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EDUCATIONAL CHALLENGES OF AIDS ORPHANED CHILDREN AND POSSIBLE SOLUTIONS IN ADDIS ABABA

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FESEHA WOLDE MICHAEL TADESSE

JUNE 2003

EDUCATIONAL CHALLENGES OF AIDS ORPHANED CHILDREN AND POSSIBLE SOLUTIONS IN ADDIS ABABA

A THESIS PRESENTED TO THE SCHOOL OF GRADUATE STUDEIS ADDIS ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN SPECIAL NEEDS EDUCATION, DEPARTMENT OF EDUCATIONAL PSYCHLOGY

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BY
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APPROVAL BY THE EXAMINING BOARD:

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Abstract

HIV/AIDS is a human catastrophic virus/disease which has killed thousands and thousands of people including immature growing up kids. "Today more than 13 million children under the age of 15 have lost one or both parents to AIDS (UNAIDS, 2002:3). Undoubtedly, the number of AIDS orphans is increasing at an alarming rate and parental death to AIDS has resulted in their dropping school , labour exploitation, stigma and discrimination.

This study has been conducted with the objective to investigate the educational problems of AIDS orphaned children and to seek possible educational approaches to them. 'AIDS orphans are likely to be less well nourished, may be over worked by their guardians and lack proper supervision, care and school or vocational training.... schooling for orphans is unexplored and new issue which needs to be addressed (Gachuhi, 1999:8).

Of the various sectors, education is the one heavily affected by HIV/AIDS. HIV/AIDS affects the demand for education, the supply and quality of education, the available resources for education, etc. Therefore, attempts have been made to evaluate the kind of care and support AIDS orphans have received within the extended family circle, and to see their academic achievements, school enrollment rate, needs, values and motivations , the deficits they have had and the solution that have been undertaken.

Using convenient and purposive sampling method, a total of 406 individuals were selected for the study.Based on this sample two types of questionnaires have been developed to be completed by AIDS orphans & caretakers. The views of concerned Ministries and Associations of HIV carriers like Dawn of Hope and Mekedim Ethiopia have been gathered by way of an interview. Observations have been made on AIDS orphans who have themselves been HIV carriers. Two focus group discussions were conducted with AIDS orphaned children. The quantitative data have been analyzed using descriptive statistics such as mean, variance & standard deviation. In addition, ANOVA, t-test, Chi-square test, Spearman rho correlation and percentage have been employed. The qualitative data gathered have been transcribed by the use of words and sentences.

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The findings of the study have revealed that more than half of the AIDS orphans are being reared in the extended family circle. They are receiving support like wheat, food oil and money from Associations of HIV carriers and local NGO's, but the support they get is not sufficient and lacks uniformity among the different supporting agencies. AIDS orphans also lack psychological support from the care takers.The majority of the AIDS orphans who have been included in the study have succeeded in attending schools. Most of them are in regular schools of both government and privately owned ones, but very few are in night school programs. Concerning class attendance a significant difference has been observed between boys and girls. More boys attend classes than girls. AIDS orphans are found to be stigmatized and discriminated by their age mates. Despite the prevailing stigma and discrimination, these AIDS orphans have been found to have high self-esteem and above average self-efficacy. However,they are not in a position to receive sufficient amount of educational materials, food and medicine.

In line with these findings of the study, recommendations are forwarded to change the existing Education and Training Policy for possible in a way that include the issues of AIDS orphans and the proper implementation of ESDP statement. It also suggests a systematic & timely data collection of the affected and infected children and teachers from as low as school level to as high up to the Ministry of Education. The paper also proposes a way of sensitizing and capacitating the extended family in order to realize the Community Based Rehabilitation (CBR) program; establishing community schools; the use of distance education for AIDS orphans; and organizing AIDS orphans to speak out their mind about their rights.

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ACRONYMS AND ABBREVIATIONS

AIDS :	Acquired Immunodeficiency Syndrome
EFA:	Education For All
ESDP:	Education Sector Development Program
GOs:	Governmental organizations
HIV:	Human Immunodeficiency Virus
IIEP:	International Institute for Educational Planning.
ILO	International Labor Organization
MOE:	Ministry of Education
MOH:	Ministry of Health
MOLSA:	Ministry of Labor and Social Affairs
NGOs:	Non-Government Organizations
TASO:	The AIDS Support Organization
UNAIDS:	Joint United Nations Program on HIV/AIDS
UNICEF:	United Nations Children's Fund
UNESCO:	United Nations, Education, Science and Culture Organization
WHO:	World Health Organization

CCRDA

Table of contents

	Page
Acknowledgements	i
Abstract	ii
Acronyms and Abbreviations	iii
List of Tables	iv
CHAPTER ONE: INTRODUCTION	1
1.1 Background of the study	1
1.2 Objectives of the study	5
1.3 Statement of the problem	7
1.4 Significance of the study	10
1.5 Scope of the study	11
1.5.1 Delimitations of the study	11
1.5.2 Limitations of the study	12
1.6 Definition of terms	12
CHAPTER TWO: REVIEW OF RELATED LITERATURE	13
2.1 The Spread of HIV/AIDS in the World	13
2.1.1 Prevalence of HIV/AIDS in Eastern and Southern Africa	14
2.1.2 Prevalence of HIV/AIDS in Ethiopia	15
2.1.3 The Prevalence of AIDS Orphans in Eastern and Southern Africa	16
2.2 Theoretical Frameworks	17
2.2.1 Perceived Self-efficacy	17
2.2.2 The Just World Theory	19
2.3 Care and support to AIDS orphans	22
2.4 The impact of HIV/AIDS on the Education Sector	26
2.4.1 The Impact of HIV/AIDS on the Demand for Education	26
2.4.2 The Impact of HIV/AIDS on the Supply and Quality of Education	28
2.4.3 The impact of HIV/AIDS on Available Resources for Education	30

CCRDA

2.5 Impacts of HIV/AIDS on the Education of AIDS Orphan Children 30
CHAPTER THREE: DESIGN AND METHODOLOGY OF THE STUDY 39
3.1 Sampling 39
3.2 Variables 40
3.3 Data collection procedures 41
3.3.1 Questionnaire development 41
A. Questionnaire for AIDS orphaned children 42
B. Questionnaire for caretakers of AIDS orphaned children 42
3.3.2 Interview 43
3.3.3 Observation 44
3.3.4 Focus group discussion 44
3.4 Methods of data analysis 44
3.4.1 Quantitative methods 44
3.4.2 Qualitative methods 45
CHAPTER FOUR: Findings 46
CHAPTER FIVE: SUMMARY,DISCUSSIONS, CONCLUSSIONS AND RECOMMENDATIONS 87
5.1 Summary and Discussions 87
5.2 Conclusions 112
5.3 Recommendations 116
REFERENCES 120
APPENDICES

CCRDA

List of the tables

		Page
Table:1	Sex of the Respondents	46
Table:2	Ages of AIDS Orphaned Children As Stated By Caretakers	46
Table 3:	Age of AIDS Orphaned Children As Stated By Themselves	47
Table 4:	The Lost Parent(s) to AIDS	47
Table 5	Age and Educational Background of Caretakers	48
Table 6	Family Size and Number of Orphans In The Family	49
Table 7	Types of Job and Average Monthly Income of Caretakers	49
Table 8	Grade levels of AIDS Orphaned Children When They Lost Their Parent(s) to AIDS and Current Status	50
Table 9	Support Given to AIDS Orphaned Children Soon After Parental Death.	51
Table 10	Growth Status of AIDS Orphaned Children	52
Table 11	The Kind of Support AIDS Orphaned Children and Their Caretakers are Receiving	53
Table 12	School Enrollment of AIDS Orphaned Children	54
Table 13	Forms of Schooling AIDS Orphaned Children are Enrolled	55
Table 14	School Attendance Rate of AIDS Orphaned Children	56
Table 15	Class Attendance of AIDS Orphaned Children During Last Week	57
Table 16	Class Attendance of AIDS Orphaned Children in Relation to Parental Death Status	58
Table 17	Problems Related to Teaching- Learning Process and Follow up of Caretakers	59
Table 18	Classroom Behaviours of AIDS Orphaned Children	60
Table 19	Attitude of Agemates to wards AIDS Orphaned Children and their Manifestations	62
Table 20	Societal Discrimination of AIDS Orphaned Children	63
Table 21	Availability of Free Time to AIDS Orphaned Children to do School Tasks	65
Table 22	The needs of AIDS Orphaned Children to Learn	67

CCRDA

Table 23	Sex of AIDS Orphans and the Need to Learn.....	68
Table 24	Current Age of AIDS Orphans and the Need to Learn.....	68
Table 25	The Need to Learn and Parental Death Status.....	69
Table 26	Manifestation of AIDS Orphaned Children's Effort to Learn.....	70
Table 27	AIDS Orphaned Children and their Caretakers;' Value of Education.....	71
Table 28	The Reason(s) for Very High and High Values of AIDS Orphaned Children to Education.....	72
Table 29	Sex of AIDS Orphans and Value to Education.....	73
Table 30	Current Ages of AIDS Orphans and Value to Education.....	73
Table 31	Value to Education and Parental Death Status.....	74
Table 32	AIDS Orphaned Children's Motivation to Learn.....	74
Table 33	Parental Death and its Impact on the Motivation of AIDS Orphaned Children.....	75
Table 34	Degree of Motivation of AIDS Orphaned Children Vs Parental Death Status.....	76
Table 35	Motivation of Learn and Current Ages of AIDS Orphaned Children.....	76
Table 36	Factors Contributed to High Motivation of AIDS Orphaned Children to Learn.....	77
Table 37	School Achievement of AIDS Orphaned Children.....	77
Table 38	Academic Scores of AIDS Orphaned Children.....	78
Table 39	Availability of Educational Materials, Food & Medicine.....	80
Table 40	The Feelings of AIDS Orphaned Children on the Care and Support they Received.....	82
Table 41	Problems Faced to AIDS Orphaned Children.....	84

CCRDA

CHAPTER ONE

Introduction

1.1. Background of the Study

Nearly two decades ago, a human catastrophic disease, Acquired Immuno Deficiency Syndrome (AIDS) caused by Human Immunodeficiency Virus (HIV) came into being. The first report of AIDS came from the Centers of Disease Control in Atlanta, Georgia (a public health body responsible for investigating epidemics and reports of new or unusual disease in United States) which described the cases of 5 young previously healthy homosexuals who had been treated in Los Angeles hospital for a rare infections of the lungs pneumocystic carinii pneumonia (PCP). " At the same time in 1981 came reports of 26 previously healthy homosexuals in New York and California who had developed a severe form of a rare malignant cancer called Kaposi's sarcoma. Eight of these patients died within 24 months of diagnosis ..." (Daniels, 1987: 1-2).

The first reported case in the United Kingdom, in December 1981, was a 49 year- old homosexual in Bourne Mouth who presented AIDS nine months after returning from Miami. Since then, every country in the world has reported AIDS cases. UNAIDS has estimated that at the end of 1998, 33.4 million people, in the world were living with HIV/AIDS of which 22.5 million or 67% were in Sub-Sahara Africa. This number however increased to 40 million, by the year 2000, of which 90% were in developing countries. The reported deaths from the onset of the epidemic has reached more than 20 million world wide, including almost 3 million children under the age of 15 (UNAIDS, 2002). Parental death to AIDS has resulted in school dropout, labor exploitation, stigma and discrimination of AIDS orphaned children (Afework, Mebratu 2000). Regarding the number of children orphaned by AIDS, the data is frustrating as to UNAIDS report. It says this:

One of the most telling and troubling consequences of the epidemic's growing reach is the

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number of children it has orphaned or seriously impacted. Today more than 13 million children currently under age 15 have lost one or both parents to AIDS, most of them in Sub-Sahara Africa. By 2010, this number is expected to jump to more than 25 million (UNAIDS, 2002: .3)

In Sub-Sahara African countries the infection rate is just in the rise. In addition to death toll, HIV/AIDS is also attributed to poverty. As the death of the most productive section of the population increases due to AIDS, economic deterioration and a decrease in per capita is inevitable. A recent study estimated that Africa's income growth per capita is being reduced by about 0.7 percent per year because of HIV/AIDS. Had the HIV prevalence not reached 8.6 percent in 1999, African's income per capita would have grown at 1.1 percent per year - or nearly three times the growth rate of 0.4 percent per year achieved in 1990-1997 (World Bank, 2000 b in UNAIDS, 2001)

The World Bank report further explained the role of AIDS as a cause of poverty and poverty as a contributor to AIDS. The general linkages between AIDS and poverty would be cited as impact indicators that help to portray the effects of AIDS on poverty .Such effects include decrease in growth rate of per capita income, increase in the number of AIDS orphans ,and their corresponding poorer nutrition and lowered school attendance rates, reduction in output and cash income in house holds of an AIDS death, and increases in household out -of-pocket health spendings (UNAIDS, 2001)

The impacts of HIV/AIDS on the education of orphans have been studied in various countries of Africa. Studies in Uganda have shown that following the death of one or both parents, the chance of orphans going to school is halved and those who go to school spend less time there than they did formerly. In another study of high prevalence countries like Central Africa Republic, Cote d'Ivoire and Zambia, AIDS is eroding the supply of teachers,there by increasing class sizes, which in turn is likely to reduce the quality of education.

CCRDA

The negative outcomes of HIV/AIDS to education have been seen from pupil, teacher, and school perspectives.

At the level of the pupil, there have been declines in enrollment, increases in dropouts, and gradual increases in absenteeism. Students who had lost both parents have been less well-dressed and less-well fed. Many students are at risk of exclusion, abuse, discrimination, and stigma (IIEP, 1993; UNAIDS, 2002). UNICEF has recently reviewed the effects being orphan have on schooling and child labor in 20 Sub-Saharan African countries. In all countries, children aged 5-14 who had lost one or both parents were found less likely to be in school and more likely to be working more than 40 hours a week. A National Survey on the Prevalence and Situations of AIDS Orphaned Children in Ethiopia has been conducted in collaboration with children, youth and Family Affairs Department (MOLSA), UNICEF, and an Italian Co-operation (2003), using a total sample size of 2683 children and adults. The income generating activities of both AIDS orphan and non-AIDS orphan children were studied. The data showed that 16% and 21%, respectively were engaged in various economic activities. The finding seem to be contrary to one's expectations, but due to other supportive data like weak provision of food, high prevalence of begging, and stigma against AIDS orphans, it is highly probable that community members prefer to employ non- AIDS orphans compared to AIDS orphans.

In the same study the educational status of AIDS orphans had been examined and subsequent analyses revealed that 93% of both AIDS orphans and non-AIDS orphans were enrolled in elementary schools once upon a time. But after the death of their mothers or both parents a significant number of them were forced to dropout of school. As the results of the study indicated, 17.7% of non-AIDS orphans dropped out of school compared to 11.9% of AIDS orphans following the death of mother's. No statistically significant difference was observed between the two groups .However, the reasons seem to be to their inability to pay school fees and, buy school uniforms and materials.

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A survey of 649 orphaned and 1,239 non-orphaned children in Kenya found out that 52% of orphaned and 27% non-orphaned children were not in school for such reasons(UNAIDS, 2002). Generally, from the above studies one can conclude that the education of AIDS orphaned children is highly threatened, and there is a need of finding a way out to mitigate the problems.

Teachers' death from HIV/AIDS has resulted in the deterioration of the provision of quality education to both orphans and non-orphaned children. While many countries lack reliable data on AIDS-related deaths and HIV prevalence among teachers, already available evidence points to an increased teacher mortality rate because of HIV/AIDS. The death of one teacher can deprive a whole class of children from having education. As estimated 860,000 children in Sub-Sahara Africa have lost their teachers to AIDS in 1999 (Kelly, 2000d, in World Bank, 2002).

As some studies in some African countries revealed, HIV/AIDS has escalated the shortage of teachers' supply in schools. A report of the World Bank (2002),for example, has stated that in Central Africa Republic 85 percent of the teachers who died between 1996 and 1998 were HIV positive, and on the average these teachers died 10 years before they were to retire (UNAIDS, 2000a). In Zambia 1,300 teachers died in the first 10 months of 1998, compared to 680 teachers in 1996 (Kelly, 1999). In Kenya teachers' deaths rose from 450 in 1995 to 1,500 in 1999.In one of Kenya's eight provinces 20 to 30 teachers die each month from AIDS (Gachuhi, 1999).Besides, HIV/AIDS, has generally resulted in teachers' absenteeism, and lowered motivation to teach when they feel sick. It has also increased the proportion of untrained teachers, and led to their reluctance to be transferred to, or remain in, heavily affected districts.

At school level strain and stress have been reported because of the increasing number of orphans. The distress and isolation experienced by these children, both before and after the

CCRDA

death of their parent or parents, have strongly been exacerbated by the shame, fear and rejection that often surrounds people affected by HIV/AIDS. Because of this stigma and the often -irrational fear surrounding them, children are denied access to schooling and health care (UNICEF, 1999).

In the Convention on the Rights of the Child, education for the child especially at primary level is considered compulsory and freely available to all. Article 32:1 says that

> **state parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development (1992:47)**

This article highlights the all round support a child should receive from the society.

Similarly as was stated in the Salamanca Conference, children who are AIDS orphaned are included in special needs category. The Conference passed resolutions that community-based rehabilitation (CBR), Education for All and inclusive educations have all common roots, and children labeled in special needs group should secure access to basic human rights whether in education or health (Salamanca Conference, 1994).

Ethiopia is one of the Sub-Sahara African countries that are heavily affected by HIV/AIDS pandemic. Death from HIV/AIDS has been increasing since the start of the epidemic in the early 1980s. The number of AIDS orphans is still increasing at alarming rate. Due to the pressing needs of educating AIDS orphans, government, non-governmental organizations, and the community at large need to join hands so that timely solution (s) can be sought.

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1.2 Objectives of the Study

The experiences of other countries have shown us AIDS orphan children are by and large out of school. Ensuring that orphan children receive education presents one of the greatest challenges to governments, nongovernmental organizations, donor agencies, and local

communities. Achieving Education for All is held as one of the Millennium Development Goals. Efforts to achieve universal access to education are almost always based on the education sector and encompass all formal, non -formal, informal, and popular education.

Some countries have devised strategies to educate AIDS orphans. For example, to increase access to the formal system, Malawi and Uganda have eliminated primary school enrollment fees (for up to four children per household). In Zambia there is a still levies fee, but orphans are eligible for a subsidy. Some countries have community schools, established by local communities -often with NGO support, to benefit the non- formal sector. Neither fees nor uniforms are required; timing of teaching can be adjusted to local needs. Distance learning using media such as radio is an option increasingly used for educating out-of-school children and youth. Distance education for primary school children has been used in a mentored group setting in eight countries and has reached a national scale in three countries (World Bank, 2002).

This study is, therefore, intended to investigate issues related to the education of AIDS orphan children with focus on:

- educational problems of AIDS orphan children
- Possible educational approach (es) to AIDS orphans.

More specifically the study is intended to investigate

- the living conditions of AIDS orphaned children
- the academic status (achievement level) of AIDS orphans as compared to pre-parental death.
- School attendance or dropout rate of AIDS orphans.
- the educational efforts AIDS orphan children make to be successful in school
- the needs, values and motivations of AIDS orphan children to learn
- the deficits AIDS orphans have and the solutions being undertaken.

CCRDA

1.3. Statement of the problem

Among other things one of the worst impacts of AIDS to young adults is an increase in the number of orphans. Some children lose their father or mother to AIDS and many more lose both parents. In Ethiopia there were an estimated 980,000 AIDS orphans by 2002 and this number could increase to 2.1 million by 2014 (MOH 2000). Though the data reported at different times are inconsistent, the MOH (2002) report of AIDS orphaned children shows an increase in number. In 2002 there were 1.2 million AIDS orphans and this number would increase to 1.8 by 2007 and 2.5 million by 2014. On the other hand , the latest estimates of UNAIDS (2002) have pointed out that 3.8 million orphaned children existed in Ethiopia by 2002. Of these, almost 1 million children are AIDS orphans. (i.e. 26% of the total orphan populations). By 2010, about 2.16 million children will be AIDS orphans, representing 43% of the 5 million estimated orphans. In a survey conducted in Ethiopia on the prevalence of AIDS orphaned children, sampled children and adults were drawn from major cities, small towns and rural areas. The prevalence rate of AIDS orphans were 14.69% in major cities, 16.67% in small towns, and 14.77% in rural areas. At alpha 0.05 ,there is no significant difference across the three strata implying that HIV infection is increasing the rate of AIDS orphans similarly in all the three sites (MOLSA, UNICEF, and Italian cooperation, 2003).This is a very big and shocking number, compared to the country's economic growth. For a country like Ethiopia, providing adequate food, clothing, health care and schooling for this huge number of AIDS orphans is almost impossible.

The study has been carried out in Addis Ababa. Therefore, we looked into the prevalence rate of HIV/AIDS and AIDS orphans in the city. The HIV prevalence in Addis Ababa has increased from about 17 percent of the adult population in 1997 to 20 percent by 2001 and has stabilsed at that level since then. A recent report of MOH shows the HIV/AIDS prevalence rates of some urban areas in which Bahir Dar stands first with 23.4 percent,

CCRDA

followed by Jijiga 19 percent and Nazerath third with 18.7 percent. The prevalence rate for Addis Ababa in this report is 15.6 percent (MOH, 2002), which is different from the former report (HIV/AIDS in A.A., 1999). By 1999, the cumulative number of AIDS deaths from the beginning of the epidemic were estimated at about 53,000. Over the coming 15 years, 1999-2014, an additional 554,000 persons in Addis Ababa are likely to die from the disease, which could result in a cumulative total of about 697,000 deaths by 2014 (HIV/AIDS in Addis Ababa, 1999)

Like wise ,the number of AIDS orphans would rise quickly from 20,000 in 1999 to over 64,000 in 2004 and to more than 145,000 in 2014 (HIV/AIDS in Addis Ababa 1999).This makes it very hard to care for and provide them with necessary facilities. As a result the number of street children will rise and child labor will become more common as orphans look for ways of survival. Orphans often lose the necessary financial, material and emotional support that they need for successful schooling.

Based on the report presented above, currently more than 20,000 AIDS orphans exist in Addis Ababa. Except for mere prediction, no one can say for sure how many of them are in school and how many out of it. which ones are living with whom, and what kind of support which of them receive from where.

The Federal Democratic Republic of Ethiopia developed an HIV/AIDS policy. Under the general strategies, the Ministry of Health has been delegated to provide technical assistance to the Ministry of Education in the curriculum development & implementation of HIV/AIDS / STDS education beginning from the primary level, including the youth out of school in rural and urban areas. Again in the strategic Framework for the National Response to HIV/AIDS in Ethiopia 2000-2004, the objectives of the Education Sector Development Program (ESDP) are stated. Among the objectives, one is increasing the enrollment ratio from current 35% to 50%. In the strategies for achieving this objective, promoting the girl child education and supporting

CCRDA

orphan education are mentioned. In order to realize the objectives set in ESDP, the Ministry of Education has developed HIV/AIDS Education program in which it has put a detailed work plan for the years 2002 -2003. The document narrates how and when HIV/AIDS education are to be integrated in the curriculum and co-curricular activities. The overall objectives set for HIV/AIDS education program by the MOE are as follows:

- to contribute to the National effort to prevent HIV/AIDS
- to promote behavioral change that prevent the spread of HIV/AIDS
- to develop knowledge & understanding of HIV/AIDS among students & the staff of MOE
- to develop positive attitudes towards those who are infected by HIV and have AIDS.
- to enable students delay sexual intercourse until marriage.
- to develop communication skills & other life skills among students regarding HIV/AIDS .
- to train teachers to provide effective HIV/AIDS education through behavioral change methods" (MOE, 2001).

However, none of these objectives are formulated in line with the education of AIDS orphans. It seems that there is a contradiction between the objectives of ESDP and the objectives set for its implementation.

Surprisingly enough, there is no statement in the New Education and Training Policy of Ethiopia about HIV/AIDS, the orphaned children or a possible educational support they can be given.

Evidence indicates that a major problem with the HIV/AIDS epidemic is the rapidly increasing population of orphans. Research points to the fact that orphans have higher mortality rates, are likely to be less well nourished, may be over worked by their guardians and lack of proper supervision, care& school or vocational training. Such problems may be aggravated if the child is

CCRDA

uprooted from family and community, either through out right orphan-hood or because of the often enforced migration of widows and their children. Such circumstances are resulting in increasing number of abandoned, exploited and unschooled street children. Schooling for orphans is unexplored and new issue which needs to be addressed (Gachuhi, 1999:8).

Therefore, this study is intended to find solution to the following research questions.

1. How are AIDS orphans in Addis Ababa being taken care of?
2. Do AIDS orphaned children succeed in attending their schooling? If so, what froms of classroom behaviors are they manifesting?
3. What kind of educational efforts do AIDS orphaned children make to achieve success in school?
4. What level of motivations, needs and values AIDS orphan children have to learn? Do AIDS orphaned children have positive self-image upon themselves?
5. Are there differences among AIDS orphan children of different backgrounds (e.g.. sex, age, parental death status, etc) in the care and protection received, schooling and motivations to learn?

1.4. Significance of the Study

HIV/AIDS is an epidemic disease, which has claimed the lives of the productive forces of the nation. As a result, the dependents of the victims, especially children become hopeless & helpless. At the family level, there can be increased burden and stress on the extended family. In major urban centers like Addis Ababa, the traditional family structures are not as strong as in the countryside to support AIDS orphans. Therefore, based on the objective conditions in which children are , possible living arrangements should be made. In some countries of Africa, for example, in Botswana(a National Orphan Programmed), Malawi(National Orphan Care Task Force), Zambia (Community-based Orphan Support Program), and Zimbabwe (Community-based Orphan Care Projects) have been developed at different times to support AIDS orphan children (UNICEF, 1999). Thus,in many countries AIDS orphan children are

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cared for by community based programs, foster cares and institutional care as a last resort. This study is intended to encourage policy makers to look into the appropriate support mechanisms to AIDS orphans in Addis Ababa.

Though inter sectoral support is needed to combat the spread of HIV/AIDS, andre the education of AIDS orphan children, the Ministry of Education is expected to play a major role in this regard. Understanding the living conditions of these children, and devising educational provisions which go in line with their current status, remains the responsibility of the Ministry. Therefore, this study is hoped to be a good help to those who ought to incorporate the issue of AIDS orphan education while revising the education and training policy.

Education is a tool which increases productivity. "Researchers in this area have shown that even a minimum of two years of basic education enables an individual to increase productivity up to 16 percent"(Reddy, 1994:122) . So, the study has been planned to pose ideas to GOs, NGOs and the community at large to think over possible ways for cost effective educational provisions to AIDS orphan children.

Though studies in Ethiopia regarding the education of AIDS orphans are non-existent, the resercher has, through readings come across facts about the situations in some other countries. In Sub-Sahara African AIDS orphans are the first to be denied education when extended families cannot afford to educate all children of the household. Leave alone schooling, AIDS orphans are at greater risk of being malnourished and stunted than children who have parents to look after them(UNICEF,1999). Therefore ,the study will give ideas as to the support system already in use by some countries and possibly new initatives.

1.5. Scope of the study

1.5.1. Delimitations of the study

The study is expected to focus on AIDS orphan children in Addis Ababa. The emphasis was to find educational problems or challenges of AIDS orphan children.

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For the purpose of this study ,children under 15 who have lost their mothers, fathers or both by HIV/AIDS were taken as a sample.

The study has been conducted in Addis Ababa, which is the capital city of Ethiopia. Nearly, 3 million people are estimated to live in the city.

1.5.2. Limitations of the study:

In order to get a clear picture of the educational problems of AIDS orphan children, the study should have been extended to cover wider areas and larger sample size. But due to time, financial constraints, unwillingness of caretakers & AIDS orphans to be part of the study the researcher is forced to conduct the study in a limited sample size & confined to Addis Ababa. Inorder to make comparison on the academic achievements of AIDS orphans before and after the death of their parents,I could not able to get access to students marks.

1.6 Definition of Terms.

The following are some of the terms that need operational definitions.

1. Educational challenges:- are problems related to enrollment, dropout, absenteeism, stigmatization, etc. of AIDS orphaned children.
2. AIDS orphans- are children under age 15 whose mothers, fathers or both parents have died. It is classified into:
   - Maternal orphans, children under age 15 whose mothers have died.
   - Paternal orphans, children under age 15 whose fathers have died .
   - Double orphans, are children under age 15 whose mothers and fathers have both died;

CCRDA

CHAPTER TWO

Review of Related Literature

2.1 The Spread of HIV/AIDS in the World

Estimates by the joint United Nations program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) have indicated that by the end of 1999,of the 30 million people infected by HIV 27 million did not know their HIV status. By then 12.7 million people around the world had lost their lives to AIDS. The virus continued to spread causing nearly 16,000 new infections a day. Indeed, HIV/AIDS is among the top ten killer diseases world wide (UNAIDS, 1999). A year after, i.e. in 2000, UNAIDS estimated that since the beginning of the epidemic, 50 million people had been infected with HIV, and 16.3 million adults and children have died of it (A White Oak report,2002). In another report by World Bank (2002), the pandemic had already killed 25 million people, and 40 million more are currently infected. In the first year of the millennium, 5 million more people have became infected. Variations do occur in the infection rate among countries of the world. The Eastern and Southern African countries are the ones that have heavily been affected by HIV/AIDS. The global Summary of the HIV/AIDS epidemic reported by UNAIDS (2002:3) is presented as follows:

Number of people living with HIV/AIDS	Total	42 million
	Adults	38.6 million
	Women	19.2 million
	Children under 15 years	3.2 million
People newly infected with HIV in 2002	Total	5 million
	Adults	4.2 million
	Women	2 million
	Children under 15 years	800,000
AIDS deaths in 2002	Total	3.1 million
	Adults	2.5 million
	Women	1.2 million
	Children under 15 years	610,000

The report further noted that in Eastern Europe and Central Asia, the number of people living with HIV in 2002 reached 1.2 million. In the Baltic States, the Russian Federation and several Central Asian Republics, HIV/AIDS was expanding rapidly. The Asian and pacific

CCRDA

regions were the ones which showed the growth of the epidemic. Currently, these areas consist of 7.2 million people living with HIV. As projected, between 2002 and 2010 an additional 45 million people are expected to become infected with HIV in 126 low and middle income countries. To curb such an over flooding increase in HIV victims, a lot of work need to be done by concerned bodies throughout the world.

2.1.1. Prevalence of HIV/AIDS in Eastern and Southern Africa

African countries now account a for four- fifths of AIDS related deaths and for 70 percent of new the infections globally. "The pandemic is concentrated on the so-called "AIDS belt" stretching from East through Central and Southern Africa where the infection rates are now between 20 and 30 percent of the sexually active population (Gachuhi, 1999: 1). Dis proportionally females aged 15-24 are most affected.

In Sub-Sahara Africa 28.1 million people are infected with HIV/AIDS (UNAIDS, 2001). The increase in the mortality rate has resulted in the deterioration of population growth rate. For example, in Kenya and Uganda, infant mortality rates are projected to increase by 50 percent and child mortality rates to double. In Malawi, due to AIDS deaths, the 1997 population census shows that the overall populations growth rate is now only 1.9 percent per annum compared to the projected growth rate of 3.2 percent in the 1987 census (Gachuhi, 1999).

Mrs. Williet Mabeza reported the killing effect of HIV/AIDS to Zimbabwe's population in a workshop organized in Lake Victoria Hotel at Windsor on 15 September 2000. She indicated that approximately 1,200 persons in the country were dying every week due to AIDS, and more than 600,000 persons were estimated to have died by 1999. In others Eastern and Southern African countries the prevalence rate was almost similar. In a recent report by UNAIDS (2002) of the 42 million people living with HIV/AIDS world wide, Sub-Sahara Africa accounts for 29.4 million adults & children. The adult prevalence rate was 8.8 percent,

CCRDA

with 3.5 million adults and children being newly infected. Surprisingly enough, except the Caribbean countries which have an adult prevalence rate of 2.4 percent, in the rest of the regions, the prevalence as the report revealed was below one percent. In four southern African countries, the national adult HIV prevalence exceeded 30 percent. These countries are: Botswana. (38.8%), Lesotho (31%), Swaziland (33.4%), and Zimbabwe (33.7%). As a result of the death of the young, productive adults, the latter three countries faced food shortage. HIV/AIDS has brought about a challenge not only to individuals infected and affected by HIV/AIDS but also to governments at large. In one of his public speech, the former president of South Africa ,Nelson Mandela ,said that "the time for action is now, and right now". Therefore, to reduce the negative effects of HIV/AIDS, politicians, NGOs and Civic organizations should join hands just now before the generation is eroded by this disease. This is a big task mainly to responsible entities in Eastern and Southern Africa.

2.1.2 Prevalence of HIV/AIDS in Ethiopia

Ethiopia is one of the Sub-Sahara African countries hit hardest by HIV/AIDS. By the year 2000,the Ministry of Health estimated that about 2.6 million people were infected with HIV/AIDS (MoH, 2000). However, the estimated figures were not consistent across different reports. Up to June 2000, there were 83,487 reported AIDS cases all over the country. But this number could be far less than this due to several reasons. Firstly, some people never seek hospital care for AIDS: secondly, some doctors do not have good recordings; thirdly, some people with HIV infection could die of other diseases; fourthly; in rural parts of the country, the possibility for HIV test is less; and finally, many people have poor access to health services.

Due to the stated factors above, the exact number of AIDS cases in Ethiopia since the beginning of the epidemic has not been known. However, by the end of 1999, it was estimated at 400,000 (MoH, 2000). In Addis Ababa, the capital city of Ethiopia, by the year 1997, the prevalence rate of HIV infection was estimated at 17 percent, and by 2001, the figure was

CCRDA

projected to 20 percent and by 2002 it was put at 15.6 percent. The death of adults to AIDS resulted in massive parentless orphaned children. In any case the projected number shows how deep rooted the problem has become and how much a challenge it is to the development of the city.

2.1.3 The Prevalence of AIDS Orphans in Eastern and Southern Africa

According to the projections, by the end of the year 2000, globally a cumulative total of 13 million children would have lost their mother or both parents to AIDS, and 10.4 million of them would still be under the age of 15 (UNICEF, 1999).

In another estimation by the World Health Organization (WHO), by the year 2000, from 5 to 10 million people would live with it in Central and Eastern regions of Africa (CIDA, 2000). UNAIDS (2000a in World Bank, 2002), estimates that 12.1 million children under 15 in Sub-Sahara Africa have lost their mother (Maternal orphans) or both parents (double orphans) from AIDS since the beginning of the AIDS epidemic. This number is by and large higher than the population of Somalia, Dijubuttie and some other countries. It is just like losing the population of one or two countries in two decades.

If we see the condition in some specific countries, the problem becomes clearer. The rate of AIDS orphans in some Sub-Sahara African countries is described below. According to the US Agency for International Development (USAID), by the year 2000, 1.2 million orphans existed in Zambia. This means that 1 in every 4 Zambian children is an AIDS Orphans. Of these an estimated 930,000 have lost at least one parent to AIDS (Africa Recovery, 2001). In Malawi, by the end of 1997, 6 percent of the children under the age of 15 were orphans (UNAIDS, 1999). Of the worst AIDS affected Southern African countries, Zimbabwe is one. By the end of 1997, there were some 360,000 children orphaned by AIDS. This means that 7 percent of all children under 15 were orphans. In Ethiopia, an estimated number of 750,000 AIDS orphans were there by the year 2000 and the projected rate escalate to and will reach 1.8

CCRDA

million by the year 2009 and 2.1 million by 2014 (MoH, 2000; UNAIDS, 2000). Since the beginning of the epidemic there have been 1,200,000 AIDS orphans , of which 903,372 are currently living orphans.

The UN Secretary General, Kofi Annan, speaking to leaders of industrialized countries at the July 2001 Group Eight meeting in Geneva, noted that the needs of AIDS orphans are as immediate as their next meal and as extended as access to education, guidance and care until the end of their adolescent years. To care for all whose lives have been devastated by AIDS, particularly the orphans is of moral and spiritual obligations to you ,leaders of the big nations (Africa Recovery, 2001).

2.2 Theoretical Frameworks

2.2.1 Perceived Self-efficacy

AIDS orphaned children are expected to have the capacity to resist educational and life problems in general. To capitalize this view, the researcher is indebeted the idea of perceived Self-efficacy from Albert Bandura as a theoretical model. Bandura is a social psychologist, mainly known in the role of modeling for development of children. Whether or not we can demonstrate mastery or learned helplessness in tackling a given task depends a great deal on how we perceive our ability, i.e. perceived self-efficacy. The way in which perceived Self-efficacy affects a person's performance can be described as follows.

> **People whose perceived self-efficacy is positive will pursue a relatively high level of performance. They will not put off easily, they will do their best, seek new solutions and also persevere in the case of difficult task assignments. Effort strategy development and perseverance not only lead to good achievements but also to the development of people's actual competence (Cervone & Peake, 1986 in Vrugt, 1994 :465).**

On the other hand, if a person's perceived self-efficacy is negative, he or she will pursue a lower level of performance. Serious doubts and uncertainty while performing difficult task lowers a person's concentration and he/she will easily give up or quit their effort (Bandura &

CCRDA

Schunk, 1981; Bandura, 1982 in Dworetzky, 1988; Bandura, 1989 in Vrugt, 1994).

From the above discussion, one can observe how performance varies directly with a person's level of perceived self-efficacy. In general, the more perceived self efficacy a person shows, the greater is his/her performance and accomplishments. High perceived self-efficacy in any given condition will help an individual to cope up with or face problems. Therefore, beyond and above material, educational & psychological support we can give to AIDS orphaned children, we need to help them to develop their level of perceived self-efficacy to challenge all life problems.

According to Bandura (1982 in Dworetzky, 1988), there are four major ways to raise perceptions of self-efficacy: direct action, observing others, verbal persuasion, and the perception of ones own physical states.

The actual experience you have in a particular situation is direct action. Learning through direct experience so that what you do can be successful and that you are capable to do it will enhance self-efficacy. Failure in especially one's first experience can lower self-efficacy.

Observing other people similar to you be successful at a task generally also will raise your perceived self-efficacy- it makes you more confident that you, too, can be successful. Of course watching some one similar to oneself failing at a task can lower one's perceived self-efficacy.

We human beings compare ourselves not only to those who are similar to us but also to important others. In this respect Bandura (1986 in Vrugt, 1994) pointed out that comparing one's own competence and achievements with those of relevant others plays an important role in the development and maintenance of self-efficacy. He does not, however, pay attention to the role that the direction of social comparison might play, this comparison may be with a person who is worse (down ward comparison) or with a person who is better (upward

CCRDA

comparison). Taylor and Lobel (1989 in Vrugt 1994), suggest that people who have to contend with fear and stress can be motivated and inspired by a good example, (i.e. up ward compression).

Verbal persuasion sometimes can raise one's perceived self-efficacy. It is widely used to get people to believe that they possess capabilities that enable them to achieve what they seek. Although social persuasion alone may be limited in its power to create enduring increases in self-efficacy, it can contribute to successful performance if the heightened appraisal is within realistic bounds. Persuasive efficacy influences, therefore, have their greatest impact on people who have some reason to believe that they can produce effects through their actions (Chambliss & Murray, 1979a, 1979b). To the extent that persuasive boosts in self efficacy lead them to try hard enough to succeed, such influences promote development of skills and a sense of personal efficacy (Bandura, in APA February, 1982).

You often monitor physiological factors, such as fatigue, exhaustion, or fear as an indication of your self-efficacy (Dworetzky, 1988). People read their visceral arousal in stressful and taxing situation & as an ominous sign of vulnerability to dysfunction. Because high arousal usually debilitates performance, people are more inclined to expect success when they are not beset by aversive arousal than if they are tense and viscerally agitated. In activities involving strength and stamina, people read their fatigue, aches, and pains as indicants of physical inefficacy (Bandura, in APA February, 1982).

Generally, as Bandura's perceived self-efficacy model depicts, children who have lost their parents to AIDS like any other human being ought to get support from the people around them so that they can use their own cognitive and motivational states to face the challenges.

2.2.2 The Just World Theory

Melvin Lerner of the University of Waterloo, has intensively explored the importance

CCRDA

of people's belief in justice and its consequences for understanding observers' reactions to victims.

In Lerner's view, most of us believe in a just world "where people get what they deserve" and also "deserve what they get" (Lerner, 1970: in Grusec, Lockhart, and Walters, 1990). This belief in a just world leads us to expect that goodness will inevitably triumph and evil will be vanquished. The notion is obviously strongly leminiscent of the Judeo-Christian ethic, and this tradition of morality may well be one of its principal sources (Lerner, 1980; Rubin & peplau, 1975 in Grusec, Lockhart Walters, 1990: 683).

..... According to Lerner, the belief in a Just World performs an important psychological function: It enables the individual to view the environment as a safe, stable, and relatively predictable "World", in which foresight, ability, and effort allow one to be reasonably confident of attaining the ends one desires and avoiding unpleasant fates. As Lerner (1980: in Grusec, Lockhart & Walters, 1990: 683) aptly puts it: "people ..... believe... in a just world so that they can go about their lives with a sense of trust, hope, and confidence in their future".

Unfortunately AIDS orphaned Children are maltreated and discriminated either in the family or in the larger community. AIDS orphans are reported to have been subjected to different forms of child maltreatment, including physical, emotional, sexual abuse, neglect and exploitation (UNAIDS, 1999). Various studies identify the family as the first line of response in mitigating the HIV/AIDS impact on children (Donahue, 1999 in a national survey 2003). But in some cases stigma and discrimination begin at home. Family members do not want to touch anything that the member of the family living with the virus touched. They also want the person to use different plates, glasses, and cups (Strode and Grant, 2001). Fear, shame, and rejection that surround people affected by HIV/AIDS create additional stress & exclusion for children both prior to & after their parents' death (Schonteich, 2001 in a national survey 2003).

Stigma and fear of rejection were seen as major problems of HIV/AIDS. As Ankrah

CCRDA

(1993 in Lie, 1996) indicates, AIDS epidemic is a new kind of stress factor that has caused both psychosocial and economic challenges to numerous families. "AIDS, in several cases has disturbed the capacity of the nuclear and extended families to respond to the needs of members affected by HIV and AIDS.... The AIDS patients' family members need to be prepared for the challenges they face, and plans must be made for the care of future orphans....." (Lie, 1996: 286)

Stigma has been defined by several classical theorists and social psychological researchers. For example, Goffman (1963 in Lie 1996) defines stigma as" an attribute which is deeply discrediting". Others like Crandall and Coleman (1992) in Lie, 1996 indicate that "stigma, by its very nature, is a mark which legitimatizes treating the bearer in some ways less humanely than those without the mark." They further noted that in most of the social psychological research on Stigma, the emphasis was on those who stigmatize, but the psychological consequences of being stigmatized is often overlooked. Under a variety of conditions stigma interferes with the normal process of relationship, causing the stigmatized, as well as those who interact with him or her, to feel tense, awkward and embarrassed. Therefore, stigma is a social disease that affects the social relationship of individuals and people with AIDS in particular. Above all it is an existential threat and violation of human right declarations.

As the Convention on the Rights of the Child indicates, irrespective of the situation the child is in, governments are expected to take" .... all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse...." (Article 19:1). Similarly, the year 2003 is designated by the slogan "Live and let live" signifying the applicability of the just world theory.

CCRDA

2.3 Care and Support to AIDS Orphans

One of the most agonizing worries of people with AIDS is the fate of their children after they die. In some African countries including Uganda, it is traditional for relatives to adopt children whose parents have both died. However, due to lack of awareness as to the means of spreading the disease some relatives are afraid of contracting it themselves, and reject children orphaned by AIDS.

Grandmothers who would normally count upon sons to provide for their old age are instead burying their adult offspring and caring for seven, ten and thirteen parentless children with no means and little strength to do so. These days young widows raise not only their own children without conjugal support, but those their late husbands' dead co-wives, facing dubious health and survival prospects of their own. The problem of how the extended family can continue to provide food, clothing, and educational expenses, not to mention love and affection, for all the extra children it has to absorve may soon become the most important challenge in AIDS affected Africa (UNICEF, 1990).

Today the idea of institutionalization is greatly criticized and replaced by community based support system. Thus, the AIDS Support Organization (TASO) in Uganda believes that AIDS orphaned children are best cared for within families rather than in orphanages. If no relatives are available, every effort should be made to place the child with friends of the deceased parents. TASO helps clients to identify relatives or friends who can adopt their children after both parents have died. In addition, TASO counselors also teaches potential foster parents regarding the way how AIDS can be transmitted from person to person so as to dispel misconceptions and stigma associated with the disease. Above all TASO receives support from save the children so as to provide foster parents with food, clothing, and money to enable children orphaned by AIDS to attend school (Action Aid, 1990).

The Socio-economic status of most AIDS orphan families is characterized by high

CCRDA

illiteracy rate of heads of households, low family income, and lack of availability of facilities, which are features of poverty. A study in two regions in Zambia revealed that the status of AIDS orphan children in the communities was poor and that the ability of households to meet the basic needs of their members was very limited (Mc Kerrow, 1996 in MOLSA 2003). A similar study carried out in four regions in Uganda revealed that families in which orphans reside in are relatively large and the orphan load heavy. The study further affirmed that these families did not have much with regard to household property beyond the minimum for basic needs, very few having any assets of permanent value (Ministry of Labor and Social Affairs and UNICEF, 1993). As a result, soon after their death, children will easily be exposed to hunger and malnourishment, and most dropout school to find means of survival working outside home.

As to the National Survey conducted in Ethiopia, orphans in general ,and AIDS orphans in particular ,employ different coping mechanisms. These can be categorized into four major groups, namely, relying on members of extended families, and strangers' charity; engaging oneself in economic activities; abandoning the environment altogether and migrating to other places in search of better opportunities and committing crime (MOLSA, UNICEF and Italian cooperation, 2003).

As experience shows us, efforts to protect children orphaned by AIDS are nearly as old as the epidemic, and many are beginning to show real progress. Botswana, Malawi, Zambia and Zimbabwe have exhibited good achievements in the area. "Uganda has been at the forefront of initiatives to protect children from AIDS through improved basic social services. A major success has been increased enrolment in primary schools…' (UNICEF, 1999)

In Botswana a National Orphan Program was established in April 1999 to respond to the immediate needs of orphaned children. Various government departments, NGOs, CBOs and the private sector run the program with its objectives being to review and develop policies,

CCRDA

build and strengthen institutional capacity, provide social welfare services; support community-based initiatives; and monitor and evaluate activities. Based on the Convention on the Rights of the Child, developing a comprehensive National Orphan Policy has been the Major goal of the program. The government encouraged the community to provide care for orphans and to rely on institutional care only as a last resort. Orphans in Botswana, therefore, are still being absorved by the extended family, and their caretakers are predominantly women. Various organizations provide services in communities throughout the country, ranging from family counseling and day care for the orphaned to providing basic needs such as food, clothing and education (UNICEF, 1999)

In Malawi as early as 1991, the government established a National Orphan Care Task Force. In 1992, with advisers from the Uganda Government and NGOs, Malawi's National Orphan Care Task Force developed the Sub-region's first guidelines for the care of orphans. The main points of these guidelines were :(i) the first line of approach in orphan care must be community based programs;(ii) formal foster care will be the second most preferred type of care;(iii) institutional care should be the last resort;(iv) the registration of birth and deaths should be improved so as to assist the monitoring of orphans; and (v) NGOs are encouraged to set up programs of community-based care, etc (UNICEF, 1999).

Zambia has the highest proportion of children orphaned by AIDS in the world next to Uganda. By the end of 1997, of some 360,000 children,9 percent of children under 15- were orphaned because of AIDS. Zambia has several policies that pertain to children, but no national orphan policy. Although many ministries have included AIDS issues in their planning, the Government has been slow to respond to the AIDS orphan crisis. Therefore, communities remained to be at the front line of care for orphans in Zambia. NGOs, Community Based Organizations, churches and other volunteer organizations have made significant contributions in strengthening local communities. However, at present, they succeed in providing assistance

CCRDA

to about only 7 per cent of the needy (UNICEF, 1999)

The Zimbabwe government developed a National Policy on the care and protection of orphans in 1995, which was finally approved by the cabinet in May 1999. The Policy reaffirmed as a position that orphans should be placed in institutions only as a last resort (UNICEF, 1999). When we come to the situation in Ethiopia, we find that though there is an HIV/AIDS policy and strategic frame work, in which orphan care and support are mentioned here and there, there is no AIDS orphan care task force or orphan care policy which has a legal background. However, in Developmental Social Welfare policy developed by MOLSA, there are two statements related to the welfare of children under difficult circumstances. They are:(i) "Every effort shall be made to create an environment conducive to addressing problems of children in especially difficult circumstances; and (ii)conditions that will enable orphaned and abandoned children to get the assistance they need and to eventually be self-sufficient shall be facilitated" (MOLSA, 1996:68). In order to address the needs of AIDS orphaned children, concerned government Ministries, NGOs and others involved in HIV/AIDS activities should join hands to develop an orphan care policy.

The UNAIDS Committee of Co-sponsoring organizations outlined five strategies in November 2001. In addition, the committee endorsed 12 principles to guide organizations helping children affected by HIV/AIDS. The strategies to assist children are:

1. **Strengthen and support the capacity of families to protect and care for their children**
2. **Mobilize and strengthen community based responses**
3. **Strengthen the capacity of children and young people to meet their own needs**
4. **Ensure that governments develop appropriate policies, including legal and programmatic frame works, as well as essential services for the most vulnerable children.**
5. **Raise awareness within societies to create an environment that enables support for children affected by HIV/AIDS (UNAIDS, UNICEF, 2002 : 13-14)**

Therefore, taking into account the above five strategies, governments who have special concern

CCRDA

for the over all development of AIDS orphans shall develop the orphan care policy.

2.4 The Impact of HIV/AIDS on the Education Sector

2.4.1 The Impact of HIV/AIDS On The Demand for Education

Of the many impacts HIV/AIDS have the one is its effect on the demand for education. Because HIV/AIDS resulted in fewer children to educate; fewer children wanting to be educated; fewer children able to afford education; and fewer children able to complete their schooling (IIEP, 1993 in Kelly, 1999).

The decrease in the demand for education can be manifested through different indicators. The one is the reduction in the number of adults of childbearing age due to HIV/AIDS and lower fertility among surviving adults. In countries hardest hit by the epidemic such as Zimbabwe and Zambia, the number of children of primary school age will be 20 percent lower by 2010 than pre-AIDS projection (UNAIDS, 2000g, in World Bank, 2002). A study in Tanzania estimates that in 2020, in the worst case scenario, because the school cohort will be relatively smaller when AIDS is present than when it is not, there will be 22 percent fewer children than anticipated enrolled in primary school (World Bank, 1992 in IIEP, 1993).

The other reason which heavily affects the demand for education is dropout of children as a result of parental death or illness to AIDS. A study of commercial farms in Zimbabwe found that nearly half of the orphans of primary school age and in Uganda a quarter of children aged 13 to 18 whose parents have HIV/AIDS dropout of school (UNAIDS and UNICEF, 2002). Another study in Uganda indicates that "since orphans from grandparent families are not disciplined enough to accept and respect school authority they were more likely to dropout of school" (Barnett & Blaikie, 1992 in IIEP, 1993: 46).

In the Rakai district of Uganda, total enrollment in the primary schools studied went from 1534 in 1989 to 950 in 1993. The primary school dropout rate for the district in 1993 was 27 percent considerably higher than the national rate of 15 percent per year (Katahoire, 1991 in

CCRDA

IIEP, 1993). However, such a decrease in enrollment and increase in dropout may not be entirely attributed to HIV/AIDS. But the largest causal factor was HIV/AIDS. In another study in Northwestern Tanzania found that maternal orphans and children in households with an adult death delayed enrollment in primary school, but were not more likely to dropout of primary school once enrolled (AlnSworth, Beegle, and Koda, 2001, in World Bank, 2002).

There may also be relatively fewer children wanting education, or fewer parents wanting their children to be educated. There will be partly due to a reluctance of parents to make the considerable investment which an education requires. For example, in Tanzania, nearly 26 million Tanzanian shillings needed for eight years of primary school, four years of secondary education and three years of university education (World Bank, 1992 in IIEP, 1993). Parents considered schools or education as having poor return, and not willing to send their children. This affects the demand for education.

A further major impact on demand is observed due to parental inability to afford the payment for education. This includes a number of issues. The one is direct loss of family income due to AIDS. When the mother or father felt sick, the family income will be affected. So, most families seemed to have decided to postpone education. It is a choice between education and satisfying basic needs like food, clothes, etc. The other reason is the loss of income due to expenditures on treatment, care and funeral cost. One World Bank study showed that affected households in 1991 spent roughly $60 per year which was equivalent to rural per capital GDP on such costs (World Bank, 1993). The expansion of extended families is taken as a reason for affecting the demand for education. There are many more children of school age in a family often led by less productive adults (grand-parents) or teenage children. In such families, there may not be enough money to cover fees and other schooling costs of all the children (IIEP, 1993).

A further impact of AIDS on demand may be that fewer children are able to complete

CCRDA

their education. This is due to illness of children. Even if some HIV- infected children and those ill with AIDS live to enter primary school, the increasingly debilitating episodes of HIV related illness perhaps up to 6 episodes prior to death will likely make it difficult for them to complete schooling.

2.4.2 The Impact of HIV/AIDS on the Supply and Quality of Education

The impact of HIV/AIDS on supply and quality of education is reflected by several factors. To cite just some of them, high death rate and lack of teachers in schools, teachers absenteeism, rural drain, death of prospective teachers (university students), etc., are worth to mention.

As the studies in some African countries revealed teachers' mortality rate is higher than the general population. In South Africa, for example, teachers are believed to have a higher HIV/AIDS incidence than the general population, perhaps because of their relatively higher socioeconomic status, greater mobility, and postings away from home leads to more sexual contacts and therefore increased risk of infection (World Bank, 2002). In Kenya 10 teachers died annually before the epidemic. By 1996, this had skyrocketed to about 1,000 and still increasing. According to estimates by UNICEF, 95,000 Kenyan primary school students had a teacher die of AIDS in 1999. In the same year, of the 247,000 teaching force, 1406 teachers died of AIDS. For a country which spends 40 percent of her government budget on education, teachers death on AIDS is a real threat to overall aspects of education. Mr. Urban Jonsson, the UNICEF regional representative for Eastern and Southern Africa says the crisis in education caused by AIDS will become an economic crisis and in turn a political crisis. "The education system (Across Africa), apart from being under funded and marginalized in terms of political priorities, is "now being devastated by this disease" (Monitor, July, 25, 2000). Even if we do not have a study in this area, the condition seems to be observed similarly in Ethiopia.

A smaller supply of pupils either through lower initial enrollment or through high dropout rates will lead to a similar decrease in the number of classes and schools. Schools that

CCRDA

have enrollments below a certain minimum may be closed and their remaining pupils moved to other schools; more complex solutions, such as the introduction of multi-grade teaching, might create other complications (IIEP, 1993). This explanation clearly shows that the impact of HIV/AIDS resulted in not only of teachers death but also a decrease in students participation (enrollment) and dropout.

Teachers absenteeism is another factor which bears a deadly effects on the quality of education. HIV/AIDS increases teachers absenteeism, which leads to disruption of class schedules and inturn reduced the quality and quantity of education. According to a study by World Bank (1999), a teacher will spent 6 months of working days before developing a full-blown AIDS, and 12 months after developing the disease. In another study by Kelly (2000a in World Bank, 2002), in Zambia a teacher is estimated to face an average of 12 to 14 AIDS related sickness episodes before the terminal illness. On the other hand, teachers may be absent from classes as a result of sick families, i.e.,. to care for the sick or to attend funerals. A recent survey in Botswana found that absenteeism among female teachers averaged 6.6 percent, compared with 3.3 percent for male teachers.

Rural drain is particularly badly affected the supply of teachers in rural areas. AIDS affected teachers need to be close to hospitals or clinics, as a result, they are transferred in urban areas. This in turn created shortage of teachers in rural areas, where majority of school age children resides.

To mitigate the problem of teachers supply, some countries are rehiring retired teachers, recruiting foreign teachers, combine classes and shorter teaching time. A few education systems are even trying to pupils for some forms of peer education. For- example, in Botswana, 12 percent of teachers are temporarily untrained, reflecting efforts to keep schools open. This has a clear implication for deteriorating quality.

Some countries are focusing efforts on increasing the output from teacher training

CCRDA

colleges to maintain supply. For example, Guinea, has reduced the length of the training syllabus and achieved a more than 10 folds increase in out put from training colleges. Zambia has almost doubled the training out put by modifying the teacher development course so that the second year college training is spent in schools. By this it ensures quantity by compromising quality. Many other strategies have been devised by some other countries to alleviate shortage of teachers in the education system.

2.4.3 The Impact of HIV/AIDS on Available Resources for Education

When teachers are infected by HIV and developed to full-blown AIDS, long sick leaves are given to them on a payment basis. This benefits the sick but creates burden on education budgets. On the other hand, training cost to replace those who cannot work and have died of AIDS is another headache for administrators, Policy makers and the government at large.

The World Bank study in Tanzania estimates that some 14,460 teachers will die by the year 2010 and 27,000 by 2020. Approximately, US $ 37.8 million will be required to train replacement teachers, an amount the Tanzanian government can ill afford (World Bank, 1992 in IIEP, 1993). In Uganda an estimates of 2200 teachers suffering or dying from AIDS between 1993 and 1996, with a cost of replacement of 1.1.billion Uganda shillings or US $ 1 million (Along At woki, 1993 in IIEP, 1993). The impact of AIDS on different aspects of the education sector aggravates the backward development of countries

CCRDA

2.5 Impacts of HIV/AIDS on the education of AIDS orphan children

As we have seen in the preceding discussion, HIV/AIDS is a great challenge to the education sector. On top of that its effect also manifested on children who are victimized by this disease.

HIV/AIDS makes the millennium development goals and Education For All (EFA), which are the motto of the United Nations unrealizable. Achieving universal primary education and promoting gender equality and empowering women are the two goals of

education for all. Even without HIV/AIDS, the education sector faces major challenges. More than 113 million children aged 6 to 12 are out of school in developing countries, two-third of them are girls. By 2015 a total of 55 poor countries is estimated to be unable to achieve primary education, of which 31 are among the 36 countries worst affected by HIV/AIDS. Gender disparities in primary & secondary education was planned to be eliminated by year 2005. However, due to the greater likelihood of girls dropping out of school by HIV/AIDS, achieving this goal in the remaining years seems impossible. The regions at greatest risk of not meeting EFA goals are Africa and South Asia, where 80 percent of primary age population are out of-school (World Bank, 2002). This is really a big and challenging home work for governments in these countries to fight competing problems, HIV/AIDS, millennium development goals and Education for All.

Children who have lost their parents to AIDS are in a problem to attend schools. Mothers are the prime caregivers to children, if passed away leave alone schooling their survival would be threatened. As a result, some of the educational challenges observed are decline in enrollment, increase in dropout, gradual increase in absenteeism, forced child labour, etc,. Therefore, these problems will be discussed one after the other.

The need for children to work and to care for ill adults is one of the reasons for absenteeism and dropout of schools. Preliminary results in Tanzania showed that the death of an adult female in previous 12 months is associated with lower enrollment possibilities for female labour such as fetching water and collecting firewood (Ainsworth & Koda, 1993). In another study , a 16 year old boy orphaned by AIDS in India reported that" since the death of my parents we have been living with our grandparents. I earn 50 to 60 rupees a day (approximately US$1.00) by selling vegetables or pulling the riskshaw. I have three younger brothers. I want to study, but my grandfather says he cannot afford to keep us in the house unless I contribute my family's share "(UNICEF, and UNAIDS, 2002:22).

CCRDA

HIV/AIDS is a major development problem which is threatening to reverse a generation of achievements in human development. The pandemic has manifested it self in the world of work, younger and less qualified children forced to get employment in private and government organizations. Therefore, HIV/AIDS has a profound effects, not only on the size, but also on the composition and quality of the labor force in high prevalence countries. Studies in Tanzania, Cameroon, Zambia, Swaziland, Kenya and other sub-Sahara African countries revealed that HIV/AIDS pandemic result in economic deterioration by as much as 25 percent over a 20 year period (ILO, 2000)

Nevertheless, the convention on the Rights of the child accepts the right of the child to be free from any form of exploitation. It says, "State parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education or to be harmful to the child's health or physical, mental, spiritual, moral or social development" (Article 32:1). The paradox here is that, the convention put declaration for children not to join the world of work early in their life. But due to the HIV/AIDS death toll children lost parents and forced to engage in a job for survival.

Trauma related to the illness and death of family members leads to difficulty in concentrating in classroom and in acquiring the skills and knowledge offered in school. Children in schools and classrooms suffered due to infection or to a membership in a family with HIV infection & AIDS deaths. An officer in Rakai district said that people look at AIDS victims with a negative eye. They treat them as promiscuous people and prostitutes. And these attitudes transcend to school pupils who use them tease their fellow orphans. In the same district a grade 5 pupil, her father died of AIDS reported that some of her friends no longer played with her and instead pointed fingers at her saying that she might also have AIDS. She said, sometimes she felt bad & cried. She could not share anything with other pupils and she

CCRDA

no longer had money to buy her own snacks as before and her fellow pupils gave her nothing to eat (Katahoire 1993 in IIEP, 1993)

In a National Survey conducted in Ethiopia (MOLSA, UNICEF, Italian cooperation, 2003), the social environment of AIDS orphans and Non- AIDS orphaned children examined at two levels the peer environment and the general social environment consisting of neighbors, and school community. Regarding social interaction," 54.8% of non-AIDS orphans and 45.2% of AIDS orphans indicated that they had friends, which implies that significant number of the children might have difficulty in making friends. More that have of these children who claimed to have friends indicated that their friends were sympathetic and more than a quarter of both groups of orphans children pointed out that they get support from their friends. However, some of the AIDS orphan and non-AIDS orphan children indicated that they are confronted with unhealthy attitudinal set from their friends where they are considered as unlucky, cursed which exposes them to ridicule and ostracizing. Similarly, data collected on the quality of social interaction the child enjoys in the larger social environment has shown that more than half of the children live in a social environment that is sympathetic & understanding. However, only less than one third of these children revealed that the community around them is able to provide them with support .

The lower motivation provided by an extended family, perhaps caused both by the lower level of education possessed by guardian grandparents or their lower levels of awareness as to the possible usefulness of education & of households to orphans in such families. A study in one region of Uganda, Hunter (1990) reported that AIDS orphans may be over worked by relatives or other guardians who consciously or unconsciously view them as a burden. Lack of supervision, proper care taking and school or vocational activities leads to poor socialization, alienation from guardians and the community and possible delinquency.

The early marriage of girls and their dropout of school is another challenge which

CCRDA

widen gender disparities in education. This can occur due for several reasons, because they are pushed out from overcrowded extended families, or men seek younger & presumably uninfected wives, at times parents make an arrangement for a reliable partner for their daughter early in their life (Van de Walle, 1990 In IIEP, 1993). Girls and young women are highly vulnerable to HIV/AIDS. When they engage in early marriage, lack of education aggravates the problem. A study in 72 capital cities (32 in Sub-Sahara Africa) showed significantly higher HIV infection rates not only for girls, but also for all adults, where the gap between male and female literacy rates was larger (Over, 1998 in World Bank, 2002). This shows the role education has in preventing the spread of HIV/AIDS.

A study was conducted in collaboration of World Bank and the University of Dar-es-Salaam on adult death and child schooling in the Kagera region of Northwestern Tanzania. Children aged 7-19 years and a total of 1,897 samples were selected to investigate their enrolment and school attendance. The focus of the study was on the impact of adult death (due to all causes) on child schooling. About half of the adult deaths were thought to have been caused by AIDS. On average, 57 percent of children aged 7-19 years were enrolled in school in the previous 12 months (60 percent boys and 54 percent girls).

The death of an adult in the household in the past 12 months and its consequences has been analyzed. The death of a male adult in a household in the past 12 months did not appear to have an effect on either measure of schooling. On the other hand, the death of a female adult in the past 12 months was associated with lower school enrollment in the previous 12 months, especially for the age-group 7-10 and 15-19 years (IIEP, 1993)

The importance of child labor and the perceived poor returns from schooling may be the reason for non-enrollment of children in school. Orphans and other children in foster families may be particularly disadvantaged in this respect.

The HIV/AIDS epidemic also reduces girls' access to education. Girls are more likely

CCRDA

than boys to be retained at home for domestic work when household income drops due to AIDS deaths or to care for sick relatives.

The same study conducted in Tanzania revealed that the overall enrollment rates in the previous twelve months were highest in urban areas, which also showed the highest proportion of enrolled students who were orphans. This is due to the fact that higher income families live generally in urban areas. These areas are also the most infected by HIV/AIDS, which may explain the higher degree of orphan hood among students enrolled in primary schools in these areas (IIEP, 1993). This study showed us that though parents deceased by AIDS, if they had money and property their children will continue schooling at least for some times.

In a meeting organized by African Development Forum, held here in Addis Ababa from 3 -7 December 2000, the impact of HIV/AIDS on the school enrollment of orphans in Sub-Sahara region was thoroughly discussed. Within a decade, in Kenya the number of children of primary school age will be 13 percent, in Swaziland, 23 percent, in Uganda, 12 percent, in Zambia 20 percent, in Zimbabwe 24 percent lower than if there had been no AIDS. In countries like Swaziland, Zambia & Zimbabwe the impact is clearly observed.

Orphans run greater risks of being denied education than children who have parents to look after them. For instance, in Mozambique 24 percent of children who have parents had died were attending school compared with 68 percent of those with both parents still living. Orphans who are left to their own resources can seldom pay school or training fees either from parents left out or working different activities like shoe polishing, mini-trading, etc. Grand parents and other family members who take over the care of orphaned children may also have difficulty in meeting school costs, may give priority to their own children, or may depend on orphan labor for survival.

In extreme cases, which are all too numerous, orphans turn to the street where their physical needs and financial desperation make them vulnerable to crime, substance abuse and

CCRDA

sexual exploitation. This places a significant number at risk of contracting HIV through virtually inescapable income generating prostitution (African Development Forum, 2000). By and large, most of AIDS orphan children are in a problem to attend schools unlike other children of their ages who have parents alive. This on the other hand, is a challenge for leaders in Sub-Sahara African countries. Because having such huge uneducated children and thinking about the development of a country is quite paradoxical.

The educational problems girls have been facing are by far more serious than boys. Girls are more exposed to early pregnancy, HIV infection, unprotected or coercive sex, etc. All these bear their own scare on school dropout, and other psycho-social problems on girls. In a small study conducted in South Africa, in 1997 showed that 9.5 percent of pregnant girls under 15 years of age were HIV- infected (UNICEF, 1998). Even in the age group 15-19 girls in Sub-Saharan African are becoming infected and dying earlier than boys. In major urban areas of eastern and southern Africa, epidemiological studies have shown that 17 to 22 percent of girls aged 15 -19 are already HIV infected compared with 3 to 7 percent of boys of similar age. 'Sexual mixing' is one lesson where older men engage sex with young girls. In many countries where economic conditions make it difficult for girls to afford school fees, some seek favors of a sugar daddy' (an older man who affairs compensation in cash or kind in exchange for sexual favors), engage in transactional sex (that is, exchange for money or goods on an occasional basis) or enter sex work (willingly or forced) to pay for school, support their families or take care of themselves. (UNICEF, UNAIDS & World Bank, 2002).

In another study conducted in South Africa, an estimated 10,000 children live or work on the city streets. More than half of 141 street children interviewed in South Africa reported having exchanged sex for money, goods or protection, and several indicated they had been raped.

Girls are likely to dropout of school to care for parents infected with HIV or for younger

CCRDA

siblings. Orphans also leave school because of discrimination, emotional distress or because they cannot afford to pay school fees. (UNICEF, USAID & World Bank, 2002)

Girls will likely to be taken out of school sooner than boys when fees cannot be paid, when ill or orphaned siblings and relatives need to be cared for, perhaps also when many kinds of productive labour must be done and when the prospect of early marriage becomes possible (IIEP, 1993)

So many young pupils leave school at grade 6 and have limited information about HIV/AIDS and STDs once they are out of school. Integrating HIV/AIDS in primary curriculum resulted in sustaining the lives of children and encouraging them to stay in the school accepting all the challenges (International Center for Women, Report in Brief- 1993)

Regarding the impact of HIV/AIDS on children, the Zambia, Ministry of Health (2000), explained that children may have to give up school to care for sick parents or younger siblings. This restricts their earning potentials later in life, and may make them vulnerable to occupations or lifestyles which increase their own risk of HIV infection. The capacity of extended families to cope with growing numbers of orphans is being stretched. Some orphans in their early teens are already heading households. In many areas children end up on the streets, and are exceptionally vulnerable to survival strategies that expose them to HIV and other health problems.

A study conducted in Rakai District in Uganda 20 pupils were randomly selected form upper grades of three primary schools, 10 girls and 10 boys, 10 orphans and 10 not. The result showed that the AIDS epidemic was having a serious impact on the pupils. Nineteen of the pupils reported having been absent from school for periods ranging from five weeks to one and a half terms during the past one year. The most common responses given for absenteeism were lack of school fees and helping with the nursing of AIDS patients at home. It was reported by 15 of the pupils that their school life has been affected by the death of their parents or

CCRDA

guardians. In addition to lack of school fees, pupils explained that they had to miss school sometimes because of no uniforms, books, pens, etc.... they often stayed at home for several days at a time to attend funerals of their relatives.... Due to the increasing number of AIDS patients, pupils (especially girls) were required to take turns at home nursing the sick and helping out on the farm, especially with the decrease in farm labor in the homes.... (Katahoire, 1993, in IIEP, 1993: 42).

To reduce all the negative outcomes of HIV/AIDS starting from grass root levels a lot of work need to be done. To do so, education is a key to reduce the spread of HIV/AIDS and its impact on the education of children.

As the studies reviewed so far revealed HIV/AIDS worsen the lives of AIDS orphaned children. School dropout, inability to pay school fees, lack of uniforms and other educational materials are common day to day experiences of AIDS orphans. However, little has been said on the needs, motivations and values of AIDS orphaned children to education. Moreover, the kind of care and support given to them varies from country to country. Therefore, this study is intended to bridge the knowledge gap in these areas.

CCRDA

CHAPTER THREE

Design & Methodology of the Study

3.1 Sampling

This study is mainly a descriptive type intended to provide information as to the living conditions and educational challenges of AIDS orphaned children in Addis Ababa. Therefore, the study population includes AIDS orphaned children below age 15, their caretakers, i.e. surviving parents, relatives, charity organizations, governmental, non-governmental organizations and associations formed by HIV carriers. In addition, expertise from concerned ministries such as HIV/AIDS "Prevention and Control Office, Ministry of Health, Ministry of Education, Ministry of Labor and social Affairs, panel head of Addis Ababa city administration HIV/AIDS prevention and control office, Co-curriculum coordinator of Addis Ababa Education Buearu, Anti-AIDS club Co-ordinator & head of School clinic of Minilik the II primary school participated in the study.

Initially the study was intended to be conducted in some selected woredas and the sample AIDS orphaned children and their care takers be drawn from selected woredas and Kebeles in Addis Ababa. Unfortunately, due to the stigma and discrimination directed to AIDS orphaned children and caretakers including surviving parents, they did not disclose their conditions and project their parent's death to some other diseases. As a result the researcher was forced to approach local NGOs and Associations formed by HIV carriers. AIDS orphans living in Woreda 25 included in the study through personal contact of my self & friends. Therefore, convenient sampling method was used to select the desired sample size. Participants of the study were drawn from Dawn of Hope (Tesfa Gohe), Mekedim Ethiopia, Tesfa Berhan, and Hiwot Ethiopia. The first two are associations formed by interested individuals who themselves are HIV carriers. Tesfa Berhan is an association formed by AIDS

CCRDA

orphaned children. Hiwot Ethiopia is an indigenous NGO founded with the very aim of supporting AIDS orphaned children and HIV/AIDS patients. In this study, 228 AIDS orphaned children and 128 caretakers filled the questionnaires. Similarly, 10 AIDS orphaned children and 10 caretakers including surviving parents were interviewed. Moreover, expertise in different ministries and heads of associations, were represented in the study. Purposive sampling method was employed in the selection process of these concerned individuals. One person each from Ministry of Education, Addis Ababa Education Bearue, National HIV/AIDS Prevention and Control Office, Addis Ababa City administration HIV/AIDS Prevention and Control Office Ministry of Health, office, Ministry of Labor and social Affairs, Dawn of Hope, a Anti-AIDS club & school clinic Head of Minilik II primary school, but two persons from Mekedim Ethiopia, Tesfa Berhan and Hiwot Ethiopia. This means 12 individuals participated in the study as key informants. In two focus group discussions 18 AIDS orphans were participated. By and large, a total of 406 individuals were included in the study.

3.2 Variables

Following are variables upon which data were collected and analysis made to answer the basic questions of the study.

No.	Basic question	Variables	Description
1.	How AIDS orphaned in Addis Ababa are being taken care of?	Family related variable	• Questionnaires were designed to assess with whom AIDS orphaned children are currently living with • The kind of support GOs, NGOs and Associations formed by HIV carriers to AIDS orphaned children • Focus group discussion, Interview

CCRDA

No.	Basic question	Variables	Description
2.	Do AIDS orphaned children succeed in attending their schooling? If so, what form of classroom behaviors are they manifesting?	Student-level variable	• Questionnaires administered to caregivers and AIDS orphaned children themselves. • Interview with AIDS orphaned children, caregivers and supporters (like GOs, NGOs & Association heads
3.	What kind of educational efforts AIDS orphaned children make to achieve success in schools?	variable related to the individual child	• Questionnaires administered to AIDS orphaned children and their care givers • Interview • Observations made in an AIDS orphanage who themselves are HIV carriers.
4.	What level of motivations,needs and values AIDS orphan children have to learn? Do AIDS orphaned children have positive self-image upon themselves?	Individual and school related variables	• Questionnaire to AIDS orphaned children Interview Observation • Self- efficacy Scale • Self-esteem scale
5.	Are there differences among AIDS orphaned children of different background (e.g. Sex, age, parental surviving status, etc) in the care & protection received, school attendance, motivation, needs and values to learn	Individual level variable (student-level variable)	• Sex of AIDS orphans Age " " parental surviving status, matched with care & protection, school attendance rate, motivation, need and values • Interview • Observation • Questionnaire • Focus group discussion

CCRDA

3.3 Date Collection Procedures

3.3.1 Questionnaire development:-

Two types of questionnaires were developed one each for AIDS orphaned children and care takers including surviving parents. In order to write the items for the questionnaire, the

researcher made what ever possible review of Related Literatures and studies done mostly in African countries. Then after, major ideas for the questionnaires to be based were identified. Finally, the items were written as draft questionnaires.

A. Questionnaire for AIDS orphaned children:-

This questionnaire consisted of 70 items. Part one was about personal information of respondents which has 9 items in it. Part two was about general information concerning the kind of care and support, educational and other issues related in one way or another to the education of AIDS orphaned children. A total of 50 open and closed ended questions were included.

Part three was a self-efficacy scale consisting of 10 items with 5 ratings ranging from one strongly disagrees to five which was strongly agree. All the items designed were based on the theory of Self-efficacy developed by Albart Bandura. The aim of developing the Self-efficacy scale was to evaluate the personal strength or Self-efficacy of AIDS orphaned children due to loss of their parents to AIDS.

Part four was a four point Self-esteem scale developed by Rosenberg (1965) and adapted and used for the study. The scale consisted of 10 items. The scale was written in English but adapted and translated into Amharic to fit the intention of the study. Back ward translation also made to see the validity and reliability of the scale.

All the items in the questionnaire presented to AIDS orphaned children in Amharic and the direct English translation was attached in Annex 1 of this research paper.

B. Questionnaire for caretakers of AIDS orphaned children

The questionnaire designed for caretakers of AIDS orphaned children consisted of two parts. The first part was about personal information having 12 items, and the second part was about general information on the topic of the study which consisted of 31 items of both closed & open ended type. All the items were written and presented to respondents in Amharic, and

CCRDA

the English version was attached in Annex 2 of this research paper.

Pilot Testing of the Questionnaires

After the questionnaires have been developed & typed twenty copies were duplicated 10 each from AIDS orphaned children and care takers type for pilot testing purposes. Ten AIDS orphaned, five males and five females were selected from Mekedim Ethiopia when they were coming to the Association for their own personal matters. Similarly, 7 women and 3 men were requested to fill the questionnaire designed for care takers, including surviving parents.

Attempts have been made to analyze the quality of each item using item analysis. However, the major challenge was to designate the answer for the item. For simple calculation, hypothetical answers were taken based on the researcher personal judgment as to the majority of the respondents would like to respond for each item. Above all, in the pilot testing process respondents were oriented to indicate items with ambiguous wordings, disorganized sentences, and illogical ordering.

The same questionnaires were given to a social worker in Mekedim Ethiopia, Health expert in the Ministry of Education and to a colleague working his masters study for comment. The researcher finalized the questionnaires taking all the constructive ideas from all these sources.

CCRDA

3.3.2 Interview

The second major source of data was interview. Those who have been working with AIDS orphaned children in one way or another were selected for interview. Counseling officer and social workers of Mekedim Ethiopia, social worker of Hiwot Ethiopia, the Addis Ababa branch president of Dawn of Hope were interviewed based on semi-structured interview questions designed for each in line with the responsibilities they shouldered and the topic of the study. Similarly, Health expert of MOE, Addis Ababa city administration Education Buearu

Co-curricular activity Co-coordinator, Addis Ababa city administration HIV AIDS Prevention and Control Office, panel head children, youth & Family Affairs Department head of MOLSA, Anti-AIDS club coordinator and school clinic of Minilik II primary school, member form Tesfa Berhan were interviewed, and the items were Annexed at the end of the paper.

3.3.3 Observation

Based on personal relationship with AIDS orphaned children and their care takers, I have visited 3 homes, in woreda 25 kebele 16 (in the former naming of the Addis Ababa city administration). On the other hand, I visited an orphanage for AIDS orphaned children who themselves are HIV carriers located at Asseko, named as Mother Teresa Children's Home. Due to ethical reasons, I was not allowed to make interview or ask children to fill questionnaire, but make an observation while playing & attending classes.

3.3.4 Focus Group Discussion

Two focus group discussions were organized drawing AIDS orphaned children supported by different NGOs and associations of HIV carriers and those drawn from woreda 25. A total of 18 persons were in attendance of the discussion. The first group consisted of 8 members & the second group had 10 members.

CCRDA

3.4 Methods of Data Analysis

Both quantitative and qualitative methods of data analysis were employed in the study.

3.4.1 Quantitative Methods:-

The data gathered using two types of questionnaires (i.e. for AIDS orphaned children and the caretakers) were analyzed quantitatively using SPSS version 10.0 program. As a result,

- For some of the basic questions raised in the study ANOVA, t-test and Chi-square tests were conducted.
- Spearman rho correlation co-efficient test was also used to examine the degree of

relationships on some selected variables, such as the need to learn and value to edcation.

- Percentage was also widely used in the study.

3.4.2 Qualitative method.

Results of Interview, observation and focus group discussion were analyzed qualitatively using words and sentences.

CCRDA

CHAPTER FOUR

Findings

In line with the basic questions of study indicated in the preceding units, the relevant data have been gathered using two types of questionnaires, interview, observation and focus group discussion. In the following pages, the data is systematically presented and analysis be given under each table.

To begin with, general information of the respondents would be presented

4.1 General Information of the Respondents

Table 1: Sex of the Respondents

Respondent		Male		Female		Total	
	Variable	N	%	N	%	N	%
AIDS Orphaned Children	Sex	86	37.7	142	62.3	228	100.00
Care takers of AIDS orphans	Sex	34	26.6	94	73.4	128	100.00

As Table 1 indicated, 37.7 % of the AIDS orphaned children participated in the study were males, where as the majority, i.e., 62.3 % were females. Likewise, smaller percent of the caretakers of AIDS orphaned children, i.e. 26.6% were males, and 73.4% were females. From this we can infer that majority of the sampled respondents were females.

Table 2: Ages of AIDS Orphaned Children as Stated by Caretakers

Age boundary	Age of AIDS orphans when they lost their parent(s) to AIDS		Current age of AIDS orphaned children	
	N	%	N	%
below 5 years	42	32.8	4	3.1
5-10 years	82	64.1	74	57.8
11-14 years	4	3.1	50	39.1
Total	128	100.0	128	100.0

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Table 3: Age of AIDS Orphaned Children as Stated by Themselves

Age boundary	Age of a child when he/she lost his/her parent(s)		Current age of AIDS orphaned children	
	N	%	N	%
below 5 years	22	9.6	0	0
5-10 years	76	33.3	20	8.8
11-14 years	130	57.1	208	91.2
Total	228	100.0	228	100.0

According to the response of caretakers, 32.8% children were below 5 years when they lost their parents and search for adopters; where as 64.1% of them were in the age range of 5-10 years. Just a few, i.e. 3.1% were 11-14 years old. Regarding the current age of AIDS orphaned children, in 2003 when the study has been conducted 3.1% were below 5 years of age, 57.8% were 5-10 years old and the rest 39.1 % were in the age range of 11-14 years.

As stated by the AIDS orphaned children, 9.6% were below 5 years, 33.3% were 5-10 years and 57% were 11-14 years of age when they lost their parent(s) to AIDS. Regarding their current age, majority of them, i.e. 91.2% were 11-14 years old. However, there seems a contradiction between the responses of caretakers and AIDS orphaned children.

Table 4: The Lost Parent(s) to AIDS

Death Status of Parents	N	%
Mother only	24	10.5
Father only	58	25.4
Both mother & father	146	64.1
Total	228	100.0

According to the AIDS orphaned children who responded to the questionnaire (N = 228; 24 children i.e. 10.5%) lost their mothers only to AIDS, other (58, 25.4%) their fathers, and majority of them, i.e. 146 in percent 64.1% lost both their mothers and fathers. From this we can say that majority of them were double orphans and AIDS resulted in the disorganization of family structure.

When we see, parental death it seems evenly distributed across the range of years, but

CCRDA

gradually increased in the years 1994-1995 E.C. or 2002/2003 . For both Mothers' and fathers' the rate of death was very high in the year 1994-1995 E.C or 2002/2003 ,36.5% and 46.1% respectively. This showed how HIV victims of years ago have died in increasingly alarming rates.

Table 5: Age and Educational Background of Caretakers

Age of Care takers		Educational Level of Caretakers			Total
		4-6 grades	7-10 grades	11-12 grades	
Below 20 years	N	0	6	0	6
	%	0	4.7	0	4.7
20 - 30 years	N	16	22	18	56
	%	12.5	17.2	14.1	43.7
31- 40 years	N	8	22	0	30
	%	6.3	17.2	0	23.5
Above 40 year	N	10	20	6	36
	%	7.8	15.6	4.7	28.1
Total	N	34	70	24	128
	%	26.6	54.7	18.7	100.0

Regarding the age and Educational background of caretakers, Table 5 revealed that (4.7%) were below 20 years of age and grades 7–10, (12.5%) were in the age range of 20-30 years and in grades 4-6, (17.2%) were in grades 7 -10, and (14.1%) were in grades 11-12. In the age range 31-40 years, (6.3%) were grades 4-6, & (17.2%) were 7-10 grades. Finally, in above 40 years category, (7.8%) were grade 4-6; (15.6%) were 7-10 grades and (4.7%) were 11–12 grades. Therefore, majority of the caretakers i.e. 43.7% were in the age range 20-30 years. The second age category of caretakers was above 40 years of age, which consisted of 28.1%. A close third was 31-40 years category with 23.5%.

The other variable considered was the educational status of caretakers. As a result, disregarding the age range, majority of the caretakers (54.7%) were in grades 7-10, which was seconded by grades 4-6 with 26.6%. In general, what we can conclude from this table was that most of the caretakers were too young and less educated.

CCRDA

Table 6: Family Size and Number of Orphans in the Family

Variables	Less than 3 Family		3-6 Family		Above 6 Family		Total	
	N	%	N	%	N	%	N	%
Number of family members	20	15.6	84	65.6	24	18.8	128	100.00
Number of AIDS orphans in the family	52	40.6	60	46.9	16	12.5	128	100.00

Based of the response of care takers presented in table 6, twenty respondents, i.e. 15.6% said that they have less than 3 family members. The rest 84 persons, i.e. 65.6% reported having 3-6 families, and 24 (18.8%) were reported as having above 6 family members.

Regarding the number of orphans in the family, the caretakers responded that, 52 persons (40.6%) families carry less than 3 orphaned children, 60 persons (46.9%) of them have 3-6 AIDS orphans in their family and lastly 16 persons (12.5%) supported more than 6 children. If we add up the last two responses, i.e families who have been supporting 3 AIDS orphaned children and above are 59.4%. In a city like Addis Ababa, supporting and upbringing 3 and more AIDS orphaned children is a great challenge.

Table 7: Type of Job and Average Monthly Income of Caretakers

Type of Job	Average Monthly income											Total
	No Monthly income		Less than 50 birr		50-100 birr		101-500 birr		above 500		missed	
	N	%	N	%	N	%	N	%	N	%		
Guleit	22	18.0	12	9.8	-	-	-		-	-		
Housewife	32	26.2	-	-	-	-	-		-	-		
Waiter	-	-	-	-	2	1.6	-		-	-		
Close cleaning	-	-	4	3.3	-	-	-		-	-		
Daily Laborer	-	-	8	6.6	-	-	-		-	-		
Government employee	-	-	-	-	-	-	2	1.6		-		
Pension	-	-	-	-	8	6.6	2	1.6		-		
Petty trading	-	-	-	-	6	4.9	-	-	-	-		
Trading	-	-	-	-	10	8.2	4	3.3		-		
Private job	-	-	-	-	8	6.6	-		-	-		
No job	2	1.6	-	-	-	-	-		-	-		
Total	36	45.9	24	19.7	34	27.9	8	6.6	-	-	6	N = 128 %= 100

CCRDA

The type of jobs caretakers involved to lead there lives have been listed out in the table above including their monthly incomes. As indicated, 45.9% of the respondents have no monthly income, but engaged in different income generating activities, 19.7% of them less than 50 birr, 27.9 % received 50-100 birr monthly income, and finally 6.6% of them have monthly income between 101-500 birr. If we add up the first three categories, i.e. those who have monthly income of birr 100 and below, we could get 93.5%. This means most of the caretakers, strived to upbring their own children and dependents caused by HIV/AIDS with this meager economy.

Table 8: Grade Levels of AIDS Orphaned Children when They Lost Their Parent(s) to AIDS and Current Status

Grades	What was your grade when your parents died?		What is your grade now?	
	N	%	N	%
Not started schooling	10	4.4	0	0
Kindergarten	24	10.5	-	-
1-4 grades	108	47.4	50	21.9
5-8 grades	86	37.7	174	76.3
Grade 9 & above	0	0	4	1.8
Total	228	100.0	228	100.0

As indicated in Table 8 above, 4.4% AIDS orphaned children were very young to go to school when their parents died of AIDS, 10.5% were at kindergarten level, 47.4% were in grades 1-4, and the rest 37.7% were from grade 5 to 8. In general, we can say 85.1 %of AIDS orphaned children were in the first and second cycle primary schools when they lost their parents to AIDS.

On the other hand, 21.9 % of AIDS orphaned children are currently enrolled in grades 1-4, 76.3% are in grades 5-8, and 1.8% are in grades 9 and above. This shows that most of the respondents are second cycle primary school students.

CCRDA

4.2 Detailed information

Table 9: Support Given to AIDS Orphaned Children Soon After Parental Death.

Response of AIDS orphans	N	%	Response of care takers	N	%
Elder brother	32	14.0	Brother's child	6	4.7
Elder sister	18	7.9	Sister's child	50	39.0
Uncle	18	7.9	Grand child	30	23.4
Aunt	14	6.1	Neighbors child	2	1.6
Grand parent	42	18.4	Others	40	31.3
Parents' Friend	8	3.5			
Charity organizations	54	23.7			
Others	42	18.4			
Total	228	100.0	Total	128	100

As presented in the Table 9 above, 54 children, i.e.(23.7%) of them responded that charity organizations extended their hand for support soon after parental death. But this does not mean that unlike the popular saying to support the AIDS orphaned children in big cities like Addis the extended family lose its strength and stretch to be broken. However, in this study, if we add up the responses given, 54.3% of AIDS orphaned children have been supported by the extended family. The last response in the column was an open choice for respondents, so 42 children, i.e.(18.4%). This group includes surviving mothers, fathers, and those who went out to street devoid of caretakers. In a separate cases, support by grandparents carry the second highest weight responded by 42 children, i.e. 18.4% of AIDS orphaned children participated in the study.

A similar question was raised to caretakers of AIDS orphans to indicate their relationship to AIDS orphaned children they are adopting. From the responses given, 39% of them were sister's children, 31.3 % included in others category comprising surviving mothers, surviving fathers, and other form of blood ties, and 23.4% were grand children. Therefore, from the responses of AIDS orphaned children and their caretakers, we can see greater similarities

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with some differences. Except with the response of caretakers who responded to a greater degree as if they are taking care of their sisters' children, in the rest of the responses the views were almost the same.

Table 10: Growth Status of AIDS Orphaned Children

	If you have brother(s) and/or sister(s), did your caretakers support you all together or separated?		Did you take all or some of the AIDS orphaned children for adoption?	
	Response of AIDS Orphans		Response of Care takers	
	N	%	N	%
Grow together/All	128	61.0	118	93.7
Separated/some of them	44	21.0	8	6.3
Other	38	18.0	-	-
missed cases	18		2	
Total	228	100.0	128	100.0

As the table above showed, 61% of the AIDS orphaned children reported that their caretakers supported them together after their parents death, 21% said that due to economic and some other reasons, they could not able to up bring them together. Finally, 18% were reported diverse responses. To cite just some of them, some respondents revealed the way in which relatives discussed on the issue of dividing the AIDS orphaned children. Some use draw or random allocation while others use other criteria like economic condition of the caretaker and the age of the child. Meaning in order for younger children to get better support, they can be given to a relative with good economic stand. Some relatives also agreed to support AIDS orphaned children while living in their own homes. In this case the older child in the family was given the responsibility of taking care of the younger kids of his/her own brother(s) and sister(s).

As discussed with some of the participants during interview sessions, they also explained the cases in their locality where parents of AIDS orphaned children left their homes when the HIV/ test result reported was positive and the neighbors carry the responsibility of

CCRDA

upbringing their kids employing a servant. Even in some worst case, the relatives did not reach the house of the AIDS patients, and when they died no body extend his/her hand to support the helpless children. As a consequence of that some children forced to go out to street and lead life as street children.

Regarding the response of the caretakers, majority of them responded that they tried whatever possible to up bring siblings together. Only 6.3% of the respondents were forced to up ring some of the kids taking their economic condition into account. In the interview I had with caretakers of AIDS orphaned children, some of them frankly reported the behavioral and economic challenges they have been facing in upbringing these children. The younger the child when parents died of AIDS, the easier for adjusting to new parent structure.

Table 11: The Kind of Support AIDS Orphaned Children and Their Caretakers are Receiving

	Response of AIDS orphans				Caretakers' Response			
	Wheat & food oil		Financial Support		Wheat & food oil		Financial Support	
	N	%	N	%	N	%	N	%
School	-	-	12	10.5	-	-	-	-
Individuals	-	-	2	1.85	-	-	4	3.2
Kebele	16	-	6	5.3	-	-	4	3.2
Charity organizations (NGOs)	30	26.3	-	-	56	43.6	50	40.4
Kebele/Woreda HIVE AIDS office	12	10.6	-	-	-	-	-	
Association of HIV carriers	56	49.1	94	82.4	72	56.4	66	53.2
Total	114	100.0	114	100.00	128	100.00	124	100.0

From the above table, one can see that both AIDS orphaned children and their caretakers are receiving support from different organizations. Of all the responses of AIDS orphaned children, charity organizations supported them in providing food oil & wheat reported by 26.3%. On the other hand, 49.1% and 82.4% of AIDS orphans respectively received wheat & food oil and financial support from Associations of HIV carriers. Though it is

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minor schools, kebeles, and individuals extend their hand to support AIDS orphans in 10.5%,5.3%,and 1.85% respectively.

Similarly, the responses of caretakers of AIDS orphans have been analyzed. In their response 43.6% received wheat & food oil, and 40.4% acquired financial support from NGOs working in support of AIDS orphans & AIDS patients. By the same analysis 56.4% and 53.2% received wheat & food oil & financial support from Associations formed by HIV carriers respectively. Therefore, from this we can conclude that NGOs & Associations of HIV carriers supported AIDS orphans & caretakers to a greater degree.

Table 12 : School Enrollment of AIDS Orphaned Children

Items	Yes		No		missed	Total	
	No	%	N	%		N	%
Are you currently attending your education? (AIDS orphans)	194	85.1	34	14.9	-	228	100.0
Are you able to teach the orphan(s) you are upbringing? (Caretakers Response)	98	77.8	28	22.2	2	128	100.0

As Table 12 showed, and reported by themselves 85.1% of AIDS orphaned children are currently in the school. Whereas 14.9% of them dropout of school due to their inability to cover all school expenses. On the other hand, 77.8% of the caretakers also responded that they succeeded to teach the AIDS orphaned children, and the remaining 22.2 % do not manage to teach AIDS orphans who are living under their supervision.

Majority of the AIDS orphaned children participated in this study were drawn from Elwot Ethiopia, Tesfa Gohe (Down of Hope), Mekedim Ethiopia and Tesfa Berhan. But there are some children drawn from woreda 25. As discussed above, these local NGOs and Associations of HIV carriers are supporting AIDS orphans education including school fees, uniforms, etc. The precondition to get all form of school related support was school attendance of the child. If we take, Mekedim, as an example, there are 220 AIDS orphaned children under their direct support. From the AIDS orphaned Children in the family at least

CCRDA

one is taken for support. If the money shared for at least three children in the family, a total of 660 children are attending their education with the support received.

Table 13: Forms of Schooling AIDS Orphaned Children Are Enrolled

Item	Day Regular program		Night School		Total	
	N	%	N	%	N	%
The forms of schooling in which AIDS orphaned children are attending with?	176	90.7	18	9.3	194	100.0

Table 13 presented that 176 students or (90.7) of AIDS orphaned were in regular day schools & very few of them, i.e18,(9.3%) were in Night schools. In an interview conducted with social worker of NGOs and Associations of HIV carriers, majority of the students were in government schools, but very few students were in private schools before the death of their parents, and continued their education with the support of these local NGO and Associations of HIV carriers. However, AIDS orphaned children also engaged in different income generating activities such as selling goods like chewing gums, daily laboring, shoe polishing, etc., to supplement their earnings. As some of these children revealed, their caretakers were not satisfied with the support given from these local NGO and Associations and forced them to earn additional money. This in turn affected the school attendance rate of AIDS orphaned children.

The head of Anti-AIDS club and school clinic of Minilik II primary school was interviewed as to the Anti-AIDS club activities in the school, the number of AIDS orphaned children, and other matters pertaining to AIDS orphaned children. He responded that the club is functioning properly, and especially with the support of Missionary of Marry (MM), and organizations working with HIV/AIDS, 21 schools have been organized to prepare an HIV/AIDS festival to be held on 18 April 2003. Currently, MM is supporting 3 AIDS orphaned children from the school. Regarding the number of AIDS orphaned children, shortly

CCRDA

he said except these three children there is no data as to who is an AIDS orphaned child. Therefore, nothing is being done to give material, educational as well as psychological support to them.

Similarly, counseling head of Mekedim Ethiopia stated that since the number of children attending their schooling scattered through out to Addis Ababa, it was very difficult to make follow up. But when these children faced problems or when the school needs to consult the supporting Agent, they go to respective schools. On the other hand, he reported that there are a number of students attending technical and vocational training in different colleges. For these, strict supervision is being made and their grade reports have been checked in each and every semester. He also noted that, for the last 3 years, tutorial classes have been given to primary and secondary school students by employed part time teachers and volunteer university students. These classes were directed not only to academic issues but also to awareness creation, and behavioral change to fight HIV/AIDS. Significant progresses have been seen on students' academic achievements and knowledge of HIV/AIDS.

Table 14 : School Attendance Rate of AIDS Orphaned Children

Items	Yes		Sometimes/ I do not		I usually / do not		Others		Total	
	N	%	N	%	N	%	N	%	N	%
If you are attending your education, do you usually go to school? (AIDS orphaned Response)	124	63.9	46	23.7	20	10.3	4	2.1	194	100
Do your adopted child (ren)go to school regularly? (Caretakers Response)	114	100	—	—	—	—	—	—	114	100

The responses of AIDS orphaned children and their caretakers were presented in Table 14. The respondents were those who have been attending their education in this academic year 2002/2003. From the total 194 respondents of AIDS orphaned children (63.9%), were reported

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as attending their schooling on a regular basis. Others N = 46(23.7 %) were not in school for sometimes, 20 students, i.e. 10.3% stated that they usually do not attend classes, and 2.1% reported several reasons. Some AIDS orphaned children explained sickness of their family, attending funeral ceremony due to parental death, etc; for their occasional withdrawal from schools.

All in all, 114 respondents of caretakers of AIDS orphaned children, i.e 100% revealed that their adopted children were regularly attending schools. This response generally implied that majority of AIDS orphaned children regularly attend schools.

Table 15 : Class Attendance of AIDS Orphaned Children During Last Week.

	For how many days you were in the school last week?	
	N	%
All days	88	45.4
Four days	52	26.8
Three days	24	12.4
Two days	8	4. 1
One day	8	4. 1
None of the days	14	7 .2
Total	194	100.0

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As Table 15 depicted, 45.4% AIDS orphaned children were in the schools all days a week before filling this questionnaire. On the other hand, 26.8% of them were absent only for one day, 12.4% were in the school for three days. At the bottom of the table, 4.1% students each were in the school for two and one days, respectively and 7.2% were not in the school all the school days of the week. If we add up the percentage of students who were in the school all the school days, and those who were absent for only one day, we would get 72.2%. This showed that majority of AIDS orphaned were in the school a week before filling this questionnaire, i.e. the first & second week of March 2003.

Those who were absent from schools all days of the week and for sometimes were requested to reason out the causal factors. Inability to understand subjects given in school, daily

laboring, lack of stationery materials, sickness of children themselves, family sickness, selling ' kolo', etc were just some of them. Therefore, still there are children who need to attend their education but forced to be absent due to different reasons.

The number of days both male and family AIDS orphans went to schools a week before filling the questionnaire for this study was assessed. The calculated mean class attendance of boys was 4.15 and girls 3.63 for that specific week. The t-test calculated ($t = 3.664$, $P = .016 < 0.05$), shows that there existed a significant difference between boys & girls in their classroom attendance for a week period when the data gathered. In short more boys were in attendance of classes than girls.

In line with the above investigation, parental death status, meaning Mothers' or fathers' death and its impact on regular class attendance of AIDS orphaned children was examined. The mean class attendance of AIDS orphaned children was examined. The mean class attendance of AIDS orphans who lost their mothers only was 3.57 where as the mean class attendance of those who lost their fathers only was 4.45. The t-test was calculated to make sure whether or not there existed a statistically significant mean difference. There fore, ($t = 27.899$; $P = .004 < 0.05$), we can say there is a statistically significant mean difference between parental death (i.e mother or father) and class attendance rate of AIDS orphans. In this case those who lost their mothers attend less compared to those who lost their fathers. This means maternal death affects the class attendance of AIDS orphaned children. On the other hand, a one way analysis of variance calculated by adding the third variable, i.e, the death of both parents to AIDS and its impact on class attendance.

Table 16 Class Attendance of AIDS Orphaned Children in Relation to Parental Death Status.

Source of variation	SS	df.	Means squares	F-ratio	P
Between groups	21.9428	2	10.9714	5.0767	.0071
Within groups	412.7799	191	2.1611		
Total	434.7216	193			

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As table 16 above showed ($F(2,191) = 5.0767$, $p < .05$) there is a significant mean difference between school attendance and parental death status of AIDS orphaned children. The mean values for those who lost only their mothers, only their fathers and for those who lost both parents were 3.57, 4.45 and 3.66 respectively. This in short might be interpreted as maternal death affects class attendance more followed by both parents death & lastly fathers' death resulted in less outcome in class attendance.

Table 17 : Problems Related to Teaching - Learning Process and Follow up of Caretakers

	Yes		Sometimes		No		Total	
	N	%	N	%	N	%	N	%
• Are their problems, which you are facing, *in the teaching-learning process?* (AIDS orphaned Response)	94	48.5	_	_	100	51.5	194	100.0
• Do you follow up the teaching-learning process of your adopted child (ren)? (Caretakers Response)	86	71.7	28	23.3	6	5.0	120	100.0

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In Table 17 above, two interrelated items were posed to AIDS orphaned children and caretakers. The first item was intended to investigate whether or not AIDS orphaned children have been facing problems in the teaching - learning process. As a result, 94 (48.5%) of them explained that there are problems, which they are currently facing. On the other hand, 100 (51.5%) were reported that there is no problem in the teaching -learning process.

Those who responded by saying 'yes' justified their reasons. Some of the problems they were facing include isolation, lack of proper food (going to school with empty stomach) and educational materials, difficulty in understanding some of the contents in certain subjects due to frequent absenteeism from classes, insult by classmates, confusion and hopelessness, forgetfulness and problems related to acquiring uniforms on time. In a focus group discussion,

participants reported that leave alone school age children, in some cases even teachers and vice directors do not understand the problems of AIDS orphans and threw them disguising words.

The second question was directed to caretakers of AIDS orphaned children. Of the total 120 respondents, 86 (71.7%) reported that they frequently follow the education of their adopted children. In a smaller percentage, i.e.28 (23.3%) make an occasional follow up, and 6 (5.%) responded that they do not make any sort of assessment regarding the education of AIDS orphaned children.

From the above table we can conclude that half of the AIDS orphaned children believed that they are facing problems in the teaching - learning process, and the remaining half not. Majority of the caretakers follow up on the students learning. Students (AIDS orphaned children) were requested to explain the classroom behaviors they are manifesting. The next table will show up the diverse classroom behaviors of AIDS orphaned children.

Table 18: Classroom Behaviors of AIDS Orphaned Children

Possible classroom behaviors	What class room behaviors AIDS orphaned children manifested?	
	N	%
• Disturbing & talking	4	1.9
• Quarreling with classmates	24	11.2
• Doing class & Home works property	22	10.3
• Worry, depression & anxiety	66	30.8
• Inability to have complete educational materials	8	3.9
• Lateness	2	.9
• Attending classes actively	48	22.4
• Isolation	22	10.3
• Others	18	8.4
• Missing	14	--
Total	228	100.0

Regarding classroom behaviors of AIDS orphaned children, the responses of AIDS orphans distributed widely across different classroom behaviors. As shown from table 18, (30.8%) which was the highest response of AIDS orphaned children, explained their worriness,

CCRDA

depression and anxiety as their major classroom behaviors. The second highest response was the needs of orphans to follow classes actively, i.e. 22.4%. The rest of the responses were quarreling with classmates (11.2%), doing class & home works properly and isolation each consisted of (10.3%), inability to have complete educational materials (3.8%).

Therefore, we can conclude that except anxiety, worriness and depression, which achieved the highest percentage on classroom behaviors of AIDS orphaned children, the rest are behaviors commonly seen by children in every classroom. So, there are no significant behavior problems manifested by school age AIDS orphaned children.

The other explanation that was given by caretakers of AIDS orphaned children capitalizes the above conclusion. Though not presented in a table, one of the questionnaires item for caretakers was on the discipline of these children. Whether or not they were called on by directors or class teachers on disciplinary problems. In their response 34 caretakers or 27.9 percent reported their occasional visit to schools to discuss with Directors and schoolteachers. The misbehaviors committed by AIDS orphaned children were fighting with classmates, assignments and home works not completed and gradual decrement of test marks. The rest 88 care takers (72.1 percent) revealed that they were not called in the schools due to misdeeds of AIDS orphaned children. During the interview I had with some surviving parents and caretakers, they appreciated the behaviors of their children and the adopted ones.

Similarly, home behaviors of AIDS orphaned children and the relationship they have with the child (ren) of their caretakers were discussed. Due to death of their parents, orphans displayed behaviors like hot tempered and crying, anger and embarrassment, yearning, dreaming the deceased parent, especially the younger children expecting the died parent(s) to come again, loss of appetite, disturbed sleep, forgetfulness, fear of the surviving parent will die soon, etc,

Regarding conflict between AIDS orphaned children and children of the caretakers; an

CCRDA

item has been raised in the questionnaire distributed to the caretakers. Based on the response of caretakers none of them reported frequent clashes, 23.6% said that though there are conflicts but occurred on occasional basis and 76.4% reported the non-existence of conflict between or among children. Instead, caretakers reported conflict between AIDS orphans and themselves on different matters such as nature of dressings, having wrong friends, etc.

In this study the researcher also succeeded to make repeated observation on HIV carrier AIDS orphaned children institutionalized at Mother Terisa Children's Home located in Asseko, Addis Ababa. The orphanage inaugurated in 2003 to host children lost their parents to AIDS and they themselves are HIV carriers. A foreigner who has been working in the orphanage has a vice head noted how these children are disciplined and cared for one another.

Table 19 : Attitude of Age mates to wards AIDS Orphaned Children & Their Manifestations.

Item	Yes		No		missed	Total	
	N	%	N	%		N	%
Being you are an AIDS orphaned child, is there any negative influence of your class mates upon your education?	92	43.8	118	56.2	18	210	100

When we see the response of AIDS orphaned children as presented in Table 19, there existed a close relationship in their response to yes and no categories. From the total respondents N = 210, (43.8%) of them revealed the negative influence of age mates / class mates upon their education as a result of death of their parent(s) to AIDS. On the other hand, 56.2% responded saying the attitude of classmates have no negative effect in their education.

A similar question was raised to AIDS orphaned children to state the manifestation of their age mates attitudes. As a result, list of ideas were presented, of which kindness or light heartedness achieved first with 55.9%. The rest of the responses were negative, carrying 44.1%. To put it in an explicit why, 16.1% of them said that age mates throw ugly & insulting words, 14.0% reported considering them as hopeless, 10% of them revealed their

CCRDA

discrimination or alienation from any sort of interaction, and 3.2% reported their classmates' views as if AIDS orphaned children have no right or chance to be educated.

In an interview with caretakers and surviving mothers, and the focus group discussion to AIDS orphaned children, social discrimination reported as the major challenge which discolored the taste of life in general. They do not feel at ease with their interaction to the so-called 'normal'. It is also a big threat to the right of their children and themselves. The following table presents discrimination of AIDS orphaned children by the society they are living with.

Table 20: Societal Discrimination of AIDS Orphaned Children

Items	Yes		No		Some times		I am not sure		missed	Total	
	N	%	N	%	N	%	N	%		N	%
Do you have problem of being discriminated & pin pointed by the society you are living in? (Response of AIDS orphaned)	66	28.9	94	41.2	68	29.8	_	_		228	100.0
Is there any discrimination directed to AIDS orphaned child (ren) you are adopting from the society? (Care takers response)	62	49.2	38	30.2	_	_	26	20.6	2	126	100.0

Regarding the prevalence of discrimination directed to AIDS orphaned children from the society they are living in, AIDS orphaned children and their caretakers reported as follows. Of the total (N= 228) AIDS orphaned children replied to the item, 66 (28.9%) say ' yes', meaning they have been discriminated by the society in their own locality, 94 (41.2%) reported that they are not discriminated and the rest 68(29.8%) stated that people sometimes discriminated them from freely participating in social issues. If we add up the yes & sometimes

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responses, we would get 58.7% , which is the high percentage to indicate the existence of discrimination of any form in consistent and occasional basis directed to AIDS orphaned children by the society.

Similarly, the caretakers of AIDS orphaned children revealed the presence of discrimination. Of the total respondents (N = 126), 62 (49.2%) accepted the predominate occurrence of stigma upon AIDS orphans children. On the other hand, 38 (30.2%) reported these children were not discriminated. The last category, 26 (20.6%) of the respondents was not sure whether or not these children received negative social treatment. Any way surviving parents and caretakers generally believed the existence of stigma & discrimination in the social interaction of AIDS orphan children.

During interview with surviving parents, caretakers and AIDS orphaned children, the societal stigma & discrimination reported was so serious. As a result, due to fear of stigma, after the death of one parent and the other get tested and received the medical result, they never immediately go to the Associations formed by HIV carriers like Dawn of Hope & Mekedim. Even they do not identify their HIV status and get financial, material and medical support from local and international NGOs operating in their locality. But after they finished all their remnant financial capital and sold their ornaments, they bring their medical certificate to helping agencies. That was the point were they lost their personal strength to fear social stigma and discrimination.

As the counseling officer of Mekedim Ethiopia explained, initially when they came to the Association, surviving parent, and AIDS orphaned children were depressed. But gradually, when they get counseled, they feel relaxed and became assertive.

One worker from Mother Tirese Home for HIV / AIDS orphanage reported that, one of the major missions in opening this institution is stigma and discrimination directed upon HIV/AIDS orphans who themselves are HIV carriers. They lost their parents by AIDS and

CCRDA

they are also tested and proved positive for the virus. Therefore, no one feels comfortable to host these children.

When parents get sick for an extended period of time and died of AIDS, children remain subjected to social stigma. During interview a mother who is an HIV carrier reported how and when she knew her HIV status and the situation after wards. She had two daughters aged 11and 3. The first child was from the first husband and the second child from the nearly died third husband. Three of them died one after the other while living together in the marriage circle. When the third husband died she cried bitterly calling his name and the deceased the former two husbands. People who were in attendance of the funeral ceremony murmured and back bitted her. At that moment a friend came nearer to her ears and warned her not to mention the names of the former two husbands. It was the moment in which she became suspicious of her HIV status and tested HIV positive. The last husband was the member of the army force and they were living in Kality campus .The stigma from the people around started upon her and the two daughters. Finally she was forced to leave the campus and the husband proved to get no pension.

Table 21 . Availability of Free Time to AIDS Orphaned Children to do School Tasks

Items	Yes		No		I am not sure		missed	Total	
	N	%	N	%	N	%		N	%
• Do you have enough time to do school tasks such as home works, and study subjects? (AIDS orphans response)	128	65.9	66	34.1	-	-	--	194	100.00
• Do your adopted child (ren) have enough time to do school tasks? (care takers response)	78	72.2	20	18.5	10	9.3	11	108	100.0

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Two interrelated items were presented in table 21, which emphasized the availability of free time to AIDS orphaned children to study. The first question was forwarded to AIDS orphaned children. Based on their response (N=194), 65.9 % reported as having ample time to do school tasks, where as 34.1% responded that they have difficulty to get free time to study and do school tasks.

The second question dealt with the attitude of caretakers to wards students' available free time to study. The question coined in a way that if AIDS orphaned children participated in income generating activities, did they have enough time to do school tasks? From the total response of caretakers for this item (N=108), 72.2% reported that AIDS orphaned children have enough time to do school tasks. On the other hand, 18.5% explained lack of time due to their involvement in income generating activities like shoe polishing, selling Kolo, sugar cane, chewing gum, and daily laboring, and the rest 9.3 % indicated their uncertainty to make judgment.

Regarding AIDS orphaned children's involvement in income generating activities, there were items raised to both orphans & their caretakers. A very limited number of children engaged in moneymaking activities, but most of them received minimal income. However, if they are organized and credit scheme is laid, they will be at least self- supportive.

In an interview with an expert from HIV/ AIDS Prevention and Control Office (HAPCO), HIV/ AIDS carriers were organized and credit was given to them to generate their own income. The program was not carefully studied and profit-making activities properly identified. Therefore, the participants failed to get sufficient income. One of the major problem was the stigma directed to HIV/AIDS victims. Most of them make bread and injera' for sale. But once their HIV/ AIDS status is known no body becomes willing to buy and use these items. However, as the expert revealed especially for AIDS orphaned children, well-studied and properly organized Credit scheme will have an advantage. Because support from

CCRDA

World Bank and other international organization will never be long lasting. From the above table we can conclude that AIDS orphaned children have no problem of time to study & do their home works or school tasks in general.

Table 22: The Needs of AIDS Orphaned Children to Learn

Items	Very high		High		Medium		Low		Very Low		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
What is your need to wards learning? (AIDS Orphans Response)	130	57	46	20.0	40	17.5	6	2.6	6	2.6	228	100
What is the needs of AIDS orphaned child (ren) you are adopting for learning?(care takers Response)	90	70.3	20	15.6	18	14.1	-	-	-	-	128	100

Regarding the need to learn of AIDS orphaned children, two items have been raised to AIDS orphaned children and their caretakers. The items were designed in a scale having five parts from very high to very low. Based on that, the responses given by both parties were analyzed. Of the total respondent AIDS orphaned children (N=228), 57% reported as having very high need to learn, 20.2% high need, 17.5% of them have medium need, 2.6% low & 2.6% very low need. If we add up the very high and high response categories, we will get 77.2%, which shows the positive need of AIDS orphaned children to learn.

Caretakers were also requested to express their observations as to the needs of AIDS orphaned children to learn. From the total respondents (N=128),70.3% indicated a very high need of AIDS orphaned children to learn. The rest 15.6% reported a high need and 14.1% medium need. In the caretakers response there was no student who labeled as having low and very low needs to learn.

From the AIDS orphaned children and caretaker's response, we can conclude that despite all the challenges and problems they have related to the teaching learning process,

CCRDA

AIDS orphaned children generally have positive needs to learn. This implies how AIDS orphaned children are easy to be educated & bring a significant change in their life.

The correlation co-efficient, of the need to learn and the value AIDS orphaned children to education was computed. Based on that (r = 0.96) achieved, which indicated a strong relationship between the two variables tested. The implication is that, those who have high need to learn also give high value of education.

An attempt has been made to assess which of the two sexes, i.e. boys or girls have a higher need to learn. The mean values of boys and girls were 4.51 and 4.11 respectively. In order to make further investigation, the one way analysis of variance calculated.

Table 23 Sex of AIDS Orphans and the Need to Learn

Source of variation	Sum of squares	df.	Mean squares	F	P
Between groups	8.5250	1	8.5250	8.6132	.0037
Within groups	223.6856	226	.9898		
Total	232.2105	227			

As the table revealed, (F(1,226) =8.6132, P <.05) there is a significant difference between the sex of AIDS orphans and the need to learn. This fact was also reflected in the mean difference of the two sexes. There fore, boys AIDS orphans have relatively higher need to learn compared to girls.

The calculated mean value for age category between 5-10 was 4.70 and for 11-14 age category it was 4.22. Which simply shows, AIDS orphaned children who are younger have a higher need to learn compared to the older age category. For further evaluation of the difference a one way analysis of variance calculated.

Table 24 Current Age of AIDS Orphans & the Need to Learn

Source of variation	Sum of squares	df.	Mean Squares	F	P
Between groups	4.1836	1	4.1836	4.1446	.0429
Within groups	228.0269	226	1.0090		
Total	232.2105	227			

As the table indicated, there is a significant difference between the current age of AIDS

CCRDA

orphans and the degree of their need to learns (F (1,226) = 4.1464, P < .05) level. Therefore, we can conclude that the younger age group has higher need to learn than the older age group AIDS orphaned children.

As discussed in the preceding pages, parental death status have been classified into three levels, i.e. mothers only, fathers only or both parents died. The other variable to be investigated was the need to learn, in the absence of mother, father or both parents to AIDS. The calculated mean values for mothers died, fathers died and both parents died were 3.75, 4.24 and 4.36 respectively. Form this one can say that mothers death resulted in lower need to learn followed by fathers death.

A one way analysis of variance calculated to make an in depth assessment of variables under discussion.

Table 25 The Need to Learn and Parental Death Status

Source of variation	Sum of squared	df.	Mean squares	F	P
Between groups	7.6104	2	3.805.2	3.8120	.0235
Within groups	224.6001	225	.9982		
Total	232.2105	227			

As F-value (F(2,225) = 3.8120, P < .05 there is a significant mean difference between parental death status and the need to learn by AIDS orphans. Maternal death affects the need to learn more compared to other death.

On the other hand, in my observation and discussion with vice center head of the Mother Tiresa Orphanage for AIDS orphaned children; I have been able to notice how even the carriers of the virus are enthusiastic to learn. In their leisure time, they discuss on academic issues such as multiplication table, analyzing the body parts of a human being using pictures, etc.

CCRDA

Table 26: Manifestations of AIDS Orphaned Children's Effort to Learn

Response of AIDS orphaned children	Manifestations of AIDS orphans need to learn	
	N	%
• Using program to study	44	20.0
• Interest to score good result	46	20.9
• Classroom participation (questioning & answering)	40	18.2
• Doing home works daily	22	10.0
• Using libraries in their free times	18	8.2
• Asking help from elder brother (s) and sister (s).	22	10.0
• Using program to study and classroom participation	20	9.1
• Class room participation and doing home works daily	8	3.6
Total	200	100

AIDS orphaned children were asked to indicate the factor(s), which show their needs to learn. Based on that, respondents selected the idea(s) which contributed to have positive interest to learn. From the total respondents (N=200) 20 %, reported their use of study programs, 20.9% have great need to score good results, 18.2% reported their classroom participations in asking & answering questions, 10% do their home works daily, 8.2% revealed their use of libraries in their free times, 10% were requested help from elder brother(s) and/ or sister(s), 9.1% use program to study and participate actively in classrooms and the rest 3.5% have good classroom participation and do home works regularly.

Of the major manifestations of AIDS orphaned children's needs to learn, using program to study, interest to score good result, and classroom participation in asking and answering questions constituted 59.1% . This generally showed the high needs of AIDS orphaned children to learn and the kind of effort they were making to achieve success in schools.

CCRDA

Table 27. AIDS Orphaned Children and Their Caretakers' Value to Education

Items	Very high		High		Medium		Low		Very Low		missed	Total	
	N	%	N	%	N	%	N	%	N	%		N	%
What value do you give to education? (AIDS orphaned children's response)	124	55.9	46	20.7	46	20.7	6	2.7	-	-	6	222	100
What is your attitude to words the value of education? (care takers response)	106	82.8	16	12.5	2	1.6	-	-	4	3.1	-	128	100

In order to get information about AIDS orphaned children and their caretakers' value to education, parallel questions were designed. Based on the total respondents, (N=222) , 55.9% AIDS orphaned children reported as having very high value to education compared to caretakers (N=128), responded very high value they give to education with 82.8%. On the other hand, 20.7% AIDS orphans and 12.5% caretakers reported their high value to education. Similarly, 20.7% AIDS orphans revealed that they have medium value to education compared to 1.6% response of caretakers. Finally, 2.7% AIDS orphans respond their low value to education and 3.1% caretakers indicated their very low value to education.

If we sum up the very high and high responses of AIDS orphans and caretakers, we would get 76.6%, and 95.3% respectively. From this one can conclude the positive and high value AIDS orphaned children and their caretakers give to education.

CCRDA

Table 28. The Reason(s) for Very High and High Values of AIDS Orphaned Children to Education.

What is / are the reason(s) for having high or very high value to education?	AIDS Orphans Response	
	N	%
• I believe that education will help me to be self supportive	58	39.2
• Since I am an AIDS orphaned Child the only chance I have for may future is education.	50	33.8
• Teachers' encouragement and thought to achieve success.	24	16.2
• High support from caretakers	16	10.8
Total	148	100.0

In Table 28 above AIDS orphaned children were asked to explain the reason (s) which attributed to have very high or high value to education. Among the alternatives listed in the questionnaire, (N=148),39.2% reported that education will help them to be self - supportive, where as 33.8% considered education as the only choice for their future. Students stated that 16.2% had positive value to education due to teachers' encouragement and their own thought to be successful. The last group revealed that 10.8% developed positive attitude towards value to education as a result of caretakers support. These responses generally implied how AIDS orphaned children perceived the value to education.

Those who responded their value to education as low and very low also noted their reasons. Some said that lack of support to complete their education and poor achievement scores received in school subjects resulted in low value to education.

During an interview with AIDS orphaned children and caretakers including surviving parents, the value these children give to education and the reasons for high or low values to education have been raised. In their explanation some children are very much fearful of losing the surviving parent and forced to dropout of school. While thinking this way they loose appetite to education. Even those who have been cared for by relatives and non- relative adopters are not confident enough in the sustainability of the care and support. In addition, the stigma& discrimination directed to AIDS orphaned children either from their peers or the

CCRDA

society at large resulted in negative value to education.

The value boys & girls AIDS orphaned children give to education has been examined. As the calculated mean values indicated, boys scored 4.56 compared to girls 4.13. A one way analysis of variance run to assertain whether or not there exists a significant difference in the value the two sexes give to education.

Table 29 Sex of AIDS Orphans & Value to Education

Source of variation	sum of squares	df	Mean squares	F	P
Between groups	9.5514	1	9.5514	12.7486	.0004
Within groups	164.8269	220	.7492		
Total	174.3784	221			

The difference observed in the mean values of boys and girls as to how they value education was also reflected in the result of a one way analysis of variance. Therefore, ($F(1,220) = 12.7486$, $P < .05$) there existed a significant difference between boys & girls regarding their value to education. So boys AIDS orphans gave a higher value to education compared to girls AIDS orphans. This difference might be attributed to societal expectations, difference in responsibilities, etc.

A one way analysis of variance run to make valid judgment as to the relationship between current ages of AIDS orphaned children and the value they give to education.

Table 30 Current Ages of AIDS Orphans & Value to Education

Source of variation	Sum of squares	df.	Mean squares	F	P
Between groups	3.5645	1	3.5645	4.5909	.0332
Within groups	170.8139	220	.7764		
Total	174.3784	221			

From the table above, ($F(1,220) = 4.5909$, $P < .05$) there exists a statistically significant difference between current ages of AIDS orphaned children and the value they give to education. As the mean values revealed children in the age ranges between 5 -10 years achieved 4.70 compared to 11-14 year categories with the mean value of 4.26. Therefore, the younger age group have higher value to education unlike the older age category.

CCRDA

A one way analysis of variance was calculated to see whether there is a significant difference or not between variables under study, i.e. value to education & parental death status.

Table 31 Value to Education & Parental Death Status

Source of variation	Sum of Squares	df.	Mean Squares	F	D
Between groups	6.2874	2	3.1437	4.0658	.0179
Within groups	168.0910	219	.7675		
Total	174.3784	221			

As the table shown ($F(2,219) = 4.0958$, $P < .05$) level there is a significant difference between parental death to AIDS the value AIDS orphans give to education. The mean value calculated for those who lost their mothers only was 3.83, for those who lost their fathers only was 4.28 and for those who lost both parents was 4.38. This finding supplements the result of a one way analysis of variance. Maternal orphans gave low value to education compared to those who lost their fathers and both parent to AIDS.

Table 32: AIDS Orphaned Children's Motivation to Learn

Items	Very high		High		Medium		Low		Very Low		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
What is your motivation to learn? (AIDS orphaned response)	120	52.6	58	25.4	44	19.3	-	-	6	2.6	228	100.0

Regarding AIDS orphaned children's motivation to learn, an item has been raised in the questionnaire having five categories ranging from very high to very low. Respondents gave their response to this item. Therefore, from the total respondents (N=228), 52.6% were reported as having very high motivation to learn, 25.4% high motivation, 19.3% medium and 2.6% very low motivation to learn. The sum of responses of AIDS orphaned children to very high and high categories, gave as 78.0% . This really implied good motivation of AIDS orphaned children to learn.

CCRDA

Table 33: Parental Death and its Impact on the Motivation of AIDS Orphaned Children

Items	Yes		No		I am not sure		missed	Total	
	N	&	N	%	N	%		N	%
• Did your parent's death affect your motivation to learn? (Response of AIDS orphans)	142	63.4	44	19.6	38	17.0	4	224	100
• Do you think that the death of parent (s) affect the motivation of AIDS orphaned children to learn? (Caretakers response)	46	36.5	60	47.6	20	15.9	2	126	100.0

In order to evaluate the impact of parental death on motivational state of AIDS orphans an item has been raised. As they responded, from the total (N = 224), 63.4% explained that their parental death affected their motivation to learn. Contrary to this, 19.6% responded their parental death to AIDS have no negative impact on their motivation to learn. The rest, 17% were not sure of their parental death and its impact on their motivation to learn.

The caretakers' responses were quite the opposite of AIDS orphans response. To caretakers, of the total (N = 126), 36.5% responded that parental death of AIDS orphans affected their motivation to learn. On the other hand, 47.6% responded that parental death of orphans had no negative effect and lastly, 15.9% were not sure whether the death of parent(s) of AIDS orphans had no positive or negative effect on the motivation to learn.

The views of AIDS orphans were substantiated by their response during focus group discussion. In the discussion, children revealed internal & external problems they are facing in, partly in their relationship with their caretakers and partly from peers and the society at large, which gradually eroded their motivation to learn.

The Chi square test is done to find whether or not parental death to AIDS has an impact on the motivation of AIDS orphaned children to learn. Therefore, (x^2 = 10.39593; df = 2; .00553 < 0.05), and we can say that there is a significant difference between parental death to

CCRDA

AIDS and motivation of AIDS orphaned children to learn.

Table 34 Degree of Motivation of AIDS Orphaned Children Vs Parental Death Status.

Source of variations	Sum of squares	df.	Mean squares	F	P
Between groups	18.8294	2	9.4147	11.4865	.0000
Within groups	184.4162	225	.8196		
Total	203.2456	227			

As the table shows, ($F(2,225) = 11.4865$, $P < .05$) there is a significant mean deference between motivation of AIDS orphans to learn and parental death status. When we see the mean value for those who lost their mothers only, is 3.42, and the standard deviation of 1.472. This implies above average motivational level of AIDS orphans to learn. Lastly, for those who lost both parents to AIDS the mean value is 4.36 which shows the high motivation to learn. Therefore, we can conclude that maternal death affects the motivation of AIDS orphans children more compared to the death of a father or the death of both parents.

Using one way analysis of variance, the motivational state of AIDS orphaned children has been compared to their current age level. Students who filled the questionnaire were classified into two age categories, those from age 5-10 and 11-14 year olds.

Table 35: Motivation to Learn & Current Ages of AIDS Orphaned Children

Source of variation	Sum of squares	df.	mean squares	F	P
Between groups	12.1879	1	12.1879	14.4170	.0002
Within groups	191.0577	226	.8454		
Total	203.2456	227			

As the table depicted, ($F(1,226) = 14.4170$, $P < .05$) the one way analysis variance resulted a significant difference between the current age of AIDS orphans and the degree of motivation to learn. The mean value for children with age ranges from 5-10, was 5.00 which assumed to be the maximum value and indicated the very high motivation to learn compared to the second age groups, 11-14 year olds with the mean value of 4.18. Therefore, from this we can conclude that the younger age group AIDS orphaned children are highly motivated compared to the older ones.

ECRDA

Table 36: Factors contributed to High Motivation of AIDS Orphaned Children to Learn

Alternatives	What are the factors that contributed to have high motivation to learn?	
	N	%
• Consistent believe to achieve success (Inner strength)	62	27.4
• What I learnt from the failure of parents as grown up child	62	27.4
• From successful individuals in my 1ocality who achieve progress	22	9.7
• Encouragement from teachers and caretakers	40	17.7
• Repeated high scores achieved in school	18	8.0
• Inner strength, parental & teachers support	10	4.4
• Inner strength, parental & teachers support and model of others	6	2.7
• Missing case	2	--
Total	228	100.0

AIDS orphaned children were requested to report those factors, which contributed more to their motivation to learn. Of the alternatives, at least some of them chosen repeatedly. From the total respondents (N=226), 27.4% reported their consistent believe to achieve success or inner strength as factor for motivation. On the other hand, 27.4% reveled that lesson learnt from failure of parents as grown up child was another source of high motivation to learn. Encouragement and support from teachers and caretakers carry 17.7% of the response. Though very minor, the rest of the alternatives also selected by respondents. What can be concluded from the above table is that, diverse factors played a role for AIDS orphaned children to have high motivation to learn.

Table 37: School Achievement of AIDS orphaned children

Items	Very high		High		Medium		Low		Very Low		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
How do you evaluate your achievement scores in the course of your school life?	64	28.0	74	32.5	70	30.7	12	5.3	8	3.5	228	100.0

As presented in Table 37, the school achievement scores of AIDS orphaned children

CCRDA

range from very high to very low, but the responses declined when you move down from medium to low& very low. To put it in an explicit way, of the total (N= 228) respondents 28% reported as having very high school achievement scores in the course of their school life, 32.5% revealed that their scores were high and 30.70% stated a medium score achieved in their school life. However, this classification of achievement scores relied on subjective judgments of students. Since students participated in this study came from diverse schools in Addis Ababa, it was very difficult to get access to school marks. Therefore, the validity of their response may be questioned. On the other hand, AIDS orphaned children were requested to indicate the ranks achieved during 2001 / 2002 1st , & 2nd semesters and 2002/2003 Academic year first semester. Students are at different grade levels and the number of children in each class is different. Therefore, it is difficult to make comparison across all the sampled children.

Similarly both AIDS orphaned children and their caretakers were asked to make judgment as to when the scores of AIDS orphans were better.

Table 38: Academic Scores of AIDS Orphaned Children

Alternative	When were your academic scores better? (Orphaned children)		When were the academic scores of AIDS orphaned children high? (Caretakers)	
	N	%	N	%
• After my parents death	26	11.8	4	3.4
• When my parents were alive	110	50	42	35.6
• No change in my academic scores before and after my parents death	66	30	8	6.9
• Though there are improvements in some subjects generally my scores poor at present	10	4.5	26	22
• Due to my caretakers support I become clever now	8	3.6	20	16.9
• Others	0	0	18	15.2
• Missing cases	8	-	10	-
Total	228	100.0	128	100.0

Two items were raised to AIDS orphaned children and their caretakers regarding as to when the academic achievements of AIDS orphans higher. Of the total respondent AIDS

CCRDA

orphans (N=220), 11.8% reported that their scores were better after the death of parents, 50% revealed that they achieved good scores when they were living with parents, 30% explained no change in their academic scores before & after the death of parents . At the bottom of the list, 4.5% explained that though they scored high marks in some subjects, the overall results were considered to be low at present. 3.6% of AIDS orphaned children indicated their positive achievements due to support received from the caretakers.

On the other hand, the caretakers' response for the same item analyzed here after. From the total respondents (N=118), 3.4% indicated the scores of AIDS orphaned children were better after their parents' death. 35.6 % registered high scores when their parents were alive. From the table, 6.8% explained that there was no change in the scores of AIDS orphaned children before and after the death of parents, 22.0% stated despite success achieved in some subjects, AIDS orphans scored low scores in school subjects currently. 16.9 % AIDS orphans reported that due to support received from caretakers they succeeded to score good results. The last alternative in the questionnaire was an open ended type which allowed care takers to express their views which is different from the list of alternatives. 15.2% of the caretakers indicated that the support given from tutors during Saturday & Sunday improved their scores; while others replied the difficulty they had since some of the students dropped out of school and difficult to compare their scores.

Generally, we can conclude that majority of the AIDS orphaned children and caretakers revealed the academic scores of AIDS orphans were better when they were living with their parents.

CCRDA

Table 39: Availability of Educational Materials, Food & Medicine

Item	Yes		Partially		No		missed	Total	
	N	%	N	%	N	%	N	N	%
Do you have problems in getting educational materials, food and medicine? (AIDS orphans response)	104	46.0	64	28.3	58	25.7	2	226	100.0

AIDS orphaned children were requested whether or not they have problems to get educational materials and others necessary for survival such as food, and medicine. Based on their response, of the total respondents (N=226), 46% indicated that they have problems to get educational materials, food and medicine. Others, 28.3% reported the partial fulfillment of the stated elements, and the rest 25.7% explained that they have no problem of securing educational and materials related to their survival. Therefore, from table 39 above, we can conclude that AIDS orphaned children have problems to get educational materials, food and medicine which are essential to progress in their education and stay alive.

While collecting data for this study I have been able to observe and interview AIDS orphans, surviving parent, and caretakers. When Mekedim Ethiopia and Dawn of Hope were distributing wheat and food oil, I was there all through the weeks searching for volunteers who could fill the questionnaire and willing to be interviewed. One thing, which I noticed was that, the amount of wheat & food oil distributed in these two Associations for HIV carriers, AIDS patients and orphans were different. Dawn of Hope distributed 100kg of wheat and 4 liters of food oil per month where as Mekedim 15-20kg of wheat and 1 liter of food oil. On the other hand, both Mekedim and Dawn of Hope allocated money for medicine. In an interview I had with the Addis Ababa branch Dawn of Hope president, each and every HIV/AIDS Victim has the right to use up to 400 birr to buy medicine per month, if he/she produced a valid prescription from government Hospitals. Similarly, Hiwot Ethiopia, Mekedim Ethiopia, Dawn of Hope and Tesfa Berhan supported AIDS orphaned children by providing uniforms, pay

CCRDA

school fees, and purchase educational materials such as books, exercise books, pens & pencils. But AIDS orphans reported that the supply of these educational materials were not sufficient.

In an interview I had with expert from HAPCO and Ministry of Labor and Social Affairs, especially with the Head of Children, Youth and Family Affairs Department, and panel head of Addis Ababa HIV/AIDS prevention & control office regarding the lack of uniformity in materials distributed to infected and affected individuals, both agreed that there existed a problem in having uniform support. But they noted that some NGOs and Associations are active in preparing good projects so that they can get support from different sources and distribute something better to the users or members. The Head of Children, Youth and Family Affairs Department (MOLSA) said so far we have no HIV/AIDS orphan care policy. But there is an orphan care guideline and orphans task force, which is not yet mandated by the government. He explained the debate among professionals in the field. Some supporting the need to have an HIV/AIDS orphans policy to address the specific needs of these children, while others forwarded there views that producing an HIV/AIDS orphan policy aggravate the stigma & discrimination. Still others take an arbitrary position by saying that let's have a child policy; within it the specific problems of children will be addressed. There are also professional who oppose the need to produce a new policy. These groups claimed that in developmental Social Welfare Policy children under difficult circumstances and the need to support them was stated. Therefore, based on that policy statement detailed guideline can be prepared and support be given to the needy. As a final point, he agreed to have a guideline for NGOs and Associations working with HIV/AIDS victims and the affected family to have a uniform support system. Concluding his response one thing he mentioned was that, an NGO Desk has been set up in MOLSA Addis Ababa branch that will develop a guideline for NGOs to organize a uniform care and support mechanisms including strict follow up of their activities.

CCRDA

Table 40: The Feelings of AIDS Orphaned Children on the Care & Support They Received

Items	Yes		No		Sometimes		Total	
	N	%	N	%	N	%	N	%
• Do you feel confident and relaxed for having caretakers?	88	38.6	140	61.4	_	_	228	100.0
• Do you think that you have problems in getting love, care, support and advice?	84	35.8	70	30.7	74	32.5	228	100.0
• Do you feel suspicious or anxious of having an HIV virus?	38	16.7	112	49.1	78	34.2	228	100.0

Very closely related items have been presented in table 40. The first item was in connection with the feelings of AIDS orphaned children on the care and protection they received from caretakers. From the total respondents (N= 228) , 38.6% reported that they feel relaxed and confident for having some one who cared for them. On the other hand, 61.4% explained their fear and lack of confidence regarding the care and support they have been receiving from the caretakers. In an interview with AIDS orphaned children, their caretakers and surviving parent, supportive ideas have been acquired. AIDS orphaned children reported occasional conflict with caretakers and they are afraid of losing their support. Besides, AIDS orphaned children living with surviving parent (i,e mother or father) are highly anxious of their health status and loose of their support. When their parent frequently felt sick, they became embarrassed. Therefore, we can conclude that majority of the AIDS orphaned children were not confident and feel relaxed on the care and support they received.

Regarding whether or not AIDS orphaned children have problems in getting love, care, support and advice, responses were presented in the table above. Of the total (N = 228) respondents, 36. 8% reported that they have problems to get Psychological support like love, care, support and advice. On the other hand, 30.7% explained that they have no problem of getting love, care, support and advice. The last category i.e. 32.5% reported the occasional occurrence of the problems in getting love, care, support and advice. If we add up the "yes" and

CCRDA

"sometimes" responses, we will get 69.3%.During focus group discussion AIDS orphaned children stressed the problem of psychological support from their caretakers. Therefore, one can conclude that majority of AIDS orphaned children perceive lack of psychological support on consistent and occasional bases. As discussed with the social worker of Mekedim Ethiopia, president of Dawn of Hope and social worker of Hiwot Ethiopia, the major emphasis and support given to AIDS orphans and the infected HIV / AIDS patients was more of material, financial and medical. The psychological care and support is highly forgotten. Even those assigned to give psychological support are busy working on other issues and the affected and the infected are consistently demanding material, financial and medical support but not of the psychological support.

The other issue raised in table 40 was about the suspicion & anxiety AIDS orphaned children have being infected by an HIV virus. From the total respondents (N = 228), 16.7% indicated that they are fearful of contracting the virus. Where as, 49.1% reported since they are grown ups, and most of them do not yet started sex, which is the major source of contracting the HIV virus, they never feel frustrated and anxious of being infected by the virus. The last category or group of children, i.e 34.2% occasionally felt that they might contract the virus from the deceased parent (s). In actual sense the sampled children for this study were in an HIV/AIDS free age. Therefore, despite fear and suspicion of contracting the virus through other means, the age was considered as the best moment to produce an HIV/AIDS free generation. Most of our sampled children noticed the sufferings of their parents to AIDS and no need of teaching about HIV and AIDS. Because they learnt a lot from experience while taking care of their sick parents.

CCRDA

Table 41 : Problems Faced to AIDS Orphaned Children

Items	Yes		No		I am not sure		Total	
	N	%	N	%	N	%	N	%
• Did you know AIDS orphaned children in your kebele who forced to lead life in the street devoid of caretakers? (caretakers response)	54	42.2	66	51.6	8	6.2	128	100
• There are sayings that AIDS orphaned children are forced to dropout of school, labour exploitation, specially girls exposed to rape, abduction & engaged in prostitution . Do you think that these problems are really reflected up on children in your locality? (caretakers response)	98	76.6	12	9.4	18	14.0	128	100

Table 41 include two items posed to caretakers of AIDS orphaned children. For the first question 42.2% of the caretakers responded that there children whom they knew due to lack of supporters either from the members of an extended family or others in their locality and forced to lead life on the street. The other responses were those who say no with 51.6%. These respondents did not know for sure that the death of people in their locality attributed to AIDS and family disorganization which followed be blamed for it. The last 6.2% of the respondents revealed their uncertainty to respond to the question raised.

During an interview with caretakers and surviving parents, they explained cases where due to death of mothers to AIDS how family structure became shocked and grown-ups suffered from depression and anxiety. They reported how the psychological effects of separation to death so great for very young kids. On the other hand, father's death to AIDS mostly reported in its economic impact. In this case when the family income deteriorated, grown ups would be forced to go out on the street in search of money either through begging or, participating in

CCRDA

different form of income generating activities.

Head of Children, Youth and Family Affairs Department in Ministry of Labor & Social Affairs noted how the number of street children increased year after year. In his sayings it is due to partly parental death to AIDS and inability of extended family to absorb these grown up kids. MOLSA has developed Alterative childcare guidelines to show interested NGOs and those working in child care activities to apply in the carrying process. He further elaborated that community- based childcare support programs, child - family reunification, foster family care, adoption and child care institutions are the alternative included in the guidelines. But he explained community based childcare and support as the first choice and cost effective and institutionalization as the last resort and too costly. From the point of view of psychological and social advantages to grown up children, community - based childcare support program need to be strengthen by building the capacity of the society or community.

The second item treated in the table was about the extent to which AIDS orphaned children forced to drop out of school, and labor exploitation, especially girls exposed to sexual abuses and engage in prostitutions. Respondents were requested to judge the validity of the statement. Based on that, from the total (N= 128) respondents, 76.6% approved the idea that AIDS orphaned children like the case in other countries exposed to different forms of exploitation. On the other hand, 9.4% opposed the proposition to be true and valid, and the rest 14% were not sure of supporting or rejecting the idea. From the responses of caretakers, we can conclude that majority of the respondents believed that AIDS orphaned children are exposed to inappropriate treatment and different forms of exploitation.

In an interview with Addis Ababa city administration education Bureau, coordinator of co -curricular activities explained that with the support from UNICEF nearly 1000 street children have been taught different life skill trainings. He further noted that Reproductive and Anti - AIDS clubs have been established nearly all the schools in Addis Ababa. Using mini -

CCRDA

media programs, an awareness creation about HIV /AIDS causes, means of transmission, etc are prepared & passed to students on a regular bases. Despite all these efforts to increase the awareness of students about HIV /AIDS the behavioral changes to abstain from sex will never decrease. He added that in a base line study conducted in two consecutive years within the same schools, and the same age population, sexual practices increase from 27% to 34%.

Based on the report of 2002 (1994 E.C), nearly 28, 000 students failed and dropped out of schools in Addis Ababa. Though we did not have the statistics, which indicate the drop out of AIDS orphaned children, undoubtedly; some of the dropouts were AIDS orphans. In order to know the impact of HIV /AIDS on the education of AIDS orphaned children, properly organized data is essential. Right from the school levels high up to the Ministry of Education, channeling proper information regarding drop out rate of AIDS orphans ought to be mandatory. This data collection & information flow should include the mortality or death rate of teachers.

In order to evaluate the self-efficacy and self-esteem of AIDS orphaned children two scales with 10 items each were developed and adapted. The self-efficacy scale has 5 levels, where as self-esteem scale was with four levels. The maximum mean value for self-efficacy scale is fire and for self-esteem it is four. Using the SPSS program the calculated mean value of Self-efficacy was 3.598, which showed above average and positive self-efficacy of AIDS orphaned children. On the other hand, the mean value for self-esteem scale was 3.584, which indicated the high self-esteem of AIDS orphans. Based on the mean values of the scales, we can conclude that AIDS orphans have higher self-esteem compared to self-efficacy.

CCRDA

CHAPTER FIVE

Summary, Discussions, Conclusions & Recommendations

5.1 Summary & Discussions

At the beginning of this work, five basic questions were raised to be investigated thoroughly. To refresh the memory of the reader the questions are listed below once again.

1. How are AIDS orphans in Addis Ababa are being taken care of?
2. Do AIDS orphaned children succeed in attending school? If so, what forms of classroom behaviors are they manifesting?
3. What kind of educational efforts do AIDS orphaned children make to achieve success in school?
4. What level of motivations, needs and values AIDS orphan children have to learn? Do AIDS orphaned children have positive self-image upon themselves?
5. Are there differences (e.g., in sex, age, parental death status the care and protection received, schooling and motivations to learn) among AIDS orphan children of different background?

Using convenient, and purposive sampling methods, AIDS orphaned children, caretakers, and key informants from concerned Ministries, Associations of HIV carriers and NGO were selected for the study. A total of 406 individuals took part in the study and their views were taken using two types of questionnaires, interview, focus group discussion and observation.

As the findings of the study indicate 37.7% of the AIDS orphans are boys and 62.3% girls. Similarly, 26.6% of the caretakers are males and 73.4% are females. We can, therefore, conclude from this that the majority of the participants in the study are girls and women. Studies conducted in the area of HIV/AIDS consistently report that girls and women are, in one

CCRDA

way or another, the victims of the problem. In 1997 a brief study conducted in Southern Africa showed that 95% of the pregnant girls under 15 years of age were HIV-infected (UNICEF, 1998). The results of another study conducted in major urban areas of Eastern and Southern Africa have shown that 17 to 22 percent of girls aged 15-19 are HIV infected, a very high prevalence when compared 3 to 7 percent of boys of similar age (UNICEF, UNAIDS & World Bank, 2002). Katahoire (1993, in IIEP, 1993), states that due to the increasing number of AIDS patients, mainly girls are required to take turn at home nursing the sick and to render help out on the farm. These and similar other studies affirm the reason why more girls and women are likely to be represented in such a study.

Regarding the age at which AIDS orphaned children lose one or both parents to AIDS and their current ages, differences have been observed in the responses of caretakers and the orphans themselves. As stated by the caretakers 32.8%, 64.1% and 3.1% of AIDS orphans were below 5years, 5 - 10 years and 11-14 years respectively when they lost their parents. With respect to the current age levels, caretakers reported that 3.1%, 57.8% and 39.1% are below 5 years, 5-10years and 11-14 years respectively.

On the other hand, the response of AIDS orphans have shown that when they lost their parents to AIDS, 9.6%, 33.3% and 57.1% of them were below 5 years, 5-10 years and 11-14 years of age respectively. Concerning their current ages, 8.8%, and 91.2% of them reported that they were in the age ranges of 5-10 years, and 11-14 years respectively. If we take just one case for comparison the response on the age range of 11- 14 years, we find that the 39.1% of caretakers and 91.2% of AIDS orphans themselves differ a great deal. What this difference confirms is the fact that such variation can only be attributed to the absence of birth registration systems.

As estimated by UNAIDS (2002), more than 13 million children who have lost one or both parents to AIDS were under 15 years of age, and most of these, in Sub-Sahara Africa. The

CCRDA

report has further noted that, in Ethiopia, 3.8 million orphaned children exist of which 1 million of them are AIDS orphans. This represents 26% of the total orphan population. By 2010, it is projected that 43% of orphans will be AIDS orphans.

The targeted AIDS orphaned children were requested to identify their lost parent(s) to AIDS. 10.5% of them reported that they lost only their mothers, 25.4% of them, their fathers; and 64% of them, both parents. This finding seems contrary to popular expectation since mothers are considered as vulnerable to the HIV/AIDS infections due to different reasons. If we take the UNAIDS (2002) report, of the total adult death rate in 2002, i.e. 2.5 million, nearly 50% of them, i.e. 1.2 million were women. In another study, (Gachuhi, 1999), females 15-24 are mostly affected by HIV/AIDS. In any case other studies in this area may iron out why such discrepancies occur in the rate of deaths between males and females. However, one fundamental fact that has been revealed by this study is that, the majority of the AIDS orphans, i.e., 64%, is double orphaned (lost both parents to AIDS).

Concerning the age and educational background of the caretakers themselves, this paper has found out that 26.8% of them were in grades 4-6, while the majority of them, i.e. 54.7% completed grades 7-10; and, 18.7% were in grades 11-12. There were also caretakers who cannot read and write but that participated in the interview. Another line of investigation that this study looked into was the age of caretakers. Based on the response of caretakers, 43.7% of them were in the age range of 20-30 years, followed by 23.5% of 31-40years categories. Those who have been taking care of AIDS orphans, and having an age above 40 consisted of 28.1%. The remaining 4.7% is for surviving parents and child headed families.

Another item in the questionnaire was a point related to the question who supported the AIDS orphans soon after their parents' death. This question was raised to both AIDS orphaned children and their caretakers. The response of the AIDS orphans, was that some of them have been reared by their elder brothers (14.0%); some by elder sisters (7.9%); some by

CCRDA

Uncles (7.9%); some by Aunts (6.1%); and some others by Grandparents (18.4%). The overall sum shows that 54.3% of AIDS orphans are being taken care of by an extended family. Similarly, Caretakers were requested to tell the blood tie they had with the AIDS orphaned children. The response was that 4.7%, 39.0% and 23.4% was brother's child, sister's child and grandchild respectively. Some AIDS orphans, 3.5% stated that they were reared by neighbors, while some caretakers 1.6% indicated that they brought up their neighbors' children. Again this shows that a cumulative percentage of 67.1% bring up children of their own relatives. These findings generally indicate that more than half of AIDS orphans are being supported by the extended families.

The Zambian Ministry of Health (2000), reveals the extent to which extended families are trying to cope up with the growing numbers. It confirms that some orphans, even those in the early teens, are heading households.

In a report on AIDS in Addis Ababa (1999), a similar views was presented which said that in major urban cites like Addis Ababa, the traditional family structures are not so strong as are those in the countryside to support AIDS orphans. There is a grain of truth in this statement, but still more than half of the AIDS orphans in Addis Ababa have been cared for by the extended families.

The monthly income of caretakers and the income generated by the AIDS orphan themselves were other two issues presented in the questionnaire, interview & focus group discussion. The findings supplement one another as the figures indicate here. Firstly, 45.9% of caretakers, say that they have no monthly income; 19.7% of them say that they earn less than 50 birr per month; 27.9% of them receive 50-100 birr, and only 6.6 % of them have a monthly income between 100-500 birr. Secondly; very few orphaned are children involved in income generating activities (only 18.5%) however, the income generated by these orphans is very minimal to support the family.

CCRDA

Mc Kerrow (1996) states that the socio-economic status of most AIDS orphan families is characterized by high illiteracy rate of heads of households, low family income, and lack of availability of facilities, which are features of poverty. What this study confirms is this very fact.

Another study (Ankrah, 1993in Lie, 1996), indicates that AIDS epidemic is a new kind of stress factor that has caused both psychosocial and economic challenges to numerous families. He adds saying that AIDS, in several cases, has disturbed the capacity of the nuclear & extended families to respond to the needs of members affected by HIV and AIDS. The outcome of the present research also reflects the same.

The AIDS Support Organization (TASO) in Uganda believes that AIDS orphaned children are best cared for within families rather than in orphanages. It also holds that if no relatives are available, every effort should be made to place the child with friends of the deceased parents. TASO helps clients to identify relatives or friends who can adopt their children after both parents have died. TASO also provides support to foster parents with food, clothing and money to enable them provide children orphaned by AIDS with these necessities and to help them get education or attend school (Action Aid, 1990).

In an alternative guideline developed by MOLSA, community based support system was taken as the first and cost effective mechanism for children who are orphaned and vulnerable to such risks.

A study in two regions of Zambia revealed that the status of AIDS orphan children in the communities was poor and that the ability of households to meet the basic needs of their members was very limited (Mc Kerrow, 1996 in a National Survey, 2003). A World Bank report, as quoted by UNAIDS (2001), the general linkages between AIDS and poverty were impact indicators that help to portray the effects of AIDS on poverty, which resulted in a decrease of growth rate of per capita income, an increase of the number of AIDS orphans, ... a

CCRDA

reduction in out put and cash income, a rise in the number of households with an AIDS death, and an increases in household out-of-pocket health spending.

In a National Survey on the prevalence and situations of AIDS orphaned children in Ethiopia (2003), low percentage of AIDS orphans, i.e. 16%, have been found to be, engaged in income generating activities. The present paper also show similar findings.

AIDS orphaned children and their caretakers were asked to indicate the kind of support they get and the source for it. Such support pertains to wheat, food oil and financial support. As to the source of such a support, Associations of HIV carriers, and local NGO were cited at first rate. Though the percentage is very low, schools, Kebeles and individuals have also played a role in supporting AIDS orphans. In Zambia, communities remain on the front line of providing care to orphans. NGO's, Community Based Organizations, churches and other volunteer organizations are making significant contributions in strengthening local communities. However, at present, they can provide assistance to only 7 percent of the needy (UNICEF, 1999).

As to the data gathered on whether or not the AIDS orphaned children are being reared together or separately, the majority of the AIDS orphans (61.0%) and almost all the caretakers (93.7%) responded that they grow together. Only less percentage, (21.0% of AIDS orphans & 6.3% of caretakers) noted that they were forced to live in separate homes of their relatives and go out to the street due to the inability of caretakers. As reported by caretakers during the interview, the younger the child at parental death, the easier it is for its adoption in a new parent structure.

An issue, which was considered critically and assumed to be fundamental for further discussion in this study was the family size and the number of AIDS orphans in the family. As the findings indicate, 15.6%, 65.6%, and 18.8% of the caretakers assured that they have less than 3, 3-6, and above 6 family members respectively. Pertaining to the number of AIDS

CCRDA

orphans in the family, 40.6%, 46.9% and 12.5% of caretakers claimed that they have been hosting less than 3, 3-6 and above 6 AIDS orphans respectively. Generally, we can conclude that 87.5% of the caretakers are forced to rear six and less number of AIDS orphans with very low income. Providing the basic facilities and education to this huge percentage of AIDS orphans is a real threat to the well being of the extended family.

In a study by (UNICEF, 1990), grand mothers who would normally count upon sons to provide for their old age are instead burying their adult offspring's and caring for seven, ten and thirteen parentless children with no means or little strength to do so. Similarly, young widows raise not only their own children without conjugal support, but also their late husbands' dead co-wives, facing thus dubious health and survival prospects of their own. The problem of how the extended family can continue to provide food, clothing, and educational expenses, not to mention love and affection, for all the extra children it has to absorve, may soon become the most important challenge in AIDS affected Africa.

A meeting organized by African Development Forum, here in Addis Ababa, from 3-7 December 2002 emphasized how much a burden AIDS orphans are to the extended family. Grand parents and other family members who take over the care of orphaned children also have difficulty in meeting school costs, since they give priority to their own children, or depend on orphan labor for survival.

A similar study carried out in four regions in Uganda revealed that families in which orphans reside are relatively large and the orphan load heavy. The study further affirmed that these families did not have much, with regard to household property, beyond the minimum for basic needs. Only very few have any assets of permanent value (Ministry of Labor and Social Affairs and UNICEF, 1993). Therefore, one bold confirmation we can make in relation to this is that, the current study surely capitalizes the studies that have been conducted in this area.

CCRDA

To examine the school enrollment rate of AIDS orphaned children, parallel questions were raised to both AIDS orphans and caretakers. The findings reveal that 85.1% of AIDS orphans and 77.8% of caretakers indicate that AIDS orphans are enrolled in schools. On the other hand, 14.9% and 22.2% AIDS orphans and caretakers respectively reported dropout. The school enrollment of AIDS orphans was assessed and the Chi-square result showed, ($F = 3.664$, $P = .057 > 0.05$) that there is no statistically significant difference between boys' and girls' school enrollment.

Generally, the school attendance of AIDS orphans is higher than expected compared to the prevalence rate of death through AIDS in the city. Moreover, school attendance is a major criterion to get support from Associations of HIV Carriers and NGOs. That seems to be the case why more AIDS orphans go to school than expected.

In a National survey on the prevalence of AIDS orphans in Ethiopia, (2003), the educational status of AIDS orphans was assessed, and the result showed that 93% of them were enrolled in Elementary schools at some point in their life. Though no statistically significant difference was observed, more non AIDS orphans (17.7%) than AIDS orphans (11.9%) dropped out school following their parents' death due to their inability to pay for school fees, school supplies and uniforms. With the point of stigma & discrimination in mind on one hand, and the result of this study on the other hand, one may question why more non-AIDS orphans' dropout of school than AIDS orphans.

In a study conducted in Rakai district of Uganda, the enrollment rate of primary school children decreased from 1534 in 1989 to 950 in 1993. The primary school dropout rate for the district in 1993 was 27 percent which is considerably higher than that of the National rate of 15 percent per year (Katahoire, 1991, in IIEP, 1993). This was attributed largely, not totally, to HIV/AIDS. Another study in Northern Tanzania found out that maternal orphans and children in households with adults' death delayed enrollment in primary schools, but most were not

CCRDA

likely to dropout of primary schools once enrolled (Aln Sowrth, Beegle, and Koda, 2001, in World Bank 2002).

A similar study conducted in Tanzania revealed that the overall enrollment rates in the previous twelve months were highest in urban areas, which also showed the highest proportion of enrolled students who were orphans. This is due to the fact that higher income families generally live in urban areas. These areas are also most infected by HIV/AIDS, which may explain the higher degree of orphan hood among students enrolled in primary schools in these areas (IIEP, 1993). The present study also shows that though parents die of AIDS, if they had money and property their children would continue schooling at least for sometime to come..

In Ethiopia, according to Education statistics, 27% of students dropped school before reaching grade two (Solomon W & Eyob Lemma, 2000). In an interview with Addis Ababa Education Buearu, Co-curricular activities co-coordinator, the writer of this paper found out that by 2001/2002, nearly 28,000 students failed exams and dropped schools in Addis Ababa. Even though, there is lack of accurate data as to how many students exactly dropped school for reasons of AIDS deaths of parents, undoubtedly some of them were victims of such a case.

As to the forms of schooling, AIDS orphan children are found to be attending schools thus. Some (90.7%) of them stated that they are in regular schools, either in government or private owned ones. And (9.3%) of them claim that they are attending night school programs. Some countries have devised strategies to educate AIDS orphans. For example, to increase access to the formal system, Malawi and Uganda have eliminated primary school enrollment fees (and this, for up to four children per household). In Zambia there is still levies fees & subsidy. Some countries have community schools, established by local communities often with NGO's support, to benefit the non-formal sector. Distance teaching, using media such as radio, is being applied to educate out-of-school children and youth. Kuhango and others cited in Tesfaye Ejigue (2000) indicate what the rational is for using distance education. They say

CCRDA

distance education can reach a wider student audience and meet the needs of students who are unable to attend on-campus classes. There is also a marked increase in cost-effectiveness, particularly in capital expenditure. A distance education system is potentially more cost-effective than a conventional system for particularly teaching similar subject matters to massive and ever increasing number of people who are widely dispersed and at low density.

Another advantage of distance education is its flexibility and capacity to adapt to different local conditions (Routledge and Kegan, 1973).These days, there is a tremendous growth and diversity in distance education in the number and types of individuals learning outside traditional classrooms, in the variety of the lessons it provides, and the range and effectiveness of media technology serving as instructional tools of learning. For primary school children distance education has been used in a mentored group in eight countries and has reached a National Scale in three countries. For instance, to increase access to primary education, the interactive radio instruction model has achieved national coverage in AIDS affected Lesotho and South Africa (World Bank, 2002). Therefore, for the country like ours with backward economy, massive AIDS orphans, high HIV prevalence, and low rate of literacy, finding possible educational alternative is of paramount importance. To this effect, the most timely choice is distance education.

CCRDA

Distance education as a system is often regarded as the most innovative, which gives learners independence of high degree. This idea has been clearly expressed by Charles Awedemeyer (in Holmberg, 1955:8) as follows:

- Instruction should be available any place where there are students or even only one student whether or not there are teachers at the same place at the same time.
- Instruction should place greater responsibility for learning on the student.
- Instructional plan or system should free faculty members from custodial duties so that more of the teacher and learner's time can be given to truly educational tasks.

- The instructional system should offer learners wider choices (more opportunities) in subjects, formats, and methodologies.
- The instructional system should use, as appropriate, all the teaching media and methods that have been proven to be effective.
- The instructional system should mix and combine media and methods so that each subject or unit within a subject is taught in the most effective may.
- The media and technology employed should be articulated in design & use; that is, different media or technologies should reinforce each other and the structure of the subject matter and teaching plan.
- The system should permit students to start, stop, and learn at their own pace, consistent with learner short- and long-range goals, situations and characteristics.

The points stated by Awedemeyer are very crucial and self-explanatory about the nature of distance education. However, though not mentioned by Awedemeyer, distance education also suffers from short comings.

Some of the problems and issues common to all distance education institutions in third World Countries are:

- lack of adequate finances;
- shortage of communication and infrastructural facilities;
- no proper government policies;
- under utilization of the range of audio-visual media available;
- shortage of personnel in media and course material production; and
- above all a skeptical attitude towards distance education with regard to quality of learning achieved....(Reddy, 1994:205);

If the government is committed to use distance education as one method of

CCRDA

training/educational provision, the stated problems above would be minimized or eradicated through times. These days, the number of AIDS orphans is increasing in a alarming rate. Most of the orphans are expected to dropout of schools. So, if Go's and NGO's are firmly join hands and look for distance education as an alternative method of teaching, possibly we can minimize the impact of AIDS on school age children., mainly on education.

The regular school attendance of AIDS orphan children was also assessed by presenting parallel items to both AIDS orphans and caretakers. The findings indicate that (63.9%) of AIDS orphans and (100%) caretakers reported regular attendance. On the other hand, (23.7%) of them responded that they would be absent sometimes while (10.3%) of them affirmed that they usually do not go to school. Those who would be absent from classes sometimes and those usually absent ascribed their reasons due to parental sickness, death of parents, attending funeral ceremony, engagement in income generating activities, taking care of younger siblings, etc. A t-test result shows that there is a significant mean difference between class attendance of AIDS orphans and parental death status at (alpha=.05). AIDS orphans who lost their mothers have less attendance than those who lost their fathers or both parents. The participants in the focus group discussions approved the idea. The need for children to work and to care for ill adults is one of the reasons for absenteeism and dropout of schools. Preliminary results in Tanzania showed that the death of an adult female in the previous 12 months is associated with lower enrollment possibilities for reasons of females labor such as fetching water and collecting firewood (Ainsworth & Koda, 1993). The findings of the current study also supplements the one conducted years back along this line.

One question raised in the questionnaire for AIDS orphaned children relates to the number of days they were in school the previous week. The results of the study indicate that, 45.4% of them were in school all the five days; 26.8% of them said for four days; 12.4% of them for three days; and 4.1% each for two and one day(s). The rest 7.2% affirmed that they

CCRDA

were not in school all days during that particular week. Adding the responses of those who were in school all days and those who were there for four days, we get a percentage of 72.2%. This finding hints that the majority of AIDS orphans are attending classes. The participants in the focus group discussions also supported this result. When children are absent from classes repeatedly, they are asked to bring their caretakers or surviving parents, or a valid medical certificate if they had been sick. When the supporting agent knows the frequent absenteeism or dropout of the child from school, a last warning is given to the orphan, and to the caretaker who are made to learn a subsequent termination of the support, unless things urgently take up the right course.

Although the time frame and the sample size differ, a study conducted in Rakai district in Uganda, has witnessed the impact of parental death on school attendance of AIDS orphaned & nonorphaned children. A total of 20 pupils were randomly selected from upper grades of three primary schools, 10 girls and 10 boys, 10 orphans and 10 not. The result showed that the AIDS epidemic was having a serious impact on the pupils. Nineteen of the pupils were reported to have been absent from school for periods ranging from five weeks to one and a half terms during the past one year. The most common responses given for absenteeism were lack of school fees and rendering help in nursing AIDS patients at home (Katahoire, 1993, in IIEP, 1993).

The World Bank in collaboration with the university of Dar-es-salaam conducted a study to assess the impact of adult death due to all causes on child schooling in the Kagera region of North Western Tanzania. A total of 1897 Children, aged 7-19 years, were selected as samples to be studied for enrollment and school attendance. About half of the adult deaths were thought to have been caused by AIDS. On the average, 57 percent of children aged 7-19 years were enrolled in schools in the previous 12 months with good attendance (IIEP, 1993).

In Mozambique, a comparative study was done between children who were orphans and

CCRDA

those who were not, i.e. those that had parents to look after them. The result showed that 24 percent of the children whose parents had died were attending school compared with 68 percent of those whose parents were still both living (African Development Forum, 2000). The difference among studies might be due to differences in sample size, methodology, the kind of support received, etc.

In the present study, parallel items were presented to both AIDS orphans and caretakers regarding problems that children are facing in the teaching learning process. The findings indicate that 48.5% of AIDS orphans and 71.7% caretakers noted the prevalence of various problems students are confronting day to day. On the contrary, 51.5% of AIDS orphans and 5% caretakers reported that there was no problem in the teaching-learning process. The remaining 23.3 % of caretakers stated that there had been occasional problems as was told to them by their AIDS orphan dependents. This finding was substantiated by caretakers & surviving parents interviewed and focus group discussions to AIDS orphans themselves. The difference observed between the responses of AIDS orphans and caretakers was due to differences in perception of the problems related to the teaching learning process. Problems that parents consider as consistent relate to requests made by their children to have all the necessary school materials such as pens, pencils, exercise books, textbooks, uniforms and other financial needs such as contributions to clubs, and monthly or quarterly payments if their children are in private or public schools.

On the other hand, problems that AIDS orphans consider as serious mainly relate to classroom issues like isolation, lack of proper meals, inability to get educational materials, insult by classmates, occasional offence by teachers and school heads, confusion, hopelessness, forgetfulness etc. In one study (Katahoire, 1993, in IIEP, 1993), it was pointed out that trauma related to illness and death of family members led to difficulty in concentration in the classroom and in acquiring the skills and knowledge offered there. Children in schools

CCRDA

or classrooms suffer a great deal when infected or when a member of their family is infected or die because of HIV infection or AIDS . UNICEF (1998), reported that the educational problems girls have been facing are by far more serious than boys. Girls are more exposed to early pregnancy, HIV infection, unprotected or coercive sex, etc.. All these bear their own impact on school dropout, and other psycho-social problems of girls.

The classroom as well as home behaviors of AIDS orphaned children have been examined using the data gathered through questionnaire. Regarding their classroom behaviors, the findings show that (30.8%) were manifestations of worriness, depression, and anxiety, followed by (22.4%) of active classroom participation. Quarrelsome with classmates (11.2%), engagement in class and home work activities (10.3%) and isolation from age mates (10.3%). The majority of the responses reveal that 63.3% were negative in one way or another.

An officer in Rakai district said that the people look at AIDS victims with a negative eye. They treat them as promiscuous people and prostitutes. These attitudes transcend to school pupils who use them to tease their fellow orphans. In the same district a grade 5 pupil, who lost her father to AIDS reported how her friends pointed fingers at her saying that she might also have AIDS. They isolated her and gave her nothing to eat, as she no longer had money to buy her own snacks as she used to when her father was alive (Katahoire, 1993 in IIEP, 1993).

In connection with home behaviors of AIDS orphans at the caretakers and that of the children of the caretakers the following findings have been secured. Whether or not caretakers were called on to schools on disciplinary cases the data gathered manifested that (27.9%) were called on to schools due to disciplinary problems of AIDS orphans, while (72.1%) of them said that they were not. On occasional clashes between the child /ren of caretakers and AIDS orphaned ones, (23.6%), reported that there have been some while the majority (76.4%) stated that there was no conflict of such a kind. As the caretakers interviewed discussed, conflict

CCRDA

occur among AIDS orphans and themselves when they are trying to correct the misbehaviors of one another.

Another study in Uganda indicated, that since orphans from grandparent families were not disciplined enough to accept and respect school regulations, they were more likely to be dropout (Barnett & Blaikie, 1993 in IIEP, 1993). Generally, we can conclude that classroom behaviors of AIDS orphaned children are negative compared to their home behaviors. This might be due to stigma & discrimination directed to them by their age mates in schools. In a like manner, the findings of this study seems to be consistent with other studies conducted in Africa.

Regarding the needs of AIDS orphaned children to learn, two items were raised in a form of scale ranging from very high to very low for both AIDS orphans and caretakers. The data gathered showed that (57%) of the orphans and (20%) of the caretakers claim that AIDS orphans have very high and high needs of learning respectively. Down on the scale, i.e. (17.5%) responded medium, while (2.6%) stood for each low & very low needs of learning. From the point of view of AIDS orphans, the sum of very high and high responses (i.e. 77%) reveales a positive need for learning. Similarly, 70.3%, and 15.6% of caretakers responded that their adopted children have very high and high need for learning respectively. The rest (14.1%) said that orphans have medium need for learning. Consequently, the sum for very high and high responses, i.e. 84.4%, affirms that AIDS orphaned children have positive needs for learning as to their by caretakers.

A 16-year-old boy orphaned by AIDS in India reported that since the death of his parents they had been living with their grandparents. He added; I earn 50 to 60 rupees a day (approximately US$ 1.00) by selling vegetables or pulling the riskshow. I have three younger brothers. I want to study, but my grandfather says he cannot afford to keep us in the house unless I contribute my family's share (UNICEF, and UNAIDS, 2002). The present study is

CCRDA

quite similar to the findings reported by the boy above. Though there are economic problems which hinder children from seeking education, there is, indeed, a very high desire for it as is expressed by both AIDS orphans and their caretakers.

The efforts AIDS orphaned children make to achieve success in school have been examined. In this regard diverse alternative responses have been provided for the item. But of all the alternatives, respondents selected; using program to study (20%), scoring good result (20.9%), and participating in classroom activities (i.e., asking and answering questions) 18.2%). These responses already make (59.1%) of the overall. This is an indication of high self-esteem and high self-efficacy. Whether or not people demonstrate mastery or learn helplessness in tackling a given task depends a great deal on how they perceive their ability, i.e. in their perceived self-efficacy. People whose perceived self-efficacy is positive do pursue a relatively high level of performance. They are not likely to put off easily; they do their best, to seek new solutions and to persevere in cases of difficult task assignments (Cervone & Peake, 1986 in Vrugt, 1994).

The value AIDS orphaned children and caretakers give to education was also examined on the basis of five alternative items. The responses were that AIDS orphans gave very high (55.9%) and high (20.7%) values. The rest responded medium (20.7%) and low (2.7%) value to education. Consequently, we can declare that 76.6% of AIDS orphans have positive value to education. By the same token, 82.8% and 12.5% of the caretakers responded very high and high value for education. On the other hand, 1.6% and 3.1% of the caretakers reported medium and very low value for it. As a result of this, we can claim that the majority, (i.e. 95.3%) of the caretakers have positive outlook towards education.

In another related item, AIDS orphaned children were asked to state the contributory factors to having very high and high value for education. As to their responses 39.2%, indicated that education would help them to be self-supportive; 33.8% reported that since they

CCRDA

are AIDS orphaned children, their only possible way for success is education; 16.2% reported that teachers encourage them for this and believe that they would achieve success (inner strength, or self-efficacy); and, 10.8% said that the high support they get from caretakers attributed to their giving high value to education.

A one-way analysis of variance revealed that there exist a significant difference between the two sexes of AIDS orphans and the value they give to education. More boys have positive value to education than girls. Another investigation has been done between the current ages of AIDS orphaned children and the value for education. The result showed that there is a significant difference in the two variables tested. Children in the age range of 5-10 valued education more than those in 11-14 years categories. Regarding parental death and value for education the result of a one-way ANOVA shows the prevalence of a significant difference. In this respect, AIDS orphans who have lost only their mothers value education less than those who have lost only their fathers or both parents.

In a study conducted by World Bank (1992 cited in IIEP, 1993), nearly 26 million Tanzanian shillings are needed for eight years of primary school, four years of secondary education and three years of university. Because education is expensive, to this extent parents consider school or education as having poor return, and so are not willing to send their children to school. Undoubtedly, this kind of perception should affect the value parents give to education. However, the results of the World Bank study in Tanzania seem contrary to the findings we have discussed above. The contrast might be that, parents in Tanzania may undervalue education by comparing it to other sectors, which they may assume to have immediate and positive outcomes.

Regarding three things: (i) the motivation of AIDS orphaned children to learn, (ii) parental death and its impact on this , and (iii) factors contributing to high motivation , three interrelated items were forwarded to the participants in the study. The findings indicated that,

CCRDA

52.6% and 25.4% of AIDS orphans have, in a respective manner very high and high motivation to learn. Generally, (78%) of AIDS orphaned children have positive motivation to learn. AIDS orphans were asked to make a point on the factors which contribute a lot to having high motivation to learn. Of all the alternatives listed in the questionnaire, two of them, i.e. consistent belief to achieve success (inner strength), and lesson learnt from the failure of parents who achieved success through repeated trial earned of 27.4% each; these were seconded by encouragement from teachers and caretakers which had 17.7 % of the respondents. Whether or not parental death to AIDS affected the motivation of AIDS orphaned children to learn were assessed through an item raised in the questionnaire to both AIDS orphans and their caretakers. The results were contradictory. As reported by AIDS orphans, 63.4% said that their motivation to learn was heavily affected by the death of their parents to AIDS; 19.6%, as having no effect ;and 17% as being not sure of its impact. On the part of the caretakers, 36.5%, 47.6% and 15.9% said that parental death have a negative effect, no effect and were not sure of its impact on motivation respectively.

In order to see the impact of parental death on the motivation of AIDS orphans to learn, Chi-square test was done. The result indicated that there is a significant difference. The question whose death brought about a higher demotivation was also assessed by the use of a one-way ANOVA. The difference was again significant ; children who lost only their mothers happened to be the ones who are highly demotivated.

These views of the AIDS orphans were supported at the focus group discussions. AIDS orphans revealed the internal and external problems they have been facing which resulted in reducing their motivation to learn. The differences in the responses of AIDS orphans and their caretakers might be due to differences in perception of the existing problems.

As Hunter (1990) puts it, the lower motivation provided by an extended family, is perhaps caused either by the lower level of education possessed by guardian grand parents or

CCRDA

their lower level of awareness as to the possible usefulness of education and of households to orphans in such families, or by both of these. AIDS orphans my be over worked by relatives or other guardians who consciously or unconsciously view them as burden. This, through time, can also affect the motivation of AIDS orphans not only for learning but also for life in general.

The achievement of AIDS orphaned children at school was one of the issues addressed in the questionnaire. A Likert scale form of item having five alternatives ranging from very high to very low was presented to AIDS orphaned children. The findings indicated that (28.0%) and (32.5%) of them stated that they had very high and high scores respectively during their school years, and (30.7%) of them reported that they scored medium. A very small percentage, i.e., (5.3%) and (3.5%) responded that their academic scores were low and very low respectively. From this, cumulative result of (60.5%), one can conclude that at school, AIDS orphans scored very high and high scores.

Besides their school achievement scores AIDS orphans were asked to tell when their school marks were high. Two interrelated items were presented to both AIDS orphans and their caretakers for this purpose. The result indicated that (50%) of AIDS orphans and (35.6%)of caretakers said that the academic scores of AIDS orphans were high when they were living with their biological parents. On the other hand, (30%) of orphans reported that there was no change in their academic scores before and after their parents' death. (22.0%) of caretakers replied that though the scores of AIDS orphaned children were generally low, they showed some improvements in some subjects ;(16.9%) of them responded that due to the support given to the orphans their scores improved to a higher degree; (15.2%) of them reported that the children have dropped out of school currently and is therefore, difficult to make comparison, etc.

CCRDA

An attempt has been made to evaluate the available free time AIDS orphaned children have to do school tasks. To this effect two items were developed and distributed to AIDS orphans and caretakers. From the responses gathered, (65.9%), and (72.2%) of AIDS orphans and caretakers respectively were found to have indicated that they have enough time to do school tasks. On the other hand, (34.1%) AIDS orphans & (18.5%) caretakers reported that they had lack of free time due to the fact that AIDS orphans are involved in some income generating activities. However, the income they generate is very minimal. Generally, the findings indicate that the majority of AIDS orphans have free time to study.

In a study conducted by (MOLSA, UNICEF, and Italian Co-operation, 2003), the income generating activities of both AIDS orphan and non-AIDS orphan children in Ethiopia were assessed. The data showed that (16%) of ADIS orphans and (21%) of non AIDS orphans were found to be engaged in various economic activities. As to the findings of that study more non-AIDS orphans than AIDS orphans were engaged in income generating activities. This appears to be due to the high probable fact that community members prefer to employ more non-AIDS orphans than to AIDS orphans.

UNICEF has recently reviewed the effects orphaning has on schooling and child labor in 20 Sub-Saharan African countries. The result has shown that in all countries, children aged 5-14 who had lost one or both parents were less likely to be in school, and were more likely to be working more than 40 hours a week. What this leads to is the fact that depending upon the situation AIDS orphaned children are in and the support they receive from the extended families, or other supporting organizations, etc., matters a lot for their having or not having time for doing school tasks and being in school regularly.

In order to evaluate the availability of educational materials, food and medicine, a question was given to AIDS orphaned children. As to their response (46.0%) were found to have reported that they have problems of getting educational materials, food and medicine at

CCRDA

the right time and in a sufficient manner. Others (28.3%) stated that the support they get is not adequate, but allows them to stay alive and attend school. Finally, (25.7%) of the respondents positively affirmed that they get sufficient supply of the needed materials, either from the caretakers or other supporting agencies. From this, one can conclude that AIDS orphans have problems of getting sufficient support in order that they can survive and progress in their education.

In a report by IIEP (1993) and UNAIDS (2002), it was found out that a high proportion of children in school (25-30%) are AIDS orphans, and of these, those who had lost both parents were less-dressed and less-well fed. AIDS orphans often lose the necessary financial, material, and emotional support that they need for successful schooling (HIV/AIDS in Addis Ababa, 1999).

The attitude of age mates towards AIDS orphaned children was assessed. The findings show that (43.8%) indicate that there was discrimination and stigma directed to them. But the remaining (56.2%) reported that there was a positive attitude of age mates to them. A similar question was raised to AIDS orphans to express the manifestations of their age mates' attitude towards them. Kindness, sympathy, and lightheartedness were reported by (55.9%); the rest (44.1%) responded negative attitudes such as throwing ugly and insulting words, considering them as hopeless, alienating or discriminating them from all sorts of interaction, considering them as if they have no right to be educated and suspecting them as HIV carriers. In an interview with caretakers and surviving parents and at focus group discussions with AIDS orphaned children, social discrimination was reported as severe and most hampering in their social interaction.

A Notional survey conducted in Ethiopia (2003) reported that (54.8%) non-AIDS orphan & (45.2%) AIDS orphans had indicated that they had friends. More than half of those who claimed they had friends stated that they received sympathy & support from them.

CCRDA

However, some others said that they were confronted with unhealthy attitudinal set from their friends.

As reported by (IIEP, 1993; UNAIDS, 2002), many AIDS orphan students are at risk of exclusion, abuse, discrimination and stigma. Stigma and fear of rejection are seen as major problems of HIV/AIDS. Goffman (1963 in Lie 1996) defines stigma as "an attribute which is deeply discrediting". In the same book Crandall and Coleman (1992) indicate that stigma, by its very nature, is a mark which legitimatize treating the bearer in some way less humanely than those without the mark." They further noted that stigma is a social disease that affects the social relationship of individuals and people with AIDS in particular. Above all it is an existential threat and violation of human right declarations.

Various studies identify the family as the first line of response in mitigating the HIV/AIDS impact on children (Donahue, 1999 in a National Survey, 2003). But in some cases stigma and discrimination for HIV/AIDS begin at home, especially against family members who carry the virus. Fear, shame, and rejection that surround people affected by HIV/AIDS create additional stress and exclusion upon their children both prior to and after their death (Schonteich, 2001 in a National Survey, 2003).

According to Lerner, the belief in Just World performs an important psychological function. It enables the individual to view the environment as a safe, stable, and relatively predictable "World", in which foresight, ability, and effort allow one to be reasonably confident of attaining the ends one desires and avoiding unpleasant fates. Both the infected and the affected ones desire to be treated as equal as the so called free from the effect of HIV/AIDS. That is why the year 2003 is designated by the slogan 'Live and let Live'.

As to the feelings of AIDS orphans in connection with the care and support provided to them by the caretakers, two interrelated items were given . Of these, the feeling of confidence and relaxation for having a caretaker including surviving parent was the one the responses of

CCRDA

AIDS orphans demanded. The findings of the study show that (61.4%) of them did not feel comfortable with the support received from their caretakers, and (38.6%), noted that they had a positive perception as to the care and support they acquire.

The second item was closely related to the psychological makeup of the AIDS orphaned children. Another question assessed was how AIDS orphaned children would evaluate the love, care, support and advice they receive from their caretakers. The responses were that (35.8%) revealed that they have problems of getting love, care, support and advice, whereas (30.7%) of them indicated that they have no problem in these psychological support elements. The rest (32.5%) responded that they sometimes feel devoid of love, care, support and advice. The responses seemed equally distributed but as stressed by AIDS orphans at the focus group discussions, they generally have problems regarding the psychological support systems.

Kofi Annan, the UN Secretary General, speaking to leaders of industrialized countries at the July 2001 Group Eight meeting, noted that the needs of AIDS orphans are as immediate as their next meal and as extended as access to education, guidance and care until the end of their adolescent years. He emphasized the fact that education, guidance and care for the AIDS orphans need to be given for a long time perhaps until they reach the age when they can be self-supportive.

Two interrelated items were raised to caretakers to reveal their observations and views as to the problems of AIDS orphans in their locality. The first was whether or not they knew AIDS orphans who were devoid of supporters and went out to streets for survival. To this item (42.2%) responded that there are children who lost their mothers or both parents to AIDS and start life on the street. The other (51.6%) indicated that there were no cases which they clearly know about children who lead life on the street as a result of their parental death to AIDS. The last (6.2%) said that they were not sure of this matter to give comment.

Concerning the different forms of problems AIDS orphaned children have been facing

CCRDA

such as labor exploitation, and especially girls being exposed to rape, abduction and prostitution, and both sexes being forced to drop school, the number of caretakers who support the above views seemed very high, i.e., (76.6%). The rest (9.4%) and (14.0%) responded, in a respective manner, that they do not agree to the statement raised ,that they do not know about the prevalence of the stated problems upon AIDS orphans in their locality . Therefore, we can conclude that the majority of AIDS orphaned children are exposed to different forms of exploitation and are forced to dropout of schools, if they do not get support form any source. In an interview with concerned persons from Addis Ababa Education Bureau, MOLSA, Addis Ababa HIV/AIDS Prevention and Control Office and HAPCO, the writer of this paper secured no data as to the number of AIDS orphaned children in the country or the capital city. As a result, it is very hard to make an analysis on the type of problems they have been facing or the number of children under very high risk in this aspect.

In extreme cases, which are all too numerous, orphans turn to the street where their physical needs and financial desperation make them vulnerable to crime, substance abuse and sexual exploitation. This puts a significant number of them at risk of contracting HIV through virtually inescapable income generating prostitution (African Development Forum, 2000). In many countries where economic conditions make it difficult for girls to afford school fees, some seek favors of a sugar daddy' (UNICEF, UNAIDS and World Bank, 2002). In another study conducted in South Africa, an estimated 10,000 children live or work on the city streets. More than half of 141 street children interviewed in South Africa reported that they have exchanged sex for money, goods or protection, and several indicated that they had been raped (UNICEF, USAID, and World Bank, 2002). Generally, studies in the area of AIDS orphans and the findings of this paper show that the situation of orphans in general and AIDS orphans in particular are very serious that demand the attention of concerned bodies.

CCRDA

5.2 Conclusions

On the basis of our findings in the preceding chapter, the following conclusions could be drawn.

Background Issues

1. Majority of the participants in the study were girls (62.3%) and women (73.4%) compared to boys (37.7%) and men (26.6%).
2. The findings of the study indicate that (10.5%) of AIDS orphans lost only their mothers, (25.4%) of them only their fathers and more than half, i.e. (64.1%) lost both their mothers and fathers. This implies that the greater number of children who participated in the study were double orphans.
3. Concerning home behaviors of AIDS orphans, the majority of them, i.e., (76.4%) were peaceful; there existed very minor conflicts between the child (ren) of the caretakers and their AIDS orphans dependents. Instead, while disciplining AIDS orphans, frequent clashes occurred between AIDS orphans & caretakers.

Care and Support to AIDS orphans

1. The cumulative percentage (54.3%) of AIDS orphans were taken care of by the extended families such as elder brothers (14.0%), elder sisters' (7.9%) ,Uncle (7.9%), Aunt (6.1%), and grand parent ,i.e,. mother and/or father (18.4%) as reported by the AIDS orphans themselves. On the other hand, accumulative percentages of (67.1%) of caretakers are bringing up children of their own relatives. Therefore, we can say that more than half of the AIDS orphaned children have been reared in the extended family circle.
2. As to the kind and source of support AIDS orphans and caretakers receive wheat, food oil, and financial support are learnt to be the major ones. Regarding the source of support, Associations of HIV carriers, and local NGO's were in the forefront followed

CCRDA

by kebeles, schools and individuals in small scales. However, as was reported by AIDS orphaned children and their caretakers, the support lack uniformity across different supporting agencies and it is very minimal to satisfy their needs.

3. The findings of this paper also indicate that more than half, (61.4%) of AIDS orphaned children are not comfortable with the care and support provided to them by their caretakers & surviving parents.
4. Regarding the psychological support such as love, care, material support and advice that AIDS orphaned children get from their caretakers, they generally perceive that they have problems in these areas.

School attendance and Classroom behaviors

1. In relation to the school enrollment of AIDS orphaned children, (85.1%) AIDS orphans and (77.8%) caretakers indicated that AIDS orphans have been attending schools. Compared to the prevalence rate of AIDS deaths in the capital city, a higher proportion of AIDS orphaned children are enrolled in schools. This is due to the fact that school attendance is the major criterion for AIDS orphans to get support from Associations of HIV carriers and local NGO's.
2. Regarding the forms of schooling AIDS orphan children are attending in, (90.7%) have been in regular schools of both government and privately owned ones. The remaining (9.3%) of them are in night school programs.
3. As far as the regular school attendance of AIDS orphaned children is concerned, (63.9%) of AIDS orphans and (100%) caretakers reported that AIDS orphans go to school on a regular basis. AIDS orphans ascribed the reasons for absenteeism to parental sickness, death of a parent, funeral ceremony, taking care of younger siblings, participating in income generating activities, etc. AIDS orphans reported that they are at school all days of the week (45.4%) and four days of the week (26.8%) the week

CCRDA

before filling the questionnaire for this study. Sex as variable attributed to a significant difference in classroom attendance. In this respect AIDS orphan boys attend classes more regularly than do AIDS orphan girls.

4. Though there has been a variation in the perception of problems that AIDS orphaned children are confronted with in the teaching-learning process, slightly less than half of AIDS orphans (48.5%) and the majority of caretakers (71.7%) admitted the occurrence of problems. On the other hand, (51.5%) of AIDS orphans and (5%) of caretakers reported that there is no problem in the teaching-learning process. At focus group discussions, AIDS orphans listed out the kinds of problems that they are facing in the teaching learning process of which the main ones are isolation, lack of proper meals, inability to get educational materials, insult by classmates, and occasional offence by teachers and school heads, confusion, hopelessness, forgetfulness, etc.
5. Regarding classroom behaviors of AIDS orphaned children, the findings of the study were that (30.8%) manifested worry, depression and anxiety, while (22.4%) affirmed active class attendance and participation. Therefore, more than half of the respondents, (63.3%) revealed that AIDS orphans' classroom behaviors appear to be of negative nature of the kind worriness, depression, anxiety, quarrelsome and isolation. Nevertheless, the majority of the caretakers (72.1%) were not called on to school for disciplinary reasons.
6. Concerning the attitudes of age mates towards AIDS orphaned children, slightly less than half (43.8%) reported the existence of problems such as discrimination and stigma. On the other hand, 56.2% revealed the positive and sympathetic relationship they have with their age mates. However, as interviewees and focus group participants stress, the stigma and discrimination are so severe that they disturb their smooth social interaction.

CCRDA

Educational efforts of AIDS orphans

1. As to the kind of efforts AIDS orphaned children make to achieve success in school, diverse alternatives were presented in the questionnaire. Using program to study, interest to score good result and classroom participation in asking and answering questions consisted of (59.1%). This generally indicates the positive efforts of AIDS orphans and their inner urge to pursue education for everlasting success.
2. School achievement of AIDS orphaned children was assessed using an item designed in a Likert scale format ranging from very high to very low. Based on this five scale format, 60.5% of AIDS orphans scored very high and high scores. The response they gave for medium was undoubtedly high i.e., (30.7%). Therefore, we can conclude that more than half of the AIDS orphans scored very high and high scores in their school years.
3. As to when the academic scores of AIDS orphaned children were higher, the findings show that (50%) of AIDS orphans and (35.6%) of caretakers indicate that AIDS orphans achieve high scores when they are living with their biological parents. On the other hand, (30%) of AIDS orphans revealed that there was no change in their school achievements before and after the death of their parents. This clearly shows that the role parents play in the academic success of children is very great
4. Regarding the availability of free time for school tasks, the majority of AIDS orphans (65.9%) and caretakers (72.2%) replied that AIDS orphaned children have enough time to do school related tasks and to study their subjects. However, there are children who are engaged in income generating activities and lack adequate time for school activities.
5. Almost half of the AIDS orphans do not receive sufficient amount of educational materials, food and medicine.

Needs, values, motivation and self-image of AIDS orphans

1. In relation to the needs of AIDS orphaned children to learn, (77%) of AIDS orphans

CCRDA

themselves and (84.4%) of caretakers reported that the orphans have positive needs of learning. This is really a very good asset for AIDS orphans to make progress in their education.

2. Regarding the value AIDS orphaned children and their caretakers give to education, two interrelated items with five alternatives for each were presented to both groups. The findings indicate that both AIDS orphans (76.6%) and caretakers (95.3%) attach positive value to education.
3. The findings of the study also indicate that (52.6%) and (25.4%) of AIDS orphans have very high and high motivation to learn respectively. This means that the majority (78%) of AIDS orphans have positive motivation to learn. Regarding the impact of parental death on the motivation of AIDS orphans to learn, contradictory responses were secured from AIDS orphans and caretakers. More than half of AIDS orphans (63.4%) stated that their motivation to learn is heavily affected by the death of their parents.
4. As to factors which contribute to the positive or high value of education, AIDS orphaned children have revealed some issues .Among these understanding or apprehending the role of education to be self-supportive, considering education as the only possibility for their future, teachers' encouragement, their own inner strength to be successful and high support from the caretakers were in the list.
5. AIDS orphans have been found to have high self-esteem and above average self-efficacy as evaluated by the scales.

5.3. **Recommendations**

In line with the conclusions stated above, the following recommendations are suggested.

Policy issues

1. Revision of the existing policy materials to include issues related to the education, care

CCRDA

and support of AIDS orphaned children is essential. Otherwise, like other Eastern and Southern African countries, there is a need to establish AIDS Orphans Task Force or AIDS Orphan Care Policy to address the special needs of AIDS orphaned children. To this effect MOLSA, HAPCO, Ministry of Education, Ministry of Health and other non-governmental organizations working in the area of HIV/AIDS should join hands and find ways of forming such a task force.

2. There is no statement in the New Education and Training Policy about HIV/AIDS and the support that can be given to educate AIDS orphans. On the other hand, in the Education Sector Development Program (ESDP), there is a statement which says support will be given to educate orphan children. However, in the detailed work plan developed by MOE for the year 2002-2003, and the objectives listed, we find no statement on how these children need to be supported. Therefore, an urgent revision of the education policy and the inclusion of HIV/AIDS issues on the one hand and the proper implementation of these on the other are tasks awaiting the Ministry of Education.

Issues related to the statement of the problem

1. The majority of AIDS orphans have been supported by relatives in the extended family circle. In order to realize the intention of community based rehabilitation for AIDS orphaned children, strengthening the capacity of the community in general and the extended family in particular has paramount importance. Therefore, designing a small scale family level credit scheme need to be introduced either by NGOs working in the area and/ or by the Addis Ababa HIV/AIDS Prevention and Control Office.
2. In order to minimize and gradually eradicate the stigma and discrimination directed to AIDS orphaned children either in schools or in the society, a wide sensitization program

CCRDA

should be designed. Similarly, in the family or criminal law, codes which can protect the welfare of AIDS orphans need to be promulgated.

3. In order to evaluate the impact of HIV/AIDS on the education sector in general and upon AIDS orphaned children in particular, gathering objective data has tremendous benefits. Therefore, the Addis Ababa Education Bureau should formulate a format to register AIDS orphans, and their educational status including teachers' deaths caused by AIDS. At the Ministry level, a strong data base needs to be set up to collect data on students & teachers infected and affected by HIV/AIDS.
4. Non governmental organizations and Associations of HIV carriers working in Addis Ababa are not in a position to address the needs of AIDS orphaned children. This seems to be because of the number of AIDS orphans is increasing day by day. Thus, increasing the financial capacity of supporting agencies on the one hand, and developing a uniform support guideline to be used by NGOs and Association of HIV carriers on the other need to be carried out by the Addis Ababa HIV/AIDS Prevention & Control Office and MOLSA.
5. In order to minimize the burden of the government and NGOs working in the area of HIV/AIDS, especially in educating HIV/AIDS orphaned children, distance Education can be taken as an alternative approach. Using distance education orphans who are above grade 5 can pursue their education while, at the same time, they can be involved in generating their own incomes. To this end, the Addis Ababa Education Bureau, Ministry of Education, and NGO's can work co-operatively.
6. While living in the extended family circle, AIDS orphans have reported the prevalence of psychological deprivation. As part of the sensitization program, family who are bringing up AIDS orphaned children have to be oriented as to the role of love and affection to the proper development of children. Knowledge about HIV/AIDS coupled with concepts of guidance and counseling should be given to caretakers.

CCRDA

7. The local community with the support of GOs, NGOs and their own resources, should establish community schools. Using these schools life skill training and/or formal education can be given to AIDS orphaned children.
8. AIDS orphans have high self-esteem and above average self-efficacy. In order to maintain this strength professional support with respect to the formation of AIDS orphans' association which can echo their rights, spirits and privileges is very essential.

CCRDA

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APPENDICES

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Addis Ababa University

Post-graduate program

Faculty of Education

Department of Educational Psychology

A Questionnaire to be filled by AIDS Orphaned Children

Objective:- The aim of this questionnaire is to study the educational problems AIDS orphaned children are facing, and suggest possible recommendations on how the problems can be minimized or avoided. Therefore, I kindly request you to read each item thoroughly and provide the correct response.

Thank you in advance

Feseha W/Michael

Note:

- No need of writing name
- The response you give for this questionnaire will be confidential and used only for this study.
- For the items presented in a multiple choice form choose the response which you think is right, for the open ended questions write your response in the space provided.

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Part I: Personal Information

1. Sex: A. Male B. Female
2. How old are you? ----------
3. The deceased parent(s) is (are)
   A. Mother only
   B. Father only
   C. Both (Mother & Father)
4. When or in which year(s) did your parent(s) die?
   Mother 19_____ E.C.
   Father 19 _____E.C.
5. How old were you when you lost your parent(s)? ----------
6. In which grade were you when your parents passed away? ----------
7. Which grade are you at present? ----------
8. What is the name of your school which you are currently enrolled in? ----------
9. Your residence: Woreda _____ Kebele _____

Part II: General Information

1. Soon after the death your parent (s) who provided you care and support?
   A. elder brother
   B. elder sister
   C. aunt
   D. Uncle
   E. Grand parent (male or female)
   F. Friend of you parents
   G. Charity organization
   H. No one to care for me and I went to street
   I. If others, please specify ----------
2. With whom are you currently living in ? ----------
3. Do you have brothers and sisters or are you the only child in the family? ----------

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4. If you have brothers and sisters, do your caretaker support you all together or separated?

   A. They are upbringing us together

   B. They could not help us together due to different reasons then separated

   C. If others, please specify ----------

5. Would you please indicate the kind of support you have been receiving from the following individuals public, governmental and non-governmental organizations?

   - Through the school you are enrolled in ----------
   - Through individuals ----------
   - Through Kebele you are residing in ----------
   - Through charity organizations ----------
   - Through Kebele or Woreda HIV/AIDS office ----------
   - Through association of people living with HIV virus ----------

6. Are you attending schooling?

   A. Yes B. No/Dropout

7. If your response to item No 6 is yes, are you usually or always attending your schooling?

   A. Yes C. I usually do not attend schooling

   B. I some times do not go to school

8. Please try to recall back your last week, for how many days you were in school.

   A. All the school days D. Two days

   B. Four days E. One day only

   C. Three days F. I was not in school all days of the week

9. If you sometimes or usually do not go to school what are the reasons for your absence?----------

10. If you dropout of school what is the reason for? ----------

    ----

11. While attending schooling who cover your school fees?

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12. Of the following which one do you think contribute their share to cover your school expenses?

    A. My adopters cover all the expenses
    B. My adopters contribute part of the expenses
    C. Working as a daily laborer such as carrying goods, acting as messengers, etc
    D. Working pity trading
    E. Shoe polishing
    F. Selling "Kollo", chewing gums & sugar cane
    G. If others, please specify ----------

13. If you contribute something to cover part of your school expenses, on the average how many hours in a day did you spend working? ----------

14. On the average how much money do you earn in a day? ----------

15. In which form of schooling are you in?

    A. Regular day school
    B. Night school
    C. Distance (Correspondence) Education

16. Do you face problems related to the teaching-learning process?

    A. Yes, I have
    B. No, I don't have
    C. If there are problems, please mention ----------
    ----

17. Of the following classroom behaviors, which one do you consistently show? (You are free to choose more than one response).

    A. Chatting, twiddling talk
    B. Conflict with classmates
    C. Working home and class works properly
    D. Anxiety, depression, worry
    E. Problem in having books, exercise books, etc.
    F. Delay to go to school
    G. Following the school tasks consciously

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H. If others, please specify ----------

18. Being parentless, do your classmates influence you in your education?

A. Yes C. If there is/are problems, please indicate ----------

B. No

19. Of the following which one clearly reflects your classmates attitude to you? (You can give more than one response)

A. Sympathy

B. Consider me as if I have no right or lack to learn

C. Consider me as hopeless

D. Throwing ugly words or back bitting

E. Consider me as an HIV career

F. Discrimination

G. If others, please specify _____

20. What do you think will be the reason for the positive attitude of your classmates to you? ----------

21. What do you think will be the reason for the negative attitude of your friends to you? ----------

22. What efforts do you make to protect yourself from unfavorable attitude of your friends? ----------

23. Do you have adequate time to study, and do your home works?

A. Yes, I have B. No, I don't have

24. If you say that you do not have enough time to study, what is the reason behind? ----------

25. What kind of efforts do you make to achieve success in your schooling? ----------

26. Which of the following clearly reflects your effort to achieve success in your schooling? (You are free to choose more than one response).

A. Doing my school tasks using programme

B. Inner motive to achieve good scores

C. My effort to ask & answer questions in class.

D. Doing my home works regularly

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E. My effort to use library in spare times I have

F. My ability to request support from elder brothers & sisters.

G. If others, please specify ----------

27. How do you explain your need to learn?

A. Very high B. High C. Average D. Low E. Very low

28. Can you list out the factors which affect your need to learn? ----------

---

29. What factor (s) do you think contribute to have a very great need to learn? ----------

---

30. How do you value education?

A. Very high C. Medium E. Very low

B. High D. Low

31. If your answer to the above question is 'very high' or 'high', what is your reason?

A. Since I believe that education will help me to be an independent person

B. Being parentless ,the only hope I have is education

C. I believe that I will be successful and my teachers encourage me to be so

D. My adopters encouragement is very high

E. If others, please specify ----------

32. If you value education 'low' or 'very low', what do you think will be the reason for that? ----------

---

33. What factors do you think contribute to value education low or very low? (You are free to choose more than one response).

A. I believe that my intelligence does not allow me to learn

B. I feel that my adopters will not support me any longer

C. Low encouragement received from teachers, adopters and friends

D. Low achievement scores in school subject which I am attending

E. Apart from academic, teachers fail to explain the role education plays in economy and social life

34. What do you think will be your motivation to learn?

A. Very high B. High C. Average D. Low E. Very low

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35. If your motivation to learn is 'very high' or 'high', what do you think will be the reason? ----------

36. Which of the following do you think attributed to have high motivation to learn? (you can choose more than one response)

    A. The belief that I am always successful (Inner strength)
    B. The experience I get from my parents who achieve success after repetitive failure
    C. The experience of others who succeeded after several attempts in my locality.
    D. Encouragement of teachers and my adopters
    E. A very high and repeated achievement scores I have in the school
    F. If others, please specify ----------

37. If you have low or very low motivation to learn, what factors attributed for that?

    ----

38. Do you think that the death of your parents affect the motivation to learn?

    A. Yes B. No C. Not certain

39. If it has an effect in your learning, how do you explain it? ----------

    ----

40. How do you evaluate your achievement' scores in general ?

    A. very high B. High C. Low D. Very low

41. When was your achievement score high?

    A. After the death of my parents
    B. When my parents were alive
    C. There is no difference in my score before & after the death of parents
    D. Though I have shown progress in some subjects, generally the achievement scores are deteriorating now.
    E. Owing to the assistance of my adopters, I have shown greater success than ever before
    F. If others, please specify _____

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42. In grade levels you have been attending during two semesters of 1994 E.C and first semester of 1995 E.C can you tell me your rank?

1994 E.C 1st Semester: Rank _____

Number of students in class _____

Second Semester: Rank _____

Number of Students in class _____

1995 E.C First Semester: Rank _____

Number of Students in class _____

43. Do you have problems to get educational facilities such as pen, exercise books, books, uniforms, etc., food and medicine needed for life?

A. Yes B. Partly fulfilled C. No

44. Do you feel comfortable & relaxed in the care and protection received from your adopters?

A. Yes B. No

45. Do you think that as a result of your parental death, you are deficient of love, care, support and advice?

A. Yes B. No C. Sometimes I feel deficient

46. In the community you are living, are you discriminated and being the target of stigma?

A. Yes B. No C. Sometimes I feel so

47. Are you anxious of contracting the HIV?

A. Yes B. No C. I sometimes feel suspicious

48. What are the major problems faced by AIDS orphaned children? ----------

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49. What do you think are the reasons which affect the education of AIDS orphaned children? ----------

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50. How can these problems be resolved? ----------

Than you in advance

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Part III: Self- efficacy Model

Direction: For the following ten questions, put a "√" Mark in the box based on your agreement. The rating will be 5 point for strongly agree, 4 for agree, 3 for uncertain, 2 for disagree and 1 for strongly disagree.

		1	2	3	4	5
1.	When I faced problems related to my parents' death I feel desperate (hate my self)	☐	☐	☐	☐	☐
2.	All in all, I am inclined to feel that I am a failure.	☐	☐	☐	☐	☐
3.	Though there is lack of parental love, shortage of educational materials, etc' I do believe that through repeated attempts I will become successful	☐	☐	☐	☐	☐
4.	I feel I do have much to be proud of	☐	☐	☐	☐	☐
5.	I feel that I am a person of worth, at least on equal basis with children whose parents are alive.	☐	☐	☐	☐	☐
6.	With my personal strength, I succeeded in coping up with the stigma & discrimination directed to me as a parentless child.	☐	☐	☐	☐	☐
7.	Those who were at times orphaned children and achieve success in life act as a model to me	☐	☐	☐	☐	☐
8.	I never attempt those activities which are beyond and above my capacity.	☐	☐	☐	☐	☐
9.	Verbal presentations which I receive from the friends' of my deceased parents are the sources of my strengths	☐	☐	☐	☐	☐
10.	I learn from my failures and develop self-confidence.	☐	☐	☐	☐	☐

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Part IV Self-esteem Scale

Directions:- Following are ten items presented to measure the self-esteem of an individual. Put a "√" mark in a box which you think is proper.

Key for marking:

1 = Strongly agree

2 = Agree

3 = Disagree

4 = Strongly disagree

	1	2	3	4
1. Though I have no parents, I believe that I am a child of worth	☐	☐	☐	☐
2. There are things which I feel proud of	☐	☐	☐	☐
3. Lack of parental love and protection forced me to think that I am a worthless child	☐	☐	☐	☐
4. Being orphaned does not create a problem from doing things just like non-orphaned children	☐	☐	☐	☐
5. I feel I do not have much to be proud of	☐	☐	☐	☐
6. Without feeling ashamed of my parents' death, I take a positive attitude towards myself.	☐	☐	☐	☐
7. On the whole, I am satisfied with myself	☐	☐	☐	☐
8. I wish I could have great self-esteem.	☐	☐	☐	☐
9. As a result of my parents' death, I sometimes feel that I am good for nothing	☐	☐	☐	☐
10. I sometimes think that I am bad	☐	☐	☐	☐

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Addis Ababa University

Post graduate program

Faculty of Education

Department of Educational Psychology

A Questionnaire to be filled by the Caretakers of AIDS orphaned Children

Objective:- This questionnaire is presented to those who have been taking care of AIDS orphaned children. Its aim is to find problems related to the education of AIDS orphaned children, and suggest possible solutions. Therefore, you are kindly requested to read each items thoroughly and provide the correct response.

Thank you in advance

Feseha W/Michael

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Note: - No need of writing name

- The response you give for the questionnaire will be confidential and used only for this study.
- The items presented in a male sex form will be applied to females
- For the items presented in a multiple choice form, choose the response which you think is right. For the open ended questions, write your response in the space provided.

Part I: Personal Information

1. Sex: A. Male B. Female
2. Age ----------
3. Educational Status: ----------
4. Occupation ----------
5. Average monthly income ----------
6. Residence: Woreda ---------- Kebele ----------
7. The relationship between you and the AIDS orphaned child (ren) is/are
   A. Nephew
   B. Niece
   C. Grandson/daughter
   D. Neighbor's child
   E. If others, please specify ----------
8. The number of individuals under your supervision ----------
9. Number of AIDS orphaned child (ren) your are adopting ----------
10. When did the parents of your adopted child (ren) die?
    Mother 19 ---------- E.C Age of the mother ----------
    Father 19 ----------E.C Age of the father ----------
11. How old was/were your adopted child (ren) when you received him/her for adoption?
    ----
12. How old is/are your adopted child (ren) at this moment? ----------

Part II: General Information

1. Have you received all or some of the children who lost their parents to AIDS? ---------
---
2. Did the parents of your adopted child (ren) have fixed assests?
3. Have you succeeded in teaching the adopted child (ren)?
4. From which grade on wards did your adopted child (ren) continue their education? ----
---
5. In which grade is/are they currently enrolled ? ----------

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6. How is the school expenses of the adopted children covered? (You are free to choose more than one response)
   A. Totally from the adopter's pocket
   B. Partly by the adopter
   C. The contribution of the AIDS orphaned child doing jobs such as carrying goods and acting as messengers etc.
   D. Working pitty trading and earn money
   E. Income generated by shoe polishing
   F. Selling "Kollo", chewing gum, sugar can. etc..
   G. If others, please specify ----------
7. If your adopted child (ren) contribute something to cover their school expenses, on the average how many hours in a day spent working out side? ----------
8. On the average how much money do they earn in a day? ----------
9. If they learn while working different income generating activities, do you think that they have enough time to do school tasks?
   A. Yes B. No C. Not certain
10. Do your adopted children attend schooling regularly?
    A. Yes B. Sometimes they do
11. Do you make supervision or follow up whether they attend schooling regularly or not?
    A. Yes B. Sometimes I do C. No
12. Have you ever called on by the school director for the misbehaviour committed by your adopted child (ren)?
    A. Yes B. No
13. If you have called on, would you please indicate the kind of misbehavior committed?
    ----
14. If you are not in a position to teach your adopted child, would you tell me the reason?

    ----
15. Is there any support you received by adopting an AIDS orphaned child (ren)? ---------
    ----

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16. Is there any support your received from the following public, governmental and non-governmental organization, please indicate the kind of support

- The Kebele administration you are residing ----------
- Charity organization(s) ----------
- HIV/AIDS office at woreda/keblel level ----------
- Association of people living with HIV ----------
- Others who indicate their names and the kind of support ----------

17. Are problems of misbehavior of AIDS orphaned child(ren) manifested? Please list them out ----------

---

18. How many children do you have? ----------

19. Are there any conflicts between your biological child(ren) and the adopted ones?

A. Yes, always happened
B. It occurs sometimes
C. Not at all

20. Are there discrimination and stigma directed to the adopted children from the community they are living in?

A. Yes B. No C. Not certain

21. How is the learning needs of AIDS orphaned children?

A. Very high C. Average E. Very low
B. High D. Low

22. How do you value education?

A. Very high C. Average E. Very low
B. High D. Low

23. Do you think that parental death of the adopted children affect their motivation to learn?

A. Yes B. No C. Not certain

24. If your response to question 24 is 'yes', what is there manifestation?

---

25. When was the achievement scores of the AIDS orphaned children better?

A. After the death of their parents

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B. When their parents were alive

C. There is no difference in their achievement score before and after their parents death.

D. Though he/she achieved better scores in some subjects, generally the results are low

E. He/She is achieving better scores now

F. If others, please specify _____

26. Do you know AIDS orphaned children who failed to get foster parents and forced to lead life on the street?

A. Yes B. No C. Not certain

27. AIDS orphaned children are forced to dropout of school, labour exploitation, especially girls exposed to rape and prostitution. Do you think that it is valid or real in your locality?

A. Yes B. No C. Not certain

28. Would you tell us the kind of care and support AIDS orphaned children are receiving in your locality? ----------

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29. What are the major problems of AIDS orphaned children? ----------

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30. What do you think are the major problems which affect the education of AIDS orphaned children? ----------

---

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31. How can these problems be resolved? ----------

Thank you very much

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Interview Guide

Health Expert, Ministry of Education

1. Is there any impact assessment / evaluation of HIV/AIDS on the education sector?
    - Impact on enrollment rate (male & female students)
    - Teachers' death
    - Supply and quality of Education.
2. Regarding the education of AIDS Orphaned children , what the ministry has planned to do ?
3. Is there any data concerning the death rate of teachers and the number of children who are devoide of education as its consequence?
4. In ESDP there is a statement which says 'attempt will be made to support AIDS orphan children'. Is the plan being implemented? what kind of support are they given?
5. Is there any guideline which put into effect from school level high up to Ministry that can fight discrimination of AIDS orphans & other negative effects?

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Interview Guide for Anti-AIDS club Co-ordinator in School

1. Are their manifestations on the impact of HIV/AIDS in education system of your school?
    - Teachers' death
    - School dropout of children
    - Death of school children by AIDS, etc.,
2. Is there any data concerning the number of AIDS orphaned children?
   If so, how many students are there in your school?
3. How many students dropout of school due to their parents death to AIDS?
   If so, how many of them are boys, and how many are girls? who dropout of school more ?
4. Is there any support from the school given to AIDS orphaned children not to dropout of school? What kind of support you are given to them? Food supply, uniform, stationery materials, etc.
5. What are the activities the school anti-AIDS clubs are currently performing? Are there supports the school receive from NGOs and the contribution of its members to react to the needs of AIDS orphaned children?
6. Girls are highly vulnerable to the impact of HIV/AIDS. Do you know girls who lost their parents to AIDS and forced to live schools and engage in prostitution for survival?
7. How do you think the impact of HIV/AIDS on the education of AIDS orphaned children be resolved?

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Semi - structure Interview Guide

Children, Youth and Family Department Head, MOLSA.

1. Ethiopia has an HIV/AIDS policy and strategic frame work which are being in practice. Is there any AIDS orphan policy or AIDS orphan task Force which aimed at reducing the suffering of AIDS orphans ? If so, what are the contents of the policy?

   If not, what are you (your office) planned in the future?
2. Do you have the data, as to the number of AIDS orphaned children in Ethiopia ? What the branch office in Addis Ababa is working in this direction?
3. There are complaints that NGOs and Associations of HIV carriers working in care & support of AIDS orphans do not give uniform support. Is there any attempt being made to correct this problem?
4. In social welfare development policy, there are articles about "children under risk and orphan and vulnerable children". Do you think this article includes AIDS orphans? If so, what kind of support they are planned to get?
5. Does an alternative child care guideline developed to address the issue of AIDS orphans?

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Interview Guide

Ministry of Health

1. The Ministry had tried its label best in order to produce an HIV/AIDS policy. Is there any attempt made to rehabilitate or support AIDS orphaned children ?
2. Is there any data concerning the number of AIDS orphaned children at National or Addis Ababa level ? If so how many of them are school age children?
3. What the Ministry is doing to curb the spread of HIV/AIDS in Ethiopia?
4. Is there any data regarding teachers' death by AIDS?
5. Is there any joint effort made by the Ministry of Health, Ministry of Education, HAPCO, MOLSA and other concerned Ministries to care for and support HIV/AIDS orphaned children ?

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Semi-structure Interview Guide

HIV/AIDS Prevention and Control Office (HAPCO and Addis Ababa HAPCO)

1. The HIV /AIDS policy and strategic Frame work have been developed and being implimented nation wide. Is there any orphan care policy or orphan care task force which attempt to address the needs of AIDS orphaned children ? If there is, what kind of support they are going to receive ?

2. Do you know the number of AIDS orphans in Ethiopia or in Addis Ababa? Is there any thing HAPCO is doing in this area?

3. Is there any attempt to develop standard in which NGOs working on HIV/AIDS & Reproductive Health to render uniform support to the needy?

4. HAPCO structured down to woreda levels. For example, what activities the Addis Ababa HIV/AIDS, Prevention and Control Office expected to play?

5. " Live and let live " is the slogan for year 2003. What activities HAPCO is doing currently?

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Semi - Structured Interview Guide

Tesfa Berhan, Association of AIDS orphaned children

1. How and when the association for AIDS orphaned children named as Tesfa Berhan established ? How many members did the association consisted of at its inception?
2. What is the age range of members?
3. What were the objectives of the association?
4. Inorder to realize the objectives of the association , what are you doing and in which streams?
5. From where do you get the financial support?
6. What kind of support do you give to members of the Association ?
7. What kind of support AIDS orphaned children who are in school received? (uniform, exercise books, etc.)
8. Is there any AIDS orphan policy or AIDS orphan Task force in Ethiopia? If not what role do you think your association can play in this regard?

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A Guide for Focus Group Discussion

1. How and with whom AIDS orphaned children below 15 years old are being reared? What do you say about clothing, feeding and general well being of these children?
2. What problems do AIDS orphans faced in education such as in school campus, inside class rooms, peer interaction, etc? How do these problems including stigma & discrimination be resolved?
3. Do you have educational problems such as books, exercise books, uniforms, etc? If so, how do you explain the status of the problem? What kind of solutions being made? What kind of arrangements are there to find lasting solutions?

   Eg. Credit scheme, learn while working different activities
4. What the Ministry of Education has been doing in support of AIDS orphaned children? What the ministry fails to do in this direction?
5. What kind of support the National HIV/AIDS prevention and control office as well as the Addis Ababa HIV/AIDS prevention and control office need to play in support of AIDS orphan education? If so, is the support satisfactory?
6. The support given to AIDS orphans reached only to small section of the needy. Beyond and above, there is a big disparity among supporting agencies. What strategies should be designed to correct the problems?
7. Some Eastern and Southern African countries developed an AIDS orphan policy as well as AIDS orphan Taskforce to give uniform care and support to AIDS orphaned children. What is being done in this direction?

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I here by declare that this is my original work. All the relevant sources used for the thesis are dully acknowledged.

Name : Feseha Woldemichael Tadesse

Signature:_____

Date :June 2003

Place :Addis Ababa University,Facultiy of Education,

Department of Educational Psychology.

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