the response. Multiple answers are possible AND, always probe a minimum of 3 times to get further answers)*
    Sad, unhappy
    Sorrowful
    Worried
    Angry
    Scared
    Isolated, alone
    Resolute, determined
    Comforted, relieved
    Happy, contented
    Other----------
16. How do you get along with your **brothers, Sisters and the other children** you moved with into this household?
    Very well
    Well
    Poorly
    Very poorly
    Not applicable (no other children)
    other ----------
17. How do you get along with the **other children you found** in your current household?
    Very well
    Well
    Poorly
    Very poorly
    Not applicable (no other children)
    other ----------
18. How do you get along with your guardian?
    Very well
    Well
    Poorly
    Very poorly
    other ----------

19. What do you do in your leisure time? (multiple answers possible)

1.Football, other sports, physical activity	4. Being with friends, playing	8. Other _____
2. Games non-physical	5. Being with family	
3. Go to church	7. Reading	
	6. Taking drugs	

c) Communications in Household

1. Did your parents ever discuss their health condition with you before they died?
   Yes
   No
   Other _____
2. Do you think parents/guardians should talk about their health condition with their children/dependants?
   Yes — Maybe or in some cases
   No — Other ____ _____
3. If yes or may be, why is that?

   ---
4. If no, why?

   ---

d) Background information and Child's feelings on late mother/father/guardian

1. What do you think was the cause of your parents' death? *(Do not read out. circle if mentioned. you will need to probe a little without being coercive. don't accept don't know right away.)*
   1. HIV/AIDS
   2. TB
   3. Pneumonia
   4. Long illness
   5. Accident
   6. Bewitched
   7. Malaria
   8. Other _____
   9. DON'T KNOW
2. After your parents died, what did you do to help yourself feel better?
   Talked to friend
   Talked with relative
   Cried
   Nothing
   Other _____
3. What has changed in your daily life **(circumstances, etc)** since your parents died? (*Do not read the response. Multiple answers are possible AND, always probe a minimum of 3 times to get further answers)*
   My school attendance has declined or stopped
   My grades have worsened
   I have to do more chores
   I have to take care of smaller children
   I have to take care of my parent
   We have less food/money as a family
   I have less food/clothes as an individual
   Started school late
   No shelter
   Nothing at all
   Other_____
4. How has the loss of your parents affected the way you **feel** about life? (*Do not read the response. Multiple answers are possible AND, always probe a minimum of 3 times to get further answers)*
   Sad, unhappy
   Sorrowful
   Worried
   Angry
   Scared
   Isolated, alone
   Resolute, determined
   Comforted, relieved
   Happy, contented
   Other----------
5. Is there anything still bothering you about your parents/ guardian death?
   Yes — Other _____
   No
6. If yes, what is it? *(We expect psychosocial responses).*

   ---
7. Do you have any special personal items of your mother/father/guardian?
   Yes — Don't know
   No

8. How do you feel when you see these things?

Content	Angry
Happy	Not Applicable
Warm	Other_____
Sad	

e) Community perception about OVC situation

1. Do you think the communities (teachers, neighbors…) you live in are aware of the existence/problems of OVCs?
   Yes
   No
2. How far the people in the community are supporting the OVC?

   ---

f) Emotional well-being checklist

1. How often would you say that you have scary dreams or nightmares?

Often	Never
Sometimes	Other _____

2. How often would you say that you ever feel unhappy?

Often	Never
Sometimes	Other _____

3. How often would you say that you ever get into fights with other children?

Often	Never
Sometimes	Other _____

4. How often would you say that you prefer to be alone, instead of playing with other children?

Often	Never
Sometimes	Other _____

5. Who do you play with?

_____	No one

6. How often would you say that you ever feel worried?

Often	Never
Sometimes	Other _____

7. What kinds of things do you worry about?

_____	DON'T KNOW
Nothing	

8. How often would you say that you feel frustrated easily when something does not go your way?

Often	Never
Sometimes	Other _____

9. How often do you feel happy?

Often	Never
Sometimes	Other _____

10. What makes you happy?

_____	DON'T KNOW
Nothing	

11. How often would you say that you ever become very angry?

Often	Never
Sometimes	Other _____

12. How often would you say that you ever feel afraid of new situations?

Often	Never
Sometimes	Other _____

13. How often would you say that you ever have trouble falling asleep?

Often	Never
Sometimes	Other _____

14. How often would you say that you ever have difficulty making friends?

Often	Never
Sometimes	Other _____

15. How often do you feel hopeful?

Often	Never
Sometimes	Other _____

16. What makes you feel hopeful?

_____	DON'T KNOW
Nothing	

17. How often would you say that you ever feel like running away from home?
    Often — Never
    Sometimes — Other _____
18. When did you start feeling like this?

    DON'T KNOW
    NO RESPONSE

19. How often would you say that you ever refuse eating at mealtimes?
    Often — Never
    Sometimes — Other _____
20. Tell me something about your life that makes you happy?
    _____ — DON'T KNOW
    Nothing

g) Copying strategies during parent(s)'illness & after death of parent(s)

1. What do you do to help your self feel better when you have a problem? (multiple answers possible)
   Talk to somebody — Pray
   Cry — Nothing (keep it to myself)
   Ignore it — Other _____

2. Who do you talk to when you have a problem or a worry?
   Guardian — Friends, other children
   Guardian's husband/wife/relative — No one, keep to myself
   Child's brothers/sisters — Other _____
   Step-, foster-siblings

IV. RISK BEHAVIORS

1. Do you have any experiences related to sexual intercourse, taking alcoholic drinks, taking drugs?
   Yes
   No
   No response
2. If Yes, Which of the following have you tried?

V. ACCESS TO SUPPORT SERVICE

1. Are you receiving any form of assistance from outside the family for your well-being?
   Yes No
2. if yes from who receive the assistance ---
3. If you receive support (from relatives/organization) how regular is the support?
   Daily — Once a month
   Once a week — Once in 3 months
   Once in 2 weeks — DON'T KNOW
4. What nature/kinds of support do you receive?(multiple answers possible)
   Financial assistance
   Food Assistance — Training (IGA)
   Health Care — Education
   Clothing — School fee & other related costs
   Psychosocial support /counseling — Others (specify)---
5. Do you think the support you receive enough to meet your daily life?

   ---
6. What kind of support do you need to bring life changes?

   ---
7. Are you engaged in some sort of IGA activities to help your self? 1. Yes 2. No

አዲስ አበባ ዩኒቨርስቲ
ድህረ ምረቃ ት/ቤት
የሳይኮሎጂ ትምህርት ክፍል

ወላጆቻቸውን በሞት ያጡና ለችግር በተጋለጡ ህፃናት የሚሞላ መጠይቅ

ዓላማ፡- የዚህ መጠይቅ ዋና ዓላማ ወላጆቻቸውን ያጡና ለችግር የተጋለጡ ህፃናት የሚደርስባቸውን ችግሮችን ለመለየትና የሚደርሱባቸውን ችግሮች ለመቅረፍ እየተወሰዱ ያሉ እርምጃዎችን በተመለከተ መረጃ ለማግኘት ነው ::

ይህ መጠይቅ ሶስት ዋና ዋና ክፍሎች አሉት :: እነሱም፡

1. አጠቃላይ መረጃን የተመለከቱ ጥያቄዎች
2. በወላጆች ሞት ምክንያት በልጆች ላይ የሚደርሱ አጠቃላይ የስነ ልቦናና የማህበራዊ ሁኔታዎችን የተመለከቱ ጥያቄዎችና
3. ልጆች የሚሠጣቸውን የተለያዩ ድጋፎችን የተመለከቱ ጥያቄዎች ናቸው፡፡

ውድ የጥናቱ ተሳታፊ፡-

- ይህን ጥናት በተሳካ ሁኔታ ለማጠናቀቅ ይቻል ዘንድ አንተ/አንች የምትሠጠው/ጭው መረጃ እጅግ በጣም ጠቃሚና አስፈላጊ ነው፡፡ ስለሆነም ሁሉንም ጥያቄዎች በቅንነትና በግልፅነት እንዲሁም በትዕዛዙ መሰረት እንድትሞላ/ይ በትህትና እጠይቃለሁ፡፡ የምትሠጠው/ጭው ማንኛውም መረጃ በሚስጥር የሚጠበቅ ሲሆን በመጠይቁ ላይ ስም መፃፍ አያስፈልግም፡፡

ለዚህ ጥናት መሳካት ለመታደርገው/ጊው ትብብር በቅድሚያ ከፍተኛ ምስጋና አቀርባለሁ፡፡

ትዕዛዝ፡- ከዚህ በታች የቀረቡትን ጥያቄዎች ከአነበብክ/ሽ በኃላ ለቀረበት ጥያቄዎች መልስ የሚሰጠው ከተሠጡት አማራጮች መካከል ትክክለኛውን ምላሽ/ቁጥሩን በማክበብ ወይም በባዶ ቦታው ምላሽ በመስጠት ነው ::

ክፍል አንድ፡- አጠቃላይ መረጃ

1. ዕድሜ ----------
2. ፆታ 1. ወንድ 2. ሴት
3. የቤተሰብህ/ሽ ሁኔታ
   1. እናቱ በህይወት የለችም
   2. አባቱ በህይወት የለም
   3. እናቱም አባቱም በህይወት የሉም
   4. ሌላ ካለ (ይጥቀሱ) ----------
5. በአሁኑ ሰዓትስ እየተማርክ/ሽ ነው? 1. አዎ 2. የለም
6. ለጥያቄ 5 መልስዎ አዎ እየተማርኩ ነው ከሆነ በምን ዓይነት ት/ቤት ነው እየተማርክ ያለህው/ሽው?
   1. በመንግስት ት/ቤት 2. በግል ወይም በማህበረሰብ ት/ቤት
7. አሁንም ለጥያቄ 5 መልስዎ አዎ እየተማርኩ ነው ከሆነ ስንተኛ ክፍል ነህ/ሽ? ----------
8. በአሁኑ ሰዓት እየተማርክ/ሽ ካልሆነ የማትማርበት/ሪበት ምክንያት ምንድን ነው?
   1. የወላጆችህ/ሽ ሞት
   2. የአሳዳጊዎችህ/ሽ ሞት
   3. ከት/ቤት ማቋረጥ
   4. በፈተና መውደቅ
   5. የገንዘብ ችግር
   6. ሥራ ስላገኘሁ
   7. በህመም ምክንያት
   8. በመማሪያ ቦታ ጥበት ምክንያት
   9. በረዳት ማጣት
   10. በእርግዝና ምክንያት
   11. ሌላ ካለ ----------
   12. አላውቀውም
9. ከአሁን በፊት ትምህርት ቤት ትማር/ሪ ነበር ? 1. አዎ 2. የለም
10. ለጥያቄ 9 መልስህ/ሽ አልማርም ነበር ከሆነ ምክንያትህ/ሽ ምንድን ነው?
    1. የወላጆች ሞት
    2. የአሳዳጊዎች ሞት
    3. የገንዘብ ችግር
    4. በህመም ምክንያት
    5. በመማሪያ ቦታ ጥበት ምክንያት
    6. በረዳት ማጣት
    7. ት/ቤት መሄድ ስለማልወድ
    8. ሌላ ካለ ----------
    9. አላውቀውም

ክፍል ሁለት፡- ስለ የስነ ልቦናና የማህበራዊ ሁኔታዎች

1. ከአሳዳጊህ/ሽ ጋር ያለህ/ሽ ዝምድና ምንድን ነው?
   1. እናቱ
   2. አባቱ
   3. አክስቱ
   4. አጎቱ
   5. ሴት አያቱ
   6. ወንድ አያቱ
   7. እህቱ
   8. ወንድሜ
   9. ጎረቤቱ
   10. የአክስቱ/የአጎቱ ልጅ
   11. ሌላ ካለ ----------
   12. አላውቀውም
2. አሳዳጊህ/ሽ አንተን/አንችን የማሳደግ ኃላፊነት ከመወሰዳቸው በፊት ምን ያህል ታውቃቸው/ታውቂያቸው ነበር?
   1. በጣም አውቃቸዋለሁ
   2. በጥቂቱ አውቃቸዋለሁ
   3. በፍፁም አላውቃቸውም
   4. ሌላ ካለ ----------
   5. አላስታውስም
3. አሳዳጊህ ከራሳቸው ልጆች ጋር ሲነፃፀር ለአንተን/አንችን የሚያደርጉልህ/ሽ እንክብካቤ እንዴት ነው?
   1. የተሻለ ነው
   2. ተመሳሳይ ነው
   3. የከፋ ነው
   4. የራሳቸው ልጆች የላቸውም
   5. ሌላ ካለ ----------

4. በአጠቃላይ አሳዳጊህ/ሽ ለአንተ/ለአንች የሚደርጉልህ/ሽ እንክብካቤ እንዴት ትገልጸዋለህ/ትገልጭዋለሽ?
   1. ጥሩ አይደለም 3. በጣም ጥሩ ነው
   2. ጥሩ ነው 4. ሌላ ካለ----------
5. በቤት ውስጥ ያሉ ሌሎች ልጆች ከአሉ ለአንተ/ለአንች የሚደርጉህ/ሽ እንክብካቤ እንዴት ነው?
   1. ጥሩ አይደለም 3. በጣም ጥሩ ነው
   2. ጥሩ ነው 4. ሌላ ካለ ----------
6. ይህ ዓይነቱ እንክብካቤ በአንተ/በአንች ላይ የፈጠረው ስሜት እንዴት ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)
   1. ደስተኛ ያለመሆን 5. ፍርሀት 9. ደስታ
   2. ሀዘን 6. ብቸኝነት 10. ሌላ ካለ ----------
   3. ጭንቀት 7. ጥንካሬ ----------
   4. ንዴት 8. ምኞት
7. በአሳዳጊህ/ሽ ቤት በመኖርህ/ሽ ምክንያት በአንተ/በአንች ላይ የፈጠረው የህይወት ስሜት እንዴት ትገልጸዋለህ/ ትገልጭዋለሽ? (ከአንድ በላይ መልስ መስጠት ይቻላል)
   1. ደስተኛ ያለመሆን 5. ፍርሀት 9. ደስታ
   2. ሀዘን 6. ብቸኝነት 10. ሌላ ካለ ----------
   3. ጭንቀት 7. ጥንክሬ ----------
   4. ንዴት 8. ምኞት
8. ወደ አሳዳጊህ ቤት ከመጣህ/ሽ ጀምሮ በአንተ/በአንች ላይ የመጣው የህይወት ለውጥ ምንድን ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)
   1. ትምህርቴን አቋርጫለሁ 5. በቤት ውስጥ የገንዘብ ሁኔታ ቀንሷል
   2. የትምህርት ወጤቴ አሽቆልቁሏል 6. አመጋገቤና አለባበሴ ቀንሷል
   3. ብዙ ሥራዎች እንድሰራ ሆኛለሁ 7. ምንም ለውጥ የለም
   4. ትናንሽ ልጆችን እንድንከባከብ ሆኛለሁ 8. ሌላ ካለ ----------
9. አሳዳጊህ/ሽ ለወደፊት የበለጠ እንዲያደርጉልህ/ሽ የምትፈልገው/ጊው ነገር ካለ ጥቀስ/ሽ? ----------
   ----

10. ወደ አሳዳጊህ/ህ ቤት ከመምጣትህ በፊት በወላጆችህ ቤት ውስጥ ከስንት ልጆች ጋር ትኖር ነበር?
    1. የወንድ ልጆች ብዛት ---------- 2. የሴት ልጆች ብዛት ---------- 3. ሌላ ካለ ----------
11. ከነዚህ ውስጥ ምን ያህሉ የአንድ አባትና እናት ልጆች ናችሁ?
    1. የወንድ ልጆች ብዛት ---------- 2. የሴት ልጆች ብዛት ---------- 3. ሌላ ካለ ----------
12. አሁን በምትኖርበት/ሪበት ቤት ውስጥ ከስንት እህትና ወንድሞችህ/ሽ እንዲሁም ከሌሎች ልጆች ጋር ትኖራለህ/ትኖሪያለሽ?
    1. የወንድ ልጆች ብዛት ---------- 2. የሴት ልጆች ብዛት ---------- 3. ሌላ ካለ ----------
13. ከአንተ/ከአንች ጋር ሲኖሩ የነበሩ ነገር ግን አሁን ሌላ ቤት/ቦታ የሚኖሩ ወንድምና እህቶችህን እንዲሁም ሌሎች ልጆችን ትጎበኛቸዋለህ/ትጎበኝቸዋለሽ?
    1. አዎ እጎበኛቸዋለሁ 2. የለም አልጎበኛቸውም 3. ሌላ ካለ ----------
14. ከወንድሞችህና ከእህቶችህ ጋር አብረህ/ሽ ባለመኖርህ/ሽ ምን ይሰማሃል/ሽ? (ከአንድ በላይ መልስ መስጠት ይቻላል)
    1. ደስተኛ አለመሆን 5. ፍርሀት 9. ደስታ
    2. ሀዘን 6. ብቸኝነት 10. ሌላ ካለ ----------
    3. ጭንቀት 7. ጥንካሬ ----------
    4. ንዴት 8. ምኞት
15. ወንድሞችህ/ሽና እህቶችህ/ሽ ከአንተ/ከአንች ጋር አብረው ባለመኖራቸው የሚሰማቸው ስሜት ምንድን ነው ብለህ/ሽ ታስባለህ/ታስቢያለሽ? (ከአንድ በላይ መልስ መስጠት ይቻላል)
    1. ደስተኛ አለመሆን 5. ፍርሀት 9. ደስታ
    2. ሀዘን 6. ብቸኝነት 10. ሌላ ካለ ----------
    3. ጭንቀት 7. ጥንካሬ ----------
    4. ንዴት 8. ምኞት

16. አሁን በምትኖርበት ቤት ውስጥ ካሉ ወንዶሞችህና እህቶችህ/ሽ እንዲሁም ሌሎች ልጆች ጋር ያለህ/ያለሽ የግንኙነት/የመግባባት ሁናቴ እንዴት ነው ?

1. በጣም ጥሩ ነው
2. ደህና ነው
3. ጥሩ አይደለም ነው
4. በጣም ጥሩ አይደለም
5. ምንም ተጨማሪ ልጆች የሉም /እኔን አይመለከትም/
6. ሌላ ካለ ----------

17. አሁን ከምትኖርበት/ሪበት ቤት ውስጥ ካገኘሃቸው ሌሎች ልጆች ጋር ያለህ/ያለሽ ግንኙነት እንዴት ነው?

1. በጣም ጥሩ ነው
2. ደህና ነው
3. ጥሩ አይደለም ነው
4. በጣም ጥሩ አይደለም
5. ምንም ተጨማሪ ልጆች የሉም /እኔን አይመለከትም/
6. ሌላ ካለ ----------

18. አሁን አብርሃቸው ከምትኖረው አሳዳጊህ/ሽ ጋር ያለህ/ሽ ግንኙነት እንዴት ነው?

1. በጣም ጥሩ ነው
2. ደህና ነው
3. ጥሩ አይደለም ነው
4. በጣም ጥሩ አይደለም
5. ሌላ ካለ ----------

19. በትርፍ ጊዜህ ምን ምን ነገሮችን ታደርጋለህ/ሽ?

1. እግር ኳስና ሌሎች የአካል እንቅስቃሴ ስፖርቶች
2. የአካል እንቅስቃሴ ያልሆኑ ጨዎታዎች
3. ከጓደኞቸ ጋር ሆኔ እጫወታለሁ
4. ቤተክርስቲያን እሄዳለሁ
5. ከቤተሰቦቸ ጋር እሆናለሁ
6. አነባለሁ
7. የተለያዩ ዕፆ ነገችን እወስዳለሁ
8. ሌላ ካለ ይጠቀስ ----------

20. ወላጆችህ/ሽ ከመሞታቸው በፊት ከአንተ/ከአንችጋር ስለ ጤንነታቸው ሁኔታ በግልፅ ይወያዩ ወይም ይነጋገሩ ነበር?

1. አዎ 2. አይወያዩም 3. ሌላ ካለ ----------

21. ወላጆች/አሳዳጊዎች ከልጆቻቸው ጋር ስለ ጤንነታቸው ሁኔታ ማውራት/መወያየት አለባቸው ብለህ/ብለሽ ታስባለህ/ታስቢያለሽ?

1. አዎ
2. ማወያየት የለባቸውም
3. በጥቂት ሁኔታዎች መወያየት አለባቸው
4. ሌላ ካለ ----------

22. ለጥያቄ 22 መልስህ/ሽ አዎ ወይም በጥቂት ሁኔታዎች መወያየት አለባቸው ካልክ/ካልሽ ምክንያትህ/ሽ ምንድን ነው? --

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23. ለጥያቄ 22 መልስህ/ሽ ማወያየት የለባቸውም ከሆነ ምክንያትህ/ሽ ምንድን ነው?

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24. የወላጆችህ/ሽ የሞት ምክንያት ምንድን ነው ብለህ ታስባለህ/ታስቢያለሽል?

1. ኤችአይቪ/ኤድስ
2. የሳንባ ነቀርሳ(ቲቪ)
3. ደም ማነስ
4. የረጂም ጊዜ ህመም
5. ድንገተኛ አደጋ
6. ጥንቆላ
7. ወባ
8. ሌላ ካለ ----------
9. አላውቀውም

25. ወላጆችህ/ሽ ከሞቱ በኃላ ለራስህ/ሽ ጥሩ ስሜት እንዲሰማህ/ሽ እና ራስህን/ሽን ለማጽናናት ምን ታደርግ/ጊ ነበር?

1. ከጓደኞቸ ጋር አወራ ነበር
2. ከዘመዶቸ ጋር አወራ ነበር
3. አለቅስ ነበር
4. ምንም አላደረኩም
5. ሌላ ካለ ይጠቀስ ----------

26. ወላጆችህ/ሽ ከሞቱ ጀምሮ በአንተ/በአንች ዕለታዊ ኑሮና ሌሎች ጉዳዮች ላይ ምን ምን ለውጦች እንዳሉ ብትገልፅልኝ/ብትገልጪልኝ? (ከአንድ በላይ መልስ መስጠት ይቻላል)

1. ትምህርቴን እንዳልከታተልና እንዳቋርጥ ሆኛለሁ
2. የትምህርት ውጤቴ ቀንሷል
3. ብዙ ሥራዎችን እንድሠራ ተገድጃለሁ
4. በቂ ምግብና ልብስ እንዳላገኝ ሆኛለሁ
5. ትምህርቴን ዘግይቼ እንድጀምር ሆኛለሁ
6. መጠለያ አጥቻለሁ
7. በቤት ውስጥ ያሉ ትናንሽ ልጆችን እንድከባከብ ሆኛለሁ
8. አሳዳጊዎቼን በቤት ውስጥ እንድንከባከብ ተገድጃለሁ
9. በቤት ውስጥ በቂ የሆነ ምግብና ገንዘብ እንዳይኖር ሆኗል
10. ምንም የተለወጠ ነገር የለም
11. ሌላ ካለ ይጠቀስ ----------
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27. የወላጆችህ/ሽ በህይወት ያለመኖር በአንተ/በአንች ላይ የፈጠረው ጉዳት/ስሜት እንዴት ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)

1. ደስተኛ ያለመሆን
2. ሀዘን
3. ጭንቀት
4. ንዴት
5. ፍርሀት
6. ብቸኝነት
7. ጥንካሬ
8. ምኞት
9. ደስታ
10. ሌላ ካለ ----------
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28. በወላጆችህ/ሽ ሞት ምክንያት እስካሁን አንተን/አንችን የሚሰጨንቁህ/ሽ ነገሮች አሉ?

1. አዎ አሉ 2. የሉም 3. ሌላ ካለ ----------

29. ለጥያቄ 29 መልስህ/ሽ አዎ አሉ ከሆነ አንተን/አንችን የሚያስጨንቁህ/ሽ ነገሮች ምን ምን ናቸው?

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30. ከወላጆህ/ሽ የወረስከው/ሽው ልዩ የግል ንብረቶች አሉህ/ህ?

1. አዎ 2. የሉም 3. የማውቀው ነገር የለም

31. ከወላጆችህ/ሽ የወረስካቸውን/ሻቸውን የግል ንብረቶች ካሉህ/ህ በምትመለከትበት ጊዜ ምን ዓይነት ስሜት ይሰማሃል/ይሰማሻል? (ከአንድ በላይ መልስ መስጠት ይቻላል)

1. የእርካታ
2. የደስታ
3. የመረጋጋት
4. የሀዘን
5. የንዴት
6. ምንም አይሰማኝም
7. ሌላ ካለ ይጠቀስ ----------
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32. አንተ/አንች በምትኖርበት/ሪበት አከባቢ ህብረተሰቡ ስለ ወላጆቻቸውን ያጡና ለችግር የተጋለጡ ህፃናት መኖራቸውን ያውቃል ብለህ/ብለሽ ታስባለህ/ሽ?

1. አዎ 2. አያውቅም

33. አንተ/አንች በምትኖርበት/ሪበት አከባቢ ህብረተሰቡ ምን ያህል ወላጆቻቸውን ያጡ ህፃናትን ይዳግፋል? ----------

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- **ስሜታዊና ስነ ልቦናዊ ለውጦች በተመለከተ**

1. ምን ያህል ጊዜ አስፈሪ የሆኑ ህልሞችንና ቅዠቶችን አይተህ/ህ ታውቃለህ/ታውቂያለሽ?
   1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
2. ምን ያህል ጊዜ ደስተኛ ያልሆነ ስሜት ተሰምቶህ/ሽ ያውቃል?
   1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
3. ከሌሎች ልጆች ወይም ጓደኞችህ/ሽ ጋር ምን ያህል ጊዜ ተጣልተህ/ህ ታውቃለህ/ቂያለሽ?
   1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
4. ከሌሎች ልጆች ጋር ከመጫወት ይልቅ ምን ያህል ጊዜ ብቻህን መሆን ትመርጣለህ/ጫለሽ?
   1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
5. ከማን ጋር ነው የምትጫወተው?
   1. ---------- 2. ከማንም ጋር
6. ምን ያህል ጊዜ የመጨነቅ ስሜት ይሰማሃል/ሻል?
   1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------

7. አንተን/አንችን ብዙ ጊዜ የሚያስጨንቁህ/ሽ ነገሮች ምን ምን ናቸው?
   1. ---------- 2. ምንም ነገር አያስጨንቀኝም 3. አላውቀውም
8. አንዳንድ ጊዜ ነገሮች አንተ/አንች በፈለካቸው/በፈለግሽው መንገድ በማይሆኑበት ሁኔታ ምን ያህል ስሜትህ/ሽ ይረባሻል?
   1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
9. ምን ያህል ጊዜ ደስተኛ ሆነህ/ሽ ታውቃለህ/ታውቂያለሽ?
   1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
10. አንተን/አንችን ደስተኛ የሚያደርግህ/ሽ ነገር ምንድን ነው?
    1. ---------- 2. ምንም ነገር 3. አላውቀውም
11. ምን ያህል ጊዜ በጣም ተናደህ/ሽ ታውቃለህ/ታውቂያለሽ?
    1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
12. አዲስ ነገሮች ወይም ሁኔታዎች በሚያጋጥሙህ/ሽ ምን ያህል ጊዜ የመረበሽ ስሜት ታሳያለህ/ታሳያለሽ?
    1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
13. ምን ያህል ጊዜ እንቅልፍ የማጣት ችግር አጋጥሞህ/ሽ ያውቃል?
    1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
14. ምን ያህል ጊዜ ጓደኛ የማፍራት/የመመስረት ችግር አጋጥሞህ/ሽ ያውቃል?
    1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
15. ምን ያህል ጊዜ ተስፋ የማድረግ ስሜት ይሰማሃል?
    1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
16. አንተን/አንችን ተስፋ የማድረግ ስሜት እንዲኖርህ/ሽ የሚያደርጉህ/ሽ ነገሮች/ሁኔታዎች ምን ምን ናቸው?
    1. ---------- 2. ምንም ነገር 3. አላውቀውም
17. ምን ያህል ጊዜ ከቤት ለመውጣት/ለመጥፋት አስበህ/ሽ ታውቃለህ/ታውቂያለሽ?
    1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
18. ከቤት ውጣ ውጣ የማለት ስሜት ካለህ/ሽ ይህ ስሜት መሰማት የጀመረህ/ሽ መቼ ነው?
    1. ---------- 2. አላውቀውም 3. መልስ የለኝም
19. ምግብ መመገብ ባለብህ/ሽ ሰዓት ምን ያህል ጊዜ ምግብ ያለማሰኘት ወይም ያለመመገብ ሁኔታ አጋጥሞህ/ሽ ያውቃል?
    1. ብዙ ጊዜ 2. አንዳንድ ጊዜ 3. ምንም ጊዜ 4. ሌላ ካለ ----------
20. አንተን/አንችን በህይወትህ/ሽ የሚያስደስትህ/ሽ ነገር ምን እንደሆነ ብትነግረኝ/ሪኝ?
    1. ---------- 2. ምንም ነገር 3. አላውቀውም

1. ችግር በሚያጋጥምህ/ሽ ጊዜ ራስህን/ሽን ለማፅናናትና ጥሩ ስሜት እንዲሰማህ ምን ታደርጋለህ/ታደርጊያለሽ? (ከአንድ በላይ መልስ መስጠት ይቻላል)
   1. ከሆነ ሰው ጋር አወራለሁ
   2. አለቅሳለሁ
   3. ለመርሳት ጥረት አደርጋለሁ
   4. እፀልያለሁ
   5. ምንም አላደርግም
   6. ሌላ ካለ ይጠቀስ ----------
2. ችግር በሚያጋጥምህ ወይም በምትጨነቅበት ጊዜ ማንን ነው የምታወያየው?
   1. አሳዳጊየን
   2. የአሳዳጊዮን ባል/ሚስት/ዘመድ
   3. የራሴን ወንድሞችና/እህቶች
   4. የእንጀራ አባቴን/እናቴን ልጆች
   5. ጓደኞቸንና ሌሎች ልጆችን
   6. ለማንም አላወያይም ከራሴ ይቀራል
   7. ሌላ ካለ ይጠቀስ ----------

1. የግብረ ሥጋ ግንኙነት የማድረግ፣ አልኮልና የተለያዩ ዕፅ ነክ ጉዳዮች የመውሠድ ልምዶች አሉህ/አሉሽ?
   1.አዎ 2.የለኝም
2. ለጥያቄ 1 መልስህ/ሽ አዎ ከሆነ ምን ምን ልምዶች እንዳሉህ/ ብትገልፅልኝ/ብትገልጪልኝ?

ክፍል ሶስት :- ልጆች የሚያገኙአቸው የድጋፍ ዓይነቶች በተመለከተ

1. ከቤተሰብህ/ሽ ውጪ ለአንተ/ለአንች በማሰብ የሚሠጥህ/ሽ ወይም የሚደረግልህ/ሽ የድጋፍ አይነት አለ?
   1. አዎ አለ 2. ምንም የለም
2. ለጥያቄ 1 መልስህ/ሽ አዎ ከሆነ ድጋፉን የምታገኘው/የምታገኚው ከምን ዓይነት ድርጅት ነው? (ከመንግስታዊ ያልሆነ ድርጅት፣ ከመንግስታዊ ድርጅት፣ ከህብረተሰብ አቀፍ ድርጅቶች፣ ከእምነት ድርጅቶች ወዘተ) ብጠቅስልኝ/ሽልኝ

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3. ለጥያቄ 1 መልስህ/ሽ አዎ ከሆነ በየስንት ጊዜው ድጋፍ ታገኛለህ/ህ?
   1. በየቀኑ
   2. በየሳምቱ አንድ ጊዜ
   3. በየሁለት ሳምንቱ አንድ ጊዜ
   4. በወር አንድ ጊዜ
   5. በየሦስት ወሩ አንድ ጊዜ
   6. አላውቅም
4. አሁንም ለጥያቄ 1 መልስህ አዎ ከሆነ ምን ምን የድጋፍ ዓይነት ታገኛለህ/ሽ?(ከአንድ በላይ መልስ መስጠት ይቻላል)
   1. የገንዘብ ድጋፍ
   2. የምግብ ድጋፍ
   3. የጤና ድጋፍ
   4. የልብስ ድጋፍ
   5. የስነ ልቦናና የማህበራዊ ድጋፍ /የምክር አገልግሎት ድጋፍ .../
   6. የስልጠና ድጋፍ
   7. የትምህርት ድጋፍ
   8. የት/ቤት ክፍያና ሌሎች ተያያዥ ክፍያዎች
   9. ሌላ ካለ ይጠቀስ ----------
5. የምታገኘው/ኝው የድጋፍ ዓይነት ለአንተ/ለአንች ሁለንተናዊ ወይም የዕለት ተዕለት ህይወት ከማሳካት አኳያ በቂ ነው ብለህ/ብለሽ ታስባለህ/ታስቢያለሽ? ----------

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6. በአንተ/በአንች ሁለንተናዊ የህይወት ለውጥ ለማምጣት ምን ምን ዓይነት ድጋፍ እንዲደረግልህ/ሽ ትፈልጋለህ/ትፈልጊያለሽ? ----------

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7. ራስህን ለመርዳት በአንዳንድ የገቢ ማስገኛ ሥራዎች ውስጥ ተሠማርተህ/ሽ ታውቃለህ/ሽ?
   1. አዎ አውቃለሁ 2. አላውቅም

o

Addis Ababa University

School of Graduate studies

Department of Psychology

Interview Guide for OVC Guardians

I. Demographic characteristics

1. Sex of the respondent 1. Male 2. Female
2. Age of the respondents ----------
3. What is your marital status?

   Single
   Married
   Divorced
   Widowed/widower
   Other----------

4. Have you ever attended formal school?
   Yes
   No
5. What is the highest level of school you completed?

   Primary
   Secondary
   College/university
   None
   Don't Know

6. What is your relationship to the child? ----------

II. House hold composition and challenges

7. How many biological children do you have?

   Total number of BOYS ----------
   Total number of GIRLS ----------

8. How many children whose parents have died live with you?

   Total number of BOYS ----------
   Total number of GIRLS ----------

9. State the main reasons for taking in these children??

   ---
10. What is the impact/challenge of HIV/AIDS on household following taking in OVC?

    ---
11. Have any of the above children currently in school?

    Yes
    No
    Not at all (how many) ----------
    Don't know

12. If "NO", why?

    ---
13. If so, by whom?

    DON'T KNOW

III. Perceptions of guardians on HIV/AIDS and related issues

14. In the past 6 months, have you seen an increase in the number of orphans and vulnerable children living in your neighborhood?
    YES
    NO
    Don't Know
15. What are the main reasons that children are being orphans and vulnerable children in your area?
    Poverty
    Accidental deaths
    HIV/AIDS
    Tuberculosis
    Other _____
    Don't know

16. In the past 6 months, have you seen an increase in the number of families taking care of orphaned children in your neighborhood?
    YES
    NO
    Don't Know

17. Do you suspect that any of the parents of the children you have taken in, died from HIV/AIDS?
    Yes
    No
    Don't know
18. If NO, what do you think was the cause of the death of parents of the children?

TB	Short Illness	Diarrhea
Malaria	Long Illness	Epilepsy
Abortion	Pneumonia	Other.....
Cancer	Accident	DON'T KNOW

19. Have you told the child (ren) the cause of their parents' death?
    Yes
    No
    Don't know
20. If yes, what did you tell him or her?

    _____

    _____

    DON'T KNOW
21. If NO, why?

    ---
22. How are the reactions of your children to the coming OVC in the household? ---

IV. Communications within the household

23. Do you talk to children about Sex?
    Yes
    No
    Don't know
24. Do you discuss/talk to children in your household about HIV/AIDS?
    Yes
    No
    Don't know
25. Do you talk about these issues in your family?
    Yes
    No
    Don't know
26. Do you feel the need that children should know about these things?
    Yes
    No
    Don't know

V. OVC needs & problems

27. What are the biggest needs for orphaned and vulnerable children? **DO NOT READ THE LIST.** (Let the respondent answer the question and circle any that they mention. Multiple responses are possible)

Financial support	Socio-emotional support
Educational support	Adjustment
Skills training	Other: _____
Medical support	Don't' know

28. What are the main concerns that you have for the child (ren) you have taken in? **DO NOT READ THE LIST.** (Let the respondent answer the question and circle any that they mention. Multiple responses are possible)

Financial support	Socio-emotional support
Educational support	Adjustment
Skills training	Other: _____
Medical support	Don't' know

29. What particular problems do you think this child may be facing? **DO NOT READ THE LIST** (Let the respondent answer the question and circle any that they mention. Multiple responses are possible)

Financial Support	Socio-economical support
Educational support	Adjustment to new home
Skills training	Other _____
Medical support	Don't Know

30. If the child may be having socio –emotional problems, what are the major ones? ---
    ---
    ---
31. Does the child suffer from stigma and discrimination? ---

32. What type of support are you give (practices) to help children deal with their grief & stress during and after parents die?

---

33. What do you do to alleviate the emotional pain orphans experience soon after the death of a parent and thereafter?

---

34. What do you think are the best ways to take care of orphans? Issues regarding the long-term care & psychosocial support.
35. Who should be responsible? (The immediate and extended family; adoption; foster care; institutional care).
36. Please tell us what are the support needs of people such as you who care for and support orphans.

VI. General livelihood issues & house hold access to support service

37. Do you (the family) have any source of income for your family?
    Yes
    No
38. If yes, How do you manage to make ends meet of the household?
    Self-employment
    One of household members working
    Support from relatives
    Support from institutions
    Other ----------
    DON'T KNOW
39. If "No" what other mechanisms does the family have to meet the needs of the families in the house hold?

---

40. Are you receiving any form of assistance from outside the family for the care of OVC?

    Yes No

41. If yes, who provided the support? (NGOs, GOs, CBOs, FBOs … mention) ----------
42. If you receive support (from relatives/organization) how regular is the support?
    Daily
    Once a week
    Once in 2 weeks
    Once a month
    Once in 3 months
    DON'T KNOW
43. What nature of support do you receive? (multiple answers possible)
    Financial assistance
    Food Assistance
    School Fees
    Psychosocial support
    Training (IGA & related)
    Medical Fees
    Other----------
    DON'T KNOW
44. Is the support enough to meet the daily life of the family for the care of OVC? ----------
45. What kinds of support do OVC in need for their well being? ----------

---

46. In the last one-year, have you received any type of training?

    Yes No

47. What type of training did you receive and who provided the training?

    a. ---------- From ----------
    b. ---------- From ----------
    c. ---------- From ----------

አዲስ አበባ ዩኒቨርስቲ
ድህረ ምረቃ ት/ቤት
የሳይኮሎጂ ትምህርት ክፍል

ወላጆቻቸውን በሞት ላጡና ለችግር በተጋለጡ አሳዳጊዎች የሚሞላ የቃል መጠይቅ

አጠቃላይ መረጃ

1. ዞታ 1 ወንድ 2 ሴት
2. እድሜ ----------
3. የጋብቻ አይነት
   1. ያላገባ 2. ያገባ 3. የተፋታ 4. ባለቤቱን/ቱን በሞት ያጣ/ያጣች 5. ሌላ ካለ ----------
4. ትምህርት ቤት ገብተው ትምህረት ተምረው ያውቃሉ? 1 .አዎ 2. የለም
5. እስከ ስንተኛ ክፍል ተምረዋል?
   1. አንደኛ ደረጃ 2. ሁለተኛ ደረጃ 3. ኮሌጅ/ዩኒቨርሲቲ 4. ምንም አልተማርኩም
   5. ሌላ ካለ ----------
6. ከልጁ ጋር ያለዎት የዝምድና ግንኙነት ምንድነው? ----------
7. ምን ያህል የራሰዎ ልጆች አለዎት?
   1. ወንድ ልጆች ---------- 2. ሴት ልጆች ----------
8. ምን ያህል የራሰዎ ያልሆኑ ወላጆችን ያጡና ለችግር የተጋለጡ ልጆች አብረዎት ይኖራሉ ?
   1. ወንድ ልጆች ---------- 2. ሴት ልጆች ----------
9. የራስዎና የሚያሳድጓቸው ሁሉም ልጆች አሁን እየተማሩ ነው?
   1. አዎ 2. የለም አይማሩም 3. ሌላ መልስ ካለዎት ----------
10. ለጥያቄ 12 መልስዎ አይማሩም ከሆነ ምክንያቱ ምንድን ነው? ----------
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11. ለጥያቄ 12 መልስዎ አዎ ይማራሉ ከሆነ ማን ነው የሚያስተምራቸው? ----------

ኤችአይቪ/ኤድስ በቤት ውስጥ የሚያስከትላቸው ተፅኖዎች/ችግሮች

12. ወላጆቻቸውን ያጡና ለችግር የተጋለጡ ልጆች የሚያሳድጉበት ምክንያት ምንድን ነው? ----------
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13. እነዚህ ወላጆቻቸውን ያጡና ለችግር የተጋለጡ ልጆች በማሳደግዎ በቤትዎ ውስጥ የፈጠረው ጫናና ተፅዕኖ አለ?
   1. አለ 2. የለም
14. ለጥያቄ 10 መልስዎ አዎ አለ ከሆነ ያሳደረውን ተፅዕኖ ቢገልጹልኝ? ----------

አሳዳጊዎች ስለ ወላጆቻቸውን ላጡና ለችግር ለተጋለጡ ህፃናት ችግሮችና ተዛማች ጉዳዮች ያላቸው ግንዛቤ

15. ባለፉት 6 ወራት ውስጥ በሚኖሩበት ጎረቤት አካባቢ ወላጆቻቸውን በሞት ያጡና ለችግር የተጋለጡ ህፃናት መከሰት ወይም ቁጥር መጨመር ሁኔታ አለ?
   1. አዎ 2. የለም 3. የማውቀው ነገር የለም
16. በአካባቢዎ ወላጆቻቸውን በሞት ያጡና ለችግር የተጋለጡ ህፃናት መከሰት/ቁጥር መጨመር ዋና ምክንያት ምን ይመስለዎታል?
   1. ድህነት
   2. ድንገተኛ ሞት
   3. ኤችአይቪኤድስ
   4. የሳንባ ነቀርሳ
   5. ሌላ ካለ ----------
   6. የማውቀው ነገር የለም

17. ባለፉት 6 ወራት ውስጥ በሚኖሩበት ጎረቤት አካባቢ ወላጆቻቸውን በሞት ላጡና ለችግር የተጋለጡ ህፃናትን የሚያሳድጉ ቤተሰቦች የመጨመር ሁኔታ አለ?

1. አዎ 2. የለም 3. የማውቀው ነገር የለም

18. የሚያሳድጓቸውን ልጆች ወላጆች በኤችአይቪ/ኤድስ እንደሞቱ ጥርጣሬው አለዎት ወይም ይገምታሉ?

1. አዎ 2. የለም 3. የማውቀው ነገር የለም

19. መልስዎ የለም/መገመት አልችልም ከሆነ የልጆቹ ወላጆች የሞቱበት ምክንያቶች ምን ይሆናሉ ብለው ያስባሉ?

1. የሳንባ ነቀርሳ
2. ወባ
3. ውርጃ
4. ነቀርሳ(ካንሰር)
5. የአጭር ጊዜ ህመም
6. የረጅም ጊዜ ህመም
7. ደም ማነስ
8. ድንገተኛ አደጋ
9. ተቅማጥ
10. የሚጥል በሽታ
11. ሌላ ካለ ----------
12. አላውቅም

20. ለልጆቹ ወላጆቻቸው በምን ምክንያት እንደሞቱ ነግረዋቸው ያውቃሉ?

1. አዎ 2. የለም 3. አላውቅም

21. ለጥያቄ 20 መልስዎ አዎ ከሆነ ምን ብለው ነግረዋቸዋል?----------
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22. ለጥያቄ 20 መልስዎ የለም ከሆነ ያልነገሩበት ምክንያት ምንድን ነው? ----------
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23. እርስዎና የእርስዎ ልጆች ለሚያሳዱጋቸው ወላጆቻቸውን ላጡ ህፃናት ያላቸው የእንክብካቤ/አመለካከት ሁኔታ እንዴት ነው? ----------

በቤት ውስጥያለው የመነጋገር ባህል

24. ስለ ወሲብና ተዛማች ጉዳዮች ከልጆቹ ጋር ተወያይተው ያውቃሉ?

1. አዎ 2. የለም አላውቅም 3. አላስታውስም

25. ስለኤችአይቪ/ኤድስናተዛማች ጉዳዮች ከልጆቹ ጋር ይወያያሉ?

1. አዎ 2. የለም አላውቅም 3. አላስታውስም

26. ስለ ወሲብና ኤችአይቪ/ኤድስ ጉዳዮች ከቤተሳብዎ ጋር ተወያይተው ያውቃሉ?

1. አዎ 2. የለም አላውቅም 3. አላስታውስም

27. ስለ ወሲብና ኤችአይቪ/ኤድስ ጉዳዮች ልጆች ማወቅ አለባቸው ብለው ያስባሉ?

1.አዎ 2. የለም 3. መልስ የለኝም

ወላጆቻቸውን በሞት ያጡና ለችግር የተጋለጡ ህፃናት ፍላጎቶችና ችግሮች

28. የሚያሳድጓቸው ወላጆቻቸውን በሞት ያጡና ለችግር የተጋለጡ ህፃናት ያሉባቸው አበይት ፍላጎቶች ምንድን ናቸው ብለው ያስባሉ? (ከአንድ በላይ መልስ መስጠት ይቻላል)

1. የገንዘብ ድጋፍ
2. የትምህርት ድጋፍ
3. የክህሎት ስልጠና ድጋፍ
4. የህክምና ድጋፍ
5. የማህበራዊና የስነ ልቦና ድጋፍ
6. የምግብና የአልባሳት ድጋፍ
7. ሌላ ካለ ----------
8. አላውቅም

29. የሚያሳድጓቸው ወላጆቻቸውን በሞት ያጡና ለችግር የተጋለጡ ህፃናት ያሉባቸው አበይት ችግሮች ምንድን ናቸው ብለው ያስባሉ? (ከአንድ በላይ መልስ መስጠት ይቻላል)

1. የገንዘብ ችግር
2. የትምህርት ድጋፍ ችግር
3. የክህሎት ስልጠና ድጋፍ ችግር
4. ህክምና የማግኘት ችግር
5. የማህበራዊና የስነ ልቦና ድጋፍ ችግር
6. የምግብና የአልባሳት ችግር
7. ሌላ ካለ ----------
8. አላውቅም

30. ልጆች በወላጆቻቸው ሞት ምክንያት የስነልቦናና የማህበራዊ ወይም የባህሪ ችግሮች አሉባአቸው ካሉ ከአለባቸው ዋና ዋና የስነልቦናና የማህበራዊ ወይም የባህሪ ችግሮች ቢጠቅሱልን? (ከአንድ በላይ ምላሽ መስጠት ይቻላል)

1. አስፈሪ ቅዠቶችንና ህልሞችን የማየት ስሜት
2. ደስተኛ ያለመሆንና የመከፋት ስሜት
3. ከሌሎች ልጆች ጋር የመጣላት/ያለመግባባት ችግር
4. ብቸኛ የመሆን ስሜት
5. የመጨነቅ ስሜት
6. በቀላሉ የፍርሃት ስሜት መሰማት
7. በቀላሉ የመቆጣት ስሜት
8. አዲስ ነገሮችን/ሁኔታዎችን የመፍራት ችግር
9. እንቅልፍ የማጣት ችግር
10. ጓደኛ የመመስረት ችግር
11. በቀላሉ ተስፋ የመቁረጥ ችግር
12. ከቤት ልውጣ ልውጣ የማለት ስሜት ችግር
13. የምግብ ፍላጎት የማጣት/ያለመመገብ ችግር
14. የአድሎና የመገለል ችግር
15. ሌላ ካለ ይጥቀሱ ----------

32. በእርስዎ አመለካከት ልጆችን የሚያስጨንቁአቸው ዋና ዋና ነገሮች ምን ምን ናቸው ብለው ያስባሉ? ----------

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33. በወላጆቻቸው ሞት ምክንያት የስነልቦናና ማህበራዊና ወይም የባህሪ ችግር ለደረሰባቸው ልጆች ምን አይነት ድጋፍ ስጥተው ያውቃሉ? ----------

34. በእርስዎ አስተያየት ወላጆቻቸውን ላጡና ለችግር ለተጋለጡ ህፃናት የስነልቦናና የማህበራዊ ወይም የምክር አገልግሎት ድጋፍ ለመስጠት በጣም የተሻለው መንገድ ምንድን ነው ብለው ያስባሉ? ----------

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35. ልጆች ጥሩ ዜጋ እንዲሆኑ የስነልቦናና ማህበራዊ ወይም የምክር አገልግሎት ድጋፍ የመስጠት ሀላፊነት የማን ነው ብለው ያስባሉ? (የቅርብና የሩቅ ቤተሰብ አባላት፣ የማደጎ ልጅ ተንከባካቢ ግለሰብ፣ አሳዳጊ ድርጅት) ----------

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36. በእርስዎ አመለካከት ወላጆቻቸውን ላጡና ለችግር የተጋለጡ ህፃናትን ጥሩ ዜጋ ለማድረግ ህፃናትን ለሚያሳድጉ ወይም ለሚረአዱ ለምሳሌ ለእንደርስዎ ዓይነት ሰዎች ምን ዓይነት ድጋፍ እንዲደረግላቸው ይፈልጋሉ ብለው ያስባሉ? ----------

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የቤተሰብ የገቢና የድጋፍ ፍላጎት ሁኔታ

37. ለቤተሰብዎ የገቢ ምንጭ አለዎት?

1.አዎ 2.የለም

38. ለጥያቄ 37 መልስዎ አዎ ከሆነ የቤተሰብዎ ፍላጎት ለማሟላት የገቢ ምንጭዎን የሚያገኙት እንዴት ነው?

1. በግል ስራ
2. በቤተሰብ ስራ
3. በዘመድ ድጋፍ
4. በድርጅት ድጋፍ
5. ሌላ ----------
6. አላውቀውም

39. ለጥያቄ 37 መልስዎ የለም ከሆነ የቤተሰብዎን ፍላጎት ለማሟላት የሚወስዱአቸው ሌሎች የአማራጭ ዘዴዎችን ምንድን ናቸው? ----------

40. ወላጆቻቸውን ላጡ ለችግር ለተጋለጡ ልጆችን ለመንከባከብ ከቤተሰብዎ ውጭ ድጋፍ ያገኛሉ?

1. አዎ 2. የለም

41. ለጥያቄ 40 መልስዎ አዎ ከሆነ ድጋፉን የሚያገኙት ከማን ነው? (ከመንግስታዊ ያልሆነ ድርጅት፣ ከመንግስታዊ ድርጅት፣ ከህብረተሰብ አቀፍ ድርጅቶች፣ ከእምነት ድርጅቶች ወዘተ) ይጠቀሱ? ----------

42. ለጥያቄ 40 መልስዎ ድጋፍ አገኛለሁ ከሆነ በየስንት ጊዜው ያገኛሉ? (በየሳምንቱ፣ በየወሩ፣ በሶስት ወር አንድ ጊዜ ...ወዘተ)

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43. አሁንም ለጥያቄ 40 መልስም ድጋፍ አገኛለሁ ከሆነ ምን ምን አይነት ድጋፍ ያገኛሉ?(ከአንድ በላይ ምላሽ መስጠት ይቻላል)

1. የገንዘብ ድጋፍ
2. የምግብ ድጋፍ
3. የት/ቤት ክፍያ
4. የማህበራዊ ስነልቦና ወይም የምክር አገልግሎት ድጋፍ
5. የስልጠና ድጋፍ
6. የህክምና ክፍያ
7. ሌላ ----------
8. አላውቅም

44. ወላጆቻቸውን ያጡና ለችግር የተጋለጡ ልጆችን የእለት ፍላጎታቸውን ለማሟላት የሚሠጠው ድጋፍ በቂ ነው ብለው ያስባሉ? ----------

45. በአጠቃላይ ወላጆቻቸውን ላጡና ለችግር የተጋለጡ ልጆችን ሁለንተናዊ ደህነት ለመጠበቅ ወይም ጥሩ ዜጋ እንዲሆኑ ለማድረግ ምን አይነት ድጋፍ ሊደረግ ይገባል ብለው ያስባሉ ? ----------
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46. ባለፉት አንድ አመት ውስጥ የስልጠና ድጋፍ አግኝተው ያውቃሉ?

1. አዎ 2. የለም

47. ምን አይነት ስልጠና አግኝተዋል? ስልጠውን ያገኙት በማን ነው?

ሀ.---------- ከ. ----------
ለ.---------- ከ. ----------

Addis Ababa University

School of Graduate studies

Department of Psychology

Key informant Interview Guide for Service Providers Organization

1. Name of the organization _____
2. Address: _____
3. Type of organizations _____
4. Name of interviewed person/position _____
   - Telephone _____
5. What is/are the objectives of the organization? a. _____
   b. _____
   c. _____
6. Does your organization undertake activities related to OVC? 1. Yes 2. No
7. Have you noticed in this area an increase in number of OVC? if yes,
   - How big is the problem of OVC now in this community? _____
   - What are the major causes of the increment of OVC in this area? _____
   - What effects do you think HIV/AIDS is having on the well being of children? _____
8. What are the major problems facing OVC in this community? Probe
   - Material needs (food, clothing, shelter, education) _____
   - Psychosocial needs (counseling, love & Care…) _____
9. What are the major support needs of OVC? _____
10. Are there specific criteria that must be met for children to benefit from your services? if so, please explain
11. What type of assistances/services does your organization provide to OVC?
    - ✓ Food
    - ✓ Health Care
    - ✓ Clothing
    - ✓ Psychosocial support /counseling
    - ✓ Financial
    - ✓ Training (IGA)
    - ✓ Education
    - ✓ School fee & other related costs
    - ✓ Others (specify) _____
12. Does your organization have access/Provide to psychosocial support/counseling for children & their families under your care? 1. Yes 2. No

13. If "yes" what type of psychosocial support does it provide? _____

_____

14. If "NO" why not? _____

_____

15. If your answer for question No 12 is 'yes 'who provided the service? (professionals, trained volunteers, etc) please explain how they provide the service? _____

_____

16. What practices/strategies are there in your organization to help children deal with their grief & stress when parents die?-

_____

_____

17. If your organization provides psychosocial support, do you think that the existing psychosocial support is adequate & sustainable? If it is not adequate, how can the existing care are improved?

_____

_____

18. What changes have you noticed in the psychosocial well being of children in the past working years?

_____

_____

19. What are the major gaps for providing the service? _____

_____

20. Does your organization have access to legal services for children & their families under your care? 1. Yes 2. No

21. How does your organization involve the community in support of OVC? _____

_____

22. What type of assistance/services does your organization provide to OVC care givers/guardians?

_____

_____

23. What do you think are the best ways to take care of OVC? Issues regarding the long-term care, psychosocial support (Helping children Deal with their emotional pain surrounding the death of their parents) etc? _____

_____

_____

24. What problems/challenges your organization is facing in relation to providing psychosocial support for OVC? _____

_____

_____

25. Do you have any additional comment on OVC psychosocial care and support and service providers' response in general?

_____

_____

_____

DECLARATION

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

Name: Desalegn Takele

Signature: ----------

Place: Addis Ababa University

Date of Submission: ---July/2007

I, the undersigned, declare that this thesis has been submitted for examination with my approval as a University Advisor.

Name: Belay Tefera (Dr.)

Signature: ----------

Place: Addis Ababa University

Date: ----------