Services for Vulnerable Children as a Means of Child Protection in Addis Ababa, Yeka Sub City,Woreda-03.

Ashenafi Tesfaye

A Thesis Submitted to

The School of Social Work

Presented in Partial Fulfillment of Requirements for the Degree of Masters of Social Work

Addis Ababa University

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This is to certify that the thesis presented by Ashenafi Tesfaye, entitled: Services for vulnerable children as a means of child protection in Addis Ababa, Yeka Sub city, Woreda-03 and submitted in partial fulfillment of the requirements for the degree of Masters of Social Work compiles with the regulation of the University and meets the accepted standards with respects to originality and quality.

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Abstract

Child vulnerability to various forms of neglect is one of the dominant social problems in Addis Ababa, Yeka sub city Woreda-03. The research attempted to describe the services available for vulnerable children. The research design was a cross sectional descriptive survey research. Among the ten sub cities of Addis Ababa, Yeka sub city woreda-03 was chosen for the study. The target groups were vulnerable children between the age group of 12-18 registered in the Woreda-03 vulnerable children list. The study used a two stage sampling to select the children. First, purposive sampling was used to select children from the list. And then, probability sampling with systematic sampling was used to select 174 children from 315 children to get the required information. The methods used to obtain the data included surveys, key informant interview, and personal observations. To address the plight of vulnerable children there are Government, Non-government and Community based organizations operating in the study area. The organizations were provided services such as food and nutrition, health care services, house renovation and economic strengthening. Psychosocial support in the form of counseling and participating in extracurricular activities were also provided. The result of the study also revealed that education and health services were the most frequently cited component of assistance provided to children .The overall assessment indicates that the children did not get adequate service. Those organizations that provided the services should focus on capacitating the children and their families instead of temporary provision. Moreover, there should be coordination among the organizations to address the needs of the children.

Keywords: Child protection, vulnerable children, services for vulnerable children, Yeka sub city Woreda-03.

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List of Abbreviations and Acronyms

CBO	Community-Based Organizations
CCF	Christian Children Fund
DOC	Daughters of Charity
FHAPCO	Federal HIV/AIDS Prevention and Control Office
GNE	Good Neighbors Ethiopia
GO	Government Organization
HIV/AIDS	Human Immune deficiency Virus
MOWA	Ministry of Women's Affairs
NGOs	Non-Governmental Organizations
OVC	Orphans and other Vulnerable Children
SHWA	Self Help Women Association
SPSS	Statistical Package for Social Sciences
TVT	Technical and Vocational Training
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
WH O	World Health Organization

Chapter One

1.1 Introduction

To a greater or lesser extent children are one of the most vulnerable groups in almost any society because of their physical, emotional dependence on adults and social status. Their vulnerability is greater in developing countries because of the higher incidence of poverty and less developed protection mechanism compared to industrialized countries. Children who grow up in socially, economically, and politically secured households and in societies where human rights respected are more likely to be self-sufficient, skilled and self confident individuals than children raised in stressful environment (Gabel, 2014:199).

Children are often considered a particular vulnerable group in society to the extent that in 1989 G.C the United Nations accorded those under 18 their own special rights under the United Nations Conventions on the Rights of the Child (UNCRC). These rights include the right to education, to family life and to be protected. Reflecting the view that society has a duty to protect children, Kofin Annan, the then UN Secretary General, declared that, 'There is no trust more sacred than the one the world have holds with children'. Most countries in the world have ratified this Convention (Spotswood et al, 2016: 211).

In Ethiopia, as in other developing countries, there are major factors that exposed children to risks and vulnerabilities which include: poverty, HIV/AIDS, war, recurrent drought and its subsequent food shortage or famine (Tsegaye, 2001). However vulnerability might be caused by other additional factors that include: sever chronic illness of parent or care giver and factors specific to the child including disability, direct experience of physical

or sexual violence or sever chronic illness (Skinner, 2006). Because of these factors vulnerable children have been suffering from various problems. Some of the problems they face include hunger, lack of access to health and education, physical and psychological abuse, lack of love and affection and negative communities' attitude towards them (Berry and Guthrie, 2003).

In response to all the problems of vulnerable children, it is necessary in an investment in health, education, and prevention of child exploitation, abuse and neglect, provision of legal protection to vulnerable children (Hailu, 2015: 213). Ethiopia has designed policies and national plans and ratified various conventions. The major policies, plan of actions and guidelines available in regarding vulnerable children are: child right conventions adopted by the country, National social protection policy, National plan of action for children and National OVC plan of action.

With the main goal of providing a standardized service for vulnerable children the Ministry of Women's affairs (MOWA) and the Federal HIV/AIDS Prevention and Control office (FHAPCO) have developed the standard service delivery guideline for Orphan and Vulnerable children (OVC). The guideline document contains seven core service areas which are considered critical components of services for vulnerable children. These core services are: food/nutrition, shelter and care, protection, health care, economic strengthening, psychosocial support and education.

Therefore a descriptive research on services provided to vulnerable children as a means of child protection was conducted in Addis Ababa, Yeka Sub-city, Woreda-03. The study identified and described the services provided to vulnerable children using the seven

core services mentioned in the standard service delivery guideline developed by MOWA and FHAPCO in 2010 G.C. The seven core service were : shelter and care, economic strengthening, legal protection, health care, psychosocial support, education, food and nutrition to vulnerable children by Government (GOs), Nongovernmental Organization (NGOs), Community Based Organizations (CBOs) and Individual volunteers in this area.

The finding indicates that education and health services were the most frequently cited component of assistant provided to children even though the services have their own limitations. Moreover the overall assessment indicates that the children did not get adequate service from the organizations. Those organizations that provided the services focus on temporary provision instead of capacitating the children and their families.

1.2 Statement of the problem

Child vulnerability to various forms of abuse and neglect is one of the social problems studied globally and nationwide. These studies focused on the type, cause, consequences of child vulnerability and preventive and protective programs in addressing child vulnerability i.e. child protection. Missaye Mulatie (2014) assessed forms of child abuse and neglect where as Daniel Hailu (2015) and Getnet Tadele (2001) explored causes of child abuse and neglect. Other researchers such as Johnson and James (2016), Hortwitz, Windom, McLaughin and White (2001) examined the consequence of child abuse and neglect on the children. Barth, Daro and Dodge, Stanger and Lansing (2009) and Darmstadt (1990) researched on child maltreatment prevention. Walsh and Douglas (2009) researched on child protective services. Landgren (2005) and Lachman, Poblete, Ebgbo, Nyandiya-Bundy, Bundy, Killian and Doek (2002) identified constraints on child protection. The last

group of researchers i.e. Abebe Senbeta, Tizita Yehualashet (2016), Yeshewahareg Feyisa (2015) focused on child protection efforts by community care coalitions.

Missaye Mulatie (2014) researched on forms of physical and psychological child abuse in North Gondar, Ethiopia. Most children faced physical abuse in the form of beating with an object, pinching and slapping on head. Moreover, substantial proportions of children were suffering from psychological abuse through terrorizing in the form of threatening with severe punishment and threatening to leave home, being seen as worthless or useless by parent or caregiver and negative comments by comparing with others.

Daniel Hailu (2015) and Getnet Tadele (2001) researched on causes of child abuse and vulnerabilities in Ethiopia with the case of children in Addis Ababa. Both researchers found poverty as a major causes of child abuse but Daniel Hailu added Globalization and HIV/AIDS as root causes of child vulnerabilities which generated other intermediate (food insecurity, exploitation and abuse, family disintegration and unsupportive parenting) and immediate (malnutrition, anxiety, depression, difficulty with trust and affective processing, disruptive behavior, aggression, addiction, peer socialization deficits and poor self-esteem) sources of child risks and vulnerabilities.

Johnson et al (2016) and Hortwitz et al (2001) examined the consequences of child abuse and neglect on later adulthood life. Their result indicates that child abuse and neglect brings more dysthymia, antisocial personality disorder, increased rates of substance abuse and relationship difficulties.

Barth, Daro et al, Stanger et al (2009) and Darmstadt (1990) researched on child maltreatment preventions in the United States. They revealed that educating parents on healthy parent-child interaction and child care practices can prevent child maltreatment. In

addition all added, except Barth, that interventions such as forming support groups facilitated by trained professionals, home visitation to deliver targeted services to individual families, community programs to provide services and access to financial support, public policies that provide maternity and paternity leaves as well as child care subsidies and individual or family therapy can prevent child maltreatment.

Abebe Senbeta, TizitaYehualashet (2016), Yeshewahareg Feyisa (2015), Walsh and Douglas (2009) explored child protection mechanisms. Whereas Walsh et al (2009) conducted their research in Qeensland, Australia the rest studied in Ethiopia. All revealed the importance of providing financial and material assistance in building the capacity of families to adequately provide for and protect their children.

Landgren (2005) and Lachman et al (2002) examined constraints on child protection. Landgren (2005) found that reluctance of the government and public on the subject of child abuses, donors' expectations of rapidly visible results, the perception that children's protection against violence and exploitation is marginal to critical development processes and the limited engagement of the private sector. Helping bring about the requisite changes not only to laws and policies but also to attitudes, customs, and beliefs that permit continued harm to children is a difficult and long term endeavor. Lachman et.al (2002) explored other constraints on child protection in developing countries namely poverty, HIV/AIDS infection and war. Poverty can be both financial and psychological which affects the effect of prevention programs. In many African and Asian countries, the AIDS pandemic has changed the social structure of society with AIDS orphans and children infected and affected by HIV/AIDS becoming more common. Many societies are in continual war zones, and to talk of child protection in these situations may not be realistic.

The above mentioned researches revealed that there have been many researches on child protection but targeted on the type, cause and consequences of child vulnerabilities. There are also ample researches on child maltreatment prevention, protection mechanisms and the constraints on child protection efforts. Despite all these, indentifying and describing the services provided to vulnerable children in addressing child protection did not adequately researched so far in Addis Ababa. This descriptive survey research addressed this gap by identifying and describing the services delivered to vulnerable children to protect them from abuse and neglect in Addis Ababa, Yeka Sub city Woreda-03.

1.3. Objective of the study

1.3.1 General Objective

The general objective of the study is to describe and analyze services provided to vulnerable children as a means of child protection in Addis Ababa, Yeka sub city, Woreda-03.

1. 3.2. Specific objectives

1. To identify and describe services available to vulnerable children in Addis Ababa, Yeka sub city, Woreda- 03.
2. To identify the Government, Non-government and Community based organizations, individual volunteers and other stakeholders that are delivering services for vulnerable children in Addis Ababa, Yeka sub city-Woreda-03.
3. To examine whether the seven core services (Shelter and care, Economic strengthening, Legal protection, Health care, psychosocial support, Education,

food and nutrition) which are considered critical components for programs that targets vulnerable children are addressed.

4. To identify and describe the views of the children towards the adequacy of the services in addressing their needs.
5. To reveal the living condition of vulnerable children in Addis Ababa, Yeka sub city-Woreda-03.

1.4 Research Question

What are the services provided to vulnerable children as a means of child protection in Addis Ababa,Yeka Sub city ,Woreda-03?

1.5. Scope of the Study

The main purpose of this study was identifying and describing services provided to vulnerable children as a means of child protection. The study was conducted in Addis Ababa, Yeka Sub city, Woreda-03. Among all the vulnerable children who are identified and registered by the Woreda's MoWAC affairs office, only children who are between the age category12-18 were selected for this research purpose.

1.6. Significance of the Study

The general objective of this study was identifying and describing the services provided to vulnerable children as a means of child protection. As its objectives the study revealed that education and health services were the most frequently cited component of assistant provided to children even though the services have their own limitations. Moreover the overall assessment indicates that the children did not get adequate service from the organizations. Therefore, this study can be used as a reference point for those organizations

that are engaged in development activities and interested to empower the vulnerable and disadvantaged groups.

The study also examined the services provided to the children in relation to the various policy documents available to improve the quality of care and services provided by governmental and non- governmental organizations involved in childcare. The document contains standard on the key component of services that should be provided to the vulnerable children by the organizations. Despite all this, the organizations operating in the study area focuses on service provision which is not in line with the guideline. It is not possible to say that all the services are provided to the children as stated in the guideline. Therefore this study revealed the gap of the policy mainly its implementation. So the concerned bodies i.e. both at the organizations and the higher levels can use this research to improve service delivery.

1.7. Definitions of Terms

Child: a child means every human being bellow the age of 18 (UNCRC, 2011). But for this research purpose a child refers to individuals whose age is between 12-18 years.

Vulnerable child: a vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights[1].

Child maltreatment: is any act of commission or omission by individuals, institutions, government, or society, together with their resultant conditions, which deprive children of

[1] Alternative Childcare Guidelines on Community-based Childcare, Reunification and reintegration Program, Foster Care, Adoption and Institutional Care Services (2009). Ministry of Women's Affairs, Ethiopia.

equal rights and liberties, and/or interfere with their optimal development (Reading et.al, 2009).

Child Protection: refers to preventing and responding to violence, exploitation, and abuse against children- including commercial sexual exploitation, trafficking, child labor and harmful traditional practices, such as female genital mutilation/cutting and child marriage (UNICEF, 2006). But for the purpose of this research a child protection refers to preventing and responding to child neglect.

1.8. Organization of the Study

This research paper was categorized in to six chapters. The first chapter deals with introduction, statement of the problem, objective of the study and research questions. The second chapter covers reviewing the related literatures that are relevant to the study. Chapter three discussed about the components of the research methods that are employed, followed by chapter four presenting the major findings of the study. The fifth chapter is about discussion of the major finding. The final chapter i.e. chapter six presented the conclusion and social work implications based on major finding.

Chapter Two- Literature Review

2. Introduction

This chapter presents the literature review obtained by summarizing the previous work related to the study from research articles, books and book chapters, published journals and accessed from the university's library in hard and soft copy. The chapter has seven main parts. The first part deals with child maltreatment, the different forms of child maltreatment. And then, the consequences of child maltreatment on the children discussed by various authors. The next part concerned with risk and protective factors for child maltreatment followed by the two response mechanisms for child maltreatment i.e. the preventive and protective mechanisms. The six part deals with the challenges for protecting the children from abuse and neglect and the last part presented the services that should be provided for vulnerable children.

2.1. Child maltreatment

The definitions of child maltreatment ranges from those that focus on the acts and harm caused to children by parents to those that define abuse relative to the social and cultural environment in which parents unable to cope at a level assumed to be reasonable by the society in which they reside. In both definitions, maltreatment is defined mainly in terms of physical, emotional and sexual violence or neglect perpetrated by individual adults, usually parents or those close to the child. In addition child maltreatment is also caused by collective harm and exploitation, for instance that caused by institutions, harmful policies and laws, war, conflict, failure of governance or social disruption (Reading et.al, 2009:332).

2.2. Forms of child maltreatment

The world report on violence and health and the 1999 World Health Organization (WHO) consultation on child abuse prevention distinguished four forms of child maltreatment:

- Physical abuse;
- Emotional and psychological abuse;
- Sexual abuse ;
- Neglect;

The following section describes the four forms of child maltreatment.

2.2.1 Physical Abuse

Child physical abuse is defined as a non –accidental injury (including bruises, welts, cuts, burns, broken bones or other tissue damage) to the child inflicted by a parent or a caregiver in a parenting role. It also consists of hitting, shaking, throwing, poisoning, or scalding, drowning, suffocating which causes physical harm to a child (Stith *et al*., 2008: 14).

Injuries such as bruises, cuts, burns, bite marks, fractures, which are inconsistent with the child's age and development are considered physical indicators of a physically abused child. Other symptoms are: the child cannot recall how injuries occurred, or offers an inconsistent explanation, reluctant to go home, frequent absences from school, fear of adults, may cringe or flinch if touched unexpectedly, may display a vacant stare or frozen watchfulness, extremely aggressive or withdrawn, extremely compliant and/or eager to please (Department of Health, 1999: 5).

2.2.2 Emotional Abuse

Emotional abuse is the persistent emotional ill-treatment of a child which causes severe and persistent effects on the child's emotional development. This involves conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. In addition emotional abuse is causing children frequently to feel frightened or in danger (Becket, 2003: 73).

Bed wetting and/or diarrhea which is non-medical in origin, frequent psychosomatic complaints: headaches, nausea, abdominal pain and insufficient weight gain or inappropriate, weight loss are the symptoms of an emotionally maltreated child. Besides, the child may show extreme withdrawal or aggressive behavior, mood swings, overly compliant; too well-mannered; too neat and clean, extreme attention-seeking behaviors, poor peer relationships, severe depression, possibly suicidal and running away from home (Department of Health, 1999: 9).

2.2.3 Sexual Abuse

The definition of child sexual abuse requires two elements: sexual activities involving a child and an abusive condition (Finkelhor, 1994: 33). Sexual activities involving a child refers to activities intended for sexual stimulation. These activities exclude contact with a child's genitals for caretaking purposes. They are generally categorized as contact sexual abuse and noncontact sexual abuse. Contact sexual abuse is touching of the sexual portions of the child's body (genitals or anus) or touching the breasts of pubescent females, or the child's touching the sexual portions of a partner's body. Contact sexual abuse is of two types: Penetration, which includes penile, digital, and object penetration of the vagina, mouth, or anus, and non penetration, which includes fondling of sexual portions of the child's body,

sexual kissing, or the child's touching sexual parts of a partner's body. Non contact sexual abuse usually includes exhibitionism, voyeurism, and the involvement of the child in the making of pornography. Sometimes verbal sexual propositions or harassment (such as making lewd comments about the child's body) are included as well.

Abusive conditions exist when the child's partner has a large age or maturational advantage over the child; or the child's partner is in a position of authority or in a caretaking relationship with the child; or the activities are carried out against the child using force or trickery. All of these conditions indicate an unequal power relationship and violate the notion of consensus.

A sexually abuse child may show unusual or excessive itching in the genital or anal area, pregnancy or sexually transmitted infection, injuries to the genital or anal areas (e.g., bruising, swelling or infection). Beside these, behaviorally, the child could show age-inappropriate sexual play with toys, self, others (e.g., replication of explicit sexual acts), age-inappropriate, sexually explicit drawings and/or descriptions, bizarre, sophisticated or unusual sexual knowledge involvement in sexual exploitation, cruelty to animals, and fear of home, excessive fear of adults' depression or other mental health challenges (Department of Health, 1999: 6).

2.2.4 Child Neglect

Child neglect is persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health and development. It may involve a parent failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical

care or treatment. It may also include neglect or unresponsiveness to a child's basic emotional needs (Stith et al, 2008: 19)

The definition of child neglect is susceptible to cultural interpretations of parenting practices. In some cultures it is not considered neglectful for children to stay in the home unsupervised because of the proximity of extended family or close ties in the neighborhood (Stanger and Lansing ,2009:)

According to Stith et al (2008), the major indicators of child neglect are abandonment, unattended medical or dental needs, lack of supervision, hunger, inappropriate dress, poor hygiene, persistent health conditions (e.g., scabies, head lice, diaper rash or other skin disorder), developmental delays (e.g., language, weight). The child may also display fatigue or listlessness, falls asleep in class, steals food, reports that no caregiver is at home, frequently absent or late for school.

2.3 Consequences of child maltreatment on children

The potential consequences of child maltreatment are profound and have both long and short term consequences. The long-term consequence includes possible brain damage, developmental delay, learning disorders, problems in forming relationships (interpersonal and social difficulties), aggressive behavior, depression, low academic achievement, substance abuse, teen pregnancy, sexual re-victimization, and criminal behavior. The more immediate effects include feeling helpless, hopeless and ashamed. Victims may feel unworthy of having friends, become fearful, isolate themselves leading to decreased self-worth, self-blame, guilt and shame as well as negative feeling about their own bodies (Lambie, 2005:250).

Brain imaging techniques have enabled scientists to document the effects of abuse and neglect on the developing brain. These images show that violence, abuse and neglect early in life damages the brain's physical structure by impairing cell growth, interfering with the formation of health and altering the neural structure and function of the young brain. These neurobiological findings explain some of the emotional, psychological and behavioral difficulties as a result of violence, abuse and neglect in early childhood (McEwen, 2007: 54).

According to Erickson and Engeland (1996), the consequences of child neglect extend beyond immediate concerns for a child's health, nutritional adequacy or medical status. Children are emotionally neglected when their caregivers are disinterested, unresponsive, or grossly insensitive to their needs. Neglected children stand out among their peers for their diminished self-esteem, lack of confidence, general unhappiness and low school achievement. They tend to be passive and exhibit some of the characteristics of learned helplessness, although angry and outbursts and noncompliance are also characteristics of neglected children.

The consequences of physical abuse on children are diverse, extending far beyond the manifest physical symptoms. A physically abused child may reveal in the long term a more aggressive behavior than other children as well as more prone to oppositional behavior, fighting, delinquency and criminality. These externalizing behaviors may be accompanied by self-injuries and suicidal behavior, substance abuse, emotional problem, difficulties in peer relationships (such as deficient social problem solving skills and limited empathic capacity) as well as problems in academic achievement (Thompson and Wyatt, 1999: 185).

The victims of sexual abuse, according to Thompson and Wyatt (1999), can also show problems including depression, anxiety, diminished self esteem, social withdrawal, age

inappropriate sexualized behavior as well as self- destructive behavior like substance abuse or suicidal attempts. The destructive feeling about self can manifest in self-mutilation, developing perfectionist tendencies and focus on overachievement as a form of escapism by concentrating on areas that may provide them with some sense of control (e.g. school success). This type of perfectionism may be accompanied by anxiety and inflexibility.

In short, the effects of child maltreatment compromise life time productivity which can cause further harm, significant cost to society and inhibit successful development. In addition many early childhood deaths attributed to child maltreatment and it is the leading causes of injury related deaths for children (Stanger and Lansing, 2009: 24).

2.4. Risk and Protective factors for child maltreatment

There is no one factor that explains why individuals abuse or neglect a child. Child maltreatment is a complex interaction among a number of factors operating at different levels. Generally factors that increases susceptibility are known as risk factors and those decreases susceptibility are referred to as protective factors.

2.4.1. Risk factors

While there are varying schools of thought on the origins of maltreatment, most theories of child maltreatment recognize that the root causes can be organized into a framework of four principal systems: the child, family, community, and the society.

The child factor

Though children are not responsible for the abuse inflicted upon them, certain child characteristics have been found to increase the risk or potential for maltreatment. Children with disabilities or mental retardation, for example, are significantly more likely to be

abused. Evidence also suggests that age and gender are predictive of maltreatment risk. Younger children are more likely to be neglected, while the risk for sexual abuse increases with age. Female children and adolescents are significantly more likely than males to suffer sexual abuse (Crosse, 1993: 22).

The family factor

Important characteristics of the family are linked with child maltreatment. Families in which there is substance abuse are more likely to experience abuse or are at a higher risk of abuse. Recent studies also have established a link between having a history of childhood abuse and becoming a victimizer later in life. Domestic violence and lack of parenting or communication skills also increase the risks of maltreatment to children (U.S. Department of Health, 2004: 2).

The family factor for child maltreatment, according to U.S. Department of health (2009), is related with the individual's close social relationships with family members or friends that influence the individual risks for inflicting and suffering from violence, abuse and neglect. Parents' lack of understanding of children's needs, child development and parenting skills, parents' history of child violence, abuse and neglect in family of origin; substance abuse and/or mental health issues including depression in the family; parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income; non-biological, transient caregivers in the home (e.g., mother's male partner); parental thoughts and emotions that tend to support or justify violence, abuse and neglect behaviors.

The community factor

The factors at the third or community level, related to the settings in which social relationships take place. This includes communities, workplaces and schools. Community violence; concentrated neighborhood disadvantage (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol outlets), and poor social connections. Abusive mothers, for example, founded to have fewer friends in their social support networks, less contact with friends, and lower ratings of quality support received from friends (Sedlak and Broadhurst, 1996:37).

The societal factor

Perhaps the least understood and studied level of child maltreatment is that of societal factors. Ecological theories postulate that factors such as the narrow legal definitions of child maltreatment, the social acceptance of violence (as evidenced by video games, television and films, and music lyrics), and political or religious views that value noninterference in families above all may be associated with child maltreatment (Tzeng, Jackson, & Karlson, 1991:43).

In a nutshell, child maltreatment is associated with many risk factors which involve the child, the parent and the context in which the child lives. For example, one clear risk factor is the child's age. Many studies indicate that the younger a child is, the higher the risk for severe or fatal maltreatment. Parent risk factors are heterogeneous and cannot be characterized by a single psychological orientation or social situation. Risk seems to be related to both internal factors (competencies and vulnerabilities that the parent brings to the situation) and external factors

Contextual risk factors that contribute to maltreatment risk include small, sparse social networks and community disorganization and violence. Some data also suggest correlations between child maltreatment in the home and domestic violence, substance abuse, single parenting, and teen pregnancy. Among contextual risk factors, the relationship between poverty and maltreatment is particularly complex. Maltreatment is more commonly reported to child welfare agencies in poor and extremely poor families than in families with higher incomes. Research does suggest a direct link between social stressors, especially perceived economic stress, and higher rates of child abuse (Stanger and Lansing 2009:25).

2.4. 2 Protective Factors

Just as there are factors that increase the susceptibly of children to violence, abuse and neglect, there are also factors that offer a protective effect. Protective factors reduce the interpersonal and environmental challenges children face and build a network of protective or supportive factors that can help children cope with risks. The factors that may protect children from maltreatment are categorized as child factors, parent and family factors, social and environmental factors (Family Support Network, 2002: 34).

Child factors

Child factors that may protect children include good health, above-average intelligence, hobbies or interests, good peer relationships, an easy temperament, a positive disposition, an active coping style, positive self-esteem, good social skills, an internal locus of control, and a balance between seeking help and autonomy (Mrazek, 1987: 99).

Parent and family factors

The parent and family protective factors that may protect children, according to Mrazek (1987), include secure attachment with children, parental reconciliation with their own

childhood history of abuse, supportive family environment including those with two-parent households, household rules and monitoring of the child, extended family support, stable relationship with parents, family expectations of pro-social behavior, and high parental education.

Social and environmental factors

Social and environmental factors that may protect children include middle to high socioeconomic status, access to health care and social services, consistent parental employment, adequate housing, family participation in a religious faith, good schools, and supportive adults outside the family who serve as role models or mentors (Family Support Network, 2002:37).

2.5 Challenges of Child Protection

The challenges facing children in the 21st century are immense and will need to be faced to achieve the goal of child protection for all. There are three major constraints that hinder the child protection efforts: Poverty, HIV/AIDS, and War. The subsequent sub sections dealt with the constraints.

2.5.1 Poverty

The effect of poverty on society and hence on child protection examined by many researchers. Ebigbo (2002) first use a philosophical approach that he got from his father to understand the concept of poverty and later use these concepts to reveal the impact of poverty on child protection in Africa. According to him there are three types of poverty i.e. Ill-tempered poverty, dependence poverty and poverty of the mind.

Let us briefly see these concepts because, as he said, poverty in Africa cannot be understood without using these concepts. The first type of poverty is Ill-tempered poverty- the person is so poor that he is always angry and curses anybody with whom he interacts. Of course the person is not in a position to even know what he can do to help him. He is condemned to perpetual poverty. The second type is about those who have learned to depend on others for their subsistence practice dependence poverty. They have not developed the attitude of self-help and have learned to be helpless. As they cannot help themselves, they cannot escape poverty without outside change in attitudes. The third type of poverty is *poverty of the mind.* This reflects the lack satisfaction with anything the person has, and he always feels cheated and disadvantaged by others even if he is cheating. He said poverty can prevent society as a whole from addressing the needs of children at risk, and it may well place children at risk (Ebigbo, 2002: 592).

Using these concepts Ebigbo discussed the impact of global debt, burden of dependency and poverty of the mind have on child protection in Africa.

The burden of debt

Global debt is now a major issue in many less developed countries. The poverty that faces the population of Africa negates against any realistic prospect of effective child protection services being developed. An examination of the African countries' debt indicates clearly that debt overshadows basic social service. This has resulted in tight controls by the IMF, World Bank, and other major economic institutions. The problem of management of debt is paramount. How can a country plan to relieve poverty when even before planning income is servicing debt? The survival instinct results in the human characteristics and leads

to war, embezzlement, military regimes, child trafficking, child prostitution, early marriage, street child existence, ignorance, poverty, and disease (Ebigbo, 2002: 593).

The burden of dependency

Even if the debt burden were to be relieved, the second type of poverty operative in Africa, namely learned dependency and helplessness prevailed. The African, having discarded culture, tradition, and having been forced into Western ways of doing things, suffers a confusion of norms and values and a misplacement of priorities.

Poverty of the mind

Ebigbo (2002) also discussed about poverty of the mind in the following way. In the midst of poverty and hard conditions, there are always some who persevere, who have learned to be ruthless and egoistic to survive. Many members of the ruling classes in Africa fall into this category of poverty. They suffer from the get-rich-quick syndrome, the wealth-amassing syndrome and the insatiable taste for wealth syndrome. If they become heads of state, they are not guided by the welfare of the people but by creating opportunities for amassing wealth and taking it out to other countries for safe keeping for themselves and their relatives. They can go to war to defend their ill-gotten wealth. This results in the spread of poverty around them.

2.5 2 HIV/AIDS

AIDS affects children in many ways and some of these we have not even begun to understand. For example, a mother may be absent for long periods during which she is unable to care adequately for her children because she is caring for a family member in another household and/or attending funerals. Orphans, especially those who lose their parents to HIV/AIDS, suffer among other things from: Having to care for sick and dying parents

(without protective clothing) and younger siblings, as they become "parentized" themselves and lose out on their childhood; Loss of income as parents are unable to work, become ill, and die; Having to witness and endure parental death(s) and the associated emotional stress; Stigma within the community if it is suspected or known that their parent died of AIDS; Uncertainty regarding the future, since cultural taboos hinder discussion of succession issues while the person is still alive and many parents do not write wills; The effects of sibling separation and dispersion intended to lighten the burden of those who take up the mantle of care, but which results in the children suffering separation trauma, loss, and emotional stress; Situational trauma, in which children in urban areas who are largely taking care of themselves cannot afford service bills (for water, electricity, and sometimes rent); Inability to access their deceased parents' estate because of not having birth certificates (Lichman et.al, 2002: 598).

The suffering of children orphaned through HIV/AIDS has three major components. *Economic*-at all levels, from family to government, lack of funds, in its worst form, poverty, makes the economic burden of caring for orphans frequently close to intolerable and at other times impractical. In fact it has been observed that poverty and HIV/AIDS reinforce each other. *Cultural*-as in most African cultures, there are clear dictates which deal with status and care of orphans. However, when confronted by the AIDS pandemic, these cultures are no longer able to cope, and children not only find themselves without caregivers but also find some alternatives proscribed, such as adoption, that violate the family totem. *Social stigma*-the ability of both traditional and modern institutions to adapt to the needs of the orphans in the HIV/AIDS context is severely constrained by the stigma attached to the disease. Indeed,

this includes the suspicion of the disease, which reduces what little help might be available by a significant amount (Lachman et.al, 2002: 599).

2.5.3 War

War in the last half of the 20th century has changed dramatically from the wars that occurred previously. Destruction of communities through instilling terror, humiliation, and degradation on ordinary citizens has become the focus of war. This has major adverse consequences for children raised under these conditions. They live with disrupted social, educational, health, and economic infrastructures. They experience the death and maiming of family members. Their families become fragmented and disintegrate. At the individual level, 10%–20% of children exposed to war are likely to develop psychiatric conditions. However, it is the psychodynamic consequences which are of particular concern. When children grow up without protective parents, observing parental humiliation and terror, revenge fantasies are likely to develop. Children's education is disrupted, with consequent limited educational opportunities (Lachman et.al, 2002: 600).

The changing face of war

The terrible face of war has undergone major transformation with dire consequences for children. The available statistics reflect the extent of the problem. There have been 35 major wars since 1980. Internationally, there are currently at least 40 areas of active conflict. During the period 1986–1996, it is estimated that more than 2 million children were killed in armed conflicts, 6 million children injured, and 1 million children orphaned (UNICEF, 1999).

A dominant feature of war and organized violence has become the use of widespread terror campaigns to disrupt the entire fabric of social, economic, and community relations,

creating a fragmented and disempowered society. The targets are psychological warfare at a grassroots community level. The battlefields are the homes, schools, neighborhoods, and villages. The people who are victimized by war are subjected to deliberate and systematic violence. War creates the disruption of community, educational, health, and economic infrastructures, coupled with loss of life, fragmentation of families, and displaced populations.

The impact of war and organized violence on children

Researchers have reported a wide range of negative consequences for children exposed to war and organized violence. Documented psychiatric symptoms include severe manifestations of anxiety, depression, post-traumatic stress disorders, and emotional and conduct disorders). However, it is the non psychiatric impact of war on children which is perhaps more pervasive, more damaging, and less readily identified. These include distorted family relations, revenge fantasies, compromised cognitive and scholastic functioning, and possibly disrupted moral development (Dawes, 1994; Paeans, 1994; Terr, 1991 cited in Lachman et.al 2002:6003.

Under normal circumstances, children grow up with a belief that their parents are strong, powerful, and able to protect them. War exposes children to situations in which they witness their parents' terror, helplessness, and humiliation. Children grow up knowing, at a developmentally inappropriate stage, that their parents are at significant risk and may lack the ability to take care of them. This disrupts the traditional family hierarchical subsystems and the belief in parental omnipotence. In psychodynamic terms, experiencing one's parent as lacking the ability to protect one has been linked to the origins of aggression, shame, and the desire for revenge. Freud, in his autobiography, described a scene in which his Jewish father

was subjected to a meaningless act of humiliation. He then identified this incident as giving rise to intense revenge fantasies and feelings of shame and humiliation when he observed his own father's submissiveness. Children raised in war suffer a compromised education. It is obvious that children living in fear cannot attend to their education. Anxiety, depression, poor concentration, fatigue, and ill health all impede scholastic achievement, leading to poor performance, high truancy, high dropout and failure rates, with the associated problems of limited employment opportunities (Lachman et.al, 2002: 603).

2.6. Vulnerability

In the literature, there are five versions of vulnerability. The subsequent paragraphs describes this versions identified by Hurst (2015).

The first is human finitude. Vulnerability in this sense is a fundamental characteristic of human beings: we are interdependent, fallible; capable of suffering, mortal. This notion is, of course, important. Were we not vulnerable in this sense, our moral life would no doubt be very different. This form of vulnerability, however, because it is common to all human beings, cannot provide grounds to identify persons requiring special protection.

The second is incapacity to defend one's own interests. In this version, persons are considered vulnerable if they are incapable of giving free and informed consent, or if they are more likely to be exploited. The third version of vulnerability is fragility. Here, vulnerability is viewed as a greater risk of injury or physical or mental harm. Etymologically, vulnerability denotes the ability to be hurt. In the fourth version, vulnerability is viewed as resulting from barriers to health. Persons are considered vulnerable if their access to care is limited, or if their chances for good health are limited.

In a fifth version, some abandon the goal of providing a view of vulnerability altogether and consider whoever is on a list of vulnerable populations or persons to be vulnerable. Different lists have thus been compiled, mostly in research ethics guidelines. Children are always included in such lists. However, some are so extensive that it becomes unclear if anyone can truly be considered as not particularly vulnerable.

2.7. Responses for child maltreatment

The types of programmatic response for the protection of children from violence, exploitation and abuse can be broadly categorized into preventive and protective. Whereas the preventive focus on addressing systems that have failed to protect children, the protective concentrates on addressing symptoms (Howing, Wodarski, Gaudin and Kurtz, 1989:56).

2.7.1 Preventive Approaches

Children's protection from violence, exploitation, and abuse is weak in much of the world. The types of programmatic response supported have tended to be curative rather than preventative in nature, addressing symptoms rather than the underlying systems that have failed to protect children. Prevention is intuitively and morally preferable to intervening after the fact (Landgren, 2003: 215).

Child maltreatment prevention efforts divided into three and discussed as *Universal prevention efforts* which attempt to influence the attitudes and behaviors of the population at large to achieve primary prevention, *Targeted (selective) efforts* which are aimed at specific programs in particularly defined "at-risk" populations to achieve secondary prevention and *Indicated efforts* which are designed to prevent further maltreatment where abuse has already been reported. Universal and targeted approaches are considered to be "before -the -fact"

prevention efforts, while indicated interventions are "after-the-fact" approaches (Stanger and Lansing (2009:24).

Although several strategies are reported to prevent child maltreatment, the most common strategies associated with child maltreatment prevention are: home visiting, parent education, early childhood centre-based services, family resource centers, communications i.e. changing social and cultural norms, legal reforms and the promotion of child rights (Palusci and Haney, 2010:9). The following sections will clearly describe these prevention strategies.

2.7.1.1 Home Visiting

Home visiting is an increasingly popular method for delivering services for families, and as a strategy for preventing child abuse and neglect. It provides one-to-one parent education and support and has been used as a way to serve hard-to-reach families, frequently in situations where parents are isolated and/or they are unlikely to participate in parent groups. Using home visiting programs as one strategy for reaching children can help prevent more long-term costs and promote healthy social and emotional development. These programs offer information, guidance, and support directly to families in their home environments, eliminating many of the scheduling, employment, and transportation barriers that might otherwise prevent families from taking advantage of necessary services (Stanger and Lansing (2009:36).

Home visiting programs aims to prevent child abuse and neglect by influencing parenting factors linked to maltreatment like inadequate knowledge of child development, belief in abusive parenting, empathy, sensitive, responsive parenting, parent stress and social support, and the ability to provide a safe and stimulating home environment. By changing

these factors, home visiting programs also seek to improve child development and health outcomes associated with abuse and neglect. These programs noted the reductions of 40% of child maltreatment (Palusci and Haney, 2010:10).

2.7.1. 2. Parental Education

One of the strategies that have received increasing attention is parent education programs. Parent education interventions can be delivered in a wide variety of settings and are designed to develop positive discipline approaches, increase knowledge of child development and promote positive parent child interactions. These programs have been implemented at community level where the program is available to all as well as a more targeted population identified to be at risk. Although some argue that parent education cannot succeed unless family problems are also addressed, much evidence suggests that first helping parents to be more effective with their children can address a range of individual and family risk factors (Palusci and Haney, 2010:10).

The successes of parenting programs are varied and dependent on the retention of the parents and their ability to adopt and implement the positive behaviors to reduce child violence, abuse and neglect. Effective parent education programs had explicitly stated measurable outcomes, were of sufficient length and intensity , had interventions tailored to a family's developmental milestones, were based on a strength based model, and demonstrated an ecological approach that was sensitive to the influence of neighborhood and community contexts(*ibid*).

2.7.1. 3. Centre-based Early Learning Programs

Early childhood development programs, both formal and informal, for preschool children provide an ideal opportunity for ensuring positive child development and in

strengthening the quality of families to provide and care for their young children. While the organization and structure of early learning programs vary widely, the goal of quality programs address all aspects of children's development (social-emotional, language, cognitive and physical) and provide a solid foundation for the child's success in early primary school. Applying the strengthening families approach, early childhood settings provide support to parents to help them develop positive relationships, increase knowledge of parenting and child development. Services for parents include peer support groups, lending libraries, parent-information sessions, or volunteer projects. The focus is on protective factors but early childhood staff is also trained to recognize risk and respond to early warning signs of abuse and neglect (Stagner and Lansing, 2009: 26)

2.7.1. 4. Community Strategies

Large body of theory and empirical research suggests that intervention at the neighborhood level is likely to prevent child maltreatment within families. The two components of intervention that appear to be most promising in community strategies are social capital development and community coordination of individualized services. Social disorganization theory suggests that child abuse can be reduced by building social capital within communities—by creating an environment of mutual reciprocity in which residents are collectively engaged in supporting each other and in protecting children (Palusci and Haney, 2010:11).

Community strategies to prevent child abuse and promote child protection have focused on creating supportive residential communities whose residents share a belief in collective responsibility to protect children from harm, and on expanding the range of services and instrumental supports directly available to parents. Both elements—individual

responsibility and a strong formal service infrastructure—are important. The challenge, however, is to develop a community strategy that strikes the appropriate balance between individual responsibility and public investment (Daro & Dodge, 2009: 72).

Daro and Dodge (2009) have also noted that, in the short run, the case for community prevention is promising on both theoretical and empirical grounds. Community prevention efforts are well grounded in a strong theory of change and, in some cases, have strong outcomes. At least some of the models have reduced reported rates of child abuse and injury to young children, altered parent-child interactions at the community level, and reduced parental stress and improved parental efficacy. When focusing on community building, the models can mobilize volunteers and engage diverse sectors within the community such as first responders, the faith community, local businesses, and civic groups in preventing child abuse. This mobilization can exert synergistic impact on other desired community outcomes, such as economic development and better health care.

2.7.1. 5. Communications: Changing Social and Cultural Norms

Social and cultural norms contribute in powerful ways to the presence of child violence, abuse and neglect. Legal reform is unlikely by itself to exert a major impact unless it is accompanied by a change in norms regarding the value and status of children, the effectiveness of punishment, gender roles and family privacy. Public awareness and media campaigns can play an important role in highlighting the extent and nature of child violence, abuse and neglect (Palusci and Haney, 2010:14).

Evidence to change norms is difficult to ascertain. A few studies of large-scale interventions have found shifts in attitudes and norms regarding the use of violence against young children. Public campaigns can encourage adults to understand and identify the

warning signs of abuse and act on them before an act is committed. Advocacy campaigns can also identify help and support for those at risk of abuse. Social norms are critical variables in the development and implementation of prevention programs.

2.7.1. 6 Legal Reforms and the Promotion of Child Rights

The Convention on the rights of the child committed countries to take all appropriate legislative, administrative, social and educational measures to prevent violence against children. Translating the convention into national laws and giving judicial systems the power and responsibility to enforce these laws are fundamental prevention strategies. Legal frameworks can play a role in shaping social norms against violence, abuse and neglect of young children. Prohibiting harsh physical punishment and establishing legal requirements to report have been instrumental in countering the idea that child violence, abuse and neglect is a private matter only to be left to the family (Reading et al., 2009: 332).

2.7.1. 7. Challenges in Developing a Prevention Approach

Several barriers have slowed development of a prevention orientation in the field of child maltreatment. The first has been difficulties in defining the problem to be prevented. The second one is a failure to understand the full consequences and costs of child maltreatment and the third has been incomplete understanding of the causes of maltreatment and the ways in which intervention might interrupt those causes (Stanger, and Lansing, 2009: 23).

Moving from an approach that has been primarily palliative to one which is systemic and includes prevention poses huge challenges. Where violent, exploitative, or abusive practices are linked to traditions or belief systems, broaching change becomes a sensitive matter, touching on religion, politics, cultural identity, and shame. Sex and violence issues

which permeate child protection are frequently taboo for public and even private discussion (Langren, 2005:223).

2.7.2 Protective Approaches

The protective approach to child maltreatment focuses on protecting children after the incidence of maltreatment occurred. It involves treating abusive parents and the bused children. The following sections discussed the child protection approaches identified by various researchers.

2.7.2.1 Treatment with Abusive Parents

The different forms of maltreatment may involve different cause. Therefore, treatment goals for work with maltreating parents vary as a function of the types of abuse or neglect that have occurred. The treatment with physically abusive parents should focus on improving parent-child interaction and on increasing parental flexibility in responding to child behavior, where as treatment with neglectful parents should center on the provision of supportive services and the development of increased family cohesion and parental responsiveness. The treatment goal for sexual abusive parents aimed at ending the abuse through removal of the perpetrator or victim from the home, assisting the perpetrator in accepting full responsibility for the sexual misconduct, helping the victim to deal with his or her emotions, strengthening the mother's ability to protect the child and assisting the perpetrator, victim, and other family members to establish appropriate role boundaries (Howing et.al, 1989:331). Generally interventions for maltreating parents fall into four categories: individual therapy, group therapy, family therapy and community-based services.

According to Howing et al (1989), the individual therapy involves basic problem solving such as case-work counseling. It uses behavioral techniques with neglectful and

physically abusive parents. It focuses on teaching parents to track child behavior and utilize non physical punishment procedures (for example, time-out, response cost and withdrawal of privileges) to change parent-child interactional patterns. Techniques are selected according to individual assessment of treatment goals and may include verbal instruction, modeling, behavior rehearsal and the use of parent training manuals. Behavioral techniques also effectively have increased self-control and control of anger among abusive parents. The techniques include modeling, role play, relaxation, systematic desensitization, cognitive restructuring, self instruction and stress inoculation.

The group therapy involves a structured, time limited parent training programs in group. The program present information on child development, child management, stress reduction and anger management through lectures, discussion, films and home work assignments. Parents are thought to benefit from the mutual sharing of coping strategies and from peer feed-back and support. In addition, group treatment is seen as helpful in reducing social isolation, and is more economical than individual treatment (Evans, Garner and Honig, 2016: 1297)

Family therapy is effective with families involved in child neglect and somewhat other forms of maltreatment. It is also seen as a treatment choice for sexual abuse. However, the approach is contraindicated for physically or sexually abusive families. The self centered, destructive relationships of physically abusive parents with their children and the abusive parent's own needs for nurturance are seen as undermining the therapist's effectiveness in working with the physically abusive family system (Evans, Garner and Honig, 2016: 1298)

The community-based services rely on a broad range of community services to provide support to maltreating families. Child welfare agencies respond to a family's basic

needs for food, clothing, emergency shelter, medical services, transportation and legal assistance through referrals to other agencies. In addition they may provide services such as home visitors, respite care, home maker services or lay therapy (Brown, 1995: 39).

2.7.2.2 Treatment with abused children

Treatment with children is warranted not only to alleviate the developmental effects of maltreatment and to interrupt the generational cycle of maltreatment, but also to reduce the likelihood that maltreatment of the victim will recur. Treatment goals for maltreated children include helping the child to verbalize thoughts and feelings, identifying and decreasing cognitive deficiencies, addressing and ameliorating aggressive tendencies, improving social interaction skills with peers and adults, and supporting mastery of developmental stages (Steward et al, 1986: 44).

Howing et.al (1989) discussed three interventions most often utilized with children: individual therapy, group treatment, and community-based services. The individual therapy tailored to the maltreated child's specific needs and developmental stage. For the younger child, the approach uses play therapy, which utilizes the child's natural medium of communication. By assuming the roles of the child, parent, teacher, therapist or other significant person, the child may be able to work through his or her fear, hurt, confusion and anger within a relationship of trust. For the older maltreated child, individual therapy usually focuses on helping the victim self-disclosure about the trauma and verbalizes feelings about it. Art, writing and bibliotherapy are among the types of therapies used to encourage expression.

Group treatment contributes to positive outcomes for child and adolescent victims of maltreatment. It involves peer interaction and particularly useful with adolescents since they are developmentally predisposed to more open communication with peers. It is especially appropriate for younger maltreated children, who are thought to exert a corrective influence on each other through their observations and interpretations of shared traumatic experiences (Howing et.al, 1989:334).

The community based services for maltreated children involves day care programs which offer affection nurturing, stimulation and monitoring of nutrition and health care. Abused girls may benefit from daily social experiences outside of their nuclear families. In addition the provision of temporary shelter care for maltreated adolescents may also produce notable gains.

2.8 Orphan and Vulnerable Children (OVC)

A vulnerable child is one who is living in circumstances with high risks and whose prospects for continued growth and development are seriously threatened. In the international community, the term "Orphans and other Vulnerable Children," or "OVC" sometimes refers only to children with increased vulnerabilities because of HIV/AIDS. At other times "OVC" refers to all vulnerable children, regardless of the cause – incorporating children who are the victims of chronic poverty, armed conflict, or famine (PEPFAR, 2006:2).

The standard service delivery guideline for OVC care and support (2010) of Ethiopia defined a vulnerable child as a child who is less than 18 years of age and whose survival, care , protection or development might have been jeopardized due to a particular condition

and who is found in a situation that precludes the fulfillment of his or her rights. However, for these standards a more inclusive definition is used which includes all of the following:

- A child who lost one or both parents
- A child whose parent(s) is/ are terminally ill and can no longer support the child;
- Children living on or in the streets;
- A child exposed to different forms of child abuse, violence, and/or exploitation;
- A child in conflict with the law;
- A child who is sexually exploited;
- A child with disabilities;
- Unaccompanied children due to displacement.

2.8.1. Services for Vulnerable Children

The inclusion of child-friendly policies in national agendas does not in itself constitute a panacea to the plight of OVC. Effective and sustainable OVC interventions and programs are also necessary to meet the needs of OVC. Programs addressing the HIV/AIDS and related OVC crises have evolved considerably since the healthcare-centric programs characteristic of the initial years of the epidemic. Recognizing the strong interconnection between HIV/AIDS and development, most large-scale OVC programs began implementing activities along an established continuum of services to include interventions in health, psychosocial support, economic strengthening, education, shelter, food security and nutrition, and child protection (Senefeld and Perrin, 2014:131). The following section briefly describes these services which are also found in the standard service delivery guideline developed by MoWA and FHAPCO in 2010.

2.8.1.1 Food and Nutritional Support

According to the standard service delivery guideline developed by MoWA and FHAPCO (2010) food and nutrition services aim to ensure that vulnerable children have access to similar nutritional resources as other children in their communities. These are important components of OVC support since malnutrition underlies the major causes of deaths in children under five in developing countries. Food-security issues are extremely complex, and other organizations and international partners have strong comparative advantages in providing food assistance.

2.8.1.2 Shelter and Care

The HIV/AIDS epidemic overloads impoverished communities to the point where many children are left without suitable shelter or care. Those children who find themselves without a caregiver become highly vulnerable to abuse and stunted development. While institutional care might seem like a logical response to this situation, in some cases, it can impede the development of sustainable solutions and often does not meet the complex needs of children. While there is sometimes a role for institutional arrangements, they are not optimal for child development, sustainability or cost-effectiveness. Given the number of OVCs, particularly in sub-Saharan Africa, and their complex needs, the most effective responses place families, households and communities at the center of interventions (PEPFAR, 2006: 7).

Shelter and Care services strive to prevent children from going without shelter and work to ensure sufficient clothing and access to clean safe water or basic personal hygiene. An additional focus is ensuring that vulnerable children have at least one adult who provides them with love and support (MOWA and FHAPCO, 2010:9).

2.8.1.3 Legal Protection

According to PEPFAR (2006) the core values of OVC support is rooted in the principles of child protection – developing and implementing programs that place the best interests of the child and his or her family above all else. Thus, programs should include efforts to confront and minimize the reality of stigma and social neglect faced by OVCs, as well as abuse and exploitation, including trafficking, the taking of inherited property, and land tenure.

The desired outcome of legal protection for OVC is children receive legal information and access to legal services as needed including birth registration and property inheritance plans, OVC are protected from all forms of abuses, violence and neglect. It aim to reduce stigma, discrimination and social neglect while ensuring access to basic rights and services to protect children from violence, abuse and exploitation (MOWA and FHAPCO, 2010: 14).

The standard service delivery guideline also discussed access to legal protection for vulnerable children as legal services are free for OVC; strong referral networks are established between stakeholders; services are child-friendly and information is easily understandable and accessible; services are provided proactively to children instead of the child having to search for services; service mapping is available and identifies legal service providers; information about services is available in a variety of media including electronic, print and public forums such as schools, *Kebele* offices, media etc.

2.8.1.4 Health Care

OVC programs must take active measures to meet the general health needs of children at every age level. Programs must disaggregate health requirements and interventions by the age groupings (infant, toddler, child and adolescent), as the health needs and recommended interventions differ significantly among these groups, and programs should facilitate access to primary health care for OVCs (PEPFAR, 2006:8).

According to the standard service delivery developed by MOWA and FHAPCO (2010) the desired outcome for health care services for vulnerable children are access to health services including HIV and AIDS prevention care and treatment . It includes the

provision of primary care, immunization, treatment for ill children, ongoing treatment for HIV positive children and HIV prevention.

Access to health care services also includes the existence of a referral network of local services; community-based services are strengthened; services are provided locally (either in the community by community based workers or at local health facilities or service providers); barriers to health care services are assessed and addressed (i.e. transportation, fee waivers); on-going access to treatment (including ART) is ensured and services are child-friendly (MOWA and FHAPCO, 2010: 16).

2.8.1**.5 Psychosocial Support**

Healthy child development depends a great deal on the continuity of social relationships and the development of a sense of competence essential to normal family life and child development. Children affected by HIV/AIDS suffer anxiety and fear during the years of parental illness, followed by grief and trauma with the death of a parent. Cultural taboos surrounding the discussion of AIDS and death often compound these problems. Children and their caregivers need love and emotional support, and the opportunity to express their feelings without fear of stigma and discrimination. Programs should provide children with support that is appropriate for their age and situation, and recognize that children often respond differently to trauma and loss. OVCs sometimes turn to drugs and alcohol as a means of coping with this trauma so programs must provide support to avoid these counterproductive activities (PEPFAR, 2006:9).

According to the standard service guideline, psychosocial Support services aim to provide OVC with the human relationships necessary for normal development. It also seeks to promote and support the acquirement of life skills that allow adolescents in particular to

participate in activities such as school, recreation and work and eventually live independently.

Access to psycho social support for OVC includes having play materials and environment; training and other service areas are convenient; materials and services are in accordance with beneficiaries' cultural and linguistic settings; every child has access to counseling – with Para-professional or laypersons, and with professionals if needed or requested; all services in community are accessible regardless of gender, disability etc.; every child/caregiver has information about where and how to access resources/services; environment and participation are free from stigma and discrimination; all community services are child- friendly; HIV-related counseling, testing, and treatment is confidential and of high quality; children have access to guidance and therapy as needed.

2.8.1.6 Education and Vocational Training

Research on children demonstrates that education can leverage significant improvements in the lives of orphans and other vulnerable children. Schools not only benefit the individual child, but can also serve as important resource centers to meet the broader needs of communities. Schools can provide children with a safe, structured environment, the emotional support and supervision of adults, and the opportunity to learn how to interact with other children and develop social networks. An education is the key to employability and can also foster a child's developmentally important sense of competence (UNICEF, 2009:32).

According to UNICEF (2009) communities must identify the barriers to education (e.g., requiring a father to register a child, mandatory payments for uniforms, book or tuition fees) and define locally-appropriate strategies for attracting and keeping children, especially girls, in school. Programs must give special attention to the vulnerability of girls, by

addressing the disproportionate levels of risk they face when leaving school at an early age. Schools must also be made safe for children, especially girls.

Vocational training is an important component of life preparation. Conversely, the lack of opportunity to learn a trade or the lack of a sponsor to enter vocational networks can compromise an adolescent's long-term economic prospects. Education is an important area for leveraging additional resources at both national and local levels. Partnerships with education programs sponsored by external donors and governments often provide resources that can help to ensure that children affected by HIV/AIDS have access to education. Education services seek to ensure that orphans and vulnerable children receive educational, vocational and occupational opportunities needed for them to be productive adults (UNICEF, 2009:32).

2.8.1.7 Economic Opportunity/Strengthening

Economic strengthening is often needed for the family/caregivers to meet expanding responsibilities for ill family members or to welcome OVCs into the household. Also, maturing children and adolescents need to learn how to provide for themselves and gain sustainable livelihoods. Linking OVCs and their families with programs providing economic opportunities is important. It is important to look for programs that base their economic-strengthening activities on market assessments and undertake joint efforts with organizations. Providing livelihood training without prospect of a job must be avoided. Interventions that save household labor and expenses can relieve the burden of diminished capacity and perhaps allow families to allocate resources for more productive, remunerative uses (UNICEF, 2009:39).

The desired outcome economic strengthening for OVC, according to the standard service delivery guideline, includes households caring for vulnerable children have sufficient income to care for children. It also has additional objectives of convenience to target group is considered when delivering services; all training materials are in accordance to and respectful of the local context; geographical proximity to OVC should be considered when arranging service delivery; selection criteria are transparent and prioritize the most vulnerable and families should have access to financial resources.

Chapter Three- Research Methodology

3. Introduction

In designing research, three questions needs to be addressed: what knowledge claims are being made by the researcher, what strategies of inquiry will inform the procedures, and what methods of data collection and analysis will be used (Creswell, 2003: 6). Based on this conceptualization the following section describes the research design used for identifying and describing the services provided for vulnerable children as a means of child protection in Addis Ababa, Yeka sub city Woreda- three.

3.1. Philosophical Assumption

Researchers may claim knowledge based on careful observation and measurement of objective reality that exists "out there" in the world (Creswell, 2003: 7). The reality of identifying and describing service provided for vulnerable children in Addis Ababa, Yeka sub city, Woreda-three can best be understood using this post positivist's philosophical construct.

This study had a primary purpose of making a descriptive survey on the types of services delivered to vulnerable children in the study area. Questionnaire was developed to interview vulnerable children selected for the study on the services they are receiving from different stakeholders. Moreover, observation check list and interview guide were prepared to get a more picture of nature of the services.

3.2 Research design

The research design of this study was a cross sectional descriptive survey as it was planned to identify and describe the services provided for vulnerable children in Addis

Ababa, Yeka sub city-Woreda- 03 by Government, Non government, community based organizations and individual volunteers. Here the intent was to generalize the service provision for vulnerable children as a means of child protection using a sample size of 174 vulnerable children between the age categories of 12-18 as the researcher believes that children in this category can express easily the types of services they are receiving from the concerned bodies.

The data collected within five days from vulnerable children included in the sample to describe the services provided for vulnerable children in Woreda. In a cross sectional descriptive survey, data are collected at one point in time from the sample selected to describe some larger population at that time (Rabbie, 1973:79.). A descriptive research has a major goal of describing a particular state of affair-determining type, forms and magnitude of its existence. It is a scientific investigation that tries to give a pictorial account of an event, behavior or situation (Belay and Abdinasir, 2015: 68).

Being cross sectional descriptive survey enquiry, this research identified and described the types of services provided for vulnerable children as a means of child protection using the Standard Service Delivery Guidelines for Orphans and Vulnerable Children (OVC) Care and Support Programs developed by Ministry of Women's Affairs (MoWA) and Federal HIV/AIDS Prevention and Control Office (FHAPCO) in 2010 as a reference. The guideline document contains seven core service areas which are considered critical components of services for vulnerable children. These seven service areas are: Shelter and care, economic strengthening, legal protection, health care, psychosocial support, education, food and nutrition.

The purpose of survey research varies depending on the types of research question that the researcher wants to answer. In descriptive survey research the purpose is describing the distribution of certain traits or attributes. The researcher is not concerned with why the observed distribution exist, but merely what that distribution is. Example: age and sex distribution, extent of unemployment or describing sub samples and comparing them (Rabbie, 1973: 76). This research asked "What are the services provided for vulnerable children as a means of child protection in Addis Ababa, Yeka sub city-Woreda three". So utilizing a descriptive survey research method, this research identified and described the services provided for vulnerable children by using frequency and percentage.

3.3. Methods of data collection

The common data collection methods applied to questions within the realm of descriptive research includes surveys, interviews, observations and portfolios (Mc Lellan and Knupfer, 1995: 1198). This research used survey, interview, and observation check list. Survey can take several forms and data can be collected in many ways. It can also be in the form of written questionnaires, personal interviews or telephone interviews. The researcher used questionnaires to fill the question by interviewing the children going to their house.

3.4. Study Area

Yeka is one of the ten sub cities in Addis Ababa City Administration. It is situated in the North Part of Addis Ababa, bounded from South by Bole, from West by Gulele, Arada and Kirkoss, from North and East by Ormoiya region. At present, the sub city is divided in to 13 woredas , 124 sub woredas, 394 villages (sefers), and 1344 blocks. The sub city has a land area of 8213.11 hectares and according to the 2007 census, the total population within the

sub city is 346, 484, from which 161, 480 are male while 185, 004 are female (Addis Ababa city Administration Integrated Land Information Center, 2014:21).

Yeka sub city woreda-03 is one of the thirteen Woredas in the sub city. It is found in west of woreda 10(Kotebe area), East of Ferensay legasion, North of Woreda -04 (Menelik hospital) and to the south of Ankorcha district. The land area covered by woreda -03 is 349.59 hectare and this constitutes 4.26 % of the total land area covered by the sub city. Moreover, according to the report of the central statistics office (CSA, 2007), the Woreda has about 18, 841 inhabitants (8540 male and 10301 female) which is about 5.44% of the sub city population.

Social services provided in the woreda by government, non government, or individual investors for the benefits of the dwellers. These services include education, medical care, housing and other social infrastructure that can be used to promote the well being of the community. Addis Ababa city administration plays a major role in a provision and management of municipal services such as parking, street cleanings, sanitation, housing, water supply, power supply, wastewater treatment, flood management, primary and secondary school, health care planning and zoning fire and ambulance services and other related public works in the woreda.

Education is one of the social services and a basis for countries social, economic, cultural and political development. Based on the survey made by integrated land information center there are only 4 KG and 2 primary schools in Woreda-03. Health is also the other principal social services in the woreda. Base on the information from Woreda-03 health

office currently there is one hospital, health center, medium clinic, lower clinic, laboratory and one pharmacy.

With regard to worship places, there are two Orthodox Church, one Islam Mosque and two protestant church. There is no cemetery and festival site in the woreda. There are also six governments and four non government organizations. In addition there are two community police stations, one financial institution, one Kebele entertainment center, one public library and the woreda is a residential place for Italy embassy.

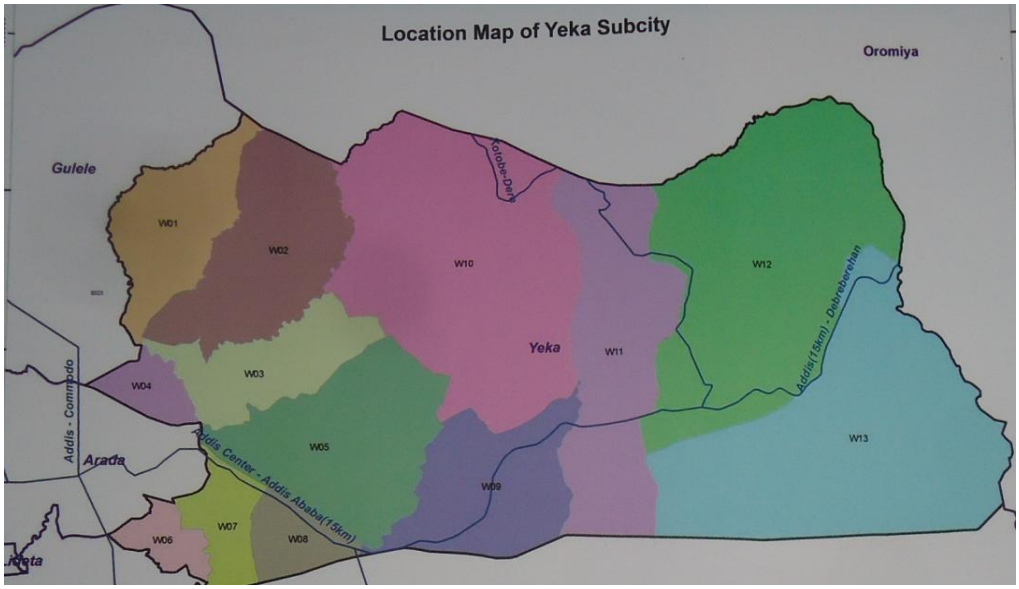

Fig 1 location map of Yeka sub city

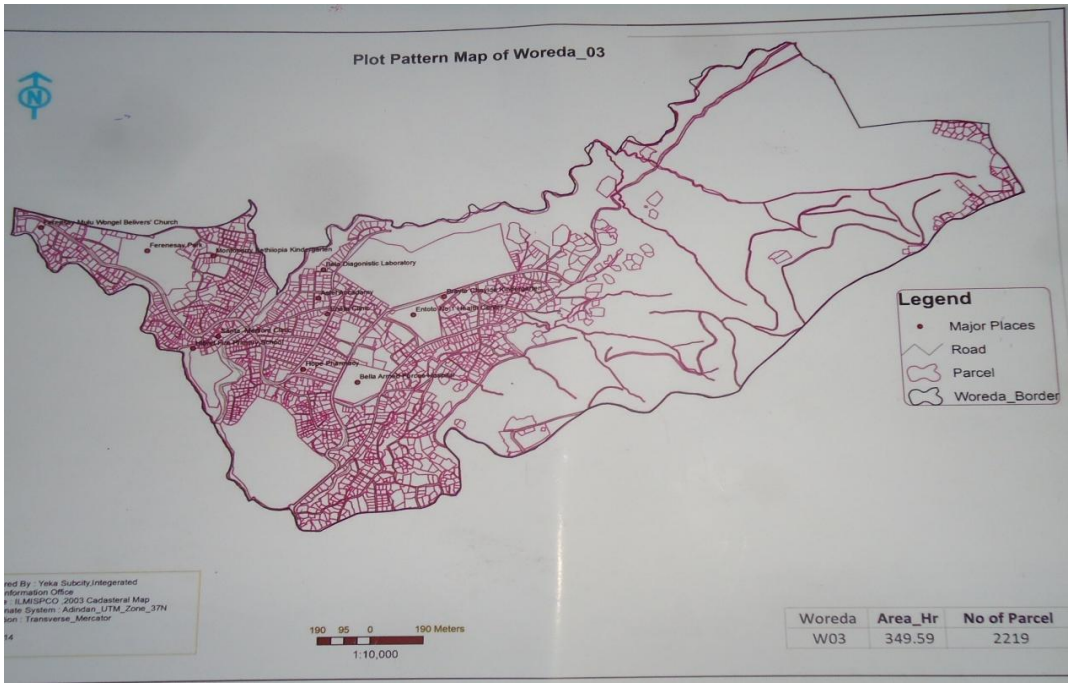

Fig 2 Plot pattern map of Woreda -03

Source: Addis Ababa city Administration Integrated Land Information Center (2014)

3.5. Population

The theoretically specified aggregations of elements generally termed as a survey population. A survey population is an aggregation of elements from which a survey sample is actually selected (Rabbie, 1973:79). According to a recent document from the Woreda-03 vulnerable children list there are 1367 children registered for various supports. From this there are 315 children who are in the age categories of 12-18. This served as a sampling frame for this study. Therefore the population of this research is defined as all registered vulnerable children in the age category of 12-18 in Yeka Sub city, woreda -03 of Addis Ababa.

3.6. Sampling and Sample Size

There are two types of sampling methods: probability and non probability sampling. In probability sampling all the members of the population have equal chance of being selection in the sample where as in non probability sampling all members of the population will not have equal chance of selection in the sample (Rabbie, 1973: 78). This study utilized a two stage sampling. First it used purposive sampling to select children between the age categories of 12-18 and applied probability sampling with systematic sampling. Using the general formula for calculating sample size which is drawn from a known population the sample size for this study was 174 vulnerable children between the age categories of 12-18.

The sample size was determined using the general formula for determining the sample size (n):

$$n = \frac{Z^2}{4e^2 + \frac{Z^2}{N}}$$

Where: n=the sample size

e= level of error=0.05

Z=the confidence interval=1.96

N= the population=315

$$n = \frac{(1.96)^2}{4\,(1.96)^2 + \frac{(1.96)^2}{315}}$$

$n \approx 174$

3.7. Data collection procedure

The researcher have collected the data by interviewing the vulnerable children to fill the questionnaire by presenting in their home for three days after school time i.e. after 3:30 pm and Saturday and Sunday the whole day to get more response, respond to questions arise from respondents and probe to get adequate answer. Qualitative data was also gathered by interviewing selected vulnerable children and using personal observation. This data used to supplement the data gathered from survey questionnaire.

3.8. Ethical Consideration

Certain ethical considerations were taken in this study as the survey is conducted among vulnerable children while collecting the data. The researcher was guided by certain ethical consideration obtained from ESOMAR World Research Codes and Guidelines (2009) for interviewing Children and Young People. Based on the code and guideline the following ethical consideration ware taken:

1. The welfare of the children was the overriding consideration – maximum care was taken to protect the children from harm or disturbance by the experience of being interviewed
2. The researcher collected the data in the presence of parents/guardian and key informants during the interview.
3. The parents or the guardian was ensured about the confidentiality of the research project towards the latter's safety, rights and interests.
4. Respondents had their own right either to respond or skip the question they were asked

5. The researcher reached in agreement with the authorities i.e. the Worda-03 Woman and children affairs office about taking the highest ethical standards and that there can be no question of any possible abuse of the children involved by explaining about the survey questionnaire.
6. As the survey was carried out in the home of the children the permission of a parent/guardian or any adult related to the child was first asked to do the interview. Moreover the researcher wait until the parent, guardian or any other adult presented to make an interview i.e. a child did not under any circumstances approached for an interview unless he or she is accompanied by an adult.
7. When requesting permission to carry out an interview, sufficient information were given to the person responsible for the child about the survey and the content of questions to reach in decision about giving such permission. Where it is not practicable for questions to be asked, the subject and general nature of the interview were explained. Moreover the identity of the person giving the permission for the interview was noted.

3.9. Methods of data analysis

After collecting data using questionnaire from the vulnerable children, answers were coded and analyzed using the Statistical Packages for Social Sciences (SPSS) soft ware. The data were analyzed using frequencies, percentage and cross tab. The variables for this study were the socio demographic data and the types of services delivered to vulnerable children.

Chapter Four- Findings of the study

4.1 Introduction

This chapter presents the findings obtained from the descriptive survey research. The primary data was obtained from survey questioner, interviewing key informant and personal observation. First different facts about vulnerable children under study were identified and described. And then the various services provided to vulnerable children as a means of child protection were described and the data was analyzed in relation to the services. The findings have been presented in two parts.

The first part focused on description of the socio-demographic characteristics of respondent children and analysis of variables using frequencies, measures of central tendency and cross tab. The cross tab was used to cross tabulate the average family size with the number of rooms of the children's house to know the adequacy of house for the children compared to the family size. Furthermore, the finding analyzed the sex and age distribution, the child main caring person and orphan hood status of the child.

The second part concerned with identifying and describing the service delivered to vulnerable children as a means of child protection using frequencies, percentage and cross tab. The seven key services for vulnerable children includes: Shelter and care services(housing condition and potential care giver identified and described), food and nutrition services (access to food and the nutritious content of the food), economic strengthening for the parents or guardians, health care services, educational services, psychosocial services and legal protection services were identified and described.

4.2. Demographic characteristics of respondent

The sex composition of vulnerable children selected for the study were 46.6% (Freq. =81) Male and 53.4 %(N=93) Female. The age of respondent children also indicates that 47.7% (Freq. =83) falls between the age interval 12-14 and the remained 52.3% (Freq. =91) fall between the age interval 15-18. The average family size of vulnerable children in the study was 4.15. The study also shows that 29% (Freq. =51) children live with both parents, 26.7% (Freq. =47) are living with one of the parents, 8.5% (Freq. = 15) live with siblings, 11.9% (Freq.=21) live with grandparents, and 22.7% (Freq.= 40) live with relatives. Finally from the interviewed children 21.3% (Freq. =37) are double orphan and 20.1% (Freq.=35) are single orphan.

Table 1 Socio-demographic data.

Variables			
		N	%
Sex	Male	81	46.6
	Female	93	53.4
	Total	174	100.00
Age	12-14	83	47.7
	15-18	91	52.3
	Total	174	100.00

Care giver	Both parents	51	29.3%
	One of the parent	47	27.0%
	Siblings only	15	8.6%
	Grand parents	21	12.1%
	Relatives	40	23%
	Total	174	100.00%
Orphan hood status	Double orphan	37	21.3%
	Half orphan	35	20.1%
	Total	72	41.4%
Educational level	Never attend school	3	1.7
	Primary (1-4)	21	12.1
	Junior (5-8)	87	50.00
	Secondary (9-10)	44	25.3
	Preparatory (11-12)	11	6.3
	TVT and above	8	4.6
	Total	174	100%
Current-educational enrollment	Attending school	141	81.0
	Dropout of school	28	16.1
	Finished TVT & above	2	1.1
	Not begun school	3	1.7
	Total	174	100%

4.3. Finding on Services for vulnerable children

4.3.1 Shelter and care services

The finding on shelter services indicates that all children under study have shelter from which 31% (Freq.=54) children live in a rental house from government, 7.5% (Freq.=13) live in a house which is privately owned by parents or guardians, 36.2% (Freq.=63) in a rental house from private owners, 5.7%(Freq.=10) live in a temporary shelter provided by the government and the remained 19.5% (Freq.=34) live in others house with temporary provision by individual volunteers. Moreover 70.1% (Freq. =122) children's house is in weak condition which needs renovation and the remaining 29.9 %(N=52) in good condition which does not need renovation.

The researcher observed that the housing conditions were characterized by dilapidated, crowded and without ventilation. In addition there is shortage of water tap, in adequate toilet (simple pit latrine without slab), kitchen, sanitary, sewerage and poor healthy living environment. The situation is worse for those who rented from the private owners as they pay an average monthly fee of 800.00Eth Birr let alone the quality of the house.

From the children under study only 10.3% (Freq. =18) children have got house renovation services in the last two years from which 2.87% (Freq. =5) and 7.47% (Freq.=13) the house renovation provided for those who live in a private and government rented house respectively. The majority of house renovation i.e. 5.2% (Freq. =9) were provided by Good Neighbors Ethiopia (GNE), 2.9% (Freq.=5) by Fetiled, and 2.3 % (Freq.=4) by Korean International Cooperation Agency (KOICA). The opinion of children towards the house renovation service also indicates that, 11.1% (Freq. =2) gave an excellent for the housing renovation i.e. the house renovation brings an excellent change in the family's life than prior

to the house renovation services, 33.3%(Freq. =6) gave very good, 27.8% (Freq. =5) gave good and 23.8% (Freq.=5) gave fair from the response scale.

The study also identified the proportion of family size with the number of rooms in which the children reside. The average family size for vulnerable children under study was 4.15 of which 62.1% (Freq.=108) children live in single room, 29.3% (Freq.=51) children live in a house which have two rooms and the remaining 8.6% (Freq.=15) children live in a house which have three rooms.

Table 2 Cross tabulation of house property, number of rooms and house condition

Type of house property	Number of rooms						House condition			
	One		Two		Three		Weak which needs renovation		Good which does not need renovation	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Private	1	0.6	9	5.2	3	1.7	11	6.3	2	1.1
Rent from government	44	25.3	8	4.6	2	1.1	36	20.3	18	10.3
Rent from private owners	40	23	21	12.1	2	1.1	43	24.2	20	11.5
Others	17	9.8	10	5.2	7	4	24	13.8	10	5.7
Temporary shelter	6	3.4	3	1.7	1	0.6	8	4.6	2	1.1
Total	108	62.1	51	28.8	15	8.5	122	69.2	52	29.7

The study also revealed that 81.1 %(Freq. =141) children have toilet while the remained 19.1 %(Freq. =33) children does not have toilet and uses bush or field. From those children that have toilet, 25.5% (Freq. =36) children have toilet owned privately by the

family of which 20.6 %(Freq. =29) is simple pit latrine without slab and 5 %(Freq. =7) have simple pit latrine with slab. In addition 74.5% (Freq. =105) children uses a public toilet by sharing with neighborhood of which 61.7 %(Freq. =87) is simple pit latrine without slab and 12.8 % (Freq. =18) simple pit latrine with slab.

Table 3 Cross tabulation of toilet owned type and types of latrine

Toilet owned type	Simple pit latrine		Pit latrine with slab	
	Freq.	%	Freq.	%
Private owned	29	20.6	7	5
Public/Shared	87	61.7	18	12.8
Total	116	82.3	25	17.8

The study also found that all the children were living with parents, relatives or other guardians which indicates first that there is no child who is abandoned, live in street or live alone and second that the children are living with a potential of caring adult i.e. the children have at least one caring adult.

4.3.2. Food and nutrition services

The finding on access to food and nutrition indicates that only 21% (Freq.=35) children get their meal regularly i.e. they get breakfast, lunch and dinner regularly. The majority of respondents i.e. 79% (Freq.=139) children does not get food regularly from which 35.3(Freq.=49) always miss one of their meal, 41% (Freq.=57) often miss their meal, 21.6% (Freq.=30) sometimes miss and the remaining 2.2% (Freq.=3) children miss their

meal rarely. Moreover all the children under study replied that they eat same kind of food regularly.

This survey also revealed that 58.6% (Freq. =108) children have received food in the form of aid and the remaining 41.4% (Freq.=72) children in the study have never got food aid. From 58.6% (Freq.=102) children, 33.9% (Freq.=59) received only wheat flour, 8.6% (Freq.=15) only Teff flour and 16.1(Freq.=28) received wheat flour with edible oil. All the food aid came from NGO's found in the Woreda. In addition 21.3% (Freq. =37) children usually took the food aid from the organization to home. The remained 16.1 (Freq. =28) children's food aid took by parents or guardians, 12.1 % (Freq. =21) by siblings, 4% (Freq. =7) by neighbors, and 5.2% (Freq. =9) by relatives.

With regard to the rate of food aid provision the majority of respondents, 52.9% (Freq.=92) received these food aid once in every three month, 1.7% (Freq.=3) once in every two month and 4% (Freq.=7) received the food aid with unknown time interval which depends on the interest of organizations. The data on organizations that were providing services for vulnerable children also indicates that, 24.7% (Freq.=43) children received the food aid from GNE, 13.8% (Freq.=24) from Gurara freedom and 20.1% (Freq.= 35) from Mekaneyesus church. The opinion of children towards the food aid also shows that, 31% (Freq.=54) disagreed on the adequacy of food aid and 8.6% (Freq.=15) strongly disagree that the food aid is adequate but 14.4% (Freq.=25) children agreed that the food aid is adequate and the remained 4.6% (Freq.=8) did not decide to put their opinion. Those who disagreed explained that the food provision does not consider the characteristics of their family more importantly their family size.

Table 4 Descriptive data on access to food services

Variables			
		Freq.	%
Access to meal regularly	Yes	35	21
	No	139	79.0
Total		174	100

		Freq.	%
Time in which the child	Always	49	35.3
miss meal	Often	57	41
	Some times	30	21.6
	Seldom	3	2.2
Total		139	100

4.3.3. Economic strengthening

This study identified the major household's means of income of vulnerable children under study. The majority of children's parents or guardians i.e. 36.8% (Freq. = 64) gets their income by engaging in daily labor such as construction work, janitor and washing closes. In addition 27.6% (Freq.=48) get income from petty trade, 20.7% (Freq.=36) from monthly salary such as government employee, serving as a guard and pension, 2.9% (Freq.=5) from assistance by relatives, 6.3% (Freq.=11) from individual volunteers and the remaining 5.7% (Freq.=10) children's parents or guardians uses begging as a means of income.

The study also found that 32.7% (Freq=57) children's parents or guardians have got credit services from NGO's in the Woreda to start their own business. From these, 31.6(Freq.=18) children's parents or guardians got the service from GNE, 31.6% (Freq.=18) from Self Help Women Association(SHWA), 21.1 % (Freq.=12) from Christian Children's Fund (CCF), and 15.8% (Freq.=9) from Daughters of Charity (DOC). Using the credit service, the parents were engaged in the following business: dry food preparation, petty trade, hand craft, weaving, fruit and vegetable selling, animal rearing, poultry production etc. All these parents or guardians have received training on saving, credit and business management particularly from which the majorities are women and all the trainings were facilitated by NGOs.

The opinion of the children's parents indicates that, 63.2% (Freq. =36) the credit service brings an improvement in the socio-economic condition of the family's life because it enabled to begin their own business, diversify household means of income, the profit helped to cover other household consumption and to cover the school expense of their children. Whereas 22.8% (Freq. =13) did not see any improvement due to the credit service. These parent mentioned that inadequate loan to begin business, lack of production and market place as an obstacle to begin their own business.

Children in the study were also asked whether they received financial support which is delivered freely and 20.1% (Freq.=35) said that they have received free financial provision. The majority of respondents or 8% (Freq.=14) received money within the range of 200 to 300 Ethiopian Birr from Merijoy Development Association monthly. On the other hand 2.9% (Freq.=5) and 2.3% (Freq.=4) responded that they received less than 200 birr per-month from German church school and St. Yared school respectively. The remaining 4% (Freq.=7) and

2.9% (Freq.=S) children received free finical service from CCF and GNE with unknown time interval and the amount of money depends on the interest of sponsors.

Table 5 Views of parents or guardians on the socio-economic change observed on the family due to saving and credit services

Access to saving and credit service	Opinion of parents/ guardians							
	Agree		Neutral/Undecided		Disagree		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Yes	36	63.2	8	14	13	22.8	57	100

4.3.4. Health care service

The vulnerable children in this study were asked about their current health status including their health condition with in the last two years, if they get treatment during illness, the name of organization that covered the cost for health care if it was covered by the organization. In addition children were also asked if they have access to sanitation education, sanitary material support and the frequency of sanitary materials provision.

The finding on the above information indicates that fifteen children live with HIV/AIDS, twelve suffers from tuberculosis, fifty attacked by diarrhea disease and six children live with disabilities. Moreover, acute upper respiratory infection, epilepsy, infection to skin and subcutaneous tissue because of sanitation problem and accidents were the other diseases or cause of illness among children under study.

Table 6 Description data on major causes of health problem among the children

Major causes of health problem	Number of children				Total	
	Male		Female			
	Freq.	%	Freq.	%	Freq.	%
HIV/AIDs	6	9.9	9	13.63	15	22.72
Tuberculosis	7	10.6	5	7.57	12	18.18
live with disabilities	3	4.54	3	4.54	6	9.09
Diarrhea diseases	21	31.81	12	18.19	33	50
Total	37	56.07	29	43.93	66	100

The study also identified that 153 children had illness with other causes in addition to the causes identified above during the last two years from which 84.3% (Freq.= 129) children get medical service during illness where as 15.7% (Freq. =24) children did not get medical service during illness. The major reason mentioned by the children for not getting medical service were financial problem even if primary medical service in government health center is free for those who have free card there are other cost which is not provided freely such as cost for medicine and other treatment if it is not available in the health center. The children also mentioned that even if they are appropriate to get free medical service they do not have the document i.e. fee card which allows getting free medical services as they are not selected by the heath center to get the card. In addition the parents or guardian does not have a stable home i.e. they change their rented house to search job and get low cost house so they become out of selection criteria as one criterion to get free medical service is long stay in the woreda and have a witness for this.

From those children who get medical service from organizations 39.7% (Freq.=69) children received free medical services from the government health center i.e. from Entoto number one health center, 16.7% (Freq.=29) got the service from which the cost covered by GNE, 8% (Freq.= 14) by Gurara freedom, 3.4 (Freq.=6) by Mekaneyesus and 2.9% (Freq.=5) by Cheshire service. The remained 17.8% (Freq. =31) and 6.3% (Freq.=11) received health cost covered by parents or guardian and individual volunteers respectively.

Children were also asked if they get sanitary materials support and 56.9% (Freq.= 99) said they received sanitary materials. All of these children received item such as soap, hair oil and skin lubricant from the NGO's. The majority of respondent 44.8% (Freq.= 78) received the sanitary material once in energy three month, 6.3% (Freq.=11) once in every two month and the remaining 5.7% (Freq.=10) received the sanitary material with unknown time range. In addition 21.3% (Freq.=37) respondent said they received the sanitary material from GNE, 13.2% (Freq.=23) from DOC, 5.7% (Freq.=10) from CCF, 9.8 (Freq.=17) from Mekaneyesus, and 6.9% (Freq.=12) from Gurara freedom.

Table 7 Descriptive data on children access to medical services when they get illness

What happens when the child is ill?	Number of children who had health problem	
	Freq.	%
Got medical service	129	84.3
Did not get medical service	24	15.7
Total	153	100

4.3.5. Educational service

The study on the enrollment in school of respondent children indicates that, 1.7% (Freq.=3) never attended school, 12.1% (Freq.=21) are in primary school, 50% (Freq.=87) in junior, 25.3% (Freq. =44) in secondary school, 6.3% (Freq.=11) in preparatory and the remained 4.6 % (Freq.=8) attended TVT and above. This shows that the majority of children 98.3% (Freq.=171) are enrolled in school.

The finding revealed that, 90.2% (Freq. =157) are currently attending school where as 6.9% (Freq.=12) are dropped out of school, from which 5.2 %(Freq. = 9) are female and the remaining 1.7(3%) are male. The major reason mentioned by the children to drop from school were engaging in paid work in order to obtain food and other necessities for themselves and other family members, health related problem, caring younger children and sick parents or guardians, inability to pay other education related costs.

The study also identified that 6.3 %(Freq. =11) between the age category of 12-14 are in primary (1-4) grade which is not equivalent to their age level since children in this age category are expected to be in junior (5-8) grade. The main reason for mentioned by the children were entering to school lately since they came from other place to live with relatives, school dropout and repeating grades as a major reason.

Concerning the scholastic materials, 63.2% (Freq.=110) vulnerable children received material support such as provision such as Exercise book, Pen, Pencil and School uniform. From these, 48.9% (Freq.=85) children received the support from NGO and 14.4% (Freq.=25) from CBO. From the children that received educational material support, 22.7% (Freq.=25) get the educational material from GNE, 18.2% (Freq.=20) from Plan

international, 10% (Freq.=11) from DOC, 10% (Freq.=11) from St. Yared school, 7.3% (Freq.=8) from Gurara freedom, and the remained 6.4 %(N=7) received the educational material from Mekanyesus.

The opinion of children on the adequacy of the scholastic materials indicates that, 34.5% (Freq.=38) children strongly agreed and 31.8 (Freq.=35) agree that the scholastic materials are adequate which can serve for the whole academic year. On contrary to this, 4.5 %(Freq.=5) disagreed, and 20.9 % (Freq.=23) strongly disagreed that the scholastic materials provided are adequate which can serve for the given academic year.

This survey also revealed that 51.7% (Freq.=90) children's educational fee were covered by organizations found in the community. From these, 38.5% (Freq.=67) covered by NGO. The majority of support came from GNE which provided for 14.4% (Freq.=25) children, CCF which provided for 8% (Freq.=14) children, DOC which provided for 6.3% (Freq.=11) children, and Mekaneyesus which provided for 4% (Freq.=7) children. Furthermore 13.2% (Freq.=23) children's school fee were covered by CBO operating in the woreda. From these CBO, German church school covered school fee for 8% (Freq.=14) children and St. Yared school covered for 6.3% (Freq.=11) children.

The survey also identified that, 37.4% (Freq.=65) children received school uniform support from NGO. From these NGO's, 14.4% (Freq.=25) children's school uniform covered by GNE, 8% (Freq.=14) by CCF, 4.6% (Freq.=8) covered by Gurara freedom, 6.3 % (Freq.=11) by DOC and 4% (Freq.=7) covered by Mekaneyesus. The remained 14.4% (Freq.=25) were provided by CBO. From these 6.3% (Freq.=11) children's school uniform

cost were covered by St. Yared school and the remained 8% (Freq.=14) children's school uniform were covered by German church school.

To enhance vulnerable children's performance at school tutorial services are important. The finding revealed that, from the interviewed children, 14.9% (Freq. =26) received tutorial service in their school and all the services were covered by the government i.e. the school administration.

In order to ensure that hunger does not prevent vulnerable children from attending school, school based feeding program is vital. From the interviewed vulnerable children, 22.4% (Freq.=39) children received food support from feeding program in their school. From these, 17.8% (Freq.=31) children get food from "Yenatwog", 2.3% (Freq.=4) from world together and 2.3% (Freq.=4) children the food from "Abogida" organization in their school.

Generally the study identified that the majority of children, 97.36% (Freq.=107) children seen an improvement in their educational status because of educational support. One interviewed children explained that the educational material support improved school performance by eliminating school absenteeism, doing assignment on time which was one of the challenges prior to getting the support. From the response scale which indicates the improvement due to the educational service an average of 71.1% (Freq.=68.89) responded extreme, 8.2 %(N=7.56) very good, 92% (Freq. =12.6) moderate change in their education, 6.04% (Freq. =5.87) slightly seen a change and only 3% (Freq.=2.6) did not see any change in their educational status due to the support by organization. Generally, those who saw a change in their educational status because of the support explained that the educational materials were adequate which can serve for one year. This minimizes their worry to quarrel

with their parents and teachers due to inadequacy of the educational materials for each subject prior to get the service.

Table 8 Descriptive summery on the overall change observed because of the support on education

Variables	Degree of change observed									
	Extremely		Very		Moderately		Slightly		Not at all	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Change observed because of scholastic materials support	78	70.9	9	8.2	12.6	10.5	7.3	6.67	3	3
Change observed because of school fee support	64.33	71.4	7	8.2	12.6	12.63	5	5.57	2.6	3
Change observed because of school uniform support	64.33	71.4	6.67	8.2	12.6	12.63	5.3	5.9	2.3	3
Average	68.89	71.2	7.56	8.2	12.6	11.92	5.87	6.04	2.6	3

4.3.6. Psychosocial support

This survey identified that 12.6% (Freq.=22) children received counseling services. From these 4% (Freq.=7) children received counseling service from professional, 8% (Freq.=14) from paraprofessionals and 0.6% (Freq.=1) from lay persons. The survey also identified the barrier to get the counseling services and 48% (Freq.=84) replied that they have no information where to go when they need counseling services, 23.6% (Freq.=41) children

replied that there is no counseling service in their nearby places, and the remained 15.5 (Freq.=27) said that they did not need counseling service at all.

The psychosocial support also have additional objective of vulnerable children to be happy by participating in activities so that they are not isolated, become interactive, confident and empowered to be decision makes. From the interviewed 174 children in this study 36.8% (Freq.=64) participated in extracurricular activities. Of these, 20.7% (Freq.=36) children participated in extracurricular activities facilitated by government, 11.5% (Freq.=20) facilitated by NGO, 0.6 (Freq.=1) by CBO, and4% (Freq.=7) by individual volunteers. The major activities in which these children participated are sport clubs, red-cross club, science & technology, traffic police, literature and music clubs.

4.3.7. Legal protection services

This survey first revealed that 7.5% (Freq.=13) needed legal services so far and 5.7% (Freq.=10) children received legal service. The major reasons for not getting the legal service were lack of information and fear of perpetrators. Finally from the respondent children 44.3% (Freq.=77) have birth certificates and the remained 55.7% (Freq.=97) did not have birth certificate. There were no children that have a will (property inheritance document).

Table 9 Legal services

Variables		Freq.	%
The child needed legal services for the last two years	Yes	13	7.5
	No	161	92.5

Total		174	100.0
		Freq.	%
Did the child got legal service	Yes	10	5.7
	No	3	1.7
Total		13	7.5
Variables			
		Freq.	%
Reason for not getting the service	No information where to report the case	2	1.1
	Fear of perpetrators	1	0.6
Total		3	1.7
		Freq.	%
Access to birth certificates	Yes	77	44.3
	No	97	55.7
Total		174	100.0
		Freq.	%
Will (inheritance document)	Yes	-	-
	No	174	100.0
Total		174	100.0

Chapter Five- Discussion

Child vulnerability to various forms of neglect is one of the challenge that faced children in Addis Ababa city, Yeka sub city Woreda-03. The study first assessed the various socio demographic data obtained from survey questioner and personal observation to reveal the overall situation of the children. And then the various services provided to vulnerable children as a means of child protection was identified and described. The finding on socio demographic data indicates that a significant number of children under study were lost one or both of their parents due to death, divorce or birth out of wedlock. These children were also exposed to various forms of neglect. The major factors were being orphan, poverty, lack of access to basic services such as food, adequate shelter, health care and education, lack of parental guidance, support and protection.

The finding is the similar with the research finding by Senefeld and Perrin (2014). The researchers found that child vulnerability can be linked to ecological factors even though orphaning brings vulnerability among children. Child vulnerability is greater due to poverty and household location. Indeed, vulnerability depends on a variety of factors such as HIV/AIDS infection of parents or children, social and economic conditions. Moreover children who are deprived of the guidance and protection of their primary caregivers are more vulnerable to health risks, violence, exploitation, and discrimination whereas researchers such as Welbourne and Dixon (2016) raised the other dimensions /causes of child vulnerability. Governments sustain risks for children by failing to prohibit internationally widely unacceptable child practices (such as recruitment, forced or otherwise of children as soldiers) or the commodification of the poorest and most vulnerable children for profit (such as child trafficking, child pornography and prostitution, child labor, and child marriage).

Children are placed at risk by the breaking down of the extended family, as a result of urbanization when the nuclear family needs but lacks the kinship safety net, in the absence of one provided by the state. Poverty creates risks for all children, but it can create catastrophic risks for female children throughout childhood.

This descriptive research also identified and described services provided for vulnerable children in addressing child protection using the key services for orphan and vulnerable children. The core service assessed during the finding served as the framework for discussion about the finding. These are education, shelter, economic strengthening, food and nutrition, health, protection, and psychosocial support.

In response to the challenge that faced vulnerable children on food shortage, different organizations were providing food support for these children. The food items provided by the organizations were wheat, Teff, corn flour and edible oil. The majority of children i.e. 52.9% (Freq.=92) received this food items once in every three month. The food items were provided without considering the child's age, health status and family size. Moreover the opinion of children towards the food provision indicates that the food provision is not adequate to fulfill their own and other family members need.

Despite all the efforts by the organization, food shortage is one of the challenges that faced vulnerable children under study. The majority of respondent children, 79% (Freq. =139) replied that they do not get food regularly and in a consistent manner. They usually miss one of their meals in a day. More over these children eat same type of food regularly irrespective of the nutrition content. The overall response indicates that hunger, being denied food and lack of getting enough food for the day were the major challenges mentioned by the children. Children in the study also replied that they usually miss class or dropped out of

school in search of food. This is one form of child maltreatment because it is a failure to act on the part of parents or guardian to provide adequate protection which resulted to various problems. Here this finding is the same with a research finding by Weiser et al (2007) in Botswana and Swaziland. The researchers found that denying children to get adequate food is one form of child maltreatment. It leads vulnerable children for malnourishment. Child-hood food malnourishment is irreversible and inter-generational with consequences for child health including impaired intellectual capacity, increased risk of diet-related chronic diseases, and reduced resilience to shocks. It affects school enrolment, educational attainment and productivity thus contributing to the cycle of poverty.

The research also found that, 98.3% (Freq. =171) vulnerable children under study are enrolled in school. The major service provided to vulnerable children was scholastic materials, school uniform and school fee. These services enable the children to see change in the overall educational condition. The major changes observed due to the support were improvement in their educational performance, absent from school due to lack of educational materials minimized and promotion from grade to the next grade improved.

This finding is the same with the research finding made by Eshetu Gurmu and Dula Etana (2012). The researchers found that getting an education is an important prerequisite for vulnerable children to leverage improvement in their life. Academic learning non only increases job opportunity and earning potential but also reduce children's risk of engaging in risky or exploitative work. For girls, it lessens the chances of premature marriage or pregnancy. Schools can also provide a supportive environment for vulnerable children by helping them to learn social skills, provide peer and psychosocial support.

The finding on the service provided to the vulnerable children is also in line with the desired outcome for educational services mentioned by the standard service delivery guideline for vulnerable children as the service provision ensured the children to enroll attend school and completes a minimum of TVET and preparatory education. Even if primary school attendance in government school is free, there are other school costs that may hinder enrollment and attendance of vulnerable children such as registration fee, contribution for infrastructure development in the school, educational materials and school uniform cost etc. The organizations found in the woreda fulfilled those needs by covering all the costs.

The main household's means of income of vulnerable children's under study came from low paid job such as from daily labor by engaging in construction activities, serving as a janitor, and washing closes, were pensioners and engaged in low paid government work. In order to assist the family begun their own business, the NGO's found in the woreda provided credit services for the children's family. Using the opportunity, the parent engaged in activities such as dry food preparation and selling, fruit and vegetables selling, hand craft, animal husbandry and poultry production. In addition these parents received training related to saving and credit and business management from the NGO. The credit service brings an improvement in the socio-economic condition of the family's life because it enabled to begin their own business, diversify household means of income, the profit helped to cover other household consumption and to cover the school expense of their children. The finding by Duncan, Magnuson, and Votruba-Drzal (2014) confirm this finding. The researcher states that families who live in poverty face disadvantages that can hinder their children's development in many ways. As they struggle to get by economically, and as they cope with substandard housing, unsafe neighborhoods, and inadequate schools, poor families

experience more stress in their daily lives than more affluent families do, with a host of psychological and developmental consequences. The researchers confirmed that increasing poor parents' income by creating opportunity such as engaging in income generating activities can help to improve the vulnerable children's living condition.

Limited accesses to health care and adequate sanitation are the major challenges to vulnerable children's well being, development and survival. The study identified that disease related to sanitation problem such as diarrheal is among the major causes of ill health among vulnerable children. Children suffer emotionally as well since they worry about their health. HIV positive children have particular concern such as adhering to their antiretroviral therapy (ART). Children under study said that while ART is free, medication for related condition is not and they could not afford to buy medicine. Even if the health care service for vulnerable children under the standard service delivery guide line have intention of ensuring vulnerable children to have access to health services, including HIV and AIDS prevention, care and treatment, the children have challenges in accessing to this service.

The housing conditions in which the children reside were characterized by inadequate light, without window, dilapidated, crowded and without ventilation. In addition there is shortage of water tap, kitchen, sanitary, sewerage and poor healthy living environment. The situation is worse for those who rented from the private owners as they pay the major portion of their income let alone the quality of the house. In addition the family size does not match with the number of rooms and characterized by overcrowded.

The study also indicates that there is an inadequate sanitary service as the majority of children, 82.3% (Freq. =116) have simple latrine without slab. Generally the shelter is not

safe in which the walls and roof in worse condition to protect from rain and wind, without widows and the latrine does not have water source and clean which exposed children to various disease related to sanitation problem. The shelter is also suffocated without ventilation. Such kinds of house condition exposed children to various forms of abuse from which emotional abuse is the major one since they are not staying in a safe shelter within their communities.

The finding is in line with the research made by Daniel *et al.* (1999). The researchers found that children's developmental pathways can be adversely affected by a range of circumstances including: incidents of physical or sexual abuse, chronic situations such as environments of neglect, family stressors, structural inequalities and socio-economic disadvantages.

A range of services and activities should be provided for vulnerable children under the auspices of psycho social support for vulnerable children. The identified services provided for vulnerable children as a psychosocial support was counseling and participating in extracurricular activities such as in sport and clubs. But only few children got counseling service from professional and Para professional in an unorganized way. There seems a lack of professional and lack of awareness among the children to seek the service since the service can help them to improve their social and emotional well being. For a child, when psychosocial support is successfully mainstreamed the child will feel socially and emotionally supported in every aspect of their lives.

Children without parental care are defined as all children not in the overnight care of at least one of their parents. They include children living in a wide variety of settings, including in residential care, with extended or foster family, in child headed family, in

juvenile detention, on the streets or with employers and orphans. The study identified that there are a lot of child headed households.

Generally children cited education and health services as the most common component of assistant provided to them. However, these services had their own limitation. Those children who have access to free medical service said that free access to health service is only limited to health center or referral hospital. Children may be required to purchase medicines if it is not available in the center. The survey revealed that non government organizations in the Woreda are only assisting the vulnerable children by covering cost related expenses to medical services and hygiene education.

Chapter Six- Conclusion and Social Work Implications

6.1 Conclusion

Child vulnerability to various problems is one of the dominant social problems in Yeka sub city Woreda-03. A significant number of children lost one or both of their parents due to various reasons. In adequate housing, food and nutrition shortages, school dropout and regular absenteeism from school, poor educational performance, and exposure to various diseases, and neglect characterized the children under study.

To address the plight of vulnerable children there are Government, Non-government and Community based organizations operating in the study area. One of the key services that should be provided for the children is food and nutrition. Even though there are organizations that provide food for these children the provision is inadequate to fulfill their consumption needs. It does not consider factors such as family size, age and nutritional needs. In terms of education, the majority of the children have received services such as scholastic materials, school uniforms and school fees. The study identified that the service brings an improvement in their educational performance, minimizes school absenteeism and drop out.

The organizations were also delivered health care services. The government health center provide free medical service for those who have free card, the Non-governmental organizations address the health care services by covering the cost as well. The other key service is shelter and care. Even though the government provide low cost government house by giving priority for these children's family, the majority of the children live in a rental house from private owners. The house condition is characterized by dilapidated, crowded, without ventilation, inadequate water tap, sanitary, sewerage and poor health environment.

Moreover only few households received house renovation service from the non-governmental organizations in the last two years.

In order to assist the family begun their own business and sustainably solve the economic condition of the family, the Nongovernmental organizations found in the woreda provided services such as credit, training related to saving and business management. Those families who obtained the service mentioned that the service brings an improvement in the socio-economic condition of the family's life because it enabled to begin their own business, diversify household means of income, the profit helped to cover other household consumption and to cover the school expense of their children.

Psychosocial support in the form of counseling and participating the children in extracurricular activities were also the major services provided to the vulnerable children. However, few children received the counseling service from professional and par professionals. Lack of information and unavailability of the counseling service were the major challenges to get the counseling service. With regard to legal services including birth registration and property inheritance plan the study identified that the children have access to legal service whenever they need, while the majority of the children does not have birth certificate and a will (property inheritance plan).

In general the children cited education and health services as the most common component of assistance even though the services have their own limitations. Moreover the overall assessment indicates that the children did not get adequate service from the organizations. Those organizations that provided the services follow assessing and correcting

problems and deficits instead of capacitating the family using the strengths found in the children, families and communities.

6.2 Implication to social work

This research has implication for social work practice, social policy, education and further research. The first part focuses on describing the implication of the research to the practice of social work. The second part discuses the implication of the research for social policy in light of strengths based approaches as it is argued that a strengths-based approach to policy is a more perfect reflection of social work values which may lead to more effective social policies. The third part focuses on the implication of the study for education if the research utilized for education purpose or what it communicates for someone who is interested to know about service for vulnerable children and finally it discusses the implication of the research for further research.

The primary mission of social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty (NASW, 2005). Poverty, low institutional capacity, inadequate response and low protection mechanisms are considered as the major challenges of vulnerable children in the study. It is important to eliminate such barriers and enhance the children's wellbeing, empower the communities and families in general and the vulnerable children in particular.

Social work has developed out of community recognition of the need for providing services to meet basic needs, services which require the intervention of practitioners trained to understand the services, the individuals, and the means for bringing all together (IFSW and

IASS, 2004:6). Thus, the research implies that social work practitioner has to promote an intervention for the vulnerable children to meet their basic needs, an understanding of the effectiveness of the services to bring the necessary change and understanding the community where the children live.

As a method, the social work practitioner has to engage in facilitating interaction and empowering the vulnerable children, parents/guardian and the community to participate on matters that affect their lives. Moreover, the practitioner has to convey the duty bearers (the concerned bodies) to discharge their obligations to provide a more sustainable and meaningful service systems for the disadvantaged children, parents/guardians and communities.

In a nut shell the values of social work lead to improve the vulnerable children's life condition by respecting their equality, worth, and dignity. There also needs meeting all their human needs and developing their potential. Moreover human rights and social justice has to serve as a motivation and justification for social work action. Unless resource are distributed fairly, their human rights are respected, poverty is alleviated the children remains vulnerable and oppressed.

The major intervention mechanisms to ameliorate the challenges of the vulnerable children used by the government , non government organizations in the study areas was assessment and correction of problems by providing services, focusing deficits and pathology of the vulnerable children families let alone the inadequacy of the services. The overall intervention mechanism was curative instead of preventive mechanisms. This needs-based approach assumed assistance as voluntary and even charitable deed wholly dependent on the

good will of providers without considering the realities of the vulnerable children and parents/guardians. This is in sharp contrast with the strength based frame work for policy.

It is argued that a strength-based approach to policy is a more perfect reflection that social work values may lead to more effective social policies. This includes encouraging informed participation in shaping social policies and institutions, advocating changes in policy and legislation to improve social conditions and to promote social justice. Doing so insures that all persons have access to the resources, services, and opportunities they require (Rapp, Pettus and Goscha , 2006: 3-6).

Cognizant of the needs to promote a strategic shift from subsistence form of care to a more sustainable and meaningful service systems the Alternative Childcare Guidelines in 2009 G.C was developed. The guideline has a major objective of improving the quality of care and services provided by governmental and non- governmental organizations involved in childcare and advance the welfare of the orphans and other vulnerable children in the country. Despite all this, the organizations operating in the study area focuses on service provision which can solve their immediate needs instead of capacitating the children and families to solve the challenge by themselves. Even if the policy is there, to utilize the principles of strength based policy when coming to implementation it is non existence. So the concerned bodies i.e. both at the organizations and the higher levels have to ensure the implementation of the policy document to change the situation of vulnerable children, families and communities.

This research has also implication for further research. The main objective of this research was identifying and describing services provided to vulnerable children. Using this

research as a reference point researchers can identify the major obstacles and barriers to the service. In addition the service effectiveness of organizations in alleviating the challenges of vulnerable children and other determinant of children wellbeing beyond the service mentioned in the standard service guideline can be explored.

Those who have the chance to read this research paper would get various lessons. First the research can alert policy makers, implementers and advocators about the dire situation of vulnerable children in the study area. Second, the service delivery mechanisms of concerned organization were clearly communicated in the research so the research can ensure the way government decisions i.e. the policy can be increasingly influenced by better knowledge to change the living situation of vulnerable children in the study area. Finally, the research can give a good lesson for students, social work practitioners, researchers and policy makers about the importance of capacitating the children, family and community to sustainably solve the situation of children.

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Appendix–I

SURVEY QUESTIONNAIRE FOR CHILDREN

INTRODUCTION:

Greeting! I am Ashenafi Tesfaye. I am a student at Graduate School of Social Work at Addis Ababa University. This questionnaire is prepared by me to collect information about services provided to vulnerable children as a means of child protection in Addis Ababa, Yeka sub city Woreda-03. Your answers are completely confidential. Your name will not be written and will never be used in connection with any of the information you provide. I would greatly appreciate your help in responding to this questionnaire.

Child Code: _____

1. Demographic Data		
1.1	Sex(Observe):	1. Male 2. Female
1.2	Age:	_____
1.3	Family Size	_____
1.4	Educational Level	1. Never attend school 2. Nursery school 3. Primary (1-4) 4. Junior (5-8) 5. Secondary (9-10) 6. Preparatory (11-12) 7. TVT and above
1.5	Current educational status	1. Attending school 2.Drop out of school 3. Finished TVT and above
1.6	The child is living with	1. Both parents 2. One of the parents 3. Siblings only 4. Grandparents 5. Relatives 6. Foster parent 7. Live alone 8.Adoptive parent 77. Other please specify_____
1.7	The child is	1. Double orphan 2.Single orphan

2. Shelter services		
2.1	Type of house property:	1. Private 2. Rent from government 3. Rent from private 4. Others
2.2	Number of rooms (Observation)	1. 1 2. 2 3. 3 4. 4 5. Above 4
2.3	The house condition is (Need observation)	1. Weak which needs renovation 2. In good condition which does not renovation
2.4	Toilet owned type:	1. Private 2. Public/shared toilet 3. Open pit (Bush/field etc) 4. Others _____
2.5	Type of toilet	1. Simple latrine 2. Simple latrine with slab
2.6	Have you ever get any house renovation service?	1. Yes 2. No (If your answer for question number 2.6 is No, skip to question number 2.10)
2.7	If your answer for Q No. 2.6 is yes, who provided the service?	1. GO's 2. NGO'S 3. CBO's 4. Individual volunteers 77. Other, please explain_____.
2.8	Please tell the name of organization if your answer for Q-2.7 is 1, 2, or 3:	_____
2.9	The overall change observed because of house renovation services (Observe the house condition)	1. Excellent 2.Very Good 3.Good 4.Fair 5. Poor
2.10	Toilet construction services	1.Yes 2.No

2.11	Toilet constructed by	1. GO's 2. NGO'S 3. CBO's 4. Individual volunteers 77. Other, please explain_____.
2.12	The name of organization that constructed toilet	
2.13	Bed materials support for the last two years	1.Yes 2.No
2.14	Bed materials provided by	1. GO's 2. NGO'S 3. CBO's 4. Individual volunteers 77. Other, please explain_____.
2.15	Name of organization that provided bed materials	_____
2.16	Please list the bed materials you got so far	_____
2.17	Do the child have adequate sleeping place (Need observation)	1. Yes 2. No
2.18	The bed materials that the child sleep is (Need observation)	1. Good 2. Fair 3. Poor
3**. Food and nutrition**		
3.1	Do you get meal such as breakfast, lunch and dinner regularly?	1. Yes 2. No
3.2	If your answer for Q-3.1 is No please specify the time in which you miss meal	1. Always 2.Often 3. Some times 4. Seldom 5.Never

3.3	Please tell the food item that you usually eat	_____
3.4	Have you ever received any supplementary food in the form of aid?	1. Yes 2. No (If your answer for question number 3.4 is No, skip to question number 4.1)
3.5	If your answer is Yes for Q-3.4, please list the food item that you received.	_____
3.6	The food support comes from:	1. GO's 2. NGO'S 3. CBO's 4. Individual volunteers 77. Other, please explain_____.
3.7	Please tell the name of organization if your answer for Q-3.6 is 1, 2, or 3:	_____
3.8	How often do you get the food aid?	1. Every week 2. Every month 3. Once in every two month 4. Once in every three month 77. Other, _____
3.9	The food aid is adequate	1. Strongly agree 2. Agree 3. Undecided 4. Disagree 5. Strongly disagree
3.10	Food item taken to home by	1. Child 2.Parent 3. Siblings 4. Neighbors 5. Relatives 77. Other

4. Economic strengthening		
4.1	Household's means of income:	1. Petty trade 2. Monthly salary 3. Daily wage 4. Assistance from relatives 5. Assistance from organization 6. Individual volunteers 7. Beggary 8. Other_____
4.2	Please tell the name of organization if your answer for Q-4.1 is 5:	_____
4.3	Does any of your parents/guardian get saving and credit services?	1. Yes 2. No (If your answer for question number 31 is No, skip to question number 34)
4.4	If your answer for Q-4.3 is yes, the service is provided by:	1. GO's 2. NGO'S 3. CBO's 4. Individual volunteers 77. Other, please explain_____.
4.5	Please tell the name of organization if your answer for Q-4.4 is 1, 2 or 3:	_____
4.6	Type of activity because of credit service	_____

4.7	The socio- economic condition of family changed after engaging in income generating activities	1. Agree 2. Undecided/Neutral 3. Disagree
4.8	Do any of your parents/ guardians received training related to saving and credits?	1. Yes 2.No (If your answer for question number 4.8 is No, skip to question number 4.11)
4.9	If your answer for Q-4.8 is yes, the service is provided by:	1. GO's 2. NGO'S 3. CBO's 4. Individual volunteers 77. Other, please explain_____.
4.10	Please tell the name of organization if your answer for Q-4.9 is 1, 2 or 3:	_____
4.11	Do you have any financial services delivered freely?	1. Yes 2.No (If your answer for question number 4.11 is No, skip to question number 5.1)

4.12	If your answer for Q-4.11 is yes, the service is provided by:	1. GO's 2. NGO'S (from sponsors) 3. CBO's 4. Individual volunteers 77. Other, please explain_____.
4.13	Please tell the name of organization if your answer for Q-4.12 is 1, 2 or 3:	_____
4.14	Please tell the amount and frequency	_____
5. Health Care		
5.1	Have you got any health problem in the last two years?	1.Yes 2.No (If your answer for question number 5.1 is No, skip to question number 5.3)
5.2	If your answer for Q-5.1 is yes, please tell the name of disease.	_____
5.3	Do the child has chronic illness	1.Yes 2.No (If your answer for question number 5.3 is No, skip to question number 5.5)

5.4	If your answer for Q-5.3 is yes, please tell the name of disease.	_____
5.5	Do you get treatment during illness	1.Yes 2.No
5.6	If your answer for Q- 5.5 is yes, who covered the cost?	1. GO's 2. NGO'S 3. CBO's 4. Individual volunteers 5. Parent/guardian 77. Other, please explain_____.
5.7	Please tell the name of organization if your answer for Q-5.6 is 1, 2 or 3:	_____
5.8	How do you rate the health service provided by the organization	1. Excellent 2. Very good 3. Good 4. Fair 5.Poor
5.9	Have you ever received sanitary materials supports?	1. Yes 2. No (If your answer for question number 5.8 is No, skip to question number Q-6)
5.10	If your answer for question number 5.9 is yes, please list the	_____

	sanitary materials that you got:	
5.11	Please tell the name of organization that provided the service	_____
5.12	How often do you get the sanitary materials?	1. Every week 2. Every month 3. Once in every two month 4. Once in every three month 77. Other, _____

6. Education

S/n	**Which service did you get so far from organizations or individual volunteers?**	**Which organization provided the service?**					**Name of the organization that provided the service**
		1. GO	**2. NGO**	**3. CBO**	**4. Ind. Volunteer**	**5. Other**	
6.1.1	Educational material (Eg. Ex. Book, pen and pencil)						
6.1.2	School fee						
6.1.3	School uniform						
6.1.4	Tutorial support						
6.1.5	School feeding						

6.2 Opinion of the children towards education services

S/n	Please rate your opinion on the changes observed due to educational support	Opinion toward educational services				
		Extremely	**Very**	**Moderately**	**Slightly**	**Not at all**
6.2.1	The school performance of the child improved because of the support					
6.2.2	School absenteeism minimized due to the educational support					
6.2.3	The support enabled the child to promote from grade to grade					

7. Psychosocial support		
7.1	Have you ever got any counseling services?	1. Yes 2. No (If your answer for question number 7.1 is No, skip to question number 7.4)
7.2	If your answer for Q-7.1 is yes, the service is given by:	1. Professionals 2. Para professionals 3. Lay person
7.3	Do you remember something important you got from the counseling, please explain	_____ _____ _____
7.4	If your answer for Q- 7.1 is No, what was the reason?	1. I did not need counseling service 2. No information where to go 3. No counseling service at all

		77. Other reason_____
7.5	Do you participate in extracurricular activities?	1. Yes 2. No (If your answer for question number 7.5 is No, skip to question number 8.1)
7.6	If your answer is yes for Q-7.5, who provide the service?	1. GO's 2. NGO'S 3. CBO's 4. Individual volunteers 77. Other, please explain_____.
7.7	Please tell the type of activities that you are participating:	_____.
8. Legal Protection		
8.1	Have you ever in need of any legal services so far?	1. Yes 2.No (If your answer for question number 8.1 is No, skip to question number 8.3)
8.2	If your answer for Q-8.1 is yes, did you get the service?	1. Yes 2.No (If your answer for question number 8.2 is yes skip to question number 8.4)
8.3	If your answer for Q-8.2 is No, please tell the reason:	1. I have no information whether to report the case 2. No legal institution in nearby places 3. Fear of the perpetrators 4.Other reason, specify_____
8.4	Do you have birth certificate?	1. Yes 2. No

8.5	Do you have a will? (If parents are not alive)	1. Yes 2. No

Appendix–II

Check list to interview the Woreda three Women's and Children's Affairs Office.

1. Do you regularly assess the needs of vulnerable children in your Woreda? Please explain.
2. In your opinion, what are the major challenges of vulnerable children in this Woreda?
3. Please tell the number of vulnerable children that are registered by the woreda.
4. In what way do you identify and provide basic services such as educational, health, shelter, economic strengthening, nutrition, psychosocial support, and legal protection for the vulnerable children?
5. Could you tell me the number of children who are getting basic services such as educational, health, shelter, economic strengthening, nutrition, psychosocial support, and legal protection by the government, NGO'S and other CBO'S?
6. Please mention the government, non-government and community based organization (that are operating in the woreda) including their activity
7. How do you link vulnerable children with stakeholders such as legal institution, Kebeles, CBO's and NGO'S?
8. What are the major success and challenges of service for vulnerable children in the Woreda?

Annex III Consent Form

Greeting! I am Ashenafi Tesfaye. I am a student at Graduate School of Social Work at Addis Ababa University. This questionnaire is prepared by me to collect information about services provided to vulnerable children as a means of child protection in Addis Ababa, Yeka sub city Woreda-03. Your answers are completely confidential. You can skip any question, or withdraw from the entire process your name will not be written and will never be used in connection with any of the information you provide. I would greatly appreciate your help in responding to this questionnaire. If you agree to be participant in this study, signing on this consent paper helps the research. Singing on this paper means you understand the purpose of the research as it was stated on the consent paper.

Thank you for your cooperation and honest response!

Name of participant_____ Name of the Researcher: Ashenafi Tesfaye

Signature; _____ Signature _____

Date: _____ Date _____