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Community Response to Provision of Care and Support for Orphans and Vulnerable Children, Constraints, Challenges and Opportunities: The Case of Chagni Town, Guangua Woreda

Yohannes Mekuriaw

Addis Ababa University

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Advisor: Professor Alice Johnson Butterfield

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Graduate School Of Social Work

Approved By Examining Board

Advisor_____ Signature _____Date_____

Examiner_____ Signature _____ Date_____

DEDICATION

This Thesis is dedicated to my deceased Mother w/ro Simegnesh Shitahun without which my Educational Career Development would have been impossible.

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Abstract

The impact of HIV/AIDS on orphan and vulnerable children is one of the challenges that communities in sub-Saharan countries encounter. Yet, in countries such as Ethiopia, the effort that communities exert to combat and address the problem and extent of the response has not been fully documented. This thesis begins to address this gap in existing scholarship by presenting a case study of one community's response to the care of orphan and vulnerable children (OVC). Its purpose is to come up with inputs for designing community-based programs and strategies to address the problem in the study area. The study was conducted in Guangua woreda, Awi Zone, Amhara National Regional state. The methods employed are qualitative, utilizing data collection techniques such as interviews with OVC caregivers, service providers, community-based organizations (CBOs), civil society associations, and faith-based organizations (FBOs). The research methods also include three case interviews with OVC and field observation. The main findings suggest that community awareness to the problem of OVC is relatively high in Chagni- town, but response to the problem is low. HIV/AIDS and poverty are the main factors that attribute to the vulnerability and problems of OVC and their caregivers. Almost all OVC and their caregivers live in abject poverty and are unable to meet their basic needs. The extended family and local HIV/AIDS projects are the main providers of care and support to OVC in the community. Nevertheless, some community initiatives exist. These include Egna-Legna Orphan and Street Children Association (ELOSCA), an OVC association, and care and support by community iddirs. The types of care and support provisions are mainly financial and material; medical, legal support and psychosocial support are generally non-existent. The main challenges that the community encounters in OVC care and support are stigma and discrimination, poverty and lack of OVC policy and guidelines on community-based care and support. Policy and practice implications of the study include the need for more extensive community assessments of the situation of OVC and their caregivers. There is also a need to build the capacity of local communities to respond to OVC, including advocating and lobbying for adoption and foster care, as well as resource mobilization for comprehensive care and support for OVC living in the community. Moreover, there is a need for the endorsement of OVC policy as guidelines for implementing community care and support. The study also suggests the need for more comprehensive community-based, integrative approaches that incorporate the prevention of HIV/AIDS in the community and poverty alleviation programs for children and families.

1. INTRODUCTION

1.1 Background of the Study

According to the Joint Nations Program on HIV/AIDS (UNAIDS), about 40 million people are currently living with HIV/AIDS including, nearly 2.2 million children under the ages 15. In 2004, 4 .9 million people acquired the virus, and 3.1 million died from AIDS. Sub-Saharan Africa remains the most affected region with 25.4 million people living with HIV/AIDS at the end of 2004, 1.9 million of whom were children under the age of 15. The United States Agency for International Development (USAID), the Untied Nations Children Fund (UNICEF) and the United Nations Joint Program for HIV/AIDS (UNAIDS) estimate that at the end of 2003, 15 million children under the age of 18 had lost one or both parents to AIDS with the majority (82%) in sub –Saharan Africa. In just two years, from 2001 to 2003, the global number of children orphaned by AIDS increased from 11.5 million to 15 million. By 2010, it is expected that this deadly virus will orphan more than 25 million children. Due to ten-year time lag between HIV infection and death, officials predict that orphan populations will continue to rise for a similar period, even after the HIV prevalence rate begins to decline (Salaam, 2005). HIV/AIDS has already a profound impact on life expectancy, infant mortality, economic development, and social instability in Africa where the situation is the most desperate. In 19 African countries, AIDS has created more orphans than all other causes combined and is expected to account 72 % of all maternal and double orphans combined by the year 2010 (Oak Report, 2000).

With an estimated 1.5 million people living with HIV/AIDS and a national prevalence rate of 4.4% (12.6% urban and 2.6 % rural), Ethiopia is one of the hardest hit countries by HIV/AIDS epidemic (MOH, 2004). Ethiopia hosts the fifth largest number of people living With HIV/AIDS globally Out of 1.5 million PLWHA, 817, 000 are women and 96,000 are

children under 15 years. There are about 537, 000 orphan children due to AIDS. Some 245,000 PLWHA will be in need of Anti-Retroviral Therapy (ART) during 2004. Deaths due to AIDS brought down life expectancy gains from 53 to 46 in 2001. If the current death continues, the projected life expectancy gain to 59 years by 2014 will be reduced to 50 years.

A number of underlining factors contribute to the spread of HIV/AIDS in Ethiopia, including poverty, illiteracy, stigma and discrimination to those infected/affected by HIV/AIDS , high rates of unemployment, widespread commercial sex work, gender disparity, population movement including rural – urban migration, harmful cultural and traditional practices (HIV/AIDS Prevention and Control Office: HAPCO, 2004). Therefore, to alleviate such a critical societal problem, there should be grassroots level research that identifies community efforts to address the problem. It is also time to anchor community- based interventions by government and non-governmental organizations (NGOs) to empirical research and information obtained through such processes. Therefore, this research will attempt to explore the situation of orphan and vulnerable children in Awi zone and assess the extent of community response to this problem in order to give insights to program intervention in the area. It also assesses the response of the community to the provision of care and support for orphan and vulnerable children (OVC) in the study area. This research will overview the constraints and challenges that community face and opportunities they utilize for effective intervention at grassroots level such as in woredas and kebeles. Therefore, the focus of this particular study will be in one district of Awi –Administrative Zone, Guangua woreda, Chagni Town.

1.2 Statement of the problem

One measure of massive social change still to come is the number of orphans, children affected by HIV/AIDS, and other children made vulnerable by the pandemic. According to revised 2000 estimates, 34.7 million children under the age of 15 in 34 countries have lost their mother, father, or both of their parents to HIV/AIDS and other causes of death. By 2010, that number will be 44 million. Without AIDS, the total number of children orphaned would have declined by 2010 to less than 15 million (FHI, 2005).

The human and social costs these estimates represent are staggering. Although the majority of AIDS orphans and vulnerable children are living with surviving parents or extended family many of them are being cared by remaining parent who is sick or dying elderly grandparents who themselves are often in need of care and support, or impoverished relatives struggling to meet the needs of their own children. Children living in these situations are at increasing risk of losing opportunities for school, health care, growth, development, nutrition, and shelter. In short, they are deprived of their right to a decent and fulfilling human existence (FHI, 2005).

The growing demand for care and support of orphans and vulnerable children at the community level has strained traditional coping mechanisms and reached to crisis stage in the most heavily affected countries. An increasing number of communities and government structures are struggling to harness the impact of AIDS on orphans and their families. In the absence of support, there will be long-term developmental impacts on children and the future of these countries. Failure to support children to overcome this trauma will have a negative impact on society and might cause dysfunctional societies. Reducing year of investment in national development puts pressure on the national economy. Ethiopian families,

communities, and NGOs are the front line of defense for its four million orphans, including 1.2 million orphans due to AIDS (POLICY Project, 2004; UNICEF, 2003).

In spite of the growing number of orphan and children made vulnerable by HIV/AIDS comprehensive and suitable programs that support children and meet all of their needs are very minimal, and in some geographically regions non-existent . Moreover, there has been no policy and guideline, which directs action towards care and support for orphans and vulnerable children in Ethiopia. There is a dearth of research and documentation with regard to community-based, participatory care, and support programs for OVC and PLWHA in all districts of Awi Zone. Therefore, this research will contribute as an input for further research and intervention strategies that mainly focuses on community-based care and support for orphan and vulnerable children in Amhara regional state in general and in Awi zone in particular. Any prevention model that is developed must reflect local conditions and resources, which require mobilization and adequate community support. Studies conducted by UNICEF indicate that in many regions of the country, psychosocial care for OVC is the most neglected dimension of OVC care provided. Counseling to care givers is practically non-existent (Policy Project, 2004).

Thus for effective community-based and participatory intervention strategies to be designed thorough knowledge of current community resources, patterns of responses in provision of care and support, is very essential. Therefore, in this particular research the extent of community response to orphans and vulnerable children and the type of care and support rendered by the community will be studied and analyzed. Most importantly, this particular study will give a general insight about community constraints and challenges that exist within local settings in face of the epidemic and care and support context in Awi-zone, Amharic Regional state.

1.3 General Objectives of the Study

The aim of this study is to explore community response to orphan and vulnerable children care and support in Guangua woreda, Chagni town and to investigate the challenges that the community faces.

1.4 Specific Objectives of the Study

- To assess the level perception and awareness of the community to the problem of orphan and vulnerable children
- To explore the current socio-economic situation of orphan and vulnerable children and their caregivers in the community
- To investigate community resources available to provision of care and support for orphan and vulnerable children
- To identify the local organizations currently active in provision of care and support for orphan and vulnerable children
- To examine the kind of care and support provided for orphan and vulnerable children by community members and local projects
- To identify the challenges and constraints that the community face in provision of care and support for orphan and vulnerable children
- To understand the current pattern of care and support at community level and the implications of this to social work knowledge and practice
- To suggest some recommendations for future intervention strategies to care and support programs that focus on the community.

1.5 Research Questions

1) To what extent is the community aware of the problems of orphan and vulnerable children in the study area?
2) What are the current socio-economic situations of OVC and their caregivers?
3) How are community resources mobilized to care and support for orphans and vulnerable children?
4) What kinds of services does the community render to orphan and vulnerable children and which criteria are used for inclusion?
5) What challenges, constraints and opportunities exist in the community for the provision of care and support for orphan and vulnerable children?

1.6 Significance of the study

Awi- zone is a newly established administrative unit of Amhara National Regional state. The zone is only 10 years old. It comprises of five woreda (districts). Like other areas of Amhara region, HIV/AIDS coupled with poverty have been the main social problems of the community. Since and following the establishment of the zone, HIV/AIDS became the main killer disease next to malaria and tuberculosis. The number of PLWHA has increased over the past few years. Even though there has been no concrete and reliable data that shows the number of OVC population, based on care and support needs assessment and registration, the number of OVC population is increasing at a fast rate in all districts of Awi- zone. The largest OVC population in the zone is found Guangua and Dangila woreda, and most of these OVC have rural origins. In addition, rural – urban migration of children is a serious problem that the local government and service providers encountered since and before the advent of HIV/AIDS in the administrative zone.

Nevertheless, there is no research or systematic formative assessment done by any individual or organization on the situation and impact of HIV/AIDS on children, families and community. In the same way, there is no organized data that shows the number and situation of PLWHA and OVC living in the zone. However, the zonal HIV/AIDS Secretariat, in collaboration with some philanthropic agencies, coordinates HIV/AIDS prevention and control activities. Thus, a few PLWHA and OVC get care and support from donor driven funds. However, except for a bold statement that the local government is a concerned on HIV/AIDS prevention and control, nothing is known about OVC and their caregivers current situations, community response to OVC care and support, and in general, of the impact of HIV/AIDS on the community At the same time, even though the scope of intervention is narrow, some local and international NGOs have conducted HIV/AIDS prevention and control activities in a few of the districts. At the same time, community and civil society originations have started to take initiatives and develop an interest. For example, Action Aid Ethiopia (AAE), World Bank, Global Fund and CVM Ethiopia have started to work on prevention of HIV/AIDS, provide care and support to OVC in the community. Today, there is a general trend and paradigm shift that community care is superior to institutional care for OVC and programs and project focus on this strategy. This is because of the various merits that community-based care exhibits, such as ownership and participation, cost minimization and above all to ensure sustainability.

Currently, more than 7000 OVC are estimated to live in the zone, most of who are HIV/AIDS orphans. Thus, before designing an intervention strategy to address the problem of these OVC, an empirical research which shows the situation and pattern of care and support currently underway, and the involvement of the community in the process of care and support provisions to OVC, is important in order to make interventions effective and

efficient. Therefore, the study is part of the effort that gives an insight on the situation of OVC and community initiatives and capacity to provide care and support to OVC and the gabs that exist in the process. For such purpose, the researcher selected one district, and in a district one town and analyze the implication of this finding to the zonal effort in combating HIV/AIDS prevention and control.

2. LITERATURE REVIEW

2.1 An Overview of HIV/AIDS and its Impact on Children

The impact of HIV/AIDS on children is just beginning to be explored not only are children orphaned by HIV/AIDS affected by the virus but also those who live in homes that have taken in orphans or those families who care to AIDS orphans are also affected. Children with few resource and those living in areas with high HIV prevalence rates are also impacted. Children who have been orphaned by AIDS may be forced to leave school, engage in causal labor or prostitution, suffer from depression and anger, or engage in high-risk behavior that makes them vulnerable to contracting HIV/AIDS. Children who live in homes that take in orphans may see a decline in the quantity and quality of food, education, love, nurturing, and may be stigmatized. Impoverished children living in households with one or more ill parents are also affected as health care increasingly absorbs households funds which frequently leads to the depletion of savings, and other resources reserved for education, food and other purposes (Salaam, 2005)

The extended family was the traditional social security system and its members were responsible for protection of the vulnerable, care for the poor and sick and the transmission of social values and education. Families, particularly in traditional societies, involve a large number of connections among people extending from varying degrees of relationships

including multiple generations over a wide geographical area and involving reciprocal obligations (Foster, 2000). AIDS wears down extended families resources over a period of several years, at the same time as the number of orphans is increasing. The extended family is not a social sponge with an infinite capacity to soak up orphans. Blanket statements about the role of the extended family in Africa as a safety net and assumptions that relatives will be ready and able to assist members in need should be treated with caution Extended families can be over burdened by the need to care for relatives suffering from AIDS. Better off households may slip in to poverty, and poor families can slide in to destitution. This generalized decline in the level of living increases the vulnerability of children to a range of consequences including illiteracy, poverty, child labor, exploitation, and unemployment (Foster, 2002).

Research findings in Zimbabwe, Kenya and other African countries indicate that the care and support that the extended families exhibit is being weakened. The indicators that substantiate these phenomena include increasing number of child headed households, the separation of siblings from each other and their eviction from the locality where they were brought up in search of jobs for survival. These are some of the manifestations of the impact on communities where prevalence of HIV/AIDS is rampant.

With little or no financial support from the Ethiopia government, families and communities are being forced to spend down their own meager earnings to support the swelling population of orphaned infants and children. This short-term remedy is destined to fail as more and more families plunge deeper into poverty and community agencies are unable to meet orphan demands for food, clothing, shelter, education, and psychosocial support. Caretakers, families, and communities are in desperate need of long- term strategies that incorporate direct aid and income generation so that the trend can be reversed (Policy Project, 2004)

Although a family member's death from AIDS may be a catalyst that propels children into escalating trouble, the psychosocial needs of children are too often perceived somehow less important than their economic necessities. If children are to develop the resilience to deal with the challenges in their lives, their psychosocial need must receive proper and prompt attention (Oak Report, 2004). Though the family network and social support in Ethiopia is the most dominate family structure that gives care and support for orphans and children made vulnerable by HIV/AIDS, support from government and NGOs is minimal. There are few community-based programs and projects operating which do not meet the need of all orphan and vulnerable children living in the zone. Conversely, the number orphan and vulnerable children in need of care and support is increasing. The existing programs are not as such community focused and participatory that puts sustainability. HIV/AIDS orphans in Ethiopia tend to have a minimal social services particularly education. Base line data conducted by World Food Program (WFP) found that an estimated 75 % of AIDS orphans were not attending school in Ethiopia (Policy/Project, 2004).

The issue of AIDS orphan is the worst crisis as compared to all crises caused by death of adults of AIDS. In view of the prevailing AIDS related general and specific death rates, the number of AIDS orphans would increase from 1.2 million to 1.8 million by 2007 and to 2.5 million in 2014. Clearly, the increase in number of orphans is likely to aggravate severe problem of homeless children who seek to make a living out of working and living in city streets (MOH, 2002). Lack of fiscal resources and infrastructure at the national government level has forced the GOE to prioritize education and health services at expenses of social welfare programs. As a result, a vast majority of orphan and vulnerable children (OVC) caregivers and organizations receive little or no government or donor assistance. At the same time, a large number of OVC appear not to be accessing these government services in part

because outreach is not specific to the need or location of orphans. Complementary to this group are local organizations like iddirs and other civil associations that rescue orphan and vulnerable children in Ethiopian context.

According to February 2003 survey, the prevalence and characteristics of AIDS orphans in Ethiopia the majority of AIDS orphans were from three primary ethic groups Amhara (58 %), Oromo (17%) and Tigray (9 %). An examination of the religious distribution of the orphan children shows that the lion's share is Orthodox Christian (75 %) while the next largest group is Muslim (15.8 %). It can be implied from the above data that the largest AIDS orphan population is concentrated in Amhara Regional State (MOLSA, 2003).

2.2 Response to OVC Care and Support

There has been an increasing collaboration at international level with many of the organizations such as USAID, UNICEF, UNAIDS, WHO and other international agencies that address the needs of orphan and vulnerable children. The case in point is, the effort exerted by the United Nation's General Assembly Special Session on HIV/AIDS. This agency has developed Declaration of Commitment on HIV/AIDS, which forced national governments to develop OVC policies in 2003, and implement it in 2005. It has been done mainly to strengthen government, community and family capacity to support children affected by HIV/AIDS (UNGASS, 2001). Accordingly, priority action areas were identified, these were

1) Strengthening the capacity of families to protect and care for orphan and vulnerable children

2) Mobilizing and strengthening community-based response

3) Ensuring access to essential services for orphan and vulnerable children

4) Ensuring that government protect the most vulnerable children

5) Raising awareness to create supportive environment for children affected by HIV/AIDS.

UNAIDS recently reported that 39% of the countries with generalized HIV/AIDS prevalence rate of 1% and more have no national policy on OVC to provide care and support and 25% these countries have no plan to design either (UNAIDS,2003). When it comes to Ethiopia, the country has endorsed HIV AIDS prevention and control policy in 1998; however, with a general HIV/AIDS prevalence rate of 4.4% has no policy on care and support to OVC on national level and strategy for community care and support neither. At the national level, the OVC Task Force that constitutes international and national organizations that call themselves as adhoc members has been established. United Nations Children's Fund (UNICEF) and Ministry of Labor Social Affairs (MOLSA) guide this Task Force and are responsible for endorsement of policy, strategy, and programs on OVC care and support appropriate to all levels and context. In addition, a representative from Save the Children US (SC/US) and Save the Children Sweden (SC/Sweden) are members of the Task Force.
Very recently, National HIV/AIDS Prevention and Control Office (HAPCO) has endorsed a General Guideline for care and support to PLWHA, OVC and affected families that would work on community-based care and support at the grassroots level, but as such there is no organized response by government at levels as far as OVC community care and support is concerned in Ethiopia. .

2.3Conceptual Framework

2.3.1. Community-based Care and Support

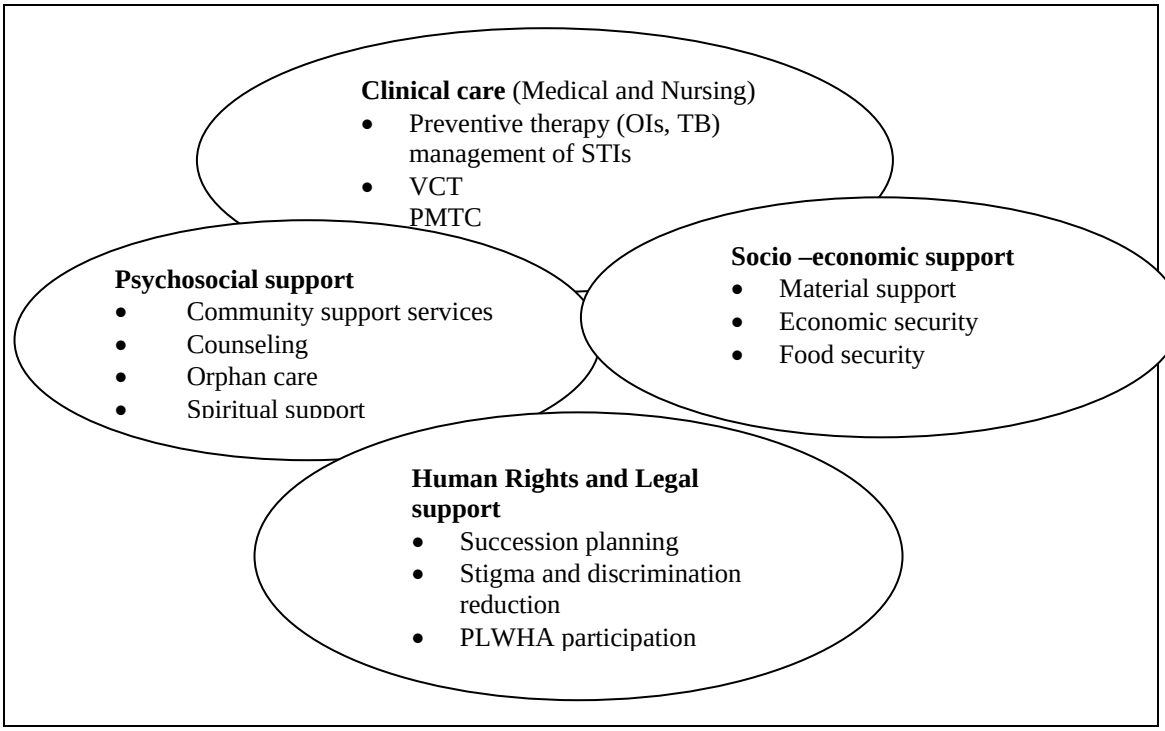
The definition of care and support is adapted from a guideline developed by National HAPCO for care and support to PLWHA, OVC and affected families. Community- based care and support is defined as the continuum of care and support that OVC and their caregivers

receive in their locality through the members of their communities within a network of health and welfare systems in that community (HAPCO, 2005)

2.3.2. Care and Support Model

A model that apparently applies to this research is community care where CBOs, NGOs, Local government representatives and Civil Society Organization (CSO), tend to assume major roles and responsibilities

Comprehensive HIV/AIDS Care and Support Supportive policy and Environment



Source: - HAPCO 2005 Guideline for PWHA, OVC and Affected Families, Comprehensive community-based Care

In this research, the types of care and support that the community provides to OVC is analyzed in this framework.

Orphan: A child who is less than 18 years of age and who has lost one or both parents regardless of the cause of the loss (HACI, 2004, HAPCO, 2005)

***Vulnerable children*:**-A child who is less than 18 years and whose survival, care protection or development might have been at stake due to a particular condition or circumstance. These groups of children include those whose parents are terminally ill, children who are on and off the street, children who live in poverty, children who are vulnerable to HIV/AIDS an exploitation of child labor, sexual abuse (UNICEF, 2003; HAPCO, 2005; Foster, 2002).

3. METHODOLOGY

3.1 Study Design

A community-based cross-sectional study design was employed to undertake this study. The study employed a participatory research approach. In this study OVC, their caregivers, community leaders, and CBOs, NGOs and FBOs and CSOs participated. The study employed mainly qualitative research methods. Description of the situation of OVC and the response of the community to care and support reported and analyzed. The study mainly employed a qualitative study method.

3.2. Description of the study Area

Awi- Zone is one of the 11 – zones of Amhara National Regional State. The zone gets its name and status during the transitional incumbent government of Ethiopia. It is divided in to five woredas (Districts) and a total population of 1,029,328. The study site is Guangua woreda, one of the districts in Awi-zone, 505-kilo meter away from Addis Ababa situated in southwestern part of Awi- zone. Guangua woreda is located and bounded by Beneshangul National Regional State in the west, Dangila woreda in the North, Banja shikuda woreda in the east and Ankesha –woreda in the south. The woreda has 30 –kebeles (27- rural and 3 urban) and a total population of 218, 497, of which 180,038 (82%) live in

rural areas 38, 459(18%) in urban areas. It is divided in to seven ketenas, (an administrative unit next to woreda and consisting of many kebeles). Guangua woreda hosts many nationalities and ethnic groups among which Amhara, Agew, Gumuze, Shenaha Oromo are the major ones. Amhara and Agew ethnic groups are the dominant ethnic groups. According to data from to Amhara, the woreda has 3 Agro-ecological zones, woyna – Dega, Dega and kolla with and elevation that ranges from 800 – 2300 above sea level and an average rainfall 1550mm annually (ANRS, Bureau of Finance and Economic Development, 2005).

Chagni is a woreda town in Guangua where this study has been conducted. In the town, the prevalence of HIV/AIDS and stigma and discrimination related to it is very high. The town has three Kebeles. The number of OVC population is estimated to be more than 1000. Some local projects funded by external donors provide care and support to orphan and vulnerable children. Community Iddirs and OVC association are community institutions, which provide care and support to orphan and vulnerable children. There are no empirical assessments on HIV/AIDS conducted in this town except one by Zonal HIV/AIDS prevention and control in collaboration with Action Aid Ethiopia is one kebele, 02. The findings of the assessment demonstrated that there is awareness and perception of OVC problems in the town by the community but commitment and response is very low (ZHAPCO, 2004).

3.3 Study Participants

Orphan and Vulnerable Children between 12-18 year-old, caregivers of the sampled OVC, government agencies, NGOs, CBOs and FBOs SCOs with OVC, service providers and opinion leaders are the subjects of the study.

3.4 Sample Size Determination and Sampling Procedure

Three kebeles of the town was represented in the study by using non-probability sampling method. Purposive sampling was used to choose the subjects of the study. To determine the sample size of the participants of the study, OVC, the list of all OVC who are beneficiaries of the OVC association were taken as a sampling frame. From this sampling frame, with the help of the chairperson of OVC, 10 children were interviewed and the questionnaire pre- tested before two days that the final interview was conducted. After minor modifications on the questions for individual interview, from this sampling frame, 32 OVC were selected (14 female and 18 male). Purposively on such variables as OVC who get provisions, aged 12-18 vulnerable or at risk and their willingness to participate in the study were the criteria to select orphan and vulnerable children in the community.

After obtaining verbal consent from each OVC to participate in the study, the heads of households of caregivers of the selected OVC were informed and asked their permission to participate in the study. Children were interviewed or allowed to participate with the informed consent supported by parental/caregiver permission. Where the child consented to participate in the study but the caregiver refused to give consent, the interviewer did not proceed with the interview. With this procedure, 32 OVC were selected for an individual interview by the researcher. After informed consent with OVC and their caregivers, an individual interview was scheduled, with place and time specified. Maintaining confidentiality and privacy during discussion was an important issue before the actual interview was conducted.

The informants were selected from community leaders, OVC caregivers, service providers, program implementers and government line departments. In the way focus group discussion (FGDs) participants were chosen from community organizations, service providers, kebele officials, woreda and zonal HIV Secretariat OVC caregivers or guardians

and civil society associations. The maim criteria employed to select these participants was mainly their knowledge and experience to OVC community care and support.

3.5 Sources of Data

The source of data for this study comprised both primary and secondary sources of information. Using various data collection instruments, primary data were collected. To supplement the primary data, available and relevant secondary sources were reviewed and embodied in the analysis to enrich the study.

3.6 Data Collection Techniques

Different data collection techniques were employed to collect information on the current situation of OVC, community awareness to the problems, type of care and support provisions. Information was also collected on such issues as good practices for scaling up of programs and the selection criteria employed to include OVC and their caregivers. To collect information on constraints, challenges and opportunities the participants were interviewed on different issues.

3.7 Data Collection Tools

Individual Interview

An interview with OVC respondents was conducted using a semi-structured questionnaire. The researcher selected two data collectors with previous skills of interviewing subjects as assistants. Using availability sampling 18- male and 14 – female OVC were selected and interviewed. To minimize bias on situational analysis of OVC 20, OVC who currently get services from community organization and local projects through Egna- Legna Orphan and Street Children Association (ELOSCA) were selected assisted by the chairperson

of the OVC Association. The remaining 12 were recruited from households on the waiting list for care and support through the Association. . A semi-structure interview conducted with these groups of orphans and vulnerable children. Through this technique, information about the situation of orphans and vulnerable children and type of care and support offered by the community assessed children's coping mechanisms and future life orientations explored.

These groups of respondents were interviewed on their current living situations, caregivers' history and relationships, coping mechanisms, suggestions in solving their problems and plan to improve their life and perceptions of their problem. They were also interviewed on current community response to care and support to orphan and vulnerable children living in the community. The data collection techniques are qualitative. These include the individual interview (with semi-structure questionnaire), in-depth interviews, key informant interviews, focus group discussions (FGDs), and observation orientations.

Key informant interviews

Key informants from community leaders, civil society associations, government line departments, HIV/AIDS prevention and control project coordinators, human service organization manager's spiritual leaders orphan guardians and child-headed households were interviewed.

Focus Group Discussion (FGDs)

This data collection technique is employed to substantiate and generate more information about the community response on care and support to orphan and vulnerable children in the study area. One facilitator and one note-taker were involved in the discussion. Six focus group discussions (FGDs) were conducted with different community members. Each FGD comprises of 8-12 members one facilitator and one note-taker. The composition of the

discussants were heterogeneous drawn from different community leaders, such as Iddir, Equib, Mahiber, and Anti-AIDS clubs kebele representatives and other civil society associations and spiritual leaders. With these groups, four FGDs were conducted. The other two FGDs were with service providers and community caregivers.

Case study

To illustrate the situation of OVC, three in -depth interviews with orphan and vulnerable children were conducted. The selection criteria include the parental situation (double orphan), children whose parents are poor to support the child, and single-parent children. These categories align with definitions of OVC and were selected to see more deeply into the situation of OVC and their caregivers.

Observation

In the process of data collection, the researcher observed community resources available, and the physical and emotional conditions of orphans and vulnerable children. The researcher also observed the community setting where there were different kinds of community meetings and discussions on various issues including HIV/AIDS.

3.8 Data Analysis and Interpretation

The information collected through all the above methods and techniques was summarized by using and categorizing the research concerns according in to the main thematic issues. The findings are presented by dividing the research subjects and the information obtained into two groups. The first group is OVC respondents and the other group consisted of different community members, and service providers and OVC caregivers. First was done first to see whether there is a different view on community response to care and support to OVC living in the community. This method of analysis adheres to address the different research

questions and objectives by looking at different groups and analyzing all information obtained from both groups separately. Next, the information was brought together by a method known as the triangulation of content analysis. Conclusions and recommendations, in the context of care and support for OVC at the community level, are based on the overall findings.

3.9 Consent and Ethical Consideration during Data Collection and Analysis

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

3.10. Operational Definition of Terms

Child – As defined in the convention on the rights of the child and ratified by the Ethiopian government on Dec.1991, a child is any human being below the ages of 18 years (HACI,2004)

Orphan Children- Children who have lost one or both of their biological parents regardless of the cause of death

Vulnerable children -Those children who are living with HIV/AIDS, parents are sick, because of AIDS, children under difficult circumstances, poverty, discrimination, or exclusion whether because of HIV/AIDS or not (UNICEF, 2003).

Child headed households-Households, which are managed or led by children themselves either because one of the parents are died or seriously sick.

Extended family –A type of family related by blood or affiliation, which takes care of OVC in the community setting.

Community- Those group of people living in the urban and surrounding areas of Guangua woreda with common, values and culture but not necessarily engaged in the same economic activity that provide care and support to OVC in the study area.

Community Organization: Organizations established by the community members who function for the community, serve as a safe guard at times of crisis and emergency, and play a traditional and cultural role (e.g., Iddirs and Equib).

Community Response: - the whole set of responses by community organizations, individuals, groups, and civil society organizations, local governmental and non-governmental organization in specific geographical area in this case Guanga Woreda, Chagni town.

Care and Support :- A comprehensive and inclusive program that addresses the whole needs of OVC such as , economic, social emotional, psychological and medical care of orphans and vulnerable children and their families by anyone of the stakeholders in the community.

3.11. Limitation of the Study

The study has two main limitations, one of scope and depth and the other of methodology. The research is confined and conducted in one district and urban setting. It would have been better if done in different districts of Awi-zone where comparison would be possible between geographical area and target population. However, this was not possible

because of time and financial constraints that the researcher has encountered. In addition, the study employs qualitative methods, and was conducted in a small sample size of a larger population. Usually a research that employs both quantitative and qualitative methods is more reliable than employing one. This was mainly because surveys need more human and financial resources than the researcher had; limited time and finances were allocated for this research by Addis Ababa University.

4. FINDINGS AND DATA PRESENTATION

4.1. Results from OVC Respondents

4.1.1. Socio-demographic Characteristic of Respondents (OVC)

Table1:-Socio- Demographic information of OVC Respondents (N=415, participants n=32)

Socio-Demographic Variable		**Number**	**Percent**
Sex	Male	18	56
	female	14	44
	Total	**32**	**100**
Age	10-14	10	31
	15-18	22	69
	Total	**32**	**100**
Ethnicity	Amhara	21	67
	Agew	11	33
	Others	-	-
	Total	**32**	**100**
Religion	Orthodox	31	96
	Muslim	1	4
	Others	-	-
	Total	**32**	**100**
Level of Education	Illiterate	-	-
	Elementary (1-4)	3	9
	Junior (5-8)	27	84
	High school (9-10)	2	7
	Preparatory (11-12)	-	-
	Total	**100**	**100**

Note: others - Religion – Protestant, Catholic, Juba, etc.
Ethnicity – Gumez, Shenesha, Oromo, etc.

More than half of the sample orphan and vulnerable children respondents, n= 18 (56%) OVC were male, and (n=14; 44%) of them were female. All respondents (both male and female) were teenagers whose age ranges between 12-18 years. The largest proportion of the respondents (n= 22; 68.75%) were single orphans whose parents are alive but unable to meet the needs of their children due to various reasons such as poverty, and chronic illness by HIV/AIDS and other diseases. The majority of the respondents (n= 21; 67%) were from Amhara ethic group and only (n=11; 33%) were Agew (one of the minority ethic group as defined by the federal Democratic Republic of Ethiopia). The highest proportion (n= 31; 96%) of the respondents are the follower of orthodox religion while (n= 1; 4%) is Muslim.

As to the level of education, all respondents are literate. Almost all OVC except one respondent are currently attending school and one respondent is a drop out. The majority of the orphan and vulnerable children respondents, (n=27; 84%) were attending at a level of junior school (5-8th grade) and n=3; 9%) attending elementary school and the rest (n=2; 7%) attending their high school education (9-10th grade).

According to the Convention on the Rights of the Child, the right of children to education is one of the measures of child welfare in any society or community. Though it is hasty to generalize to all OVC living in the study area, it would be safe to say that most OVC are attending school at different levels. However, this does not mean that children who attend school are with out any problem. This is because most OVC and their caregivers in the study sample live in absolute poverty and OVC live in desperately difficult situations because of parental death or chronic illness.

4.1.2. Socio-economic Situations of OVC Respondents and Caregivers

Table2 Current caregivers to OVC (n=32)

Type of Caregiver	No of Respondent	Percentage
Parents	5	16
Relatives	13	41
Grand parents	5	16
Uncle/ aunt	5	16
Brother / sister	3	9
None relatives(friends, foster families)	6	18
Child headed households (siblings) self help and self care	8	25
Total	32	100

With regard to the living situation of OVC and their caregivers, from 32 OVC respondents, only (n=5; 12.5%) are currently living with their parents (they are either paternal orphans or maternal orphans). While (n=13; 41%) are living with their relatives, (uncles /aunts and grand parents brothers and sisters) and (n= 8; 25%) live with siblings who are accountable to care for them. Moreover, six (n=6; 18%) of the OVC respondents live with other children or adults who are not relatives but friends helping at times of difficult circumstances. Most caregiver respondents state that the capacity to care for OVC has reached a situation such that they cannot manage as their resources are depleted. Therefore, the pressure of HIV/AIDS on families and children is paramount and multi -dimensional. According to these caregiver respondents, the financial assistance they get from service providers for the provisions of care to OVC is minimal and not enough to meet the needs of children.

The majority of the caregivers (n=25; 78%) are unemployed in any of the government, non-government and private organizations operating in the community. Almost all caregivers and OVC guardians (n=30; 93%) are employed in the informal sector. They make a living by operating such activities as making local drinks like "*Tella:"* and *"Areke*" and selling them to the local people. Others prepare and spin cotton for making "Shama"(a local cloth dressing by

males and females) for sale to the local people in rural and urban areas. It is in this way that they generate income to their family. Therefore, as OVC respondents confirmed it and their caregivers alike, children are expected to work for the caregivers when they back to home from school. Consequently, orphan and vulnerable children work as daily laborers, shoe shiners, or lottery sellers to substantiate the family income to caregivers or OVC guardians. In general, the caregivers and orphan and vulnerable children are living in destitute situation in which the needs of OVC are deprived and not yet met. It was also clear from female OVC respondents that female children are expected to accomplish some of the household chores like cleaning a house, taking care of the infants and the elderly, housekeeping while members of a household are outside and in some cases, even taking the whole responsibility of the family at early age. This is not in line with the Convention of the Rights of the Child, which Ethiopia has ratified few years ago. It is also very clear that children living in this situation are subject to child labor abuse and exploitation and exposed to HIV/AIDS. In addition, to vulnerability and their well-being is usually at stake.

Thus, with the findings of some scholars, in most sub- Saharan African countries and the situation in Ethiopia is similar. With few exceptions, the traditional safety net to absorb OVC in the community context is still taken over by the extended family. However, the capacity of the family structure to do so is getting decreasing as the number of OVC is increasing, especially in communities where HIV/AIDS prevalence is rate is high (Foster, 2002; UNICEF, 2003).

4.1.3. Care and Support History of OVC Respondents

Most respondents receive support from the local projects operating through external donor funds. Out of 32 OVC respondents, 18 get local support, 2 of them from Community-

based Organizations (*CBOs*), and the other 12 OVC get care and support from their association through contributions by some volunteers living in the community. The main types of provisions are financial support that ranges from 50 -100 Birr and occasional educational materials support such , exercise books , pen , pencils , bags ,etc. Some selected teenagers reported (n= 10; 32%) obtaining vocational training and provided with seed money (start up) capital for engaging in income generating activities. Some teenagers (n=15; 47%) therefore, are currently engaged in such income generating activities as sheep fattening and rearing, small shops, street vending, shoe shining and other related activities. All OVC respondents prefer vocational skills training and income-generating activities (IGA) as sponsored by local projects to financial and material support for their subsistence.

One problem is the scarcity or non-existence of technical and psychosocial support from service providers and community members while they are working on income generating activities. The major donors for the financial and material support that OVC have been provided are from external donors such as Global Fund, UNICEF, World, and Bank for prevention of HIV/AIDS. These projects are to be implemented by Guangua woreda HIV/AIDS Secretariat in collaboration with the *"Egna-Legna"* Orphan and Street Children Association (ELOSCA) established in the year 2004. Among children who are already engaged income generating activities supported by local projects, many of them (n=15; 47%) stated that they become successful and able to lead their own life in a better way than before. A 17 year-old male child further argued:

> *Now days, my life is changing mainly because of the seed money and my initiative to under take income generative activities. Thanks to God, I have a small shop that my sister and I make a living. Each of us is now attending school, rent a house and led a better life than before. Our plan is to take money on credit bases in local credit*

intuitions and expand this small shop to a better one and save money every month in local equibs in chagni town

Nevertheless, few of them (n=8; 25%) were unable to generate income because of market failure and lack of technical support from the projects staff and community members.

4.1.4. Coping Mechanisms, Suggested Solutions and Their Plan for the Future

Nearly all respondents agreed that the first strategy to cope with their problems is through engaging in activities like daily labor, washing clothes in neighborhoods, selling lottery tickets and street vending. For example, Abonesh, a 15 years old female child stated:

Being an orphan, I usually work domestic chores whenever I am not in school to my grand mother who is my caregiver. During weekends and holidays, I work out side, wash neighbor's' clothes, and receive money, give to caregiver to support the monthly expenditure of the family.

Some OVC (n=4; 12.5%) help each other by renting a house together and cost sharing. Each one of the teenagers benefit by one another is possible whenever there are economic difficulties, counseling at times of hopelessness and helplessness, socialization and reciprocity, the accountability of members in groups. Other OVC cope with problems by soliciting help from caregivers, including extended family network and other social support mechanisms employed. Another group of OVC respondents search for potential service providers including local projects operating in the community especially HIV/AIDS prevention and control projects funded by external donors. One challenges that OVC respondents are unable to cope with is the stigma attached to them by the community members and their peers. The Psychological and emotional problems that OVC experienced is so severe that they do not want to reminded and think about it again.

Suggested solutions to the problems that OVC face is one of the questions asked to orphan and vulnerable children. Almost all respondents replied that they are part of the solution to their own problems. They suggested children must involve in these issues. For example, children should be involved in need identifications, selection of OVC beneficiaries, and above all, in decision-making that highly affects their lives. The most important coping mechanism that OVC mentioned repeatedly is the existence ELOSCA. The Association is helpful in soliciting care and support to OVC that could be in most cases financial and educational materials support. It is a forum to discuss their concerns and a source of psychological support for each of the orphans problems and difficulties and search solutions for OVC beneficiaries in the association. In this case, OVC meet once every week, discuss their issues with the assistance of volunteers in the community who are founders of the Association. However, the majority of them are still in desperate situations. There is no psychosocial and emotional support to OVC from any of the community members except some volunteers who are administrators of children's Association.

As far as soliciting solutions to the problem of OVC is the largest proportion of OVC respondents argue that children should be engaged in self - help activities like income generation activities, few even continue in such manner that they will not wait financial and material support from local projects while they can work for themselves and get one. All underlined in their responses that the community should help OVC care and support initiatives, strengthening their association. They also expect moral and technical support from community members in their quest to undertake income generative activities. As to their plan in the improvement of their life, OVC rely highly on their education, a few fear interruptions because of economic and social problems that may happen to them and their caregivers.

4.2. Results from Key Informants and FGDs Response

4.2.1. Level of Community Awareness to the Problems of OVC

The information gathered from the key informants and focus group discussants indicate that the level of community awareness to the problems of orphan and vulnerable children is relatively high. However, the magnitude of stigma and discrimination on HIV/AIDS orphans is still manifested within the community. The participants also argued that the largest proportion of orphan and vulnerable children are living in destitution and absolute poverty. The commitment from local government officials and the private sectors, for example, the business community is very low to provision of care for OVC as compared to the day-to-day increment of orphan and vulnerable children population in the town. The following table can better illustrate this.

Table3, the Number of OVC population in 5 selected small towns of Awi-zone

No	Town	District	Current status of children			Remark
			Orphan	Vulnerable	Total	
1	Dingilla	Dangilla	508	89	597	
2	*Chagni	Guangua	670	167	837	Research area
3	Enjibara	Banija	462	149	611	
4	Tilili	Banija	284	39	323	
5	Gimjabet	Ankesha	293	34	327	
	Total		2217	478	2695	

Source: Awi-Zone Labor and Social Affairs Preliminary Survey report, January 2006

As Table 3 above shows, the number of OVC population is significantly greater in Chagni town of Guangua district than other small towns. It also clear that the proportion of orphan children is much higher than vulnerable children. Consequently, the impact of HIV/AIDS on children and their families is paramount in these communities where this study bases itself. Although community response to the problem of orphan and vulnerable children is low, there are some pockets of community initiatives, which suggest promise for future care

and support in Guangua Woreda (District), Chagni- town. A model initiative undertaken by a few primary school teachers who are volunteers can be taken as a case in point. These interested teachers who are six in number, started the first initiatives and established an Association called “Egna- Legan” Orphan and Street Children Association. “Egna- Legna” literally means “us for ourselves” that gives hope for OVC living in the community. This Association was established in May 2004. It currently consists of 415 orphan and vulnerable children as members of the Association.

The other initiative mentioned by most focus group discussants and key informants was the practice of *Iddirs*. A key informant from “General *Iddirs B*oard” stated that there are more than 21 Iddirs in Chagni- town. Seventeen *Iddirs* are organized into one distinct unit of organization called “General *Iddirs***”** Board. Nine members manage this organization, including ‘educated people, consisting mainly of teachers, staff the Board. According the chairperson of the Board, the objectives of iddirs is to help members of the community during difficulties, funeral ceremonies, bereavements and in a very few instances to those who care for chronically ill and need financial, psychosocial and emotional support. However, today, the activities of iddirs in Chagni- town are more than that. Iddirs for example, are involved in HIV/AIDS prevention and control, community health and sanitation and above all, in development undertakings.

Kebeles in Chagni town have also started to teach the community about the prevention of HIV/AIDS and care for orphan and vulnerable children. For example, it was observed that community volunteers who have taken trainings on home based care were teaching the community about care and support for people living with HIV/AIDS. These community volunteers were also teaching more than 50 orphan and vulnerable children near “*Egna- Legna* Orphan and Street Children Association” office, *Kebele* 01, about HIV/AIDS prevention and

control. It was also confirmed by *kebele* 01, chairperson of Chagni town as one of the key informants in this research that kebele officials are mainstreaming HIV/AIDS prevention and control activities. They took the issue of HIV/AIDS prevention and control as one of the agendas in their meetings and panel discussions, for example, in development programs, malaria eradication campaigns and other similar concerns to which many of the kebele people participate. However, not much has been done regarding on care and support to orphan and vulnerable children, when compared to the widespread and multi-dimensional nature of the problem in the community are social orphans.

The other approach used to measure the level of awareness of the community to the problems of OVC includes the perspective of focus group discussants. Most focus group discussants conceptualized orphan children as those who lost one or both biological parents regardless of the causes of death. These groups of participants also debated a lot about conceptualization of vulnerable children. Some argued that vulnerable children are children whose parents are chronically ill, live in poverty and could not care for them under any circumstances. And in this case, these children could be called “social orphans.” The majority of the participants agreed that vulnerable children are those whose parents are died of AIDS, infected and affected by HIV/AIDS and live in difficult circumstances. Only few defined those vulnerable children is a general concept that represents those who are “socially orphaned.” This literally means that those children who have no one to care for him or her, even when their parents are alive and live with in the community.

This discrepancy in conceptualization of OVC in the community greatly affects the type of criteria that would be employed in care and support provisions for OVC beneficiaries in the community context. Most of the key informants and focus group participants argued that HIV/AIDS is the main cause of orphan-hood in the community. This, in turn, is an important

factor for the existence of stigma and discrimination on orphan and vulnerable children living within the community. FGDs are of the opinion that community-based care and support should be more valued than institutional care. The rationale behind their argument is that community resources such as volunteerism, existence of ideal community, structures, CBOs, FBOs, and above all, OVC would better learn norms, values and culture of the community and can easily integrated to the wider society. They also disclosed that if community-based care and support should be backed up by a minimum technical and financial support by service providers so that it would be effective and successful from the point of view of cost effectiveness.

Orphan and vulnerable children respondents also prefer community care to institutional care and because they will not feel isolated, or detached from the community and can better learn community culture. However, current community care and support for OVC is very low for reasons that they could not explain well. The assumption that the knowledge and attitude of the community members about the problems of OVC in chagni-town is at its infancy and so the commitment to care is low.

4.2.2 Community Resources Mobilization, Care and Support for OVC

An exemplary work in the community that the focus group participants repeatedly raised was the activities undertaken by *Egna-Legan* Orphan and Street Children Association and the initiatives that *Iddirs* take in orphan care and support.

4.2.2.1. Background and Establishment of Egna-Legan Orphan and Street Children Association

This Association established in December 2004 and gets its legal status in May 2004. According to the volunteer founder and chairperson of the Association, Egna-Lagan as the name implies is ultimately community initiative care and support mechanism established by

six voluntary primary school teachers in Changi town. The reason for the establishment of the association is the death of two primary school teachers, husband and wife, by HIV/AIDS, which left five children alone. The first thing that the primarily schoolteachers did for these orphan children was soliciting contributions from fellow teachers in the same school. They were successful and able to support these HIV/AIDS orphans financially, emotionally and psychologically. Hence, each of the children could attend school and were supported with their basic needs. A few months later, the founders were able to increase the number of volunteers who contribute money for care and support to orphan and vulnerable children. In addition, 63 OVC were registered for financial support and the total number OVC who get care and support reached to 68 children. Volunteers came up with a new idea of establishing OVC association to better mobilize the community for care and support of orphan and vulnerable children living in the town. Thus, the establishment of Egna- Legna orphan and Street Children Association was materialized. Currently, the association has 415 OVC beneficiaries most of whom get care and support via the Association. Today, the number of volunteers has increased from 6 to 70 individuals. This is not from teachers alone, but professionals from other sectors, GOs, NGOs, private agencies, and interested individuals from the community. Thus, association is used as the springboard for addressing the problems of OVC in the community. Many of the service providers, CBOs, and local community-based projects recruit their OVC beneficiaries mostly from this Association.

Table (4): Egna-Legna Orphan and Street Children Association beneficiaries, by sex, age and current situation

No	Parent situation	Sex	Age				Total	Remark
1	Double orphans		0-5	6-10	11-15	16-18+		
		Male	3	27	82	48	160	Parents died
		Female	2	35	83	20	140	
		Total	5	62	165	68	300	
2	Paternal Orphans	Male	-	12	18	5	35	Mothers are daily laborers
		Female	-	12	27	3	42	
		Total	-	24	45	8	77	
3	Maternal orphans	Male	-	2	10	3	15	
		Female	-	1	4	-	5	Neglected children by fathers
		Total	-	3	14	3	20	
4	Vulnerable children	Male	-	-	9	7	16	
		Female	-	-	2	-	2	Street children
		Total	-	-	11	7	18	
Grand Total		Male	3	41	119	63	226	
		Female	2	48	116	23	189	
		Total	5	89	235	86	415	

Source: Egna –Legna Orphan and Street Children Association, 2005 revised statistics for care and support and a record document by the volunteers in the Association

As can be seen from Table 4 above, the highest percentage (n= 235; 56.62%) of orphan and vulnerable children in the association are in the age range of 11-15 years. Most of the beneficiaries (n= 300; 72.28%) are also double orphans. Even though the causes of death of the parents was not defined at a time of data compilation, it could be implied from the key informants interview and focus group discussion that HIV/AIDS claimed the lives of many of the Children's parents. This may hold true, especially for double orphans in cases where both the husband and the wife died one after the other in the community context. Comparing the number of maternal and paternal orphans, the paternal orphans are by far greater than the maternal orphans. Though most paternal orphans are living with women headed families, they are living in destitute conditions. These groups of women are dependent on meager income

that they generate, as daily labor is too small to support the family members of which a paternal orphan is a part. Therefore, it can be argued that poverty is one of the problems of OVC and their caregivers living with in the community. Currently *"Enga- Legna"* orphan and Street Children Association is implementing a local project funded by UNICEF (70,000 Ethiopian birr), and the World Bank (49,000 Ethiopian birr) for orphan and vulnerable children care and support. Almost all of the beneficiaries are drawn from the Association.

The second community resource for the care and support for OVC living in Chagni town is the initiative made by community *iddirs*. Through their membership contributions, Iddirs support some OVC living in the community. According to chairperson of the Iddirs General Board, after a continuous lobbying and advocacy of zonal and woreda HIV/AIDS Secretariat and Anti-Malaria Association iddrs involve in HIV/AIDS prevention and control activities. In the year, 2005 iddirs have conducted 2 panel discussions with the collaboration of the above stakeholders. The main agenda of the above stakeholders in the panel discussion was that, iddir members decided to participate in HIV/AIDS prevention and control efforts as one stakeholder. Each iddir member has paid 2 birr as membership fee. Once they are registered, they ought to pay 2 birr each moth and should attend monthly meeting as the internal by law oblique them to do so.

According to the chairperson, the monthly meeting of iddirs is an ideal forum for awareness creation to the problem of orphan and vulnerable children and designation of care and support mechanisms for them. For example, after contiguous discussion with *iddir* members, decisions were to support 4 OVC to enable them attend school. Now, the plan is to support more OVC living in Chagni town .Some iddirs have the financial capacity to support more OVC living in the neighborhoods. For example, *"Sellasie- Moredaja"* Iddir that has 160 members with the capital of 12,000 birr in cash and some physical assets that can support

more OVC in the community.

As to the prevention of HIV/AIDS, iddirs promote community mobilization efforts with the collaboration of other stakeholders can be reflected by the role of *Iddirs* in combating HIV/AIDS and their involvement in general community health activities. Currently, Iddirs provide financial support to 4 OVC living in the community. The amount of money they attribute to each orphan child is 75 birr each month. What is interesting is the promise that this financial support that iddirs attributed to 4-OVC will continue up to their high school graduation in Ethiopian context of 10^{th} grade. The main criteria that iddirs employ to select OVC beneficiaries for financial and material support are the following:

- OVC status ---------- Double Orphans
- Caregiver Situation--Those who have guardians
- Level of poverty------Those OVC who live in absolute poverty
- Family Size----------OVC who live in families of more dependants
- Education ----------Those OVC who currently attend school

Having the above criteria as a springboard, the screening committee, which constitutes of iddir board members, service providers, kebele officials and OVC representatives from *Egna-Legna* Orphan and Street Children Association, would select orphan and vulnerable children for care and support.

The key informants from different service providers also confirmed that, more often, than not the criteria is widely employed in the selection of OVC and caregivers in the community context. The case applies for example, to the Anti-Malaria Association, which currently provides care and support for 8 OVC to help them attend school and cover part of their monthly food expense of orphan and vulnerable children. However, participants of the focus group discussion argued that there is no psychosocial and emotional support to OVC

beneficiaries in the community. This is mainly because there are no social workers and counselors working in the community -based projects operating in the area. The other community mobilizers are the woreda, Anti- Malaria Association and the Kebeles at grassroots level. Guangna woreda Anti-Malaria Association and three kebeles of the Chagni town, kebele 01, 02 &03, are working in collaboration with Egna-Legna Orphan and Street Children Association(ELOSCA). For example, according to Anti-Malaria Association (AMA) provide 8 OVC who are drawn from the ELOSCA for the provision of financial and material support. The kebeles are involved in selection of OVC beneficiaries to service providers in the community .The screening committee is also made up of kebeles and Anti-Malaria Association as well. Guangua woreda Anti-Malaria Association has a plan to expand its care and support provision to OVC in its HIV/AIDS prevention and control project funded by membership contribution and external donors. The kebeles are the ones, which closely work with ELOSCA on care and support programs for orphan and vulnerable children. For example, Chagni- town, kebele, 01, administrative office provides office to the OVC Association. The OVC conduct their weekly assembly in the kebele meeting hall, facilitated by volunteers from the association who are primary school teachers in Changi- town.

Still the other semi-government offices that coordinate and facilitate HIV/AIDS prevention and control activities in general and community mobilization for care and support for OVC in particular in Awi-Zone and Guangna woreda 1 HIV/AIDS prevention and control Secretariat. These secretariat offices coordinate and facilitate to help implement all community-based service providers and donors (internal and external) for the benefits of OVC living in the community. The effectiveness of all community-based care and support programs and projects are evaluated, strengths and weakness of each discussed and future planning and strategy designed with the consultation of the zonal and woreda Secretariat.

Many of the focus group discussants and key informants remarked that the initiatives started by few community-based organizations like iddirs and civil society associations established by some volunteers can be taken as a model practice. However, the commitment from local government officials and the private sector is very low. The involvement of faith based organization like Ethiopian Orthodox Church and Islamic Religion to OVC care and support is minimal though their contribution and role in this regard was highly valued by the community members.

All the participants concluded that much effort has to be exerted by all stakeholders to change the attitude of the community towards HIV/AIDS orphans. Moreover, if the current plights of HIV/AIDS and its multi-dimensional impact on the community are to be reduced, the commitment of the community members to OVC care and support is very essential. The participants also underlined that the importance of the involvement of such Associations as women's association, youth Associations, and other social and economic local organizations. Like *"mahiber"* Equib, saving and credit Associations based on government, professional associations like teachers association should provide care and support to OVC living within the community. These community-based organizations could be seen as potential stakeholders for future intervention that focus on orphan and vulnerable children in the context of HIV/AIDS prevention and control activities in the district.

4.2.3. Types of Care and Support Currently Rendered to OVC: - the Criteria Employed For Selection Of The Beneficiaries.

Table (5) care and support providing institutions and type of support provided to OVC in Changi Town.

No	Name of institution	Type of support and No of OVC supported			Total No of OVC supported
		Educational materials	IGA	Food expense	
1.	OVC Association (ELOSCA)	282	88	-	370
2.	Anti- Malaria – Association	-	-	8	8
3.	CBOS,*(Iddir*)	-	-	4	4
	Total	282	88	12	392

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Table 5 shows that the lion's share of the support came from ELOSCA. The type of support that this association offers is educational materials (school uniform, pen, pencils and exercise book and seed money for income generating activities (IGA) to those OVC who are teenagers and interested to work and help themselves and their family. The source of funds that the association gets mainly comes from external donors and members ship fees and contributions in each month. Even though there is an interest and plan to support more OVC by CBOs and AMA, the number of OVC supported by these institutions is minimal when compared to existence of large vulnerable children in the community. Key informants from OVC Association were asked as to why the Association focuses on educational material support and IGA to orphan and vulnerable children living in the town .The main reason they explained was fear of dependency from OVC and caregivers abuse of the financial support. As it is understood from the information collected , the main care and support providers in the

community are the extended family. Though these groups of families take care of orphan and vulnerable children in the community, they are living in absolute poverty and unable to meet the needs of children as far as their current economic capacity is concerned. The next care and support providers in Chagni-town are stated by the local project operating in the area. These projects are mainly funded by external donors like UNICEF, World Bank and Global Fund with the objective of preventing HIV/AIDS in the community.

Most orphan and vulnerable children are currently getting financial and educational materials support from these project funds, through their Orphan Association. Evident from the participants FGDs, and partly from orphan and vulnerable children beneficiaries of these projects, the type of support that OVC get from projects are financial , education support like , exercise books , pens , pencils and school uniforms . Very few (n=8; 25%) beneficiaries get micro-business skills training and engage in small micro- business activities like sheep fattening, and rearing, street vending, shoe – shining and in some cases, small shops establishment in neighborhoods and selling few house hold utilities.

4.2.4. The Constraints, Challenges and Opportunities in Care and Support Provisions to Orphan and Vulnerable Children

4.2.4.1 Constraints and Challenges

The main constraints for provision care and support to OVC is the low commitment and response of the community members towards the problems and needs of orphan and vulnerable children in the community. Following this are the misconceptions about the death of parents of orphans that most community member believe to be HIV/AIDS. This is the same to Alula's finding in Addis Ababa for IGAs to PLWHA in raising income of the families (Alula, et al, 2004). Shortage of skilled professional like community mobilizers, social workers and counselors and para –counselors mentioned as the main factors for this low

awareness of the community about the problems and needs of OVC. For example, the only sector that promotes the Convention on the Right of the Child is Awi Zone Labor and Social Affairs at intervals while it has no woreda structure or outreach in the community. Since there is low commitment and response of the community to OVC care and support, the number of caregiver volunteers, except for extend families is very low. However, the respondents appreciated the small community-based initiatives such as by ELOSCA and some iddirs commitment and plan to provide care and support to OVC.

The other serious constraint is the dearth of data on the number of OVC and their current situation that could be used as a basis for care and support interventions by other stakeholders in Guangua Woreda. Most of the focus group discussants asserted that there are great challenges while providing care and support to OVC in the community. Some of the challenges are multi-dimensional and interrelated. Poverty is the leading challenge because many of the OVC caregivers have reached the point in which they no more able to continue support. This is mainly because of the low income they generate from the informal sector. Some of these problems are so deep-rooted that they need the involvement of many stakeholders and actors. The case in point is again the situation of caregivers or guardians of OVC who are living in absolute poverty. These people are engaged in such informal economic activities as making "*injera***"** (bread) for sale, preparing local drinks and selling and others in street vending that provide subsistence life. OVC respondents confirmed that they are living with caregivers or guardians who cannot able to meet their daily needs.

Another challenge mentioned by the group of participants is the increasing magnified and number of problems OVC living with the community. On the contrary, an increasing number of OVC population and less response from the community side is also a challenge. This is aggravated by OVC rural –urban migration expecting better life in urban areas. The

basic factors that push most orphans from rural areas to urban areas are poverty and HIV/AIDS. The key informant from the OVC association also stated that the caregiver's and guardian's perception of orphan and vulnerable children as a means of generating income from service providers was one of the challenges in provision of care and supp. There also exists stigma and discrimination against HIV/AIDS orphans with in the community. The case in point was the problem that three HIV/AIDS orphans face while they started income generating activities. The key informant from General Iddirs Board stated:

> *There were three girls who we HIV/AIDS orphans and provided with seed money to prepare a local drink "Tella "and sell for the community members. Nevertheless, the local people did not want to drink, in this case "Tella" for fear of transmission of HIV/AIDS through the local drink because of the once who prepared that local drink were HIV/AIDS orphans.*

The absence of OVC policies, strategies and guidelines that could be applicable at grassroots level by service providers, implementers is also stated as a challenge to provision of care and support for OVC. Low local government commitment to the prevention and control of HIV/AIDS, in general, and care and support to orphan and vulnerable children living in the community is another challenge. Informants from ELOSCA also stated that the higher expectation of support from OVC is a serious challenge in the care and support effort in the community.

4.2.4.2. Opportunities for OVC Care and Support within the Community

While focus group participants and key informants were mentioning a number of constraints and challenges in orphan care and support effort in the community, they also list some the opportunities. Mentioned among them were, the existence of community-based organizations and their interest to engage in HIV/AIDS prevention and control and local

development activities. This can be seen by the initiations that iddirs took to conduct panel discussions with local partners working on HIV/AIDS prevention and control. Moreover, Iddirs initiation and commitment to support OVC with educational materials including and food support up to their high school gradation is an opportunity that encourages children and their caregivers to invest on education. Most iddirs also organized themselves in to a General Iddirs Board which could help create synergy in mobilizing their members and build better financial capacity for care and support. This could also give them a wide range of opportunities for investment and generation of income. Some kebele officials stated that the decentralization policy that the government is promoting could give the community relatively better empowerment to mobilize resources by its own initiatives. The same group of people who are working in government offices mentioned control activities. The establishment of ELOSCA in which most care and support providers focus for their activities was mentioned as a good opportunity. The key informants also stated that the motivation and high interest of orphan and vulnerable children in their association. Thus, service providers could take incomes generative activities as the best opportunity for care and support provision. In addition, this could be good for local projects or community-based initiatives, which have an interest to provide care and support to OVC. Consequently, OVC using their association would engage in self –help efforts to lead their own life as was stated by the key informant in the Association. The community has many local forums and events that could be used as a means for addressing HIV/AIDS prevention and control. *Iddir* members meet in every Sunday once in a week, as a tradition Equibs do the same, youth associations, women's associations and, Amhara credit and saving institute (ACSI)) Guangua woreda branch that organize a number of meetings for its customers could be used as a forum for mobilizing the community to OVC care and support.

The positive attitude that the community in general has on OVC Association and the aspiration, which people develop to become members of the association and contribute their technical and financial input, is another opportunity. The other opportunity that was communicated by the key informant of the Association was the attitude of local project donors like UNICEF, World Bank and other external donors to fund the Association. The money from these external donors is especially used for OVC skill development and income generating activities. Orphan and vulnerable children's courage to engage in self- help and income generating activities is the other asset that helps to promote care and support provision with in the community.

4.3. Case Illustrations

To supplement the information obtained from OVC respondent and to see the situation of orphan and vulnerable children, and their caregivers, the researcher has arranged an in-depth interview with three OVC, two male and the other – female. The for the sake of confidentiality, the names of these children are given pseudo- names as Balcha, Feten and Zuriash.

Case 1

Balcha male and born in near by rural areas of Chagni town and is a 14-year-old vulnerable child. "I am a 6^{th} grade student. I have parents both mother and father and by occupation they are farmers. The family has 10 members Dad and Mama and 8 children (7 male 1 female) I am the fourth child for my family. The family in much of the times is in absolute poverty where some times we have no enough food to eat, no clothing through out the year, and is unable to cover educational fees. The whole family depends on such assets as two cows, two horses (used for ploughing) and 0.75 hectare of land. The main source of income is farming and livestock rearing. The land is not productive; every year less produce is

expected. I came to the chagni town expecting better life in urban areas, but in reality life in urban areas but in reality, life in urban areas is very critical and troublesome. Most of the days of the week, I am unable to feed myself with my small income in shoe, shinning in the town. The only support that I currently get from the family is shelter. I dislike working as a shoe-shiner *(*"*listera*" Ethiopia context) but it becomes a coping mechanisms and a strategy to live and be able to pay fees for my education. My uncle (brother of my father) helped me to have shoe-shining equipment. In this, case *"listero* "and buy me other necessary material by investing 20 Ethiopian birr. I took this money on credit basis so that I am expected to return back one day working on "lestros "in my spare time (weekends and while I return from school). My daily income from making "listero "ranges 3-4 birr. But very occasionally, a maximum of 6 birr per day. Sometimes, I came up with no income at all. I saved money for my critical times other than paying back my debt to my uncle who bought me the life for shoe shining. Other than making my living by shoe shining, I am able to cover my educational expensive myself. Therefore, I am a self –sponsored student.

A critical problem I came across in my life was when I was injured at the leg while playing football with my peers in the neigh hoods. For medical treatment, I could able to get free medication from the nearby government health center for the kebele wrote a letter that entails my family's poor economic background and my status. Nevertheless, at all expenses, I was not cured from my injury and continued to live with a pain and even unable to attend school. I could not continue working on shoe shinning because of the illness. By this time, I went to my parent's house and lived together. After a number of trials for treatment in the health center and referred to BahirDar Referral Hospital for better treatment in 2004.

My father borrowed 300 birr for this purpose. In this hospital, I was hospitalized for 9 days for my leg injury was operated for the injury. Before I finished the medication as

prescribed by the physician, I returned home because of my father's inability to pay for the hospitalization cost. After 4 months, I was in critical health problems, got sick once again because of the injury, and I suffer much.

In March 2006, the kebele for the second time wrote me a letter of cooperation for individual contributions to save my life. At this time, government employees in chagni- town contributed 240 birr, HIV/AIDS secretariat office 100 birr that add up to 340 birr for medical treatment to the previous referral hospital. Although I am suffering from my leg injury, I was working on my "*listero*" and attend school. Nevertheless, now days I am in critical psychological problem because of the continuous illness for fear of dropping out of school for economic and academic reasons. I have no one to help me, except a few contributions for medical treatment for my injured leg. I need any organization, individual or group to rescue my life misery and change my mind, not to work on shoe shining activity. I need financial, educational materials support if my life is to be improved at all."

Case2

Kibiru is 16-year-old male child from Amhara ethic group. He is single orphan who migrated from rural area to urban because of abject poverty in the family. He had lived for the last 13 year with his widowed father." My father lives with his elder daughter preparing food. I did not know my Mama since she was dead before 15 years when I was two months old. I migrated from rural area to urban areas because the family is unable to meet my basic needs, food, education, love, and affection because of my Mother's death. I started to 'taste' city life before two years ago. My family comprised of five members, my father and four children. One of my sisters works as daily labor in the rural area and generate income for the family, the other married. I am now a dropout of school working as daily laborer to cover part of my subsistence. Now I have no relatives around who help me.

As daily laborer, I make living and occasionally I support my family, by sending a kilo of coffee, sugar during holidays, while visiting the family. My father is now making a living by selling fuel wood and charcoal in urban areas. The family of mine has no livestock or land possessions in rural areas. With desperate situation, I have such personal health problems as unable to sleep, chronic economic problem, used to live on street with other children. I face problems of isolation, helplessness, hopelessness, and above all psychological stress for difficulties in my life as 16-year-old orphan. As a single orphan, I had had an opportunity to be accessed as beneficiary in local projects funded by external agency, by CVM Ethiopia, with other fellow orphans and started to live in orphanages for 8 months. After some 10 months, that orphanage is claimed to be unfunctional because of administrative and financial reasons. Later on, a strategy was designed by the agency to reunify beneficiaries to foster families with provision of 500 birr each. I was reunified to my family of origin in which father is a head of a family. I started income generative activities (IGAs). Consequently, the agency bought me four sheep, all of which died. I became a bit nervous because of my "bad" luck the occasion created. On those days, I was so upset that I migrated to the nearby town, Changi- and started to live once again as street children. Now, I am drop out at 6th grade, and work as a daily laborer to make a living. As a coping mechanism, five of the street children rent a house by 25 birr. Therefore, we pay each 5 birr for the house rent and now I can not help my family as before and plan to continue my education one day."

Case3

Zuriash is a 15-year-old double orphan from Amhara- ethic group. She is currently attending school and a 9th grade student. She narrates her life situations and current way of living us follows. "I migrated from rural areas before two years. I do know who my parents are because they died while I was 2 year old. I am told that my parents were teachers after they

died, I used I live with my grandmother who was poor and unable to meet the household needs. She died two year when I was 2 years old. I have information from neighbors that my father died of AIDS. Now I get support from my uncle. I came here before two years for my education. I live with my aunt's daughter and we rent one room and live together. I have inherited nothing from my parents because though my father was a government employee, he was not pensioned for he had to serve 10 years as the Social Security law demanded in Ethiopian context. My uncle sponsored the whole expense of my education including food expense and house rent. I used to get financial help from local projects for four months. Later, the project phased out and help discontinued. But now days, my uncle is telling me that he is not in apposition to help me from his meager income he gets from painting a house and decorating activities . In addition, I am now in dilemma whether to continue my education or not. Therefore, I am thinking of an organization or individual for sponsoring my education and monthly food expense so that I would graduate from high school. My plan is to finish high school education, search for job, and help myself and my uncle who should deserve a reward for his continuous help after my parents' death. God knows what would happen next."

All cases depict rural- urban migration because of dysfunctional families. Thus, rural urban migration is the most important factor that children in the community experienced. It is implicitly understood that HIV/AIDS claimed the parents of many of orphan children in both rural and urban settings. Orphan and vulnerable children came to the urban areas in search of better life, value their education, work as daily laborer, and cover part of their educational expense.

4.4. Observation

Observation as a method is employed mostly in ethnographic research as a means of generating and supporting qualitative data. It needs relatively long period of watching, recording and occasionally interpreting community practices. Even though the duration of the researcher's attachment in the research community was short, the researcher could observe few of the practice those community groups' exercises, which have an implication on HIV/AIDS prevention and control in general, and OVC care and support in particular.

In Chagni- town, the researcher has observed trained community caregivers teaching the community on prevention and control of HIV/AIDS. For, example in kebele 01**,** the kebele people were coming to the kebele office to request of sugar for their household consumption since the price of sugar in the market was too expense to buy. The kebele officials facilitate the meeting of these people together. And trained community home based caregivers, takeover use the opportunity to inform the *kebele* people about HIV/AIDS prevention and home based care to PLWHA. Trained community home based caregivers also teach orphan and vulnerable children about HIV/AIDS prevention, risk reduction, peer support and counseling.

The other observation that should be traced here is the different social forums that were conducted by different segments of the community. March 8 was an International Women's Day and the Gungua –woreda Women's Association was conducting a meeting with woreda women residents. The kebele officials were also conducting a meeting with the kebele people. There was also the elderly men's patriot meeting near *kebele* 01 of in Chagin town. Amhara National Regional State, Credit and Saving Institution (ACSI) was conducting a meeting with clients who came from rural and urban areas. Ethiopia Orthodox Church, woreda diocese, was also conducing a meeting with many of the church administrators. Priests coming from both

rural and urban parish churches attended this meeting. The main point that the researcher is to mention here is the potentiality and opportunity of using these different forums for educating the different segments of the community on prevention and control of HIV/AIDS in general and care and support for people living with HIV/AIDS (PLWHA) and OVC. These forums could also be used as a means of fund raising and advocacy to care and support for OVC living in the community

The other observation was the weekly meeting that OVC conduct in the ELOSCA. These groups of children meet together once a week (every Sunday), discuss their problems, needs, and solicit solutions. They have committees and sub committees each with its own roles and responsibilities of monitoring each OVC beneficiaries in the neighborhoods and while they are in schools. Therefore, each committee is expected to report what has happened for the last week. This is opportunity can be exploited by community-based projects with minimum technical and financial back up that promotes the establishment of self-help group within the OVC Association.

5. DISCUSSION

This part discusses the major findings obtained using different data collection tools from various segments of the community including literature reviewed and field observation made by the researcher.

5.1 Causes of vulnerability and current situation of OVC and caregivers

Implicit in the findings is the impact of HIV/AIDS on the community. It has claimed the parents of many children. Orphan hood is rampant within communities in which HIV/AIDS prevalence is high coupled with severe poverty. HIV/AIDS has complicated the traditional role of extended families to care for OVC. In line with the findings of different

surveys (MOLSA, 2003; FHI, 2005; Policy Project, 2004), a significant number of OVC get care and support from the extended family. Most of these extended family members are grand parents, uncle/aunts sisters or brothers of children affected by HIV/AIDS .Critical problem that OVC caregivers face is poverty and fear of HIV/AIDS and related stigma attached to it. Most of the caregivers are women headed households who live in desperate poverty and are unable to meet the needs of their own children and those who are fostered. These groups of women are self-employed in the informal sector and generate meager household income. To fill the shortage of income for the monthly expenditure, children in the household are expected to work as daily laborers. Therefore, most of the time, children are vulnerable to child labor, sexual abuse (girls) and likely exposed to HIV/AIDS. In combating HIV/AIDS, the issue of poverty alleviation should come in the scene if the households' capacity to absorb vulnerable children is to be practical and effective.

5.2 Options to Current Problems and Sustainable Response

CARE'S Model of household based intervention in communities affected by HIV/AIDS is the best practice. This model was effective in Kenya and Malawi. It is now pilot project in Ethiopia where PLWHA are making income-generating activities to sustain their life (ISCFI, 2004). The main logic behind this model is that by addressing safety net programs within the community, and raising the income level of children and families, it is possible to combat the effects of poverty on households. This, in turn, leads to reduction of HIV/AIDS impacts on the community. These kinds of interventions should be replicated to wider segments of the community where OVC caregivers and young orphan and vulnerable children can make use of and improve their life by generating income. These have to be technically and financially supported by different actors operating through community development. It is a

holistic approach, not an isolated effort that brings social change on HIV/AIDS other related issues.

Significant in care support designing program is the number of child- headed households in the community is a critical incident that should be seen as part of the process in analysis of community care and support. Foster(2002) argued that the emergence of child headed households within the community is one of the manifestations of weak social bonds and less absorbing power of the extended family than the OVC population in highly HIA/ AIDS affected communities. Children in these communities live in dysfunctional families and become emotionally and psychological affected which causes them to anxiety, stress, depression hopelessness and helplessness. He also argued that the extended family is not a sponge that absorbs OVC all the time. Significant numbers of children slip from the safety net mainly because of the depletion of resources in the extended family or households that provide care to OVC. If the current patterns of care and support and prevalence of OVC continues, the extended family no longer will play its conventional roles as far as care and support to OVC is concerned. The role of the community as the next line of defense to provide care and support to orphan and vulnerable children is unquestionable. The proportion OVC population in AWI-zone with its multi dimensional problems is increasing. Community response to this problem is at its infancy but encouraging as a few community-based organizations provide care and support to OVC in the town.

5.3 Alternative and Comprehensive Care and Support and Integrative Response

Type of care and support that OVC get currently are mainly financial and material, which are only part of the comprehensive care support packages as framework of care and support and minimum package for care support entails. Children should get education, health,

and protection, economic, psychosocial and legal support. The point that should be considered here is that care and support, and therapeutic treatment alone do not ensure the well- being of those who get the service. Prevention strategies and wider approach to OVC problems in the community is important. Changing the perception of the community on stigma and discrimination, increasing risk perception of the community about HIV/AIDS, accesses and provision of Anti-Retroviral therapy to PLWHA and helping them live long reduces the number of OVC living in the community by decreasing the number of deaths of many children. There fore, intervention should focus on prevention, care, support to for OVC beneficiaries, and their caregivers. The emphasizing should also be in empowering and providing technical and social-economics support by implementers of certain program or community response at the grassroots level. To achieve these objectives establishing social and economics groups within the beneficiaries and community initiatives to facilitate the process is wider and long-lasting effect that ensure sustainability. Income generative schemes through IGAs is one option for this to happen and support such a program

In the study community, some OVC are engaging themselves in IGAs supported by local projects funds. The caregivers are also involved in the informal sector. To both groups, there should be a needs assessment and feasibility study as to how this business is profitable and to support the livelihood of the beneficiaries in the community. The majority of the people in the informal business in developing countries are poor women with limited schooling, skills and technical knowledge. These groups also face a number of constraints in their micro-enterprise activities, skills training, capital constraints a market for selling their products and networking their activity to the formal sector (Sethuraman, 1997). OVC working on IGAs should therefore be supported with technical and financial support so that they can cope with economic problems and develop self-efficacy and self-confidence. Activities that OVC facilitate for the

sale of their products include micro- credit service links with local credit and saving institutions are some needed supports given to OVC in this business. Orphans and vulnerable children suffer psychological trauma, reinforced with the illness and death of their parents, followed by a cycle of poverty, malnutrition, stigma and discrimination. Hence, OVC need especial psychosocial support and counseling in their community context. Most of them have double responsibility of attending school, working as daily laborers to back up household expenditure and a few work on IGAs on their spare time .Psychosocial counseling either by para –counselors trained with in the community outreach or professionals employed by local projects is therefore necessary for care and support to OVC in the community. Before conducting such program, needs assessment, training, and prioritizing the needs is necessary.

Orphan and vulnerable children are part of the problem of HIV/AIDS and active members in soliciting the solutions to address their problems. For example, OVC who are homeless get together and rent house, share costs and "help" each other at times of difficulties. A number of OVC engaging in IGAs become successful within a short period. Such groups of children should be taken, as a model for other teenagers to do the same. Therefore, involving OVC beneficiaries in designing, implementing and evaluation of local projects that focus on OVC welfare is an asset to be exploited. Promoting and encouraging children in these coping strategies would make them more productive and lessen their socio- economic vulnerability. Establishing self help social groups in this process may also develop self – reliance, leadership skills development and self-efficacy that ensures sustainability. This could be witnessed in Gardening Project and income generating activities in Zimbabwe where local resources were mobilized for OVC support. Community gardening was used for supporting OVC living in the community (Foster, 2002).But one thing to note here is rehabilitative programs for OVC are interrelated and needs the concerned effort of all actors operating in the community ,individual

, group, organizations, and other stakeholders.

The practice of most community- based programs and projects may achieve short-term goals and objectives, but it frequently fails to ensure long-term impacts and sustainable development (Maser, 1997, Foster, 2002). Most external actors have a great deal to learn about the nature and diversity of community initiatives including their organization , evaluation , needs , capacity and limitations of the community if long term and sustainable change has to come (Altman,1994; SCFI, INC, 2003). The level of awareness to the problems of OVC in the community is increasing. Nevertheless, the commitment and response of individuals, groups and community members in general is low. On the contrary, OVC population in the community and the need for care and support is demanding multi- dimensional response. Assessments on needs and response of OVC in Ethiopia show that OVC are becoming the growing burden of an already impoverished community (MOLSA, 2003; HAPCO, 2005). On the other hand, the commitment local governments to care and support to OVC is very insignificant. The current care and support providers are mainly local projects funded by external agencies. However, the majority of these projects neither meet all needs of OVC in the community nor stays for relatively long period. The other critical problem is only a few get the service and many of the OVC are in need of care and support. .This has an impact on children in the first place and the whole community. Seen in its wider perspective it may lead to social disorder, criminality, and emergence of dysfunctional families and hinder national development.

Although community response to OVC care and support in general is not up to standard, and in scope, there are model practices that should be scaled up in other areas of Awi- zone. At the center of these practices is the activities undertaken by the OVC Association. Both OVC beneficiaries and care and support programs implementers see this

association as the nucleus of care and support programs on the community. Service providers start and provide every service through the association and select the beneficiaries. Orphan and vulnerable children in the community highly rely on this association for their socio-economic improvement and change. The Association. Facilitated IGAs of OVC. Viewing OVC care and support in a wider perspective, the association is a base for development of voluntary service by community members. The current shortage of skilled personnel is a constraints that the OVC association experience and should be addressed.

To run the association effectively, as administered by few committee now, lacks competence and shortage of time because volunteers have been working for the association on part- time bases. Establishment of the OVC Association is not an end by itself. Further steps have to be designed that synchronize the involvement of OVC and more community members for its sustainability and effectiveness.

The initiatives that Iddirs are undertaking should also be promoted. Linking and coordinating these initiatives with other formal structures for technical and financial backup is vital if the current initiatives are effectively able play their role in the community in their full capacity. It is also vital to follow the following strategies while working with OVC in the community: build the capacity of the family, mobilization and supporting community-based responses, ensuring essential services, ensuring that communities protect the most vulnerable children and establishing an enabling environment for the care and support programs (Ife, 2002; UNICEF, 2003; HAPCO, 2005).

The most important issue to rise and discus is the selection criteria that service provides and community organizations deploy to the OVC beneficiaries. The process and selection criteria are relevant. For example, the establishment of the screening community and its representatives from different section of the community is positive and transparent.

However, the selection criteria should be inclusive and focus on gender, disability, and should critically consider age as variable because infants and children have no alternative than social financial help from the community. The variable that a child is an orphan shouldn't always be taken as a necessary condition for selection because, there are some vulnerable children who are not orphan but live desperately living in chronic social and economic problems. The selection of orphans as AIDS orphans is dangerous and unreliable criteria For one thing, most parents did not check their sero- status before they died. Even when they did, they do not want to tell to anyone including their children because of the existence deep -rooted stigma and discrimination in the community .Therefore, the criteria set by the community being good with some modification should usually take the children and caregivers in context.

Community resources mobilization is one option that enables OVC care and support to be sustainable and effective. The best strategy that facilitates community mobilization for care and support to OVC is utilization of the existing social, economic and political structures that function within the community. Mobilization of community iddirs means fueling other members of the community for many people in the community are member of iddirs .When looking at the community mobilization in the study area, already except for Iddirs and voluntary individuals, the response is not up to the expectation.

5.4 Collaboration and Scaling Up Good Practices

Few elementary teachers working in the OVC Association, the mobilization effort made by service providers, project implementers, and governmental organizations is not up to expectation again. On the other hand, there are a number of social organizations that are established in the community yet, these potentially with ideal structures but not exploited for community mobilization to take place. These are, the different kebele meetings, HIV/AIDS

community dialogues, holiday ceremonies, youth clubs and associations civil society organizations (Teacher's Association, Women's Association), and the like should be exploited. Therefore, for future intervention, programs or projects should be designed in such away that community mobilization is one major component of the main activities to be undertaken in the community context.

The constraints that communities encounter in the process of care and support can be viewed from different angles. Some of them are technical and beyond the capacity of the community. For example, absence of OVC policy and the dearth of research on OVC situational analysis are beyond the capacity and mandate of the community. Most of the other constraints and challenges could be managed and solved by community members. These types of constraints are reduction of stigma and discrimination, supporting OVC through advocating foster care and adoption and increasing the number of children supported, and reducing the shortage of skilled personnel by training community members on community mobilization, para-counseling, peer education project planning and implementation, etc. The community members could solve the other constraints with concerned effort. Behavioral change and change of attitude on HIV/AIDS orphans could be solved through an integrated effort by GOs, NGOs and community as a whole. The absence of a workable OVC policy and strategy for community -based care and support practice implies that government or its partners should think of social policy that ideally fits and address the problem. The social policy should also include the legal aspects of formal and informal adoption, foster care and care and the advocacy of child rights in the wider community.

Poverty is the biggest challenge that communities experience in the provision of care and support. Poverty in its wide perspective means many things it away the opportunities to have a life unmarked by sickness decent education a secure home and along retirement.

Poverty steals ones life chances in the future (Alcock, 1997). However, for the sake of understanding and conceptualization and to see its impacts on OVC care and support it would be limited to social and economical handicapped ness and inability of the community caregivers to provide basic needs to orphan and vulnerable children. There has to be mechanism through which a government and non-government organizations participate to at least for the most vulnerable women headed- households and child -headed households that are unable to meet their basic needs because of abject poverty.

Opportunities that communities should exploit and scale up are further expansion and widening of OVC association services so that it would be able to absorb more vulnerable children in the community. Through the association, OVC would easily be accessed and ready to intervention for care and support. The positive attitude that the community has to the OVC Association is another opportunity for development of volunteerism in the community. These opportunities could be exploited for further and extensive outreach care and support programs. The OVC association could bring together the different actors to address the problem. The aspirations and enthusiasm that OVC develop towards the association could be utilized as a strategy that children would involve in solving their own problems.

5.5. The Implication to Social Work Practice

Social work is an empowering profession that facilitates positive change for individuals, groups, family and communities. It is also true that social workers community work are devoted to such underlying principles as social change, social justice, and equality of opportunity for the vulnerable and marginalized segments of the society. If change is to come from below at the community level, mobilizing the community resources and proper functioning of community organizations is very crucial.

In the context of this research on provision of care and support to orphan and vulnerable children, social workers can do several things. One of the critical problems that communities face is undertaking community assessment before intervention of any program that benefits the community. Social workers conduct research on scope and magnitude of OVC problems and distinguish the major gaps that hinder change, identify target groups for care and support and prioritize action accordingly. Social work educates to the needs, and right of children based on the framework of the CRC (Convention on the Rights of the Child) is another aspect of social work practice. Social workers also collaborate with other community organization CBOs, NGOs, CSOs and FBOs in provisions of services for OVC living in the community. Most OVC and caregivers are in need of psychosocial support such as counseling, small self- help group establishment and facilitation of leadership and self- reliance development, which are in concordance with social group work.

Poverty and HIV/AIDS are the two most important factors that cause the plights of OVC and their caregivers living in the community. This has also direct implication for social work practice in alleviating the impact of HIV/AIDS and poverty on the local community in general and OVC and their caregivers in particular. Social workers, for example can design program or a project that addresses and influence the problems of HIV/AIDS in the local context. Social workers can follow up and monitor appropriate service delivery to OVC and their caregivers and Prevention of Mother to Children transition of HIV.

Social workers can facilitate arrangement to foster care and adoption for children who have no one to take care of them in the community context. They also facilitate referral services to OVC beneficiaries who are critically in need of care and support .At the macro-level social workers can influence policy makers and program designers to enact of law, social policy guidelines that have direct impact on community-based interventions for the benefit of

the community in general and OVC and their caregivers. Social workers work on sustainability within the community and alleviate some of the critical constraints that hinder community response to OVC care support.

6. CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

Implicit in this finding is HIV/AIDS and poverty are the leading causes of vulnerability to OVC living in the community. This situation complicates the community response to orphan and vulnerable children. The study confirms that though the extended families as a safety net continue to care for children, the capacity that these families have to absorve more OVC is limited. This is mainly because of abject poverty in most households and the deep-rooted stigma prevalent in most communities. Foster's research findings in Zimbabwe and Malawi also strengthen this arguments and findings (Foster, 2002)

The socio- economic situation that most OVC and their caregivers are experiencing is full of hardships severe and their life chances and choices are very limited. They live in small and meager income where they generate in the informal sector as daily laborers, local drinks sellers and street venders .The heavy burden on OVC care and support lies on women- headed households and siblings of child headed -households. This makes the concern of care and support more complicated and difficult for these groups are already under stress and socially and economically weak and unable to meet their daily needs.

Advocates for children affected by HIV/AIDS point out those efforts to respond to their need are not commensurate to the scale of the problem. The study demonstrated that even though there is awareness to the problem of OVC living in the community, response is generally low. The schools and community organizations as iddirs took initiative and able to

respond to OVC care and support but governmental line departments and faith-based organizations are in the bottom of the response effort to address the problems of vulnerable children in the community. Even though insufficient and discontinued at many occasions, local projects funded by external donors are the main actors in care and support to OVC in the community. The types of support that most caregivers provide to OVC are mainly financial and material and thus do not fit to the minimum package of care and support and comprehensive care and support models recommend. These minimum packages and compressive models suggest that OVC should get, social, economic, medical, legal and psychical and emotional support.

The study yielded that in combating the impact of HIV/AIDS in the community, not one but multi -dimensional and wider approaches that integrate and address the problems of OVC and their caregivers is necessary. Some of these approaches would be community development, community empowerment, community assessment, resource mobilization that should be taken critically and analyzed before designing a certain community-based intervention programs. In mobilizing the community resources, capitalizing of the existing local structures and organizations are very vital for this also ensures ownership and suitability of OVC care and support program. At macro – level there has to be OVC policy, Strategies and guidelines that all stakeholders would utilize for effective care and support. Otherwise, community efforts to address the problem of OVC will follow different lines that in turn degenerate the appropriate management and implementation of local programs and projects (HAPCO, 2005).

The study also revealed that care and support alone does not alleviate OVC problems in the community unless the long lasting and sustainable well being of children is to be affected. This could be possible through integrating prevention and care as inseparable

activities. For example, the prevention programs include prevention of mother to child transmission of HIV (PMTCT), ART to PLWHA, public and mass education of HIV/AIDS and prevention of rural -urban migration of OVC due to poverty.

The research demonstrated that involving OVC as partners in the effort of alleviating their problems is crucial. Children with many problems have also different coping mechanisms. They are, for example, active participants in income security schemes development such as IGAs and work as part time, daily laborer to fill the gap of household monthly expenditure. They are also part of the HIV/AIDS prevention and control effort that community exerts with the long-term goal of reducing the impact of HIV/AIDS on children and families. The study suggests building the capacity of community members to care and support and strengthening local responses is part of the process. For the activation and facilitation of such efforts, scaling up of good practices to other districts and communities is very essential. The case in point is the practice of iddirs and OVC association, which can be taken, are good models that service providers can utilize for better well being of children in the community.

The study also suggests that further research on situation of OVC and their caregivers for the design and implementations of services that focus on children. Currently, the provision of care and support given by local projects has to continue and other new projects are necessary as the number of OVC is increasing at a faster rate than the community response. However, in long run side by side with the implementation of these projects should be community mobilization and increased government's commitment to care for orphan and vulnerable children. The study show that the main challenges that community encountered is its effort to provide care and support emanated from different sources. Individuals, groups, community and national and local governments would solve most of these challenges through

collective effort.

6.2 Recommendations

Based on the finding of the exploratory study in the community and literature reviewed on the issue, the researcher recommends the following.

- Further community assessment and situational analysis in the zone is necessary before intervention of OVC care and support programs and projects.
- Psychosocial support to OVC and their caregivers by service providers and the wider community should be part of every OVC program design.
- Scaling up good practices and replication of successful projects in other woredas of Awi – zone.
- Building the social and economic capacity of extended families and child headed households and ensure better care and support to OVC in the community.
- Linking and networking the existing IGAs of OVC to the formal structure of government and non government agencies and credit institutions and plan for expansion
- Continuous and consistent behavioral change (BCC) education on HIV/AIDS related stigma and discrimination by all stakeholders operating in the area.
- Provision of a separate OVC policy, guideline and enactment of law on the rights of children and PLWHA and its implementation by local government and the community.
- Designing a project for women headed orphan caring households to enable them care for OVC, by NGOs operating in the area.

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ANNEXES

Annex I

Verbal Consent Form for Participants of the Study

Introduction

My name is Yohannes Mekuriaw. I am from graduate school of social work at AAU. I am currently collecting data regarding community response to orphans and vulnerable children in Chagni Town. As part of my assessment, I am talking to a wide cross section of people in the town. I would use the information for fulfill my thesis requirement and to present information to help those concerned bodies to plan activities that will address the identified needs of orphans and vulnerable children.

Confidentiality and consent

I may ask some personal questions that some people find difficult to answer. I am not going to talk to any one about what you tell me. Your answers are completely confidential. Your name will not be written on this form and will ever be used in connection with any of the information you tell me. You do not have to answer any question that you do not want to answer, and you may end this interview at any time you want. However, your honest answer to these questions will help me better understand the present situation of OVC in this town. I would greatly appreciate your help in responding to this study. The interview will take 45minutes to an hour. Would you be willing to participate?

Signature if interviewer_____

(Respondents have given certifying that informed consent verbally)

Annex II. Questionnaire for orphan and vulnerable Children

I.**Background information**

1. Sex (male) (female)
2. age ----------
3. Ethnicity----------
4. Religion----------
5. level of education----------
6. type of respondent ----------

Orphan ( ) vulnerable children ( )

II. **Socio -economics situation of respondents**

1. Are you currently in school? Yes ( ) No ( )
2. If your answer to question (1) is No, why?
   A) Parental death B) academic failure C) Household chores D) others (specify)
3. With whom are you living now?
   A) Parent B) Relative C) Friends D) Other (specify) ----------
4. If your answer to Question. (3) Is relative, what your relationship
   A) Uncle /Aunt B) Grand parent C) Brother /sister D) Brother In- law /sister in -law E) Other (specify) .
5. How many children are living in the household you are a member? ---------
6. Have you been neglected in this household?
   Yes ( ) No ( )
7. If your answer to question (6) is yes , from which members of the household (Don't ask, Circle)
   A) Household head B) care giver C) Other children D) Other (specify)
8. Is you caregiver is employed? Yes ( ) No ( )
9. If your answer to question (8) is, No, what is the source of income for the household?

A) support from other family members B) support form NGOs, C)support from community (CBOs) D) self employed E) Other (specify).

III. Care and Support History

1. Have you ever been provided with care and support services from any organization /institution for the last 5 years? Yes ( ) No ( )
2. If your answer to question (1) is yes, which organization/institution?
   A) CBOs, B) NGOs. C) Government D) civil society Associations E) FBOs F) others (specify)
3. What kind of support did you get from the organization you mentioned?
   A) Financial B) Medical C) vocational (training) D) emotional and Psychological E) other (specify)
4. If your answer to question (3) is finance, how much was it? Write in Ethiopian birr
   A) 50-100 B) 100-150 C) 150-200 D) 200+
5. Was the support enough to meet your daily life Yes ( ) NO( )
6. Using question (3) as a reference , which type of support do you prefer , and why ?

IV. **Coping mechanisms and suggested solutions to the problems**.

1. Have you ever encountered problems in the households you live? Yes( ) No( )Describe type of problem
2. If you answer to question (1) is yes , who helped with this?
   A) Household members B) Religious leaders C) Police D) service providers E) Relatives.
3. What do you feel whenever there exists conflict in the household?
   A) Isolation B) hopelessness C) emptiness E) no feeling

4. What do you do when you encountered problems in the household?
   A) Runaway B) Cry C) ask some one for help D) ask excuse to household? E) Nothing? F) Other specify----------
5. When ever you face, economic problem what do you do?
   A) beg for financial support B) work as a daily laborer C) work on street Vending business D) Other (specify)----------
6. Do you believe that children should be involved in solving their own problems? Yes ( )
   No ( )

7. If your answer to question (6) is yes, in what way would they be involved?
   A) Participate in every aspect of their concerns
   B) Identify their needs C) implement children focused projects D) other (specify) ----------
8. Who do you suggest would be more responsible for children's issues?
   A) Family and relatives B) community C) NGOs D) Government E) children F)If you say more than one, specify----------
9. What do think should be improved in the current care and support practice in this town? (Prove, finical, technical, emotional support)

10. What is your plan to improve your life? (Probe, education, employment,)

11. Who do you think would be the most important for improvement of your life in the future? (Probe relatives, friends, and service providers)

12. Any thing you want to add before we close this session. (Probe for general comments and suggestions).

Annex III. Guide Line for Key Informants Interview.

I. **Background information**

1. Name of organization ----------
2. Type of organization (Gos, NGOs, CBO,) other (specify) ----------.
3. Type of program ----------
4. Legal status ----------
5. Position of the key informant in the organization on ----------
6. Which Kinds of Activities are undertaken by your organization?
---

7. Is your organization involved in care and support for orphan and vulnerable children? if yes , How many children benefited in this program?----------
8. What kind of care and support does your organization provide to OVCs?
   A----------
   B----------
   C----------

9. What kind of support does your organization provide to OVC caregivers?
10. what was the selection criteria employed for OVCs care and support?
    A----------
    B----------
    C----------
11. What selection criteria do your organization used for caregivers support?
    A----------
    B----------
12. How was the involvement of the community ?----------
    ---
13. How do you mobilize the community for care and support to OVCs in this town? ----------
    ----

14. What were the methods employed to mobilize the community care and support for orphan and vulnerable children?
    A----------
    B----------
    C----------
15. Which organizations were your stakeholders?
    A----------
    B----------
    C----------
16. What were the constraints / challenges your organization encountered with regard to care and support to OVCs?
    A----------
    B----------
    C----------
    D----------

17. What opportunities in the community were suitable for such a program? A----------
B----------

18. Which type of care and support do you advocate to OVC in the context of this woreda? (Probe, family, community, intuitional)
A----------
B----------
C----------
D----------

19 In what way does the community be able to provide care and support for OVCs? (Probe the capacity)----------

20 What part of OVCs problems and needs are still not addressed ?----------

21 which types of OVC needs can be addressed by the community?----------

22 what kinds of support are needed for care givers /guardians and OVC currently in this woreda ?----------

23 what strategies you suggest can improve the current care and support for orphans and vulnerable children in this woreda ?----------

24 How could such strategies be participatory and suitable in this community ?----------

25 Do you have any additional comment on OVC care and support and community response in general?----------

Annex IV. Guide Line For In -Depth Interview with Orphan and Vulnerable Children.

I. Background information
   1. Name ----------
   2. Sex ----------
   3. Age ----------
   4. Ethnicity----------
   5. Level of education----------

II. **Family background and life history**.

1. What is the name of the place you are born?
2. How long is the place of birth to the town you are living now?
3. Were your parents legally married?
4. Have your parents been separated or divorced in life?
5. If the answer to question (3) is yes, what were the causes of separation or divorce?
6. How many children do your parents have?
7. Where you went when your parents divorced or separated? (probe , Father , Mother, relatives)
8. Were your parents from rural area?
9. What was their occupation?
10. Were they educated?
11. If your parents died, what is the cause of death?

III Social and Economic situation

1. If your parents were rural origin, why you came to urban area? (probe parents death , education , employment ,)
2. How long you lived in this town.
3. What was your first impression to urban community? (threatened , friendly , cooperative , don't know)
4. Have you inherited resources from your parents?
5. If your answer to question (4) is yes, who administer it? (probe elders siblings , relatives)
6. What kinds of resources you inherit?
7. Who helped you in your first arrival in this town?
8. What were the things you did in your first arrival?

IV. **Current status and future plan**.

1. With whom are you living now?
2. Are you attending school?
3. Who sponsored your education? (Individuals, groups, organizations, community,)
4. If you are not attending school, why not?
5. If you are not attending school, what are you doing?
6. Have you been ill? (Yes) (No),

7. If your answer in question (6) is yes, what was the causes illness? Where did you go for treatment? (Probe, traditional healers, health institutions)
8. Do you have a caregiver?
9. If the answer in question (5) is yes, what is your relationship (probe, parent, relative, adopter, foster care?)
10. Did you get care and support from any organization/ institution, for the last 5 years?
11. If your answer from question (10) is yes, name the organization and kind of care and support you get from those institutions
12. What are the most critical problems you encountered and yet not addressed?

    A.
    B.
    C.
    D.
    E.
13. Who do you think is responsible to solve such critical problems (probe, family, Gos, NGOs, community)
14. How would the urban community be involved in care and support for OVC?
15. What is your plan to improve your life in the future?
16. What do you need to implement such a plan?
17. Any thing you want to add before we close this session.

Annex V. Guideline for Focus Group Discussion (FGD) With Different Community Members, Government Line Department Heads, Service Providers, OVC Caregivers

Number of participants

Male ---------- Female ----------

1. How do you defined orphan and vulnerable children in this community? (probe , age , parents situation) difference between orphan Vs vulnerable children) causes of orphan hood and vulnerability
2. Do you think the problem of OVC is the problem of the community? How? (probe , social , economic psychological crisis)
3. What are the perceived needs of OVC in this community?
4. who in this community is providing care and support to orphan and vulnerable children (probe types of care , capacity of the community , resources mobilization
5. What are the measures taken to address the problem of orphan and vulnerable children in this community?
   At Family level
   At Community level
   By Gos and NGos
6. Which type of care and support for OVC do you appreciate or prefer ?probe, Institutional VS community probe (merits and demerits of the two)
7. What were the constraints, challenges or opportunities of the community in providing care and support to OVC? (probe – constraints and challenges at one time and Opportunities at the other time)
8. How did the community, cope up with these constraints and challenges and utilized the opportunities?
9. What practices with regard to care and support to OVC in this community are models to be scaled, up to other communities? (probe lessons learned ,)
10. What do you suggest for sustainable care and support to OVC in this community? (probe , social , economic , technical capacity of the community

Declaration

This thesis is my original work and has not been presented for a degree in any other university, and that all sources of material used for this thesis have been acknowledged.

Name of student: Yohannes Mekuriaw Abera

Signature _____

Date June 21, 2006

Advisor: Professor Alice Johnson

Signature_____

Date_____