ASSESSMENT OF SOCIOECONOMIC PROBLEMS OF ORPHAN AND VULNERABLE CHILDERN: THE CASE OF BOCHE BORE KEBELE IN JIMMA TOWN

MSW DISSERTATION RESERCH PROJECT PROPOSAL

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Abstract

This study was conducted in Jimma town Boche Bore kebele administration. The general objective of the study was to identify and assess the socioeconomic problem of Orphan and Vulnerable children (OVC) in Boche Bore Kebele of Jimma town.

This study used both qualitative and quantitative approach. Data was collected from sample size of 40 Orphan vulnerable children (OVC) by using systematic random sampling technique and interviewed by a questionnaire. Both primary and secondary data were collected and investigated in detail

The collected data were processed and analyzed using editing and coding. The analyzed data were interpreted in the form of percent, table and charts and discussed; Summary and conclusion was provided.

Finally, the better supposed the identified conclusion and recommendation was given on each problem identified.

Acronyms

AIDS: - Acquired Immune Deficiency Syndrome

ARV: - Antiretroviral treatment

CSA: - Center Statistic Authority

HAPCO: - HIV/AIDS Prevention and Control Office

HCT: - HIV Counseling and Testing

HIV: - Human Immune Virus

MDG: - Millennium Development Goal

MOH: - Ministry of Health

OVC: - Orphan and Vulnerable Children

PEPFAR: - Presidents Emergency Plan for AIDS Relief

PMTCT: - Prevention of Mother to Child Transmission

UNAIDS: - Joint United Nation Program on HIV/AIDS

USAID: - United States Agency for International Development

Table of Contents

Acknowledgement I

ABSTRACT..II

Table of contents III

Acronyms V

Chapter one--1

1. Introduction 1

1.1 Background of the Study--1-4

1.2 Statement of the Problem---4-6

1.3 Objective of the study 6

1.3.1 General objectives.. 6

1.3.2 Specific Objective 6

1.4 Significance of the study... 7

1.5 Scope of the Study 7

1.6 Limitation of the Study 7

1.7 Operational definition 8

1.8 Organization of the paper... 8

Chapter Two---9

2. Literature Review... 9

2.1 Impactof HIV/AIDS --9-10

2.2 Defining OVC--10-12

2.2.1 Shelter and care 12

2.2.2 Legal protection 13

2.2.3 Economic sterngthening 13

2.2.4 Health care--14

2.2.5 Psychosocial Support---14

2.2.6 Education Support---14

2.2.7 Food and nutrition support………………………………………………….15

2.3 Financial impact 16

2.4 Impact on work and school 16

2.5 The impact of HIV/AIDS on welfare…………………………………………………..17
Chapter three 18
3. Research design and methodology……………………………………………………..18
3.1 Research apporch 18
3.2. Study design 18
3.3. population and area 19
3.4 Sampling and sampling size 19
3.5 Method of data collection 20
3.6. Method of data analysis 21
3.7 Ethical consideration 22
Chapter four ---23
4. Data presentation, analysis and interpretation---23
4.1 Findings--23-36
4.2 Discussion--37-38
Chapter Five 39
5.1. Conclusions……………………………………………………………39-40
5.2 Recommendation 41
REFERENCES 4-52

Chapter one

1. Introduction

1.1 Background of the study

For people infected and affected by the epidemic, HIV is not only a medical experience. It is also a social and emotional experience that profoundly affects their lives and their futures. Programming for children orphaned and made vulnerable by HIV/AIDS contributes to the achievement of an AIDS-free generation by responding to the social (including economic) and emotional consequences of the disease on children, their families, and communities that support them.

During the 30 years of the global HIV epidemic, an estimated 17 million children have lost one or both parents due to AIDS; 90 percent of these children live in sub-Saharan Africa. In addition, 2.9 million children under age 15 are living with HIV. Despite some decline in HIV adult prevalence worldwide and increasing access to treatment, the number of children affected by or vulnerable to HIV remains alarmingly high,(Joint United Nations Programme on HIV/AIDS (UNAIDS,2012).

The social and emotional effects of the disease are numerous and profound. While poverty is at the core of many of these issues, HIV/AIDS deeply complicates the environment both for the consequences of and the response to the epidemic. As a result of the social effects of HIV/AIDS, millions of HIV-affected children are highly vulnerable, as they are more likely to be victims of abuse, live in institutional care or on the street, and engage in hazardous and/or exploitative labor. More specifically, children who live with an ill adult or who have been orphaned by AIDS have a dramatically greater risk of abuse and exploitation. School drop-out (as children leave school to care for ill family members), and psychosocial distress. Orphaned and vulnerable children are also far more likely to move from being “affected” by the virus to becoming infected, as well as facing other risks. This is especially true for adolescent girls who have lost a mother and who are then more likely to engage in risky sexual behavior. Children infected by the disease are even more greatly impacted. Where there is no PMTCT program, children are often infected by the virus at birth or soon after. Even with the mother on treatment, HIV negative but exposed children experience delayed cognitive development. Additionally, HIV-positive children sometimes have the compounded tragedy of being rejected by their families and abandoned to

orphanages, further contributing to impaired cognitive and physical development.(Cluver , Orkin , Boyes , Gardner F, Meinck,2011

HIV/AIDS is reversing many of the hard- own development gains in many countries and leaving population more vulnerable to poverty, malnutrition ill health, and mortality. The adverse effects of the AIDS epidemic are felt most severely in some of the world's poorest countries. Like in Sub- sahran Africa where one of its consequences has been an upsurge number of orphan children. More than four-fifths of all children orphaned by HIV/AIDS worldwide live in Sub-Saharan Africa, where every eighth child is an orphan that is, has lost one or both parents (UNICEF, 2003, UNICEF, UNAIDS and USAID 2004, UNICEF and UNAIDS, 2006).

First and foremost, in many countries HIV/AIDS has received improvement in child morbidity and mortality rates achieved during the last several decades. The epidemic influence child survival both directly through mother to child transmission and indirectly through diverting resources and attention away from children to care and treatment of a sick parent. In several sub-saharan African countries, infant and child mortality rates have already risen substantially and are expected to increase further in the coming years (UNICEF, UNAIDS and USAID, 2004)

6.6 million Children under five died in 2012. Almost 75% of all child deaths are attributable to just six conditions: neonatal causes, pneumonia, diarrhoea, malaria, measles, and HIV/AIDS. The aim is to further cut child mortality by two thirds by 2015 from the 1990 level.

Reaching the MDG on reducing child mortality will require universal coverage with key effective, affordable interventions: care for newborns and their mothers; infant and young child feeding; vaccines; prevention and case management of pneumonia, diarrhoea and sepsis; malaria control; and prevention and care of HIV/AIDS. In countries with high mortality, these interventions could reduce the number of deaths by more than half. (WHO, updated September, 2013)

While some countries are on track to meet MDG by 2015, many lag behind, and some have even shown increasing child mortality rates. This multimedia feature shows the progress of the 60 "priority countries," – who together represented 94% of all under-five child deaths in 2004 – in

achieving MDG 4. In-depth, country-specific information on MDG 4 progress is also available through Countdown to 2015: Maternal, Newborn & Child Survival.

The good news is that solutions exist to improve child health and survival. However, a greater worldwide effort, commitment and investment will be needed to bring life-saving interventions to the most vulnerable children, prevent more child deaths, and help all countries reach MDG number 4 by 2015,(Millennium Development Goals,2010 report).

In addition, HIV/AIDS importantly affects children life and the families of children or caregivers. Children of HIV – positive parent suffer from the trauma of sickness and eventual death of a parent and associated hardships. The burden of caring for a sick parent often falls on children, and many are forced to drop out school and take on adult roles as a result. Parental HIV –related illness and death often substantially diminish household resources due to treatment costs and job loss, which often affects children health care and nutritional status.(UNICEF 2003, Case et al. 2004, UNICEF and UNAIDS 2006)

Because HIV/AIDS predominantly attacks people of child bearing age, the impact of this is having on children, extended families, and communities are devastating. If a parent dies of AIDS, the child is three times more likely to die, even though he or she is HIV negative. Besides increased risk of death, children whose parents have died due to HIV/AIDS also face stigmatization and rejection, and often suffer from emotional distress, malnutrition, a lack of health care, poor or no access to education, and most importantly, a lack of love and care. They are also at high risk for labor exploitation, sex trafficking, homelessness, and exposure to HIV. Extended families and communities in highly affected areas are often hard-pressed to care for all the children. In communities hard hit by the double hammer of HIV/AIDS and poverty, there are millions of children who are not orphans, but who have been made more vulnerable by HIV/AIDS, (PEPFAR July, 2006).

With total population of over 73.9 million, Ethiopia is the second most populous country in Africa, more than half (55.5%) of the population is constituted by children below the age of 18 (CSA, 2007). Though the national prevalence of HIV in Ethiopia, estimated to be 2.3%, is considerably lower than rates in other sub-Saharan African countries, the number of people living with HIV and orphans continue to grow. As of 2009, Ethiopia is estimated to have

5,459,139 orphans of whom 855,720 are orphans due to HIV / AIDS (single point HIV prevalence estimate, MOH 2007), one of the largest populations of OVC in Africa. According to Jimma Town Health Office and Women Affairs Office report there are 5000 OVC, in Jimma, and data received from Boche Bore Kebele indicate about 1200 OVC were registered under the kebele administration. Given the context of Ethiopia, majority of OVC, directly or indirectly are vulnerable to HIV/ AIDS and other health, socioeconomic, education, psychological and legal problem. This vulnerability may be linked to extreme poverty, hunger, and armed conflict and child labor practices, among other threats. All of these issues fuel and are fuelled by HIV/AIDS.

Many community based organizations, non government organization, government organization and others different actors have been contributing significant effort in alleviating the problems of Orphan and Vulnerable Children's based on the organizations own initiative and programs. So, to make OVC's support holistic and also need based we have to make this kind of investigation that focuses specifically on them so that it enables us to achieve the desired goal, (HAPCO report, 2010). Therefore this research is designed to assess the socioeconomic problem of AIDS orphan in Boche Bore Kebele.

1.2 Statement of the Problem

The continued increase in international HIV rates is proving devastating for governments heavily affected by HIV/AIDS, not only because their most productive populations are being decimated, but also because the future of these countries and their children is at risk. Governments with significant populations of children orphaned and made vulnerable by HIV/AIDS may be faced with a range of issues, including surging street children populations, increase in child labor, child prostitution and other forms of exploitative work, vulnerability to crime.

In Ethiopia, 5.5 million children, around 6% of the total population, are categorized as orphans or vulnerable children (OVC). OVC comprise almost 12% of Ethiopia's total child population. Over 83% of these OVC are living in rural settings and, of these, 855,720 are children orphaned as a result of the death of one or both parents due to HIV/AIDS. The 2005 Ethiopian Demographic Health Survey estimates that 18% of all Ethiopian households are presently caring for an orphan. On the other hand, Federal HIV Prevention and Control Office (HAPCO)

estimates that there are 804,184 AIDS orphans of age less than 17 in Ethiopia in 2010 (HAPCO, 2010 report).

The impact of AIDS on children is multifaceted. Children who have been orphaned by AIDS may be forced to leave school, engage in labor or prostitution, suffer from depression and anger, or engage in high-risk behavior that makes them vulnerable to contracting HIV. 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 parent are also affected, as health care increasingly absorbs household funds, which frequently leads to the depletion of savings and other resources reserved for education, food, and other purposes (PEPFAR, 2005)

The majority of children orphaned or made vulnerable by HIV/AIDS are living with a surviving parent, or within their extended family (often a grandparent). However, an estimated 5% of children affected by HIV/AIDS worldwide have no support and are living on the street or in residential institutions. Although most children live with a caretaker, they face a number of challenges, including finding money for school fees, food, and clothing. Experts contend that effective responses must strengthen the capacity of families and communities to continue providing care, protect the children, and to assist them in meeting their needs. There are thousands of localized efforts, many of them initiated by faith-based groups, to address the needs of children made vulnerable by AIDS (PEPFAR, 2005)

Children affected by HIV/AIDS need support in a wide range of areas, including economic, material, emotional, health and legal protection. Although a number of organizations seek to meet the needs of children orphaned and made vulnerable by HIV/AIDS, local communities continue to be the primary loci of support for these children. One USAID survey found that 74% of relatives provided food for orphans and vulnerable children, and 19% of they relied on their friends for food. Religious groups were used the remainder of the time (7%), when needed. (PEPFAR, July 2005)

Many children affected by HIV/AIDS in our country are being denied access to better education, health, economic and other basic services because these social services are inadequate and there

are very few social support systems that exist outside of families. A child who has lost his/her mother or parents and is not attached to a caring adult is several times more vulnerable to a childhood disease, malnutrition and the psychological consequences of disharmonious development (Barnett and Whiteside, 2002).

Cognizant of the above idea and the fact that HIV/AIDS is creating an acute socioeconomic crisis in the society, no time can be spared to propagate and mitigate the impact of the spread of

The disease and simultaneously protect HIV/AIDS orphaned children. Despite the magnitude of the problem, their occurrence differs up on different part of the country and hence, it is crucial to try to have a look at the situation of OVC's in the kebele selected for this study in Jimma town particularly Boche Bore kebele. In different time researches have been conducted on AIDS orphan problems and consequence. But this study aims at identifying and assessing the magnitude of AIDS orphan problem and what types of AIDS orphan need support and how to address the unmet needs of AIDS orphan.

In view of the aforementioned reality of the problem, this particular research tries to answer the following basic questions:

1. What are the psychosocial problems of AIDS orphans in /Bocho bore kebele in Jimma?
2. What are the services that are being provided by different organizations to AIDS orphan?
3. What are the unmet needs of AIDS orphan?
4. What are the attitudes of the community towards AIDS orphans?

1.3 Objectives of the Study

1.3.1 General objective

The general objective of the study is to identify and assess the socioeconomic problem of AIDS orphans and the attitude of the community towards AIDS orphan in Boche Bore Kebele of Jimma town.

1.3.2 Specific Objectives

- To assess the problems of AIDS orphans, like, shelter problem, food and nutrition, health and education.
- To investigate the services that is being offered by different organizations to the AIDS orphan in the community.
- To explore the unmet needs of AIDS orphans.
- To assess the situation of AIDS orphans with regard to stigma and discrimination they might face in community.

1.4 Significance of the Study

This study helps to identify and assess the socioeconomic problems that are affecting AIDS orphan in relation to HIV/AIDS. In addition to this it will be helpful as a source of data for persons who will conduct research regarding orphan venerable children (OVC). This study may give the following information.

- The study may serve as source of information for other researcher who wants to study this issue.
- The study was provides useful information about socioeconomic problem of AIDS orphan It is also very significant for the researcher to fulfil the academic requirement for graduation.
- In general, this study is expected to be useful for the parents, OVC themselves, government, non governments organizations, city municipality and etc. will be use as reference.

1.5 Scope of the study

The study was conducted in Jimma town particularly in Boche Bore Kebele. It would be more comprehensive if it had included other kebeles in the town, nevertheless, due to time and financial constraints, the study was limited to only Boche Bore Kebele, those who lost their parents only due to HIV/AIDS. This study mainly focused on the assessment of socioeconomic problems of AIDS orphans

1.6. Limitation of the study

The study faced or encountered some limitation and short comings. The main limitations of the research include:-

- Limitation of field work or lack of sufficient time for field work
- Shortage of budget for the research materials

1.7 Operational definition of terms

- **Socioeconomic impact**

Socioeconomic impact is used in this research to refer to the negative effect of HIV/AIDS on social interaction, livelihood and economic aspect of orphan and vulnerable children. It refers to, the negative effect of the pandemic on holistic aspect of OVC's like their social relation or more of psychosocial attachment, access to social services, and economic (capacity of them in achieving of their different needs) and in general the fulfillment of needs of OVC's to attend their unmet needs.

- **Orphan** is to mean those children under the age of 18 and have lost either or both of their parents and/or guardians due to HIV/AIDS(Guide to mobilizing and strengthen community –led care for OVC, (World Vision,2005).
- **Vulnerable child** is to mean those who are under harsh, unsecured and unsafe condition because of absence or low capability of parents or guardians. (Guide to mobilizing and strengthen community –led care for OVC,(World Vision,2005).
- **Maternal orphans** are children under age 17 whose mothers, and perhaps fathers, have died. (Guide to mobilizing and strengthen community –led care for OVC, (World Vision,2005).
- **Paternal orphans** are children under age 17 whose fathers, and perhaps mothers have died (Guide to mobilizing and strengthen community –led care for OVC, (World Vision,2005).
- **Double orphans** are children under 18 whose mothers and fathers have died
- **Care giver:-** a parent or guardian who is charged with the responsibility for a child welfare (Guide to mobilizing and strengthen community –led care for OVC, (World Vision, 2005).

1.8 Organization of the theses (paper)

The paper is organized under five parts. The first part is the introductory section that deals with the background, statement of the problem, the study approach and methodology, significance and objective of the study; the second part is the review of the related literature. The third research design and methodology and part four presents the analysis,

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Chapter Two

Review of Literature

2.1 Impact of HIV/AIDS

HIV not only affects the health of individual , but also housholds, communites, and the devleopment and economic growth of nations. Many of the countries strike by HIV also suffer from other infection diseases, food inscercurity, and other serious problem. Despit these challangeing , new global efforts have been mounted to address the epidemic, particularly in the last decade, and there are signs that the epidemic may be changing. The number of people newly infected with HIV and the number ofAIDS- related death have declined contributing to the stablization of the epidemic (UNAIDS, 2012).

Globally, an estimated 35.3 (32.2–38.8) million people were living with HIV in2012.An increase from previous years as more people are receiving the life-saving antiretroviral therapy. There were 2.3 (1.9–2.7) million new HIV infections globally, showing a 33% decline in the number of new infections from 3.4 (3.1–3.7) million in2001. At the same time the number of AIDS deaths is also declining with 1.6 (1.4–1.9) million AIDS deaths in 2012, down from 2.3 (2.1–2.6) million in 2005 (UNAIDS, 2013).

The number of people (adult and children's) acquiring HIV infection in 2011 (2.5 million [2.2million-2.8 million] was 20% lower than in 2011, underscoring the importance of continuing and strengthening HIV prevention efforts in the region. In 2012, 1.6 million [1.4 million -1.9 million] people died from AIDS related causes worldwide. This represents a 30% decline in AIDS related mortality compared with 2005 (when 2.1 million [2.1 million -2.6million] deaths occurred). The number of people dying from AIDS-related causes in the sub-Saharan Africa declined by 32% from 2005 to 2011, although the region still accounted for 70%. In addition this young people, ages 15-49 account for approximately 40% of new HIV infection (among those 15 and over). Globally, young women twice as likely to become infected with HIV as their male counterparts, in some areas, young women are more heavily impacted than men. In 2012, the 9.7 million people receiving antiretroviral therapy in low- and middle-income countries represents only 34% (32-37%) of the 28.6 (26.5-30.9) million people eligible in 2013.It is increasingly clear that everyone infected with HIV will eventually need treatment. With an

estimated 35.3 (32.2–38.8) million people now living with HIV, this represents a significant need to scale up HIV testing and treatment, while continuing to invest in prevention and other programmes to combat new HIV infections. (UNAIDS 2013 report on Global AIDS Epidemic).

Ethiopia is among the countries most affected by HIV/AIDS. The overall HIV prevention is 1.5% among the general population. The prevalence among males and females were 1.9% and 1% respectively. According to the 2011 WHO and UNAIDS report 972,209 adults and children living with HIV/AIDS Ethiopia and there are 37,244 new infections. Deaths due to HIV/AIDS account for 67,580 in the country. (UNAIDS 2006 report on Global AIDS Epidemic)

The Jimma zone being the high in populous and it is located in the south western part of Oromiya National regional state. It is bordered with East Wollega zone in the North, with East shawa zone and Southwest Shawa zone in North East, with SNNP administration in the South East and South part, and with Illubabor zone in the West, in 2011, the total adult HIV prevalence in the Jimma zone is estimated at 1.6 % (1.3% among male and 1.9% among female). Coupled with low awareness to HIV/AIDS services and fragmentation of services are barriers to achieve the desired targets in HCT, PMTCT, pediatric ARV and TB/HIV. A myriad other challenges also have limited access to high-quality treatment, care and preventive services. (Jimma zone health office)

2.2 Defining Orphan and Vulnerable Children

Conceptually, a vulnerable child is one who is living in circumstances with high risks and whose prospects for continued growth and development are seriously impaired. In the international community, the term “Orphans and other Vulnerable Children,” or “OVCs,” sometimes refers only to children with increased vulnerabilities because of HIV/AIDS, and other times refers to all vulnerable children, regardless of the cause (e.g., chronic poverty, armed conflict, famine). Since the Emergency Plan focuses on those with increased vulnerabilities from HIV/AIDS, this guidance defines “OVC” in the following way:

A child 0-18 years old, who is either orphaned or made more vulnerable because of HIV/AIDS,.

- Orphan: Has lost one or both parents to HIV/AIDS
- Vulnerable: Is more vulnerable because of any or all of the following factors that result from HIV/AIDS: Is HIV-positive, Lives without adequate adult support (e.g., in a

household with chronically ill parents, a household that has experienced a recent death from chronic illness, a household headed by a grandparent, and/or a household headed by a child),Lives outside of family care (e.g., in residential care or on the streets),Is marginalized, stigmatized, or discriminated against.

The above OVC definition identifies those who are potentially eligible for services, but does not identify those most in need of services. For programmatic decisions, each community will need to prioritize those children most vulnerable and in need of further care. Communities will also need to distinguish which core services each child needs to facilitate his or her age-appropriate development. (PEPFAR, 2006)

Because children develop at varying rates as they age, they can differ greatly in their needs, capacities, and individual vulnerabilities. It is important to address child-development issues through age-specific, child-focused programming that also aims to preserve family structures as much as possible. While there is some variation in how different organizations define these age categories, PEPFAR, 2006)

The concept of AIDS orphans has been gradually expanded to include other children made vulnerable by the HIV/AIDS epidemic. The situation of orphans does not address the full scale of the problem; the HIV/AIDS epidemic and the surrounding poverty intensified by the disease are generating a context where large numbers of children are becoming vulnerable; hence the term "orphans and vulnerable children." According to UNAIDS, vulnerable children refer to children whose survival, well-being, or development is threatened by HIV/AIDS (UNICEF, UNAIDS et al., 2004).

However, vulnerability remains difficult to define. The non-governmental organisation (NGO) World Vision has identified vulnerable children in a context of HIV/AIDS as children who live in a household in which one person or more is infected by HIV/AIDS, dying or deceased; children who live in households that take in orphans; and children who live with persons too old or too young to take care of them (World Vision, 2002).

Other factors relating to vulnerability need to be considered to better define the general aspects of the child's context, such as poverty, access to shelter, education, health facilities or other basic

services, stigma due to HIV/AIDS, and political and socio-economic crisis—all factors that influence vulnerability.

The definition of a vulnerable child is based on indicators of basic needs. Skinner et al. have identified a list of variables to measure vulnerability in children (Skinner, Tsheko et al., 2004) :

- Death or desertion of parents
- Severe chronic illness of parents: HIV/AIDS or others
- Illness of a child
- Physical or mental disability of a child
- Poverty
- Access to basic needs: education, health, social services, etc.
- Inadequate clothing
- Emotional problems
- Abuse of the child
- Drug abuse by caregivers or the child

According the federal democratic republic of Ethiopia, the standard service delivery of OVC contains seven core service areas which are considered critical components of a set of service for programming targeting vulnerable children. The seven service areas include the following. (standard service delivery guidelines for OVC, federal democratic republic of Ethiopia, February, 2010).

2.2.1 Shelter and care

These services strive to prevent children from going without shelter and work to ensure sufficient clothing and access to clean safe water or basic personal hygiene. An additional focus is ensuring that vulnerable children have at least one adult who provide them love and support. The HIV/AIDS epidemic overloads impoverished communities to the point where many children are left without suitable shelter or care. Those children who find themselves without a caregiver become highly vulnerable to abuse and stunted development. While institutional care might seem like a logical response to this situation, in some cases it can impede the development of sustainable solutions and often does not meet the complex needs of children. Given the number of OVCs, particularly in sub-Saharan Africa, and their complex needs, the most effective

responses place families, households and communities at the center of interventions. (The President's Emergency Plan for AIDS Relief Office of the U.S. Global AIDS Coordinator July 2006,standard service delivery guidelines for OVC, federal democratic republic of Ethiopia, February, 2010,)

2.2.2 Legal protection

Theses service aim to reduce stigma, discrimination and social neglect while ensuring access to basic right and service protecting children from violence, abuse and exploitation. The core values of this OVC guidance are rooted in the principles of child protection – developing and implementing programs that place the best interests of the child and his or her family above all else. Thus, programs should include efforts to confront and minimize the reality of stigma and social neglect faced by OVCs, as well as abuse and exploitation, including trafficking, the taking of inherited property, and land tenure (PEPFAR, July 2006).

2.2.3 Economic Strengthening

These services seek to enable families to meet their own needs from an economic perspective regardless of changes in the family situation. OVCs and caretakers often experience diminished productive capacity and cash resources for necessary household purchases. Economic strengthening is often needed for the family/caregivers to meet expanding responsibilities for ill family members or to welcome OVCs into the household. Linking OVCs and their families with programs providing economic opportunities is often an important service. Look for programs that base their economic-strengthening activities on market assessments, and undertake joint efforts with organizations that have strong experience and a high level of expertise in this area. Food and fuel typically absorb the greatest share of household expenditures. Interventions that save household labor and expenses can relieve the burden of diminished capacity and perhaps allow families to allocate resources for more productive, remunerative uses. Maturing children and adolescents need to learn how to provide for themselves and establish sustainable livelihoods. (PEPFAR, July 2006, standard service delivery guidelines for OVC, federal democratic republic of Ethiopia, February, 2010,)

2.2.4 Health care

These services includes provision of primary care, immunization, treatment for ill children, ongoing treatment for HIV positive children and HIV prevention OVC programs must take active measures to meet the general health needs of children at every age level. Programs must disaggregate health requirements and interventions by the age groupings (Infant, toddler, child and adolescent), as the health needs and recommended interventions differ significantly among these groups, and programs should facilitate access to primary health care for OVCs. The President's Emergency Plan for AIDS Relief Office of the U.S. Global AIDS Coordinator July 2006, standard service delivery guidelines for OVC, federal democratic republic of Ethiopia, February, 2010)

2.2.5 Psychosocial support

These service aims to provide OVC with the human relationships necessary from normal development. It also seeks to promote and support the acquirement of life skill that allow adolescent in particular to participate in activities such as school recreation and work and eventually live independently. Healthy child development hinges greatly upon the continuity of social relationships and the development of a sense of competence. HIV/AIDS can undermine the fundamental human attachments essential to normal family life and child development. Children affected by HIV/AIDS suffer anxiety and fear during the years of parental illness, then grief and trauma with the death of a parent. Cultural taboos surrounding the discussion of AIDS and death often compound these problems. Children and their caregivers need love and emotional support, and the opportunity to express their feelings without fear of stigma and discrimination. Programs should provide children with support that is appropriate for their age and situation, and recognize that children often respond differently to trauma and loss. OVCs sometimes turn to drugs and alcohol as a means of coping with this trauma. Programs must provide support to avoid these counterproductive activities.

Many of those who are providing support to others are living with the trauma of HIV/AIDS in their own lives. Psychosocial counseling, rotational duties, and other interventions might be necessary to keep them from burn-out. (PEPFAR, July 2006, standard service delivery guidelines for OVC, federal democratic republic of Ethiopia, February, 2010, Aiddis Ababa)

2.2.6 Education support

Theses service seek to ensure that OVC receive educational, vocational and occupational opportunities need for them productive adults. Research on children and AIDS demonstrates that education can leverage significant improvements in the lives of orphans and other vulnerable children. Schools not only benefit the individual child, but can also serve as important resource centers to meet the broader needs of communities. Schools can provide children with a safe, structured environment, the emotional support and supervision of adults, and the opportunity to learn how to interact with other children and develop social networks. An education is the key to employability and can also foster a child's developmentally important sense of competence. Countries and communities must identify the barriers to education (e.g., requiring a father to register a child, mandatory payments for uniforms, book or tuition fees) and define locally-appropriate strategies for attracting and keeping children, especially girls, in school. Programs must give special attention to the vulnerability of girls, by addressing the disproportionate levels of risk they face when leaving school at an early age. Schools must also be made safe for children, especially girls. In addition, vocational training is an important component of life preparation. Conversely, the lack of opportunity to learn a trade or the lack of a sponsor to enter vocational networks can threaten adolescents' long-term economic prospects.

Partnerships with the education sector provide an important opportunity to ensure that children affected by HIV/AIDS have access to education. Education is an important area for leveraging on national and local levels. (PEPFAR, July 2006, standard service delivery guidelines for OVC, federal democratic republic of Ethiopia, February, 2010, Aiddis Ababa)

2.2.7 Food and nutrition support

These service aims to ensure that vulnerable children have access to similar nutritional resource as other children in their communities. Food and nutritional are important components of OVC support. Malnutrition underlies more than one half of deaths in children under five in developing countries. Lack of food has a serious consequence on a day to day life of OVC in a way that it affects their growth and development, school attendance, and social interaction and ultimately leads to migration. (PEPFAR, July 2006, standard service delivery guidelines for OVC, federal democratic republic of Ethiopia, February, 2010, Aiddis Ababa)

2.3 Coordination of care

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

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

Coordination care is not a service by itself but it is the vehicle through which all the other services are delivered to OVC. In order to ensure quality service provision, partners should be able to monitor children's/ households' receipt of necessary services through linkages and referrals. Coordination of care can be observed at three levels: child/ household level, coordination of care involves assessing needs, planning care for a child or family, monitoring care, and making adjustments to the combination of services when needed. Coordinators of care will usually provide both direct care and referral for services. Effective coordination of care at the point of service delivery requires a great deal of coordination and information sharing at other levels. The following activities must be carried out to enable coordinated care and referral at the household level: community mobilization, service mapping and network building.

2.4 Financial Impact on households

One of the most frequently observed ways in which HIV/AIDS affects households and individuals is through the sudden and tragic loss of income and economic security as household earnings decline and medical expenses increase. Household resources erode quickly while exposure to economic risk is exacerbated by the stress of illness as, first, adults and, then, children become caregivers for sick family members. Owing to the burden of HIV/AIDS, female-headed households generally undergo the most severe distress. In responding to the needs of children who have lost one or both parents to HIV/AIDS, extended families become further impoverished and indebted. Most households have no reserves to pay for a sudden increase in health care expenditures or to Weather a sudden loss in income. As a result, AIDS can cause poor households to dissolve and push no poor households into poverty. Research conducted for the United Nations Development Program (UNDP).

2.5 HIV/AIDS Impact on Work and School

Education is widely seen as critical to social mobility, equality of opportunity, the development process, and poverty alleviation. Children in families affected by AIDS may face reduced opportunities to enjoy the benefits of education. Children, especially girls, are often required to care for AIDS-infected family members and often stay home from school to do so. The death of a parent may further reduce educational opportunities for children. As a result, children's school attendance and educational attainment may suffer. Research has also shown that children are much less likely to complete their education when a parent, particularly the mother, has died. As educational opportunities diminish, the vulnerability of children and youth to HIV infection is expected to increase. HIV/AIDS is causing unprecedented threats to children's well-being, including deepening poverty, the pressure for girls and then boys to drop out of school as financial resources are redirected, the assumption of adult work and care-taking responsibilities, and anxiety and loss of family as siblings are placed with relatives to spread the economic burden of their care. (Behrman and Knowles, 1999).

2.6 The impact of HIV/AIDS on welfare

HIV would affect not only the health of individuals but also the welfare and well-being of households, communities and entire societies. There are undoubted technical problems of how to measure social and economic impacts of excess death as well as illness. Whether countries are with high or low economic development, high or low prevalence rate, AIDS hinders development, exacting a devastating toll on individuals and families. In the most affected countries, it is erasing decades of health, economic and social progress – reducing life expectancy by years, deepening poverty, and contributing to and exacerbating food shortages. Source McElrath, 2002; World Bank, 2004 Bradshaw.et.al, 2002; UNAIDS, 2004; USAID, 2006 UNAIDS, 2005

Chapter Three

3. Research design and Methodology

3.1 Research Approach

The study employed quantitative approach. Quantitative research is research that uses numerical analyses. Quantitative research approach is used to determine the relationship between independent variable and dependent variable in a population, with quantitative methods such as surveys and questionnaires (closed-ended questions). Based on this the researcher uses the methods of questionnaire. Quantitative research is quicker and cheaper to conduct and this methods code data to numerical values so a lot of data can be gathered efficiently.

The functional or positivist paradigm that guides the quantitative mode of inquiry is based on the assumption that social reality has an objective "ontological structure" and that individuals are responding agents to this objective environment (Morgan & Smircich, 1980). Quantitative research involves counting and measuring of events and performing the statistical analysis of a body of numerical data (Smith, 1988). The assumption behind the positivist paradigm is that there is an objective truth existing in the world that can be measured and explained scientifically. The main concerns of the quantitative paradigm are that measurement is reliable, valid, and generalizable in its clear prediction of cause and effect (Cassell & Symon, 1994).

3.2 Study Design

The study was under taken by using a community based cross-sectional study design which is the most commonly used design in social sciences (cite). The design was conducted to identify and assess the socioeconomic problem of AIDS orphan in Boche Bore Kebele of Jimma town.

Quantitative data refer to the information that is collected as, or can be translated into, numbers, which can then be displayed and analyzed mathematically. Quantitative data are typically collected directly as numbers. Some examples include:

- The frequency (rate, duration) of specific behaviors or conditions
- Test scores (e.g., scores/levels of knowledge, skill, etc.)
- Numbers or percentages of people with certain characteristics in a population

3.3 Study Population and Area

The study population was AIDS orphan registered and known under Boche Bore Kebele of Jimma town area who are under the age group of below 18 years old. Jimma town administration is found in the south west of Oromia regional state and located around 355 km far from the capital city Addis Ababa. The town is divided into 13 kebeles. This research was conducted in one of the kebele, Boche Bore. According to the information obtained from Boche Bore kebele administration, the current population of the kebele is 29,428 from these 14,102 females and 15,326 males. And the total of OVC, registered in Boche Bore kebele were 1200 from these 420 were males and 780 were females and from the total number of OVC 120 OVCs were AIDS orphans so that the study focus on AIDS orphan.

3.4 Sampling and Sampling size

The researcher employed probability sampling technique for the survey (quantitative data). The sampling techniques that was used for the study is the systematic random sampling technique because the number of OVCs are already registered and known under selected kebele. In systematic random sampling, the researcher first randomly picks the first item or subject from the population. Then, the researcher selected each n'th subject from the list. The procedure involved in systematic random sampling is very easy and can be done manually. From the total number of orphan vulnerable children registered under Boche Bore kebele 120. The researcher proposes to take 40 AIDS orphan of sample size due to the shortage of financial and time limitation. And the researcher use the following formula S= N/n, therefore, 120/40= 3, based this information the researcher first randomly picks 1, evey 3rd interval was selected from the total number of OVC.

Description: n= Sample size to be selected

S = the nth value of the subject

N= total population of OVC

3.5 Methods of Data Collection; using structured questionnaire

This study used both primary and secondary data collection sources. The primary data was collected through questionnaire. Both open and closed ended question was administered through the questioner respondents. The researcher employed structured interview based on the willingness of the respondents to respond the required information. The research used open ended and close ended questions to collect the data.

A questionnaire is a group or sequence of questions designed to elicit information from an informant or respondent when asked by an interviewer or completed unaided by the respondent. When an interviewer is involved, the questionnaire is sometimes referred to as structured interview. Structured questionnaire is one in which the questions asked are precisely decided in advance. When used as an interviewing method, the questions are asked exactly as they are written, in the same sequence, using the same style, for all interviews. Nonetheless, the structured questionnaire can sometimes be left a bit open for the interviewer to amend to suit a specific context. Main modes of questionnaire administration are face-to-face questionnaire administration, where an interviewer presents the items orally. And the questionnaire administer by researcher.

3.6 Method of Data Analysis

The data analysis begin by restriction and classifying the collected data in to a more meaningful and relevant information Data edition involves the process of examining the collected data to identify error and omissions and to correct them the way they are required. Then, it was arranged in to groups or classes on the basis of common characteristics. The analyzed data was organized in to tables using percentages. A graph was used to put or represent some part of the data. After having the above analysis, a corresponding interpretation was made.

Quantitative analysis is considered to be objective – without any human bias attached to it – because it depends on the comparison of numbers according to mathematical computations. And generates reliable population based and generalizable data and is well suited to establishing cause and effect relationship.

Interpretation and discussion of the data gathered. Finally, the last chapter deals with the conclusion and recommendation of the study.

3.7 Ethical Consideration

In this study the following ethical measures were taken.

- Explanation of the objective and significance of the study was given to the sample population and the kebeles.
- The questionnaire was approved by the advisor.
- Confidentiality of the subjects was ensured before filling the questionnaire. Permission from guardian of the subjects was secured by being notified that their idea will not be exposed and also their taking part in the research it has no any harm on them.

Chapter Four

Data presentation, Analysis and interpretation

4.1 Findings

This section deals with the presentation of the collected data in to meaningful information by using tables, chart and full descriptions. The data was collected from Jimma town Boche Bore Keble dwellers. In this research, the main focus is was to assess the possible socioeconomic impacts of HIV/AIDS on those children who have lost their parents due to HIV/AIDS. To understand this effect the researcher collected data from 40 AIDS orphan. After the data collected it was analyzed in the following way.

4.1.1 Socio- Demographic characteristics.

As part of the socio-demographic characteristics, the age range and sex of the AIDS orphan respondents was considered. This is indicated in Table 1 below.

Table 1, Age and Sex composition of the respondents

		No of respondents	**Percentage (%)**
Age	5-10	6	15%
	11-15	27	67.5%
	16-18	7	17.5%
	Total	40	100%
Sex	Male	19	47.5%
	Female	21	52.5%
	Total	40	100%

Table one, above shows that the majority 27 (67.5%) of the respondents fall within the age group of 11-15, This shows that children are exposed to different challenges before reaching their maturity level. And 7 (17.5%) were the age group of 16-18 and the remaining 6 (15%) fall in between the age group of 5-10. Concerning the sex composition as we have seen from the above table, 19 (47.5%) respondents were males and the rest respondents, 21 (52.5%) were female.

4.1.2 Educational background of the respondents

According to the data collected from children all of the respondents are enrolled in school. This implies that access to education for orphan venerable children and AIDS orphan is better than from other services.

Table 2, The educational level of respondents

Variables	Are you student	Number of respondents	Percentage%
children attending school	Yes	40	100%
	No	0	0%
	Total	40	100%
Educational status of children	Kinden guardian	0	
	Elementary level(1-6)	23	57.5%
	Junior level (7-8)	9	22.5%
	Secondary level (9-10)	8	20%
	Above grade 10	0	-
	Total	40	100%
Which school do you attend	Government	32	80%
	Private	6	15%
	NGO	2	5%
	Total	40	100%

According to table 2, all of the respondents 40 (100%) are enrolled in school. This shows that access to education for AIDS orphan is good. In the other way, level of education of respondents 23 (57.5%) respondents is elementary school, 9 (22.5%) respondents were junior level and 8 (20%) were secondary school. This is indicates that majority of children's the status of education is at elementary level and needs continue support from community, family members and other actors.

Most of the respondents 32 (80%) attended in government school. This indicates that children attended government school maybe because of minimum school fee than private school . And 6(15%) respondents attended in private school and 2(5%) respondents attended in NGO School.

4.1.3 Respondents living condition

The living conditions of respondents were varying from one respondent to the other respondents. The researcher requested different question for respondents and the following table shows that the analysis of living condition of respondents.

Table 3, Respondents living condition

Questions	Categories	Number of respondents	Percentage%
With whom you are living	self	0	-
	sister	2	5%
	brother	6	15%
	Grandmother	8	20%
	aunt	5	12.5%
	Father	6	15%
	Mother	13	32.5%
	Total	40	100%
Who is your care giver	Institution	9	22.5%
	Mother	12	30%
	Father	5	12.5%
	Other	14	35%
	Total	40	100%
How can you explain the affection of your care givers as compared to your parents	Very good	1	2.5%
	Good	29	72.5%
	fair	10	25%
	Not Good	1	2.5%
	Extremely bad	0	-
	Total	40	100%

How many people live together in your house hold?	2	18	45%
	3	8	20%
	Above 3	14	35%
	Alone	0	-
	Total	40	100%
Do you think that the family size affects your life?	Yes	14	35%
	No	26	65%
	Total	40	100%

The above table 3, indicates that most of or 13 (32.2%) respondents live with mother this shows that most of them (respondents) maternal. And 8 (20%) respondents were live with grandmother, from the total respondents 6 (15%) respondents were live with father and 6 (15%) respondents live with brother. The other respondents 5 (12.5%) were live with aunt. Finally, 2 (5%) respondents were with sister.

According to data collected care giver for respondents 14 (35%) were aunt, elder brother, grandmother and sister. From the total respondents 12 (30%) of care givers were mother. And 5 (12.5%) respondents the care givers are father. In addition to these 9 (22.5%) of respondents the care giver is institution. Concerning to affection of respondents care givers as compared to parents are the data shows that 29 (72.5%) respondents answered that the affection is good and 10 (25%) respondents answered fair. And 1(2.5%) of respondents response the affection is not good. Generally the data shows that most of respondents have good relationship with care givers and the degree of affection is good.

The household size was, on average 2-3. On the other hand, 18(45%) respondents live with other family members, 8(20%) respondents live with family members and the remaining 3 (35%) respondents live with relatives. And 14 (35%) respondents answer that the family size affected their life on different issues, like shortage of blanket, insufficient food, bed, toilet and other basic assistance materials.

4.1.4 Socio-economic characteristics

HIV/AIDS epidemic has a paramount impact on human and socioeconomic developments such as clothing and shelter etc. As part of examining the socio-economic situation of the respondents, there was a question forwarded to the respondents to see their housing and ownership condition.

Table 4, Ownership of housing condition of respondents

Questions	Categories	Number of respondents	Percentage%
Where are you living now?	In house	40	100%
	On street	0	-
	Total	40	100%
What is the housing condition of your household	Made from mud	32	80%
	Made from cement	8	20%
	Cottage	0	-
	Total	40	100%
Owner ship of house you reside	Privately owned	18	45%
	Rented from private owner	9	22.5%
	Rented from kebele	13	32.5%
	Total	40	100%
If the house is rented how many cost per month?	Below 50 birr	11	27.5%
	100 – 150 birr	5	12.5%
	Above 200 birr	6	15%
	Total	22	55%
Who pay this rent for you?	Your self	9	22.5%
	Government	-	-
	Relatives	4	10%
	Other (NGO,	9	22.5%
	Total	22	55%
is the house you live in fulfills	Yes	15	37.5%

sanitation facilities (safe water, and latrine)	No	3	7.5%
	either clean water or toilet	22	55%
	Total	40	100

Table 4, shows that from the total respondents 40 (100%) live in house. This indicates that all respondents are not exposed to live in street. But the condition of the house is varying from person to person or one respondent to the other. From data collected 32 (80%) respondents argued that their house is made from mud and the reaming respondents 8 (20%) respond as their house made from cement.

Concerning the ownership of house from the total respondent's 18 (45%) lives in private and 9(22.5%) respondents rented from private owner. The reaming respondents 13 (32.5%) rented from kebele. Respondents who live in rented house 11 (27.5%) pay per month below 50 birr. 5(12.5%) respondents paid from 100 birr to 150 birr per month. The remaining respondents 6 (15%) pay on monthly bases 200 birr and above. And from the total respondents 9 (22.5%) cover the cost of rent by them. And 4 (10%) respondents argued that the cost of rent is covered by relatives. 9 (22.5%) of respondents the cost of rent cover by others that is NGO, friends and sponsorship.

Based on the data collected form respondents only 15 (37.5%) of the respondents live in a house with tap water, toilet and other facilities. But, 3 respondents live in a house with no sanitation service and the rest 22 (55%) have access to either clean water or toilet and use communal toilet in the case of absence of toilet. Speculation

Table 5, Economic aspects of respondents

Questions	Categories	Number of respondents	Percentage%
What was your family main source of income before the death of your parents?	From employment	27	67.5%
	Own business	-	
	From relative	-	
	From organization support	-	
	Petty trade	7	17.5%
	Others	6	15%
	Total	40	100%
What is your main source of income currently?	From employment	5	12.5%
	Own business	12	30%
	From relative	-	-
	From organization support	15	37.5%
	others	8	20%
	Total	40	100%
Are you currently receiving any economic support from different actors?	yes	17	42.5%
	No	23	57.5%
	Total	40	100%
Who provides the support	Relatives	-	
	Neighbors	-	
	friends	-	
	kebele	2	5%
	NGO	15	37.5%
	Total	17	42.5%
What kind of support received	clothes	4	10%
	food	14	35%
	shelter	-	-
	Education support	16	40%

	Total	34	85%
Did you receive seed money (working capital)	Yes	1	2.5%
	No	39	97.5%
	Total	40	

From total, 27 (67.5%) of the interviewed respondents reported that, before death the source of income of the families was employment. The employment place could be either government or other private organizations. 7 (17.5%) respondents before death they are deploy in petty trade business. The other respondent's family's 6 (15%) earn income before death from daily laborer and house made.

After death of families of respondents the source of income is changed. This was further explained by respondents 5(12.5%) earn of income from employment which is they employed private business sector .And 12(30%) respondents from own business. 23 (57.5%) of respondents from support of NGO, relatives, friends. The below chart shows that families income before death and after death

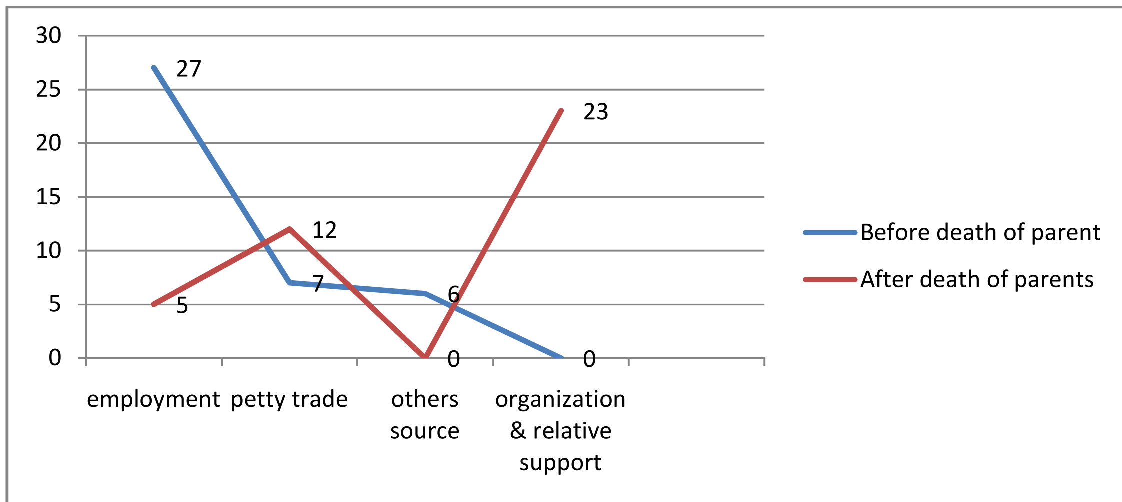

fig.1 family income before and after the death of parents

17(42.5 %) respondents receiveed economic support from different actors and the remaining respondents (23) or (57.5%) didn't get any economic support from any organ. And 15(37.5%) respondents obtain economic support from NGO and the remaining respondents 2(5%) received from kebeles. In addition to this 4 (10%) respondents have received clothing support and 14 (35%) respondents received food support. The other respondents (16) (40%) receive education

support. the other issues is about seed money support 39 (97.5) respondents not received any seed money support and only 1(2.5%) respondent received seed money from NGO.

4.1.5 Food and nutrition support

Food and nutrition support need is almost universal among the OVC and their families. All respondents got food three times per day. But the problem of food and nutrition has been clearly reflected in the research when beneficiaries were asked about adequacy of their household food. Lack of food has a serious consequence on a day to day life of OVC in a way that it affects their growth and development, school attendance, and social interaction and ultimately leads to migration.

Table 6 food and nutrition support of respondents

		Number of respondents	**Percentage%**
Where did you get food support?	Relatives	19	36.5%
	neighbors	11	21.1%
	Friends	10	19.2%
	kebele		
	NGO	12	23%
	Total	52	100%
How do you assess adequacy of food supply in your house?	Not enough	12	30%
	Barely enough	24	60%
	Just enough	4	10%
	Excess	-	
	Total	40	100%

The above table shows that 19 (36.5%) of respondents received food and nutritional support from relatives and 11 (21.1%) and 10 (19.2%) of respondents they have got food support from near neighbors and friends respectively. The remaining respondents 12(23%) received food from non government organization. Concerning on adequacy of food supply the respondents answered that 12(30%) of respondent not got enough food, this indicates that food intake of their own family has not improved/not enough both in quality and frequency. And 24 (60%)

respondents said that barely enough food and the remaining four respondents 4(10%) said just enough.

4.1.6 Psychosocial support

Children suffer anxiety and fear during the years of parental illness, then grief and trauma with the death of a parent. Children need love and emotional support, and the opportunity to express their feelings without fear of stigma and discrimination.

Table 7 psychosocial support of respondents

Question	Category	Number of respondents	Percentage%
Who do you talk or to whom can you go for support when you have encountered some troubles or things get different in your life.	Guardian	19	36.5
	Relatives	8	20
	Friends	15	28.9
	teachers	8	15.4
	Brothers/sisters	2	3.8
	Total	52	100%
Do you receive any psychosocial counseling?	yes	18	45%
	No	22	55%
	Total	40	100%
Who provide you counseling?	Health workers	11	27.5%
	Teachers	3	7.5%
	CBO leaders		
	Kebele leaders		
	Others (friends, relative etc	4	10%
	Total	18	
How can you explain	Very good		

the interaction between you and non AIDS orphan?	Relatively good	40	100%
	bad		
	Extremely bad		
	Total	40	100%

Psychosocial supports have paramount importance for AIDS orphans in order to help them overcome different stresses and anxiety. Nineteen respondents interview got counseling and psychological support from guardians. And other respondents 8(20%) got support from relatives and respondents with friends as peer to peer counseling. They cope up their challenges so that 15(28.9%) respondents have been receive psychological support. Teachers also contributed to orphan and venerable children psychological support in school and 8(15.4%) of respondents have got the support from teachers. The remaining respondents 2(3.8%) receive the psychological support from family members which is from brothers and sisters.

In addition to this, 18(45%) respondents they have received psychosocial counseling and the other 22 (55%) didn't receive any psychosocial counseling. Majority of the respondents 11(27.5%) receive counseling from health works and others respondents 3 (7.5%) receive counseling from teachers and the remaining respondents 4 (10%) received counseling from other actors. The interaction between AIDS orphan and non AIDS orphan is relatively good and all of the 100 respondents had good interaction with non AIDS orphan.

4.1. 7 Education support of respondents

Education is very important indicator which can determine effectively the living condition of children in a given society. It enables persons to contribute in development and empowerment of their life for themselves.

Table 8 Education support of respondents

Variables		**Number of respondents**	**Percentage%**
Did you receive any educational supports from different actors?	yes	30	75%
	No	10	25%

	Total	40	100%
Who provide you educational support	Guardian	10	25%
	relative	13	32.5%
	Friends	9	22.5%
	Teachers	3	7.5%
	Brother /sisters	5	12.5%
	Total	40	100%

Education is vital for OVC and the above table shows that 30 (75%) of respondents received educational support from different actors which is exercises book, pen, pencil and uniform, And 10 (25%) of respondents didn't receive school support from any actors. And educational support providers were guardian, relative ,friends ,teachers, and brother/sisters and based on interview 10(25%) respondent received school support from guardian, 13(32.5%) of respondents received from relative, 9 (22.5%) of respondents received from friends, 3(7.5%) of respondents received from teachers and the other respondents receive school support from brother /sisters.

4.1.8 Social and legal aspects of respondents

Social and legal protection support have aim to reduce stigma, discrimination and social neglect while ensuring access to basic rights and services protecting children from violence, abuse and exploitation.

Table 9 Social and legal aspects of respondents

		Number of respondents	**Percentage%**
How can you explain the access to different facilities in your school because of being AIDS orphan?	Limited access to library as compared to others	0	
	Sharing a sit in a classroom with others is difficult as compared t others	0	

	There is no difficulty in accessing everything	40	100%
	Difficulty of accessing involvement in extracurricular activities as compared to others	0	
	Low access to play ground with others	0	
	Total	40	100%
Is there any problem you are facing in accessing proper social service in the community (such as education health care shelter, nutrition, clothing and others)?	yes	10	25%
	No	30	75%
	Total	40	100%
How do you see the general knowledge, attitude and perception of your friends and neighbors towards HIV/AIDS as well as OVC?	Very good	1	2.5%
	Good	33	82.5%
	No idea	3	7.5%
	Poor	3	7.5%
	Total	40	100%
Do you get any sort of human right and/or life skill training from any source ?	Yes	14	35%
	No	26	65%
	Total	40	100%
Have you encountered any legal problem?	Yes	0	-
	No	0	-
	Total		
Have you referred or linked to any legal service ?	Yes	0	-
	No	0	-
	Total		

10(25%) of the respondents have a challenge of social problems such as education, health care, shelter and food but the other respondents 30(75%) do not have a problem access to different service. Concerning general knowledge, attitude and perception of respondents friends and neighbors towards HIV/AIDS, 33 (82.%) of the respondents and 1(2.5%) of respondent respond very good, 3(7.5) of respondents argue poor and the remaining respondents 3(7.5) don't have idea regarding to the question raised.

Legal protection and life skill training aim to reduce stigma, discrimination and social neglect while ensuring access to basic rights and services protecting children from violence, abuse and exploitation. 14 (35%) of respondents have accessed different legal protection and life skill training. 26 (65%) of respondents not access any training on legal protection and life skill training.

4.2 Discussion

Orphans and Vulnerable children and AIDS orphan are those who need care and support from the community.. HIV/AIDS also have brought catastrophic effects on developing countries like Ethiopia. To reach those Orphans through different basic support and needs, community based, governmental and nongovernmental organizations role is found to be vital.

The objective of this study is to identify and assess the socioeconomic problem of AIDS orphans in Boche Bore Kebele.

By using structured interview the data was collected on area which identify and assess the socioeconomic problem of AIDS orphans on living condition, ownership of hosing, economic aspect, food and nutrition, psychosocial aspects, education aspects, and social and legal aspects of AIDS orphan.

For this study the researcher offer AIDS orphan received educational material and the majority AIDS orphan attended in government school. And as part of economic support different actors has been providing training and provide to AIDS orphan start up cost to start own business and they started business.

Psychosocial support, this service aims to AIDS orphan with the human relationship necessary for normal development. It also seeks to promote and support the acquirement of skill that allow adolescents in particular to participate in activities such as school, recreation and work and eventually live independents. The result of this study showed that, almost all AIDS orphan have receiving psychosocial support from different actors.

Food and nutrition support need is almost universal among the OVC and their families. All respondents got food three times per day. But the problem of food and nutrition has been clearly reflected in the research when beneficiaries were asked about adequacy of their household food. Lack of food has a serious consequence on a day to day life of OVC in a way that it affects their growth and development, school attendance, and social interaction and ultimately leads to migration.

Based on my finding on adequacy of food supply the respondents answered that not got enough food, this is indicates that food intake of their own family has not improved/not enough both in quality and frequency.

Regarding, to social and legal aspects, these service aims to reduce stigma, discrimination and social neglect while ensuring access to basic right and service protecting children from violence, abuse and exploitation. The result of this study showed that, AIDS orphan have a challenge of social problem.

Generally there is difference in living conduction among AIDS orphan (respondents). Based on my finding children live in home and the conduction of the house is varying from person to person majority children house made from mud. In addition to this the size of family also various aspects and it is small family size that have better living conditions than large family size.

Chapter Five

Conclusion and Recommendation

5.1 Conclusion

The major findings of this study indicated that HIV/AIDS is not a health problem alone rather it is a complex Social, economic, medical, political, and human rights problem. Considering this, the study takes a closer look at the challenges faced by AIDS orphans and what they need to compressive support. As a result the study identified that AIDS orphans lack not even proper but the least basic needs which are crucial for survival.

The major emphasis of the study was the socio-economic dimensions of the HIV/AIDS impact on AIDS orphans. In this regard, major socio-economic issues that aggravated the problems and inhibited AIDS orphans from social services in accordance with the objective were identified.

- The socioeconomic determinants like Food, Shelter & clothing, Nutrition, medication, psychosocial support, legal issues and education, are not properly and sufficiently addressed.

- NGO's involved in the orphan services provide scholastic support and medication fully for half of the OVC's in the school, sanitation materials and food in limited way for very little number but, all the services provided are not in accordance with the standard set and are not in full component.

- In addition, lack of proper support from their care givers or guardians as well as community members is not adequate. Also the support given from the organizations in most cases is not adequate, qualitative and well-coordinated.

The major emphasis of the study was the socio-economic magnitude of the HIV/AIDS impact on AIDS orphans. In this regard, major socio-economic issues that provoked the problems and inhibited AIDS orphan health and social services in accordance with the objective were identified. Majority of AIDS orphan, directly or indirectly are vulnerable to HIV and AIDS and other health, socioeconomic, education, psychological and legal problem. Based on this finding 13 (57%) children live with mother and 8(20%) of respondents live with grandmother. This implies that women are highly suffered to care their children. According to this finding after

death of families of respondents the source of income is changed. This was further explained by respondents 23 (75.5) earn of income supported by NGO.

Different governmental and private actors and NGO's engage on support of AIDS orphan in the community particularly in the research area. But the given service and support by actors is limited. Many children have significant problems of getting adequate food; clothe health care, economic and other service due to loss of their parents and lack of person who look for them. Particularly the head of the household and the guardians are facing difficulties in providing food for the family members. Based on this finding respondents answered that 12(30%) of respondent not got enough food. This is indicates that food intake of their own family has not improved/not enough both in quality and frequency. This is the most common form of difficulty they are facing and forced to spend much of their time looking for piece of work to provide food for the household.

Psychosocial support have paramount importance for AIDS orphan in order to help them overcome stresses, grow health and grow into self reliance and socially achieve in their life. Based on this finding 22(55%) didn't received any psychosocial counseling

Now the day's communities at grass root level have good knowledge about HIAV/AIDS. In the case of stigma and discrimination although it can be said it is decreasing there is a tendency of the orphans to isolate themselves during different social interactions. Based on this finding 33 (82%) of respondents have good knowledge attitude and perception of respondents friends and neighbors towards HIV AND AIDS.

In general, socioeconomic problems of AIDS orphans in the community are not adequately addressed according to standard service delivery guidelines for OVC.

5.2 Recommendation.

Based on the findings and taking in to account the fact that no fundamental change can be made to the standard service given to OVC, the following are doable recommendations.

- Majority of the AIDS orphan needs comprehensive package of care and support which may include several of the seven service(education , psychosocial support, economic strengthening, food and nutrition , health care, legal protection , shelter and care)
- More intensify capacity building supports for the community is required to enable them support orphan and vulnerable children and also for the sustainability of the ownership. This can be through providing more training for kebele leaders and other community leaders.
- Provide training on anti-stigma education for community and the education particularly aimed to reducing the stigma faced by HIV/AIDS orphan.
- Involvement of AIDS orphan in IGA is crucial to reduce dependency and to build their dignity and self-esteem
- Increasing communities understanding through providing capacity building training of and action on the socioeconomic needs of children and older OVC and the responsive roles community members can take to improve socioeconomic wellness.
- Any effort of alleviating socio-economic problem of AIDS orphans by concerned actors including government institutions, non-government and community based organizations, international institutions, religious institutions and individuals should consider the involvement of the OVC's in order to achieve set goal.
- Adequate access to basic necessities, education, health care and other social services should be provided to AIDS orphans by different organizations and other concerned bodies in order to ensure a bright future for them and to help them become economically and socially active adults.
- Establish strong referral linkage system should be put in place with health facilities, NGO and kebele to facilitate free access of OVC and families to health services.

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Dear Respondents, this questionnaire is designed to assess the socioeconomic problems of AIDS orphans. Therefore, the intention is to collect the necessary information and data on the topic so as to contribute to the solution. Understanding this fact you are kindly requested to provide honest and reliable answers to the questions presented.

We would greatly appreciate your help in participating and giving your time. The information collected in this study will remain confidential. We are not interested to know your name or anything that can be connected to your identity except information you tell us.

Instructions

1. Do not write your name and please give as possible as accurate answers to the following questions accordingly:

2. For the questions with possible choice please chooses the answer by making a tick " ✓" in the box and for questions with a given blank space please put your possible answer briefly.

1. Background information

1. Age ☐

A. 5-10 ☐

B. 11-15 ☐

C. 16 -18 ☐

2. Sex ☐

A. Female ☐

B. Male

3. Are you a student?

A. Yes ☐

B. NO ☐

C. If No why? ______________________

4. If yes what is your education status?

A. Read and answer

B. elementary level (1-6)

C. Junior level (7-8)

D. secondary (9-10)

E-Above grade 10

5. Which school do you attend?

A. Government

B. private

C. NGO

D. Other

6. With whom you are living now?

A. Self

B. sister

C. Brother

D. grandmother

E. Aunt

F. Father

G. Mother

H. If other specify________________________________

7. Who is your care giver?

A. institution

B. mother

C. father

D. if other specify_______________________________________

8. How can you explain the affection of your care givers as compared to your parents?

A. Very Good

B. Good

C. Fair

D. Not Good

E. Bad

F. Extremely bad

9 How many people live together in your house hold?

A. 2 ☐

B. 3 ☐

C. above 3 ☐

D. Alone ☐

10. Do you think that the family size affects your life?

A. Yes ☐

B. No ☐

If your response is yes how? Explain

____

____

____

2. Questions regarding Shelter aspects

11. Where are you living now?

A. In house ☐

B. On Stree☐

12. If live in street why? ________________________

13.. If live in house what is the housing condition?

A. Made from mud ☐

B. Made from cement. ☐

C. Cottage ☐

D. If other specify________________________________

14. Owner ship of house

A. Privately owned ☐

B. Rented from private owner ☐

C. Rented from kebele ☐

D. Other (specify) ___________

15. If the house is a rented one how much you pay per month?

A. Below 50 birr ☐

B. 100-150 birr ☐

C. Above 200 birr ☐

16. Who pay this rent for you?

A. Your self ☐

B. Government ☐

C. Relatives ☐

D. If other specify____

17. is the house you live in fulfills sanitation facilities (safe water, latrine, and other)

A. yes ☐

B. No ☐

3. **Questions regarding economic aspect**

18.-What was your family's main source of income before the death of your parent/s?

A. From employment ☐
B. Own business ☐
C. From relative ☐
D. From organizations support ☐
E. Petty trade ☐
F. If other specify____

19.. What is your main source of income after the death of your parent/s?

A. From employment ☐
☐

B. Own business

C. From relative

D. From organizations support

E. If other specify____

20 . Are you currently receiving any economic supports from different actors?

A. yes

B. no

21 .if ' yes, who provides the support?

A. Relatives

B. Neighbors

C. Friends

D. Kebele

E. NGO

F-Other _____________

22. What kind of support

A. Clothes

B. Food

C. Shelter

D. Education material

E.If other specify ____

23 Did you receive seed money (working capital)

A. yes

B. no

24. if ' yes, who provides the support?

A. Relatives

B. Neighbors

C. Friends

D. Kebele

E. NGO

4. Questions regarding food and nutrition aspects

25. Currently how often do you have a meal per day? Write number _______

26 Where did you get food support?

A. Relatives ☐

B. Neighbors ☐

C. Friends ☐

D. Kebele ☐

E. NGO ☐

F.If other specify____

27. What is your current daily menu? (List the daily food items)

____

____

____

____

28. How do you assess adequacy of food supply in your house?

A. not enough ☐

B. barely enough ☐

C. Just enough ☐

D. Excess ☐

5. Questions regarding psychological issues

29. Who do you talk to or from whom can you get support when you have encountered some trouble or when things get difficult in your life

A. Guardian ☐

B. relative ☐

C. friends ☐

D. teachers ☐

E. Brothers/sisters. ☐

F.If other specify _____________________________

30. Did you receive any psychosocial counseling?

☐

A. yes

B. No ☐

31 Who provide you counseling?

A. Health workers ☐

B. teachers ☐

C. CBO leaders ☐

D. kebele leaders ☐

E- Religious figures ☐

F. others_______

32. How can you explain the interaction between you and none AIDS orphan

A. Very Good

B. relatively Good

C. Bad

D. extremely bad

33. If you answer number 31 is C and D why? Please explain the reason

____

____

____

6. Questions regarding education support aspects

34. Did you receive any educational supports from different actors?

A.Yes ☐

B. No ☐

35. Who provide you educational support? (you can provide more than one answer)

A. Guardian ☐

B. Relative ☐

C. Friends ☐

D.Teachers ☐

E. Brothers/sisters. ☐

36. What are the main educational problems that you encountered as a result of the death of your parents?

____

____

____

____

7. Questions regarding social and legal aspects

37. How can you explain the access to different facilities in your school because of being AIDS orphan? (you can provide more than one answer)

A. Limited access to library as compared to others ☐

B. Sharing a sit in a classroom with others is difficult as compared to others ☐

C. There is no difficulty in accessing everything ☐

D. Difficulty of accessing involvement in extracurricular activities as compared to others ☐

E. Low access to play ground with others ☐

38.. Is there any problem you are facing in accessing proper social services in the community (such as education, health care, shelter, nutrition, clothing and other, services from Ider, services from religious institutions)? (I think you need to prepare question for each item in the bracket e.g. education, health services, etc)

A. Yes ☐

B. No ☐

39. If yes, what is the reason? (for each of the issues I indicated earlier)

____

____

____

____

40. How do you see the general Knowledge, attitude and perception of your friends? and neighbors towards HIV/AIDS as well as AIDS orphan s?

A. Very good ☐
B. Good ☐
C. no idea ☐
D. Poor ☐

41. Where did you go or whom did you ask for support when you encountered any problem in relation to your legal right? What supports received in this regards?

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42. Do you get any sort of human right and/or life skill training from any source

A. Yes ☐
B. No ☐

43. Have you encountered any legal problem

A. Yes ☐
B. No ☐

44. Have you referred or linked to any legal services

A. Yes ☐
B. No ☐