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SCHOOL OF GRADUATE STUDIES

THE PSYCHOSOCIAL AND EDUCATIONAL PROBLEMS OF HIV/AIDS ORPHANS: THE CASE OF SOME SELECTED AIDS ORPHANS IN ADDIS ABABA AND AWASSA

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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES,
ADDIS ABABA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN SPECIAL NEEDS EDUCATION

BY
ABEBE LEALEM

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BY

ABEBE LEALEM

Approved by Board of Examiners

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Abstract

The main purpose of this study was to find out the psychosocial and educational problems of AIDS orphans. Accordingly, attempts have been made to assess the social, psychological and educational conditions of AIDS orphans in Addis Ababa and Awassa.

140 AIDS orphans, 53 caretakers and 3 representatives of non-governmental organizations, who directly involved in care and support of AIDS orphans were respondents of this study. The HIV/AIDS orphans were selected from Mekdim HIV Positive and AIDS Orphans Association, Tesfa Berhan AIDS Orphans Association and AIDS Orphans who get support from EOC-DICAC in Awassa. Available purposeful and stratified random samplings were used, in selecting the respondents. The instruments used for collecting the data were questionnaires and interviews.

Analysis of the data was made using quantitative (percentage) and qualitative methods. Results of the study showed that AIDS orphans faced problems in terms of social aspects; isolation, discrimination, and neglect by adults and their peers. Educationally many of them specially girls dropped out of school and those who managed to continue their education show low school performance. Their psychological adjustments are also poor. The orphans fear a new situation, were frustrated and are full of worries. The response of the caretakers' of AIDS orphans and representatives of non-governmental organizations who give support to the AIDS orphans were included. In accordance with the findings recommendations are forwarded.

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Abbreviations and Acronyms

AIDS - Acquired Immune Deficiency Syndrome

HIV - Human Immunodeficiency Virus

UNAIDS- Joint United Nations Program on HIV/AIDS

UN- United Nations

UNICEF- United Nations Children's Fund

FAO - Food and Agriculture Organization

UNCRC- United Nations Convention on the Rights of Child

IRIN - Integrated Regional Information Network

CRC - Convention on the Rights of the Child

ILO - International Labor Organization

EOC - Ethiopian Orthodox Church

EOC -DICAC – Ethiopian Orthodox Church Development and Inter- Church Aid Commission

CBO - Community Based Organization

MOLSA - Ministry of Labour and Social Affairs

WHO - World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1. Background of the Problem

AIDS is now the greatest threat to child development in many parts of the world. In responding to HIV/ AIDS, however, the children affected by the epidemic, especially those indirectly affected, are too often the forgotten ones. The needs of children who are affected through the sickness and death of parents, guardians, siblings and others in the community, however, have not been seen as a priority.

By the end of 2000, an estimated 13.2 million children under the age of 15 will have lost one or both parents to AIDS in which the majority of them are in Africa (UNICEF and UNAIDS, 1999). The growing pressure HIV/AIDS exerts on both household and community is shown by the increase in elderly careers and child-headed household in severely affected African and Asian countries.

Many families in Africa live in abject poverty, crammed into huts in the circle of drought, poverty and HIV/ADIS. For this already poor house holds the advent of AIDS can lead to a transition from poverty to extreme poverty, or even destitution (Williamson, 1995).

Although the problems experienced by children living in HIV/AIDS affected households are often the same problems that poor children face everywhere, HIV/AIDS exacerbates them. Stigmatization, discrimination, the psychological impacts of long-term care for sick parents and relatives and the escalating number of AIDS deaths in the family and wider community are problems that are largely unique to children affected by HIV/AIDS (Grainger, et al. 2001).

In terms of the impacts of HIV/AIDS on education of children, many studies suggest education of AIDS orphans is severely affected in terms of school enrollment, school drop-out and performance. According to World Bank Report, at national level, differences of up to 20 percent in enrolment rates between AIDS orphaned and non-orphaned children have been recorded in countries severely affected by HIV/AIDS (World Bank, 1997).

The AIDS epidemic also exacerbates gender imbalance in access to education. In most developing countries, school enrollment, attendance rates and literacy are already lower for girls than boys (UNICEF, 1999c). When children are taken out of school to contribute to help in the home or field, or to care for siblings on the death of a parent, girls are usually withdrawn first (Williamson, 1995).

Ethiopia houses the second largest population of children orphaned by AIDS in sub-Saharan Africa, next to Nigeria. The number of AIDS orphans in Ethiopia by the end of 2001 was estimated at 990,000 (UNAIDS, 2002). According to the Ministry of Health of Ethiopia, the number of AIDS orphans is estimated to be 1.2 million in 2002. This figure will rise to 1.8 million in 2007 and 2.5 million in 2012 (MOH, 2002).

A recent study indicated that the prevalence of AIDS orphans among all children was estimated at 14.7%, 16.7% and 14.8% in major cities, small towns and rural areas, respectively (MOLSA, Italian Cooperation & UNICEF, 2003), which shows that a large number of the child population in Ethiopia is severely affected by the AIDS pandemic.

As a result most AIDS orphans are unable to sustain their lives, as they are expelled from their parental residences following the death of their parent, and resort to living with relatives, friends, neighbors, alone by themselves or get hired as house

servant which makes them vulnerable to lack of family care, love, affection, support and follow up (MOLSA, Italian Cooperation & UNICEF, 2003).

> *Social, cultural and religious practices strongly influence children's needs. A child from a culture in which the extended family is the principal care-giving unit for children will have different needs from a child from a community where nuclear families are the norm or where there is a high proportion of female-headed households or elderly care-givers. The organization of households and families, the roles assigned to men, women and children within the family, and the cultural practices associated with sickness, death and property inheritance are just some of the factors which determine the needs of children (Grainger et al. 2001p. 14).*

With regard to the above point, one can relate it with the practices of Ethiopia, where Ethiopia is a country with diverse socio-cultural dimensions and languages and people have different attitudes to ward children. Therefore, one has to use different strategies, based on their socio-cultural practices, to address the problems of HIV/AIDS orphans. However, in this study as the majority of the respondents are from one ethnic group and one religious domination, the socio-cultural impact on addressing the issue of HIV/AIDS orphans is not addressed.

The present study on the psychosocial and educational problems of HIV/AIDS orphans in Addis Ababa and Awassa attempted to identify the severity of the problems they faced. Furthermore it is believed to throw some light on the psychosocial and educational problems they experiences and motivate other researchers to further investigation.

1.2. Statement of the Problems

So much has been said about the dramatic increase of HIV/AIDS but AIDS orphans are hidden away, invisible, voiceless and forgotten. The issue of their health and right is not on the normal agenda as children are voiceless.

Studies reveal that the right of HIV/AIDS orphans is abused. They are discriminated, whether they are identified as HIV negative or HIV positive, they run a high risk of stigmatization that will have a great effect on their normal development. Even their relatives for fear of being infected by HIV neglect most of them, which is of course the low level of awareness about how HIV/AIDS is spread (Tedla, 1996).

Many AIDS orphans dropped out of school in which the majority of them were girls. The education of girls is affected to a greater extent than that of boys due to the gendered role of caring for the sick (Grainger, et al. 2001).

Generally the distress and social isolation experienced by children, both before and after the death of their parents are strongly exacerbated by the shame, fear and rejection that often surrounds people affected by HIV/AIDS. Because of this stigma and often irrational fear surrounding AIDS, children may be denied access to schooling and health care.

This study tries to answer the following research questions:

1. What are the major psychosocial problems of HIV/AIDS orphans?
2. What are the psychological problems of HIV/AIDS orphans?
3. What are the educational problems of HIV/AIDS orphans?
4. Are female HIV/AIDS orphans at special disadvantages in terms of education?
5. What are the strategies used to reduce the problems of HIV/AIDS orphans?

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1.3. Objectives of the Study

General objective:-

The general objective of this study is to identify and describe the psychosocial and educational problems of HIV/AIDS orphans in Addis Ababa and Awassa.

Specific objectives:-

This study specifically intends:

- to find out the major psychosocial and psychological problems of HIV/AIDS orphans
- to point out the educational problems of HIV/AIDS orphans
- to find out if female HIV/ AIDS orphans are at special disadvantages in terms of their education
- to find out the strategies used to arrest the problems of HIV/AIDS orphans.

1.4. Significance of the Study

The problem of HIV/AIDS orphans is serious and needs serious solution. To take serious solution, the extent of the problem and the needs of those children must be identified.

- Identifying the psychosocial and educational problems and needs of HIV/AIDS orphans helps to create awareness in the society;
- It helps the government (decision makers) to take an action in keeping HIV/AIDS orphans in school, specially girls with out which it is impossible to stop the spread of HIV.

- It will help national and international non-governmental organizations (NGOs), who are engaged in various activities related to the improvement of the condition of HIV/AIDS orphans in Ethiopia.
- It will help the CBOs, and the communities, such as religious and community leaders in how to cope with problems of HIV/ADIS orphans.

1.5. Delimitation of the Study

The problem of HIV/AIDS orphans is a countrywide issue, hence it is needless to say that studying the problem and its solution throughout Ethiopia is necessary. However, with regard to the research site, it is delimited to some selected areas of Addis Ababa and Awassa to make the study manageable.

With regard to the sample size, the reason behind working only with 140 HIV/AIDS orphans was that it was very difficult to get more HIV/AIDS orphans.

With respect to the scope of the study, only a few parts of the problems of HIV/AIDS orphans are addressed, their psychosocial and educational problems.

1.6. Limitation of the Study

There is a scarcity of accurate information regarding the magnitude of HIV/AIDS orphans. An attempt has been made to get full information on the magnitude, however, complete information that reflects the actual number of HIV/ AIDS orphans in the country could not be found.

Attempt was also made to see the school performance of the HIV/AIDS orphans. However, due to lack of their previous record about their academic performance, the result is based on the response from the respondents.

The other limitation of this study is that, even if the samples were taken from different regions, they are not representatives of the multicultural and multiethnic groups of Ethiopia. Therefore, it is not possible to generalize the findings to all the country.

1.7. Definitions of Basic Terms

Child- the term child generally encompasses a person under 18 years of age. The UN Convention on the Rights Of Child defined a minor as a person of either sex who has not attended the full age of eighteen years (CRC, 1992).

AIDS- stands for the Acquired Immune Deficiency Syndrome, a cluster of medical conditions, often referred to as opportunistic infections and cancers and for which, to date, there is no cure (ILO, 2001).

HIV- means the Human Immunodeficiency Virus, a virus that weakens the body's immune system ultimately causing AIDS (ILO,2001).

Discrimination- is any distinction, exclusion or preference made on the basis of real or perceived HIV status that has the effect of nullifying or impairing equality of opportunity and treatment (ILO, 2001).

Stigma- is a barrier and discourages individuals and their families from getting the help they need due to the fear of being discriminated against (Guest, 2001).

HIV/AIDS orphans- in this study, it refers to children who lost their mother to AIDS before the age of 18 years. Some of those children have also lost or will later lose their father to AIDS. According to UNAIDS definition, the upper limit of the age is 15 years. But the researcher finds it important to have the age limit to 18 in line with the Convention on the Rights of Child (CRC, 1992).

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CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1. Psychosocial Status of AIDS Orphans

2.1.1. Stigma and Discrimination of AIDS Orphans

Since the onset of the HIV epidemic, discrimination has been explained in different forms. For example, discrimination has tended to fall into two basic categories, legislative forms of discrimination, which reflects the stigma that has been officially sanctioned and legitimated through laws or policies. These forms of discrimination include restrictions on travel, enforced isolation and mandatory testing and reporting. The other form of discrimination is communities' level form of discrimination in which marginalized groups experience this in variety of less formal contexts (Horizons, 2001).

Most research is based on an assumption that an "epidemic of AIDS orphans" is a threat to society, developing antisocial behavior, conceptualized as disease in itself, a breeder of criminals, militia and sex workers. For example, the study conducted by Guest (2001) pointed out that the current violence in many parts of Africa resulted from the feeling of hopelessness believing that they do not have long to live. This idea repeated by the media reinforces and perpetuates the stigma and discrimination on AIDS orphans.

According to IRIN (2003) Special Report, the danger is not orphanhood, but the way society deals with parentless children. Several studies point out that, more than the lose of one or both parents to disease, it is the stigma to AIDS that makes life hard for orphans. Using a variety of participatory approach, a study by Save the Children in South Africa (2002) found that orphaned children face discrimination within their

families, community, churches and schools before and after the death of their parents (Save the Children Denmark, in MOLSA, Italian Cooperation & UNICEF).

Other studies also indicate that in most cultures, children who are either HIV-positive themselves, or associated with an adult who is HIV positive or who died of AIDS, routinely face discrimination from their peers, their guardians and teachers, and from the community in general. They may be barred from school, harassed by peers and even prevented from joining in village activities (Brown and Sittitri, 1995 cited in Grainger et al., 2001).

This is also true in Ethiopia, as many school authorities refused admission of HIV positive children because parents were not willing to send their children to schools unless such schools are free from HIV infected children (Wondwsen 2000 cited in Alem, 2002). This is also true in India where the government decided to arrange home tuitions for the HIV infected siblings after they were forced to leave the lower primary school in Kollam (UN, 2002).

As many studies indicate, the traditional family is an asset in Africa, promising for caring to AIDS orphan, but sadly the current response towards children affected by HIV/AIDS has been treated differently. Many families find it easier to adopt non-AIDS orphan children than AIDS orphans since there is a misconception that AIDS orphan children can transmit the virus (Grainger et al. 2001).

Due to the low level of awareness among family members, friends and the large community, AIDS orphans are subjected to different forms of child maltreatment including physical, emotional, sexual abuse, neglect and exploitation (UNAIDS, 1999).

Even the term "AIDS orphans" reinforces labeling and stigmatization. Since, the term "AIDS" is attached to these children, it is used as a ground to discrimination. To

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avoid the stigma and discrimination attached to the term AIDS orphans, one study in USA recommended not singling out the cause of parental death in application for assistance (IRIN, 2003).

Generally why do we label an orphan with the cause of its parent's death? No one talks about "car crash orphans" or "cancer orphans" and our failure to eradicate the sinful stigma attached to the disease seems to be a good argument to stop labeling children who have enough to deal with.

2.1.2. Psychological Status of AIDS Orphans

One key factor regarding the long-term impact is the psychological and mental health of children who have nursed and lost their parents under traumatic conditions due to AIDS (German, 2002).

Children affected by HIV/AIDS suffer from stigma and discrimination associated with the disease, the loss of caring adults, and depletion of household financial resources. Intervention must go beyond health issue and respond to the broad range of child and family needs (UNAIDS, 2002).

Many studies deal with the numbers and age of orphans and their material needs. There is little research on quality of life, childcare arrangements and psychosocial support needed. Financial and material needs are usually presented as the most pressing, neglecting the emotional needs.

The result is a focus on material needs such as distributing blankets, food and clothes and little counseling, emotional and psychological support. In her Botswana study, Daniels said that it was hard to find workable means of dealing with emotional trauma in what she called "hidden wounds"(IRIN, 2003).

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The trauma of HIV/AIDS orphans starts way before, their parents' death. It starts during illness; selling assets for medicine and child care responsibility beyond their years. Many children constantly worry about going to school and leaving their parents to die. As study suggests, parental death is the most stressful events for the child (Toomey & Christie, 1990).

There is a controversy between informing and not informing the child before the death of his/her parents by AIDS. According to some studies, generally, children who know about their parents HIV positive status are less stressed than those who have not been told. Gilborn and her colleagues from Mekerere University and PLAN International in Uganda designed a research that began when parents were alive and reported that earlier awareness is effective in improving the long term well-being of children than those that were informed only after parents die. The primary enhancement within the intervention is a "success on planning" component to help HIV-positive parents plan for their children's future. This includes assistance in choosing a guardian and in acclimating children to the new guardian, will-writing workshops, legal counseling to avoid "property grabbing", and income generating programs for both parents and guardians. The National Association of Women Living with AIDS (NACWOLA) of Uganda (Gilborn, 2002) pioneered this approach.

Another research conducted in Uganda reported that the vast majority of older children want their parents to be honest with them about their HIV infection. They want to do what they can to help, they want to know the truth, and they do not want to learn about their parents' infection through gossip (Ibid).

HIV/AIDS orphans are vulnerable in almost all aspects of their lives. They have lower access to basic health care, show lower school enrollment rate and nutritional status, are emotionally and sexually abused, exploited and physically abused.

Child abuse affects the child's psychological development and personal identity. It leaves a profound impact on the child. Emotional or psychological child abuse has a more profound impact than either physical or sexual maltreatment. This is because it leaves a lasting scar on the child's inner feeling. Emotional abuse could also be inflicted by offensive remarks such as ridiculing and belittling words that degrade the over all personality or the achievement of the child. This can result in feelings of depression, bitterness, emotional disturbance and hopelessness (Ayalew and Elias, 1999).

The impact of parental death on children is complex and affects the child's mental health and social energy. HIV/AIDS orphans might have stunted development of the emotional intelligence and life skills such as communication, decision making, negotiations skills etc. Further more HIV/AIDS orphans often show lack of hope for future and a low self-esteem (Ibid).

The practical observation in the life of thousands of orphans leads to the conclusion that parental death, especially double death as often is the case with AIDS is a high risk factor that causes psychological stress with long term development impact on children (German, 2002).

Those HIV/AIDS orphans can cope and over come the problems through some social support. There are some grounds for believing that social support reduces stress levels. It influences health status because it reduces long term levels of negative affect. If the social support is available, the HIV/AIDS orphans may perceive negative occurrence as less severe, or spend less time worrying about the consequences of the

events, that is less time in thinking the negative affect. Having available confident support from close relationships may also reduce negative affect because the person is available to talk to about worries and concerns. Emotional support could be related to long-term affective states through enhancement of self-perceptions such as self-esteem and self-efficacy, with effects on coping persistence generated by having available persons who express confidence in a person's eventual success in dealing with problematic situations (Wills, 1990).

Generally an important goal of social support is inclusion enabling affected people to live without fear and to continue functioning as other members of society. Psychological and social support can help reduce stigma and other negative consequences of HIV/AIDS impact. For example association of HIV/AIDS orphans are one mechanism that provide both psychological and social support. To encounter the social isolation often experienced by HIV/AIDS orphans and to allow them to share and discuss their experience and problems openly and safely, these mutual support mechanisms provide peer support and help members cope with stigma and discrimination (UNAIDS, 2000).

From the above foregoing arguments on the social support, one can infer that integrated family, peers, and the community support help the HIV/AIDS orphans to cope with the psychosocial problems they faced. The stigma and discrimination practiced on HIV/AIDS leads to low social support. According to different studies, low social support may lead the children to smoking, alcohol use, or relapse to either of these (Wills, 1990).

Generally many of these children affected by the death of a parent can experience depression, low self-esteem, disturbed social behavior and poor life skills. Counseling those children after the severe traumatic loss can help them function better

and proceed to have a healthy and happier life. It is important to empower affected children and treat them as active social participants, rather than victims.

2.2. Educational Status of HIV/AIDS Orphans

It is reasonable to think that in normal circumstance at their age children should be enrolled in school where they could at least acquire the rudiments of education in terms of reading, writing and arithmetic. But this is far from being the case (Velis, 1995).

In Africa, even in the cities, schooling is still out of reach for many children for needy families, especially when they have been rejected and neglected. Schooling costs both time and money. All pupils must have a uniform and various items of school equipment, which is difficult, if not totally impossible, for street children and orphans to acquire. Children must attend school regularly and follow the timetable. Children who spend most of the day trying to find the means of subsistence for themselves or the families do not have enough time left over to sit on a school bench. Whenever day those dawns poses the problem of where and how to find enough to eat, then school is a luxury (Velis, 1995).

From the above situation one can understand that the problem is not only for HIV/AIDS orphans. It is common for the developing countries specially for those in sub Saharan Africa. What is special about the HIV/AIDS orphans is the issue of lack of love, exclusion or discrimination and the stigma attached to AIDS.

Education is the means where by HIV/AIDS orphans can realize the possibility of productive employment, minimizing their risk of being exploited and of themselves becoming infected with HIV. But for many African countries like Ethiopia poverty and HIV/AIDS have forced them to exclude children from school (Matshalaga, 2002).

As several studies indicate, many HIV/AIDS orphans were forced to dropout of school as a result of stigma attached to HIV/AIDS and extend in to the next generation placing an emotional burden on children who may also be trying to cope with death of their parents from AIDS. They are rejected and shunned by their friends (UNAIDS and UNICEF, 2002).

As indicated earlier, HIV/AIDS orphans are traumatized and it has been observed that traumatic behavior is evident mainly in orphans. Trauma has usually a negative effect on children's educational development and their relationship with families and other people (Tedla, 1996).

The relationship of children with peers has a lot of implications. For example, for peer relationship to be constructive influence, it must promote feelings of belonging, support and caring, rather than feelings of hostility and rejection. Peer acceptance is positively correlated with willingness to engage in social interaction to the extent that students provide positive social rewards for peers and the utilization of abilities in achievement situation. Peer rejection and isolation in the classroom is associated with high anxiety, low self-esteem and disruptive classroom behavior (Gordon et al., 1968).

Most HIV/AIDS orphans are forced to work because their survival and that of their families depend on it. As a result of lack of adult supervision, they are overworked, under paid, ill-treated and have no opportunity to go to school. The lives of these children can be improved only by providing them with basic services including health, nutrition and education (Ayalew, 1993).

The study conducted by (MOLSA, Italian Cooperation & UNICEF 2003) indicates that 93% of non-AIDS orphans and AIDS orphans were enrolled in elementary school at

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some point in their life. However, according to the study the considerable number of the orphan children dropout of school following the death of the mother or both parents.

The new education and training policy (TGE, 1994) states the following:

> *Special attention and protection shall be made for children so that conducive environment will be created for their physical, spiritual, psychological and social development. Particularly special support shall be offered to those children who have no parents and other persons who look after them (Article 8.6.3).*

From this article one can infer that those HIV/AIDS orphans should be protected from many things, which negatively affects their physical, psychological and social development .

Recent studies point out that orphans who lost either one or both parents to AIDS have a much harder time staying in school. The trauma for these children is either too difficult to manage or they are discriminated against by their peers. According to MOLSA, Italian Cooperation & UNICEF (2003) study, the majority of the children who drop out of school, because of AIDS are girls. Girls take on the responsibility of caring for sick parents or their orphaned siblings at home (UN Foundation and Ad, 2002).

MOLSA, Italian Cooperation & UNICEF (2003) study also indicates that twenty percent of AIDS orphans drop out of school following the death of their mother. One of the best indicators as to whether children are benefiting from social services is school attendance. According to a review made by UNICEF (2002), in 20 sub-Saharan African countries, children between the ages of 5 to 14, who had lost one or both parents were less likely to attend school, and more likely to work for more than 40 hours a week. A survey of 646 orphaned children and 1,239 non-orphaned children in Kenya revealed

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that 52% of the orphaned were not in school, while only 2% of the non-orphaned children were not enrolled. The same study in Zambia showed that 32 percent of orphans in urban areas were not enrolled in school, as compared with 25% of non-orphaned children. The problem of inability to benefit from social services is expected to be more severe for AIDS orphans due to stigmatization and the probability of losing both parents. For example, a study conducted in Addis Ababa found that 15% of the AIDS orphans had defaulted schooling after the death of their parents and 4% had AIDS. The same study revealed that some AIDS orphans faced abandonment, displacement and lack of medical care at the time of illness (Save the Children, Denmark, 2002 cited in MOLSA, Italian Cooperation & UNICEF, 2003).

2.2.1. Gender Disparities

Studies have shown that rates of girl's education is a key indicator for societies economic and social development. Therefore, the education of girls is a must. Because the AIDS epidemic keeps girls out of school, it also hinders the development of the societies (UNF & Ad council, 2002).

AIDS epidemic is not the only problem that keep girls out of school but also many reasons can be cited for low rate of girls school enrollment. Emebet's study indicated that the number of girls in school is less than that of boys because of culture and school related problems (Emebet 2000). This is also indicated in UNESCO report that due to socio cultural handicaps and all sorts of prejudices against women create lower schooling expectance than boys (UNESCO, 1982).

The study conducted by Alem on female AIDS orphan problems also shows their sex play significant role for dropping out of school (Alem, 2002). Other studies also

shows that HIV/AIDS increase educational disparities between boys and girls as girls are removed from school to nurse siblings, caring for sick parents and other relatives. Moreover, girls may be encouraged to marry early because they are forced out or seek escape from over crowded extended families. Economically girls are mostly dependent on males. This is also reflected in case of female AIDS orphans. According to UNICEF report after the death of parents particularly in the case of girls, may deny their inheritance and property (UNICEF, 1999 c).

In Keneya also a study of orphans discovered that 56 percent of girls compared with 46 percent of boys dropped out of school with in a year following a parents death (Elmore Meegan et al., 1999). In Swaziland, school enrollment is reported to have fallen by 36 percent as a result of AIDS, with girls the most affected (UNAIDS, 2001).

In contrast to the above finding (Case et al., 2003) find that lower enrollment of orphans is equally severe for boys and girls.

The sex of the head of the household also play a great role in school enrollment of orphans. Study in Uganda indicated some difference in schooling. This study suggesting that an orphan's educational access is more assured when the household is headed by a woman (Aspaas, 1997).

2.3. Coping Strategies With the Stigma and Discrimination Attached to HIV/AIDS

HIV stigma comes from the powerful combination of shame and fear. The shame is arise from its transmition by sex or drug injections that are surrounded by taboo, and fear because AIDS is relatively new and deadly.

A study in Ethiopia found that much of the stigmatizing language and description of stigmatizing and discriminatory behavior centers on the sexual transmission of HIV.

According to the study, many people believe, those with HIV contract it through their own bad behavior namely sexual activity that is not socially accepted or that goes against religious teaching. The study further suggests, the society concluded that they are 'careless' or 'unable to control themselves' and have brought HIV up on themselves. They are also blamed for bringing it in to the community (Garbus, 2003).

Raising awareness of HIV/AIDS, ensuring children's protection, multicultural response, ensuring access to education, addressing children emotional needs are some important task to be done to avoid stigma and discrimination related to HIV/AIDS (Grainger et al, 2001).

In Thailand and Uganda, government planned national campaigns that have brought together ministries; NGOs, organizations from grass root level and the private sector to raise awareness of HIV/AIDS have lead to a decline in stigmatization and in HIV infection rates (FAO, 1999).

NGOs can raise awareness in communities where they are worked and trusted. They can help develop information systems, to give information and advice to affected communities and thus reduces stigmatization and discrimination of affected children (Mukoyogo and Williams, 1991).

The involvement of community elders, religious leaders and other influential men or women in the activities related to HIV/AIDS orphans can act to decrease stigmatization of those affected by HIV/AIDS. A project in Thailand is involving Buddhist monks and nuns and village elders and chiefs in providing information to community about HIV/AIDS and services such as counseling (SMP, 1999, cited in Grainger et al., 2001).

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In Zambia, the surviving family of some one who's died of AIDS will not shunned as they might be in other countries. Since the disease is common and it has lost much of its social stigma (Guest, 2001).

The other important point to avoid stigma and discrimination related to HIV/AIDS is ensuring children's protection. The United Nation Convention of the Right of Children (UNCRC) places a duty on governments to protect and respect children's right using this UNCRC, as a framework for program planning would lead to avoiding stigma and discrimination. Because the UNCRC contains in many of its articles, the right to protection from physical and mental abuse and from discrimination (Article 2 and 19). If the convention is not realized, the impacts of HIV/AIDS deprive children off their rights, for example by removing them from parental care and love, separate them from their possessions and alienating them from their communities; forced them to drop out school.

Home based support for people affected by HIV/AIDS can alleviate suffering for the sick, help children to adjust psychologically to the situation and accept the reality. This also helps the child for future planning, and the support make the children continue their education. Happier, healthier and better-educated children are less likely to be at risk of HIV infection (Sanei, 1998).

Other important concept in reducing the psychosocial problems of HIV/AIDS orphans is being open and honest with children about their parents' HIV- positive states before their death. A study in India indicated that children whose parents had told them of their HIV-positive status were better able to accept the condition than children whose parents did not able to speak about their HIV positive status. Children Who were aware of their parents' HIV status were also more ready to take additional responsibilities at

home, including caring for sick parents. Such disclosure can assist with the arrangements of foster care for the children after the adult's death, and can bring children in to discussion (Gilborn, 2002).

It has been suggested that a combination of psychosocial and technical support for children and their families may enable African families to cope with the growing number of HIV/AIDS orphans. Organizations, those who give care and support for HIV/AIDS orphans may aware of their psychosocial needs, but often feel they lack the skills to address them appropriately. However, trained specialists and therapists is rarely available to children in developing countries. Nor, is it necessarily appropriate. Each culture has its own particular model for explaining calamities, expressing distress, and arranging support for who suffer. Therefore, communicating with children and getting their trust is the skill that should be encouraged in communities affected by HIV/AIDS. Church organizations, NGOs, informal community based groups, and other organizations can provide this vital support under the general heading of 'counseling (Grainger et al, 2001).

In summary, awareness raising, mobilizing of community and religious leaders, and involving the media are the most important strategies that will lessen discrimination and stigmatization of HIV/AIDS orphans and enhance their ability to cope with the psychosocial impacts of HIV/AIDS.

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CHAPTER THREE

METHODOLOGY

In this chapter, the methods used in the study are described. The sampling procedure and its variant forms together with their rational have also been presented. The description of the tools and techniques, and method used to analysis are provided.

3.1. Research Design

A descriptive survey research method was employed for this study. It is appropriate to make description and analysis of the existing psychosocial and educational status of HIV/AIDS orphans.

3.2. Sample Selection

Data for this research were obtained from different sources. They were obtained from HIV/AIDS orphans, care takers of HIV/AIDS orphans and the representatives of non-governmental organizations who give care and support to HIV/AIDS orphans.

140 HIV/AIDS orphans, 53 HIV/AIDS orphans' caretakers and 3 representatives of the organization, which give care and support to HIV/AIDS orphans participated in the study. The HIV/AIDS orphans were selected from Mekdim HIV Positive and AIDS Orphan Association, Tesfa Berhan AIDS Orphan Association and AIDS orphans who get support from Ethiopian Orthodox Church Development and Inter-Church AID Commission in Awassa. About 250 HIV/AIDS Orphan are members of Mekdim HIV Positive and AIDS Orphans Association. From this number 67 AIDS orphans were selected by stratified random sampling; and 46 were selected from Tesfa Berhane AIDS Orphans Association.

From Awasa all (27) HIV/AIDS orphans who registered in EOC-DICAC of Awassa branch were taken. The available caretakers were also selected from the mentioned organization. They are 53 in number. The selection of the organization was purposeful.

3.3. Instruments for Data Collection

To obtain reliable and objective information, data were collected in different methods. For this purpose questionnaires and interviews were used.

Part I. Questionnaire:- this part contains close-ended and open-ended questions. It was used to collect data from HIV/AIDS orphans.

Part II. Structured and Semi-Structured Interview:- These were used to collect data from the care takers and the representatives of the organization, such as Mekdim HIV Positive and AIDS Orphans National Association, Tesfa Berhan AIDS Orphan Association and EOC-DICAC Awassa branch.

Most of the interview items prepared for the caretakers were structured. Where as for the representatives of the organizations, semi-structured interview items were prepared.

3.4. Procedures

Before developing the instruments related literature was thoroughly examined and items were prepared in English. Then it was translated in to Amharic.

Finally, the instruments were tested on a pilot study, which was carried out on a sample of 20 AIDS orphans (10 boys and, 10 girls) and 10 caretakers. They were not

part of the main study. Thus the feedback obtained from the pilot test was used to refine the instruments, to incorporate new ones, and to delete items that had deficiencies.

Since the issue of AIDS is sensitive, establishing rapport has been very essential before the administration of the questions. First the researcher visited the stated organization and made preliminary survey and got consent.

Prior to the administration of the questionnaire, 15 data collectors were recruited and training given to them. Following the training, the actual data collection was carried out and the process was controlled and supervised by the researcher.

3.5. Data Organization and Analysis

The data collected is organized in line with the objectives of the research. In this process both quantitative, primary descriptive method, i.e., percentage and qualitative analytic procedures are used.

CHAPTER FOUR

RESULTS AND DISCUSSION

This chapter deals with the findings obtained from the questionnaire, and structured and unstructured interviews. It consists of two parts; the first part deals with presentation of results and the second part is concerned with the discussion.

4.1. Results

Three groups of respondents, HIV/AIDS orphans, HIV/AIDS orphans' caretakers, and representatives of a non-governmental organization who deals with the care and support of HIV/AIDS orphans, were the subjects (respondents) of the study.

4.1.1. Background Characteristics of HIV/AIDS Orphans

Table 1: Demographic Characteristics of the Sample Orphans

No	Age	Sex				Total	
		M		F			
		No	%	No	%	No	%
1	6-12	9	13.23	14	19.14	23	16.42
2	13-18	59	86.76	58	80.55	117	83.57
	Total	**68**	**100**	**72**	**100**	**140**	**100**

The age of the respondents ranges from 6 to 18 years, whereby 83.57% fall in the age range of 13-18. Therefore, the majority of them belongs to the appropriate age group to give relevant information about themselves and others. With respect to the sex, 51.4% were females and 48.6% were males.

Table 2: Religion and Ethnic Group of HIV/AIDS Orphans

No	Religion	No	%
1	Orthodox	123	87.85
2	Protestant	13	9.28
3	Muslim	4	2.85
	Total	140	100
No	**Ethnic group**	**No**	**%**
1	Amhara	96	68.57
2	Oromo	25	17.85
3	Tigre	7	5.0
4	Gurage	7	5.0
5	Wolayita	3	2.14
6	Sidama	2	1.42
	Total	**140**	**100**

As to the religions of the respondents, 87.85% were found to be Orthodox, 9.28% were protestants and 2.85% were Muslims. Regarding the ethnic group of the respondents, 68.57% were Amhara; 17.85% were Oromo; 5% were Tigre, 5% were Gurage, 2.14% were Wolayita and 1.42% were Sidama.

Table 3: Educational Profile of the Sample Orphans

No	Level of Education	Sex				Total	
		Male		Female			
		No	%	No	%	No	%
1	Illiterate	-	-	14	19.44	14	10
2	1-4 grade	11	16.17	4	5.55	15	10.71
3	5-8 grade	37	54.41	45	62.5	82	58.57
4	9-10 grade	14	20.58	5	6.94	19	13.57
5	Above grade 10	6	8.82	4	5.55	10	7.14
Total		**68**	**100**	**72**	**100**	**140**	**100**

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Most of the AIDS orphans (58.57%) were in 5^{th} to 8^{th} grades. 13.57% were in grades 9 and 10, and 10.71% were in grades 1 to 4. But sadly, 10% of them have never been in school and are illiterate. A few are above grade 10, such as in preparatory or in vocational training.

4.1.2.The Psychosocial Conditions of AIDS Orphans

Table 4: Psychosocial Condition of the Orphan Respondents

No	Item	Response	
		No	%
1	With whom do you live now?		
	- Grand parents	20	14.28
	- Aunts	31	22.14
	- Uncle	12	8.57
	- Themselves	60	42.85
	- Friends	10	7.14
	- Non-relatives	7	5.0
	Total	**140**	**100**
2	Do you think adults treat HIV/AIDS orphans differently?		
	- Yes	103	73.57
	- No	17	12.14
	- I do not know	20	14.28
	Total	**140**	**100**
3	If 'yes' how do they treat AIDS orphans differently?		
	- Neglecting and discriminating	49	47.59
	- Teased, physically and verbally abused	14	13.59
	- Taking away property	12	11.65
	- Not allowing to go to school	17	16.50
	- By making them do more chores	11	10.67
	Total	**103**	**100**
4	When you were at school or around your home were you ever been called names or been teased by other children because of your parents' deaths?		
	- Yes	26	18.57
	- Some times	49	35.0
	- No	65	46.43
	Total	**140**	**100**
5	What type of response do you get from children of your age?		
	- Sympathetic	25	17.86
	- Ostracizing	39	27.86
	- Providing all kinds of support	16	11.43
	- Consider me as unlucky	-	-
	- Consider me as cursed	20	14.29
	- Ridicule me	15	10.71
	- Nobody knows about my parents death by AIDS	25	17.86
	Total	**140**	**100**

6	What did you feel when you heard the term 'AIDS orphans'		
	- Shame	81	57.86
	- Sadness	43	30.7
	- Anger	16	11.43
	- Nothing	-	-
	Total	**140**	**100**
7	How happy are you living in this home?		
	- Very happy	-	-
	- Happy	44	31.43
	- Sad	72	51.43
	- Very sad	24	17.14
	Total	**140**	**100**
8	Are you happy as most boys and girls?		
	- Yes	104	74.3
	- No	36	25.7
	Total	**140**	**100**
9	Do you spend a lot of time thinking about your parents' death?		
	- Yes	125	89.3
	- No	15	10.7
	Total	**140**	**100**
10.	You have only a few friends		
	- Yes	88	63.0
	- No	52	37.0
	Total	**140**	**100**
11	If 'yes' state the reasons		
	- Because I am AIDS orphan	25	28.4
	- Because parents of other children told them not to play with me	33	37.5
	- Because they teased me	14	18.1
	- I do not want to have more friends	16	15.9
	Total	**88**	**100**

The majority of the HIV/AIDS orphans live alone 42.85%; where as 22.14% of them live with their aunts, 14.28% live with their grandparents and 8.57% of them with their uncle, 7.14% live with their friends and the rest of them (4%) live with non-relatives.

Majority of the respondents (73.57%) said 'yes' while 11.42% of them said 'no' and 15% of them said I do not know regarding differential treatment. The majority of them believe that they are treated differently because they are AIDS orphans.

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47.5% of those who reported being treated differently disclosed they are neglected; 10.67% were treated differently by making them do more chores; 11.65% of them expressed that adults took away their properties; 13.59% of them inferred that they are teased, physically and verbally abused by adults. More over 16.5% disclosed they were not allowed to go to school.

Regarding being called names and teased by other children because of their parents death by HIV/AIDS, the majority of them (46.43%) answered no; 35% of them disclosed that they encounter such conditions some times; and the remaining 18.57% of them answered that they are called names and teased by other children.

27.86% disclosed that they were ostracized by other children, 17.86% of them get sympathy from other children. Likewise, 17.86% of them also indicated that other children do not know that they are AIDS orphans. 14.29% of them said they were considered as cursed by other children. 11.43% answered that they got all kinds of support from other children; 10.71% of them said other children ridiculed them.

The majority of them (57.88%) reported that they feel shame when they heard that they are "AIDS orphans". This is the result of stigma attached to AIDS. 30.71% of them disclosed that they feel sadness. The rest of them (11.43%) indicated that they were angry when they heard the term AIDS orphans.

No one indicated that they feel very happy in the home they live. But 51.43% of them disclosed that they are sad; 31.43% of them indicated that they are happy. A large number (17.14%) of them answered that they are very sad.

They were asked if they are happy or not compared to other children: 74.3% of them indicated they are not happy as other children. The rest of them (25.7%) said they are happy as other children are.

Regarding thinking about the death of their parents, 89.3% of them said 'yes'. The rest of them (10.71%) answered "no". This indicated that the trauma of their parents' death is still disturbing them.

Item 10 of Table 4, is based on the number of friends they have. Accordingly, 63%of them indicated that they have a few friends; 37.14% of them reported they have many friends.

28.4% of those who had a few friends indicated that as they are AIDS orphans other children do not want to make a friend with them; 37.5% of them said that parents of other children told their children not to play with AIDS orphans to protect themselves from AIDS 18.1% of them indicated, that they do not want to have more friends and 15.9% of them were afraid that they will be teased.

4.1.3. The Educational Conditions of AIDS Orphans

Table 5: Educational Condition of the Orphan Respondents

No	Item	Respondents					
		M		F		Total	
		No	%	No	%	No	%
1	Are you currently enrolled in school?						
	- Yes	54	79.14	33	45.83	87	62.14
	- No	14	20.58	39	54.16	53	37.84
Total		**68**	**100**	**72**	**100**	**140**	**100**
2	Have you dropped out of school?						
	- Yes	14	20.58	25	34.72	39	27.85
	- No	54	79.41	33	45.83	87	62.14
	- Never been at school	-	-	14	19.44	14	10.0
Total		**68**	**100**	**72**	**100**	**140**	**100**
3	If 'yes' the reasons for dropping out of school is						
	- To care for my younger sister and brother	2	14.28	16	64	18	46.15
	- Fearing of stigma and discrimination	4	28.57	5	20	9	23.07
	- Financial problems	8	57.1	4	16	12	30.76
Total		**14**	**100**	**25**	**100**	**39**	**100**
4	(For those who have never been in school) state the reasons						
	- Taking care of my sick parents until they die, and then my siblings	-	-	9	64.28	9	64.28
	- My care takers are not interested to send me because I have to help in house	-	-	5	35.71	5	35.71
Total		**-**	**-**	**14**	**100**	**14**	**100**
5	Do your teachers know about your parents' death?						
	- Yes	33	61.11	20	60.60	53	60.9
	- No	21	38.88	-	-	21	24.13
	- I do not know	-	-	13	39.39	13	14.94
Total		**54**	**100**	**33**	**100**	**87**	**100**
6	If 'yes' do you think that they treat you better, the same as other or worse?						
	- Better	20	60.6	15	75	35	66.0
	- Same as other students	3	9.0	3	15	6	11.3
	- Worse	10	30.3	2	10	12	22.6
Total		**33**	**100**	**20**	**100**	**53**	**100**

62.14% of the respondents are presently in school; 37.85% of them either dropped out of school or completed their education or never been in school.

27.86% of the respondents have dropped out of school and 10% of them have never been in school. Item 3 in Table 5, was presented for those who dropped out of school to state the reasons. From the female AIDS orphans who dropped out, 64% of them disclosed that they dropped out to care for their younger siblings. 20% of them indicated that they dropped out because they were afraid of the discrimination at school. 16% of them answered that the cause for their dropping out was financial problem. 57.1% of the male AIDS orphans indicated that the cause for their dropping out was financial problem; 28.57% of them indicated being afraid of discrimination and the rest of the male AIDS orphans (14.28 %) indicated that they dropped out of school to care for their younger siblings.

Item 4, in Table 5, was presented to those who have never been in school to state the reasons. All of them were females. 64% of them disclosed that they take care of their sick parents before their death, and after the death of the parents they care for their siblings. The rest of (36%) AIDS orphans said that their caretakers are not interested to send them to school.

Regarding the knowledge of teachers about the death of their parents, the majority of the orphans (60.9%) indicated that their teachers know that they are orphans. While, about 14.94% of them disclosed that their teacher didn't know that they are orphans. 24.14% of them answered that they didn't know about the knowledge of the teacher.

Item 6 of the same table was presented for those who answered 'yes' in item 5; 66.03% of them said that teachers treated them in a better way. They added that in the

activities that require the involvement of parents, teachers act as their caretakers. They also elaborated that many teachers told them that they have to keep themselves from different harmful experiences like quitting school, running out of home etc. even if they faced different problems. 11.32% of them answered they are equally treated in the same way as the other students. 22.64% of the students reported that they were treated in a worse condition than other students. They added that when they faced shortage of money to buy writing materials or when they come late or are absent, many teachers insulted them or forced them to leave classroom.

4.1.4. Data From Structured Interview With the Care Takers of HIV/AIDS Orphans

Since the interview that was presented was highly structured, the data are presented in percentage form.

Table 6: Age of the Sample Caretakers

No	Item	Response	
	Age in year	No	%
1	12-18	14	26.41
2	19-24	9	16.98
3	25-30	7	13.20
4	31-45	6	11.32
5	46-60	15	28.30
6	> 60	2	3.77
Total		**53**	**100**

As can be seen from Table 6, 28.30% of the caretakers are in the age range of 46-60. The next age group is from 12-18, which accounted for 26.41% of the respondents. The remaining, 3.77% of the respondents are above 60 years old.

Regarding to the sex of the caretakers, 79.24% of them were females and 20.76% were males.

Table 7: Educational Profile of the Care-Takers

No	Level of Education		
		No	%
1	Illiterate	15	28.3
2	Literate	18	33.96
3	Grade 1-4	8	15.09
4	Grade 5-8	7	13.2
5	Grade 9-10	3	5.66
6	Certificate	2	3.77
7	Diploma and above	-	-
Total		**53**	**100**

Most of the caretakers (33.96%) are literate i.e., they can read and write with certain basic arithmetic skills. 28.3% of them are illiterate. No respondent has a diploma and above level of education.

Table 8:Relation of Care Takers to the Children

No	Care Taker	No	%
1	Remaining Parents	-	-
2	Grand parents	7	13.20
3	Aunts	18	33.96
4	Uncles	3	5.6
5	Sister & brother	14	26.41
6	Non relatives	8	15.09
7	Friends	3	5.6
	Total	**53**	**100**

Compared to other caretakers, the aunts were about 34%; 26.41 % were sisters and brothers; the grand parents were about 13% and non-relative caretakers were about 15%. The rest were friends and uncles.

4.1.5. Psychosocial Conditions of the Children from Care-takers Response

Table 9: Psychosocial Conditions of the Sample Orphans

No	Question/Item	No	%
1	How happy is the child compared to other children of the same age?		
	- Happier	2	3.77
	- The same, some times happy, some times unhappy	13	24.53
	- Some what unhappy	14	26.4
	- Very unhappy, sad or depressed.	24	45.28
	- Don't know	-	-
	Total	**53**	**100**
2	What makes this child happy?		
	- Being with friends, talking, playing	21	39.62
	- Being with family	15	28.3
	- Reading	-	-
	- Going to school	4	7.54
	- Being alone	13	24.52
	Total	**53**	**100**
3	What makes this child sad?		
	- Hunger	3	5.66
	- Punishment	5	9.43
	- Being called "AIDS orphan"	35	66.03
	- Physically abused or being hit	-	-
	- Being given chores, kept from playing	10	18.86
	- Others	-	-
	Total	**53**	**100**
4	Does this child cry a lot over small things or over nothing during the course of the day?		
	- Yes	40	75.47
	- No	6	11.32
	- Sometimes	7	13.2
	Total	**53**	**100**
5	Does he /she have scary dreams or night mares?		
	- Yes	34	64.15
	- Some times	15	28.3
	- No	4	7.54
	Total	**53**	**100**
6	Does he/she seem worried?		
	- Yes	25	47.16
	- Sometimes	20	37.73
	- No	8	15.09
	Total	**53**	**100**

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7	Does he/she become frustrated easily when things do not go his/her way or something doesn't work?		
	- Yes	17	32.07
	- Sometimes	30	56.6
	- No	6	11.32
	Total	**53**	**100**
8	Does he/she become afraid of new situation or change?		
	- Yes	40	75.47
	- Sometimes	8	15.09
	- No	5	9.4
	Total	**53**	**100**
9	Does he/she become very angry?		
	- Yes	18	33.96
	- Sometimes	26	49.05
	- Never	9	16.98
	Total	**53**	**100**
10	Does he/she have trouble falling asleep?		
	- Yes	4	7.54
	- Sometime	10	18.86
	- Never	39	73.58
	Total	**53**	**100**
11	How does this child get along with other children?		
	- Very well	18	33.96
	- Well, but not perfectly	-	-
	- Some what well	14	26.41
	- Poorly	-	-
	- Very poorly	21	39.62
	Total	**53**	**100**
12	Does he/she ever choose to be alone, instead of playing with other children?		
	- Yes	30	56.60
	- Sometimes	17	32.07
	- Never	6	11.32
	Total	**53**	**100**
13	Is this child stubborn or disobedient at home?		
	- Yes	5	9.43
	- Sometimes	7	13.2
	- Never	41	77.35
	Total	**53**	**100**
14	Does he/she attack other children?		
	- Yes	43	81.13
	- Sometimes	5	9.43
	- Never	5	9.43
	Total	**53**	**100**

15	Does he/she have problems making friends? - Yes - No	 31 22	 58.49 41.50
Total		**53**	**100**
16	Does he/she ever run away from home? - Yes - No	 33 20	 62.26 37.73
Total		**53**	**100**

Item 1 of Table 9 asked the respondents how happy the child they care for was. In accordance with this, the majority (45.28%) of them responded that the children are very unhappy, sad and depressed. The other respondents about 26.41% of them answered that they are somewhat unhappy.

The large number of the respondents (39.62%) responded that being with friends and playing make the children happy. 28.30% answered that they are happy when they were with family members. 24.52% of them are happy when they are alone.

As Item 3 of the same table indicating the majority of the respondents (66.03%) responded that being called "AIDS orphans" makes them unhappy and depressed; 18.86% of them responded that being kept from playing and giving them house work make them sad. Punishment and hunger make them sad according to 9.43% and 5.66% caregivers, respectively.

75.47% of the respondents disclosed that the children do cry over nothing during the course of the day. Most of the respondents (64.15%) reported sleeping problems, and 28.30% of them said that some times have nightmares.

47.16% of the respondent answered that those children whom they cared were worried. 37.73% of them said they seem worried some times. Moreover, 56.60% disclosed that they were frustrated easily when things do not go his/her way or something doesn't work.

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The majority, (75.47%) of the caretakers said that, the child is afraid of a new situation or change: 15.09% said they some times.

49.05% of the respondents disclosed that, those children are very angry sometimes. 33.96% of them said they are very angry. The rest 16.98% of them said they were never angry.

Concerning Item 10, (falling asleep) the majority (73.58%) of them had no problems, and 18.86% of them said they faced problems some times.

The social relation of those children is generally poor. Accordingly, 39.62% of the respondents said their relation is very poor. According to the caretakers response, 56.60% of them said the child prefers to be alone instead of playing with other children, and 32.07% of them some times choose to be alone. But small number of the respondents (11.20%) indicated that the child prefers playing with other children. The majority of the respondents (77.35%) said that the child is disobedient at home.

81.13% of the caretakers disclosed that the child whom they cared tried to attack other children of his/her age.

According to Item 15 of Table 9; 58.49% of the respondents indicated those children faced problems in making friends. The rest (41.50%) of them however, replied that the children had no problem in making friends. Moreover, 62.26% of the respondents pointed out that the child did run away from home.

4.1.6. Caretaker's Responses on Educational Condition of the Children

Table 10: Educational Conditions of the Sample Orphans

No	Item	Response	
		No	%
1	Is the child currently enrolled in school?		
	- Yes	41	77.35
	- No	12	22.64
	Total	**53**	**100**
2	If 'no' what are the reasons?		
	- Financial problem	10	83.3
	- Help us in house chores	2	16.7
	- Others	-	-
	Total	**12**	**100**
3	What is this child's class position?		
	- Very good	4	9.75
	- Good	9	21.95
	- Fair	5	12.19
	- Poor	15	36.58
	- Very poor	8	19.5
	Total	**41**	**100**
4	How regular does this child attend school?		
	- Every day	4	9.75
	- Most of the time	12	29.26
	- Sometimes	18	43.90
	- Very irregular, mostly at home	7	17.07
	Total	**41**	**100**
5	Is there any special reason why this child misses school some times?		
	- No money for school expenses	5	12.19
	- Child refuses school	3	7.31
	- Family needs child's help caring for other children	31	75.6
		-	-
	- Child does not get along with other children	2	4.89
	- Child is sick		
	Total	**41**	**100**
6	Has the child's performance in school change after the death of his/her parents?		
	- Yes	40	97.56
	- No	1	2.44
	Total	**41**	**100**

7	If 'yes' what exactly has caused his/her performance to get worse? - Child stays home to help - We can no longer afford school expenses - Child is worried, distracted - Child is also sick - No relationship between school performance and their death	 8 2 30 - -	 20.00 5.00 75.00 - -
Total		**40**	**100**
8	Has the child dropped out of school? - Yes - No	 12 41	 22.64 77.35
Total		**53**	**100**
9	If 'yes', the reason for dropping out school - We can no longer afford school expense - The child help us in house chores - Truancy/school dismissal - They are not happy in attending school	 - 7 2 3	 - 58.33 16.60 25.00
Total		**12**	**100**

77.35% of the respondents answered to Item 1 of Table 10 that those children whom they cared for are currently enrolled in school; and 22.64% of them said they are currently not in school; 83.3% of those who are not in school are due to financial problem and 16.7% of them said they help in house chores.

36.58% of the respondents answered that their class position is poor; 21.95% of them said it is good, 19.5% of them said it is very poor; 12.19% of them responded that their position is fair. But 9.75% of them said that their class position is very good.

Only 9.75% of them responded that the child attends school every day. But 29.26% of the caretakers said that children attend school most of the time and 43.90% of the caretakers disclosed that those children attend school some of the time.

Concerning the reasons why the child misses school, the majority of them (75.60%) said, that they need child's help to care for them and other children.

All of the respondents except one said that their school performance changed negatively. The majority (75.0%) of them said the child is worried, distracted and give no attention to his/her lesson.

22.64% of the caretakers, responded that the child dropped out of school; they further suggested reasons for dropping out. Accordingly, 53.33% disclosed that they dropped out of school to help in the house chores. 16.66% of them said, because of much absence from school due to different problems they were dismissed. The rest (25%) of the caretaker disclosed that the child was afraid to go to school after the death of their parents, as other children teased at them.

4.1.7. Summary of Data Obtained from the Representatives of the Organizations that Provide Support to AIDS Orphans

This result is obtained from three respondents. They are representatives of Mekdim HIV Positive and AIDS Orphans Association, Tesfa Birhan AIDS Orphan Association, and Ethiopian Orthodox Church Development and Inter Church AID Commission Orthodox HIV/AIDS Campaign Center, Awassa Branch.

The objectives of the organizations are to prevent and control HIV/AIDS and help those who live with the virus economically and psychologically, and rehabilitate those children who have lost their parents by HIV/AIDS.

For the question, what technique do you use to solve the psychosocial problems of the HIV/AIDS orphans? From EOC-DICAC, the representative narrated the following.

"Still now, we didn't use any methods, but in the future we have planned to train the priests in counseling to give them counseling service for those children, to accept the reality of death of their parents and help themselves".

From Mekdim Ethiopia, especially they give counseling service to those who live with the virus, but for AIDS orphans they gave some economical support and little counseling.

They were asked about the main problems of AIDS orphans. EOC-DICAC representative said that, food, clothes, and the basic necessities are their main problems where as the Mekdim & Tesfa Berhan underlined psychological problem as the main problem faced.

Furthermore, they were asked about the roles of the caregiver of HIV/AIDS orphans. They suggested that most of the caregivers use those AIDS orphans as a

means of income, or never treat them properly. This might be because of their own economic problems.

When they were asked about the attitude of the society about AIDS orphans; the society has mixed feeling about them. Some of them believed that, they were like their parents, and have HIV in their blood. Some others believed that the children might get HIV from their mothers. On the other hand, whether they are HIV positive or HIV negative they couldn't transmit by casual contact, therefore, they believe that they have to handle them as other children. Generally the attitude of the society is both negative and positive based on their awareness level about HIV.

They were also asked, about the obstacles they faced while trying to solve the AIDS orphans problems. They answered that because they were afraid of the stigma and discrimination associated with the term 'AIDS', many of them denied to explain and even to call the term AIDS. The other is financial problem to meet there needs, to pay school fees, house rent & for health care.

The other question forwarded was about the relationships that exist among themselves. When they (AIDS victims) come together to discuss their problem they become very happy knowing that they are not alone. Because of this they have a good relationship.

When they were asked if any change is observed in the psychosocial and educational condition of those children because of their support, the EOC-DICAC representative suggested that since they have started recently, they do not expect a change; but the representatives of Mekdim & Tesfa Berhan suggested that a great change is observed.

At the end, they were asked to suggest possible solutions to eliminate or reduce their problems. Mobilizing the society, empowering the caretaker and providing counseling to both the caretaker and AIDS orphans were suggested.

4.2. Discussion

4.2.1. Demographic Characteristics of the HIV/AIDS Orphans

The age of the respondents' ranges from 6 to 18 whereby the majority (85.84%) falls between ages 12 to 18. The oldest age group of AIDS orphans is most sensitive to the orphan problems, because many of them are double orphans and therefore have both problems of lack of parental care and of lack of money especially for school fees and house rent. This is also true in case of female AIDS orphans at this age as they are often sexually abused and forced to commercial sex work as a means of income. On the other hand, from the AIDS orphans, the youngest ones are the least affected by orphan problems since they are less aware of what is happening to them and hence adjust more easily to the care by non-parents than do older children.

The sex mix of the respondents indicates that about 51% were females and about 49% were males. Concerning the ethnic group and religion of the respondents, 68.57% were Amhara and 87.85% were Orthodox about 18% of the respondent were Oromo.

The educational profile of the AIDS orphans indicated that the majority of them (80%) were in the grade level up to 8^{th}. When we compare their grade level with their age there is an indication of delays in admission. Because the majority of them were in the age of 13-18, the expected grade level are 7 and above. This is one indication of the problems of AIDS orphans.

4.2.2. The Psychosocial Conditions (Problems) of AIDS Orphans

Caring for sick parents and siblings places a heavy emotional burden on children. They not only the witness the illness and death of their parents, but also suffer the stigmatization, and neglect based on their parents' death by AIDS. The majority of the

respondents of the AIDS orphans i.e. 73.57% of them disclosed that adults treated them differently. Moreover, they treated them by neglecting (47.57%); by taking away their property (12.14%); 22.33% of them were forced to work at home chores. All these are violations against the Convention on the Rights of the Child, which Ethiopia has ratified in 1991.

Discrimination and neglect of those affected children, on the other hand, may cause further emotional problems. For example, a child who experiences discrimination is more likely to develop feelings of fear & anxiety (Papalia, 1982). The caretakers of AIDS orphans in this study indicated that the majority of those children had emotional problems. 56.60% of them said that the children whom they cared for were frustrated easily. Further more another indication of emotional problem is that these children are afraid of a new situation or change, (75.40% of the caregivers confirm this fact). This finding is in agreement with MOLSA, Italian Cooperation and UNICEF (2003); Dunn et al., (1992), and Poulter (1997).

Discrimination and neglect have some consequences on the psychosocial adjustment of those affected children. They faced difficulty in expressing themselves and in making friends. Both of the children and their caregivers argued that the orphan children have few friends. This may be partly because they are afraid of the stigma and tend to isolate themselves (Voluntary withdrawal from social interaction) and partly others isolate them. According to this study, 63% of the AIDS orphans indicated that they have a few friends. The majority of them elaborated that, as AIDS orphans, other children may not need to be a friend of them.

The other psychological problem those AIDS orphans encountered is the phrase used to label them as "AIDS orphans". The term "AIDS orphans" by itself is

conceptualized as a disease and one understands from the term that those children are criminals, militia and sex workers.

From this study, 57.88% of the AIDS orphans reported that they feel shame when they hear and are called AIDS orphans; and 30.71% of them also indicated that they feel sadness. From this one can safely conclude that labeling those children as AIDS orphans aggravated their psychological problems. About 66% of them disclosed that those children were very angry when called as "AIDS orphans".

Generally the psychosocial problems of those AIDS orphans' is measured in terms of emotional & social adjustment problems they faced. As explained earlier, their emotional adjustment is seen in terms of frustration, fear, worries, irrational fears & lack of sleep. In terms of those variables the majority of the respondents, the caretakers, the children themselves indicated that they encountered great problems. When we see the social relation of those children it is very alarming because the majority of the AIDS orphans (about 73% of them) reported that they were treated badly by adults, and the majority of them even prefer to be alone than with others because they become disobedient. This self-isolation is the result of stigma (Alonzo & Reynolds, 1995). Those children have not only been treated badly by adults, according to their response, but also by their peers. About 52.26% of them indicated that they didn't get positive response from other children. Those children may accept the norms and values that label them as having negative characteristic. As a result they accept and 'deserve' to be treated poorly and unequally, which generally affects the over all development of them.

From this one can concluded that these negative responses affect the self-esteem of those children, since the self-esteem of an individual is affected by the reflective appraisal of the others (Owens, 1993).

4.2.3. Educational Problems of the AIDS Orphans

Children affected by HIV/AIDS are vulnerable in almost all aspects of their lives. They have often had lower school enrollment, they have less access to basic health care and they suffer from emotional distress.

Education of HIV/AIDS orphans is affected. This can be seen in terms of school enrollment, drop out rates and their performance. According to this result from the given sample of AIDS orphans 10% of them have never been in school through out their life; about 28% of them dropped out. Most of those who have never been in school were females and 64% of the drop outs were females. From the total number of female AIDS orphans, 43% were dropouts. This finding is in line with previous research by Elmore-Meegan et al. (1999), the World Bank (2002), and UNAIDS (2002), which indicated that girls are at special disadvantage.

The researcher further investigated the causes of dropout. The majority of the orphans themselves (about 64% of them) suggested that they dropped out after the death of their parents to care for their younger siblings and to be elder care taker. Although the majority of them suggested the above reasons, about 20% of them dropped out because of social isolation and distress experienced by the children both before and after the death of their parents.

In terms of school performance, all the caretakers except one said that their school perform ace changed negatively. The possible reasons for this is due to low class attendance, trauma associated with the death and illness of their parents, the stress associated with the stigma and discrimination.

The other factors that contributed for the educational problems of AIDS orphans are lower level of education, being distantly related, the age and sex of caretakers

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(Graniger et al. 2001). As can be seen from the gathered data, about 66% of the caretakers were literate including those who can only read and write, with some basic arithmetic knowledge and about 28% of them were illiterate.

The following table indicated the number of dropout AIDS orphans in relation to their caretakers.

Table 11: Dropped out Orphans in relation to Their Caretakers

No	AIDS Orphans Cared by		AIDS Orphans Dropped out		Remain in School/Home	
			No	%	No	%
1	Grand parents	20	5	25.0	15	75.0
2	Aunts	31	11	35.0	20	65.0
3	Uncle	12	3	25.0	9	75.0
4	Themselves	60	10	16.66	50	83.34
5	Friends	10	6	60.0	4	40.0
6	Non relatives	7	4	57.15	3	42.85
Total		**140**	**39**	**27.85**	**101**	**72.14**

Table 11 indicates that AIDS orphans who live with non-relatives and friends dropped out of school more than others. That means from the total AIDS orphans supported by non-relatives and friends, 57% and 60% of them are dropped out of school respectively. The possible reasons for this might be due to the fact that relatives invest more than non-relatives to their children, because of the affinity to their own children and hope to receive transfers from them in later life. This is in line with Case et al. (2003), who elaborated that children who live in house holds headed by non-relatives are less likely to be enrolled in school.

As can be observed in Table 11, the majority of AIDS orphans are looking after themselves. This is also confirmed by another study that children themselves prefer to

take care of themselves to keep siblings from dispersal and to protect themselves from ill treatment of the extended family or non-relatives (Mc Kerrow, 1996). This is in contrary to the assumption that, it is traditional for the extended family to take care of children who have lost their parents. The extended family, the AIDS orphans, and the representatives of the organization who give care and support for the orphans disclosed that many of the society members including the extended families are not interested in taking care of AIDS orphans. They assume that those children may be HIV positive and they can transmit the virus to them and their children. This finding is also consistent with the result that indicates many families prefer to take non-AIDS orphans than AIDS orphans or the extended family want the child to be tested for HIV before they will pay school costs (Grainger et al. 2001).

The other major problem of the extended family is economic problem. Because of poverty the extended families refuse to take those children even if they were willing to take them.

This irrational fear of HIV is partly because of the low awareness level of the public and partly due to the stigma attached to HIV/AIDS. One cannot conclude that the public has low level of awareness about HIV/AIDS. Because one study indicated that 61% of the people who have the knowledge about the transmition of HIV also neglect and discriminate those people who were affect by AIDS (Garbus, 2003).

Generally the education of AIDS orphans is affected by different reasons. Grief and depression associated with sickness and death in the family, as well as discrimination and stigmatization that AIDS orphans routinely experience at school are likely to influence both attendance and performance.

Unlike other research findings such as (Wondwosen, 2000 cited in Alem, 2002), and UN (2002), the researcher didn't find any government or non-government school that refused to accept AIDS orphans or/and those who forced them to leave school after identifying the reason for their parents death. Further more the result of the study indicated that those teachers who knew AIDS orphans in their school treated them in a better way. According to the response of the those currently enrolled in school, 67% of them disclosed that their teachers treated them in a better way. But about 23% of them reported that they were treated in a worse condition. This might be due to different attitudes of the teachers.

4.2.4. Coping Strategies Employed to Overcome Psychosocial and Educational Problems

In an open- ended item, the respondents were asked to explain what mechanisms or strategies they utilized to overcome their problems.

They reported that they get social support from Mekedem HIV Positive and AIDS Orphans Association, Tesfa Birhan AIDS Orphans Association, and Ethiopia Orthodox Church Development and Inter Church AID Commission Orthodox HIV/AIDS Campaign Center Awassa Branch (those are the organizations where the respondents were selected from), and from other volunteers especially exercises books and invitation during holydays.

According to this study it was only less than half of the respondents who get their caretakers' support. As explained earlier many of the AIDS orphans take care of themselves or live alone. Moreover, those who live with the caretakers are also not happy in living with them. They lack adult supervision to develop effective coping skills

with the problems they encountered. Because of this, many of them explained that they are powerless to solve the problems they faced. Crying, running away, trying to attack other children; and voluntary isolation are observed in the majority of those children. It is difficult to imagine how those AIDS orphans acquire effective coping skills. Because effective coping skills obtained when the child raised in a social environment, in which both parents present exuded a sense of efficacy, providing guidance and consistent discipline provide high expectation and support and encouraged in the child a future orientation (Toomey & Christie, 1990).

The strategies used by the children themselves, the caretakers and the representatives of the organizations are some what like experiences of other countries strategies, such as associations of the affected children, empowering the extended families to take the AIDS orphans. But presently in many Africa countries especially those who scored a good result in reducing the stigma of AIDS and reducing infection rates, many intervention strategies started before the death of parents. This is implemented during the home-based care for the sick parents. At this time, helping children whose parents are ill to express parents impending death are important tasks. Moreover, the parents will assign the guardian for the children, and will writing will be confirmed. These experiences are supported by research, such as Reid (1997), Gilborn (2002) and Williamson (1995).

In contrast to this experience, most of the AIDS orphans in this study heard the cause of their parents death through gossip, after the death of their parents. They confirmed the cause of their death after or during the time when they joined their association or the organization, which give them support.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1. Summary

The respondents of this study are 140 AIDS orphans, 53 AIDS orphans' caretakers and 3 representatives of non-governmental organizations. The AIDS orphans were selected from Mekdim HIV Positive and AIDS Orphans Association, Tesfa Birhan AIDS Orphans Association and those who registered to get support from EOC-DICAC Awassa Branch. 72 of them are females and 68 are males. 83.57% of the AIDS Orphans are in the age range from 13-18 years. The majority (68.57%) of the respondents, were Amhara, 17.85% were Oromo and 13.58% were other ethnic groups. Regarding the religions of the AIDS orphans, 87.85% were Orthodox, 9.28% were Protestants and 2.28% were Muslims. But the ethnic group and religions of the respondents does not necessarily imply anything about the psychosocial and educational problems of the AIDS orphans in this study.

58.57% of the AIDS orphans were in 5^{th} to 8^{th} grades. 13.58% were grade 9 and 10. 10.71% were in grades 1 to 4. But sadly, 10% of them have never been in school and are illiterate. A few are above grade 10, such as in preparatory or vocational training.

The majority (42.85%) of the AIDS orphans are living alone; 22.14% are living with their aunts while 14.28% are living with their grand parents; the rest are living with their uncle, friends and non-relatives.

73.57% of the AIDS orphans are treated differently by adults, this means that they are neglected, forced to work at home chores, and took away their properties. And 52% of them reported that they didn't get positive response from other children.

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The majority of those orphan children were frustrated easily and fear a new situation or change.

63% of the orphans have a few friends as the majority of them elaborated that as AIDS orphans, other children do not want to be friends of them.

57.88% of the AIDS orphans reported that they feel shame when they hear and are called 'AIDS orphans' and; 30.71% of them also feel sadness. Their caretakers also confirmed this.

From the sample, 10% of the AIDS orphans have never been in school. 28% of the orphans dropped out from school from which 64% of them were females.

From the total number of female AIDS orphans (who enrolled in school), 43% were dropouts. The majority of (64% of them and about 58% the care takers) indicated that they dropped out after the death of their parents to care for their younger siblings and to be elder care taker. Although the majority of them suggested the above reasons, about 20% of them dropped out because of social isolation and distress experienced by them both before and after the death of their parents.

There is also an indication of delays in admission to school of these AIDS orphans. In this study the AIDS orphans, their caretakers, and the representatives of the organizations confirmed that there are no government or non-government school that refused to accept AIDS orphans and/or those who forced them to leave school after identifying the reason for their parents death. Furthermore, many teachers who knew AIDS orphans in their school treated them in a better way.

Only 9.75% of the care takers suggested that AIDS orphans (whom they cared) attends school every day. The majority of them said that those children mostly stayed at home. They missed school to care for their parents and other children. All of the

respondents except one said that there school performance changed negatively. The possible reason for this is due to low class attendance, trauma associated with death and illness of their parents, and the stress associated with the stigma and discrimination.

The coping strategies available are generally based on solving the economic problems; mainly providing some amount of money for house rent, stationary materials and invitation during holydays by different organizations and volunteers. This support is not sustainable and continuous.

The counseling service given to the AIDS orphans is not sufficient. According to the data obtained from the representatives of the organizations, meeting AIDS orphans' material needs has taken precedence over meeting their emotional needs.

5.2. Conclusion

This study tried to explore some aspects of the psychosocial and educational problems of HIV/AIDS orphans. They are affected by direct and indirect effect of HIV/AIDS epidemic. Besides coping with death of their parents which is the most stressful event for the child and, the economic problems they faced, they are subjected to stigma and discrimination. Their rights are abused. Many of them are treated badly by the adults and by their peers based on the ground of their parents death. Generally the psychosocial well-being of those AIDS orphans are abused in the following ways.

- Negative response from the adults and from their peers
- Forced to work at home chores
- Took away their properties
- Teased and ridiculed

This study also shows that AIDS orphans tend to stay away from school in order to take care of their siblings. The majority of them also take care of themselves due to different reasons; as they prefer to be with their siblings, the extended families are not interested to take AIDS orphans to live with them due to their economic problems and due to the suspicion that they might be HIV-positive themselves. This resulted in a large number of child headed households. It is clear that in child headed households they face problems from lack of adult supervision and care, to poor nutrition and educational failure.

Those AIDS orphans who have lived and been cared by extended families, friends or non-relatives are also not happy in living with them. Because the caretakers use the AIDS orphans as a means of income. They also forced them to stay at home and work at home chores.

Many AIDS orphans dropped out of school, of which a larger proportion are females. Those who managed to continue their education, their academic performance is declining. Delays in school admission is also observed for AIDS orphans. If this condition is not well addressed soon, a new generation of children will grow lacking basic knowledge of how to protect themselves against HIV, as well as all the other opportunities that education affords.

It is confirmed that the traditional safety net to cope with AIDS orphans is stretched to breaking point, due to large number of orphans, poverty, stigma and discrimination associated with HIV/AIDS

Those children affected by HIV/AIDS suffer from stigma, discrimination and multiple losses. Such suffering resulted in profound grief. But material needs has taken precedence over meeting their psychosocial needs by different organizations and the caretakers. Some phrases such as "AIDS orphans" aggravate the psychosocial problems of those affected children.

The support provided by organizations and the communities are not sustainable. Mostly it is based on curbing the immediate material needs of those children.

5.3. Recommendations

Based on the findings and the conclusion drawn, the following recommendations are made.

- Older children who dropped out of school may not wish to return to school; therefore it is very important to provide them with in-come generating skills.
- Empower the community in terms of psychosocial support to keep the AIDS orphans in their community.
- Raising awareness among teachers and students of the psychosocial impacts of HIV/AIDS in children is an effective way of avoiding stigma and providing emotional support.
- Dealing with avoiding stigma is relatively new, there is a limited experience, therefore, further work should test different approaches to stigma reduction.
- Efforts should be made to raise awareness of families, schools and the society in general about the rights of children such as being treated equally regardless of their HIV status.
- The family and the community can support a child's acquisition of skills that will help the child meet needs and successfully deal with psychosocial tasks.
- It is important to avoid using some words that have negative implication on the psychosocial development of children. In supporting those children, first their needs should be assessed including their psychosocial needs.
- The care takers should provide, for the orphans, time for home work and to study their lessons.
- The organizations that deal with care and support for orphans must give counseling service based on their own culture.

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- Efforts should be made to change the cultural bias that assigns the heaviest burden on females such as all the house chores and caring for the siblings.
- Parents who are infected with HIV/AIDS should be advised to be open and discuss the issue early, and assign the guardian for their children.
- Expand childcare programmes, which permit older siblings to continue in school rather than care for younger children.
- Focus must be given on reaching those AIDS orphans not in school.
- Special efforts must be given to keep AIDS affected children especially girls in school.
- Provision of some psychosocial support to the family before the death of the parents (especially during illness) is important to help the children to develop coping skills with problem they will face after the death of their parents.

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Annex 1

Addis Ababa University

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Department of Psychology

Dear Respondents

Thank you for the willingness to respond to my questions. I am going to ask you some very personal questions. I am not going to talk to any one about what you tell me or answer. Your name will not be written on this form, and will never be used in connection with the information you gave me. Your honest answers to these questions will help us better understand about the psychosocial and educational problems of AIDS orphans. I would appreciate your help in responding each questions.

Part I. Respondents Background Characteristic

(for AIDS orphans)

1. Age ----------
2. Sex ----------
3. Are you currently in school?

   1. yes 2. no
4. What is your level of education?

   1. ---------- (your grade)
   2. illiterate
   3. read and write only

5. Ethnic origin

1. Amhara 2.Oromo 3. Hadiya

4. Gurage 5. Tigre 6. Kambata

7. Sidama 8. Wolayita 9. Others (specify) ----------

6. Religion

1. Orthodox 2. Muslim 3. Protestant 4. Catholic

5. Others (specify)----------

Part II. Psychosocial and Educational Condition of the Respondent Child

1. With whom do you live now?

1. Grand parents 2. Aunts

3. Uncle 4. Themselves

5. Friends 6. Non-relatives

2. Do you think adults treat HIV/AIDS orphans differently?

1. yes 2. no

3. If "yes" how do they treat AIDS orphans differently?

1. Neglect and discriminating
2. Teased, physically and verbally abused
3. Taking away property
4. Not allowing go to school
5. By making them do more chores

4. When you were at school or around your home were you ever called names or teased by other children because of your parents' death?

1. yes 2. some times 3. no

5. What types of response do you get from children of your age?

1. sympathetic
2. ostracizing
3. providing all kinds of support
4. consider me as unlucky
5. consider me as cursed
6. ridicule me
7. no body knows about my parents death by AIDS

6. What did you feel when you heard the term 'AIDS orphans'?

1. shame
2. sadness
3. anger
4. nothing

7. How happy are you living in this home?

1. very happy
2. happy
3. sad
4. very sad

8. Are you happy as most boys and girls?

1. yes
2. no

9. Do you spend a lot of time thinking about your parents' death?

1. yes
2. no

10. you have only a few friends.

1. yes
2. no

11. If 'yes' state the reasons.

1. because I am AIDS orphans
2. because parents of other children told them not to play with me
3. because they teased me
4. I do not want to have more friends

12. Have you dropped out from school?

1. yes
2. no
3. never been at school

13. If 'yes' the reasons for dropping out of school is

    1. to care for my young sister and brother
    2. fearing of stigma and discrimination
    3. financial problem 4. Other (specify) ----------

14. (For those who have never been in school) state the reasons

    1. taking care of my sick parents until they die and then my siblings
    2. my care takers are not interested to send me because I have to help in house
    3. others (specify)----------

15. Do your teachers know about your parents' death?

    1. yes 2. no 3. I do not know

16. If 'yes' do you think that they treat you better, the same as other or worse?

    1. better 2. same as other students 3. worse

18. What type of support do you get from your care taker? From government, non-governmental organizations and other volunteers?

    ---

19. Are you satisfied with your school work?

    yes 2. no

    3. if 'no' why ----------

20. What strategies did you use to eliminate the problems you faced?

THANK YOU AGAIN FOR THE ASSISTANCE

Annex 2

Addis Ababa University

School of Graduate Studies

Department of Psychology

Dear Respondents

Thank you for the willingness to respond to my questions. I am going to ask you some very personal questions. I am not going to talk to any one about what you tell me or answer. Your name will not be written on this form, and will never be used in connection with the information you gave me. Your honest answers to these questions will help us better understand about the psychosocial and educational problems of AIDS orphans. I would appreciate your help in responding each questions.

Part I. Respondents Background Characteristic (for guardians/care takers)

1. Age ----------
2. Sex ----------
3. Education ---------- (specify, the grade level. certificate or diploma awarded)
4. Religion ----------

Part II. Psychosocial and Educational condition of the child

1. Is the child enrolled in school?

   1. yes 2. no

2. If 'no' what are the reasons?

   1. financial problems 2. help us in house chores

   3. others (specify) ----------

3. What level in school is he/she?

Grade ----------

4. What is this child's class position? (When compared with other students).

1. very good 2. good

3. poor 4. very poor

5. How regular does this child attend school?

1. every day 2. most of the time

3. some of the time 4. very irregularly, mostly at home

6. Is there any special reason why this child misses school sometimes?

1. no money for school expenses
2. child refuses school
3. family needs child's help caring for other children
4. child does not get along with other children
5. child is sick

7. Has the child's performance in school changed after the death of his/her parents?

1. yes 2. no

8. If 'yes' what exactly has caused his/her performance to get worse?

1. child stays home to help
2. we can no longer afford school expenses
3. child is worried distracted
4. child is also sick
5. no relationship between school performance and their death

9. Has the child dropped out of school?

1. yes 2. no

10. If 'yes' the reason for dropping out school

1. we can no longer afford school expense
2. the child helps us in house chores
3. truancy /school dismissal
4. they are not happy in attending school

11. How happy is the child compared to other children of the same age?

1. happier 2. the same, some times happy, some times un happy
3. some what unhappy 4. very unhappy, sad or depressed
5. don't know

12. What makes this child happy?

1. being with friends talking, playing 2. being with family
3. reading 4. going to school 5. being alone

13. What makes this child sad?

1. hunger 2. punishment
3. being called "AIDS" orphans 4. physically a bused or being hit
5. being given chores, kept from playing 6. others (specify)----------

14. Does the child cry a lot over small things or over noting during the course of the day? 1. yes 2. sometimes 3. no

15. Does he/she have scary dreams or night mares?

1. yes 2. some times 3. no

16. Does he/she seem worried?

1. yes 2. some times 3. no

17. Does he/she become frustrated easily when things do not go his/her way or something doesn't work? 1. yes 2. some times 3. no

18. Does he/she become afraid of a new situation or change?

1. yes 2. some times 3. no

19. Does he/she become very angry?

1. yes 2. some times 3. no

20. Does he/she have trouble falling asleep?

1. yes 2. some times 3. no

21. How does this child get along with other children?

1. very well 2. well, but not perfectly

3. some what well 4. poorly 5. very poorly

22. Does he/she every choose to be alone, instead of playing with other children?

1. yes 2. some times 3. never

23. Is this child stubborn or disobedient at home?

1. yes 2. some times 3. never

24. Does he/she attack other children?

1. yes 2. some times 3. never

25. Does he/she have problems making friends?

1. yes 2. some times 3. never

26. Does he/she ever run a way from home?

1. yes 2. sometimes 3. never

27. What strategies did you use to eliminate the problems of the child?

28. suggest possible solution to solve the problems of these children.

THANK YOU AGAIN FOR THE ASSISTANCE

Annex 3

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Interview Guide For HIV/AIDS Orphans Service Provider. (Mekdim HIV Positive and AIDS Orphan Association, Tesfa Berhan and AID Orphan Association EOC-DICAC)

1. What are the objectives of the Organization?
2. What are the intervention measures you are talking to solve the psychosocial problems of HIV/AIDS orphans?
3. What are the major problems they faced after the death of their parent by AIDS?
4. What are the role of the care giver toward HIV/AIDS orphans?
5. How do you perceive the reaction of the community (CBOs, Kebele, 'idir'...) to wards HIV/AIDS orphans?
6. What challenges have you faced in the effort of supporting those children?
7. What is the relationship among HIV/AIDS orphans looks like?
8. Are there any change observed on the target children and their psychosocial & educational characteristic due to the program?
9. Suggest possible solution to solve the problems of these children.

THANK YOU FOR THE COOPERATION

Declaration

I the undersigned, declare that this thesis is my original work, has not been presented for a degree in any other university and that all sources of materials used in this thesis have been duly acknowledge.

Name: *Abebe Lealem*

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

Date: June 2004