DEVELOPMENTAL IMPLICATIONS OF HIV/AIDS, THE CASE OF AIDS ORPHANS & CAREGIVERS IN ADDIS ABABA

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Key words

AIDS orphans, Caregivers, Development, Discrimination., Extended family, HIV /AIDS, Impact, Poverty, Social Stigma,

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Acronyms

AACAHB	Addis Ababa City Council Administration Health Bureau
AIDS	Acquired Immuno Deficiency Syndrome
CBOs	Community Based Organizations
CSA	Central Statistical Authority
ECA	Economic Commission for Africa
FDRE	Federal Democratic Republic of Ethiopia
FGDs	Focus Group Discussions
HIV	Human Immunodeficiency Virus
ILO	International Labor Organization
KII	Key Informants Interview
MMM	Medical Missionaries of Mary Social Services and Counseling Center
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
NAC	National HIV/AIDS Council Secretariat
NGOs	Non-Governmental Organizations
OAU	Organization for African Union
OSSA	Organization of Social Services for AIDS
PLWHA	People Living With HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
SSA	Sub- Saharan Africa
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Abstract

Children orphaned due to HIV/AIDS are those with broken families, beyond their control they are vulnerable to various kinds of survival and human rights problems. Their problems are so complex, multi-dimensional and very serious and have been increasing in the sub-Saharan Africa. Ethiopia, as one of SSA country, is most seriously affected by the HIV/AIDS pandemic with the estimated number of AIDS orphans between 720,000 to 1,200,000 while this number, in the study area is estimated to be about 20,000 to 30,000. There are different reports indicating the problems of AIDS orphans yet adequate documentation is lacking in Ethiopia. Thus, studies on the developmental impact of AIDS orphans are very rare in the country. There fore, this study, which is the first of its kind in the country, gives a glimpse of how these children are surviving after losing their parent/s. The objectives of this study, therefore, are to reflect and describe on the major survival problems and factors aggravating the orphans' problems; to describe the roles of extended family, community and institutions in caring for the AIDS orphans, and to find out who is the most vulnerable orphan in the community. To achieve its objectives, this exploratory study used qualitative research method (plus a quantitative method) by triangulating methods, information and the respondents. The study covered a total of 71 AIDS orphans, 27 caregivers, 20 key informants, 11 focus group discussions with 78 participants of different categories, one anecdotal account and observation method. The children (study subjects)- the units of analysis were selected using purposive sampling method.

The results of this study showed that the orphaned children and their families were confronting the economic, psychological and social problems, which are hindering them from accessing basic needs and services. The findings also revealed that girl orphans and those orphans heading their household are the most vulnerable to various kinds of problems and they are overburdened by shouldering the responsibility of care giving to the siblings and other members of the family. Based on the findings of this study and due to the fact that the impacts of having many AIDS orphans are multidimensional and complex, it is suggested that a combination of intervention strategies and approaches of reducing the vulnerability, preventing infection and premature mortality, impact mitigation and provision of adequate care and support for the AIDS orphans and their families, intensified and integrated plan of actions targeted both on poverty alleviation and HIV/AIDS, social mobilization and the like are imperative in order to ameliorate the problems of AIDS orphans and the consequent implications on local and national development.

Part I. General Background

1. Introduction

Development is a multidimensional process involving positive social, economic, political, attitudinal and cultural change that ensures people's opportunities, access to resources and basic services, reduction of inequality and poverty alleviation (Meier, 1995; Todaro, 1994)) so as to improve their well being. However, natural and man-made calamities such as famine and drought, war and ethnic strife as well as the devastating impacts of HIV/AIDS deter people from benefiting the fruits of development.

It is well known that local economic development [LED] is the process by which development actors (public, private, NGOs, CBOs etc) within a locality come together to create better conditions for economic, social and cultural development (World Bank, 2001 cited in RLDS /AAU, 2001).It is a process in which partnerships between local governments, community-based groups and the like are established to manage existing resources to stimulate the economy of a well-defined area (Helmsing, 2001).However, the process of local development in countries likes Ethiopia face multitude of challenges –inadequacy of basic services, presence of poverty, the crisis of AIDS pandemic which are seriously affecting local/sub-regional or national development endeavors.

Even though decentralization has enabled the local governments of Africa to identify and decide on their developmental problems and plan strategies with in the context of local economy. Yet the processes of development endeavors are retarded and localities and regions falling challenges in taking responsibilities for their own development (Helmsing, 2001). Among the vital factors acting as bottlenecks for LED or national development is the social and economic implications brought by HIV /AIDS epidemic (Plilipos, 2002).

Signs of the first AIDS cases were seen in 1981 when doctors in the USA began to notice a series of unusual infections in gay men in San Francisco, New York and other big cities. The pandemic and its multifaceted dimensions resulted in unprecedented fed global concern. In spite of global effort to find cure or vaccines, the epidemic is still on the increase every where but affecting people in the developing world to a greater extent. Countries in sub-Sahara Africa, are severely hit by the pandemic. In this regard, HIV/AIDS pandemic has become a major concern as a major

developmental problem having tremendous implications on the lives of children, families and the society at large. Hence the pandemic is a full-blown development crisis affecting all settings and sectors of the economy and country.

As one of the development crises, the HIV/AIDS epidemic is fast spreading all over the world and expanding its spatial coverage even to the very remote areas. HIV/AIDS is nowadays the biggest developmental challenge that the world has ever confronted (Botchwey, 2000; Petros, 2002, MOH, 2000 & 2002), - a disease which UNAIDS ($2000_{a\ \&\ b}$) noted as "unique in its devastating impact on the social, economic and demographic foundations of development", thus has a negative implications for development.

Ethiopia is one of those countries highly affected by HIV/AIDS in Africa, south of Sahara. The Ethiopian Government responded to HIV/AIDS epidemic by establishing National AIDS Control Program in 1986 under ministry of health (MOH and UNICEF, 2000), adopted a national policy on health in 1993, on HIV/AIDS in 1998 and national strategic framework in the year 2001 by realizing HIV/AIDS not only as a health problem but also a developmental challenge (MOH, 2000*; NAC, 2001)***.**which are designed to guide the implementation of successful programs to prevent the spread of HIV and AIDS (MOH and UNICEF, 2000; MOH, 2000; Philipos, 2002, NAC, 2001).

HIV/AIDS has a large social, psychological, demographic and economic impact on both the individual and society, thus leading to painful stress, disability, death of adult parents and children, and the induced orphan hood.

Even if HIV/AIDS is not only a health problem, good health of the society enables them to be active participants in the overall development processes. However, in countries like Ethiopia, where the health care delivery system is entangled with complex problems of quality, accessibility and equity(Philipos, 2000), the necessary health and the related infrastructure to provide adequate services such as HIV/AIDS prevention and care through multi-sectoral involvement is insignificant. Therefore, inadequacy of the health facilities and infrastructure indicate low status of the health care provisions and inadequate prevention and care for AIDS affected members of the society of the country.

At some point in the 1970s, unbeknownst to the world, the HIV gained a foot hold and began its insidious spread, forever dividing the 20th century in to two eras- before and after AIDS. The AIDS era is likely to be an enduring one, stretching far into the century ahead. No end is in sight. The pandemic will be with us for many decades to come.It presents us at the same time with an emergency situation: unless every effort is made now, immediately, to stem the further spread of HIV, countless new infections will occur and inexorably progress on AIDS, adding their weight to the overwhelming burden of suffering, death, familial disruption and socioeconomic havoc already imposed by the pandemic.

It is a tragic irony that almost 20 year after the AIDS pandemic started its threat on social, economic and demographic foundations of the poor countries. The number of people infected with HIV in the world already reached an estimated number of 42 million with about 95% living in the developing world and a staggering 75% in sub-Saharan Africa alone. What is more, the rate at which the epidemic is spreading is alarming (UNAIDS/WHO, 2001 & 2002).

HIV/AIDS has taken on different forms at different settings and parts of the world. In some populations, the epidemic is equally prevalent among men and women, in others, certain vulnerable groups have been disproportionately affected; in many cases the situation is dynamic and the disease has moved between different sub-populations evolving with time. Explanations for these distinct patterns are to be found in diverse factors including biology, behavior, gender, geography, culture, poverty, level of development, mobility and the interplay between.
In the underdeveloped countries, it is fair to say the initial orientation of the vast majority of the policy makers and other stakeholders were to see the AIDS epidemic not a development challenge as such. However, nowadays, the pandemic has become recognized as a threat to local/regional/national and international development so that attempts of “mainstreaming” AIDS in to instruments of development is both desirable and a necessary condition (Philipos, 2002).

In poor countries HIV/AIDS is condemning millions to misery and poverty. So far, globally, AIDS has left behind 13.2 million orphans- children who, before the age of 15, lost either their mother or both parents to AIDS (UNAIDS/WHO, 2000c; Philipos, 2002). Many of these children have died, but many more survive, not only in Africa- where almost 95% currently live, but also in developing countries through out Asia and the Americas. In Africa HIV/AIDS is generating orphans so quickly that family structures can no longer cope. In the absence of effective efforts to

mitigate the effects of AIDS pandemic on this generation, whole societies will become dysfunctional, with negative consequences for human development and even basic security as well.

The problem of HIV/AIDS in poor countries has been the top and prior agenda for the last one or two years. None the less, the social and economic development statuses of these countries lag behind due to natural and man made catastrophes. Their social, economic as well as institutional infrastructures are not well developed. These and other problems are believed to aggravate the crises of HIV/AIDS in these countries.
In response, many of the national and international agencies have searched and still searching every nook and cranny to find the way out of the mess of AIDS pandemic. Yet, the ultimate results of these efforts were not able to adequately address the problem.

*In this regard, the increasing number of infected persons, premature mortality of adults and the number of AIDS orphans in Ethiopia are all the signs indicate that HIV/AIDS epidemic is escalating very fast in the country. It is now common place to see scores of funeral procession for AIDS victims, especially in the urban centers (In fact the epidemic is being rampant in the rural settings too).
According to the National AIDS Council Secretariat (2001) and PRSP (2001), estimated 2.9million Ethiopian adults and 250,000 children are living with HIV/AIDS more than any country except South Africa and India.

It is generally true that society's economic and social well being is a pre-requisite for the general development of a nation. However, poverty increases people's risk of getting HIV infection and HIV/AIDS illnesses, death and induced orphan hood leads to absolute poverty. All of the socio cultural differences not withstanding, people every where have the same basic needs. They want security, they need food, and children everywhere need to be taken care of, need to be raised, need to be educated. These all are global factors.

However, due to the impact of AIDS epidemic, in poor countries, the family insecure due to loss of income and costs related to illness and death hence indebtedness increases.AIDS weakens the coping mechanism of communities, deteriorates the extended family system and aggravates poverty (UNAIDS, 1997, 2000*b*; World Bank, 2001*b*). This shows that AIDS has become and

continues to be a developmental hazard threatening the socio-economic and socio-cultural aspects because of its dreadful effects on individuals, families and the society at large.

Since the epidemic is taking a devastating toll in terms of human suffering, it is jeopardizing economic growth, development prospects and like. Moreover, AIDS pandemic and its induced problems continue to be a subject of uncertainty, a cause of anxiety, a basis for myths, prejudice, stereotypes, stigmatization and discrimination. Thus its consequences multifaceted, affecting both the general development environment and prospects and welfare of the households and individuals.

The fact that once the parents have died, children primarily lack protection, income, security, care and support, badly nourished, lack access to basic necessities of survival. And as a coping mechanism due to their exposure to economic dependency and social stigma, AIDS orphaned children are often forced to fend for themselves or obliged to live in the streets, vulnerable to physical abuses, sexual violence and STIs including HIV/AIDS.
The general purpose of the paper is to identify and assess the social, economic and developmental impacts of increasing number of AIDS orphans. The paper is intended to survey the problems and issues underlying developmental implications of HIV /AIDS with special emprises on the impact of having so many AIDS orphans on development. It investigates the major survival and human rights problems and coping strategies of AIDS orphaned children. That is, it presents an exploratory and cross-sectional account on the problems of AIDS orphans and extended families that are providing care and support to the orphans.

This paper has = parts. The first part deals with the general background, statement of the problem, significance and objectives of the study and background about the study area. The = part deals with the review of related literature on the stated problem. The = part describes the major research questions, conceptual framework and methodology. The fourth part depicts the results of field findings. The= part deals with discussion and analysis of the major findings. The sixth part presents conclusion and recommendations.

2. Rationale

As we know there is an increasing awareness of the public about AIDS in Ethiopia. Yet, much has to be done in making the people aware of the developmental danger posed by HIV/AIDS.

HIV/AIDS and its devastating impacts like premature mortality of adults/parents and induced orphan hood are so complex, thus the study helps to map out strategies to tackle the problem of AIDS affected/afflicted members of the community. Its findings can be used as a starting point for interventions and encourage development planners and policy makers to incorporate the impacts of having many AIDS orphans on local/regional and national development in their strategic planning process. In addition, the study will help to foster increased commitment and awareness of the public and encourage stakeholders to address the problems of AIDS orphans as one aspect of regional and local development.

In countries like Ethiopia where there is scanty information available on the issues of AIDS orphans, this study gives an insight on the major problems under consideration. In addition, the results of the study can be used as a beginning point for further investigation on the orphan's problems.

The growing numbers of AIDS orphans and vulnerable children in Ethiopia represent a grave concern for education, health, and social welfare development organizations.

While in most parts of underdeveloped statistics on orphans are not always reliable, they are consistently alarming (Voysey, Wilson andTheresa, 2001). Before HIV, care and protection of orphans in African countries was mostly absorbed by the communities. Now, the increasing numbers are rapidly having beyond coping capacities of many communities.

It is well documented that AIDS induced illnesses and deaths adversely affect households. Principal income earners who are HIV positive are likely to lose their source of income and medical expenses represent a significant strain on household income, as does their death. Consequently, orphaned children lose their right to a decent and humane existence, without the care and protection of parents, or an appointed caregiver, children are more likely to lose the opportunity for schooling, nutrition, shelter, health care and the love, affection and guidance required for growth into responsible adulthood.

The importance of being able to control and prevent the spread of HIV/AIDS and its induced problems is crucial in any development issues because only a 'healthy' people can do a full job and reach an optimal economic level. It is also true that the health of the people is the wealth of the country thus the economic value of improved 'health' condition could be proved as an increase in human capital and productivity (Philipos, 2000).

Even if AIDS affects all sectors of the economy (Ainsworth and Over, 1994), the impacts that are incurred as a consequence of HIV/AIDS are not just financial in nature but fundamentally social and psychological. There is no conceivable way of measuring all AIDS induced costs and burdens, however, it is possible to explore the ways in which the disease affects different economic and social sectors and development at large (Botchwey, 2000).

The study undertaken by the World Bank (2000) depicted That AIDS deaths were not merely indicating the data. But it revealed that of socially and economically active members: fathers and mothers, brothers and sisters, doctors and nurses, schoolteachers, engineers, community leaders, finance managers, entrepreneurs, researchers, and farmers trying to lift their families out of poverty. The crisis of HIV/AIDS is a global problem but its impacts are much more severe in the resource-constrained countries. An increasing number of AIDS orphans nowadays become one of the critical issues raised as challenges to development. For instance, the number of AIDS orphans is increasing yet their demand for basic services are not met through the kinship and traditional support systems. Consequently, the majority of these children do not have access to basic services thus forced to seek for care and support from the incapacitated relatives, NGOs or else search for other coping mechanisms, which may further create poverty in the future. Furthermore, due to their exposure to economic dependency and social stigma, orphaned children are often forced to fend for themselves or obliged to live in the streets, vulnerable to physical abuses and sexual violence as well (UNAIDS/WHO $_{b\&c}$, 2000; UNAIDS, 1999 $_{a\&b;}$ Philipos, 2002).Unless they are properly supported and cared, they end up in being street children (OSSA, 2001). The burden of caring for the children orphaned by AIDS will strain the extended family network and disrupts the social systems (World Bank, 1996).

According to UNAIDS/WHO (2000_b), as the number of orphans grows and the number of potential caregiver shrinks, traditional coping mechanisms are stretched to breaking point. HIV/

AIDS is an epidemic that possibly wipes out a generation and unlike other diseases, it shrinks down those in prime of life. Consequently, the young people, the weak and the vulnerable are left in the household to carry the burden of caring for orphaned children and other members of the family. By actually causing the destruction of families due to the death of either one or both of the parents, the pandemic creates social instability (UNAIDS/WHO, $2000_{a\& b}$).

Regarding the statistics of AIDS-orphans in Ethiopia, UNAIDS/WHO (2000_c) estimated 1,200,000 orphans while the Ethiopian MOH (2000) and NAC (2001), reported approximately 750,000 AIDS orphans by the year 2000. Due to increased premature mortality of parents from AIDS, the size of orphans and the magnitude of their problems increases and if they are not properly cared and assisted, they will become hopeless and their future contribution to the development endeavors will be minimal.

3. Conceptual Model and Analytic Framework

The term impact can mean many different things for different people and what it means depends on the perspective adopted by the researcher, the conceptual framework and other research instruments (Barnet and Whieside, 2000).These writers further noted that the impacts imposed by HIV/AIDS vary across different level (from macro-to- meso- then to micro level impacts); disciplines(social or economic impacts); time(short-term, medium or long-term impacts). However, usually it is hard to measure the national impacts because the instruments of macro-economics and the available data do not provide fine enough measures, thus impacts should often be seen at micro and meso levels(Barnet and Whieside, 2000).

"Impact" can mean many different things for different people and what it means depends on the perspective adopted by the researcher and the concepts and other research instruments that their discipline offers. As noted by Barnet et al (2000) if impact is to be found it must be searched for and if impact is to be seen it will be most clearly seen at the micro and meso- levels.. Macro impact means the impact on the whole economy and society while micro impact means an impact is concerned with the individual, households and communities. Meso- impact, on the other hand refers to the institutions and activities such as firms, local government units, large community organizations, religious organizations and like.

Conceptually, AIDS orphans are those children who lost their mother or both parents to AIDS when they were under the age of 15(UNAIDS/WHO, 2000 $_{b\&c}$; Botchwey, 2000; ADF, 2000).

Since the major aim of this study is the systematic assessment of the social, economic and psychological outcomes and implications of HIV/ AIDS and the major problems the orphans are facing.

Source: Formulated from the literature review ideas by the researcher (January 2002).

Child – Person under the age of 18, unless by law majority is attained at an earlier age (convention on the

Orphan – In the absence of an official definition in Ethiopia, the definition in this instance is a child who has lost one or both of his/her parent (s). In the context of the HIV/AIDS epidemic in Ethiopia, which is predominantly heterosexually transmitted, a child who has lost a parent due to HIV/AIDS is likely to have an infected remaining parent. A child orphaned by HIV/AIDS is not always easy to distinguish from other orphans due to the fact that cause of death and parent's whereabouts are often and records are often not available. The number of orphans has increased in Ethiopia and it is assumed this is due to the escalating AIDS- Related mortality rates.

Vulnerable Children – In the context of HIV/AIDS, vulnerability refers to children living in a household where the duty bearer and bread winner is ill AIDS or died of it. It also refers to children living in a household that takes in orphaned children.

HIV/AIDS Affected Family–A family who is caring for someone in the immediate or extended family who is infected with HIV, or that the family has experienced a death from AIDS in their household and is straggling to keep itself together, or it can mean that the family has had to absorb several orphans.

Based on the purpose of the study, both the general and analytic frameworks are constructed as a guide for exploratory and explanatory investigation of meso- and micro-level impacts of the pandemic. The logic of the framework traces the major problems faced by AIDS orphans and caregivers and the resultant implications on the local and regional development efforts.

The framework postulates that when children encounter parental death, the most immediate problems are: loss or decline in income and transition in to relative poverty; dispersion of the children to different homes within and outside the extended families; the surviving families will severely compromise their resources; orphaned children lack access to the basic needs/services and often forced to discontinue schooling because of resource constraints that are intensified by medical and funeral expenses or due to the demand for participation in home care activities; traditional coping mechanism of caring for the orphans is overburdened thus the social welfare system is severely affected; the children become vulnerable to streetism, abuses and violence due to lack of proper care and support.

Therefore, all of these risk factors, on their own or together, tend to increase the economic, social and psychological vulnerability of AIDS orphans and have the overall negative implications on the development efforts of the community and nation at large. The framework also postulates some of the mitigating factors to ameliorate the problems under consideration that impedes both the local and national development.

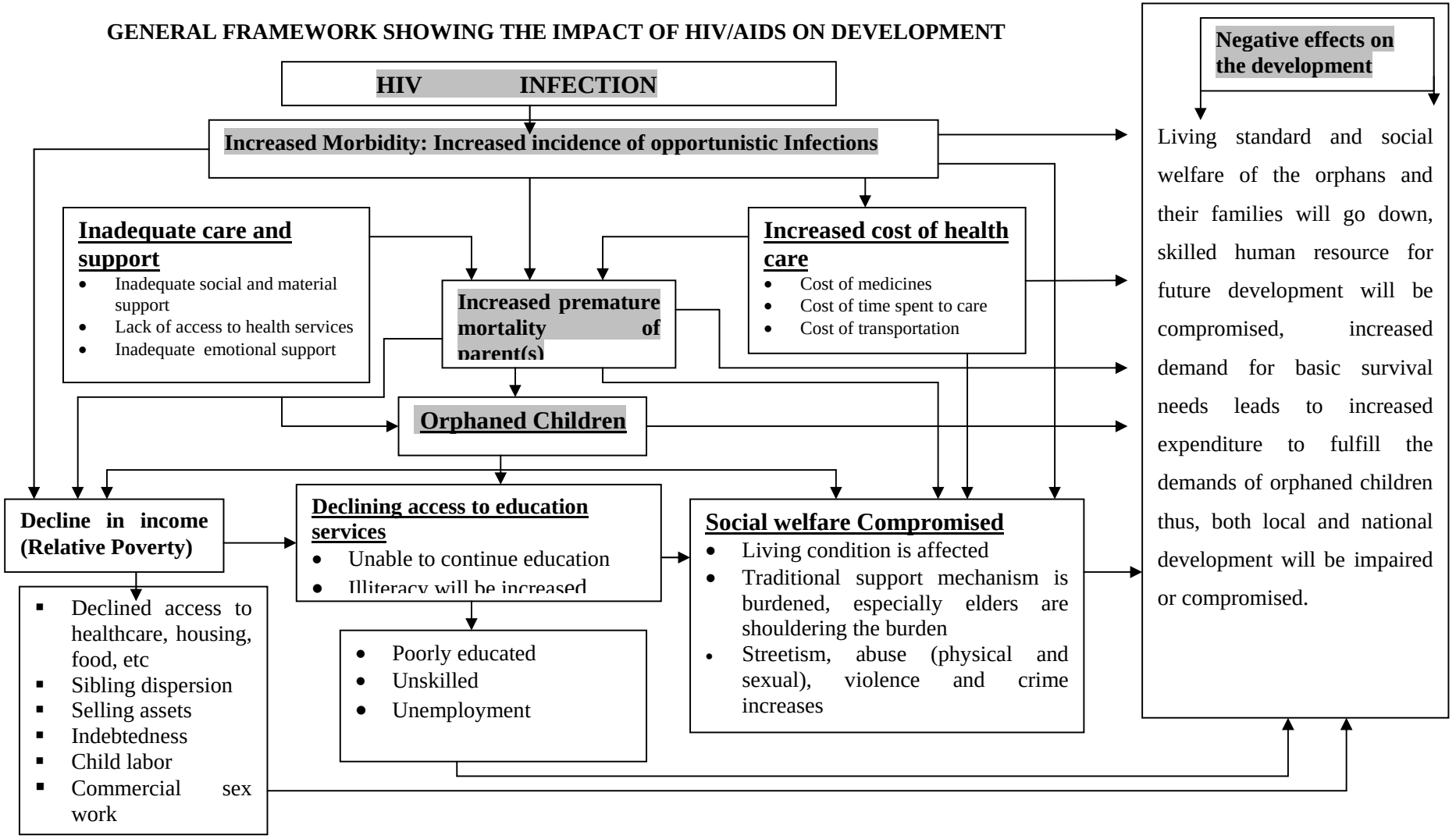


Fig. 5 General framework showing the impact of HIV/AIDS on Development in relation to AIDS orphans

Source: Formulated from the literature review ideas by the researcher (January 2002).

Analytic Framework for studying the developmental impact of HIV/AIDS, the case of AIDS Orphans

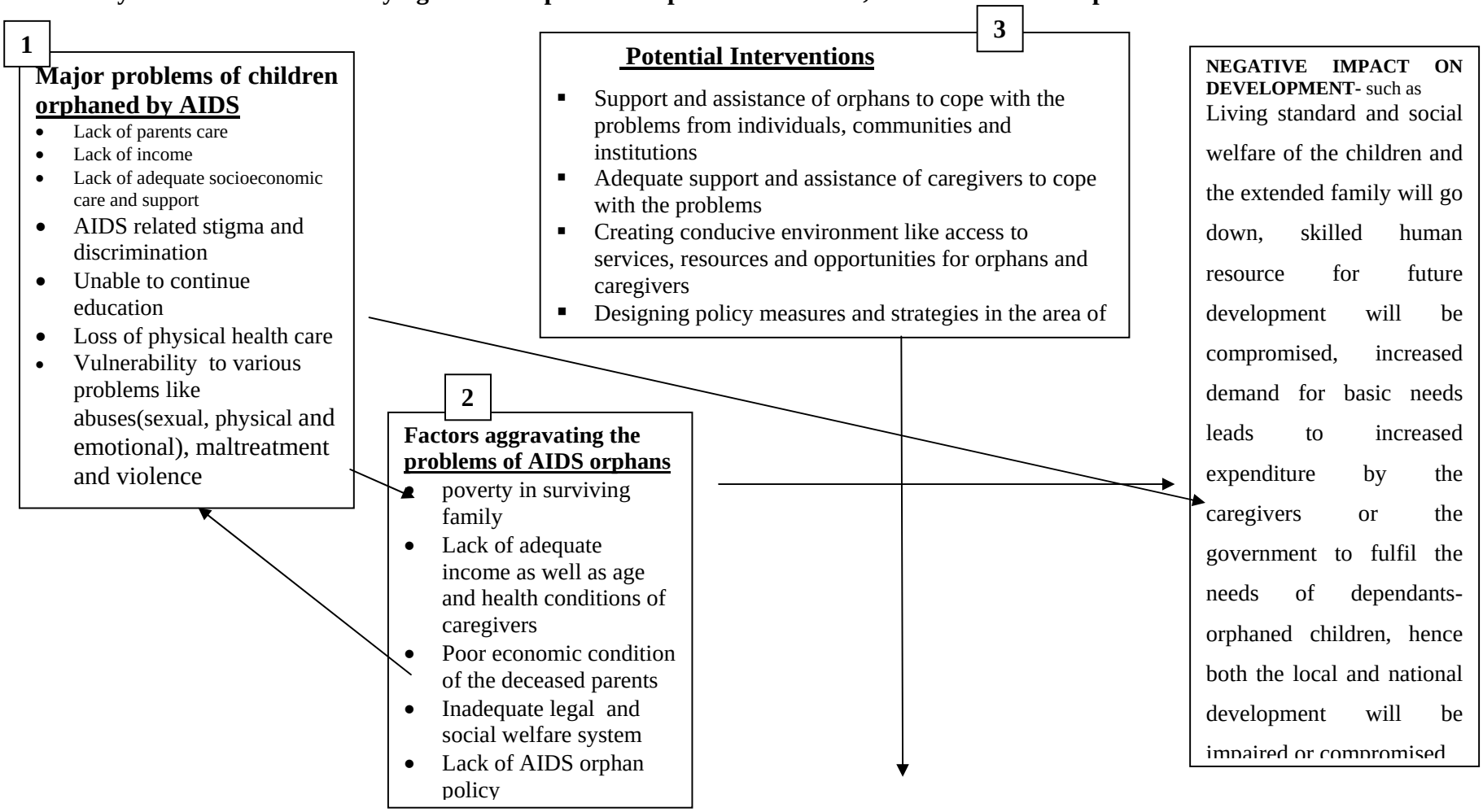


Fig. 6 Analytic framework for studying the developmental impact of HIV/AIDS, the case of AIDS orphans

Operational Definitions

For the purpose of this particular study, the "developmental implications of HIV/AIDS" is the social, economic and psychological effects of HIV/AIDS on development in general and the effects of AIDS pandemic on the lives of AIDS orphaned children, and the implications of having many AIDS orphans on the welfare of the household, extended family and community at large.

Impact can be direct and indirect or intangible and tangible. Direct impacts are those consequences directly affecting the individual AIDS orphan or caregivers, or households due to AIDS induced income loss, lack of access to basic needs and services. Whilst indirect impacts are those impacts affecting the community or institutions by making them shoulder the burden of care giving to the orphans or sharing their resources. Tangible impacts are those impacts, which can be direct or indirect impacts that can be quantified. Intangible impacts are those associated to grief, trauma, social exclusion and stigmatization, which is not quantifiable thus often, presented in a qualitative form.
"AIDS orphans" are those children aged below 20 years, who lost either one or both parent(s) due to AIDS.

"Caregiver" is member of the household and extended family network or neighbors and other community members who are giving the social, economic and psychological care and support to the AIDS orphans.

"Extended family" is conceptualized as the network of family structure or relatives which comprises grand parents, parents, and their children, uncles, aunts and like who either share a common residence or not living in the same household but maintaining close ties with the nuclear family".

Part II Study Setting and Methodology

2.1 Setting

The study area, the city of Addis Ababa, is selected for the research because it satisfies conditions like both the infection and adult deaths as well as the induced orphan hood in general are higher in the urban areas. In addition, the availability of NGOs and associations working with AIDS orphans and the affected families made the writer to get knowledgeable respondents, the study subjects and access information regarding the problem under consideration.

Even if the 1994 National Census Report, projected the 1999 population of Addis Ababa to be 2.57 million with the annual growth rate of 3.79% yet the city's current total population is estimated to be more than 3 million, which makes the city one of the fastest growing towns in the sub-Saharan Africa. With respect to the HIV/AIDS situation in Addis Ababa, the first two AIDS cases in Ethiopia were identified in the city of Addis Ababa (1 from Addis Ababa and 1 from Russia) in the year 1986 (MOH, 1998, 1999 and 2000). The adult prevalence rate was estimated at 16.8 percent, which was 13.4 % for other urban areas in 2000 (National AIDS Council, 2000). The MOH (2002) reported the prevalence rate for the country as 6.6 and that for the city of Addis Ababa as==. While MOH and UNICEF on the other hand reported the prevalence of HIV infection in Addis Ababa as 17%(MOH and UNICEF, 2000) while 1 of 6 persons were infected by HIV in the city of Addis Ababa (MOH, 2000).

Moreover, Organization for social Services for AIDS (OSSA) and the City Council Administration Health Bureau described the existence of over 350,000 HIV infected people in the city, and up to 60,000 residents of Addis Ababa would still become newly infected in each year (AACAHB, 1999; OSSA, 2000). It is further indicated that HIV infected people in the city will rise to 455,000 by 2014 ; between 1999 to 2014, the projected death due to AIDS in the city is between 53,000 to 554,000 and in the year 2014, the cumulative death will be 607,000.
(AACAHB, 1999). Between these years, it is estimated that the HIV virus infects each day 85 persons of Addis Ababa.

Further more, the number of children orphaned due to AIDS is estimated at 20,000(AACAHB, 1999) and 30, 000(OSSA, 2000) and this figure would be 64,000 in 2003(AACAHB, 1999) and it is expected to increase to 145,000 by 2014(AACAHB, 1999; OSSA, 2000) (See Appendix--).

This indicates how the number of AIDS orphans is escalating at alarming rate and will create deleterious effects on all aspects of life and become a developmental hazard.

2.2. Study Design and Methodology

The nature of the study necessitated the use of either or/ both the qualitative and quantitative data collection techniques. Therefore, the study mainly employed qualitative research methodology by triangulating techniques, information and methods. Data were analyzed thematically by using content and textual analysis methods.

As far as the use of qualitative method is concerned, open-ended and semi-structured interview and focus group discussion guides were used as the main data collection instruments.

2.2.1. Rationale for Adopting Qualitative Method

There are a number of reasons for choosing a qualitative research methodology for this particular study. Firstly, qualitative research is considered to be an appropriate methodology for researchers whose research questions lead them towards an 'inductive' or ' data driven' approach- that is, to look at what is going on and try to make sense of that by testing out themes and patterns. Secondly, qualitative research is said to suit research in which descriptions and explanation (rather than prediction based on cause and effect) are sought, when it is not possible or feasible to manipulate the potential causes of behavior, and when variables are not easily identified or are too embedded in the phenomenon to be extracted for study (Hudelson, 1994; Pope and Mays, 1999). Thus qualitative research is well suited to understand and examine complex social phenomena like that of AIDS induced orphan hood.

Therefore, due to the complexity of the topic of study and lack of ready made and reliable data at national and regional level, entirely qualitative methodology was employed by using different interview techniques such as in-depth interview, focus group discussions, key informant interviews, direct observation, and anecdotal accounts to gather first hand information. Quotes from the interviews are integrated in the presentation to elucidate the issues (Berhane et al., 2001) as brought forth in the respondents' own words.

2.2.2. Subjects and the Study population

In this study different category of respondents participated. Even if the unit of analysis are AIDS orphaned children and their caregivers, information was collected from various categories of study population so as to ensure the validity and reliability of data.

AIDS orphans

AIDS orphans were selected from NGOs providing support for them. Some subjects were selected from orphans heading their household and those living lonely; those cared by parent's friends or by those people who have no blood relation with them and those living with their relatives and surviving parents or grand parents. Age of the orphaned children (between 10 –20 years old) was considered as a selection criteria for the purpose of obtaining reliable data thus, children in this age category are considered to be knowledgeable and they can express their views regarding the issues and problems induced due to HIV/AIDS.

Caregivers-They were also selected from same institutions where the orphaned children were selected.

NGO workers-These are key informants who were selected from NGOs working with AIDS orphan

Workers from government institutions

These are also key informants selected from relevant institutions of religious institutions, HIV/AIDS secretariat offices and other public sectors, and the local government *(kebele*).

Focus Group Discussants

These include CBO representatives, Caregivers, AIDS orphans and local government representatives

Regarding the total number of study population, those AIDS orphans participated were 114(71 respondents of in-depth interview and 43 focus group discussants), that of caregivers were 41(27 respondents of in-depth interview and 17 participants of focus group discussion)(See Table 4.1 for detail).

2.2.3. Instruments Used

2.2.4. Ethical Considerations

The researcher followed a standard and scientific procedure of doing research in such a very sensitive topic. Accordingly, the subjects and study population were introduced first about the purpose of the study, keeping confidentiality of the information gathered from them. Then informed consent from respondents and relevant officials of the institutions covered in the study was obtained to discuss with and interview them. The participants were also informed that they have full right to discontinue or refuse to participate in the study.

PART III DEVELOPMENTAL IMPLICATIONS OF HIV/AIDS

HIV/AIDS Impact in Context

In deed AIDS is caused by the HIV. The virus attacks a person's immune system by entering the blood stream through sexual intercourse; use of contaminated blood or its products, or sharing of sharp equipment; and through mother to child. Once a person has been infected with HIV, he/she will remain infected until death. One of the crucial points that have to be made about the epidemic is that it is different from most other epidemics and diseases. The factors that make it unique are- it is a new epidemic which was first recognized in 1970s and 80s; it has a long incubation period; in the absence of an effective therapy and vaccine, at the end of the incubation period, a person will usually experience periods of sickness increasing in severity, duration and frequency, until he/she dies.

HIV/AIDS is a global phenomenon, which cuts across all geographical boundaries of nations and nationality, gender, age, class, education and occupation. The figures speak for themselves. With an estimated million sons with HIV in 2001, HIV/ AIDS its induced impacts are in immense human, economic and social tragedy. It is also understood that HIV is a treat to human rights, because PLWHA, AIDS orphans and the affected /afflicted families are subject to stigmatization and discrimination. Individuals who suffer discrimination and lack of human rights protection are both more vulnerable to becoming infected and less able to cope with the burdens of HIV/AIDS.

Economic problems of the country have further aggravated the impacts of HIV/ AIDS. The growing poverty level aggravated the disruption of the extended family system. For instance, if a child lost either a mother or a father, or both, the extended family would take over the responsibility of caring for

the orphaned children. However, the poverty situation and rising number of AIDS orphans, the likelihood for the disruption and discontinuation of traditional coping mechanism is looming larger.

According to ILO (2000a), economic growth could be as much as 25 percent lower than it might otherwise have been over a 20–year period in high prevalence countries. Their population will be about 20 percent lower by the year 2015 than they would have been without HIV/AIDS, and their labor forces in the year 2020 will be between 10 to 20 percent smaller. HIV/ AIDS also has a significant impact on ht composition of labor force in terms of in terms of age, skills and experience.
From gender perspective, HIV/AIDS is threat to gender inequality owner are highly vulnerable to HIV/ AIDS for biological, social, economic and cultural reasons. They are particularly affected when a male head household falls ill. The burden of caring for orphaned children is born mainly by women (ILO, 2000a).

HIV/AIDS also increases child labor. The tremendous pressure on households and families often forces children to work. As a result, it is difficult for them to attend school, they do not receive proper care and guidance, and easily fall victim to all kinds of exploitation. For all these and other reasons, HIV/AIDS is a major, factor undermining the welfare of community and local regional and national development as well.

Various studies (Kifle, 2002, Kidane,2002, Mahmud, 2001, Serpell, 2000; UNAIDS/WHO, 2000b, World Bank, 2002) have indicated the multidimensional nature of the implications of HIV/AIDS pandemic in the African countries. These effects are considered as demographic; social; economic and developmental in nature. Regarding its demographic impacts the findings of the above studies revealed that AIDS will affect the population in a numerous ways- increased morbidity leads to reduced fertility rates, yet the epidemic will not stop population growth, nor will it cause population size to fall, thus any idea that " AIDS is the solution to the population problem" is unfounded. What it will do in some regions of Africa, is slow the rate of population growth and alter the structure of the population (population pyramid changed to population chimney). With respect to the economic implication, it was found that at the household level, the effect of the pandemic is obvious; increases expenditure for medical care and related costs, production and income reduced while at the national economic level,

illness and death of producers and the diversion of resources from savings (and, eventually, investment) to care.

Whilst with respect to its developmental consequences, if it is accepted that development is about more than economic growth and increases in GDP per capita, and includes things such as longevity; standard of living, and distribution of income, then it is at this point that the impact will be felt first and worst.

Macro and Micro impacts

HIV/AIDS impacts right across the social, economic and political spectrum from the national to the individual levels. It is however well known that national impact is hard to measure because the instruments of macro economics and the available data like savings, GDP, GNP do not provide, in our country's context, fine enough measures.

In this regard, Mahmud (2001) described that the macroeconomic impact assessment of HIV/AIDS is difficult. However, from other countries perspective like Swaziland, Kenya, Tanzania, Cameroon, South Africa, etc there are studies showing several mechanisms by which AIDS affects macroeconomic performance and hence social and economic development. He further indicated that the overall impact of HIV/AIDS on the macro economy is small at first, but it increases significantly over time. By directly ruining the human capital, HIV/AIDS threatens the socioeconomic equilibrium of high-prevalence countries. It therefore appears necessary to account for this economic impact on a nationwide scale, as do the authors of macroeconomic models.

Nonetheless, from Ethiopian perspective, the literature on macroeconomic impacts of HIV/AIDS is very scanty. Yet Kello (1998) assessed the impact of AIDS on the Ethiopian economic and health care system. This study calculated both direct and indirect costs related to HIV/AIDS. Accordingly, in terms of per capita patient cost, the low scenario (lowest figures) gives US$ 12.03 outpatient cost and US$ 24.64 inpatient cost. The high figures scenario per capita outpatient visit cost is US$ 41.30 and the per capita inpatient costs are US$ 197. The total real cost of preventive services will amount to US$ 56 million in the next 10 years. Indirect costs in terms of income loss due to premature deaths over the ten-year period (1997-2006) stood from US$ 1496 to US$ 2719 million.

Studies on the micro level impacts of HIV/AIDS in Tanzania and Zambia on the other hand indicated the links established between the illnesses and food insecurity and impoverishment of certain families and the like. Other studies like that of Aventin et al (1999) in Cot d'ivoire and Bersufekad(1994) of Ethiopia assessed the socioeconomic implications of AIDS on industrial firms indicated the correlation between HIV/AIDS and length of sick leaves lead to the decline of the output and amount of per capita income Mahmud (2001).According to these studies, for Africa, HIV/AIDS is perhaps the single most important obstacle to social and economic progress.

According to the estimates of UNAIDS/WHO, some 40 million adults and 2.7 million children were living with HIV by the end of 2001(UNAIDS/WHO, 2001). Already, 18.8million people around the world have died of AIDS, 3.8million of them are children while 34.3million people were living with HIV till the year 2000 but in 1999 alone, 5.4million people were newly infected with HIV (UNAIDS/WHO, 2000_c).

Before the advent of HIV/AIDS, approximately 2% of children in developing countries were orphans but by 1997 this proportion increased to 7 % and has today reached 11% in some countries. An overwhelming majority, that is, 24.5 million PLWHA are living in Sub-Saharan Africa(UNAIDS, 2000_c).

UNICEF reported that children whose parents have died of AIDS are less likely to attend schools than those who have not lost a parent. The report further indicated that among AIDS orphaned children, girl orphans are at a double disadvantage and they contend with more severe challenges such as stronger cultural constraints, deeper poverty, discrimination, and early sexual activities that increase the risk of infection with HIV/AIDS (UNICEF, 2000).

Moreover, it is indicated that AIDS epidemic poses paramount threat to development in SSA. HIV/AIDS has erased many of the development gains of the past generation and now threatens to undermine the next with so many African children have been orphaned. AIDS is costing the region close to 1 percent of economic growth each year, while imposing an unsustainable and mounting burden on households, firms, and the public sector (World Bank, 2000).

In most of the African countries, the HIV status of orphaned children is not clearly known (World Bank, 2001_a). While Admasu (2000) described, by citing the 1997 report of U.S Census Bureau that 15.6 million children will have lost their mothers or both of their parents by the year 2000 in 23 countries heavily affected by HIV/AIDS, 19 of which are in sub-Saharan Africa.

The fact that SSA has been severely affected by HIV/AIDS, of the estimated 16.3 million people who have died of AIDS in the past 20 years or so, 13.7 million of them have been in sub-Saharan Africa, this accounts for 84% of all cumulative AIDS deaths worldwide (Dwaine, 2000). Although sub-Saharan Africa accounts for only 10 percent of the world 's population, it is home to approximately 70 percent of the global HIV infected people. UNAIDS/WHO (2000_c) shown that seven out of ten newly infected people are in Africa, and that 85% of AIDS-related deaths and 95 percent of AIDS orphans are also in Africa.

Moreover, Michael (2000) showed that since HIV/AIDS is mainly transmitted through unprotected sexual intercourse in Africa, when one parent dies from AIDS, the likelihood of the surviving parent being HIV-infected is very high and it is very likely that a child who has lost one parent from AIDS will soon become a double orphan. Recent estimate for the African region as a whole placed the number of cumulative AIDS-orphaned children at 12 million as of January 2000. By the year 2010, there will be 35 million AIDS orphans in Sub-Saharan Africa, almost triple the number today (UNAIDS/WHO, 2000_c cited in World Bank, 2001_a) (See Appendix--).

At the African Development Forum (ADF), it was indicated that the magnitude of the problems and needs of AIDS orphan crisis threatens to destroy African social support systems - extended family, with far reaching irreversible damage to development aims (ADF, 2000 $_{a\&b}$). Hunter and William (2000) described that AIDS orphans are distributed in SSA in the same patterns as HIV prevalence.

The Situation of HIV/AIDS in Ethiopia

HIV/AIDS is fast becoming the number one threat to young Ethiopians. Although the pandemic was also been the cause of death among many educated and well-to-do groups, it is disproportionately

higher among high-risk groups such as the unemployed, out-of school youth, commercial sex workers, street children and like (Govindasamy, Pav, Aklilu & Hailom, 2002; MOH,,2002; UNAIDS, 2002b).
It is difficult to measure and assess the impact of HIV/AIDS on national economic growth, on households and on development; it is even harder to assess the social consequences. Much of what follows is speculative and the true effects will only become apparent as the epidemic unfolds.

The first evidence of HIV infection in the country was seen in 1984, while the first cases were reported in 1986. The AIDS epidemic has spread to all parts of the country, some parts are worse hit than others, but no part of Ethiopia is exempted from the crisis. HIV has infected over all 1 of every 13 adult Ethiopians, while in the urban areas one out of every six adults is infected (MOH, 2000).

Since 1984, a cumulative total of 107,575. AIDS cases were reported to the Ministry of Health (MOH, 2002).However, due to several reasons (under-diagnosis, under-reporting, delayed reporting, HIV cases not coming to health institutions and so forth) the actual number of AIDS cases was reported at 40000, yet roughly 2.7 million in 1997 and 2.9 million at the end of 2000(National HIV/AIDS Council, 2001).

In Ethiopia, since 1989 up to the end of 1999, the estimated number of people living with HIV/AIDS were about 3 million (adults and children) (UNAIDS,2000; CRDA, 2001), this figure was reported as 3.2 million with 1 million projected AIDS cases in the country by MOH and UNICEF (2000); 2.9million adults aged 15-49, 1.6million (women aged 15-49), and 150,000(children aged 0-14), with the estimated AIDS deaths of 280,000. NAC (2000) noted that although Ethiopia has been hit by the HIV/AIDS epidemic later than many East African countries, the adult prevalence rate was estimated for urban areas to be 13.4 percent and rural area is 5%.

Pertaining to the cumulative number of deaths from AIDS, the Ministry of Health (2000) estimated 1. 2 million in 2000, and projected 1.7 and 5.2 million for the years 2002 and 2014, respectively (See Appendix-). While CRDA reported about 3 million Ethiopian PLWHA and 280,000. According to the 2001 HIV/AIDS surveilance results, analysis of data from the 34 sentinel sites produced an estimated national prevalence rate of 6.6%, which was 7.3 % for 2000. However, the highest urban HIV prevalence in Ethiopia is reported for Bahir Dar, 23.4 % followed by Jijiga, 19%, then Nazareth,

18.7% and Addis Ababa- from 4 sentinel sites is 15.6 %(MOH, 2002, AIDS in Ethiopia). The surveillance was conducted in the six rural and 28 urban sites on 12, 689 pregnant women aged 15 to 49. The mean prevalence rate for the urban areas other than Addis Ababa is 12. 8 %. Whilst the mean prevalence rate for all urban sentinel sites including Addis Ababa is 13. 2%. Extrapolating this data onto the total urban population using EpiModel, an urban prevalence rate of 13.7 % was obtained (MOH, 2002).

The MOH (2000) reported the existence of about 750,000 AIDS orphans in Ethiopia in the year 2000 and this number could increase to 990,000 by the end of 2001(UNAIDS, 2002b) to 980,000 by the year 2002, to 1.8 million in 2009 and to 2.1 million by 2014. It is also indicated that lack of proper care and supervision of these children will have a tremendous strain on the social systems of the country as well as increased burden and stress for the extended family network and increased burden on the side of the national level public services (MOH, 1998, 2000). As UNAIDS (2002a) noted, weakened by AIDS, traditional coping strategies become too frail to deal with future crises by saying "HIV/AIDS and humanitarian crises". Ethiopia is the second in terms of PLWHA and first in the number of children living with AIDS in SSA (UNAIDS/WHO, 1999 a &b).

The major avenue of transmission of HIV infection in Ethiopia is heterosexual intercourse and the practice of multiple sexual partnerships, particularly in urban areas (MOH, 2002). Whilst poverty and its manifestations sow seed for infections like HIV/AIDS (Petros, 2000 & 2002).

According to MOH (2002), about 91%of HIV infections in Ethiopia occur among adults aged between 15 and 49 years for the years 1986-2001. Given that this age group range comprises the most economically productive segment of the population, hence economic and social development is affected seriously. The number of male and female AIDS cases are roughly equal because most infection is by and large, acquired through heterosexual contact. According to the above report, the peak ages for AIDS cases are 25 to 29 for the males and females. However, the number of females infected between 15 to 19 years is much higher than the number of males in the same age group.
Highest infection rates are concentrated among the group 15 to 24 years, mainly 20-24 years in general and 15 to 29 particularly in the case of females .The HIV prevalence rates as well as the number of infected persons seen to decline with age. Absence of many AIDS cases among age groups of 5 to 14

("window of hope") shows that infection is not transmitted through causal contact and by agents like mosquito(MOH, 2002).

Regarding the HIV /AIDS pyramid in Ethiopia, the MOH has received reports of 107,575 cases since the beginning of the epidemic; these cases represent only the visible part of the epidemic. However there is much more to the epidemic than is revealed by the number of reported cases due to a number of reasons stated some where in this paper (MOH, 2002). While the number of PLWHA is 2.2.million in 2001, this figure would increase to 2.6 million in 2006 and to 2.9 million by 2010.

According to the 2002 report of MOH, the impacts of HIV /AIDS are multifaceted. For instance, it increases the general mortality rates. The rapid increase in AIDS related mortality is eroding the gains made in reduced mortality and increased survival probabilities at all ages. It is also reducing life expectancy at birth as well as at older ages. The impact on life expectancy in Ethiopia explained as it was 45 and 53 years in 1989,2001, respectively, and projected at 55 in 2007, barring major destabilizing events. But this major destabilizing agent appeared in the form of HIV /AIDS. Estimates taking into account the impact of AIDS resulted in life expectancy of 46 years instead of 53 years in 2001, and 50years instead of the expected 59 years in 2014.

HIV /AIDS also has impact on child survival. According to MOH (2002), about 30-40% of infants born to infected mothers are likely to be infected with HIV. Most of these babies will develop AIDS and die within two years. Few still survive past the age of 5. AIDS is undoubtedly already a major cause of child death. In addition, it has impact on population size and growth. The pandemic is killing individuals who are already in the population, and most of these individuals are within the productive and reproductive age groups. With or without AIDS, the population of Ethiopia has been growing steadily. From a little more than 40 million in the 1980s, Ethiopia's population increased to approximately 57 million in the mid-1990s and will reach 91 million in 2014.

The other serious impact of HIV/AIDS, in fact, the main concern of this study, is an increase in the number of orphans. According to the Ethiopian ministry of health, an AIDS orphan is a child under the age of 15 who has lost its mother to AIDS. In reality, given the importance of heterosexual

transmission in the spread of the virus, many children are likely to lose both parents (Petros, 2002; MOH, 2002).

In view of the prevailing AIDS –related general and age-specific death rates, the number of orphans in Ethiopia would increase from 1.2 million in 2001 to 1.8 million by 2007 and to 2.5 million in 2014 (Petros, 2002; MOH 2002), other things being equal. Clearly the increase in the number of AIDS orphans is likely to impact and aggravate the already severe problem of homeless children who seek a living out of working and living in city streets.

The MOH (2002) contend that the social costs of HIV/AIDS manifest themselves in a number of ways; an increasing number of orphans many of whom are reduced to abject poverty from lack of alternative care and protection; and the negative economic and social impact of HIV/AIDS on worker productivity, as manifested in the loss of experienced human power in the workplace as well as the social and economic implications of loss of income at the household and community level.

The federal government of Ethiopia currently established a national, regional and sub-regional level HIV/AIDS prevention and control office (HAPCO) with the objective of mobilizing multi-sectoral and grassroots efforts in the fight against the HIV/AIDS epidemic(Petros, 2002; MOH, 2002;Degefe, Nega and Tafesse, 2002)..

The fundamental objective of Ethiopia Mulit--Sectoral HIV/AIDS Project (EMSAP) is to reduce the spread of the epidemic, alleviate its impact and increase access to treatment, care and support for those infected and affected by HIV/AIDS. The project will help accelerate implementation of the Federal and Regional Multi-Sectoral HIV/AIDS Strategic plans, particularly through the provision of HIV/ AIDS preventing, care, and treatment services in a number of sectors (MOH, 2002; Degefe, Nega and Tafesse, 2002).

Developmental Impacts of HIV/AIDS in Ethiopia

Development is a complex process and state. It is understood differently by different people thus, it can easily be realized when it is understood from different perspective. With in the rubric of development, there are varieties of questions with which Ethiopia is currently grappling in order to improve the welfare of its people. Most of these questions are developmental but have significant social, economic environmental and political implications. Currently a major theme in Ethiopia is the challenge of reducing poverty (Gebregziabher, 2002). Even though the Ethiopia government has made some progress in the areas of education, health and local development, the HIV /Aids epidemic is eroding those gains (MOH, 2002).

As noted by Jhingan (2002)., LED is related to qualitative changes and upward movement of the entire social system (The fact that the country's economy can grow but it may not develop because poverty and inequalities may continue to persist due to the impacts of AIDS pandemic and like. Since poverty leads people to risks and vulnerability to HIV infection and HIV /AIDS in turn leads to poverty, then the cumulative effects affect both the human development process of enlarging people's choices that are created by expanding human capabilities - freedom of choice or enhancing chances for attaining higher standards of health, knowledge, self–respect and ability to participate in the community life and development processes in general.

The death of a family member to AIDS may result in a loss of remittance, a reduction in savings and thus investment. AIDS is found to be more devastating and a great misfortune to families where only one person in the family has a job. This is most observed in Ethiopia. For instance, women in Ethiopia mostly do not have formal employment. In such circumstances, when husbands with jobs pass away, the wives with no jobs are left to destitution, hence forced to go into prostitution which leads them to HIV infection. Therefore, without economic independence, such women often are not in a position to follow safe prevention techniques that are needed for reducing the spread of HIV infection (Degefe, Nega and Tafesse, 2002).

From macro-economic impact point of view, *HIV/AIDS impact on economic development arises from its negative effects on human capital, saving capacity and erosion of scarce financial resources and institutional capacities. A*

government would be required to spend more on the basic social service sectors (health, education, etc.) This on the one hand, aggravates budget deficit constraints and on the other reduces investment, which in turn reduce long-term growth and development (MOH, 2002;Degefe, Nega and Tafesse, 2002).

Whilst from micro-economic impact perspective, the report indicated that it is not only macro sectors impacted by the pandemic. In this regard, households are the most directly affected entities by HIV/AIDS epidemic. The welfare of AIDS affected/afflicted families suffer significantly through loosing dearest family member, incurring additional cost of treatment and burial ceremony, foregone income earnings and life-long morale support.

Due to the fact that Ethiopia is one of the least developed countries in the world, to day the majority of her people live below the poverty line. And as a result of the political, economic and social problems created by the ousted military regime a great number of Ethiopian's welfare is affected; the county's economy too, has been devastated (MOLSA, 1996). The country's developmental situation has been aggravated by, among other things, the crisis of HIV/AIDS epidemic and its induced consequences (Petros, 2002).

According to the MOLSA policy document (1996), from the 1994 whole population of the country [54, 939,000] 48.6% or 26,675,000 being children under 15. About 5,535,200 of these 26,675,000 children in the above age group were estimated to be in especially difficult circumstances, who had difficulty of accessing the basic social services. MOLSA (1996) defined the concept family *"as a vital social institution and the smallest unit of society where in children are reared appreciating their heritage (historical, cultural and social) So that they will want to pass it on to their children, there by ensuring that posterity is tied to its ancestry. Family is the best arrangement for the paper up brining of children, too, and has, as such, no substitute what saver".*

As MOLSA noted in 1996, an estimated 60% of all Ethiopian families in 1994, excluding Afar and Somali Regions, live in abject poverty. A large number of families in our country are disintegrating due to poverty and other related problems, thereby swelling the number of abandoned and street children in the cities.

Political, Demographic and Socioeconomic characteristics

According to MOH (2002), Ethiopia is one of the most populous countries in Africa ranking third after Nigeria and Egypt. The country is a multi-ethnic society with approximately 100 nations, nationalities and peoples contributing their own culture and language.

Regarding the political and administrative set up of the country, the constitution of Federal Democratic Republic of Ethiopia established a federal system of government with 9 regional states and 2 city administrative councils (Dire Dawa and Addis Ababa). The federal governments have the role of directing the country's fiscal, defense, and foreign affairs and articulating economic and social policies. State and sub- regional government are empowered to design and operate region-and-locality specific programs and policies in the management of natural resources, primary and secondary education, health services and the maintenance of internal law and order (MOH, 2002).

The Ethiopia government has adopted an Agricultural Development Led Industrialization (ADLI) policy and programs that recognize the interdependent relationship between agricultural and industrial development. This particular policy is directed to addressing the dual need for bringing about a relatively rapid structural differentiation of the economy and for dealing with the problem of food insecurity, which is a serious developmental challenge (MOH, 2002). Despite all these efforts of dealing with developmental problem through ADLI policy, the country is still confronting multifaceted social and economic backlogs, of which HIV/AIDS and its induced problems are the major ones.

From a development perspective, the social sector is of the country is still weak. National health coverage, for instance is 51% up from about 30% a decade ago; and the education sector is of course undergoing rehabilitation, etc.

While Gebregziabher described (2000) it is not only the level of poverty in Ethiopia that is worrying, but also the rate of increase in the number of poor joining the poverty group or poor. He further indicated the number of poor in cities such as Addis Ababa are found to increase at an alarming rate .In this regard, the author of this paper argues that HIV/AIDS induced poverty further aggravates the existing poverty situation in the urban centers of the country (of course, rural poverty seems to be

dominant in the country). This is manifested by growing number of school drop outs, street children, age /cause /sex –specific beggars and the like in the major urban centers like Addis.

Therefore, the developmental implications of HIV/AIDS are the major backlogs for the efforts of poverty reduction and attainment of social welfare of the community.

Based on the context of the current decentralization policy of Ethiopia, the question of local and regional development is acquiring more significance. However, both man-made and natural catastrophes as well as the devastating impacts of HIV /AIDS are becoming backlogs of ensuring local /regional development endeavors.

The way in which HIV/AIDS pandemic impedes the local and country-level development endeavors is that in addition to increasing infection /illness and premature mortality rates, increasing number of AIDS orphans, the pandemic is leading the affected /afflicted families to dive in a state of abject poverty and forcing the local community to shoulder the burden of caring responsibility and sharing already scarce resources and even sharing poverty as well.

PART IV IMPACT OF HIV/AIDS ON CHILDREN

Children are the ones who are paying the biggest price due to AIDS. This is not only a physical issue when they get infected with the virus, but also emotionally when AIDS deprives them of a father, or a mother or even both parents at once. There fore, it is very difficult to overstate the trauma and hardship that HIV/ AIDS has brought up on children. Since the breadwinner of the household become ill and are unable to work and obtain an income, the economic security of the household inevitably deteriorates. Children will then be called up on to care for the ill or to contribute to the household income. This often leads them dropping out of school, access to food, shelter, and health services will be deteriorated.

The major serious impact posed by AIDS pandemic is that it has become a critical cause for an increase in the number of orphans. Children whose parents are dead are doomed to be malnourished, to have no access to education and to join street life. Girls are often taken out of school to look after the ill member of the family, which sharply constrains children's opportunities for higher income later in

life. In such circumstances, the poor are forced to reduce their expenditure on food, which further reduces their resistance to the opportunistic infections of HIV/AIDS.

Like any other children, AIDS orphaned children are in need of the basic needs (food, clothing, shelter) as well as social needs (health, education, socialization and emotional support). However, they are more deprived than any other child, fundamentally where their needs are greatest given the social pressure of stigma. They might also be poorly socialized and require to under take a large share of household chores or wage labor (UNAIDS, 1999a &b).

The problem faced by orphans as a result of AIDS begins long before their parents death parental sickness results in a reduction of nutritional status of children due to a reduction in the house hold income .The lack of adequate nutrition even has profound consequences for the development of children (UNAIDS, 2000).

The social, economic, cultural and political circumstances of a given country determine the income level, nutrition and education as well as access to and quality basic services. However, parental illness and death leads to decline or loss of income, which in turn results in inadequate basic necessities thus affecting the welfare of ADS orphans (UNAIDS/WHO, 2000a,b &c).

Most importantly, HIV positive children are at a higher risk of communicable disease because their caregivers may lack adequate time, funds and commitment to care for and seek health care for the children. They are also at risk of poor hygiene as they are less likely to have in consistent caregivers (UNADS/WHO, 2000a,b &c) .

Globally, up to the end of 1999, AIDS has left more than 13.2 million orphans. The number of African children who had lost their mother or both parents to the epidemic by the end of 2000 are12.1 million (UNAIDS, 2001; Petros, 2002) is forecast to more than double over the next decade. These orphans are especially vulnerable to the epidemic, and the impoverishment and precariousness it brings. In traditional Africa, Ethiopia is one; the extended family support system has been the main stay of orphans. However, due to AIDS crisis and poverty, this system is changing and hence the context and definition of extended family is gradually going to disappear. Consequently, the potential and capacity

of extended families will not be able to afford proper care and support for the orphaned children (Petros, 2002).

In addition, the scope and complexity of the challenges facing children affected by HIV/AIDS can not be overstated; they are more likely to drop out of school, contract HIV, or be forced to work (including child labor) in order to survive.

It is further noted that particularly the girl orphans seem to be more disadvantaged than boys. AIDS orphans are facing the challenges of uncertainty, multiple losses, frustration, depression, grief and trauma thus they are not achieving their full human potential. Botchwey (2000) further noted that many of these orphans are impoverished and may end up unskilled and unsocialized, unable to contribute to the economy of the country due to the social, psychological and economic impacts they confront. While Ntozi (1997) described the Uganda experience that the orphans problem is complicated by the financial strains of caregivers, age of their care takers which may be either too young or too old, and some other children who lost their parents were cared by non- biological parents. The impact of AIDS on orphans is not only carrying the emotional burden of watching a loved one suffer and die, but they also experience the trauma of the family unit collapsing, the stigma associated to parental death from AIDS and a severe decrease in the family's economic power (UNAIDS, $1999_{a\ \&b}$). They are traumatized by watching parents die, forced out of school to take the place of adults at home, and often suffer from different kinds of discrimination (OSSA, 2001).

The Revised report of the U.S. Census Bureau estimated that 15.6million children under 15 have already lost their mother or both parents to AIDS or other causes. By 2010, there will be 24.3 million maternal and double orphans. If children who have lost their father are also included, the global total will be 44 million by 2010. Most of these deaths will result from HIV/AIDS and complicating illnesses. In at least eight countries of sub-Saharan Africa, between 20 and 35 percent of children under 15 have lost one or both parents from all causes (USAID, 2000).

Because of its nature, some people describe HIV/AIDS as a curse unprecedented in the history of humanity. This curse strikes children not only bodily when they themselves are contaminated by the virus, but also emotionally when AIDS deprives them of a father or mother, or often the two at once.

Children who find themselves head of the family or who are scattered-fraternity shattered-unless a grad parent takes them in. In Uganda, a grand mother brings up her 20 grandchildren on her own, her nine children and their spouses all having died of AIDS. Therefore, because of AIDS the number of orphans continues to rise so much so that the wider family can no longer take on the responsibility. What will they become tomorrow? Many of them will have only the street as a solution….

Poverty is inability of people to attain a minimum standard of living and lack of access to and unitization of basic services.

> *"Proxy indictors of poverty (Per capita income; social indicators like health, education, nutrition housing, safe water are further deteriorated by the impacts of HIV/AIDS pandemic. Hence the social welfare of the affected/ afflicted people is severely jeopardized. Due to its multidimensional socioeconomic effects and its consequences on families and communities, the HIV/AIDS epidemic has the potential to impact on all aspects of people's lives. The social consequences of HIV/AIDS epidemic have the potential to impact an all aspects of people's lives. The social consequences of HIV/AIDS have now been noticed as it has begun to impact on the welfare and stability of the family."(Petros, 2002; UNAIDS, 2001 & 2002)*

PART V SOCIAL MEANING OF HIV /AIDS AND STIGMA

In explaining the social and cultural dimension of an infectious diseases like HIV /AIDS, scholars like Murdock (1978) and Rushing (1995)[cited in Kidane, 2002] classified the definition in to three categories: archaic, metaphorical, or medical scientific. Spirits, witches and other supernatural forces base the archaic conceptions on the premises that diseases are caused. Archaic conceptions define diseases as punishment for misconduct and the breaking of cultural taboos; it is viewed in moral terms.

The metaphorical conceptions, on the other hand argue that sick people have frequently been continued to be viewed as being polluted. Their social worth is questioned, and they are treated as deviants or despised as in the case of lepers and their families. Metaphorical interpretations may reflect other aspects of society besides conceptions of morality. For example, "hated", marginalized or outcast groups maybe accused of causing a disease, in which case the disease is a metaphor for divisions in the

social structure. The third category, the biomedical conception, defines a disease as biological phenomena with natural internal and external causes over which the individual has little, if any, control.

Reactions based on archaic and metaphorical conceptions also appear in the AIDS epidemic and were shaped by social conditions in the same way. As with any disease, societal reactions to HIV /AIDS are not just a function of the medical definition and physical aspects of disease .They are also function of social conditions. It is for this reason that community's perception on the meaning of AIDS and towards the care of HIV/AIDS orphans are treated as crucial in this study for understanding the dynamics of social medication of diseases through stigma. No less than the etiology of HIV /AIDS the social reactions to the AIDS epidemic pose serious social problems that are troubling, as are medical aspects of the disease. In fact HIV is the apparent biological cause of AIDS, but social factors determine the behavior that is crucial in most transmissions of HIV and explains why some groups and populations have higher rates than groups and population.

The culture of silence around HIV/AIDS, stigma and discrimination of PLWHA, AIDS orphans and the afflicted/affected family continue to plague the fight against the further spread of HIV and mitigation efforts on the impact of HIV and AIDS on individuals, families (extended) and community levels (Muchini, 2001).

Stigma and discrimination continue to pose the greatest challenge for those infected and affected by HIV/AIDS. Being HIV infected and having AIDS, and being AIDS orphan have become the most subtle and painful causes for stigma. Above all, inadequate knowledge and awareness of the public about the mechanisms of HIV transmission and subsequent death from AIDS and its induced orphan hood contribute much for being stigmatized.

Gurmessa (1999) on the other hand noted that discriminations and stigmatization weakens the existing social relationships between AIDS stricken family and the neighborhoods, and will lead to social and family disorganization and deterioration. That is what most of the sociologists call deterioration of the social system, which is one of the outcomes of AIDS induced stigma and ostracization from the traditional society.

Impact

HIV/AIDS puts enormous social and economic stress on households as they care for sick family members, experience the loss of productive adults or absorb orphans. In African countries, Ethiopia is one, the ability of extended families to cope with the consequences of HIV/AIDS relies largely on their capacity to stabilize or increase their incomes. When their own safety net fails, households turn to their extended family, neighbors and community (Petros, 2002; Kidane, 2002). AIDS pandemic is unraveling years of hard-won gains in economic and social development. The Scale of the social and economic impacts of the HIV/AIDS pandemic are large and getting larger. Life expectancy will drop to 40 years or less in some SSA countries by 2010, and AIDS –related mortality will substantially reduce gains made in child survival in many countries. A 1% increases in HIV prevalence, on average, cause a lot of human development (as measured by the Human Development Index-HDI) of 2.2 years (Donahue, 2001; USAID, 2000). Accordingly, HIV/AIDS is not only an increasing case of death among adults, infants and young children, it also slowly impoverishing and dismembering families, leaving growing numbers of orphans in its wake. At all stages of the epidemic, families bear most of the social and economic consequences.

Problem with data

The system of reporting AIDS case varies greatly among countries. Most of the industrialized countries report almost all AIDS case, while others report very few cases. Overall, the cumulative number of AIDS case reported is less than 15% of the total estimated number of AIDS cases. This results from under-diagnosis, incomplete reporting, and reporting delay (World Bank, 1997 cited in Degefe, Nega and Tafesse, 2002).

SUB- SAHARAN AFRICA

Over two–thirds of all the people living with HIV in the world live in sub-Saharan Africa accounting for 83% of the word's AIDS deaths. This figure accounts for over 23 million PLWHA. Almost 70% of the global total inhabited in the region (UNAIDS, 2000 cited in Degefe, Nega and Tafesse, 2002; ILO, 2000a).According to the 2002 AIDS epidemic Update, by far the worst affected region, SSA, is now home to 29.4 million PLWHA. Approximately, 3.5 million new infections occurred there in 2002, while the epidemic claimed the lives of an estimated2.4 million Africans in the past year. Ten million young people aged 15-24 and almost 3 million children under 15 are living with HIV virus. The worst of the epidemic clearly has not yet passed, even in southern Africa where rampant epidemics are under

way. In four southern African countries, national adult HIV prevalence has risen higher than thought possible, exceeding 30 %: Botswana, 38.8 %; Lesotho, 31%; Swaziland 33.4 % and Zambia, 33.7%. Yet there are new hopeful signs that the epidemic could eventually be brought under control. In S. Africa, for pregnant women under 20, HIV prevalence rates fell to 15.4 % in 2001 down from 21% in 1998 (UNAIDS, 2002).

The prevalence rate of HIV in Asia and Pacific. Whilst the prevalence rate in vast, population countries of the world. India, china and Indonesia, loses meaning, which is lower than 1% (UNAIDS, 2001). A decline in HIV prevalence has also been detected among young inter-city women in Addis Ababa, Ethiopia. Infection levels among g women aged 15-24 attending antenatal clinics dropped from 24.2% in 1995 to 15.1% in 2001. However, similar trends were not evident in outlying areas of the city, nor is there evidence of them occurring elsewhere in the country. While giving the cause for optimism, these positive trends do not yet offset the severity of the epidemic in these countries. All of them face massive challenges not only in sustaining and expanding prevention successes, but in providing adequate treatment, care and support to the millions of PLWHA or orphaned by the epidemic(UNAIDS, 2002).Moreover, the best current projections suggest that an additional 45 million people will become infected with HIV in 126 low- and middle-income countries between 2002 and 2010 unless the world succeeds in mounting a drastically expanded, global prevention effort(UNAIDS, 2002)

According to the UNAIDS epidemic Update Report of December (2001)-"HIV/AIDS is reclaiming the Future". The impact is being increasingly felt in many countries across the world; African continent continues to be the worst affected area. In countries already burdened by huge socioeconomic challenges, HIV/AIDS threatens human welfare, developmental progress and social stability on an unprecedented scale.

Based on the above fact, HIV/ AIDS epidemic has a profound impact on growth, income and poverty. It is estimated that the annual per capita growth in half the countries of sub-Saharan Africa is falling by 0.5– 2% as a direct result of AIDS. By 2010, per capita GDP in some of the hardest hit countries may drop by 8% and per capita consumption may fall even further. Calculations show that heavily affected countries could lose more than 20% of GDP by 2020. Companies of all types face higher costs in

training, insurance, benefits, absenteeism and illness. A survey of 15 firms in Ethiopia has shown that, over a five-year period, 53% of all illnesses among staff were AIDS-related (UNAIDS, 2001).

In hard hit areas, households copy by cutting their food consumption and other basic expenditures, and tend to sell assets in order to cover the costs of health care and funerals. Almost everywhere, the extra burdens of care and work are deflected onto women-especially the young and the elderly. Families often remove girls from school jeopardizing the girl's education and future prospects.

In the worst affected countries like Botswana, Malawi, Mozambique and Swaziland now have a life expectancy of less than 40 years. Were it not for HIV/AIDS, average life expectancy in Sub-Saharan Africa would be approximately 62 years; instead, it is about 47 years. In South Africa, it is estimated that average life expectancy is only 47 years, instead of 66, of AIDS were not a factor (UNAIDS, 2001).

In the developing countries like Zambia AIDS has severe social and economic impacts both at the family and country levels: (1) At the individual family level it leads to: loss of income - earning opportunities because of sickness and the need to care for the sick; money being diverted away from food, schools and other household expenditures to pay for medical costs, funeral expenses and the caring for orphans; withdrawal of children from school to reduce expenditure and increase labor; stigmatization, prejudice and persecution of PLWHA; and (2)At the country level AIDS is having an impact on development through: loss of productive trained labor reducing productivity; money being diverted from other development issues to treatment of AIDS patients(Serpell, 2000; Hubley, 1995).

Moreover, from SSA point of view, Botchwey (2000) noted that due to its social and economic implications, the quality of life is being eroded thus the most devastating impact of HIV/AIDS on afflicted families is to dive it in to poverty. While Ayieko (1997) argued that AIDS deaths in Kenya are threatening economic and social well-being, and bearing the heavy burden of households with over-stretched resources as well as leaving children as orphans. Most of these children are left in the household with limited or no resources, which deprive their opportunity to go to school; the economic hardship lead them to look for means of subsistence that increase their vulnerability to HIV infection, substance abuse, child labor, sex work and delinquency.

The impact of HIV/AIDS on the lives of children orphaned due to AIDS, both the short- and long-term economic and social costs on the local and national economies and the society at large are described by the World Bank as,

> *In the short-term, households suffer from a reduction in income when the infected become ill. Surviving adults may also have to reduce their labor time in order to care for the ill or additional dependent children, resulting in a greater drop in income. Any loss of income may lead to children being pulled from school as priority change or the dropped household income may result in a worsening of their diet, and inadequate nutrition may impede their ability to learn. Lack of access to educational opportunity leads to less productivity in the future, leading to a host of negative externalities. In the long-term, the nation will suffer a reduction in productive human capital resulting from a poorly educated population- double orphaned children have lower school enrollment rates than single orphaned or non-orphans (World Bank, 2001$_a$).*

Poverty=AIDS affliction itself becomes the cause of household poverty or the further exacerbation of poverty as households are driven in to crippling levels of indebtedness and assets are depleted to pay for health care and other basic needs during the illness or expenditures after death (Serpell, 2000). It is also indicated that orphaned children experience extreme or increased poverty and live in fear that they have the disease themselves (Botchwey, 2000).It is true that HIV has affected all social classes, but not equally. Regarding the situation, some members of the African society consider AIDS as the diseases of poverty, particularly the poor women labeled AIDS as “Acquired Income Deficiency Syndrome" than Acquired Immune Deficiency Syndrome (Berer and Ray, 1993). Since HIV/AIDS places a heavy burden on the already poor people by draining away valuable household and extended family resources in Zambia, many of the orphaned children are then left in the care of distant relatives, elderly grand parents or have to care for themselves; these orphans may never realize their full potential for development (Michael, 2000). What is clear from the above descriptions is that AIDS increases poverty. Moreover, in almost all of Africa, the dependency ratio is already close to or above 1, meaning that for every potential worker between 15-64 years old, there is close to or more than 1 dependent. While the dependency ratio for Ethiopia reported as 0. 85 (World Bank, 2001$_{a\&b}$; Berhane, et al, 2001).

Impact= Further more, the Ethiopian Ministry of Health (1998) indicated an increasing number of orphans as one of the worst impacts of AIDS. The implication will be a tremendous burden and strain

on the social systems to cope with. Consequently, the burdens associated with AIDS orphans are complex and many in nature. In addition, due to its impact of generating social stigma, HIV/AIDS has the potential to disintegrate the society.

Due to increasing number of children orphaned by HIV/AIDS, there would be a tremendous strain on the social systems to cope with such crisis (MOH, 2000). This shows that the grand parents and elderly are forced to confront the problems by shouldering the burden of care for the orphans in their final years of senility when they are customarily supposed to be enjoying the comfort and social support of the family.

In response to the illness and death of an adult from AIDS, household members will often reallocate their resources to minimize the impact on their well-being. Depending on the success of such traditional coping mechanism, the living arrangements of the families and welfare of survivors is affected. Thus, households with no prime-aged adult are believed to be less economically viable and more demanding of the time and energy of the elderly in terms of caring for orphaned children and generating income, these arrangements potentially could increase the dependency ratio in the household (Ainsworth and Dayton, 2000).

The traditional pattern of caring for orphans in many societies of Africa shows that the children are to be taken into the families or relatives. In addition, due to the increasing number of AIDS orphans, even under the most optimistic economic growth prospects, the traditional community coping mechanisms- Africa's mainstay- seem to be coming under severe stress (World Bank, 2001_a).

The Roles of Community and Institutions

In the underdeveloped countries where resources available from public revenues and public sector's safety net is extremely thin, most assistance for AIDS orphans and the needy families is financed through the extended household, community or non-governmental organizations (Ainsworth and Over, 1994).

With respect to the multidimensional challenges and problems of AIDS affected children in SSA, Dwaine (2000) noted that AIDS do not only deal with health and economy but also impact the religious, professional, psychological, familial, and societal roles of these individuals. In response, the

community, including CBOs and institutions are beginning to recognize that millions of AIDS affected children are in need of having their basic needs fulfilled. To scale-up these challenges, the involvement of local community will become useful if they focus on culturally adapted interventions. In related issues, Aggleton writes, *"We can not hide the fact that the required empowerment and community development that HIV/AIDS epidemic demands is subversive"* (Aggleton et al, 1995).

According to Marcus (1993), a community-driven targeting approach in Uganda and Malawi seems to make a lot of sense for both identifying orphans and delivering the subsidies, but inter-mediation and oversight by religious group and NGOs may be necessary. Income-generating schemes (IGS) for fostering families are unlikely to be effective unless followed up with training and marketing support. Moreover, even when successful, these schemes must build in long term incentives for families to care for orphans.

Whilst Hubley (1995) described that where orphans are numerous and community coping has reached its limits, the case for wider institutional innovations such as "children's villages" appears strong. Even if it is costly to meet all the basic needs of the orphans at once, these can be funded by contributions from the local community and individuals. Pertaining to the problems associated to the increasing number of AIDS orphans, Roman(2000) noted that " same as to that of other African countries, the problem of HIV/AIDS in Ethiopia has been the burden of institutions including NGOs due to the increasing number of death of adults that have given rise to 1.2 million AIDS orphans to be taken care by families or some NGOs working with these children."

Part III RESULTS

3.1. Major Problems of AIDS Orphans

3.1.1. Economic or financial problems

AIDS orphans and other categories of participants of this study described economic or financial problems like lack of income and psychosocial problems- social stigma and discrimination as the major problems faced by AIDS orphans.

In this regard, the participants described that economic problem, emanated from income loss due to the death of parent/s from AIDS, considered as the major problems hindering the children from access to the basic survival needs like shortage of food, shelter, and clothing as well as the problem of health and education. Mast importantly, lack of money as one aspect of economic or financial problem are affecting the survival of orphans and their families.

The respondents (interviews with the subjects, key informants, care givers and FGD) described these by saying: "death of parents from the AIDS pandemic directly leads to transition of the orphans and their families into a 'relative poverty', economic shocks/lack of income, are deterring the orphans from adequate feeding, clothing, schooling, shelter, health care services and the like thus the livelihood and welfare of AIDS orphans will go down".

"orphaned *children suffer a lot of problems related to AIDS induced poverty by saying in national language Amharic, as "* ***AIDS Nits'uh dehi'netin Ya'tefal****" (AIDS induced problems aggravate the existing poverty and dehumanizes orphans and caregivers thus these children are unable to pay lots of unpaid house rent which in turn leads them to be denied from access to health services that will be provided freely from public health institutions for the poorest social groups because of their inability to present poverty certificate from kebele councils"(FGD with caregivers, orphans and CBOs).*

3.1.2. Psychosocial Problems: Social Stigma and Discrimination

AIDS orphans described psychological and emotional problems like lack of love/affection, stigmatization and discrimination affecting their personality and day-to- day life. They elaborate their experience by saying: "we missed a lot of things due to our parent/s loss; we do not forget grief and trauma attached in our mind when we were watching our parents suffering from HIV illness and died turn by turn. For us, loss of parent/s means **loss of everything-** is meant love, hope, protection or security, care and support, 'guardian' and the like". Some orphans described their experience as: "we are exposed to different problems that require parent's care and protection, it affected our identity and personality, we have no one to hug us that is why we are emotionally jealous when children around us were hugged by their parents" (FGD with orphans).

Negative psychosocial implications like social stigma and discrimination from different corners, which are expressed through rejection, hatred, insulations, beating, harassment, abuse and ostracization by community, peers and some relatives"(interview and FGD with orphans). This idea was shared by some key informants as "social stigmatization has severe impact on the psychology of orphans even not less than the pressing survival needs".

" due to social exclusion and stigma, orphaned children are vulnerable to sexual exploitation and labor abuse, which leads them to live in a difficult situations- streetism, child prostitution and the resultant risk of being infected by the HIV"(KII).

Due to stigma and discrimination from some members of the community and institutions, orphaned children are denied from access to basic social services like health, education, shelter, *iddir* membership. Because of these, the orphans are self stigmatizing them selves to cope with the problem of abuses and stigma (FGDs with orphans, caregivers and caregivers).

The children provided their own reasons for the causes of stigmatization and discrimination as: "negative attitudes, misconceptions about the cause and mechanism of HIV transmission, the society see AIDS orphans as if HIV-infected children. Some neighbors do not allow their children to play with us, they reject and insult us; some neighbors are pointing their finger on us, they do not allow their children to play, to eat or talk with us, they do not allow us to watch TV in their home with their children, they always insult us by calling our deceased parents' name and that hurts us, we feel scared to integrate with others, we do not concentrate in the class by recalling what our neighbors and school friends are saying" (FGD with orphaned children).

According to the caregiver and CBO representative FGD participants description," due to low level of people's attitude or perceptions and misconceptions, the community is stigmatizing not only PLWHA but the orphaned children and those families affected/afflicted by the pandemic".

Some participants reported that some orphans develop deviant or antisocial behavior after losing their parents. This is due to the negative implications posed by the pandemic- stigma, deprivation of basic survival needs, destitution and lacking parental protection. In supporting this statement, a 16 years old girl orphan who was participated in in-depth interview and one of the FGD described that;

> "We are eight and lost both parents, our elder brother/the first son, who is the head of household, dropped out of school and involved in daily labor work. Our financial and psychosocial problems are worsened by the bad behavior of the second older brother (chewing **khat**-a plant stimulating like amphetamine, drinking, involved in harassment, theft, and assaulting people and other anti-social acts). He developed such a behavior immediately after the death of our parents. He was the primary caregiver of them when they were suffering in hospital from AIDS illnesses**.** Due to his bad behavior, he was arrested so many times; our caregiver brother left home by renting house from private individuals. Now our family is deteriorating because our care giving brother, is not around us, we are insecure, not protected. Some of our neighbors and friends not willing to come to our home, they hate us not only because of our parents death but also due to our brother's anti-social behavior. Since our neighbors know the cause of the death our parents and our brother's bad behavior, they stigmatize us and deny integrating and lending their support for us".

Further more, it was reported that"after the death of breadwinner fathers, teenage orphans are reluctant to conform to the family and social norms and values by developing bad behaviors which they had never practiced before. Because of stigma and discrimination from friends and neighbors, the orphans' mental and emotional condition is negatively affected and hence developed bad behavior that makes them vulnerable to risky behaviors including HIV infection"(*Interview with widowed mothers*).

Inadequacy of care and support provided from NGOs working with orphaned children or from the community and institutions was reported by almost all categories of the study population and subjects .Even if some of the study subjects voiced "barely adequacy" of social support and assistance provided from NGOs and community to sustain the lives of all members of the affected families, some key informants said that "we know that the needs/problems of these children is very complex yet due to limited resources, our objective is protecting them from street life and make them able to continue education but not fulfill all their needs. They further indicated that the magnitude of the problems/needs of these children is increasing from time to time, there is a gap between children's needs and the existing resources".

In addition some of the caregiver FG participants expressed an interesting view by saying: "we heard from media that a lot of financial aid is provided to the NGOs working with orphans and PLWHA but in reality, we are not benefiting from it. That is why most of the children are suffering from lack of basic services-education, health care, shelter; access to skill training and employment and the like."

Whilst some respondents expressed conflicting but interesting experiences by saying: “thanks to some NGOs, neighbors and CBOs. You know why? We are still not discontinued our schooling because they care for us, they assisted us in whatever they can.”

The overwhelming majority of key informants also indicated that “lack of adequate care and support is mainly attributed to the stigma emerging from misconceptions and lack of adequate awareness among the public regarding the issues and problems of AIDS orphans, caregivers and the affected/afflicted families”.

Burden of Care Giving and Coping Mechanisms

Regarding the burden of care (from 71 interviewed subjects, 55 were double orphans) the overwhelming majority (35 out of 71) are heads of the household and shouldering the burden of care giving for their sibs reported that they are coping with the burden by compromising their education, engaging in the informal business activities, being hired as housemaids or selling the remaining assets of the deceased parents.

All of the interviewed caregivers, who are either elderly grand parents and/or widowed survivors described as they are obliged to shoulder the burden of care giving for their own or kin’s children orphaned by AIDS without any income. They further indicated the situation by saying: “Our burden of care for orphans is aggravated not only due to lack of income but also our age and health conditions because most of us living with HIV virus, which is a double and triple burden; as the age of orphans increases, their needs and problems also increases, yet our potential deteriorates thus life becomes misery for both the orphans and us”.

One caregiver elderly mother, who has no blood relation with the deceased parents said that " the mother of these four orphans(their father was died 3 years prior to the mother) told me striking word which has strong social and cultural meaning. You know what she was saying to me 5 days before she passed away? She told me a "word" / **K'aal** in Amharic/ which says, **“be’midir Y’setehushin be’sema’y ik’belishalehu"** meaning, “take the responsibility of caring for my children, this is the responsibility I am giving to you in this temporary world, i will ask you it in the heaven”. Therefore, i have to be careful and innocent enough to respect her **k'aal**. It is our culture to respect the will words of the deceased. What i am telling you is only about my

neighbors orphans but do not forget that i have no income; i am the housewife heading the household female house hold head, living with my own 6 children, 11members of the family living in a 2 room dilapidated kebele "

Among caregivers, widows said that "*what happened to us is already happened and passed but we do not want our children to be troubled even until our death, however, they are suffering a lot because we have no income, we are ill, we are not assisted well by NGOs, Community and the government in particular to fulfill the survival needs of these children. All these situations are aggravated by the stigma we are facing. It is crisis for our living condition" (Interview with AIDS widows).*

In addition, from the observation of living condition of some of some orphans and caregivers, it was found that orphaned children, particularly those who are managing their life as heads of the household have severe problems of clothing, food, and shelter- dilapidated homes around *woreda* 11and "**korea** and "**tureta sefers** located at *woreda* 13 of Addis Ababa.

Factors Aggravating Orphans' Problems

All of the subjects and study population described socioeconomic status of the deceased parents, socio-demographic and economic situations of caregivers[lack of income, age and health conditions] as well as non- optimal interventions of the stakeholders as the major factors aggravating care giving responsibilities for and survival problems of the AIDS orphans.

In one of FGDs, caregivers described that *"in addition to our socio- economic problems, lack of caregiver-targeted programs of NGO; inadequate care and support by the government overburdened of care giving responsibility for these additional children with out any income or support."*

Regarding non-optimal interventions by stakeholders, the majority of orphan and caregiver FG participants reported that weak social and economic development of the country incapacitates the government to provide adequate support and promote optimal interventions.

Some of the key informants reported that the existing social welfare policy and legal framework did not adequately address the problems of AIDS orphans. Consequently, "some orphans are confronting problems of human rights like sexual and labor abuse and denied to inherit property and wealth of the

deceased parents". Whilst one widowed woman, who has 4 children (2 aged above 20 and the other two below 20 years) participated in one of the FGDs and in-depth interview as a caregiver described the situation as: "children aged above 18 year are not allowed for transfer of pension payment from deceased parents and she expressed her pessimistic views on government's law and social policy. She suggested that AIDS orphans must be treated in a special condition but what has been happening in our country/Ethiopia in practice is the reverse".

In addition, the subjects, caregivers and CBO representatives presented an interesting experience by saying: "bylaws and regulations of some CBOs/ iddirs where the deceased parents were members discriminating and forcing the orphans to pay certain amount of money to be registered as new members is another factor that impedes the problems of the children. Even if iddirs in Ethiopia are traditional safety nets established with the objective of social and economic support when members face problems related to death thus exclusion of orphaned children from iddirs, according to the study participants means loss of security for the orphans.

"the policy and regulation of some NGOs that are considering age as a criteria of entitlement for social support excludes so many orphans reached beyond the age limit of 18 years, which is the upper age limit for entitlement. As a result, these children are obliged to end up on the street to become beggars, deviants, delinquents and prostitutes which fuels the already existing poverty and creates vicious circle of HIV infection. In addition, some caregivers reported that to benefit from care and support programs of those NGOs, caregivers, particularly the widows must have HIV positive status, i. e, they must present a certificate indicating that the must be HIV positive. This is a very critical problem of human rights violation and severe form of stigma and discrimination hence fuels HIV /AIDS crisis in the country" (FGD with orphans and caregivers).

Coping Mechanisms

The orphaned children described their coping mechanisms from the above stated problems as: leaving their 'original' living habitat due to abuses and stigma; seeking aid and assistance from institutions, relatives, community and parent's friends; compromising education to seek for income generating activities including the engagement in the risky behaviors or combing work with school attendance-often attend the school at night), compromising consumption, and using their clothing, shoes and

school materials by shifting with their sibs who are living in the same household*(FGD & interview with AIDS orphans)*

Key informants on the other hand, described their experience regarding," how the local communities and CBOs/Iddirs are affected and then coping with the emergence of AIDS orphans?", by saying: "Some individuals and community share their limited resource with the orphans and their families while those individuals and community, whose attitude and awareness about HIV/AIDS is relatively raised, identify and refer the orphans to the institutions supporting AIDS orphans while those community members whose awareness was not yet changed are kicking out the children from their home or community organizations like iddirs".

The Most Vulnerable AIDS Orphans

Key informants described that: "AIDS orphaned children in general are equally vulnerable to various types of survival problems but the girl orphans are particularly vulnerable to problems like abuses (sexual, physical and verbal), HIV infection, denial from accessing basic services,". Some of the key informants further indicated that, " if we see from gender perspective, it is girl orphan who is much more vulnerable to social and economic problems while based on HIV infection, while those orphans infected by the virus are much more vulnerable to rejections, exclusion by others due to fear of infection. .This description is supported by some other countries experiences and studies (UNICEF/UNAIDS/WHO, 2002; UNICEF, 2002, Children on the Brink2002) which state that girl orphans are very vulnerable while those orphans infected with HIV are much more vulnerable to social economic and human rights problems.

Almost all of the informants described about the most vulnerable AIDS orphans in the community as "double orphans, especially heading the household by their own and shouldering the burden of care for the sibs, are prone to leave school, seek any jobs to earn income and when the worst comes, they can get involved in sexual exploitation (girl orphans) to support their family income; those orphans who are managing their own households and those who do not have blood relatives are much more likely to be out of school, less likely to receive health care and employment, highly vulnerable to end up on street life and contracting HIV infection."

Some of the key informants on the other hand reported that because of the social, biological, cultural and economic reasons, it is the girl orphan who is at risk and their vulnerability is multidimensional. They are much more responsible and culturally expected to substitute their mother or take mothers role to care for the family. Thus they shoulder the burden of household care due to which they abstain from school earlier than boys and in the worst cases they can get involved in sexual exploitation to support their family income. Due to overburdened responsibilities, their health and nutrition status, and academic performance will go down.

Illustrative Case

While rape cases were reported by some key informants and attempt was made to interview the rape victims but failed because some of them were displaced from their original home due to stigma and others excluded from social support programs of the NGOs because of the policy and regulation of the stakeholder NGOs.

"Sexual and economic exploitation" was raised as one of the major problems faced by girl orphans. In order to illustrate this scenario, a 19-years-old girl orphan reported the problem of girl orphans by saying: "My youngest sister, who was 14 years old, raped by the young boy of the house in which we were rented from his family. At present she gave birth and I adopted her to an old woman who is living 500 Km away from Addis Ababa. Such a sexual abuse and harassment was not ended on my sister alone but a man [from same family] living with his children and wife, was attempted more than two times to rape me. Even if the attempt was failed, now we are forced to vacate the house, the locality and community we were living".

Some of the FG discussants revealed that "it is not only girl orphans but those orphans not entitled for assistance by NGOs; caregivers who have no income are all vulnerable to various kinds of problems emerged due to parent's death from AIDS."

Almost all of the study participants described that even if it varies from place to place, the contribution and participation of the public at large in caring for and providing care and support for AIDS orphaned children is very low. For these participants, inadequacy of knowledge and misconceptions of the community about the mechanisms of HIV transmission ; negative attitudes and perceptions- seeing PLWHA, the affected/afflicted families and orphaned children as sinners and blaming them for their

bad and anti-social behavior by the society are considered as some of the determinants for low involvement and participation of the community.

None the less, an old woman living with 9 children, of whom 4 are orphans (FGD6) reported different /conflicting but interesting experiance by saying: “Thanks to my neighbors who are always providing clothes and school materials for ‘**my children**’”- ‘ my children for this grand parent is the AIDS orphans who are the children of her son and daughter.

Description of anecdotal account

This is a very long and painful story, which took more than 90 minutes discussion period.
The case was an 18 years-old girl orphan who does not know whereabouts of her father and lost mother from AIDS in 1993. At the time of the study period living alone at a dilapidated one room *kebele* house. The case described the past and present living condition. She described financial, social/psychological- lack of security, love, guardian, stigma and ostracization and human rights problems like labor and sexual abuses as major problems she was facing.

Based on the above anecdotal account, it was found that AIDS orphaned children, particularly those managing their own life as head of the household and girl orphans are much more vulnerable to various kinds of survival and human rights problems and the consequent vulnerability to abuse and risky behaviors including exposure to HIV infection as well. The major problems raised by this particular case were almost same as those found from the other instruments of data collection.

Part IV DISCUSSIONS

The fact that this study is qualitative and exploratory in nature, selection of representative sample was not its purpose. Therefore the findings may not to be necessarily generalized to all AIDS orphans of Addis Ababa. Thus its findings should not be seen as exhaustive but more as a reference point and guidance for actual interventions of HIV/AIDS orphan programs and projects.

Despite the stated limitation, as the purposively selected respondents are considered to be knowledgeable about the problem under consideration, it is believed that this study gives a realistic impression on the issues researched. Thus, the findings of the present study demonstrated that AIDS orphans are confronting various kinds of survival problems emanated from loss of income/ economic problem, AIDS induced stigma and discrimination and hence living in very disadvantaged circumstances.

The result of this study indicated that economic constraints, psychosocial problems, inadequacy of care and assistance from stakeholders and increased burden of care giving by the orphan heads of the household are the major problems faced by AIDS orphans. While weak socioeconomic condition of the deceased parents and caregivers, non-optimal interventions of role players, reported as factors aggravating the orphans' problems.

Some studies (Nitozi,1997; UNICEF/UNAIDS/USAID,2000; Serpell, ; Donhaue, ; Muchini, ; UNICEF, 2002) tried to indicate the effect of AIDS on children and explored the seriousness of the implications for orphans and the extended family' welfare. Results from the present study also support such findings of the impact of ADIS on the living conditions of the orphaned children and caregivers.

It is found that the result of having many orphaned children in the household or family has a complex implications on the lives of orphans, their families, the community and traditional support mechanisms as well as on the quantity and quality of care and support provided by institutions working with the orphans and PLWHA.

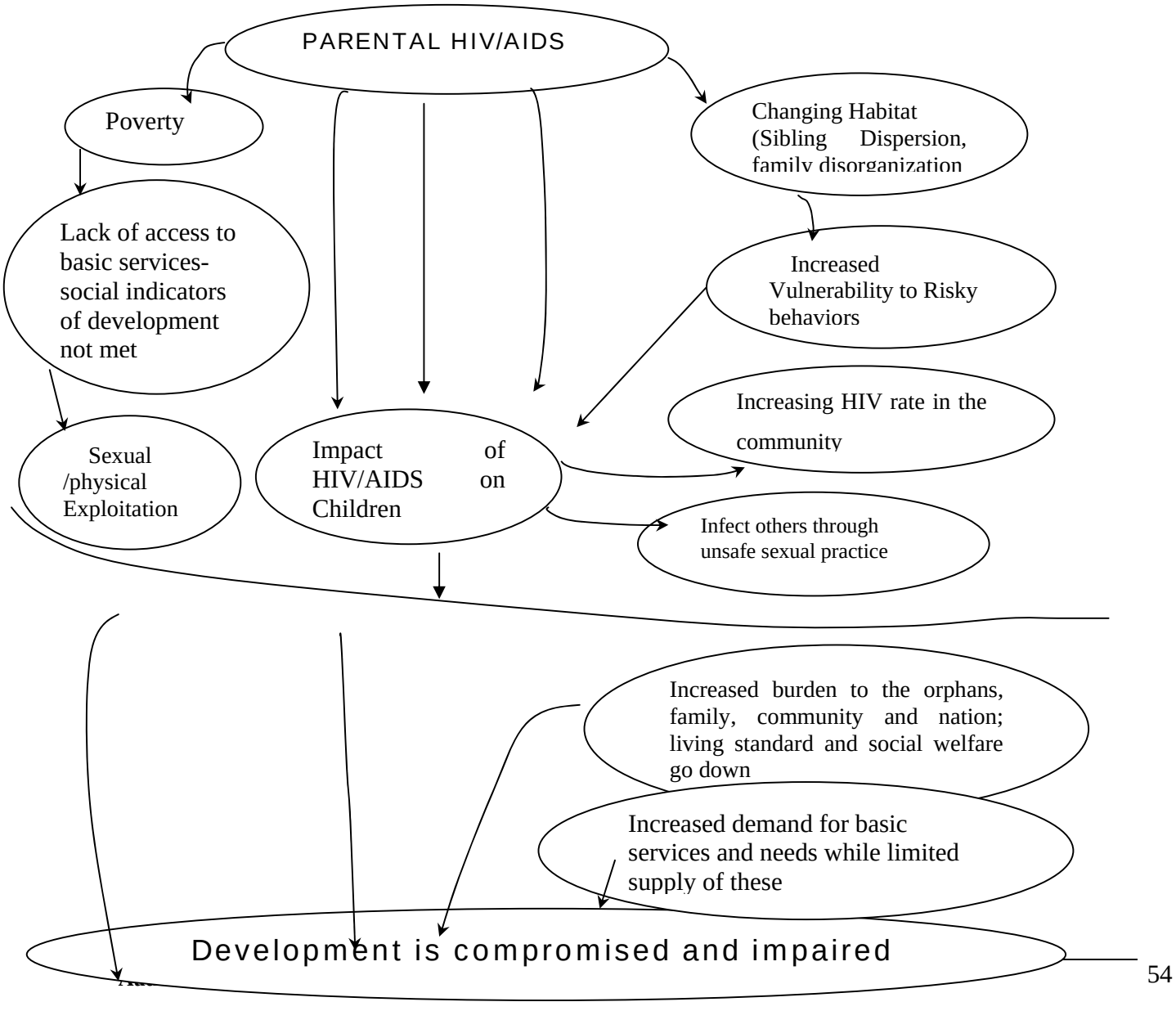
In fact the orphans and caregivers are coping with the AIDS induced poverty and social stigma by using different kinds of coping strategies. Never the less these coping mechanisms are more likely to produce unexpected long-term economic shocks within the household or extended families.

This study, like a number of previous studies (UNAIDS/WHO, 2000; Botchwey, 2000; Donahue,2001; Michael, 2000; Muchini, 2001; Nitozi, 1997; World Bank, 1997; World Bank, 2001a; UNICEF, 2001a, 2002; UNICEF/UNAIDS, 1999; UNAIDS/WHO, 2000 a,b &c; Serpell, 2000; Ayeiko,2000; Dwaine, 2000) on the social and economic impacts of HIV/AIDS in the developing countries, has indicated that

when the parent/s die, income of the family declines and the social indicators of development were worsened and hence leads to delayed attainment development.

The study also revealed AIDS induced impact leads to income loss in the household/family; erosion of the social capital; deterioration of social networks and traditional support mechanism; quality of life of the AIDS orphans and their families will go down; and a generation of children is growing up without socialization, emotional and economic support of their parents. Therefore, such a multitude of problems are slimming both the local/sub regional and national development.

Summary of Findings



Based on the above figure, the effect of HIV/AIDS on the parent/s(infection, illness and death) and the consequent implications on the orphaned children has both direct and indirect impacts. Children orphaned due to AIDS are directly affected by both the social and economic impacts. The social impacts like lack of parent's love and affection, protection and care, social exclusion and stigmatization which leads the children to be abused and maltreated by the community and some community organizations or institutions.

Part VI Conclusion and Policy Implications

CONCLUSSION

Despite traditional ways of life still prevail in Africa; the devastating crisis posed by HIV/AIDS pandemic crediting social and psychological distance and even the definition of family or extended family is in the process of disappearing. Thus, this author highly recognizes the design of new definition of family system in AIDS- hit regions of Africa. Therefore, such definitions of extended family is found to be incorruptible with the newly emerging forms of the family like child headed households, widowed households, orphan headed households, children cared by unrelated family, and so on.

Infection with HIV and its effect- the AIDS are rampant problems worldwide with broad social, cultural, economical, ethical and legal implications. HIV/AIDS has become the most devastating disease human kind has ever faced. Five million people were infected with HIV in 2001 and there were about 42 million people with HIV/AIDS as of December 2002. The 3 million deaths in one year, 2001 or 2002 alone brought the estimated total number of deaths since the beginning of the epidemic to 20 million (UNAIDS, 2001&2002; Getu, 2002).

There is no doubt that HIV/AIDS pandemic is having a severe impact on the social and economic developments at both local and national development efforts. As noted by ILo (200a)&b) over and above the immensity of the personal tragedy, it is leading to a reduction in economic growth, loss of

gains made in development, a decline in the size and quality of the welfare and increased costs and diminished performance. As such, it is severely undermining the right to decent life of AIDS affected/afflicted families in general and that of the AIDS orphans in particular.

Ethiopia, as a highly AIDS hit African country, experiencing a staggering growth of HIV/AIDS spread among its productive young adult population. The unprecedented 6.6% prevalence rate has a profound dislocation and social exclusion implications on poverty ridden families and hence resulted in a phenomenal growth of AIDS orphans and their survival and human rights problems.

This exploratory study has provided an important contribution to the limited literature on the developmental impact of HIV/AIDS in the country. The major findings of this study indicated that as the death of adults/parents increase, the number of orphans and their problems increase as well.

Those orphans who are caring for themselves are worried about their future because of the effects of social stigma and discrimination, lack of opportunities and access to basic services and income generating activities. Whilst, those orphans who are cared by the elderly grand parents are worried too much about themselves what will happen tomorrow if these elderly die. However, it is not only the orphans worried too much but the surviving caregivers (usually widowed and elderly grand parents) worried about themselves and the fate of orphaned children.

The study indicated that AIDS orphans are forced to live with persistent pains of life and being out of it is beyond their control. They are socially, economically and psychologically disadvantaged, thus lost some aspect of normal childhood development. By being exposed to sexual, physical and emotional abuses, they are vulnerable to make street as their abode and prone to risks and dangers including HIV infection. If HIV/AIDS continues unchecked, it will alter the trajectory of the country's investment, exacerbating poverty, and leaving the next generation increasingly venerable. For this reason HIV/AIDS cannot be viewed as merely among many competing priorities in the nation's development. Investing adequately in HIV/AIDS is now precondition for virtually all other development efforts to succeed. Thus, Ethiopia's future development depends on addressing AIDS epidemic forcefully and timely in a more committed ways.

Policy Implications

The findings of the study revealed multi-faceted developmental implications of HIV/AIDS on the lives of AIDS orphans and caregivers and the community at large. On the basis of the broad findings of the study, the following policy implications can be drawn for various kinds of stakeholders- local, regional, national/federal government bodies, NGOs and other role players.

1. Social stigma and discrimination must be ameliorated by changing public attitude through social mass education campaign;

2. Social welfare development policy should be revised to incorporate the policy of HIV/AIDS orphans based on both poverty indicators and AIDS indicators rather than either indicator alone;

3. Promote community based initiatives through the networking of NGOs, CBOs, religious groups, PLWHA and AIDS orphans by ensuring the community coping responses and must establish central coordination units regarding AIDS orphans issues;

4. To supplement the coping mechanisms expenditures and fees related to schools, health care services, housing facilities must be subsidized for the most vulnerable AIDS orphans; empower them with the aim of reducing further risks and vulnerability;

5. Promote social and economic support to improve incomes of caregivers through income generation activities;
6. Institutions working with AIDS orphans and local community organizations like CBOs/iddirs must revise their bylaws and regulations so as to make the orphans self supportive and protect them from further risks and vulnerability;
7. A further in-depth study to explore adequate information on the implications of HIV/AIDS, coping mechanisms, best strategies to adopt for orphan support programs based on the sociocultural context of the region or country by employing both quantitative and qualitative methods of investigation;
8. The findings of the present study clarified that the developmental implications of having many orphaned children should be incorporated into the social and economic development programs of

the country. Based on this fact, for the AIDS orphans in the city of Addis Ababa, the city administration/municipality, those institutions and CBOs and like have to consider the survival and human rights problems of the orphans and caregivers and incorporate these problems in to their development programs and projects.

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Appendix 1. : Distribution of the study population in terms of category and sex

Category of the Subjects and primary data sources	Number of Participants		
	Male	Female	Total
1. AIDS orphans[a]	17	54	**71**
2. Caregivers[b]	-	27	**27**
3. Key informants	13	7	**20**
5. Focus Group Participants			
1.Caregivers	1	13	14
2. Orphaned children	8	35	43
3. CBO Representatives	1	14	15
4. Local Government Representatives	3	3	6
Total	**13**	**65**	**78**
Grand Total	**43**	**153**	**196**

[a,b] *are those orphaned children and caregivers participated in the in-depth interview*

Source: Own Survey (March 2002)

Appendix 2: Statistical tables on the Estimates of Orphans (1990-2010) orphans Estimates for selected countries.

1990

Country	Population of Children < age 15	Maternal & Double orphans from all cause	¼ of material double orphans from AIDS	Total orphans from all cause
East Africa				
• Ethiopia	21,910,544	1,242,005	15.1	3,105,213
• Kenya	11,540,769	243,223	40.2	600,050
• Uganda	10,302,273	557,104	29.1	1,392,960
Southern Africa				
• Botswana	577,404	10,050	9.1	25,125
• South Africa	13,769,200	237,441	6.4	593,603
• Zambia	3,021,260	320,666	61.2	021,665
• Zimbabwe	4,667,540	165,760	57.0	414,420
West and central Africa				
• Cost divorce	5,660,130	305,699	29.3	764,240
• Chana	6,716,517	220,593	1.3	551,403
• Nigera	42,106,461	1,347,726	1.7	3,369,315
Country	**Population of Children < age 15**	**Maternal & Double orphans from all cause**	**¼ of material double orphans from AIDS**	**Total orphans from all cause**
Asia				
• Thailand	16,223,391	167,020	0.0	417,570
Latin America and The Caribbean				
• Brazil	52,462,653	399,990	5.2	999,995
• Haiti	2,669,464	120,200	4.0	320,550
• Honduras	2,176,167	20,999	3.9	52,400
		1995		
East Africa				
• Ethiopia	25,776,090	1,710,760	29.3	4,296,920
• Kenya	12,517,352	456,353	63.0	1,40,003

• Uganda	10,200,290	041,110	45.5	2,102, 795
Southern Africa				
• Botswana	622,312	19,906	53.7	49,765
• Zambia	4,222,463	400,120	70.7	1,200,300
• Zimbabwe	4,035,536	304,012	75.7	762,030
West & Central Africa				
• Cote divoire	6,731,600	440,745	44.5	1,101,063
• Ghana	7,607,215	252,770	5.6	631,945
• Nigeria	47,950,551	1,611,331	7.2	4,020,320
				Asia
• Thailand	15,190,551	194,020	5.3	407,073
L. America & The Caribbean				
• Brazil	51,712,017	516,550	19.7	1,219
• Haiti	2,036,462	154,013	32.6	307,033
• Honduras	2,430,005	24,231	9.7	60,500
	2000			
East Africa				
• Ethiopia	30,144,741	2,317,260	45.0	5,140,467
• Kenya	12,905,450	547,520	69.0	1,216,711
• Uganda	11,923,399	1,059,329	55.3	2,354,064
Southern Africa				
• Botswana	640,070	46,032	04.0	102,293
• South Africa	14,093,765	577,445	62.1	1,203,211
• Zambia	4,561,504	562,417	76.3	1,240,016
• Zimbabwe	4,496,405	400,016	07.0	1,066,702
West & Central Africa				
•Co'te d'ivoire	7,500,047	561,001	56.0	1,246,669
• Ghana	104,200	270,456	10.5	601,013
• Nigeria	54,053,337	2,091,416	27.0	4,647,591

Asia				
• Thailand	14,493,241	22,716	19.9	494,924
L. America & The Caribbean				
• Brazil	50,270,034	16,735	51.0	1.014,967
• Haiti	2,023,603	157,916	39.0	350,924
• Honduras	2,664,300	29,499	30.1	65,553
	2005			
East Africa				
• Ethiopia	34,557,933	3,042,025	50.3	6,004,050
• Kenya	12,364,247	743,504	70.7	1,407,000
• Uganda	13,507,441	1,129,190	50.0	2,250,300
Southern Africa				
• Botswana	621,500	5,075	93.4	170,150
• South Africa	13,179,300	1,252,139	5.0	2,504,270
• Zambia	4,009,414	614,596	79.9	1,229,192
• Zimbabwe	4,067,419	622,143	92.1	1,244,206
West & Central Africa				
• Co'te d'iviire	170,431	671,776	65.3	1,343,552
• Ghana	51,005	303,467	35.9	606,934
• Nigeria	60,441,470	3,050,927	49.0	6,117,054
Asia				
• Thailand	14,711,277	250,016	33.2	501,632
L. America & The Caribbean				
• Brazil	47,052,940	1,151,051	60.6	2,302,102
• Haiti	2,774,712	159,004	46.4	319,600
• Honduras	2,022,763	47,162	59.4	94,324
	2010			
East Africa				
• Ethiopia	30,677,577	3,774,304	67.3	6,062,516

• Kenya	11,517,416	745,590	0.9	1,357,451
• Uganda	15,301,394	1,140,660	59.1	2,000,407
Southern Africa				
• Botswana	590,640	113,040	96.3	205,542
• South Africa	11,619,097	1,969,013	92.3	3,501,470
• Zambia	5,109,675	645,260	2.4	1,173,200
• Zimbabwe	3,690,605	695,226	94.6	1,264,047
West & Central Africa				
• Co'te d'ivioire	23,700	777,006	72.0	1,414,193
• Ghana	7,607,902	334,000	50.0	600,007
• Nigeria	65,941,090	4,100,533	64.1	7,579,151
Asia				
• Thailand	14,529,924	254,090	39.0	461,902
Latin America & The Caribbean				
• Brazil	45,005,607	1,200,064	72.00	2,196,400
• Haiti	2,054,540	161,090	51.6	292,905
• Honduras	2,072,903	75,000	76.9	137,455

Source: US. Bureau of the census (USAID, 2000).

Appendix 3 **A development Prevalence Rate in Selected African Countries**

Country	Prevalence Rate	Country	Prevalence Rate
Zimbabwe	25.1	Sudan	1.0
Zambia	20.0	Ethiopia	10.6
South Africa	19.9	Uganda	8.3
Kenya	14.0		
Djibouti	11.8		
Chana	3.6		
Senegal	1.8		

Source: UNAIDS Background paper for ADF 2000, cited in Befekadu , Berhanu and --, 2002.

Appendix-4 Global Summary of HIV/AIDS Epidemic (December 2001)

People newly infected with HIV in 2001	Total	5 million
	Adults	4.3 million
	Women	1.8 million
	Children <15 year	800,000
Number of PLWHA	Total	40 million
	Adults	37.2million
	Women	17.6million
	Children <15 year	2.7million
AIDS Deaths in 2001	Total	3 million
	Adults	2.4 million
	Women	1.1 million
	Children <15 year	580,000
Total number of AIDS orphans* since the beginning of the epidemic	**13.2 million**	

*Source: UNAIDS/WHO 2001 and 2000[c]), * data obtained from UNAIDS/WHO, 2000[c]*