COMMUNITY SUPPORT SYSTEMS FOR THE CARE OF ORPHANS AND VULNERABLE CHILDREN (OVC): A CASE OF KAMPALA CENTRAL DIVISION

BY

TUMUHAISE GODFREY

MADAM/8615/51/DU

A THESIS SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTERS' DEGREE IN DEVELOPMENT ADMINISTRATION AND MANAGEMENT OF KAMPALA INTERNATIONAL UNIVERSITY

OCTOBER 2007.

Declaration

I Tumuhaise Godfrey do hereby declare that to the best of my knowledge, this is original work of my research; it has never been presented to any University or any institution for academic award.

Signature:

.....

TUMUHAISE GODFREY

Date: 26/10/07.....

APPROVED BY

.....

KAFEERO KIGUNDDU

DATE..26th October 2007.....

DEDICATION

Firstly to my Father and Mother Mr. and Mrs. Tarsis Kabakozao

Secondly, to my Fiancé Nakiwu Grace. all my sisters and brothers

I dedicate this work.

ACKNOWLEDGEMENT

Thanks be to God for the protection he has rendered to me till now. I wish to acknowledge the invaluable support received from various people who enabled me to bring this work into reality. Without your efforts this work would not have been produced.

I would like to extend my special thanks to Rev. Dr. Kafeero Kigunddu for the tireless efforts in providing guidance and support to this work.

I would like to further express sincere appreciation to Dr. Canene, the Associate Director School of Postgraduate Studies, Mrs. Atwine Imelda the Administrator school of postgraduate studies for their academic support in various ways towards completion of this work and the entire course.

Completion of this work would not have been possible without the support of my friends with whom I shared academic challenges during my stay in the university. The continued support and commitment of the students is very highly appreciated.

I wish to extend my sincere gratitude to my dear Fiancé, Sisters, relatives and friends for their love, prayers and faith in me.

TABLE OF CONTENTS

CHAPTER FOUR

LIST OF TABLES AND FIGURES

LIST OF TABLES

LIST OF FIGURES

ABRREVIATION AND ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
AMICAALL	Alliance of Mayors and Municipal Leaders Initiative for Community Action on HIV/AIDS at the Local Level
HIV	Human Immune Virus
BEUPA	Basic Education in Urban Poverty Areas.
CRA	Child Rights advocates
DPWO	Department of Probation and Well fare Officer
FGD	Focus Group Discussion
MoGLSD	Ministry of Gender Labour and Social Development
KCD	Kampala Central division
KCC	Kampala City Council
KCCC	Kamwokya Christian Caring Community
NGO	Non Governmental Organizations
OVC	Orphans and Vulnerable Children
SUCIO	Strengthening Urban Community Interventions for Orphans and other Vulnerable Children
UK	United Kingdom
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

ABSTRACT

A big gap still exists between what has been done and what ought to be done to meet the needs of Orphans and Other Vulnerable Children and protect their rights. This study investigates community responses to the problem of OVC.

A case study research design employing both quantitative and qualitative research methods were used to carry out this study. The study population comprised of 600 household heads and 620 OVC. Both household survey questionnaires and focus group discussions were used as data collection instruments.

The findings of this study suggest that most OVC are cared for within family lines with women being the majority of care givers. To cope with the large numbers of OVC, households have devised a number of coping mechanisms such as engaging in various income generating activities which include: produce, retail shop keeping, saloning, bar attendants, working in garages, and petty trade.

However, these mechanisms are still inadequate in meeting both physical and social needs of OVC, and protecting their rights.

This study, therefore, recommends greater involvement of government and other stakeholders to strengthen the existing coping mechanisms to meet the needs of OVC.

CHAPTER ONE

ntroduction

This chapter gives the context of this study. It focuses on background information, esearch problem, research questions, justification for the choice of the study area and definition of key concepts used.

Background

Addressing the plight of millions orphans and other vulnerable Children (OVC) is one of he development challenges facing developing countries in the 21st century. It has attracted the attention of local communities, national governments, multilateral and bilateral agencies and non-governmental organizations. For example, in the USA, Assistance for Orphans and Other Vulnerable Children in Developing Countries Act of 2004' was passed. Similarly, in Uganda, a national OVC policy has been formulated to address the issues that affect OVC (MoGLSD, 2004).

The triple crisis of HIV/AIDS, tropical diseases and violent conflict has worsened the situation of OVC in developing countries (Subbarao, 2001). HIV/AIDS in particular has had an immense impact on OVC; not only has it threatened their right to life and family environment, it has also undermined a multitude of other rights (Buckhurst et al., 2004).

OVC are likely to suffer severe psychological distress as a result of losing one or both parents; OVC may also lack food, shelter, clothing and healthcare. Due to pressure on he household, OVC may be forced to drop out of school to work or care for sick relatives or younger siblings (World Vision, UK, 2005). On top of all these, they are

ikely to face stigmatization and discrimination and may be at risk of abuse or exploitation (UNICEF, 2003). This plight of OVC is illustrated in the story bellow.

*Hajjara Naziwa lost both of her parents to HIV/AIDS at the tender age of eight years. She was the eldest of four children. When the parents died their land lord was sympathetic and let them stay in the room for three years without paying rent. However, being the eldest child, Hajjara had to find ways of buying food for her siblings and this is what led to her becoming a prostitute at an early age. Hajjara and her siblings were eventually evicted from the one-roomed house and had to move to the streets. By then however, Hajjara had contracted the HIV/AIDS virus and was unable to fend for her siblings, one of whom was also infected having been born with the virus. (**As told by FGD from Kisenyi II parish - Church Area zone).***

Such is the reality for thousands of OVC in Kampala Central Division and for millions of them in Uganda and across sub-Saharan Africa. In the long term, such suffering and neglect like that of Hajjara Naziwa reflected in the story above is likely to have catastrophic consequences, not only for children themselves but also for their communities and nations as whole.

Brandt (2003), argues that improving and protecting the lives of OVC must be central to efforts to combat HIV/AIDS. If countries are to avoid the very worst economic and development scenarios that Aids might bring, investment in the future of OVC is essential.

The findings of the United States Congress (2004) indicate that more than 111, 000,000, orphans live in sub Saharan Africa, Asia, Latin America and the Caribbean. These children are often disadvantaged in numerous and devastating ways and most

households with orphans cannot meet the basic needs of health care, food, clothing and educational expenses.

The United Nation's Fund (UNICEF) in its study entitled Africa's Orphaned generations, reported that 12% of the children who are orphans are found in sub Saharan Africa compared with 6.5% in Asia and 5% in Latin America and the Caribbean. The number of orphans in Uganda according to this study was 1,731,000, 15% of the total children population in 2001, 51% of these were orphaned by AIDS (UNICEF, 2003).

This UNICEF study further noted that the orphan crisis is not especially visible because, millions of children; are dispersed over many families in communities where hardships of individual children are ignored.

Some orphans may be more visible, particularly those who are forced onto the streets to work and live, but even then, they simply add to the many children, orphaned or not who struggle to make a living on the African streets (UNICEF,2003. p.33)

Other studies conducted by UNAIDS, UNICEF, USAID, put the number of orphans in Uganda at 2 million, 19.7% of the total population (UNICEF and UNAIDS. 2002).

According to the Uganda Socio Economic survey, (2003), 14% of the children have lost one or both parents. Out of these, 3.2% have lost both parents, 2.2% have lost mothers and 8.4% have lost their fathers (Uganda Bureau of Statistics, 2003).

HIV/AIDS and violent conflict have worsened the situation of orphans by increasing their numbers and over stretching the socio-cultural systems intended to look after them. The proportion of orphans among children under 18 years has increased nearly five fold over the last two decades due to armed conflicts and HIV/AIDS (Ministry of Gender, Labor and Social Development, 2003).

One in every four households in Uganda is taking care of an orphan and many more households are of other vulnerable children. Elderly caregivers or fellow children with capacity to provide effectively, the required care and protection, head these households.

According to the policy report published by Help Age International and International HIV/AIDS Alliance in 2003, many governments are still a long way from fulfilling their commitments toward support to OVC despite declarations made at International summits. Such summits include: the United Nations General Discussion on "Children living in a World With AIDS' 1998; African Regional Meeting on Orphans and Vulnerable Children held in Zambia, in 2000 and the Windhoek workshop on Children Affected by HIV/AIDS, 2002 (World Vision UK, 2005).

The Help Age policy report (2003) indicates that few national HIV/AIDS policies pay adequate attention to the growing numbers of OVC affected by HIV/AIDS and even fewer countries make provision for older carers and guardians.

Similarly, the World Bank (2001) in a report observed that although awareness of the plight of orphans is growing, no country has mounted the kind of response that is needed to match the severity of the crisis. The World Bank further noted that despite the variety of interventions being tried, current efforts to address the orphan crisis are inadequate and piecemeal. This report therefore, recommends that the enormity of the problem of OVC demands a coordinated response by African governments, the World Bank, other development partners, NGOs and local communities.

However, Helen (2002) animated that it is the effectiveness of the African extended family system in absorbing millions of vulnerable children that has contributed to the

complacency of external agencies concerning the orphan crisis. Similarly, UNICEF 2003) stated that, government action has been slow to emerge in most countries because families and communities have shouldered most of the strain. African traditions of community cooperation have relieved the pressure on governments and national institutions.

Statement of the Problem

While there is growing concern about the plight of OVC by different stake holders and a number of interventions being tried in response to their ever growing numbers, an enormous gap still exists between what has been done and what needs to be done to protect their rights and address their needs. For example, in a survey of 326 OVC households in Uganda, approximately 84% indicated that they had not received any form of assistance from government, or external agencies even though the majority were living in poverty (Wakhweya, 2002).

Without addressing the rights and well being of OVC, the overall development prospects of affected countries is in jeopardy (UNICEF, 2003).

In this study, therefore, this researcher seeks to investigate strategies and mechanisms communities have put in place to bridge the existing gaps between the support and care that are being given and what ought to be given; the extent to which the various needs of OVC have been addressed and how best they can be implemented.

Research Questions

1. How do communities cope with the problem of OVC?
2. What are the caring arrangements for OVC?
3. To what extent have communities responded to the needs of OVC?

Objectives of the Study

1. To find out the extent to which communities have responded to the problem of OVC in Kampala Central Division.
2. To find out whether the mechanisms and strategies employed by households and communities have been able to meet the needs of OVC.
3. To find out the extent to which the needs of OVC have been met and what can best be implemented.

Study Hypothesis

It is hypothesized that:

A big gap still exists between what has been done and what ought to be done to meet the needs of OVC and protect their rights.

The study investigates community responses to the problem of OVC.

- The community has attempted to provide for the needs of OVC
- The needs of OVC can not be handled by the community alone

There is need to fill the gap between what has been done and what ought to be done.

Scope of the study

Kampala Central Division is one of the five Divisions forming Kampala District. It is the smallest and most centrally located. The population concentration per Km2 is very high. According to the 2002 census, Kampala Central Division has a total population of 117,894 growing at a rate of 5.2% annually. HIV/AIDS disease as it affects the individual's productivity through ill health effects, the attendance of children at schools, deaths of family heads through HIV/AIDS infection and the deprivation of warm parenting particularly in the formative stages of development; and the affected children therefore, are most likely to miss the cohesive influence of their parents and are very prone to the bad socio-cultural influence of their peers.

In Kampala Central Division children are the most vulnerable group; and the situations that render them vulnerable include: Situations where children live with single parents, where they lack parenting; orphanage, infected children who are prone to sickness/ ill health from opportunistic infections. Further more, these are also juvenile (those who conceive while under age). It should be noted that, Kampala Central Division, being at the center of Kampala district, has many street children who come from all different corners of the country and are among the most vulnerable OVC. Therefore, the high numbers of persons living with HIV/AIDS, large number of households caring for OVC, make Kampala Central Division, an ideal area for a study on OVC.

In a survey of 500 households, 40% had orphans. The survey further revealed that for every two households there is an orphan (Kampala Central division household baseline survey, 2004). Over 75% of the children in Kampala Central division are vulnerable in one - way or the other.

Significance of the study

The policy is deemed to ensure empowerment of local population to participate in planning, decision-making and management of development process for their growth and well-being.

The focus of this study therefore is to examine what has been done and what ought to be done for orphans and vulnerable children.

The study will be helpful to both the policy makers and the respective policy implementers for it provides basic data on orphans and vulnerable children under the study area. The scholars interested in the research will also find this study useful for consultation since it is the first of the kind.

Definition of Key Concepts

In this section, the researcher gives the working definitions of the key concepts used in the study. These are defined from the perspectives of different scholars and development agencies and the researchers own perspective.

Caregivers

Caregivers in the context of this study will be individuals who take primary responsibility for the physical, mental and emotional needs and well-being of children. Many of the households are hard pressed to provide the financial, social, psychological, and educational and health needs for the children they are raising. The various categories of caregivers include:

- Surviving parents
- Members of the extended family
- Children taking care of their young siblings
- House keepers / domestic servants
- Friends

Care

The process that results in the creation of an environment that can support the child's optimal development. Care systems are usually embedded in a people's culture. Significantly, care has to do with what the communities / caregivers and others in the child's life are able to provide, such as a healthy and state environment, supportive and affectionate interaction and time. (Ressler, 19993)

Community:

A group of people staying together with common characteristics, such as profession, interests, age, ethnic origin, shared health concern or language.

Child Rights Advocates (CRAs)

These are the trusted 'appointed' persons by the community in a very parish to over see and make sure that the rights of OVC are protected in their respective areas of residence.

Community Support Systems:

Community support systems for the purpose of this study, mean, mechanisms and strategies employed by households and groups within the community to provide

upport and care to OVC. The support systems in the community include all of the ndividuals and systems that are connected to any OVC. These include:

- Family members (parents, siblings)
- The extended family (relatives, clan members)
- Health workers
- Community leaders (Local Council)
- Department of Probation and Welfare
- Volunteer care givers / friends
- NGO / CBO workers
- Schools (teachers, peers)
- Residential care facilities

Orphan

Different scholars and agencies have variously defined the term orphan:

A child below the age of 18 who has lost one or both parents (NSPPI, 2003, World Vision, 2003, Subbarao and Coury, 2004)

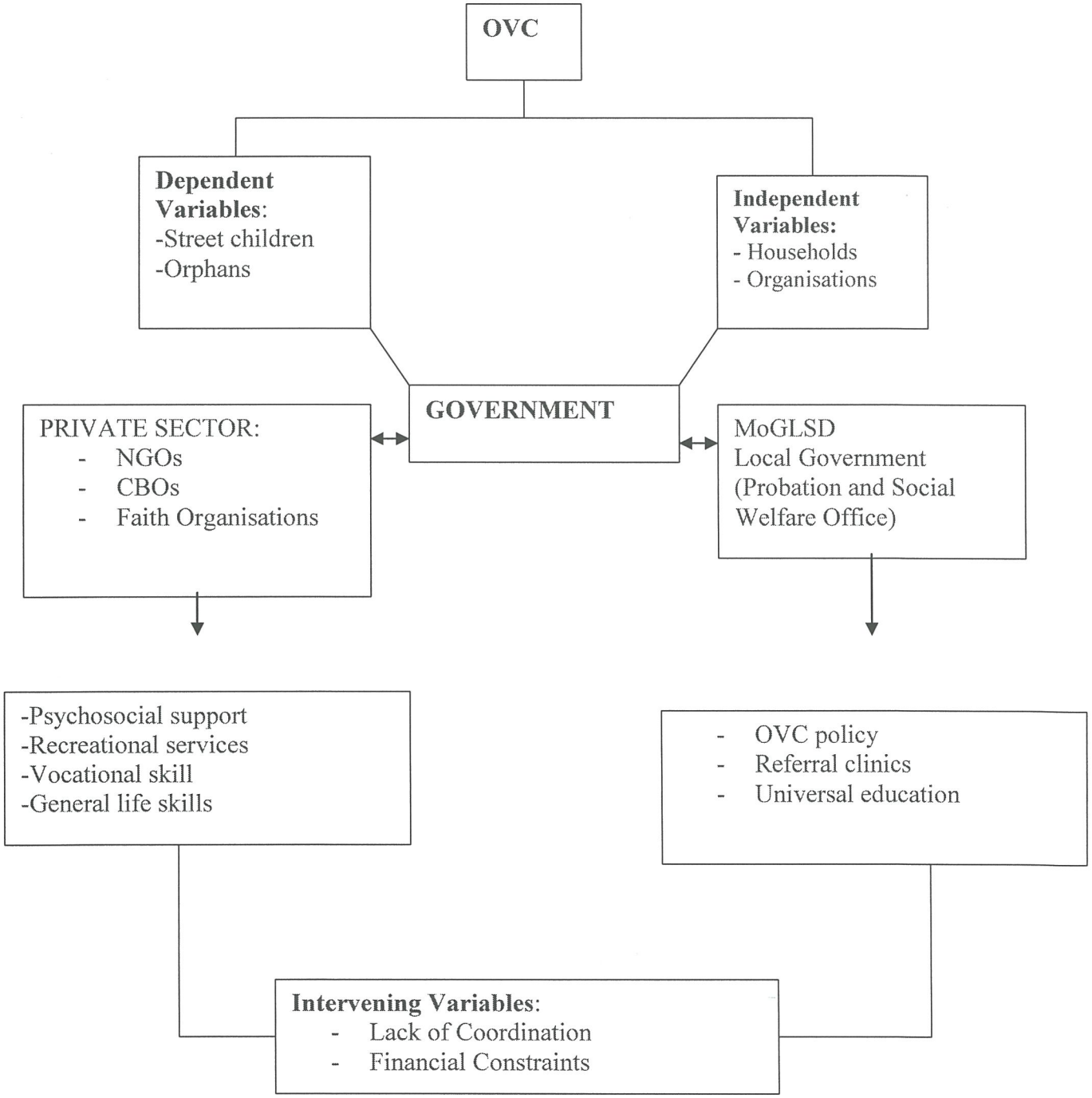
Other Vulnerable Children

Other Vulnerable Children are those whose safety, well-being, and development are, or various reasons, threatened. These are children who have endured unimaginable abuses; children with disabilities; and children in institutional or other forms of foster care and are often unstable. Of the factors that accentuate children's vulnerabilities, he most important are lack of care and affection, adequate shelter, education, nutrition and psychological support. Although children exposed to many facets of

leprivation and poverty are vulnerable, children who have lost their parents may be ›articularly vulnerable, because they do not have the emotional and physical maturity o address adequately and bear the psychological trauma associated with parental loss Subbarao and Coury, 2004).

Conceptual Framework

STAKEHOLDERS INVOLVED IN THE PROVISION OF SERVICES TO MEET THE NEEDS OF OVC



As seen in the diagrammatic illustration above, it's conceptualized that provision of services to meet the needs of OVC is dependent on various stakeholders. The government of Uganda acted to meet more of the social and development needs of OVC by providing an enabling environment through which different stakeholders could respond and intervene in the provision of services for OVC.

Within Kampala Central Division alone, there are likely to be over, 30 Non-governmental organizations all administering fairly similar interventions for OVC. The interventions in the form of mainly projects and sometimes programs include a broad range of activities; psychosocial support, vocational training skills, general life skills training, recreational facilities, counseling, education (both formal and informal), specialized services for needy OVC, and a wide range of research on problems facing children among others.

Because the different efforts to support OVC and the communities are extensive and varied, it is difficult to identify any overarching goals or purposes. OVC policy has been formulated and programs designed, however, with little or no apparent attention to their collective impact on OVC.

In the face of these factors how can the resources, projects and programs that are directed towards the welfare of OVC and communities be improved? How can the different actors ensure that their interventions culminate in real positive impact for OVC? There are no easy answers to these questions just like there may be several attempts to it.

Therefore, better mechanism (systems) for the better services and benefits for OVC; need increased efficiency and coordination among various stakeholders that are involved in designing program interventions for OVC.

Several publications have been produced describing the problems of OVC and suitable intervention strategies that may be used to help the millions of OVC. These publications and documents are valuable in their detail in explaining the problems OVC face and the most suitable interventions; however, are limited in their understanding of the processes and key factors that continuously limit the impact of the individual interventions.

To obtain this type of knowledge, policymakers, organizational managers require an understanding of the process and factors within the public arena of services delivery for OVC, which go beyond simply responding to a need and extend to determining the most effective ways of ensuring that the need is resolved conclusively.

As already indicated in the diagram, different stakeholders are involved in providing services to meet the needs of OVC. The most logical response to meet the needs of OVC would be the need for organizations to collaborate and coordinate their efforts. Different organizations compete by working independently rather than collaborating. It's true some organizations may be capable of empowering their individual communities without interaction with other organizations but, in order to achieve broader empowerment of the wider community and meet the needs of OVC, they must work together.

.ocal government (Central Division) has limited contributions in OVC related service ›rovision; the service coverage both in numbers and locations across Kampala Central)ivision is limited yet the number of those in need is high.

CHAPTER TWO

LITERATURE REVIEW

This Chapter gives the conceptual framework of the study and discusses the variables used in the research and shows the linkages among the variables. It focuses on: Coping mechanisms and strategies employed by households and communities in providing support to OVC, caring arrangements for OVC and the extent to which their needs have been met. The key issues for which literature has been reviewed concern the concepts of community support systems and care for orphans and vulnerable children.

In this chapter, the researcher also gives personal reflections on the different issues raised on the subject under investigation by different scholars and development agencies.

Coping Mechanisms within Households and Communities

There is a growing recognition among development agencies, non-governmental organizations and national governments that the coping mechanisms within African communities are breaking down in the face of HIV/AIDS, violent conflict and increasing poverty levels.

Church World Service (2004), for example, observes that traditionally, children who became orphaned or vulnerable were absorbed by the extended families. But, with the rise of HIV/AIDS, and its impact on health and livelihood of extended families and communities, it is increasingly more evident that this absorption process is being strained. Families and extended families are breaking down as sick family members,

›rphans, widows, and elderly are forced to join other households or even worse remain .lone.

As observed by the World Church Service, the case of Kampala Central division is ›ecoming worse. There are high numbers of OVC as they come from all over the ountry to look for survival. The extended family system is not applicable in the city. 'he problem is not that the extended families are breaking down, but the OVC in :ampala Central division are taken care of by care givers whose support is inadequate. Wakhweya, citing Barnett and Blaikie (1991) noted that the AIDS scourge has weakened he community support structures and burdened family and kinship networks in Jganda (Wakhweya et al . , 2002, p.53). Many households are distancing themselves rom their extended families, as they are increasingly unable to cope with many lemands for support that have accompanied the HIV pandemic. The forces of nodernization, urbanization and globalization, interacting with a predominantly .grarian based economy have led to wide spread dislocation and poverty making it nore difficult for households and communities to provide financial support to their listant kith and kin.

Vorld Church service view that guardians are being forced to withdraw children from chool no longer holds because with the introduction of universal primary education in Jganda most of the children are in school.

Similarly, Wakhweya's view that households are distancing themselves from their :xtended families is unlikely to be true in all communities. If this is happening it may ıot be that such households are completely unable to take in an extra child. In fact, nost households that distance themselves from their extended families are the rich

ones who are capable of supporting an extra child (Helen, 2002). The researcher's view herefore is that those who are distancing themselves from extended families do so nost probably because of the life style.

A World Bank study on social protection of Africa's OVC (2001) found similar findings. n that World Bank study, it was observed that traditional community coping nechanisms- Africa's mainstay seem to be coming under severe stress in the wake of overty, conflicts, AIDS and natural disasters. Even though, the severity and nature of he problem may differ across countries and between rural and urban settings, there is ittle doubt that the number of OVC has already reached catastrophic proportions in ome countries (World Bank, 2001).

Undoubtedly the wake of poverty, violent conflicts, AIDS and natural disasters, the bility of households and communities to care for OVC has been weakened. In Uganda, articularly in the Kampala Central Division, the number of OVC has reached atastrophic proportions. This view may sound rather alarmist since households and ommunities still seem to have mechanisms for coping with the current numbers of VC. Nevertheless, the existing coping mechanisms may have weaknesses that would e need to be addressed.

Foster and Germann (2002), found that the extended family is not a social sponge vith an infinite capacity to soak up orphans. According to (Helen 2002 p 282), the lramatic increase in orphan prevalence, reduction in the number of caregivers and nraveling of the social safety net as a result of social change. This view of Foster and Germann is supported by a study of Child-Headed Households on Commercial Farms in Zimbabwe by Farm Orphan Trust of Zimbabwe (FOST) that revealed that the majority of

he child -headed-households had lost connections with extended family members FOST, 2002).

Despite skepticism surrounding the ability of African families and extended families o provide support for OVC, there are indications that the family and the extended amily are still the major source of support to OVC in communities world over.

In a situational analysis of orphans in Uganda, Wakhweya et al. (2002) found that Africa's rich tradition of community and group welfare reflected in broad network of structures of extended family and kinship formed strong social safety nets to support orphaned children in the past. They found that the remnants of these social bonds are still observable in widespread practices of sharing among people with a tendency oward spontaneous and informal grass root initiatives and community based projects.

In Uganda, such group welfare is reflected in such practices as sharing esponsibilities during the last funeral rites. During such functions, an heir is appointed o provide support to the OVC in the family of the deceased. However, in Kampala Central Division, the situation is totally different. Most of the OVC survive on their own; households hardly provide any support to OVC. Most of them are not in school, and urvive on their own on unadequate food, medical, shelter and clothing.

The caregiver of an orphaned Ugandan child was probably a surviving parent, with grandparents and other extended family members usually assuming primary esponsibility for the orphan when that surviving parent died or could no longer care or the child. UNAIDS, (1995), Ministry of Finance and Economic planning, (1995) Monk, 2001) suggested that.

Similarly, the results of a field survey by Wakhweya et al. (2002) revealed that 47% of all the OVC visited lived with mothers with other extended family members assuming esponsibility when the parents could no longer provide. This survey further revealed hat 41% of the household heads were women; 62% of the male households were narried and 22% were widowed; 61% of all the household heads were 65 years of age r older. Of these, 55% were female headed, comprising 13% of all female-headed rphan households.

Foster and Williamson (2003) found that as a result of increasing numbers of orphans nd shrinking number of care givers, orphans tend to live in bigger households headed y much older relatives'.

Foster, found that less than 1% of households in most countries, headed by hildren under the age of 18. In many more households, older siblings (18 years or lder) who have been caring for brothers and sisters during the parent's illness would arry on as the heads of households. Even if orphans stay in households headed by an dolescent, or young adults for extended periods, they probably would be over seen y members of the extended family in the form of clustered foster care (Foster, 1997).

From the findings of these studies, women seem to be shouldering a greater burden n looking after OVC than men. This may partly explain why there is still a very big gap etween what is being done for OVC and what ought to be done since women are likely o own fewer resources than men.

Separation of siblings is another coping mechanism employed by families to cope vith the increase in the number of OVC in households in a study by Family Health nternational in Zambia, it was found that orphaned siblings were placed in different

iomes as a way of distributing the burden of care, 60% of a sample of five saw their brothers or sisters less than once a month (Family Health International, 2002).

Separation of siblings as coping mechanism may be the only viable alternative especially where parents died and leave many children who cannot be absorbed in a ingle household. However, such children may suffer enormous emotional problems.

In Kampala Central Division, this is likely to happen because the number of children ber household is large. According to the World Vision Uganda (2004), there are iouseholds in Kampala with as many as 8 OVC. Meeting the needs of such a number of OVC with limited resources is an enormous task for caregivers who may be earning neager incomes separating such children and distributing them into different iouseholds, therefore, becomes inevitable if their material needs are to be adequately net.

When families cannot adequately provide for the basic needs of their children, the ommunity is the next safety net for essential support (UNICEF, 2003).

A policy report by HelpAge International and International HIV/AIDS Alliance has locumented the copying mechanisms employed by communities across the world: in uba Sudan, older community counselor makes house to house visits to provide families vith advice on child care, referral to schools and health services; in Vietnam, older beople have formed clubs to provide support to OVC; in Uganda parents who are still live encourage their children to visit and socialize with as many relatives as possible o that they get to know their extended families; other coping mechanisms locumented include making memory books to help children learn about family events,

raditions and family trees- (HelpAge International and International HIV/AIDS Alliance 2003).

Similarly in the United Republic of Tanzania, villagers have set up 'Most Vulnerable Children committees' that mobilize and distribute villagers' donations of food and unds and also organize income generating activities and other forms of support. In Swaziland local people have established Orphans and Vulnerable Children Committees o pool resources and organize community support. One such committee has used the noney raised from community donations to establish a shop at the local primary chool, the income from which pays the school fees for several children. Another has established Neighborhood care points managed by local volunteers to provide day care UNICEF, 2003).

Efforts at the community level to provide care to OVC such as those documented in hese studies are likely to be common in communities where the families or extended amilies have been disrupted by disasters such as civil wars and where epidemics such as HIV/AIDS have wiped out the entire extended family. However, where the families or extended families are still intact as in the case of Kampala Central Division, community nembers may be reluctant to come together to offer support to OVC.

Sources of Income of OVC Care givers

Wakhweya et al., (2002) found that subsistence farming was one of the main sources of ncome used by OVC caregivers, over 80% depended on this source of income to support OVC under their care, while about 4% depended on formal salary, 31%

lepended on petty trade, 19% on wage labour and 5% on alcohol brewing (Wakhweya et ıl., 2002).

A Feasibility study on viable Income generating activities for older persons taking care ›f HIV/AIDS orphans conducted in Ahero, Nyando District and Asumbi, HomaBay)istrict, Kenya conducted by HelpAge Kenya, revealed that older people were selling ınd, property, cattle and other assets in order to meet their own need, and to care for heir grandchildren (HelpAge Kenya, 2002).

Similarly, HelpAge International and International HIV/AIDS Alliance in a study on ›lder people and child Care in Tamil Nadu, India, reported that older people sold their ›roperty, or pledged it with money lenders for borrowing money at between 36% and 20% interest per annum, to provide health care to treat family members (International HIV/AIDS Alliance, 2003).

A study by HelpAge Zimbabwe, found that 76% of the respondents had household nembers under the age of 15 contributing to household income through waged labour. Those under 15 years were usually employed as casual laborers at nearby farms specially during school holidays), work as herd boys or housemaids for well to do nembers of the community in urban areas or work as laborers for rural district councils ›r in the surrounding areas (HelpAge, Zimbabwe, 2002).

Non-contributing pension programmes in South Africa, Botswana and Namibia are n important source of income for caregivers of OVC (University of Manchester, 2003). lon-contributory pension programmes are known to have a significant impact on educing poverty and vulnerability among OVC households. However, in a low-income

ountry such as Uganda with a limited tax base, the introduction of such a pension rogramme may not be feasible without external support.

Meeting the Needs of OVC

The United Nations Children's Fund (UNICEF 2003, p.33) initiated that providing mmediate support to families and communities to ensure that all of Africa's orphans ave a secure and healthy childhood can alter the course of the orphan crisis. Offering Children free basic education, giving them safe and viable option for earning a living nd providing families with financial and other assistance can mean that many orphans who might otherwise be separated from their families are able to remain with them. The family, whether the head of the household is a widow, elderly grandparent or oung person-represents the single most important factor in building a protective nvironment for children who have lost their parents to HIV/AIDS or to any cause.

The World Bank (2001) indicated that, while private and community responses to hildren in need have been widespread and commendable, society and the community re still unable to cope with the growing magnitude of the crisis.

A situational analysis conducted in Zambia reported that orphans identified three ignificant problem areas in their care; lack of love, outright discrimination, and being xcluded (Zambia Participatory Assessment Group, 1999)

A study by Orphan trust of Zimbabwe (FOST 2002) revealed that, most of the hildren surveyed lacked physical/material support and psycho-social support- 64% were not in school, 68% had no identification documents, 65% were living in poor ouses, 59% were relying on casual work and 24% were relying on collecting roots and

ruits from the bush, and fish from local dams, 53% had been deprived of property by heir relatives, 40% had experienced abuse and 36% had no access to health care (FOST, :002).

Similarly, surveys conducted in urban areas of Zambia showed that only one third of ıouseholds with orphans were receiving any kind of support (Family health nternational, 2002).

Of the surviving parents interviewed, 54% reported experiencing emotional lifficulties due to raising one or more orphans, 14% of the household heads nterviewed claimed that their families ate only once a day while 33% could provide hree meals a day; while 86% of the household heads indicated lack of medical care a najor problem.

While the extent to which the needs of OVC have been met may differ from ommunity to community, one thing is clear from the findings of these studies, there is till a big gap between what has been done and what ought to be done. This state of .ffairs may not be different from Kampala central division.

This inability to fulfill needs of OVC may be attributed to the fact that caregivers are onstrained by inadequate resources, yet there are many children to share the little esources available within the households. This also reflects lack of commitment by ıovernments in countries with large numbers of OVC.

CHAPTER THREE

RESEARCH METHODOLOGY

ntroduction

his chapter presents the methods that were used to conduct the study. Research trategy, study population, sampling methods and procedures and data collection nstruments and the criteria for interpretation of results.

esearch Design

he subject of OVC has become a global issue because the contributing factors to rphan- hood, such as HIV/AIDS, violent conflict, and tropical diseases, are global in imension. The most appropriate research strategy to study this kind of subject was herefore, a case study research design. The research design allows both qualitative nd quantitative data collection methods.

tudy Population

he population included: 600 household heads, 250 (42%) males and 350 (58%) emales, and 620 children drawn from 240 households and different organizations AMICAALL SUCIO-Project and Kamwokya Christian Caring Community); 414(67%) of he children were males and 206(33%) were females. All these were randomly selected rom 60 villages as indicated in table below:

'able 1: Villages from which the Study Population was drawn.

PARISH	VILLAGE / ZONE
UKESA	- CHURCH ZONE - JAMBULA ZONE - KAKAJJO I - KAKAJJO II - HAJI KATENDE ZONE - KIYINDI - NAMALWA I ZONE - NAMALWA II ZONE - NSALO ZONE
:AGUGUBE	- KIVULU I - INDUSTRIAL AREA - KIVULU II - KAGUGUBE - L D C - NATIONAL HOUSING FLATS - KITAMANYANGAMBA
:AMWOKYA I	- VILLAGE A - VILLAGE B - VILLAGE C - VILLAGE D
:AMWOKYA II	- CHURCH AREA - KISENYI I

	- KISENYI II - KIFUMBIRA I - KIFUMBIRA II - CENTRAL ZONE - COUTAFRICA - MAWANDA - GREEN VALLEY - MARKET AREA
ISENYI I	- MUZAANA ZONE - BLUE ROOM - CENTRAL ZONE - BUWANIKA
ISENYI II	- KIGANDA - MARKET VIEW - SCHOOL VIEW - MBIRO - KASAATO - LUBIRI TRIANGLE - KIBWA - KAKAJJO - CHURCH ZONE - MENGO HILL
ISENYI III	- KAWEMPE - NOOK - LUZIGE

	- KIGULI - SAPOBA
ʌENGO	- LUBAGA ROAD A - LUBAGA ROAD B - MUSAJJALUMBWA FLATS - MUSAJJALUMBWA VILLAGE - SOCIAL CENTRE - NANOZZI - YOANA MARIA
)LD KAMPALA	- ZONE A KYAGWE ROAD - ZONE B MARTIN ROAD - ZONE C - ZONE D

ource: Office of the Probation Officer Kampala Central Division

hree focus groups comprising six to ten (6-10) members were randomly selected for ualitative data collection. Members included local council one leaders (15), caregivers f OVC(30) and OVC (30) themselves selected from 60 zones.

ampling Method

Cluster sampling

n this method, the number of clusters selected from each geographical area is proportional to the number of elements (in this case households), in that geographical rea. This means that more clusters were selected from areas with higher population han areas with lower population.

he parish was taken as a primary sampling unit while a number of villages make up a arish. Based on this method, parishes with more villages had more villages sampled rom them than those with fewer villages. Kamwokya II and Kisenyi II parishes have the ighest population in Kampala Central Division according to the 2002 national Housing nd Population Census, so more households were selected, while Kamwokya I and isenyi with the lowest population had fewer clusters selected from them. Because the lements within the cluster were randomly selected, each element had equal chance of eing selected.

imple Random Sampling

his was used to select a cluster (Villages) within a parish to ensure that each cluster as equal chance of being selected like the rest.

ystematic List Random Sampling

his was used to select a household within a cluster (Village). A list of households was btained from local council one chairpersons with the help of CRAs and selection was

lone using systematic list random sampling to ensure that each household within a cluster has equal chance of being selected like the rest. This same method was used to elect participants for the focus group discussion with local council one members, care givers of OVC and OVC themselves.

ampling Procedures

tep One: Determining the number of clusters

ixty (60) clusters (villages) were selected from 71 clusters in Kampala Central Division fter constructing sampling frame.

tep two: Determining the number of households per cluster.

he number of households per cluster was determined using the following formula:

lumber of households per cluster = sample size (240) divide by 60 = 240 divide by 60 = 4.

tep three: Selection of households within a cluster (Village)

fter determining the number of clusters to be surveyed in each parish as per sampling rame, the four households to be surveyed in each of the sampled clusters were elected. This was done randomly using the following procedure: A list of all ouseholds in every cluster to be surveyed was obtained from local council one hairpersons and a systematic list random sampling used to select the households ithin each cluster. The total number of households in each cluster was divided by four

sample size four households) to get the sample interval. Using a table of random numbers, the households to be surveyed were selected from the list.

tep four: Selecting children within households

or every household surveyed, two to three (2-3) children were randomly selected and lata collected on them using the principal caregiver as the major respondent. A total of 20 children were randomly selected from 240 households and two NGOs (KCCC and MICAALL SUCIO- Project) within Kampala Central division.

)ata Collection

nstruments used

lousehold survey Questionnaire

wo household survey questionnaires with closed ended questionnaires were designed nd used to collect data from the sampled households. The first questionnaire ollected data from the household heads while the second questionnaire collected data rom selected children within the surveyed households and organizations.

hese instruments were used to collect quantitative data on: copying mechanisms vithin households and the community, caring arrangements for OVC within households nd extent to which OVC needs have been met.

he questionnaire for the household heads collected data related to the household and he community in general while the questionnaire for children within the surveyed

ıouseholds and organizations collected data specific to children within these ıouseholds.

:lose ended multiple choice questions were used in the two questionnaires. This made : easy for the respondents to choose among the alternatives of interest to the esearcher. Secondly, standardized responses were easier to analyze and close-ended ıuestions eliminated the unanticipated and therefore uncontrolled biases that could ıave arisen from the interviewer's way of recording responses. Close-ended questions lso eliminated responses that could have been too general and difficult to interprete.

ocus Group Discussions (FGDs)

'o compensate for the limitations inherent in a household survey questionnaire, focus ıroup discussions of six to ten (6-10) people using an interview guide were onducted. The FGDS complemented the household survey questionnaire and helped to heck on the reliability of information obtained from household survey questionnaires nd interpret it's meaning.

pecifically, the focus group discussions enabled the researcher to obtain a variety of ıpinions and get information from those who are shy to speak while alone. The focus ıroup discussions also enabled respondents to generate as many responses as ıossible and gave the researcher a better understanding of issues not brought out learly in the household surveys.

Data analysis techniques

Analysis of quantitative data

Data collected from different categories of respondents was put together and assigned identification marks for easy processing.

Inspecting and Editing

This was done to discover items misunderstood by respondents or to monitor the accuracy of research assistants. Editing was done with care to avoid distortion of data from the respondents.

The data obtained from household survey questionnaires, were coded and entered in the computer using excel program to generate tables of frequencies and percentages. Further analysis of data such as presenting in pie charts and bar graphs was done using the excel program.

Analysis of qualitative data

Qualitative data from focus group discussion was grouped according to the merging themes and corroborated with information from household questionnaires.

Criteria for Interpretation of results

The criteria for the interpretation of results included: the context of the study, conceptual framework, generally held views and the researcher's perspective.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

This chapter presents the analysis and interpretation of empirical data as obtained from the household survey questionnaires and focus group discussions following the three research questions.

The empirical data was collected on: caring arrangements within households and communities, coping mechanisms within households and communities, and the extent to which the various needs of OVC have been met.

Caring Arrangements within Households and Communities

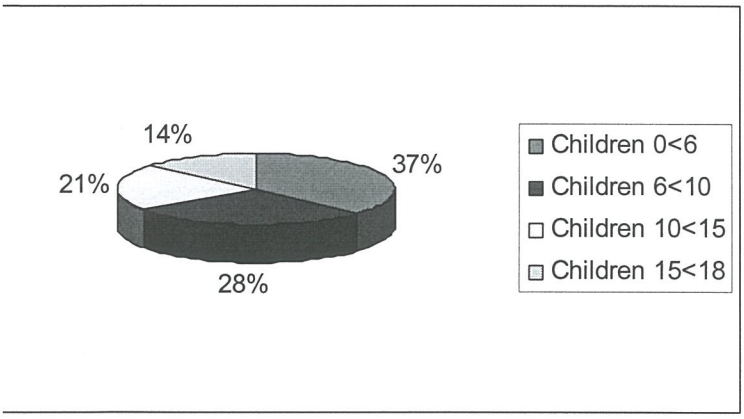
Residence Status of the Households surveyed

Most of the households surveyed, 94.9% were adult headed and only 5.1% were child headed. A similar trend is reported by Foster, (1997), in their study entitled Factors leading to the Establishment of Child Headed Households. They found that less than 1% of the households were headed by children less than 18 years.

However, findings of this study contrast the situation in Kabira sub-county, Rakai District where a significant proportion of OVC are living on their own (Mugabi, 200).

Figure 1 below, shows the age pattern of OVC within the surveyed households. Thirty seven (37%) were in the age range of 0-6 years, 28% were in the range of 6-10 years, 21% were in the range of 10-15 years and 14% were in the age range of 15-18 years.

Figure 1: Age pattern of OVC within surveyed Households (Household Heads)



ource: Field Survey Data: Household Questionnaire

'he age pattern of OVC has important implications for the provision of resources for hem. There are substantial differences in the needs of children of different ages, the elevant child protection measures for each group and how communities should ddress needs of each age group. For example, children aged 0-6 years may require pecial attention because they are the most vulnerable group.

)ther studies, however, show that most OVC are in the age bracket 12-17 years JNICEF, 2004). In such a situation, communities still need to understand the specific equirements of each age group.

:aring arrangements for OVC

Household based care was the most dominant form of caring arrangements for OVC hroughout the study area. However, a high percentage of OVC in Kampala Central)ivision lives on its own (street dwellers). In most of the surveyed households, OVC

vere being cared for within family units, however, some other OVC more especially street children do not have family units to care for them. Table two below, shows the most common family units within which OVC live in the study area:

Table 2: Family Lines within which OVC live (Household Heads)

Mother	38%
Father	21%
Sister	2%
Brother	3%
Uncle	4%
Aunt	8%
Grand mother	5%
Grand father	2%
Foster mother	4%
Foster father	1%
Friends	12%
Total	100

Source: Field Survey Data: Household Questionnaire

Living with a surviving parent

Thirty eight (38%) of the caregivers were mothers while 21% were fathers. 20% of the children in the surveyed households were living with either mother or father. The rest lived with either a relative or friends.

The predominance of women as care givers of OVC has several implications: Firstly, women are likely to stay at home most of the time thus making it easier for them to accept care giving roles for OVC than men who may spend most of their time a way from home. Women, although they are engaged in small businesses, can at least make sure that the OVC are cared for. Secondly, women are more likely to be more caring than men. Thirdly, men are likely to find it more difficult than women to care for their children, and so they often send them to their relatives; (as reflected in the literature review by Foster).

Remarriage is another possible reason why fathers are less likely to stay with children than mothers. When a father re-marries, it may be difficult for the new wife to accept the children who are not hers. Subbarao and Coury, (2004) suggested that the death of a mother is followed by the dissolution of the family, implying that maternal orphans are less likely to live with their surviving father.

Living with a surviving parent, when feasible, ensures that siblings remain together in family environment. This means that prolonging the life of a surviving parent should be central to all efforts aimed at meeting the needs of OVC.

<u>Living with Extended Family</u>

In the absence of either a mother or father, the extended family was the next option within which OVC were being cared for-18%, of the caregivers were relatives and

riends to the children and not their biological parents, aunties (8%), and uncles (4%), .nd grand mothers, (5%) and friends 12%.

Jrassa et al., 1997; Case et al., 2002; Beers et al., 1996; Foster et al.,; Foster et al.; Vakhweya et al., 2002 and UNICEF 2003 found similar trends of relatives taking care of)VC in the absence of parents. In all these studies, grandmothers were the most lominant relatives taking care of OVC.

'hough, grandmothers may provide a secure and loving environment that helps hildren to socialize, they may find it difficult to respond to children's psychological, .nd legal economic and basic needs. Grand mothers may be old and may be hemselves sick and tired. They may face many constraints if they do not receive any xternal support.

ıs it will be seen later when analyzing sources of incomes for OVC caregivers, very few eceive remittances from relatives.

'his therefore, means, for OVC living with old caregivers whether grandfather or randmother, external support is needed if the needs of OVC are to be adequately met.

iving with Unrelated Families

'his was the common form of caring arrangements throughout the study area. 17% of he caregivers were not related to the OVC they were caring for.

everal factors are likely to account for this low percentage of non-relatives looking fter OVC. Firstly, the deeply rooted tradition of children fostering within the extended amilies may be one of main reasons for non-relatives not taking care OVC. Secondly, he economic point of view; life in Kampala is all about survival, hence, many families

ind it a burden to add OVC on the number of children and family they already have....

Thirdly, taboos and cultural beliefs may discourage people from taking unrelated hildren in their homes. For example, Perry (1998), found that fear of ancestral spirits the avenging spirit) was discouraging members in Zimbabwe to take care of OVC.

n Uganda, adoption of a child by a non-relative has several legal implications. For xample, upon adoption by a non-relative, the adopted child, acquires the same rights s the biological children of the foster parent (The Children Act, pp. 34-35).

uch legal implications are likely to discourage many people from fostering children rom non-relatives for fear of such children claiming the same rights as their biological hildren. Besides, the legal procedures involved in adopting a child seem to be so umbersome that an average person in an urban setting community like Kampala Central Division is unlikely to fulfill.

lowever, Subbarao and Coury (2004) report that in Rwanda after the genocide many on-relatives were willing to take orphans in their homes. This is further collaborated y Bandawe and Lour (1997) in their study of orphans and vulnerable children in Malawi.

/hat this means is that the care of OVC by non-relatives may only be feasible, in ituations where the entire family or extended family has been wiped out by civil war ke in Rwanda scenario or where HIV/AIDS has wiped out entire family like in Malawi. ither situation does not exist in Kampala central Division. In Kampala Central Division, here are many OVC who have been evicted from their homes because of the War in lorthern Uganda. Some of these OVC have seen the family members being killed, thus

hey resorted to come to Kampala to seek refuge in form of survival. However, these)VC have nobody to take care of them.

Coping Mechanisms Within Households and Communities

Separation of Siblings

Separation of siblings into different households is one of the coping strategies employed by the caregivers of children in the study area to reduce the burden of many)VC on one caregiver. The findings of the field survey, show that a small number of children in the surveyed households were living with their siblings in the same household while the majority were separated from their siblings; (as reflected in the literature review by Family Health International Zambia)

)uring focus group discussions with community leaders, it was pointed out that this was an old strategy employed after the death of the parents where children are distributed among the relatives of the deceased and was becoming more common with he advent of HIV/AIDS where one finds both parents dead. It was noted by community eaders during the focus group discussions that before HIV/AIDS became a problem, hildren were put into different households due to poverty.

imilarly, today it is done because no single extended family can shoulder the burden f looking after all OVC put under its care when their biological parents die or when hey are chronically ill.

rom the field study, a significant proportion of the sampled children, had a very large umber of siblings. The implication is that it may be difficult for one single relative to

ntegrate all these children into his or her family unless she /he receives extra support rom the community.

As results of this study indicated, a large number of these caregivers were women single mothers, 38% and Aunties 8%) who may have a low capacity to earn income to upport such a large number of children.

However, such children may experience serious emotional problems because of such eparation from their siblings. This is likely to be so for children who have just lost heir parents and those whose parents are chronically ill. They need their siblings so as o console one another.

This coping mechanism though it relieves the caregivers of the burden of care, it lenies the child the opportunity to live with his or her siblings and enjoy the love from hem.

Main Sources of Income of OVC Households

To cope with the diverse needs of the children under their care, the caregivers of OVC are engaged in various economic activities. The majority of the caregivers were engaged in small scale businesses which ranged from: small shops, selling produce, public water taps, kiosks, working in garages, small markets, video halls, saloons, ailoring and others were engaged in selling alcohol in their own homes (front part of he house being used as a bar).

Most of the caregivers of OVC were engaged in non-agricultural economic activities as heir major sources of income. However, a small percentage of the caregivers works in

he formal sector, others in wage labor; street vendors, petty trading and some other caregivers / households have no main source of income.

A similar trend emerged from focus group discussions. Most participants mentioned: alcohol selling, charcoal selling, rearing of chicken and other petty trade as the main sources of income. Other sources were only regarded as being supplementary.

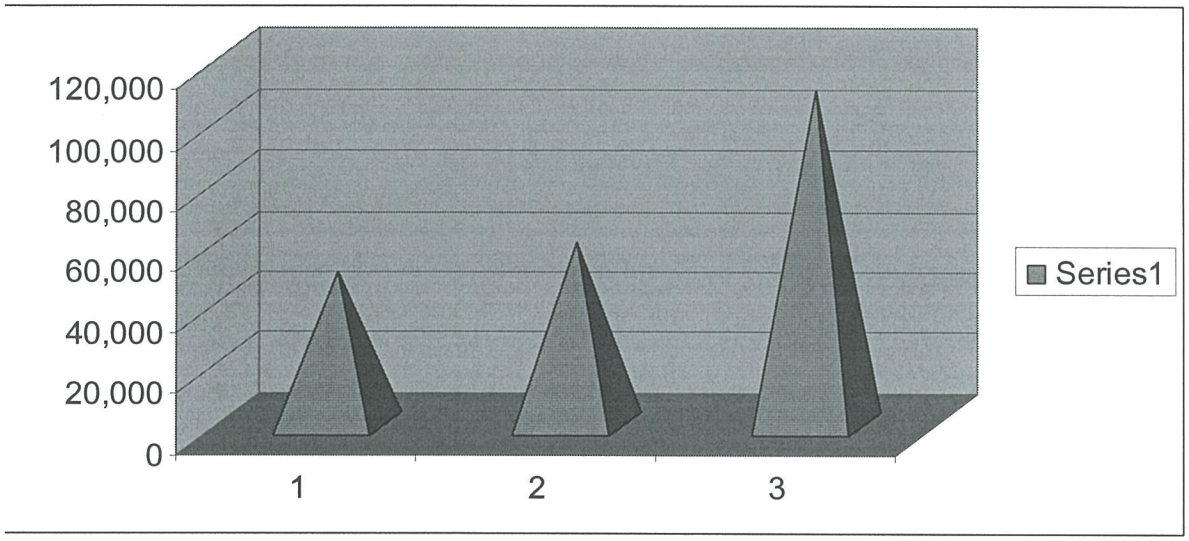
Small scale enterprises (petty trade) predominate as main sources of income for OVC caregivers mainly because through petty trade, the families can meet most of their food requirements and other needs of children such as health care and education. Much of these small enterprises is done nearby home, hence it doe not require the care givers to leave home like in the case with other sources of income such as formal employment. Another interpretation of this could be that OVC caregivers lack skills required in the alternative forms of employment like salaried employment (majority being women, like working nearby home).

The implication of this is that any development intervention geared towards providing support to households with OVC should include improving the economic productivity by embarking on Income Generating Activities (IGAs).

Income Earned from Main Sources of Income Per Month

As indicated in figure three below, the income earned from the main source of income per month by the majority of households is very low.

Figure 3: Income earned per Month by OVC Caregivers from Main source (Household Heads)



Source: Field Survey Data: Household Questionnaire

The economic profile of the guardians and parents of OVC reveal that these are not economically strong to provide adequately for the basic needs of OVC, which often culminates into "violation" of child rights in households. It is, for instance, clear that sizeable proportions (65%) of the households earn less than 50,000/= Ugandan shillings a month and are involved in economic activities that are not lucrative; and only 35% earned more than 100,000 shillings per month. The low monthly income earned reflects the sources from which it is earned. The predominance of small enterprises as the main source of income may partly explain the low income earned by most household heads per month.

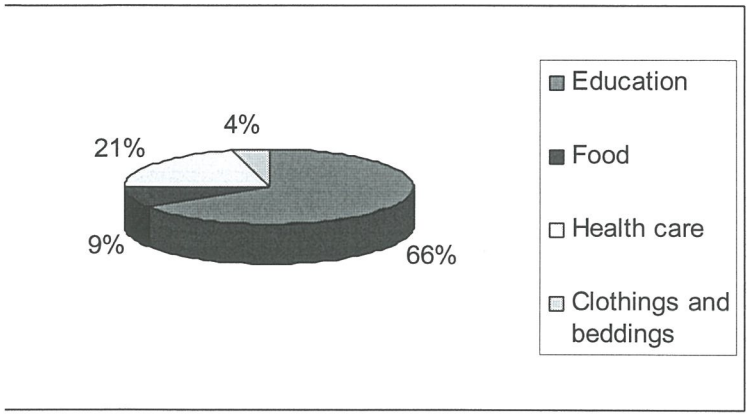
Similarly, the existence of few household heads in formal employment or wage labor, petty trade and other forms of employment that are more remunerative, may explain why few household heads earn above 100,000 shillings a month.

The implication of such low levels of income is that without support from external sources, household heads may fail to meet all the basic needs of OVC under their care. This may force some household heads especially single mothers to resort to socially unacceptable means of earning a living or abandoning the family altogether when the burden becomes too much. For instance, in Kamwokya Church Area zone, a woman grand mother) selling alcohol forced the grand daughter to have constant sex with men who come to drink at her bar (at home) for the sake of keeping customers. In the end, the girl became pregnant, contracted HIV/AIDS and her uterus was damaged. This is one of the socially unacceptable means of earning that some women engage in order to survive in the city. A lot of similar cases happen in other slum areas of Kampala Central Division.

Area of OVC Care that takes much of the households income

The analysis of the income earned per month from the main source indicates that households with OVC are surviving marginally. To cope with the low household income earned, household heads said they prioritize and spent on the most vital items. Figure 4: below summarizes the priority areas of expenditure by household heads looking after OVC.

Figure 4: Areas of OVC Care that Takes Most of the Households Income (Household Heads)



Source: Field Survey Data: Household Questionnaire

From figure 4 above, Health care and education of OVC take much of the household income while food and clothing seem not to be priority areas. This explains why most of the OVC in Kampala central division are on the street trying to look for survival. To some extent, the OVC are catered for in terms of education and health, this is not enough if adequate food is not provided. This leads them to engage in all sorts of unacceptable social behaviors.

The greatest priority given to education may partly be attributed to the government policy on Universal Primary Education; household heads have no choice but to spend most of the income on providing some scholastic materials.

Food seems not to be priority area of expenditure for most households because; they can not afford two meals a day. The majority of the households surveyed survive on a single meal a day. Some households go as far as two days without a meal. The OVC in such households try on their own to look for something to eat. This explains why most

of them (boys); engage in selling scrap, and girls selling their bodies to look for survival (under age).

Discrimination in the Allocation of Resources in OVC Households

The results of the household survey indicated that there was no discrimination in the allocation of resources among the OVC in the surveyed households, 80% of the household heads interviewed said that there was equal treatment of children in regard to education, health care, food allocation and other opportunities within the household. However, a small proportion 20% acknowledged discrimination in allocation of household resources as one way to cope with scarcity within households.

When resources are scarce, priority was given to biological children. While household survey results indicate that discrimination was rare in the households with OVC, the findings from the focus group discussions with community leaders show that discrimination is widespread in OVC households, all the participants unanimously agreed that OVC were discriminated in allocation of food, education, health care and work allocation- OVC were given heavier work than the biological children of the household heads.

Discrimination was said to be more common in households where OVC were living with stepmothers than households where they are living with other relatives.

The following reasons were given for discrimination especially in households where OVC were living with stepmothers: jealousy, rivalry, stepmothers look at girls under their care as co wives; boys are discriminated against because the step mothers fear,

hey will inherit all the household property, also boys are found of raping the small girls in the house (*bakwata abaana baffe).*

The statements below best illustrate how serious discrimination is, in households looking after OVC:

- They give their children bigger portion and give us smaller ones.
- They take their food in the bedrooms and distribute it from there.
- Serve themselves in the main house and leave us to serve ourselves from the kitchen

(Participants of FGD with OVC)

Zambia participatory Assessment group (1999) identified outright discrimination and being excluded as serious problems in OVC households.

Discrimination in allocation of resources, though, may be seen, as a way households cope with the burden of looking after OVC, should be discouraged. Such differential treatment of children is likely to groom them into selfish and individualistic adults who do not care about needs of others. Discrimination is also contrary to the African values of sharing resources with the needy and caring for others.

Reduction in the number of Meals per Day

In times of scarcity, households with OVC resort to reduction in the number of meals eaten per day to be able to cope with the large numbers of children and ensure that the food available takes them through the most difficult period.

n all of the surveyed households, food insecurity was common and reduction of meals vas the only coping mechanism employed. More than three quarters (3/4) had only one neal a day; and a small percentage had two to three meals a day.

A study by Farm Orphan Trust of Zimbabwe (200) reports OVC having similar food problems and resorting to reduction in number of meals and eating wild roots and ruits.

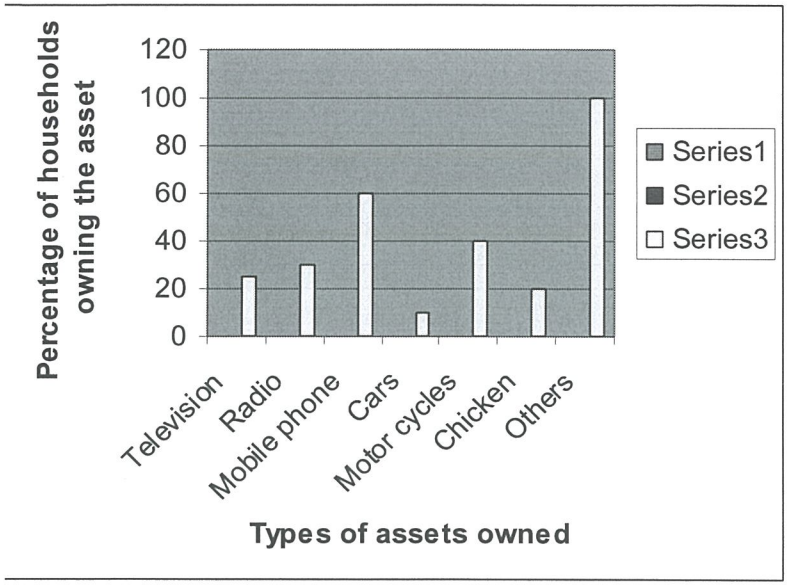
Asset Ownership among OVC Caregivers

This significance of asset ownership is that, household assets act as a buffer in times of hardships when the family has nothing to sell to get income to support OVC.

During focus group discussion with guardians of OVC, participants said in times of hardship they resort to selling assets as a way of coping. Common assets mentioned during focus group discussion were: mobile phones, chairs, and television sets, pieces of land left by the deceased and other valuable items in the household. These are sold when children are going to school to raise school fees. However, some assets belonging to OVC are misappropriated by the caregivers.

Studies by: World church service (2004), Wakhweya et al. (2002) and Help Age (2002) report caregivers of OVC resorting to sale of Land, cattle and other household assets in . struggle to meet household needs.

Figure 5: Asset Ownership among OVC Households (Household Heads)



Source: Field survey Data: Household Questionnaire

Considering the role household assets play in cushioning OVC households in times of hardship, broadening the assets base of OVC households should be central to any interventions aimed at meeting their needs. Assets such as live stock can multiply and provide a sustainable source of income to households. However, caregivers, as soon as a problem arises, they rash to the village to sell some of these assets which could have remained to help the OVC in future.

Organizations within the Community Providing Care for OVC

The number of Organizations (NGOs); within the community involved in the care of OVC are inadequate. Only 10% of the respondents in a sample of 240 households mentioned organizations involved in providing support to OVC. Some respondents mentioned credit and savings groups as community effort to toward providing support

o OVC. Majority of the respondents (90%) were not aware of any organization providing support and care of any kind to OVC.

There was a strong agreement between the findings of the household survey and focus group discussion with community leaders; all members of focus group discussion said, they had heard of NGOs in the community providing support to care for OVC. However, the few NGOs in the community do provide: Psychosocial support, vocational training skills, scholastic materials, Bylaws and Income generating activities (IGAs) to the OVC.

There were several reasons given for the failure of local groups to emerge. These included: Widespread poverty, dependency syndrome created by the NGOs, lack of compassion, dishonesty and untrustworthiness among community members.

These findings reflect lack of a cooperative spirit among community members in Kampala central division and high degree of individualism. In such a situation, the future of OVC, especially those who can not find close relatives to care for them is likely to be at stake.

HelpAge International and International HIV/AIDS Alliance (2003), however document a number of cases where communities have taken up the burden of looking after OVC, which greatly contrasts these findings.

Without community effort to support the OVC, there are likely to be serious social problems such as prostitution, stealing and all of which may come with frustrations of being neglected. In fact, in Kampala central Division young OVC: young girls by the age of 11 years; they are already engaged in sexual behaviors because of the situation.

Mechanisms to Protect OVC from Abuse

When children are orphaned or become vulnerable, they are susceptible to many forms of abuse that increase their vulnerability.

The various mechanisms used by caregivers to protect OVC from abuse are as summarized in table 3, below:

Table 3: mechanisms to Protect OVC from Abuse (Household Heads)

Counseling	20%
Confining at home	10%
Providing necessities	5%
Telling them risky place	15%
Teaching good manners	50%
Total	100

Source: Field Survey Data: Household Questionnaire

It is interesting to note that very few (5%) respondents considered providing an OVC with basic necessities of life as protective mechanism. The reasoning behind this is that if the OVC's basic necessities are provided, it may not be possible for them to be enticed and abused especially by outsiders.

However, a child can still be abused even if his or her basic needs are provided. For example, in Kivulu Kagugube Makerere a young boy (Ivan- 11 years) decided to abandon the mother and run away to the street. He was provided with everything

ncluding school fees; however, this did not stop him from running away from the nother to the street.

Confining children at home (10%); though as one of the mechanisms for protecting OVC rom abuse, may work for very few children in Kampala Central Division. Children who ıre older may need to be given skills to avoid abuse other than just confining them at ıome.

Providing psychosocial support: counseling, teaching good manners, and telling them ıbout risky places are more empowering and sustainable than either providing ıecessities or confining them at home.

Teaching the OVC good manners is the best way of protecting them from abuse. However, KCD being a city, it is not easy for the OVC to follow what they are taught by he care givers. We have the presence of many video halls, drinking joints, selling of lrugs; children are easily misled into these anti social behaviors.

To get a different perspective, the researcher also sought the views of CRAs together vith community leaders through FGDs. At the community level, strategies employed to ›rotect children from abuse were: sensitizing the guardians on the dangers of child .buse; reporting cases of child abuse to police and prosecuting guardians who ›erpetually abuse OVC under their care.

From the above analysis of mechanisms used to protect OVC from abuse, it can be oncluded that the combined efforts of the guardians, who are the principal caregivers .nd community leaders who are the custodians of people's lives including OVC are equired. The community leaders are likely to play a leading role in situations where)VC are abused by their caregivers.

Mechanisms Used to Protect the Inheritance rights of OVC

Besides being subjected to all sorts of abuse and exploitation, OVC are also likely to be denied their inheritance rights.

The findings of the household survey indicate that only, 20% of the household heads had received training on succession planning while the majority (90%) had not received any training on succession planning and had no knowledge of making a will. UNICEF 2003) in its study, *African's Orphaned Generations*, reports that *will writing* is still a challenge in Uganda.

However, this is greatly attributed to the belief that young children do not own or inherit property and low literacy rates among OVC caregivers.

During the FGD with guardians of OVC, most participants said though they had not received any training on succession planning, but, they had a number of mechanisms in place to ensure that the inheritance rights of children under their care are protected. These included: ensuring their property with honest people, keeping the OVC updated on the property left behind by their deceased parents until they reach an age when they can take control of the property themselves.

Contrary to these findings, UNICEF (2003), reports that widows and orphans are most likely to have their property seized even when the inheritance rights of women and children are spelled out in the law. Such rights are difficult to claim and are poorly enforced, UNICEF further reports.

Given this state of affairs, it calls for increased legal literacy among OVC caregivers and community leaders if the inheritance rights of OVC are to be protected.

Care for Young Children when Principal Caregiver is away.

Young children are very vulnerable and need adequate protection at all times. Caregivers of young OVC employ a number of mechanisms to ensure that children are protected in their absence. These are summarized in table four below:

Table 4: Helpers of Children while the Principal caregiver is away from Home (OVC within surveyed households)

Maid	5%
Grand mother	27%
Day care centres	30%
Older sister	10%
Other relative	8%
Neighbor	20%
Total	100

Source: Field survey data: Household Questionnaire.

As indicated in the table four above, use of maids was the least commonly employed way to protect young OVC when the principal caregiver was away. This greatly contrasts the common practice of using maids, commonly called house girls especially in Kampala central division.

This situation may be so because of a number of factors: First it is possible that the OVC caregivers can not afford the services of a housemaid, Secondly, it could be that there are few maids willing to work in households that can not pay and feed them well.

t should be noted that Kampala central division being at the center of the city, day care centres are used by 30% of the principal caregivers to keep OVC during their absence. The OVC receive some education and psychosocial support at these centres hence, they are of a great benefit to the children.

A small proportion of the care givers leave the children alone at home. Though this represents a small number of children, by leaving them at home alone, the caregiver exposes such children to a great risk.

In summary, it can be said that caregivers of OVC by devising means protect OVC while they are away, are conscious of the risks the children are likely to face when left alone at home.

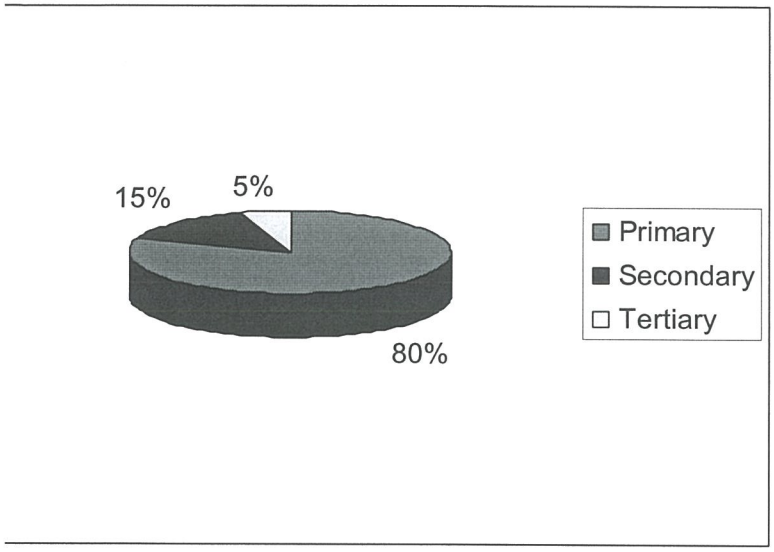
The Extent to which the Needs of OVC have been Met

<u>Education</u>

Education is one of the critical needs of OVC. In a survey of 620 OVC, 70% of the children were in school while 30% were not in school. The majority of the children 80% were in UPE schools (Government aided schools) while 20% were in private schools/ institutions.

As indicated in the figure 8 below, the majority of the OVC 80% were in primary school and 15% were in secondary school. A small number of 5% were in tertiary institutions.

Figure 8: Level of schooling of OVC (OVC within surveyed households)



Source: Field survey Data: House Questionnaire

The high percentage of children in primary school can be attributed to the Universal Primary education programme which supports all children. Secondly, it is possible that guardians can easily afford the demands that come with primary education. Thirdly,, it could be that primary schools are easily accessible making it possible for the OVC to enroll.

When it comes to secondary education, the low percentage enrolled, could imply high drop out rates from primary to secondary level. However, with the introduction of Universal secondary education, the number is expected to increase in the near future.

The percentage of OVC (5%) in tertiary institutions is negligible. This can be attributed to the two possible factors: age and cost. Only 10% of the OVC were in the age bracket of 15-18 years, which is fit for tertiary education. The other possible reason for the low

enrolment of OVC in tertiary institutions could be that the cost of tertiary education is prohibitive. However, with the coming of NGOs such as AMICAALL SUCIO project, some OVC have been identified and enrolled for tertiary vocational skills training.

Despite all the possible hindering factors discussed above with regard to secondary and tertiary education, one can say that there is high value attached to education of OVC by the guardians as evidenced by the high numbers in primary school.

Reasons for OVC not being in School.

The reasons given for the OVC not schooling were: lack of school fees, lack of scholastic materials, child labor, sickness, lack of interest and under age. Similarly, the Uganda Bureau of statistics, in its National service Delivery Survey Report of 2004, reports: under age, long distances to school, high cost, and lack of interest, disability and child labor are the reasons that keep children out of school countrywide.

However, when it comes to Kampala Central Division, it is quite different; in almost every corner, there is a school and UPE schools are also available, and where possible BEUPA schools are also provided; but still some OVC do not go to attend school. This can be attributed to high numbers of children who are on the street mainly coming from broken families, children from northern Uganda who run away from the war and others may be lack of interest as already stated.

This, therefore, means that these factors hindering must be addressed if OVC are to remain in school.

Possession of Birth Certificates by OVC

The registration of a child's birth is fundamental to the realization of a number of rights and needs. This includes not only access to health care and schooling but also the prevention of exploitative practices.

Birth registration also helps the child to prove his or her citizenship and ethnicity, which are key to the child's future participation in the political affairs of his / her community.

Given the ethnicity of this need, the researcher wanted to know to what extent it has been met for OVC. In a survey of 620 OVC, 10% had birth certificates; the majority lacked this important identification document.

A study by World Vision, UK (2005), in Rukiga County in Kabala District and Kasangombe Sub County in Luwero District reveals a similar scenario. In this study, 67% of the OVC did not have birth certificates.

However, since birth registration is something foreign to Africa, it is possible that many caregivers are not aware of its importance. It is also possible that, the process involved is cumbersome making OVC caregivers lose interest.

It may therefore, require sensitization of the OVC guardians and simplifying the process involved if this need is to be met.

Possession of clothing and Beddings

In a sample of 620 OVC, only 33.4% had enough clothing; the majority lacked. Similarly, only 20% of the OVC in the same sample had no adequate bedding while the majority lacked and were sleeping on the floor and others on the street. A similar study by Farm

Orphan Trust of Zimbabwe (2002), found that 65% of the OVC in surveyed households lacked clothing and beddings.

Clothing and beddings though are important for the child, a caregiver who is already burdened with other needs of the children like food, health care and education may not give these items top priority. It therefore calls, for additional support from the community if caregivers of OVC are to meet their clothing needs.

Health Needs of OVC

Health care is one of the most vital needs of OVC and key determinant of their survival. However, as the results of field survey of OVC indicate that; the majority fell sick at least one to two times a months. This reflects a high rate of morbidity among OVC in Kampala Central Division. It also reflects poor health services delivery in the division, despite the different sources of treatment available in the community. Lack of money is the major contributing factor for lack of access to the treatment, but also KCC health centers lack adequate drugs. Mulago hospital is also available, but the services offered are no longer free and possible as it is supposed to be.

Sources of Treatment when OVC Fall Sick

The most common sources of treatment for OVC were: health centres and hospitals, drug shops, private clinics and herbalists. The significance of the source of treatment for OVC is that it affects the quality of treatment given. For example, it is unlikely that a child who is taken to a herbalist, drug shop or private clinic when he has acute malaria

vill get quality treatment. Similarly, poorly equipped health centers or hospitals are ınlikely to provide quality health care to OVC.

Therefore, if adequate healthcare is to be provided to OVC, community needs to be ıssisted to put in place adequate healthcare infrastructure.

Person / Institutions Responsible for Paying Medical Bills for OVC

For OVC to get adequate healthcare, the involvement of different stakeholders is key. Table one below, gives a summary of different stakeholders paying medical bills for OVC.

Table 5: institutions/ Individuals paying Medical Bills for OVC (OVC Within surveyed Households)

Medical bills paid by:	Frequency	Percent
Government / KCC	68	11.0
NGO	43	7.0
Guardian / caregiver	402	65.0
Friends	107	17.0
Total	620	100

Source: Field Survey Data: Household Questionnaire.

From the table 6, it is clear that the guardians of OVC shoulder much of the burden of paying medical bills for OVC. Only 35% of the OVC had their medical bills paid by other stakeholders such as government, NGOs, and friends of OVC families.

Though the health centers and hospitals are the main sources of treatment for OVC, the findings suggest that there are virtually no free health services in all the health facilities where the OVC are taken for treatment. This may partly explain why most OVC fall sick so frequently.

In a situation where health services are not free, it maybe very difficult for the guardian to single handedly provide quality health care to the OVC. If OVC are to receive quality and adequate healthcare, it will require government and non-governmental organizations to increase their contribution.

Psychosocial and Emotional needs of OVC

To gauge the psychological condition of OVC, the researcher asked the OVC to talk about their hopes and fears for the future. Similarly, to assess their emotional attitudes the researcher asked them to recall their happiest and saddest moments in life.

During focus group discussions with the OVC, it was clear that these children had fears about the future. In general there was a sense of desperation and lack of hope among all the OVC interviewed. Most of the OVC in the group (both boys and girls), had fears of dropping out of school, failing examinations, becoming sick and getting infected with HIV/AIDS.

However, some fears of the boys differed from those of girls, while the boys had fears hat they could steal or engage in premarital sex and be embarrassed, the girls feared getting pregnant, contracting HIV/AIDS and on top of that to be chased out of home.

The OVC were also able to recall the happiest and saddest moments in their lives. First, he OVC mentioned times when they fell sick and guardians failed to take them for reatment. Secondly, when their siblings were left at home; and the rest of the children vent to school. Thirdly, when guardians fail to raise school fees; fourthly, death of parents or guardian as one of the participants narrated:

> When my father and mother died, I felt so bad because they were so dear and loving to me. After their death, I have never had any one to offer such love to me. (Participant, FCD with OVC)

The only happiest moment the OVC, could recall was when they are at school or when hey are bought something good such as clothes.

Vakhweya et al. (2002), report death of parents, being mistreated, inability to attend chool and times of sickness as the saddest moments for OVC.

OST (2002), on the other hand reports, living in perpetual poverty and getting infected vith HIV/AIDS as the greatest fears of OVC.

uch fears about the future and bad feelings about past events are likely to affect the VC's social and psychological development.

t is important therefore, that OVC receive adequate counseling to cope with the trauma hey experience as a result of painful moments they go through in life.

Nature of Houses for OVC

Housing conditions under which children stay determine and affect their health and other aspects of their lives such as self-image. The result of the field survey indicated 3% of the children live in permanent houses, 50% live in semi permanent houses, 17% live in temporary houses and 20% live on the streets.

Table 6: Nature of houses OVC live in (OVC within surveyed households)

Nature of house	Frequency	Percentage
Permanent	83	13%
Semi permanent	309	50%
Temporary	107	17%
Streets	121	20%
Total	620	100

Source: Field survey data: Household questionnaire

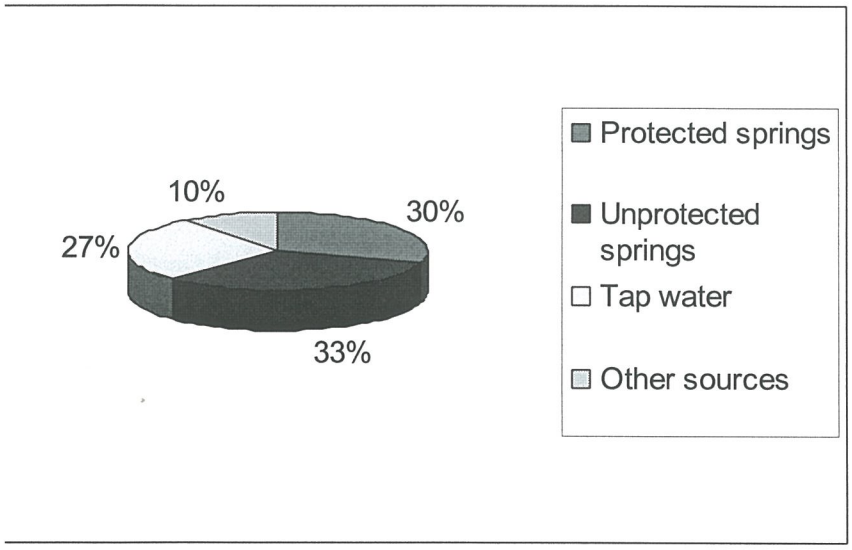
The findings of the field survey presented in table 2 above, suggest that housing needs of OVC have been met to greater extent. However, a lot has to be done for the OVC who are staying on the streets and those in temporary houses.

ources of Drinking water for OVC

Vater is a very important need for OVC because the quality and quantity used, letermine the quality of life of a person. Water is a source of life if it is clean and safe, nd a source of morbidity if it is contaminated.

ooking at the source of water the OVC use, assessed the extent to which their water eeds have been met. Figure 9 below, summarizes the sources of water which OVC use.

igure 9: Sources of Drinking water for OVC (OVC within surveyed households)



ource: Field survey data: Household Questionnaire

s indicated in figure 9 above, 57% of the OVC in a sample of 620, had access to water rom protected source.30% had access to protected springs and 27% had water from aps. However, a significant proportion (33%) of the OVC, were getting water from nprotected springs. In some parts of KCD, OVC have been seen collecting water from rainage channels. This may partly explain why OVC fall sick so frequently.

hese findings suggest that the community of Kampala central division is still a long way in meeting its water needs in general and those of the OVC in particular. Since vater is basic need, the community of KCD needs to invest more of its resources in the vater sector so as to improve the lives of OVC.

anitary facilities in OVC Households

anitary facilities are important needs for the children and directly affect their health tatus. Poor sanitary facilities can be a source of morbidity and lead to ill health.

able 3 below, summarizes the types of sanitary facilities used by the OVC. The najority of the OVC, 87% had access to a latrine, of these 48% had access to an rdinary pit latrine, 17% had access to a ventilated improved latrine (VIP) and 22% to ublic toilet. However, reasonable proportion of OVC (13%) had no access to a latrine nd were using polythene bags commonly known as buvera to dispose off their xcreta.

he proportion of OVC using latrine reflects a high degree of awareness in the ommunity about sanitation and hygiene.

he percentage of those who do not have access to a pit latrine / public toilets may epresent OVC who are on the streets and those from very poor households that can ot afford money for daily paying to use the public toilets.

Table 7: Type of sanitary facility used by OVC (OVC within surveyed households)

Type of sanitary	Frequency	Percentage
Pit latrine	297	48%
VIP latrine	108	17%
Public toilets	136	22%
Polythene bags	79	13%
Total	620	100

Source: Field survey data: Household Questionnaire

In summary, there has been an attempt to meet the basic needs of OVC, though a big gap still remains. This is big probably brought about by weaknesses in the coping mechanism employed to address these needs.

CHAPTER FIVE

IMPLICATIONS, CONCLUSIONS AND RECOMMENDATIONS

'his chapter presents the implications, major findings, recommendations and onclusion of this study based on the analysis and interpretation of the empirical data.

nplications:

nplications from Methodology and Data Availability methodology

, study of OVC like this one touches cross cutting issues in the communities where)VC live. It involves the issues of childcare, survival, protection and participation, conomic capacities of households and communities within which OVC live and, esource allocation and utilization within households and communities.

'he degree to which these are managed will determine how well the major ulnerabilities (education, health, nutrition, shelter and work) faced by OVC in ouseholds and communities are minimized. These are quite complex social issues.

'he implication from methodology is that one must employ a more robust method of nvestigation employing qualitative data collection technique for the all issues nentioned above to be brought out clearly. For example, the issue of discrimination in he allocation of resources within OVC households, which had not been clearly brought y the data gathered using the household questionnaire, was clearly brought during ocus group discussions.

)ata Availability

)ata was available on all the three research questions. During household survey and ocus group discussions respondents, gave information without reservations.

'he implication from data availability is that the issues affecting OVC are well ıternalized by people within the study area.

mplications for Theory and Policy

mplications for Theory

'he findings indicate that the care of OVC has been arranged through private safety:)aternal orphans typically remain with their mothers, and maternal or double orphans re absorbed within the extended families of their deceases parents.

Iowever, because HIV/AIDS, which is the major cause of orphan hood and vulnerability, ; sexually transmitted, it is highly probable that children who lose one parent will also)se the other, further burdening the extended family (uncles, aunties, grandmothers, rand fathers, older sisters and brothers) who may be resource constrained.

ıs the findings indicate, the majority (65%) of the sampled households earn less than 0,000/= a month (less than USD 30). With such meager monthly earnings, the aregivers are unlikely to meet the needs of OVC and protect their rights.

ı the case of OVC, the inability of families and communities to meet all their basic eeds is analogous to market failure. The monetary and opportunity costs of tending he dying and raising their children can severely burden caregivers, especially randmothers who are very old and weak.

xtended families such as those headed by elderly relatives may disintegrate under train. Furthermore, where relatives accept to integrate OVC in their families, there is a trong possibility of discrimination against them.

f community arrangements can not be carried out for whatever reason, the care of OVC ies outside the market and has a potential to become a massive social problem in the :ommunities if public intervention is not sought. Secondly, because OVC are :oncentrated among very poor families, public intervention is justified on redistributive jrounds as well.

mplications for Policy

'he findings of this study have a number of implications for public policy. The issues hat affect OVC are interlinked. For example, performance at school is linked to health, vhich is linked to the income of the households within which OVC live.

'his, therefore, implies that no single national policy can address the problems faced y OVC and families within which they live. It requires a policy mix to address the roblems of OVC.

'hough there is a National OVC Policy with guiding principles and strategies on how to rovide support to OVC, their families and communities, issues affecting OVC should e integrated in all national policies on social services.

lational policies like: the health policy, education policy, HIV/AIDS policy, and gender olicy should have clear strategies on how the needs of OVC should be addressed.

Major Findings

Caring arrangements for OVC within Households

The most common caring arrangements for OVC was household based care where OVC ve either with their surviving parents or relatives in extended families. However, some)VC in Kampala Central division do live with friends who are non relatives.

Child headed households seem to be a rare phenomenon in Kampala central division.)nly a few of the surveyed households were child headed.

Iowever, there is a possibility of the percentage of child headed households increasing the existing family ties are not maintained.

To some extent, there is a growing number of OVC on the streets of Kampala central ivision. These could not be termed as child headed; because they have no permanent laces of residence. These OVC are seen in the drop in centres during the day, and in he evening they go back to their streets.

Vomen predominate as caregivers of OVC, 59% of all the caregivers were women while nen constituted only 41%. From these findings, one can say that women shoulder nuch of the burden of looking after OVC.

Coping Mechanisms within Households and Communities

To cope with the diverse needs of OVC, caregivers were engaged in different kinds of ncome earning activities. Small scale enterprises was the most common source of ncome for the majority (65%) of caregivers of OVC and a small percentage had the pportunity to engage in the employment labor sector.

he monthly income for the majority (65%) of OVC caregivers was very small (less than 0,000 Uganda shillings equivalent to US. $29. Such a meager income is likely to npose a limit to what caregivers can do in terms of meeting the needs of OVC and rotecting their rights.

he findings from the focus group discussions with the community leaders suggest iat discrimination in resource allocation is widespread in households with OVC. Most articipants acknowledged that OVC are discriminated in food allocation, education, ealthcare and allocation work.

uch differential treatment is likely to breed individualism and selfishness among hildren and groom them into selfish and greedy adults. Selfishness and greed are ontrary to the African values of sharing resources and caring for the needy.

eduction in the number of meals was a common strategy employed by most of the urveyed households in times of food shortage (which is a constant common problem ı KCD for low income earners). For example, the majority of the households reported aving only one meal per day, others hardly get a reasonable meal in one to two days. his reflects serious food insecurity in OVC households.

ale of OVC assets was one of the coping mechanisms employed by OVC caretakers in mes of difficulty. Most of the households surveyed mentioned to at least to have sold ome assets belonging to OVC in times of need; although others sold them out of isperacy.

he findings of this study suggest that joint efforts aimed at providing support to OVC re negligible. There were no groups within the study area that were involved in roviding support to OVC apart from NGOs like AMICAALL SUCIO Project which

rovides OVC with: psychosocial support, apprenticeship skills, vocational skills 'aining and recreational facilities. Save the children: sensitization and child rights. SHID: provision of scholastic materials, micro grants for IGAs, playing kits for ecreation and improving sanitation.

hus, apart from NGOs, at the division level there were no arrangements to specifically upport OVC.

nalysis of mechanisms employed both at household and community levels to protect VC from abuse, suggest that there is a high level of consciousness of child protection 1 Kampala central division. However, some protection mechanisms employed such as onfining children at home and providing their necessities may not offer adequate rotection in certain situations.

lthough, this is not very common in Kampala Central Division, but in some surveyed ouseholds it exists. For example a case in Old Kampala zone was reported whereby a oung girl who was always confined at home was raped. This girl was denied of ducation and some other necessities like clothing. Her mother and father died and she ; only staying with the uncle whose support is inadequate.

'he extent to which OVC Needs have been Met

ducation

'he findings of this study suggest that parents can only meet the education needs of VC up to primary school level. Meeting the education needs of OVC up to secondary chool or tertiary institution level is still a very big challenge for most OVC caregivers.

lowever, with the government policy on universal Secondary Education (USE), the umber of OVC enrolling in secondary schools is likely to increase in the near future.

Identification Documents

he findings of this study suggest that caregivers of OVC are still ignorant of the nportance of identification documents such as birth certificates. Such ignorance puts)VC rights to healthcare, education, and protection from exploitative practices in eopardy.

Clothing and Beddings

Most of the OVC in the surveyed households, lacked clothes and beddings. Clothes and eddings are very important for children because they can help in improving their self-nage and health status. Children who grow up lacking such basic necessities are likely o indulge in socially unacceptable behaviors or have low self-esteem and become ocial misfits.

Health Needs

nalysis of health needs of OVC, suggest that the existing mechanisms both at ousehold and community are far from being adequate. The findings of the field survey ndicate a high frequency of sickness among OVC and inadequate water and sanitary acilities in the community and OVC households respectively.

Psychosocial and emotional Needs of OVC

sychosocial and emotional needs of OVC have not been adequately addressed. Most of he OVC interviewed during the study had fears and negative attitudes toward the uture. Such fears and negative attitudes are likely to undermine the OVC's social and sychological development.

ecommendations

asing on the conclusions from the findings of this study, the researcher recommends ne following courses of action to be undertaken by the different stakeholders roviding support or who may intend to provide support to OVC.

aring Arrangements and Coping Mechanisms within Households and Communities

overnment of Uganda through relevant ministries such as: Ministry of gender Labor nd Social development, Finance, Planning and Economic development should trengthen support households with OVC to build their economic capacities.

overnment of Uganda through the Ministry of Gender, Labor and Social Development, hould formulate a policy on child headed household to guide lower local government n providing support to OVC living in such households.

ince women constitute the majority of caregivers of OVC, government and other takeholders concerned about the welfare of OVC should ensure that women's articipation in decision making at all levels of society is strengthened and sustained. nvolvement of women in decision-making is likely to influence the allocation of public esources to the poorest households where the majority of women are the household eads.

eparation of siblings as a coping mechanism though reduces the burden of care on ndividual caregivers should be discouraged. Instead, caregivers should be supported o care for OVC when they are together. Children need to stay together to get motional support from one another.

ince small scale enterprises is the main source of income for the majority of OVC ouseholds, government, NGOs and other stakeholders should assist these households) improve on their business skills by providing them with relevant training and inputs. his will not only solve the problem of income but also reduce on the burden of basic eeds insecurity among OVC households.

overnment should help OVC caregivers widen their income base by providing an nabling environment for Micro Finance institutions to operate in those needy badly-off ouseholds. This will enable some OVC household heads to access affordable financial ervices so as to generate more income.

overnment of Uganda through the Ministry of Gender, Labour and Social development hould explore the possibility of introducing a non-contributory pension scheme to enefit OVC caregivers like old grandmothers who can no longer engage in any ieaningful income generating activity.

overnment working through its lower organs such as district /division councils should iscourage discrimination in resource allocation among OVC households by sensitizing aregivers on the rights of OVC using an appropriate approach.

iovernment in collaboration with NGOs working at the grassroots should encourage ie formation of community care coalition teams for care of OVC at the community evel. This will enable OVC who do not have any specific caregiver to have their needs ddressed.

iovernment, NGOs and community leaders should work together and design a ionitoring system that will ensure that all cases of child abuse either at household

:vel or community level are reported to relevant authorities and appropriate action ıken promptly.

xtent to Which the Needs of OVC have Been Met

overnment working in collaboration with NGOs at the grassroots and community :aders should educate the OVC caregivers on the importance of identification ocuments such as birth certificates. Furthermore, government should simplify the rocess involved in getting birth certificates to make it easy for OVC to acquire this nportant document.

overnment through the Ministry of Health should provide more resources in terms of ersonnel and money to local governments to ensure adequate and free health services ɔ the poor especially OVC and their caregivers.

ll stakeholders dealing with OVC should ensure that psychosocial support is part of ıe development package given to OVC and their caregivers. This is very vital especially ɔr OVC who go through painful and traumatizing situations in their lives.

here is need to define community- specific problems and vulnerabilities at the outset nd pursue locally determined intervention strategies. The circumstance of any given ommunity is unique in terms of the problems experienced, priorities identified and the esources available

ın essential aspect of programming to support orphans and vulnerable children is to ngage community members in assessing their needs and priorities so that locally ailored interventions can be developed.

he identification of orphans and vulnerable children and the collection of baseline information about them, including the households in which they live, are necessary efore support activities can be designed.

he government together with the concerned ministries should support families, ommunities and local organizations in their ongoing care for OVC. There is need to trengthen professional and governmental capacity to respond to this crisis; articularly provision of permanent shelter for OVC in difficult circumstances.

amilies and communities do provide the vast majority of day to-day care for OVC. ccording to the field survey, majority of OVC are taken in by unties, grand mothers nd other relatives a response built on a strong and long-standing tradition of xtended family networks and informal fostering. However, families and communities re strained in their efforts to care for OVC; hence, local efforts should be strengthened rough capacity building and support for NGOs, faith-based and other community rganizations, and through a wide range of development efforts that ensure access to ood, safe water, healthcare, school, psychosocial support and legal assistance.

Community activities that can be supported by outsiders such as visiting programs, obilizing resources for school fees, engaging local leaders in advocating for OVC, and ffering economic opportunities for families fostering orphans should be highly upported by the government

is also very important to include as part of the solution the Ministries, political fficials, and the professionals- teachers, psychologists, social workers, and lawyers ho have the skills and the responsibility to protect OVC for now and the future.

he government in conjunction with the concerned donors should strengthen ommunity mobilization to increase the capacity of communities to identify vulnerable hildren and design, implement and monitor their own OVC support activities; trengthening and supporting the capacity of families to protect and care their OVC). mphasis should be on enhancing the capacity of families and communities to respond ıe psychosocial needs of OVC and their caregivers.

onclusion

lthough, the community has tried to provide for OVC, there is need for more efforts to romote equality and prohibit discrimination in access to rights and services; such as ducation, healthcare, protect OVC from abuse and exploitation from harmful ractices, protect their rights to inheritance; promote appropriate models of alternative are for children without adequate family care and support roles and responsibilities of aregivers.

REAS FOR FURTHER RESEARCH

he study was limited in scope and geographical area because of the limited time and ther factors. Thus, it has been suggested that a wider research on the similar topic overing the whole Kampala district or Uganda in general be undertaken. Also a topic ke "The impact of NGOs on OVC" should be widely researched on.

IBLIOGRAPHY

OOKS

ackhurst, et al. , 2004. Small Voices, Big Concerns: A child Rights Approach to HIV/AIDS. Milton Keynes: World Vision, UK.

ailey. D. Kenneth. (1987) Methods of Social Research. New York. Free press.

randt, D., 2003. 'Meeting Basic needs OVC: A Global Imperative with Emphasis on Education and Health Care in Africa. In: Currah, K. & Whaites, A. (EDS.), False Economics-Why AIDS- Affected Countries are Special case for Action._Washington, DC: World Vision International.

elpAge International and International HIV/AIDS Alliance, 2003. Forgotten Families: Older people as Carers of Orphans and Vulnerable Children. Brighton,_Brighton, UK: International HIV/AIDS Alliance.

elen, J., 2002. Africa A Continent In Crisis. Harare, Zimbabwe: SAFA AIDS

akoza. T. (1996). An Introduction to Research Methodology. Uganda. The national Adult Education Publication.

lonk, N.,2001. Understanding the magnitude of Mature Crisis: Dynamics of Orphaning and Fostering in Rural Uganda. Orphan Alert: International Perspective on Children by HIV/AIDS.

ubabrao, K. Coury, 2004. Reaching out to Africa's Orphans: A Framework for Public Action. Washinton, DC: World Bank.

NICEF, 2003. Africa's Orphaned Generations._New York: UNICEF

/hite, J., 2003. Children Orphaned or otherwise Made Vulnerable by HIV/AIDS: Examples of UNICEF's Response in East and Southern Africa. New York: UNICEF

/orld Church Service, 2004. Orphan and Vulnerable Children Capacity Building through Peer Exchange- YWCA/ Rwanda. Washington, DC: World Church Service.

/orld Vision, 2002. Transformation Development Indicators, Field Guide to implementation of Household Surveys. Washington, DC: World Vision, Development Resource Team.

UBLICATIONS AND JOURNALS

MICAALL UGANDA PROGRAMME, (2006), Report on Situational Analysis of Child Rights Violation in Urban Centres in Uganda

oster, G, et al . , 1997. Factors Leading to the Establishment of Child Headed Households. The case of Zimbabwe; In Health Transition Review, Vol.7

oster, G. and Williamson, J. 2000. A Review of Current Literature of the Impact of HIV/AIDS on Children in Saharan Africa: AIDS, 2000 Year in Review._Vol.14

arm Orphan Support Trust of Zimbabwe, 2002. A Study of Child headed Households on commercial Farms in Zimbabwe. Harare: Farm Orphan Trust of Zimbabwe.

amily health International, 2002. Results of the Orphan and Vulnerable Children Head of Household Baseline Survey in Four Districts in Zambia. Zambia: Family Health International.

ıternational HIV/AIDS Alliance, 2003. Study Report on Older People and Child Care. Tamil, Nadu: International HIV/AIDS Alliance.

elpAge Kenya, 2002. Feasibility study on Viable Income generating Activities for Older Persons Taking care of HIV/AIDS Orphans in Ahero, nyando District and Asumbi, Home Bay District, Kenya_Nairobi: HelpAge Kenya.

ational steering Committee on OVC, Strategic Programme Plan of Interventions for OVC, Fiscal Year 2004-2008/9. Kampala: Government of Uganda.

S. Global AIDS 2006. Orphan and other Vulnerable Children programming Guidance for United States Government in-Country staff and Implementing Partners. Office of the US. Global AIDS Coordinator

linistry of Gender, Labor and Social Development. (1995-2005). A Review of Literature. Highlights of knowledge, Attitudes, Beliefs and Practices related to Orphans and Other Vulnerable Children in Uganda

linistry of gender, Labor and Social development, 2004. National Policy on Orphans and Vulnerable Children Kampala: Government of Uganda.

linistry of Gender, Labor and Social Development. 2006. Guidance for Disseminating the National Policy and Strategy for Orphans and Other Vulnerable Children. Government of Uganda.

linistry of finance and Economic Planning, 1995. National Population Policy for sustainable Development. Kampala: Ministry of Finance and economic Planning.

lodels of learning team, 2003._ADP Tool Kit for HIV/AIDS programming. Kampala: World Vision International, HIV/AIDS Hope Initiative

ubbarao, K. et al ., 2001. Social Protection of Africa's OVC: Issues And Good Practice Programme Options: Africa Region Human development Working Paper Series. Africa Region: World Bank

NAIDS and UNICEF, 2002. Children on the Brink, A Joint Report on Orphans Estimates and Program Strategies. New York: UNICEF.

NAIDS and UNICEF, 2004. Children on the Brink. A Joint Report of New Orphan Estimates and a Framework for Action. New York: UNICEF

SA, 2004. The "Assistance to OVC Act of 2004" Washinton DC: USA

'akhweya et al . , 2002. Situational Analysis of Orphans in Uganda, Orphans and Their Households: Caring for their Future- Today. Kampala: Government of Uganda/ Uganda AIDS Commission.

PPENDICES

ppendix I: Questionnaire for OVC household heads

AMPALA INTERNATIONAL UNIVERSITY,

CHOOL OF POST GRADUATE STUDIES

---

ear Sir /Madam.

'e are carrying out this study to find out how the OVC in Kampala Central Division are eing cared for. The results of this study will help us to make recommendations to the elevant government ministries and departments to design policies that will enable you nd your community looks after OVC better.

lease answer the following questions as honestly as possible. All the information given ill be treated with the highest confidentiality and used only for the purpose of this tudy.

hank you for your cooperation.

odfrey Tumuhaise

esearcher

ATE OF INTERVIEW..... TIME OF INTERVIEW.....

NTERVIEWER..... VILLAGE/ ZONE.....

ARISH.....

NSTRUCTIONS

1. Fill in the blank spaces
2. Tick the appropriate answer
3. Do not omit any item of information

. SOCIAL BACKGROUND

1. Name.....
2. Gender.....
3. Age.....

. COPYING MECHANISMS WITHIN THE HOUSEHOLD

4. Residence statuses
   1. Adult headed
   2. Child headed

. Total number of OVC in the household.....

Total number of OVC:

o.	Age bracket (years)	No. of persons
	< 6	
	6-<10	
	10-<15	
	15-<18	

. Relationship with OVC in household

elationship	No. of OVC
. Mother	
. Father	
. Sister	
. Brother	
. Uncle	
. Auntie	
. Grandmother	
. Grandfather	
. Foster mother	
0. Foster father	

. What is your main source of income?

1. Salaried Employment (specify).....
2. Petty trade (specify).....
3. Wage labor.....
4. Chicken/ any other animal rearing
5. Renting houses
6. Selling alcohol / Bar
7. Video hall
8. Car washing Bay

. How much do you earn in a month from your main source of income

1. Less than 10,000/=
2. 15,000/=
3. 20,000/=
4. 25,000/=
5. 30,000/=
6. 35,000/=
7. 40,000/=
8. 45,000/=
9. 50,000/= and above

10. Household assets:

. Chicken/ other animals	Yes/No	If yes, No.
. Bicycle	Yes/No	If yes, No.
. Motorcycle	Yes/No	If yes, No.
. Car	Yes/No	If yes, No.
. Mobile phone	Yes/No	If yes No
. Radio	Yes/No	If yes, No.
. Television	Yes/No	If yes, No.

ther assets specify.....

1. What area of OVC care takes much of your income?

1. Education
2. Food
3. Clothing and bedding
4. Health care
5. Recreation
6. Shelter

2 .Do all the children have equal access to the above services?

1. Yes

2. No

3. How many meals do you have per day?

1. One
2. Two
3. Three
4. More than three times
5. None

4. What are the local groups in this community that are involved in the care of OVC?

1. Churches
2. CBOs
3. Credit and saving groups
4. Mother's union
5. IGAs by Kampala Central Division
6. None

5. What do you do to protect these children from abuse and exploitation?

1. Counselling them
2. Confining them at home
3. Providing them with adequate necessities of life
4. Teaching them good manners
5. Stopping them from moving around and within town

6. Stopping them from going to Video halls

6. Have you been trained on succession planning (making will)?

1. Yes
2. No

ND

hank you for sparing your time to talk to us.

ppendix II: Questionnaire for individual OVC within the households

AMPALA INTERNATIONAL UNIVERSITY

CHOOL OF POST GRADUATE STUDIES

---

ear Sir/ Madam

'e are carrying out this study to find out how the OVC in Kampala central division are eing cared for. The results of this study will help us to make recommendations to the elevant government ministries and departments to design policies that will enable you nd your community look after OVC better.

lease answer the following questions as honestly as possible. All the information given ill be treated with the highest confidentiality and used only for the purpose of this tudy.

hank you for your cooperation.

odfrey Tumuhaise

Researcher

ATE OF INTERVIEW..... TIME OF INTERVIEW.....

NTERVIEWER..... VILLAGE/ ZONE.....

ARISH.....

NSTRUCTIONS

1. Fill in the blank spaces
2. Tick the appropriate answer
3. Do not omit any item of information

. SOCIAL BACKGROUND

1. Name.....
2. Gender.....
3. Age.....

OPYING MECHANISMS WITHIN HOUSEHOLDS

. Is this child's biological mother still alive?

1. Yes
2. No
3. Do not know
4. If mother is deceased cause of death:.....

. Is the child's biological father stills a live?

1. Yes
2. No
3. Do not know

. Relationship of the child to head of the household

1. Son
2. Daughter
3. Brother
4. Sister
5. Niece
6. Nephew

7 Grand daughter

8. Grand son

9. Not related at all

. Does this child have siblings in this household?

1. Yes
2. No
3. Not applicable

. If yes, how many:.....

.How many are living in another household?.....

Of those living in another household, are they in the same household?

1. Yes
2. No
3. Not applicable

. Is the child in school?

1. Yes
2. No

. If yes, what is the level of schooling?

1. Primary
2. Secondary
3. Tertiary institution

0. Who owns the school?

    1. Government

    2. Private individuals/ company or NGO

1. Who is paying school fees?

    1. Guardian

    2. Government

    3. NGO/CBO

    4. Neighbor

    5. In-laws

    6. Church

    7. Local council

2. Who pays for scholastic materials?

    1. Guardian

    2. Government

    3. NGO/CBO

    4. Neighbor

    5. In-laws

    6. Church

    7. Local council

3. How much is paid per term?.....

4. Why is the child not in school?

1. Lack of school fees
2. No scholastic materials
3. Sick
4. Working
5. Not interested in studies
6. Underage

5. Who looks after any children left at home when others are a way?

1. House girl
2. Grandmother
3. Grandfather
4. Elder Sister
5. Stays alone
6. Other relatives
7. Neighbor
8. Day care center

TTEMPTS TO SOLVE OVC PROBLEMS

6. Does the child have sufficient clothing?

1. Yes
2. No

7. Does the child have adequate beddings?
   1. Yes
   2. No

8. Has this child been sick in the past year?
   1. Yes
   2. No

   If yes, how many times?.....

9. How would you characterize this child?
   1. Sickly
   2. Excellent health

0. Where does this child get treatment from?
   1. Drug shop
   2. Private clinic
   3. Central division health center
   4. Hospital
   5. Herbalist

1. Who pays the medical bills when this child falls sick?
    1. Government
    2. NGO/ CBO
    3. Neighbor
    4. Church
    5. Self help group
    6. Friends
    7. In-laws
2. How much does it coast to treat this child per month?

3. How do you rate this child's psychosocial health?
    1. Non communicative
    2. Withdrawn
    3. Shy
    4. Animated

4 what is the nature of the house this child lives in?
    1. Permanent
    2. Semi-permanent
    3. Temporary
5. Where does the water this child drinks come from?
    1. Unprotected spring
    2. Protected spring

3. Bore hole
4. Tap water

6. How do you manage the waste this child gives out?
   1. Pit latrine
   2. Flash toilet
   3. Polythene bags
   4. Public toilet
   5. Other

PPENDIX III: INTERVIEW GUIDE, FGD WITH COMMUNITY LEADERS

AMPALA INTERNATIONAL UNIVERSITY

CHOOL OF POST GRADUATE STUDIES

ITERVIEW GUIDE FOR COMMUNITY LEADERS OVC STUDY

e. Probation and Social Welfare Officer, CRAs, LCIs and NGO project Coordinators

ear Sir/ Madam

'e are carrying out this study to find out how the OVC in Kampala central division are eing cared for. The results of this study will help us to make recommendations to the

elevant government ministries and departments to design policies that will enable you nd your community look after OVC better.

ease answer the following questions as honestly as possible. All the information given ill be treated with the highest confidentiality and used only for the purpose of this udy.

hank you for your cooperation.

odfrey Tumuhaise

esearcher

. COPYING MECHANISMS WITHIN THE COMMUNITY

1. Who are OVCs and with whom do they live?
2. How do you ensure that children who have no guardians are looked after well?
3. How do you ensure that stigma and discrimination against OVC is reduced?
4. What local groups or institutions are providing support for the care of OVCs?
5. How do you help the OVC cope with the problems they encounter as a result of loss of their parents or with increased number of children in the household?
6. How are the psychosocial and spiritual needs of OVC being addressed in this community?
7. How is the Kampala Central division addressing the problem of OVCs?

PPENDIX IV: INTERVIEW GUIDE, FGD WITH OVC GURDIANS

AMPALA INTERNATIONAL UNIVERSITY

CHOOL OF POST GRADUATE STUDIES

ITERVIEW GUIDE FOR OVC FAMILIES

ear Sir/ Madam

'e are carrying out this study to find out how the OVC in Kampala central division are eing cared for. The results of this study will help us to make recommendations to the elevant government ministries and departments to design policies that will enable you nd your community look after OVC better.

ease answer the following questions as honestly as possible. All the information given ill be treated with the highest confidentiality and used only for the purpose of this udy.

hank you for your cooperation.

odfrey Tumuhaise

esearcher

OPYING MECHANISMS WITHIN HOUSEHOLDS

1. What do you do to support these OVCs
2. What local groups or institutions are giving you support?
3. How is the Kampala central division assisting you cope with the burden of looking after OVCs?
4. How do you ensure that these children are not abused or exploited?
5. How do you help these children cope with the trauma of losing their parents?
6. How do you ensure that the inheritance rights of OVC are protected?

PPENDIX V: INTERVIEW GUIDE, FGD WITH OVC

AMPALA INTERNATIONAL UNIVERSITY

CHOOL OF POST GRADUATE STUDIES

ITERVIEW GUIDE FOR OVC (FGD)

ear Participants

'e are carrying out this study to find out how the OVC in Kampala central division are eing cared for. The results of this study will help us to make recommendations to the elevant government ministries and departments to design policies that will enable you nd your community look after OVC better.

ease answer the following questions as honestly as possible. All the information given ill be treated with the highest confidentiality and used only for the purpose of this :udy.

hank you for your cooperation.

odfrey Tumuhaise

esearcher

OPYING MECHANISMS

1. Now that you do not have your mother or father, how do you manage your life?
2. How do you contribute to the family well being?
3. What local groups in this community do you know that give support to the needy children like orphans?
4. How do you help your siblings?
5. How do you comment on the way things are distributed at home (resources are shared)?

HE EXTENT TO WHICH NEEDS OF OVC ARE BEING MET

6. What has been the most difficult time in your life?
7. What are the things that make you unhappy?
8. What are those things that make you happy?

9. What do you consider to be your major problems?

10. How do you know of an organization with programmes to address these problems?

11. What are your fears?

Appendix VI: Participants of Focus Group Discussions (FGD)

O	OVC GUARDIANS	OVC	COMMUNITY LEADERS
	Nanfuka Deborah	Nalugwa shamim	Lwebuga Sam
	Ajiambo Hadijah	Williams kyanjo	Kakooza Lawrence
	Namatende Nasiata	Najingo Lydia	Nakalyango Hadijah
	Balinda Ronnie	Nampijja Mary	Ejang Grace
	Mugabo Fred	Kato Hussien	Katongole Joseph
	Nakubulwa Margaret	Byaruhanga Yuda	Bandese Ahammed
	Nyembo zafalin	Nakitende Shidah	Namatovu Imelda
	Kasibante Ali	Nambaasa Stella	Kituwi Oliver
	Mumbeja kiwanuka	Gordon Mugisa	Mananu James
0	Naava Nalongo	Abbo Teddy	Hajji Muwanga
1	Mukaire Nuru	Kisembo Beatrice	Bariah Mohsin
2	Mugalu sarah	Byakagaba sarah	Sssebagala martin
3	Twaha Ssali	Olong shakirah	Pastor Mbuga
4	Mugera willy	Kayiwa moses	Chief Mwilu

5	Nantambi Gertrude	Nakiwunga Teopista	Oduka Wilson
6	Nakilidde jesca	Namazzi Phiona	
7	Kisakye Catherine	Kalawuka Innocent	
8	Lukooya Robert	Kabagenyi Innocent	
9	Mutyaba Isaac	Kamuru Michael	
0	Nantongo Joan	Aine Isaac	
1	Kyatereka Mary	Kasamba Ivan	
2	Lubega Godfrey	Nsigadde Sarah	
3	Kasule Stephen	Mulindwa Simon	
4	Egesa Desire	Mayongo Fatuma	
5	Mukangabiro mary	Amanyine Sam	
6	Zikusoka Nalongo	Sempa Yusuf	
7	Katimbwa Dorothy	Mutebi ibrahim	
8	Katongole Agnes	Timuntu Mubaraka	
9	Maguzi Wilson	Naziwa Hajara	
0	Muwanga Paul	Ora lawrence	