

The needs of AIDS orphans are as immediate as their next meal  
and as extended as access to education guidance  
and care until the end of their adolescent years.  
- United Nations Department of Public Information 2001

Although AIDS is forcing on increasing number of  
children onto the street or into institutional care  
they are a very small percentage of all children  
orphaned and otherwise make vulnerable; most live  
within families and communities.  
- UNICEF,2001

**GUIDE**

**ON /APPROACHES TO/**

**CARE AND SUPPORT**

**FOR AIDS ORPHANS**

**/CHILDREN AFFECTED BY HIV/AIDS/**

The UNICEF Executive Director, Carol Bellamy, noted that “there are not enough orphanages in the world to take care of these kids. We’ve got to strengthen the extended family” [Africa Recovery/UN Department of Public Information].

Currently, one child is orphaned  
because of AIDS every 14  
seconds.- UNICEF

## ACRONYMS

1. AIDS            Acquired Immuno Deficiency Syndrome
2. UNAIDS        United Nations Joint Program On AIDS
3. WHO            World Health Organization
4. USAID.        United States Aid For International Development
5. UNICEF        United Nations International Childrens Fund
6. UNGASS        United Nations General Assembly
7. MOH            Ministry of Health
8. EMSAP        Ethiopian Multisectoral AIDS Project
9. MOLSA        Ministry of labour and social affairs
10. BOLSA        Bureou of labour and social affairs
11. HIV            Human Immuno Defieciency Virus
12. CBO            Community based Organization
  
13. NGOs        Non-Governmental Organization
14. CBHC        Community based
15. \_WFP        World Food Program

## **TABLE OF CONTENT**

### **TITLE**

### **PAGE**

## **1. BACKGROUND**

**3**

### **1.1 MAGNITUDE /PREVALENCE OF OVC**

- 1.1.1 GLOBAL
- 1.1.2 REGIONAL
- 1.1.3 NATIONAL AND LOCAL

### **1.2 IMPACT OF HIV/AIDS ON CHILDREN/ORPHANS**

- 1.2.1 GLOBAL- IMPACT /UNICEF ASSESSMENT/
- 1.2.2 NATIONAL/LOCAL IMPACT / ASSESSMENT

### **1.3 GOALS**

- 1.3.1 GLOBAL - The UNGASS goals:

- 1.3.2 NATIONAL - goals:

### **1.4 STRATEGIES/ FOR GUIDING RESPONSES**

- 1.4.1 Global- STRATEGIES (IATT)
- 1.4.2 National- STRATEGIES.

## **2. PROGRAM IMPLEMENTATION**

### **5.1 PROBLEM IDENTIFICATION**

#### **5.1.1. BENEFICIARY SELECTION CRITERIA**

- 5.1 I MOH 1996 -guideline recommendation on CBHC
- 5.1 I EMSAP experience

#### **5.1.2. PRIORITIZATION SCALE FOR BENEFICIARIES**

### **5.2 PROGRAM –COMPONENTS/ACTIVITIES**

#### **5.2 I. Regional /African Experience**

#### **5.2 II. Ethiopia Experience**

- 5.1 I MOH 1996 -guideline recommendation on CBHC
- 5.1 I EMSAP experience
- 5.3 II MOLSA-Guide-line

### **5.3 PROGRAM –COST ESTIMATION**

#### **5.3 I. African Experience**

#### **5.3 II. Ethiopia Experience**

- 5.3 II BOLSA-experience:

### **5.4 PROGRAM –MONITORING AND EVALUATION**

## **BACKGROUND**

### **1. MAGNITUDE /PREVALENCE OF OVC**

#### 1.1.1 GLOBAL

- Approximately 13.2 million children under the age of 15 years have lost their mother or both parents to AIDS [UNAIDS, WHO].
- By 2010, the total number of AIDS orphans could be twice that and as high as 44 million from all causes including AIDS [USAID].

#### 1.1.2 REGIONAL /AFRICA/

- Approximately 11 million children under the age of 15 years have lost their mother or both parents to AIDS [UNAIDS, WHO].

#### 1.1.3 NATIONAL AND LOCAL

- Today an estimated 750,000 -- 1.2 million children have lost their parents through AIDS in Ethiopia.
- There are an estimated 20- 40 thousand AIDS orphans in Addiss Ababa.

## **1.2. IMPACT OF HIV/AIDS ON CHILDREN/ORPHANS**

### **1.2.1 GLOBAL- IMPACT /UNICEF ASSESSMENT/**

- Loss of their family and their identity, their destiny.
- Increased malnutrition..
- Loss of health care.
- Reduced opportunities for schooling
- Homelessness and child – headed households.
- Psychosocial distress.
- Increased demands for labor.
- Exposure to HIV infection.
- Loss of inheritance.
- Forced migration.
- Lack of protection from abuse and neglect.
- Limited time for socialization and transfer of life skills.

### **1.2.2 NATIONAL/LOCAL :According to admasu (2000), “ AIDS ORPHANS**

- less likely to attend schools;
- have lots of unpaid amount of house rent
- lack of access to medical services;
- food and clothing problems; and
- discrimination and stigmatization”
- the traditional support system is minimal in the urban settings
- overburdens the existing traditional coping mechanism of the family and community at large (aacahb, 1999).

## 1.3. GOALS

### 1.3.1 GLOBAL - The UNGASS goals :

for children orphaned and made vulnerable by HIV/AIDS state that:

- By 2003, develop and by 2005 implement **national policies and strategies**
- Build and strengthen **governmental, family and community capacities** to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS,
- Providing appropriate **counseling and psychosocial support,**
- Ensuring
  1. their enrolment **in school** and
  2. access to **shelter,**
  3. good **nutrition**
  4. **health and social services** on an equal basis with other children:
- Protect orphans and vulnerable children from all forms of **abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;**
- Ensure **non – discrimination and full and equal enjoyment of all human rights**

through the promotion of an active and visible policy of de – stigmatization of children orphaned and made vulnerable by HIV/AIDS;
- urge the international community, particularly donor countries, civil society, as well as the private sector, to complement effectively national programmes

**to support programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub – saharan africa.**

### 1.3.2 NATIONAL GOALS

#### POLICY GOALS

**1.1** To encourage government sectors, non-governmental organizations private sectors and communities to take measures in order to **alleviate the social and economic impact of HIV/AIDS.**

**1.2** To promote proper institutional, home and community based health care and psychosocial support for people living with HIV/AIDS, **orphans and surviving dependents.**

**1.3** Make the necessary provision of care and support to people living with HIV/AIDS and **their affected family members.**

## 1.4. STRATEGIES/ FOR GUIDING RESPONSES

### 1.4.1 MODELS AND OPTIONS IN A SYSTEM OF CARE FOR VULNERABLE CHILDREN\*

Model/option	Responsible party	Percentage of vulnerable children	Input needed
Family – based care	Two biological parents One biological parent Extended family No parents/child – headed households Formal foster parents of adoptive parents	55 percent	Free access to basic social services Psychosocial support and monitoring Government assessment and monitoring
Community care	Village committees Local government Volunteers Community – based organizations (CBOs) NGOs Religious organizations Private sector	35 percent	Management training Financial and material support Training in psychosocial counseling Child rights training Monitoring and evaluation Awareness raising advocacy
Temporary shelters	Street children shelters Feeding centers Places of safety	5 percent	Management training Financial and material support Psychosocial counseling
Institutions	Orphanages, children’s homes Hospices Hospitals Home – based care Remand homes Jails Boarding schools	5 percent	Facility construction, equipment Guidelines, policies, standards Awareness raising Fostering and out-placement Counseling Community visiting CRC training Government assessment Monitoring and evaluation Fundraising skills Networking and outreach services
System as a whole	Government and partners	100 percent	Legal and policy framework Conceptual base Referral networks, monitoring, identification

## **1.4.2 DISADVANTAGE OF A CENTRALIZED SYSTEM OF CARE**

- Vulnerable children are too numerous for government to support or monitor directly.
- Public welfare benefits reach only a small proportion of vulnerable families and children affected by the epidemic.
- Centralized systems encourage dependency and are not sustainable over the long term.
- These approaches professionalize childcare unnecessarily, discrediting family and community programs.
- Centralization makes systems inelastic, inflexible to local needs, budget-driven instead of needs-driven and not tailored to local preferences.

## **1.4.3 ADVANTAGE OF FAMILY-AND COMMUNITY-BASED APPROACH**

- Encourages community self-reliance.
- Encourages voluntary and spontaneous links with HIV/AIDS prevention activities.
- Recognizes and builds on the reality that PLHA and affected and communities.
- Builds on natural family and community roles in protecting children and the elderly.

- Social workers and other professionals can focus on serving difficult cases, monitoring, training, and support.
- Delivers more benefits effectively and inexpensively.
- Fewer children fall through safety nets.
- Builds on African preference to keep children within their families and communities.

#### 1.4.4 Global- STRATEGIES

THE FIVE STRATEGIES THE INTER – AGENCY TASK TEAM (IATT) ON OVC

1. **Strengthen The Caring And Coping Capacities Of Families:** for example, through training on child care practices
2. **Mobilize And Strengthen Community – Based Responses:** for example, by setting up community committees to monitor orphans and other vulnerable children;
3. **Strengthen The Capacity Of Children And Young People To Meet Their Own Needs:** for example, through provision of free basic education and educational materials, life skills education, and vocational training;
4. **Strengthen The Capacity Of Governments To Protect The Most Vulnerable Children:** for example, by instituting legal reform (inheritance property, adoption, and fostering laws);
5. **Create An Enabling Environment For Affected Children And Families:** for example, by reducing stigma and discrimination based on HIV/AIDS;

## 4.2 NATIONAL - STRATEGY

It is indicated in the general strategy of the national HIV/AIDS policy (1998) that efforts for provision of proper care and support shall be made to the AIDS-orphans when one or both parents die of HIV/AIDS.

### POLICY STRATEGY

#### Medical Care and Psychosocial Support

- 6.1 Government institutions, non-government organizations, religious organizations, religious organizations, bilateral & multilateral agencies, private sectors, community based institutions and the community at large shall be mobilized **to support people living with HIV/AIDS and affected family members**. Special attention shall be given to people who are abandoned and helpless.
- 6.2 Psychosocial. Economic and medical support to PLHAs and affected members shall be encouraged through eliciting established patient's familial and social network.
- 6.3 Health workers and counselors shall provide counseling services to build up the confidence of people living with HIV/AIDS.
- 6.4 Efforts shall be made to create self supportive and income generating opportunities for people living with HIV/AIDS as need arises.
- 6.5 The MOH and the RHBs shall train health care providers on medical care for AIDS patients.
- 6.6 The MOH and the BHBs shall ensure the availability of drugs for the treatment of the most common opportunistic infections.

## **FIVE YEARS STRATEGIC FRAME WORK**

Objectives: To provide social support to AIDS dependants and orphans.

Strategies :

- Establish community care, financial and material support for orphans
- Increase opportunities for skill training in income generation to orphans

## **2. PROGRAM IMPLEMENTATION**

### **2.1 IDENTIFICATION OF THE PROBLEM**

#### **2.1.1 BENEFICIARY SELECTION CRITERIA**

MOH 1996 -guideline recommendation on CBHC

\*criteria for assistance could include

- The death of father who is the bread winner of the family
- Both parents alive but illness prevents employment
- A symptomatic child whose parents are unemployed
- A symptomatic child whose parents are unknown

EMSAP experience:

criteria for assistance could include :

- Orphans in the age group between 0-18 years
- Residing in the kebele ,
- Providing a certificate confirming that  
one or both parents died of HIV/AIDS or HIV related diseases.

Indicating that they have no source of income

Either from from kebele fird shengo

OR- from health institution.

- N.B. those who could provide certificate from the health institution could get more priority.

WFP

- Food insecure people infected / affected by HIV/AIDS and their dependants.
- Children who lost both parents will receive food support up to one year to facilitate to the transition to foster family .

**2.1.2 PRIORITIZATION SCALE FOR BENEFICIARIES.**

NUMBER AND VULNERABILITY OF CHILDREN NEEDING CARE AND PROTECTION

		<b>Number of Children</b>	
		<b>LOW</b>	<b>HIGH</b>
<b>VULNERABILITY</b>	<b>HIGH</b>	Very young orphans Orphans with disabilities Orphans with elderly guardians Children in female-headed and poor households	HIV+ children Street children Child sex workers Orphans in child-headed households Children in under-funded State institutions
	<b>LOW</b>	Orphans in stable families of reasonable means	Children in stable two-parent families of reasonable means Children in well-resourced institutions

## **2.2 . PROGRAM –COMPONENTS/ACTIVITIES**

### **2.2.1 Regional /African Experience.**

- **Zambia: food , plots for gardens, pay for vocational training, school fees.**
- **Zimbabwe: donations of food, blankets, clothing, school fees, seeds and fertilizer to the most needy households. offer emotional and material support. farming communal fields.**
- **Malawi: material assistance to orphans and vulnerable children, and receiving and distributing food, clothing and other donated items.**

### **2.2.2 Ethiopia**

MOH 1996 -guideline recommendation on CBHC

#### Areas of assistance

- School fees (books and other writing and reading materials)
- Clothing
- Basic nutritional supplements
- Medication
- If extended families do not exist ,placement of orphans in to institutions
- Practical skill training
- Provision of other basic materials.

### 2.2.3 MOLSA- AUGUST 20001 community based child care programme guide line

#### Recommendation

- Food aid
- Shelter aid
- Education
  - Academic education
  - Vocational education
  - Psycho social education
  - Libraries.
- Health care
- Guidance and counseling
  - i. Educational guidance
  - ii. Vocational guidance
  - iii. Health counseling
  - iv. Behavioral guidance and counseling
- Special services

Children with special needs like the children living with hiv/aids , aids orphans ,child with disability , steert children , the girl child,working children ,etc.get special serviceincluding drop in centers.

- Children receiving care from community -based child care get alternative child care programs.

- i. Foster home
- ii. Child sponsorship
- iii. Family re-unification
- iv. Adoption
- v. Reintegration

- Recreation

#### I. Counseling

Ii. play and recreation

Iii. special care for the child with

## 2.3 PROGRAM –COST ESTIMATION

### 2.3.1 African Experience

<b>Care for HIV-Positive Children</b>	
Cost of palliative care per child	Taken to be two-thirds of the costs of care of adults <b>Low: \$14.30</b> Medium: \$17.20
Cost of clinical management of OI Per child	Low – income countries <b>Low: \$163</b> Medium \$237 High-income countries: Low: \$311 Medium: \$461
Cost per child in an orphanage	Living expenses include food, clothing and basic commodities. School expenses include subsidies for fees and uniforms. Based on estimates from Boerma and Bennett (1997) for orphanage care in Tanzania; assumed to be financial and full cost. <b>Low: \$120</b> Medium: \$180
Cost per child for community assistance with living expenses	Taken from Drew et al. (1998) for programs in Zimbabwe, implemented by community based organizations, using volunteers who visit families with orphans; cost assumed to be financial and full. <b>Low: \$9</b> Medium: \$35 Derived from Boerma and Bennett (1997), in the context of district-based programs for communities in a high-prevalence setting. This includes support to new orphans and community feeding posts; cost assumed to be financial and full.
Cost per child for school expenses	Based on estimates from Boerma and Bennett (1997) for Tanzania. Weighted average of primary and secondary school costs; assumed to be financial and full cost. <b>Low: \$25</b> Medium: \$33

### 2.3.2 Ethiopian Experience

<p>Food Cost per child in an orphanage</p>	<p><b><u>BOLSA-EXPERIENCE:</u></b></p> <p>Food cost per child based on the market at the time and basic daily requirements (menu-based) Based on estimates from Bourue of social and labor office in Addis Ababa (1992 E.C.) for orphanage care in Addis Ababa ; assumed to be financial and full cost.</p> <p>1.for child under 1— 4.99/dayx30=150birr/month</p> <p>1.for child 1—7 years 3.74/dayx30=112.20birr/month</p> <p>1.for child above 7 Yrs.— 3.94/dayx30=118.20birr/month</p> <p>1.for child disability— 4.88/dayx30=146.40birr/month</p> <p>Cost per hospitalized patient M.O.H.1985 4.78/dayx30 = 143.40</p>
<p>Cost per child for community assistance with living expenses</p>	<p><b><u>EMSAP EXPERIENCE :</u></b> Woreda -5 &amp; 7Anti-AIDS Council Recommendation.</p> <p><b>Cost For Food Support.</b></p> <p>1.When one of the parents is sick with HIV/AIDS. In addition to100- 150 birr 50%for the children./month</p> <p>2.When both parents are not alive.</p> <p>single child 80-120 birr/month &gt; 1 child 80-120 birr + 50% for the next children.</p> <p><b>Cost For Clothing Support.</b></p> <p>1.When both parents are not alive single child 100-200 birr/year</p>

	<p>&gt; 1 child 100-200 birr/year + 50% for the next children.</p> <p><b>Cost For Medical care</b></p> <p>1. Free Medical care from Government Health institution with exemption letter from the kebeles/even with social workers in the health institution for sero positive patients claiming for free service Automatically during beneficiary section process could get free exemption for medical care and school.</p> <p>2. Cost For Drugs Not Available at Government Institutions. 50-100 birr/month.</p> <p>3. For personal hygiene expense 10 -15 /birr month</p> <p><b>Cost For School Expense.</b></p> <p>School Uniform= 40-50 birr/child/year School fee =</p> <p>If free Government School is not available. For KG For night school</p> <p>20-30 birr/month</p> <p>Stationary cost=30-50birr/child/semester</p> <p>School bag 35 birr/per year Transport cost for bus- 15birr/month/perchild</p> <p><b>Cost For Shelter</b></p> <p><b>For kebele house: 25-30 birr/month</b> <b>For private rented house :75-90 birr/month</b></p> <p>Range=</p>
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	<p>NGO experience=  Range=  WFP recommendation</p> <p>Ration composition and size</p> <p>-- children less than 15 yrs</p> <p>Famix-- daily gm -- 200 and monthly 18 kg  ( consisting of 3 individual rations of  famix or cbs to meet the special nutritional  needs of younger children in the hh and  five individual rations of wheat and  vegetable oil.)</p> <p>Wheat daily gm -- 300 and monthly 45 kg  Vegetable oil daily gm --20 and monthly 3  kg</p> <p>Famix is a local blended food consisting of  79 grams ( or 74 when 5 grams of sugar are  added ) of whole maize /wheat flour ,20  grams of whole soya flour and 1 gram of  iodized salt( as well as a vitamin/mineral  premix) and providing 400kcal,14 grams of  protien7 grams of fat per 100 grams.</p>
	<p><b>B.O.E.</b>  <b>RECOMMENDATION</b>  School Uniform= 70 birr/month</p>

<p>Cost per child for school expenses</p>	<p>School fee (public school)</p> <table border="0"> <thead> <tr> <th>Grade</th> <th>Fee</th> </tr> </thead> <tbody> <tr> <td>1-2</td> <td>11 birr/month</td> </tr> <tr> <td>3-4</td> <td>12 birr/month</td> </tr> <tr> <td>5</td> <td>13 birr/month</td> </tr> <tr> <td>6</td> <td>14 birr/month</td> </tr> <tr> <td>7</td> <td>15 birr/month</td> </tr> <tr> <td>8</td> <td>16 birr/month</td> </tr> </tbody> </table> <p>Stationary cost=</p> <table border="0"> <thead> <tr> <th>Grade</th> <th>Cost</th> </tr> </thead> <tbody> <tr> <td>1-4</td> <td>16 birr/ semester 6-exercise book 4-pencils</td> </tr> <tr> <td>5-8</td> <td>34 birr/semester 12-exercise book 10-pens</td> </tr> </tbody> </table>	Grade	Fee	1-2	11 birr/month	3-4	12 birr/month	5	13 birr/month	6	14 birr/month	7	15 birr/month	8	16 birr/month	Grade	Cost	1-4	16 birr/ semester 6-exercise book 4-pencils	5-8	34 birr/semester 12-exercise book 10-pens
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<p>Cost per child for personal clothing</p> <p>Molsa recommendation</p> <p>Type of clothing</p> <p>i. A childcare institution shall provide various types of clothing for children including:</p> <ul style="list-style-type: none"> <li>a. Personal clothing</li> <li>b. Shoes</li> <li>c. Bed wears.</li> </ul> <p>ii. Less than one year</p> <ul style="list-style-type: none"> <li>a. Six sets of sanitary clothing</li> <li>b. Four sets of personal</li> </ul>																					

<p style="text-align: center;">clothing</p> <p>c. One pair of shoes</p> <p>d. Two sets of bed wear</p> <p>iii. 1-3yrs/yr</p> <p>a. Two sets of sanitary clothing</p> <p>b. Two sets of personal clothing</p> <p>c. Two pair of shoes</p> <p>D. Two sets of bed wear</p> <p>iv. 3-6yrs/yr</p> <p>a. Kg uniform</p> <p>b. Two sets of personal clothing</p> <p>c. Two pair of shoes</p> <p>v. D. Two sets of bed wear</p> <p>Total cost 87.50birr/child/year</p> <p>vi. &gt; 7 yrs /yr</p> <p>a. School uniform</p> <p>b. Two sets of personal clothing</p> <p>c. Two pair of shoes</p>	
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D. Two sets of bed wear	
Cost for house rent/shelter	
Cost for medical care	

## **2.4. MONITORING AND EVALUATION**

From program point of view the following could be done.

1. The purpose is to ensure that the orphans would stay in school and their health is kept well .
2. the rights and obligation of each primary stakeholder would be discussed and consensed on before the launching of the program.
3. If possible the general nutritional, health and educational status of the orphans would be taken as a base line data. Therefore, before enrollment to this support program all those who would benefit from this program.
  - Would have at least anthropometric measurement.
  - Would have routine medical check up.
  - Bring thier students certificaes showing their educational status.
4. The gurdians should confirm that they took the responsibility of day to day follow up the orphans especially in the area of
  - a. Education
  - b. Health
  - c. General well bieng

5. Woreda facilitators would take responsibility of
- a. Incollaboration with the woreda hiv/ads council ensure the selection of the right beneficiaries in the woreda.
  - b. Ensure that a base line data on the nurtritional, and health and educational status of the orphans would be taken in collaboration with the local nearby healthpost/station.
  - c. Facilitate the distribution of food aid support at each woreda incollaboration with the pmu at rhe regional level and the woreda council at theworeda level.
  - d. Report the monthly, quarterly report of all the food aid support activity to pmu at the regional care and support team.
  - e. Monitor and evaluate the general program activity at the woreda level in terms of the health, educational status of the orphans.
- The educational status of the orphans would be assessed using the following indicators.
    - School attendance,
    - Comparison of their school average status,
    - School drop outs.
    - Promotion/repeatition status.
  - Their health status could also be monitored by
    - Assessing the verbal episodes of illness /
    - Visit to health facilities and

Assessing if possible their nutritional status.

**FORMAT**

1. Serial number-----

**IDENTIFICATION OF THE BENEFICIARY**

2. Name of the child-----

3. Age-----

4. Sex-----

5. Address W----- K----- HN-----

**EDUCATIONAL CONDITION /STATUS-----**

6. Name of the school

7 Owner : Government

Public school

8. If Public school , School Fee

9. Means of transportation : walking distance / by bus

**VULNERABILITY STATUS**

7. Health status :

Very young

HIV-serostatus

Other health problems

disability

Parents condition

mother : dead /alive

if dead : WHERE ,WHEN

cause of death --TB,CONFIRMED AIDS, CHRONIC ILLNESS

ALLEGED HIV/AIDS

7. Gurdians name -----

8. Gurdian status

Age

**9.HOUSE HOLD STATUS/ LIVING CONDITION**

with whom does the child lives

child headed HH

female-headed HH

number of siblings

live in

kebele house

owned house

private rented house

families souce of income

amount of income

Gurdians name

4.relationship of the guardian with the child.

## **5. 8. Type of HIV/AIDS Care-Support Service rendered**

**Food AID**

**Health care –AID**

**Clothing–AID**

**School–AID**

**other–AID**

9. committes Comment about the child

10. I declare that all the information above are true and correct

Name and signature of the Gurdian

Name and signature of the Child

**FORMAT -II**

-the numberof children and families getting assisstance

-type of assisstance provided

-duration of assisstance rendered

-amount spent on each child

Qouta/ration estimation

Minimum types of service

Optimum type of sevice

Ngo

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## 10. prevention and care FHI