THE SOCIO-ECONOMIC SITUATION OF ORPHANS AND VULNERABLE CHILDREN IN DESSIE TOWN, ETHIOPIA

by

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DECLARATION

I declare that the work, *The socio-economic situation of orphans and vulnerable children in Dessie Town, Ethiopia,* is my own work and that it does not contain sections copied in whole or in part from any other source unless explicitly identified in quotation marks and with detailed, complete and accurate referencing. This work has not been submitted before for any other degree at any other institution of higher learning

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DEDICATION

This dissertation is dedicated to my loving wife Genet Girma and my children Yonatan Endris, Leul Endris and the new born baby Yared Endris.

SUMMARY

This study was a situation analysis of the socio-economic conditions of orphans and vulnerable children in Dessie Town. Specifically the study assessed the educational attainment, economic status, social isolation, adjustment, discrimination and psycho-social status of OVCs, the characteristics of the care-givers of OVCs and the support systems for OVCs. Therefore, 270 OVCs, 130 guardians and 4 OVCs service-providing organisations were selected as respondents. A survey research design was used. The study found that OVCs and their households faced problems such as school dropout, low educational performance; economic and food insecurity, lack of adequate clothing; social isolation and emotional hardships due to separation of siblings; discrimination, and neglect. Children's housing conditions, toilet facilities, and access to clean water and health facilities were poor. The majority of guardians were unemployed and unable to fulfil the needs of the OVCs in their care. It is recommended that support systems for OVCs be strengthened.

Key words: Orphans, vulnerable children, Dessie Town, Ethiopia, socio-economic appraisal

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARLSAB	Amhara Region Labour and Social Affairs Bureau
ANC	Antenatal Care
ARVs	Antiretrovirals
ART	Antiretroviral therapy
CBOs	Community-Based Organisations
CRC	Convention on the Right of the Child
EDHS	Ethiopian Demographic and Health Survey
EMOH	Ethiopian Ministry of Health
FBOs	Faith-Based Organisations
FDRE	Federal Democratic Republic of Ethiopia
FHI	Family Health International
GDP	Gross Domestic Product
GOs	Government Organisations
FHAPCO	Federal HIV/AIDS Prevention and Control Office
HAPCO	HIV/AIDS Prevention and Control Office
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPI	Human poverty index
HSRC:	Human Sciences Research Council
HTPs	Harmful traditional practices
ILO	International Labour Organisation
Km^2	Square Kilometre
LDC	Least Developed Countries
LSAB	Labour and Social Affairs Bureau
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
N	Number of cases

LIST OF ACRONYMS AND ABBREVIATIONS (Continued)

NGOs	Non-government Organisations
NHAPCO	National HIV/AIDS Prevention and Control
NMCF	Nelson Mandela Children's Fund
OVCs	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHIV	Person(s) living with HIV
PMTCT	Prevention of mother to child transmission
RAAAPR	Rapid Assessment Analysis Action Plan Report
SCUK	Save the Children United Kingdom
SNNPR	South Nations Nationalities and People's Region
SPSS	Statistical Package for Social Scientists
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
SWZA	South Wollo Zone Administration
TB	Tuberculosis
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

CHAPTER 1: SITUATING THE RESEARCH PROBLEM

1.1 INTRODUCTION

In this chapter information on the socio-economic situation of orphans and vulnerable children (OVCs) and the impact of HIV/AIDS on their lives is given as background to the research issue. The rationale for the study, the statement of the problem, the assumption and objectives are also stated. This chapter ends with definitions of key terms used in the study and a review of the chapters of the dissertation.

1.2 BACKGROUND TO THE STUDY

Ethiopia has been severely challenged and characterised by decades of conflict, food insecurity, widespread and abject poverty, and rapid population growth (UNICEF, UNAIDS & USAID 2004). It is one of the least developed in the world, with a gross domestic product (GDP) *per capita* in 2007 of US 245 dollars (UNDP 2009). Children in particular have been profoundly affected by such adverse circumstances and are the most vulnerable segment of Ethiopian society (Ethiopian Central Statistics Authority 2005). The severity of the problem becomes even more apparent when this is seen in the context of a youthful population profile in Ethiopia where children constituted more than 50% of the total population of the country in 2007 (Amhara Region Labour and Social Affairs Bureau 2008).

Large numbers of children in Ethiopia suffer from the ills of poverty and illiteracy. They are victims of several harmful traditional practices (HTPs) such as early marriage, female genital mutilation, physical punishment, labour exploitation, conflict, family separation, and are exposed to various physical and sexual abuses (Ethiopian Central Statistics Authority 1998). Children are trafficked, are orphaned due to AIDS-related mortality and infected with HIV. They are also

affected by high infant and child mortality rates; which are 77 and 50 per 1 000 live births respectively in the country (Ethiopian Central Statistics Authority 2005). Moreover, children in Ethiopia have less access to school than other children in developing countries (Ethiopian Central Statistics Authority 1998). The literacy level among the population aged 15 years and above was 35,9% with a deep gender gap as the male literacy rate was 50% whereas the female literacy rate was 22,8% for 2007.The adult illiteracy rate for people (aged 15 and above) for the same period was 64,1%. The primary school enrolment gross rate was 49%, (UNDP 2009) which is among the lowest in Sub-Saharan Africa. Lack of access to schooling mainly affects girl children (Alelign 2004). Currently though there is an improvement in educational provision, and particularly in the total primary school enrolment rate in Ethiopia, which increased from 64,4% in 2002/2003 to 79,2% in 2004/2005 and to 91,3% in 2005/2006 (WHO 2009). However, difficulties in terms of access to education and high rates of school dropout still prevail.

In general, children in Ethiopia also suffered from poor health due to inadequate access to clean water, sanitation facilities and nutrition (Ethiopian Central Statistics Authority 2005). For every 1 000 children born in Ethiopia, 77 die before they reach their first year (one in every twenty three children) and 123 (one in every eight children) before they turn five years of age (Ethiopian Central Statistics Authority 2005). The nutritional state of children shows that 2% of children are severely wasted[1], 11% of children are wasted, eleven per cent of children under five are severely under-weight, 47% of children are under-weight, 24% are severely stunted and 47% are stunted[2] (Ethiopian Central Statistics Authority 2005).

According to research by the Ethiopian Central Statistics Authority (2005) and Alelign (2004), most children in Ethiopia were engaged in various productive and

[1] Wasting means that the individual's weight is below minus two standard deviations from median weight for height of reference population (UNICEF 2008:121)

[2] Stunted means that the individual's height is below minus two standard deviations from median height for age of reference population (UNICEF 2008:121)

household chores and activities which are characterised by poor occupational safety, long working hours, very low wages, and a work environment which is hazardous to their health. For example, a survey by the Ethiopian Central Statistics Authority (cited in Alelign 2004:3) about child labour in Ethiopia revealed that 85% of children are engaged in household chores and related activities. In the rural areas, 89% of children are engaged in agriculture and related activities. The Ethiopian Labour Law (quoted in Alelign 2004) prohibits children below the age of 14 years to be engaged as employed workers but the practice is different from what is stated in the law. Children are commonly involved in domestic chores, and assist in the agricultural sector by tending to domestic animals, weeding crops and harvesting. In urban areas, children are often forced into labour due to the economic circumstances of their parents or guardians. Among the working children, 66% joined the labour force to assist in their family business and 24% to supplement family income (Ethiopian Central Statistics Authority 2005). The proportion of children working to assist themselves was 29%. Furthermore; about 68% children contribute to their family income and among this group, 42% are responsible for the entire family income and 26% partly contribute to the family income.

UNAIDS (2004) indicates that, although most data on HIV/AIDS are based on projections from limited samples, which may be revised in the light of more detailed studies, the data nonetheless reveal disturbing trends in which Africa (and Ethiopia in particular) is clearly shouldering the burden of the consequences of HIV/AIDS morbidity and mortality. Since the beginning of the pandemic some 20 million people are estimated to have died from AIDS. In 2003 alone three quarters of the estimated 2,2 million AIDS deaths were in Africa (Tesfye, Pankhurst & Gebre 2005). According to UNAIDS (2004) the estimates of potential deaths in Africa by 2025 vary between 53 and 66 million depending on diverse intervention scenarios (Cited in Tesfye *et al* 2005).

According to Kidman, Petrow and Heymann (2007) there are 12 million orphans in sub-Saharan Africa as a direct consequence of the HIV/AIDS pandemic. As orphans have traditionally been absorbed by their extended family networks, many households are struggling to meet the needs of the orphans in their care (Kidman *et al* 2007). The loss of parents has far-reaching and lasting consequences, because orphans are more likely to suffer from:

- malnutrition (UNICEF 2002)
- poor physical health (Kamali, Seeley, Nunn, Kengeya-Kayondo, Ruberantwari & Mulder 1996)
- poor mental health (Foster & Williamson 2000)
- educational disadvantages (UNICEF 2002)
- exploitation for child labour (UNICEF 2002) and
- stigma and social exclusion (Gilborn 2002; Kidman *et al* 2007; UNICEF 2004).

Furthermore, orphans' needs are often unmet as a result of a lack of available care-givers in many communities and many orphans live on their own, or are cared for in child-headed households or by grandparents, who, because of their own health problems, are unable to provide adequate care and support.

The magnitude of the HIV/AIDS pandemic in Ethiopia is only recently becoming all too apparent. In Ethiopia; 1.22 million people are living with HIV, of which 79 871 are children under the age of 15 years in 2010 (FHAPCO 2007). In general, Ethiopia has the third largest number of people living with the HI-virus globally next to South Africa and Nigeria (Radeny & Bunkers 2009). The pandemic started from a low base in the 1980s and spread rapidly in 1990s to reach the current level of 2,1% prevalence rate at national level with 7,7% in urban and 0,9% in rural areas in 2010 (FHAPCO 2007).

Next to Nigeria, Ethiopia is home to the second largest population of children orphaned by AIDS in Sub-Saharan African (Tekle 2007:3). In Ethiopia in 2010, there were 5,4 million children under the age of 17 years who are estimated to be

orphans for different reasons of which, 804 184 children are AIDS orphans (FHAPCO 2007). The total number of AIDS orphans in Ethiopia is projected to increase until 2010; although the rate of increase is expected to lessen due to the impact of the planned antiretroviral therapy (ART) services (Ethiopian Government, Federal Ministry of Health/National HIV/AIDS Prevention Control Office 2007).

According to studies conducted by Tesfye *et al* (2005) and, Abebe and Aase (2007), the number of children who are orphaned in Ethiopia is increasing at an alarming rate and most of this increase is explained by AIDS-related adult mortality. As mentioned by Abebe and Aase (2007:2058): *"The impact of the HIV/AIDS epidemic in creating a burden of care of orphans for the traditional family structure is well documented in a handful of culture-specific studies."* However, having to deal with large numbers of orphans is not a new phenomenon. UNICEF (cited in Abebe & Aase 2007:2058) reports that *"there are ca.5 million orphans—defined as children under 18 years of age in Ethiopia who have lost one or both parents—of which 1.5 million (30%) are due to the HIV/AIDS epidemic"*. The remaining 70% of orphans are non-AIDS orphans, often classified as 'famine orphans,' 'war orphans, 'malaria orphans,' and 'social orphans,' or children who have been abandoned mainly due to poverty (Abebe & Aase 2007:2059). According to a recent study by Save the Children UK (2009), within Ethiopia 5,5 million children, around 6% of the total population and 12% of the child population, are categorized as orphans or vulnerable children (OVC); of which over 83% of OVCs are living in rural settings and, of these, 855 720 are children orphaned as a result of the death of one or both parents due to HIV/AIDS (Save the Children UK 2009).

Skinner *et al* (cited in Simbayi *et al* 2006) indicate that in addition to the increasing rates of children who are orphaned, HIV/AIDS also contributes to other forms of vulnerability among children who are affected. Some children become vulnerable by living in households where one or both parents are sick; others become

vulnerable because care-givers are too sick to provide care; and others end up leaving school to take care of their sick parents. The Rapid Assessment Analysis Action Plan Report (RAAAPR) of the national situational analysis of OVCs in Ethiopia (The Policy Project 2005) indicates the vulnerability of these orphans as demonstrated by the data on households. It showed that 42% of OVCs were living in female-headed households and that the school attendance rate for those 10 to 14 years of age was only 34% for single orphans and 26% for double orphans, whereas the rate for non-orphans was 43%. Nationally representative data on other aspects of the well-being of orphans has not been studied, but a national situation analysis revealed that significant proportions of orphans were facing shortages in daily meals, clothing, school uniforms and supplies, and were also experiencing elevated school drop-out rates, morbidity as well as abuse and neglect. The conditions of children orphaned by HIV/AIDS are worse since they are more likely to experience various psycho-social problems and are less likely to be adopted by other members of the community (UNICEF 2002).

Compared to other children, the psycho-social and socio-economic situations of OVCs are more likely to be multifaceted and worse in Ethiopia. In this respect, studies conducted by the Ministry of Labour and Social Affairs (Ethiopian Government, MOLSA 2003 & 2004) indicate that OVCs in Ethiopia face severe social, economic, legal and psychological problems. They have poor nutrition, poor health status, lack educational opportunities and are likely to drop out of school, lack love, care and attention, experience stigma, discrimination, exploitation and abuse, lack emotional support to deal with grief and trauma, experience long-term psychological problems, take illegal drugs and other substances and become involved in crime and are vulnerable to HIV- infection (Ethiopian Government, MOLSA 2004).

Dessie Town, as the capital city of South Wollo, is an administrative zone in the Amhara region which is highly affected by the HIV/AIDS pandemic. According to the Ethiopian Government, for 2010, the prevalence of HIV/AIDS in Amhara

Region was 2,9% and the number of OVCs in the Amhara region was estimated to be 1,53 million, of which 318 220 are AIDS orphans (Ethiopian Government, FHAPCO 2007). On the other hand, in the South Wollo Zone the estimated number of orphans from all causes and the total number of AIDS orphans for 2005 were 293 169 and 39 552 respectively (Amhara Region Labour and Social Affairs Bureau 2007). The Dessie Town District Information's census survey in 2007, estimated the number of orphans at 4 422 (Amhara Region Labour and Social Affairs Bureau 2007).

To address the multifaceted socio-economic problems faced by OVCs, a strengthening of support offered by government organisations (GOs), non-government organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), international organisations and the private sector is needed. However, to make suggestions in this regard, it is first necessary to explore, describe and document the socio-economic situation of orphans and vulnerable children of Dessie Town – thus the need for this study.

1.3 STATEMENT OF THE PROBLEM

Although HIV/AIDS has spread almost into every part of the world, no other region has been as severely affected as Sub-Saharan Africa, including Ethiopia, which houses three quarter (22,5 million) of the world's population living with HIV (Shewanmoltot 2010; Nyambedha, Wandibba & Aagaard-Hansen 2003). By 2010, the number of children orphaned by HIV/AIDS is projected to exceed 25 million, and the number of other vulnerable children will greatly surpass that number (UNAIDS, UNICEF & USAID 2004). As one of Sub-Saharan countries, Ethiopia is hard hit by the HIV/AIDS pandemic. Nationally 1, 22 million people are living with HIV of which 79 871 are children under the age of 15 years in 2010 (Ethiopian Government, FHAPCO 2007). Ethiopia's high number of orphans is due in part to AIDS, relentless and severe poverty, poor protection of the rights of children and

women, chronic food insecurity, conflict, war, malnutrition and other diseases (The Policy Project 2005).

To alleviate and address the multi-faceted problems of OVCs, it is crucial to undertake a situational analysis. Therefore, the aim of this study is to explore the socio-economic problems of OVCs in Dessie Town. The study also attempts to examine the situation of OVCs at the household level (thus information about the care-givers of OVCs are needed) and to document the responses of service providers towards the socio-economic problems of OVCs.

1.4 RATIONALE OR PURPOSE OF THE STUDY

Dessie Town was purposely selected as the intended study site due to a high prevalence of HIV infections and significant numbers of OVCs. This study is intended to identify major social, economic and cultural problems faced by OVCs that have worsened their living conditions. Insights gained from the study can contribute to suggestions for appropriate interventions using available local resources. The overall objective is to gain knowledge that can be used to improve the living conditions of OVCs; to support households and families to cope with the increasing burden of care for OVCs; to strengthen community-based support systems; and to build community-based systems for sustained care and support for OVCs.

1.5 OBJECTIVES OF THE STUDY

The general objective of the study was to undertake a situation analysis of OVCs at Dessie Town. Secondary objectives were to:

1. Gather data and assess the socio-economic conditions (education, economic status, domestic arrangements and housing) of OVCs

2. Describe OVC-affected households in terms of school attendance and other problems
3. Obtain information about the characteristics of the care-givers of OVCs
4. Describe the psycho-social status (social isolation, adjustment, discrimination) of OVCs in the study site
5. Describe the biographical characteristics of OVCs such as orphanhood status, nutritional status and household communication about risk-taking behaviour
6. Identify and describe existing and potential support systems for OVCs.

1.6 ASSUMPTIONS

In this study the researcher, based on a review of literature, assumes that OVCs have an increased risk of malnutrition when compared to those children living with their parents. OVCs are assumed to be stigmatised and discriminated against because of their, and/or their parents' HIV statuses (Simbayi *et al* 2006:2). OVCs are less likely to enrol in school and are more likely to drop out than non-orphans of the same age. The social and economic situation such as educational attainment, food intake and psycho-social wellbeing of OVCs are assumed to be poor. It is also assumed that identifying the mitigating factors of children's conditions in the area of HIV/AIDS is crucially important for OVCs. Various government and non-government organisations are working in favour of OVCs, but there is a need to coordinate such efforts. To do so and to make sound decisions, a description of the socio-economic needs of OVCs is needed.

1.7 THE SIGNIFICANCE OF THE STUDY

Many studies about OVCs have been undertaken in a number of African countries. For example, Botswana has conducted a situational analysis on the socio-economic conditions of OVCs in 2007 (Tsheko 2007), Zambia completed a situational analysis of OVCs in 1999 (Zambian Steering Committee 1999) and Nigeria conducted a situational analysis on orphans and other vulnerable children in 2001 (FHI 2001). Such studies contributed to the planning and implementation of policies and programmes in these countries but in Ethiopia, there is a need for further research. Whereas a number of programmes exist to address the needs of OVCs in Ethiopia, there is no coordinated effort to care for and help these children.

The current study should prove to be significant in that it deals with the socio-economic situations of OVCs in Dessie Town. As James Kaboggoza-Ssembatya (cited in Family Health International 2005:4) puts it: "*A situation analysis of orphans and other vulnerable children is necessary before you plan for meaningful interventions to solve their problems and restore their hope for a meaningful future. It articulates the magnitude and the impact of the orphan situation in a given society and brings out all the ramifications and complexities compounding the problem. It provides clarity on what the real issues are and a basis for appropriate responses to these issues."*

In this respect this study will be used to determine the magnitude and status of OVCs in Dessie Town and to describe support systems offered by community-based organisations (CBOs), NGOs and the government to cope with their problems. In addition to this, the study tried to articulate the socio-economic problems of OVCs and coping mechanisms attached to it. Generally, investigating the socio-economic problems of OVCs can provide baseline information on the

breadth and magnitude of their problems and in turn instigate services aiming to redress such problems.

1.8 DELIMITING THE STUDY

Ethiopia is bordered by Djibouti, Eritrea, Sudan, Kenya and Somalia. Topographically, Ethiopia is a country with great geographical diversity reaching the highest peak at Ras Dashen which, is 4 550 meters above sea level, down to the Afar Depression at 110 meters below sea level (Ethiopian Central Statistics Authority 2000). Its territory covers a total area of 1 117 127 km^2. About two thirds (66%) of its land area is potentially usable for agricultural production (Seid 2003). Ethiopia has a population of 73 918 505 (37 296 657 males) and 36 621 848 females) (Ethiopian Central Statistics Authority 2008). The majority of the population, 82,4%, lives in rural areas and the average population growth rate is 2.7% for the years 1994-2007 (Ethiopian Central Statistics Authority 2008). Ethiopia's population is young as 44,5% are younger than 15 years of age and those between the ages 15 and 64 years are 52,5% of the total population and only 3,3% is composed of elder people (Ethiopian Central Statistics Authority 2008).

Ethiopia has more than 80 different ethnic groups and has a federal system with nine regions and two Administrative Councils, namely Addis Ababa and Dire Dawa (Ethiopian Government, MOH & HAPCO 2007). Due to the poor performance of the economy; the level of poverty in the country is very high. According to the last Human Development Report (UNDP 2009), Ethiopia ranks 171st out of 182 based on its Human Development Index (HDI). This Report also ranks the country 130th out of the 135 developing countries for which the Human Poverty Index (HPI-1) was calculated in the case of Ethiopia it is 50.9 (UNDP 2009).

Amhara region, where Dessie Town is located, is one of the nine regional states of Ethiopia and is home to 20,1 million people (Amhara Region Labour and Social Affairs Bureau 2008), of which 53% are children under the age of 18 years. The region is characterised by rapid population growth (2,7% per annum) and the proportion of children in the population has been steadily increasing. The socio-economic situation of the region reflects the living standard of the population and children in general. Although 89% of the population in the region depends on agriculture for a living, about 42% of the population live under the poverty line and face chronic food insecurity. More than two-fifths of all children in the region are stunted and under-weight due to malnutrition (Amhara Region LSAB 2008). Malaria, HIV/AIDS, respiratory diseases, and tuberculosis (TB) widely prevail in the region. Due to the high HIV-positive prevalence rate; HIV/AIDS also contributes to the illness and mortality of people.

Although there are few rural areas (or kebeles) recently incorporated (in 2006) as part of Dessie Town, the study was delimited to the earlier Dessie Town because of financial and time constraints. Thus the study site covered all of Dessie Town's ten Kebele Administrative centres which have been established for administrative purposes long ago. However, due to recent structural changes and the emphasis placed on urban development by the Amhara Regional State, many towns in the region were expanded and thus include some rural kebeles since 2006. Therefore, the total urban and rural kebeles of Dessie Town are sixteen which are home to 179 227 people in the urban areas (83 322 males and 95 905 females) and 46 244 people in the rural areas (22 534 males and 23 710 females). From this population, children under the age of 19 years number 94 439 in the urban areas and 23 954 in the rural areas (Amhara Region LSAB 2008). According to a census by the Dessie Town Municipality (Amhara Region LSAB 2008), about 4 422 OVCs were identified. The problems faced by the OVCs in the town are diverse and include lack of access to social services, exploitation, abuse, stigma and discrimination.

This study area was sought by the researcher because no research has been undertaken on the socio-economic situations of OVCs in Dessie Town, despite the severity of the problems faced by the OVCs in the area. The researcher resides in the area.

1.9 THE RESEARCH DESIGN

A cross-sectional survey methodology employing structured questionnaires was used to meet the above stated objectives. Random sampling was used to select the respondents for the OVCs and the care-givers whereas purposive sampling was used to select the service organisations. Full details on the methodology followed and the ethical considerations are discussed in Chapter 3 of this dissertation.

There is paucity of data on the well-being of orphans at national level. This made comparisons over time impossible and implied that this study is baseline information for future follow-up investigations.

As mentioned above, the sampling frame for this study - especially the quantitative part - was taken from OVCs census survey study undertaken by Dessie Municipality in 2007. This study focused on registering counting OVCs and their care-givers with respect to selected demographic characteristics for the purpose of identification of the needy population for service provisions. Thus the researcher tried with his study to move beyond a mere head count in order to assess the economic, education, cultural, social and psychological conditions or problems of OVCs in the area.

1.10 DEFINITIONS OF KEY TERMS, CONCEPTS AND VARIABLES

Some of the key concepts as used in this study are defined in this section. Other important concepts are defined in the text where they are discussed and the section here is therefore not a definitive list. The definitions below act as sensitising explorations of the meanings of certain key notions.

1.10.1 Situational analysis

According to Williamson, Cox and Johnston (2004) a situation analysis is a process of gathering and analysing information to guide planning and action. It provides a synopsis of a particular situation at a given point in time that can be useful to different audiences for a variety of purposes, including: policy and strategy development, advocacy, social mobilisation, information exchange, stakeholder coordination and collaboration and programme design.

1.10.2 Child

For the purpose of this study a child is defined as a person older than 7 years of age and younger than 18 years of age at the time of the survey (Skinner *et al* 2004). Therefore, infants, from birth to age 7 are excluded from this situational analysis.

1.10.3 Vulnerable child

This refers to a child aged below 18 years who is either HIV-positive or has lost one (single orphans) or both parents (double orphans) because of AIDS-related deaths and lives without adequate adult support (e.g., in a household with a chronically ill parent, a household headed by a grandparent, and/or a household headed by other relatives or foster parents, neighbours or the vulnerable child or

another child). Smart (2003) and Skinner *et al* (2004) suggest that vulnerable children include children living with sick and dying parents; children who primarily depend on a breadwinner who has died as a result of AIDS; children who experience precarious care as a result of being dependant on extremely old, frail or disabled care-givers; and children in households that assume additional dependency by taking in orphaned children. Although many programmers profess to target orphaned children, they inevitably and rightly include vulnerable children in their intervention (Skinner *et al* 2004).

1.10.4 Orphans and other vulnerable children

In the context of the HIV/AIDS pandemic, UNAIDS (as cited in Jooste, Managa & Simbayi 2006:2) defines an orphan as a child who has lost its mother (a maternal orphan), or both parents (a double orphan) before the age of 15 years (Skinner *et al* 2006). At this stage, up two or three times as many orphaned children are not covered by this definition because they have lost father, rather than a mother (UNICEF 1999). The reason for the greater number of parental orphans is that men have higher mortality rates than women of the same age, and women tend to have children with men who are older than themselves. UNAIDS has chosen not to try and count or target parental orphans, because in many parts of the developing world, fathers are often only loosely connected to children and the households in which they live. However, the figures indicate some of the dilemmas involved in targeting 'orphans' by the UNAIDS definition (Jooste *et al* 2006).

Apart from orphaned children, the HIV/AIDS pandemic has rendered many children vulnerable because they have lost a household breadwinner, or because their mother is sick and unable to care for them, or because their families have taken in kin who are ill or left destitute resulting in a situation in which already scarce household resources have to be shared among many more people (Skinner *et al* 2004). Thus OVCs include "*all children who are affected by the wide*

spread death and social disarray that follows in the wake of the HIV/AIDS epidemic'' (Simbayi *et al* 2006:2).

1.10.5 Psycho-social problems

Psycho-social problems are psychological and social problems affecting the emotional wellbeing and social conditions of orphans and vulnerable children as a result of losing parent(s) due to HIV/AIDS (Meles 2008).

1.10.6 Social isolation

According to Cantor and Sanderson (1999 cited in Meles 2008), social isolation refers to living without companionship or social connectedness. It is the absence of significant others to interrelate with, to trust, and to turn to in a time of crisis which causes social isolation.

1.10.7 Stigma

Stigma is a social process, experienced or anticipated, characterised by exclusion, rejection, blame, or devaluation that result from the experience or reasonable anticipation of an adverse social judgment about a person or a group (Weiss & Ramakrishna 2004:253).

1.10.8 HIV/AIDS-related discrimination

The International Labour Organisation (cited in Lealem 2004:7) defines HIV/AIDS-related discrimination as any distinction, exclusion or preference made on the basis of a real or perceived HIV-positive status that has the effect of nullifying or

impairing equality of opportunity and treatment.

1.10.9 HIV/AIDS orphans

According to the Convention for the Rights of Children of 1992 (cited in Lealem 2004), HIV/AIDS orphans refer to children who lost their mother to AIDS-related causes before the child has reached the age of 18 years. Some of those children have also lost or will later lose their fathers due to AIDS-related causes. According to UNAIDS definition; the upper limit of the age is 15 years. However, in this study the researcher deemed it necessary to change the upper age limit up to 18 years in line with the Convention of the Rights of Children (Lealem 2004).

1.10.10 Socio-economic support

Socio-economic support refers to support services attending to the social, economic and emotional wellbeing of orphans and vulnerable children in the research site.

1.10.11 Guardian/care-giver

A guardian or care-giver is a person (such as a grandparent, parent, foster parent or relatives), who took the responsibility of looking after a child who lost one or both parents due to HIV/AIDS.

1.11 OVERVIEW OF THE CHAPTERS OF THE DISSERTATION

Chapter one describes the socio-economic situation of orphans and vulnerable children in Ethiopia and in the research site and touches on the impact of HIV/AIDS on the lives of these children. In this chapter the rationale for the study, the central research problem, the assumptions, objectives and definition of key terms are given.

In **Chapter two** a review of the literature concerning the socio-economic problems of OVCs, the prevalence, incidence and the impact of HIV/AIDS on children are discussed.

Chapter three outlines the research methodology, the process used to collect the data, the research setting, the study design, the sample, the pilot study, the reliability and validity of the research instruments and the ethical considerations of the study.

Chapter four presents the results and discussion of the study.

Chapter five presents the summary of findings, recommendations and conclusion

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses the socio-economic situations of orphans and vulnerable children (OVCs) and reports on the magnitude of orphan-hood, the prevalence of HIV/AIDS and the impact of HIV/AIDS on children.

2.2 THE SOCIO-ECONOMIC SITUATIONS OF OVCs IN ETHIOPIA AND THE PAUCITY OF INFORMATION ON OVCs IN DESSIE TOWN

As no direct information on OVCs in Dessie Town specifically was available for this study to draw on, this section is based on a review of literature that covers OVCs in general and in Ethiopia nationally. According to the State of the World's Children (UNICEF 2001), Ethiopia is characterised by severe and abject poverty and rapid population growth (UNICEF 2001). As UNDP 2009 Human Development Report, the GDP per capita income of the country for 2007 is only 245 US dollars which is the 12th lowest in the world and its National Poverty line for 2000-2006 is 44,2% (UNDP 2009).

This UNDP Report indicated that, for 2007, the life expectancy at birth in Ethiopia was 54,7 years compared to the least developed countries, with very high human development index, estimate of 75,5 years of the world population (UNDP 2009). The adult literacy rate for 1999-2007 was also 35,9% (UNDP 2009), whereas the rate for Sub-Saharan Africa was estimated at 58,6%, for least developed countries. Ethiopia's infant mortality rate for 2005 was 77 while under-five mortality rates were 123 (Ethiopian Central Statistics Agency and ORC Macro 2006). The net primary school attendance rate for boys was 32,8% and 27.5% for girls (Ethiopian Central Statistics Authority 2005). Only 38% and 12% of the residents have been using safe water sources and adequate sanitation facilities respectively (WHO 2010).

As mentioned in chapter one, in Ethiopia there was an estimated total number of 5,5 million OVCs under the age of 18 years (Save the Children UK 2009) and 5,4 million orphans between the ages of 0 to 17 years old in 2010 (Ethiopian Government, FHAPCO 2007). The percentage of households taking care of orphans in Ethiopia is 18% (Ethiopian Central Statistics Authority 2005), which shows the inadequate response of communities to care for and support OVCs in the country.

Generally, the available data also shows that orphans perform relatively poorly on indicators of well-being such as school attendance, satisfaction of basic needs, health and psycho-social support. For instance 42% of households with orphans are female-headed and possess an average of 1,6 orphans per household (Ethiopian Central Statistics Authority 2005).

The school attendance rate for children aged 10 to 14 years is 34% for orphans and 26% for double orphans as compared to 43% for non-orphans (UNICEF *et al* 2004). Although national level data comparing orphans with other children on the basis of indicators of welfare such as the satisfaction of basic material needs by their families, malnutrition, food-insecurity, psychological health, the incidence of early sexual involvement, connection with adult care-giver, property dispossession and others are not present; a situation analysis carried out nationally in 2002, indicated that many orphaned children had great difficulty in securing daily meals, proper clothing, school uniforms, school supplies and school fees which led to higher drop-outs rates (Ethiopian Government, Ministry of Labour and Social Affairs 2003). Almost a quarter of orphaned children below ten years of age were reportedly ill within the two weeks prior to the interview, while 6,5% of them reported that they had been subjected to abuse and neglect.

Many children orphaned by HIV/AIDS suffer from social isolation, stigma, discrimination, social and emotional adjustment problems and had more difficulty in securing safe employment (UNICEF *et al* 2004).

The number of children orphaned due to HIV/AIDS in Ethiopia increased from 720 000 in 2003 (Simbayi *et al* 2006) to 1.5 million in 2007 (Asebe & Aase 2007); which is the largest size in absolute terms in the world. The number of children infected with HIV was estimated at 250 000 in 2000 and increases rapidly (Alelign 2004). Hence the HIV/AIDS pandemic has become one of the major health and social problems that affect the youth of Ethiopia.

Globally, there were an estimated 15 million AIDS orphans (i.e. children who had lost one or both parents due to HIV- or AIDS-related mortality) in 2007, the majority (77%) of which lives in Sub-Saharan Africa (UNAIDS 2008). Furthermore, there were approximately 2,5 million children living with HIV in 2009. In 2001, this number increased to 1,6 million so that children represented approximately 7% of the total number of people living with the HIV (UNAIDS 2010). Moreover, an estimated 370 000 children were newly infected with HIV in 2009, accounting for 14% of all infections. In 2009, 260 000 children died of AIDS-related illnesses which accounted for approximately 14% of the total number of deaths due to AIDS-related causes (UNAIDS 2010).

According to the programmatic guide of OVCs' situation of World Vision (2005), children affected by HIV/AIDS are at high risk of being deprived of a full, healthy and productive life. The children left behind when parents die may not have acquired adequate skills to perform important agricultural and economic activities. Moreover, these children are increasingly drawn into adult responsibilities by parents or guardians and may be taken out of school and this has a long-term negative impact on their ability to acquire literacy-based skills. In addition to the psychological suffering of losing one or both parents, they may be required to care for chronically ill adults or young siblings. Orphans and other children made

vulnerable by HIV/AIDS often lack financial resources and go without even the most fundamental human rights, such as food, shelter, clothing, or health care. They may face social stigma, isolation, discrimination, abuse, or exploitation. Girls, in particular, are less likely to be immunised, more likely to be malnourished, less likely to go to school, and more vulnerable to abuse and exploitation. Disadvantaged of parental guidance and protection, they may themselves become vulnerable to HIV infection (World Vision 2005).

Findings of research on the psycho-social issues affecting orphaned and vulnerable children in two South African communities (Simbayi *et al* 2006) indicate that orphans may grow up without basic material resources and may lack love and support that emotionally–invested care-givers usually provide. In addition; they may be discriminated against because of the stigma attached to their parents' HIV-positive status; and they may be forced to cease their education because of lack of money or the need to take care of their siblings. From a social point of view, the effect of large numbers of children being raised without parents will prove costly for the affected country. There are both direct costs related to relief work and indirect costs associated with an increased risk of ill health and/ or social pathology. There are also opportunity costs related to lost years of education and work preparedness. As a general response in Sub-Saharan Africa, families and communities have taken orphaned children and included them as a part of extended families (Simbayi *et al* 2006). In line with this, the Ethiopian Demographic and Health Survey found that 18% of households are taking care of orphans and that 42% of all care-givers of orphans are women. There are 1,6 orphans per household, 20% of all orphans live away from their surviving family members and 6.1% of all orphans are beggars (Alelign 2004). There seems to be a trend in which decreasing numbers of relatives are providing care for orphans.

According to the OVC RAAAP Report of Ethiopia (The Policy Project 2005), the effectiveness of responses to the OVC crisis is conditioned by the nationwide context in which they are to be implemented. The policy and regulatory

environment is an important element of this context. Although there is not as yet any policy on orphans, the Constitution of Ethiopia contains provisions which protect the rights of orphans (UNICEF *et al* 2004*).* Also, there are a number of guidelines which exist or are in the process of being developed which are relevant to OVCs. These include the National Plan of Action for Children currently being finalised; the Guidelines for Alternative Childcare Programmes; the National Strategic Framework for HIV/AIDS; the National Guidelines on Care and Support for PLWHAs and OVCs; and the Clinical Guidelines for Children Infected by HIV/AIDS (UNICEF *et al* 2004).

On the other hand, legal provisions and law enforcement institutions have erratic efficacy in protecting the rights of orphans. However, the existence of the recently revised National Family Law and laws on adoption, protection of street children, child labour and protection of children from abuse and neglect is important; yet the enforcement of laws in other areas of child rights is weak due to low institutional capacity, low public awareness of child rights and the influence of customary norms and laws. In addition to the existence of policies, guidelines and laws, protection of orphans is also dependent on the extent of resources allocated to them. The Ethiopian government prioritises interventions to address the underlying issues of chronic poverty and food security instead of general social welfare programmes. The weaknesses in the delivery of education and health services to OVCs, despite their provision without cost to the poor, reflect the poor access to such services on the part of the general population (UNICEF *et al* 2004).

Moreover the OVCs RAAA Report (The Policy Project 2005) mentions that in Ethiopia, NGOs and faith-based organisations (FBOs) are significantly involved in providing different types of support to OVCs and advocating for their rights, but their role is constrained by their partial reach, low capacity in terms of funds and human resources, lack of guidelines on the support of OVCs, lack of forums and networks among them, and considerable deficits in the areas of psycho-social

care and gender sensitivity. Limited community awareness and institutional capacity with respect to OVC-related issues are also important obstacles to current and future interventions in this area. Therefore, the prevalent social and economic conditions that orphans find themselves in are significant contextual factors that influence the welfare and effectiveness of the national response to OVCs. Widespread poverty and the lack of resources to be allocated for OVCs obviously seriously compromise their welfare and efforts to alleviate it (UNICEF *et al* 2004).

A report by the Policy Project (2005) demonstrates that significant number of OVCs have been receiving various forms of support in the country from governmental and non-governmental agencies. The most widespread form of support provided by OVCs is regular financial assistance to help them meet their basic needs as well as school expenses. From the government's side, HAPCO and MOLSA have been providing such support in diverse parts of the country. NGOs and FBOs provide financial and material assistance as well, the largest number of which are active in Addis Ababa, followed by the larger regions of Amhara, Oromia and SNNPR (UNICEF *et al* 2004).

2.3 HIV/AIDS AND THE PREVALENCE OF ORPHANS AND VULNERABLE CHILDREN IN ETHIOPIA

Table 2.1 National HIV/AIDS estimates for 2010

	Total	Urban	Rural
Adult HIV prevalence %	2,4	7,7	0,9
Adult HIV prevalence-Male %	1,9	6,2	0,7
Adult HIV prevalence-Female %	2,9	9,2	1,1
HIV-positive population	1 216 907	760 475	456 432
HIV-positive pregnant women	90 311	_	_
Adult HIV incidences %	0,29	_	_
Annual HIV-positive births	14 276	_	_
New HIV Infections in 2010	137 494	86 130	51 364
Annual AIDS-related deaths	28 073	17 586	10 487
ART needs	397 818	_	_
Maternal orphans (0-17 yrs.)	2 637 359	500 572	2 136 787
Paternal orphans '	3 497 501	601 811	2 895 690

Dual orphans '	711 401	184 052	527 349
Total Orphans '	5 423 459	1 348 765	4 074 694
Total AIDS orphans '	4 850 727	344 959	4 505 768
HIV-positive population-children (0-14 yrs.)	79 870	48 355	31 515
New HIV infections-Children(0-14 yrs.)	14 276	8 943	5 333
Annual AIDS-related deaths - children(0-14yrs)	3 538	2 216	1 322

(Source: Ethiopian Government, FHAPCO 2007).

As shown in the Table 2.1 above, the prevalence of HIV/AIDS and OVCs in Ethiopia is high. The Ethiopian Government Federal HIV/AIDS Prevention and Control Office (2007a) found that the national HIV prevalence for 2010 was 2,4%; 1,9% among males and 2,9% among females. The estimated prevalence in urban areas was 7,7% (6,2% among males and 9,2% among females) and 0,9% in rural areas (0,7% among males and 1,1% among females). Furthermore, the overall HIV incidence estimate for Ethiopia 2010 was 0,29% and this 2007 estimate indicated that a total of 1 216 907 people were living with HIV/AIDS in 2010. Of the total, 760 475 were living in urban areas and 456 432 in rural areas.

In the age group 15- to 29-years, there were more women living with HIV/AIDS than men; in the age group 30 years and older, there were more men living with HIV/AIDS than women. On the other hand, AIDS accounted for an estimated 34% of all young adult deaths in Ethiopia and 66.3% of all young adult deaths in urban Ethiopia (Ethiopian Government, FHAPCO 2007).

Moreover, as shown in Table 2.2 above, in 2010 there were an estimated 137 494 new HIV infections (86 130 in urban areas and 51 364 in rural areas) including 14 276 HIV positive births, and 28 073 annual AIDS-related deaths (including 3 538 children aged younger than 5 years). In addition to this, there were an estimated 5 423 459 total orphans aged birth to 17 years; 2 637 359 were maternal, 3 497 501 paternal, and 711 401 dual orphans. Furthermore, there were an estimated 397 818 (including 26 053 children) persons requiring ART in the same year.

Although the behavioural trends (2001 versus 2005) from the DHS survey among the general population demonstrate high level of awareness; decreases in the prevalence of pre-marital sex and multiple sexual partners; and increases in condom use with at-risk sexual encounters; and increases in the prevalence of those ever tested for HIV among males, much remains to be done. The urban HIV/AIDS-epidemic is at an unacceptably high prevalence level of 10,5% (Ethiopian Government, FHAPCO 2007a).

In terms of the development of the national epidemic, the Ethiopian Ministry of Health HIV/AIDS Prevention and Control office estimated that 3,2% of the population was infected in 1993, 7,3% in 2000, 6,6% in 2002, 4,4 % in 2004 and 3,5% and 2,4% in 2005 and 2010 respectively. As for deaths in 2001, it was estimated that 117 000 to 208 000 people aged 15- to 49-years died of AIDS-related causes (Pankrest *et al* 2005).

Worldwide, there were a total of 33,3 million people living with HIV in 2009, of which two-thirds (67%) were found in Sub-Saharan Africa (UNAIDS 2010). As for deaths, UNAIDS (2010) indicates that in 2009 1,8 million people died of AIDS-related illnesses, and that approximately 72% of these deaths occurred in Sub-Saharan Africa Besides, of the 2,6 million people who became newly infected with HIV in 2009, 1,8 million were in Sub-Saharan Africa. And in 2009 approximately 2,3 million children in Sub-Saharan Africa were living with HIV, which represents 92% of all children living with HIV worldwide (UNAIDS 2010) .

As mentioned above, Sub-Saharan Africa has been hit harder by HIV/AIDS than any other region in the world. Two-thirds of people living with HIV/AIDS and three-quarters of deaths from AIDS-related causes occurred in Sub-Saharan Africa. People living with HIV and AIDS –are not the only persons affected as HIV and AIDS also affect families and communities. The disease targets people during their most productive years, making economic progress in many Sub-Saharan African countries even more of a challenge (UNAIDS 2011). Nevertheless, many

of the world's poorest countries have been able to make progress in their fight against HIV/AIDS in recent years thanks to increased political will and global resources to fight the pandemic. The launch of initiatives such as the Global Fund and PEPFAR have made treatment, prevention and care available to millions of people in the world's poorest countries like Ethiopia. More than 5 million Africans are receiving lifesaving antiretroviral treatment (up from only 50 000 in 2002), and through its partnerships with more than 30 countries including Ethiopia, PEPFAR directly supported 11 million people with care in 2010 alone. Despite these global efforts, HIV infection rates are still far outpacing the number of people put on treatment. In the long-term, winning the fight against HIV and AIDS is not possible without sufficient investments in prevention, including research to find a vaccine, and treatment. (UNAIDS 2011)

Table 2.2: Amhara region HIV/AIDS estimates for 2010

	Total	Urban	Rural
Adult HIV prevalence (%)	2,9	9,8	1,4
Adult HIV prevalence-Male (%)	2,3	7,9	1,1
Adult HIV prevalence-Female (%)	3,5	11.8	1,7
HIV-positive population	379 096	181 830	197 266
HIV positive pregnant women	30 123	_	_
Annual HIV-positive births	5 029	_	_
New HIV infections	42 543	20 268	22 275
Annual AIDS-related deaths	9 739	4 956	4 783
ART needs	126 066	_	_
Maternal orphans	744 291	112 955	631 336
Paternal orphans	975 434	131 980	843 454
Dual orphans	184 772	46 150	138 622
Total orphans	1 535 105	198 584	1 336 521
Total AIDS orphans	318 219	80 033	238 186
HIV-positive population - Children (0-14yrs)	29 540	14 794	14 746
New HIV infections - Children (0-14yrs)	5 029	2 769	2 260
Annual AIDS-related deaths- children(0-14yrs)	1 350	751	599
ART needs- Children (0-14 yrs.)	9 603	_	_

(Source: Ethiopian Government, FHAPCO 2007b).

As shown in Table 2.2, (above) the prevalence of HIV/AIDS and OVCs is also high in the Amhara region where Dessie Town is found. The table shows that the regional HIV prevalence estimates for 2010 for Amhara region in general is 2,9% (2,3% for males and 3,5% for females) while for urban areas it is 9,8% (7,9% for males and 11,3% for females) ; which is the highest for the four largest regions next to Addis Ababa. Due to their relatively large population sizes and high HIV incidence rates, Addis Ababa and urban areas of Amhara, Oromia, and SNNPR share 83,4% of the total estimated HIV positive pregnancies, and 83,6 % of new infections of Urban Ethiopia in 2005 (Ethiopian Government, FHAPCO 2007b). In other words, the HIV incidence rate and new HIV infections for Amhara region, as shown in Table 2.2, above, for 2010 is 0,34 and 42,543 respectively; which showed an increment as compared to 2005 incident rate and new HIV infections rate of the region which was 0.30 and 39,552 respectively (Ethiopian Government, FHAPCO 2007b).

Moreover, as demonstrated in Table 2.2, (above) there were an estimated 379 096 HIV-positive persons in all age groups with 29 540 HIV-positive children (aged 0-14 years). This constitutes an increase as compared to the PLWHA living in urban areas of the region in 2005, which were 155 322 for all ages and 15 139 for children (aged 0-14 years). This is the highest number of PLWHA living in urban areas of Amhara region of Ethiopia next to Addis Ababa region, which were 207 220 for 2005 and 210 306 for 2010, of all ages correspondingly (Ethiopian Government, FHAPCO 2007b). In addition to this, there were an estimated 1 535 105 orphans aged 0 to 17 years in the Amhara region (744 291 maternal orphans, 975 434 paternal orphans, and 184 772 double orphans) in 2010. Besides, in the same period there were 318 219 AIDS Orphans.

Concerning the prevalence of HIV of the region, the single point HIV prevalence estimate of 2007 showed an increasing trend that is 2,7% in 2008, 2,8 % in 2009 and 2,9% in 2010 (Ethiopian Government, FHPCO 2007b). Furthermore, Table 2.2, (above) shows that there were 9 739 annual AIDS-related deaths including 1 350 annual AIDS-related deaths to children aged 0 to 14 years in 2010 in Amhara. With regard to the needs for ART, there were 126 066 persons in need of ART including 9 603 children aged 0 to 14 years in Amhara region in 2010. Moreover, the number of orphans and vulnerable children (OVCs) in the Amhara region where the selected study site, Dessie Town, is located, is not only increasing at an alarming rate, but are also living in desperate socioeconomic situations (ARLSAB 2007)

2.4 THE IMPACT OF HIV/AIDS ON CHILDREN IN THE HOUSEHOLD

HIV infection and AIDS-related causes have become the leading cause of death worldwide for people aged 15- to 49- years (Orne-Gliemann *et al* 2008). The pandemic is also having a dramatic impact on child mortality, which is increasing in parts of Sub-Saharan Africa most affected by HIV/AIDS (Orne-Gliemann *et al* 2008).

The impact of the pandemic on children is also seen dramatically in the rising number of children orphaned after their parent(s) died from AIDS, reaching an estimated 15,2 million children worldwide in 2005. More than five million children living with chronically ill family members in 2005 were estimated to become orphans unless appropriate care and treatment was provided (Orne-Gliemann *et al* 2008).

In Ethiopia, according to the national HIV prevalence estimate of ministry of health 2007, the estimated number of children (under the age of 17 years) who had lost their mother or father or both parents to AIDS and non-AIDS-related causes at the

end of 2010 were 5 423 459 total orphans. Of these there were 2 637 359 maternal orphans which comprised 569 032 AIDS orphans and 2 068 327 non-AIDS orphans and 3 497 501 paternal orphans which included 509 214 AIDS orphans and 2 988 287 non-AIDS orphans, and 711 401 double orphans which consists 274 062 AIDS related causes orphans and 437 339 non-AIDS related causes orphans. Hence the total AIDS orphans in the estimated period were 804 184 (Ethiopian Government, FHPCO 2007b). As can be deduced from the above figures that 38,1% of Ethiopian orphans are maternal, 64,5% paternal, and the remainder 13,1% double orphans.

Another study by HAPCO (2005) on the status of AIDS orphans indicate that as there were 529 777, maternal, 464 506 paternal, and 250 195 dual orphans.. Thus, the World Health Organisation (WHO) concluded that the number of AIDS orphan children in Ethiopia continue to rise from year to year.

The impact of parental death on children is complex and affects the child's mental health and social development. OVCs might have stunted development in terms of their emotional intelligence and life skills. They also often show a lack of hope for the future and low self-esteem (Ayalew & Elias 1999). German (cited in Lealem 2004:12) also points out that "*the practical observation in the life of orphans leads to the conclusion that parental death, especially double death as is often the case with AIDS is a high risk factor that causes psychological stress with a long term development impact on children* ".

The large numbers of OVCs living in Ethiopia due to the loss of their parents to HIV/AIDS face many challenges in their everyday lives. For instance, the psychological impact of HIV/AIDS on children in low-income countries has been greatly overshadowed by socio-economic considerations and there is a critical lack of research on counselling and social support needs of children affected by HIV/AIDS (Orne-Gliemann *et al* 2008).

Research has found that orphans were less likely to enrol in school than non-orphans of the same age groups due to poverty, the priority given to the children in the core family and stigmatisation. Yet schools play a significant role in the socio-emotional development of children. Finally, the legislative and governmental support for the provision of essential services to children affected by HIV/AIDS seems greatly insufficient and largely influenced by the stability of the political environment (Orne-Gliemann *et al* 2008).

According to UNICEF and UNAID (2003) research to understand the impact of HIV/AIDS on households and children is an important first step in the planning of programmes to support extremely vulnerable children. The HIV/AIDS epidemic has left many children from all age groups to be raised by their grandparents. Such children are at a greater risk of malnutrition, illness, early school termination, abuse and sexual exportation. Many will also have to come to grasp with the stigma and discrimination that is associated with HIV/AIDS, which may further limit their access to basic social and educational services (Simbayi *et al* 2006).

According to Simbayi *et al* (*2*006), as mentioned above, it is vital to gain an understanding of the impact of HIV/AIDS on households and children in order to prioritise, plan and evaluate programmes to support extremely vulnerable children. The President's Emergency Plan for AIDS Relief (PEPFAR 2006) indicates that because HIV/AIDS mainly attacks people of childbearing age, the impact this is having on children, extended families, and communities is devastating. If a parent dies of AIDS-related causes, the child is three times more likely to die even irrespective of whether the child is HIV negative. Besides increased risk of death, children whose parents have died due to HIV/AIDS also face stigmatisation, and often suffer from emotional distress, malnutrition, a lack of health care, poor or no access to education, and often most importantly, lack of love and care. They are also at high risk of labour exploitation, sex trafficking, homelessness and exposure to the risk of HIV infection. Extended families and communities in highly affected areas by HIV and AIDS are often hard-pressed to

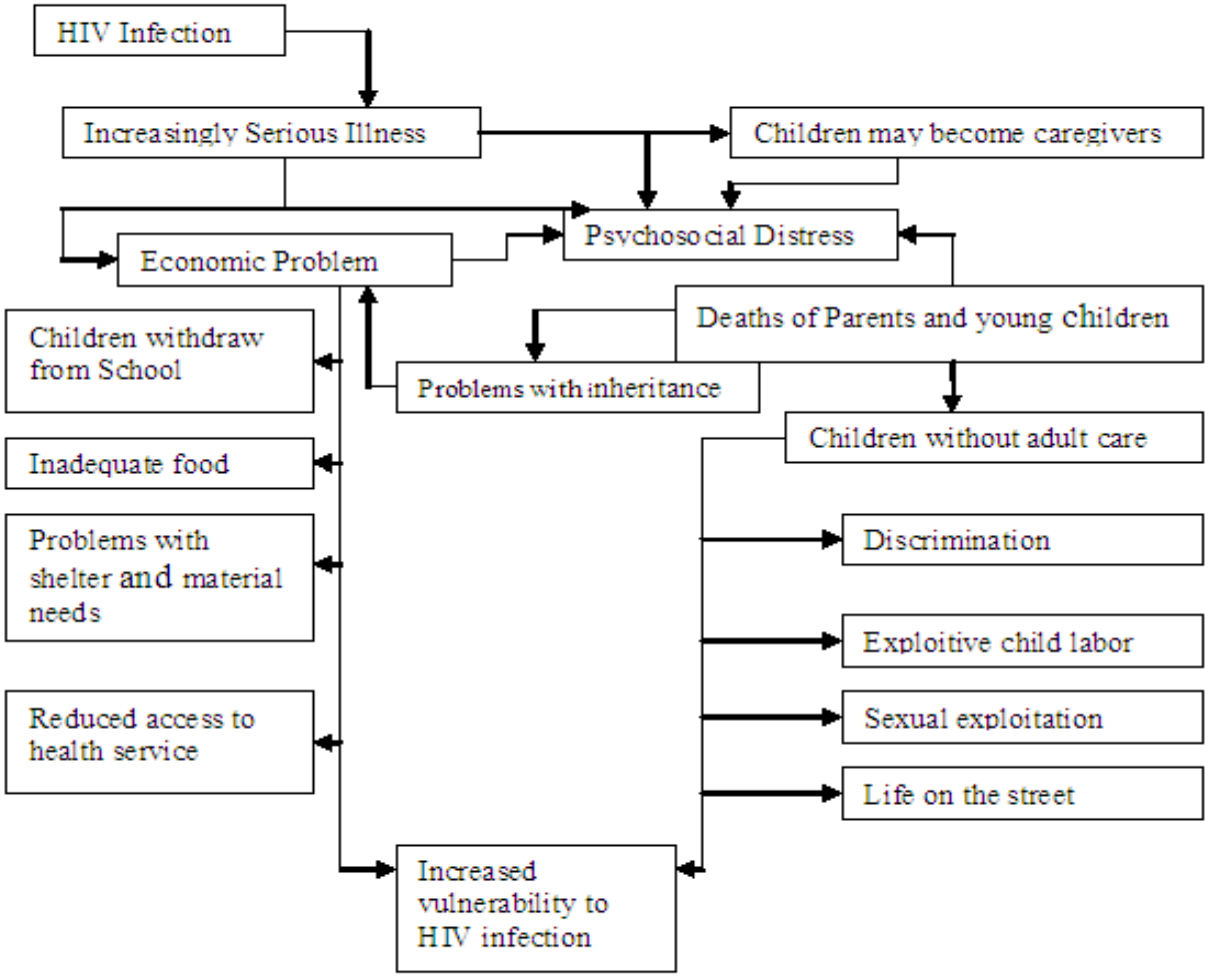
care for all children. In Ethiopia where HIV/AIDS and poverty often occur together, there are millions of children who are not orphans, but who have been made more vulnerable by HIV/AIDS. For example, children whose parents or care-givers are infected with HIV might not receive the care and support they require, and may instead become their parents' care-givers, often dropping out of school and becoming the main source of income in the household. Research indicates that these children, caring for sick and dying parents, are the most vulnerable of all (PEPFAR 2006).

In line with this, a recent survey conducted by MOLSA (2003) indicates that the impact of HIV and AIDS on children is many-sided and complex. AIDS orphans suffer devastatingly and largely unmitigated losses; living as they do in societies already weakened by under development, poverty and the HIV/AIDS pandemic itself. This is particularly true in Sub-Saharan Africa, were few social support systems exist outside of families and where basic social services are largely insufficient (MOLSA 2003). According to this study, children suffer from psychosocial distress and increasing material hardship due to HIV and AIDS.

HIV and AIDS affect children across a number of dimensions, as shown in Figure 2.1 and discussed below. Although the scope is discussed separately, they are interdependent and have joint impacts on children.

Figure 2.1:

Problems among Children and Families Affected by HIV/AIDS



Source: Williamson (March 2000)

As mentioned and shown in the Figure 2.1(above), children and families can been affected by HIV/AIDS in different ways. For example, HIV infections increase serious illness among children and families. And the illness of parents may result in the children becoming the primary care-givers in the family. At the same time, serious illness among parents leads to economic problems and psychological distress among children and families. In the face of economic problems in the family, children may be forced to drop out of school, not to have adequate food,

shelter, material needs and accesses to health services. These conditions and problems increase the vulnerability of children and families to HIV infections.

The figure also indicates that the deaths of parents and young children bring about psychological distress and imply that children live without adult care. This in turn may lead to discrimination, exploitation of child labour, sexual exploitation, and life on the street among other destitute adults and children. This lack of adult care and its consequences increase children's vulnerability to HIV infection.. The deaths of parents also lead to problems of inheritance among children and families which emanate from economic problems and a lack of succession planning.

2.4.1 The demographic impact of HIV/AIDS on OVCs

Demographic analysis shows that the burden of orphans is disproportionately distributed among communities. For example, the national orphan prevalence rate in Ethiopia is 10,7%, but much higher rates are found in the Addis Ababa (15,7%), Afar (20,7%), and Somali (14,4%) (Williamson *et al* 2004). In Sub-Saharan Africa, non-relative child fostering (once an uncommon practice) has increased in some countries. The proportion of orphans who have lost both parents and are under the care of non-relatives increased in four countries – Kenya (from 3,1% to 8,7%), in Tanzania (from 2,1% to 4,2%), in Namibia (from 4,9% to 9,3%), and in Zambia (from 2,2% to 3,5%). These results are an indication that the number of relatives that care for orphans has declined or that these relatives have become over-burdened (Conroy, Tomkins & Landsdown 2000; Williamson *et al* 2004).

Demographically speaking, migration is an essential family and community coping mechanism in the face of the HIV/AIDS pandemic. Recognised forms of migration as a response to HIV/AIDS is the so-called 'going-home-to-die'- return migration; rural widows migrating to urban areas to seek employment or the help of relatives; and potential care-givers and dependants moving between households to attain the optimum care and support arrangements possible. Children are often

relocated to a new home, either with or without care-givers. Young people very often are affected by migration, as girls are sent to help out in other households, or children are encouraged to try and fend for themselves by working and by becoming street children (Simbayi *et al* 2006).

The demographic impact of morbidity and mortality related to HIV/AIDS also affect the composition of households and the domestic care arrangements of children. According to Nampoyna-Serpell (cited in Simbayi *et al* 2006), changes in care-givers and family composition were observed in households and communities because of the impact of HIV/AIDS. As a result of death and migration, family members, including dependent children, move in and out of households. Care-givers change and siblings may be separated, a factor which has been found to be a contributing factor in emotional distress in children and adolescents affected by HIV/AIDS (Simbayi *et al* 2006). Children become more at risk when they are cared for by very old relatives in relationships of mutual dependency. Child-headed households are usually headed by adolescent girls who can perform the role of care-givers. At times, there are nearby relatives to offer direction to the child-headed household. Sometimes there are siblings who desire to stay together, or a dying parent has asked for them to stay together. All these situations can happen in single households in the community (Simbayi *et al* 2006).

At the outset, the social impact of HIV/AIDS often causes families and communities to be paralysed, a response that is connected to the fear of the unknown situation in communities where traditional coping patterns give no easy answers to the problems. Thus, Lealem, (2004) states that fear is followed by stigmatisation of the affected individuals and families. Family or household and community patterns can change as a result of and traditional social safety nets can become accustomed to the new crisis in an effort to alleviate the negative impact. In this regard, the extended family was the traditional social safety net in most of African countries including Ethiopia. Over the past decades, poverty in

general and the scale of the problem of orphans and other vulnerable children destabilised extended family networks (Tekle 2007). The need to care for ill family members, the increased number of orphans to look after and the reduction in the number of prime-age care-givers has put the extended family safety net under great stress.

Although Germann, Madorin and Ncube (2002) recognise that AIDS puts families under great stress, most families in Southern Africa still provide some level of care for OVCs. Grainger, Webb and Elliott (2001) suggest that most families who agree to take in foster children from were already living below the poverty line before taking on such care burdens, whilst wealthier relatives tend to maintain minimal links with orphans apart from some kind of financial support. Many families find it easier to adopt non-AIDS orphan children than OVCs since there is a misconception that OVCs can transmit the virus (Lealem 2004).

In line with this, the Ethiopian Government, FHAPCO (2004) stresses that the general level of poverty and the growing demand for care and support of OVCs in Ethiopia has weakened social cohesion and traditional care and support mechanisms (for example support offered by extended families). Often orphans inherent money, but their basic psycho-social needs are not cared for and this leaves them vulnerable to other psycho-social problems (The Ethiopian Government, FHAPCO 2004).

Similarly, household and family structures also affect vulnerability, coping, and caring capacity. Extended, nuclear, female-headed and child-headed households each have different capacities for coping with parental illness, death, and care of surviving orphans. Coping responses are powerfully influenced by the roles of women, men, and children within families and these roles differ among ethnic, social, and religious groups. Gender takes on particular relevance in connection with HIV/AIDS, as in most affected societies women provide a disproportionate share of care for the sick and orphaned (Williamson *et al* 2004).

2.4.2 Changes in the responsibilities and employment status of OVCs

Simbayi *et al* (2006) state that the workloads and responsibilities of children tend to change when HIV and AIDS affect their families and when their parents die. According to UNICEF (2000), numerous studies have shown that responsibilities and work, both within and outside the household, increase radically when parents are ill or have died, and that such burdens are placed on children as young as five years of age (Simbayi *et al* 2006). This includes domestic tasks, subsistence agriculture, and care-giving of younger, aged and sick members of the household. Work outside the home may be formal or informal labour, including begging for food (Simbayi *et al* 2006).

Due to the low productivity of sick parents, the workload of children and extended family members may increase. Children may be forced to work in the formal and non-formal labour market to earn money for the household (Williamson *et al* 2004). According to Ayalew and Elias (1999), most OVCs are forced to work because their survival and that of their families depend on it. As a result of lack of adult supervision, they are overworked, underpaid, ill-treated and have no opportunity to go to school. The lives of these children can be improved only by providing them with basic services including health, nutrition and education (Lealem 2004).

2.4.3 Changes in household incomes and the impact on OVCs

Economic patterns and conditions in areas affected by HIV/AIDS are among the most significant contextual aspects to assess the situation analysis (Williamson *et al* 2004). HIV/AIDS have contributed to increased poverty and have left vulnerable even some families not necessarily considered as poor. Most of the problems of vulnerable families and communities result from or are intensified by the impact of

AIDS in their economic situation. HIV/AIDS has a multi-sector, multidimensional economic implication for persons living with HIV, their families and households, the children they leave behind, and the community at large. As discussed below, the economic impacts of a parent's illness on the family (especially on children) are felt in the area of education, labour, food security, health and shelter (Williamson *et al* 2004).

Studies in urban household in Cot d'Ivoire, for example, show that when a family member has AIDS, the average household income falls by 52% to 67%, whereas expenditure on health care quadruples, savings are exhausted and families fall into debit to care for the sick. Similar findings have been reported for HIV/AIDS affected households in South Africa (Simbayi *et al* 2006). According to UNICEF (1999), food consumption has been found to decline by 41%. Loss of income of breadwinners declines because of selling of assets to pay for health care and funeral costs. This may deplete all current and future financial reserves of households (Simbayi *et al* 2006). It was found that households' asset base eroded with the incidence of HIV/AIDS as expenditures related to health care and funeral arrangements increase (Drimie, Tefesse & Frayne 2006).

Another study in Ethiopia conducted by the Central Statistics Authority (2005) found that children and women are most vulnerable to malnutrition in developing countries because of low dietary intakes, infectious diseases, and lack of appropriate or suitable care and equitable distribution of food within the household. The study by Tekle (2007) in Ethiopia illustrated that the health and nutritional status of orphans were lower compared with non-orphans. Furthermore, the study by MOLSA (2003) in Ethiopia showed that almost a quarter (25%), and 6,5% of orphan children below ten years reported illness, abuse and neglect respectively. Thus, these negative effects on the health status of children may be due to poor economic and health conditions and the lack of proper care by care-givers. According to another study, as HIV-infection as an illness progresses, parents are less able to care for their children and themselves

(Kamili *et al* 1996). Generally, serious illness and thereafter the death of parents negatively affect the social, intellectual and physical development of children.

One of the first visible impacts of prolonged parental illness on children can be that their education is interrupted due to a lack of financial resources and the children's increased responsibility for household and care-giving chores. Even for orphans that continue with schooling, their performance is often lower than that of their non-orphans peers. According to Bicego, Rutstein and Johnson (2003:1235), education is considered a principal means for families and children to self-advancement: *"Orphans are less likely than non-orphans to be at the proper educational level, with the effect stronger at younger ages (age 6–10) than older ages (11–14). Loss of both parents places a child at a particular disadvantage, and loss of a mother appears more detrimental than loss of a father with regard to educational attainment"*. Kamali *et al* (1996:509) suggest that "*orphans experience slightly lower school attendance rates than non-orphans".*

Matshalage (2002) argues that education is a means whereby OVCs can realise the possibility of productive employment, minimising the risk of being exploited and of becoming infected with HIV. However, for many African countries like Ethiopia, poverty and HIV/AIDS have forced children to drop out from school (Lealem 2007:14). Williamson *et al* (2004) state that school attendance drops in households affected by HIV and AIDS. This is because these children's labour is needed and because families use money earmarked for school expenses to instead pay for medication and health services. Attending school may also interfere with the many other duties that OVCs are required to perform. In addition, stigmatisation may prompt OVCs to remain away from the school rather than suffer being isolated and excluded at school.

A study in Zambia found that 75% of non-orphaned children in urban areas were enrolled in school compared to 68% of orphaned children (Simbayi *et al* 2006). A World Bank study in Tanzania projected that HIV and AIDS may reduce the

number of primary school children by 22% and secondary school children by 14%, as a result of increased child mortality as well as lower attendance and rising absenteeism (Simbayi *et al* 2006). In line with this, the study conducted in Ethiopia by MOLSA (Ethiopian Government, MOLSA 2003) indicates that OVCs drop out of school following the death of the mother or both parents. On the other hand, a study conducted in Zimbabwe found that in situations where most farm workers' deaths are attributable to AIDS-related causes, 48% of the orphans of primary school age dropped out of school, usually at the time of the parent's illness or death (Simbayi *et al* 2006). A study conducted in Kenya found that 64% of the boys gave economic reasons for dropping out of school, while 28% girls said that they had become pregnant and 41% had left to get married (Conroy *et al* 2000).

According to UNAIDS and UNICEF (1999), studies indicate that many OVCs were forced to drop out of school as a result of stigma attached to HIV/AIDS and this extended in the next age group placing an emotional burden on children who may also be trying to cope with the death of their parents from AIDS-related causes. They are rejected and shunned by their friends (Lealem 2004). Smart *et al* (2006) investigated the impact of HIV and AIDS on the education of OVCs in many African countries including Ethiopia. They concluded that in households affected by HIV and AIDS, school attendance of children decreased as their labour is needed for subsistence activities. Moreover loss of household income and increased spending resulting from the illness of adults lead to the money allocated for school expenses to be used for basic necessities instead. In those households where children were not forced to drop out of school, their education nevertheless was curtailed as additional household burdens were placed on them. This was particularly true for female children.

Lealem (2004) found that orphans were less likely to enrol in school than non-orphans of the same age group due to poverty, the priority given to the children in the core family and stigmatization due to HIV and AIDS. Lealem (2004) states that

as far as the educational and psychological problems of AIDS orphans in Addis Ababa and Awassa are concerned, 10% of the OVCs were not enrolled in school and 28% dropped out of school. A study conducted in Switzerland also confirmed that school enrolment falls by 36% as a result of HIV and AIDS, with girls the most affected (UNAIDS 2004). A study of orphans conducted in Kenya stated that 56% of girls compared with 46% boys dropped out of school within a year following the death of a parent (Meegan *et al* 1999). The study conducted by MOLSA (2003) in Ethiopia stressed the idea that OVCs drop out of school following the death of their mothers or both of their parents (MOLSA 2003).

According to Drimie *et al* (2006), the relationship between the HIV pandemic and the food security situation in Ethiopia is complex. However, it is likely that the pandemic will contribute to worsening widespread food insecurity, and conversely, food insecurity will increase the vulnerability of the population to HIV infection. At the household level, there is a two-way relationship between livelihoods and HIV/AIDS. Insecure livelihoods aggravate the risk and vulnerability environment for HIV/AIDS. At the same time, illness and death connected with AIDS destabilises livelihood options. Vulnerable people are forced to make decisions, often involving trade-offs among basic needs. For example, a family with an insecure livelihood, but with a fair amount of food on hand, may have to sell stocks of food in order to raise cash for school fees or medical care – even though they know they will have to buy back food later at a higher cost. In this environment, insecure livelihoods aggravate the risks and vulnerabilities of HIV and AIDS.

Lack of options can push some people into activities or situations that put them and others at high risk of HIV, such as commercial sex work. Lack of food, money and health-care are key factors in rapid progression from HIV infection to onset of AIDS. People with insufficient resources find it harder to properly take medication, including anti-retroviral. Finally, those with weak livelihoods are more vulnerable

to social and economic impacts of illness and death in their families and communities (Drimie *et al* 2006).

As discussed in detail in the section above, the policy framework for orphans and other children made vulnerably by HIV and AIDS for South Africa assumes that the impact of HIV and AIDS on orphans and vulnerable children manifests in the areas of

- material problems such as livelihood (increased poverty, loss of property and inheritance, loss of food security, loss of shelter),
- health (lower nutritional status, poor concentration when sick, less likely to be immunized, increasingly vulnerability to disease, less access to health services, increase vulnerability to HIV and AIDS, higher mortality rate, higher exposure to opportunistic infections),
- education (withdrawal from school to save costs, increased truancy, lower educational performance, premature termination of education, fewer vocational opportunities, traditional knowledge not passed on) and
- non-material problems such as protection, welfare, emotional health (loss of family and identity, decreased adult supervision, decreased affection and encouragement, increased labour demands, harsh treatment, discrimination, stigma and social isolation, forced early marriage, sexual abuse and exploitation, abandonment, grief and depression, poor well-being, antisocial and difficult behaviour; homelessness, vagrancy, crime, increased street living, increased malnutrition, starvation, forced migration.

2.4.4 The socio-cultural impact of HIV/AIDS on OVCs

According to Germann *et al* (2002), HIV and AIDS seem to have a negative impact on children's socialisation with respect to their identity formation and social development. Children affected by HIV/AIDS may feel a sense of alienation, stigmatisation and isolation. The health and nutritional status of orphans compared with non-orphans is lower. This is a matter of concern, as not only is it

a child rights violation but also during childhood, malnutrition is associated with reduced productivity in later life (Tekle 2007).

Culture-based explanations and beliefs about how illness in general and HIV/AIDS in particular are caused can affect whether these children receive help from their extended families, communities, or service providers. In many countries, traditional healers are very powerful and the first line of response to illness. They can influence beliefs about illness and healing, behaviours that can prevent or spread HIV infection, the types of care given to people with AIDS and vulnerable children, and stigma and discrimination directed at people living with or affected by AIDS (Williamson *et al* 2004). These authors extend elaborating the impact of cultural factors in the AIDS pandemic that acknowledge the roles of culture and religion in promoting security and survival which can help to encourage an understanding of risk behaviour and positive behaviour change. Likewise, identifying the kinds of support extended family and other social networks may provide can be very useful.

2.4.5 The psycho-social impact of HIV/AIDS on OVCs

In addition to their physical needs, children have critically important emotional, cognitive, social, developmental and spiritual needs. Fulfilment of these needs is essential to positive human development, and the impacts of HIV/AIDS can impede this. Germann *et al* (2002) demonstrate that OVCs suffer from multiple losses through the loss of fathers, mothers, siblings, aunts, and other relatives. In addition to direct losses caused by death, they experience loss of familiar surroundings, friends and schooling and can lose hope for the future. Generally, OVCs suffer from stigma and discrimination associated with the disease, the loss of caring adults and reduction of household financial resources. A child whose mother or father is HIV positive begins to experience loss, grief and distress long before the parent(s) death (Tekle 2007).

Since HIV infection progresses from initial infection to mild HIV related illness to the life threatening illness, children can live through long periods of uncertainty and intermittent crisis, as the health of parents deteriorates and death occurs. OVCs who witness the prolonged illness and death of one or more family members may suffer psychological distress as a result. According to a study carried out in Ethiopia by Save the Children Denmark (2002), some of the psycho-social challenges faced by OVCs are loss of family, anxiety, depression, lack of health care, lack of education, early entry into paid and unpaid labour, loss of inheritance, early marriage, vulnerability to abuse and increased risk of HIV/AIDS. According to the International HIV/AIDS Alliance's report (quoted in Tekle 2007), the psycho-social problems faced by OVCs include stress, anxiety, loss of self-esteem and confidence, stigma, discrimination and depression. According to this author different authors indicate that common feelings experienced by children when they lose their parents include guilt, anger and sadness.

In line with this Simbayi and others (2006) further discussed the psychological impact of HIV/AIDS by suggesting that children affected and orphaned may endure stress from work and worry, as well as insecurity and stigmatisation. Loss of a home and dropping out of school, separation from siblings and friends, increased work load and social isolation, are all associated with poor mental health status. Studies of children's reactions have suggested that they show internalised behaviours, such as aggression or other forms of anti-social behaviour (Simbayi *et al* 2006)

A rise in the percentage of children living in child-headed households would be an important indicator of the impact of HIV/AIDS and a useful advocacy finding (Bicego *et al* 2003). HIV infection has a negative impact on child survival and development. As studies indicate, orphans are more likely to be HIV positive and their expected mortality rates are considerably greater than that of non-orphans in the same age-groups (KamilIi *et al* 1996). As mentioned (above) child-headed households are usually headed by adolescent girls who can perform the role of

care-givers (Williamson *et al* 2004). A study by Williamson (2000) showed that serious illnesses among parents result in children becoming care-givers.

2.4.6 The vulnerability of OVCs to HIV infection

Foster and Williamson's (2000) study about the impact of HIV and AIDS on vulnerability indicate that apart from other socio-economic impacts, children affected by HIV and AIDS are themselves highly vulnerable to HIV infection. Their risk for infection arises from the likelihood of an early onset of sexual activity, commercial sex work and sexual mistreatment. These risks may be brought about by economic need, peer pressure, lack of adult supervision, exploitation and rape. Simbayi *et al* (2006) note that OVCs can be protected against these risks by the safety net provided by extended families and communities, but that such safety nets are often better preserved in rural areas. The study done by Foster and Williamson (2000) indicate that apart from other socio-economic impacts, children affected by HIV and AIDS are themselves highly vulnerable to HIV infection.

In line with this the UNAIDS AIDS global report on the impact of HIV/AIDS on women and young people with respect to vulnerability stated that in sub-Saharan Africa, where women represents 59% all adults living with HIV/AIDS (according to recent study which also true for Ethiopia), gender inequalities in social and economic status and in access to prevention and care services increase women's vulnerability to HIV infection. Sexual violence may also increase Women's risk, and women especially young women are biologically more vulnerable to HIV infection than men (UNAIDS 2008). The study further stated that teens and young adults, particularly girls and young women, continue to be at the centre of the epidemics. Young people aged 15-24 account for about 45% new HIV infections (among those 15 and above). Thus, In Sub-Saharan Africa, the HIV/AIDS prevalence rate among young women aged 15-24 is nearly three times elevated than the rate among young men in the same age group (UNAIDS 2008)

Generally, as discussed in the Literature part of the study mentioned (above) on the impact of HIV/AIDS on children/OVCs CRS Report for Congress (2005) stated that the impact of HIV/AIDS on children is just beginning to be explored. Not only are children orphaned by AIDS affected by the HIV virus, but those who live in homes that have taken in orphans, children with little education and resources, and those living in areas with sky-scraping HIV rates are also impacted. Children who have been orphaned by AIDS may be forced to cease school, engage in labour or prostitution, suffer from depression and anger, or engage in high-risk behaviour that makes them vulnerable or susceptible to contracting HIV, children who live in homes that take in orphans may be stigmatised. Impoverished children living in households with one or more ill parent/care-giver are also affected, as health care increasingly absorbs/take up household funds, which regularly leads to depletion of savings and other resources served for education, food, and other purposes (CRS Report for Congress, 2005).

2.5 CONCLUSION

Chapter 2 described a review of the literature concerning the socio-economic problems of OVCs. It explained the prevalence, incidence and the impact of HIV/AIDS on orphans and vulnerable children. The researcher regards the study of the socio-economic situations of orphans and vulnerable children in Dessie Town as a sociological study because sociological concepts and skills were used to develop an understanding that the care of children in social institutions such as families or welfare institutions is subject to profound changes due to HIV and AIDS. From a sociological vantage point, the researcher was able to consider that social phenomena (here, the socio-economic situation of OVCs in an urban area in a developing country) are conditioned by social structures as well as by intentional human agency. The next chapter will discuss the methodology employed in the study.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

In this chapter, the methods used in the study are described. The sampling techniques and its variant forms together with its rationale are presented. The description of the tools and techniques used to collect and analyse the data and the ethical considerations pertinent to the study are also discussed.

3.2 STUDY DESIGN

The general objective of the study was to undertake a situation analysis of OVCs at Dessie Town. Secondary objectives were to gather data and assess the socio-economic conditions of OVCs, to describe households in terms of school attendance and other problems, obtain information about the characteristics of the care-givers of OVCs, describe the nature of the domestic arrangements, housing and socio-economic vulnerability of OVCs in the study site, describe the biographical characteristics of OVCs such as orphanhood status, nutritional status, decision-making powers and risk taking behaviour and identify and describe existing and potential support systems for OVCs. In order to reach these stated objectives, a descriptive survey research method was chosen for the study.

This study gathered evidence about specific indicators of socio-economic vulnerability of OVCs in Dessie Town. Three cross-sectional (baseline) interview–based surveys were conducted:

1. The first survey was conducted among randomly selected OVCs.
2. The second survey was conducted among purposefully selected guardians and parents of OVCs, and 3 the third survey was conducted among representative of organisations providing services for OVCs in Dessie Town following a non-random selection of organisations.

For this study, a quantitative, survey-type approach was regarded as the most appropriate and effective means of data collection as this approach allowed the researcher to get a comprehensive overview of the issues pertinent to the objectives of the study. The researcher employed quantitative research methods to describe and analyse the various existing socio-economic factors that contour in the lives of OVCs. In this regard, structured questionnaires, administered by trained interviewers were used to collect data in each selected household from the parent/guardian and from the OVCs.

A mixed design was used to gauge the perceptions of selected service provider organisations on the problems regarding OVCs in the study site. This implied the generation of both quantitative and qualitative data for this third level of the multi-phased study.

3.3 SAMPLING TECHNIQUES

For background information and a sampling frame, the researcher relied on information obtained from the Dessie Town Municipality and the Dessie Town Labour and Social Affairs Office's OVC survey which was carried out in 2007. By using the complete listing of households with OVCs of 4 422 units, the researcher drew a sample of 6,6 % or 292 OVCs by starting at a random place on the list and choosing every 15^{th} name from this survey list. The list was organised according to the 10 kebeles. In addition to this, 130 guardians/care-givers of the sampled OVCs were purposely selected and interviewed for the study. Furthermore, four OVC service provider organisations in Dessie Town were selected. These were purposefully selected so that governmental, NGO-, CBO-and FBO- service providers were included.

3.4 DATA COLLECTION TECHNIQUES AND DATA GATHERING INSTRUMENTS

The main data collection instruments were structured questionnaires administered in face-to-face interviews to the selected parents/guardians and the OVCs by trained interviewers. Less structured interview schedules were used to collect data from the service organisations.

The baseline questionnaires on the socio-economic situations OVCs were developed by adopting the instruments used in other studies, namely a study on psycho-social issues affecting OVCs in two South African communities (Simbayi *et al* 2006) and Family Health International's *Participatory Situational Analysis Of Orphans And Vulnerable Children Affected By HIV/AIDS* (FHI 2005). The instruments were first developed in English by the researcher and then translated into local Amharic by a language expert to make it easily understandable to the respondents.

In the study five interviewers and a supervisor were trained to assist in the data-generation. The researcher personally trained the interviewers and supervisor on how to reach the sampled respondents, administer the questionnaires in face-to-face interviews and complete the questionnaires. Training also included making the goals of the study, the method of respondent selection, the data collection techniques, fieldwork organisation, the administration of informed consent forms and maintaining the confidentiality of the completed questionnaires clear to all the collaborators.

Interviewers were selected with the assistance of the respective kebele officials at the Dessie Town Labour and Social Affairs Office. The interviewers were paid birr 240.00 each to complete and administer an average of 85 questionnaires each. Furthermore, the supervisor, Ato Messfin, was paid birr 400.00 for his coordination and assistance.

Recruitment of the interviewers took place from 5 to 10 February 2010. They were trained on the 8th of February 2010 in the researcher's office at the Ethiopian Development Bank in Dessie Town. Fieldwork commenced on the 10th of February 2010 and was completed by the 16th of February 2010.

As the five interviewers resided in the chosen kebeles where the research was conducted, they were each given a list of addresses for the selected OVCs and guardians. The researcher and the supervisors checked with the interviewers each day of the data-gathering to make sure that the instructions were followed and that no problems affecting the quality and reliability of the data-collection occurred. The interviews for the OVCs and guardians took place in their respective houses.

The researcher was aware of the potential that the study participants may experience psychological discomfort during the process of data collection. Taking this into account, the researcher developed informed consent forms for the research participants. For the child participants in this study, an informed consent for participation was not only obtained from the children but also from their parent/guardians.

The researcher trained all the interviewers on the proper administration of informed consent prior to each interview, on the participants' rights to refuse participation or to stop the interview at any time and how to debrief each interviewee after the completion of the interview with assurances of confidentiality and advice on where to access any further information on the study. Furthermore, the interviewers were trained on how to deal with OVCs and possible reactions to questions related to health, abuse and other sensitive matters. During the fieldwork process, the researcher remained in constant contact with each of the interviewers to discuss progress and issues in the field. The researcher and the research assistants constantly contacted and assisted the interviewer at the

visiting point while they conducted the interview. Any problems encountered by interviewers were solved together on the spot. The availability of cell phones on most of the interviewers makes easy the researcher follow–up activities. The researcher was able to visit the interviewers at work to make sure that each interviewer conducted the interview at the correct visiting point.

Before employing the questionnaires and the interview schedule to gather data from the respondents, pre-tests were conducted. The questionnaires were administered to a convenience sample of 12 OVCs and 5 of their care-givers in Dessie Town. The interview schedule for data-generation with the service organisations was also pre-tested with one OVC service provider who was excluded from the actual study. Based on the feedback obtained from these pre-tests, the researcher changed the wording of some of the question items so that these could be more easily understood by the respondents. Moreover, more response options were included in some of the closed questions.

For the qualitative interviews with the service providing organisations, an interview schedule was developed by the researcher based on the objectives of the study and the literature review as presented in Chapter 2 of this dissertation. The researcher personally conducted these interviews. He first contacted these organisations and explained the goal of the study. Appointments were made with World Learning Ethiopia (an NGO), Dessie Town District HAPCO Office (a GO), Addisalem Edir (a CBO), and Mekaneyesus Bureau (an FBO). Persons contacted were Ato Esseye, Ato Nuru, Ato Shimelis, and Dr Fekade. Before commencing with each of these interviews, the researcher obtained informed consent from each of the participants to continue with the interview and to audio-tape the interviews. Each interview lasted for 30 minutes. Fieldwork for this qualitative phase of the study commenced on the 25th of February, 2010 and was completed on the 30th of February 2010.

3.5 RELIABILITY AND VALIDITY OF DATA COLLECTION IN THE QUANTITATIVE PHASE OF THE STUDY

The questionnaires were adapted from existing research as explained earlier in this chapter and pre-tested and refined as explained above. The researcher recruited and trained experienced interviewers to collect the data and closely supervised them. As mentioned above, during the fieldwork the researcher remained in constant contact with each of the interviewers to discuss progress and issues in the field. The researcher and the research supervisor remained in close contact. The supervisor assisted the interviewers at the visiting points while they conducted the interview.

All of the interviewers had their own cellular telephones and this made it easy for the researcher to follow–up on their activities.

3.6 DATA ANALYSIS AND INTERPRETATION

The quantitative data from the questionnaires were coded, computerised as an Excel file and then analysed with the help of the Statistical Package for Social Scientists (SPSS). The analysis began with descriptive statistics on all the question items to summarise the essential features of data. Bivariate analyses were also undertaken as well as chi-square calculations to assess statistically significant associations between the various socio-economic variables relating to the living conditions of OVCs.

The audio-taped interviews with the representatives from the four service organisations were transcribed verbatim into separate word-processed computer files for each interview. The researcher read these files several times and listened to the tapes to make sure that the transcriptions were accurate. All of these interviews were conducted in Amharic. From the transcribed interviews and from the stated objectives of the study, the researcher was able to develop a list of

codes for the qualitative data. The data was coded and organised and summarised thematically.

3.7 ETHICAL CONSIDERATIONS OF THE STUDY

The researcher first obtained written permission from the Dessie Town District Labour and Social Affairs Office and the Dessie Town Municipality to conduct the study and to access the necessary OVCs and households data from the survey conducted in 2007.

The highest ethical standards were upheld during the quantitative data collection and analysis due to the potential problems of stigma attached to HIV/AIDS. The researcher was aware of the potential that the study participants may experience psychological discomfort during the process of data collection. Taking this into account, the researcher developed informed consent forms for the research participants. For the child participants in this study, an informed consent for participation was not only obtained from the children but also from their parent/guardians. The researcher trained all of the interviewers on the proper administration of informed consent prior to each interview, on the participants' rights to refuse participation or to stop the interview at any time and how to debrief each interviewee after the completion of the interview with assurances of confidentiality and advice on where to access any further information on the study.

Furthermore, the interviewers were trained on how to deal with OVCs and possible reactions to questions related to health, abuse and other sensitive matters. As mentioned above, permission to conduct the research from Dessie District Youth and Social Affairs Office was obtained. Before the data collection took place, an arrangement was made by the office and the researcher to identify and assign, trained experienced data enumerators, 5 from the ten kebeles (one enumerator for two adjust kebeles) who knew the household levels study

participants by the office and the researcher. As explained in the sampling technique section above, the enumerator made house to house rounds and explained the purpose of the study to selected OVCs and guardians and conducted an interview with those who agreed voluntarily to participate in the study. Kebele level supervision and follow up was made by the research assistants and the researcher. Research participants in need of further counselling were referred by the interviewers to service providers in the community for further intervention.

For the qualitative interviews with the representatives of the four service organisations, the researcher also protected the confidentiality of the participants by asking them to sign informed consent forms. The signed forms were kept in a safe place by the researcher. The tape recorded interviews and the transcribed interviews were kept in a safe place at the researcher's residence. Pseudonyms were assigned to each research participant during the transcription phase.

3.8 SUMMARY

Chapter three described the methodology used in study. It explained the research setting, the technique and the entire procedure on how the data was collected and analysed. Finally, the chapter explained how ethical considerations were applied in this study. The next chapter will explain the results of this study.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

This chapter deals with the findings obtained from the questionnaire, and structured and unstructured interviews. This study had three groups of respondents. The first group was the OVCs, aged 7 to 18 years. Data in relation to this first group is discussed first in this chapter. The second group of respondents was the parents or care-givers of the OVCs and the third group were key informants from service organisations that deal with the care and support of OVCs.

4.2 FINDINGS FROM THE OVCs SURVEY

As explained in the previous chapter, 292 OVCs were randomly selected and interviewed using a structured questionnaire. In the section below, the demographic characteristics of the sample of OVCs are discussed. This is followed by a discussion of the findings related to the OVCs, their care-givers and migration, the educational status of the OVCs, the descriptions of their dwellings, and the problems they experience.

4.2.1 Background characteristics of the OVCs

As shown in Table 4.1 (next page), 21,2% of the sample was in the 7 to 9 year old age group with 16,4% of the males and 25,7% of the female respondents falling into the lowest age group. Less than half (47,3%) of the respondents were between 10 and 15 years of age with 48,6% of the males and 46,4% of the females falling into this middle category. Finally 31,5% of the respondents were in the age range of 16 to 18 years with 35% of the male respondents and 28,3% of the female respondents falling into this lower end of the age categories.

Therefore, females were slightly over-represented in the youngest age group. In terms of gender, 52,1% was females and 47,9% were males.

Table 4.1: The age groups of the OVCs by sex (N=292)

Age-group	Sex				All respondents	
	Male		Female			
	Number	%	Number	%	Number	%
7-9 years	23	16,4	39	25,7	62	21,2
10-15 years	68	48,6	70	46,0	138	47,3
16-18 years	49	35,0	43	28,3	92	31,5
Total	140	100,0	152	100,0	292	100,0

The religious and ethnic backgrounds of OVCs are important social indicators in understanding the background of the parents of OVCs in the study town.

Table 4.2: Religious and ethnic group composition of the OVCs (N=292)

Religion	Number	%
Ethiopian Orthodox	188	64,4
Muslim	92	31,5
Protestant	9	3,1
Catholic	3	1,0
Total	**292**	**100,0**
Ethnic origin		
Amhara	273	93,5
Ormo	3	1,0
Tigre	16	5,5
Total	**292**	**100,0**

Table 4.2 (above) shows that 64,4% of the respondents indicated their religion as Ethiopian Orthodox, 31,5% were Muslim, 3,1% were Protestant and 1,0% was Catholic. Regarding the ethnic group of the respondents, 93,5% were Amhara, 5,5% were Tigre and 1,0% was Ormo. These proportional sizes of the sample by religion and ethnic group are similar to the proportional representation of the population in the study site according to religion and ethnicity.

As indicated in Table 4.3 (next page), the mean number of adults per household aged 18 years and above was 5,85 (2,66 for males and 3,19 for females). It is interesting to note that the 60 to 70 age category showed the mean number of persons per household. This probably means that elderly (probably grandparents)

live in the same households as the OVCs. The mean number of children per household aged from birth to 17 years was 6,96. It can thus be deduced that the OVC households sampled had a large number of potentially economically inactive persons (those too young to work and those too old to work).

This composition of the OVCs households also indicated a total mean number of household members of 12 persons. Table 4.3 also shows that the mean number of children per household was greater than mean number of adults per household and the mean number of females in both cases was greater than the mean number of males. Generally, the study found large household sizes in the OVCs under study in particular, and in Dessie Town in general, where it is difficult for most parents to fulfil the basic economic, social and developmental needs of the household members due to poverty.

Table 4.3: Compositions of the OVCs households (N=292)

Age Categories	Mean number of males	Mean number of females	Mean number of persons
18-25 years	0,68	0,79	1,47
26-39 years	0,39	0,90	1,29
40-59 years	0,39	0,39	0,78
60-70 years	0,80	0,92	1,72
Older than 70 years	0,40	0,19	0,59
Mean number of adults per household	**2,66**	**3,19**	**5,85**
Birth to 2 years	-	0,60	0,60
3-5 years	-	0,22	0,22
6-9 years	1,00	1,06	2,06
10-14 years	1,01	1,01	2,02
15-17 years	1,04	1,02	2,06
Mean number of children per household	**3,05**	**3,91**	**6,96**
Mean household size	**5,71**	**7,10**	**12,81**

Table 4.4: Type of orphanhood status of the OVCs (N=292)

Type of orphanhood	Number	%
Maternal orphan	58	19,9
Paternal orphan	103	35,3
Double orphan	119	40,8
Other	12	4,0
Total	292	100,0
Are you part of a child-headed household?		
Yes	33	11,3
No	259	88,7
Total	292	100,0

As shown in Table 4.4 (above), the largest category of respondents (40,8%) indicated that they were double orphans (that is, they have lost both of their parents), whereas 35,3% of the respondents were paternal orphans,19,9% were maternal orphans and 4,0% indicated that they were unsure of their orphanhood status. In addition, more than 1 in every ten respondents (11,3%) indicated that they belonged to a child-headed household.

Table 4.5 (next page) shows that 44,5% of the respondents indicated that they had living siblings who did not live with them in their current households. Amongst these 130 respondents, 71,5% had at least one brother and 61,5% at least one sister who lived elsewhere. In addition, 45,4% of these respondents never had any contact with their siblings and 33,9% had contact only once a year. This separation from living siblings and infrequent contact with them held negative emotional consequences for the respondents. Table 4.5 shows that 51,5% of the 130 respondents said that this separation made them feel isolated and alone, whereas 23,1% indicated that they felt sad, 21,5% said that they felt scared and worried and 3,9% said that they felt angry.

Table 4.5: Information on siblings not living with the respondents (N=292)

Do you have brothers and sisters who do not live here with you in the same household?	**Number**	**%**
Yes	130	44,5
No	162	55,5
Total	292	100,0
If "yes" how many brothers do not live here with you?		
1	93	71,5
2	27	20,8
3 or more	10	7,7
Total	130	100,0
If "yes", how many sisters do not live here with you?		
1	80	61,5
2	36	27,7
3 or more	14	10,8
Total	130	100
If you have siblings who do not live with you: How often do you visit with them?(N=130)		
Every day	2	1,5
Once a week or every 2nd week	2	1,5
Once a month	3	2,3
Every few months	20	15,4
Once a year	44	33,9
Never	59	45,4
Total	130	100,0
If you have siblings who do not live with you: How do you feel about being separated from them? (N=130)		
Unhappy or sad	30	23,1
Angry	5	3,9
Scared/worried	28	21,5
Isolated/alone	67	51,5
Total	130	100,0

4.2.2 Responses of the OVCs on questions related to their care-givers and migration

Objective 4 of this study was to describe the nature of the domestic arrangements, housing and socioeconomic vulnerability of OVCs in the study site. In this section, data on the relationship between the current care-giver and the OVCs, place of birth of the OVCs, migration to Dessie Town, school attendance,

food consumption and perceptions about the treatment received from the care-givers are discussed.

Table 4.6: Relation of the current care-givers to the OVCs (N=292)

Relation of current guardian to the respondent	Number	%
Mother/Stepmother	72	24,7
Father/ Stepfather	27	9,2
Brother/Stepbrother	2	0,7
Sister/ Stepsister	18	6,2
Grandmother	65	22,3
Grandfather	12	4,1
Foster Care Parent(s)	36	12,3
Aunt	35	12,0
Uncle	17	5,8
Neighbour	5	1,7
Care-giver/Housemaid unrelated to the respondent by blood or marriage ties	3	1,0
Total	292	100

According to Table 4.6 (above), 24,7% of the OVCs are cared for by their mothers/stepmothers, whereas 22,3% are cared for by their grandmothers. In fact, female relatives comprise about 65,5% of all current care-givers when the responses of sister/stepsister and aunt to the responses for mothers/stepmothers and grandmothers are added. Only 7,2% of the respondents were cared for by other foster parents,1,7% by neighbours and 1% by an unrelated care-giver or housemaid.

A South African study found that 52,4% of guardians to OVCs were female relatives (Simbayi *et al* 2006). A situational analysis of OVCs in Amhara (Amhara 2008) found that a large proportion of widowed biological parents (63,7%) act as a care-givers for OVCs. In contrast, this study found that biological parents account for 33,4% of care-givers. The difference in findings may be due to the fact that the ARLSAB employed a house-to-house enumeration of birth to 18- year olds in all zones of the Amhara region, including rural areas.

The researcher, with some circumspection, concludes that in Dessie Town, maternal relatives play a greater role in taking care of OVCs than paternal and non-relative carers. Moreover, familial bonds tend to drive care-giving of OVCs in Dessie Town.

Figure 4.1 (below) shows that 43% of the respondents reported that they knew their current care-givers very well before they began caring for of them, whereas 23% reported that they knew their care-givers well; 15% said that they knew them a little; 8% did not know them at all and 11% of the respondents did not give a response.

Figure 4.1 How well did you know your care-giver(s) before he/she/they started caring for you? N =292

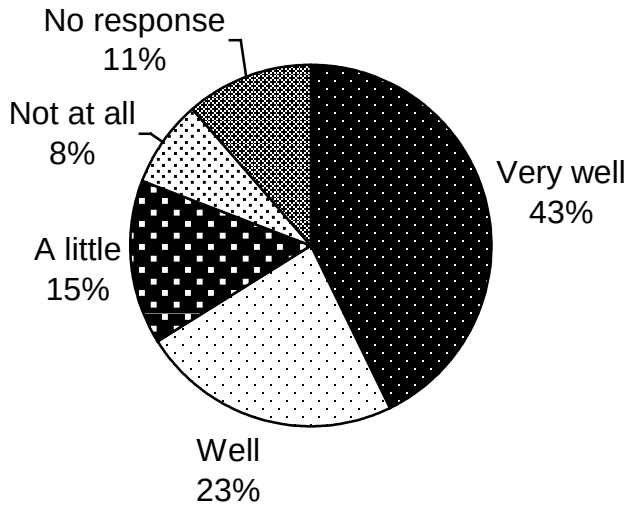


Table 4.7: Respondents' feelings about their current living arrangements (N=292)

How happy are you living in this home?	Number	%
Very happy	36	12,4
Happy	114	39,0
Sad	104	35,6
Very sad	35	12,0
Do not know	3	1,0
Total	292	100,0

As shown in Table 4.7 (above), only 12,4% of the respondents indicated that they feel very happy in the home they live in; whereas 39% said that they were happy; 35,6% indicated that they were sad and 12% said that they are very sad. Three respondents declined to answer this question.

Table 4.8: Per cent affirmative responses to statement about changes observed since the respondents came to live with their current care-givers (N=292)

Issue that has changed ("yes" responses, respondents replied for more than one statement at a time)	Number	%
Stopped going to school	59	19,0
Started going to school less regularly	43	13,8
School grades got worse	24	7,7
Had more chores	45	14,5
Had to take care of younger children	37	11,9
Got less food to eat each day	46	14,8
Gets less money as a household	57	18,3

In Question 14 of the questionnaire, the respondents were asked to respond "yes", "no" or 'don't know" to seven statements about aspects of their lives that might have changed since they moved to the current households in which they are cared for. The "yes" responses to these question items are indicated in Table 4.8 (above). Thus it shows that almost 1 out of 5 respondents (19,0%) indicated that they had stopped attending school, whereas 18,3% said that as a household they now earned less money; 14,8% said that they had less food to eat each day, 14,5% indicated that they had more chores to do; 13,8% said that their school

attendance became less regular; 11,9% said that they now had to take care of smaller children and 7,7% said that their school grades got worse.

Table 4.9: Comparison of how current care-givers treat the respondents and their own children (N=292)

Statement: My current care-giver treats me…	Number	%
Better than his/her/their own children	48	16,4
The same as his/her/their own children	97	33,2
Worse than his/her/their own children	51	17,5
Cannot say/care-giver does not have own children at home	44	15,1
Don't know/Unsure	52	17,8
Total	292	100,0

Respondents were also asked to compare the way that their current care-givers treat them to the way in which their care-givers treat their own children. The results to this question are shown in Table 4.9 (above). Almost a third (33,2%) of the respondents reported that their care-givers treated them the same as their own children; whereas 17,8% of the respondents did not give an answer to this question,17,5% felt that their care-givers treated them as worse than their own children; 15,1% felt that they could not judge as they did not witness the treatment their care-givers gave to their own children and 16,4% said that their care-givers actually treated them better than their own children.

As the researcher wanted to gain information on the physical mobility of the OVCs as a direct result of their orphanhood, a series of questions were asked about being born in Dessie Town, the previous place of residence if not born in Dessie Town and the major reason for the move to Dessie Town. As shown in Figure 4.2 (below), 77,7% of the respondents were born in Dessie Town, whereas 18,5% were born elsewhere and 3,8% of the respondents did not know their place of birth.

Figure 4.2 Where you born in Dessie Town? (N=292)

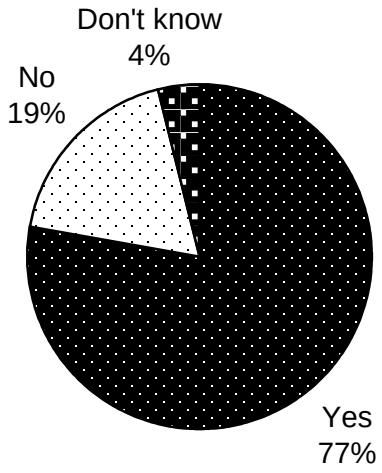


Table 4.10: Previous place of residence and reason for migration to Dessie Town among respondents who were not born in Dessie Town (N=54)

Previous place of residence	**Number**	**%**
A town near Dessie Town	9	16,7
A rural (farm) area near Dessie Town	12	22,2
Another town, far from Dessie Town	20	37,0
A rural (farm) area far from Dessie Town	10	18,5
Do not know	3	5,6
Total	54	100,0
Reason for migration		
To be near relatives	12	22,2
To attend school	6	11,1
My family moved	6	11,1
Quarrel with parents	3	5,6
To find a job (respondent or family member)	2	3,7
Illness of parent(s)/family member(s)	3	5,6
Death of parent(s)/family member(s)	19	35,1
Poverty	3	5,6
Total	54	100,0

According to Table 4.10 (above), 53,7% of the respondents who have ever lived elsewhere migrated from another urban area with 16,7% of the respondents

migrating from another urban area near Dessie Town and 37% of the respondents migrating from urban areas much further away. Less than half (40,7%) of the respondents who were not born in Dessie Town migrated from rural areas, with 22,2% migrating from rural areas near Dessie Town and 18,5% from rural areas far away from Dessie Town. Three of the respondents did not know where their previous place of residence was. Whereas the results should be treated with circumspection as the data shows the perceptions of the respondents of their previous place of residence and are thus subject to memory error, it seems that rural in-migrant OVCs migrated over shorter distances than urban in-migrants. Concerning the cause of migration to Dessie Town, more than a third (35,1%) of the respondents said that they came to Dessie Town due to the death of a parent/both parents. Other reasons were to be close to relatives (22,2%), because their families migrated (11,1%), to attend school (11,1%), due to illness in the family, (5,6%), due to a quarrel with their parent(s) (5,6%) or as job-seekers for themselves or a relative (3,7%).

4.2.3 Educational status, nutrition, clothes and dwellings of the OVCs

The second objective of the study was to describe the sample of OVCs in terms of their school attendance and other problems. The first and fifth objectives were to describe the nature of their domestic arrangements, housing, nutritional status and socioeconomic vulnerability. These aspects are described in this section.

As depicted in Table 4.11a (next page), 89,4% of the respondents have attended school; with 89,5% of males and 89,3% of females who attended school. Regarding the OVCs who have never been to school, (Table 4.11b on the next page) 71,0% of the respondents reported that they had never attended school because of their care-givers and parents' death; while 29,9% of them reported that they never attended school because of the lack of support, financial problems and stigma respectively.

Table 4.11a School attendance: ever attended school (N=292)

Have you ever attended school?	Yes		No		Total	
	Number	%	Number	%	Number	%
All respondents	261	89,4	31	10,6	292	100,0
Males	125	89,5	16	10,5	141	100,0
Females	136	89,3	15	10,3	151	100,0

Table 4.11b Reasons for never attending school (N=31)

Reasons	Number	%
Death of parent(s)	11	35,5
Death of guardian(s)	11	35,5
Lack of support	4	12,9
Financial problems	3	9,6
Teased and stigmatised	2	6,5
Total	31	100,0

Table 4.11c Current school attendance (N=292)

Are you currently attending school?	Yes		No		Total	
	Number	%	Number	%	Number	%
All respondents	226	77,4	66	22,6	292	100,0
Males	110	78,6	30	21,4	140	100,0
Female	116	76,3	36	23,7	152	100,0

Table 4.11d Grades for current school goers (N=226)

Current grades	Number	%
Grades 1-4	71	31,4
Grades 5-8	107	47,3
Grades 9-10	44	19,5
Grades 11-12	4	1,8
Total	226	100,0

Table 4.11e Reasons why respondents are not currently at school (N=66)

	Number	%
I am too young to go to school	2	3,0
Death of guardian(s)Death of parent(s)	12	18,2
Financial problems	12	18,2
Illness	9	13,6
Lack of support	2	3,0
Poor health	18	27,3
Dropped out of school	3	4,6
Gets teased and stigmatised	6	9,1
Other	2	3,0
Total	66	100,0

Regarding school attendance at the time of the survey (see Table 4.11c on the previous page), 77,4% of the respondents was at school with 78,6% males and 76,3% of female respondents at school. The discrepancy between males and females might be partly explained by the fact that more of the female respondents were at the younger ages than the males, but also due to education being stronger emphasised for boys than for girls. For the respondents at school at the time of the data-gathering (see Table 4.11d on the previous page), 47,3% were in 5^{th} to 8^{th} Grades; 31,4% were in Grades 1 to 4; 19,5% were in Grades 9 to 10; 1,8% were in Grades 11 to 12. Regarding the reasons why respondents were not attending school (see Table 4.11e on the previous page), less than a third (27,3%) of them reported lack of support; 36,4% due to death of parents and guardians, 13,6% cited financial problems, 9,1% dropped out of school; 4,6% due to poor health, the other 9% cites reasons including being too young to attend school, suffering from illness, or being teased or stigmatised.

To gain information on the nutritional status of the respondents, they were asked to indicate how often they ate particular types of food. As depicted in Table 4.12 (on the next page), 74,7% of the respondents eat *injera* (Ethiopian flatbread made of *teff* flour and containing no vitamins, some protein, 2% calcium and 32% iron) with *shiro* (a mixture of fried onions, *berbere*, and *shiro* powder) or *kik wot* (red lentil stew) every day. Moreover, 44,2% of respondents reported that they ate bread with tea every day. More than half (50,7%) of the respondents ate boiled or roasted cereals only once a month; with a fair proportion (14,7%) of them never eating such food at all. More than half of the respondents (63,4%) never ate *injera* with meat or meat sauce and 77,4% of the respondents reported that they have never received milk or milk products. Moreover, more than one third (38,0%) of the respondents reported that they have never eaten vegetables and 31,5% of the respondents have never eaten fruit. More than two thirds (69,9%) of the respondents reported that they have never eaten eggs. If it is assumed that the diets of the respondents were largely determined by the food that their care-givers

bought, prepared and gave to them. It seems that overall the diets of the respondents were high in carbohydrates but low in calcium, minerals and vitamins.

Table 4.12: How often respondents eat different types of foods (N=292)

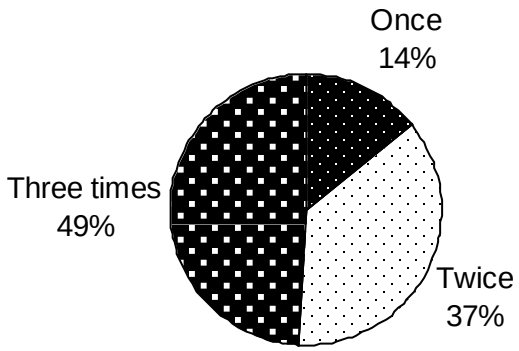
How often do you eat the following kinds of food?	Number	%
***Injera* with *Shiro* or *kik wo*t**		
Every day	216	74,0
Once a week	76	26,0
Total	292	100,0
Bread with tea		
Every day	129	44,2
Once a week	133	45,5
Once a month	14	4,8
Less than once a month	7	2,4
Never	9	3,1
Total	292	100,0
Boiled/roasted cereals		
Every day	40	13,6
Once a week	52	17,8
Once a month	148	50,6
Less than once a month	43	14,3
Never	9	14,7
Total	292	100,0
***Injera* with meat/meat sauce**		
Once a month	40	13,7
Less than once a month	67	22,9
Never	185	63,4
Total	292	100,0
Milk and its products		
Every day	2	0,7
Once a week	16	5,5
Once a month	20	6,8
Less than once a month	28	9,6
Never	226	77,4
Total	292	100,0
Vegetables		
Once a week	34	11,6
Once a month	33	11,3
Less than once a month	114	39,1
Never	111	38,0
Total	292	100,0
Fruits		

How often do you eat the following kinds of food?	Number	%
Everyday	8	2,7
Once a week	54	18,5
Once a month	56	19,2
Less than once a month	82	28,1
Never	92	31,5
Total	292	100,0
Eggs		
Everyday	3	1,0
Once a week	8	2,7
Once a month	35	12,0
Less than once a month	42	14,4
Never	204	69,9
Total	292	100,0

In Ethiopia, Injera forms the staple of household diets as do cereals (made from melit, sorghum, wheat, barley or maize) with shero/kik wot. In fact in southern and south western Ethiopia ‘’kocho” with and without “kitifo” (cooked or uncooked meat with butter and berbere) is common. Injera made from teff is usually used in economically better-off households (white teff is more expensive than red teff) while Injera prepared from cereals is usually common in low-income households. As shown in Table 4.12 (above), the majority of respondents eat vegetables and fruit only rarely or never at all and very few of them eat milk and eggs which are important for their development. However, it is expensive and difficult for most of the parents to purchase such food. The Ethiopian Demographic and Health Survey (Ethiopian Central Statistical Agency & ORC Macro 2005) found that children and women are very vulnerable to under- and malnutrition because of inadequate dietary intakes, infections, disease, lack of appropriate primary health care and inequitable distribution of food within the household.

Question 22 in the questionnaire asked the respondents to indicate how many times they ate a meal on the day preceding the interview. As shown in Figure 4.3 (below), 14,1% of them reported that they ate a meal only once on the previous day; more than one third (36,6%) of them ate two meals; while 49,3% of them had three meals. None of the respondents indicated that they had nothing to eat on the day preceding their interviews. It thus seems that despite possible deficient diets, about half of the respondents regularly consumed a meal.

Figure 4.3: How often did you eat a meal yesterday?
(N=292)



Respondents were also asked to comment on how they feel about the clothes that they wear. As shown in Figure 4.4 (see next page), more than half (57,2%) of the respondents indicated that they felt sad about the clothes they currently have; 6,8% of them reported that they felt very sad; 22,3% and 12,0% indicated that they were happy and very happy respectively. Finally 1,7% of the OVCs did not answer this question.

Access to food, clothes, and shelter are basic human needs. To this end, the study showed that more than half of the OVCs did not have food more than twice a day in their households. This is therefore a clear indication of food shortages in the households with OVCs. The survival and development of OVCs are mainly depending on the socio-economic status of care-givers in the household. This means that the living standard of OVCs is a reflection of the socio-economic situation of care-givers in the household. In other words, the diets and other needs of OVCs were largely determined by the capacity of their care-givers to purchase and supply food items and other needs. This study found that OVCs' basic and developmental needs like school attendance, school attainment, food

intake, fair treatment, and psychological well-being were not met by most of the care-givers in the households mainly due to poverty.

The means of livelihood (economic conditions) of parents and care-givers as mentioned above is one of the indicators of the well-being of children. Poor households cannot fulfil the basic needs like food, clothes, and shelter for their members which exacerbate the need for the current study.

Figure 4.4: How do you feel about the clothes you currently have?

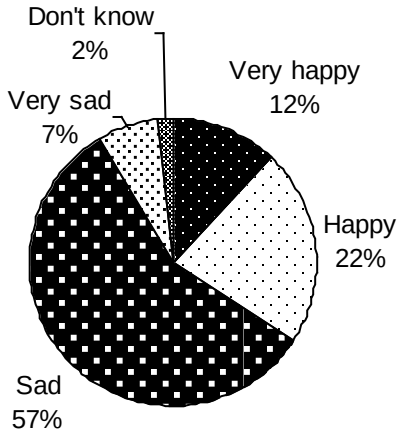


Table 4.13 (on the next page) shows results for various question items intended to obtain information about household amenities. Concerning the number of rooms available in the dwelling for sleeping,15,1% of the respondents reported that their dwelling had no such rooms available; whereas 66,1% said that there is 1 room only that can be used as a bedroom in their dwelling, 17,8% said that their dwellings have 2 bedrooms, and 1% said that there are 3 rooms available in their dwelling for sleeping. Given the average household sizes (as calculated in Table 4.3), overcrowding in the dwellings seems obvious.

More than one in ten respondents (11,6%) reported that their dwelling has no electricity whereas 88,4% of them have reported that they have electricity. Just below two thirds of the respondents (65,8%) reported that their dwellings have no tapped water. The majority (78,1%) of the respondents with no access to tapped water inside their dwellings make use of a communal tap; 13% fetch water from a river, stream, unprotected spring or well and the remaining 8,9% use a protected spring or well to draw water for household use. As far as toilet facilities are concerned, 70,2% of the respondents reported that their dwellings did not have an inside toilet; while 29,8% of respondents' dwellings had an inside toilet. The majority (68,3%) of the respondents with no toilet inside their dwellings used a communal toilet; 20% of them used an open field and 11,7% of them used a temporary toilet.

Table 4.13: Household facilities available in the dwellings (N=292)

	Number	%
Number of rooms in the dwelling available for sleeping		
None	44	15,1
1	193	66,1
2	52	17,8
3	3	1,0
Total	292	100,0
Does the dwelling have electricity?		
Yes	258	88,4
No	34	11,6
Total	292	100,0
Does the dwelling have tap water?		
Yes	100	34,2
No	192	65,8
Total	292	100,0
If tap water in the dwelling is not available: What is the main source of water for household use? (N=192)		
Communal tap	150	78,1
River/Stream/unprotected Spring/well	25	13,0
Protected spring/well	17	8,9
Total	192	100,0
Does the dwelling have an inside toilet?		
Yes	87	29,8
No	205	70,2
Total	292	100,0

If there is no inside toilet - where is the toilet? (N=205)		
Open field	41	20,0
Communal toilet	140	68,3
Temporary toilet	24	11,7
Total	205	100,0

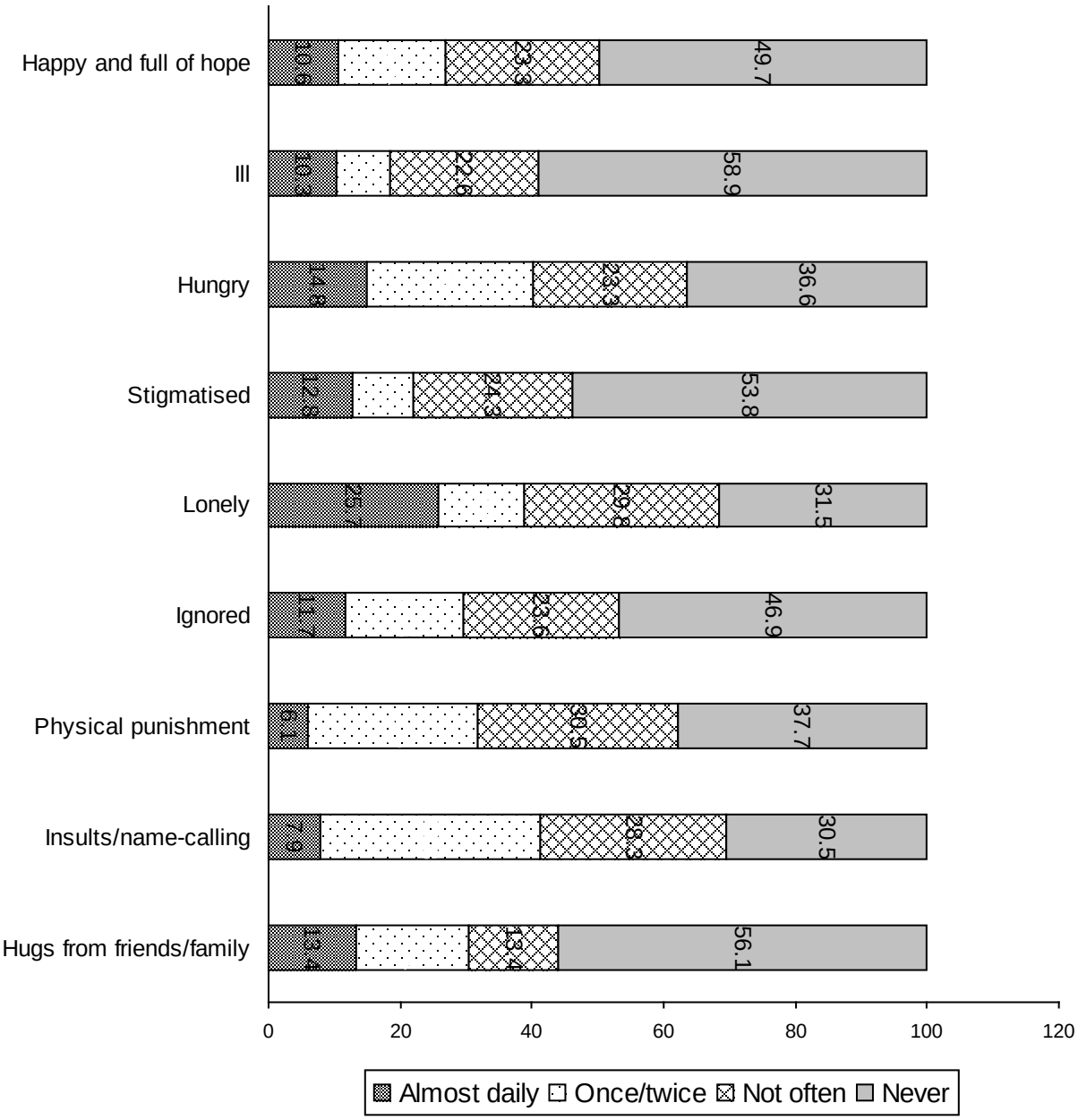
Facilities in the dwelling are linked to the health status of the occupants. The study thus found that the amenities in most of the dwellings were inadequate. This is in line with the WHO (2010) study of the national situation which found that only 38% of the residents in Ethiopia have access to safe drinking water and that only 12% had access to adequate sanitation facilities. Since poor access to clean drinking water and toilets are linked to communicable diseases, the potential for continued poor health outcomes for the majority of OVCs in this study is obvious.

4.2.4 Problems experienced and support received by the respondents

The final section of the questionnaire for the OVCs posed questions about typical problems and types of support that OVCs may encounter. These issues were identified through a review of literature. The responses to these questions are discussed in this section.

Question 28 in the questionnaire asked the respondents to comment on how often in the previous week they experienced positive (for example receiving hugs, feeling happy and full of hope) and negative actions and emotions (for example insults, name-calling, physical punishment, being ignored, loneliness, stigma, hunger and illness).

Figure 4.5: How often respondents experienced certain actions or emotions in the previous week (N=292)



As shown in Figure 4.5 above, 13,4% of the respondents reported that they received hugs from friends and family almost daily in the week preceding the survey; 17,1% received hugs once or twice in a week; 13,4% infrequently

received hugs and a staggering 56,1% of the OVCs never received hugs from friends and family.

Regarding insults or name-calling, 7,9% of the respondents faced that almost every day; 28,3% received this infrequently; 33,3% faced this once or twice in a week; while 30,5% never faced such a problem. Concerning physical punishment, 6,1% of the respondents were punished almost every day; 25,7% faced this once or twice; 30,5% faced this infrequently and 37,7% never received physical punishment.

The figure shows that 11,7% of the respondents reported that they felt ignored almost every day; 17,8% experienced this once or twice; 23,6% infrequently felt ignored and 46,9% never felt ignored. As far as feeling lonely was concerned, 25,7% of the respondents reported that they felt lonely almost every day; 13,% felt lonely once or twice; 29,8% felt lonely less often and 31,5% never felt lonely. Figure 4.5 shows that 12,8% of the respondents reported that they experienced being stigmatised daily; 9,1% felt this once or twice a week; 24,3% felt this less often and 53,8% of the respondents never felt stigmatized.

Almost one sixth (14,8%) of the respondents reported that they went to bed hungry almost every day in the week preceding the interview; 25,3% said that this happened once or twice in the week; 23,3% did not often go to bed hungry and 36,6% never went to bed hungry. Just more than one in ten (10,3%) of the respondents reported that they felt ill almost every day in the last week; 8,2% felt ill once or twice in the week; 22,6% felt ill infrequently and 58,9% never felt ill. Just below half (49,7%) of the respondents stated that they never felt happy and hopeful in the week prior to the survey; 10,6%, 16,4%, 23,3% of the respondents felt happy and hopeful almost daily, once or twice, and infrequently respectively.

Overall, the responses seem to suggest that hugs from friends and family and feeling happy and hopeful were seldom experienced by the respondents, whereas

illness, stigmatisation and being ignored did not feature as problems often experienced by the group of respondents. As indicated above, 69,5% , 68,5%, 63,4%, 62,3%, and 53,1% OVCs under study experienced insults, feeling of loneliness, going to bed hungry, physical punishment, and being ignored, respectively, in the week prior to the survey.

The findings of the study corresponds to those of a previous study by ARLSAB (2008) concerning the traditional methods for discipline employed by parents in the Amhara region which found that 88% of the care-givers used severe forms of punishment like insults (70%), physical punishment (58%), ignoring the child (22%), scolding (12%) and withholding food (11%). On the other hand, a study by Abebe (2004) found that 73,5% of the OVCs in his study were ill-treated by care-givers in the form of neglect (47,5%), taking away their property (12,1%); and by forcing them to do heavy household chores (Lealem 2004).

Jeppsson, Tefsu and Persson (2003) have identified a number of frequently occurring and potentially harmful traditional practices that are performed on children in Ethiopia. Some of these practices were listed in Question 29 of the questionnaire, namely tonsillectomy (sometimes removed by hand/fingernail by the traditional healer and often leading to infection), tattooing (sometimes performed for so-called medical reasons), milk tooth extraction (done as a traditional cure for diarrhoea and fever during teething), early marriage, male circumcision and female genital mutilation (Jeppsson *et al* 2003).

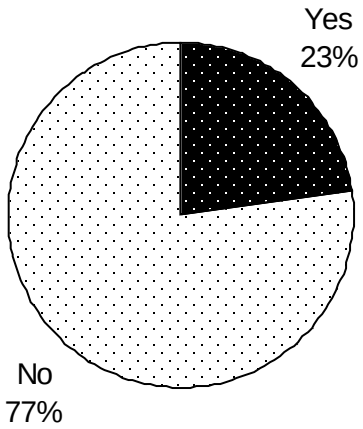
Table 4.14: Respondents' experiences of potentially harmful traditional practices (N=292)

Did any of the following things ever happen to you?	Number	%
Removal of Tonsils		
Yes	48	16,4
No	72	24,7
Don't know	172	58,9
Total	292	100,0
Receiving a tattoo		
Yes	12	4,1
No	244	83,6
Don't know	36	12,3
Total	292	100.0
Extracting your milk teeth		
Yes	19	6,5
No	122	41,8
Don't know	151	51,7
Total	292	100,0
Early marriage		
Yes	12	4,1
No	244	83,6
Don't know	36	12,3
Total	292	100,0
Male Circumcision (Male respondents only)		
Yes	73	52,1
No	62	44,3
Don't know	5	3,6
Total	140	100,0
Female genital mutilation (Female respondents only)		
Yes	60	39,5
No	48	31,6
Don't know	44	28,9
Total	152	100,0

As shown in Table 4.14 (above), 16,4% of the respondents reported that they had had their tonsils removed; 4,1% received a tattoo; 6,5% had their milk teeth removed; 4,1% were victims of early marriage; 52,1% of the male respondents were circumcised and 39,5% of the female respondents were victims of female circumcision. These findings should be treated with circumspection as they are based on self-reporting and not verified as actual experiences. Also, the relatively high proportions of "don't know" responses for each of the items listed in Table

4.14 suggest that some of the respondents did not know what the procedure entailed.

Figure 4.6: Whether respondents are currently caring for a bedridden father/mother/grandfather/grandmother (N=292)

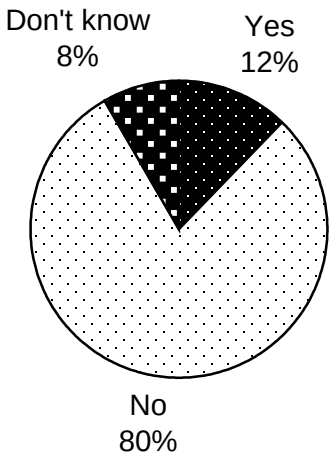


As shown in Figure 4.6 (above) 22,8 % of the respondents indicated that they were taking care of their bedridden father, mother, grandfather, grandmother or other adult at the time of the survey. Thus, almost two out of every ten respondents were care-givers of adults at the time of the survey. Therefore, it can be deduced that these children are likely to have to come to terms with the death of an adult loved one and face increased vulnerability as a result of that. In addition, it is possible that in households were parents or guardians become bedridden, most of the income might be used for the care of the sick. As a result of this emphasis on the ill adult, the children may suffer a lack adequate adult attention and they are likely to face severe socio-economic problems.

Generally, serious illness and death of parents or guardians negatively affects the social, intellectual and physical development of children (ARLSAB 2008).

Moreover, Kamili (*et al* 1996) document how the onset of illness of mothers and fathers marks the beginning of a deterioration of the family unit and results in negative emotional, psychological and material outcomes for the affected children.

Figure 4.7: Whether the respondents inherited property or money from their parent(s) (N=292)



As depicted in Figure 4.7 (above) 12,3% of the respondents reported that they have inherited money or property from their parents; 79,4% did not inherit any property or money from their parents, and 8,2% were unable to give an answer. This finding is almost identical with a study done in South Africa entitled "The Psychosocial issues affecting orphan and vulnerable children in two South African communities'' which reported that 16.0% of OVCs had inherited their parent's property or money (Simbayi *et al* 2006). It is true that the majority of respondents (OVCs) in this study did not inherit money or property from their parents. This is mainly due to lack of succession planning of parents for their children before they get sick or die; which usually is a problem for OVCs to inherit money or property from parents. Relatives and other nearby people usually either take the share or

take away the money or property that OVCs were supposed to inherit from their parents.

In a wellness and inheritance study conducted by the Save the Children Alliance, *et al* (2004), entitled *Orphans and Vulnerable Children Affected by HIV/AIDS - Policy versus. Practice,* it was found that:

- There is a pressing need to increase access to legal services for OVCs in order to ensure that their best interests are promoted.
- Counselling guidelines should include advice on issues regarding inheritance and that counsellors should be trained on how to assist OVCs in such matters exercise the same issue in their practices.
- Counselling guidelines should contain a separate section which focuses on ways of raising awareness of parents and children regarding their rights to inheritance.

As shown in Table 4.15 (below), 43,2% of the respondents reported that they received help from outside the family for their well-being; whereas 56,8% did not. For respondents with outside support, 70,6% of them were supported by NGOs; 12,4% by community-based organisations; 10,5% by governmental organisations, and 6,5% by faith-based organisations. According to the 126 respondents who receive such support, these organisations provide their beneficiaries with money (29,5%); food (39,3%); school fees (20,9%); skills training (1,4%), assistance for health care (10,0%) and psychosocial support (0,9%).

Table 4.15: Help and assistance from outside the family (N=292)

	Number	%
Are you receiving any form of help outside of your family?		
Yes	126	43,2
No	166	56,8
Total	292	100,0
If "yes" who provides the support? * (N=126)		
Non-governmental Organisation	108	70,6
Government Organisation	16	10,5
Community-based Organisation	19	12,4
Faith-based Organisation	10	6,5
Do you get help for any of the following?* (N=126)		
Money	58	27,5
Food	83	39,3
School fees	44	20,9
Someone to talk to about your feelings	2	0,9
Training (IGA and related)	3	1,4
Help when you need to see a doctor or pay for medicine	21	10,0
**Respondents gave more than 1 answer*		

4.2.5 Summary: OVC survey

In this section on orphans and vulnerable children's responses findings concerning the demographic characteristics, the relationship between the current care-giver and the OVCs, place of birth of the OVCs, migration to Dessie Town, school attendance, food consumption and perceptions, the descriptions of their dwellings like the nature of the domestic arrangements, housing and socioeconomic vulnerability of OVCs and the typical problems and types of support that OVCs may encounter were discussed.

4.3 FINDINGS FROM THE INTERVIEWS WITH THE CARE-GIVERS

The researcher randomly selected 130 care-givers of OVCs to be included as respondents in the study. This section presents the data obtained from the interviews with the care-givers via a semi-structured questionnaire. The issues that are discussed in respect of the care-givers are their demographic characteristics, the characteristics of their households, the challenges they face in becoming care-givers to OVCs, the reasons for becoming care-givers, perceptions about HIV, AIDS and OVCs, communication in the household, perceptions of the needs of OVCs and general livelihood issues.

4.3.1 Demographic characteristics of the care-givers

As shown in Table 4.16 (see next page), 60,8% of the respondents were females and 39,2% were males. In terms of their age groups, 48,5% of the respondents were aged 15 to 44 years and 51,5% were aged 45 years and older. It is interesting to note that 20,8% of the care-giver sample was aged 60 years and older. In terms of religious grouping, 53,1% of them were Ethiopian orthodox, 43,9% were Muslim, and the remaining 3% of the care-givers were Protestant and Catholic.

ARLSAB (2008) also found that the majority of care-givers of OVCs are female (62%). It is interesting to note that a larger proportion of older people were found to be caring for OVCs in this study than what has been found for the Amhara region as a whole.

Table 4.16 shows that as far as the marital status of the care-givers were concerned, 62,1% of the respondents had a marital or cohabitating partner. Thus just below 2 out of every 3 guardians in this study had partners who can offer support in taking care of the OVCs in their care. At the same time, however,

34,6% of the care-takers were divorced, while 10% and 2,3% was single and widowed respectively.

Table 4.16: Demographic characteristics of the care-givers (N=130)

Characteristic		Number	%
Sex	Male	51	39,2
	Female	79	60,8
	Total	130	100,0
Age group	15-19 years	1	0,7
	20-25 years	2	1,5
	26-29 years	11	8,4
	30-35 years	8	6,2
	35-39 years	14	10,8
	40-44 years	27	20,8
	45-49 years	17	13,1
	50-59 years	23	17,7
	60-70 years	21	16,2
	Older than 70 years	6	4,6
	Total	130	100,0
Religion			
	Ethiopian Orthodox	69	53,1
	Muslim	57	43,9
	Protestant	2	1,5
	Catholic	2	1,5
	Total	130	100,0
Marital status			
	Married	42	32,3
	Single	13	10,0
	Widowed	3	2,3
	Cohabiting	27	20,8
	Divorced	45	34,6
	Total	130	100,0
Highest level of education			
	No schooling	68	52,3
	Primary school	39	30,0
	Secondary school	15	11,6
	Tertiary non-degree	6	4,6
	Read and write only	2	1,5
	Total	130	100,0

With regard of care-givers' educational level, more than half (52,3%) of the respondents did not attend formal school, while 46,1% held some level of formal school education. Just below a third (30%) completed primary school, whereas

15,5% and 4,6% attained secondary and tertiary non-degree educational levels respectively and 1,5% could read and write only.

The OVC data showed that that there were 65,5% maternal relatives, 24,7% paternal relatives and 8,2% non-relatives who acted as care-givers to the OVCs. By contrast, the care-giver data show that a slightly smaller proportion of females (60,8%) answered questions in this part of the study. This could be due to sampling error, but the larger representation of female carers is consistent for both the OVC and the guardian data sets.

4.3.2 Household characteristics of the care-givers

Table 4.17: Mean numbers of biological and foster children per household (N=130)

	Min value	Max value	Mean	Standard Deviation
Own boys under 18 years	0	5	0,79	0,96
Own girls under 18 years	0	4	0.73	0,81
Foster boys under 18 yrs.	0	2	0,46	0,59
Foster girls under 18 yrs.	0	2	0,39	0,52
Boys under 18 in the household	0	5	1,25	1,06
Girls under 18 in the household	0	4	1,12	0,88
Foster children under 18 in the household	1	2	1,16	0,89
Children under 18 in the household	1	7	2,38	1,39

Table 4.17 (above) shows the mean number of own children and foster children from birth to 17 years per household for the 130 care-givers interviewed. It shows that the maximum number of children under the age of 18 years in some households reached 7. The average care burden for children below the age of 18 years for the 130 households in the study was 2,38 children. Earlier in this chapter it was reported that a mean number of 6,96 mean children per household was

found for the OVC data set (see Table 4.3). Again the differences can be due to sampling error, or the OVC respondents could have over-estimated the number of children in their households.

Table 4.18 (below) shows the relationship between the respondents and the OVCs in their households and the primary care-givers of such OVCs. When comparing these two categories (primary care-givers and respondents), it can be seen that in the case of 2 respondents, they were not the primary care-givers of the OVC, but answered questions on behalf of the paternal grandparent of the child. Regarding the primary care-givers 31,5% of the respondents were maternal grandparents; 16,9% were maternal relatives; 11,5% were paternal relatives; 9,2% were paternal grandparents; 8,6% were adoptive parents, 6,9% were stepparents, 3.5% were others and 3% were siblings.

Table 4.18: Relationship of respondent to the OVC and primary care-givers (N=130)

	Number	%
Relationship of respondent to the OVC		
Grandparent-paternal	10	7,7
Grandparent-maternal	41	31,5
Family/relative-maternal	22	16,9
Family/relative-parental	15	11,5
Sibling (Sister or brother)	4	3,0
Other not related by blood or marriage	17	13,1
Stepparent	10	7,7
Adoptive parent	11	8,6
Total	130	100,0
Primary care-giver of the OVC		
Grandparent-paternal	12	9,2
Grandparent-maternal	41	31,5
Family/relative-maternal	22	16,9
Family/relative-parental	15	11,5
Sibling (Sister or brother)	4	3,0
Other not related by blood or marriage	15	11,5
Stepparent	10	6,9
Adoptive parent	11	8,6
Total	130	100,0

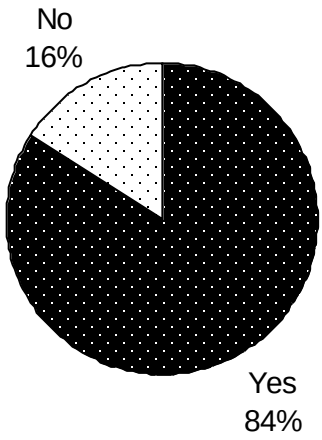
The prominence of relatives as care-givers seems to indicate the traditional safety net of the extended family in taking care of children in Dessie Town is still operational and should be strengthened. However Williamson *et al* (2004) found that the proportion of orphans who have lost both parents and are cared for by non-relatives increased in four countries, namely: in Kenya from 3,1% to 8,7%, in Tanzania from 2,1% to 4,2%, in Namibia from 4,9% to 9,3%, and in Zambia 2,2% to 3,5%.

Table 4.19: Main reason why the respondent became the primary care-taker of the OVC (N=130)

	Number	**%**
Maternal death	27	20,8
Paternal death	31	23,8
Death of both parents	61	47,0
Poverty	6	4,6
Child/children abandoned	2	1,5
Migration (parents moved away)	1	0,8
Children abused	2	1,5
Total	130	100,0

Table 4.19 (above) shows that 91,6% of the respondents mentioned that the deaths of parent(s) were the main reason for taking over the care of these children. Other reasons were poverty (4,6%), child abandoned (1,5%), child abuse (1,5%) and migration which accounted (0, 8%).

Figure 4.8: Whether taking on the care-giving of OVCs has a definite impact on the household of the respondents (N=130)



The care-givers were asked to indicate whether they felt that taking on the role as care-givers to OVCs had a definite impact on their households. As shown in Figure 4.8 (above), the majority (83,8%) of them reported that there was an impact whereas 16.2% said that they did not feel such an impact.

The respondents were asked to indicate whether the children in their care were at school. As shown in Table 4.20 (see next page), 76,2% of care-givers reported that the children they are taking care of in their households were attending primary or secondary school; while the remainder 23,8% reported that the children they are taking care of did not attend school

Table 4.20: Whether the OVCs cared for by the respondents are attending school (N=130)

	Number	%
Yes	99	76,2
No	31	23,8
Total	130	100,0

4.3.3 Perceptions of the care-givers regarding HIV/AIDS, OVCs and the problems experienced by OVCs

Care-givers were asked whether they had noticed an increase in the number of people living with HIV in their community in the six months prior to the survey. Table 4.21 (see next page) shows that in terms of the reported perceptions of the respondents, this problem became more visible to more than half of the care-giver group (57,7%); whereas 9,2% did not observe an increase and 33,1% were unable to give an answer. Care-givers were also asked whether they had observed an increase in the number of OVCs living in their neighbourhoods in the sixth months prior to the survey. As shown in Table 4.21, more than half (56,9%) of the respondents reported that they had seen such an increase; 13,1% did not observe an increase and 30,0% could not give an answer. Care-givers were also asked whether they had noticed an increase in the number of families taking care of OVCs in their neighbourhoods in the sixth months prior to survey. More than one third (38,5%) of the respondents reported having seen such an increase; 17,7% did not observe such an increase and 43,8% did not know whether this was an increasing trend. It can thus be concluded that just more than half of the sample of care-givers observed that the burden of HIV and AIDS has increased in the areas where they live over a six month period leading up to the survey in terms of the number of people living with HIV and the number of OVCs needing care, but that a smaller proportion confirmed that they have observed a growing trend of families taking on the care of OVCs.

Table 4.21: Whether respondents observed an increase in people living with HIV and OVCs in their neighbourhoods in the past 6 months (N=130)

	Number	%
In the past 6 months, have you observed an increase in a number of people living with HIV in your community?		
Yes	75	57,7
No	12	9,2
Don't know	43	33,1
Total	130	100,0
In the past 6 months, have you seen an increase in the number of orphans and vulnerable children living in your neighbourhood?		
Yes	74	56,9
No	17	13,1
Don't know	39	30,0
Total	130	100,0
In the past 6 months have you seen an increase in a number of families taking care of orphaned children in your neighbourhood?		
Yes	50	38,5
No	23	17,7
Don't know	57	43,8
Total	130	100,0

The respondents were also questioned about their perceptions of the major causes of orphanhood. As shown in Figure 4.9 (see next page), 71,5% confirmed that HIV/AIDS was the main factor in causing orphanhood. Only 19,2% and 6,2% of the respondents perceived HIV/AIDS as a big factor and a factor respectively, followed by 3,1% who did not know. More than three-quarters (77,7%) of the respondents perceived poverty as the main factor leading to orphaned and vulnerable children; whereas 11,5% and 10,8% reported that poverty was a big factor and a factor respectively. Just below a third (31,5%) of the respondents regarded tuberculosis as a main factor in rendering children vulnerable to orphanhood; whereas 26,2% and 20,8% perceived TB as a big factor and a factor respectively; 7,7% reported tuberculosis not as a factor and 13,8% were unable to respond. Regarding accidental death as a cause of orphanhood, 25,4% of respondents reported it as a factor, 25,4% as a big factor, 35,4% as a main factor; 12,3% as not a factor at all and the remaining 1,5% did not know. HIV and AIDS

thus stood out as the main driver in orphanhood and in the vulnerability of children.

Figure 4.9: Respondents' opinions of the contribution of various factors in orphanhood and vulnerability of children (N=130)

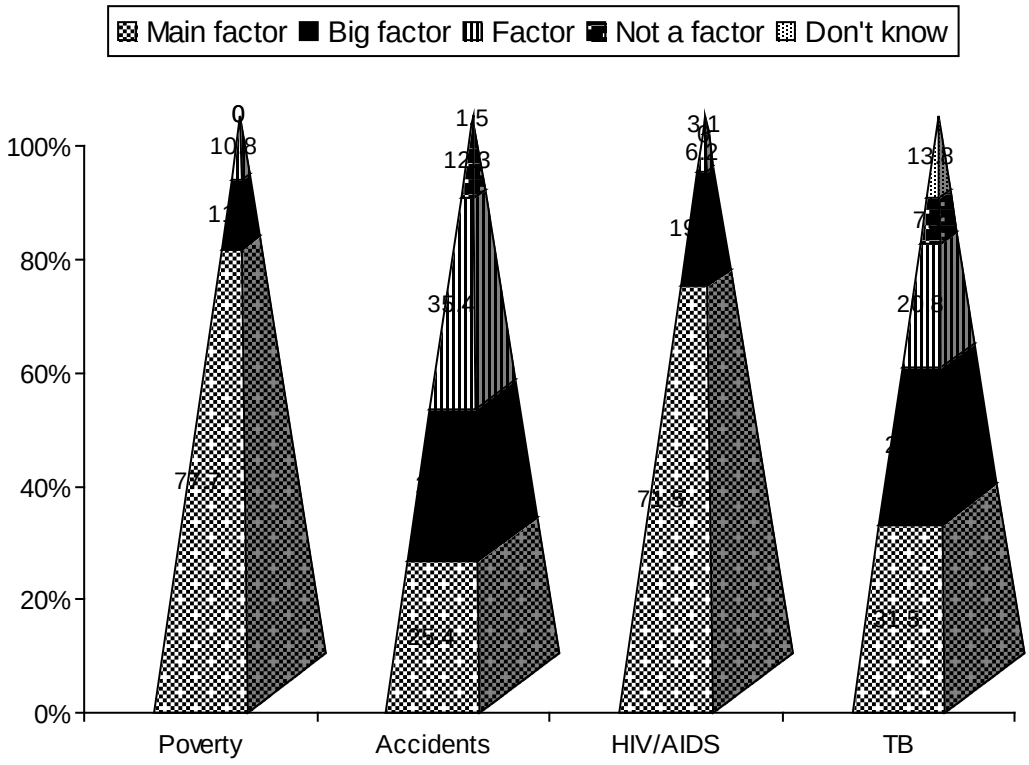


Table 4.22 (see next page) shows that HIV and AIDS as causes of child vulnerability in Dessie Town loomed large in the perceptions of the care-giver sample. A staggering 88,5% of the respondents indicated that HIV/AIDS leading to orphanhood influenced child vulnerability to a large extent. Concerning the extent to which HIV infection in children influenced child vulnerability, 43,1% of the respondents felt that this was a large contributing factor. Other causes of orphanhood besides HIV and AIDS were also regarded as having a large influence on rendering children vulnerable as more 41,5% of respondents felt this way.

Table 4.22: Perceptions of how certain issues influence child vulnerability in the respondents' communities (N=130)

	To a large extent	To some extent	To a small extent	Not at all	Don't know	Total
Early marriage	15,4	13,1	33,1	13,1	25,3	100,0
Child Prostitution	33,8	21,5	29,2	10,8	4,7	100,0
Orphaned due to HIV/AIDS	88,5	6,9	3,1	0,0	1,5	100,0
Street children	36,3	18,5	34,5	9,2	1,5	100,0
Children in conflict with the law (juvenile offenders)	9,3	26,2	16,9	23,8	23,8	100,0
Orphaned due to causes other than HIV/AIDS	41,5	33,2	22,3	1,5	1,5	100,0
HIV infection in children	43,1	14,6	33,1	6,2	3,0	100,0
Displaced children	21,5	29,3	23,8	8,5	16,9	100,0
Sexually abused children	22,3	26,9	23,1	4,6	23,1	100,0
Sexually exploited children (such as child prostitution)	26,2	27,7	26,2	9,2	10,7	100,0
Abandoned children	27,0	25,5	19,0	19,0	9,5	100,0
Children under the age of 18 who has to work to earn an income	34,6	32,4	23,8	4,6	4,6	100,0
Mental and/or physical disabilities in children	28,4	23,8	28,5	13,1	6,2	100,0
Being a child housemaid or child minder	26,2	29,2	26,2	13,1	5,3	100,0

More than a third (36,3%) of the respondents said that being street children influenced child vulnerability to a large extent; whereas 18,5% perceived this phenomenon as influencing child vulnerability to some extent; 34,5% reported that this influenced child vulnerability only to a small extent and 9,2% said that it never influenced child vulnerability. More than one third (34,6%) of respondents perceived child labour as influencing child vulnerability to a large extent. More than one third of (33.8%) the respondents also perceived child prostitution as influencing child vulnerability to a large extent; 21.5% said that it did so to some extent; 29,2% considered it to have a small influence and 10,8% reported that it did not influence child vulnerability at all. In comparison with the question item on how being child housemaid or child minder influences child vulnerability, a slightly smaller proportion (26,2%) of the respondents said that this influences child vulnerability to a large extent.

Less than one third (28.4%) of the respondents indicated that mental and/or physical disabilities in children influences child vulnerability to a large extent. The table shows that 27% of the respondents perceived child abandonment as having a large influence of child vulnerability. Sexual abuse was indicated by 22,3% of the respondents as having a large influence on child vulnerability; whereas a slightly larger proportion (26,2%) felt that the sexual exploitation of children influence child vulnerability to a large extent. About two in every ten respondents (21,5%) perceived displacement of children as having a large influence on child vulnerability. Only 15,4% of the respondents regarded early marriage as influencing child vulnerability to a large extent; whereas 13,1% perceived it to do so to some extent; 33,1% regarded this as contributing to child vulnerability to a small extent while 13,1% said that early marriage did not influence child vulnerability at all. Juvenile crime (and being in trouble with law enforcement) was the item that was least perceived as having a large influence on child vulnerability.

The respondents were asked to indicate whether they suspected that the parents of children in their care had died due to AIDS-related causes. As shown in Figure 4.10 (see next page), more than half (51,5%) of the respondents suspected that the parents of the children in their care died due to AIDS-related causes. Slightly more respondents (39,2%) suspected that the children's fathers died of AIDS-related causes than their mothers (only 12,3% suspected that the children's mothers died of AIDS-related causes). Only 27,7% of did not suspect that AIDS-related causes led to the deaths of the children's parents and 20,8% said that they did not know or declined to answer. Among the 36 respondents who said that AIDS was not the cause of the children's parent's deaths:

- 12 indicated that the parents died after a short illness
- 8 said that the children's parents died after a long illness
- 6 said that the fathers died due to unknown causes
- 2 indicated that the fathers died due to TB
- 2 indicated that cancer led to the deaths of fathers

- 4 indicated that pneumonia caused the deaths of parents
- 1 said that a mother died because of malaria
- 1 said that a father died due to diarrhoea

Figure 4.10: Responses to the question: "Do you suspect that any of the parents of the children you now care for, died due to AIDS-related causes?" (N=130)

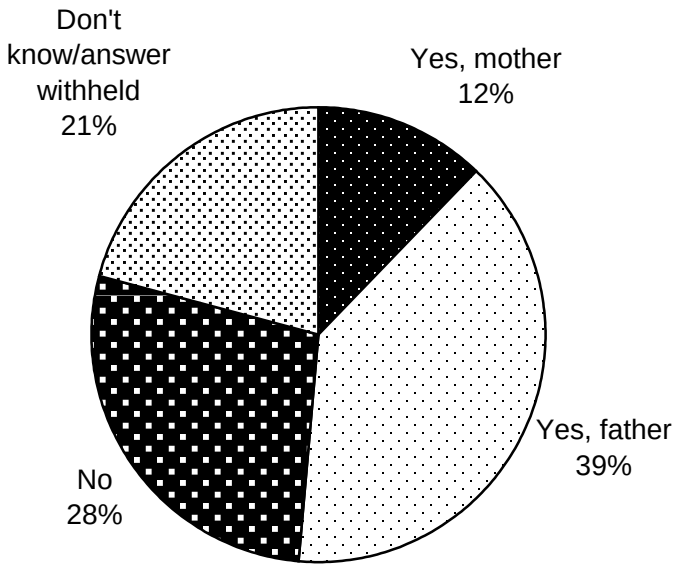
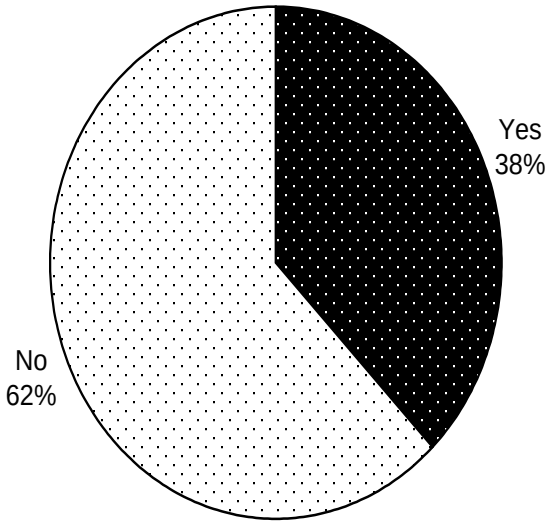


Figure 4.11 (see next page) shows that more than half (62,3%) of the respondents did not tell the children in their care about the actual cause of their parent's death.

Figure 4.11: Responses to the question: "Have you told the children in your care what the actual cause of their parents' death were?" (N=130)



Respondents were asked to comment on the current health status of the OVCs in their care. As shown in Figure 4.12 (see next page), among respondents with 1 child in their care, 32,19% said that the child were often ill, 25,7% that the child was seldom ill; 10,1% that the child was always ill; 27,6% that the child was never ill and 4,5% said that they did not know. The remaining 21 respondents had two foster children in their care and among these, 10 reported that both the children were never ill, 6 that only one of the children were never ill and the remaining 5 that only one of the children seldom had health problems.

Figure 4.12 Perceptions of health status of OVCs in care (N =130)

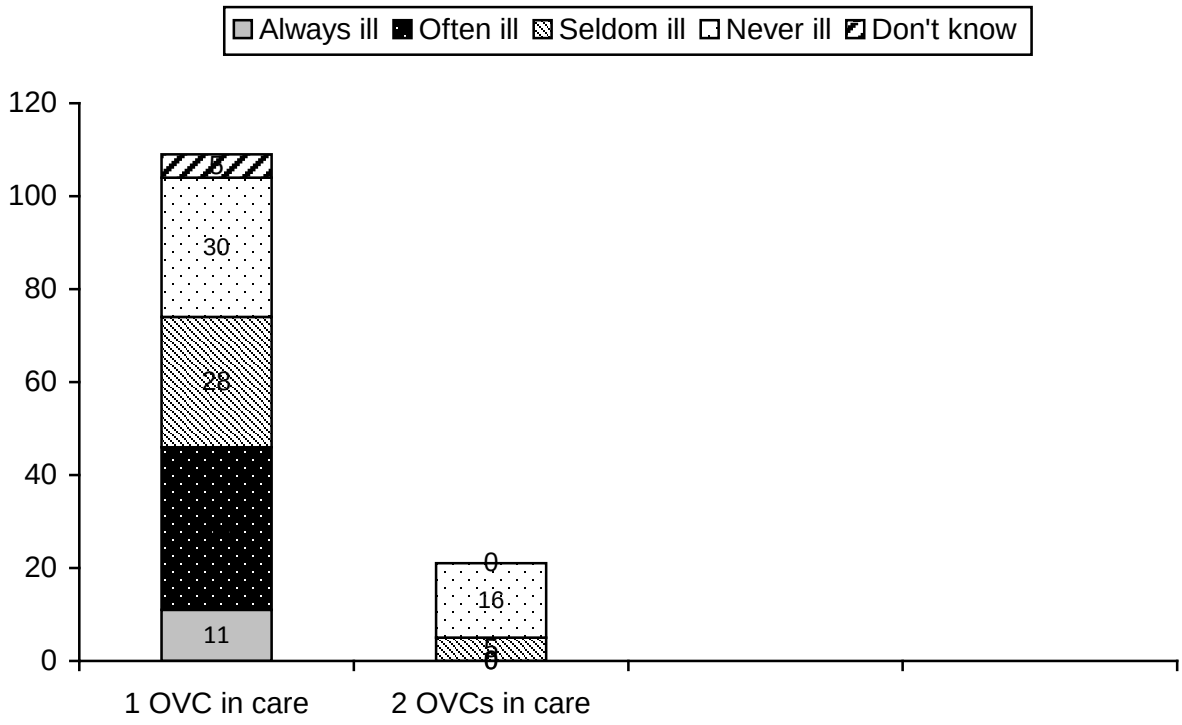


Table 4.23: How often the household has an open discussion about various issues (N=130)

	Very often	Often	Seldom	Never	Total
Sex and related issues	21,5	10,3	30,3	37,9	100,0
How HIV is transmitted	50,0	20,8	9,8	19,4	100,0
HIV and AIDS	39,2	15,4	16,0	28,4	100,0
Teenage pregnancies	16,9	24,6	16,2	42,3	100,0
Children orphaned due to AIDS	36,2	13,1	24,6	26,1	100,0

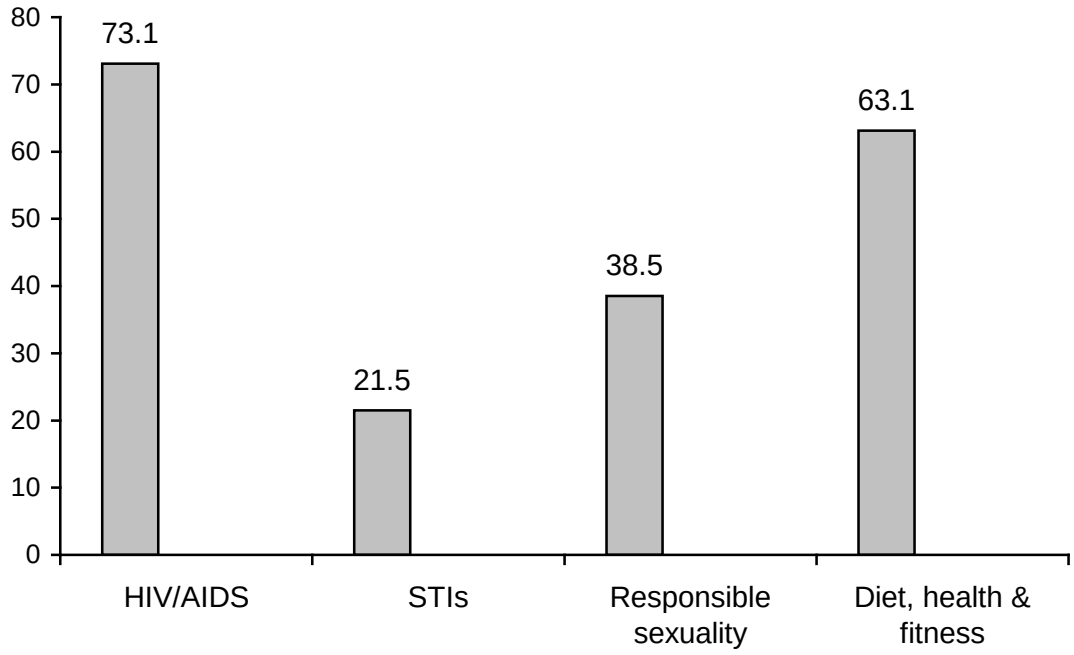
Respondents were asked a series of questions aimed at establishing the extent of communication within their household, particularly with regard to open discussions about sex, HIV/AIDS and teenage pregnancy. As shown in Table 4.23 (above), 70,8% of the respondents indicated that they often or very often talk openly about HIV-transmission in their households. At the same time, however, 67,9% of the respondents indicated that they seldom or never openly discussed

sex-related issues in the household. This placed doubt on how the open discussion of ways in which HIV is transmitted actually unfolds in the households of the respondents. In addition, 42,3% said that they never openly discuss the matter of teenage pregnancy.

As the researcher resides in the area, he is aware that for the majority of Ethiopians, particularly in Dessie Town, it is not common practice for parents to discuss topics such as sex, teenage pregnancy and STIs with the children in the household.

To further narrow down the issues of discussions, respondents were asked to indicate whether they discuss certain health issues in their families whilst including the children in such discussions. The findings are depicted in Figure 4.13 (see next page). Again, open discussions about HIV/AIDS were emphasised with 73,1% of the respondents confirming that they talked about HIV/AIDS in their families. A noticeably smaller proportion of respondents (21,5%) confirmed that they talked about sexually transmitted infections (STIs.) Here it should be kept in mind that HIV infection is a STI. More than a third (38,5%) of the respondents confirmed that they talked about responsible sex; whereas just below two thirds (63.1%) said that they talked about diet, health and fitness in their families with the children present at such discussions. These are positive signs regarding the willingness to communicate about health issues. However, these findings should be read holistically and seem to suggest that the sexual transmission of HIV and other STIs are still not easily discussed with children or younger family members. Whereas the age-appropriateness of such discussions is a matter to consider, it should also be considered that according to Table 4.1, 32% of the OVCs were in the age group 16 to 18 years.

Figure 4.13: Per cent respondents who confirmed that they discussed the following health issues with the children in their households (N=130)



Respondents were asked to indicate how they rated typical needs of children in terms of the needs of the OVCs in their own households. As depicted in Figure 4.14 (see next page), financial support (89,2%), followed by educational support (67,7%), and medical support (67,7%) were identified as very important needs. Socio-emotional support was regarded as very important by 53,8% of the respondents, followed by adjustment (47,7%) and skills training (47,7%).

Figure 4.14: Importance of particular needs of OVCs in the household (N=130)

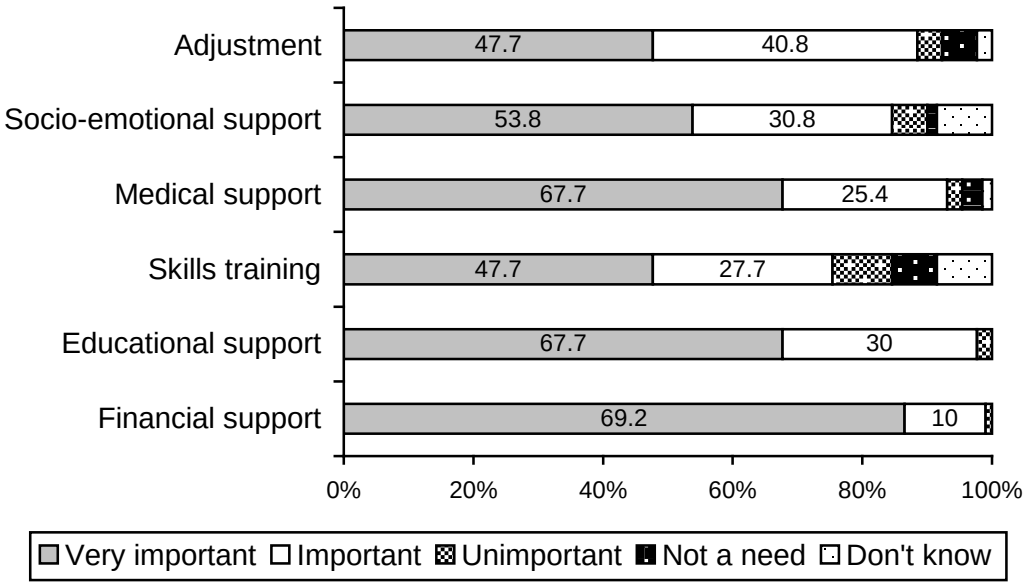
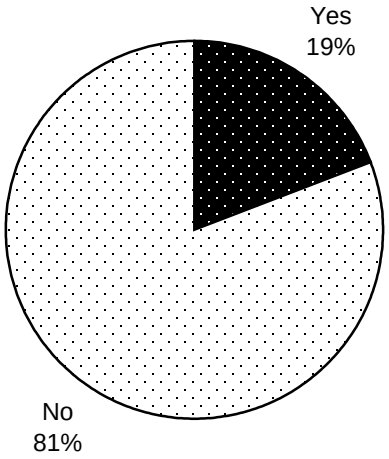


Figure 4.15: Responses to the question: "Do you have enough money to fulfill your households' needs for basic items, such as food and clothes?" (N=130)



Respondents were also asked whether they had enough money to fulfil the basic needs of their households. As shown in Figure 4.15 (previous page) 80,8% of the respondents answered that they did not have enough money to fulfil their households' basic needs such as food and clothes. To obtain greater detail on the actual needs of the households, the respondents were asked to rank certain items in terms of the challenge these presented to their households in caring for all the children. These items were scaled from 1 to 7, with 1 representing a very big challenge and 7 indicating that that particular item did not represent a challenge to the particular respondent and his or her household at all. The median values of all the items are shown in Table 4.24 below. It is shown in the Table that a shortage of money, food and school requirements were ranked as the most pressing problems faced by the care-givers in their households. By contrast, discipline was regarded as the least challenging issue, whereas illness and adjustment to the situation were also not important concerns.

Table 4.24: Median scores of challenges faced by the household (1=very important; 7 not important; N=130)

Item	Median score
Shortage of money	1,00
Not enough or lack of food	1,00
Lack of school requirements	1,00
Illness	5,50
Discipline	7,00
Helping everyone to adjust to the situation	4,00

Respondents were asked to similarly rank certain items, but this time in terms of the challenge these presented for the care of OVCs in their households. These items were scaled from 1 to 7, with 1 representing a very big challenge and 7 indicating that that particular item did not represent a challenge to the particular respondent and his or her household at all. The median values of all the items are shown in Table 4.25 below.

Table 4.25: Median scores of challenges faced by the household in the care of OVCs specifically (1=very important; 7 not important; N=130)

Item	Median score
Lack of money and financial security	1,00
Poor support to stay in school	1,00
Poor support to be trained in a skill	2,00
Poor chances to get a job after school/training is completed	1,00
Medical problems and lack of medical support	1,00
Emotional problems	1,00
Stigma and discrimination by their friends	7,00
Stigma and discrimination by other family members	7,00
Stigma and discrimination by neighbours	7,00
Stigma and discrimination by members of the community	7,00
Problems with adjustment	7,00

Table 4.25 shows that economic problems were ranked as the most pressing problems related to the care of OVCs – in particular lack of financial security, lack of support to keep the children in school, poor prospects for further training or job security for the OVCs and poor medical support. Dealing with the emotional problems of the OVCs was also scored as very important, whereas skills training were important but not very important. Stigma and discrimination as well as adjustment of the OVCs to their care households were scored as unimportant issues by the care-giver respondents in this study. It is important to note that these findings reflect perceptions of the care-givers. They perceive the more immediate problems of the means to care for and to give an education to the children in their care as being the most pressing problems they are faced with.

4.3.4 General livelihood of care-givers and their households

As shown in Table 4.26 (next page), 27,0% of the respondents were daily labourers; 20,0% were unemployed; 18,5% were pensioners; 12,3% were civil servants; 10,8% were petty traders; 3,8% were private enterprise employees;

8,9% were soldiers or police officers, high to middle traders, and government factory workers.

Table 4.26: Employment status of care-givers (N=130)

	Number	%
High/middle trader	3	2,3
Government factory worker	2	1,5
Civil servant	16	12,3
Private Enterprise Employee	5	3,8
Pensioner	24	18,5
Daily Labourer	36	27,7
Petty Trader	14	10,8
Soldier/Police officer	4	3,1
Unemployed	26	20,0
Total	130	100,0

It should be noted that the salaries of civil service employees, factory workers, police officers and soldiers tend to be low. Regarding the source of income, Table 4.27 (below) shows that 33,5% of the respondents reported that they relied on an informal income; 25,0% received a government pension or grant; 15,3% relied on a formal salary or earnings; 8,0% relied on the contributions by adult family members or relatives; 8,0% received grants or donations from private welfare organisations and 10,2% relied on contributions by younger family members or relatives and other sources.

Table 4.27: Sources of income for the family (N=130)

	Number	%
Government pension or grant	44	25,0
Informal income	59	33,5
Formal salary or earnings on which tax is paid	27	15,3
Contribution by adult family members or relatives	14	8,0
Grants or donations by private welfare organisations	14	8,0
Contribution by younger family members or relatives	12	6,8
Other source	6	3,4
Respondents gave more than 1 answer		

Table 4.28: Sources of support, regularity of support, kind of support and adequacy of the support received from outside the family (N=53)

	Number	%
Source of the support (Respondents gave more than 1 answer)		
Non-governmental Organisation (NGO)	44	47,3
Government Organisation (GO)	21	22,6
Community-based Organisation (CBO)	16	17,2
Faith-based Organisation (FBO)	10	10,8
Other	2	2,1
How regular is the support?		
Daily	3	5,7
Once a month	13	24,5
Once in 3 month	15	28,3
Less often than four times a year	16	30,2
Don't know	6	11,3
Total	53	100,0
Per cent yes responses to the question: "Does the kind of support you receive include the following?"		
Financial assistance	34	32,1
Food assistance	26	24,5
School fees	21	19,8
Psychosocial support	9	8,5
Training (IGA and related)	6	5,7
Medical fee	10	9,4
Whether the support enough to meet the daily needs of the respondents' families		
Yes	5	9,4
No	48	90,6
Total	53	100,0

Not shown here, 53 out of the 130 respondents, or 40,8% indicated that they received assistance from outside their families for the care of the OVCs in their households. Table 4.28 (above) is a breakdown of such support in terms of the source of the support, how regularly such support is received, and the kind of support offered and whether that support is enough to meet the daily needs of the family. More than a third of the respondents who received support indicated that this was given by NGOs. With regard the nature of support that were reported, 32,1% received financial assistance followed by food support and educational fees which was 24,5% and 19,8% respectively. However 90% of the respondents receiving support stated that it was inadequate. Less than a third of the 53 respondents reported that they receive assistance less often than quarterly;

28,3% received it once in three months, 24,3% received support monthly; 5,7% received support daily and 11,3% did not give an answer. Thus it can be concluded that less than half of the guardians have received support from outside their family to care for the OVCs. The support was given to them largely from NGOs with limited areas of support such as finance, food and educational fees which is highly inadequate to sustain the children.

4.3.5 Conclusions about the care-givers

In this section the demographic characteristics of the sampled care-givers their relationships with the OVCs, the challenges they face, their perceptions of problems related to the care of OVCs, trends in household communication, general livelihood issues and access to support services were discussed.

4.4 FINDINGS FROM INTERVIEWS WITH THE SERVICE ORGANISATIONS

In this section, information obtained through interviews with individuals at four organisations providing services to OVCs are presented and discussed. As shown in Table 4.29 (next page), a substantial number of OVCs from Dessie Town receive services from GOs and FBOs.

The key informants interviewed at these four organisations were asked what the main objectives of their organisation were. Three major objectives were identified, namely:

1. To prevent new HIV infections through different interventions; such as providing care and support for OVCs
2. To expand the existing support by communities by providing care, support and protection to OVCs
3. To mitigate the impact of the epidemic on OVCs, their care-givers and families.

Table 4.29: Background information on services provided to OVCs by 4 organisations

Type of organisation	Numbers of OVCs supported*			Type of service provided	Type of area where services are provided
	Male	Female	Total		
GO	4 942	7 112	12 054	Food, health care, clothes, psychosocial support, financial support, school material, skills training (IGA related)	Including the nearby rural Kebele of Dessie Town
NGO	1 642	1 995	3 637	Food, school material (uniform, soap, exercise books, pens, health care, financial support, legal protection, psychosocial support, skills training (IGA)	Only urban Kebeles of Dessie
CBO	18	12	40	School material including school fees, skill training, psychological/counselling support	Only urban Kebeles of Dessie
FBO	4 226	3 990	8 216	Food, educational support, health care, psychosocial support, shelter and care, legal protection, livelihood and economic support	Including the nearby rural Kebele Dessie

* ***Note:*** *These figures do not represent the exact numbers of OVCs in Dessie Town. Some children may receive services from more than one organisation. In addition, two of the above organisations extended their service to the nearby rural kebeles.*

In responding to the question on the socio-economic problems faced by OVCs, the key informants identified the lack of stable care, a heightened risk of malnourishment, emotional under-development, illiteracy, school dropout, poverty, sexual exploitation, lack of medical care and HIV infection. All four key informants indicated that they have experienced a dramatic increase in the number of OVCs needing care in the area over the last few years. HIV, AIDS and poverty were identified as the main drivers behind this increase in the number of OVCs. In particular, the key informants said that HIV and AIDS result in a gradually worsening lack of parental and adult care and support; the development of emotional, social and economic problems. With regards to major problems

encountered by OVCs in Dessie Town, the four informants mentioned food shortages, lack of school supplies, lack of care, love, attention and protection, and vulnerability to abuse and sexual exploitation.

The respondent from the Ethiopian Evangelical Church Mekaneyesus, Dessie Branch made mention of the fact that *"the lack of parental love, food, clothes, and living in ever-deteriorating situations are common features in the lives of OVCs in Dessie Town''*. The representative from the Addisalem Burial Association and Edir also mentioned the *"lack of food, clothes and support*" as the main problems faced by OVCs. In addition, he mentioned the lack of welfare organisations to assist these children permanently; the lack of scholastic materials, uniforms and food. The representative of the World Learning Ethiopia listed "*lack of school supplies (such as exercise books, pens, uniforms and registration fees), lack of food, medical fees, lack of shelter and protection and lack of psycho-social support "*

In responding to the question on what criteria are used by their organisations to select OVCs to render their services to, the key informants quoted different criteria such as:

1. A child is included as a service recipient after losing both parents or a parent to an AIDS-related illness
2. A child is included on the basis of certain criteria of economic vulnerability
3. Service recipients are not only orphans but other socially and economically disadvantaged children

All four respondents felt that the service rendered to OVCs by their organisations were minimal and inadequate. Major problems encountered in service provision were the increasing gap between the demand and supply of services, the lack of funding, the absence of clear guidelines, strategies and programme design, the

shortage of human resources, a poor grasp of the psycho-social issues faced by OVCs and poor networking between service organisations.

As the existing and potential support system for OVCs, the key informants all expressed a desire to strengthen their capacity in terms of finance (raising funds locally and internationally; lobbying the community to participate), human resources (increasing staff in numbers and skills), guidelines/strategic programme design (developing sound strategies) and outreach to OVCs in the area through awareness raising and mobilizing the community. Increased community mobilization to strengthen the capacity of communities to identify vulnerable children and to design, implement, and monitor their own OVCs support activities are strategies expressed by the key informants.

4.5 CONCLUSION

In this chapter, as mentioned above, orphans and vulnerable children's, care-givers and key informants of service-giving organization's responses and findings were discussed in detail. To this end, the OVCs' responses and findings with regard to their demographic characteristics , the relationship with care-givers, place of birth, migration to Dessie Town, education, food intake, perceptions, housing condition, socioeconomic vulnerability, problems, and the type of support that they encountered were discussed. In addition to this the care-givers' responses and findings were dealt with, the demographic characteristics, household relationship, education and challenges, perceptions, communication of parents to children, perceptions of needs and problems of OVCs, general livelihood issues and household access to support services were also examined. Furthermore, the key informants of OVCs service-giving organisations' responses encompassed the type of service rendered to OVCs, main organizational objectives to provide services to these OVCs, the major problems encountered by OVCs, the criteria used by these organizations to rendered services to OVCs, the extent of the service given to those OVCs, major problems encountered in giving

services to such OVCs, the promise of the key informants/service-giving organisations and potential support systems are considered and summarised.

In addition to this the researcher was able to show a link between the socio-economic situation of OVCs in Dessie Town and the framework developed by Williamson (2000) about the problems of children and families affected by HIV/AIDS as shown in Chapter 2. As it has been stated in the findings, OVCs in Dessie Town have multidimensional socio-economic problems which comply with Williamson's chart. For example, many children are taking care of their sick parents, face economic problems, have dropped out of school, consume inadequate diets, live in inadequate shelter, and suffer psychological distress, labour exploitation, and other forms of socioeconomic vulnerability.

CHAPTER 5: SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

The objectives of the study were to:

1. Describe the socio-economic conditions of OVCs their households and care-givers in Dessie Town
2. Describe OVC-affected households in terms of school attendance and other problems
3. Obtain information on the characteristics of the care-givers of OVCs
4. Describe the psycho-social status (social isolation, adjustment, discrimination) of OVCs in the study site
5. Describe the biographical characteristics of OVCs such as orphanhood status, nutritional status and household communication about risk-taking behaviour, and
6. Identify and describe existing and potential support systems for OVCs.

In this chapter, the significant findings of the study with regard to the profile of OVCs, care-givers of OVCs and key informants of service-rendering organisations in relation to the above objectives are briefly discussed and conclusions are drawn. The limitations of the study are also highlighted.

5.2 OBJECTIVE 1: THE SOCIO-ECONOMIC CONDITIONS OF THE OVCs AND THEIR HOUSEHOLDS IN DESSIE TOWN

The study found more female OVCs than male OVCs. This gender composition is similar to the OVCs situational analysis that was undertaken by the Amhara Regional Labour And Social Affairs Bureau (2008); which was reported a proportion of 51% females.

The largest age group proportionally was the 10 to 15 years age bracket which accounted for 47,3% of the OVCs in this study. It implied that the sampled children were able to give relevant information about themselves and others. Large mean household sizes were uncovered for both the OVC data and the care-giver data.

The study found that over a tenth of OVCs (11,3%) lived in child-headed households. Generally, many OVCs, including those in child-headed households, dropped out of school.

Facilities available in the dwellings of households are indices of health status and these were found to be poor among the OVCs and care-givers in this study. Many of the respondents (80%) lived in dwellings that had inadequate bedrooms given the number of occupants. Only 34,2% and 29,8% of OVCs had tap water and inside toilet facilities in their dwellings respectively. Besides, over a tenth of respondents (11,6%) did not have any electricity in their dwellings. Thus, the housing conditions and facilities indicate that the living standard of the OVCs in the study was poor.

The study found that more than half (57,2%) of the OVCs under study indicated that they felt sadden by the clothes they had to wear. The survival and development of OVCs are largely dependent on the socio-economic status of care-givers in the household. The means of livelihood of parents and care-givers are indicators of the well-being of children. Poor households lack the ability to fulfil the basic needs of children in terms of food, clothes and shelter.

With reference to inheritance, as stated in chapter four, more than a tenth of the OVCs (12,3%) were found to have inherited money or property from their parents in the area; while the bulk (about four fifths) had not inherited any property or money from their parents. This finding is similar to those of a study that was

undertaken in South Africa which found that only 16,0% of OVCs had inherited their parents' property or money (Simbayi *et al* 2006). This low prevalence of inheritance by OVCs in the study area should be seen against the backdrop of pervasive poverty and the lack of succession planning by parents for their children. Therefore, greater access to legal services for OVCs in order to ensure that their best interests are met, should be encouraged, publicised and promoted.

The study found that more than half of the OVCs under study did not get support outside the family. Of all the support given to OVCs, the majority came from NGOs that provided food, money and school fees. Therefore, supporting OVCs and their care-givers through different means of socio-economic support is of paramount importance. Government's commitment in designing priority plans, the increased number and coverage of service giving organisations (GOs, NGOs, FBOs, and CBOs) and international institutions, the existing domestic and international conventions and legislation that covers the rights, care and support of OVCs create an important conducive environment to cope with the increasing burden of OVCs. The trend of improving and developing a national plan of action for OVCs is also another potential support system that enables the government to monitor the implementation and to determine gaps in policy.

5.3 OBJECTIVE 2: OVC-AFFECTED HOUSEHOLDS AND THE PROBLEMS THEY FACE IN TERMS OF SCHOOL ATTENDANCE AND OTHER ISSUES

The second objective of this study was to describe the problems faced by OVC-affected households in the study site. It was found that some children indicated that they faced neglect, had a burden of household chores and in caring for younger children in their households they live. More than one fifth (19,0%) of the OVCs indicated that they stopped going to school, 18,3% reported that they get less money than others in the household, 14,8% that they get less food to eat every day, 14,5% had more chores, 13,8% started going to school less regularly,

11,9% of them had to take care of younger children, and 7,7% of OVCs school grades got worse since they moved to their current care-givers homes.

More than 10,6% of the OVCs under study (of which 10,3% were males, and 10,5% females) did not attend school in the study area. About two thirds of the OVCs reported that the death of their parents and guardians was the major cause of not attending to their education followed by lack of support, financial problems and stigma. This is in line with the conclusions drawn by Lealem (2004) that orphans were less likely to enrol in school than non-orphans of the same age group due to poverty, the priority given to the children in the core family and stigmatization.

Overall, the study found that OVCs' basic and developmental needs like school attendance, school attainment, food intake, fair treatment, and psychological well-being were not met.

5.4 OBJECTIVE 3: THE CHARACTERISTICS OF THE CARE-GIVERS OF OVCs

The study found that about two thirds (65,2%) of OVCs were cared for by maternal relatives including mothers/stepmothers, grandmothers, sisters/stepsisters and aunts. Studies in South Africa also found that female relatives (55%) act as guardians to OVCs (Simbayi *et al* 2006). On the other hand, the OVC situational analysis conducted in the Amhara region (ARLSAB 2008) found a larger proportion of biological parents acting as care-givers than was found in this study for Dessie Town. From these findings, it can be conservatively claimed that maternal relatives play a greater role in taking care of OVCs than paternal relatives in Dessie Town. Although there are socio-economic problems uncovered that were compounded due to the increased household sizes, care-giving of OVCs by relatives was observed as a major trend in this study and should therefore be strengthened.

The study found that two thirds of the OVCs (66%) knew the current guardians well or very well before moving into their care. Just below half (47,6%) of all OVCs were not happy in the homes they were living in.

It was found that over seven tenths the guardians (70,9%) were aged of 18 to 59 years followed by 16.3% and 13.1% of them under the elderly and extremely aged category of older than 59 and 70 years respectively. This finding corresponds with the study done by the Amhara Regional Labour and Social Affairs Bureau (2008), which had similar results. However, it is interesting that in the current study, it was found that more than one in tenth was very old guardians who were taking care of OVCs in the area. These elderly care-givers are themselves in need of care and should be assisted through community support systems.

Concerning the level of education of OVCs guardians, the study found that more than half (53,8%) of the guardians of OVCs were illiterate; and a third of those who attended education only completed their primary education. Thus most of the care-givers had low levels of education and engaged in economic activities tended to generate low incomes.

5.5 OBJECTIVE 4: THE PSYCHO-SOCIAL STATUS OF OVCs IN THE STUDY SITE

The study found that positive experiences (such as receiving hugs, feeling happy and full of hope) and negative experiences (such as receiving insults, name-calling, physical punishment, being ignored, loneliness, stigma, hunger and illness) were experienced in equal part by the OVCs. Thus, as mentioned in chapter four, over half of the OVCs experienced insults, feeling of loneliness, having to beg for food, physical punishment, and being ignored.

Generally in Ethiopia, especially in the study area, it is common for parents and guardians to advise, warn and beat a child as part of traditional disciplinary methods in order to correct misconduct or misdeeds. Nevertheless, there was neglect and maltreatment of children by guardians. Therefore, the study showed the need to address the emotional experiences of OVCs in the area.

Furthermore, as revealed in chapter four, the study found a number of frequently occurring and potentially harmful traditional practices that are performed in the study area. Thus, the study revealed that over a third of the OVCs (33,7%) under study were victims of female genital mutilation while 16,4%, 6,5%, 4,1%, and another 4,1% of the OVCs under study had their tonsils and milk teeth removed, received tattoos and experienced early marriage, respectively. On the other hand, more than half of the male respondents (52,1%) were circumcised. In this regard Jeppsson *et al* (2003) that reported vuvclectomy at 41,8%, milk teeth extraction at 33,7% and tonsillectomy at 24,5%. These harmful traditional practices, which can be considered as culturally normalised phenomena, predispose children to poor health outcomes (Shewanmoltot 2010).

5.6 OBJECTIVE 5: THE BIOGRAPHICAL CHARACTERISTICS OF OVCs SUCH AS ORPHANHOOD STATUS, NUTRITIONAL STATUS AND HOUSEHOLD COMMUNICATION ABOUT RISK-TAKING BEHAVIOUR

About two fifths (40,8%) of OVCs in the study were double orphans, followed by about one third paternal orphans (35,3%) and almost 2 out of 10 maternal orphans (19,9%). Furthermore, as depicted in chapter four, the study found that 45,5% of the OVCs had living siblings who did not live with them in the current household in the study area; of which over seven tenth (71,5%) had at least one brother and about two fifths (61,5%) at least one sister who lived elsewhere. In addition, more than two fifths of these OVCs (45,4%) never had any contact with their siblings. The results of this study strengthen this idea that as a result of death and migration, family members (including dependent children), move in and

out of the household. This results in care-givers and siblings being separated, a factor which has been found to be a contributing factor in emotional distress in children and adolescents affected by HIV/AIDS (Simbayi *et al* 2006).

The study reviewed the food intake of OVCs and found that their diets were high in carbohydrates but low in calcium, minerals and vitamins. The study found more than half (50,7%) of the OVCs had not eaten food more than twice a day prior to the survey. It seems that despite possible deficient diets, and the inability to consume three meals a day, about half of the OVCs under study regularly consumed a meal. This finding is in line with the Amhara Region Labour and Social Affairs Bureau's (2008) OVC situational analysis which reported that 51% of the OVCs had not eaten a meal more than twice in a day. Poverty seems to be the major cause for the nutritional problems in this area. So, nutritional education and the support given outside the family by institutions to OVCs should be strengthened in order to address these problems.

The study found that over a fifth of OVCs (22,8%) were taking care of their bedridden father, mother, grandfather or other adults at the time of the survey. As the result of this and the emphasis on the sick, most of the income is likely to be used for the care of the sick adult, thus children lack adequate adult attention and they are likely to face severe socio-economic problems (Amhara Regional Labour and Social Affairs Bureau 2008). Generally, serious illness and death of parents negatively affect the social, intellectual and physical development of children. To this end, establishing and strengthening community-based support systems and working with institutions working in the care and support activities of such people is needed. Home-based care and economic strengthening are important strategies to minimize such problems.

The fifth objective was also tested from the perspective of the care-givers. In this regard, they confirmed perceptions of poverty, HIV and AIDS as causes of child vulnerability in Dessie Town. A staggering four fifth (88,5%) of the respondents

indicated that HIV/AIDS leading to orphanhood influenced child vulnerability to a large extent.

The study examined the extent of communication between care-givers and children on how HIV is transmitted, and other sex-related issues. It was found that over seven tenths of the guardians (70,8%) indicated that they often or very often talk openly about HIV-transmission in their households. At the same time however, over two third of the guardians (67,7%) indicated that they seldom or never openly discussed sex-related issues in the household. Moreover, more than two fifth (42,3%) said that they never openly discuss the matter of teenage pregnancy. This seems to be contradictory since HIV is mainly transmitted through sexual contact.

The study indicated that the three major very important needs of OVCs, as rated and identified by care-givers were: financial support, educational support, and medical support. Socio-emotional support, followed by adjustment and skills training was also regarded important needs in this study.

5.7 OBJECTIVE 6: EXISTING AND POTENTIAL SUPPORT SYSTEMS FOR OVCs

The responses by the key informants from the service providing organisations indicated that the socio-economic problems of OVCs in terms of educational opportunity, access and availability of nutrition, health care, protection, and psychosocial support are worse when compared to the needs of non-orphans of the same age. Respondents indicated that HIV/AIDS-affected children faced problems such as the lack parental care and support, emotional problems and economic problems. More specifically, the problems encountered by OVCs in Dessie Town according to the key informants were food shortages, lack of scholastic materials, lack of clothes, lack of care, love and attention, and poor protection against abuse and sexual exploitation. Services provided included

food, school material or educational support, clothes, health care, skills training, legal support, and psychosocial/counselling support. All of the respondents also commented that the service given to OVCs by the organisations were minimal and inadequate. Therefore, service providing organisations, including the government, should improve the services given to OVCs in the area in terms of quantity and quality.

5.8 RECOMMENDATIONS FOR POLICY AND PROGRAMMES

Ethiopia has ratified the Convention on the Rights of the Child (UNCRC), but it has not yet been published in the Negari Gazette. Therefore, the government of Ethiopia should put forward this ratification for publication in the Negri Gazette to ensure that the provisions are enforced in Ethiopian courts. Stemming from this, the government needs to develop a national policy on school health and nutrition with specific focus on OVCs. As a provision of basic health services, the government needs to revise the current HIV/AIDS policy of the country so as to include the specific needs of OVCs.

A large number of OVCs in the study were double orphans. This indicates the health conditions of parents. Therefore, there is a need to strengthen and introduce comprehensive programmes to address the needs of OVCs. This should include a reflection on the special needs and extreme circumstances of child-headed households and street children. In addition, primary prevention of new HIV infections should continue to be a priority.

The majority of OVCs were also found to be cared by relatives and maternal relatives in particular. This implies that efforts to address the problems of OVCs have to place the family at the centre of interventions. Therefore, the Dessie Town Labour and Social Affairs Bureau should coordinate efforts that are directed at strengthening familial support systems for OVCs.

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The study found that a significant number of OVCs, including child-headed households, have never been enrolled or attended any kind of schooling. This was mainly due to their parents/guardians death and lack of support. The government needs to step up efforts to provide formal and non-formal education and vocational training to all children. In addition, specific interventions should be planned to address school dropout rates.

Communities should be encouraged to use culturally appropriate and accepted strategies to facilitate positive behaviour change. Therefore, those OVCs who are likely to be exposed to harmful traditional practices should be protected.

The integration of OVCs support with home-based care for bedridden parents and care-givers should be investigated. Service providing organisations and the government should work closely together to improve the socio-economic conditions of guardians who are taking care of OVCs in their households through micro-finance programmes, insurance programmes and opportunities to engage in income-generating activities. Nutritional support needs to be given to the OVCs in the study town**.** Introduction of social protection measures including cash transfer, food vouchers, and education support is needed.

Non-governmental organisations (NGOs, CBOs and FBOs) are central partners in government initiatives. They need to be supported to give holistic, coordinated, adequate, quality and sustainable services to OVCs.

5.9 SUGGESTIONS FOR FURTHER RESEARCH

The current study provided baseline information for the Dessie Town area. Stemming from the findings, the researcher made some suggestions for policy and programme implementation. In order to develop interventions, formative evaluations done via collaborative research between the government sector and the NGO service providing organisations should be encouraged. In addition, the similarities and differences between Dessie Town OVCs and OVCs in other

African countries impressed on the researcher the value and importance of international collaboration in research – especially collaborations with researchers in other African countries with large HIV prevalence figures.

As immediate follow-up to this baseline study, the researcher recommends a participatory action study (in which OVCs, guardians, representatives of governmental and non-governmental service-rendering organisations participate) intended to develop an optimum of services for OVCs in Dessie Town.

5.10 STRENGTHS AND LIMITATIONS OF THE STUDY

The strength of this study lies in the fact that it provides baseline data from which interventions and further research can be planned. In order to track the success of interventions, implementers would require baseline data to see whether the policy and programme changes that were made and implemented had the desired effects.

As all social research is subject to limitations, the researcher wishes to note the following:

- The interpretations of the findings were hampered by the fact that official statistics on the educational and health status and housing conditions of OVCs and other children in order to compare trends in school attendance, enrolment, health status and housing conditions in the study site were unavailable.

- Since this was a baseline study, budget and time constraints made it impossible for the researcher to include other research orientations such as qualitative, in-depth work or participatory action research.

This study has sociological significance as it deals with children and their vulnerability not only at the level of their individual experiences, but also in relation

to their families and care-givers. It thus links individual experience (or the intrapersonal or micro-level phenomenon of vulnerability) to the interpersonal care-giving roles of family members and the community (the meso-level). Moreover, in interpreting the findings, the researcher made reference to the structural and contextual factors in Dessie Town and Ethiopia that shapes the vulnerability and socio-economic circumstances. The interplay between structure and agency came to the fore in this study that portrays the social isolation, inadequate adjustment, neglect and discrimination faced by OVCs.

As mentioned in chapter one, the overall objective of this study was to gain knowledge that can be used to improve the living conditions of OVCs; to support households and families to cope with the increasing burden of care for OVCs; to strengthen community-based support systems through CBOs, FBOs, NGOs and the government and to build community-based systems for sustained care and support for OVCs. In that sense, this study is one step in the direction to engage in the planning and implementation of policies and programmes in Dessie Town to effect change in the lives of its most vulnerable citizens.

5.11 CONCLUSION

This study of the socio-economic situation of OVCs in Dessie Town was informed by a review of literature and in particular the framework for understanding the problems faced by children and families affected by HIV/AIDS as developed by Williamson (2000) and depicted in Figure 2.1 of this dissertation. The researcher was able to gauge information on all the key dimensions in Williamson's framework, namely:

1. Children as care-givers to ill parents
2. OVCs facing economic problems in terms of interrupted school attendance or dropping out of school, inadequate diets, inadequate shelter and poor provision in their material needs
3. Problems with inheritance

4. Children lacking adult care
5. Psychological distress
6. Exploitation of OVCs in labour, domestic chores, child minding and other forms of exploitation.

However, in terms of the final dimension in Williamson's framework, namely increased vulnerability to HIV infection, the researcher could not gather information of the HIV-status of the OVCs in the study as such a matter would be too sensitive. However, it is theoretically possible that the OVCs are at a heightened risk of vulnerability to poor health outcomes including HIV infection due to their socio-economic vulnerability.

Finding the most feasible response strategy towards the socio-economic plight of OVCs in Dessie Town will not be an easy task given the multi-dimensional nature of their unmet needs. This study found that much of the current care-giving to OVCs is anchored in familial systems that may be faltering under the weight of increasing numbers of household members in need of care and of persistent poverty. Thus, beyond familial and community-based interventions, there is a pressing need in Dessie Town for appropriate support by governmental and external agencies. It is thus the conclusion of the researcher that despite the severe structural conditions (poverty, the impact of HIV and AIDS) that are straining traditional familial child-care practices, communities still have the inherent capacity to address the problems of OVCs.

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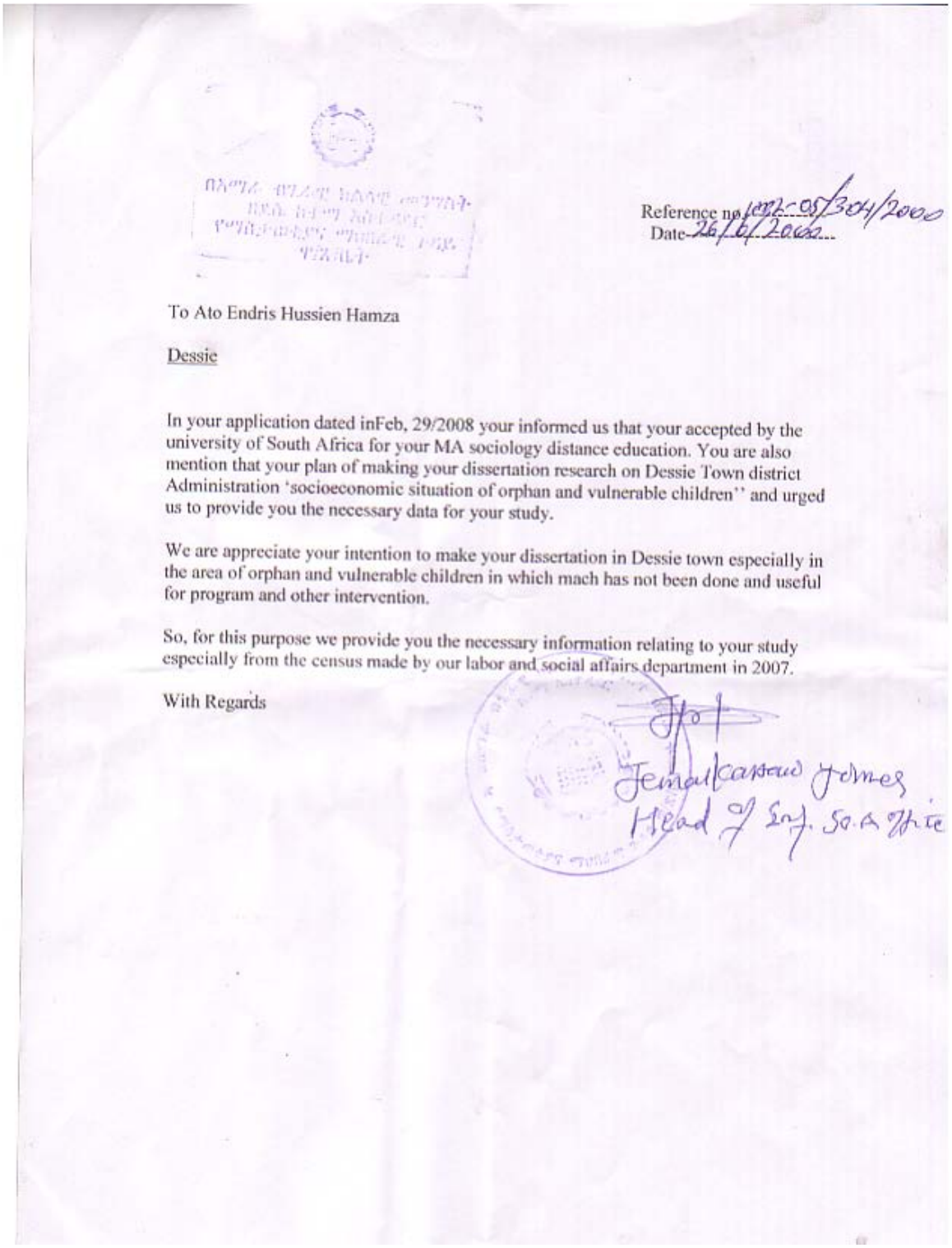
APPENDIX A: ACCESS LETTER



Reference no 1077-05/304/2000
Date 26/6/2000

To Ato Endris Hussien Hamza

Dessie

In your application dated inFeb, 29/2008 your informed us that your accepted by the university of South Africa for your MA sociology distance education. You are also mention that your plan of making your dissertation research on Dessie Town district Administration 'socioeconomic situation of orphan and vulnerable children'' and urged us to provide you the necessary data for your study.

We are appreciate your intention to make your dissertation in Dessie town especially in the area of orphan and vulnerable children in which mach has not been done and useful for program and other intervention.

So, for this purpose we provide you the necessary information relating to your study especially from the census made by our labor and social affairs department in 2007.

With Regards

Jemal Kassaud Jemes
Head of Lab. So. A Affairs

APPENDIX B: INFORMED CONSENT/ASSENT FORM

I want to thank you for taking the time to meet with me today. My name is (interviewer's name) and I would like to talk to you about participating in a study entitled "A situational analysis of the socio-economic conditions of OVCs in Dessie Town, Ethiopia". This research is vital for the city administration, policy makers, researchers, governmental and non-governmental organisations in order to devise ways of addressing the problem faced by OVCs and those who care for them.

If you participate in the study, you will be asked answer questions. This should take about an hour or less. Your name is not asked and will not appear on the questionnaire. All completed questionnaires will be kept in a safe place and treated as confidential material. The information that will be included in the report does not identify you as the respondent. You may decline answering certain questions or stop the interview at any time.

Do you have any questions about what I have just explained?

Are you willing to participate in this interview?
All signed consent forms will be kept separately from the completed questionnaires.

_____ _____ _____

Interviewee Witness Date

Assent:

For interviewees younger than 18:

Are you willing to participate in this interview?

All signed assent forms will be kept separately from the completed questionnaires.

_____	_____	_____
Interviewee	Legal guardian	Date

APPENDIX C QUESTIONNAIRES FOR PARENTS/GUARDIANS OF OVCS

Questionnaire number	
Interviewer number	
Date of interview	

The primary aim of this study is to undertake a socioeconomic situational analysis of OVCs at Dessie Town. Most questions require the interviewer to simply tick the answers. Only a few require short answers to be written in the spaces provided. Your name does not appear on the questionnaire and you should not write your name anywhere on the questionnaire. This will mean that your name will not be known to the researchers or revealed in the publication of the results. We intend to interview –other parents and guardians of OVCs in Dessie Town. Your participation in this study is purely voluntary and you are free to grant or refuse your consent to participate. We promise to treat all information you provide as strictly confidential and will not disclose individualized information to anyone unrelated to this study. Your cooperation and assistance is highly valued.

SECTION I DEMOGRAPHIC CHARACTERISTICS

1. Gender of respondent

Male	1
Female	2

2. Age of the respondent

0-14	1
15-19	2
20-25	3
24-29	4
30-35	5
35-39	6
40-44	7
45-49	8
50-59	9
60-70	10
Older than 70	11

3. Religion of respondent

Ethiopian Orthodox	1
Muslim	2
Protestant	3
Catholic	4
Other (please specify)_____	

4. What is your marital status?

Married	1
Single	2
Widowed	3
Cohabiting	4
Divorced	5
Other (please specify)_____	

5. What is the highest level of education you attained?

No schooling	1
Primary school	2
Secondary school	3
Tertiary non-degree	4
Tertiary degree	5
Other (Please specify)_____	

SECTION II HOUSEHOLD RELATIONSHIP, EDUCATION AND CHALLENGES

6. How many biological (own) children under the age of 18 years do you have?
6.1 Boys: _____ (number)
6.2 Girls: _____ (number)

7. How many children (who are not your own biological children) and under the age of 18 years live with you in this household?
7.1 Boys: _____ (number)
7.2 Girls: _____ (number)

Interviewers: Please add the total number of children under the age of 18 from Questions 6 and 7 for this household. Total number of boys under 18_____+ total number of girls under 18_____. Ask: I just want to check, there are _____children under the age of 18 in this household – am I correct. If this is correct, proceed with Question 8, if not, re-ask Questions 6 and 7.

8. Please indicate **your relationship** to the child/children mentioned in Question 7.

Grandparent-paternal	1
Grandparent-maternal	2
Family/relative-maternal	3
Family/relative-parental	4
Sibling (Sister or brother)	5
Other not related by blood or marriage	6
Stepparent	7
Adoptive parent	8
Other (please specify)_____	

8.1 Who is the **primary caretaker** of the child/children mentioned in Question 7?

Grandparent-paternal	1
Grandparent-maternal	2
Family/relative-maternal	3
Family/relative-parental	4
Sibling (Sister or brother)	5
Other not related by blood or marriage	6
Stepparent	7
Adoptive parent	8
Other (please specify)_____	

Interviewers: If there is a difference between the responses for Question 8 and Question 8.1, please probe and write notes here.

_____
_____
_____
_____

9. What is the **main reason** for taking in the child/children mentioned in Question 7?

Maternal death	1
Paternal death	2
Death of both parents	3
Poverty	4
Child/children abandoned	5
Migration (parents moved away)	6
Children abused	7
Other (please specify):_____	

10. Was there a definite impact on your household following taking in and caring these OVCs?

Yes	No
1	2

11. If yes, mention the impacts ----------

_____
_____
_____
_____

12. Are any of the above children in the household currently at secondary or primary school?

Yes	No
1	2

13. If "No", why aren't they in school ----------

_____
_____
_____
_____

SECTION III: Perceptions of guardians of OVCs of problems and related issues

14. In the past 6 months, have you observed an increase in a number of people with HIV/AIDS in your locality/community?

Yes	No	Don't know
1	2	3

15. If yes, state the impact and challenges it brings?-

_____
_____
_____
_____

16. In the past 6 months, have you seen an increase in the number of orphans and vulnerable children living in your neighbourhood?

Yes	No	Don't know
1	2	3

17. What, in your opinion, is the contribution of each of the following factors in making children orphans and vulnerable persons in your area?

	The main factor	A big factor	A factor	Not a factor at all	I don't know
Poverty	1	2	3	4	5
Accidental deaths	1	2	3	4	5
HIV/AIDS	1	2	3	4	5
Tuberculosis (TB)	1	2	3	4	5
Other (please specify)_____					

18. In the past 6 months, have you seen an increase in the number of families taking care of orphaned children in your neighbourhood?

Yes	No	Don't know
1	2	3

19 As a caregiver yourself, to what extent do you think that the following factors influence child vulnerability in your community?

	To a large extent	To some extent	To a small extent	Not at all	Don't know
Early marriage	1	2	3	4	5
Child Prostitution	1	2	3	4	5
Orphans due to HIV/AIDS	1	2	3	4	5
Street children	1	2	3	4	5
Children in conflict with the law (juvenile offenders)	1	2	3	4	5
Orphan due to causes other than HIV/AIDS	1	2	3	4	5
HIV infection in children	1	2	3	4	5
Displaced children?	1	2	3	4	5
Sexually abused children (such as raped children)	1	2	3	4	5
Sexually exploited children (such as child prostitution	1	2	3	4	5
Abandoned children	1	2	3	4	5
Children under the age of 18 who has to work to earn an income	1	2	3	4	5
Mental and/or physical disabilities in	1	2	3	4	5

	To a large extent	To some extent	To a small extent	Not at all	Don't know
children					
Being a child housemaid or child minder	1	2	3	4	5

20. Do you suspect that any of the parents of the children you have taken in, died from HIV/AIDS?

Yes, the mother died of HIV/AIDS	1
Yes, the father died of HIV/AIDS	2
No	3
I don't know or I don't want to give an answer	4

21. If No, what do you think was the cause of the death of parents of the children? Please answer in terms of the mother and the father if you can

Cause of death	Father			Mother		
	Yes	No	Don't know	Yes	No	Don't know
TB	1	2	3	1	2	3
Cancer	1	2	3	1	2	3
Malaria	1	2	3	1	2	3
Short illness	1	2	3	1	2	3
Long illness	1	2	3	1	2	3
Pneumonia	1	2	3	1	2	3
Accidental death and/or suicide	1	2	3	1	2	3
Diarrhoea	1	2	3	1	2	3
Epilepsy	1	2	3	1	2	3
Other (please specify)						

22. Have you told the child/children the actual cause of their parents' death?

Yes	No
1	2

23. How would you describe your biological children's attitudes the OVCs growing up under your supervision?

_____
_____
_____
_____

24. How would you describe the current health status of the OVCs under your care?

I**NTERVIEWER: If there is only 1 such a child in this household, then ask: "Can please tell me is this child is:**

Always ill	Often ill	Seldom ill	Never ill	Don't know
1	2	3	4	5

INTERVIEWER: If there are more than 1 such a child in this household, then ask: "Can you please tell me are:

	Always ill	Often ill	Seldom ill	Never ill	Don't know
All of these children	1	2	3	4	5
Most of these children	1	2	3	4	5
Only a few of these children	1	2	3	4	5

SECTION IV Communication of parents to the children in the household

25. How often do you talk openly to the children in your household about the following?

	Very often	Often	Seldom	Never
Sex and related issues	1	2	3	4
How HIV is transmitted	1	2	3	4
HIV and AIDS	1	2	3	4
Teenage pregnancies	1	2	3	4
Children orphaned due to AIDS	1	2	3	4

26. Do you discuss the following health issues in your family (that is with the children as well)?

	Yes	No
HIV/AIDS	1	2
Sexually transmitted infections (STIs)	1	2
Responsible sexuality	1	2
Diet, health and fitness	1	2

SECTION V Perceptions of needs and problems of OVCs

29. What, in your own opinion, are the biggest needs of the OVCs growing up under your supervision?

	Very important need	Important need	Unimportant need	Not a need at all	Don't know
Financial support	1	2	3	4	5
Educational support	1	2	3	4	5
Skill training	1	2	3	4	5
Medical support	1	2	3	4	5
Socio-emotional support	1	2	3	4	5
Adjustment	1	2	3	4	5
Other (please specify)					

30. Do you have enough money to fulfil your household's need for basic items, such as food and clothes for all of the children in the household?

Yes	No
1	2

31. Please rank the following items in terms of the challenge it presents to your household in caring for all the children. 1 it is a big challenge and 7 means it is not a challenge at all.

Shortage of money	1	2	3	4	5	6	7
Not enough or lack of food	1	2	3	4	5	6	7
Lack of school requirements	1	2	3	4	5	6	7
Illness	1	2	3	4	5	6	7
Discipline	1	2	3	4	5	6	7
Helping everyone to adjust to the situation	1	2	3	4	5	6	7

32. In terms of the OVCs you have to care for – how important are the following problems that this child/these children are facing? 1 it is a big challenge and 7 means it is not a challenge at all.

Lack of money and financial security	1	2	3	4	5	6	7
Poor support to stay in school	1	2	3	4	5	6	7
Poor support to be trained in a skill	1	2	3	4	5	6	7
Poor chances to get a job after school/training is completed	1	2	3	4	5	6	7
Medical problems and lack of medical support	1	2	3	4	5	6	7
Emotional problems	1	2	3	4	5	6	7
Stigma and discrimination by their friends	1	2	3	4	5	6	7
Stigma and discrimination by other family members	1	2	3	4	5	6	7
Stigma and discrimination by neighbours	1	2	3	4	5	6	7
Stigma and discrimination by members of the community	1	2	3	4	5	6	7
Problems with adjustment	1	2	3	4	5	6	7

SECTION V1 General livelihood issues and household access to support service

33. What is your employment status?

High/middle trader	1
Government factory worker	2
Civil servant	3
Private Enterprise Employee	4
Pensioner	5
Daily Labourer	6
Petty Trader	7
Local Beverage Seller	8
Soldier/Police officer	9
Unemployed	10
Other (please specify)	

34. Does your household have any of the following sources of income?

	Yes	No
Government pension or grant	1	2
Informal income	1	2
Formal salary or earnings on which tax is paid	1	2
Contribution by adult family members or relatives	1	2
Grants or donations by private welfare organizations	1	2
Contribution by younger family members or relatives	1	2
Other sources (please specify)		

35 If you have answered “NO” to all the categories in Question 34, please tell me what other strategies of survival do your household have to meet the needs of the household?

_____
_____
_____

36. Are you receiving any form of assistance outside the family for the care of OVCs?

Yes	No
1	2

37. If “yes” at Question 36, who provided support? If ‘no” at Question 36, please go to Question 41

	Yes	No
Non-governmental Organization (NGO)	1	2
Government Organization (GO)	1	2
Community-based Organization (CBO)	1	2
Faith-based Organization (FBO)	1	2
Other (please specify)		

38. If you receive support (from organization/relative) how regular is the support?

Daily	1
Once a week	2
Once in two weeks	3
Once a month	4
Once in 3 months	5
Less often than four times a year	6
Don’t know	7

39. Does the kind of support you receive include the following?

	Yes	No
Financial assistance	1	2
Food assistance	1	2
School fees	1	2
Psychosocial support	1	2
Training (IGA and related)	1	2
Medical fees	1	2

40. Is this support enough to meet the daily needs of your family?

Yes	No
1	2

41. What kind of support does your family need the most in order to best care for the OVCs?--------
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THANK YOU VERY MUCH FOR YOUR KIND CO-OPERATION

APPENDIX D. QUESTIONNAIRES FOR OVCs (7-18 YEARS OLD)

Questionnaire number	
Interviewer number	
Date of interview	

In this study we want to know the problems that children who are orphans face in Dessie Town have to face. The interviewer will ask you a question and then make a tick mark on the questionnaire to note your answer. Sometimes the interviewer will write short answers in the spaces provided. Your name will not be written on the questionnaire. This will mean that your name will not be known to the researchers or revealed in the publication of the results. We intend to interview –other orphans and vulnerable children in Dessie Town. Your participation in this study is purely voluntary. This means that you are free to grant or refuse to participate. We promise to treat all information you provide as strictly confidential (as a secret between you and this interviewer). Your cooperation and assistance is highly valued.

SECTION I. Background Information

1. Age: (Interviewer: only respondents between 7 and 18 years must be interviewed after informed consent forms have been signed)

7-9	1
10-15	2
15-18	3

2. Sex:

Male	1
Female	2

3. Religion:

Ethiopian Orthodox	1
Muslim	2
Protestant	3
Catholic	4
Other (please specify)_____	

4. Ethnic origin:

Amhara	1
Oromo	2
Tigrie	3
Gurage	4
Other (please specify)_____	

5. Type of the respondent: (Interviewer: check from sampling records and from interviewee):

Maternal orphan (Your mother has passed away) 1
Paternal orphan (Your father has passed away) 2
Double orphan (Your mother and father has passed away) 3
Other (please specify)_____

6. I am now going to ask you some questions about the people that make up your household.

6.1 First tell me about the adults (people 18 years and older. How many men and women are there in your household: (INTERVIEWER: ASK IN RESPECT OF EACH AGE GROUP AND ENTER THE NUMBER IN THE TABLE. IF THE RESPONDENT DOES NOT KNOW, ENTER 99 FOR UNKNOWN)

In the age groups	Men	Women
18-25?		
26-39?		
40-59?		
60-70		
Older than 70		

6.2 Now tell me about the children (babies from new-born to children aged 18). How many boys and girls are there in your household: (INTERVIEWER: ASK IN RESPECT OF EACH AGE GROUP AND ENTER THE NUMBER IN THE TABLE. IF THE RESPONDENT DOES NOT KNOW, ENTER 99 FOR UNKNOWN)

In the age groups	Boys	Girls
New-born to 2 years old?		
3-5 years old?		
6-9 years old?		
10-14 years old?		
15-18 years old?		

6.3 Are you part of a child-headed household?

Yes	No
1	2

(Interviewer: Use the data in 6.1 and 6.2 to check whether the answer to 6.3 corresponds with answers about the household. If there are inconsistencies, please probe to correct or write comments below)

_____
_____
_____
_____

7. Do you have brothers and sisters who do not live here with you in the same household? (Interviewer: if "yes", complete Questions 7.1, 7.2, 8 and 9. If "no", skip to Question 10).

Yes	No
1	2

7.1 If "yes" how many brothers do not live here with you? _____

7.2 If "yes", how many sisters do not live here with you? _____

8. How often do you visit with your brothers/sisters (or how often do they come to see you) who do not live with you in this home?

Every day	Once a week or every 2nd week	Once a month	Every few months	Once a year	Never
1	2	3	4	5	6

9 How do you feel about being separated from your brothers/sisters? Please tick each emotion that applies:

Unhappy or sad?  Angry?  Scared/ worried?  Isolated/alone 

SECTION II. Relationship of OVC with Guardians and migration

10. Is your current guardian:

	Yes	No
Your mother/stepmother?	1	2
Your father/stepfather?	1	2
Your brother/ stepbrother?	1	2
Your sister/stepsister?	1	2
Your grandmother?	1	2
Your grandfather?	1	2
Foster care parent(s)	1	2
Your aunt?	1	2
Your uncle?	1	2
You neighbour?	1	2
A Caregiver/housemaid who is not related to you?	1	2
Other (Please specify)		

11. Where you born here in Dessie Town?

Yes	No	Don't know
1	2	3

11.1 If "no": You were not born in Dessie, but just before you came to live here did you live:

In another town near Dessie?	1
In a rural (farm) area near Dessie?	2
In another town, but far from Dessie?	3
In a rural (farm area) far from Dessie?	4
Don't know	5
Other (Please specify)	

11.2. If "no": You were not born in Dessie, did you come here:

	Yes	No	Don't know
To visit relatives?	1	2	3
To come to school here?	1	2	3
Because your family had to leave?	1	2	3
Because you had a quarrel with your parents?	1	2	3
Because your parents divorced?	1	2	3
Because you or your relatives wanted to find a job here?	1	2	3
Because you or your relatives wanted to find land here?	1	2	3
Because you liked the things that the city life can offer?	1	2	3
Because you or your relatives were ill?	1	2	3
Because your mother or father or both of your parents has died?	1	2	3
Because your family was very poor?	1	2	3
Other			

12. Before your current guardian began to take care of you, how well did you know him/her?

Very well	1
Well, but not very well	2
Only a little bit	3
Not at all	4

13. How happy are you living in this home?

 Very happy?  Happy?  Sad?  Very sad? Don't know

14. Since you moved to this household, did

	Yes	No	Don't know
You stop going to school?			
You start going to school less regularly?	1	2	3
Your school grades get worse?	1	2	3
You have to do more chores?	1	2	3
You have to take care of smaller children?	1	2	3
You get less food to eat each day?	1	2	3
You get less money as a household?	1	2	3

15. When you think of how your guardian treats you and how he/she/they treat his/her/their own children, would you say that your guardian treats you…

…Better than his/her/their own children?	1
…The same as his/her/their own children?	2
…Worse his/her/their own children?	3
…Cannot say, my guardian does not have any children of his/her/their own	4
…Don't know	5

SECTION III. Educational Status of Orphans and vulnerable Children (OVC)

16. Have you ever been in school?

Yes	No
1	2

17. If no, why have you never been to school? If "yes" go to Question 18.

I am too young to go to school	1
Death of parent(s)	2
Death of guardian(s)	3
Financial problems	4
Illness	5
Lack of school space	6
Lack of support	7
Don't like school	8
I get teased and stigmatised	9
I get bullied at school	10
Poor health	11
Don't Know	12
Other	

18. Are you currently in school?

Yes	No
1	2

19. If you are currently in school, what grade are you in? If not currently in school, go to Question 20.

Grade 1-4	1
Grade 5-8	2
Grade 9-10	3
Grade 11-12	4
Other	

20. If you are not currently in school, why are you not currently attending school? If currently in school, go to Question 21.

I am too young to go to school	1
Death of parent(s)	2
Death of guardian(s)	3
Financial problems	4
Illness	5
Lack of school space	6
Lack of support	7
Don't like school	8
Poor health	9
Dropped out of school	9
I get bullied at school	10
I get teased and stigmatised	11
Got a job	12
Don't Know	13
Other	

SECTION IV Nutrition and Clothes

21. How often do your eat the following kinds food?

	Every day	Once a week	Once a month	Less than once a month	Never
Injera with Shiro/ kik wot	1	2	3	4	5
Bread with tea	1	2	3	4	5
Boiled/roasted cereals	1	2	3	4	5
Injera with meat/meat sauce	1	2	3	4	5
Milk and its products	1	2	3	4	5
Vegetables	1	2	3	4	5
Fruits	1	2	3	4	5
Eggs	1	2	3	4	5

22. Yesterday, how many times did you eat a meal?

Once	Twice	Three times	Did not eat at all
1	2	3	4

23. How do you feel about the clothes you currently have?

 Very happy?  Happy?  Sad?  Very sad? Don't know

SECTION V. Dwelling

24. How many rooms are there in this dwelling available for sleeping? _____rooms.

25 Does this dwelling have electricity?

Yes	No
1	2

26. Does this dwelling have tap water?

Yes	No
1	2

26.1 If "no:" what is the main source of water for household use?

Communal tap	1
River/Stream/unprotected Spring/well	2
Protected spring/well	3

27. Does this dwelling have an inside toilet?

Yes	No
1	2

27.1. If "no" where is the toilet?

Open field	1
Communal toilet	2
Temporary toilet	3

SECTION VI Problems experienced by children

28. In the last week how often did you experience the following?

	Almost every day	Once or twice	Not so often	Never
Hugs from friends and family	1	2	3	4
Insults or people calling you names	1	2	3	4
Physical punishment	1	2	3	4
Being ignored	1	2	3	4
Feeling lonely	1	2	3	4
Being stigmatised	1	2	3	4
Going to bed hungry	1	2	3	4
Feeling very ill	1	2	3	4
Feeling very happy and full of hope	1	2	3	4

29. Did any of the following things ever happen to you?

	Yes	No	Don't know
Removal of Tonsils	1	2	3
Receiving a tattoo	1	2	3
Extracting your milk teeth	1	2	3
Early marriage	1	2	3
Male Circumcision	1	2	3
Female genital mutilation	1	2	3

30. Are you currently taking care of a bedridden father, mother, grandfather, grandmother or any other adult?

Yes	No
1	2

33 Did you inherit any property or money from your parent(s)?

Yes	No	Don't know
1	2	3

34. Are you receiving any form of help outside of your family?

Yes	No
1	2

35. If "yes" at Question 34, who provides support?

	Yes	No	Don't know
Non-governmental Organization (NGO)	1	2	3
Government Organization (GO)	1	2	3
Community-based Organization (CBO)	1	2	3
Faith-based Organization (FBO)	1	2	3
Other (please specify)			

36. Do you get help for any of the following?

	Yes	No
Money	1	2
Food	1	2
School fees	1	2
Someone to talk to about your feelings	1	2
Training (IGA and related)	1	2
Help when you need to see a doctor or pay for medicine	1	2

APPENDIX E: KEY INFORMANT INTERVIEW GUIDE FOR SERVICE PROVIDER ORGANISATIONS

1. Name of the organisation
2. Address
3. Type of organisation
4. Name of interviewed person/position
5. Telephone
6. What is/are the objectives of the organisation?
7. Does your organisation undertake activities related to OVCs?
8. What are the problems faced by OVCs in Dessie Town? (Probe: educational opportunities, school attendance, and performance and nutrition, health care and psychosocial conditions)
9. Have you noticed in this area an increase in number of OVCs?
10. If yes, how big is the problem of OVC now in the community?
11. What are the major causes of the increase of OVCs in this area?
12. What effects do you think HIV/AIDS is having on the well-being of children?
13. What are the major problems facing OVCs in this community?
13.1 Material needs (food, clothing, shelter, education)
13.2 Psychosocial needs (counselling, love & care)
14. What are the major support needs of OVCs?
15. Are there specific criteria that must be met for children to benefit from your services? If so, please explain
16. What type of assistances/services does your organisation provide to OVCs?

Food ☐ Training (IGA) ☐
Health care ☐ Education☐
Clothing ☐ School fee and other related costs☐
Psychosocial support/counselling ☐ other (specify)
Financial ☐

17. Is the services offered to OVCs by your organisation is adequate?
18. Does your organisation have access/provide to psychosocial support for children and their families under your care?
190. What are the major problems experienced by your organisation when providing care and support for OVCs??
20. What type of socio-economic support do OVCs need for their sustainable well-being?