ASSESSING THE MULTI-SECTORAL RESPONSE OF HIV/AIDS-THE ROLES OF HIV/AIDS COMMITTEE ON PROVISION OF CARE AND SUPPORT WITH SPECIAL EMPHASIS IN CARING HIV/AIDS ORPHAN AND VULNERABLE CHILDREN-CHALLENGES AND PROSPECTS-THE CASE OF FITCHE TOWN

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Annexure VII

CERTIFICATE

This is to certify that Mr. Ajema Gondel student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for his Project Work for the Course MSWP-001.

His Project Work entitled ASSESSING THE MULTI-SECTORAL RESPONSE OF HIV/AIDS-THE ROLES OF HIV/AIDS COMMITTEE ON PROVISION OF CARE AND SUPPORT WITH SPECIAL EMPHASIS IN CARING HIV/AIDS ORPHAN AND VULNERABLE CHILDREN-CHALLENGES AND PROSPECTS-THE CASE OF FITCHE TOWN which he is submitting, is his genuine and original work.

Place: ……………………………………… Signature……………………………

Date: ………………………………………

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Annexure VI

DECLARATION

I here declare that the dissertation entitled ASSESSING THE MULTI-SECTORAL RESPONSE OF HIV/AIDS-THE ROLES OF HIV/AIDS COMMITTEE ON PROVISION OF CARE AND SUPPORT WITH SPECIAL EMPHASIS IN CARING HIV/AIDS ORPHAN AND VULNERABLE CHILDREN-CHALLENGES AND PROSPECTS-THE CASE OF FITCHE TOWN submitted by me for the partial fulfillment of the MSW to Indira Gandhi National Open University, (IGNOU) New Delhi is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirement for any other program of study. I also declare that no chapter of this manuscript in whole or in part is lifted and incorporated in this report from any earlier work done by me or others.

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CONTENTS

Acknowledgement……………………………………………………………………….i
Contents……………………………………………………………………………ii
Abstract……………………………………………………………………………iv
List of Acronym………………………………………………………………………..vi
INTRODUCTION………………………………………………………………….. .1
1.1Background…………………………………………………………………...1
1.2 Statement of the problem………………………………………………………….3
1.3 General Objectives of the study…………………………………………….......5
1.4 Specific Objectives of the study……………………………………………….......6
1.5 Research Questions……………………………………………………………..6
1.6 Significance of the study……………………………………………………......6
2. LITERATURE REVIEW…………………………………………………………9
2.1 An Overview of HIV/Aids-A global threat……...…………………………………...9
2.2 HIV/AIDS and its Impact on orphan and vulnerable children …………………….... 9
2.3 Response to OVC Care and Support……………………………………………..11
2.4 System and Structure……………………………………………………………..13
2.5 Family-centered Approach to OVC Care and Support……………………………..14
2.6 Service Components and Quality Dimensions……………………………………...15
2.7 Conceptual Framework……………………………………………...............17
2.6.1 Community based care and support………………………………………………17
2.6.2 Care and support model…………………………………………………………..18
3 .METHODOLOGY……………………………………………………………20
3.1Organization of the fieldwork……………………………………………………….20
3.2 Study Design…………………………………………………………………….20
3.3 Description of the study Area/Universe of the study …………………………21
3.4 Study Participants………………………………………………………………..22
3.5 Sample Size Determination and Sampling Procedure…………………………….. 22
3.6 Sources of Data………………………………………………………………… 23
3.7 Data Collection Techniques……………………………………………………...23
3.8 Data collection Tools……………………………………………………………….24
3.9 Data Analysis and interpretation…………………………………………………26
3.10 Consent and Ethical consideration during Data Collection and Analysis…………26
3.11 Operational Definition of the Study………………………………………………27
3.11 Limitation of the study ………………………………………………………………28
4. FINDINGS AND DATA PRESENTATON……………………………………...29
4.1 Results from OVC Respondents…………………………………………………….29
4.1.1. Profile of Respondents (OVC)……………………………………………………29
4.1.2. Socio-economic Situations of OVC Respondents…………………………31
4.1.3 Community Resource mobilization, Care and Support for OVC…………….......34
4.1.4 Care and Support ……………………………………………………………....36
4.2 Results from Key Informants and FGDs Response……………………………….....41
4.2.1 Background information……………………………………………………………..41

4.2.2 Level of key informants and focus group discussion Participants'………...42

4.2.3 Care and Support to OVC……………………………………………………………44

4.2.4 Challenges and Opportunities in Care and Support Provisions…………………...46
4.3 Case Illustrations………………………………………………………………… 49
4.4 Observation…………………………………………………………………………….54
5. DISCUSSION……………………………………………………………………...56
5.1 The impact of HIV/AIDS on OVC and caregivers …………………………….56
5.2 Provision Care and support to OVC-Options and Models …………………………56
5.3 Care and support provided to OVC………………………. ……………………..58
5.4 Strengthening Social Capital……………………………………………………..61
5.5 Multi setoral response-roles and responsibilities in care and support………………63
5.6
6 CONCLUSION AND RECOMMENDATIONS…………………………………...68
6.1 Conclusion………………………………………………………………………..68
6.2 Recommendations………………………………………………………………..70
REFERENCES………………………………………………………………… 73
ANNEXES ………………………………………………………………………..75

ABSTRACT

The impacts of HIV/AIDS, in Africa in general, and sub Sahara Africa including Ethiopia, in particular, is tremendous. In most countries including Ethiopia, OVC infected and affected by HIV are among community members who need essential care and support services. Despite the efforts exerted by stakeholders that have been involved in providing care and support services, one could not be naïve to assume that the problems associated with HIV and AIDS or even OVC have been controlled. 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 the prevailing community response, structures, particularly roles, challenges and prospects/opportunities of HIV/AIDS committee. Its purpose is to collect and analyze data on the responses of community and roles of HIV/AIDS committee in the provision of care and support with special emphasis on roles and responsibilities of HIV/AIDS committee in caring orphan and vulnerable children infected and affected by the HIV/AIDS. The study was conducted in Fitche town of North Shewa Zone of Oromia Regional State. The methods employed are both quantitative and qualitative, utilizing data collection techniques such as interviews with key informants drawn from GOs and NGOs, focus group discussion with OVC caregivers and HIV/AIDS committee members. Self administered questionnaires were filled-out by OVC. The research methods also include two case interviews with OVC and field observation. The main findings suggest that HIV/AIDS problem of OVC is relatively high in the study area, 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. 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 initiatives, mainly donors' support, exist. The types of care and support provisions are mainly educational materials; other services critical minimum services are not, generally, provided adequately. The main challenges that encountered in providing care and support to OVC care and support are stigma and discrimination, poverty and lack of adequate knowledge in OVC guideline and unclarity on the roles and responsibilities of the HIV/AIDS committee.

The research demonstrated that involving OVC as partners in the effort of alleviating their problems is crucial. It suggests building the capacity of community members to care and support and strengthening local responses is part of the process. The study concludes that 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. 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 secured. Some of these approaches would be community development, community empowerment, and community assessment, resource mobilization that should be taken critically and analyzed before designing a certain community-based intervention programs focusing OVC.

LIST OF ACRONOMY

ACRWC	African Charter on Rights and Welfare of Child
AIDS	Acquire Immuno-Deficiency Syndrome
ART	Antiretro Viral Therapy
CBOs	Community-Based Organizations
CRC	Child Rights Convention
FBOs	Faith-Based Organizations
FHAPCO	Federal HIV/AIDS Prevention and Control Office
GOE	The Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
LNGOs	Local Non Government Organizations
MARPs	Most At Risk Populations
MCH	Maternal and Child Care
MOH	Ministry of Health
MOWCA	Ministry of Women and Children Affairs
MOWA	Ministry of Women Affairs
NGOs	Non Government Organizations
NPHHC	Nutrition Plus Holistic Home Care
HAPCO	HIV/AIDS Prevention and Control Office
OVC	Orphan and vulnerable Children
PLHIV	People Living With HIV
PMTCT	Prevent the Transmission of HIV from Mothers to their Children
SWAAE	Society for Women and AIDS in Africa-Ethiopia
UN	United Nation

UNAIDS	United Nation AIDS
UNICEF	United Nation Children Education Fund
USAID	United State of America for International Development
VCT	Voluntary Counseling and Testing
WFP	World food Programme
WHO	World Health Organization

1. INTRODUCTION

1.1. Background

The Global HIV/AIDS progress report of (WHO & UNAIDS, 2011), indicates that annual number of people newly infected with HIV continues to decline, although this varies strongly between regions. For example, in 2010, an estimated 2.7 million people were newly infected with HIV, 15% fewer than the 3.1 million people newly infected in 2001 and more than one fifth (21%) fewer than the estimated 3.4 million in 1997. However, there are variations among regions. For example, the situation in Sub-Saharan Africa shows little improvement, and it still continues to bear a disproportionate share of the global HIV burden. In mid-2010, about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population.

Despite the fact the decline in HIV/AIDS prevalence, in Ethiopia, HIV has a prevalence of 2.1% in the general population, most at risk populations among the town and peri-urban areas along the transportation corridors across the country are disproportionately high.

The impacts of HIV/AIDS, in Africa, in general, and sub Sahara Africa including Ethiopia, in particular, are tremendous. Ethiopia has lost its citizen due to AIDS, and its struggle to come-out of poverty has been challenged by this epidemic. FHAPCO, 2010 progress report towards implementation of the UN Declaration of Commitment on HIV/AIDS indicates that HIV/AIDS has left 5.4 million orphans and vulnerable children of whom 900, 000 are from HIV/AIDS.

The situations and impacts of HIV/AIDS in *Oromia* are similar to other regions of the country. Oromia Health Bureau coordinates the activities of all actors involved in the prevention and control of the spread of HIV/AIDS and reducing its impacts. According the report from the region, despite the Office operates in a situation of difficulties, resource shortages, and capacity limitations in an environment where many people are exposed to the danger of HIV/AIDS, suffering from HIV and burdened with the impact of AIDS, OHAPCO is working to be very

strategic in its purpose, direction and operations to mitigate the impacts of the virus (OHAPCO, 2009).

Despite the efforts exerted by stakeholders that have been involved in providing care and support services, one can take cognizance of the fact that with increasing incidence of HIV and the worsening economic situation, these problems tend to persist. However, many argue that they are not insurmountable, as the restless efforts of individuals and communities create a convergence of action required to create the desired change in the lives of children, in general, and OVC in particular (Save the Children USA, 2012).

As part of the efforts, the government of Ethiopia has issued OVC Care and Support Standard Service Delivery Guideline for Orphan and Vulnerable Children to ensure quality services to OVC (MOWA & HAPCO, 2010). The application of the Standard Service Delivery Guidelines will require, among others, concerted efforts by all stakeholders at various levels including the federal, regional and local levels. In line with this, specific roles and responsibilities for each level clearly spelled-out. Accordingly, at *Woreda* and *Kebele* levels, among others, building partnerships, coordinate and follow-up implementation of OVC programs; Creating enabling environment for implementing partners; mobilizing community and resources to support OVC activities; building partnerships with all actors and coordinate OVC programs are included.

In Ethiopia, it is commonly understood and legally defined that an orphan is defined as a child who is less than 18 years old and who has lost one or both parents, regardless of the cause of the loss. A vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights. The guideline developed by (HAPCO, 2003) defines OVC in the following manner: *maternal orphan*-Children who lost their mother to AIDS; *paternal orphan*-children who lost their father to AIDS; and *double orphan-children* who lost both parents to AIDS. *Vulnerable children* are those with a chronically ill patient (mother or father) very sick for 3 or more months. A model that apparently applies to this research is community care where different stakeholders, tend to assume major roles and responsibilities-Comprehensive HIV/AIDS *Care and Support Supportive policy and Environment.*

Through the findings and analysis, the writer has managed to answer the research questions, and, therefore, met the objectives.

The paper is divided into six parts. The first part presents the introduction, statement of the problem, objectives, research questions, significance of the study. Part two explains conceptual and the related reviews of the study. Part three presents methodology of the study. The fourth part is devoted to presentation of the findings, and part five discussions of the research findings. The last part is used for the researcher's concluding remarks and recommendations.

1.2. Statement of the Problem

A study indicates that, due to structural factors, one in every five children under the age of fifteen in developing countries lives under extremely difficult circumstances. Such children are victims of varieties of factors, including abject poverty, rapid urbanization, draught and famine, trafficking, HIV/AIDS and armed conflicts. They are also consistently exposed to physical dangers, exploitation and all forms of abuse. These children include orphans, destitute children, unaccompanied children, victims of armed conflict, abused and neglected children, trafficking children, street children, children with HIV/AIDS, orphans, child workers, youth trapped in bondage or prostitution and juvenilia delinquents. Children whose parents have died due to HIV/AIDS, particularly, 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 (PEFAR, 2006). Despite the effort made to mitigate the impact of HIV/AIDS on OVC, the situation has persisted, and according to FHAPCO, 2010 progress report towards implementation of the UN Declaration of Commitment on HIV/AIDS indicates that HIV/AIDS has left 5.4 million orphans and vulnerable children of whom 900, 000 are from HIV/AIDS.

In communities hard hit by the double hammer of HIV/AIDS and poverty, there are millions of children who are not orphans, but who have been made more vulnerable by HIV/AIDS. For example, children whose parents are infected with HIV/AIDS might not receive the care and support they require, and may instead become their parents' caregivers, often dropping out of school and becoming the breadwinner (PEPFAR, 2006).

Though projects have contributed to provide support through different interventions; and employ different strategies, the persistent vulnerability to HIV/AIDS of many poor families in general, and OVC and their caregivers, in particular, remain inadequately touch. The situations of OVC and their care givers have been remain as one of the challenges in the attempt to overcome poverty and maintain growth. Addressing the problems of OVC and their families/care givers, will definitely improve the situation of the households and ultimately contribute to the national efforts to end poverty and ensure the realms of development (International Save the Children Federation, 2004).

Ethiopia has a large and very vulnerable population, with an estimated 15 percent of the population living below the poverty line. HIV/AIDS is one of the key challenges for the overall development of Ethiopia, as it has led to a seven-year decrease in life expectancy and a greatly reduced workforce.

According to February 2003 survey, the prevalence and characteristics of AIDS orphans in Ethiopia the majority of AIDS orphans were from three primary ethnic groups Amhara (58 %), Oromo (17%) and Tigray (9 %) (UNICEF,2003).

The towns along or close to the transportation corridors to the North *Shewa* zone of *Oromia* region including *Fitche* are economic and social "hotspots" with establishments of catering for both travellers and residents. Young people are particularly at risk, as 15-24 year olds comprise high percentage of new infections, yet they have lower risk perception and face greater challenges. The HIV/AIDS prevalence in *Oromia* region is 1%, and North *Shewa z*one of the region has a prevalence rate of 1.5%. The impacts of HIV/AIDS on families and children are immense.

According to the information obtained from the town health office, the estimated number of OVC is 1500. The HIV/AIDS prevention and care and support program that different organizations have been undertaking in *Fitche* town is lead or coordinated by HIV/AIDS

Committees organized at town level and in four *Kebeles*. The committees have the responsibilities of providing care and support for OVC and their guardians infected and affected by HIV/AIDS. As social work is a profession that is concerned in helping disadvantaged and underprivileged members of the society, enhancing the well being of OVC within their social context and addressing the well-being of society as a whole, assessing the responses of the community, in general, and the roles of HIV/AIDS committees in providing appropriate care and support services to OVC, in particular, is very crucial to strengthen the Multi-Sectoral Response of HIV/AIDS by identifying and addressing the challenges and exploiting the opportunities to improve quality of services to OVC as prescribed by National OVC Service Delivery Guideline developed for the purpose. Thus, the approaches and activities of HIV/AIDS committees need to be strengthened and closely collaborate with social work service provision organizations for the better benefit of the community, in general, and OVC, in particular. This is due to the fact that in the absence of care and support, OVC and their caregivers will face problems in their well being which ultimately resulted in dysfunctional societies.

Therefore, the writer assesses the prevailing community response, structures, particularly roles, challenges and prospects/opportunities of HIV/AIDS committee in *Fitche* town in *Kebele* 3 where 417 OVC residing with the belief that the research would provide some new information on the issues raised above through seeking answers to carefully formulated research questions.

1.3. General Objectives

The main purpose of this research is to collect and analyze data on the responses of community and roles of HIV/AIDS committee in the provision of care and support with special emphasis on roles and responsibilities of HIV/AIDS committee in caring orphan and vulnerable children infected and affected by the HIV/AIDS in Fitche town and to investigate the challenges and opportunities.

The study was guided by the literature on HIV/AIDS care and support services, in general, and OVC care and support, in particular as well as the concept of care and support.

1.4. Specific Objectives

- To explore the socio-economic conditions in which OVC orphan and their caregivers live.
- To assess the knowledge and practices of HIV/AIDS committees in providing care and support services orphan and vulnerable children.
- To examine the kind of care and support provided for orphan and vulnerable children through HIV/AIDS committees and others.
- To identify the challenges and gaps, and opportunities prevailing in provision of care and support for OVC.
- To understand the care and support provided to OVC and the implications of this to social work knowledge and practices.
- To provide recommendations that could help in designing of program/projects, and strategies aim at OVC.

1.5. Research Questions

The research will attempt to provide answers for the following questions.

1) What are the current socio-economic situations of OVC and their caregivers?
2) What are the current knowledge and practices in the provision of care and support services?
3) What are the services/care and support activities rendered to OVC?
4) Do OVC receive all standard services components as described by OVC Care and Support Standard Service Delivery Guideline?
5) What are the challenges and opportunities in delivering the care and support services?
6) What are the findings of the research to social work profession and/or social workers?

1.6. Significance of the study

Fitche town is centre for north *Shewa* zone of *Oromia* region. Like other regions, of *Oromia* region HIV/AIDS coupled with poverty has been the main social problems of the community. There is large number of PLHIV. Even though there has been no concrete and reliable data that shows the number of OVC population, based on the information obtained from the town relevant offices and registrations, the number of OVC population is estimated to be 1500. One of the *Kebeles* where OVC population is high is *Kebele* 3, 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 town, in general, and *Kebele* 3, in particular.

There is neither research nor impact assessment undertaken on HIV/AIDS and children, families and community in *Fitche* town. There is also absence of organized data that shows the number and situation of PLHIV and OVC living in the town and *Kebele*. However, the town and *Kebele* HIV/AIDS committees try to coordinate HIV/AIDS prevention and control activities. Through existing GOs and NGOs, very few OVC and their caregivers get care and support services. However, there is lack of adequate information about OVC and their caregivers' current situations, or whether HIV/AIDS committee is playing its roles in providing care and support services to OVC. There is also lack of information about the types of care and services that OVC and their caregivers received as per the national standard set for such endeavors. At the same time, even though the scope of intervention is narrow, some local NGOs have implement HIV/AIDS prevention and control activities in the town and in selected *Kebele*. For example,TesfaIntegrated and SWAAE have been working on prevention of HIV/AIDS, provide care and support to OVC in the town, in general, and in the selected *Kebele*, in particular. Today, there is a general trend and paradigm shift that community care is superior to institutional care for OVC and programs and projects which currently implementing focus on this strategy or approach in the believe that community care has various advantages including ownership and participation, cost minimization and above all sustainability.

According to key informants, currently, more than 1500 OVC are estimated to live in the town, most of who believed to be HIV/AIDS orphans. There is also a great hope that these OVC are provided with care and support services available with active leadership of HIV/AIDS committee. Therefore, this study shows the situation and pattern of care and support currently underway, and also looks into the roles and responsibilities of the HIV/AIDS committee in the process of care and support provisions to OVC as prescribed by Ethiopia OVC Standard Service Guideline. Therefore, the study gives an insight into roles and responsibilities of HIV/AIDS committees in providing care and support to OVC. It also identifies the gaps and challenges, as well as the opportunities that exist in the process. The researcher selected one *Kebele,* and

analyzes the implication of the findings to the town, zonal, region and national efforts in alleviating the impacts of HIV/AIDS, in general, and providing care and support to OVC in particular. All stakeholders such as GOs and NGOs including committee can be the possible beneficiaries of this research finding.

2. LITERATURE REVIEW

2.1 An Overview of HIV/AIDS-A Global Threat

HIV/AIDS is indiscriminately affecting human race worldwide and has claimed the lives of thousands millions of people across the globe. It has left behind millions of orphans and vulnerable children, disintegrating families, devastating livelihoods, impoverishing communities and destabilizing economies of nations around the world. Speaking from economies and livelihoods perspectives, HIV/AIDS has long been a threat to the wellbeing of families, communities, institutions and ultimately states.

The report of WHO indicates that in 22 countries, national models of HIV prevalence showed that the incidence of HIV infection declined by more than 25% between 2001 and 2009 – including in some of the countries with the largest epidemics in the region: Ethiopia, Nigeria, Zambia and Zimbabwe.

The aims to advance global progress in achieving country set targets for universal access to HIV prevention, treatment, care and support and to halt and reverse the spread of HIV and contribute to the achievement of the Millennium Development goals by 2015 has been identified as UNAIDS strategy. Among the strategy goals, creating access to essential care and support those people living with HIV and households affected by HIV is one of them (UNAIDS, 2010).

2.2. HIV/AIDS and its Impact on Orphan and vulnerable Children

Orphans and other vulnerable children guidance prepared by United State Government in-country Staff and Implementing Partners explains the magnitude of the impact of HIV/AIDS on people in general, and children in particular. It says:

> *"Because HIV/AIDS predominantly attacks people of childbearing age, the impact this is having on children, extended families, and communities is devastating. If a parent dies of AIDS, the child is three times more likely to die, even though he or she is HIV negative" (PEPFAR, 2006).*

Most argue that the impact of HIV/AIDS on children is not explored only due to children are orphaned by HIV/AIDS but also the extended impacts of the virus on household, community and society at large. Children living in households with one or more ill parents/caregivers are also affected as income of the households is declined due to expenditures for health care services, which in turn affects household consumptions (Salaam, 2005).

(Foster, 2000) argue that 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. Expenditures on AIDS deplete extended families assets over a period of several years. This will definitely increase the number of orphan which exerts greater pressure on households. Extended families, as alternative, assume responsibilities, and later on can be over burdened. Due to poverty, families can slide in to destitution. This, according to (Foster, 2002), increases the vulnerability of children to a range of problems including illiteracy, child labor, exploitation, unemployment, migration, and child prostitution.

Yohanes (2006) points out that care and support that the extended families declines as research findings in Zimbabwe, Kenya and other African countries indicated. Various factors contributes to this situation including child headed households, the separation of siblings from each other and their eviction from the locality for jobs seeking etc.

In Ethiopia, as part of the efforts mitigating the impact of HIV/AIDS, guidelines have been developed as a road map to direct, coordinate and monitor progresses of care and support given to those affected by the virus. Government partners have also exerted effort to alleviate the devastating impact of HIV/AIDS and provide care and support for those affected by the virus. A good example is the PEPFAR funded projects that have been implemented throughout the country during the last nearly ten years, and its guideline (PEPFAR, 2006).

Parents' death to AIDS, among other, is a factor that aggravates children's problems including psychosocial needs that often given less attention and importance than their economic needs. Psychosocial support, as coping mechanism, need to receive proper and prompt attention (Oak Report, 2004). The Ethiopian society is characterized by family network and social support that

gives care and support for disadvantages groups including HIV/AIDS orphans. Despite the prevailing of large number of OVC who need care and support, there are few community-based programs and projects operating in the country. The programs are not also community focused and participatory which facilitate the participation of all stakeholders including OVC. HIV/AIDS orphans in Ethiopia receive limited 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).

AIDS orphan is the worst crisis as compared to all crises caused by death of adults of AIDS. to HIV/AIDS orphan, among others, particularly, 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 (PEFAR, 2006). The millennium Development Goals (MDGs) and other international commitments forced the government of Ethiopia (GOE) to prioritize education and health service. As a result, relatively, a vast majority of orphan and vulnerable children (OVC) have got chances to get education and health services. However, there are a large number of OVC who could not access the services in part because of various reasons.

2.3. Response to OVC Care and Support

Many stakeholders, directly or indirectly, both at international and national levels including USAID, UNICEF, UNAIDS, WHO, the GOE, international and local NGOs and other international agencies are working on OVC care and support. Declaration of Commitment on HIV/AIDS, which forced national governments to develop OVC policies in 2003, and implement it in 2005 was instrumental to strengthen government, community and family capacity to support children affected by HIV/AIDS nationally (UNGASS, 2001).

Ethiopia has endorsed HIV/AIDS prevention and control policy in 1998. The policy indicates, among other, the need to promote proper institutional, home, and community based care and support for PLHIV and orphan; and empower women, youth and other vulnerable groups to take action to protect themselves against the virus (HAPCO, 1998).

The government of Ethiopia has taken various measures to positively address the complex issues. The Federal Constitution has clearly articulated the rights of children in Article 36. Ethiopia has

ratified both the UN Child Rights Convention (CRC) and the African Charter on Rights and Welfare of Child (ACRWC). The country has harmonized domestic laws and policies with the provisions of both conventions and which creates an enabling environment for improving the wellbeing of OVC. MOWA is the government ministry mandated to coordinate the issue of children including OVC. FHAPCO is charged with leading and coordinating the overall multi-sectoral response to HIV and AIDS, including the issue of care and support for OVC (MOW and FHAPCO, 2009).

The legal and policy framework created by the government has enhanced the involvement of NGOs, UN agencies, LNGOs, FBOs and CBOs in the provision of various care and support services to OVC. In spite of all the positive steps forward, there have no uniformity in the services and support offered to OVC and their caregivers. Until the government of Ethiopia has made efforts to the smooth implementation of care and support for OVC and issued OVC Care and Support Standard Service Delivery Guideline for orphan and vulnerable children to ensure quality services to OVC (MOWA & HAPCO, 2009). Structures through which community responses could be obtained in the prevention and care and support has already been put in place. The application of the Standard Service Delivery Guidelines requires, among other, concerted efforts by all stakeholders at various including the federal, regional and local levels. Specific roles and responsibilities for each level clearly spelled-out. Accordingly, at *Woreda* and *Kebele* levels, among other, building partnerships, coordinate and follow-up implementation of OVC programs; Creating enabling environment for implementing partners; mobilizing community and resources to support OVC activities; building partnerships with all actors and coordinate OVC programs are included.

While a number of policies, strategies and guidelines concerning care, support and treatment have been issued by the national government, it is civil society organizations in Ethiopia that have been at the forefront of providing care and support services to PLHIV and OVCs (HAPCO and GAMET, 2008).

2.4. Systems and Structure

Roles and Responsibilities of Stakeholders

The application of the Standard Service Delivery Guidelines will require concerted efforts by all stakeholders at various including the federal, regional and local levels. Specific roles and responsibilities for each level-National, regional, *Woreda,* and *Kebele* are clearly identified.

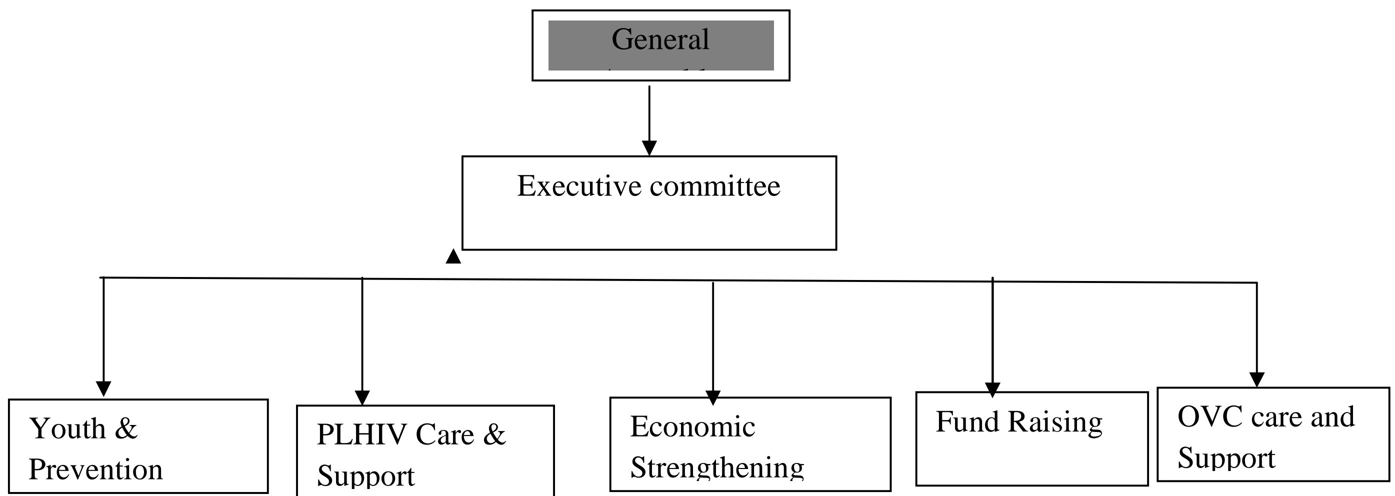
The, *Kebele* level roles and responsibilities of HIV/AIDS committee, for example include:

- Identify partners and support the application of Standard Service Delivery Guidelines;
- Lead the identification of OVC and organize a database which includes geographic coverage ;
- Identify needy OVC in collaboration with key actors, mobilize community resources and coordinate the responses of various players;
- Promote and protect the human and legal rights of OVC including reduction of stigma and discrimination;
- Facilitate access to health care (issue IDs and recommendation letter for free services) and birth
- registration services for OVC;
- Facilitate the integration of OVC services with *Kebele* level services; and
- Participate in program planning, implementation, monitoring and evaluation and reporting on OVC activities.

The very important question that comes to the mind of everyone is: Are the structures at all level capable of discharging the roles and responsibilities assigned to them?

The national guideline for OVC describes the roles and responsibilities of the structures at all level. The study by Yohannes (2006) has disclosed the active roles played at local level rather than at national level.

The structure of the HIV/AIDS includes a sub-committee for care and support services. This sub-committee is expected to provide care and support to people infected and affected by the virus including OVC.



HIV/AIDS committee at town/Kebele level (source Save the Children US, TransACTION Program)

2.5. Family-centered approach to OVC Care and Support

A number of OVC focused programs are aimed at reducing vulnerability among OVC and their families by strengthening systems and structures to deliver quality essential services and increase resiliency. The program follows a family-centred approach and approach to child welfare social work in which the family is seen as the primary unit of attention. Respecting, strengthening, and supporting the family—while guaranteeing child safety—are the hallmarks of this method (PACTE, 2011).

The belief that the best approach to protect children is to strengthen families acknowledges that there are times in the lives of families when they may encounter difficulties because of the stress of poverty, inadequate housing, substance abuse, domestic violence, mental illness, or other challenges.

Why Emphasize Family-Centered Practice? Or ‘Prioritize family/household care.’ Why? In seeking the answers for the question, it could be the simplest question for those who live with their parents.

The family is generally the optimal environment for a child to develop. Assistance programs should enable vulnerable children to remain in a loving family situation in which they can maintain stability, care, predictability, and protection. Institutional care is not optimal for child development, sustainability, or cost-effectiveness. There are, however, instances when residential care could be the only practical alternative; for example, abandoned children, practically HIV positive children, for whom there is no alternative. Every institution that cares for children should prioritize the maintenance of strong links with extended families, the reintegration of children back into the community and securing a stable, family-based placement. Attention should be given to keeping sibling together.

Yet despite its familiarity, for many people the reason for the current, almost overwhelming emphasis on family-centred practice is a mystery. Others, though they can describe and may even embrace the beliefs and principles underlying the family-centred approach, are still unclear on how to put these concepts into practice with actual families.

2.6. Service components and quality dimensions

Meeting the basic needs of children and youth is not only vital for ensuring their current well-being, but is also critical to their future. Basic or "core" needs include food/nutrition, shelter and care, protection, health care, psychosocial support, education, economic strengthening. The Ethiopian OVC guideline identified these core services as critical minimum. Critical minimum activities are activities that must be done by all partners implementing services for OVC (MOWA and FHAPCO, 2009).

The Ethiopian Government adopted the United Nations Convention on the Rights of the Child on December 1991 and thus becomes an integral part of the law of the land. Furthermore, policy documents on health, education and social welfare articulate statements that uphold the protection, care, health and optimal development of the child within their sphere of influence (UN.1989).

Given the number of OVCs, particularly in sub-Saharan Africa including Ethiopia, and their complex needs, the most effective responses place families, households and communities at the

center of interventions. The Ethiopian government also promotes community care and support approach than institutional care.

Many OVC programs exert 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 though incorporating protection as core one of core services to place the best interests of the child and his or her family above all else.

If one considered the health services alone, the general Health Needs of OVCs (including HIV/AIDS prevention) should take into account to meet the general health needs of children at every age level.

The study on HIV by WHO (2007) disclosed that without appropriate treatment, over 50 percent of children born HIV-positive die within the first two years. Provision of HIV-related health care to exposed or infected infants is very essential and a high priority in OVC care and support. When ill or suffering from the onset of AIDS, children supported under OVC programs should have timely access to appropriate ART. Programs should make available other health care for children born to HIV-infected mothers and known HIV-positive children, and related support either through direct access to health providers, or, preferably, with arrangements and referrals established with programs such as providers of interventions to prevent the transmission of HIV from mothers to their children (PMTCT), or specialized pediatric ART providers. ART adherence interventions for HIV-positive OVC are among the essential health care required for HIV-positive children. (PEPFAR, 2006)

With regard to education support, history has shown mankind the fact that education is the key to social, economic and political development. It is also proved that investment in education during early childhood brings in significant long term benefits for children, their families and the society. The United Nation Child Right Convention also states that all children have the right to be given the very best start in life (UN.1989). Based on the same premises, the PEPFAR and the national guidelines include education as one of the core services to OVC. Explaining the impact of HIV/AIDS on educational needs of orphans and vulnerable children, Tania Boler and Kate Carlloll (2003) clearly stated that millions of children around the world have been orphaned by

the AIDS crisis. Aside from the emotional and psychological effects that losing a parent can have, there is clear evidence that orphaned children are dropping out of school at a higher rate than non orphaned children.

However, when looking at the impact of orphan hood on education, it is important to consider not only enrolment rates, but also the quality and consistency of attendance. Anecdotal evidence also suggests that the opportunity costs of schooling increase and that AIDS-related stigma in the classroom (and discrimination on the part of teachers, students and parents) can also cause children to drop out of school. Such stigma and discrimination in schools contravenes the underlying principles of Education for All, and governments must legislate against all forms of discrimination.

In addition to providing core services to OVC, all stakeholders and program implementers should adhere to and take into account the dimensions of quality. These dimensions of quality are not seen separately from the seven core service areas which are considered critical components of a set of services for Programming targeting vulnerable children (MOH and FHAPCO, 2009). The national guideline underline the need to take into consideration the dimensions of quality when providing quality services to OVC, and urge all stakeholders and program implementers to adhere to and take into account the dimensions of quality including safety, access, effectiveness, technical performance, efficiency, continuity, compassionate relations, appropriateness, participation, and sustainability

2.6 Conceptual Framework

2.6.1. *Community-based Care and Support*

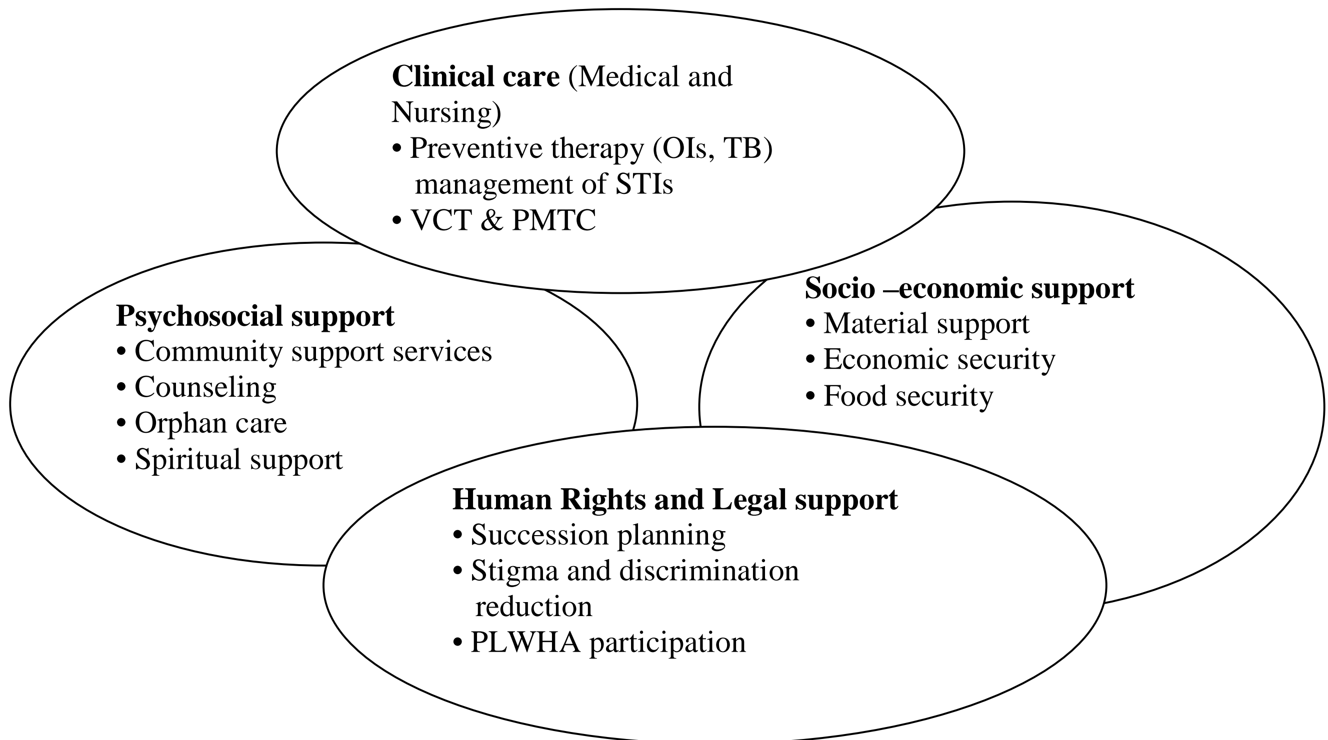
The definition of care and support is adapted from a guideline developed by National HAPCO for care and support to PLHIV, OVC and affected families. Community- based care and support is defined as:

> *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).*

2.6.2. *Care and Support Model*

A model that apparently applies to this research is community care where different stakeholders, tend to assume major roles and responsibilities-Comprehensive HIV/AIDS Care and Support Supportive policy and Environment.

Comprehensive HIV/AIDS Care and Support Supportive policy and Environment



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

The writer, largely, uses community-based care when discussing and analyzing the findings on OVC care and support that the community provides to OVC. Attempts are also made to relate the care and support with social work principles and practices.

There are various definition and understanding with regard to orphan and vulnerable children (OVC). HACI, 2004, and HAPCO, 2005 define 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.

Vulnerable children are children who are 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).

Boler and Kate Caroll (2003) urge that in deconstructing the OVC concept, the working group on education and HIV/AIDS summarizes issues raised from a meeting in London on 10 December 2003 concludes that it remains important to retain some definition of children who are affected by the AIDS epidemic, whilst acknowledging that the impact of the epidemic on children is multi-faceted.

In Ethiopia, OVC context is commonly understood and legally defined orphan as a child who is less than 18 years old and who has lost one or both parents, regardless of the cause of the loss. A vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights (MOW, and HPCO, 2009).

The term OVC has been coined in light of the high number of children affected by the AIDS epidemic. Yet the OVC category is conceptually problematic: who should be included, and who should not? Some argue that in high prevalence countries, all children are already affected by the epidemic (Boler and Kate Caroll, 2003). However, the writer prefers to use operational definition of orphan vulnerable children.

The Standard Service Delivery Guideline for Orphan and Vulnerable Children's Care and Support programs, as stated in operation definition of terms, apply a more inclusive definition is used.

3. METHODOLOGY

3.1. Organization of the fieldwork

The fieldwork for this study was conducted in June and until middle of July, 2012. Prior to the fieldwork, an extensive review of the literature on HIV/AIDS, especially the impact of HIV/AIDS, in general, and OVC, in particular, was carried out, so as to obtain a conceptual understanding of the issues. In the first week of the fieldwork, the writer has tried to made communication with town municipality and sector offices, so as to identify a potential informants in all categories. Consequently, *Ato Letike*, became an assistant because his relationships with potential participants believed instrumental in finding subjects for the research as well. All prior preparation activities were performed as per the work plan. The study participants were identified and schedule has been set to undertake different data and information gathering activities. Due care has been taken to avoid overlapping of activities. In this regard, the participants, especially HIV/AIDS committee's members have been approached through town and *Kebele* administrators, OVC and guardians through PLHIV Association leaders and through direct approach through assistant, *Letekie,* who has been working in a local NGO for long time and has adequate knowledge and information about the town.

3.2. Study Design

A community-based cross-sectional study design was employed to undertake this study. The study employed a participatory research approach.

The study was sectoral-specific case study which basically explains the existing situations on the study area and initiates to generate data and information that can be used for national-wide, region specific studies to be conducted by interested groups in the future. In this study OVC, their caregivers, community leaders, and CBOs, FBOs and CSOs participated. The study employed mainly qualitative research methods. This is due to the fact that assessing the roles, challenges, and prospect of the HIV/AIDS committees in providing quality as per standard set in OVC guideline and National Monitoring and Evaluation Framework for Multi-Sectoral Response of HIV/AIDS in Ethiopia issued by FHAPCO care and support services to OVC in general and AIDS orphans in particular call for qualitative research. Description of the situation of OVC and the response of the community to care and support reported and analyzed. Direct beneficiaries

(OVC with mixed gender) have been participants' through questionnaire that was developed in the English language and translated into *Amharic* and *Afan Oromo* for the purpose. Triangulation of data and information obtained through the questionnaire and qualitative findings has been made in order to assist the writer to gauge whether HIV/AIDS committee has discharged its roles and responsibilities in coordinating the multi-sectoral HIV/AIDS responses, in general, and providing care and support for OVC in particular; whether OVC are receiving all services components or not, and the like. Case study has been included to triangulate the data collection and validate the findings.

3.3. Description of the study Area/Universe of the study

Purposive technique was used to select the study area. The area was selected on the basis of providing greatest data and information about the research topic. The area was selected due to:

- Contact available in the town-the writer is working in *Oromia* Region Health Bureau, and knows the area very well.
- The writer is speaking *Afan Oromo* fluently which is an asset to collect data and information from participants.
- The writer interest to work in one of relatively food insecure areas of *Oromia* regional state, where OVC problems also believed to be relatively huge.

North *Shewa* zone is one of the 18 zones of *Oromia* regional state. In the region, there are also 6 zonal town administrations. The habitant of the zone is estimated to be 1,388,617 people is divided into 13 *Woreda* and one town administration, *Fitche* town with an area of 3321.25 hectare is located some 110 Kms north of Addis Ababa. It is an administration centre of the North *Shewa* zone of *Oromia* Region. It has an estimated population 32,513 of whom 15,295 (47%) are males and the majority 17,219 (53%) are females residing in four *Kebeles.* The town hosts many nationalities and ethnic groups among which dominantly Oromo. *Amhara,* and *Guragie* are also residing in the town. According to the data from to town, the town has different ecological zones. 4281.6 sq.km (47.63%) is *Dega*/high land, 3322.58 sq.km (36.96%) *Woyna dega*, and the rest 1384.81 sq.km (15.41%) is *Kola*/low land.

Fitche is categorized as high land in terms of agro-ecological zone with and elevation that ranges from 974mt to 3531mt above sea level and an average rainfall 1700 mm annually.

According to the town Health Office, the number of OVC population is estimated to be more than 1500. In the selected *Kebele*, the estimated number of OVC is 417 of whom 26 are living with the virus and the remaining is OVC affected by the HIV/AIDS. According to the health office representative, the number of AIDS OVC is estimated more than what has been reported as many of them is not willing to disclose their sero-status. Some local projects run by local NGOs (CSOs) funded by external donors provide care and support to orphan and vulnerable children. Community *Iddirs* and PLHIV association are community institutions, which provide care and support to orphan and vulnerable children. Empirical assessments on HIV/AIDS have not been conducted in this town.

3.4. Study Participants

Orphan and Vulnerable Children between 5-18 year-old, caregivers of the sampled OVC, government offices heads/representatives, representatives from non government organizations working with OVC, and community structures including HIV/AIDS town and *Kebele* level committee leaders and members are the subjects of the study.

3.5. Sample Size Determination and Sampling Procedure

The study has been involved purposive sampling, and, therefore, purposive sampling was employed to select the subject. Those participants who were believed could provide answers to issues/questions incorporate in the study instruments were selected. Ten children who were selected by the *Kebele* Women and children Affairs office, were interviewed before two days which enabled the writer to pre-test the questionnaire. After minor modifications on some of the questions, questionnaires were made to be filled-out.

Prior to interviewing the subject, 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. The interviewer did not precede the

interview without the consent of the subject. After informed consent with OVC and their caregivers, an individual interview was scheduled, with place and time specified. Accordingly, 60 OVC (22 male and 38 female) were selected to fill out the questionnaires. Two OVC (mixed gender) were selected for an in-depth interview by the researcher. Maintaining confidentiality and privacy during discussion was an important issue before the actual interview was conducted.

The key informants were selected from government line departments, local NGOs, *Kebele* HIV/AIDS committee. In the way focus group discussion (FGDs) participants were chosen from OVC caregivers or guardians, and HIV/AIDS committee members. The main criteria employed to select these participants was mainly their knowledge and experience to OVC community care and support.

In conducting the research the writer's relation with participants has been brief but personal. The issues of entry, issues of reciprocity-efficiency in terms of role, as well as interpersonal ones that capture during the conduct of research and issues of ethical dilemmas have been carefully maintained.

The study has been conducted according to work plan developed for the purpose. The writer has been managed to use his probing skill as much as possible so as to obtain the data and information rigorously without prodded back into the setting for the completion of the work.

Bearing in mind the underlined principles for such endeavors, the writer has enabled to build trust, maintain good relations, respect the norms of reciprocity, and, more importantly, has tried his best to be more sensitive regarding ethical issues.

3.6. Sources of Data

Primary sources, using various data collection instruments including key informant interview, focus group discussions, in-depth interview, questionnaire, and secondary sources observation and archival data collecting methods have been employed as data sources. The secondary data collection method has been employed to supplement the primary data with available and relevant secondary sources embodied in the analysis to enrich the study.

3.7. Data Collection Techniques

A combination of different data collection techniques were employed to collect information on the profile and current situation of OVC, HIV/AIDS awareness to the problems and the care and support, type of care and support provisions. Information was also collected on current care and support services for scaling up of programs and the selection criteria employed to include OVC. Data have also been collected with regard to challenges and opportunities/prospects on the issues raised.

3.8. Data Collection Tools

Key informant interview

Key informant interview method has been employed as method of collecting data and information from relevant government sector offices including heads of Women and Children affairs, health office, police office, labor and social affair office, local administrators, and non government organizations representatives using a semi-structured questionnaire.

Questionnaire

The researcher selected two data collectors with previous skills of interviewing subjects as assistants. Using availability sampling 22- male and 38 – female OVC were selected and interviewed. To minimize bias on situational analysis of OVC, 24 OVC who currently get services from community organization and local projects through SWAAE were selected assisted by the chair person of the *Kebele*. The remaining 36 were recruited from households on the waiting list for care and support through the *Kebele* 03. Through this technique, information about the profile, socio-economic situation of orphans and vulnerable children and type of care and support offered by the HIV/AIDS or community, challenges and opportunities on caring OVC assessed. Information on current community response to care and support to orphan and vulnerable children were also asked.

Focus Group Discussion (FGDs)

Focus group discussions have been made with those participants who have been selected from OVC caregivers and HIV/AIDS committee members. Two focus group discussions involving 16

participants (8 in each group) drawn from caregivers and HIV/AIDS committee have been conducted. The composition of the discussion participants was heterogeneous in terms of education status, age, and gender. They are homogenous with respect to their economic status. This data collection technique was employed to substantiate and generate more information about the HIV/AIDS committee response on care and support to orphan and vulnerable children in the study area. The researcher and one note-taker were involved in the discussion.

Case Studies of life Histories as a Methodological Tool

According to Miles (1993), life histories form the basic component of oral history, and are increasingly becoming popular in contemporary research, because they are generally seen as a way of uncovering hidden information about the past. A case study was designed to triangulate the data collection and validate the findings. The writer has prepared a special guideline to undertake the activity. The consent of the participants has been maintained. Both to triangulate the findings and illustrate the situation of OVC, two in -depth interviews with orphan and vulnerable children were conducted. The selection criteria include those who are affected/infected with the virus, the parental situation (double orphan), and children whose parents are poor to support the child. Based on the criteria two single AIDS orphans were selected and interviewed. The gender mix of the participants was also maintained to see the gender dynamic of the impact of HIV/AIDS and care and support services provided to OVC. These categories align with definitions of OVC used by the writer in this paper.

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 HIV/AIDS meetings and discussions on various issues including HIV/AIDS. The NGOs working on OVC has been observed by the researcher. On top of these, the researcher observed town and *kebele* level committee activities regarding care and support for OVCs as well as association of PLHIV.

Data quality assurance

Since in qualitative study what matters most is authenticity, efforts were made to ensure that the exact wording of the participants are transcribed as it is to "give a fair, honest, and balanced account of social life from the view point of [the participants] who live it every day" (Kreuger &

Neuman, 2006). Part of the transcription that was quoted directly was given to a language expert to ensure accuracy of meaning. The participants were also contacted to ensure meaning. In addition, a separate analytical memo was kept where the researcher had put or discussed all thoughts and ideas about the coding process and thematic formulation (Kreuger & Neuman, 2006). The use of experienced assistant during data collection has also contributed to the data quality.

3.9. Data Analysis and Interpretation

The data and information that has been recorded using note book, and observation dairies were summarized by using and categorizing the research concerns according to the main thematic issues. As the data and information collected have been both quantitative and qualitative, both methods were used to analyze the result of the findings in terms of the roles that have been played by the HIV/Committees, the challenges encountered, and the prospects/opportunities. Quantative data are summarized and analyzed using SPSS. Qualitative analysis has been, particularly, employed to analyze information obtained from key informants, particularly on challenges and possible remedies and prospects to improve care and support services promotion. Due care has been taken the 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.

3.10. 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. Bearing in mind the underlined principles for such endeavors, the writer has built trust, maintains good relations, respects the norms of reciprocity, and, more importantly, has tried to be more sensitive regarding ethical issues. 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. Accordingly, the informed verbal consent has been obtained from the respondents. OVC were only interviewed or allowed to participate in interviews when supported by parental

or caregivers' permission. The writer has not come with instances where caregiver consented to the interview, but the child refused to give consent. 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 case studies participants in the report are not mentioned or presented by pseudo names.

3.11. Operational Definition of Terms

Orphan Children- Children who have lost one or both of their biological parents regardless of the cause of death. A child who has lost one or both his/her parents to HIV/AIDS.

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). 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); or
- Is marginalized, stigmatized, or discriminated against. "(PEPFAR, 2006)

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.

Family-centred refers to an approach to child welfare social work in which the family is seen as the primary unit of attention. Respecting, strengthening, and supporting the family—while guaranteeing child safety—are the hallmarks of this method.

Social Capital- In sociology, social capital is the expected collective or economic benefits derived from the preferential treatment and cooperation between individuals and groups.

3.12. Limitation of the Study

The study has two main limitations, one of scope and depth. The research is confined and conducted in one *Kebele* and urban setting. It would have been better if done in different *Kebeles* of the town where comparison would be possible between *Kebeles* and target population. However, this was not possible because of time and financial constraints that the researcher has encountered. In addition, it was conducted in a small sample size of a larger population.

4. FINDINGS AND DATA PRESENTATION

4.1. Results from OVC Respondents

4.1.1. Profile of Respondents (OVC)

Table1*:-Socio- Demographic information of OVC Respondents (N=417, participants n=60)*
Socio-Demographic Variable Number Percent

Socio-Demographic Variable		Number	Percent
Sex	Male	22	37
	Female	38	63
	Total	**60**	**100**
Age	6-10	7	12
	11-15	38	63
	16-18	15	25
	Total	**60**	100
Religion	Muslim	12	20
	Christian Orthodox	38	64
	Christian Protestant	8	13
	Christian Catholic	2	3
	Other	0	0
	Total	**60**	**100**
Level of Education	Illiterate	**0**	0
	Church	0	0
	Koran	0	0
	Reading & Writing	7	11
	Grade1-6	10	16
	Grade 7-8	28	48
	Grade9-10	9	15
	Grade 11 and above	6	10
	Total	**60**	**100**
Status	Orphan	27	45
	Vulnerable	33	55
	Total	**60**	100

More than half of the sample orphan and vulnerable children respondents, n= 38 (63%) OVC were female, and (n=22; 37%) of them were male. Most of the respondents (both male and female) were teenagers whose age ranges between 11-18 years. The highest proportion (n=38 (64%) of the respondents are the followers of Christian Orthodox religion, while Muslim and Christian Protestant comprises (n= 12; 20%) and (n=8; 13%) respectively. As to the level of

education, all respondents are literate. Almost all OVC except seven respondents are currently attending school. The majority of the orphan and vulnerable children respondents, (n=28; 48%) were attending at a level of primary school Second Cycle Grade7-8; (n=10; 16%) attending primary school First Cycle school and the rest (n=15; 25%) attending their high school (third and fourth cycle) education grade 9 and above.

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 without any problem. As indicated in the findings, this is because most OVC and their caregivers in the study sample live in a situation where poverty is deep-rooted and some of the OVC orphan who live in desperately difficult situations because of parental death.

Almost half 27 (45%) of the sample orphan and the rest 33(55%) are vulnerable children.

4.1.2. Socio-economic Situations of OVC Respondents
Table 2 OVC (n=60)

		Number	Percent
Are you currently in school?	Yes	48	80
	No	10	17
	No. reply	2	3
	Total	**60**	**100**
Reason for not attending school currently	Parental death	4	50
	Academic failure	1	9
	Household chores	5	41
	Other	0	0
	No. reply	0	0
	Total	**12**	**100**
With whom are you living now	Parent	25	41
	Relative	17	28
	Siblings	9	15
	Friends	5	9
	Other	0	0
	No reply	4	7
	Total	**60**	**100**
Source of income for the household	Salary	9	15
	Street vendor	17	28
	Daily labor	25	40
	Other	0	0
	No reply	1	2
	No income	10	17
	Total	**60**	**100**
Those not having income get assistance	Relative	0	0
	NGOs	6	60
	Community	4	40
	Other,	0	0
		10	100

Respondents were asked about schooling, and the majority (n=48 (80%) responded that they are currently attending their education; while the (n=10 (17%) are not attending; and two respondents did not reply. Parental death and household chores were mentioned as reasons for not attending school. With regard to the living situation of OVC, from 60 OVC respondents, (n=25; 41%) are currently living with their parents (they are either paternal orphans or maternal orphans). While (n=17; 28%) are living with their relatives, (uncles /aunts and grandparents

brothers and sisters), and (n= 9; 15%) lives with sibling who is accountable to care for them. Only three (n=5; 9%) of the OVC respondents live with other children or adults who are not relatives but friends helping at times of difficult circumstances; and (n=4; 7%) did not respond. 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.

Only five (n=9; 15%) are employed in the government, non-government and private organizations operating in the community. OVC reported that forty eight (n=40; 66%) of caregivers of OVC are employed in the informal sector-street vendor and daily labor; and only N=1; 2%) did not respond. 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. As it was also confirmed by 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. For example, Birkie, a 15 years female single orphan stated:

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

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. Those eight (n=10; 17%) OVC who declared that the households do not having income get assistance confirmed that the source of income of the household derived from NGOs and community support. None of them have reported that they have received income from HIV/AIDS committee or Women and children Affairs Office or other government body.

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 rate is high (Foster, 2002; UNICEF, 2003).

4.1.3. Community Resources Mobilization, Care and Support for OVC

Table 3: Orphan and Vulnerable Children in Kebele 03, by sex, age and current situation

No	Parent situation	Sex		Age			Total	%
1	Double orphan		0-5	6-10	11-15	16-18+		
		Male	2	9	10	3	24	
		Female	3	8	12	9	32	
		Total	**5**	**17**	**22**	**12**	**56**	**13**
2	Paternal	Male	3	12	26	3	44	
		Female	8	12	18	5	43	
		Total	**11**	**24**	**44**	**8**	**87**	**21**
3	Maternal	Male	8	7	11	10	36	
		Female	7	8	19	9	43	
		Total	**15**	**15**	**30**	**19**	**79**	**19**
4	Vulnerable	Male	0	20	30	22	72	
		Female	0	38	42	43	123	
		Total	**0**	**58**	**72**	**65**	**195**	**47**
	Grand Total		**31**	**114**	**168**	**104**	**417**	**100**

Source: Kebele 03 HIV/AIDS committee (M=176, F=241)

As can be seen from Table 3 above, the highest percentage (n= 168; 40%) of orphan and vulnerable children in the association are in the age range of 11-15 years. Most of the beneficiaries (n= 195; 47%) are also vulnerable children. 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 (n=56; 13%) 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 and the maternal orphans are almost proportional (21% and 19%) respectively. The key informants from *Kebele* 03 disclosed that though most paternal orphans are living with women headed families, they are living in destitute conditions. Most of them are engaged in informal sector and get small amount of income which is too small to support the household 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 within the community.

The 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 *Fitche* town is the Health office. The Health Office coordinates and facilitates, and also provides support to community-based service providers and donors for the benefits of OVC living in the community. According to the health office key informant, the effectiveness of all community-based care and support programs and projects are evaluated periodically to identify the strengths and weakness of each service providers. It was reported that the office hold discussions on plans and strategies issues as well.

Both focus group and key informants 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. 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 for PLHIV, in general, and particularly OVC infected and affected by HIV/AIDS in the town. All key informant respondents underlined the need to strengthen the coordinating roles played by HIV/AIDS committees.

4.1.3. Care and Support

The majority of the respondents confirmed that they have received support from the local projects operating through external donor funds. Out of 60 OVC respondents, (n=39; 65%), of whom the majority 24 female. get from CSOs operating in the town, namely:Tesfaintegrated development association, *Abebech Gobena*, UNICEF, different churches such as *Salale Hagera Sibket, Mekanyesus, Muluwongel Genet* church, *iddir*, Society for Women and AIDS in Africa-Ethiopia (SWAAE) and *Tesfa Berhan* PLHIV association. One of them from Community based Organizations (CBOs), and the other 6 OVC get care and support from HIV/AIDS committee. The main types of provisions are education support in terms of educational materials support such as exercise books, pen, pencils, bags, etc. Some (n=12; 20%) reported that they are provided with health support and the rest (n=5; 8%) have got legal protection support. OVC respondents were asked to rate the level of satisfaction they have obtained from the existing care and support services. The result indicated educational support has been beneficial followed by health, legal protection and psychosocial support. The majority (n=52; 86%) of OVC respondents prefer vocational skills training and income-generating activities (IGA) as sponsored by local projects to financial and material support for their subsistence.

4.1.4. Types of Care and Support Currently Rendered to OVC:

All categories of research participants have no similar understanding on the types of services provided to OVC. Most of focus group discussion participants have no full range of services that are to be provided to OVC. Some of them emphasize on educational supports while others understood a combination of education and health services. Very few of them have, essentially, a clear understand on the full package of services described in the national OVC guideline described as critical services. On the other hand, except the HIV/AIDS committee respondents of Kebele 03, key informants from sector offices, on the other hand, understood OVC care and support in relation to their office mandated for. For example, key respondents from Police department and legal services have understood legal protection as the only OVC support service. Similar understanding was reflected from health office respondent and understood OVC support as health support only.

OVC respondents were asked to rate the level of satisfaction obtain from current care and support provided to them. Respondents listed the level of their satisfactions starting from most satisfied to low. The ranking was labeled as: 1= for most satisfaction, 2= for satisfaction, 3= Average satisfaction and 4= low satisfaction

Table:4: OVC services

Core Services/needs	Ranking				
	1	**2**	**3**	**4**	**No response**
Food and nutrition	0	4	8	40	8
Education	42	11	4	0	3
Health care	15	19	17	4	5
Protection	9	17	24	4	6
Shelter and Care	6	7	114	29	4
Psychosocial support	5	4	10	33	8
Economic Opportunity/Strengtheni***ng***	1	6	4	42	7

Table 4 shows that OVC have greater satisfaction with the educational support they are receiving currently. On the other hand, OVC responded that they have low satisfaction in the food and nutrition, shelter care, psychosocial support, and economic strengthening services.

The type of educational support offers to OVC is educational materials by different institutions including SWEEA which, currently, provides mainly education support (school uniform, pen, pencils and exercise book). There are attempts to provide health services through referral to government health care facilities. The source of funds that the organization gets mainly comes from external donors. Even though there is an interest and plan to support more OVC by CBOs, the number of OVC supported by this organization is minimal when compared to existence of large vulnerable children in the community. Key informants from SWAAE were asked as to why the organization focuses on educational material support to orphan and vulnerable children living in the town in general, and *Kebele* 03 in particular. The main reason, according to the informant, is donors' guidelines and to comply with project agreement signed with the donors. 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 *Fitche* town are stated by the local project operating in the area. These projects are mainly funded by external donors like UNICE, and Global Fund with the objective of preventing HIV/AIDS in the community.

Problems and Coping Mechanisms

All respondents declared that they have encountered problems sometimes in their life. The data from the respondents indicates the types of the problems in the order of ranking starting the most problem include: food shortage for daily consumption, shelter, violence or treat for violence, health. 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, Tafa, a 16 years double orphan stated:

> *I usually encounter a number problems including food for daily consumption. I also sometimes have nothing to pay for drugs prescribed by physicians. In order to cope up with the problems I engage in activities like daily labor and street vending. With little amount of money I receive, I manage to buy food items. Sometimes I share the problem with peers, and eat food together. My caregiver, a generous person, is the one who buy me clothe once a year. But not shoe. I remain barefoot for the last many years.*

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 such as SWAAE which recently provide care and support for high vulnerable children (HVC) funded by USAID through PACT-Ethiopia. One challenges that OVC respondents are unable to cope with 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.

Respondents when asked to mention who has helped them when encountered problems, the majority (n=34; 57%) responded relatives and people they know in the town, notably like

teachers. Some (n=18; 30%) reported that they used to get supports from CSO, particularly recently. Only n=8; 13%) of the respondents confirmed that they have received support from HIV/AIDS committee when encountered problems.

OVC respondents were also asked to answer what they do when you encountered problems in the household. Large proportion of the respondents (41; 68%) responded that they run away from the caregivers for some days. The remaining say that they will cry, search someone to help them, asked excuse to caregivers, few of them responded they cry and/or nothing do.

Suggested solutions to the problems that OVC face is one of the questions asked to OVC respondents. 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 of SWAAE and *Tesfa Berhan*. SWAAE, which started recently, is helpful in soliciting care and support to 190 OVC of which 10 (4 male and 6 female HIV positive that could be in most cases educational materials support. However, so far, it is not a forum to discuss their concerns and a source of psychological support when orphans encountered problems and difficulties and in search of solutions. There is no psychosocial and emotional support to OVC from any of the community members except some people and volunteers who are residents of the *Kebele. Tesfa Berhan* is providing support to 26 OVC (8 male and 18 female) who are infected by HIV/AIDS.

Respondents suggest that the more responsible for children's issues are the children themselves. Almost all respondents replied that they are part of the solution to their own problems. It was mentioned that family and relatives, NGOs, and government are also responsible for Children's issues. 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.

Suggested solutions to improve the current care and support practice in the town is one of the questions asked to OVC respondents. They suggested children must involve in the issues that they concern them. 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 a OVC focused forum that would have, among other, a role coordination and facilitation support. It was mentioned that the forum will assume the responsibilities of solving each of the orphans problems and difficulties and search solutions as well. However, the majority of them are in desperate situations. There is no psychosocial and emotional support to OVC from any of the community members except some volunteers from SWAAE.

The answers for the question forwarded to the respondents with regard to care and support services obtained from HIV/AIDS committee are almost similar.

The respondents declared that HIV/AIDS committee does not even facilitate to get supports from other agencies. It was mentioned that, mostly, the town and Kebele Women and children Affairs Offices take the initiative. All underlined in their responses that the community should help OVC care and support initiatives

The plan to improve their life in future 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. *Background information*

Table 5: background information of the key informants

Name of the Office/organization	Sex		Type of organization	Position	Do you provide OVC Care and Support	
	M	F	GO		Yes	No.
Law Enforcement	X		GO	Security Information Processor	↗	
Labor and Social Affairs	X		GO	Reorganizing Association Processor	↗	
Women and children Affairs		X	GO	Training and Education Processor	↗	
Health	X		GO	HIV/AIDs Mobilization Processor	↗	
Kebele 3 Administration	X		GO		↗	
SWAAE		X	NGO	Supervisor	↗	
Hiwot Integrated Development Association	X		NGO	Community mobilization Officer	↗	

The *Fitche* town Law Enforcement, Labor and Social Affairs, Women and children Affairs, Police and Health offices*,* *Kebele* 3 Administration, SWAAE andTesfa*Integrated Development Association* are entities which provide care and support to OVC directly or indirectly. With the exception of SWAAE and *Tesfa Berhan Integrated Development Association*, all are government entities.

The responses of key informants indicate that the town Mayor Office, Women and Children Office, Health Office, and Labor and Social Affairs Office are responsible in selecting eligible OVC for various supports. Children whose parent(s) dead due to AIDS, high vulnerable and who have not provide with support by another organization were also mentioned as selection criteria. The committee at *Kebele* level members comprises of Chairperson, Deputy Chairperson, secretary, known personality, representatives from different organizations and children parliaments, and are responsible for selected OVC. Respondents declared that priority is given to AIDS orphans.

With regard to care and support to OVC, the information obtained from the key informants indicates that different organizations provide different kinds of supports to OVC. The supports are, mainly, focusing on the respective offices roles and responsibilities and legally established for. The services from the Law Enforcement Office mainly focused on legal protection including sensitizing community on child rights and protection issues. It also mentioned that the office is also provide psychosocial support for those OVC faced with violence and/or treat of violence and reported to the office(s) the case. It was reported that the labor and social affairs office is organized to provides, among others, training, material, cash, advice and support to OVC. The Women and Children Office, on the other hand, is the main government office dealing with children affairs, in general and OVC in particular. It was reported that the office provide support to OVC through facilitation and coordinating the support from other government and NGOs, provide or facilitate OVC to get educational, food, psychosocial, etc. support. The respondent from the town Police Office reported that the office provide a combination of many supports to OVC. From ensuring the legitimacy of the selection of OVC for support, following-up the fairness of supports provided to OVC by various organizations, writing letter of recommendation to OVC for referral services particularly for health services or support. The respondent from the Health Office has confirmed the responses of other key informants.

4.2.2. Level of key informants and focus group discussion Participants' Awareness to the Problems of OVC

Respondents were asked to express their level of 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 respondents have little knowledge regarding responsibility of caring HIV/AIDS OVC. They have also little know how about the role and responsibilities of HIV/AIDS committee. However, appreciation and giving priority to HIV/AIDS OVC has been

the focus of the activities undertaken in the provision of care and support to OVC and their caregivers.

It was reported that government and NGOs including *Kebeles* in the 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. It was also confirmed by *Kebele* 03, chairperson, vice chair person, and Women and Children Affairs Office among the key informants in this research that *Kebele* officials are organized a committee with ten members and provide them with training about issues relating OVC care and support. 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, 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. Respondents were also mentioned the difficulty encountered in identifying AIDS orphan due to fear of stigma and discrimination.

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 participants 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 within the community.

There are different understandings on conceptualization of OVC in the community which, this 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 be integrated to the wider society. They also disclosed that if community-based care and supported with technical and financial support by service providers, it would be cost effective and successful. Focus group participants has confirmed the views and suggestions of OVC respondents that the problems of OVC would be better addresses if OVC played the leading roles and took the responsibilities. They prefer community care to institutional care because they will not feel isolated or detached from the community and can better socialized with the 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 F*itche* town is beyond its infancy and, on the other hand the commitment to care declared to be low.

4.2.3. Care and Support for OVC

The information obtained from different groups of respondents, notably, the OVC and their caregivers revealed that there are different, but not well coordinated efforts made to mitigate the impacts of OVC and provision of care and support. An exemplary work in the community that the focus group participants repeatedly raised was the activities undertaken by *SWAAE* and the initiatives that *Tesfa Integrated Development Association* take in orphan care and support. The Women and children key informant stated that:

> "*While a number of policies, strategies and guidelines concerning care, support and treatment have been issued by the national government and many resources are allocated for implementation, it is civil society organizations in Ethiopia, such as*

SWAAE and Tesfa Integrated Development Association that have been at the forefront of providing care and support services to PLHIV and OVCs.

The selection of eligible OVC is carried out with active involvement of all stakeholders. The organization undertakes the selection of OVC after assessment is made together with Women and Children Affairs office and *Kebele* HIV/AIDS committee. The organization has been successful and enabled to support OVC including HIV/AIDS orphans. Hence, each of the children could attend school and were supported with their 'basic needs'. Initially, 250 OVC were registered for support. Currently, 190 OVC are provided with education, health, food and nutrition supports. The key informant from SWAAE reported that the health support is provided through referral linkage with government health facilities including Fitche Hospital. It was also responded that the organization has plan and budget to hygienic materials such as soap and pad and, therefore, the 190 OVC will be provided throughout the project period. The organization is also working on integration of OVC with parents/caregivers. Food and nutrition support has been provided to 60 needy OVC including 10 who are infected by the virus. Psychosocial support is also provided to the OVC.

Similar to OVC respondents, key informants interviewees identified community-centered services as the best alternative in OVC care and support. It was also reported that the number of OVC is known by the committee, but the difficulty lies on identifying those OVC who are infected by HIV. The committee has made efforts to provide coordinated care, and, therefore, fourteen OVC were receiving support from *Abebech Gobena*, NGO which has been implementing OVC project in the town. Others were receiving support from *Mekane Yesus* Church, UNICEF, *Iddir*. Food and nutrition, education, legal protection, health etc. supports were provided to the OVC. Those OVC who come to the *Kebele* from rural areas have been also provided with care and support.

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 not as expected. 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.

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

4.2.4.1 Challenges

Focus group and in-depth interviewee participants were asked to identify the most critical problems that encountered and yet not addressed with regard to OVC care and support. The same question was also raised for key informants. The responses of all respondents were found similar. . 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, promotion of Convention on the Right of the Child is made by *Fitche* town Labor and Social Affairs at intervals while it has no structure or outreach *at Kebele* level. 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 of some *iddirs* commitment and plan to provide care and support to OVC. As it is the case in most part of the country in general and *Oromia* region in particular, 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 *Fitche* town was identified as major constraint by key informants.

Challenges in the provision of care and support to OVC have been also identified. Most of the focus group participants also 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 identified as the leading challenges encountered in many of the OVC caregivers, and have reached the point in which they are no more able to continue support. PEPFAR, (2006), is confirmed the poverty as one of the main challenges in OVC care and support and stated that communities are hard hit by the double hammer of HIV/AIDS and poverty. This is mainly because of the low income caregivers or guardians of OVC generate from the informal sector such 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. Some of these problems are so deep-rooted that they need the involvement of many stakeholders and actors.

The increasing number of OVC living with the community has been also mentioned by focus group of participants as challenge. It was mentioned that the increase is, mainly, among other, the migration of OVC from rural to *Fitche* town expecting better life in urban areas. The basic factors that push most orphans from rural areas to urban areas are poverty and HIV/AIDS. On the contrary, an increasing number of OVC population and less response from the community side is also a challenge. The key informant from the *Kebele* 03 administration 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 support. The existence of stigma and discrimination against HIV/AIDS orphans within the community has also been identified by focus group participants. This was the case an HIV/AIDS orphan face while he started income generating activity-selling lotteries in the town. The key informant from *Tesfa Berhan* Association stated:

> *There was HIV/AIDS maternal orphan who provided with seed money to sale home-made bread, (Enjera famous food of Ethiopians)). Nevertheless, the local people who know her status did not want to buy for fear of transmission of HIV/AIDS through the bread. She told me the situation she was in and the whole stories by the time I asked her about the business and the return she has got. She said: "Low sale and no profit. I think people have heard about my sero-status and fail to demand for the bread even if I offer a great, and maintain its quality".*

Failure to have clear and full understanding on OVC policies, strategies and guidelines by service providers working at grassroots level, implementers is also stated as a challenge to provision of care and support for OVC. Less commitment of some of HIV/AIDS committee members 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 SWAAE and chair person of *Kebele* 03 and HIV/AIDS committee of the same also stated that the higher expectation of support from OVC is a serious challenge in the care and support effort in the community. The inactive role played by the HIV/AIDS committee, particularly, in leading and coordinating care and support to AIDS orphan was mentioned as challenge. The less awareness of the service providers on Standard Service Delivery Guidelines has also been mentioned as challenges.

In nutshell, the participation of community in general and HIV/AIDs committee in particular is inadequate. In addition, low awareness about OVC and OVC care and support, failure to know roles and responsibilities, less attention to OVC issues, failure to conduct selection of OVC as per the criteria set for the purpose, and turnover of members and *Kebeles*' officials capacity constraints to fully address OVC demand for the services, dropout of schooling, the presence of elastic demand for support, less awareness and failure of community to provide support were mentioned as challenges. Particularly, providing all critical minimums to OVC care and support is found very challenging. Opportunities for OVC support have been also mentioned. The awareness of the community has been improved, attentions of GO and NGOs has been improved, the availability of nation OVC care and support guideline, the inclination of older OVC to engage in IGA, and the presence of the committees at every government hierarchy were mentioned as opportunities.

4.2.4.2. Opportunities for OVC Care and Support

Similar to the questions regarding challenges on OVC care and support, key informants and focus group discussion participants were asked to provide their response on the prospects/opportunities that are existing in providing care and support to OVC and their caregivers in the community. Focus group participants and key informants were mentioning some the opportunities including 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* are showing their interests to work on HIV/AIDS prevention and control. Moreover, *Iddirs* initiation and commitment to support OVC with educational materials and create synergy in mobilizing their members and build better financial capacity for care and support. *kebele* 03 key informants 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 informants informed the inclinations of some government offices employees to provide care and support to OVC, in general, AIDS orphan in particular were mentioned. The presence of SWAAE in which most OVC are provided with care and support was mentioned as a good opportunity. The key informants also stated that the motivation and high interest of orphan and vulnerable children to engage in income 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 would engage in self –help efforts to lead their own life as was stated by the key informants of Labor and Social Affair and Women and children Affairs offices in the Association. This validates the response of the OVC with regard to the best alternative for care and support for OVC. The issuance of the Standard Service Delivery Guidelines has been also mentioned as an opportunity by the key informants. They mentioned that the guideline could assist service provider to provide standardized service delivery to OVC and to enable key stakeholders to uniformly provide services to beneficiaries at varying levels

The other opportunity that was communicated by the key informants of the *Tesfa* Integrated Development Association was the attitude of local project donors like USAID, and other external donors to fund the Association.

4.3. Case Illustrations

To triangulate the data collection and validate the findings, and also to supplement the information obtained from OVC respondent and to see the situation of orphan and vulnerable children, the researcher has conducted an in-depth interview with two OVC, a male and a female. Both in-depth interview participants are AIDs orphan. For the sake of confidentiality, the names of these children are given pseudo- names as *Liensa* and *Tolosa.*

Case 1

Tolosa is born to a peasant family not far from *Fitche* town. I had wanted to interview him about his life, because my key informant had suggested that he would be a good subject for a case study. However, initially, *Tolosa* rebuffed all my approaches to talk to him, and latter agreed when understanding the objective. *Tolosa*'s parents died when he was about ten years old. "I am a 9th grade student. I have no parents. The family had 8 members Dad and Mama and 6 children (4 male 2 female) I am the fourth child for my family. The family was living adjacent to *Fitche* town, and in much of the times was in absolute poverty where some times we had no enough food to eat, no clothing throughout the year, and was unable to cover educational fees. The whole family depends on such assets as a cow and two sheep, and 0.75 hectare of land. The main source of income was farming and livestock rearing. Though the land was productive; every year less produce was gained due to decline in land fertility and the size of the land. To supplement family income, my father had been working as daily laborers in *Fitche* town. Sometimes he was passing nights in *Fitche* town. As many daily laborer, with the little amount of money he got as wage, he drank local drinks, such as *Tella* and *Arkie.* After some times, he became sick. So did my mother. As a result, the family had encountered a serious problem. I came to *Fitche* town expecting better life in urban areas, but in reality life in urban areas is very critical and troublesome. Most of the days of the week, I was unable to feed myself with my little income I earn from shoe shinning. The only support that I currently get from my uncle, the caregiver, was shelter. I dislike working as a shoe shiner *("listero*" Ethiopia context) but it became a coping mechanisms and a strategy to live and be able to buy educational materials. My uncle (brother of my father) is a good man and who was helped me to have shoe-shining equipment. In this, case *"listero* "and buy me other necessary material by investing some Birr 40. 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"* was ranging from Birr 4-8. But, very occasionally, I managed to get a maximum of Birr 12 per day. Sometimes, I came up with no income at all. I could not 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 was able to cover my educational expensive myself for 3 years. Therefore, I was 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 neighborhood. For medical treatment, I could able to get free medication from the nearby government health center for the *kebele* 03 wrote a letter that entails my family's poor economic background and the situation I was in. 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.

Kebele 03 for the second time wrote me a letter of cooperation for individual contributions to get treatment. *Kebele* 03 HIV/AIDS committees provide me Birr 100 and also facilitate the contribution of Birr 240 from individuals 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, later on I was in critical psychological problem because of the continuous illness for fear of dropping out of school for economic and academic reasons. I had no one to help me, except a few contributions for medical treatment for my injured leg. I was in search of any organization, individual or group to help me and change my mind, not to quit my education. I shared the idea to my uncle. He felt suddenness and told me a new story about the death of my parent to HIV/AIDS.

It was during this time that I went to the *Kebele* office to tell them the situation I was in including the situation I lost my parents. The Chair person of the *Kebele*, after attentively listen to me, he told me the existence of HIV/AIDS committee at the *kebele* level chaired by him, and which could facilitate to get support.

He gave me appointment to come the next day to write me a letter of support to SWAAE, an NGO working on OVC care and support in the town. I had submitted the letter to the organization and have got supports which enabled me to continue my education through the educational materials received from the organization. I am now a grade 9 student. Thanks for the *Kebele* 03 HIV/AIDS committee, and the chair person of the same, I am continuing my part time job-"*Listero*" earn income which could assist me my daily consumption partially.

Case 2

Lensa is 11-year-old female child. She is single orphan who was born and grown up in *Fitche* town. She had lived for the last 2 year with her widowed father." My father lives with us and my elder sister preparing food. My Mama was dead before 2 years when I was 9 years old. By the time she dead, the cause of her death has not been known. After a year when my father became a TB patient, our neighbors and people living nearby had rumors, and started to talk the cause my mother's death to AIDS, though they did not brought with written evidence from the physicians. During this time I started to work to our neighbor, a 40 years old woman because the family was unable to provide me with the support of food and education materials, love and affection because of my mother's death. I started to 'taste' a new life which demanded to work harder. My family comprised of five members, my father and four children. One of my sisters had quitted her education and started to work as daily labor and enabled to generate income for the family, the other married. My sister who had been working as daily laborer and supports the family with the little amount of money she earns has left the town in search of job. I was tried harder not to drop out of school, and I had preferred to work as local drinks (*Tella* and *Arekie*) and work harder in my education. My father had passed away after 1 year of illness. By that time, I had no relatives around who help me.

As daily laborer, I make living and occasionally I support my youngest brother, by buying foods. The family of mine had neither assets nor land possessions in rural areas to be hired or contract out, nor a house, at least government owned/*"Kebele"* house with low amount of monthly rent. The person who had rented the house for my family, after allowing us to live free of rent for 3 months since the death of my father, requested us to find other means. With desperate situation, I had such personal health problems as unable to sleep, chronic economic problem, used to live in the 40 year-old woman for whom I worked for. My youngest brother had got shelter in our eldest sister who had married a person working in dairy farm near by *Fitche* town. I face problems of isolation, helplessness, hopelessness, and above all psychological stress for difficulties in my life as 11-year-old orphan. As a double orphan, I had had an opportunity to be accessed as beneficiary in local projects funded by external agency, by USAID, with other fellow orphans and started to live in orphanages for 8 months. After some 8 months, that orphanage is claimed to be dysfunctional because of administrative and financial reasons. Later on, a strategy was

designed by the organization and town level HAC to reunify beneficiaries to foster families with provision of 500 birr each. I was reunified to my family of origin in which a married sister husband as a head of a family. I started a street vendor as income generative activities (IGAs). *Kebele* 03 had started registration of OVC, particularly AIDS orphan to provide care and support. I know, at least heard, that my parents died to AIDS. I became a bit nervous to tell the truth because of my “bad” luck the occasion created. On those days, I was so upset that I preferred not to be registered. I planned to migrate to the nearby town, *Debre Tisge*- and decided to live once again as local drink house worker. The other alternative brought to my mind was to drop out my education at 6th grade, and live and work in *Fitche* town adjacent *Kebele (Kebele 2)* where people did not know the cause of the death of my parents, as a daily laborer to make a living. The second alternative succeeded, at least theoretically, as a coping mechanism, I talk a 37 age woman widow who sales local drinks and tea to hire me. She agreed. But, I became confused, and frustrate to leave my brother. I knew that they were not happy to leave in our sister house, as her husband had already started complaining and was not comfort with the situation. I finally decided to rent a low cost house and engage in selling local drinks. I told the decision to my sister, and requested her to provide me some local drinks processing materials and Birr 50. She agreed and facilitated the situation. She had already known her husband discomfort with us. I succeed and started to work as I was working previously. Life was continued in the same track.

The *Kebele* 03 administration, particularly, HIV/AIDS committee, was very concerned with the situation of we were in, and heard also my drop out from school. In addition, I was in dilemma whether to continue my education or not. Therefore, I was thinking of an organization or individual for sponsoring my education and other support so that I would graduate, at least, from high school. One day the *Kebele* Health Office head came in our house early in the morning and told us that the *Kebele* office chair person had ordered him to tell them to come in the *Kebele* office. We went and got advice from the chair person of the *Kebele.* He also told us the support ready to us, particularly as he had information that we are HIV/AIDS double orphan. He finally formed linkage with SWAAE to get care and support. My plan became to finish high school education, search for job, and help myself and my youngest brother, and the *Kebele* chair person and members of HIV/AIDS committee who should deserve a reward for their continuous help after my parents’ death. God knows what would happen next.”

4.4. Observation

The researcher has employed observation as a method of obtaining qualitative data. The duration of the researcher's with the research community was very short. However, the researcher manages to observe few of the practices which have an implication on HIV/AIDS prevention and control, OVC care and support in particular. In addition, other initiatives such as activities of FGAE and SWAAE have been observed.

In *Fitche* town, the researcher has observed some of the actors on prevention and control of HIV/AIDS. For, example in *kebele* 03**,** 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 expense to buy. The *kebele* officials facilitate the meeting of these people together. And had trained community home based caregivers, to inform the *kebele* people about HIV/AIDS prevention and care and support to those affected by the virus. 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 *kebele* 03 officials were conducting a meeting with the *kebele* people. Ethiopia Orthodox Church, *Woreda* diocese, was also conducting 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 and OVC, in particular. These forums could also be used as a means of resources mobilization and advocacy to care and support for OVC living in the community.

The other observation was the weekly meeting that OVC conduct in the SWAAE. 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

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 groups.

5. DISCUSSION

5.1 Understanding the situation, 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. According to FHAPCO (2010), it has left 5.4 million orphans and vulnerable children of whom 900, 000 are from HIV/AIDS 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 grandparents, 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. The above case presented to illustrate and triangulate the findings as well as the respondents of different groups indicate that the causes of vulnerability is found to be, mainly, poverty and HIV/AIDS.

5.2. Options to Current Problems and Sustainable Response

Family-centered approach, in general, is one of guiding principles of many OVC programs. This is due to the fact that the primary purpose of family-centered approach and practice is to strengthen the family's potential for carrying out their responsibilities. Family-centered interventions help mobilize resources to maximize communication, shared planning, and collaboration among the many community and/or neighborhood systems involved with the family (PACT, 2011).

Often, programs in OVC strongly insist that institutional care is not optimal for child development, sustainability, or cost-effectiveness. There are, however, instance when residential care could be the only practical alternative.

CARE'S Model of household based intervention in communities affected by HIV/AIDS is also the best practice. This model is effective in many sub-Sahara countries Ethiopia, Kenya and Malawi. It is also implementing project implementing by CARE Ethiopia where PLHIV 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 have been 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. In this regards, the PEPFAR initiative, in Ethiopia, such as Strengthening Community Response to HIV/AIDS (SCRHA) project funded by USAID can be a good example in employing a household centered approach. Most argue that these kinds of initiatives have to be technically and financially supported by different actors operating through community development since it focuses on holistic approach, not an isolated effort that brings social change on HIV/AIDS and OVC care and support.

Significant in care and 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 HIV/ 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, as the cases illustrate in this research. It is 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 of OVC population in *Fitche* town 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 as they are social capitals.

5.3. Care and support provided for orphan and vulnerable children

Type of care and support that OVC get currently are mainly educational and health care, which are only part of the comprehensive care support packages as framework of care and support and minimum package for care support entails through the National Services Standard OVC Guideline. The guideline entails that 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 PLHIV and helping them live long reduces the number of OVC living in the community by decreasing the number of deaths of many children. The roles of HIV/AIDS committee, in this regard, found inadequate. Therefore, intervention should focus on prevention, care and support for OVC beneficiaries, and their caregivers. The emphasizing should also be in empowering and providing technical and social-economic 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, as part of economic strengthening support, is one option for this to happen and support such a program

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 works on IGAs on their spare time. Psychosocial counseling either by para –counselors trained within the community outreach or professionals employed by local projects are therefore necessary for care and support to OVC in the community. Before conducting such program, needs assessment, training, and prioritizing the needs is necessary. This, among others, should be the responsibility of HIV/AIDS committees who take responsibility to lead and coordinate the activities.

Orphan and vulnerable children are part of the problem of HIV/AIDS and active members in soliciting the solutions to address their problems. 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. 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). Similar strategy was employed in the OVC focused project funded by USAID through Project Concern International in *Machew* town, *Tigray* where schools and household gardening were promoted to supplement income of OVC caregivers (NPHHC, 2009). 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, schools, 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 (HAPCO, 2006). On the other hand, the commitment of 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 services 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 the country. At the center of these practices is the activities undertaken by the *Iddir* in *Dire Dawa* which became centre of excellence in local initiative regarding OVC care and support (Save the Children USA, 2009). The *Iddir* facilitated IGAs for older OVC and OVC guardians. Viewing OVC care and support in a wider perspective, the *Iddir* is a base for development of voluntary service by community members. This local initiative should be replicate to other areas too.

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 in *Fitche* town 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 of stigma and discrimination in the community as cases in this study illustrate. Therefore, the criteria set by the community are sounding with

some modification should usually take the children and caregivers in context. However, if disclosed and a reliable evidence available, special criteria should be set to give priority to AIDS orphans. In this regards, the roles and responsibilities of HIV/AIDS should be strengthened.

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 capitals of the community discussed below.

5.4. Strengthening Social Capitals

It appears important that social capitals of the community contribute to provide care and support to OVC, in general and AIDS orphan in particular, and strengthen collaboration and partnership in the same. In this regard, the qualitative data obtained from the informants include: the family, the NGOs, community structures and networks, government interventions such as education and health, religious institutions were considered as social capital.

Family as social institution could play in socializing young people about the problems and issues related to OVC. As a result, there could be attitudinal changes that could be assist individual man to take responsibilities in OVC issues, particularly with regard to caring HIV/AIDS orphan. This had been a great concern during focus group discussion.

Some NGOs such as FGAE *Fitche* town could deal with the community norms, value, beliefs that hinder participation and partnership in OVC care and support. The strategies designed to increase the awareness of the individuals on OVC problems and the need to provide the necessary care and support include discussions using different forums and association such as youth and women associations, "*Mahaber"* and "Idder". These approaches make the conversations to continue both in formal gatherings and in the neighborhood. According to the key informants, the impact of *Abebech Gobena* in *Fitche* town had been tremendous.

In general the Ethiopia Communities have social structure and net works for exchanging information and collectively dealing with social problems. Although these social structures very much used to maintain the social norms, values, and customary practices prevailing in the community with the aim of maintaining social harmony, could be used to create values and norms appropriate to deal with OVC issues, such as mobilizing resources for OVC care and

support. The *Geda* system could be serve to transmit issues that are relating to OVC. The study conducted by MHRC (2004) also emphasized on the role of *Geda* system in combating HIV/AIDS among the *Oromo* communities. On the other hands, *Gudifacha* as one of the most important social capital has been experienced in *Oromo* culture for up bringing the OVCs in almost all corners of the country. This practice has to be scaled up in all parts of the world where the social problem like HIV/AIDS is affecting OVCs.

Edir, Mehaber, sports and music clubs among youth can have roles to play to discuss on the issues of OVC, and will enhance community involvement and partnership on the issues raised.

Government interventions, especially education and health services provisions, can have contribution to bring both the desired attitudinal changes among people and create rooms for OVC matters, as it was mentioned by the informants. Schools can sensitize students to OVC issues.

The data obtained from the key informants in the health office indicated that the maternal and child care health department (MCH) has been providing health education, and the need to provide health care services to OVC, particularly youngest (0-5 years old) OVC. The VCT centre, which provides services, operating in the health centre; mainly provide services for adults could serve to teach OVC to get HCT.

The religious structures, both Islam and Christian, as well as other traditional belief system such as *Wakefata* could enhance partnership different actors working with OVC care and support. Muslim and Christian religious as well as the *Geda* leaders are involved in HIV prevention, care and support programs and activities. They work to stop harmful traditional practices such as extra-marital sex, early or underage marriage, sexual violence including rape and abduction, and also to combat the spread and impacts of HIV/AIDS. These, according to the respondents, indicated that religious and traditional institutions could be considered as social capital towards OVC care and support and partnership in the same. Religion can be fertile ground to transmit the messages of the advantages of OVC care and support and partnership.

Respondents' views towards the efforts OVC care and support and partnership centered on structural factors which broadly categorized as economic, socio-cultural factors, such as poverty.

Therefore, it could be helpful if any efforts were excreted to minimize the influences of those factors so that the desired attitudinal changes could achieve towards OVC care and support in general, and AIDS orphan in particular. In this regard, the study findings showed that the social capitals of the community could be used to promote OVC care and support and partnership in the issues raised. Exploiting the social capitals of the community to OVC care and support is the issue remains adequately untouch by HIV/AIDS committee in *Kebele* 03.

5.5. Multi sectoral-responses-roles and responsibilities in OVC care and support

The writer has tried to assess the prevailing community structures, particularly roles, challenges and prospects/opportunities of HIV/AIDS committee in *Fitche* town in *Kebele 3* where 417 OVC residing.

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.

Ethiopia has endorsed HIV AIDS prevention and control policy in 1998 (HAPCO, 1998). With theme *"Accelerating Access to HIV/AIDS Treatment in Ethiopia*' as in the case of the first Road Map, 2004 – 2005, the second road map, 2007-2008, which has been developed under the leadership of Federal HAPCO, and were instrumentals in prevention and mitigating the impacts of the virus and provide care and support to those who are infected and affected by the spread of the virus.

The application of the National Standard Service Delivery Guidelines has also been instrumental in concerting efforts by all stakeholders at various actors including the federal, regional and local levels. Specific roles and responsibilities for each level-National, regional, *Woreda,* and *Kebele* are clearly identified.

In some instances, the HIV/AIDS committees at different levels play vital roles in preventing the spread of the virus and provide care and support for those infected and affected by the virus though the roles are varied among different levels. The study by Yohannes (2006) has disclosed the active roles played at local level rather than at national level. The structure of the HIV/AIDS

includes a sub-committee for care and support services. This sub-committee is expected to provide care and support to people infected and affected by the virus including OVC.

The data obtained from the key informants indicted that children who have been orphaned by AIDS are forced to leave school, engage in causal labour, suffer from depression and anger, or engage in activities (such as selling local drinks) that lead them to high-risk behaviour 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.

The first and most important issue to rise and discus is the selection criteria that service providers and community organizations deploy to the OVC beneficiaries. The process and selection criteria are relevant. The key informants from *Kebele* 03 responded the existence of the criteria. The criteria, however, are not adequately understood by neither HIV/AIDS committee members nor by Women and Children office. The most challenge that the committee faced is to identify AIDS orphans as most of them do not disclosed their status. This created difficulties in provision of care and support to such OVC.

Lack of adequate knowledge with regard to the types of services to be provided to OVC is also the observations and discussions indicated. Children in this community live in dysfunctional families and become emotionally and psychologically affected which causes them to anxiety, stress, depression hopelessness and helplessness, as the cases illustrate in this research. It also argued that the extended families are limited. 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 as the cases in the study demonstrate. The role of the community as the next line of defense to provide care and support to orphan and vulnerable children is unquestionable. Here comes the need to have a coordinating body, which commonly a government structure which takes the responsibilities of leading and coordinating the efforts made in OVC care and support activities. Key informants from *Kebele* 03 have repeatedly underlined the limited capacity of the committee in terms of managing and coordinating the activities. However, establishing linkage OVC to get for support, providing psychosocial support to AIDS OVC is activities to be strengthened.

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 roles played by HIV/AIDS committee at the community mobilization in the study area, already the activity is not up to the expectation.

Mapping the available services and creating conducive condition for referral services is vital in OVC care and support. In this regards, it was found inadequate roles played by the *Kebele* 03 in general, HIV/AIDS committee of the same in particular. Health service as integral part of OVC care and support is expected to be provided through referral services. The finding of the study, however, disclosed that OVC are not adequately provided with health referral services. Rather the OVC are striving to solve their health problems and needs by themselves.

In nutshell, when looking at the roles and responsibilities of HIV/AIDS committee, in general, and the lenses of OVC care and support described in the national guideline and also stated in the review literature in particular, in, the roles and responsibilities of the committee are inadequately addressed.

The Implication to Social Work Practice

> *Social work is a professional and academic discipline that seeks to improve the quality of life and wellbeing of an individual, group, or community by intervening through research, policy, community organizing, direct practice, and teaching on behalf of those afflicted with poverty or any real or perceived social injustices and violations of their human rights.(Wikipedia, the free encyclopedia)*

Social work is a profession that is concerned in helping underprivileged members of the society, enhancing the well being of people within their social context and addressing the well-being of society as a whole. It 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 including OVC. 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 in general and AIDS orphans in particular, 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. Research in social work is often focused on areas such as human development, social policy, public administration, psychotherapy, program evaluation, and international and community development. 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 could 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.

The HIV/AIDS committee structure established at every government hierarchy to coordinate the social work activities for those infected and affected by the virus including AIDS OVC, is one example of social work practice.

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 use the challenges and opportunities of HIV/AIDS committee identified through this study to

ensure quality of care and services stated in the National Service Delivery Guideline. Social workers can follow up and monitor appropriate service delivery to OVC and their caregivers.

Social workers can facilitate arrangement to foster care and adoption (*Gudifacha* in local context) for children who have no one to take care of them in the community context. They can also facilitate referral services to OVC beneficiaries who are critically in need of care and support. Above all, 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 HIV/AIDS response to OVC care support; and strengthen the prevailing opportunities. This particular study is, therefore, part of social work efforts focusing on assessing the responses of the community in general, and roles and responsibilities of HIV/AIDS committee in particular, which is part of area of social work.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1. Conclusions

The study has been aimed at assessing community responses to OVC in general and AIDS OVC in particular with special emphasis exploring the roles and responsibilities of HIV/AIDS committees. In this regard, the views of OVC and their caregivers, and representatives from OVC service providers including GOs and NGOs obtained under the major themes. The study also assessed the challenges and opportunities in providing care and support. Therefore, the findings of the study draw the following conclusions.

Understandings the problems OVC and the means of mitigating the same are not found similar among community members including service providers. Service providers, mainly HIV/AIDS committee, knowledge and awareness on package of services (critical minimums) described in the Nation OVC Standard Service Delivery Guideline is varied and also, in some cases, limited. There is limitation, for example, on the importance of psychological support to be provided for OVC who faced psychological and emotional problems, particularly, AIDS orphans.

The research highlighted economic factors such as poverty could have influences on the well being of OVC. The study pointed out that HIV/AIDS and poverty are the leading causes of vulnerability to OVC, in general, and AIDS OVC in particular living in the community as the study implicitly indicates. The prevailing of these problems are not found only a cause to vulnerability, but they 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 absorb more OVC is limited. This is mainly because of the prevailing 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)

This research validates the conventional views and the position of many people with regard to family and community centered OVC care and as best alternative.

The study has also identified OVC as the prime decision maker to become out of poverty. The finding of the study revealed that the care and support to OVC could sustain if OVC involve in all project cycle- design, implementation, and evaluation.

The roles and responsibilities of HIV/AIDS committee in caring and providing support to AIDS OVCs has been tend to be challenged through this research findings. The committee has not adequately discharged its roles and responsibilities.

Most of the OVC and their caregivers are 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 extended families and 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.

The study demonstrated that even though there is, in general, awareness to the problem of OVC living in the community, response is generally low. Even though insufficient and discontinued at many occasions, local projects funded by external donors are the main actors in care and support to OVC. The types of support that most caregivers provide to OVC are mainly education and thus do not fit to the minimum package of care and support and comprehensive care and support models recommended.

In mobilizing the community resources, capitalizing of the existing local structures such as HIV/AIDS committees and organizations such as Women and Children affair office are very vital since all for play to ensure ownership of OVC care and support program. It is equally also important to exploit the existing social capitals of the community.

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 effected. 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 PLHIV, public and mass education of HIV/AIDS and issues related to 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 towns/areas 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.

Currently, the provision of care and support given by local projects has to be continued 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 community'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.

6.2. Recommendations

Much effort has to be exerted by all stakeholders to change the attitude of the community towards HIV/AIDS orphans.

Strengthen the commitment of the community members to OVC care and support in order the current plights of HIV/AIDS and its multi-dimensional impact on the community, in general, and OVC, in particular, are to be reduced.

Involvement of all stakeholders in OVC care and support associations such as women's association, youth Associations, and other social and economic local organizations is crucial to

reach more OVC and provide quality care and support services. 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 general, and providing care and support for infected and affected by the same in the town. Above all, involving OVC in all aspects of OVC initiatives and programs is crucial as they are affected by the problem, and can be also part of the solutions.

The roles played by HIV/AIDS committees have to be strengthening to coordinate and lead the multi-sectoral response to HIV/AIDS efforts including providing care and support to those infected and affected by the virus, particularly AIDS OVC.

HIV/AIDS and poverty are the leading causes of vulnerability to OVC, in general, and AIDS OVC in particular living in the community as the study implicitly indicates. Therefore, it would be recommended that all stakeholders working on poverty alleviation and HIV/AIDS to strengthen collaboration among themselves to combat the impacts of poverty.

Community development, community empowerment, and community assessment, resource mobilization should be critically analyzed before designing a certain community-based intervention programs focusing OVC.

Community mobilization and increased community's commitment to care for orphan and vulnerable children are very important.

Collective efforts of individuals, groups, community and national and local governments would solve most of these challenges encountered by the HIV/AIDS committee. It is also equally important to strengthen the capacity of all actors working on OVC and properly exploit the opportunities prevailed currently.

Hence, it appears important to conduct OVC related study. In this regards, the study suggests that further research on situations and issues of OVC and their caregivers for the design and implementations of services that focus on children is essential.

Strengthening social work activities through involving social workers in designing, implementing, evaluation activities of all GOs and NGOs is vital.

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ANNEXES
Research Instruments

Consent Form and Research Instruments

Annex I

Verbal Consent Form
Introduction
My name is Ajema Gondel . I am a post graduate student from Indira Gandhi National Open University. Currently, I am writing my thesis in Partial Fulfillment of the Requirements for the Degree of Master of Social Work.

I am currently collecting data and information regarding HIV/AIDS Committee(s) response to orphans and vulnerable children in Fitchee Town. The data and information would assist me to write my thesis.

First of all I would like to make you clear what I mean by orphans and vulnerable children in order to assist you to answer the questions to the point.

"A child, 0-17 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); or
- Is marginalized, stigmatized, or discriminated against. "

Confidentiality and consent
I may ask some personal questions that some people find difficult to answer. I am not going to talk to anyone 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 are not expected to answer any question that you do not know or 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 like to thank you in advance for your cooperation, and appreciate your for being one of the respondents to this study. The interview will take 30 to 45 minutes (It may depend on the type of the method). Would you participant?

(Respondents will be asked to give informed consent verbally before the interview

Annex II.

Questionnaire for orphan and vulnerable Children

I. **Background information**

1. Sex---------------------------------- Male ☐ Female ☐

2. Age

A. 0-5 B. 6-10 C. 11-15 D. 16-18

3. Religion

A. Muslim B. Christian Orthodox C. Christian Protestant
D. Christian Catholic E. Other, specify-----------------------

4. Level of education

A. Illiterate B. Church education C. Kuran D. Reading and write
E. Grade 1-6 F. Grade 7-8 G. Grade 9-10 H. 11 and above

5. Type of respondent ---------------- Orphan ☐ vulnerable children ☐

II. **Socio -economic situations 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. How many children are living in the household you are a member? ---------

5. What is the source of income for the household?

A) Salary ☐ B) Street vendor, ☐ C) Daily labor ☐ D) Other (specify)-----------------
E. No income

6. If your answer for question 5 is “E”, from where do you get support/ income?

A. Relative B. NGOs C. Community D. Other, specify----------------------

III. Care and Support

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) HIV/AIDS committee ☐ G. others (specify)--------------------

3. What kind of support did you get from the organization you mentioned? You can answer more than one answer
A) Food and nutrition ☐ B) Heath ☐ C) Education ☐ D) Psychosocial E) Protection/Legal ☐
F) Shelter G) All ☐ H) other (specify)-----------------------------

4. Please rank the services you have received starting from most satisfied. Please label 1 for most satisfaction, 2 for satisfaction, 3 Average satisfaction, 4 low satisfaction

Core Services/needs	**Rate**
Food and nutrition	0
Education	
Health care	
Protection	
Shelter and Care	
Psychosocial support	
Economic Opportunity/Strengtheni***ng***	

IV. Challenges/Problems and prospects/opportunities.

1. Have you ever encountered problems in the households you live? Yes ☐ No ☐
2. Describe type of problems--
----
3. 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. ☐ F. HIV/AIDS committee ☐ F) Other, specify-------------------------

4. What do you do when you encountered problems in the household?
A) Runaway ☐ B) Cry ☐ C) ask someone for help ☐ D) ask excuse to household? ☐
E)Nothing? ☐ F) Other specify----------

5. Whenever 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. 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--

7. What do you think should be improved in the current care and support practice in this town? (Prove, finical, technical, emotional support)

8. Have you or your caregivers ever received any support from HIV/AIDS committee Or Does the committee facilitated to get supports?
9. Who do you think would be the most important for improvement of your life in the future? (Probe relatives, friends, and service providers).

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

9. Anything 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 the organization---
2. Sex--
3. Education--
4. Type of organization (Gos, NGOs, CBO,) other (specify) ---
5. Type of program related to HIV/AIDS and OVC your organization engaged in -------------------
----
6. Position of the key informant in the organization on ---
7. What Kinds of Activities are undertaken by your organization?
----
8. Is your organization involved in care and support for orphan and vulnerable children? If yes, How many children benefited from program?------------
9. Who have been involving in selection of OVC?

A--
B---
C---

10. What are some of the criteria used for selection of OVC?

A--
B--
C--

11. What are the roles that have been played to provide care and support to OVCs?

A--
B---
C---
D---
E---
F---

12. What kind of support does your organization provide to OVC caregivers?

A--
B---
C---

13. Which one of the services is the most demanding by OVC-----------------
14. What selection criteria do your organization used for caregivers support?

A--
B---
C--
D--

15. What kinds of support do caregivers received?

A--
B--
C--

16.Do community participate in caring OVC? If yes how?

A---

B--
C--
D---
17. Do you provide coordinated care for OVC? If so, with whom?
A---
B--
C--
18. Which organizations were your stakeholders?
A---
B--
C--
19. What were the constraints / challenges your organization encountered with regard to care and support to OVCs?
A---
B--
C--
D---
20. What prospects/opportunities do exist for caring OVC?
A---
B--
C---
21. What type of care and support approach do you recommended to provide quality of care to OVC and sustain the same in the context of this town? Why? (Probe, family-based, community-based, intuitional)
A---
B--
C--
D---
22. What activities have you undertaken in pulling resources to care and support for OVCs? (Probe the capacity
A--
B---
C--
D--
23. What part of OVCs problems and needs are still not addressed?
A---
B---
C---
D--
24. Which one of the support is need due attention to care givers /guardians and OVC currently in the town?
----
25. what strategies you suggest can improve the current care and support for orphans and vulnerable children in this town?--
26. Do you have any additional comment (s)? --

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. **Background**

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?
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.
4. Have you inherited resources from your parents?
6. What kinds of resources you inherit?
5. Who administer it? (Probe elders siblings, relatives)

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, HIV/AIDS committee)
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?
7. If your answer in question (6) is yes, what was the cause's illness? Where did you go for treatment? (Probe, who help you to be treated)
8. Do you have a caregiver? If so, what is your relationship (probe, parent, relative? adopter, foster care?)
10. Have you ever got care and support from any organization/ institution, for the last years? If yes from which organization?
12. What are the most critical problems you encountered and yet not addressed?

A.--
B.---
C.---
D.--
E.---
13. What is your plan to improve your life in the future?
14. Anything you want to add before we close this session.

Annex V.

Guideline for Focus Group Discussion (FGD) with HIV/AIDS committee Members, and OVC Caregivers

Number of participants

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

1. Are there many OVC in the town?
2. What are the perceived needs of OVC in this community?
3. Who in this community is providing care and support to orphan and vulnerable children?
4. What are the activities under gone to alleviate the problems of orphan and vulnerable children in this community?
5. Do OVC receive basic or "core" needs include food/nutrition, shelter and care, legal protection, health care, psychosocial support, economic strengthening and education?

5. What are the roles played by the HIV/AIDS committee and other agencies in providing care and support to OVC and their caregivers?
6. What were the constraints, challenges faced in providing care and support to OVC?
7. What are the prospects/opportunities in providing care and support to OVC and their caregivers?
8. With all challenges, do you think that OVC are satisfied with the care and support given to them?
9. What is the most important aspect of care and support activities that need improvement?
10. What do you suggest for sustainable care and support to OVC in this community?