ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

IMPACT OF HIV/AIDS ON AIDS ORPHANS WITH SPECIAL EMPHASIS ON SOCIAL CAPITAL

BY
SELAMAWIT YOSEF

JUNE,2005
ADDIS ABABA

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(RLDS)

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DECLARATION

I declare that this thesis is my original wok and has not been presented for a degree in any university and all the sources of materials used for the thesis are duly acknowledged.

_____

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June,2005

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This thesis has been submitted for examination with my approval as a university advisor.

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Dr. Abdulhamid Bedri Kello

June,2005

DEDICATION

This thesis is dedicated to the memory of my father,
Yosef Demissew (1942 – 2003) who instilled in me the drive and determination to follow my dreams and pursue my goals.

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Selamawit Yosef
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ABBREVIATIONS

AIDS	-	Acquired Immunodeficiency Syndrome
HIV	-	Human Immuno Deficiency Virus
PLWHA	-	People Living With HIV/AIDS
KAP	-	Knowledge, Attitude, Perception and Practice
FDRE	-	Federal Democratic Republic of Ethiopia
FGD	-	Focus Group Discussion
GO	-	Government Organizations
NGO	-	Non Governmental Organization
CBO	-	Community Based Organization
MOH	-	Ministry Of Health
MOLSA	-	Ministry of Labor and Social Affairs
AAHPCO	-	Addis Ababa HIV/AIDS Prevention and Control Office
UN	-	United nations
UNAIDS	-	Joint United Nations Program on HIV/AIDS
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
WHO	-	World Health Organization
UNESCO	-	United Nations Educational, Scientific and Cultural Organization

ABSTRACT

The HIV/AIDS epidemic has claimed the lives of over 20 million leaving a total of over 14 million AIDS orphans world wide. Out of these, over 12 million children who lost at least one parent to AIDS are believed to live in Africa. Ethiopia, as one of the highly affected countries, is a home for an estimated number of 539,000- 1.2 million AIDS orphans. The epidemic continued posing a serious threat on the social and economic well being of these children. While HIV/AIDS is a complex economic, health, social, cultural, political, human right and development problem, the existing studies have not given due attention to the impact of social capital.

Social capital has a beneficial impact in addressing the problem of HIV/AIDS and its effect on AIDS orphans. It can sometimes also facilitate adverse outcomes. This study therefore, attempts to provide a better insight of social capital that has contribution in the prevention and control of the problem. The objectives of this study are to examine the socio-economic situation in which AIDS orphans live; to identify the major problems affecting AIDS orphans and their care givers in their day to day life and in accessing social services and to investigate the major socio-cultural barriers that limit access of AIDS orphans to basic social services. A qualitative data collection method was mainly used to gather information from a total of 228 AIDS orphans, 52 care givers, 14 key informants and 2 focus group discussions with 18 participants. The data were analyzed using percentages and chi-square tests.

The results of the study showed that AIDS orphans were facing various physical, social, economic and psychological problems after the death of their parent/s. Furthermore, the majority of the AIDS orphans lost both their parents and in general their living standard declined. Care givers also were facing various economic and social problems in addition to the burden of responsibility of taking care of the orphans. The findings also revealed that there were various socio- cultural factors that aggravated the problems and hindered AIDS orphans to proper access to social –services. Finally, based on the findings, the study suggested means of alleviating the problem such as encompassing socio-cultural aspects in any AIDS orphans related endeavors, intensive awareness creation and provision of adequate access to basic necessities.

CHAPTER ONE

2. INTRODUCTION

This chapter gives highlights to the issue to be discussed. The brief explanation of the background to the problem, the statement of the problem, the objectives of the study, the significance of the study, definition of terms, scope and limitation are included.

2.1 Background to the Problem

The Human Immuno Deficiency Virus (HIV) epidemic continues to spread around the world. The joint United Nations Program on HIV/AIDS (UNAIDS, 2004) indicated that over 40 Million people are living with HIV/AIDS and over 20 Million died since the beginning of the pandemic producing orphans on a scale unrivaled in history. Currently there are a total of over 14 million AIDS orphans.

The HIV/AIDS pandemic is having an overwhelming impact globally and mainly in the sub-Saharan Africa. According to UNAIDS' report of 2004; approximately 70 percent of the world's 40 million HIV- positive population lives in this region. In addition, an estimate of 2 millions of children is dependant on people who are living with HIV/AIDS.

In addition to its human toll and suffering, HIV/AIDS has had a profound negative impact on social and economic development, diminishing the economic viability and, potentially, the political stability of countries with high rates of infection. In addition, the impact on social, cultural, gender and human rights is also a great concern (Silverman, 2004).

Ethiopia is one of the most devastatingly affected countries in the world. As stated in the UNAIDS/WHO report of 2000, 4.6 million of Ethiopians are living with HIV/AIDS. Of these 1.6 million are women, and 250,000 are children. The first AIDS cases were reported in 1986 and the number of AIDS cases has presently reached over 4 million of which the number of orphans and vulnerable by HIV/AIDS could increase at an alarming rate (MOH,2002) .

1.2 Statement of the Problem

One of the devastating consequences of the HV/AIDS pandemic is the vast number of children it leaves orphaned. According to a joint report released by the UNAIDS, out of the total of over 14 million children who lost one or both parents to AIDS, 13 million are under the age of 15 and most of them are found in Sub- Saharan Africa. The number of AIDS orphan children is expected to rise in the coming years. As indicated by UNAIDS/WHO (2004), by the year 2010 among all the orphan children , the percentage orphaned due to AIDS in Ethiopia will reach 43%.

Famine, wars and other disease outbreaks often cause a large increase of orphans, but are always short-term calamities that quickly end. However, AIDS continues to create millions of new orphans for decades. Orphans create strain on the resources of families, communities and government and also have unprecedented set of child welfare problems. Tony Barnet, a professor at the University of East Anglia, in Great Britain, who studied the social and economic impact of AIDS, says that orphans lose education and economic security and a loving environment where child would be cuddled and cared for. He even further noted that there is a cost which we do not know how to measure (Barnett and Whiteside, 2002).

Currently, in Ethiopia, an estimate of 700,000 to 1.2 million children are believed to be AIDS orphans and that millions of children are dependent on people living with HIV/AIDS. Furthermore, many children affected by HIV/AIDS are being denied access to better education and other basic services because basic social services are inadequate and there are very few social support systems that exist outside of families. Generally, the rapid expansion of the disease is severely affecting the country by deteriorating the chance of getting the access of better education, health care and other vital services. Mothers and children living with HIV/AIDS, AIDS orphans, and children dependant on people who are living with the disease are the most affected (Save the Children /Alliance, 2001; USAID, 2002).

Orphan children lack the proper care and supervision they need at the initial period of their lives. A child who has lost his/her mother or parents and is not attached to a caring adult is several

times more vulnerable to childhood diseases, malnutrition and the psychological consequences of disharmonious development.

As recognized by previous studies, AIDS orphans are vulnerable to a lot of economic, social and psychological problems and due to these interrelated problems they get deprived of the basic social services that a child needs to get for his/ her holistic development.

As mentioned in the Proceedings of the National Workshop on Orphans and Vulnerable Children Affected by HIV/AIDS (2001), AIDS orphans in addition to psychological and emotional distress of seeing their mother or father die, are often forced to interrupt schooling. In addition these children, particularly the elders are forced to look after the remaining siblings. These young children, who are unprepared to assume such a huge responsibility of parenthood, likely reject to respond to these pressures and eventually join the street life in cities for their survival. As a result they become sexually active and in many instances are causes for HIV/AIDS transmission (Save the children /Alliance, 2001)

AIDS orphans have the potential to develop their abilities and play a useful role in the society. Instead they face a prospect of a relentless struggle for physical survival, for basic education, for love and affection, and for protection against exploitation abuse and discrimination
(Shinn, 2001).

The problem of meeting the needs of these children represents a major new challenge that requires an in-depth study. In light of the seriousness of the problem in Ethiopia, studies regarding the socio- economic and demographic profile of AIDS orphans in Addis Ababa are very limited. A study which attempts to enumerate the cause and identify the problems associated with AIDS Orphans and which indicates plan of action for future interventions in addressing the problem becomes a vital issue at the moment. Therefore, cognizant of the fact that the HIV/AIDS pandemic is creating an acute socio-economic crisis in the society, no time can be spared to propagate and mitigate the impact of the spread of the disease and simultaneously protect HIV/AIDS orphaned children. Despite the magnitude of the problem, the studies on HIV/AIDS are not exhaustive enough to address the issue on a full-fledged manner.

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

1. What is the extent of social capital impact of HIV/AIDS on AIDS orphans?
2. What is the attitude and general awareness of the neighborhood and communities towards HIV/AIDS and AIDS orphans?
3. What is the socio- economic situation in which the AIDS orphans are in?
4. What are the socio –cultural barriers that limit access of AIDS orphans to basic social services?

1.3 Objective of the Study

The general goal and objective of the research is to examine and discuss the impact of HIV/AIDS on AIDS orphans with special emphasis on social capital by gathering qualitative information about the extent and nature of the problem and to provide action–oriented recommendations that would enable government institutions, NGO's and local communities to cope up with the problems faced by AIDS orphans.

The specific objectives are:

- To examine the extent of social capital impact of HIV/AIDS on AIDS orphans.
- Investigate the socio- economic situation in which the AIDS orphans live.
- To examine the psychological and physical characteristics of AIDS Orphans.
- To explore the general awareness, perceptions, attitudes and practices of study population on HIV/AIDS as well as AIDS orphans.
- To explore the socio-cultural factors that limit acess of AIDS orphans to basic social services.

1.4 Research Methodology

1.4.1 Sampling Technique

In this study, non -probability sampling method was used to select the subjects of study, key informants and focus group discussion with participants. In this regard, the selection of the study subjects was done by purposive sampling method. Initially, seventy non government and community based organizations working on providing care and support for AIDS orphans in Addis Ababa were selected in coordination with Addis Ababa HIV/ AIDS secretariat. Based on the list, nine NGOs and two CBOs that mainly work with or who have a major program component of supporting AIDS orphans were selected. In addition to working with AIDS orphans, the sub-cities in which they are working were also given due consideration. In this regard, five sub-cities where there are concentrations of organizations were identified. After the selection of the research areas; AIDS orphans, care givers and participants of key-informants were selected randomly from each organization.

1.4.1.1 Sample Size

From the 11 NGOs and CBOs working with AIDS orphans, the writer selected 228 respondents, taking the list of people from the organizations as a sampling frame. Initially, a total of 276 AIDS orphans were randomly selected by at least taking 10% sample size from each NGO and CBO. However, there were only 228 valid cases to be analyzed for the reason that the rest were not available for an interview due to time constraint or refuted for their own reasons. In like manner, a total of 54 care givers were selected from nine NGOs and CBOs and there were 52 valid cases. The sample size was taken only from nine organizations because the other two were institutional care providers. In addition, a total of 18 participants were selected for two focus group discussions. Accordingly, the 8 participants of the first group discussion (which was conducted with AIDS orphans only) and the three care givers and 5 AIDS orphans who participated in the second one (which was conducted with care givers, AIDS orphans and NGO workers) were selected randomly. On the other hand, the two NGO workers were selected purposively based on experience and availability (please refer Annex 1. for details). In addition

there were a total of 14 key informant interviews, three from government organizations and 11 NGO and CBO representatives.

1.4.2. Method of Data Collection

This study employed both qualitative and quantitative data collection techniques. The qualitative data collection method was consisted of in-depth interviews with key informants by adopting open-ended and close-ended questions, focus group discussions and direct observation and review of written documents. A quantitative data collection technique was also used to gather data from AIDS orphans and care givers through an in-depth interview with open-ended and close- ended questions.

A qualitative data collection method was used due to the complex nature of the problem and the difficulty of easily accessing some information regarding AIDS orphans through the traditional survey research method. Moreover, the researcher used qualitative research approach as it is naturalistic inquiry method. The approach analyzed individual beliefs, thoughts and perceptions. The method was flexible and adaptable and gives room for probing, clarifying and elaborating on responses to achieve accurate answers.

In this study primary data was gathered through interviewing AIDS orphans, Care givers, and key informants (from government and non-government bodies working with AIDS orphans). Furthermore, focus group discussion and direct observations were used. These primary data collection techniques are discussed at some length.

In-depth interviews were made with AIDS orphans, Care givers, NGO workers and government workers (from Ministry of Labor and Social Affairs, Addis Ababa HIV/AIDS Prevention and Control office and Ministry of Education). The questions were designed in order to examine phenomena that can not be observed such as feelings, thoughts and intentions. The majority of interviews were made by the writer with an assistance of three assistant researchers.

The focus group discussions were done with two groups with the aim of increasing the reliability of the information gathered from other techniques. It was also the writer's belief that additional information would be gathered from the focus discussion due to the fact that some respondents tend to encourage others who were reluctant to express their views in the in-depth interview. Besides, all of the participants were also included in the in-depth interviews. The first focus group discussion was only with AIDS orphans with the belief that the participants would feel free to express their views without others present. In the second focus group discussion AIDS orphans, care givers and NGO workers participated. Even though, there was an attempt to record the proceedings by a tape recorder, it was not accepted by participants which the writer believed was due to the sensitivity of the subject. Hence, the information was documented through note taking.

The writer also made a direct observation by conducting some interviews in the homes of the respondents and also by being present in the provision of supports by NGOs. This was done to gather information regarding the types of houses they were living in, their physical condition and any other indicators their living condition.

The secondary data was gathered through consulting related and available published and unpublished materials were consulted. Additionally, reports and project documents of selected organizations that are working with AIDS orphans were consulted.

1.4.3 Method of Data Analysis

The first step of the analysis was editing the data before data entry was carried out. Later on the data was entered into a computer using SPSS Version 10. Descriptive statistics and chi-square analysis were used. Hence, percentages were mainly used to indicate the magnitude of the issues discussed in the paper. In addition, triangulation method was used to analyze the data gathered from different sources to provide confirmation and completeness.

1.5 Significance of the Study

This study may serve as a spillover for further research in the area. On top of that, it is believed that the research may turn out to be valuable in bringing significant ideas to the fore so as to provoke discussions on the impact of HIV/AIDS pandemic on AIDS orphans. Despite the magnitude and severe consequences of the pandemic, the necessary data on the prevalence and the situation of AIDS orphans is lacking. In line with this, the study will seek ways and means for the proper handling of AIDS orphaned children and to fight the social problems that the victims are facing.

1.6 Scope and Limitation of the Study

The study was conducted in six sub cities of Addis Ababa(Kirkos, Yeka, Arada, Lideta, Nifas Silk and Addis Ketema). Even though HIV/AIDS brings several consequences on AIDS orphans, this study mainly focuses on the impacts of HIV/AIDS on AIDS orphans in particular the social capital impacts. It also examines the Impact on access to social services. This was done deliberately to make the study manageable.

Time constraint put a limit to investigate more information than it appears now. The other limitation is that the study employed only descriptive statistics which may arrest the situation to make robust conclusions.

1.7 Definition of Terms

AIDS Orphans- Children who are between 0-18 and who have lost either or both parents to AIDS

Society: An extended human society having a distinctive cultural and economic organization

Social capital: The term social capital encompasses various aspects and many scholars differ in their definition of social capital. For example:

- Social capital was defined by Stone and Hughes (2000) as "… networks of social relations that are characterized by norms of trust and reciprocity. ….. social capital can be understood as a resource to collective action, which may lead to a broad range of outcomes, of varying social scale".
- Bourdieu and Wacquant (1992) defined social capital as "…the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition*"* .
- Social capital is "The total stock of a society's productive assets, including those that allow the manufacture of the marketable outputs that create private-sector profits, and those that create non-marketed outputs, such as defense and education" (Bannock et al., 1992).

Operational Definition of Social Capital :

As far as this paper is concerned, ***social capital*** refers to the set of socio- cultural values, norms, attitudes, relationships, organizations and networks within as well as beyond family that shape the interaction, collaboration and cooperation of community members to achieve mutual social and economic goals.

Social: the interaction of the individuals and the group as being members of society. (Merriam-Webster Online Dictionary, 2005).

Culture: Unique value systems, knowledge, traditions, believes and ways of living built up by a society (UNESCO, 2002).

Socio-cultural – factors relating to both social and cultural aspects.

Social services: services provided by local or national government for the general welfare of people in society, e.g. housing, education and health.

Institutional care: Provision of care and support in orphanages/group homes.

1.8 Organization of the paper

The paper is organized under four parts. The first part is the introductory section that deals with the background, statement of the problem, the study approach and methodology, significance and objective of the study; the second part is the review of the related literature which was presented in two parts. The third part presents the analysis, interpretation and discussion of the data gathered. Finally, the last chapter deals with the conclusion and recommendation of the study.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

This chapter is presented in to two parts. The first deals with HIV/AIDS and its epidemiology while the second deals with the impact of HIV/AIDS.

PART I

2.1 HIV/AIDS: THE DISEASE AND ITS EPIDEMIOLOGY

2.1.1 BACKGROUND OF THE DISEASE

HIV/AIDS is both an emergency crisis as well as a long- term development issue. It continues to spread in all parts of the world despite the global effort of increased funding, political commitment and progress in expanding access to HIV treatment. The pandemic is having an overwhelming impact globally and mainly in the sub- Saharan Africa. The disease in this region is killing some 6,000 people each day, which is more than deaths caused by wars, famines and floods. According to UNAIDS' latest report of 2003, approximately 70 percent of the world's 40 million HIV- positive population lives in this region. In 2004, an estimated 3.1 million people became newly infected, 2.3 million died of AIDS and 2 million children became dependant on people who are living with HIV/AIDS. Among young people aged between 15 and 24, an estimated 2.2% of men and 6.9% of women were living with HIV at the end of 2004. Furthermore, WHO estimated that the number of people who will be sick in relation to HIV/AIDS by the year 2020 will reach 200 million (Hubley, 2002; UNAIDS, 2004).

Related studies show that the second highest HIV prevalence is in the Caribbean. AIDS has become the leading cause of death among adults aged between 15 and 44 years in this region. According to the UNAIDS report of 2004, the number of people living with HIV/AIDS increased by almost 50% in East Asia between 2002 and 2004, where China is the hardest hit. There has also been 40% increase in HIV/AIDS infection in Eastern Europe and Central Asia during the same period, mainly in Ukraine and the Russian Federation (Hubley, 2002; UNAIDS,2004).

Another devastating consequence of the epidemic has been the HIV positive children it leaves behind. Globally, especially in the developing nations, HIV infection became the major contributing factor to childhood disease and mortality. According to USAID (2004), about 700,000 children became infected in 2003 and an estimated 1,700 children become infected with HIV daily. It is also estimated that over 5 million infants have been infected with HIV since the beginning of the epidemic. Out of these, 90% were born in Africa. The largest source of infection in children below the age of 15 is mother to child transmission. AIDS is also producing a huge number of orphaned children as a result of parents dying form the disease. Africa is the most affected with 12 million of the total 15 million orphaned children (Bradshaw.et.al, 2002; UNAIDS, 1999; USAID, 2004).

2.1.2 WHAT IS HIV/AIDS?

Definitions

According to Stine (2003):

HIV (Human immuno deficiency virus) - is a virus which attacks the body's immune system and leaves it vulnerable to numerous health problems that would other wise not develop in an individual with a healthy immune system.

Acquired Immunodeficiency Syndrome (AIDS) – life threatening illnesses acquired as a result of an HIV infection.

Acquired – a virus received from someone else.

Immune – an individual's natural protection against disease causing microorganisms.

Deficiency – a deterioration of the immune system.

Syndrome – a group of signs and symptoms that together define AIDS as a human disease.

HIV and AIDS

The human body is protected from germs such as viruses, bacteria, other parasites and fungi by its immune system. It is the white blood cells called lymphocytes (B cells and helper T- cells) activity that defend the body against germs. However, this process is impeded in the case of HIV infection. The virus weakens the body immune system and makes it susceptible to many health

problems which would otherwise not develop in a person with a healthy immune system. This is caused by HIV's sole activity which is the production of new copies of itself by continuously searching new cells to permit replication. This activity unintentionally causes the inability of the immune system to fight infection as well as to generate new immune system. Hence, the replication rate of the virus increases to a very high level by weakening the ability of the immune cells to suppress HIV. Although the decline of the immune system that occurs with AIDS is not fully understood, most scientists and researchers agree that this process gradually leads to the development of Acquired Immunodeficiency Syndrome(AIDS) (Smith,2001).

There are two types of HIV viruses. The first one, which is known as HIV 1, is found all over the world and is a cause of most infections. The second type, HIV 2, is mainly found in West Africa and is less infectious (Stine, 2003).

Transmission of the virus

Despite its complexity, much has been learned about HIV's physical, biochemical, and genetic structure. The major modes of transmissions have been clearly identified. Unlike many other viruses, HIV can only be transmitted through contaminated body fluids. The main modes of transmission, in order of importance are:

- Unprotected sexual intercourse with an HIV-infected person.
- Transmission from infected mother to child during pregnancy, childbirth, and/or breastfeeding.
- Infected blood used in transfusions, and infected blood products used in the treatment of certain diseases and disorders (like hemophilia), before March, 1985. (Since 1985, federally mandated screening of the blood supply has reduced the risk of transmission through this route in the United States to 1 in 255,000).
- Sharing drug injection equipment (needles and/or works); or being accidentally stuck by needles or sharp objects contaminated with infected blood.
- Other modes of transmission involving blood; for example bleeding wound
- Transplanted organs from infected donors. (Routine screening of organ donors also began in 1985) (Hubley, 2002).

Unlike many bacteria and fungi, HIV is incapable of reproducing itself or maintains infectiousness outside its living host. Hence, scientists and medical authorities agree that HIV does not survive in the environment making environmental transmission remote. According to The Body: An AIDS and HIV information (2004), HIV is not only found in blood but it is also found in varying concentrations or amounts in saliva, breast milk, semen, vaginal fluid and tear.

2.1.3. HISTORY OF HIV/AIDS

The period before 1980 is called the silent period because HIV was being transmitted before AIDS was recognized as new disease and before anything was known about the virus. The first development in the epidemiology of the disease was in 1981 when it was discovered that healthy young men were developing pneumonia caused by a microorganism *Pneumocyctis carinii* which does not usually cause the disease in normal healthy persons. In the same year another puzzling disease, which is a very rare skin cancer called Kaposi's sarcoma, was discovered by New York doctors. This disease has been previously reported only in people with damaged immune systems. In addition many of the patients were suffering from sexually transmitted diseases such as gonorrhea and syphilis. Therefore it was thought likely that this new disease was also a sexually transmitted disease (Hubley, 2002). Further studies came across with the fact that similar symptoms were also found in persons injecting drugs such as heroin. Many of the injecting drug users did not sterilize their needles and share them with other addicts. Hence it became clear to the researchers that not only was AIDS a sexually transmitted disease but it could also be transmitted through blood (Essex et.al, 2002).

By the year 1982, in Rakai district in Uganda, a disease, which was later known us 'slim disease', was found where young people dramatically lost weight and died. In 1983 this same disease was reported in Zambia together with Kaposi's sarcoma. The symptoms of these diseases in Africa were the same as the new disease in US. After taking all the aforementioned findings into consideration, the Centers for Disease Control in Atlanta, US, decided that enough was known about the disease to produce a provisional case definition. Following this, in January 1983, Luc Montognier and colleagues at the Paster Institute in Paris identified the agent that

destroys an essential portion of the human immune system as a VIRUS. The virus was given its present name, Human Immuno Deficiency Virus, by the Human Retrovirus sub- committee of the taxonomy of virus.
(Hubley, 2002).

In 1985, a second type of HIV was discovered in West African prostitutes. Beginning year 2003 a total of 94 HIV-2 infections have been reported from 22 states of the United States. The earliest evidence to date of an individual exposed from HIV-2 comes from Guinea Bissau in the late 60s. HIV-2 is bound to be less harmful to the cells of immune systems and it reproduces more slowly than HIV-1. Also, HIV 1 encodes different genes than HIV 2 (Essex et.al 2002).

2.1.4 HIV/ AIDS: A GLOBAL VIEW

HIV/AIDS has caused unalterable economic, social, cultural, emotional and spiritual devastation around the world. The epidemic varies in scale or impact within regions; some countries are more affected than others, and within countries there are usually wide variations in infection levels between different provinces, states or districts. Even though, the achievements of the global response to date should not be underestimated, much more challenge is still ahead. Unless all people world wide accept the task of preventing the spread and dealing with the consequences of HIV/AIDS, tackling the disease that affected Millions of people would be farfetched (McElrath, 2002; World Bank, 2004).

In the contemporary society, HIV/AIDS has become one of the most important public health concerns. It is true that there is a vast regional difference between continents as well as countries regarding the prevalence, incidence and impact of HIV/AIDS. For example, according UNAIDS/WHO (2004) out of the over 40 million people living with HIV/AIDS , the share of high-income regions such as Western Europe and United States is only 1.6 million. Unlike the situation in other regions, the great majority of people living with HIV in these countries have access to antiretroviral therapy. So they stay healthy and survive longer than infected people elsewhere. Hence, the immense impact of HIV/AIDS is affecting mainly the developing and most impoverished countries of the world like Sub-Saharan Africa where almost two thirds of all

people living with HIV/AIDS are found. This region is a home of just over 10% of the world's population. Additionally, almost 90% of the global burden of HIV is on 73 low- and middle – income countries. This is due to different reasons such as very low incomes, extremely poor living conditions, poor service provision, low levels of cultural perceptions about HIV/AIDS (McElrath, 2002).

The other regional variance was observed in the probable means of HIV transmission. For example, the primary mode of transmission in countries like Australia, Switzerland, United States was found to be men having sex with men, whereas, in other regions such as Central & Eastern Europe, China, Spain, Ireland, behaviors associated with injecting drug use are believed to be primary exposure category for HIV/AIDS. On the other hand, it is heterosexual transmission which is most common in developing countries (UNAIDS/WHO, 2004).

Another Global fact of HIV/AIDS is that, if one looks at the world wide percentage, nearly 50% of all people living with HIV are female. Also, studies show that in most countries, women are being infected with HIV at an earlier age than men. In Sub-Saharan Africa, women account for 57% of people living with HIV/AIDS, where 76% of young people aged between 15 and 24 living with HIV are female. In most other regions too, women and girls represent an increasing proportion of people living with HIV, compared with five years ago. The epidemic has a greater impact on women and girls because they are the ones that usually take care of sick people, lose jobs and schooling as a result of illness and face stigma and discrimination. The gender and cultural inequalities, violence, unawareness, lack of basic education and employment opportunities are some of the major factors that contribute to the vulnerability of women and girls to the epidemic. In addition, women are physically more susceptible to the HIV infection than men. A male to female transmission of the virus, during sex, is about twice as likely to happen as female to male transmission (UNAIDS,2004).

Latest Trends in AIDS Epidemic

As mentioned above, Africa is the hardest hit region by the epidemic but there is a variance among countries in levels and trends of infection. Southern African countries have the highest

prevalence rate exceeding 25%. The prevalence rate among pregnant women in Botswana, Lesotho and Swaziland is more than 30%. An estimated 5.3 million people with HIV, the highest number in the world, lived in South Africa by the end of 2003. Out of these around 2.9 million of them were women. Additionally, in nine countries in this region, life expectancy has dropped below 40 years. On the other hand, although the epidemic is far from being reversed, there is a sign of real decline in HIV prevalence in some countries of East Africa such as Uganda (from 13% in early 1990s to 4.1% by the end of 2003), Kenya (from13.6% in 1997/1998 to 9.4% in 2002) and Ethiopia (from 24% in mid-1990s to 11% by the end of 2003). Although there is variance in scale and intensity, the epidemic in most West and Central African countries appears to have stabilized. The prevalence is lowest in most of these countries except in Burkina Faso, Cote d'ivoire and Nigeria where there is a high number of people living with HIV/AIDS (UNAIDS, 2004).

The Caribbean is the second worst affected region by HIV/AIDS. AIDS has become the leading cause of death among people aged 15-44 and the major mode of transmission is through heterosexual sex. Its prevalence is also growing in North America and Europe mainly due to unprotected heterosexual sex. According to CDC (2003), in the United States, AIDS is mainly affecting African Americans and Hispanic Women and it became one of the three leading causes of death among African American women aged 35-44. In Western Europe, AIDS has become the fastest-growing serious health condition. Injecting drug use is contributing largely to the growing number of HIV infection in Eastern Europe (UNAIDS, 2004). ASIA, a home to 60% of the world's population, is another region where the epidemic has a huge impact. The prevalence is high among injecting drug users, men who have sex with men, sex workers, clients of sex workers and their immediate sexual partners. India has the second largest number of people living with HIV/AIDS (5.1 million) in the region . On the other hand, Thailand and Cambodia have been more successful in fighting HIV/AIDS and the reduction of the infection rates among sex workers by focusing on tackling high risk behavior, such as sex work (UNAIDS,2004).

2.1.5 HIV/AIDS IN ETHIOPIA

According to Shinn (2001), Ethiopia is one of the most devastatingly affected countries in the world, having the third highest number of HIV positive cases in the world after India and South Africa. UNAIDS/WHO (2004) and Ministry of Health (2004) estimated the number of people living with HIV/AIDS as 1.5 million out of which 96,000 are children under 15 years. Women account for 5% and men 3.8%. The national adult HIV prevalence is estimated to be 4.4% of which 2.6% rural and 12.6% in urban. The number of new AIDS cases in 2003 were estimated to be 123,000 of which 98,000 were adults (46% male and 54% female) and 25,000 were children. In the same year, some 90,000 adults and 25,000 children had died of AIDS. According to FHI (2002), from 1986 (the first AIDS case was reported) to the year 2000, the cumulative number of deaths were estimated to be as high as 1.2 million and this figure is projected to increase to 5.2 million by the year 2014.

According to UNICEF's projection of 1999, by the year 2005, one third of all government spending on the health sector in Ethiopia is expected to be for treatment, care and support related to HIV/AIDS. Another study by Betelehem (2000) stated that by the end of 2014, the cumulative number of deaths from the AIDS epidemic in Ethiopia is estimated to be as high as 5.2 million. Out of these, 554,000 will be in Addis Ababa. Also, approximately one out of six adults in the city (around 17 percent of the entire adult population) is already infected, reflecting much higher infection rates than in many other parts of the country . Moreover, in the city, 100 adults become newly infected everyday. There are also indications that the number of AIDS orphans and those vulnerable to HIV/AIDS in Ethiopia could increase at an alarming rate. Accordingly, by the year 2010 the estimated number of AIDS orphans in Ethiopia , among all orphans, will reach 43%. (MOH, 2002; A.A city Administration Health Bureau, 1999; MOLSA, 2003).

Other studies show that the epidemic is claiming the lives of the most productive, energetic and educated segments of the population in rural as well as urban areas of the country. Approximately 16.8% of the adult and youth sectors of the population is affected by HIV/AIDS (MOH, 2002). The alarming spread of the disease is deterring efforts to achieve economic and social development of the country. According to the UNAIDS press release (2004), there is a

sign of decline of HIV prevalence mainly in the capital city from a peak of 24% in mid 1990s to 11% by 2003, as mentioned above.

2.1.6 RESPONDING TO THE DISEASE

Over the past two decades we have experienced remarkable progress in understanding the biology of HIV, its transmission, therapy, and its relationship to the progression of AIDS. The access to key prevention and care services has improved globally. In addition global funding has increased from roughly US$ 2.1 billion in 2001 to an estimated US$ 6.1 billion in 2004 (UNAIDS 2004). According to a study in 73 low and middle-income countries (which represent almost 90% of the global burden of HIV), the collaborated effort of different nations & organizations has brought some positive results. For example, the number of secondary-school students receiving AIDS education has nearly tripled, the annual number of voluntary counseling and testing clients has doubled, the number of women offered services to prevent mother-to-child transmission has increased by 70%, and the number of people receiving antiretroviral therapy has increased by 56% between 2001 and 2003.

However, all the efforts are far from success in preventing as well as eradicating the disease. Hence, no person, once infected with HIV, has been able to eradicate it from his or her body. (Smith, 2001). Despite some signs of progress, there is a still high HIV-prevalence level world wide and there are still huge challenges to turning the tide of this epidemic. In Sub-Saharan Africa, which is predominantly affected by the disease, only less than 10% of those who need treatment receive it. If this low coverage continues, five to six million people will die from AIDS in the coming two years (UNAIDS 2004).

Prevention:

The principle of successful prevention is ensuring that people are not exposed to the disease or, if they are, they are not susceptible. However, prevention programs in many parts of the world have not been successful enough and where the epidemic has been controlled, no one is quite sure what actually worked. Furthermore, discrimination and stigmatization against persons living

with HIV and those around them is one of obstacle to prevention and care the dramatic consequences of HIV/AIDS and a major (UNESCO, 2002). The most available biomedical intervention for preventing sexual transmission is the use of Condoms. The second set of interventions seeks to prevent exposure to HIV by altering sexual behavior; these are Knowledge, Attitude, Practices & Behavior (KAPB) interventions.

Even though enough is known about effective preventive measures, the coverage of prevention program is very low. As per the UNAIDS (2004) report based on the research conducted in 73 low and middle-income countries, less than 1% of the adults aged 15 to 49 years are accessing voluntary counseling and testing services, less than 10% of pregnant women are currently offered services of proven effectiveness to prevent HIV transmission during pregnancy and childbirth and fewer than 3% of orphans and vulnerable children are receiving public support for most services .

Treatment

Even though enormous resources have gone into the search for a cure and a vaccine, neither has yet been developed. However, there have been major advances in clinical treatment. Developments in treatment have resulted in declining mortality rates from HIV among the economically well-off. There are three stages in the treatment of HIV positive people. The first is when they are infected, but CD4 cell counts are high. At this point, the emphasis is on 'positive living 'staying healthy' eating the correct food and so on. The second stage is when the CD4 cell count begins to drop. At this stage, prophylactic treatment to prevent TB and other common infections commences. The third stage is the use of anti- retroviral drugs to fight HIV directly (Smith, 2001; Becker.et.al, 2004).

Regarding developing a Vaccine, intensive research is being carried out to develop a vaccine, so far with limited success. More than 15 years have passed since the first efforts, but as yet a vaccine remains elusive. The international AIDS vaccine Initiative (IAVI); based in New York, plays an increasingly important role in mustering resources and facilitating development (Smith, 2001).

PART. II

2.2 THE IMPACT OF HIV /AIDS

HIV would affect not only the health of individuals but also the welfare and well-being of households, communities and entire societies. There are undoubted technical problems of how to measure social and economic impacts of excess death as well as illness. Whether countries are with high or low economic development, high or low prevalence rate, AIDS hinders development, exacting a devastating toll on individuals and families. In the most affected countries, it is erasing decades of health, economic and social progress – reducing life expectancy by years, deepening poverty, and contributing to and exacerbating food shortages (Adler, 2001). This part is also presented into two, the over all impact of HIV/AIDS and its impact on AIDS orphans.

2.2.1. THE OVERALL IMPACT OF HIV/AIDS ON SOCIETY

HIV/AIDS disrupts the over all existence of society through its impacts on population, development, health sector, education, women, children and other parts of society.

i. Population

Life expectancy in many countries has declined as a result of AIDS. The epidemic is distorting the structure of populations. Instead of the familiar " population Pyramid " AIDS is producing a new demographic structure where the population of men and women beyond their early 20s will shrink in affected countries leading to fewer middle- aged people. A shortage of prime-age adults has consequences for the next generation. As a result many house holds will consist of orphans and very old age care givers.

This whole situation is forcing many children to assume care giving roles to their younger siblings. Sub-Saharan Africa faces the greatest demographic impact, as the most affected region. According to UNAIDS/WHO (2003), approximately 60% of today's 15-yeas olds will not reach their 60^{th} birthday, with the current infection rate and unless effective measures are taken to

prevent the spread of the disease. However, in some countries, to reach the age of 60 could be a luxury because of the impact of the disease in addition to the highly deteriorated social and economic situation. For example, in Ethiopia the life expectancy could be as low as 45.

ii. Development

AIDS distorts the natural process of development. Development is about hope for the future and changing social and economic trajectories for the better. In the absence of effective vaccines and economically feasible and effective treatments, AIDS may be expected to wipe out half a century of development gains as measured by life expectancy at birth. The impact of HIV/AIDS on child mortality is highest in those countries that have significantly reduced child mortality due to other causes. As a result of AIDS, only 5 out of 51 countries in Sub- Saharan Africa will reach the goals the International conference on population and development for decreased child mortality. This means that for many countries, particularly in Africa, development becomes virtually impossible in the era of AIDS (Essex.et.al, 2002; Philipos, 2002).

Another aspect of development, particularly for developing countries, is agricultural self-sufficiency. In Africa, the agricultural sector is essential for the continent's well-being as it accounts for 24% of the Gross domestic product, 70% of employment and 40% of its foreign exchange. AIDS is attacking this sector by claiming the lives of agricultural workers. As estimated by UNAIDS/WHO (2003), by the year 2020, AIDS will claim one- fifth or more of the agricultural work force. According to ILO (2004), AIDS is likely to reduce the growth rate of the labor force, as it primarily strikes the working-age population. As a result, the economy of the most affected countries will be deteriorating. AIDS-affected households are likely to suffer more severe poverty than non-affected households because income and production capacity of family members who are sick is drastically reduced and it creates extraordinary care needs and increases household expenditure on medical and other services, such as funerals. In a related study by ILO (2003), HIV/AIDS threatens the livelihoods of many workers, those who depend on them and national economies. The epidemic will reduce projected growth in the labor force in high prevalence countries. It is estimated that Ethiopia will loose 10% of its labor force to HIV/AIDS by the year 2020.

iii. Health sector

The epidemic has created a need for strong health care system at a time when many affected countries have been reducing public service spending to repay debt. The already weakened systems are being forced to cope with the extra burden of sickness and the loss of essential staff through sickness and death related to AIDS. According to Essex et.al (2002), an estimated 19% to 53% of all government health employees' death in Africa is caused by AIDS. The epidemic is quickly outstripping growth in the supply of health sector workers.

iv. Women and Children

The epidemic's impact is particularly hard on women and girls as the burden of care usually falls on them. Girls drop out of school to care for sick parents or for younger siblings. Older women often take on the burden of caring for ailing adults and later, when they die, adopt the parental role for the orphaned children. They are often also responsible for producing an income or food crops. Older women caring for orphans and sick children may be isolated socially because of AIDS-related stigma and discrimination (Florence, 2002).

HIV/AIDS pandemic also leaves a vast number of children orphaned. According to a joint report released by the UNAIDS (2004) , currently more than 15 million children under the age of 15 have lost one or both parents to AIDS and most of these children are found in Sub- Saharan Africa. This will be discussed in-depth in the second part.

v. Education

AIDS is becoming a major obstacle for the key target of UNESCO's "Education for All" Initiative and the UN's Millennium Development Goals. Since many countries can not afford to train more teachers in replacement of many skilled teachers who fall sick or died, the quality of education is suffering. Furthermore, Children, especially girls, from AIDS-affected families are often withdrawn from schools to compensate for loss of income through a parent's sickness and related expenses, to care for sick relatives and look after the home. These families may also take their children out of school because they cannot afford school fees (Stine, 2003).

AIDS also has various un-measurable impacts worldwide. For example, the cost of losing a community's teacher or nurse can be estimated in many terms, but not all losses and costs can be afforded a money value. How do we value parenting? What is the cost of cuddle forgone? What is the cost to an organization of the loss of institutional memory? How do we estimate the value of lost community morale?

2.2.2 THE IMPACT OF HIV/AIDS ON AIDS ORPHANS

A. THE ORPHAN CRISIS

i. The Global Situation

Globally, So far, over 14 million children became orphans due to the AIDS epidemic, out of which 12 million live in Sub-Saharan Africa. Furthermore, as stated in the 15th International AIDS conference which was held in Bangkok, Thailand, by the year 2010, the number of orphans worldwide is expected to reach 18.4 million. Out of these, almost 50 % are younger than age 12. Three million of the children became orphans only between 2001 and 2003. However, only 17 countries at the end of 2003 had national policies aimed at AIDS orphans and related issues. It is also estimated that a child loses a parent to AIDS-related causes every 14 seconds (UNAIDS/WHO 2004).

In most of the affected countries, which are with poor economic status and with limited social support systems, families and communities are usually unable to provide adequate care to children who have lost their parents to the disease. Hence, these HIV/AIDS orphans face limited access to education, health care and economic opportunities. They suffer from inadequate nourishment and nutrition, risk of exploitation and abuse, loss of parental love, lack of guidance and protection, as well as the risk of becoming infected as they grow into young adults (Save the Children, 2001; Stine, 2003).

It should be noted that HIV-positive orphans constitute a relatively small part of the orphan population. About two-third of babies born to HIV-positive parents are not infected, and most

infected children do not survive long enough to make up a sizeable proportion of the orphans (Adler, 2001).

ii. The African situation

Sub-Saharan Africa is the most affected by the HIV/AIDS orphans problem. The proportion of AIDS orphans rose from just less than 1 million in 1990 to 12 million in 2003. By the year 2010, the number of children who have lost at least one parent to AIDS is expected to reach as high as 17 million. With only 10% of the world's population, Sub-Saharan Africa is a home to 92% of the world's AIDS orphans and 70% of all people infected by HIV (UNAIDS/WHO, 2004).

According to Essex.et.al (2002), the number of children losing a father or a mother is estimated to be more than double between 1990 and 2010. In the same period, the number of children without both parents throughout Africa is estimated to increase by 8-fold.

HIV/AIDS is generating orphans beyond the coping capacity of the family structure, mainly in African countries that have already had long, severe epidemics. While many orphans in Africa are still taken in by their kin and other members of their community, an increasing number are slipping through this traditional safety net. Also, as the disease exacerbates, families and communities are facing financial difficulties to take care of orphans. One of the major reasons for this is that many HIV/AIDS victims become infected at their early twenties and by the time they are in their mid of thirties they develop AIDS and die, leaving behind a generation of children. Hence, an increased number of orphans are dependant on economically and physically incapable grandparents or become child house hold heads (Nyambedha. et.al, 2001 and 2003; Bicego.et.al, 2002; Case.et.al, 2002).

iii. The Ethiopian Situation

According to UNAIDS (2004), at the end of 2003, there were 720,000 children who lost their mother or father or both parents to AIDS. On the other hand, Ministry of Health (2004), estimated the number as 539,000. According to USAID (2002), sources estimate that the number of children orphaned by AIDS is between 990,000 and 1.2 million. A survey conducted in 2003

by MOLSA in collaboration with UNICEF and Italian Cooperation on "The Prevalence and Characteristics of AIDS Orphans in Ethiopia" stated that the prevalence of AIDS orphans in Ethiopia is 15.6% (14.69% in major cities, 16.67% in small towns and 14.77% in rural areas).

According to Madhavan (2003), many children are placed in orphanages that lack sufficient staff and resources, as the number of AIDS orphans rise. Besides, being separated from their siblings and taken out of their communities, these children are raised in situations which do not prepare them for life as adults. Furthermore, such institutional care is practicably expensive in poor countries like Ethiopia where the cost of keeping a child in an orphanage higher than the national income per person. (Pritchard, 2002; UNICEF, 1999; Garbus, 2003). As mentioned in the First Consultative meeting on Orphans and Vulnerable Children Affected by HIV/AIDS (2001), HIV/AIDS orphans in Ethiopia are suffering from lack of access to social services such as schooling and health care due to unaffordable fees, discrimination and stigmatization, unawareness etc.

B. ECONOMIC, SOCIO-CULTURAL AND PSYCHOLOGICAL IMPACT

Of the many vulnerable members of society, children who have lost one or both parents are among the most exposed. This is mainly true in Sub-Saharan Africa, where there is inadequate provision of basic social services and where few social support systems exist outside of families. In poor countries like Ethiopia, even in normal years, the education, health, and economic situation for millions of children can be described as a crisis. As the number of adults dying of AIDS rises over the years, an increasing number of orphans will grow up without parental care and love and will be deprived of their basic rights to shelter, food, health and education (Foster, 1997; Johnson and Dorrington, 2001).

i. Economic Impact

As HIV/AIDS mostly affects the productive age group, it has a very great impact in creating severe economic crisis in nations. This is because the number of young adults, who are able to contribute to their communities through their work as parents, teachers, laborers, drivers, farmers, etc., declines. This adversely affects the entire economic and social structures of

communities (Bollinger, et.al, 1999). According to ILO (2003), nine out of ten of people living with HIV/AIDS are adults in their productive and reproductive prime. They are bases of families, communities, enterprises and economies.

HIV/AIDS threatens the future generation as children are orphaned or forced to leave school to care for family members or provide income. Many of the people who are infected are the family breadwinners and their death leaves their children without income and support. As a result of the reduced family income, children become unable even to secure their daily needs including food and shelter. This forces them to be engaged in unhealthy coping mechanisms such as beggary, migration, prostitution, theft etc. In addition, they are forced to drop out of school, become unable to get health care and other vital social services. Hence, these children face a dramatic change in their lives and became destitute. Beyond damaging the future of individual children, HIV/AIDS impedes human capital formation and hinders sustainable development. Without schooling and proper nutrition the future prospects of these children and their long term income are depressed (Basaza and Kaija, 2002; Pritchard,2002).

ii. Socio-cultural Impact

The coping capacity and problems of children can also be significantly influenced by social capital through social, cultural, and religious beliefs and practices. Social capital represents the social and cultural coherence of society that is manifested in socio-cultural values, norms, practices etc. Social capital is believed to facilitate better outcomes in the overall development of a society. However, there are some aspects of social-capital that bring adverse outcomes (Grootaert, 1998).

Culture is defined by UNAIDS (2004) as " ways of life, traditions and beliefs, representations of health and disease, perceptions of life and death, sexual norms and practices, power and gender relations, family structures, languages and means of communication; in addition to arts and creativity". There are a number of commonly observed traditional and cultural practices which are common particularly in Africa, such as widow inheritance, female circumcision, polygamy etc are now recognized as being directly responsible for the spread of HIV/AIDS. In addition, the influence of culture, tradition and social norms can be seen on patterns of caring for children as

well as adults who developed AIDS, caring for AIDS orphans, beliefs about the disease, stigmatization and discrimination toward people living with AIDS, and practices that can prevent or spread HIV. Furthermore, due to the misconception about the disease, community members including relatives and neighbors prohibit themselves as well as their children from mixing with AIDS orphans. Hence, discrimination, stigmatization and related social and cultural responses towards HIV/AIDS victims are one of the major obstacles to the prevention of the spread of the virus. This fact denied children's right of Article 2 of the UN convention of the right of a child which is to enjoy all the rights stated in the convention without discrimination of any kind (Williamson,2000; UNESCO, 2002; Save the Children/ Sweden, 2003).

In a related study, Nyblade (2003) stated major causes of stigmatization as "… insufficient and inaccurate knowledge about the disease, fears of death and the disease itself, an association of HIV transmission with socially improper sexual behavior and lack of recognition of stigma". Stigma also is influenced by societal norms, socio-economic status, age, gender etc. People living with HIV/AIDS and their children face social and physical isolation from family, friends and community. They also experience loss of rights, decision-making power and access to resources and social services. As a result they become isolated because they usually feel inferior and ashamed.

AIDS orphans often experiences shame, fear and feeling of rejection due to stigmatization and the lack of the necessary parental guidance through crucial life-stages. Often emotionally vulnerable and financially desperate, orphans are more likely to be forced into exploitative situations, such as prostitution, as a means of survival. Girls are more likely to be in a greater risk of becoming infected at a younger age than boys, because they are biologically, socially and economically more vulnerable (Gieses et.al,2003; UNESCO;2002; Lee.et.al, 2002).

In Africa, the traditional social security systems and the extended family unit have been the predominant protecting and care giving units for orphans. However, the traditional social unit is becoming unable to perform this duty due to the increasing number of orphans, the decreasing number of the prime age care givers, the inadequate information and misconception of the transmission of the disease and decline of economic capacity. This is worse in urban areas where

the life style is increasingly influenced by individualism (Essex.et.al, 2002, and Silverman, 2004).

According to Gieses et.al (2003), in many families and communities the environment for healthy growth and well being has been devastated by HIV/AIDS. The loss of material, emotional and developmental support from an adult exposes children to the distress which results from lack of affection, insecurity, fear, loneliness, grief or despair. It limits the possibility of a successful childhood and gradually affects their future as adults.

As mentioned on *The first consultative meeting on orphans and vulnerable children affected by HIV/AIDS(2001)*, organized by Save the children/Alliance, the prejudice and stigmatization goes to the extent in which AIDS orphans are "expelled from school, physically beaten, verbally abused, discriminated, given separated seats, emotionally tortured etc".

iii. Psychological Impact

This is believed to be one of the direct consequences of the disease because of the anxiety, fear and emotional insecurity the children face immediately when they loose their family unit. According to Williamson (2000), the vulnerability of children orphaned by AIDS begins well before the death of a parent. As the parent/s illness and distress progresses, the children start suffering from emotional trauma. Eventually, after the death of their parent(s), children have to adjust to drastic changes in family structure and new situation resulting from loss of family income and support. Most become main breadwinners and care takers for the younger siblings. Besides the stigma, blame and rejection AIDS orphans face as a result of their parent/s death; they may experience exploitation and abuse.

iv. The Impact on Access to Social Services.

Access to social services can be defined as: access to highest quality health care, basic education and other basic needs such as shelter and infrastructure. According to the UN Convention on the Rights of the Child (Article 18-31), children have the rights to basic health care, education, social security, child care services, adequate standard of living, play, leisure and participation in cultural activities (Save the Children/Sweden, 2003). In addition the policy of HIV/AIDS of

FDRE promotes proper institutional, home and community based health care and psychological support for orphans. (MOH, 1998). However, as Masmas et.al (2003) indicated, HIV/AIDS is depriving children's rights to basic needs by creating socio-cultural and economic difficulties. AIDS orphans, may be denied access to health care, schooling, food and housing, due to the stigma and fear attached to AIDS. They may not receive proper health care due to misconceptions such as that they are infected with HIV and their illness is untreatable. Often the negative societal outlook towards the disease is manifested in the way AIDS orphans are treated. Moreover, it limits these children's future opportunities and their right to participate in the economic, social and cultural development of their community.

In the worst affected areas, of the Sub-Saharan Africa, the impact of the AIDS epidemic on the social service system has been severe. In countries like Ethiopia, where the society is already impoverished and the traditional social security system is weakened, HIV/AIDS deprived children's rights of access to basic social services (Silverman,2004; Bicego, et.al 2002).

According to MOLSA (2003), some of the major obstacles in the adequate provision of social services to AIDS orphans are lack of awareness among society on how to properly care for AIDS orphans, lack of financial capacity, lack of mechanisms to collect and systematize data on AIDS orphans, lack of coordination among different actors that provide social services and lack of access to services.

The impact of AIDS on education, health and other social service sectors can be analyzed at different levels.

a. The impact on the **access**: children may be denied access to health care service, education and other social services due to financial inability of the family, fears and stigmatization in the community etc.
b. The impact on the **demand** (Particularly in the education sector): HIV/AIDS orphans may drop out of school for they often assume responsibilities of house hold work, care for the sick family, care for younger siblings, earning income etc. Hence, the motivation of these children to attend school may decline.

c. The impact on the **supply**: When teachers, medical personnel and other social service professionals fall sick and die, it is time, money and other resources consuming to train new personnel and replace them.
d. The impact on the **quality of service:** As the epidemic advances, it puts pressure on the economy. This forces governments to divert available funds, which could have been invested to improve social services, to emergency services in relation to the disease.

CHAPTER THREE

3. ANALYSIS, INTERPRETATION AND DISCUSSION OF THE FINDINGS

3.1 DESCRIPTION OF THE STUDY AND PROFILE OF NGOs /CBOs

Addis Ababa, the capital city of Ethiopia, is characterized by having a population from various socio-economic, cultural, religious and ethnic backgrounds. The city is selected as a study area with due consideration of the belief that it, like many other major urban areas, has a higher number of HIV/AIDS infection and AIDS orphans. Furthermore, it is a seat for different international as well as local organizations including NGOs and associations working with AIDS orphans which would make information regarding the problem relatively accessible.

Addis Ababa city covers an area of about 540 km^2. At present the total population of the city is estimated to be more than 3 million with the annual growth of 3.79%. (FHI- Ethiopia, 2002) The Addis Ababa city administration is divided into ten sub-city Administrations, under which there are a total of 203 Kebele administrations. In this study six sub- cities (Kirkos, Yeka, Arada, Lideta, Nifas Silk and Addis Ketema) were covered.

As indicated in chapter three, samples were selected from 11 NGOs and CBOs . Their profile is presented in the following table.

Table 1. NGOs/CBOs by number of orphans helped and types of supports provided

S. no	Name of NGO/CBO and year of establishment	No.of orphans at the time of the study			Kinds of major supports providing
		F	M	Total	
1	Hanna Orphans Home -2001	37	41	78	-community based support -basic necessities(food &cloths), educational materials, health care service, skill training, recreational services , counseling and guidance and tutorial services - providing group homes
2	Dawn of Hope -1998	-	-	216	-providing financial, social and psychological supports for people living with HIV/AIDS and AIDS orphans
3	Hope for children -2001	233	252	485	-providing financial, social and psychological support including institutional care
4	OSSA (organization Of Social Services for AIDS) - 1998	500	258	758	-providing financial, psychological and social supports -providing home based care and support by working with care givers and local community
5	Mekdim Ethiopia National Association 1996	164	159	323	-providing care and support to AIDS orphans and PLWHA,HIV/AIDS education, skill training, home care and other social and psychological supports
6	Medical Missionaries of Mary(MMM) Counseling and Social services center - 1993	141	105	246	-providing psychological, social and economic supports -providing school fee and materials, school uniform, food(Wheat,oil,etc), health service and other social and psychological services

S. no	Name of NGO/CBO and year of establishment	No.of orphans at the time of the study			Kinds of major supports providing
		F	M	Total	
7	Tesfa Berehan Ethiopia - 2000	76	24	100	-participating in the national effort of preventing and control of HIV/AIDS, promoting the rights of AIDS orphans and providing care and support for AIDS orphans - providing financial, social and psychological services including skill training, recreational services, legal services etc.
8	People to People - 1999	237	190	427	-providing social , financial and psychological supports including HIV/AIDS education, educational and health care supports
9	Mary Joy(one project) - 1994	226	194	420	-Providing social, economic and psychological support through a main strategy of community participation
10	Emmanuel Self Helping Fellowship (Edir) - 2001	23	21	44	- Providing food, clothing, economic, health care and educational supports -providing seminars and workshops regarding HIV/AIDS prevention and control
11	Kebele 02 Edirs Anti-AIDS and Development Council - 2004	98	113	211	-providing food, cloth, financial, educational and health care supports

3.2 CHARACTERSTICS OF THE STUDY POPULATION

In this study, different study groups including AIDS orphans and care givers were considered. In addition government and non government workers and leaders of CBOs participated in providing information.

The AIDS orphans who mainly participated in this study were those who got some kind of care and support from from NGOs and CBOs. In addition few others who were registered by the NGOs and CBOs but did not get any kind of support were also included to incorporate the insight of those without any support. The selection of AIDS orphans was done randomly from the lists of the organizations.

The care takers were also selected from NGOs and CBOs. Single parents who lost their partners due to HIV/AIDS, grand parents, close relatives, neighbors, friends and those who give care to AIDS orphans in institutions participated in the interviews and focus group discussions.

Among the key informants, NGO workers who closely work with AIDS orphans and government workers who have a close relationship with AIDS orphans as well as with NGOs supporting AIDS orphans participated in the study.

3.3 DEMOGRAPHIC CHARACTERSITCS OF RESPONDENTS

It has been often said that the HIV/AIDS pandemic is definitely afflicting the bulk of AIDS orphans. In this study, an attempt was made to investigate the situation by considering the AIDS orphans themselves by having a fair blend from each sex category. It is also to be noted that the disruptions in courses of life due to the impact of HIV/AIDS are not only experienced by AIDS orphans. Care givers are also victimized by the social, economic, demographic, cultural and other impacts of the epidemic. In this regard, the views and experiences of care givers were also given due consideration in the study.

As part of the socio-demographic characteristics investigation, the age range and sex of the respondents was considered. This is indicated in Table 2.

Table 2. Age and sex of AIDS orphans and Care givers

	AIDS Orphans				**Care givers**				**Total**
SEX	8-9	10-14	15-18	**Total**	15-20	21-45	46-70	71+	
F	4(1.8%)	48(21.1%)	75(32.9%)	127(55.7%)	6(11.5%)	21(40.4 %)	11(21.2 %)	3(5.8%)	41(78.8%)
M	1(.4%)	55(24.1%)	45(19.7%)	101(44.3%)	1(1.9%)	7(13.5%)	2(3.8%)	1(1.9%)	11(21.2%)
Tot	5(2.2%)	103 (45.2 %)	120 (52.6%)	228(100.0 %)	7(13.5%)	28(53.8 %)	13(25.0 %)	4(7.7%)	52(100.0%)

Source: survey data

Table 2 depicts that 55.7% of the respondents were females and 52.6% of the total respondents were in the 15-18 age category followed by 45.2% in the 10-14 age cohort. The rationale for the majority to be in the age range between age 10-18, as mentioned in chapter three, was due to the criteria during the sample selection, which is children between the age of 10-18. This was in view of the fact that children in this age range are believed to have a better understanding and to be able to clearly express the situation they are in. However, few others under the age of 10 were included based on the recommendation from the NGOs/CBOs.

In addition, as indicated in the table above, the majority(53.8%) of care givers were between the age of 21-45 followed by those between 46-70 (25%).It was also found out that care givers between the age of 15-20 (13.5%) are those who are physically and economically incapable child house hold heads. Also female care givers consist of the large majority i.e. 78.8%.

From the key informants and FGD participants, it was also possible to know that older women and young children often take the burden of caring for ailing adults and later, when they die, adopt the parental role for the orphaned children. Besides, AIDS orphans were left to be dependent economically and physically incapable grandparents or become child household heads. This was confirmed by the facts in the above table that a combination of those who were

either older than 46 years old or younger than 20 years old constituted 46.2%. In addition to the age range, the educational background of respondents was also investigated.

Moreover from the study, it was also possible to learn that all of the respondents from AIDS orphans have had some exposure to formal education. As reported in Table 3 below, 30.3% of the respondents have attended grades 9-12, while 68 % have attended grades 1-8. The difference in the number of AIDS orphans in each age category was statistically significant. On the other hand, As indicated in Table.3, 42.3% were illiterate while the rest have had some kind of education.. Among those who are literate, 53.8% had some kind of formal education while 3.8% did not go through formal education system. Besides, only 1.9% said they have attended college level education. The respondents further explained that the majority not having low educational level or no education at all made it difficult for care givers to qualify for jobs with decent salaries. This in turn hampered them providing proper care and support to AIDS orphans.

Table3. Educational level and age

AGE	**Educational level of AIDS orphans**					**Total**
	1-8	9-12			12+	
8-9	5 (2.2%)	-			-	5 (2.2%)
10-14	100(43.9%)	3 (1.3%)			-	103 (45.2%)
15-18	50(21.9%)	66 (28.9%)			4 (1.8%)	120 (52.6%)
Total	155(68.0%)	69 (30.3%)			4(1.8%)	228(100.0%)
Age	**Educational Level of care givers**					**Total**
	no formal education	1-8	9-12	12+	Illiterate	
15-20	-	1(1.9%)	4(7.7%)	-	2(3.8%)	7(13.5%)
21-45	1(1.9%)	13(25.0%)	7 (13.5%)	1(1.9%)	6(11.5%)	28(53.8%)
46-70	-	1 (1.9%)	-	-	12(23.1%)	13(25.0%)
71+	1(1.9%)	-	1(1.9%)	-	2(3.8%)	4(7.7%)
Total	2(3.8%)	15(28.8%)	12(23.1%)	1(1.9%)	22(42.3%)	52(100.0%)

Source: survey data

As far as family size is concerned, as shown in the table below (Table 4), 56.6% of the respondents from AIDS orphans lived in a family where the household size was, on average 6-10. On the other hand, 40.4% reported a family size of 1-5 members. This issue was also discussed in-depth in the FGDs and key informant interviews. In these discussions two major factors that abruptly increase the family size were stressed. The first was the fact that some families had to take in two or more AIDS orphans from one family. The second was that others had to take in a number of orphans from two or more families. As a matter of fact, one participant of the FGD said that she had to take in six children of her four brothers who died of AIDS in to her family. The participant said she had lost her four brothers and their wives in a three years interval. Therefore, she had to take in their children because there was no one to look after them.

Regarding family size of care givers, as shown in Table 4, 57.7% reported a family size of 1-5 members. On the other hand, while 38.5% said they lived in a family with average members of 6-10, the rest 3.8% had a family size of above 11. The table further illustrates that the majority of the respondents (80.8%) indicated that the number of AIDS Orphans they give care for is on the average 1-5.

Table 4. Family size& no of AIDS Orphans in the family by sex

AIDS orphans							
SEX	**Family size**			**Total**	**No of AIDS orphans**		**Total**
	1-5	**6-10**	**above 11**		**1-5**	**6-10**	
Female	44(19.3%)	78(34.2%)	5(2.2%)	127(55.7%)	62(27.2%)	65(28.5%)	127(55.7%)
Male	48(21.1%)	51(22.4%)	2(.9%)	101(44.3%)	61(26.8%)	40(17.5%)	101(44.3%)
Total	92(40.4%)	129(56.6%)	7(3.1%)	228(100%)	123(53.9%)	105(46.1%)	228(100%)
Care givers							
Sex	**Family size**			**Total**	**No of AIDS Orphans**		**Total**
	1-5	**6-10**	**above11**		**1-5**	**6-10**	**above 11**	
Female	22(42.3%)	18(34.6%)	1(1.9%)	41(78.8%)	32(61.5%)	8(15.4%)	1(1.9%)	41(78.8%)
Male	8(15.4%)	2(3.8%)	1(1.9%)	11(21.2%)	10(19.2%)	-	1(1.9%)	11(21.2%)
Total	30(57.7%)	20(38.5%)	2(3.8%)	52(100.0%)	42(80.8%)	8(15.4%)	2(3.8%)	52(100.0%)

Source: survey data

One serious ramification of the HIV/AIDS epidemic is an increase it brings in the number of orphans. In line with this, Table 4 further reveals that 53.9% of the respondents from AIDS orphans indicated that on average, 1-5 AIDS orphans lived in their family and the remaining indicated on average, 6-10 AIDS orphans. The difference in the number of AIDS orphans in each sex category was statistically significant at 90% confidence interval.

Regarding the reply of care givers, as indicated in the above table, 15.4% and 3.8% of the respondents stated the average number of AIDS orphans who got care and support from them as 6-10 and above 11 respectively. In addition, most care givers (76.9%) said they had to take in two or more AIDS orphans in to their family which added a great strain in their already meager livelihood.

Also, participants of the FGD as well as the key interview, presumed the rise in number of AIDS orphans at the household, community and national level. This finding was substantiated, as noted in the literature review, by studies of MOH (2002) and UNAIDS (2004).

It is to be noted that at the household level, the orphan crisis leads to changes in the household composition, to the rise in the number of child-headed households, child caregivers, and elderly caregivers. Accordingly, with the large number of AIDS orphans in each family, the issue of who was deceased and who is the care giver after the death of parents was given due consideration in the study. In this regard, maternal, paternal and double orphans were examined in the study. As reported in Table 5, 82.9% of the respondents lost both of their parents and became double orphans. On the other hand, 17.1% of the respondents lost either of their parents. From the total respondents, 16.2 % indicated that there was nobody beside them to be of some help. As such, and they took the responsibility of taking care of themselves and their younger siblings. On the other hand, 17.5% , 14.0% and 11.8% of the respondents had their close relative, sister and brother as a care giver respectively (see Table 5).

Table 5 . Care giver-Deceased cross tabulation

CAREGIVE	DECEASED			Total
	mother	father	both	
close relative	6(2.6%)	1(0.4%)	33(14.5%)	40(17.5%)
self	1(0.4%)	1 (0.4%)	35 (15.4%)	37 (16.2%)
sister	3(1.3%)	2(0.9%)	27(11.8%)	32(14.0%)
institution/group home	-	-	31(13.6%)	31(13.6%)
brother	2(.9%)	1(0.4%)	24(10.5%)	27(11.8%)
grandmother	3(1.3%)	-	16(7.5%)	19(8.8%)
mother	-	15(6.6%)	-	15(6.6%)
both brother & sister	-	-	15(6.6%)	15(6.6%)
grandfather	-	-	5(2.2%)	5(2.2%)
neighbor	4(1.8%)	-	-	4(1.8%)
father	-	-	2(0.9%)	2(0.9%)
Total	19(8.3%)	20(8.8%)	189(82.9%)	228(100.0%)

Source: survey data

In their discussion, FGD and key informant interview participants pointed out that lack of organized social support system by the government and traditional obligation of extended families to take in orphans leaves the responsibility of taking care of AIDS orphans to family, relatives and friends who were already overloaded by struggles to survive. This supports the finding of the study that a total of 62.7% of the respondents from AIDS orphans were taken in by sisters, brothers, relatives, grandparents and neighbors. FGD participants further indicated that indicated that it is common in most traditional societies like Ethiopia, grandparents and close relatives are second in line for taking responsibility of children during times of catastrophes. However, due to the widespread of the disease and the increase in number of AIDS orphans, close families, relatives and friends are becoming unable to assume their responsibilities. This, as a result, is leaving AIDS orphans with no one to help and support. This result of the study is also supported by research of Essex.et.a l (2002) , Silverman (2004) etc.

Eventhough it was not indicated in the above table, a similar question of who they lost was also forwarded to Care givers. The finding indicated that those who lost both parents constituted 15.4% of the total respondents while 7.7% lost either of their parents. Hence, a total of 23.1% respondents were left with a burden of taking care of younger siblings when their parent/s died.

On the other hand, 25% are grand parents who lost either a daughter or a son (15.4% and 9.6%) respectively. The rest 51.9% of the respondents lost a sister, brother, close relative, spouse or a neighbor.

3.4 SOCIO-ECONOMIC CHARACTERSTICS

It is argued that the HIV/AIDS epidemic has a paramount impact on human and socioeconomic developments such as housing, income saving, etc. As part of examining the socio-economic situation of the respondents, there was a question forwarded to the respondents to see their housing condition. In this regard, the Table given below (Table 6) illustrates that much of the respondents (42.5%) dwell in *Kebele* houses, which are in most cases sub standard, followed by 36.4% residing in houses rented from private owners. A gender- disaggregated data revealed further that more females lived in rented houses than their counterparts. (see Table 6)

Table 6 . Housing type

SEX	**Housing condition**				**Total**
	privately owned	rented from private owner	rented from kebele	institution/ group home	
female	10(4.4%)	44(19.3%)	61(26.8%)	12(5.3%)	127(55.7%)
male	7(3.1%)	39(17.1%)	36(15.8%)	19(8.3%)	101(44.3%)
Total	17(7.5%)	83(36.4%)	97(42.5%)	31(13.6%)	228(100.0%)

Source: survey data

Furthermore, a similar attempt was made to learn the housing condition of care givers and 75% of the respondents either lived in a house rented from private owners or from kebele while 19.2% had their own house. On the other hand, 5.8% lived in a shelter with no water, electricity and other services. The respondents further explained that not having their own house is one of the factors in their inability to provide proper care. This is because they had to give priority to payments of house rent (due to fear of eviction) than payments for health care, adequate food, education etc. A related question was also forwarded as to who is the house hold head and 76.9% said that that it is them followed by followed by a spouse (15.4%) and relatives(7.7%).

It is also a global fact (which is confirmed by several researchers such as Essex.et.al, 2002, Silverman, 2004 etc) that AIDS is rapidly eroding the ability of households to cope with the growing threat to a sustainable livelihood. One important point worth mentioning in relation to this fact is trying to know the economic status of those affected by the epidemic. Towards this end, an attempt was made to examine the major source of family income before and after the death of parent/s in each family. As reported in Table 7 below, there are three scenarios that one would observe. First, some respondents of AIDS orphans indicated that the source of family income while their parents were alive remained as a source of income at present despite variation in magnitude was observed. This was further explained by respondents that older siblings or care givers continued to earn income from a similar activity. Second, for some respondents after the death of their parents, they were depending on a completely new business. Third, half of the respondents reported that their major source of family income was obtained from support of NGO/CBOs, relatives, friends and institutional care.

Table 7. Major source of income before and after death of parent/s

AIDS orphans				
Source of income	**Before death of parents**		**After death of parents**	
	Frequency	Percent	Frequency	Percent
1.GO/NGO employment	75	32.9	2	.9
2.private sector employment	26	11.4	3	1.3
3.petty trade, daily labor, selling of local drink/food, selling of fire wood	66	28.9	39	17.1
4.beggary	7	3.1	2	.9
5.house rent, private small business	9	3.9	13	5.7
6.army	2	.9	-	-
7.farming	11	4.8	-	-
8.skilled labor	5	2.2	-	-
9.support from family, relatives & friends	1	.4	22	9.6
10.work in a bar	10	4.4	-	-
11.support from NGOs/CBOs	-	-	61	26.8
12.Institutional care	-	-	31	13.6
13. support from friends, relatives& NGOs/CBOs	-	-	23	10.1
14. Support from NGOs/CBOs, petty trade, daily labor, selling of local drink/food, selling of fire wood	-	-	23	10.1
15. do not remember/ do not know	16	7.0	9	3.9
Total	228	100.0	228	100.0

Source: survey data

According to the reply of the care givers with regards to their source of income, 51.9% of the respondents were mainly dependent on the support they got from relatives, NGOs, CBOs etc followed by 19.2% whose livelihood was from petty trade, daily labor and selling of fire wood. On the other hand, the sources of income for others were government/NGO employment (5.8%), private sector employment (7.7%), beggary (1.9%), house rent (3.8%), skilled labor (1.9%) and pension (7.7%). One can learn from the table below that, over half percent of the respondents had no regular source of income which would in any case enable them sustain a minimum life standard.

In relation to major sources of income, FGD and key informant interview participants indicated that many parents had some kind of qualification or skill which enabled them to be employed in a government, non-government as well as private organizations. As a result of their death, their families were left to look for sources of income that do not require any specific qualification or skill. This was confirmed by the finding of the study, as indicated in Table 7 that sources of income such as employment of GO/NGO , private sector as well as skilled labor after the death of parents declined from 32.9% ,11.4% and2.2% to 0.9%, 1.3% and 0% respectively.

On the other hand, the finding of the study about the decline of beggary as a major source of income after the death of parent/s from 3.1% to 0.9%, found out to be contrary to the finding from the FGDs that beggary as a major source of income increased among families of AIDS orphans. Table 7 would illustrate this best.

In addition to source of income, the amount of a household would earn was considered in the following table.

Table 8. Amount of income before and after death of parent/s

Amount of income	Before death of parent/s		After death of parent/s	
	Frequency	Percent	Frequency	Percent
1.below100	65	28.5	94	41.2
2.101-500	97	42.5	28	12.3
3.501-1000	39	17.1	2	.9
4.above 1000	2	.9	-	-
5.in kind	-	-	52	22.8
6.below100& in kind	-	-	29	12.7
7.101-500 & in kind	-	-	17	7.5
8.do not know/remember	25	11.0	6	2.6
Total	228	100.0	228	100.0

Source: survey data

The Table shows the comparison of the amount of family income before and after the death of parent/s. It was, thus, found out that 42.5%, 28.5% and 17.1% of the respondents had a monthly family income of Birr 101-500, less than Birr 100 and Birr 501-1000 respectively before the death of their parent/s. After the death of parents those with a monthly income of less than Birr 100 increased to 41% while the number of those with monthly family income of Birr 101-500 and 501-100 decreased to 12.3% and 0.9% respectively. In addition those who said they got their lively hood in kind indicated that they got food, cloth and educational materials from relatives, friend, NGOs and CBOs In general, income generated over 100 Birr by the households reduced on the average from 60.5% to 13.2%.

Even though the above table revealed only the responses of AIDS orphans, it was also possible to learn from the study that among care givers, there was an equal distribution between those with family income of below 100 Birr and 101-500 Birr (30.8% each). On the other hand, those who mainly sustained on the support they got in kind (wheat, oil, cloth, school material etc) consisted of 11.5 %.

From the figures in the above table and from the responses of the care givers, one would safely state that the economy of the house holds affected by HIV/AIDS is declining at least in monetary terms. This was also confirmed by the respondents themselves while indicating their living status before and after they lost their parents. Over all, 75.9% of them indicated that their living standard has generally declined after the death of their parent/s. Only 7.9% indicated an

improvement in their living standard compared to the situation they used to have before the death of their parent/s. The implication of this is that while the majority experienced a deprivation of financial as well as psychological conditions due to a reduction of family income or taken in by care givers with meager income, few others were taken in by care givers who could provide a better life. The rest 6.1% said they could not compare or they were too young to remember the situation while their parents were alive.

In addition, the source and amount of income was also a concern of the key informants as well as FGD participants. The apprehension of most participants was of those who mainly depended on the support from others. They indicated that since the supports were irregular and inadequate, AIDS orphans would be the most victimized of not getting adequate basic necessities

It is a common sense, in fact, to imagine that there would be a tremendous strain on social systems to cope with such a large number of orphans in a family (as indicated in Table 4 above). Despite this, the writer still needed to examine the problem faced while trying to provide orphans with what they required. Towards this end, respondents were asked to explain the type of care and support they could obtain from caregivers. They indicated that they were treated to get access to basic necessities (such as food, clothing and shelter), educational support, health care and psychological support. It was not possible for the writer to single out which was the dominant one, but was able to see that a combination of various supports was being provided to the AIDS orphans. Table 9 illustrates the type of care and support from care givers.

Table 9. Care and support from care givers

Care and Support AIDS orphans got from care givers(AIDS Orphans)		
Care and support	**Frequency**	**Percent**
1.basic necessities	19	8.3
2.educational support	2	.9
3.health care support	10	4.4
4.psychological support	3	1.3
5.basic necessities and health care	6	2.6
6.basic necessities, educational support and health care	24	10.5
7.basic necessities and educational support	21	9.2
8.basic necessities, educational and psychological support	27	11.8
9.basic necessities and psychological support	12	5.3
10.all support	69	30.3
11.no support	35	15.4
Total	228	100.0
Care and Support care givers provided(Care givers)		
Care and support	**Frequency**	**Percent**
1.basic necessities	7	13.5
2. basic necessities and educational support	5	9.6
3. basic necessities and psychological support	9	17.3
4. basic necessities, educational and psychological	11	21.2
5. basic necessities , health care and psychological	5	9.6
6.all supports	15	28.8
Total	52	100.0

Source: survey data

As indicated above, various supports were being provided to the AIDS orphans, as reported by the respondents themselves. Among those who were able to single out one dominant support, 8.3%, 4.4% and 1.3% were getting basic necessities, health care and psychological supports respectively. On the other hand, while 30.3% said they have got all four kinds of support, 11.8% received all supports except health care support. Out of the total respondents, 15.4 % said they did not get any support from others, i.e. they supported themselves. A question was also forwarded to the respondents regarding their level of satisfaction of the services they have got. As a result, 36.8% indicated that the services were more or less up to their satisfaction (14.9% said very adequate and 21.9% adequate). On the other hand, 26.8% and 21.1% replied barely adequate and not adequate respectively.

Similarly, a question was forwarded to care givers as to what kind of support and care they provide and how they manage to provide the support. Accordingly, 28% said they provided all types of supports including basic necessities, health care, education and psychological supports

and 13.5% said they were able to provide only basic necessities. The rest said they were able to provide a combination of supports. (Please see Table.9). Following this, a question was forwarded regarding how they managed to provide the support and care. As indicated in the table below (Table. 10) , 19.2% said it was with the support from NGOs and CBOs, while7.7 said by a contribution from AIDS Orphans (by working as daily laborers). Also, 5.8% of the respondents said by begging and 3.8% with support from friends and relatives. The rest 57.8% said it is the combination of the above mentioned factors that enabled them to manage to a certain extent (please see Table 10)

Table 10. Care givers mechanism of managing the support

Mechanisms	**Frequency**	**Percent**
1.support from NGO/CBO	10	19.2
2.support from relatives and friends	2	3.8
3.additional jobs	1	1.9
4.begging	3	5.8
5.AIDS Orphans contribution by working as daily laborers	4	7.7
6.pension	2	3.8
7.support from NGOs, CBOs , relatives and friends	7	13.5
8.support from NGOs, CBOs and additional jobs	3	5.8
9.support from NGOs, CBOs, relatives, friends and additional jobs	1	1.9
10. support from NGOs, CBOs, additional jobs and AIDS Orphans contribution	4	7.7
11. support from relatives and friends, additional jobs and AIDS Orphans contribution	3	5.8
12. additional jobs and AIDS Orphans contribution	12	23.1
Total	52	100.0

Source: survey data

Furthermore, Key informants and FGD participants stressed on the issue of AIDS orphans working to support the family. With this regard, some of the participants had no understanding that it is wrong in social as well as legal terms to make children work in a situation threatens their physical and mental wellbeing. On the other hand, others said they understood the illegality of child labor but they had no other choice to maintain a livelihood. Hence the study indicated that these children were denied their constitutional right (Article 36 in Ethiopian Constitution) that includes "… the right to be protected from labor exploitation and not to be forced to undertake work that may harm their education, health and well being" (Save the Children/

Sweden, 2003). This result of the study was also supported by the studies of Lee.et.al (2002) , Pritchard (2002) and Basaza & Kaija (2002).

As indicated earlier in Table 7, a total of 40.4% of the respondents from AIDS orphans said that they depended mainly on the support from NGOs and CBOs for survival. However, others said they have got some kind of support from NGOs and CBOs. In this regard, the care and support NGOs and CBOs could provide was also examined. Table.11 indicates that 1.3.% of the respondents from AIDS orphans indicated they got access to basic necessities such as food, clothing and shelter altogether. In addition, 8.3% said they got health care and educational support and 3.9% said they got health care, educational and psychological supports in addition to basic necessities. The above indicated groups of respondents are those who lived in orphanages or group homes. Others replied that the services were rather partial in the sense that while some got access to food others were given educational support as far as NGOs and CBOs are concerned are concerned.

Regarding their satisfaction with the services, 17.5% and 28.5% indicated that the support was very adequate and adequate respectively. On the other hand, 21.1% and 24.6% replied barely adequate and not adequate respectively emphasizing the insufficiency of the support provided to them to sustain a minimum daily survival. As also indicated in the FGDs, there has been irregularity in the provision of supports such as provision of food and financial support every other month or every three months and sometimes it goes to the extent of not getting any support for about six months. This caused a great strain for those who were mainly dependent on the support.

Table 11. Care and support form NGOs and CBOs

AIDS orphans		
Care and support	**Frequency**	**Percent**
1.food	11	4.8
2.cloth	41	18.0
3.basic necessities(food, cloth &shelter)	3	1.3
4.educational support	8	3.5
5.skill training	7	3.1
6.health care	11	4.8
7.job opportunity	3	1.3
8.financial support	12	5.3
9.psychological support	5	2.2
10. basic necessities, health care and educational	19	8.3
11. basic necessities, health care, educational and psychological support	9	3.9
12. financial support and psychological support	14	6.1
13.cloth , financial and educational support	37	16.2
14. cloth and health care	3	1.3
15.educational support, health care and psychological support	26	11.4
16. no support	19	8.3
Total	228	100.0

Source: survey data

In addition , the replies of care givers as to what kind of support they got from NGOs and CBOs indicated that out of the total respondents ,17.3% said they got only health care while those who said food and financial support comprised 7.7% each. On the other hand, while 51% indicated a combination of food, cloth, educational support, skill training, financial support and health care the rest 5.8% said they got no support from NGOs/CBOs. Also, others said they got cloth, educational support, skill training and job opportunity (please consult table).

In relation their assessment of the support they got was also examined and the majority 81.4% said it is not up to their satisfaction by saying barely adequate and not adequate (40.4% and 36.5% respectively) while 15.4% said it is adequate and 1.9% said it is very adequate.

Despite the support orphans were getting from care givers and NGOs/CBOs, it is the writer's worry that it would be very difficult for these orphans to get adequate service including schooling and health care in the future, which would increase the burden on society

3.5 MAJOR PROBLEMS AIDS ORPHANS AND CARE GIVERS FACED

3.5.1 Major problems care givers faced

The other aspect examined in the study was major problems care givers faced while rendering support and care to AIDS orphans. Out of the total respondents 96.2% said they have had some kinds of problems. With regards to the kinds of problems, as indicated in Table 12, 11.5% said their major problem was lack of income, 9.6% said discrimination and 3.8% said poor relationship with AIDS orphans themselves. Furthermore, for 3.8% of respondents it was lack of support from friends and relatives while 1.9% said burden of responsibility, 1.9% said unable to give as much love, guidance and attention as AIDS orphans used to get from their parents and another 1.9% said not having the physical as well as economical capability because they are AIDS patients. On the other hand, the rest 61.4% said they experienced two or more major problems at the same time (please see table 12). In relation to discrimination (which was mentioned as one of the major factors), the examined the care givers assessment of the KAP of the society. As a result, while 44.2% and 9.6% said adequate and very adequate respectively, 42% said it was not adequate. The rest 3.8% said the society had an adequate KAP but no major behavioral change has been seen.

In addition, the key informants as well as FGD participants indicated the poor relationship between care givers and AIDS orphans as a major factor. The fact that AIDS orphans were raised in a different environment and by parents with different behaviors, made it difficult for AIDS orphans and their care givers to understand each other. As a result, there would be disagreements on various issues and sometimes this served as a reason for AIDS orphans to run away from home. This was further supported by Foster (1997) and Johnson & Dorrington (2001).

Table12. Problems care givers faced while providing care

Problems	**Frequency**	**Percent**
1.lack of income	6	11.5
2.burden of responsibility	1	1.9
3.unable to give adequate love and attention	1	1.9
4.lack of support from relatives, friends, community	2	3.8
5.discrimination	5	9.6
6.poor relationship with AIDS orphans	2	3.8
7.other (being AIDS patients)	1	1.9
8. lack of income and support, responsibility burden, unable to give adequate love, discrimination and poor relationship with AIDS orphans	6	11.5
9. lack of income and support, unable to give adequate love, responsibility burden	14	26.9
10. lack of income, responsibility burden and unable to give adequate love	10	19.2
11.lack of income and support, discrimination and being AIDS patients	2	3.8
12. faced no problem	2	3.8
Total	52	100.0

Source: survey data

3.5.2 Major problems AIDS orphans faced

As part of examining major problems AIDS orphans are facing and their causes, questions were forwarded to respondents to identify the kind of problems they face at home, in the community and to get proper social services. Respondents from AIDS orphans pinpointed their major problems and their causes in Tables 13 to 17. As to social services, mainly the education and health care services were thoroughly discussed by respondents.

Table 13. Major problems AIDS Orphans faced at home

Problems	Frequency	Percent
1.inadequate basic necessities	38	16.7
2.separation from siblings	3	1.3
3.lack of proper care by care givers	5	2.2
4.household work burden	2	.9
5.psychological and emotional problems	25	11.0
6.burden of taking care of younger siblings	6	2.6
7.lack of access to mass media	2	.9
8.physical and verbal abuse	4	1.8
9.eviction from home and unable to pay debts	7	3.1
10.inadequate basic necessities, lack of proper care, house hold work burden, psychological and emotional problem	12	5.3
11.inadequate basic necessities , psychological and emotional problems	31	13.6
12. inadequate basic necessities, burden of taking care of the house and younger siblings, psychological and emotional problems	20	8.8
13. inadequate basic necessities, physical and verbal abuse	5	2.2
14. inadequate basic necessities, house hold work burden, psychological and emotional problems	21	9.2
15. inadequate basic necessities, separation from siblings, psychological and emotional problems.	13	5.7
16.face no problem	34	14.9
Total	228	100.0

Source: survey data

Table 13 illustrates that 16.7%, 11% and 2.6% stated inadequate basic necessities, psychological and emotional problems and burden of taking care of younger siblings respectively as major problems they faced at home. Moreover, while 13.6% equally considered inadequate basic necessities and psychological and emotional problems as major problems, 9.2% mentioned household work burden in addition to the two above mentioned factors. Moreover, separation from siblings, physical and verbal abuse, eviction from home, lack of access to mass media and a combination of the above mentioned problems are also stated as major problems at home. (please consult table 13).

On the other hand, 14.9% said they face no problems at home. The majority of these were those who live in institutions or group homes who said they were provided with basic necessities and other supports in a way that could prepare them to their adulthood life. This was found out to be

contrary with the study of Madhavan (2003) that most institutions in countries like Ethiopia are incapable of adequately preparing AIDS orphans for what will come with adulthood life.

As described above, 0.4% of participants have experienced some kind of physical and verbal abuse. The case of a 13 years old girl is illustrative in this respect:

> *"I was taken in by my grandmother with my younger brother before my mother died. At the time I was 9 years old and my brother was 7. Since our father died a couple of years before, it was our mother who used to take care of us by working as a daily laborer. As my mother became very ill and could not support us any more, my grand mother had no choice but to take all three of us to live with her. The income of my grandmother which she got from her pension and from working as a cook was barely enough for the family of seven including my two uncles and my cousin. The worst time of my life began right before my mother's death. I was raped by my own uncle when no one was at home except the two of us. I was bleeding and also very scared. When I told my mother, the reply I got was to keep quite because we had no where to go if they turned their face away. The anger and pain made me sick even more when ever I saw him without paying for his crime. A couple of months later my mother died and it was like the end of the world for me and my brother. My grand mother and others treated us nicely and we begun to be comfortable with our life. However, after few weeks I got raped by my uncle for the second time and I run away from home because I felt there was no one who would believe me or help me. Finally, I was taken in by an NGO that provided institutional care. I never told my story to any one until last year which was very late to gather all the necessary evidences to make charge on my uncle."*

As per the key informants and focus group discussion participants, female orphans were more likely to be physically and verbally abused than their counterparts. This was because, as explained by participants, girls were physically and socially more vulnerable. In addition the above case story and the other findings indicated in the above table were substantiated by studies of Bicego.et.al (2002) Case.et.al (2002) and Gieses et.al (2003). The problems AIDS orphans face goes beyond their home and the following table shows the problems indicated to get proper education.

Table14. Major problems AIDS orphans faced in getting proper education

problems	Frequency	Percent
1. low academic performance due to psychological problems, not having enough time and energy	15	6.5
2. forced to drop out of school	12	5.3
3. lack of school materials	49	21.5
4. unable to pay school fee	6	2.6
5. Discrimination , stigmatization and lack of emotional support	12	5.3
6. verbal abuse(name calling & cursing)	1	.4
9. low academic performance, lack of school materials, discrimination and stigmatization.	30	13.2
10. low academic performance, lack of school materials, discrimination and verbal abuse	24	10.5
11. discrimination, stigmatization and verbal abuse	15	6.6
12. low academic performance, lack of school materials and unable to pay school fee	20	8.8
13. face no problem because people did not know their being AIDS orphans	33	14.5
14. Face no problem even if people knew	11	4.8
Total	228	100.0

Source: survey data

As indicated in Table14, respondents pointed out major problems they faced in getting proper education. While lack of school materials was a major problem for 21.45% of the respondents, low academic performance was for the other 6.5%. The respondents further explained why they had low academic performance by stating causes such as psychological and emotional problems due to loss of parent/s, not having enough energy after taking care of the house work and younger siblings and not having enough time and appropriate place to study. From the total respondents, 5.3%, 2.6% and 5.3% stated discrimination and stigmatization by class mates and teachers, unable to pay school fee and forced to drop out of school respectively. While some singled out one problem in their reply, others stated two or more problems as more or less significant in hindering them from getting proper education. Accordingly, 13.2% stated low academic performance together with lack of school materials, discrimination and stigmatization as major problems and 10.5% pointed out verbal abuse in addition to the three. On the other hand, 14.5% and 4.8% said they faced no problem because people did not know their being AIDS orphans and face no problem even if people knew respectively.

In addition, in the FGDs, it was discussed that some teachers did not consider AIDS orphans as competent in class as other students with parents. However, this was not stated as an intentional act but as lack of knowledge. The findings of this study regarding the above mentioned problems supports the issues raised in The First Consultative meeting on Orphans and Vulnerable Children Affected by HIV/AIDS(2001), Basaza and Kaija (2002).

The other factor which was given due consideration in this study was the problems faced by AIDS orphans in the community. The responses to the question of what kinds of problems they face in the community are shown in the following table.

Table 15. Problems faced by AIDS orphans in the community

Problems	**Frequency**	**Percent**
1. Discrimination and stigmatization	81	35.5
2. verbal abuse	4	1.8
3. lack of support	39	17.1
4. lack of recreational facilities	2	.9
5. Discrimination, stigmatization and verbal abuse	25	11.0
6.Discrimination, stigmatization, verbal abuse and lack of support	5	2.2
7.Discrimination, stigmatization and lack of support	14	6.1
8.face no problem b/c people did not know	38	16.7
9.Face no problem even if people knew	20	8.7
Total	228	100.0

Source: survey data

Table 15 shows that 35.5% of the respondents said that discrimination and stigmatization is the major problem they were facing in the community. They indicated that community members considered them as trouble makers just because they did not have parents to guide them in the 'right' direction. Also they faced difficulty in renting a house because people were afraid they might transmit HIV virus to them. The case of discrimination is best illustrated by a 12 years old boy as:

> " *When both my father and mother died due to AIDS, my grandmother started to look after me and my two older brothers. My grandmother used to support us by baking and selling bread. Since she went through a lot of suffering due to the disease, she believed that she could contribute to save the lives of others. Therefore, she started teaching people about the impact of the disease on the Edir meetings. However, people who did not know that our parents died due to AIDS started changing their positive attitude towards us as well as our grandmother after they learnt the case. People immediately stopped buying bread for us*

which caused a great strain in our day to day survival. They also started discriminating us by not allowing their children to play with us and by verbally and physically abusing us. It would have been better if my grandmother did not start teaching others."

Another 17.1% said that the major problem they faced is lack of financial and emotional support from the community. Furthermore, 11% gave equal weight for discrimination, stigmatization and verbal abuse and 2.2% said lack of support had equal weight with discrimination and stigmatization. On the other hand 16.7% and 8.7% replied they faced no problems because people did not know and faced no problem even if people knew respectively.

In addition FGD and Key informant interview participants indicated that some members of the community made AIDS orphans feel that they had some contribution to the death of their parents by using sayings such as 'gefi' (a mortifying name traditionally given to children who are believed to be a cause of death of their parents)

In Table 16, the major problems AIDS orphans were facing to get proper health care services are shown.

Table 16. Health care problems faced by AIDS orphans

Health care problems	**Frequency**	**Percent**
1.lack of money to get service and bureaucracy to get ' free service' paper from *Kebeles*'	102	44.7
2.not given enough attention by care givers	6	2.6
3.Discrimination and stigmatization	6	2.6
4.lack of money to purchase medicine and get service in emergency and serious cases	11	4.8
5.lack of money to get service, purchase medicine and	35	15.4
6. lack of money to get service and discrimination and stigmatization	6	2.6
7. not given enough attention by care givers, discrimination, stigmatization and lack of money to purchase medicine	16	7
8.face no problem	46	20.2
Total	228	100.0

Source: survey data

Table 16 indicates that lack of money to get health care service and bureaucracy to get "free service" paper form *Kebeles* is mentioned as a major problem by 44.7 % of the respondents. Another 4.8% said even if they managed to pay for the service, they faced problems to purchase

medicine and to get service in emergency and serious cases. In like manner, not given enough attention by care givers and discrimination and stigmatization were mentioned by 2.6% respondents each. In further explaining discrimination, respondents said that they sometimes did not receive proper health care due to misconceptions such as that they were infected with HIV and their illness was untreatable. This finding indicated that children were denied their right to non- discrimination (Article 2 of the UN convention on the Rights of the child). Moreover, while 15.4% gave equal weight to lack of money to get the service as well as to purchase medicine, 7% said it is the combination of lack of enough attention by care givers, discrimination and lack of money to purchase medicine. On the other hand 20.2% said they have not faced any problems so far.

Additionally, care givers were also asked what they think are the major problems AIDS orphans are facing and their responses are illustrated in the table below. Their views mainly focused on cross cutting problems AIDS orphans could face.

Table 17. Major problems AIDS orphans were facing

Problems	**Frequency**	**Percent**
1.lack financial and emotional support from care givers, relatives and friends.	3	5.8
2.inadequate basic necessities	1	1.9
3.psychological and emotional problems	2	3.8
4.difficulty in adapting to the new living arrangement	2	3.8
5.verbal abuse	1	1.9
6.physical abuse	1	1.9
7.lack of proper health care and education	2	3.8
8.burden of house hold work and taking care of younger siblings	2	3.8
9.discrimination and stigmatization	5	9.6
10.lack of financial and emotional support from care givers, relatives and friends, inadequate basic necessities, psychological and emotional problems	3	5.8
11. lack of financial and emotional support from care givers, relatives and friends, inadequate basic necessities, psychological and emotional problems, difficulty in adopting to the new living arrangement combination and lack of proper health care and education	8	15.4
12.All except physical abuse and difficulty in adopting to the new living arrangement	18	34.6
13. lack of financial and emotional support from care givers, relatives and friends, inadequate basic necessities and lack of proper health care and education	4	7.7
Total	52	100.0

Source: survey data

Table. 17 illustrates that discrimination , lack of financial and emotional support from care givers, friends and relatives; lack of proper education and health care service and difficulty in adapting to the new living arrangement were indicated by 9.6%, 5.8%, 3.8% and 3.8% respectively. Out of the total respondents, 34.6% said AIDS orphans face a combination of problems listed in the table except physical abuse and difficulty in adapting to the new living arrangement. On the other hand, 15.4% said it is a combination of lack of support, inadequate basic necessities, psychological and emotional problems, difficulty in adapting to the new living arrangement and lack of proper health care and education.

As shown in the above four tables (Tables 13,14, 15,16 &17), respondents from both AIDS orphans and care givers revealed the major problems AIDS orphans faced at home, in the community, to get health care service and to get proper education. As observed in the study, not all respondents faced problems in every aspect. For example, some who did not face problems at home, experienced some kinds of problems either at school, in the community or in health care services and vice versa. Hence, as shown in the following table, all respondents were able to identify major causes of the problems.

Table 18. Major causes for problems faced by AIDS Orphans

Major causes	**Frequency**	**Percent**
1.lack of income	35	15.4
2.lack of parental love and guidance	7	3.1
3.society's inadequate KAP	24	10.5
4.responsibility of taking care of the house and younger siblings	15	6.6
5.grief , loneliness& insecurity	8	3.5
6.lack of support from care givers	13	5.7
7.lack of income, parental love & guidance and society's inadequate KAP	24	10.5
8.lack of income, parental love & guidance and support from care givers.	25	11
9.lack of income, society's inadequate KAP and lack of support from care givers.	22	9.6
10. lack of income, parental love & guidance, feeling of grief, loneliness, insecurity and lack of support from care givers	14	6.1
11.lack of income, society's inadequate KAP and responsibility of taking care of the house and younger siblings	19	8.3
12.lack of parental love & guidance, society's inadequate KAP and lack of support from care givers	18	7.9
13.any combination	4	1.8
14.Total	228	100.0

Source: survey data

As per Table 18, lack of income, society's inadequate KAP and lack of support from care givers were stated as major causes of the problems by 15.4%, 10.5% and 5.7 % respectively. Grief, loneliness and feeling of insecurity (3.5%), responsibility to take care of the house and younger siblings (4.8%) and lack of parental love and guidance were also identified. In addition, 10.5% gave equal weight to lack of parental love and guidance, lack of income and society's inadequate KAP. Another 9.6% stated that lack of support from care givers, lack of income and society's equally contributed to the problems mentioned above. Furthermore, 8.3% stated responsibility of taking care of the house and younger siblings, in addition to lack of income and society's inadequate KAP. A related question was asked as to how they could assess the knowledge, attitude and practice of society towards HIV/AIDS. Out of the total respondents, 39.9 % believed that the society did not have adequate knowledge, attitude and practice of HIV/AIDS. On the other hand, 16.7% and 38.6% believed that the society had very adequate and adequate KAP respectively. The rest 4.8% believed that the society has adequate knowledge about HIV/AIDS, its transmission and impacts but there has not been a behavioral change.

In relation, care givers assessment about KAP of society was one of the factors considered in this study. While 44.2 % and 9.6% said adequate and very adequate respectively, 42.3% said not adequate. The rest 3.8% said the society had adequate knowledge and attitude; there has not been a behavioral change.

The above responses regarding the KAP of society were confirmed by FGD and key informant interview participants. They have categorized society members into three types. The first type of society members were those who did not have any knowledge and who were far from any kind of media or HIV/AIDS education. The second type was those who have had some kind of education about HIV/AIDS but did not understood properly. The third type was those who have had adequate education regarding HIV/AIDS, but did not bring any kind of behavioral change.

In addition, care givers were also asked to explain the major causes of the above mentioned problems and among those who were able to single out one major cause, as indicated in Table 14, 5.8% said sudden change of living arrangement while lack of income, misconception and lack of parental love, grief and loneliness were mentioned by equal percent of participants (3.8% each). Also, those who indicated lack of clear understanding of psychological needs of AIDS

orphans, lack of support from friends, relatives and community and inadequate attention given to the problem by GOs/NGOs ,CBOs etc, had equal distribution out of the total respondents i.e.1.9% each. Furthermore, for 7.7% indicated all of the mentioned problems had equal weight of significance.

As mentioned by Key informants and FGD participants and as also confirmed by studies of Basaza and Kaija (2002) and Prtichard (2002), problems AIDS orphans were facing could force them to go out on the streets or engaged in deviant behaviours and acts .With this regard, respondents were asked if AIDS orphans were more likely to be engaged in street life and deviant acts. They indicated that as a result of the reduced family income, inadequate care and support, children became unable even to secure their daily needs including food and shelter. This forced them to be engaged in unhealthy coping mechanisms such as beggary, prostitution, theft etc. From the study it was found out that 92.1% of the respondents from AIDS orphans believed that AIDS orphans were more likely to go out on the streets and to be engaged in deviant acts and behaviors. On the other hand, 1.3% said they do not believe that AIDS orphans are more likely to be on the streets and engaged in deviant acts and behaviors and 6.6% said they did not know.

A similar question was forwarded to care givers and out of the total respondents 86.5% answered AIDS orphans were more likely to be forced to be engaged in street life and deviant acts and behaviors while 7.7% and 5.8% answered no and do not know respectively.

A related question was asked as to in what kind of street life and deviant acts AIDS orphans were more likely to be engaged (as illustrated in Table.19), 40.4% replied that AIDS Orphans are more likely to live and work (including heavy labor work) in the streets for survival, 2.6% said they are likely to be engaged in deviant acts such as prostitution and crime and 1.3% indicated smoking, drinking and do drugs..

Table 19. Kind of street life and deviant acts

Kind of street life and deviant acts	Frequency	Percent
1.live and work on the streets(including heavy labor work)	92	40.4
2.deviant acts such as prostitution, crime	6	2.6
3.smoking, drinking and do drugs	3	1.3
4. all kinds	69	30.3
5. live & work on the street &smoking, drinking	40	17.5
6.do not know/ answered no	18	7.9
Total	228	100.0

Source: survey data

The table further illustrates that from the combination of responses given 30.3% said AIDS orphans are more likely to live and work on the streets, engaged in prostitution, crime, smoke cigarettes, drink alcohols and do drugs. For the rest 17.5%, they are likely to be engaged in others except prostitution and crime.

Care givers also indicated the kind of street life and, deviant acts and behaviors they were likely to be engaged in. Out of the total respondents, 25% said AIDS orphans were more likely to work and live on the streets while 7.7% said they were likely to be engaged in deviant behaviors and acts such as smoking, drinking alcohol and do drugs and 5.8% indicated prostitution and crime. On the other hand, 25% said they were likely to be engaged in all and 19.2 % indicated that they are likely to be engaged in smoking, drinking, working and living on the streets. The rest 19.2% answered no or do not know. Respondents were also asked to identify the major causes for AIDS orphans to be on the street (see table 20)

Table 20. Major causes for AIDS orphans to be on the streets, engaged in deviant acts and behaviors

Major causes	**Frequency**	**Percent**
1.loss of hope	21	9.2
2.lack of proper care and support from care givers	13	5.7
3.Discrimination and stigmatization	21	9.2
4.lack of basic necessitates	29	12.7
5.lack of parental love and guidance	10	4.4
6.feeling of freedom and independence	3	1.3
7.bad manner	2	.9
8. loss of hope, discrimination, stigmatization, lack of basic needs , parental love and guidance	37	16.2
9. lack of basic needs, lack of parental love & guidance, feeling of freedom and independence and bad manner	11	4.8
10. loss of hope, discrimination and stigmatization, lack of proper care and support, basic necessities, parental love and care	31	13.6
11.lack of basic necessities and parental love and guidance	27	11.8
12.loss of hope and lack of proper care by care givers	2	.9
13.Feeling of freedom and independence and bad manner	3	1.3
14.Do not know	18	7.9
Total	228	100.0

Source: survey data

Table 20 reveals that, as indicated by 16.2%, the major factors that force AIDS orphans to be engaged in the street life and in deviant acts and behaviors as loss of hope, discrimination, and stigmatization, lack of basic needs, parental love and guidance. In addition 13.6% indicated lack of proper care support from care givers in addition to the above mentioned factors. Among those who were able to single out one major problem , 12.7% indicated lack of basic necessities, while 9.2% said it is loss of hope and another 9.2% indicated discrimination. On the other hand, others indicated two or more factors as equally contributing to the problem. (Please consult the table). As also indicated by participants of the FGDs and key informant interviews, the feeling of insecurity and hopelessness due to lack of parental love and support from care givers often force AIDS orphans to run away from home and join the street life. The result of the study regarding the above mentioned issue was also confirmed by other researchers such as Pritchard (2002), Basaza and Kaija (2002).

The care givers reply with regard to the major causes was, out of the total population, 28.8% said that it is a combination of loss of hope, lack of basic necessitates discrimination and

stigmatization followed by 15.4% who indicated lack of parental love and guidance, discrimination and stigmatization. Furthermore, while 13.5% indicated lack of basic necessities, 11.5% indicated lack of proper care and support from care givers and 7.7% said bad manner as well as feeling of freedom and independence. In addition, 3.8% indicated lack of parental love, guidance, proper care and support from care givers while the rest 19.2% answered no or do not know.

The other factor which was considered in the study was the relationship of AIDS orphans with their age mates whose parents were alive. Table 21 below shows the percentage of replies of the respondents to the question.

Table21. Relationship of AIDS Orphans with other age mates

Can AIDS Orphans have normal relationship	**Frequency**	**Percent**
1.yes	60	26.3
2.no	168	73.7
3.Total	228	100.0

Source: survey data

As indicated in the table above, while 73.7 % answered no to the question, the rest 26.3% answered yes. From the study it was also possible to identify the major factors responsible for AIDS orphans not having a normal relationship with their age mates. In this regard, 27.7 % stated the fact that parents not allowing their children to play or be friends with AIDS orphans as a major factor. For the other 20.2 %, the major factors were both parents not allowing their children and the children themselves discriminating AIDS orphans. This finding indicated, as also confirmed by Save the Children/Sweden (2003), that these children were denied of their right to non-discrimination (Article 2) and to leisure (Article 31) of the UN convention of child right and On the other hand, 4.8% indicated the reason as AIDS Orphans discriminating themselves because they feel inferior.

In like manner, responses from care givers indicated that 76.9% believed that AIDS orphans did not have a normal relationship with age mates while 23.1% said they had normal relationship. As

to the reasons, 42.3% indicated parents not allowing their children and 34.6% said children with parents discriminating AIDS orphans.

The relationship AIDS orphans would have with their neighbors and relatives was also investigated. Accordingly, among respondents from AIDS orphans , those who said they did not have a good relationship comprised of 55.7% while those who had a good or medium relationship are 28.9% and 14.5% respectively of the total respondents. The rest said they did not have any kind of relationship. In relation, 46.2% of care givers said they had a medium relationship while good and not good were mentioned by equal percent of respondents (23.1% each).The rest 7.7% said they did not have any kind of relationship.

3.6 SOCIO-CULTRUAL VALUES , NORMS, ATTITUDES AND RELATIONSHIPS AGGRAVATING THE PROBLEMS

According to other studies such as Williamson (2000), UNESCO (2002) and Nyblade (2003), as mentioned in the Literature Review part, socio-cultural values and norms can influence the knowledge, attitude, believes, practices and patterns of caring for AIDS orphans. While some cultural values might be positive, respondents raised a number of social and cultural practices that contribute to the various problems faced by AIDS orphans In this regard, a total of 81.6% respondents from AIDS orphans identified socio-cultural norms and values that aggravated the problems, while 16.2% replied that socio-cultural values have no contribution and the rest 2.2% replied they do not know.

From the study, it was observed that 17.5% of the respondents identified the socio- cultural values that emphasizes on giving emotional as well as financial support after the death of a person rather than while the person is alive .(see Table 22) The respondents stressed that the support is neither long term nor adequate. They also mentioned that the socio-cultural practices after the death of a person such as expensive funeral expenses most of the time leave the orphaned children bankrupt because they had to use all the family saving or borrow from others to pay for the ceremonies. This point was illustrated by one 15 years old boy as:

> "*Both my father and father were very hard working people who managed to save some money for our proper provision of education and health care. First, my mother got sick and died followed by my father after one year leaving me and my three younger sisters without anyone to look after us. At the time they had a saving of 6,000 Birr which at least would have been enough for us to maintain our basic necessities until we were able to get support from the government or other bodies. However, my aunts, uncles and other close relatives said the money should be paid to the expensive funeral service and to the grave stone of both my parents. I knew my relatives would not be there for us after the whole ceremony would be over. Therefore, I was against the idea of using the money for the funeral expenses. However, I had no part in the decision making and we were left to go out on the streets for survival until an NGO started supporting us"*

In addition to the above mentioned socio-cultural factors aggravating the problems, 11.4% said that misconception about HIV/AIDS and its transmission was a major socio-cultural factor that contributed to the problems. Besides, 5.3%, 4.4%, 3.5% and 3.1% stated socio-cultural values that did not encourage free discussion of the disease, not giving enough attention to the problem, mass-media's exaggeration about the disease and considering AIDS patients as sinners respectively. They further explained that some people believe that there should be no free discussion about the disease because it is against religious and social beliefs. Also, people did not give enough attention to the problem because they already were overwhelmed by other problems such as poverty. When they further explained mass-media's exaggeration , the message people got from the media was that once a person is infected with HIV/AIDS , he /she is hopeless. However, they all agreed that there has been a slight improvement on the media's approach. In addition to the above mentioned values and norms, others such as considering AIDS as a curse from God , believing AIDS can only be cured and treated only by holy water were indicated by a total of 3.5% of the respondents. On the other hand , some norms of CBOs , mainly Edir's, like canceling membership of the house hold after both parents died and discontinuing any support that were given were indicated as exacerbating the problems.

In relation, care givers were also asked to identify the major socio-cultural values and norms that aggravated the problems AIDS orphans as well as care givers faced. Accordingly, 32.7% indicated cultural values that emphasizes on support after the death of a person followed by 15.4% who said socio-cultural values that do not encourage free discussion of the disease among family members. Furthermore, 13.5% and 11.5% of respondents pointed out lack of support from

Edirs after the death of parents and considering AIDS patients as sinners, respectively. They further explained that some members of society consider AIDS patients as cursed by GOD and after their death this negative outlook continue towards their children. Moreover, while 7.7% indicated misconception about the disease and its transmission , another 7.7% said it was a combination of misconception about the disease, considering AIDS as a curse of GOD and AIDS patients as sinners and emphasizes on support after the a person rather than while he/ she was alive and in need of help. The rest of the respondents said socio-cultural values and norms have no contribution.

Table 22. Socio-cultural values and norms

Socio-cultural values and norms	**AIDS orphans**		**Care givers**	
	Frequency	**Percent**	**Frequency**	**Percent**
1.misconception	26	11.4	4	7.7
2.AIDS patients as sinners	7	3.1	6	11.5
3.Emphasizes on support after the death of parents	40	17.5	17	32.7
4.Edirs do not support	2	.9	7	13.5
5.not giving enough attention to the problem	10	4.4	-	-
6.mass media's exaggeration	8	3.5	-	-
7.AIDS as a curse from GOD	5	2.2	2	3.8
8.AIDS can be cured and treated only by holy water	3	1.3	-	-
9.no free discussion	12	5.3	8	15.4
10. misconception, AIDS patients as sinners not giving enough attention and mass media's exaggeration	5	2.2	-	-
11. misconception, AIDS as a curse and patients as sinners Emphasizes on support after the death of parents,	19	8.3	4	7.7
12.misconception,AIDS as a curse and patients as sinners and AIDS can be cured and treated only by holy water	8	3.5	-	-
13. misconception, emphasizes on support after the death of parents, Edirs do not support and no free discussion	7	3.1	-	-
14. misconception, AIDS patients as sinners and emphasizes on support after the death of parents	9	3.9	-	-
15. AIDS patients as sinners, emphasizes on support after the death of parents and mass media's exaggeration	8	3.5	-	-
16. misconception, AIDS as a curse and patients as sinners, mass media's exaggeration	6	2.6	-	-
17. misconception, not giving enough attention to the problem, AIDS as a curse and it can be cured only by holy water	3	1.3	-	-
18.any combination of 1-9	8	3.5	-	-
19.Socio-cultural values have no contribution	37	16.2	4	7.7
20.do not know	5	2.2	-	-
Total	228	100.0	-	-

Source: survey data

Finally, AIDS orphans were asked to explain what they missed most because of death of their parents. Accordingly, 31.6 % said that they missed parental love and care most followed by a combination of parental love& care, good relationship with relatives and friends, proper access to basic services and feeling of security and peace of mind. On the other side of the spectrum, there were some (4.4 %) who said that they missed nothing because of the death their parents.

CHAPTER FOUR

4. CONCLUSION AND RECOMMENDATION

4.1 CONCLUSION

The major findings of this study indicated that HIV/AIDS is not a health problem alone rather it is a complex medical, socio-cultural, economic, political, and human rights problem. Considering this, the study takes a closer look at the challenges faced by AIDS orphans and their care givers. As a result the study identified that AIDS orphans lack of basic necessities, proper health care and education, psychological and emotional support. In addition, lack of support from Care givers as well as community members, discrimination and stigmatization were among the prominent problems.

The other major emphasis of the study was the social capital dimensions of the HIV/AIDS impact on AIDS orphans. In this regard, major socio-cultural issues that aggravated the problems and inhibited AIDS orphans from proper access to social services were identified. It was also found out that the socio- cultural issues identified could be among the major factors that can make a difference in the spread or alleviation of HIV/AIDS related problems. Since HIV/AIDS-related socio-cultural issues differ from society to society they need to be addressed within their specific socio-cultural context. In this regard, this study has provided an important insight of some of social capital aspects, socio-cultural values and norms in particular, that have an impact on the social, economic and psychological development of AIDS orphans in the study.

The study also showed that the majority of AIDS orphans lost both their parents and a significant number of them were taken care either by the elderly or the very young who have had very limited economic and physical ability to assume their responsibility properly. In relation, it was indicated that a significant number of orphans were engaged in various income generating activities to meet their households' financial obligations. This as a result had an adverse physical and psychological effect. It was also indicated, in this regard and others, female orphans were more vulnerable than their counterparts.

In addition, the study indicated that high poverty levels observed among the study population seem to work against efforts made to support orphans. As such, the care givers' action of taking up AIDS orphans is not matched with their ability to meet the needs of the orphans. Furthermore, AIDS orphans and their care givers to a large extent, depend on subsistence income with little or no external support. It was also observed that NGOs and CBOs that provided support to AIDS were not able to sufficiently care for the alarmingly increasing number of AIDS orphans.

Also, one can conclude that the rapidly growing group of children without adequate access to basic necessities, health services, proper education has a negative consequences by posing a serious threat to having economically and socially active future generation Additionally, the study pointed out that the economic, social psychological and emotional problems due to lack of the necessary parental love and care through crucial life-stages are likely to force AIDS orphans to join the street life and be engaged in deviant acts and behaviors. As a result, this can pose a challenge on AIDS orphans ability to constructively participate in social and economic life as adults

The results presented in this paper indicated that while the problem of AIDS orphans is one of the major factors that determine the long-term social stability of the country, adequate attention has not been given by the government and other concerned bodies. Hence, if an urgent attempt is not made, there will be a long term consequence including juvenile crime, reduced literacy, and increased economic burden on the society.

4.2 RECOMMENDATION

In view of the findings and the conclusion of the study, the following recommendations are suggested as a way forward in the effort of providing better future for AIDS orphans.

1. Any attempts of alleviating the problem of AIDS orphans by concerned actors including government institutions, non-government and community based organizations, international institutions, religious institutions and individuals should embody socio- cultural aspects for they are one of the major factors that help to achieve the desired goal. Prior to development of policies, programmes or projects, the actors should have a better understanding of the existing social capital in the community.

2. Intensive education and awareness creation programmes on HIV/AIDS and AIDS orphans should be provided to members of society by the government in collaboration with other concerned bodies so as to bring about the development of positive attitude towards the victims of the disease. In addition, incorporating influential people such as traditional and religious leaders, community leaders and elders would bring about the needed success.

3. Since families are the ' building blocks' of social capital and they play the major role for the development of children's capacity to form social relationships and networks, they should be encouraged to lead the children in the proper direction. In this regard, religious institutions, schools, community based organizations and other concerned bodies should promote this process by providing education to parents as well as care givers regarding proper parenting skill.

4. The economic capacity of care givers should be strengthened through provision of education, skill training, sponsorship and credit and saving scheme to promote their own economy and thereby provide better care and support for AIDS orphans. This should be done by a collaborated effort of the government, non- government and community based organizations, individuals and other concerned bodies.

5. Adequate access to basic necessities, education, health care and other social services should

be provided to AIDS orphans by the government, non- government and community based organizations, individuals and other concerned bodies in order to ensure a bright future for them and to help them become economically and socially active adults.

6. Finally, all efforts of various actors such as GOs, NGOs, CBOs and individuals should be collaborated in order to avoid redundancy and to properly provide support.

APPENDICES

ANNEX 1. SAMPLE SIZE BY SEX

Respondents	Sex		Total
	Female	Male	
AIDS orphans	127	101	228
Care givers	41	11	52
Focus group discussion with AIDS orphans	5	3	8
Focus group discussion with AIDS orphans, Care givers representatives from NGOs and CBOs	6	4	10
Key informants from NGOs, CBOs and government organizations	3	11	14
Total	182	130	312

ANNEX 2 Key Informant Information

S.no	Organization	Position	Level of education
1	Hanna Orphans Home	Director	Diploma
2	Down of Hope	Care and Support coordinator	B.A Degree
3.	Hope for Children	Head: Social support department	B.A Degree
4	OSSA	Assistant Coordinator	Diploma
5	Mekdim Ethiopia National Association	Social Worker	Diploma
6.	MMM	Programme Coordinator	B.A Degree
7	Tesfa Berehan Ethiopia	Social Worker	B.A Degree
8.	People to People	Director	B.A Degree
9	Mary Joy	Health Supervisor	Diploma
10	Emmanuel Self Help Fellowship(Edir)	Executive Coordinator	B.A Degree
11	Kebele 02 Edirs Anti-AIDS and Development Council	Care and Support Coordinator	High School Certificate
12	Ministry of Labor and Social Affaris	Social Worker	B.A Degree
13	Ministry of Education	Extra Curricula coordinator	B.Sc Degree
14	AAHAPCO	Expert	B.A Degree

ANNEX 3. QUESTIONS AND DISCUSSION GUIDES

A. Questions for AIDS orphans:

Date of Interview_____

Time of Interview : started at _____ and ended at_____

Background information

1. Age
2. Sex (Female =1 , male= 2)
3. Literacy level (literate =1, Illiterate 2
4. Level of Education (No formal education = 1, 1-8 = 2, 9-12=3, 12+ = 4)
5. Who is your care giver? (self=1 , sister = 2, brother = 3, grandmother= 4, Grandfather = 5, close relatives= 6, neighbors =7 , others(specify) = 8)
6. What is the size, age structure and gender composition of family members in the Household.

Age	**Sex**		**Total**
	Male	Female	
Below 18			
18-45			
46- 70			
Above 70			
Total			

7. How many AIDS orphans live with you including your self

Age	**Sex**		**Total**
	Male	Female	
0-10			
11-14			
15-18			
Total			

8. Housing condition(privately owned = 1, rented from private owner = 2, rented from kebele= 3, other(specify)= 4)

Questions regarding the problem

9. who was deceased? (Mother = 1, father= 2, both= 3)
10. what are the major problems you are facing at present?
11. what do you think causes the problems?
12. what was your main source and amount of income before the death of your parent/s?
13. what is your main source and amount of income after the death of your parent/s? /How are you managing to survive after the death of your parent/s?
14. What are the major problems you are facing in accessing proper social services such as education, health care and shelter?
15. What are the major problems you are facing because you are AIDS orphans when you go to school, health care and/or and other social service giving centers?
16. Do you think there are any socio- cultural norms / beliefs that are aggravating the problems? Please identify
17. How do you explain your relationship with neighbors? Friends? Relatives? (good= 1, Medium = 2, not good = 3 , other (please specify) = 4)
18. How do you see the general Knowledge, attitude and perception of your community towards HIV/AIDS as well as AIDS orphans? (very adequate = 1, adequate= 2, not adequate =3 , other (please specify) = 4)
19. what do you think you have missed a lot due to your parent/s loss?
20. what are the major types of care and support you are receiving from your care givers?

21. How do you assess the care and support you are receiving?(very adequate= 1, adequate= 2, barely adequate= 3, not adequate= 4)

22. Can you tell any differences in your living condition before and after your parent/s death?

23. What are the major types of care and support you are receiving from government, CBO and/ or NGOs(if any) ?

Government_____

CBOs_____

NGOs_____

Others_____

24. How do you assess the care and support you are receiving?(very adequate= 1, adequate= 2, barely adequate= 3, not adequate= 4

25 Do you think some of AIDS orphans are more likely to be engaged in street life and deviant acts and behaviors Can you tell me in what kind?

26. Can you tell me the causes?

27. Do you believe that AIDS orphans can have a normal relationship with their age mates with parents? If no why_____

28. What do you think should be done to make your and other AIDS orphans better?

29. Do you have any final comments?

B.Questions for Care givers

Date of Interview_____

Time of Interview : started at _____ and ended at_____

Background information

1. Age
2. Sex (Female =1 , male= 2)
3. Literacy level (Literate = 1, Illiterate= 2)
4. Level of Education (No formal education = 1, 1-8 = 2, 9-12=3, 12+ = 4)

5. Source of income(if any)_____

6. Type of occupation(if any)_____

7. What is the size, age structure and gender composition of family members in the Household.

Age	**Sex**		**Total**
	Male	Female	
Below 18			
18-45			
46- 70			
Above 70			
Total			

8. How many AIDS orphans are living under your care ?

Age	**Sex**		**Total**
	Male	Female	
0-10			
11-14			
15-18			
Total			

9. Housing condition(privately owned = 1, rented from private owner = 2, rented from kebele= 3, other(specify)= 4)

10. Who is the head of the house hold(self = 1, spouse=2 other(specify) =3

Questions regarding the problem

11. who was diseased? (Mother = 1, father= 2, both parents= 3, sister=4, brother=5, son=6, daughter=7, close relative=8, friend=9, neighbor= 10, other(specify)=11)

12. What are the major types of care and support you are providing ?

13. Can you tell me how you manage to provide care and support for AIDS orphans?

14. what are the major problems you are facing in providing care and support for orphans?

15. what do you think are causes of the problem/s?

16. What are the major types of care and support you are receiving from government, CBO and/ or NGOs(if any) ?

Government_____

CBOs_____

NGOs_____

Others_____

17. How do you assess the care and support you are receiving?(very adequate= 1, adequate= 2, barely adequate= 3, not adequate= 4

18. what do you think are the major problems AIDS orphans are facing?

19. what do you think are causes of the problem/s?

20. Do you think some of AIDS orphans are more likely to be engaged in deviant acts and behaviors? Can you tell me in what kind?

21.Why do you think are some orphans forced to live on the street or fall outside the extended family safety net?

22. How do you explain your relationship with neighbors? Friends? Relatives? (good= 1, Medium = 2, not good = 3 , other (please specify) = 4)

23. How do you explain the relationship of AIDS orphans with neighbors? Friends? Relatives? (good= 1, Medium = 2, not good = 3 , other (please specify) = 4)

24. Can you tell me the general knowledge attitude and perception of your community towards HIV/AIDS and AIDS orphans? (very adequate = 1, adequate= 2, not adequate =3 , other (please specify) = 4)

25. What do you think are the major problems AIDS orphans are facing in accessing proper education ,health care service and shelter?

26. What do you think are the major problems they are facing because they are AIDS orphans when they go to school, health care and/or and other social service giving centers?

27. Do you think there are socio-cultural norms / beliefs that are aggravating the problems? Please identify and explain.

28. What do you think should be done to make your and AIDS orphans' life better in the future?

29. Do you have any final comments?

C. Questions for Key informants from NGOs and CBOs

Date of Interview_____

Time of Interview : started at _____ and ended at_____

Background information

1. Age _____
2. Sex _____
3. Level of Education _____
4. Position_____
5. Profession_____
6. Organization_____

Questions regarding the problem

7. When did your organization starts working with AIDS orphans?
8. What are the major objectives and strategies your organization is following to address the problem
9. What is the age and gender structure and status of orphans getting support from your organization?

Age	sex		Status of orphan			Total
	Male	Female	Lost mother	Lost father	Lost both	
0-10						
11- 14						
15-18						
Total						

10. What is the age and gender structure of care givers that are getting support from your organization.

Age	**Sex**		**Total**
	Male	Female	

Below 18			
18-45			
46- 70			
Above 70			
Total			

11.How does your organization identify the AIDS orphans/ care givers that need support?

12. What are the major problems you are facing in the identification process?

13. What are the major types of support you are providing?

14. What are the major problems you are facing in providing the support?

15. What are the strategies you are using to solve the problems?

16. How do you assess if AIDS orphans are properly benefiting form the support you are providing?

17. Who is the most vulnerable orphan to various kinds of problems?(Girls=1, Boys= 2) ☐

What are the reasons?_____

18. What is the knowledge, attitude and perception of the community towards HIV/AIDS and AIDS orphans?

19. What do you think are the general problems AIDS orphans are facing?

20. What do you think are the general problems care givers are facing?

21. How do you think they are coping with the problems?

22. What do you think are the major problems AIDS orphans are facing in accessing social services (schooling, health care, shelter etc)

23. In your opinion, are there socio- cultural norms / beliefs that are aggravating the problems? Please identify.

24. In your opinion, what is the extent of the problem of AIDS orphans and how is it affecting the social and economic development of the country?

27. In your opinion, what should the government, care givers, CBOs, NGOs, religious institutions, and other organizations do to allivate the problem?

- the Government _____
- Care givers_____
- CBOs_____
- NGOs_____

Others_____

26. Do you have any final comments?

D. Questions for Key informants from Government organizations

Date of Interview_____

Time of Interview : started at _____ and ended at_____

Background information

1. Age _____
2. Sex _____
3. Level of Education _____
4. Position_____
5. Profession_____
6. Organization_____

Questions regarding the problem

7. What are the major problems AIDS orphans are facing?
8. What do you think are the major problems care givers are facing?
9. How do you think AIDS orphans as well as care givers are coping with the problems?
10. Who is the most vulnerable orphan to various kinds of problems?(Girls=1, Boys= 2) ☐

What are the reasons?_____

11. In your opinion, what is the extent of the problem of AIDS orphans and how is it affecting the social and economic development of the country?
12. Can you tell me the general knowledge attitude and perception of your community towards people living with HIV/AIDS and AIDS orphans?
13. What do you think are the major problems AIDS orphans are facing in accessing social services(Schooling, Health care, shelter)

14.In your opinion, are there socio- cultural norms / beliefs that are aggravating the problems? Please identify

15. In your opinion, what should the government, care givers, CBOs, NGOs, religious institutions, and other organizations do to allivate the problem?

- the Government _____
- Care givers_____
- CBOs_____
- NGOs_____
- Religious institutions_____

Others_____

16. Do you have any final comments?

E. Focus group discussion guides for Participants selected from AIDS orphans and Care givers

1. What are the causes, modes of transmission and consequences of HIV/AIDS?
2. What are the major problems AIDS orphans and care givers are facing?
3. How are AIDS orphans and care givers managing to survive?
4. What is the knowledge attitude and perception of the community towards HIV/AIDS AIDS orphans?
5. What are there socio- cultural norms / beliefs that are aggravating the problems AIDS orphans are facing?
6. What is the extent of the problem of AIDS orphans and how is it affecting the social and economic development of the country?
7. What do you think are the major problems AIDS orphans are facing in accessing social services(Schooling, Health care, shelter)
8. what should the government, care givers, CBOs, NGOs, religious institutions, and other organizations do to alleviate the problem?
9. Any comment in addition to what have been discussed.

ANNEX 4 . List of NGOs and CBOs working with AIDS orphans

No	Name of Organization	Care and Support		
		PLWHA	Affected People	OVC
1	CHAD-Ethiopia	✓	-	✓
2	ISAPSO	✓	✓	✓
3	Propride	-	-	✓
4	A/K/K/K/Kebele 02 Idir	✓	-	✓
5	Tesfa Social &Dev't Association	✓	-	✓
6	Yezelalem Minch	✓	-	✓
7	CCF Kolf KK branch	✓	-	✓
8	People to People Ethiopia	✓	✓	✓
9	HAPSCO	✓	✓	✓
10	Hibreteseb Akef	✓	-	✓
11	Mama	✓	-	✓
12	Medhin social center	✓	-	✓
13	Mary Joy	✓	✓	✓
14	Tesfa Brihan Orphan Association	-	-	✓
15	Save life of Ethiopia	✓	-	✓
16	A.A RDF	✓	-	✓
17	ESHF	✓	-	✓
18	Amanuel Dev't Ass.	✓	-	✓
19	Aba/W/T/mother /Ch/Ass.	✓	-	✓
20	Free Methodist Mission	✓	✓	✓
21	Down of Hope	✓	✓	✓
22	Safe your generation	-	-	✓
23	Hanna Orphans Home	-	-	✓
24	Save your people-Ethiopia	-	-	✓
25	Marefiya-Ethiopia	✓	✓	✓
26	MMM	✓	✓	✓

27	Ewket-Gojo Association	✓	✓	✓
28	Hiwot –Ethiopia	✓	✓	✓
29	Sabah Muslim W/D/Assoc.	✓	-	✓
30	Yewedek Ansu	✓	-	✓
31	Hope for children	✓	✓	✓
32	Gulel K/K/Keb.14/H/A/Asso.	✓	✓	✓
33	Kidist sillassie.Me.Idir	✓	✓	✓
34	Save the young-Ethiopia	✓	-	✓
35	PCSA	✓	✓	✓
36	Mekidim-Ethopia	✓	-	✓
37	Abebech Gobena chi.village	✓	✓	✓
38	WESMICO	✓	-	✓
39	Love to human being Ethiopia	-	-	✓
40	Care-Ethiopia	✓	✓	✓
41	Eth. Anti-AIDS women assoc.	✓	-	✓
42	Lemlemitu -Eth	✓	-	✓
43	BICDO	✓	-	✓
44	Center for Africa Dev't	-	-	✓
45	Arat Kilo child care and com. Dev't	✓	✓	✓
46	CCF-Ediget & Arda branch	✓	-	✓
47	Tsinant Ethiopia association	-	-	✓
48	Bereket orphans center	-	-	✓
49	FCIDF	✓	✓	✓
50	A LLTAM	✓	✓	✓
51	Shalam children &youth sup. Organization	✓	-	✓
52	Every one	-	✓	✓
53	ADEY integrated Dev't Organization	✓	-	✓
54	Love for children Org.	✓	✓	✓
55	Progynist	✓	-	✓
56	Pro-poor	-	-	✓
57	CBISDO	✓	-	✓
58	World vision	✓	-	✓
59	Society of int.mission	✓	✓	✓
60	OSSA.A.A Branch	✓	-	✓
61	Down of hope A.A Branch	✓	-	✓
62	A/K/K/K nine kebele anti-AIDS committee	✓	✓	✓
63	Kolfe K/K All Kebeles anti-AIDS committee	✓	✓	✓
64	Yeka K/K All Kebeles anti-AIDS committee	✓	-	✓
65	N/L/K/K All Kebeles anti-AIDS committee	✓	-	✓
66	Akaki Kaliti K/K All Kebeles anti-AIDS committee	✓	-	✓

67	Bole K/K All Kebeles anti-AIDS committee	✓	✓	✓
68	Gulele K/K All Kebeles anti-AIDS committee	✓	-	✓
69	Kirkos K/K All Kebeles anti-AIDS committee	✓	✓	✓
70	Emmanuel Self Help Fellowship	✓	✓	✓

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