Addressing the Problems of HIV/AIDS Orphans: A Case Study in Bahir Dar

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Abstract

In the Growth and Transformation Plan (GTP), the need to provide care and support for orphan and vulnerable children is well articulated (GTP 8:1:2). In Ethiopia, however, until recently there has been no national orphan policy. This study, therefore, aims to investigate the methods and challenges in addressing the problems of HIV/AIDS orphans in Bahir Dar. Data is collected qualitatively through interviews, FGDs and case studies. The study indicated that there are variations in orphan load across the kebeles of the city. Shim bit kebele has the highest orphan load, both male and female orphans. In Bahir Dar, services rendered to HIV/AIDS orphans include psycho-social support, educational and medical support, economic strengthening through the guardians, home to home support, legal support, vocational and skill development trainings. These methods of addressing HIV/AIDS orphans are fragmented, only need-based approach as it lacks institutional networking, sustainability and community ownership. Therefore, in order to fulfill one of the Crosses-Cutting Sectors Development Plan of the GTP, it is recommendable to address the multifaceted problems of AIDS orphans in an integrated and sustainable way.

1. Introduction

HIV/AIDS has continued to become a global social, economic and political threat. Recent findings indicated that currently 34 million people are living with HIV/AIDS. Sub-Saharan countries are particularly vulnerable to this pandemic. This region accounts for 69% of the HIV-infected individuals of the world (UNAIDS 2012).

However, as UNAIDS reports (2012) indicate, HIV infection declined in many countries during the past decade. For instance, from 2001 to 2011, the rate of the infection among adults came down by 25% in thirty nine countries. Similarly, in Sub-Saharan Africa, the death of people from AIDS declined by 32 % from 2005 to 2011 and the number of people acquiring HIV infection in 2011 (1.8 million) was 25% lower than in 2001 (2.4 million). Despite these gains, Sub-Saharan Africa accounted for 71% of the adults and children newly infected in 2011, underscoring the importance of continuing and strengthening HIV prevention efforts in the region.

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The decline of the pandemic during the mid-2000s was due to the introduction of Anti Retroviral Therapy (ART) and its effective accessibility by all nations, especially developing countries which are harshly devastated during the last two decades. ART brought about a fundamental transformation in curbing down the pandemic and saved millions of lives. Since its introduction (1995), the therapy has saved fourteen million life-years in low- and middle-income countries, including nine million in Sub-Saharan Africa.

Ethiopia, which is one of the most affected countries of the region, and ranked third in the world next to South Africa and India, has also changed the figure dramatically. It marked the decline of the incidence of HIV infection rate of adults by 50%. Currently, the National HIV prevalence is 1.5% (4.2 urban, 0.6 rural), 27,978 new infections, 41,451 annual deaths. There are around 759,338 PLWHAs (61% female) (HAPCO 2012).

Even the HIV prevalence among the adult population is lower than many Sub-Saharan African countries. However, Ethiopia's HIV/AIDS epidemic pattern showed regional variations across urban and rural areas.

While HIV/AIDS prevalence appeared to be declining in urban areas, it remained stable, even slightly increased among the rural people. For example, HIV prevalence among pregnant women in Addis Ababa has declined from 23% in 1996 to 10% in 2007.There is also variation in the prevalence among regions both by urban and rural settings. In all regions, females are more affected than males in both urban and rural areas (HAPCO 2010).

In line with the global effort, the government of Ethiopia undertook tremendous efforts towards eradicating the pandemic. It reduced the infection rate by launching integrated services such as PMTCT and HIV counseling and testing (HCT) with family planning and maternal, newborn and child health services. The HCT program has shown considerable improvement both in terms of service expansion as well as utilization. A total of 5.8 million people (53% male) received HIV counseling and testing in 2008/09. This is a 22% increase from the previous year. As of the end of 2009, a total of 241,236 people started receiving ART and 176,644 are currently on ART. Females accounted for 57.9% of ART clients. ART coverage increased from 46% in 2008 to 53% in 2009 (HAPCO 2010).

Despite the remarkable achievement, the pandemic still poses a challenge where it has left millions of children without parents in the world. Children orphaned by AIDS are found in almost every country of the world. Nearly 14 million children lost their parents as a result of AIDS (UNAIDS 2012).

The worst orphan crisis, however, is in Sub-Saharan Africa, where more than 15 million children lost one or both parents to AIDS. It is estimated that in certain countries of this region, more than 1 in 5, fourteen-year old is an orphan (UNAIDS 2011).

The tragedy of AIDS as a cause of orphanhood is particular in that, if one parent is infected with the disease, the likelihood of the other parent's infection is also increased, thereby augmenting the probability of leaving the children orphaned with both parents dying, a phenomena known as double-orphaned (UNAIDS 2011).

In Africa, AIDS orphans face several problems. As Williamson (2004:3) indicated, the problems among AIDS orphans such as inadequate food, problems

with shelter and material needs, reduced access to health care services, psychological damages and the like are severe.

Factors such as loss of household incomes, the cost of treating HIV-related illness and funeral expenses frequently left the orphan children destitute. A parent's death also deprived them of the learning values they need to become socially knowledgeable and economically productive adults (Foster 2002:4).

Furthermore, these children are also forced to raise their siblings, compelling them to face responsibilities for which they are not prepared. Due to this children, become depressed and alienated. Consequently, they became more likely to engage in dangerous work, including commercial sex work, which increases their likelihood for HIV infection (BOLSA 2008).

In Ethiopia, AIDS orphans suffer from shortage of food, cloth and shelter. Studies indicated that almost half of the AIDS orphans (49 %) in the country are malnourished. And 51 % of them do not get proper clothing. Similarly, AIDS orphans also have a serious problem of shelter. Since most parents live in rented houses, orphans were forced to be evicted and become homeless when they fail to pay the house rent (UNICEF 2010).

Furthermore, AIDS orphans have problems of access to education and health services. The same report reveals that the majority of children (82%) are not provided with the necessary health services. In the same manner, a large number of orphans do not get the chance to enter school and even those who were enrolled are forced to drop out (12%), following the death of their parents. This is due to inability to pay school fees, educational material, and uniform and transport costs (Ibid).

The collective effect of all these problems subjected the orphans to depression, hopelessness, social isolation, anxiety and confusion (Ibid).

1.1. Statement of the Problem

Ethiopia has the highest number of orphans. The proportion of orphan children due to AIDS is also alarmingly increasing in this country. It increased from 26% in 2001 to 43% in 2010 (UNAIDS 2012).

In spite of these problems, there is no national policy directly addressing HIV/AIDS orphans. This may be due to lack of knowledge about the problems of HIV/AIDS orphans. Furthermore, government agencies and non-governmental organizations who give services to HIV/AIDS orphans have been mainly restricted to the capital. This has created a situation where the majority of HIV/AIDS orphans outside the capital are left without adequate assistance.

Under the Cross-Cutting Sectors Development Plan of the Growth and Transformation Plan (GTP), the need to provide care and support to orphan and vulnerable children is well articulated (GTP 8:1:2). Although governmental and some non-governmental organizations are working with HIV/AIDS orphans, they couldn't address the problem adequately. Even if there is lack of adequate data on the overall situation of HIV/AIDS orphans in Amhara Region, the problem is more severe because of the very large size of HIV/AIDS orphans as compared to the national condition. The region accounted for 40% of the total national HIV/AIDS orphans.

Bahir Dar took the biggest share from this figure as it was the region's principal city. However, this problem was not well researched in this city except for the OVC situational assessment study of the Bureau of Social and Labor Affairs (BOLSA 2008).

Therefore, this study tries to examine the methods and challenges in addressing the problems of HIV/AIDS orphans in Bahir Dar, Amhara regional state.

1.2 Data Collection

Significant documents such as reports, annual and strategic plans were collected. Also, in-depth interviews were conducted with 20 orphaned children, 10 guardians and 2 leaders of orphan centers, 5 social experts, 3 *Idir* leaders and 4 *kebele* leaders. Five FGD sessions were arranged: two for HIV/AIDS orphans (one for female orphan and one for male orphan), and guardians and one for social experts. Furthermore, a detailed life history of four orphans (two male and two female orphans) was studied.

2. Findings and Discussions

2.1 Size and Distribution of Orphan Population

Table 1. Number of orphans in Bahir Dar

Status		Kebeles									
	Sex	Tana	Shinbit	Hidar 11	Fasilo	Ginbot 20	Belay Zeleke	Shum Abo	Gishe Abay	Sefene Selam	Total
Double orphan	Male	7	452	51	46	15	38	14	24	23	670
	Fem.	22	472	55	33	17	35	21	39	43	737
	Total	29	924	106	79	32	73	35	63	66	1407
Single orphan	Male	65	800	214	128	187	-	77	62	71	1604
	Fem.	84	1000	196	137	147	-	65	88	90	1807
	Total	149	1800	410	265	334	-	142	150	161	3411
Total	Male	72	1252	265	174	202	-	91	86	94	2236
	Fem.	106	1472	251	170	164	-	86	127	133	2509
		178	2724	516	344	366	-	177	213	227	4745

SOURCE: Amhara Women, Children and Youth Affairs Bureau

As is indicated in table 1 above, Shim bit kebele has the highest double orphan load in both male (67.46%) and female (64.04%) orphans. On the other hand, Tana and Ginbot 20 *kebele* carry less number of male (1.04%) and female double orphans (2.3%), respectively. Shim bit *kebele* has a greater number of both single

male (49.8%) and female (49.87%) orphans. Gishe Abay *kebele* has the least orphan load in male orphans (3.8%) while Shum Abo *kebele* has less orphan load in female orphans (3.6%).

The study indicates that there are variations in orphan load across *kebeles* of the . These variations emanated mainly with the size of population and other variables like rural-urban migration. As the data indicates, female orphans are higher than male orphans. This is because as certain studies (BOLSA 2008; Guday 2005; Ayele in Eva Poluha 2007) indicated, there are more female migrants than male migrants due to push factors such as early marriage, female genital mutilation, rape, work load and lack of educational opportunities and access to health. Nowadays, even this size is exacerbated by female migrants who are destined for the Middle East countries. However, some were unsuccessful as they didn't meet the age and other formalities and started living in the .

2.2. Child Protection and Development

UNICEF defines child protection as the way of "preventing and responding to violence, exploitation and abuse against children – including commercial sexual exploitation, trafficking, child labor and harmful traditional practices, such as female genital mutilation/cutting and child marriage"(UNICEF 2006).

It is reported that there are high level violations of rights of children across the world and are "massive, under-recognized and under-reported barriers to child survival and development, in addition to being human rights violations. Children subjected to violence, exploitation, abuse and neglect are at risk of death, poor physical and mental health, HIV/AIDS infection, educational problems, displacement, homelessness, vagrancy and poor parenting skills later in life"(ibid).

Ethiopia accepted most of the international conventions and declaration of the rights of children. The international Convention on the Rights Children (CRC) and the African Charter on the Right and Welfare of the Child (ACERWC) were among others. The CRC emphasizes the protection of children from discrimination, abuse and neglect. Article 36 of Ethiopia's 1995 Constitution recognizes and protects the rights of children. It provides that every child has "The right to be protected against exploitative practices and not to be permitted to engage in any employment which would prejudice its health, education or well-being''. Article 95 of the Constitution also stipulates that every "Ethiopian shall be entitled, within the limits of the country's resources, to food, clean water, shelter, health, education and security of pension". However, knowingly or unknowingly, the rights of children, particularly that of HIV/AIDS orphans are violated.

The rights of most orphans in Ethiopia as well as in Amhara region are not protected due to various socio-economic problems and cultural factors. Similarly, orphans are found in worse situations.

2.3. Major Problems of HIV/AIDS Orphans in Bahir Dar

In the of Bahir Dar, AIDS orphans faced the following problems:

2.3.1 Economic Hardship

As the regional HIV/AIDS Prevention and Control Office (HAPCO) indicated, more than half of AIDS orphans in the had serous food shortages, clothing and shelter problems. The Office reported that orphans had serious housing problems and many of them became street children because of lack of support. Even some orphan children were forced to support their siblings. Meseret (aged 18 and a double orphan) describes her situation as follows:

> My mother died of HIV/AIDS six years ago. My father also died earlier. I have two little brothers. I am an elder orphan. We are HIV negative. We live in a precarious situation without any form of support. I took the responsibility of supporting my little brothers by selling local beer. I was compelled to sell my parents' domestic goods, including jewelry.

As some orphans explained, due to the economic hardship, they dropped out of school and became street children and daily laborers. Especially for female orphans life became very challenging. They are forced to engage in risky activities like commercial sex work which has a high risk of HIV infection. From fifteen interviewed female orphans, eight were engaged in commercial sex work.

Eyerus, aged 15 and a single orphan, is one such commercial sex worker. She stated how she started it in the following way.

> My father died six years ago when I was nine. I have two little brothers aged 13 and 10. All the burden of taking care of us rested on the shoulder of my mother. She couldn't afford all our basic necessities and schooling. I am forced to drop out of grade eight and started to help my mother and brothers by working at a night club as a commercial sex worker.

Interviews with orphan commercial sex workers and FGD participants disclosed that the economic hardship exposed female orphans to HIV infection. They said that many of their friends were HIV positive. While some female orphans survived because of the Anti Retroviral Therapy (ART), others died. Some studies on orphans (BOLSA 2008; MoH 2010) have also indicated that AIDS orphans in Ethiopia are vulnerable to sexually transmitted diseases including HIV/AIDS.

Bahir Dar has become one of the major hubs of the sex industry in the country. And almost half of the commercial sex workers of the were below the age of nineteen. Orphans, including AIDS/orphans, were the highest among these child prostitutes. The problems are not confined only to orphans but also affect guardians and care givers. Their living condition has deteriorated because of the burden of taking care of the orphans.

In Amhara region, most AIDS orphans are cared for and supported by their close relatives. For instance, 70-75% of these orphans were living with their close relatives such as grandparents and siblings (BOLSA 2006). In particular, grandparents were the prime guardians who shouldered the responsibility of

supporting AIDS orphans. However, most of these guardians are too old and poor to support them. The following two cases best illustrate this problem.

Workitu (age 50 and guardian for two male double orphans aged 14 and 12 and one female orphan aged 8) tells her story as follows:

> My eldest daughter had two husbands; both died of HIV/AIDS. Three of their children are living with me. I support them with food, shelter and, educational materials, school fees and uniforms with the help of an NGO. I engaged in *gulit terrra* small business. But I couldn't repay the credit because of the burden of supporting the children. I have no income. Sometimes I beg to support them. I forced the elder orphan boy to become a shoe shiner.

Another single orphan's mother (Maritu, aged 45) tells about her economic woes in a similar way:

> My husband died six year ago because of HIV/AIDS. My son is 13 years old. I live with HIV/AIDS. Since I was following up the counseling of PMTCT during my pregnancy, my son is HIV negative. I have got a credit of 1000 birr from a certain NGO and I am engaged in local alcohol drinks business. But I didn't pay back the credit because of the unbearable economic burden I have.

Some FGD participants who live with their close relatives (guardians) revealed that they were not getting enough food and cloth even though their guardians got support from organizations like OSSA and Mekdim. They said that even their family property was used up by their guardians while they suffered from shortage of food and clothing and lack of supply of educational materials. One orphan (Marewage 13 yrs) explained it in the following way:

> My father and my mother died three years and a year ago, respectively. I live with my uncle. He has three sons. He sold our household goods like the television and sofa. I dropped out of school two years ago because of lack of support for school fee and school materials. Even his wife doesn't treat me equally with her sons. I was forced to engage in very tiresome domestic work while her children are pursuing their education. I failed to do so because of the tiresome workload. Sometimes she flogged me and deprived me of food. Nobody cared for me when I was sick.

As the above cases illustrated assets of orphans left by their parents have been ruined by their guardians. They make use of the financial support for orphans for their personal benefit. They used orphans as a means to set up a business. Due to this, some of the orphans ended up in the street and faced multiple psycho-social problems as is described below.

2.3.2 Psycho-Social Problems

HIV/AIDS orphans suffer from lack affection and depression because of the loss of their parents at an early age. As a result they had poor performance in their

education, as their teachers reported. Some elementary teachers in Bahir Dar disclosed that most HIV/AIDS orphans were not attending their education properly. They sometimes came late or missed most classes. Even in class their participation, especially that of women, is very low compared to that of non-orphan students. They sustained their education by supporting themselves (self supported). They work half a day as shoe shiners or daily laborers. Consequently, they missed most classes in a week.

Kebebew is a double orphan and a grade 3 student. He lives in a house rented for 250 birr. He is provided by OSSA with educational materials biannually and some food items like rice and oil periodically, but that is not enough to cover his house rent and food and transportation cost. Hence he is forced to engage as a daily laborer for half a day while attending class either in the morning or in the afternoon. He stated described his problem as follows:

> I am in a dilemma as to whether to continue my education or drop out. Most of the time, I go to school without having my breakfast (how can somebody learn without food?). I always worry about how I would pay my house rent. I changed my house four times due to my failure to pay the house rent on time. I did whatever daily labor there was in the shifts to cover my house rent and food costs.

Female orphan students were also overburdened with house chores to fulfill their basic necessities. Shitaye is a single orphan and a grade four student at Qulqwal Ber elementary school. She was also supported by OSSA. She rented a house for 200 birr. To cover all her expenses, she had to work as a *temelalash serategna* (day-time house maid). Her main tasks included preparation of food, washing clothes, baking *Injera* for three to four *wondelattes* (single/unmarried men), for which she was paid 150 birr each month. As a result of her work, she missed at least three classes per week and poorly performed last year, scoring below the pass mark in four subjects.

FGD participants from HIV/AIDS orphans supported by OSSA also revealed that the support rendered by the organization is not enough to cover their monthly expenses, including house rent. AIDS orphans worried about their fate after the termination of the project through which they were supported. Although it is small, they need this support. Even if some orphans wanted to drop out of their school for some health or other problems, they didn't do it as it was considered a breach of one of the rules of OSSA. The organization supports only those orphans who enrolled and pursued their education. If they dropped out of school, the organization would terminate the support immediately.

Teachers said that HIV/AIDS orphans suffered from psychological distress, depression, hopelessness, social isolation, anxiety and confusion. According to the observation of the teachers, most orphans didn't participate in the plays of children and chose to remain aloof. "When we approached them, they were reluctant to express their feelings. That is why their educational achievement is very poor," one of these teachers reiterated. As they reported, there is no psycho-social support for these orphans.

Most orphans who lived with their close relatives departed from their guardians' homes as the latter failed to care for them properly and practiced corporal

punishment. For this reason, orphans ended up in the street where they faced harsh psycho-social problems. Female orphans especially were exposed to rape and unwanted pregnancy. Finally, they became commercial sex workers.

2.4. Orphan Care and Support System in Bahir Dar

Various governmental agencies and some NGOs are involved in the support of AIDS orphans. The two governmental organizations which are mandated to address the problems of HIV/AIDS orphans are the Amhara regional HIV/AIDS Prevention, Control and Coordination Office (AHAPCO) and the Amhara Women, Child, and Youth Affairs Bureau (AWCYAB). They have the responsibility to coordinate all activities of various organizations, institutions and associations who are working with HIV/AIDS orphans.

HAPCO was established to design and provide overall guidance on regional response to HIV/AIDS. It coordinate HIV/AIDS prevention and control activities of government sectors, NGOs, CBOs, FBOs, PLWHA associations and other actors.

HAPCO is also responsible for and a lead organization in the care and support of HIV/AIDS orphans. It mobilizes the community to participate and own the response, especially in the provision of care and support. It also involves in capacity building, networking and partnership, and mobilization of resources. It undertakes monitoring and evaluation to strengthen and intensify the multi-sectoral HIV/AIDS prevention and control activities.

The other responsible organization is Amhara Women, Children, and Youth Affairs Bureau (AWCYAB). The Bureau started working with children, including orphans, in 2008. Before that the responsible body for coordinating care and support services of orphans was the Bureau of Labor and Social Affairs (BOLSA). Now, AWCYAB is one of the leading members of the regional Coalition for Community Care and Support (CCCS), but has not yet fully engaged in this task. Although it has little experience in HIV/AIDS orphan care and support, the Bureau is working largely in establishing networks with institutions that give services to HIV/AIDS orphans. It also follows up the activities of these institutions in accordance with the best interests and rights of children, including HIV/AIDS orphans. It takes appropriate measures if there is any form of incidence against the rights of children. Nevertheless, both AWCYAB and HAPCO do not directly involve in interventions for mitigating the problems of HIV/AIDS orphans.

In the of Bahir Dar, each governmental organization, except a few government developmental organizations, has also the responsibility to support HIV/AIDS orphans. For instance, currently among the governmental organizations, Amhara Water Works Construction Enterprise, Ethiopian Electric Power Corporation, Telecommunications Corporation, and Bahir Dar University support 12, 32, 30, and 22 orphans, respectively.

In Bahir Dar, there are various NGOs, community-Based Organizations (CBOs), Faith-Based Organizations (FBOs), and PLWHA associations that are involved in the delivery of services to HIV/AIDS orphans. Local NGOs like Mekdim and Organization for Social Services for AIDS (OSSA), are forerunning

organizations in the care and support program of HIV/AIDS orphans. These organizations' services were selected as exemplary practice by the Forum for Christian Relief and Development Association (CRDA) in 2006, together with Dawn of Hope, Organization for Rehabilitation and Development in Amhara (ORDA), Bahir Dar Medhanealem Orphan and Destitute Family Support and Training Center, among the institutions working on HIV/AIDS and orphans.

Among FBOs, the Ethiopian Orthodox Church-Child and Family Affairs Organization (EOC-CFAO), Fatuma Zehara Aid Organization (FZAO) and others provide various kinds of services to HIV/AIDS orphans. *Idirs* (self-help associations) are also involved in the selection of HIV/AIDS orphans and volunteers and in giving care and support services.

In general, the support ranged from financial and material, to psycho-social support. Most of the support was given through the guardians. Earlier, the care and support system was fragment. There was an OVC task force responsible for screening HIV/AIDS orphans. Now this task force has been replaced by Community Committee (CC) which is organized from *Kebele* to regional level. This Committee is established by Women, Children, and Youth Affairs Bureau. The Committee has five members at *kebele* level, which is headed by the *kebele* chairman, and the leader of the *Kebele* Women, Children and Youth Affairs Office.

Currently seven packages were identified for care and support services. The package was formulated by the Ministry of Women, Children, and Youth Affairs. Normally, not all orphans benefit from the services except for some orphans who deserve all support. Priority service is identified based on the Child Status Index (CSI). This index was prepared to give effective service and avoid giving multiple services to orphans. Based on the Index, each package of service is distributed to orphans in need of support.

2.5 Psycho-Social Support

Psycho-social support is one of the pillars of the seven packages in addressing the problems of orphans, including HIV/AIDS orphans. In the , many institutions tried to provide this support. The service is not sufficiently provided. For instance, Mekdim and OSSA integrated this service in their program. However, the service was not delivered properly. As the officers of these organizations disclosed, the service were delivered through volunteers who were trained by them. For instance, OSSA delivered the service for 240 orphans through volunteers. The service is delivered in a 1-10 ratio (one volunteer to ten orphans). However, the problem is that these volunteers are not professionals. Their educational level is low, varying from elementary to high school complete. They didn't have the required knowledge and skills in providing psycho-social services. This service should be given by professionals with a background of specialization in psychology, sociology, social anthropology and related disciplines.

Other kinds of support include free medical service, economic support through the guardians, home to home support, legal support, and vocational and skill development training. For instance, Bahir Dar Medhanealem Orphan and

Destitute Family Support and Training Center is highly involved in income generating activities and vocational and skill development trainings.

2.6. Volunteer Service in Care and Support HIV/AIDS Orphans

On average thirty volunteers were engaged in the care and support for orphans in the nine kebeles of Bahir Dar. Selection of volunteers was carried out in conjunction with the stakeholders and Community Committee based on agreed criteria like those who are willing to work for poor, those having volunteer experience, those free from any harmful addictions, those who are permanently living in the operational areas, those having acknowledgment from the existing Kebele, those have no past criminal record including arrest or conviction due to child abuse or neglect, or domestic violence, or dishonesty, etc. Their transportation cost while conducting delivering the service to orphans was covered. In addition, they get awareness education and trainings relating to their work such as Child Status Index (CSI).

Volunteers are valuable in providing support to orphans and their families. They have a great role in identifying the needs of orphans within a household and help link families with available services. The major roles and responsibility of volunteers are the following. They identify and register orphans' households; become aware of the standard service guideline and ensure its application in providing services to the orphans; participate in orphans need assessments and development of care plan; provide information to help the orphans and their families/guardians to better understand and access services, activities and resources; ensure that every child has got the services based on the care plan; document and share information about households, children and services, facilitation of service referrals, tracking of referrals and monitoring services provided; map community orphans' needs to report to his/her CC members and facilitators. The volunteers have also the responsibility of referring orphans and their caregivers to needed service providers in the community; they offer training, assist community conversations and coffee ceremony sessions.

2.7. Challenges in Providing Care and Support

As reported by the experts from HAPCO, the first challenge was the problem of screening out AIDS orphans. Due to fear of stigmatization and for the sake of support, actual HIV/AIDS orphans couldn't be cared for and supported. Sometimes, there were biases by the *kebele* OVC task force as they don't carry out the selection process as per the agreed criteria. However, this task force has now been replaced by the coalition force.

The other major challenge in care and support was lack of integrity and sustainability among the service providers. Some organizations delayed or terminated their support unexpectedly, without the knowledge of AIDS orphans, as their source of fund depended entirely on external donors like USAID, Care International and Save the Children. As a result, AIDS orphans were left without support. The program lacks community ownership.

Resource and effort duplication was still a big challenge in the care and support system. While some orphans got support from different organizations, at the same time others (more than half) remained without any form of support. Most support for orphans is through leaching out money. Some orphanages provide support until the orphans complete secondary school or graduate from the university; others cut support even before the orphans' completion of secondary school. After the graduation from orphanages, the orphans faced serious socio-economic problems.

This study has also identified that there is lack of comprehensive data and problems of data management on HIV/AIDS orphans. Data is scant in both governmental and NGOs who work on HIV/AIDS orphans. In contrast, *kebeles* are better in documenting current data but the data were not well organized.

The major challenge in addressing HIV/AIDS orphans' problems, however, is related to the country's legal apparatus and policy that should safeguard and protect orphans. **T**here is no national orphan policy except for the 2001 MoLSA service guideline (National Alternative Childcare Guideline).This Guideline was revised based on the assessment study of 2008 conducted by MWCYA. The new guideline focused on Community-Based Childcare Reunification and Reintegration Program, Foster Care, Adoption and Institutional Care Service. Nevertheless, this guideline has not yet been fully operationalized.

Some Conclusions

This study revealed that most AIDS orphans in Bahir Dar are exposed to various problems after the death of their parents. The majority of the AIDS orphans faced food shortages which in turn made them susceptible to various diseases. Since they couldn't afford school fees, they dropped out of school

In addition, AIDS orphans also faced psycho-social problems such as loneliness, emotional disturbance, and depression. The problems are not confined only to orphans but also affect guardians and care givers. Their living condition deteriorated because of the burden of taking care of the orphans. The study found that most orphans are cared for in family units through extended family networks. Orphan assets (family property of orphans) are ruined by guardians. They made use of the financial support for orphans for their personal benefit. They used orphans as a means of setting up and/or running their business. Due to this, some orphans ended up in the street.

In Bahir Dar, various governmental agencies and some NGOs are involved in the support of AIDS orphans. The support ranged from financial and material to psycho-social support. Most of the support was channeled through the guardians. Although governmental agencies and some NGOs are involved in the support of AIDS orphans, they couldn't address the problem in a sustainable way as they lack a coordinated approach. There is duplication of effort and wastage of resources. Due to this, while a few benefited from various institutions, most orphans left without any form of support.

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