COMMUNITY - BASED AND FAMILY – CENTERED INITIATIVES FOR PROVISION OF CARE AND SUPPORT FOR ORPHAN AND VULNERABLE CHILDREN (OVC) AT ARAT KILO CHILD CARE AND COMMUNITY DEVELOPMENT (AKCCCD) ORGANIZATION IN
ADDIS ABABA, ETHIOPIA

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List of Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AKCCCD	Arat Kilo Child Care and Community Development
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
CAC	Community Action Cycle
CBCCO	Community-Based Childcare Organizations
CBO	Community Based Organization
CC	Community Conversation
CCG	Community Core Group
CFS	Child Friendly Schools
CM	Community Mobilization
CRC	Convention on the Rights of the Child
CSSG	Community Self-help Savings Group
CSO	Civil Society Organizations
ECD	Early Childhood Care and Development
FBO	Faith Based Organization
FGD	Focus Group Discussion
FHI	Family Health International
HAPCO	HIV/ AIDS Prevention and Control Office
HIV	Human Immunodeficiency virus
MOH	Ministry of Health
MOWA	Ministry of Women Affairs

NGO	Non-Government Organization
OVC	Orphans and Vulnerable Children
PC3	Positive Change: Children, Communities and Care
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PSS	Psychosocial Support
SCSN	Strengthening Community Safety Net
SHG	Self Help Group
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCC	Vulnerable Children's Committee
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YHH	Youth-headed Household

Chapter I Introduction

1.1.   Background of the Study

Community based and family centered initiatives for the provision of care & support to Orphan and Vulnerable Children (OVC) may be described as a project that provides psychosocial support and other basic services through home-based volunteer community care providers to children who have lacked parental care and support. OVC services may be broadly defined as interventions that address the need to improve health, wellbeing and development of OVC.

Children orphaned or made vulnerable by HIV/AIDS faced a wide array of severe and interlinked problems. In addition to the deep psychosocial distress of losing one or both parents, they may also lack food, shelter, clothing or health care. They may be required to care for chronically ill adults or young siblings and forced to drop out of school. They may face discrimination, abuse or exploitation. Deprived of parental guidance and protection and in need of financial and emotional support they may themselves become vulnerable to HIV/AIDS.

In many communities, traditional ways of caring for orphans and vulnerable children, such as the extended family system, are being severely strained by the multiple, mutually exacerbating impacts of HIV/AIDS. The critical challenge is to find ways to help communities care for the unprecedented number of children and families rendered vulnerable by HIV/AIDS. Despite the fact that various efforts were made by the government of Ethiopia, UN agencies, international and national non-governmental organizations as well as civil society organizations the problem faced by the OVC persists. Most of the OVC are highly exposed to the various forms of psychological and physical abuses like abandonment and

property grabbing. Moreover, these OVC especially the ones affected by HIV/AIDS lack adequate nutritional and psychosocial support and access to proper health care. As HIV/AIDS undermines the fundamental human attachments essential to normal family life and child development. Mental distress due to stigma and discrimination is common among OVC who lost their parents due to AIDS and among People Living with HIV (PLHIV). Children affected by HIV/AIDS suffer anxiety and fear during the years of parental illness, then grief and trauma with the death of a parent.

The Psychosocial support and other related services provided to the OVC by different actors are generally inadequate due to shortage of professionally trained personnel and limited logistic facilities to reach the vulnerable children. Hence, there is a need to design effective psychosocial support through home-based care providers. The children whose parents have died of AIDS face significant stigma and discrimination, compounded by cultural taboos against the discussion of AIDS, sex and death. This stigma contributes to isolation and distress among affected children and PLHIV to cope with the impact of HIV/AIDS. Many are unable to benefit from the emotional support of loved ones, friends as well as from social services that can improve the quality and length of their lives, and enabling them to protect other members of the society. Therefore, the contribution of this study is to examine whether the services provided by the NGO are in line with the target groups felt needs. It is clear that the NGO has outlined its approach to the interventions which is community based and family centered care and support service. Given this, the study will try to assess the relevance and appropriateness of the intervention in light with the social work profession.

1.2.   Statement of the problem

According to the UNAIDS report on the global AIDS epidemic (2010), the overall growth of the global AIDS epidemic appears to have stabilized. The annual number of new HIV infections has been steadily declining since the late 1990's and there are fewer AIDS-related deaths due to the significant scale up of the Antiretroviral Therapy (ART) over the past few years. Although the number of new infections has been falling, levels of new infections overall are still high, and with significant reductions in mortality the number of PLHIV worldwide has increased. However, despite the modest decline in HIV adult prevalence worldwide and increasing access to treatment, the total number of children aged 0–17 years who have lost their parents due to HIV has not yet declined. Indeed, it has further increased from 14.6 million in 2005 to 16.6 million in 2009. Almost 90% live in sub-Saharan Africa.

With an estimated 1.2 million people living with HIV in 2010, Ethiopia belongs to the heavily affected countries of Sub-Saharan Africa. According to the single point estimate by Federal Ministry of Health and National HIV/AIDS Prevention and Control Office adult HIV prevalence in 2010 is estimated to be 2.4%. The average urban prevalence being 7.7% is about eight times greater than the average rural prevalence, which is 0.9% respectively for 2010. HIV Prevalence rate was 1.9% for male and 2.9% for female, and women accounted for 59% of the HIV-positive population. There were an estimated 137,494 new HIV infection (58% female) and 28,073 AIDS-related deaths (57% female).

The total estimated number of HIV-positive pregnant women and annual HIV positive births in the same year were 90,311 and 14,276 respectively. There were an estimated 79,871 children less than 15 years old living with HIV, out of which 26,053 needed ART. Due to the combined effect of poverty and AIDS, more than 5.4 million children (917,691 urban and 4,505,768 rural areas) under the age of 18 years were orphaned out of which 804,184 (15%)

are single orphans who have lost at least one parent due to AIDS. Systems for care and referral for children affected by AIDS and PLHIV vary in quality and coverage, with most areas having limited access to Antiretroviral Therapy (ART), professional health personnel and medical supplies. HIV counselling and testing services are not adequately equipped with supplies and trained personnel. Consequently, the survival of hundreds or thousands of Ethiopian children and families is threatened by HIV/AIDS, which is also a threat to the socioeconomic development of the country.

A number of underlining factors contribute to the spread of HIV/AIDS in Ethiopia, including poverty, illiteracy, stigma & discrimination to those infected/affected by HIV/AIDS, high rates of unemployment, widespread commercial sex work, gender disparity, population movement including rural – urban migration, harmful cultural and traditional practices (HIV/AIDS Prevention and Control Office: HAPCO, 2004).

For centuries, Ethiopian communities have helped neighbors in crisis. But the huge numbers of children in need meant that neighborly support is no longer enough. As a response, community members are getting together to assist children and their families within their communities. Community initiatives can provide various kinds of assistance including parenting, protection, psychosocial and spiritual support, and material assistance.

Despite the continuing absence of a separate OVC policy and strategies, the Ethiopian Government has taken various steps to address the complex issues surrounding orphan and other vulnerable children. Various researches and direct interventions were undertaken in collaboration with the international community and local civil society organizations that includes Faith Based Organizations (FBOs) and Community Based Organizations (CBOs). According to the report on progress towards the implementation of the UN Declaration of

Commitment on HIV/AIDS in 2010 by the Federal Democratic Republic of Ethiopia Federal HIV/AIDS Prevention and Control Office, the Government of Ethiopia is making tremendous efforts towards containing the epidemic. As part of this endeavour, the Government put in place a National HIV/AIDS Policy in 1998 to create an enabling environment to fight the pandemic. The above mentioned HIV/AIDS National Policy was subsequently updated in 2007. The HIV/AIDS Prevention and Control Office (HAPCO) established in 2002 and developed and implemented a 5-year national strategic framework. The framework focused on reducing HIV transmission, associated morbidity and mortality and impact on individuals, families and society. Moreover, to address the problem Ethiopia has received millions of U.S. dollars per year from PEPFAR, Global Fund, Clinton Foundation, World Bank, and UN agencies and other sources. Moreover, to ensure that quality HIV/AIDS services are delivered at the community level, various guidelines and standards were developed, distributed and being implemented in 2008, 2009 and 2010.

Therefore, this research will attempt to assess the community based and family centered care & support services provided to Orphan and Vulnerable Children (OVC) affected by HIV/AIDS and their families in Arada Sub-city of Addis Ababa, Ethiopia by an NGO called Arat Kilo Child Care and Community Development (AKCCCD) organization. The project focuses on enhancing comprehensive family centered, and child focused care and support services to 7,750 OVC in 10 woredas of Arada Sub-city of Addis Ababa through capacitating the community and government to serve vulnerable children and families.

The research will overview the efforts of the organization in the provision of care and support to the OVC through mobilizing the community in its operation area. Therefore, the focus of this particular study will be in ten woredas of Arada sub-city of Addis Ababa where the project is implemented.

1.3. Objectives of the Study

The general objective of this study is to assess the community-based and family-centered care and support services provided by Arat Kilo Child Care and Community Development Organization (AKCCCD) to Orphan and Vulnerable Children (OVC) who are affected by HIV/AIDS and their families in Arada Sub-city of Addis Ababa, Ethiopia.

Specifically, the study intends:

- To assess and identify socio-demographic and economic characteristics of the beneficiaries of AKCCCD;

- To examine the overall process of mobilizing the local community members to establish the community based voluntary structure that provide comprehensive family centered care and support to the OVC and their caregivers in the study area;

- To assess the relevance of the care and support provided by the organization to the OVC and their caregivers in addressing their respective socio-economic problems;

- To assess the efficiency of the community based and family centered care and support activities undertaken by the community volunteer's to care and support the OVC and their caregivers in the intervention area.

1.4. Research Questions

The research was designed to address the following research questions.

1. What kinds of services does the project render to the OVC and their care providers?

2. Which types of criteria did the project use for selecting and accepting the OVC as beneficiaries?

3. How relevant are the care and support services provided to OVC by the NGO in collaboration with the volunteers?

4. How was the practice of community mobilization for providing care & support to OVC in order to address their comprehensive problems?

5. What are the contributions of the NGO in its intervention areas to address problems of OVC?

1.5.   The Universe/Scope of the Study

The universe of this study would consist of all the target groups of the Strengthening Communist Safety Nets project (SCSN) which is implemented by Arat Kilo Child Care and Community Development (AKCCCD) organization in 10 woredas of Arada sub-city of Addis Ababa, Ethiopia. The Project supported a total of 7,750 orphan and vulnerable children and 1,149 their care providers who are residing in the intervention areas for 3 years of the Projects' life time.

Community volunteer cadres that assisted the project implementation, including Vulnerable Children Committees (VCC), youth mentors, paralegals, volunteer community caregivers as well as stakeholders such as government bodies (woreda administration, HAPCO, health and education) and staff of AKCCCD were also part of the study.

1.6.   Operational Definitions

? **Caregivers:** For the purpose of this study, a caregiver is a person with whom the child lives who provides daily care to the child, and who acts as the child's 'parent' whether they are biological parents or not. A caregiver can be the mother or father, or another family member such as grandparent or older sibling or someone in the community who has taken over the responsibility of a vulnerable child or children because his/her parents are unavailable to care for him/her (Save the Children Federation, Inc., 2009)

? **Care and Support Services:** In this study, care and support can defined, according to the standard service delivery guidelines for OVC care and support programs, as interventions that address the need to improve health, wellbeing and development of an OVC.

? **Child:** This study defines a child as all boys and girls aged under 18 years of age, as recognized in the UNCRC and the African Charter on the Rights and Welfare of the Child (ACRWC). (UNCRC, 1989)

? **Child Protection:** For this study, child a protection is activities that aim to protect children from harm caused by exploitation, neglect and abuse. Harm includes impacts on a child's physical or emotional development, his or her health, family and social relationships, self-esteem or educational opportunities (Save the Children Federation, Inc., 2009).

? **Children's rights:** A set of universal entitlements for every child and young person below the age of 18 enshrined in the UNCRC. These entitlements apply to children of every background and encompass what they need to survive and to have opportunities to lead stable, rewarding lives. They fall into four categories: the right to survive, be safe, belong and develop. All rights are considered to be equal, in importance and to reinforce each other. (UNCRC 1989).

? **Community-Based Approach:** A community is a group of people living in an identifiable geographical area who share a common culture and are arranged in a social structure that allows them to have a common identity as a group. Hence, a development project that implements its activities based on the felt needs and with the active involvement of this group have a community based approach.

- ✍ **Family Centered Approach:** For the purpose of this study Family-centered approach was defined as a comprehensive, coordinated care approach that addresses the needs of both adults and children in a family and attempts to meet their health and social care needs, either directly or indirectly through strategic partnerships and/or linkages and referrals with other service providers (JLICA, 2008).

- ✍ **Iddirs:** The study defines Iddirs as *(Christian, Muslim or non-faith based)* social support groups within Ethiopia. Members of these CBOs take responsibility for all burial ceremonies and household activities from 3 to 7 days after a death. Members of these groups are required to pay a regular fixed monthly contribution. Most groups have written internal regulations and an assigned leadership committee, which members nominate for a fixed period of time (Save the Children Federation, Inc., 2009).

- ✍ **Orphans:** In Ethiopia, according to the Ministry of Women's Affairs, it is commonly understood and legally defined that an orphan is a child who is less than 18 years old and who has lost one (single orphan) or both of their biological parents (double orphan), regardless of the cause of the loss. Reference is also given to children who have lost a father (paternal orphans) and children who have lost their mother (maternal orphans).

- ✍ **Vulnerable Child:** A vulnerable child is a child who is less than 18 years of age and whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfilment of his or her rights. It also includes a child who has been orphaned by AIDS and/or affected by the HIV and AIDS pandemic including children living with sick parents, children living in highly affected communities, children living without adult care. (MOWA)

- ✍ **Sub-City:** In this study Sub-city is explained as a governmental administration unit that monitors a collection of woredas/ districts.

? **District/Woreda:** The study defined woreda as an administrative division of Ethiopian government that is equivalent to a district.

? **Kebele:** In this study, kebele is the smallest administrative unit of local government in Ethiopia.

1.7.   Limitations of the Study

The study used purposive sampling technique and, therefore, does not claim to be representative of the OVC care and support programs in Addis Ababa, Ethiopia.

1.8.   Organization of the Thesis

Keeping in mind the objectives of the study, the thesis is organized in such structured ways that have five chapters and a number of sections. The **First Chapter** introduces the essence of the present study. This chapter attempts to describe the background of the present study, the statement of the problem, the objectives of the study, the universe/scope of the study, operational definitions, and limitations of the study and organization of the thesis. The **Second Chapter** deals with review of relevant literature on OVC care and support services. It discusses the conceptual/theoretical framework and other pertinent empirical literature on different aspects of the topic under consideration. The **Third Chapter** describes the designs methodology. It explains the study design, research methods, target population, sampling methods, sample size, tools of data collection and data analysis techniques. The **Fourth Chapter** presents, interprets and discusses about the major findings of the present study. It is also organized according to the specific objectives and the variables involved in the study. Finally, the **Fifth Chapter** presents the conclusions and suggestions for action based on those findings mainly supported by empirically generated quantitative and qualitative data that should be exercised to improve the efficiency of the Organization at different levels of interventions. The Chapter further presents **appendixes** which include the interview schedules, interview guides and other tools of data collection. At the end, a Performa for submission of the project proposal, declaration and certificate pages are attached.

Chapter II   Literature Review

2.1   Conceptual/Theoretical Framework OVC Care and Support

In order to address the problems of HIV/AIDS and OVC in a comprehensive manner, a number of program implementation guidelines, approaches and models were developed by concerned organizations. These models include the UNICEF's framework for the Protection, Care and Support of OVC; the Ethiopian Ministry of Women's Affairs' Alternative Child Care Guidelines on Community-Based Child Care. Reunification and Program, Foster Care, Adoption and Institutional Care Service; the United Nations' Convention on the Rights of the Child Framework; and a Comprehensive OVC Care and Support Model developed by the President Emergency Programme Fund for AIDS Relief (PEPFAR). Accordingly, let us discuss each model one by one.

2.1.1   UNICEF: The Framework for the Protection, Care & Support of Orphans and Vulnerable Children Living in a World with HIV/AIDS, UNICEF (2004, p. 14-25) states

that this framework has five key strategies for the protection, care and support OVC. These five strategies outlined below are intended to target key action areas and provide operational guidance to governments and other stakeholders as they respond to the needs of orphans and vulnerable children. Pursuing these strategies within the context of national development plans will be a key to the achievement of goals established at the Millennium Summit and at the UN Special Session on HIV/AIDS.

Strengthening the capacity of families and communities continues to be of central importance in this framework. However, increasing access to services has been given greater prominence and will require the leadership of governments as well as the support of non-governmental, faith-based and community organizations. These strategies are to be implemented hand in

hand with efforts to prevent the further spread of HIV, the loss of parents to AIDS and other causes of child vulnerability. The five strategies in the above-stated framework are:

a. Strengthen the capacity of families to protect and care for orphans and vulnerable children made vulnerable by HIV/AIDS by prolonging the lives of parents and providing economic, psychosocial and other support;

b. Mobilize and support community-based responses;

c. Ensure access for orphans and vulnerable children to essential services, including education, health care, birth registration and others;

d. Ensure that governments protect the most vulnerable children through improved policy and legislation and by channelling resources to families and communities; and

e. Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV and AIDS.

The actions described below are intended to help shape an effective response to the growing crisis. They represent the collective experience and knowledge of those working to protect and care for orphans and vulnerable children. It should be noted, however, that the impact of HIV/AIDS on children varies considerably from one context to another. There is no model or specific set of interventions that can be prescribed for all communities, countries and regions. For this reason, within each country, the mix of strategies and actions will vary according to locally identified needs, capacities and priorities.

a. **Strengthen the capacity of families to protect and care for OVC by prolonging the lives of parents and providing economic, psychosocial and other support:** When a household begins to feel the effects of HIV/AIDS, family relationships provide the most immediate source of support. Mothers or fathers who lose their spouses to AIDS are burdened with increased economic and child-care responsibilities and in some cases, may

also be ill themselves. In families where both parents die, there is no ideal placement for the children, just better or worse options. Enabling siblings to remain together with a single parent, in the care of relatives or with a family they already know and are prepared to accept as new, permanent caregivers are the better options. The vast majority of the OVC are living with surviving parents or their extended family. Even the majority of children who live on the streets maintain ties with their families.

Recognizing this reality, the core of a strategy to respond to OVC must be to strengthen the capacity of families to care for and protect their children. Families are the best hope for vulnerable children, but they require support from outside sources for both immediate survival needs and the longer term. Families require a combination of economic, material and psychosocial support. In addition, family members who are living with HIV/AIDS need support that will enable them to live longer, better and in greater dignity. Six major areas of intervention are vital to the coping capacity of families. A partnership of government and CBOs and FBOs, will be needed to provide such support. Hence for building the capacity of households or building the capacity of families there is a need to: Improve household economic capacity; Provide psychosocial support to affected children and their caregivers; Strengthen and support child-care capacities; Support succession planning; Prolong the lives of parents; and Strengthen young people's life skills.

b. **Mobilize and support community-based responses:** When families cannot adequately meet the basic needs of their children, the community is a safety net in providing essential support. In practice, care of OVC comes from nuclear families surviving with community assistance, extended families able to cater for increased numbers with community assistance, and, in extreme cases, communities caring for children in child-headed households or with no family involvement. Reinforcing the capacity of communities to

provide support, protection and care is the foundation of a response that will match the scale and long-term impact of the HIV/AIDS crisis for children.

Lessons learned through the many community activities undertaken to date in support of orphans and other children at risk indicate the need for a systematic approach to community mobilization - one that focuses on community concerns about their most vulnerable children. Four key areas of intervention nurture and strengthen community initiative and provide a solid basis for expansion, that includes: engaging local leaders in responding to the needs of vulnerable community members; organizing and supporting activities that enable community members to talk more openly about HIV/AIDS; organizing cooperative support activities; and promoting and supporting community care for children without family support. Faith-based and NGOs, along with other community structures, have a key role to play in mobilizing and supporting community efforts.

c. **Ensure access for OVC to essential services, including education, health care, birth registration and others:** OVC are at a disadvantage in obtaining essential services necessary to their welfare. In many countries, they have lower school attendance rates and are at risk of poor nutrition and health. They are also at greater risk of abuse and exploitation because of their status in society. Typically, OVC have significant psychosocial needs and their support systems to meet those needs are weak or, in extreme cases, non-existent. Article 65, Declaration of Commitment of the UN Special Session on HIV/AIDS, calls for increased access to essential services & parity for OVC. Governments have an obligation to provide services to all children and communities. At the local level, NGOs, faith-based organizations, the private sector and other indigenous community groups often play a critical role in extending the reach of these services. To

ensure greater impact and sustainability, interventions that build the capacity, quality, collaboration and reach of effective service delivery programs are warranted.

For ensuring access to essential services, the framework stipulates that children's school enrolment and attendance should be increased; birth registration for all children ensured; basic health and nutrition services provided; access to safe water and sanitation improved; judicial systems protect vulnerable children; placement services for children without family care ensured; and local planning and action strengthened.

d. **Ensure that governments protect the most vulnerable children through improved policy, legislation and by channelling resources to communities:** While the family has primary responsibility for the care and protection of children, national governments have the ultimate responsibility to protect children and ensure their well-being. Most countries have committed to achieving the goals agreed to in the UN General Assembly's Declaration of Commitment on HIV/AIDS. In order to meet these obligations, countries must undertake and be supported in a broad range of multi-sectoral actions. No ministry has sole jurisdiction over the issues surrounding OVC. Governments must find ways to bring together ministries of education, finance, health, social welfare and others to respond in a coordinated and effective way to the many needs of these children.

e. **Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS:** From the beginning, the HIV/AIDS epidemic has been accompanied by fear, ignorance and denial, leading to silence and inaction on the part of governments and other stakeholders as well as stigma and discrimination against PLHIV. OVC as well as their families are frequently victimized in this way. Stigma and discrimination give rise to rejection, hostility, isolation

and human rights violations. Reducing stigma and discrimination will require increasing access to information, challenging myths and transforming the public perception of HIV/AIDS. All stakeholders have a role to play in building a more supportive environment. Hence, to raise awareness & to create a supportive environment, there will be a need to conduct a collaborative situation analysis; mobilize influential leaders to reduce stigma, silence and discrimination; and strengthen and support social mobilization activities at the community level.

Programming Guidance

Valuable lessons have been learned through the many small-scale programs for orphans and vulnerable children around the world. These lessons can help guide implementation of the strategies described above. The guidance provided in this framework brings together common elements and key themes from these efforts and is integral for both governments and civil society seeking to strengthen their response at the community, district and national levels (UNICEF, 2004, p. 27-30).

   a. **Focus on the most vulnerable children & communities, not only children orphaned by AIDS**

Programs should not single out children orphaned by HIV/AIDS. Rather, they should direct services and community mobilization efforts towards communities where the disease is making children and adolescents more vulnerable. Orphans are not the only children made vulnerable by AIDS. All children living in communities hard hit by the epidemic are affected. Targeting specific categories of children can lead to increased stigmatization, discrimination and harm to those children while, at the same, deny support to other children in the community whose needs may be profound. Targeting in two stages has been found to be an effective approach to supporting children affected by HIV/AIDS. The first stage is to

geographically target areas where families and communities are having the greatest difficulty protecting and providing for the needs of their children. While no area is likely to be spared by HIV/AIDS, the impact of the epidemic and coping capacities will vary significantly among geographic areas and segments of the population. The second stage is to identify individuals and families in need. That stage is best carried out by communities themselves, who often know better than outsiders the local factors that contribute to vulnerability and which individuals are at greatest risk.

b. Define community-specific problems and vulnerabilities at the outset and pursue locally determined intervention strategies

The circumstances of any given community will be unique in terms of the problems experienced, priorities identified and the resources available. An essential aspect of programming to support OVC is to engage community members in assessing their needs and priorities so that locally tailored interventions can be developed.

The identification of OVC and the collection of baseline information about them, including the households in which they live, are necessary before support activities can be designed. The more central the role that communities can play in this process the more likely it is that, they will have a sense of ownership over and responsibility towards any new interventions that may emerge.

c. Involve children and young people as active participants in the response

Children and young people are not simply a passive, powerless target group to be aided. They are part of the solution to the HIV/AIDS epidemic and, as noted throughout this framework, can play a vital role in mitigating its impact. Young people can help communities to identify and understand the most critical problems faced by orphans and vulnerable children. They can

visit with children and include them in recreation and other social activities to promote social integration and a sense of connection to the greater community. They can also help affected households with basic tasks.

d. Give particular attention to the roles of boys and girls, men and women, and address gender discrimination

Much of the burden of caring for people with HIV/AIDS and for orphans and vulnerable children falls on women and girls. When illness strikes a family or children are orphaned, very often it is the girls who first dropouts of school, care for the ill and younger siblings, and take on adult tasks. Particular attention needs to be given to protecting and supporting girls in these circumstances.

e. Strengthen partnerships and mobilize collaborative action

The impact of HIV/AIDS on children, their families and their communities is far too broad and complex to be addressed without active collaboration and coordination among stakeholders. The resources needed to respond to HIV/AIDS – often scarce in even the best of times – are being severely depleted by the expanding crisis. At every level – global, regional, national and local stakeholders must find ways to piece together a set of responses that collectively matches the scale of the impact of HIV/AIDS on children. This requires the active involvement of government structures, international agencies, non-governmental, faith-based and community organizations, donors, businesses, the media and others.

f. Link HIV/AIDS prevention activities and care and support for people living with HIV/AIDS with support for vulnerable children

Programs that target children affected by the epidemic are often undertaken in isolation from those working to prevent the spread of HIV or to provide care to people living with HIV/AIDS. Often, they are also separate from programs aimed at children in general, such as

health services, education and social protection. HIV/AIDS interventions have typically fallen into such categories as 'prevention for youth', support for 'home-based care', and 'orphans' programs'. Support for home care of people living with HIV/AIDS is often focused solely on the health of people who are ill, and not on the economic and psychosocial condition of their children and families. Yet HIV/AIDS has an impact on all members of a household. Programs also tend to be organized around specific professional capabilities. The HIV/AIDS related problems of children and families, however, are complex and interlinked, and cannot be adequately addressed by any single intervention. They demand holistic, multi-sectoral and mutually reinforcing program strategies.

g. Use external support to strengthen community initiative and motivation

Generous outside funding or material assistance, while urgently needed, can have a detrimental effect on government incentive and community solidarity and can undermine local initiative. This becomes an even greater problem if external assistance ends, or if local organizations shift their programmatic focus because of donor-driven funding conditions and priorities. To prevent such dependencies, local and national mechanisms must be in place to reinforce and expand upon what is already being done. In addition, governments, donors, NGOs, FBOs and CBOs must focus on strengthening and supporting the on-going efforts of communities themselves. It is these groups that are at the front line of the response to HIV/AIDS and have demonstrated enormous capacity to care for and support vulnerable children and adolescents. Community organizations and inter-organizational mechanisms can be bolstered through training and technical assistance, organizational development and sustained financial and material support.

Furthermore, program interventions with children and communities must take into account the long-term nature of the AIDS crisis. Interventions developed today must respond to the need for large-scale, long-term efforts that address both the direct and indirect impact of HIV/AIDS on children, families & communities. Successful experience and lessons learned in supporting community initiative need to be widely disseminated and replicated rapidly.

Alternative child care guidelines on community-based childcare, reunification and reintegration program, foster care, adoption and institutional care service, MOWA (2009, p. 14) states the guideline on community-based childcare. Community based child care is an alternative that provides care and support to the children in a state of condition that is familiar to the children who used to experience it. The objective of the community-based childcare service is to mobilize the community, its resources and indigenous knowledge with the ultimate goal of addressing the needs and rights of OVC in a sustainable manner. Practically, community-based childcare is believed to be a better alternative because of the fact that it is by far cost effective and its greater advantage of reaching large number of target children in a given community. This approach encompasses a wide range of preventive, curative and rehabilitative strategies which respond to the needs and best interests of the target children. The underlining rationale behind this approach is that the grassroots community structures and organizations can provide for and fulfil the emotional, social, physiological and spiritual needs of OVC and effectively protect them from abuse and exploitation, without such children being removed from their families or community environment. Thus, organizations engaged in the provision of community-based childcare programs should focus more on building the capacity of the community to care for its OVC and working with existing structures, institutions and organizations and empowering them to assume responsibilities for providing care and support for OVC.

The guideline stipulates the process of eligibility of the community and target child. The detailed eligibility includes: the eligibility of a community and a target child. Let us briefly describe each of the criterions.

The eligibility of a community: From the perspective of the community-based childcare organization, eligibility of a community shall be established on the basis of the findings of a situation analysis or case study conducted with active participation of the community members to identify problems, target children, assets, resources of the community.

The eligibility of a target child: All the target children under the category of OVC that includes single or double orphans, street children, abandoned children, children with disability, children infected or affected by HIV/AIDS and the like are eligible to benefit from a community-based childcare program.

The detail criteria for prioritization of the most vulnerable target children shall be established by the organization based on the existing reality and the results of the situational analysis. However, the community should be actively involved in the identification and selection of target children. When identifying the eligible child, Community-Based Childcare Organizations (CBCCO) shall make sure that the child has not already been recruited for a similar support by another organization (MOWA, 2009, p. 15).

The Alternative Child Care Guidelines also stated the major roles and responsibilities of community based child care organizations (CBCCO):

1. Initiate, plan, implement, follow-up, monitor & evaluate the childcare program;

2. Design and mainstream child protection policy of the organization at the program and institutional levels to make sure that the rights of the child are dully protected;

3. Raise funds, mobilize resources and solicit support from members of the community and external sources;

4. Facilitate the meaningful participation of the community and its target children or families in its program;

5. Build the technical and financial capacity of CBCCOs, with a view to enable them to deliver proper care & support for OVC in the community environment;

6. Advocate for the rights of OVC and create a conducive environment where children could receive sustainable assistance from their community;

7. Assist a community and its members to identify, develop and utilize skills and resources they need to effect changes in their own communities in order to enhance their capacity to care for children;

8. Empowering members of a community to recognize their responsibility and obligation to the welfare/well-being of children in their community;

9. Design, with the full involvement and participation of community members, an appropriate alternative childcare program that addresses the needs of children which has the best interests of the child at its core;

10. Plan, and implement programs through which the rights of the child are understood and observed by every member of a community;

11. Create Network and collaboration with likeminded CBCCOs and other stakeholders to strengthen linkages and referral systems; and

12. Submit quarterly, biannual and annual reports to the relevant authorities (MOWA, 2009, p. 15-16)

The same guideline further detailed out the services of the CBCCOs and the mechanisms for intervention. Community-based child care organization shall be engaged in preventive, remedial or rehabilitative interventions through community-based childcare approaches and

the services provided within this framework shall be initiated from the situational analyses in which children and the community members have fully participated in; focus on orphans and vulnerable children as the prime targets; be carried out based on the priority needs of the target children; address the multifaceted needs of the children via integrated interventions; and target the rights of the child with special needs (such as children with disabilities, children living with HIV, children victims of abuses, etc.).

The types of services and minimum required activities of a community-based childcare organization shall include, but not be limited to food, education, health, economic support, psychological support and counseling, parenting education as well as legal protection.

- **Food:** Train care providers and the community at large on proper food handling and feeding practices, including exclusive breastfeeding, safe complementary feeding practices, nutrition practices and food preservation; create access to food for OVC by directly involving the caregivers in income-generating activities; and conduct advocacy work by mobilizing duty bearers for sustainable food/nutrition supply to OVC.

- **Education:** Work with CBOs to identify OVC in need of educational services and potential resources available locally; facilitate enrolment of OVC into academic or vocational education and ensure that girls right to an affirmative action of accessing education is being implemented; and build the capacity of OVC and their care givers to have access to educational facilities; provide school supplies such as stationery and uniforms when necessary and particularly at the initial stage; and work closely with the schools to promote care for target children in the school system;

- **Health:** Identify and verify the health services available in the community; train community-based care providers about the child's right to health care; provide parents and caregivers with information about preventive and curative measures on child health

problems; and work closely with the health institutions to facilitate and ensure access to formal referral systems and free health services for OVC.

- **Economic Support:** Identify elder OVC/guardians assess their economic needs; identify locally available potential resources, map market demands and service providers and utilize accordingly; provide training for beneficiaries on business development, financial management, etc.; and support beneficiaries for economic engagement after training;

- **Psychological support and counselling:** Assess the emotional situation of target children and identify their psychosocial needs; provide training to caregivers and volunteers on how to recognize and address psychosocial needs of children; promote children's interaction with their peers and adults; facilitate the provision of counseling service for traumatized children; and facilitate access to safe and supportive environments for recreation, play and cultural activities in conjunction with other children;

- **Parenting Education:** Ensure that caregivers and the community are given training on parenting; and follow-up if the caregivers are properly raising the children.

- **Legal Protection:** Identify legal services available in the community; protect the inheritance rights of target children; build the capacity of legal enforcement bodies at all levels; conduct community-based education and awareness raising around child rights, child related laws; and advocate for the protection of the rights of orphans and vulnerable children (MOWA, 2009, p. 16-18).

The alternative child care guide further stipulated that alternative placements should be arranged depending on the extent of vulnerability of children as defined by the community, community-based childcare organizations shall work with the grassroots structures and explore other alternative models of placements within the community setting. Alternatives for

placement of OVC in the community include kinship, sponsorship, child-headed household, group home, and foster family care provisions.

- **Kinship care:** facilitate the support and care by placing children in the extended family systems;

- **Sponsorship care:** facilitate the provision of care & support to OVC and their family through volunteers and organizations (inside and outside the country);

- **Child-Headed Household:** community-based childcare organizations shall support the placement of orphans (siblings) intact in their home with the elder siblings acting as a parent. This alternative is appropriate when there are children 15 years or older in the family to take care of the younger siblings;

- **Group home:** OVC can be placed in a community-based group home, where by a group of six to eight children are placed under one roof with a surrogate mother assigned to them as caretaker;

- **Foster family care:** placing the children for a short or long term care with a volunteer family is also another option to facilitate family oriented care and support to OVC (MOWA, 2009, p.18-19).

The same guideline stated that organizations implementing community-based childcare programs should take the following into account when making decisions about placing children in one or the other arrangements:

- Assess locally acceptable and appropriate model of placement;

- Enhance the capacity of the family where OVC are placed through imparting knowledge, providing training and creating access to microfinance service;

- Provide parenting skills for caregivers;

- Build OVC's capacity through Income Generating Activities (IGA) in order to help them become self-supportive;

- Discourage separating siblings in OVC placements;

- Network and coordinate with organizations working with OVC; and

- Consider the participation of OVC and the community at large in the process.

In the same guide the information management system on targets were detailed. It states that a community-based childcare organization shall keep a record on the background and progress of all its targets, which includes a baseline and periodic follow-up reports. It must follow-up on the growth and development of target children by including information on the child's health status, nutritional status, physical development, psychological status, educational status, social development and emotional and spiritual development.

According to the aforementioned guideline, MOWA (2009, p. 20-21) argues that the core values of community-based child care include participation which is a key for a successful community-based child care intervention.

- **Community participation:** Direct and meaningful involvement of the community is very crucial in all aspects of decision-making and ownership. Thus, the community should be encouraged to participate in designing, implementing, managing, evaluating and mobilizing resources for the project.

- **Participation of the Child**: children have the right to participate in and influence matters affecting their lives and their experiences and opinions about their own situation should form an integral part of the decision-making process of organizations on issues concerning the child. Child participation structures should be designed and mainstreamed into the

operational structures of the organizations by which group of child representatives take part on decisions affecting the life of the target children.

? **Holistic approach:** Recognizing that improving the situation of children requires the participation of all actor - including families, communities and other parties - while making strategic choices, priorities and taking specific actions, childcare programs need to adopt a multi-sector intervention including education, health and reproductive health, income generation and skills training, family planning, advocacy, HIV/AIDS prevention, child rights protection and promotion, community sensitization, environmental sanitation, self-help development, reunification, reintegration and foster care programs.

? **The child at the center but not the child in isolation:** Every endeavor directed to the welfare of children shall put children at the center and recognize them as rights-holders and social actors. The child should be the focus of programs but should not be considered in isolation from the family and community environments, social and cultural structures.

? **Mainstreaming disability and gender:** All programs and program components should take into account and deal with discrimination along gender and disability.

? **Program Phase-out and Sustainability:** Childcare interventions should be designed with a well-thought plan and specific phase-out strategies that are fully shared among the community and other pertinent stakeholders in order to attain financial and institutional sustainability of the services. Involving the community from the inception of the services throughout the program cycle, building the capacity of the families, the grassroots structures and the local government institutions have paramount importance to ensure the continuity of the services.

? **Protection and Safety of the Child:** Childcare programs should give adequate emphasis to protect children from all forms of violence and abuse which in one or another way affect the survival and development rights of the child. To this effect, organizations

involved in childcare program shall develop internal guidelines/policy on the safety and protection of the target children to create an environment free from all sorts of abuse.

Moreover, the alternative child care guide incorporates clear guidelines about child reunification and reintegration; foster care; adoption and institutional care. Detail procedures and actions were stipulated for undertaking each of the above mentioned activities. (MOWA 2009, p. 21-47).

The research also employed the **United Nations Convention on the Rights of the Child** (UNCRC, 1989). The United Nations Convention on the Rights of the Child (CRC) and other relevant human rights instruments guide all actions in support of orphans and vulnerable children, in the recognition that development is the realization of a set of universally applicable, inalienable rights. This approach recognizes that children are both rights holders and participants; they are not merely the recipients of services or the beneficiaries of protective measures. Globally, the CRC is the principle framework to guide action on behalf of children. As such, it is the single most important reference point concerning OVC.

The CRC affirms that the family has primary responsibility to protect and care for the child, and that governments have the responsibility to protect, preserve and support the child-family relationship. The CRC also specifies the responsibility of the State to provide special protection for a child who is deprived of his or her family environment. Particularly, Articles 5, 8, 9, 17, 18, 20, 21, 24, 25, 28, 31, 32, and 34 appear to be relevant ones to the OVC. These articles are listed as follows:

- Article 5 recognizes the responsibility of members of the extended family, community or legal guardians to provide for the child in a manner consistent with his or her evolving capacities;

- Article 8 concerns the right of a child to preserve his or her identity, including name and family relations;

- Article 9 concerns a child's right not to be separated from parents;

- Article 17 recognizes the right of access to appropriate information;

- Article 18 recognizes responsibility of the State to support parents and legal guardians in their child-rearing responsibilities and to develop services for the care of children;

- Article 20 concerns the responsibility of the State to provide special protection for a child deprived of his or her family environment;

- Article 21 addresses safeguards regarding adoption;

- Article 24 recognizes the right of children to the highest standard of health and access to health services;

- Article 25 concerns periodic review of the situation of a child who has been placed in care.

- Article 28 concerns the right of every child to education;

- Article 31 recognizes a child's right to rest, leisure, play and recreation;

- Article 32 addresses the protection of children from economic exploitation; and

- Article 34 concerns the protection of children from sexual exploitation and abuse.

The underlying values – or 'guiding principles' – of the CRC, described below, influence the way each right is fulfilled and serve as a constant reference for the implementation and monitoring of all efforts to fulfil and protect children's rights. The four principles are clearly

stipulated in the convention under Articles 2, 3, 6 and 12. Let us discuss about the four Articles in the UNCRC:

a. Best interests of the child

The CRC document states that the various possible solutions must be considered and due weight given to the child's best interests in each and every decision affecting the child. This principle is immediately relevant to OVC where decisions are being made regarding their caretakers, property and futures, but extends further to all matters that concern children, including development policies, programs and allocation of public resources.

b. Non-discrimination

All children should be given the opportunity to enjoy the rights recognized by the CRC. States must identify the most vulnerable and disadvantaged children and take affirmative action to ensure that the rights of these children are realized and protected. Orphans and vulnerable children are at risk of discrimination in all aspects of their lives and, therefore, this principle is essential in guiding all efforts to address HIV/AIDS.

c. Right to survival, well-being and development

The CRC is grounded in the recognition of the right to child survival, well-being and development. This principle is in no way limited to a physical perspective; rather, it further emphasizes the need to ensure full and harmonious development of the child, including at the spiritual, moral, psychological and social levels. States are obliged to undertake strategies to assist the most disadvantaged children, including those affected by HIV/ AIDS.

d. Respect for the view of the child

This principle affirms that children are entitled to express their views in all matters affecting them and requires that those views be given due weight in accordance with the child's age and

maturity. It recognizes the potential of children to enrich decision-making processes and to participate as citizens and actors of change. This principle underscores the importance of ensuring that OVC participate in decisions that affect them, such as those concerning their care and inheritance, and that they have important contributions to make in the fight against HIV/AIDS.

In addition the researcher tried to analyze **the implementation framework of the OVC care & support intervention model** of Arat Kilo Child Care and Community Development (AKCCCD) Organization. The model apparently applied by the organization where the research undertaken is community based and family centered care and support where the NGO under study, the community, CBO/FBOs, Local government representatives and Civil Society Organization (CSO), tend to assume major roles and responsibilities.

The three years Strengthening Community Safety Nets (SCSN) project implemented by AKCCCD in Arada Sub-city of Addis Ababa in partnership with Christian Children's Fund of Canada is funded by PEPFAR/USAID. The project is designed to mitigate the adverse impacts of HIV/AIDS on the well-being of HIV-affected vulnerable children and families while enhancing community and government capacity to serve vulnerable children and families. The strategy of this project supports a holistic service package reinforced with strengthened referral networks and improved data collection systems that enable continuous quality improvement. The project approach integrates lessons learned and effective approaches developed in Ethiopia and the region; including PEPFAR funded projects. The project's approach builds on local capacity and involvement to support a sustainable transition of ownership and control to communities and local partners over time. The model focused on four strategic approaches that include:

1. **Building on existing foundations**

Considerable resources and capacity exists within the communities and among national partners to meet the needs of vulnerable children and families. Supportive government policies and programs at the national and district level and the HIV/AIDS prevention and Control offices (HAPCO) represent an effective, if yet not fully realized, resource for decentralization management and service coordination. International and local NGOs and C/FBOs are working to mitigate the impact of HIV/AIDS on children and families, albeit with varying levels of capacity, leadership and coordination. Communities, families & children themselves have developed coping strategies and the on-going AKCCCD interventions support effective care and protection of vulnerable children are ready for scale up. This mosaic of policies and programs will enable rapid expansion of integrated, holistic and replicable interventions.

2. **Strengthened family capacity to care for children**

Families provide the healthiest and safest environment for children and thus the project should strengthen and expand home based case management services that bring support as close to the household as possible. Building on existing home based service networks developed through sponsorship and home-based care programs, community based volunteers will provide services and support to caregivers and ensure families have access to an expanded service network. Support for youth-headed households is a key priority, as is support for collaborative responses to address particularly vulnerable groups, such as children living and working in the street. In this way, the project will directly address immediate needs while strengthening family resilience for the long term.

3. Focusing on Early Childhood

Investing in early childhood development (ECD) programs for young children and their families has been shown to result in long lasting positive effects on the child, the family, and society. The project strategy prioritizes early childhood services (including the PEPFAR defined categories of infancy, 0-2, and early childhood, 3-5) that integrate psychosocial support, nutrition, child protection and primary health care services. Counseling and referrals will enhance links to paediatric HIV care and treatment, PMTCT, and ART services. Services for older children will be addressed primarily through partnership with programs in proposed areas.

4. Expanding the continuum of care

Community based ECD centers provide important health, education, and social support for vulnerable children in protective environments, while child friendly schools (CFS) ensure that educational efforts encompass an integrated and synergistic effort focused on active teaching & learning, health/nutrition, child participation and community participation. Project activities will focus on creating a continuum of care for children that continues from the home into the community by increasing the capacity of these institutions to recognize and address the needs of vulnerable children.

Strengthening Community Safety Nets Project Model
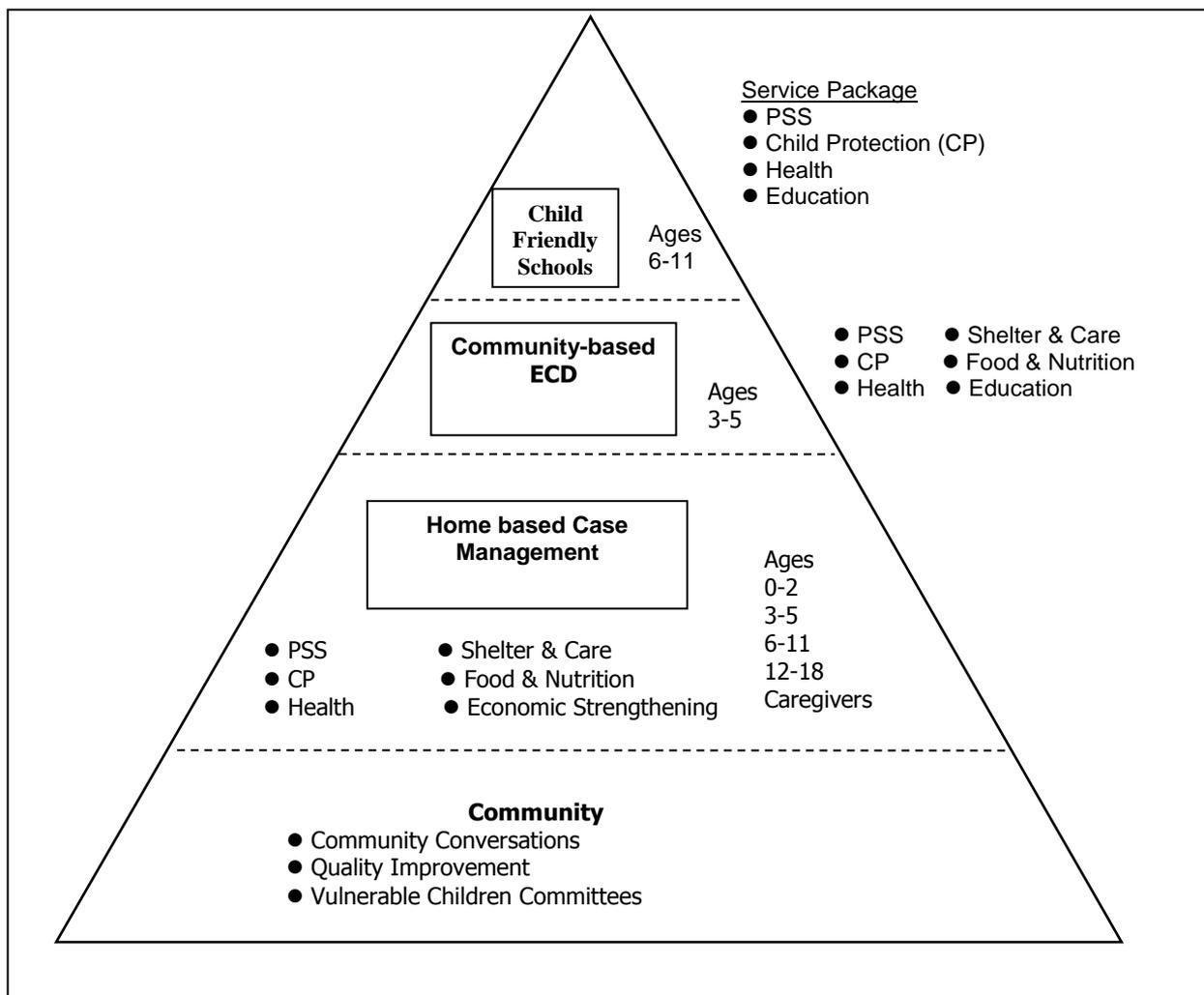
Source: Child Fund International & Christian Children's Fund of Canada Strengthening Community Safety Nets Project (2008)

Therefore, this study used the Comprehensive OVC Care and Support Model. This Model has about 7 core components in addressing the children's problems under consideration in the intervention areas in Addis Ababa.

2.2   HIV/AIDS Epidemic

An estimated 33.3 million People live with HIV globally, out of which about 22.4 million (68%) are in sub-Saharan Africa, according to the 2008 UNAIDS/WHO AIDS epidemic update report. For the estimated 33.3 million people living with HIV after nearly 30 years into a very complex epidemic, the gains are real but still fragile. Future progress will depend heavily on the joint efforts of everyone involved in the HIV response. (UNAIDS, 2010).

The latest statistics of the global HIV and AIDS epidemic were published by UNAIDS in November 2010, and refer to the end of 2009 indicated in Table 1.

Table 1: Global HIV/AIDS epidemic published by UNAIDS

	Estimate	Range
People living with HIV/AIDS in 2009	33.3 million	31.4-35.3 million
Adults living with HIV/AIDS in 2009	30.8 million	29.2 – 32.6 million
Women living with HIV/AIDS in 2009	15.9 million	14.8 – 17.2 million
Children living with HIV/AIDS in 2009	2.5 million	1.6 – 3.4 million
People newly infected with HIV in 2009	2.6 million	2.3-2.8 million
Adults newly infected with HIV in 2009	2.2 million	2.0-2.4 million
AIDS deaths in 2009	1.8 million	1.6-2.1 million
Orphans (0-17) due to AIDS in 2009	16.6 million	14.4-18.8 million

Source: Global Report on HIV/AIDS Epidemic (UNAIDS, 2009)

Overall, the HIV/AIDS epidemic in India shows a declining trend. HIV prevalence among adult population in 2007 was 0.34% and in 2008 was 0.29%. There is also a declining number of PLHIV in the country, with an estimated 2.27 million PLHIV in 2008 vis-à-vis 2.31 million in 2007, according to the India's Progress Report (NACO & UNAIDS, 2010).

It is in Africa, in some of the poorest countries in the world, that the impact of HIV has been most severe. At the end of 2009, there were nine countries in Africa where more than one tenth of the adult population aged fifteen to forty-nine was infected with HIV/AIDS

(http://www.avert.org/aroundworld). In 33 countries, HIV incidence has fallen by more than 25% between 2001 and 2009. Of these countries 22 are in sub-Saharan Africa. The biggest epidemics in sub-Saharan Africa - Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe, either stabilized or are showing signs of decline. However, several regions and countries do not fit the overall trend. In seven countries, five of them in Eastern Europe and Central Asia, HIV incidence increased by more than 25% between 2001 and 2009 (UNAIDS, 2010).

Between 1990 and 2003, sub-Saharan Africa's population of children orphaned by AIDS increased from less than 1 million to more than 12 million. The growing population of children orphaned by HIV/AIDS is a concern, because had it not been for HIV/AIDS, the global percentage of orphans would be declining instead of increasing. By the end of 2003, 43 million children (12% of all African children) were orphaned in sub-Saharan Africa, 12.3 million (32% of all African orphans) of those were due to AIDS. Although Asia had a lower number of children orphaned by AIDS in 2001, 1.8 million (2.8% of all orphans), it had a much larger overall orphan population than sub-Saharan Africa, with 65 million orphans. (Salaam, 2005).

For millions of children, HIV/AIDS have starkly altered their experience of growing up. In 2008, it was estimated that 2 million children under age 15 were living with HIV. At the end of 2007, about 15 million children under 18 had lost one or both parents to AIDS. Millions more have experienced deepening poverty, school dropout and discrimination as a result of the epidemic. (UNICEF, UNAIDS, WHO & UNFPA, 2011).

The single point estimate shows that the national HIV prevalence in Ethiopia was 2.3% in 2009 (7.7% urban; 0.9% rural; 2.8% Female; and 1.8% Male), with 1.1 million people living with HIV, out of which 336,160 were eligible for ART. At an incidence rate of 0.28%, the

number of new infections in 2009 was about 131,145. During the same year, the number of HIV positive pregnant women was estimated to be 84,189 and about 14,140 babies were expected to be born HIV positive. There are around 855,720 orphans due to HIV/AIDS out of the estimated total 5.4million orphans in the country.

2.3   Impact of HIV/AIDS at Different Levels

The multifaceted impact of HIV/AIDS across generations, communities and individual households has been significant and presents enormous challenges as to how to best address the myriad of needs that children, families and communities face due to HIV/AIDS and other issues including extreme poverty, food insecurity, and limited social safety nets. When children are confronted with these issues combined with their susceptible status as minors the result is inevitably one of extreme vulnerability.

Children affected by HIV/AIDS face immense challenges as they attempt to thrive in what is already a difficult environment. Access to health care, education and psychosocial support are extremely limited and children without caregivers frequently fall through the cracks of the minimal social safety net programs that do exist. OVC are particularly vulnerable to exploitation, both physical and economic, violence, including physical and sexual abuse. The impact on girls is especially profound as girls face sizeable challenges, including early initiation of sexual activity, exploitation, abuse and sexual violence; all factors which lead to greater risk of becoming infected with HIV. These risks are enhanced by the precarious life situation of female OVC who may not receive parental or other adult guidance and protection.

The impact of HIV/AIDS on children is just beginning to be explored. Not only are children orphaned by AIDS affected by the virus, but those who live in homes that have taken in orphans, children with little education and resources, and those living in areas with high HIV

rates are also impacted. Children who have been orphaned by AIDS may be forced to leave school, engage in labor or prostitution, suffer from depression and anger, or engage in high-risk behavior that makes them vulnerable to contracting HIV. Children who live in homes that take in orphans may see a decline in the quantity and quality of food, education, love, nurturing, and may be stigmatized. Impoverished children living in households with one or more ill parent are also affected, as health care increasingly absorbs household funds, which frequently leads to the depletion of savings and other resources reserved for education, food, and other purposes (Salaam, 2005).

The HIV/AIDS pandemic has a major impact on the social, economic and cultural life of a community. HIV/AIDS is affecting productive citizens of the country. One of the major consequences of HIV/AIDS is increasing number of mortality. The estimated number of AIDS deaths in the country in 2005 was 134,450, which means 368 persons a day (FMOH, 2006). In Ethiopia, Population between the age group of 15 to 49 constitutes 90 percent of the AIDS cases, according to the same document. This age category is the most productive and resourceful part. Similarly, as a result of AIDS, the number of orphans in the country is increasing.

Household incomes plummet when adults fall ill from HIV/AIDS and can no longer work full-time or at all. Research findings attest to the fact that on the average monthly per capita income in households where at least one person was known to be HIV-positive was less than half the income of non-affected households. The costs of treating illnesses caused by HIV/AIDS place a huge economic burden on families. Studies in urban households show that when a family member has HIV/AIDS, the household spends four times as much on health care as unaffected households. This extra expenditure is particularly onerous because household income was cut by more than half because of working days lost to illness. Even

after death, funeral expenses contribute to the toll exacted by HIV/AIDS. Evidence has shown that households with HIV/AIDS related death in the past year spent an average of one third of their annual income on funerals. Households with orphans are more likely to become poorer. This is primarily because of the increased dependency ratio, meaning that in these households the income of fewer earning adults is sustaining more dependents. In the worst-affected countries in sub-Saharan Africa, households with orphans have higher dependency ratios than those with children but no orphans.

The extended family is and will continue to be the central social welfare mechanism in most parts of sub Saharan Africa. The vast majority of orphans continue to be taken in by the extended family. In nearly every country, extended families have assumed responsibility for more than 90 per cent of orphaned children. But this traditional support system is under severe pressure − and in many instances has already been overwhelmed, increasingly impoverished and rendered unable to provide adequate care for children. Most worryingly, it is precisely those countries that will see the largest increase in orphans over the coming years where the extended family is already most stretched by caring for orphans. Where one parent has died, the majority of orphans stay with the surviving parent. There are, however, important differences between (and within) countries. Here in Ethiopia, the extended family has historically formed an intricate and resilient system of social security that usually responds quickly to the death of a mother or father.

2.4   Situation of Orphans and Vulnerable Children

UNAIDS defines an AIDS orphan as a child under age 15 who has lost one or both parents to AIDS. Worldwide, the number of children under age 18 who have lost one or both parents to AIDS stands at more than 14.3 million (UNAIDS, UNICEF & USAID, 2004). Despite the

modest decline in HIV adult prevalence worldwide and increasing access to treatment, the total number of children aged 0–17 years who have lost their parents due to HIV has not yet declined. Indeed, it has further increased from 14.6 million [12.4 million–17.1 million] in 2005 to 16.6 million [14.4 million– 18.8 million] in 2009 (UNAIDS, 2010).

Empirical evidence in the area indicates that there are many more children live with one or more chronically ill parent. Most of the children orphaned by AIDS live in developing countries, the vast majority of them (90 percent) in sub-Saharan Africa. As the infection spreads, the number of children who have lost parents to AIDS is beginning to grow in other regions as well, including Asia, Latin America and the Caribbean and Eastern Europe.

Although precise estimates are not available, a much larger number of children have been made vulnerable by the impact of HIV/AIDS. This vulnerability is due to poverty, hunger, armed conflict and harmful child labor practices, among other threats, all of which fuel and are fuelled by the epidemic. In the countries affected most, parents, adult relatives, teachers, health care workers and others essential to the survival, development and protection of children are dying in unprecedented numbers. Millions of children are living with sick and dying parents or in poor households that take in orphans. Their communities have been weakened by HIV/AIDS as have their schools, health care delivery systems and other social support networks (UNICEF, 2004).

Many countries now have to cope with large numbers of children orphaned by HIV/AIDS. Other children and young people, as well as orphans, lack support and are vulnerable. These include street children; children affected by conflict, disabled children, children affected by HIV/AIDS and girls. The majority of children orphaned or made vulnerable by HIV/AIDS are living with a surviving parent, or within their extended family (often a grandparent). An

estimated 5% of children affected by HIV/AIDS worldwide have no support and are living on the street or in residential institutions. Although most children live with a caretaker, they face a number of challenges, including finding money for school fees, food, and clothing. Experts contend that effective responses must strengthen the capacity of families and communities to continue providing care, protect the children, and to assist them in meeting their needs. There are thousands of localized efforts, many of them initiated by faith-based groups, to address the needs of children made vulnerable by AIDS. Proponents argue that supporting these "grassroots" efforts can be a highly cost-effective response, although additional mechanisms are needed to channel such resources. They further assert that additional resources are needed to expand the limited programs and to support the children who are on the street or in institutional care (Salaam, 2005).

Although only a portion of children affected by HIV/AIDS lose one or both parents, the impact on those who do can be severe. Under ordinary circumstances, the death of one young parent is not linked to the death of the other parent. But because HIV is sexually transmitted, the probability that both parents will die if one is infected is high. Moreover, many children are losing both parents in a relatively short period of time. By 2010, the number of children in sub-Saharan Africa who have lost both parents from AIDS will rise to 8 million, from 5.5 million in 2001, according to estimates. As the epidemic spreads, similar trends can be expected in other regions as well.

Ethiopia has been greatly impacted by the devastating effects of HIV/AIDS. Estimates indicate that Ethiopia has over five million OVC, with nearly 900,000 of them directly affected by HIV/AIDS. It is also estimated 855,720 have lost their parents because of AIDS.

2.5 Problems of OVC

Regarding problems of OVC, Martha Segu and Sergut Wolde Yohannes (2000) have to say the following when they stated:

> No statistics can adequately capture the human tragedy that orphans are facing in Ethiopia. For those children that have lost their parents to AIDS, grief is only the beginning of their troubles. When AIDS takes a parent, it usually takes a childhood as well. Children must witness death and suffering. The death of a parent threatens their psychosocial and physical well-being. Children lose love, affection and nurturing. The loss of a father or both parents often results in loss of income and property rights. Children who grow up without parents may be left impoverished & unprotected.

From the above-stated excerpt, we could understand that children are profoundly affected as their parents fall sick and die, setting them on a long trail of painful experiences. These are often characterized by economic hardship; lack of love, attention and affection; withdrawal from school; psychological distress; losses of inheritance; increased abuse and risk of HIV infection; malnutrition and illness; and stigma, discrimination and isolation.

Economic hardship: With the family's source of economic support threatened and savings spent on care, household capacity to provide for children's basic needs declines. Affected children and caregivers have had limited opportunity to engage in economic strengthening activities needed to meet expanding responsibilities for ill family members or to welcome vulnerable children into the household. Hence, an increasing number of children are being forced to take on the daunting responsibility of supporting the family.

Lack of love, attention and affection: The loss of a parent often means that young children are left without consistent responsive care. They can also be deprived of interpersonal, environmental stimulation, individualized affection and comfort.

Withdrawal from school: Economic pressure and the responsibilities of caring for parents and siblings can lead children to withdraw from school. This happens even while their parents are still living.

Psychological distress: The illness and death of their parents can cause extreme psychological distress in children, along with increased fatalism that is worsened by the stigma attached to HIV/AIDS and to being an orphan. HIV/AIDS undermines the fundamental human attachments essential to normal family life and child development. Mental distress due to stigma and discrimination is common among OVC who lost their parents due to AIDS. Children affected by HIV/AIDS suffer anxiety and fear during the years of parental illness, then grief and trauma with the death of a parent.

Losses of inheritance: Orphans (and widows) are often deprived of money or property that is rightfully theirs. They mostly face such complex problems.

Increased abuse and risk of HIV infection: Impoverished and sometimes without parents to educate and protect them OVC face increased risk of abuse and HIV infection. Many are forced into harmful child labour and/or sexually exploited for cash or to obtain 'protection', shelter or food.

Malnutrition and illness: Orphans and other affected children are at increased risk of malnutrition and illness and may be less likely to get the medical care they need. Vulnerable children and those affected by HIV lack adequate nutritional support and access to proper health care.

Stigma, discrimination and isolation: Children whose parents have died of AIDS face significant stigma and discrimination. This stigma contributes to isolation and distress among affected children to cope with the impact of HIV/AIDS. Many are unable to benefit from the emotional support of loved ones, friends as well as from social services that can improve the quality and length of their lives, and enabling them to protect other members of the society. Dispossessed orphans are often obliged to leave their homes and to live in unfamiliar and

sometimes unwelcoming places. Children orphaned by AIDS are more likely to be rejected by extended family members than those orphaned due to other causes.

2.6   Community Mobilization for OVC Care and Support

Community mobilization is a capacity building process through which individuals, groups or organizations can plan, implement, and evaluate activities in a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others. Community mobilization, when used successfully can bring community members together to address issues that are affecting their lives; increase community decision-making and bring added resources into community; build community skills to address the key issues and reduces barriers to positive change; and increases quality and availability of services.

From the beginning and throughout the program it is essential to empower communities to address the needs of vulnerable children in their community, foster ownership and involvement. Programs should develop a Community Mobilization (CM) Plan together with partners. Additionally, during the initial phase of program design for CM, partners developed program principles to guide all partners' activities and efforts related to OVC.

The Community Action Cycle (CAC) is the process by which the community themselves organize, assess, plan and act collaboratively to increase and improve care and support to orphans and vulnerable children. The Phases of the Community Action Cycle are: Preparing to Mobilize; Getting Organized, Exploring the OVC Issues in the Community; Planning Together; Acting Together, Evaluating Together and Preparing to Scale-up.

The CAC acts as a guide defining the process of community mobilization and capacity building of community-based organizations. Building community capacity to implement the

CAC is a key to sustaining support to vulnerable children after the life of the project. In what follows, let us describe each phase of the CAC.

The Community Action Cycle
Save the Children Federation. Inc.

Source: Save the Children Federation, Inc., 2009, p.12

Phase I: Prepare to Mobilize: During this Phase, all partners prepare themselves prior to entering communities. In this phase the program select the OVC issues and define who the OVC and the target communities are. Program team should be trained as trainers in how to mobilize communities, gather information about how communities were organized and what existing groups were currently working on supporting vulnerable children. Additionally, resources and constraints were identified and a community mobilization plan was developed for the program.

Phase II: Getting Organized: During this phase, Program partners orient the community about the overall goal of care and support for OVC, built relationships, trust, and credibility with communities, and invited community participation through the formation of Community Core Groups (CCG). These groups may be identified as key partners who would support OVC initiatives.

Phase III: Explore the OVC Issues in the Community: During this phase, the CCG explores the OVC issues within their community, and sets priorities for action. A registration process will be carried out by the CCG in a manner as to not further stigmatize the OVC, usually by going door to door to assess, review and register. During this phase, it also recommended that the CCG conduct a Service Mapping of health, social, educational and protection services available to OVC within the community.

Phase IV: Planning Together: In this phase the objectives of the planning process should be decided. Before designing the planning session the groups that will be involved in the planning process, their roles and responsibilities should be determined. Then the planning session to create a community action plan should be conducted or facilitated. During this stage, the CCG develop their Action Plan to address the needs of OVC in their communities. Then, the CCG shares their action plan with the broader community.

Phase V: Act Together: In this phase, the partners focus on strengthening the community's capacity to carry out their own action plan. CCG members monitor their own progress against their action plans, highlighting service delivery and coordinated care for OVC. During this phase partners work in an advisory role to CCGs. An institutional capacity assessment may be carried out to prioritize training and coaching needs. Highlighted are skills needed for CCGs to carry out their action plans, including leadership, conflict resolution, financial management, resource mobilization and monitoring and evaluation.

Phase VI: Evaluate Together: During this phase, efforts focus on defining what participants wanted to learn from the evaluation, an evaluation plan and instruments should be developed and the evaluation is completed. Results should be analyzed and feedback provided, including lessons learned and recommendations for future activities, to all interested stakeholders.

Phase VI: Prepare to Scale-up: Scaling up community mobilization means expanding the impact of a successful mobilization effort beyond a single or limited number of communities to the regional, national, or even multinational level. This phase should result in continued scale-up of community actions and ideas, and an increase in coverage, both in numbers of beneficiaries and/or geographic coverage (Radeny & Bunkers, 2009, p: 12-14).

2.7   Family Centered OVC care and support

Family centered OVC care and support interventions are defined across a continuum that include the following for adults and children: primary health care; HIV/AIDS specific prevention, care and treatment; educational support for children as a means of household economic relief; food security and nutrition; shelter support; psychosocial counseling and support; spiritual support as appropriate; child protection, particularly from abuse & neglect, but under the care of a caring adult; household economic strengthening; and legal support.

Families provide the healthiest and safest environment for children and thus strengthened and expanded home based case management services that bring support as close to the household as possible is essential. It is important to build the capacity of community based volunteers to provide services and support to caregivers and ensure families have access to an expanded service network. The seven core service areas which are considered critical components of a set of services for the provision of family centered care and support targeting vulnerable children includes the following:

2.7.1 Shelter and Care: The HIV/AIDS epidemic overloads impoverished communities to the point where many children are left without suitable shelter or care. Those children who find themselves without a caregiver become highly vulnerable to abuse and stunted

development. In addition to the provision of basic services, such children need an adult that provides them with care, love and support.

2.7.2 Food and Nutrition: Food and nutrition are important components of OVC support. Malnutrition underlies more than one half of deaths in children under five in developing countries (PEPFAR). These services aim to ensure that vulnerable children have access to similar nutritional resources as other children in their communities.

2.7.3 Health Care Support: These services include provision of both preventive and curative health support. It should address the health needs such as primary care, immunization, treatment for ill children, ongoing treatment for HIV positive children and HIV prevention.

2.7.4 Educational Support: Provision of educational support to orphans and vulnerable children is important for ensuring their productivity in the future. Schools can provide children with a safe, structured environment, the emotional support and supervision of adults, and the opportunity to learn how to interact with other children and develop social networks. Schools must also be made safe for children, especially girls. In addition, vocational training is an important component of life preparation.

2.7.5 Psychosocial Support Psychosocial supports would help OVC to cope up with mental distress that was created by the consequences of HIV/AIDS and would be a crucial component of OVC service package. Components of the psychosocial support are generally based on the need of OVC and are in accordance with the training provided to the providers. These services aim to provide OVC with the human relationships necessary for normal development. It also seeks to promote and support the acquirement

of life skills that allow adolescents in particular to participate in activities such as school, recreation, work and eventually live independently.

2.7.6 Child Protection and Legal Support: These services aim to reduce stigma, discrimination and social neglect while ensuring access to basic rights and services protecting children from violence, abuse and exploitation. For children whose parents or primary caregivers have died or are critically ill, legal protection for property and inheritance rights is essential so that their already vulnerable situation is not exacerbated by loss of shelter, land, and other material property.

2.7.7 Livelihood Support: Economic strengthening is often needed for the family/caregivers to meet expanding responsibilities for ill family members or to welcome OVCs into the household. Linking OVCs and their families with programs providing economic opportunities is often an important service. Look for programs that base their economic-strengthening activities on market assessments, and undertake joint efforts with organizations that have strong experience and a high level of expertise in this area. Maturing children and adolescents need to learn how to provide for themselves and establish sustainable livelihoods.

Generally, creation and provision of a comprehensive family centered package of key social, medical, psychological, educational, economic and legal support services to OVC and their families is a critical component of a basic safety net necessary for preventing, at a massive scale, unnecessary illness and death, school desertion, exploitation in its many forms and child abandonment.

2.8   Quality Standards of Care and Support to OVC and their Care Providers

While communities are best placed to deliver care and protection services to children, many lack the mechanisms and systems to ensure coordination and quality of services. With increased resources being funnelled to community-based initiatives, there is an emerging need to develop systems to support larger scale programs while at the same time ensuring consistency and quality in meeting children's basic needs. Several models exist, but the evidence is still evolving on how resources are being effectively used to improve the wellbeing of OVC.

To provide quality services to OVC, all stakeholders and program implementers should adhere to and take into account the dimensions of quality and core service components as described on the Standard Service Delivery Guidelines, (MOWA, 2009). The lessons learned from previous experiences indicate that support targeting OVC were not often standardized, comprehensive or sustainable. The need to standardize and provide the services in a uniform manner was a crucial reason for the development of the standard service delivery guidelines. The standard service delivery guidelines document contains seven core service areas which are considered critical components of a set of services for programs targeting vulnerable children. The seven service areas include the following:

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

Economic Strengthening: These services seek to enable families to meet their own needs from an economic perspective regardless of changes in the family situation.

Legal Protection: These services aim to reduce stigma, discrimination and social neglect while ensuring access to basic rights and services protecting children from violence, abuse and exploitation.

Health care: These services include provision of primary care, immunization, treatment for ill children, ongoing treatment for HIV positive children and HIV prevention.

Psychosocial Support: These services aim to provide OVC with the human relationships necessary for normal development. It also seeks to promote and support the acquirement of life skills that allow adolescents in particular to participate in activities such as school, recreation and work and eventually live independently.

Education: These services seek to ensure that OVC receive educational, vocational and occupational opportunities needed for them to be productive adults.

Food and Nutrition: These services aim to ensure that vulnerable children have access to similar nutritional resources as other children in their communities.

These 7 core OVC service areas should further fulfil the quality dimensions by ensuring the Safety; Access; Effectiveness; Technical performance; Efficiency; Continuity; Compassionate relations; Appropriateness; Participations and Sustainability of the services. In addition to the seven service areas, coordination of care is also a critical component of any comprehensive care package for OVC (MOWA, 2009).

2.9   Problems and Challenges in Provision of Care and Support

Governments bear a responsibility to care for OVC, but too often they do not. For centuries, communities in Africa have helped neighbors in crisis. But the huge numbers of children in need meant that neighborly support is no longer enough. As a response, community members are getting together to assist children and their families within their communities. Community

initiatives can provide various kinds of assistance including parenting, psychosocial and spiritual support, and material assistance. (Save the Children UK, 2007).

In Ethiopia, the plight of children affected by HIV/AIDS is gaining increased attention, there are few governmental institutions for orphans, as extended families have usually taken them in. These families are themselves likely to be poor and must therefore stretch already inadequate resources to provide for both orphans and their own children. Government social services, grossly inadequate before HIV/AIDS, are now severely overburdened and under resourced. While numerous organizations in Ethiopia provide services to these children, most have focused on increasing access to services to reach as many children as possible. A situational analysis in 2007 found that OVC service providers offered widely varying services, and there was little evidence to show that these services were making a measurable difference in the lives of those being served.

Despite the recognition of the magnitude and negative consequences of this problem, there is little evidence on "what works" to improve the well-being of children affected by HIV/AIDS. Given the lack of information on the impact of care and support strategies for OVC, there is an urgent need to learn more about how to improve the effectiveness, quality, and reach of these efforts.

2.10   Recommended Solutions

To date, the services offered to OVC by government, non-governmental and community-based organizations have not been standardized or made uniform in terms of quality and size. To address this issue, the Ministry of Women's Affairs (MoWA) and Federal HIV/AIDS Prevention and Control Office (FHAPCO) have developed the Standard Service Delivery Guidelines for Orphans and Vulnerable Children (OVC) Care and Support Programs in 2010.

The standard service delivery guidelines have been pre-tested and piloted with specific emphasis on the basic principles of quality assurance and universal access.

The OVC standard service delivery guidelines document has three parts. The first part deals with the background, guiding principles, and implementation at different levels. The second part addresses the service components and standards with their respective dimensions of quality as well as identifying the critical minimum and additional activities which should be implemented. Part three of the standard service delivery guidelines covers monitoring and evaluation.

The application of the standard service delivery guideline needs the involvement and support of different actors or stakeholders at all levels who are responding to the needs of OVC. In order to pave the ways for appropriate and necessary involvement, clear identification of the roles and responsibilities needs to be developed. (MOWA/FHAPCO, 2010, p: 34-36).

A 'family centered approach' is an increasingly important concept in HIV programming for children. Research carried out by the Joint Learning Initiative on Children and AIDS presented strong evidence to support this approach (JLICA, 2008). However, the application of the evidence and its translation into programming practice has been limited.

In summary, HIV/AIDS has been affecting people from all walks of life in the world for 3 decades. In order to address its multi-faceted impacts (such as creating OVC) at different levels in various contexts, professionals and concerned stakeholders, in their capacity, have tried to develop and implement a number of 'comprehensive' models. Among these frameworks, the Model which was developed by the Save the Children Federation, Inc., in close partnerships with the PEPFAR, USAID and Save the Children-USA in 2009 is the Model which is considered in this empirical study through social work perspective.

Chapter III   Methodology

3.1   Study Design

The study employed a combination of research methods and/or techniques such as quantitative and qualitative research designs. These research approaches were used for purpose of triangulation that enables to capture pertinent quantitative and qualitative data and pieces of information; otherwise some aspects of the issues might be missed if only one method was employed. The student researcher actively participated in the actual data collection in the field settings so that it was managed successfully to collect data from both primary and secondary sources. In this study, the OVC, their care providers, community volunteers, CBOs, FBOs and government bureaux participated. Generally, description of socio-demographic and economic situations of OVC and their care providers, the attempted responses of the NGOs and the members of the local communities to care and support reported and analyzed. Therefore, the study employed both quantitative and qualitative study designs in order to answer those research questions by taking into account the objectives and the nature of variables involved in the study.

3.2   Methods of the Study

For the purpose of primary data collection, both quantitative and qualitative research methods were employed. The primary data was gathered through interview schedules, Focus Group Discussions (FGDs) and semi-structured interviews with key informants (such as the beneficiaries and other stakeholders at different levels) using interview guides consisting of general questions. Secondary data was also collected from different types of documents, including project documents, activity and monitoring reports, work plans, progress reports, minutes of meetings, published and unpublished research reports, consultancy reports, government guidelines and documents, web-based files and documents downloaded from the

Internet. In addition, observations were employed to generate relevant data and pieces of information which could help the researcher to assess many issues as they were happening in their natural settings that may be difficult to collect them through interviews of one sort or another. Moreover, the study employed documentary analyses to generate secondary data or pieces of information.

3.3   Target Population of the Study

The study was conducted in 10 woredas/districts of the Arada Sub City in Addis Ababa where Strengthening Community Safety Nets (SCSN) Project that facilitates care and support for OVC implemented had been implemented. The study population consists of all total of OVC, and their care providers in those districts. Therefore, the target population included in this study were Orphans and Vulnerable Children whose ages were between 7 and 11 years, their respective care providers, key informants at concerned government agencies, Arat Kilo Child Care and Community Development Organization, volunteer community groups, CBOs and FBOs.

3.4   Sample size Determination and Sampling Procedures

The study used purposive sampling to draw the sample of respondents based on the established and maintained relationships with the NGO, proximity of the Project area and cost effectiveness. To determine the total sample size of the study (particularly OVC beneficiaries) a list of all OVC who are beneficiaries of the Project was taken as a sampling frame. From this sampling frame, with the help of the OVC Project Coordinator, 4 children and 2 care providers or guardians were selected from the majority of the Project intervention areas. Therefore, the researcher successfully managed to identify and draw a total sample size of 75 respondents; out of these 50 were orphans and vulnerable children, 10 care providers or

guardians, 10 community volunteer cadres and 5 stakeholders drawn that were composed of project staff, woreda/district administration officials, officials from the women affairs offices, CBOs or FBOs and those form the HAPCO of the Arada Sub City who were believed to be representatives of the 10 woredas/districts where the Project has been operating. Finally, the researcher collected data from those OVC whose ages were in the age bracket of 0 – 11 years and who were vulnerable or at risk, and who have also been getting various types of provisions from the Project and their willingness to participate in the study were the selection criteria considered.

3.5   Sources of Data

This study used both primary and secondary sources of data and/or information. Using various data collection tools or instruments, primary data were collected. In order to complement the primary data, the researcher reviewed available and relevant secondary sources of data and incorporated into the thesis to enrich data and thus, to triangulate the findings of the study.

3.6   Data Collection Techniques

After obtaining verbal consent from each OVC respondent or their respective care providers (for the younger ones) to participate in the study, the heads of the selected OVC households 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 or care providers' permission. Where the child consented to participate in the study but the care provider refused to give consent, the researcher did not proceed with the interview to collect the primary data from the respondent. Following strictly this procedure, a total of 50 OVC were selected for household survey by the researcher. After the researcher had got such an

informed consent from the OVC and/or their care providers, an individual interview was scheduled, with place and time specified. In so doing, confidentiality and privacy were maintained during the sessions.

The study further used semi-structured interviews with key informants that were selected from community volunteers, OVC caregivers, and service providers, people living with HIV, Sub-City HAPCO, project implementers and government line departments. During the sessions of the Focus Group Discussion (FGDs), the participants were chosen from community volunteers and primary care providers. In addition, the informants were chosen from government offices, CBOs, FBOs, community volunteers, project implementers, Arada Sub-City HAPCO and PLHIV association in the intervention areas. The main criteria employed to select these participants were mainly their knowledge of and relationships with the OVC care and support Project in those 10 districts.

3.7   Data Collection Tools

First of all, the researcher had developed and pre-tested the interview schedule, interview guide, FGD checklist and observation checklist two days before the actual study was conducted. After the researcher had incorporated some minor modifications in the research tools developed, both quantitative and qualitative data were collected from 50 OVC (30 females and 20 males) and other participants of the study. Generally, the research tools or instruments employed to collect the data include interview schedule, FGD checklist, semi-structured interview guides as well as observation checklist.

3.8   Data Analysis and Interpretation

The study used both quantitative and qualitative data methods. Quantitatively, the data and/or pieces of information collected through all the above methods and/or techniques were

summarized by using univariate statistical techniques (such as percentages, and frequency distributions) and then presented according to the main thematic issues under investigation. In the same framework, qualitatively, the interviews were transcribed verbatim and then read line by line to identify major themes and categories of theme. These files were kept in one folder to be used while writing up the thesis. Having analyzed the data, they were interpreted to give either numerical meanings to the figurative data or qualitative meanings to the themes or categories of theme identified. In the final analysis, the major findings of the study were discussed and then reached at conclusions regarding each issue under consideration. Based on these conclusions, the researcher would forward suggestions for action to be implemented.

3.9 Consent and Ethical Consideration

By considering the ethical consideration during data collection, the study was undertaken informed verbal consent obtained from the respondents. Children were only interviewed or allowed to participate in interviews when supported by parental or care providers' permission. When the care provider consented to the interview, but the child refused to give consent, the interviewer was not proceeding with the interview and that child did not participate. After informed consent was obtained from the participants, the interview and FGD were conducted in a scheduled place and time to avoid distraction and to maintain confidentiality and privacy during interview and discussion. To protect the identity of respondents, the names of participants including young children in the report are not mentioned.

Chapter IV Major Findings and Discussion

4.1   Presentation, Analysis and Interpretation of Data

This chapter is the heart of the whole thesis report because this part presents, describes, analyses, interprets and discusses the major findings of the study. The collected quantitative and qualitative data are presented in tabular form, analysed with the help of univariate statistical techniques. These findings in tables are interpreted and if necessary; the findings are also in terms of themes or categories of theme. These quantitative and qualitative data are presented in parts under relevant sections of the chapter. The analysis of the data generated not only presents the actual calculations but the final results as well. In so doing, the researcher has taken care of the objective(s) and scope of the study at each stage of data analysis. Generally, all attempts may give the potential readers of the thesis a clear idea concerning the status of the analysis and scope of the objectives of this study from one issue to other.

4.1.1   Socio-demographic Characteristics of Respondents (OVC)

As indicated in the specific objectives of the study, the first characteristics of the OVC examined in the study were socio demographic information like sex, age, level of education and religion. The detailed information with regard to each variable is described as follows.

Table 2: Socio-demographic Characteristics of OVC Respondents (n=50)

Socio-Demographic Variables		Number	Percent
Sex	Female	30	60.0
	Male	20	40.0
	Total	**50**	**100.0**
Age	7-8	5	10.0
	9-10	28	56.0
	11-12	17	34.0
	Total	**50**	**100.0**
Levels of Education	KG	1	2.0
	1-4 grade	25	50.0
	5-8 grade	24	48.0
	Total	**50**	**100.0**

Source: Field survey, 2011

More than half of the sample OVC respondents, 30 (60%) OVC were females and 20 (40%) of them were males. All respondents (both females and males) were children whose age ranges between 7 and 12 years. As to the level of education, all respondents were found to be literate. All interviewed OVC are currently attending school and have already promoted to the next higher grades. Half of the sampled OVC respondents, 25 (50%) were attending their schooling at the level of the first cycle (1-4th grade) while 24 (48%) of the respondents were found to attend their formal education at the second cycle (5-8th grade) of the present Ethiopian education System.

Education is one of the key factors that ensure these children have received care and protection in their community. Both boys and girls should have access to universal services; these services should include education (formal and non-formal, with no stigma or discrimination) and early childhood development, according to Save the Children-USA (2009, p.3). According to the UN CRC, 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 areas, it would be safe to say that most of the OVC are attending their schooling at different levels.

However, this does not mean that all children who are attending school are without any problem. This is because most of the OVC and their providers in the study sampled areas dwell in absolute poverty and even the OVC live in desperately difficult situations due to parental death or chronic illness.

Table 3: Religion of the OVC Respondents (n=50)

Religion	No. of Respondents	Percentage
Orthodox Christian	31	62.0
Protestant	12	24.0
Muslim	7	14.0
Catholic	0	0.0
Other(s)	0	0.0
Total	**50**	**100.0**

Source: Field survey, 2011

As shown in Table 3 above, the majority (62 percent) of the respondents were followers of Orthodox Christianity religion, while the rest, 24 percent and 14 percent were followers of Protestantism and Islamic belief systems respectively. These findings are consistent with other studies which have conducted in the capital city of Ethiopia.

4.1.2   Socio-economic Situations of OVC Respondents and their Care Providers

The other characteristics of the OVC examined in the study were socio-economic situations that include the OVC status and living arrangements. With regard to each variable under discussion, detailed pieces of information are presented described as follows.

As indicated in the Table 4, out of the 50 OVC respondents (n=19; 38%) had lost both their biological parents due to various causes, including HIV/AIDS. The second largest respondents were found to be the vulnerable children (32%) whose parents might be alive but were unable to meet their children's needs and also couldn't provide them with the necessary

care and support because of various reasons such as poverty, chronic illness by HIV/AIDS and other diseases.

Table 4: Current Status of the OVC respondents (n=50)

Category of OVC	No. of Respondents	Percentage
Double orphan	19	38.0
Paternal orphan	10	20.0
Maternal orphan	5	10.0
Vulnerable	16	32.0
Other (specify)	0	0.0
Total	**50**	**100.0**

Source: Field survey, 2011

With regard to the living situations of the OVC and their care providers, among 50 respondents, (n=28; 56%) were living with their parents (they are either paternal orphans or maternal orphans). While (n=22; 44%) were living with their relatives, (19 double orphans, 2 maternal orphans and 1 vulnerable child). Therefore, the significant proportions of the sampled children in the study are orphans (i.e., either paternal or maternal orphans). Most care providers in the study stated that their capacity to care for OVC had reached a situation such that they could not successfully manage, as their resources were already depleted. Thus, the pressure of HIV/AIDS on families and children was paramount and multi-dimensional in its nature. According to these respondents, the assistance they had got from the Project did not solve their existing problems – they could not properly care the OVC under their custody. Though the supports from the Project may help them only for a short period of time, these supports were not frequent enough in addressing all the needs of the OVC. In addition, forty-four percent of the OVC were found to be under the custody of relatives in their extend family (i.e., uncles/aunts and grandparents) unlike fifty-six percent of them who were cared and supported by either of their biological parents.

Table 5: Current Care Providers to OVC (n=50)

Type of caregiver	No. of Respondents	Percentage
Parents	28	56.0
Relatives	22	44.0
Uncles/aunts	11	22.0
Grand parents	11	22.0
Brother/sister	0	0.0
Total	**50**	**100.0**

Source: Field survey, 2011

The majority of the care providers were unemployed in any of the government, non-government and private organizations operating in the community. Almost all care providers and OVC guardians (n=10; 100%) were employed in the informal sector. They earned their livelihoods by engaging in casual works like petty trading, selling local drinks and food. Others were either hired as guards or engaged in daily labour activities, including washing clothes, baking injera (meaning Ethiopian bread) and the like. Therefore, as OVC respondents confirmed that their care providers were found to be alike. Moreover, the children were also expected to work and supplement the meagre household income in order to meet their basic needs. Consequently, most of the OVC worked as daily labourers, shoe shiners, street vendors or lottery sellers after they had come back from school or sometimes by missing their classes at their respective schools. In general, the care providers and OVC are found in destitute situation in which the needs of OVC are deprived and have not yet met. It was also found to be clear from the words of most of the female OVC respondents that girls had been expected to accomplish some of the household chores like cleaning the house, taking care of younger siblings and cooking food items in addition to the income generating activities they performed outside home.

Such situation violates the rights of children that are stipulated under the UN's CRC, which Ethiopia ratified in 1991. It is also quite obvious that these children are very much exposed to neglect, abuse and exploitation as they are living under such difficult circumstances.

4.1.3   Care and Support History of OVC Respondents

The interviewed OVC mentioned that prior to the OVC care and support Project had been implemented by AKCCCD in their respective areas they sometimes got additional supports through different methods. It was mentioned by the respondents that the supports they had been getting were either from relatives or from neighbours were mostly in the form of paying of their school fees, buying scholastic materials and school uniforms. However, regarding food and health related supports; the children were mostly relied up on their care providers.

They also stated that, in most cases, if there was no external support; it was mainly their parents that had been attempted to fulfil their needs which were not enough due to their economic status. As there would not be enough income, their parents had faced difficulty in covering school fee and food expenses for all their children at the same time. Even though there were many siblings of a child in a household, only two or one of the children could go to school, but others might either stay at home or go out to work to supplement his/her family income. Therefore, the majority of the respondents were assisted by other NGOs, neighbours, distant relatives or other benevolent persons in their respective living area on occasional basis. However, after the Project had been launched by the stakeholders in their areas, all the respondents received supports from the Project. But, out of the 50 OVC respondents, 27 were still getting additional supports from other NGOs which were operating in their locality.

Almost all the OVC respondents, in sum, agreed that the various types of support provided by the Project had helped them beyond addressing some of their immediate needs, except for the

psychosocial support. For additional support, they still relied on some benevolent persons, relatives, neighbours in their social networks and other NGOs operating in the area.

4.2 OVC Care and Support

4.2.1 Knowledge of OVC Care and Support Project

Almost all of the focus group discussants and key informants knew very well about the project's objectives and their contributions to the community under investigation. The aim of the project as described by most of the respondents was to provide basic services and psychosocial supports to OVC through the mobilization of the local communities to sustain similar supports after the project had phased out. However, these are not the only objective(s) and then the goal of such projects in Addis Ababa in particular and in Ethiopia in general.

Almost all participants of FGD and in-depth interviews knew that the beneficiaries of the Project had been those OVC aged 0-11 years old. In addition, they clearly stated the OVC selection criteria to enrol and to get care and support services in the Project. However, only those VCC members, other volunteers and the Project staff could tell the specific criteria of selection. The criteria for prioritizing one child over other as described by them were: children who lost both parents due to HIV/AIDS; paternal orphan; maternal orphan; vulnerable children in very poor families mostly women headed households or elderly; and/or youth headed households supporting 2 or more siblings.

It was described by most FGD and in-depth interview participants that the major partners in identifying OVC for supports had been the community volunteers, local government representatives, iddir representatives and Vulnerable Children's Committee (VCC) members. The VCC and community care providers were stated to be the major actors of the identification process. Both groups of volunteers were trained on how to identify and register

beneficiaries and so followed the aforementioned criteria to identify, register and select beneficiaries. Community care providers went house-to-house and listed the prospective OVC using the set criteria. The lists were then submitted to the VCC who subsequently checked, verified the whole process, made the final selection and submitted the final list to the project implementing NGO. Most of the study participants believed that the selection process of beneficiaries had been fair and transparent in most cases. Particularly, the primary care providers said that the involvement of community members which included VCC, community care providers and even neighbourhoods in the selection process had been considered as a justification for the transparency of the selection process of the beneficiaries.

As described by all participants, although the selected beneficiaries were found to be those who had been the neediest ones; they still felt that some more OVC were left unsupported by the Project because of its limited capacity. Some said that the number of beneficiaries is fixed all the time, but after raising expectation among more OVC. This has created resentment between the volunteers and those left out, but not with those of the selected OVC and their households.

Regarding the relationships between the Project and its stakeholders, it was explained that there had been smooth work relationships with district administration offices (or their different functional units) and the local communities in the intervention areas. The district administration, especially the Women Affairs Office played key roles in assisting the project implementation in terms of facilitating free education, health care and arranging shelters for OVC, according to the majority of the informants who participated in the study.

4.2.2 Level of Community Awareness of the Problems of OVC

The pieces of information gathered from focus group discussants and key informants indicated that the level of community awareness of the problems of OVC was found to be relatively high. It was also mentioned that it was due to the project activities, the community's awareness about OVC problem was enhanced. Most of the respondents in the study stated that the community had had a level of understanding in that OVC's problem as one of the social problems that should be dealt with by the local community. This was thought as a positive development in the perception of the community in contrast to the previous notion that OVC had been considered as the problem of only those affected individuals and families.

The respondents also stated that such an understanding about the nature of OVC problems further had enabled the members of the local community to work for the solutions. The volunteers during focus group discussion affirmed that the community had showed positive attitude towards tackling the problems of OVC and, in fact, mentioned some concrete examples where resource mobilizations were started.

The participants also argued that the largest proportions of OVC in their respective area had been living in destitution and absolute poverty. The recent commitment of the local government officials, the community as well as the NGO is very encouraging in the provisions of care and support to OVC as compared to the earlier periods.

The community volunteers who had been recruited and trained by the Project officials had taught the community about child protection and children's rights with regard to the problems of the OVC, their care and support needs and rights. It was also confirmed by one of the senior officials of the District 10 Administration Office, as one of the key informants, that woreda Officials had been mainstreaming HIV/AIDS prevention and control activities. They

took the issue of HIV/AIDS prevention and control as one of the agendas in their meetings and panel discussions. Much more had to be done regarding the care and support services this should have been provided to OVC because of the widespread and multi-dimensional aspects of HIV/AIDS in the local community. This was mainly due to the little amount resources available on the part of the Project compared to the number of orphans in the study areas.

The perspectives of the focus group discussants towards the problems of OVC were also used as an indicator to measure the level of awareness of the community. Most focus group discussants conceptualized orphan children as those who had lost one or both biological parents regardless of the cause(s) of death. These participants also debated a lot about conceptualization of vulnerable children. Some argued that vulnerable children were those children whose parents had been chronically ill, living in poverty and could not care for them under any circumstances. However, the majority of the participants agreed that vulnerable children were those whose parents had died of AIDS, infected and affected by HIV/AIDS and lived in difficult circumstances. This literally means that those children who have no one to care for them, even though their parents are alive and live within the community. Therefore, the study indicates that there is no consensus on the essence of vulnerability and vulnerable child among the members of the local community in the study areas.

Most of the key informants and focus group discussion 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 OVC living within the community. FGD participants are also of the opinion that community-based care and support should be more valued than institutional care. The rationale behind their argument is that community resources such as volunteerism, existence of ideal community structures, CBOs, FBOs, and above all, OVC would better learn norms, values and culture of the community and can easily

integrated to the wider society. They also disclosed that if community-based care and support should be backed up by technical and financial support by service providers so that it would be effective and successful from the point of view of cost effectiveness.

4.2.3   Process of Community mobilization

Community mobilization is a capacity building process through which individual, groups or organizations can plan, implement and evaluate activities in a participatory basis to improve their health and other needs, either on their own initiative or stimulated by others. Nearly all the respondents including the OVC know the existence of the community volunteers that assists the OVC care and support project implementing body in delivering services. The study participants agreed that the project under study gives due emphasis to community involvement and ownerships. As members of community groups play a crucial role in mobilizing the broader community to develop a communal responsibility for OVC, rather than trying to provide direct care for all OVC in their community.

The respondents were of the opinion that when family support had failed, experience shows that long term care and protection for children within a community is best provided by community managed interventions. These are likely to have been created by a strong personal and community sense of motivation and are therefore most likely to provide long term, holistic support for children. Though, the project under study did not give much room for the participation of the beneficiaries it has created community volunteer's structures and also strengthened the existing ones. It was mentioned by respondents that in all the AKCCCD's Project districts in consultation with the woreda administrations established Vulnerable Children Committee that composed of committee members ranged from 7 to 8 at the commencement of the Project. The VCC then further facilitated the Project's activities at the grassroots level through the selection and organization of other volunteer cadres (like 12-15

Community Care providers, 2-4 Youth Mentors and 1 Paralegal per woreda/district). The main roles of the volunteers in the Vulnerable Children's Committee (VCC) as reported by the research participants include:

> To identify and select other community volunteers that can facilitate the Project's activities; to lead and coordinate the activities of other volunteers; to get involved in the selection of OVC for care and support services, to make final decisions in the selection and to communicate this to the Project implementing Organization; to distribute support materials provided by the Project to beneficiaries; to coordinate the Community Conversation (CC) sessions; to initiate the involvement of responsible government and non-government bodies to contribute in some of the activities (such as the police in legal issues, the kebele offices in economic support, and house renovations, schools to support tutorials, health offices on health education and health care); to link and refer the beneficiaries to service providers and organizations when necessary; and to organize OVC guardians in CSSGs in order to strengthen their economy.

The same informants adduced that the Project had care providers who had been selected among the members of the local community in the study areas as they stated:

> Community Care providers are the main home-based care providers that have been one of the key components of the OVC Project. These people are identifying beneficiaries and their respective needs through home visits; conducting home visits to provide psychosocial supports, health education, nutritional advice, child protection and habit of savings to OVC and their families/guardians; supplying soaps to OVC and, at times, wash their clothes and help maintain personal hygiene; making referral linkages through the VCC to other service providers when required; encouraging and continuously following up progresses of saving self-help groups to start their own business; and are following up the OVC's attendance to schools and tutorial classes.

In addition to those committee members, there were youth mentors and paralegals in the intervention areas of the Project. According to the findings of the qualitative part of the study,

> The youth mentors are young volunteers who had been recruited and trained by the Project Officials in collaboration with the VCC members in psychosocial and life skills education. They provided the OVC with psychosocial support, including education on life skills and recreational activities, as well as tutorial supports for the OVC and non-formal education for their primary care providers. Youth mentors also worked with the local community care providers in identifying needy children for enrolment into the Project's supports.

As to a legal support to the beneficiaries of the Project under investigation, there are paralegal volunteers in the local communities in the study areas, when the key informants sated:

> Paralegals are those volunteers with legal background used as focal points for legal protections for OVC and their families/guardians. Their main role was teaching the community about legal proceedings of will, child rights and how to resolve conflict. Paralegals also advise OVC and their guardians on legal issues and where to get the legal protection when they require. Paralegals report for VCC and work with other volunteers concerning legal protection to OVC and guardians.

To promote the supportive environment that is so critical to the Project, which is dependent on local participation and action, the Project implements Community Conversations (CC) sessions as a method of community mobilization. Community conversations sessions are facilitated discussions that involve community stakeholders – iddir leaders, religious leaders, community elders, caregivers, children and youth. More than three persons per woreda/ district were trained as community conversation facilitators and led a number of sessions that focus on child protection; HIV/AIDS; child exploitation and abuse; including community practices that had denied children's rights by involving different groups.

Moreover, apart from the training of its staff on community mobilization for provision of the OVC care and support, the Project implemented by AKCCCD Organization had tried to follow the basic steps of the community mobilization with close collaboration of the members of the volunteer community committee, as briefly stated by the FGD discussants and key informants. The process of community mobilization in the study areas took place in six phases as follows:

Phase I: Prepare to Mobilize: During this phase, the project implementing agency prepared itself prior to entering communities. In this phase the project team organized a project launching workshop and meets with sub-city administration and HAPCO, woreda administration and HIV/AIDS representatives and other local organizations to formally

establish partnership. In collaboration with the identified partners and the community needs assessment, children and families in need of assistance were identified. The project team was trained as trainers in how to mobilize communities; further information was gathered about how communities were organized and what existing groups were currently working on supporting vulnerable children.

Phase II: Getting Organized: During this phase, project team orient communities to the overall goal of care and support for OVC, built relationships, trust, and credibility with communities, and invited community participation through the formation of VCC who would support the OVC initiatives. The VCC includes a gender balanced mix of community representatives (including children, caregivers and PLHIV), local government partners and child service organizations.

Phase III: Explore OVC Issues in the Community: During this phase, the implementing agency in collaboration with the VCC set target group selection criteria and explores the OVC issues within their community. To further assist in the project implementation in collaboration with the VCC and other relevant stakeholders three core cadres of community-level service providers (Community care providers, youth mentors and paralegals) identified. It was during this phase that volunteers started identifying OVC in their community through a careful analysis based on the defined criteria. The project guided communities to not narrowly define only children affected by HIV/AIDS, but to also include those made vulnerable for a variety of reasons. A registration process was carried out by the VCC through the other volunteer cadres (community care providers) in a manner as to not further stigmatize these children, usually by going door-to-door to assess, review and register. During this phase, the VCC were assisted by the project and started conducting a Service Mapping of health, social, educational and protection services available to OVC within the community.

Phase IV: Planning Together: In this phase, the members of the VCC were supported to develop their bye laws and action plans to address the needs of OVC in their communities. These are prepared based on the bigger plan of the Project.

Phase V: Act Together: In this phase, the main focus of the Project was on strengthening the community volunteer's capacity to carry out their planned activities. The VCC members were assisted to monitor their own progress against their action plans, highlighting service delivery and coordinated care for OVC.

Phase VI: Evaluate Together: Due to the short life span of the Project, any major activity related to this phase was not accomplished. However, the project progresses were periodically monitored with the active participation of the volunteers. In addition the quality improvement activities of the project were also the responsibility of the VCC that formed a quality improvement team.

Phase VII: Prepare to Scale-up: Issues which have to do with prepare to scale up were not incorporated as part of the Project design and implementation. However, the implementing agency in collaboration with partners and stakeholders devised different strategies to scale up the volunteers' structures.

Based on the findings of the study as stated above in terms of the six phases of the Project, this concludes that the processes of community mobilization which have been undergone are not in line with the models that are in place in Addis Ababa, Ethiopia. This is because the Project Office was not strictly following detailed activities which should be carried out at each phase of the community mobilization under discussion.

4.2.4 Types of Care and Support Currently Rendered to OVC

All OVC respondents currently receive supports from the OVC Care and Support Project which has been implemented by AKCCCD Organization. Out of 50 OVC respondents, 27 got additional support from other NGOs operating in their locality. Prior to the Project, most of the respondents were supported either by a relative and/or by neighbour(s) for their scholastic materials and school uniforms.

It was also found out that the Project overall planned to target and reach with those services to a total of 7,550 OVC by the end of the three-year project life (2008-2011) as indicated in Table 6. An OVC is counted as beneficiary if one or more of the 6+1 services are given to her or him. Those services could also be delivered once or more than one time during the Project life time to a child.

Table 6: AKCCCD OVC Care and Support Project Beneficiaries by Woredas/Districts

S. No.	No. of Project Districts	Number of target Children	No. of target Caregivers
1.	1	808	110
2.	2	740	116
3.	3	802	142
4.	4	689	132
5.	5	655	124
6.	6	875	67
7.	7	751	59
8.	8	637	96
9.	9	1,049	160
10.	10	744	143
	Total	**7,750**	**1,149**

Source: Project Document of the AKCCCD SCSN, August 2008.

The study found out the Project had been providing the OVC and their guardians the following types of care and support services: psychosocial support (PSS); child protection; health education and early childhood care and development (ECD); shelter and care; food and nutrition; and economic strengthening. Let us describe each type of service provided.

a. Psychosocial Support (PSS):

Psychosocial support is the process of meeting a person's emotional, social, mental and spiritual needs. As a result of HIV/AIDS, children might experience traumatic events such as the illness and death of parents, violence and exploitation, stigma and discrimination, isolation and loneliness, and lack of adult support and guidance. Hence, appropriate psychosocial support helps children and their families to overcome these challenges, and builds coping mechanisms, trust and hope in their future. Thus, the project provides psychosocial support through home-based care providers and youth mentors to all OVC registered to be supported by the project by assessing their needs. The components of the psychosocial support vary from OVC to OVC that includes counseling, spiritual support, recreation, life skills and home visits.

Table 7: OVC Respondents provided with the different types of PSS

Types of PSS	No.	%
Life skills education	27	54
Home visit	50	100
Recreation	22	44
Spiritual support	18	36
Guidance & counselling	38	76
Total	**50**	**100**

Source: Field survey, 2011

The above table indicated that all the respondents were provided with more than one technique of psychosocial support. They also confirmed that the community care providers visited more than 4 times almost all the respondents.

Moreover, FGD and interview participants stated that OVC generally had been considered destructive children. Some had no one to support them, guide them and some are infected or affected by HIV and isolated and stigmatized by the community. Volunteers identify these children and provide them psychosocial support, create awareness to neighbours that OVC

needed care and support not isolation and stigmatization. Many changes are brought with this support. The community even mobilized to support in cash or kind or even to adopt OVC. OVC also miss classes while searching for means of living; they were considered weak in their schooling. The other major support in this area is that OVC have little knowledge to deal with inheritance issues and other community supports. They usually worried about their loss of parents, lack direction in life and expected to play the role as the head in the household. Community care providers and youth mentors have provided counseling and life skills education; show ways to address their problems and link them with their distant relatives whenever possible. Youth mentors have said that some OVC are gone to the street, they smoke, snuffle gas and involved in stealing. As a result the community members are scared of them and protect their children from them. The youth mentors identified such OVC created sport sessions, art teachings, assist them to be enrolled in schools, give them life skills education, tutorial classes and link them where they get support. Many children have become productive because of these supports.

b. Child Protection

OVC are exploited much because they often do not have parents to protect them. Due to extreme poverty, they are obliged to engage in child labor beyond their age. VCC, paralegals, community caregivers and youth mentors educate the community about child protection, child abuse, neglect and exploitation. They created awareness in schools, during their home visits, and at every forum they get contact with the community. Many examples are given whereby child rights violated as the OVC are neglected, corporal punishment, raped and exposed to work beyond their age.

Table 8: Number of OVC Respondents provided with Child Protection Services

Types of Child Protection and legal support	No.	%
Birth certificate	5	19.0
Legal support	0	0.0
Will writing	0	0.0
Others: awareness on child protection	27	100.0
Total Respondents	**27**	**100.0**

Source: Field survey, 2011

As can be seen from the Table 8, out of the 50 respondent OVC, 27 children were able to talk about the child protection services they receive from the project whilst the rest were not recall such support. The major activities the OVC received were information about children's rights and child protection with few cases of obtaining birth certificates.

c.   Health

The health issues of OVC and their primary caregivers were addressed by the project in two broad categories i.e. preventive & curative services. According to all the key informants, FGD and In-depth interview participants the preventive aspect of health was addressed by community care providers, youth mentors and CC facilitators. These all categories were given training on awareness creation on preventive aspects of health relevant to the OVC and their caregivers. The areas covered in the prevention were personal hygiene and sanitation, reproductive health, immunization and HIV/AIDS. Volunteer care providers provided the health education during their home visits to the OVC and their primary caregivers. The volunteers also check the hygiene condition of children and sometimes give soaps and wash their clothes. They also teach about HIV/AIDS; facilitate testing for HIV with health facilities. Youth mentors also educate on hygiene and sanitation during their tutorial & life skills educational. With regard to curative health the VCC facilitated the provision of letter from the woreda for a free medical service at hospitals or health centres.

Table 9: Health Support provided to OVC Respondents by the Project

Types of Health care	No.	%
Health education	40	100.0
Medical treatment	8	20.0
Management of childhood illness	0	0.0
Immunization	4	10.0
Others - HIV testing	12	30.0
ART	6	15.0
Total	**40**	**100.0**

Source: Field survey, 2011

The above table indicated that 40 of the respondents were provided with different preventive and curative health services. However, the OVC care providers mentioned that medical treatments especially for the younger OVC were provided at the project clinic/through referral to other institutions. The ART services were mentioned to be provided in collaboration with other NGOs operating in the area. A community conversation facilitator said that they held many community sessions on hygiene and sanitation, HIV/AIDS, food and nutrition, reproductive health and related topics. They also invited Health Extension Workers (HEW) and health workers during the community conversation sessions to give professional inputs.

d. Education and Early Childhood Care and Development (ECD)

The major support under education is provision of educational materials, tutorials and follow-up of attendances of school by OVC. All FGD and in-depth interview participants said that scholastic materials such as exercise books, pens, pencils and uniforms were given to the selected needy OVC. It was given once in a year in most cases.

Table 10: The Educational Support provided to OVC Respondents by the Project

Types of Educational Support	No.	%
Scholastic materials	20	100.0
Uniforms	17	85.0
School fee	9	45.0
Tutorial	18	90.0
ECCD services	0	0.0
Total	**20**	**100.0**

Source: Field survey, 2011

The educational supports provided to 20 respondents could be one time or more and either one or more types. A child who receive scholastic materials may also get uniform too or only one of depending on their situation and the needs assessed by the volunteers.

Although all participants of the discussion appreciated the support given by the project; the support given at times was not timely and not enough quantity. However, the major achievement under the education support mentioned by all participants was the tutorial classes for OVC that is facilitated by youth mentors. The schools in the area allowed the youth mentors to use their class rooms and teaching aids freely. Because of this support some OVC improved in their school results and becoming competitive as their peers with parents. The Early Childhood Care & Development (ECCD) on the other hand strengthened existing ECCD centers through training caretakers and supplying needed materials. The center provides children aged 3-5 with both cognitive and developmental skills as well as a daily snack. Community-based ECD programs provide an ideal entry point for addressing holistic development of young children, including primary health services and nutrition.

e.   Shelter and Care

The discussions held with the project staff revealed that housing was one of the major challenges for OVC and their caregivers. As the projects have limited capacity to construct houses the only provision was undertaking minor maintenances of houses as well as provision of household utensils. Even for such minor maintenances most of the houses where OVC are living have no adequate space as they live in a crowded situation.

Table 11: The Shelter and Care Support provided to OVC Respondents by the Project

Types of shelter & care support	No.	%
House maintenance	3	33.0
Latrines	0	0.0
House ware utensils	2	22.0
Blanket	4	45.0
Total	**9**	**100.0**

Source: Field survey, 2011

Despite such hindrances the project in collaboration with the woredas and VCC was able to support few needy OVC households with minor maintenances. The maintenances were mainly wall plastering, roofs or windows. The VCC mobilized the OVC households to support the house maintenance by contributing free labor and few materials according to their capacity. Household utensils like water containers, blankets and some kitchen utensils were also provided as part of shelter and care support of the project.

Few households provided with care and support were observed which are better than their previous condition (as can be seen from photos previously taken) but they need more support to satisfy the housing condition. The main reason given by the volunteers and the project staff was the limited financial capacity of the project, lack of space between houses and the housing situation. It is a huge problem, but it is beyond a capacity of a small project like this.

f.   Food and Nutrition

This component comprises provision of food items and nutrition education to OVC and their caregivers. The support is based on an assessment conducted by volunteers on the food needs of the OVC household. The food items provided by the project constitute wheat, wheat flour, corn, chickpeas, maize and cooking oil. The OVC and their caregivers considered this support as the most important support of all. Despite the fact that the provision has been irregular, insufficient and uneven, the OVC families appreciated the provision as the most important

one. This was due to the fact that food is the biggest expense for the majority of OVC families. Hence, OVC families have greater and continuous expectations towards the organization in terms of food support. The frequency and time of food support is not always clear to the OVC families. This forced most OVC families to live with expectation and waiting for the community care providers to inform them the time for food delivery. Despite this fact, many of the informants stated the significance of the food support to the majority of the OVC at very difficult times.

Table 12: Food and Nutrition Support provided to OVC Respondents by the Project

Types of Food & Nutrition support	No.	%
Nutritional education	36	100.0
Supplementary food	8	22.0
Vitamin A	2	6.0
Food ration	36	100.0
Total	**36**	**100.0**

Source: Field survey, 2011

The nutrition education conducted to OVC and their caregivers during food distribution, home visit and community conversation. As can be seen on the table all the 36 OVC respondents received food ration and nutrition education once or more. Out of the 36 respondents few about 28% received supplementary food & vitamin A support depending on their need. It is clear that OVC generally get little food with poor nutrient value. According to community caregivers, this is not only due to shortage of food, but also due to the fact that primary caregivers often know little on how to prepare food and feed their children in a way suitable to children. Therefore, the education on proper nutrition for mothers and guardians of the OVC has been very useful in bringing about change with this regard. Provided that the communities in which the organization is working are affected by extreme poverty, expectation of food support remains a challenge for any organizations working towards strengthening community's own resources. As one community caregiver stated, "The challenges I encounter are, in most of the households I visit, the families do not have

something to eat and if I have money I sometimes buy them food. If I don't have money I feel embarrassed to go to their house. Sometimes the support is not enough and some people are not happy to see us".

g.   Economic Strengthening

The project has the objective of strengthening the economy of the poorest group within the context of the OVC. A small grant was provided for the most vulnerable groups such as the youth headed households (YHH). The youth used the financial support to strengthen the small business that helps them in assisting their siblings. The volunteers also assisted female OVC guardians in forming Community Saving Self-help Groups (CSSG) where they save their own money. Through their CSSGs the women continued their savings and started giving out loans to their members for strengthening their businesses. Out of the 50 OVC respondents about 24% saw the relevance of the economic strengthening as their caregivers were members of the CSSGs initiated by the community volunteers.

4.2.5   Relevance of Care and Support provided to OVC Respondents

Most of the OVC respondents mentioned that they were receiving the six plus one services provided by the OVC care and support project implemented by AKCCCD Organization in their respective woredas. It was also explained by the OVC respondents and their caregivers that the main types of support provided by the project were educational support like provision of pens, pencils, uniforms and tutorial support; health education through home visit and CC sessions; occasional provision of food items (wheat, wheat flour, cereals and edible oil); psychosocial support in the form of advice and guidance through home visit, life skills education, recreation; and shelter services like house renovation, house ware utensils and blanket distribution. Prior to the project majority respondents told that such necessities were

provided by either their distant relatives or neighbors which was in a very small amount. Few of the respondents also said they get additional support from other projects implemented in their areas.

The respondents further explained, though all are provided with the psychosocial, health education, home visit and child protection supports, only few selected are getting material support. It was revealed by the respondents that before the provision of any material support the home visitor community care providers filled out a form by asking the major needs of the OVC and tries to provide one or two material supports depending on availability and their problems.

As can be seen in the table 13, the children tried to rate the services provided to them according to its relevance in addressing their needs. It was also indicated during data collection that the major dissatisfaction was due to the inadequate amount and frequency of the services. However, there was a general consensus among the different participants that the project was relevant to the need of OVC and their guardians. *"The services planned and provided by the project to OVC and guardians were all needed very much by the beneficiaries. But honestly speaking, sufficiency of each of these services was far from enough,"* said FGD participants. Another respondent stated the relevance of the Project services as: *"OVC like other children need to eat, go to school, get psychosocial and legal supports, receive health care and have shelter. These services should be available to them in order to ensure that they will grow and be productive citizens. The project therefore did relevant interventions."* The services planned by the project were also in line with the national standards service delivery guidelines for OVC care and support programs of Federal HIV/AIDS Prevention and Control Office and Ministry of Women's Affairs (2010).

Table 13: Quality & Relevance of the OVC Care & Support Project of AKCCCD Organization

Types of Service	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Response Average
The Shelter & care service addressed my needs	11% (1)	22% (2)	44% (4)	22% (2)	0	18% (9)
The Health care service addressed my needs	8% (3)	28% (11)	52% (21)	1% (5)	0	80 (40)
The Educational support addressed my needs	12% (3)	24% (6)	40% (10)	24% (6)	0	50% (20)
The Food & nutrition service addressed my needs	8% (3)	42% (15)	17% (6)	33% (12)	0	72% (36)
The Psychological support provided were what I need	14% (7)	52% (26)	28% (14)	6% (3)	0	100% (50)
Child protection & legal support was what I need	0	4% (1)	70% (19)	26% (7)	0	54% (27)
Economic Strengthening support addressed my need	0	8% (1)	92% (11)	0	0	24% (12)
The overall OVC care & support services provided by the project implemented by AKCCCD in my area addressed all the needs.	0	12% (6)	40% (20)	44% (22)	4% (2)	100% (50)
Total						**100.0 (50)**

Source: Field survey, 2011

4.2.6   Efficiency of Community-based & Family- cantered Care & Support Activities

The design of the project was contested by most of the study participants and its targets were commented as ambitious. Most FGD and key informant interview participants argued that the project targeted large number of OVC with small budget and as a result most supports were not adequate to satisfy the need of the beneficiaries. "As far as adequacy of the services is concerned, it was like splashing with tip of a finger," said an FGD participant. It was stated by FGD participants that OVC who received some food supports once would be exempted and new OVC would be enrolled for subsequent distribution. It was explained by participants that this approach was used to reach the large number of OVC set to be reached at the end of the project life. They said that provision of 25 Kg of food item once or twice a year is better than nothing, but cannot solve the problem of the OVC. The other comment of the project more emphasized by the project staff and volunteers was the psychosocial support.

It was also described that beneficiaries usually expect more hard components than soft components and it was a challenge for community volunteers and implementing partners to convince the community to buy-in the project approach, especially at the start-up phase. *"A balanced approach for both psychosocial and food/material supports would have made the project more beneficial"* said a key informant. The psychosocial component according to the observations during the home visits made, the beneficiaries appreciate the psychosocial support given by a community volunteer. The primary caregiver respondents were highly appreciated the support rendered to them by community care providers during visiting their homes. Each of the volunteer care providers, due to having large numbers of OVC to care for, only visited a household at least once a month. However, the relationship they build with the OVC and family is worth mentioning. During their home visit they manage to provide guidance to the OVC and their guardians on issues like health, sanitation, nutrition, education, care and child protection issues.

The project approach that engaged the community through large number of volunteers and *Iddirs*, in which most of the population is a member was appreciated by most of the study respondents. The fact that the project was anchored in to the community through VCC and the other three volunteer groups facilitated community ownership. The various training and exchange/experience sharing visits provided to the volunteers helped them a lot in their commitment and capacity.

Many respondents questioned the appropriateness of age limitation of the beneficiaries only up to eleven. The projects supported children aged 0 to 11 years old. The volunteer cadres and VCC members stated that there were OVC who really deserved support but left out because they were above 11 years old. They further discussed that OVC between 11 and 18 years at times need more support than younger ages because this is the time when children often go

into destructive behaviour like abusing alcohol and drugs out of frustrations. Moreover, the little focus given by the project to economic strengthening support is also another area that most of the study participants contested of.

This part discusses the major findings obtained using different data collection tools from various segments of the community including literature reviewed and field observation made by the researcher. The study assessed the community based and family centered care and support services provided by AKCCCD organization to OVC who are affected by HIV/AIDS and their families in Arada Sub-city of Addis Ababa, Ethiopia. From the study it was found that though not adequate and continuous the support of the organization was quite relevant to the needs of the OVC and their families.

4.3 Causes of Vulnerability and Current Situation of OVC and their Care Providers

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

Implicit in the findings is the impact of HIV/AIDS on the community. HIV/AIDS and poverty have synergistic and symmetrical relationship. As much as HIV/AIDS exacerbates poverty through morbidity and mortality of productive adults, poverty facilitates the transmission of HIV (Thulisile Ganyaza & John Seager – HSRC, 2005). Ethiopia is home to a culture which is rich in traditions, age-old customs and strong relationships among family, kin and

community members. The onset of HIV/AIDS has tested those bonds and created enormous challenges for children, families and communities. Despite the enormity of the situation, it has also provided an opportunity for people to come together and respond to an issue which could appear insurmountable.

The large proportions of the OVC in the study area are double orphans (38%) and are taken care of by their relatives. This indicated that, HIV/AIDS has complicated the traditional role of extended families to care for OVC. For example, adults are sick and some are bedridden, forcing the young and elderly to care for them. The situation can exert untenable pressure on households in their struggle for survival. In line with the findings of different surveys (MOLSA, 2003 and FHI, 2005), a significant number of OVC get care and support from the extended family. Among the OVC respondents 44% live with their extended family members – grandparents and uncle/aunts. HIV/AIDS impacts these families on social and economic levels. On social level, households have to deal with issues around stigmatization, social exclusion and disintegration of family structure and social support networks. Women especially, are overburdened with care and support roles. In the study area 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. On the economic level, households and the surviving members have to pay medical costs and funeral expenses and, if the deceased was a bread winner, there will be further financial impacts in the form of a loss of income. Thus, the women caregivers are forced to be engaged in the informal sector where they generate meagre household income. To fill the shortage of income for the monthly expenditure, children in the household are expected to work as daily labourers (shoe shine, lottery selling and others). Therefore, most of the time, children could not attend school and are vulnerable to both physical& sexual abuse and exploitation that is likely exposed them to

HIV/AIDS. Hence, HIV/AIDS and poverty predisposes children to violations of their basic rights. Children are dependent on adult members of the household for food security, health services, education, care and support. Hence, failure to provide them with these basics may hamper their nutritional status that is placing them at risk of various infections that would undermine their health status. On the other hand, these children also face large risk of achieving low level of educational attainment and dropping out of school. Moreover, HIV/AIDS is changing the age distribution of the labour workforce with an increasing number of children facing economic uncertainty and hardship. The early entry of OVC into the labor force exacerbates the worst form of child labour, and the epidemic is forcing older persons back into the work force due to economic need. Thus, the OVC care and support project implemented by AKCCCD in the study are contributed in easing the burden of such households in caring for OVC.

4.4   Opportunities for Improving Care and Support services for OVC

The current project under study focuses on providing psychosocial and child protections support more than material and financial supports which are quite innovative. Though the respondent OVC and their caregivers appreciated the PSS at this stage, at the initial stage of the project it was an enormous challenge due to the low economic status of OVC families in the area. Accordingly, the research finding reveals that in order to meet the multiple OVC needs and strengthen the capacity of households and communities to provide care and support for them, OVC programs should balance the psychosocial support with needed material and financial support. The collaboration efforts of the project with governments, private sector entities, and communities are the strongest feature that needs to be further strengthened and scaled up.

Such responses to HIV/AIDS particularly to address the needs of OVC, such like the one under study, are uncoordinated and systematized. With an increased number of OVC and involved stakeholders working in the area of care & support, it is more important than ever to assess how well the needs of children are being met by these services. There has not been a unified approach as each stakeholder has individually addressed monitoring and evaluation issues related to their work for and with OVC. This gap has made it difficult for programs to measure progress in achieving overall outcomes for children. Thus a national standard service delivery guidelines and implementation manual that sets a framework within which stakeholders involved in the area of OVC designed and began operational since February 2010. The standard service guidelines for OVC care and support programs were designed by the Ministry of Women's Affairs (MOWA) and the Federal HIV/AIDS Prevention and Control Office (FHAPCO). This standard service delivery guideline is thought to be useful for service providers, donors and community volunteers for program planning, service delivery, monitoring and evaluation to improve overall service delivery for OVC within their family.

Moreover, there are also a framework for the protection, care & support to OVC developed by UNICEF, the alternative child care guidelines for community based childcare of MOWA and the UNCRC that should be consulted while developing such programmes. Accordingly, such guidelines stressed that, in order to provide quality services to OVC, all stakeholders and program implementers should be involved.

As has been revealed by the study the current OVC care and support project touches up on all the seven core service areas. However, the project gives minimal focus to financial and material supports which are part of the comprehensive care and support packages as the standard service guideline entails. Children should get standardized educational, health,

shelter and care, legal protection, economic, psychosocial and nutritional support. The point that should be considered here is that psychosocial support alone does not ensure the well-being of those who get the service. The OVC guardians and community volunteer respondents stressed the project's inability to economically strengthen the OVC families' capacity to better care for the children. The study respondents confirm that, very few OVC caregivers are supported by the project to be engaging themselves in CSSGs that eventually help them to enhance their income earning capacities. However such initiatives should be based on needs assessment and feasibility study as to how this business is profitable and to support the livelihood of the beneficiaries in the community. The support provided is through the establishment of CSSG with women headed households to strengthen their economic capacity and improve livelihoods. The majority of the people in the informal business in developing countries are poor women with limited schooling, skills and technical knowledge. These groups also face a number of constraints in their micro-enterprise activities, skills training, capital constraints a market for selling their products and networking their activity to the formal sector. Establishing CSSGs in this process is also helps in developing self–reliance, leadership skills and self-efficacy that ensures sustainability. Such example could be seen with the PEPFAR supported urban gardening and strengthening community safety nets projects that helps in generating income by mobilizing local resources. But one thing to note here is rehabilitative programs for OVC are interrelated and needs the concerned effort of all actors operating in the community, individual, group, organizations, and other stakeholders.

Thus, the emphasizing should also be on empowering the community through providing technical and financial support by implementing agencies at the grassroots level. To achieve this, has been observed with the project under study, the establishment of social (volunteer

structures) and economics groups (CSSGs) within the community to facilitate the process of care and support in a wider and long-lasting manner.

4.5   Collaboration and Scaling Up of Good Practices

The efforts of the three years period project for strengthening the community capacity to respond to the needs of OVC though has some contribution but still is not up to the expectation again. The project, even though anchored its implementation on community led activities still needs to go a long way to realize its goal. On one hand, there are number of community structures that are established in the community, yet, these potentially ideal structures could not stay longer with the project completed soon and execute more community mobilization activities. These different community volunteer structures include VCC, community care providers, youth mentors, paralegals and community conversation facilitators. These structures if given time and support could be an ideal platform for undertaking community led OVC care & support activities. Though community mobilization efforts were integrated within the project the actual community mobilization steps and activities were not fully executed.

Therefore, for future intervention, programs or projects should be designed in such a way that community mobilization is one major component of the main activities to be undertaken in the community context. There is also a need to enhance the partnership, networking and linkages with other organizations and institutions that are involved in similar activities. Government bodies like HAPCO and women affairs at all levels could be the main stakeholders in such endeavours. 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.

The respondents appreciated the existence of the community volunteers for facilitating the OVC care and support services. However, the volunteer structures, formed by the project under study, within the community to assist the OVC care and support activities effectively, lacks competence and shortage of time because they are working on part-time bases.

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 and very much appreciated by the respondents. For example, the undertaking of OVC selection by community volunteer care providers through house to house visits is positive and transparent. However, the project understudy OVC selection criteria should be inclusive of OVC up to 18 years old, as contested by almost all respondents.

Community resources mobilization is one of the best achievements of the project 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 through Iddirs means fuelling other members of the community as many people in the community are member of Iddirs. When looking at the community mobilization efforts in the study area, there are some initiatives of the project which needs further strengthening.

Opportunities that such agencies should exploit and scale up are further expansion and widening of community volunteerism for the provision of care and support to the OVC so that it would be able to absorb more vulnerable children in the community. Through the community volunteer structures, OVC would easily be accessed and ready to intervention for care and support. The positive attitude that the community developed towards OVC, as found by the study, is another opportunity for development of volunteerism in the community. These

opportunities could be exploited for further and extensive outreach care and support programs. The community volunteer structures could bring together the different actors to address the problem. The aspirations and enthusiasm of such structures could be utilized as a strategy where children would involve in solving their own problems.

4.6   Constraints and Challenges of the OVC Care and Support Project

The constraints that most community based OVC care and support projects encounter in the process of implementation can be viewed from different angles. Some of them are technical and policy issues. For example, the absence of separate OVC policy and strategies are some challenges such projects face whilst implementing projects. The absence of a workable OVC policy and strategy for community-based care and support practice implies that government or its partners should think of social policy that ideally fits and address the problem.

The practice of most community-based OVC care and support programs and projects may achieve short-term goals and objectives, but it frequently fails to ensure long-term impacts and sustainable development. 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. This constraints and challenges could be managed and solved in close collaboration with the community members.

Assessments on needs and response to OVC in Ethiopia show that OVC are becoming the growing burden of an already impoverished community (MOLSA, 2003; HAPCO, 2005). The current OVC care and support providers, as the case under study, 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 longer period to strengthen the community capacity. This was partly due to shortage of resources for implementing OVC care and support projects. Their resources usually mismatch with the large number of OVC in need of care and support in intervention areas. Due to the poverty situation OVC families are living the expectations usually focus on material and financial that hinders the receptivity of the psychosocial support especially during the beginning of projects. The life span of most OVC care and support projects implemented by NGOs being short the community awareness efforts may not bear the required fruits. This also reflected on the low capacity of community structures established and supported by such projects.

While HIV/AIDS crosses all socio-economic groups, its economic impacts are greater on the poor, powerless and marginalized. Poverty is the biggest challenge that communities experience in the provision of care and support to OVC. Understanding poverty within the context of HIV/AIDS is critical as it is a risk factor for and the consequences of HIV infection. Hence, a mechanism should be in placed with the participation of government and NGOs that can address at least the most vulnerable women and child -headed households that are unable to meet their basic needs because of abject poverty.

Chapter V   Conclusions and Suggestions

5.1   Conclusions

Implicit in the findings of the study on the OVC care and support services provided by the local Organization is relevant, community-based and family-cantered though is delivered in small scale contributed a lot in addressing the OVC problems. Even though, the relationship between HIV/AIDS and poverty complicates such responses to OVC; the study confirms that the NGO led community safety net continues to support and care for children. However, the capacity that such projects have to absorb more OVC is limited. This is mainly because of lack of resources, the limited volunteer involvement and the poverty in most households.

The project under study though provided services relevant for children affected by HIV/AIDS are not commensurate to the scale of the problem. The study demonstrated that there are initiatives to raise the community awareness to the problem of OVC living in the community which enhances the responses towards providing support to such groups. Even though the projects support are insufficient and discontinued at many occasions, such agencies are the main actors in care and support to OVC in the community. The types of support that the project provided to OVC and their families through community volunteers include psychosocial support, child protection and other basic services which are somehow in line with the national standard service delivery guideline for OVC care and support programs.

The study yielded that in combating the impact of HIV/AIDS in the community, the approaches the project follows that was initiated to enhance the local capacity to address the problems of OVC and their caregivers is necessary. As revealed by the study these approaches include community mobilization, community conversation, community organization, and community empowerment.

The major issue this project lacked was macro–level interventions in areas like OVC policies, strategies, guidelines and action plans. Such interventions should be addressed by all stakeholders for effective care and support programs. Otherwise, community based efforts to address the problem of OVC will follow different lines that in turn degenerate the appropriate management and implementation of local programs and projects (HAPCO, 2005).

The study also revealed that care and support alone does not alleviate OVC problems in the community unless the long lasting and sustainable wellbeing of children is to be affected. This could be possible through integrating prevention and care as inseparable activities. For example, the prevention programs include prevention of mother to child transmission of HIV (PMTCT), ART to PLHIV, public and mass education of HIV/AIDS.

The research demonstrated that involving OVC and the community as partners in the effort of alleviating the problems of OVC is crucial. Children with many problems have also different coping mechanisms. The children 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 expenditure. The project under study encourages the participation of OVC as an active member of VCC in all woredas. This ensures the children's active participation in the HIV/AIDS prevention and control effort that community based projects exerted with the long-term goal of reducing the impact of HIV/AIDS on children and families. The study suggests continuing the building of communities' capacity to care and support and strengthening local responses to be part of the process. For the activation and facilitation of such efforts, scaling up of good practices to other implementing agencies and communities is very essential. The case in point is the practice of creating volunteer structures, which can be taken, are good models that service providers can utilize for better wellbeing of children in the community.

Currently, the community based and family centered care and support given by local projects has to continue in a holistic and multi-dimensional manner with an upgraded scale that can reach the increasing number of OVC. However, in the long run in addition to the implementation of these projects there should be more macro level initiatives that increase government's commitment to care for OVC.

The study shows that the main challenge of the community-based projects encountered is lack of resources to provide large scale and longer term OVC care and support services. Individuals, groups, community and national and local governments would solve most of these challenges through collective effort.

5.2   Suggestions

For the purpose of this thesis, an attempt made to recommend some points based on the findings of the study within the community, literature reviewed and in light of the social work practice. It is believed that these recommendations somehow reflect the concerns and suggestions of the respondents and be practical. Thus, the following will be suggested for action:

1. Further research and assessment on the capacity of community based structures to address the problems of OVC and their caregivers within their localities is very vital.

2. For combating the impact of HIV/AIDS in the community, initiatives to enhance the local capacity to address the problems of OVC and their caregivers is necessary.

3. Critical assessment and analysis of community-based interventions is a requirement before designing community mobilization interventions. For mobilizing the community resources, service mapping which capitalizes the existing local structures and

organizations are very vital for this which also ensures ownership and suitability of OVC care and support program.

4. In addition to the implementation of community based OVC care and support projects there is a need to be engaged more on macro level initiatives that increase government's and other key stakeholders commitment to care for OVC. Such macro level interventions should emphasize on advocacy for the development of a separate national OVC policy or comprehensive child protection policy.

5. The study has shown that the project services though are in line with the standard service delivery guide are not currently meeting the needs of OVC. Hence, standardized support targeting OVC needs to have services delivered based on the needs and in a uniform manner. Standard OVC services should contain seven core service areas which are considered critical components of a set of services for programming targeting vulnerable children.

6. The collaboration efforts of the current OVC care and support project with governments, private sector entities, and communities are the strongest feature that needs to be further strengthened and scaled up. Moreover, strategic collaborations and working relations with the national governments and key stakeholders to develop national policy frameworks, situation analyses, program implementation guidelines, national M&E plans, and comprehensive interventions is required.

7. The initiatives started by the project to create community structures and also strengthened existing ones should continue and further empower them in better caring and supporting OVC in their localities. Establishment of the volunteer structures is not an end by itself. Further steps have to be designed that synchronize the involvement of more community

members and government structures like health extension workers for its sustainability and effectiveness. The initiatives that these community volunteers are undertaking should also be promoted. Linking & coordinating these initiatives with other formal structures for technical and financial backup is vital if the current initiatives are effectively able play their role in the community in their full capacity.

8. It is also vital to follow the following strategies while working with OVC in the community: build the capacity of the family, mobilization and supporting community-based responses, ensuring continuity of essential services, ensuring that communities protect the most vulnerable children and establishing an enabling environment for the care and support programs (UNICEF, 2003; HAPCO, 2005).

9. OVC programs should be designed to be as comprehensive as possible within resource constraints. in a way that can reduce the mismatch between the problems and the response.

10. The resilience of OVC in coping with the problem of HIV/AIDS and in soliciting the solutions to address their problems should be recognized. Older aged OVC working on IGAs should therefore be supported with technical and financial support so that they can cope with economic problems and develop self-efficacy and self-confidence. Therefore, involving OVC beneficiaries in designing, implementing and evaluation of local projects that focus on OVC wellbeing 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.

11. Scaling up good practices and replication of these types of community based and family cantered projects in other places.

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APPEDICES

Appendix I   **Verbal Consent Form for Participants of the Study**

Introduction

My name is <u>Betelihem Abraham</u>. I am a student of MSW Social Work Maters Degree Program with St. Mary University College/IGNOU. I am currently collecting data regarding the OVC care and support project implemented by AKCCCD in your area. As part of my assessment, I am talking to a wide cross section of people in the area. I would use the information to fulfill my thesis requirement and to present information to help those concerned bodies to plan activities that will address the identified needs of orphans and vulnerable children.

<div align="center">

Confidentiality and Consent

</div>

I am asking you for little of your time, about 45 minutes to one hour to participate and to help me in this study. I would like to find out some information about the lives of OVC as well as their parents/guardians. In the end it is hoped that the information you gave will help me to understand whether the project implementation with respect to supporting and improving the lives of orphans and vulnerable children and their caregivers have been undertaken according to the intended objectives

I would greatly appreciate your help in participating in the study. The information collected in this study will remain confidential. I am not interested to know your name or anything that can be connected to your identity except information you tell me. This means that your identity as a participant will never be used in connection with any of the information you tell me or will not be revealed to other people. Any references to information that would reveal your identity will be removed or disguised prior to the preparation of the research reports and publications. All research materials will be kept in confidential place. All audio recordings will be erased at the completion of the study. However, your honest answer to these questions will help me better understand the situation. I would greatly appreciate your help in responding to this study. Would you be willing to participate?

Agree _____   Disagree _____
<div align="center">(Respondents have given certifying that informed consent verbally)</div>

Appendix II   Interview Schedule for OVC

Interview Code _____   Sub-city _____   Woreda _____

I.   Socio-demographic and Economic Characteristics

1.   Sex of the child/respondent   1= Male   2= Female

2.   Age of the child/respondent_____

3.   Educational status of the child/respondent
        1= Illiterate   2= Grades 1-4   3= Grades 5-8   4= other(s) ------------------

 4.   Category of the child
        1= Double Orphan   2= Paternal Orphan   3= Maternal Orphan
        4= Vulnerable   5= Other (please specify) ---------------------------

5.   Religion of the Child
         1= Orthodox   2= Protestant   3= Muslim 4= Catholic 5= Other (please specify)------

6.   If you are an orphan with whom are you living currently?
        _____

7.   If you are vulnerable child, where do you live?
        _____

8.   Who is the bread winner in your household or family?
        _____

9.   Do you know the OVC care and support project which is being implemented by
     AKCCCD in your area/woreda?   1= Yes   2= No   3= Do not know

    10.1 If "Yes" to Q. No. 9, are you supported by the project (AKCCCD) in your woreda?
            1= Yes   2= No

II.   Practice of Community Mobilization

1. How do you get selected to be supported by the project?
        _____

2. In your opinion, who did the beneficiary selection in your area?
        _____

3. Who else in your family is supported by this project?
        _____

4. In your views, why do you think you have become the beneficiary of the project?
        _____

5. In your opinion, do you know other OVC who have not been selected by the project?
        1= Yes   2= No   3= I don't know

5.1. If "Yes" what are the reasons for not selecting them?

_____

6. Did you hear about the general community mobilization orientation meeting to start undertaking the project in your area?

    1= Yes 2= No 3= I don't know

  6.1 If "Yes" did you attend the meeting?

    1= Yes   2= No   3= I don't know

  6.2 If "No" why didn't you attend the meeting?

_____

7. Do you know the existence of the OVC Committee in your area?

    1= Yes   2= No   3= I don't know

  7.1 If "Yes" do you know how they were selected?

_____

  7.2 If "Yes" what are they doing (their roles and responsibilities)?

_____

8. Which of the following OVC services have you been provided by the project?

    1. Shelter & Care _____
    2. Health Care support, including pediatrics ART _____
    2.1 Health Care support, but not including pediatrics ART _____
    3. Educational support _____
    4. Food & Nutrition _____
    5. Psychosocial support, including life skills training _____
    6. Child protection and legal support _____
    7. Economic strengthening/livelihood support _____
    8. Others (Please specify) _____

9. What types of educational support do you get? -------------------------------------

_____

10. What types of health care support do you get? -------------------------------------

_____

11. What types of shelter and care support do you receive from the project? -------

_____

12. What types of food and nutrition support do you get? ---------------------------

_____

13. What types of psychosocial support do you receive from the project in your area?

_____

14. What types of child protection services do you get? ----------------------

_____

15. What types of economic strengthening support have you received from the project?

_____

16. What do you think regarding the various serious care and support services you have been receiving from the project?
    1= They have improved my life.   2= They have addressed my immediate needs.
     3= They have contributed little to my life.   4= They do not help me much.
     5= I have no idea.

17. If your answer is either "1" or "2" how
    17.1 Does the shelter and care support help you? ---------------------------------
    _____
    17.2 Does the health care support help you? ---------------------------------------
    _____
    17.3 Does the educational support help you?
    _____
    17.4 Does the food and nutrition support help you? ------------------------------
    _____
    17.5 Does the psychosocial support help you? -----------------------------------
    _____
    17.6 Does the child protection and legal support help you?
    _____
    17.7 Does the economic strengthening support help you?
    _____

18. So far, have the OVC committee members visit you?
     1= Yes   2= No   3= I don't remember
    18.1 If "No" what do you think may be their reasons?
    _____

19. Did the OVC committee members explore your needs/problems properly?
     1= yes   2= No   3= I have no idea
    19.1 If "Yes" how were your conditions assessed or explored?
    _____
    19.2 If "No" why did the committee members do not explore your conditions?
    _____

20. In your opinion, do you think that those care and support services provided based on the needs priority set?
    _____

21. Did you or your care provider(s) participate in planning the OVC care and support project?   1= Yes   2= No   3= I don't know

22. Did you or your care provider(s) act together in the implementation of the OVC care and support project? 1= Yes   2= No   3= I have no idea

23. Did you or your care provider(s) monitor and evaluate together the project?
     1= Yes   2= No   3= I don't know

III.   Quality Standards

Do you agree or disagree with the following statements?

1. The project beneficiaries are happy with the shelter and care support services.
   1= strongly disagree 2= Disagree 3=Neutral 4= Agree 5= strongly agree

2. The health care supports of the project are helping the beneficiaries?
   1= strongly disagree   2= Disagree   3=Neutral   4= Agree 5= strongly agree

3. The quality of the educational support provided by the project is good.
   1= strongly disagree   2= Disagree   3=Neutral   4= Agree   5= strongly agree

4. The OVC project provides quality food and nutritional support to its targets.
   1= strongly disagree   2= Disagree   3=Neutral   4= Agree 5= strongly agree

5. The psychosocial support provided by the project helps the beneficiaries well.
   1= strongly disagree   2= Disagree   3=Neutral   4= Agree 5= strongly agree

6. The project offers quality child protection and legal support services?
   1= strongly disagree   2= Disagree   3=Neutral   4= Agree 5= strongly agree

7. The project provides quality economic strengthening support.
   1= strongly disagree   2= Disagree   3=Neutral   4= Agree 5= strongly agree

8. The overall OVC care and support services provided by the project implemented by AKCCCD in your area were of good quality.
   1= strongly disagree   2= Disagree   3=Neutral   4= Agree 5= strongly agree

IV.   Problems and Challenges

1. Related to shelter and care _____
2. Related to health care support_____
3. Related to educational support _____
4. Related to food & nutrition support _____
5. Related to psychosocial support _____
6. Related to child protection and legal support_____
7. Related to economic strengthening _____

V.   The way forward – improvements

1. Shelter and care
2. Health care
3. Educational support
4. Food and nutrition
5. Child protection and legal support
6. economic strengthening
7. Community based approach
8. Family centered
9. Overall project

Appendix III Focus Group Discussion (FGD) Guide for Community Volunteers

General information about the project

1. Do you know the SCSN project that has been implemented by AKCCCD in your area? (Probe on what they know about the project, its objectives, services, when it starts and be completed as well as who implement it and how?)

2. What do you think is the project intended for?

3. What is your relationship with the project/the organization?

4. How do you establish this relationship with the organization/the project?

Characteristics of the beneficiaries of AKCCCD;

5. Do you know who the beneficiaries of the project are (groups not individuals)?

6. Do you know how the beneficiaries were identified, selected and involved in the project? (Please describe the process and the selection criteria).

7. Who were the major actors in identifying and selecting the target beneficiaries in the area? How did they organize themselves?

8. What is your opinion about the fairness of the selection process?

Relevance of the care and support provided by the organization and volunteers

9. What are the services provided to the target groups by the project?

10. Who is involved in delivering these services to them and how?

11. How was the adequacy of the services that have been provided in meeting the needs of the target groups?

12. Who are the main actors in implementing the project and what were the roles of each actor?

13. Can you briefly explain the community volunteer structure that was established to assist the project implementation?

14. What were the main activities undertaken by the volunteers working with the project?

15. What is the relationship between the project and concerned stakeholders including the local administration?

16. If the organization has to implement this project again what will you suggest for its modality of work?

Appendix IV Focus Group Discussion (FGD) Guide for OVC Caregivers

General information about the project

1. Do you know the SCSN project that has been implemented by AKCCCD in your area? (Please discuss what you know about the project, when it starts and be completed as well as who implement it and how?)

2. What do you think is the project intended for?

3. How do you establish relationship with the organization?

Characteristics of the beneficiaries of AKCCCD;

4. Do you know who the beneficiaries of the project are (groups not individuals)?

5. Do you know how the beneficiaries were identified, selected and involved in the project?

6. Who were the major actors in identifying and selecting the target beneficiaries in the area?

7. What is your opinion about the fairness of the selection process?

8. What makes you eligible for benefiting from the project?

9. Are there other families who are not benefiting from the project? Why?

Relevance of the care and support provided by the organization and volunteers

10. What are the services provided to you and your child by the project?

11. Who is delivering the services to you and your family?

12. Which of the services are most important? Why?

13. How much do you know about the community volunteers involved in the project?

14. What are their roles and relationships with you and your family like?

15. How was the adequacy of the services that have been provided in meeting your needs?

16. How is the frequency of the services provided?

17. Are there any changes on the OVC household because of the services provided by the project?

18. If the project to be implemented again how you do suggest it should be like.

19. Is there anything else you tell me about the project?

Appendix V   Interview schedule/guide for Key informants

Background Information:

1. Sub-City/Woreda_____

2. Name of Informant _____

3. Sex_____ Age_____

4. Name of office represented _____

5. Division/department worked in/ in the office. _____

6. Responsibility/job description/ in the office _____

7. Date of Interview_____

Introductory questions

1. Do you know AKCCCD organization and its OVC care and support project that is financed by USAID and implemented in your area? *Please tell me little about how and when you/your organization got involved in this project as a stakeholder/partner?*

2. What were your /your organizations' major roles and responsibilities in this OVC project?

3. Do you perceive yourself/your organization as one of the key monitoring bodies, stakeholders or partners of the project? Why? Why not?

Networking, linkage and partnership

4. Please tell me about other partners/stakeholders you know of involving in the implementation of this project? Who are they? (**Probe** *about involvement of OVC, families, guardians, community, iddir, NGO, woreda administration, youth association, association of PLHIV, women's association, etc.)*

5. What were the roles of these mentioned other partners? (**Probe:** *ask for specific examples of what partners are doing.)*

6. Is there regular meetings and discussions among the stakeholders/partners of the project in the area? How frequent are the meetings?

7. Are there task forces / committee /established to support the implementation of this project? How? By whom? In which task forces/committee you participated?

8. Is a Vulnerable Children's Committee (VCC) established in your area? Who are involved in this committee? Do you know what the committee doing?

9. Do you know about presence of community volunteers? What are their roles and what type of service they provided to the OVC and their guardians/families in the area?

10. Do you think OVC and their guardian/families benefited from the services provided by volunteers? If so, can you please describe some of these benefits with examples?

11. How much strong do you think is the linkage and partnership among the different stakeholders/partners, established task forces / committee, Vulnerable Children Committee?

OVC selection & addressing their needs

12. Would you describe how each OVC/ guardian/families in your area were identified, selected and registered to benefit from the project?

Probe: - In this community, who identified the children as orphans and vulnerable children (OVC) to be registered at the OVC care and support project of AKCCCD?
   - Who are the major partners in identifying, selecting the target OVC beneficiaries in your area? What was their role in the process of identification, selection and registration of OVC involved in the program?
   - Please explain more about the strategy and procedures and what criteria used to identify eligible vulnerable children at the community level?

13. Do you think the selection and service provision in your area were fair and adequate? Why and how?

Knowledge of care and support services provided by the project

14. Would you describe what type of care and support services are provided by the project for the targeted OVC in your area so far? What are the various services? Could you mention specific services? **Probe**: Ask what specific services provided in relation to the core service components:
   - Psychosocial Support,
   - Education,
   - Food and nutrition
   - Shelter and Care
   - Health care
   - Child Protection
   - Economic strengthening

15. Who are involved in the implementation of those mentioned core services? What were your /your organization/ major roles and responsibilities in each of the mentioned care and support services provisions?

16. In your opinion, what is the ultimate goal of the OVC care and support project? Do you think the sated goals are realizable?

17. Do you think you /your organization contributed to this project? If yes, please give some examples.

Opinion on Quality and efficiency of the services

18. How do you assess quality and efficiency of the care and support services that have been offered to OVC in your area?

19. Do you think the services provided by the project (education, health, shelter and care, protection and psycho-social support) were in line with the service standards set by the government? *Probe: Check whether they know the service standards as well as the provided services are up to their expectation*

20. How do you see changes, if there is any, taking place in the whole community as a result of the OVC initiatives over the project period?

21. Do you think that the care and support provided by the project could bring out the desired outcomes? **Probe**

   a. if educational supports improve school enrolment, attendance and completion rates of OVC;

   b. if economic strengthening help to increase income of OVC /families

   c. if psychosocial supports improve OVC's self-confidence, self-esteem, hope, and interpersonal relationships;

   d. if food and nutritional support improves nutritional status of OVC;

   e. if health care services help to ensure access and availability of health services to OVC;

   f. if shelter care help to improve housing and clothing conditions of OVC;

   g. if child protection support help to ensure legal, economic, political and social rights of OVC;

Perceived challenges and solutions

22. Please discuss benefits and challenges that OVC care and support project has brought to the community.

23. Would you describe about the factors that affected/ influenced care and support that were provided to OVC in your area?

Probe if they recognized internal and external factors that positively or negatively affected the program intervention

24. What are the main challenges/problems you have faced as you involved in this OVC care and support project?

25. What methods and solutions have been undertaken to solve challenges you encountered? What was your role in this regards?

Lesson learnt& recommendation

26. Would you discuss what lesson you have learnt from the project?

27. In your opinion, what was the biggest contribution of community members, guardians/ families, volunteers and other partners with respect to success of OVC care and support services in your area?

28. If you could give advice to project staff,

   a. What would you tell them to do differently to make the program more successful?

   b. What aspects of the program do you recommend to be kept the same?

   c. What aspects of the program do you recommend to be changed?

29. Is there anything else you want to tell me about the project?

Declaration

I hereby declare that the dissertation entitled **"COMMUNITY - BASED AND FAMILY – CENTERED INITIATIVES FOR PROVISION OF CARE AND SUPPORT FOR ORPHAN AND VULNERABLE CHILDREN (OVC), AT ARAT KILO CHILD CARE AND COMMUNITY DEVELOPMENT (AKCCCD) ORGANIZATION, ADDIS ABABA, ETHIOPIA**" submitted by me for the partial fulfilment of 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 any other institution for the fulfilment of the requirement for any other programme 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.

Place: _____   Signature:_____

                                      Enrolment No.: _____
Date: _____   Name: _____
                                      Address: _____
                                      _____
                                      _____

Certificate

This is to certify that Mrs. <u>Betelihem Abraham Gebremariam</u> student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for her project work for the course **MSWP-001**.

Her project work entitled "<u>Community - Based and Family – Cantered Initiatives for Provision of Care and Support for Orphan and Vulnerable Children (OVC), at Arat Kilo Child Care and Community Development (AKCCCD) organization, Addis Ababa, Ethiopia</u>" which she is submitting, is her genuine and original work.

Place: _____

Signature:_____

Name: _____

Date: _____

Address of the supervisor: _____

_____

_____

Phone No.: _____