

ASSESSMENT OF THE NEEDS OF ORPHANED AND VULNERABLE CHILDREN WITHIN CENTRAL DIVISION, MWINGI DISTRICT, KENYA

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other University or any other award.

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DEDICATION

To all those children who grow up without experiencing the love and care of their parents.

My supervisors Professor Zipporah W. Nyang'ya and Professor [Name] of Kenyatta University for their advice, guidance, and support during the study. I also wish to thank the Staff, Department of [Name], Kenyatta University, for their encouragement.

My appreciation is extended to the children and guardians who participated in the study for their co-operation. I express my sincere thanks to my research assistants without whom the study would have taken a longer period of time to complete.

I would like to express my sincere thanks to my husband, Eng. Benjamin W. Clotis, and children Linnet, Tracy, and Brian for their patience, support, understanding and encouragement throughout the study period.

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ABBREVIATIONS AND ACRONYMNS

AIDS	Acquired immune deficiency syndrome
ARV'S	Anti retroviral drugs
ATR	African traditional religion
CLWAS	Children living HIV/AIDS
FHI	Family health international
HIV	Human immunodeficiency virus
ILO	International labour organisation
MOH	Ministry of health
MCT	Mother to child transmission
MOEST	Ministry of education Science and Technology
NACC	National AIDS control council
NGO	Non-governmental organisation
OVCS	Orphaned and vulnerable children
PLWHA	People living with HIV/AIDS
RAAAPP	Rapid assessment, analysis and action planning process
SPSS	Statistical package for social studies
TB	Tuberculosis
USAID	United states of America International Development
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Fund
WHO	World Health Organisation
UN	United Nation

DEFINITION OF TERMS USED IN THIS STUDY

Child

A child is any person under the age of eighteen years as defined by the children's Act no.8 of 2001.

Orphan

A child who has lost one or both parents (as a result of death). A paternal orphan is a child who has lost their natural mother as a result of death and a maternal orphan is a child who has lost their natural father. A double orphan is a child who has lost both parents.

Caregiver

A caregiver is a guardian or a parent who is charged with the responsibility for the child's welfare and livelihood including comfort, upbringing, guidance, provision of basic needs and realizing of human rights.

Vulnerability

A heightened or increased exposure to risk as a result of one's circumstances

Vulnerable child

A child, whose safety, wellbeing and development are for various reasons, threatened, including children who are emotionally deprived or traumatized. This is also a child living in a high risk setting.

Abstract

The number of Orphaned and Vulnerable Children in the world is expected to rise to 25 million by the year 2010. In Kenya, the number of orphans is expected to rise to 2 million by 2010. These children have limited access to physical, psychosocial and economic support thus making them among the most vulnerable of our society. A cross-sectional study was carried out to assess the needs of Orphaned and Vulnerable Children (OVC) within Central Division of Mwingi District, Kenya. A total of 400 orphans and 90 caregivers were included in the study. The study set out to determine the needs, factors influencing provision of needs and the constraints in the provision of needs of these children. Data was collected using pre-tested structured open-ended questionnaires for orphans and caregivers. SPSS was used for analysis and Chi-square test for goodness-of-fit was used to test for the relationship between variables. The results indicated that, 61.1% of the caregivers and 51.0% OVC were females. Most OVC (51.0%) were aged 11 to 15 years and 58.0% had been orphaned for over 3 years. Majority (36.7%) of the care givers were aged 41-50 years and 62.2% were unemployed. Majority (85.0%) of the OVC attended school with no significant difference between girls and boys in school attendance ($p > 0.05$). The reasons for not attending school were: lack of school uniforms, school levies, looking after other siblings and working in order to earn income to feed the family. Most OVC (42.0%) rarely or occasionally (41.0%) fell sick. The most prevalent disease condition was malaria (43.0%) and coughing (18.0%). The health seeking behaviour of the OVC was good with the majority (91.0%) attending hospital when sick while only (9.0%) did not. The reasons for lack of medical care were: lack of drugs in hospital (100.0%), lack of money for medical fee (87.5%) and overcrowding in the hospitals (87.5%). There was a significant relationship between gender and taking OVC for regular medical check up ($P < 0.05$). Majority of the caregivers (94.4%) who did not take OVC for under their care for regular medical check up were females as compared to the males (77.1%). There was a significant association between lack of medical care for OVC and the care givers occupation, education level and the number of children in the household at ($P < 0.05$). Physical needs of the OVC were food (77.0%), clothing (76.0%), and shelter (30.0%). Food needs of the OVC were met by relatives (52.0%), grandparents (36.0%), mothers (35.0%) and the government (30.0%). The psychosocial needs of the OVC were parental guidance (36.0%) love and affection (16.0%). There was a significant difference between the gender of OVC and the psychosocial needs at ($p < 0.05$). Over 26% of caregivers had children who had been discriminated. However OVC had mostly experienced discrimination in school (100.0%) and when playing with other children (58.3%) out of school. The findings of this study are important in the formulation of policies regarding orphaned and vulnerable children. In addition, this study will be of use to social service providers in planning, Implementation, monitoring and evaluation of effective service delivery to the orphaned and vulnerable children.

CHAPTER ONE

INTRODUCTION

1.1. Background information

Orphans are children who have lost one or both parents. Vulnerable children are children living in a high risk setting. Vulnerable children comprise the internationally recognised categories of street children, children exposed to hazardous or strenuous labour, children involved in sexual or domestic trafficking, and children affected by armed conflict. In addition, children in much of Africa today are exposed to war, abduction, conscription, physical, sexual and emotional abuse; psychosocial trauma, neglect; separation; malnutrition; and poverty. Further compounding their risk most vulnerable children lack access to basic social services and social protection. The possibility that an African child will find themselves in difficult circumstances is increasing rapidly as the number of risk situations in the region grows. Indeed, the very definition of at risk children has undergone a radical transformation. The AIDS crisis, endemic warfare and frequent migrations have now changed the nature of risks faced by children and swelled the numbers of those at risk (Subbarao, K. *et al.* (2001)

A recent analysis by UNICEF on caring practices in forty countries in sub-Saharan Africa showed that extended families have assumed responsibility for more than 90% of orphaned children. It further implied that today, 20% of households with children in southern Africa are caring for one or more orphans. These family networks will continue to be central social welfare mechanisms in most countries. However, as the number of orphans increases over the coming decade and an ever larger number of

adults become affected by HIV and AIDS, many of these family networks will face even greater burdens. (UNICEF, 2003a)

The increasing proportion of children who are orphans places a tremendous strain on the social fabric of communities and nations. Even cultures and communities with strong social cohesion and traditions of providing support to orphans and other vulnerable children can be overwhelmed when the rate of increase and the overall number of orphans reach such high levels. (UNICEF, 2003b)

The burden of care for OVC is already shifting in countries with the highest HIV prevalence levels. Orphans are increasingly more likely to be living in female-headed families and grandparent households. In Zambia for example, female-headed households are twice more likely to be taking care of double orphans than male-headed households. Female-headed households also take in more orphans than male-headed households. In South Africa in households that have assumed responsibility for orphans, there are on average two double orphans in each female-headed household, and one in male-headed households.

While grandparents and other caregivers already have an important role in the care of orphans, their burden is notably increasing. In Namibia, the proportion of double orphans and single orphans (not living with a surviving parent) being taken care of by grandparents rose from 44% in 1992 to 61% in 2000. Increases have also been recorded in Tanzania and Zimbabwe (USAID, 2004).

Coping strategies in southern African countries differ considerably from other sub-Saharan African countries. High mobility due to male emigration from Botswana, Lesotho, Namibia, and Swaziland to work in Southern Africa's more industrialised areas may contribute not only to high HIV prevalence rates but to high rates of child fostering and high levels of female-headed households. Coping mechanisms that rely on the extended family may be less resilient in Africa than elsewhere in the region (USAID, 2004).

Children can lose their parents at any age; however the proportion of children who are orphans increases with age, with older orphans greatly outnumbering younger ones. For example, in sub-Saharan Africa, Asia and Latin America more than half of the orphans are aged 12 years or more. Of the 143 million orphans (12 %) in the three regions, 17.5 million are below 6 years, 47 million (33 %) are aged 6 to 11 years while the remaining 79 million (55 %) are aged 12 to 17 years (UNAIDS /UNICEF/USAID, 2004).

This age pattern has important implications for the allocation of resources to programs. There are substantial differences in the needs of children of different ages, the relevant child protection measures for each age group are unique, and programs to address each are varied. While programs for orphans are important, new needs and different elements of the protective environment must be addressed to protect and provide for the nearly 90 percent of orphans above 6 years.

The development of a child's full potential is every child's right. This development is threatened if the family environment deteriorates as a result of parental illness and

death. It is also threatened when the impacts of HIV and AIDS undermine basic social services and safety nets such as healthcare and education. The illness or death of a parent or other family member has different effects on children, depending in part on a child's age and stage of development. (UNAIDS/UNICEF/USAID, 2004).

To live and survive, children and adolescents need to grow in a family and community environment that provides for their changing needs, thereby promoting their healthy and sound development (UNAIDS/UNICEF/USAID, 2004).

1.1. Statement of the Problem

The increasing population of Orphaned and Vulnerable Children (OVC) in Kenya warrants innovative strategy framework to forestall further exacerbation. The impact of HIV and AIDS have aggravated the prevailing scenario; consequently compounding the unknown social implications of the scourge. Importantly, the economic context in which HIV/AIDS and other orphan related problems occur is contingent on the measures instituted to manage the challenge (NACC, 2003). Despite the rising numbers of Orphaned and Vulnerable Children (OVC) in Central Division, Mwingi District-Kenya, no empirical study has been carried out to investigate the needs of these children. This formed the basis of this study.

1.2. Justification for the Study

A host of epidemiological factors have engendered the increased number of orphaned and vulnerable children. The sudden increase in the number of orphaned and

vulnerable children all over the world has compounded the community's incapacity to adequately address the needs of children. Mwingi Central is not an exception; recent surveys have shown that the number of orphaned children is on the increase (ROK 2002-2008). Research and interventions are needed to establish education, nutrition, shelter, clothing, health and psychosocial needs of children as these constitute the basic underpinnings that determine their future (Laelia *et al.*, 2001).

Given a dynamic socio-economic and cultural milieu, orphaned and vulnerable children need survival, development and protection. To effectively address the life and survival needs, it is imperative to establish the nature and extent of the needs of these children.

An assessment of children's needs will be important in policy formulation as well as planning, implementation and monitoring of programmes aimed at improving their well being (Laelia *et al.*, 2001). Given that Kenya has signed and ratified the international convention on the rights of the child, innovations geared towards advancing the needs of children may contribute to the country's interventions profile on the global scene. Importantly, with 14 million children under the age of 15 years a big number of them is about to lose one or both parents to AIDS and the fact that by 2010, this number is expected to exceed 25 million, innovative approaches in addressing their needs are needed. In the absence of urgent and collective action, millions of children will face enormous risks in their struggle to survive

1.3. Research Questions

- (i) What are the needs of orphaned and vulnerable children within the Central Division of Mwingi District?
- (ii) What factors influence the provision of needs of orphaned and vulnerable children within the Central Division of Mwingi District?
- (iii) What are the constraints experienced in meeting the needs of orphaned and vulnerable children within Central Division of Mwingi District?

1.4. Null Hypotheses

- (i) Orphaned and vulnerable children within Central Division of Mwingi District do not have needs.
- (ii) There are no factors influencing provision of the needs of orphaned and vulnerable children within Central Division of Mwingi District.
- (iii) There are no constraints in meeting the needs of orphaned and vulnerable children within Central Division of Mwingi District.

1.5. Objectives of the Study

1.5.1. General Objective

To assess the needs of Orphaned and Vulnerable Children (OVC) within Central Division of Mwingi District, Kenya.

1.5.2. Specific Objectives

- (i) To determine the needs of orphaned and vulnerable children within Central Division of Mwingi District.
- (ii) To investigate the factors influencing provision of needs of orphaned and vulnerable children within Central division of Mwingi District, Kenya.
- (iii) To establish the constraints in the provision of needs of orphaned and vulnerable children within Central Division of Mwingi District, Kenya.

CHAPTER TWO

LITERATURE REVIEW

2.1. Orphaned and Vulnerable Children in Africa

It is estimated that 14 million children, mostly from developing countries, have lost parents or caregivers to HIV and AIDS (UNICEF, 2003a). In Africa, it is estimated that 12 million children have lost one or both parents to AIDS (UNAIDS, 2004). According to 2002 estimates, approximately 106 million children will be orphaned by the year 2010, of these; 25 million will be orphaned by HIV and AIDS (UNAIDS/UNICEF/USAID, 2004a). The HIV and AIDS pandemic is currently devastating the African continent. In fact, in 12 African countries it is estimated that by the year 2010, orphans below 15 years of age will comprise 15 % of all the children (Crampin *et al.*, 2003). The situation is no better for the other parts of the world. For example, statistics show that HIV rates are exponentially growing in Asia and Eastern Europe. Currently, Asia has the highest absolute number of orphaned children (65 million) (UNAIDS/UNICEF/USAID, 2004b).

In Africa, families and communities have traditionally been and remain the primary source of support for vulnerable children, but are struggling in the face of poverty and socio-political instability (Crampin *et al.*, 2003). When relatives are not able to provide care, Orphaned and Vulnerable Children (OVC) often fall through the social safety net, and face psychosocial and economic hardship, exploitation and discrimination, and increased risk of HIV infection (Hunter and Williamson, 2003; 2004).

Without the scourge of HIV and AIDS, the percentage of children who are orphans would be expected to decline as improvements in health, nutrition, and overall development lead to a decrease in adult mortality. Unfortunately, in countries where HIV and AIDS prevalence rates are highest, this trend has been reversed, with both the percentage of children who are orphans and the absolute number of children who are orphaned rising dramatically. In just two years (2001- 2003), the global number of orphans due to AIDS increased from 11.5 million to 15 million (UNAIDS/UNICEF/USAID, 2004a).

Whatever the cause, orphans and other vulnerable children face the heightened risk of malnutrition, mortality, morbidity and psychosocial damage.

2.2. Impact of HIV and AIDS on Households

Approximately 14 million children in the world, under the age of 15 years have lost one or both parents to AIDS (Crampin *et al.*, 2003). By 2010, this number is expected to exceed 25 million. The real impact of HIV/AIDS will not be felt until 2015. HIV and AIDS will continue to cause unprecedented suffering among children for at least the next two decades if not longer (UNAIDS/UNICEF/USAID, 2004c). The progression from HIV infection and death from AIDS is between five and ten years (Clive, 2000) consequently; today's prevalence levels will largely determine the number of orphans over the next decade (Hunter and Williamson, 2003; 2004). Because of the time lag between infection and death, the number of orphans will continue to increase even in countries where HIV infection rates are declining (Donahue and Williamson, 1996).

At the June 2001 United Nations General Assembly Special Session on HIV and AIDS, member countries vowed to develop national policies and strategies that build and strengthen the ability of governments, communities and families to support orphans and children affected by HIV and AIDS by 2003, and to implement those policies by 2005 (Crampin *et al.*, 2003; UNAIDS/UNICEF/USAID, 2004b). Achieving that goal requires provision of adequate nutrition, access to education, protection from exploitation and discrimination.

One of the consequences of the HIV and AIDS epidemic in sub-Saharan Africa is the increase in the number of orphans, estimated to have reached 6-11% of children less than fifteen years of age (Lindblade *et al.*, 2003). In Ethiopia, the majority of child domestic workers in the capital city, Addis Ababa, are orphans (Bicego *et al.*, 2003). In Uganda, girls orphaned by AIDS are especially vulnerable to sexual abuse in domestic housework because of the stigma attached to their orphaned status (UNAIDS, 1998). Studies reveal that orphaned children have substantially lower levels of education than children who are not orphaned (NACC, 2000; Bunyi, 2000).

The situation of Orphaned and Vulnerable children in Kenya is grim. One fifth of the Kenyan population is six years and younger and nearly half (48%) is below 15. Over 53% of Kenyans live in absolute poverty, which means that about (8.6 million) children live below the poverty line.

Unborn babies of HIV positive mothers risk infection during pregnancy, delivery and breastfeeding. Infant mortality has increased from 64 per 1000 births in 1993 to 72 per 1000 in 1998. About 36% of children living with HIV and AIDS die before

reaching their first birthday. Children may also be infected as they take care of their ailing parents. Girls are especially vulnerable given that they often assume parental responsibility in the absence of parents or when their parents become seriously ill. They may resort to early marriage or commercial sex work so as to fend for their siblings, thus exposing themselves to infection, (ROK, 2003).

HIV and AIDS have reversed the gains previously made in life expectancy and mortality rate. Life expectancy improved from 44 years in 1962 to 60 in 1993 but decreased due to HIV and AIDS from 60 in 1993 to 47 years in the year 2000 (National Development Plan, 2002-2008). With about 700 adult deaths per day, many children are rendered orphans and often lack medical attention, get separated from their siblings and lead desperate lives in deprived households headed by children or elderly persons.

There is a rapidly growing number of orphans in Kenya, and the number of orphans is expected to rise to 2 million by 2010, with HIV and AIDS contributing up to 60% of the total cases. These children have limited access to psychosocial and economic support, leaving them among the most vulnerable of the Kenyan society. Currently, estimates indicate that 2.2 million Kenyans are HIV positive; 1.5 million have died leaving 1.3 million orphans under the age of 18 years. It is projected that the figure will reach 1.8 million by the year 2005 (ROK, 2003). The scenario is alarming considering the fluid demographic transition between the rural to rural, rural to urban and urban to urban. Despite the diverse socio-economic and cultural milieu, orphans live invariably in perpetual need. The existing native framework has been overwhelmed, thus compelling adverse adjustments in households as well as in social

integrity. It is evident that the peak of HIV and AIDS has not been reached yet. The future orphan population will be contingent on the approaches instituted to combat the impacts of HIV and AIDS scourge in children (UNAIDS/UNICEF/USAID, 2004c).

2.3. Impact of HIV/AIDS in Kenya

During the year 2002, approximately 200 children under 15 years of age became infected daily with HIV and AIDS through Mother-to-Child Transmission (MTCT) (ROK, 2001). In the same year, HIV/AIDS associated illnesses caused deaths of approximately 3.1 million people world-wide, including an estimated 610, 000 children younger than 15 years (UNAIDS/UNICEF, 2003). Children orphaned by AIDS are at a greater risk of malnutrition, illness, abuse, child labour and sexual exploitation than those children orphaned by other causes and these factors increase their vulnerability to HIV infection. They also suffer from the stigma and discrimination often associated with HIV and AIDS and may be denied education, work, housing and other basic needs (UNICEF/UNAIDS/WHO, 2002).

2.4. Paternal Orphans

These are children under age 18 whose fathers have died. When a father dies the aura of social and physical security associated with male authority both within and without the family wanes in children. Mothers are seldom able to perform the paternal roles. Consequently, time budgeting becomes an ever-growing challenge as mothers struggle to attend food production and parenting obligations as the orphans face a premature call to perform adult duties. In the face of dwindling resources, children have to work to support their siblings and their ageing grandparents (Hunter, 1999). In the rural areas, children appear to be more pious as land presents the only source of

livelihood. The mother who is alive is subjected to more pressure, consequently working as a farmhand to raise much needed money. During the harvesting season, family farms may be abandoned heightening the risk for food insecurity (Hunter, 1999). At the heart of most orphan related social problems, is the attendant reality that the indigenous communities and the lower income groups across the country are yet to develop a socio-economic and political environment that adequately addresses orphans needs (Hunter, 1999).

Orphans have found themselves in a precarious position when their mothers lose their assets to the extended family and this impacts on the children's future leaving them grounded in need (NACC, 2003). In polygamous families the younger wives normally re-marry leaving behind paternal orphans who are above five years of age to fend for themselves (Bicego *et al.*, 2003). Since women are considered the caregivers, most children are compelled to live on what the women can afford. The quality of care deteriorates due to increase in the ratio of dependants on a woman without income (Hunter and Williamson, 2000). As conditions get worse, children leave their homes with potential for increased abuse in temporary shelter in streets and among relatives. In some cultures, children are not considered orphans if they lose their fathers in the light of which, such children are not presented with benefits accorded other orphans (Hunter and Williamson, 2000).

2.5. Maternal Orphans

These are children under age 18 whose mothers have died. AIDS is changing the pattern of orphan hood in sub-Saharan Africa, where maternal orphans now outnumber paternal orphans in five of the most affected countries. In the absence of

HIV and AIDS, children were more likely to become orphans because of a father's death. In the countries of Sub-Saharan Africa today, however, women have higher rates of HIV and AIDS infection than men, and there are now more maternal orphans due to AIDS than paternal orphans. In the most affected countries in the southern Africa, 60% of orphans have lost their mothers, compared with 40% in Asia, Latin America and the Caribbean (UNAIDS/UNICEF/USAID, 2004a).

Upon maternal demise the father is expected to retain and fend for the orphans. Children left in the custody of the father are normally cared for by paternal grandparents (Hunter and Williamson, 1997a). Re-marriage is justified on the need to get the children a caregiver. While in sororate marriages, orphans are genuinely bound to benefit, non-sororate marriages jeopardise the role of consanguinity in orphan care (Hunter and Williamson, 1997b). Evidence has shown that children whose father's have re-married are denied food and clothing and at the same time such children have poor relations to the stepmother (Bicego *et al.*, 2003). Children in such settings are perpetually persecuted with profound emotional trauma (ROK, 2000). It is known that children develop strong emotional attachment to their mothers and this makes the impact of maternal demise more profound (UNAIDS, 2001). An examination of support and needs of children across maternal-paternal demise may confer a clear picture of the real impacts.

2.6. Double Orphans

These are children under age 18 whose mothers and fathers have died (Saoke and Mutemi, 1995). An especially important and distinctive characteristic of HIV and AIDS in regard to orphanhood is that AIDS is more likely than other causes of death to create double orphans. With HIV and AIDS, if one parent is infected there is a high

probability that the other parent is or will become infected and that both will eventually die. This means that countries with high levels of HIV and AIDS will also have a disproportionate number of double orphans as the epidemic advances. Surveys consistently show that double orphans are more disadvantaged than single orphans (UNAIDS/UNICEF 2003).

Double orphans find it extremely difficult to be accepted in the family network. Nutritional needs of double orphans are poorly met as they are considered an extra burden by their caregivers (Bhargava and Bigombe, 2003). Additionally, abuse is common on double orphans as they are compelled to perform extra chores to be accepted as members of the extended family. Evidence has shown that many girls have ended up in sexual relations with older males to secure surrogate paternal emotional support (UNAIDS, 2001). On the part of the grandparents, economic implications have compelled them to decline caring for their grandchildren. This is a new phenomenon posing a serious threat to the family matrix. However, it is evident that most of the orphans are provided for by their grandmothers. Care of breast feeding infants poses more challenges to their caretakers and most of these children die soon after the demise of their mothers (Bhargava and Bigombe, 2003). Double orphans normally die of inadequate attention and health related complications. In most Kenyan settings, orphan infant mortality is high within the extended family network. Nevertheless, there are traditional methods of taking care of un weaned infant orphans (Saoke and Mutemi, 1995)

2.7. Needs of Orphaned Children

The development of a child's full potential; which is every child's right is seriously threatened if the family environment deteriorates as a result of parental illness and death. It is also threatened when the impacts of HIV and AIDS undermine basic social services and safety nets such as healthcare and education. The illness or death of a parent or other family member has differing effects on children depending, in part, on a child's age and stage of development. Children respond very differently to their experiences at different ages, depending on their level of physical, cognitive, emotional, and physical development. For instance, the effects of illness or death of a caregiver will be different for infants, young children, in middle childhood years, and adolescents. The development level (including emotional maturity and level of understanding) of a child or adolescent will influence how he or she reacts to the death of a mother or a father (or both), to separation from siblings, and to other possible consequences of parental death. A young person's stage of development will also be a factor in determining the kind of support and protection he or she needs to enhance the prospect of a healthy and productive future (UNAIDS/ UNICEF/USAID, 2003b).

The main expressed needs of people living with HIV and AIDS (PLWHA) are palliative and care that includes access to common drugs, emotional support, and positive consideration from their families and community, financial assistance and empathy from health staff (Stone, 2000). Children orphaned by HIV and AIDS are vulnerable to physical and emotional deprivation. The needs of orphans may be classified into physical, medical and psycho-social needs.

2.7.1. Physical Needs

These are the basic human needs and include food, shelter, clothing and education. Specific nutritional recommendations for children with HIV/AIDS should follow the recommendation for all young children, taking into consideration the increased nutritional requirements that accompany the infection and the increased likelihood of fat and nutrient malabsorption (Piwoz *et al.*, 2000). Young children need to be fed patiently and persistently with supervision and love. This is especially true for HIV/AIDS infected children who are frequently ill and are suffering from fever, mouth and throat sores and depressed appetite (Piwoz and Preble, 2000). Caregivers should feed children with a variety of the locally available fruits, vegetables, animal products and fortified foods available (Bijlsma, 2000).

Solid foods should be introduced gradually to match the age and development characteristics of the child. Foods introduced first should be soft and enriched with energy sources. Variety of the foods given is necessary to increase the intake of essential vitamins and minerals (Nerad *et al.*, 2003). Safe and hygienic practices should be followed (Bartlett, 2003). It is important to also monitor their body weight, height, arm circumference and triceps skin-fold regularly. The child's diet should be reviewed at every well-child clinic and sick-child health visits. Nutritious snacks can be provided between meals to increase consumption. Daily multi-nutrient supplements if available may be helpful in preventing nutritional deficiencies (UNAIDS, 2002).

Shelter is very important in the development of a child. Proper shelter as defined by United Nation Habitat, is one that has smooth walls, non-leaking roof, dust free floors and is properly ventilated (ROK, 2001). These children need to be given a good place to live and recognise as their home and they need to be provided with good clothes including good school uniforms.

Clothing is one of the basic needs that children must have to ensure growth health for adequate growth and development. Clothing covers nakedness, promotes cultural values, identifies sex of the child and protects the body from adverse weather conditions (Soake, *et. al.*, (1996).

Every child has a right to education, which should be directed, to the promotion and development of the child's personality, talents, mental and physical abilities. Consequently, every child should have access to free and compulsory primary education. Different forms of secondary education should be accessible to the child.

2.7.2. Health Needs

Every child has a right to the highest standard of health and medical care. Special emphasis should be on the provision of primary and preventive health care, public health education and reduction of infant mortality. Children orphaned by HIV and AIDS are likely to be more vulnerable in terms of both health and nutrition. It is therefore necessary to ensure they have access to essential health services in early childhood such as immunisation, vitamin A supplementation and growth monitoring. The treatment of HIV and AIDS in children proves to be difficult and this is compounded by two factors. Firstly, HIV and AIDS medication is unpalatable and the regimes are complex and secondly, the drugs cannot always just be scaled down in

dosage. Many HIV positive children die from common childhood illness rather than from HIV and AIDS. Most of these deaths are preventable by early diagnosis and correct management. For adolescents, education and health services focused on HIV prevention, sexual and reproductive health care are particularly vital. Treatment for HIV positive youth is also an emerging necessity (USAID, 2004).

According to the United Nation's Convention on the Rights of the Child, the child has a right to the highest standard of health and medical care attainable. Emphasis is made on the provision of primary and preventive healthcare, public health education and the reduction of infant mortality. Governments are called upon to strive and see to it that no child is deprived of access to effective health services (UN, 1989).

2.7.3. Psycho-social Needs

There are profound ways in which orphan hood, including its prelude and consequences may affect the psychosocial, development and wellbeing of children.

Earls and Carson (2001) describe 'well being' as related to ones sense of dignity, security and mastery of particular settings. In this sense wellbeing instils resilience in the face of adversity, especially when supported by resources and opportunities.

Orphans are consistently worried, fearful and show hopelessness when confronted with the question of life and survival (USAID, 2004).

Parents, families and caregivers of OVC need ongoing emotional support and empathy. Post demise care for surviving children may be especially challenging. Children may express their emotions through play, stories and art (Douglas *et al.*, 2002). Many of the orphaned children must learn how to contend with the reality of being orphans (Hunter and Williamson, 1997).

Children are expected to show affection to their younger siblings, this is a difficulty that the older children face, as they also need love and care. Worse still is the fact that many of the OVC watch as their parents are devastated by HIV and AIDS, consequently leaving them to face society's stigma towards them. They suffer anxiety and insecurity concerning their future (Clive, 2000).

Research shows that stigma prevents communities and governments from effectively responding to the orphan problems as well as hindering the economic recovery of the affected children (Stein, 2003). Stigma and discrimination also intensify violation of these children's rights, in particular their access to education, social services, community and familial support. Many orphaned children experience anger, guilt and fear, for their future. This can lead to post traumatic stress syndrome, alcohol and drug abuse, aggression and even suicide (Foster, 2002)

CHAPTER THREE

MATERIALS AND METHODS

3.1. The Study Area

The study was carried out in the Central Division, Mwingi District-Kenya. The District is one of the thirteen districts of Eastern Province. It borders Kitui District to the South, Machakos District to the West, Mbeere and Meru South to the North and Tana River District to the East (Appendix iii). The district lies between latitudes $0^{\circ} 03'$ and $1^{\circ} 12'$ South and longitudes $37^{\circ} 47'$ degrees $38^{\circ} 57'$ East. It covers an area of 10,030.30 sq. kilometres. It is divided into nine administrative divisions namely, Central, Migwani, Kyuso, Mumoni, Nguni, Ngomeni, Nuu, Mui and Tseikuru (ROK 2002-2008).

Mwingi District is plain with a few inserbergs in Mumoni, Nuu and Migwani Divisions. The highest point of the district is Mumoni Ill, with an altitude of 1747m above sea level. The landscape is generally flat, with a plain that gently rolls down towards the east and north-east where altitudes are as low as 400m.

The highlands namely Migwani, Mumoni, Central and Mui Divisions receive more rainfall compared to the lowlands Nguni, Kyuso and Tseikuru Divisions. The drier areas experience severe droughts, which have led to livestock deaths and food shortages.

The climate of Mwingi District is hot and dry for the greater part of the year. The maximum mean annual temperatures range between 26°C and 34°C . The minimum mean annual temperatures vary between 14°C and 22°C . Average annual

temperature is 24⁰ C. The district has two rainy seasons: long rains (March –May), and short rains (October –December). Rainfall ranges between 400mm and 800mm per year, but is erratic. The short rains are more reliable than the long rains.

Mwingi District is inhabited mainly by the Kamba people. The district has a population of 303,828 (1999 population census) and is projected to rise to 377,081 in 2008 at a growth rate of 2.1 % and a population density of 30 persons per sq. Km. More than 95 % of this population is rural based; while 5 % is urban.

3.2. Study Population

The study population consisted of Orphaned and Vulnerable children and their caregivers in Central Division, Mwingi District, Kenya.

3.2.1. Inclusion Criteria

Orphaned and Vulnerable Children aged 6-18 years old who had lost one or both parents and the caregivers who consented to participate in the study were included.

3.2.2. Exclusion Criteria

Children with parents, OVC and care givers who did not give informed consent to participate in the study were excluded.

3.3. Study Design

This was a cross-sectional descriptive study to determine the nature and extent of the needs of OVC and the constraints experienced in meeting the needs. A cross-sectional

descriptive survey design aims at obtaining information, which can be analysed, patterns extracted and comparisons made (Bell, 1993).

3.3.1. Sampling Methods

Simple random sampling was used to sample individual OVC from each location.

Samples in each location were stratified by gender.

3.3.2. Sample Size Determination

Probability proportional to size sampling was used to sample children from Mwingi, Kiomo and Nzeluni locations in Central division of Mwingi district.

According to the Mwingi District Development Plan (2002-2008), the number of orphaned children in Mwingi District in 2004 was 3,498 and the total population of children was 217,046. The sample size was calculated using the formulae as used by Fisher *et al.* (1998), for populations less than 10,000.

$$n_f = \frac{n}{1 + (n/N)}$$

Where $N = 3,498$, the estimate of the population

$n = 400$, the desired sample size (when the population is more than 10,000)

$n_f =$ the desired sample size (when the population is less than 10,000)

$$n_f = \frac{400}{1 + (400/3,498)} = 359$$

In order to cater for attrition among the respondents and to increase the degree of accuracy, a sample size of 400 was used.

3.4. Data Collection Tools

Data was collected using pre-tested structured questionnaires for orphans (school going) and caregivers. It captured the physical, health and psychosocial needs of the

orphans. The questionnaire was administered by using one to one technique and each questionnaire completed by the investigator.

3.5. Data Management

The Statistical Package for Social Sciences (SPSS) was used for data analysis. Chi-square was used to determine the extent and significance of the relationship between the nominal variables such as age, area, and gender. The Chi-square test was used due to the nominal nature of the data collected (Shaw and Wheeler, 1985).

3.6. Ethical Considerations

Clearance to carry out the study was sought from relevant authorities, Kenyatta University Board of Postgraduate Studies, the Children's Department Ethical Committee and the Ministry of Education, Science and Technology (MOEST). All the study participants' rights to privacy and confidentiality were respected and no orphan was exposed to any harm during the course of the study. Verbal consent was sought from all the interviewees.

3.7. Study Limitations

- (i) There was no comparison between the needs of OVC and the needs of caregivers own children.
- (ii) Access to some homes was not easy as some caregivers felt that their privacy was being compromised.
- (iii) Some selected study participants refusal to participate in the study was a big drawback.

CHAPTER FOUR

RESULTS

4.1. Demographic Characteristics of the Respondents

4.1.1. Gender of Respondents

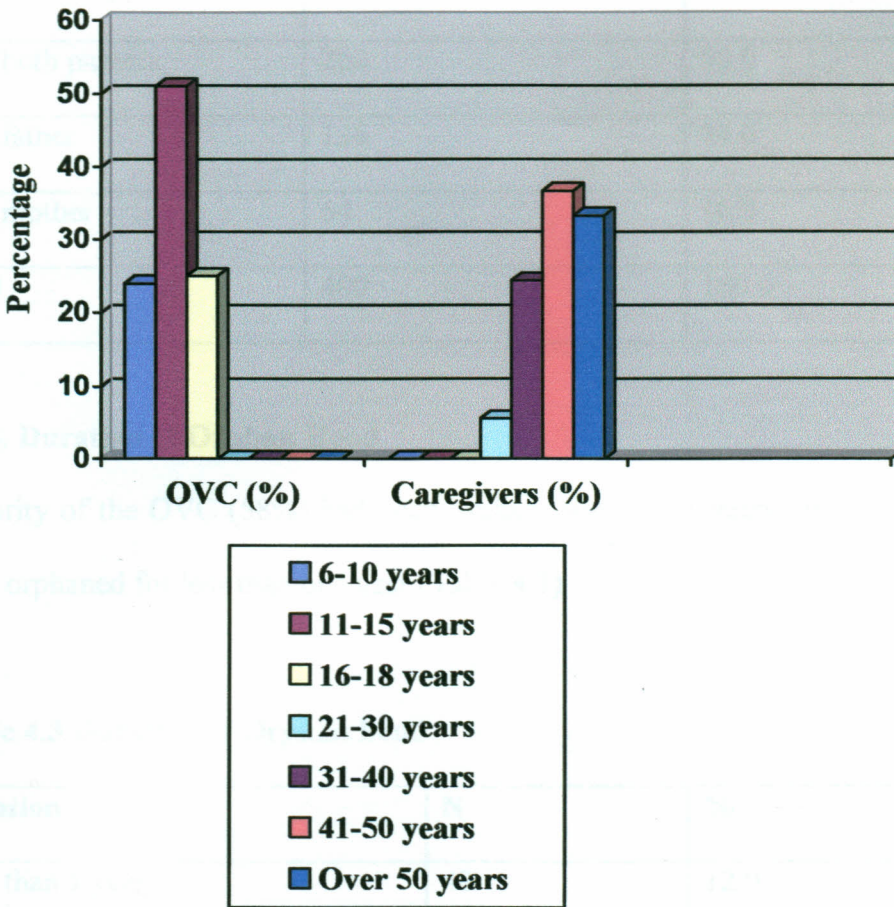
Majority of the caregivers (61.1%) and OVC (51%) were females (Table 4.1)

Table 4.1 Gender of the Respondents

Gender	OVC		Caregivers	
	N	%	n	%
Male	196	49.0	35	38.9
Female	204	51.0	55	61.1
Total	400	100.0	90	100.0

4.1.2. Age of the Respondents

Most of OVC (51%) were aged 11 to 15 years, while minority of the caregivers (36.7%) were 41-50 years (Figure 4.1).

Figure 4.1 Age distribution of the respondents

4.1.3. Nature of orphan hood

The distribution of the OVC on the basis of the nature of orphan hood is shown in Table 4. 3, 50 % of the OVC had lost both parents, (34%) had lost their father, while (16%) had lost their mother (Table 4.2)

Table 4.2 Nature of orphan hood

Nature of orphan hood	N	%
Lost both parents	200	50.0
Lost father	136	34.0
Lost mother	64	16.0
Total	400	100.0

4.1.4. Duration of Orphan Hood

Majority of the OVC (58%) had been orphans for over 3 years while only 12% had been orphaned for less than one year (Table 4.3)

Table 4.3 Duration of Orphan hood

Duration	N	%
Less than 1 year	48	12.0
1-3 years	120	30.0
Over 3 years	232	58.0
Total	400	100.0

4.1.5. Marital Status of the Caregivers

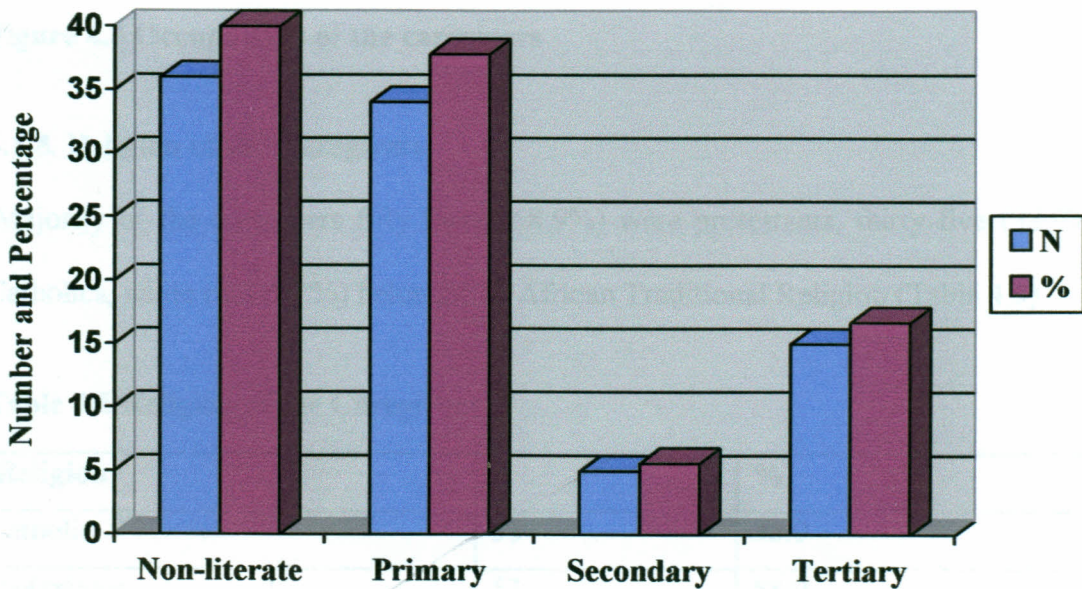
Majority of the caregivers were widowed (62.2%), 21.1% were married while 2.2% were separated (Table 4.4)

Table 4.4 Marital Status of Caregivers

Marital Status	N	%
Single	7	7.8
Married	19	21.1
Separated	2	2.2
Divorced	6	6.7
Widowed	56	62.2
Total	90	100.0

4.1.6. Education Level of Caregivers

Thirty six (40%) care givers were Illiterate, thirty four (37.8%) had primary level of education, only five (5.6%) had attained secondary level and fifteen (16.7%) had tertiary level of education (fig.4.2).

**Figure 4.2 Education Level of Caregivers**

4.1.7. Occupation of the Caregivers

Out of the 90 caregivers interviewed, fifty six (62.2%) were unemployed, six (6.7%) were self-employed, sixteen (17.8%) were casual labourers while twelve (13.3%) were civil servants (Fig. 4.3).

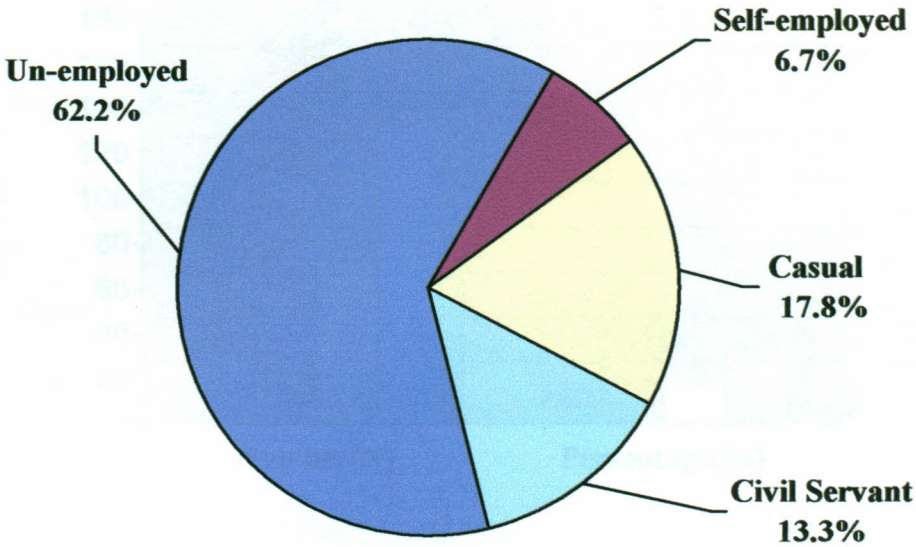


Figure 4.3 Occupations of the caregivers

4.1.8. Religion of the Caregivers

Majority of the caregivers fifty three (58.9%) were protestants, thirty five (38.9%) Catholics, while two (2.2%) belonged to African Traditional Religion (Table 4.5)

Table 4.5 Religion of the Caregivers

Religion	N	%
Catholic	35	38.9
Protestants	53	58.9
Others	2	2.2
Total	90	100.0

4.1.9. Number of Siblings

Most of the OVC one hundred and sixty four (41%) had 1-3 other siblings while one hundred and thirty two (33%) had over 5 siblings. Seventy two (18%) had 4-6 other siblings while thirty two (8%) had none (Fig. 4.4).

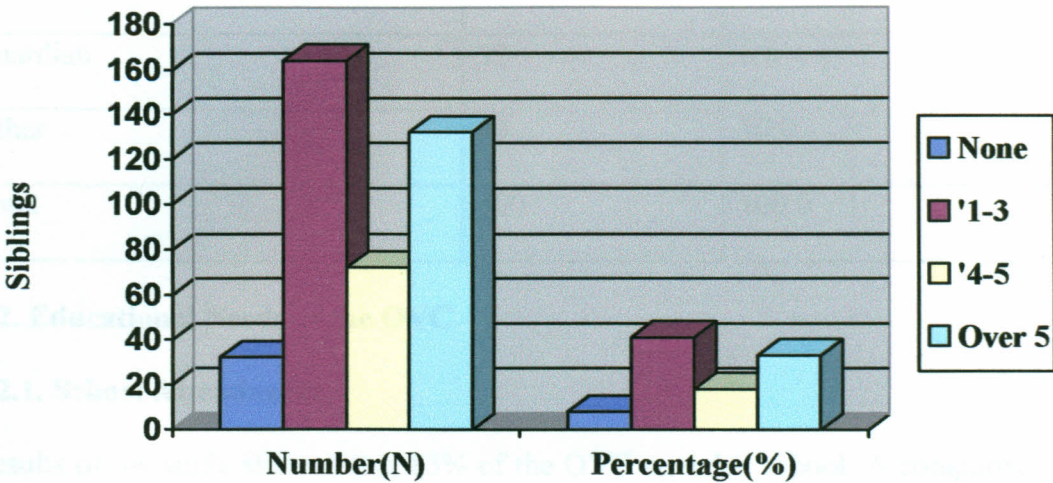


Figure 4.4 Number of Siblings

4.1.10. Persons the OVC Lived With

One hundred and thirty six (34%) OVC lived with their grandparents, one hundred and twenty eight (32%) with their mothers, while forty four (11%) lived with their fathers (Table 4.6)

Table 4.6 Person the OVC Lived With

Person	N	%
Mother	128	32.0
Father	44	11.0
Grandparent	136	34.0
Relatives	20	5.0
Guardian	32	8.0
Other	40	10.0
Total	400	100.0

4.2. Educational Needs of the OVC

4.2.1. School Attendance

Results of the study showed that 85% of the OVC attended school. A comparison on the basis of gender showed that more girls (92.2%) than boys (77.6%) attended school (Figure 4.5). There was a significant relationship between school attendance and the gender of OVC ($\chi^2=16.725$, df 1 p= 0.000).

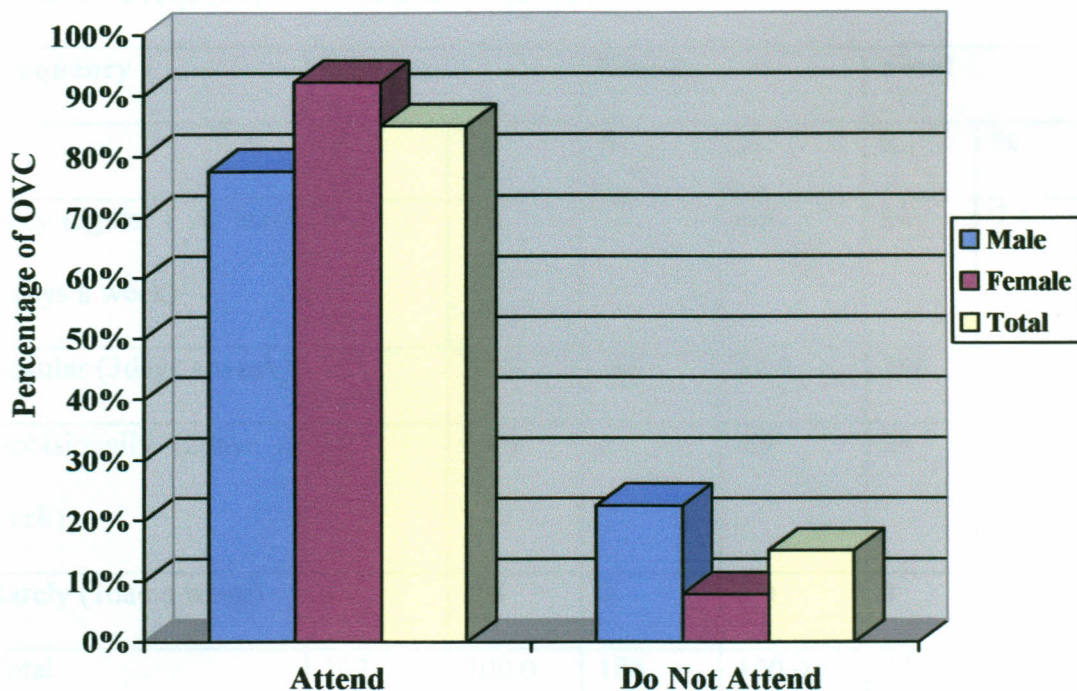


Figure 4.5 Percentage Of OVC Attending School

4.2.2. Frequency Of School Attendance By The OVC

The OVC who attended school reported varied frequency of school attendance. Majority of the OVC (84.7%) attended school regularly, while (7.1%) attended school very regularly, (7.1%) occasionally and (1.2%) rarely (Table 4.8). There was a significant difference in the frequency of school attendance by boys and girls ($\chi^2 = 11.203$ $df=3$ $p = 0.01$), (Table 4.7).

Table 4.7 Frequency Of School Attendance By OVC

Frequency	Male		Female		Total	
	N	%	N	%	n	%
Very regular (At least 4 days a week)	8	5.3	16	8.5	24	7.1
Regular (3days a week)	124	81.6	164	87.5	288	84.7
Occasionally (2days a week)	16	10.5	8	4.3	24	7.1
Rarely (1day a week)	4	2.6	0	0.0	4	1.2
Total	152	100.0	188	100.0	340	100.0

4.2.3. Reasons For Non-School Attendance By OVC

A good number of children are still not attending school even after they were accorded free primary education. The reasons for OVC non-school attendance given by caregivers is as shown in Table 4.9. These included: lack of school uniforms (62.5%), lack of school levies (43.8%), looking after siblings (37.5%) and working in order to earn income so as to feed the family (37.5%). The reasons for non school attendance by OVC themselves were lack of books and stationery (35.7%), lack of school uniform (64.3%), caring for siblings (50%) or sick parents (14.3%), and working to earn income for the family (57.1%), (14.3%) performing other household chores (57.1%).

The reasons for non-school attendance by the male orphaned and vulnerable children on the basis of gender (Table 4.8) were lack of school uniform (63.6%), working in order to earn income to feed the family (63.6%) and looking after other siblings.

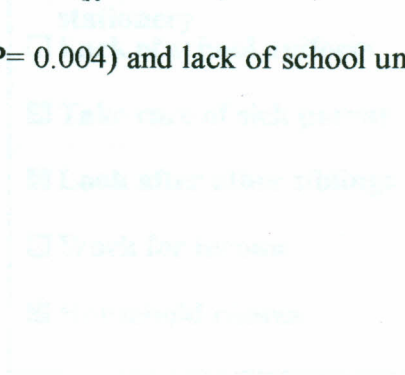
Among the females, the main reasons were lack of school uniform (63.6%), working in order to earn income for the families (33.3%), looking after the other siblings (33.3%) and taking care of sick parents (3.3%). There was a significant relationship between the non school attendance and looking after sick parents between boys and girls ($\chi^2= 4.525$, $df= 1$, $p= 0.033$)

Table 4.8 Reasons For Non-School Attendance By OVC

Reasons	Care givers		OVC		Gender of OVC	
	N	%	N	%	Male	female
Lack of school levies	7	43.8	0	0.0	0.0	0.0
Lack of books and stationery	3	18.8	20	35.7	36.4	33.3
Lack of school uniform	10	62.5	36	64.3	63.6	66.7
Take care of sick parent	0	0.0	8	14.3	9.1	33.3
Look after other siblings	6	37.5	28	50.0	54.5	33.3
Work for income	6	37.5	32	57.1	63.6	33.3
household chores	0	0.0	8	14.3	18.2	0

4.2.4. Reasons For Non-School Attendance On The Basis Of Caregiver's Education Level

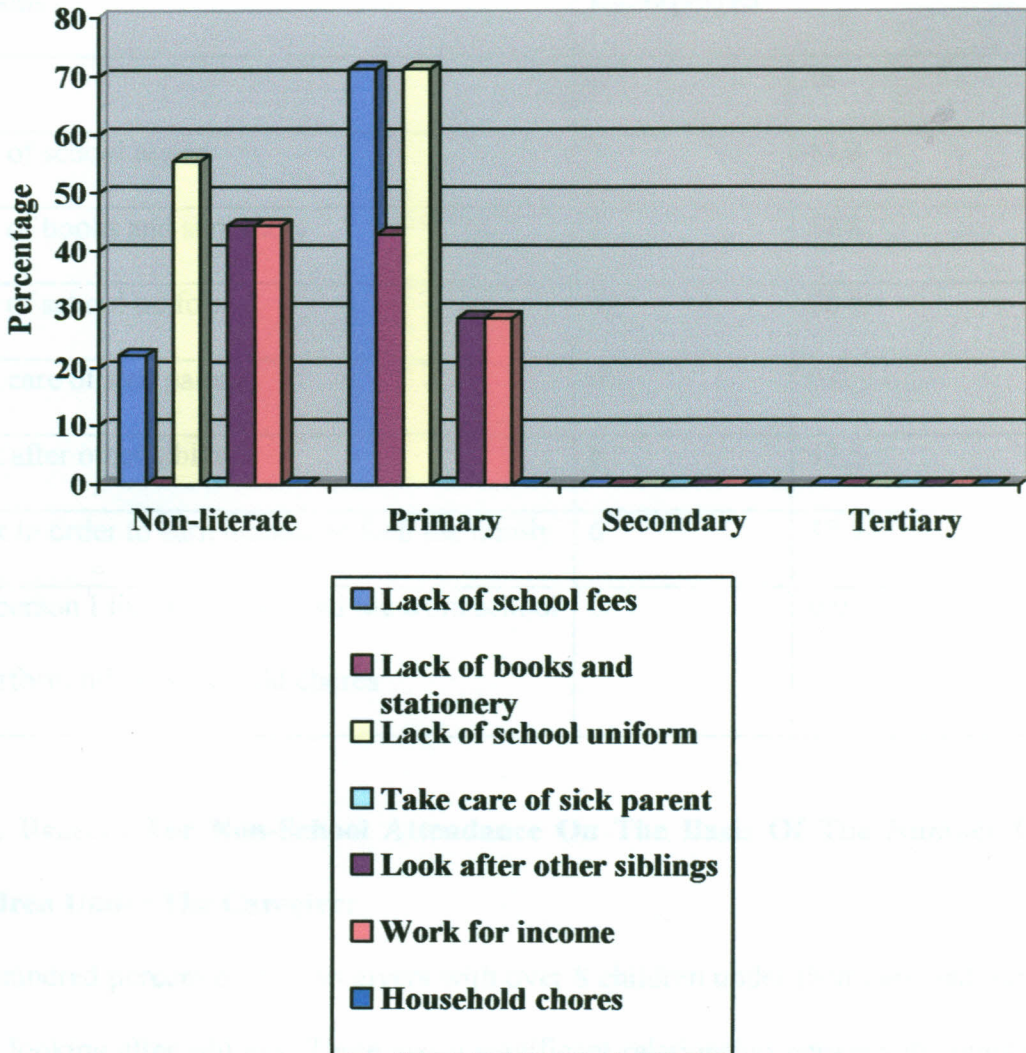
The reasons for non-school attendance of OVC by Care Givers on the basis of their Education level is as shown in Figure 4.6 Care givers with no formal education had the following reasons: lack of school uniform (55.5%), looking after other siblings (44.4%), working in order to earn income for the family (44.4%) and lack of school fees (22.2%). Reasons by Care givers with primary level of education were: lack of school uniform (71.4%), looking after other siblings (28.6%), working in order to earn income for the family (28.6%), lack of school fees (71.4%), lack of books and stationary (42.9%). There was a significant relationship between lack of school attendance by OVC and the level of education of the care givers in the three reasons as follows: - lack of school levies ($\chi^2= 9.351$, $df= 1$, $P= 0.002$), lack of books and stationery ($\chi^2= 8.123$, $df= 1$, $P= 0.004$) and lack of school uniform ($\chi^2= 4.364$, $df= 1$, $P= 0.037$).



4.2.5. Reasons For Non-School Attendance On The Basis Of Caregiver's Occupation

All the 10 caregivers who had OVC are attending school with a reason for non-school attendance. The main reason for non-school attendance was lack of school uniform in 100% (10/10).

Figure 4.6 Reasons For Non-School Attendance On The Basis Of Caregivers Education Level



4.2.5. Reasons For Non-School Attendance On The Basis Of Caregivers Occupation

All the 16 caregivers who had OVC not attending school were unemployed. The main reason for non school attendance was lack of school uniform (62.5%) (Table 4.9)

Table 4.9 Reasons For Non-School Attendance On The Basis Of Caregivers Occupation

Reasons	Unemployed	
	N	%
Lack of school levies	7	43.8
Lack of books and stationery	3	18.8
Lack of school uniform	10	62.5
Take care of sick parent	0	0.0
Look after other siblings	6	37.5
Work in order to earn income to feed the family	6	37.5
The person I live with removed me from school to perform other household chores	0	0.0

4.2.6. Reasons For Non-School Attendance On The Basis Of The Number Of Children Under The Caregiver

One hundred percent of the caregivers with over 8 children under their care had older OVC looking after siblings. There was a significant relationship between the number of siblings under the care giver and: lack of school levies ($\chi^2= 11.937$, $df= 4$, $P= 0.018$), lack of books and stationery ($\chi^2= 16.000$, $df= 4$, $P= 0.003$), looking after other siblings ($\chi^2= 16.000$, $df= 4$, $P= 0.003$), and working to earn income to feed the family ($\chi^2= 11.733$, $df= 4$, $P= 0.019$) (Table 4.10).

Table 4.10 Reasons For Non-School Attendance On The Basis Of The Number Of Children Under The Caregiver

Reasons	Number of children under the caregiver									
	1-2		3-4		5-6		7-8		Over 8	
	N	%	N	%	n	%	n	%	N	%
Lack of school fees	3	100.0	0	0.0	2	0.0	0	0.0	2	50.0
Lack of books and stationery	3	100.0	0	0.0	0	0.0	0	0.0	0	0.0
Lack of school uniform	3	100.0	0	0.0	2	100.0	3	60.0	2	50.0
I take care of sick parents	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Look after other siblings	0	0.0	0	0.0	2	100.0	0	0.0	4	100.0
Work for income	0	0.0	2	100.0	2	100.0	0	0.0	2	50.0
Household chores	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

4.2.7. Adequacy Of Learning Resources

Majority of the OVC (96.5%) had books and stationery while 3.5% did not

(Fig4.7)

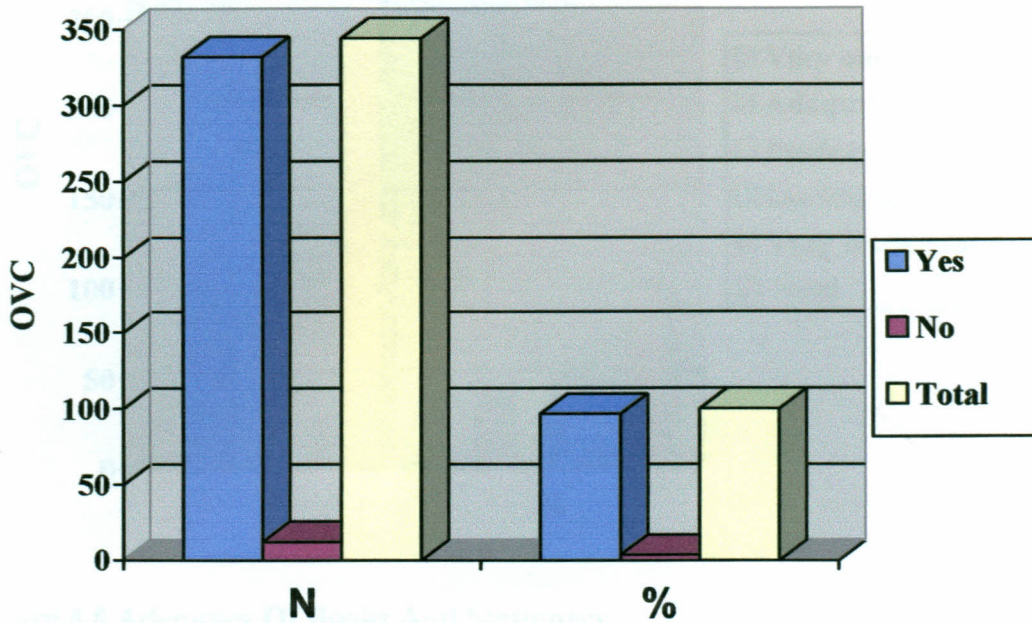


Figure 4.7 Availability of books and stationery for use in school by Orphans

The study further sought to establish the adequacy of books and stationery from the respondents on the scale: very adequate (5), adequate (4), moderately adequate (3), inadequate (2) and very inadequate (1). Majority of the OVC'S (53.0%) had moderately adequate books and stationery, adequate (34.9%), very inadequate (7.2%), inadequate (3.6%) and very adequate (1.2%) (Fig4.8)

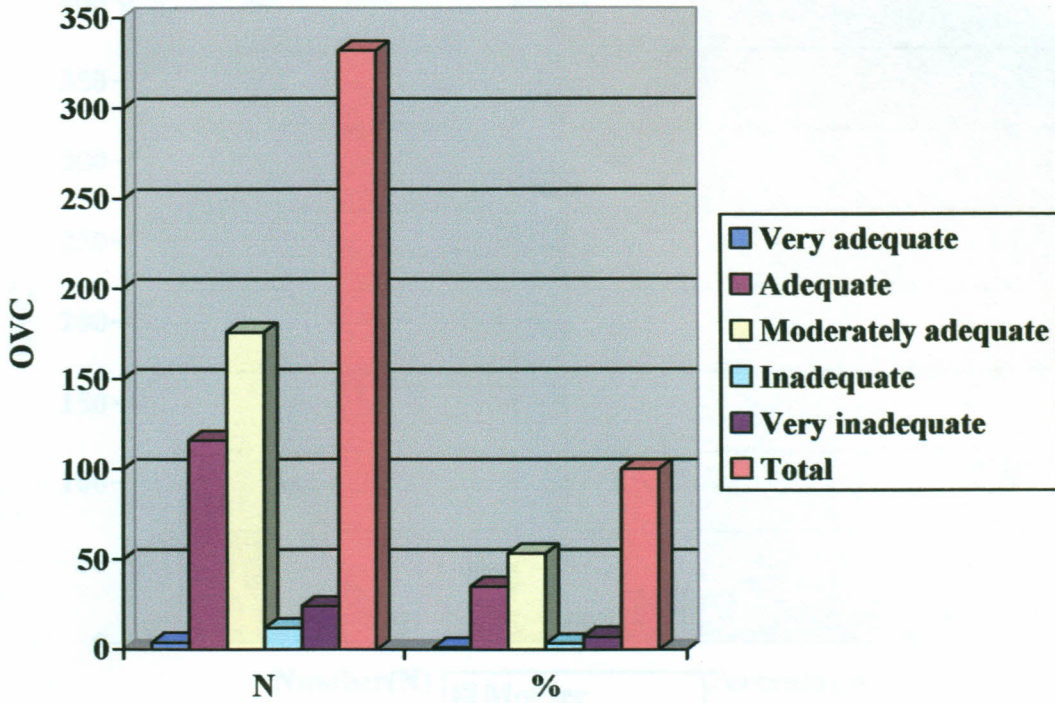


Figure 4.8 Adequacy Of Books And Stationery

4.2.8. Source Of Books And Uniforms For The OVC

Most OVC were provided with books and stationery by their grandparents (26.5%), mothers (21.7%), fathers (16.9%), NGO'S (15.7 %), Government (10.8%), and relatives (8.4%) while the church provided none (Fig4.9).

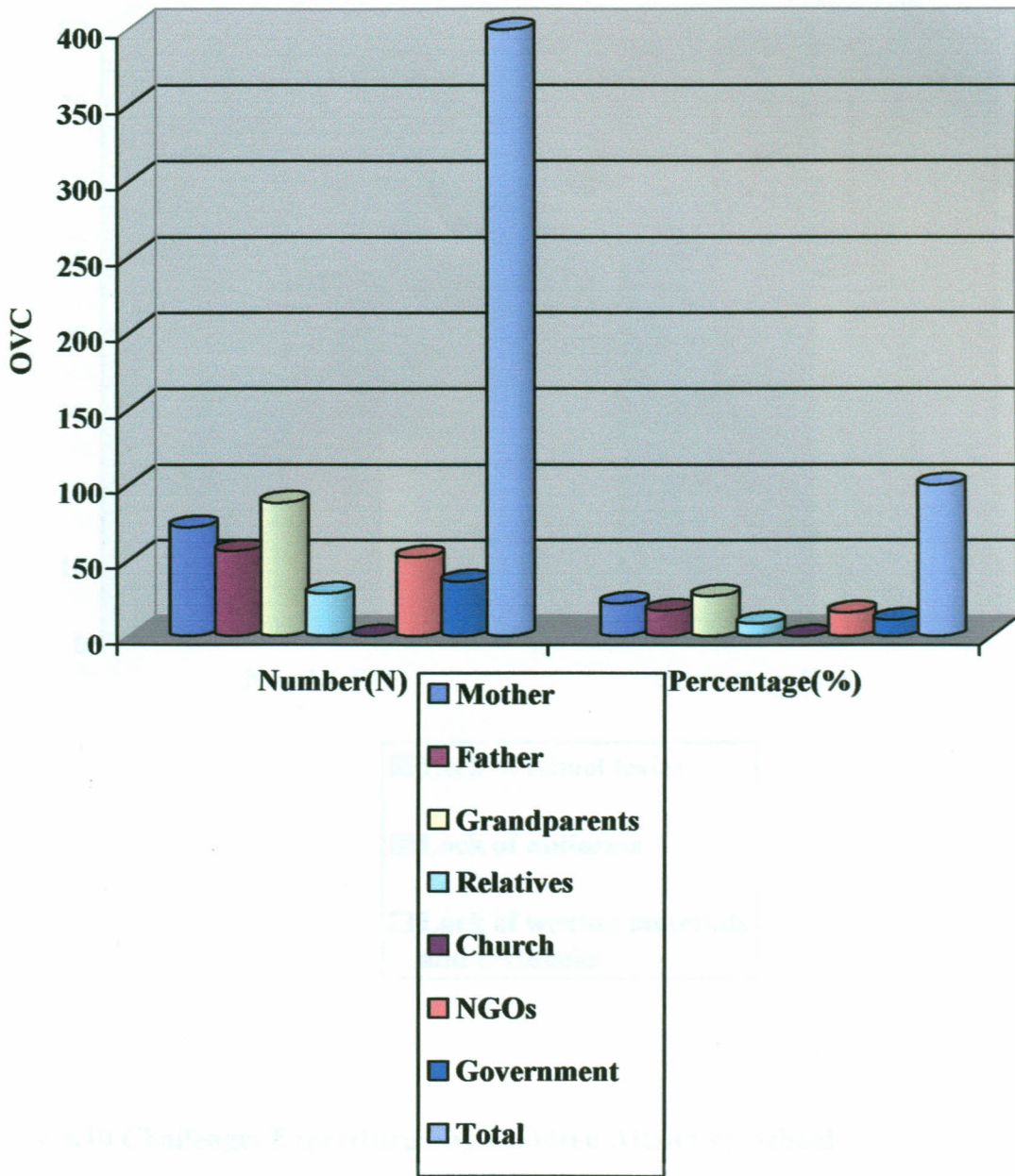


Figure 4.9 Source Of Books And Uniforms For The OVC

4.2.9. Challenges Experienced By Orphans Who Attended School

Sixty five point six percent (65.6%) of the caregivers indicated that children under their care who attended school had challenges while 34.4% did not. The challenges included: lack of school levies (54.2%), lack of school uniforms (76.3%) and lack of writing materials and textbooks (45.8%) (Fig4.10).

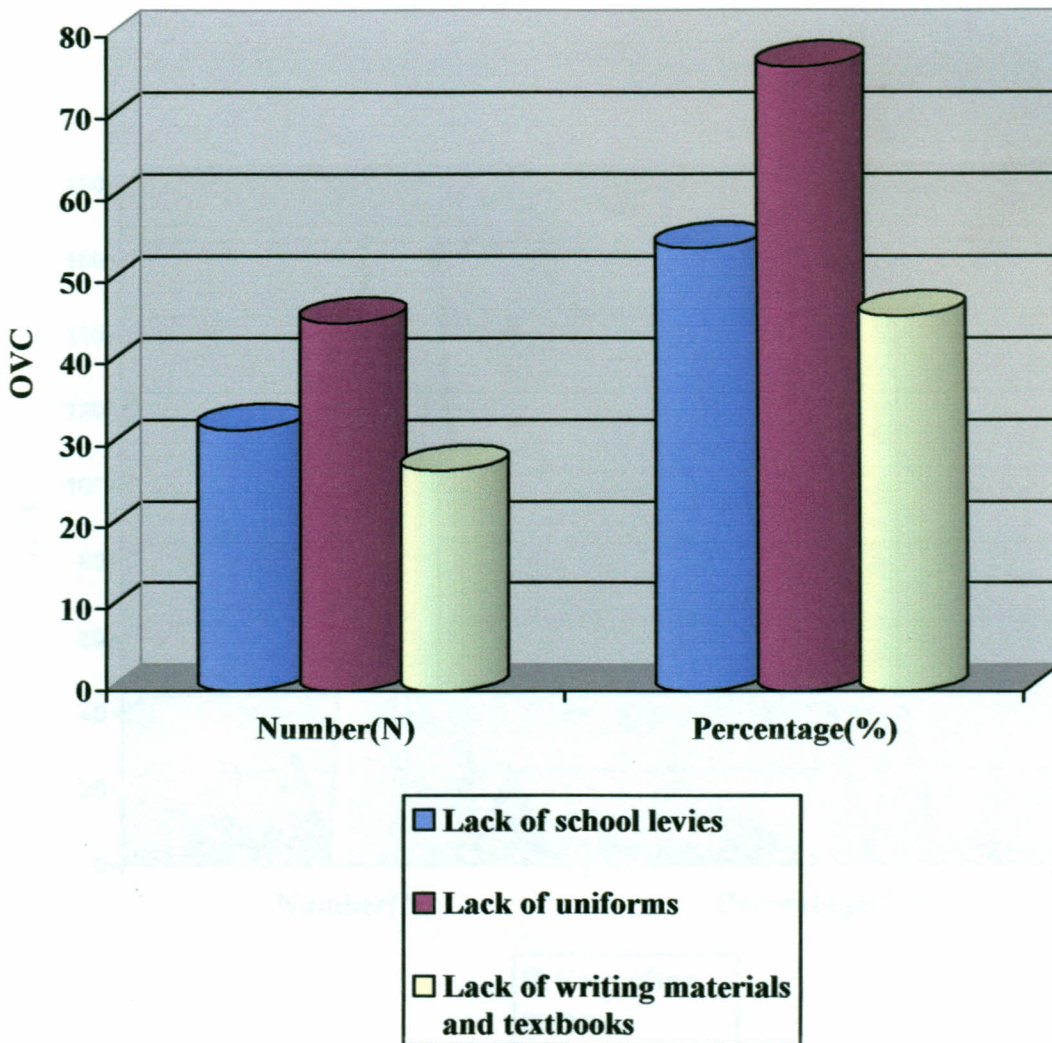


Figure 4.10 Challenges Experienced By Children Attending School

4.3. Health Needs of OVC

4.3.1. Frequency Of Falling Sick

The respondents established the frequency with which the OVC fell sick on the scale: very often (at least once a fortnight), often (at least once a month), occasionally (once in three months), rarely (once in over six months) and very rarely (once in over a year). Most of the OVC rarely fell sick (42.0%), occasionally (41.0%) fell sick, (7%) often, (6%) very rarely and only (3%) very often (Fig. 4.11).

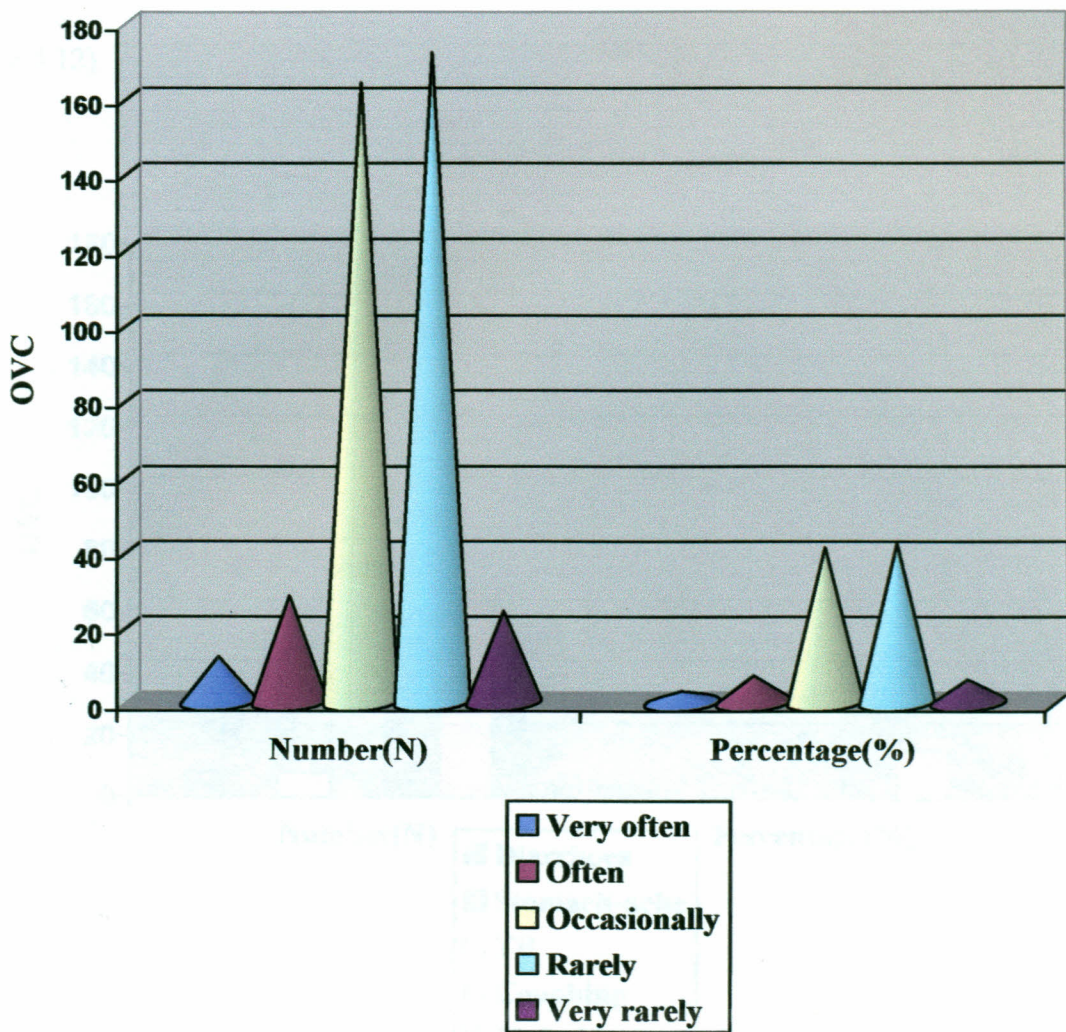


Figure 4.11 Frequency Of Sickness Of OVC

4.3.2. Nature Of Illness

Most OVC (43%) suffered from malaria, (18%) coughing, other diseases (16%), stomach ache (7%), TB (2%), diarrhoea (1%) while, (13%) of the OVC had none (Fig.4.12).

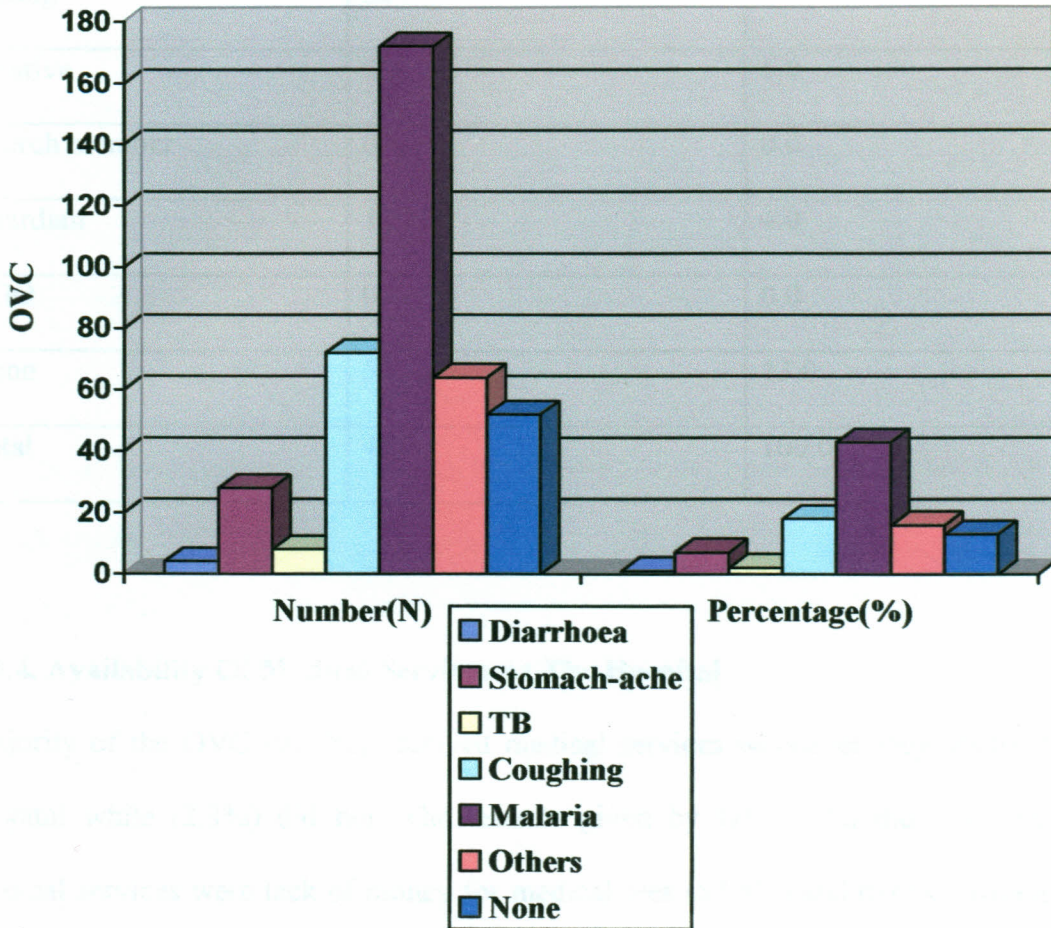


Figure 4.12 Nature Of Illness

4.3.3. Hospital Attendance In Cases Of Sickness

Majority of the OVC (91%) attended hospital when sick while (9%) did not.

Most OVC were taken to hospital by their mothers (30%), grandparent (27%), fathers (12%), while 8% were taken to hospital by siblings caregivers living with them

(Table 4.11).

Table 4.11 Persons Who Took OVC to Hospital When Sick

Person	N	%
Mother	120	30.0
Father	48	12.0
Grandparents	108	27.0
Sibling	32	8.0
Relative	24	6.0
Church member	0	0.0
Guardian	16	4.0
NGO	0	0.0
None	52	13.0
Total	400	100.0

4.3.4. Availability Of Medical Services At The Hospital

Majority of the OVC (97.7%) received medical services whenever they visited the hospital while (2.3%) did not. The reasons given by OVC who did not receive medical services were lack of money for medical fees (87.5%) and over crowding in hospitals (87.5%). However, it was established that most care givers (88.9%) did not take the OVC under their care for regular medical check up.

4.3.4a. Relationship between the Gender of the Care Giver and Medical Check-Up Of OVC

Majority of the caregivers (96.4%) who did not take the OVC under their care for regular medical check up were females as compared to males (77.1%) (Table 4.12)

There was a significant relationship between gender and taking OVC for regular medical check up ($\chi^2= 8.001$, $df= 1$, $P=0.005$).

Table 4.12 Relationship between Gender of The Care Giver And Medical Check-Up Of OVC

Response	Care givers		Male		Female	
	N	%	N	%	N	%
Yes	10	11.1%	8	22.9	2	3.6
No	80	88.9%	27	77.1	53	96.4
Total	90	100%	35	100.0	55	100.0

4.3.4b. Relationship Between The Caregiver's Education Level And Medical Check Up Of OVC

Majority of the caregivers who did not take OVC under their care for regular medical check-up had no formal education (36%) or had primary school level education (34%), while the lowest percentage were recorded on those with secondary education (5%), and those with tertiary education (5%) (Table 4.13).

There was a significant relationship between medical check-up of OVC and the educational level of caregivers ($\chi^2= 40.05$, $df= 3$, $P=0.000$).

Table 4.13 The Relationship Between The Caregiver's Education Level And Medical Check Up Of OVC

Education level	Response					
	Yes		No		Total	
	N	%	N	%	N	%
Non literate	0	0.0	36	100.0	36	100.0
Primary	0	0.0	34	100.0	34	100.0
Secondary	3	60.0	2	40.0	5	100.0
Tertiary	7	46.7	8	53.3	5	100.0

4.3.4c. Relationship Between Caregiver's Occupation And Medical Check-Up Of OVC

Fifty six (100%) unemployed, sixteen (100%) casuals and six (100%) self-employed caregivers did not take OVC under their care for regular medical check up. However, most of civil servants ten (83.3%) did, only two (16.7%) of them did not

(Fig4.13). There was a significant relationship between the occupation of the caregiver and medical check up of OVC ($\chi^2= 73.125$, $df= 3$, $P=0.000$).

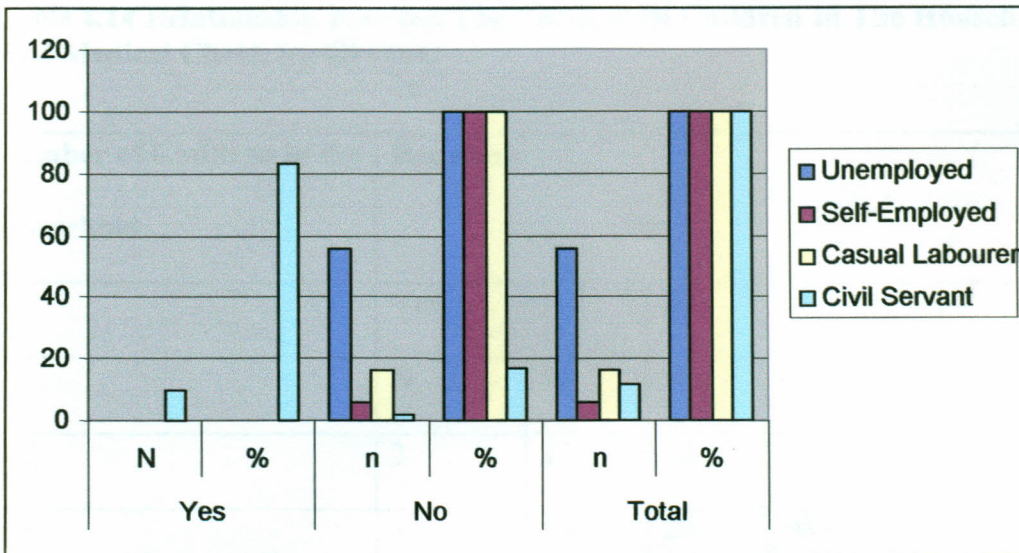


Figure 4.13 Relationship Between Caregiver's Occupation and Medical Check Up of OVC

4.3.4d. Relationship Between The Number Of Children In The Household And Medical Check-Up Of OVC

The findings indicated that 76.9% of the caregivers had 1-2 children under their care, 90.6% had 3-4 children, 81.8% had 5-6, 100% with 7-8, and 100% with over 8 children did not take OVC for regular medical check-up (Table 4.14). There was a significant relationship between the number of children under the care of a caregiver and regular medical check-up for OVC ($\chi^2= 7.970$, $df= 4$, $P=0.002$).

Table 4.14 Relationship Between The Number Of Children In The Household And Medical Check Up Of OVC

Number of Children in the Household	Response					
	Yes		No		Total	
	N	%	N	%	n	%
1-2	3	23.1	10	76.9	13	100.0
3-4	3	9.4	29	90.6	32	100.0
5-6	4	18.2	18	81.8	22	100.0
7-8	0	0.0	17	100.0	17	100.0
Over 8	0	0.0	6	100.0	6	100.0

4.3.5. Medical Care Needs Of The OVC

Majority of the OVC needed medical check up (83.0%), proper nutrition (71.0%) and drugs (58.0%). However, the least medical need was home based care when sick (14.0%) (Fig4.14)

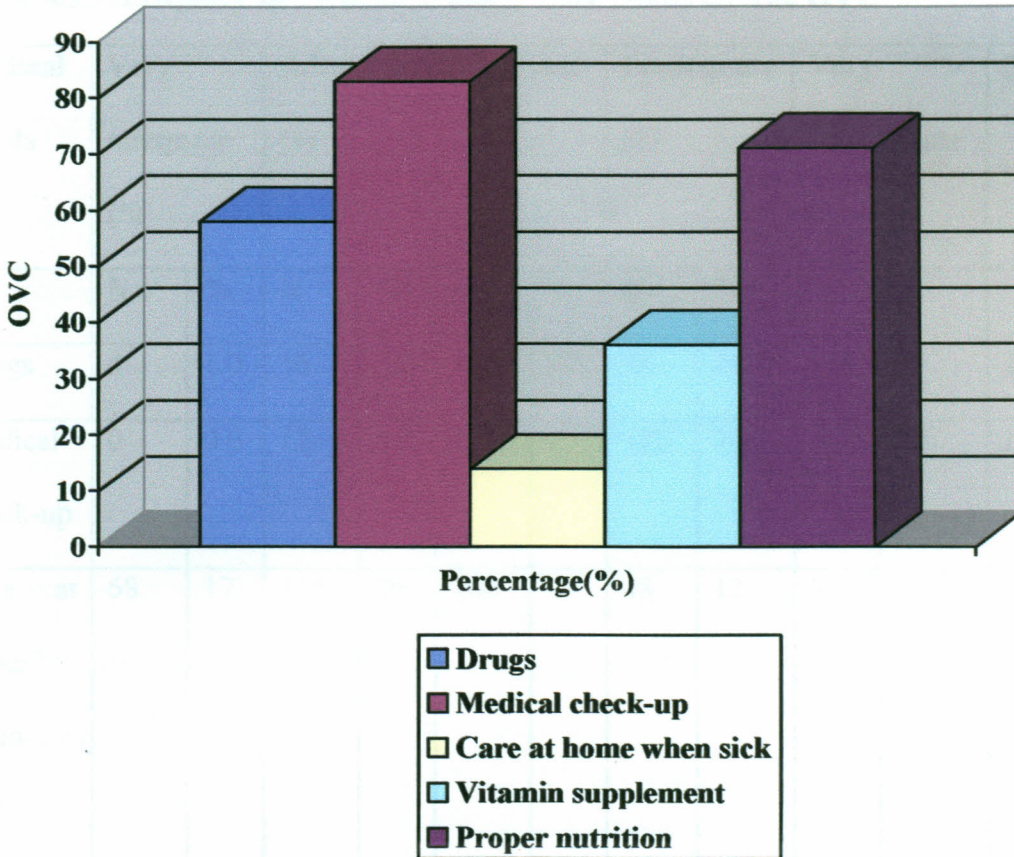


Figure 4.14 Medical Care Needs Of The OVC

4.3.6. Adequacy In Meeting Medical Care Needs

Using a scale of 1-5, the respondents were asked to rate the adequacy in meeting of medical care needs. The least met medical need of the OVC'S were: medical check-up (1.53%), proper nutrition (1.63%), drugs (2.09%), vitamin supplementation (2.32%) and home based care (3.47 %) (Table 4.15).

Table 4.15 Adequacy In Meeting Medical Care Needs Of The OVC

Medical Needs	Very adequate (5)		Adequate (4)		Moderate (3)		Inadequate (2)		Very Inadequate (1)		Mean
	N	%	N	%	n	%	N	%	n	%	
Drugs	4	1.0	16	4.0	148	37	76	19	156	39	2.09
Medical check-up	0	0.0	12	3.0	28	7	120	30	24	60	1.53
Care at home when sick	68	17.	116	29.	160	40	48	12	8	2.0	3.47
Vitamin supplement	4	1.0	24	6.0	152	38	136	34	84	21	2.32
Proper nutrition	0	0.0	12	3.0	32	8.0	152	38	204	51	1.63

4.3.7. OVC Medical Care Challenges By Caregivers

The medical care challenges experienced by the OVC were: lack of medicine (72.2%), long distances to the nearest health facility (58.9%), and lack of medical personnel at the health-care facilities (27.8%) while, (26.7%) OVC lacked medical facilities (Table 4.16)

Table 4.16 OVC Medical Care Challenges

Problem	N	%
Lack of medicine	65	72.2
Lack of medical facilities	24	26.7
Lack of medical personnel	25	27.8
Distance to the nearest health facility	53	58.9

4.4. Physical Needs of the OVC

The OVC reported their physical needs as food (42%) and clothing (42%) while, shelter was the least (16%) (Fig4.15).

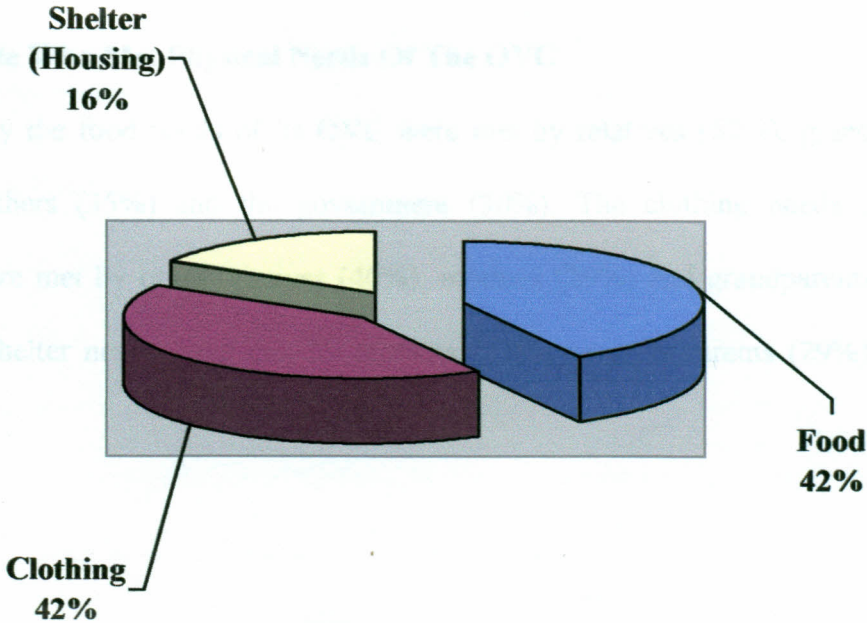


Figure 4.15 Physical Needs Of OVC

4.4.1. Adequacy In Meeting Physical Needs Of The OVC

The respondents rated the adequacy of meeting physical needs on a scale of 1-5 thus: very adequate (5), adequate (4), moderate (3), inadequate (2) and very inadequate (1) (Table 4.17). Most of the physical needs of the OVC were moderately met.

Table 4.17 Adequacy In Meeting The Physical Needs Of The OVC

Physical Needs	Very adequate		Adequate		Moderate		Inadequate		Very Inadequate		Mean
	N	%	N	%	N	%	N	%	N	%	
Food	36	9.0	56	14.0	164	41.0	140	35.0	4	1.0	2.95
Clothing	20	5.0	56	14.0	196	49.0	96	24.0	32	8.0	2.84
Shelter	20	5.0	108	27.0	212	53.0	52	13.0	8	2.0	3.20

4.4.2. People Who Met Physical Needs Of The OVC

In this study the food needs of the OVC were met by relatives (52%), grandparents (36%), mothers (35%) and the government (30%). The clothing needs of most orphans were met by other relatives (40%), mothers (29%) and grandparents (27%) while the shelter needs were met by mothers (31%) or grandparents (29%) (Table 4.18).

Table 4.18 The People Who Met Physical Needs Of The OVC

Person who meets the needs	Physical Needs					
	Food		Clothing		Shelter	
	N	%	N	%	N	%
Self	48	12.0	56	14.0	28	7.0
Mother	140	35.0	116	29.0	124	31.0
Father	44	11.0	60	15.0	68	17.0
Grandparent(s)	144	36.0	108	27.0	116	29.0
Relative(s)	208	52.0	160	40.0	76	19.0
Guardian	44	11.0	24	6.0	32	8.0
Church member(s)	56	14.0	32	8.0	0	0.0
NGOs	80	20.0	100	25.0	0	0.0
Government	120	30.0	12	3.0	0	0.0

4.4.3. Sleeping Facilities For OVC

Majority of the orphans (88.9%) shared sleeping rooms and beddings (83.3%). 88.9% OVC did not have sleeping gowns while 63% had no bed sheets (Table 4.19). Statistical analysis of the sleeping facilities for the OVC and the gender of the caregiver showed no significant difference in the availability of blankets and beds between OVC under male (62.9%) and female (78.2%) caregivers ($\chi^2=0.463$, $df= 1$, $P=0.645$). All OVC under male caregivers did not have night gowns while (18.2%) of OVC under female caregivers had.

Table 4.19 Sleeping facilities for the OVC on basis of gender of caregiver

Sleeping facility	Response		Gender	
	Yes	No	Male	Female
	%	%	%	%
Beds available	72.2	27.8	62.9	78.2
Blankets available	68.9	31.1	68.6	69.1
Sleeping gowns available	11.1	88.9	0.0	18.2
Bed sheets available	30.0	70.0	37.1	25.5
Orphans with health problems related to cold weather	25.6	74.4	28.6	23.6
Shared beds	11.1	88.9	8.6	12.7
Shared beddings	83.3	16.7	80.0	85.5
Shared rooms	88.9	11.1	94.3	85.5

4.4.4. Availability Of Sleeping Facilities For OVC On The Basis Of The Occupation Of Caregiver

In this study 100 % and 72.3 % of the OVC under the care of self employed and unemployed caregivers respectively lacked beddings while 37.5 % under the care of casual labourer's did (Table 4.20) showed a significant difference between sleeping facilities of the OVC and the occupation of the care giver ($\chi^2=16.756$, $df= 1$, $P=0.000$).

Table 4.20 Availability of sleeping facilities for OVC on the basis of the occupation of caregiver

Sleeping facility	Unemployed		Self-employed		Casual labourer		Civil Servant	
	N	%	N	%	N	%	n	%
Beds available	41	73.2	6	100	6	37.5	12	100
Blankets available	38	67.9	6	100	8	50.0	10	83.3
Sleeping gowns available	2	3.6	0	0.0	4	25.0	4	33.3
Bed sheets available	17	30.4	0	0.0	2	12.5	8	66.7
Orphans with health problems related to cold weather	15	26.8	0	0.0	4	25.0	4	33.3
Shared beds	0	0.0	3	50	0	0.0	7	58.3
Shared beddings	54	96.4	6	100	8	50.0	7	58.3
Shared rooms	54	96.4	6	100	10	62.5	10	83.3

4.4.4. Availability Of Bedding Facilities For OVC On The Basis Of The Number Of Children In The Household

Most orphaned and vulnerable children with inadequate bedding facilities (88.2%) and clothing (11.8%) were under caregivers with more than seven children in the household. There was a significant relationship between the number of children under a caregiver and adequacy of bedding facilities ($\chi^2=34.445$, $df= 1$, $P=0.000$).

Table 4.21 Availability of bedding facilities for OVC on the basis of the number children in the household

Sleeping facilities	Number of Children in the Household									
	1-2		3-4		5-6		7-8		Over 8	
	N	%	N	%	n	%	n	%	n	%
Beds available	9	69.2	22	68.8	15	68.2	15	88.2	4	66.7
Blankets available	11	84.6	20	62.5	10	45.5	15	88.2	6	100
Sleeping gowns available	2	15.4	2	6.3	4	18.2	2	11.8	0	0.0
Bed sheets available	8	61.5	8	25.0	9	46.9	2	11.8	0	0.0
Orphans with health problems related to cold weather	0	0.0	11	34.4	6	27.3	4	23.5	2	33
Shared beds	0	0.0	6	18.8	4	18.2	0	0.0	0	0.0
Shared beddings	11	84.6	23	71.9	20	90.9	15	88.2	6	100
Shared rooms	11	84.6	28	87.5	20	90.9	15	88.2	6	100

4.5. Psycho-social needs of OVC

The most pressing psychosocial needs of the OVC were parental guidance (36.0%) love and affection (16.0%) while the least pressing was appreciation (4%)

(Table 4.22).

Table 4.22 Psycho-social needs

Psycho social needs			Male		Female	
	N	%	N	%	N	%
Protection from exploitation	52	13.0	44	22.9	8	3.9
Parental guidance	144	36.0	88	45.8	56	27.5
Love and affection	64	16.0	52	27.1	12	5.9
Play and leisure	12	3.0	12	6.3	0	0.0
Acceptance	28	7.0	16	8.3	12	5.9
Confidentiality	28	7.0	28	14.6	0	0.0
Appreciation	16	4.0	8	4.2	8	3.9
Encouragement	56	14.0	48	25.0	8	3.9
Spiritual nourishment	48	12.0	40	20.8	8	3.9

A comparison of psycho-social needs and the gender of the OVC showed that males had more pressing psycho-social needs than females as shown in (Table 4.23). There were more males in need of parental guidance (45.8%) than females (27.5%). 22.9 % male OVC needed protection from exploitation while only 3.9% female OVC did (Table 4.23).

There was a significant relationship between gender of OVC and all the psycho-social needs except acceptance and appreciation (Table 4.23).

Table 4.23 Chi-square results on the psycho-social needs of the OVC on the basis of gender

Psycho-social needs	χ^2 Value	Df	Sig (2-tailed)
Protection from exploitation	31.286	1	0.000
Parental guidance	14.443	1	0.000
Love and affection	32.811	1	0.000
Opportunity to play	13.148	1	0.001
Acceptance	0.904	1	0.342
Confidentiality	32.014	1	0.000
Appreciation	0.015	1	0.901
Encouragement	36.194	1	0.000
Spiritual nourishment	26.557	1	0.000

4.5.1. Psycho-Social Needs Of OVC On The Basis Of Nature Of Orphan Hood

The OVC in need of parental guidance, love and affection were those who had lost both parents or those who had lost a mother. There was a significant difference between the type of orphan hood and the psycho-social needs of the OVC (Tables 4.22 and 4.23).

Table 4.24 Psycho-social needs of OVC on the basis of nature of orphan hood

Psycho-social needs	Lost both parents		Lost father		Lost mother	
	N	%	N	%	N	%
Protection from exploitation	24	12.0	4	3.0	24	37.5
Parental guidance	92	46.0	24	18.2	28	43.8
Love and affection	24	12.0	16	12.1	24	37.5
Opportunity to play	8	4.0	0	0.0	4	6.3
Acceptance	0	0.0	12	9.1	16	25.0
Confidentiality	20	10.0	0	0.0	8	12.5
Appreciation	8	4.0	0	0.0	8	12.5
Encouragement	24	12.0	12	9.1	20	31.3
Spiritual nourishment	16	8.0	20	15.2	12	18.8

Table 4.25 Chi-square results on the psycho-social needs of the OVC on the basis of the nature of orphan hood

Psycho-social needs	χ^2 Value	df	Sig (2-tailed)
Protection from exploitation	45.349	2	0.000
Parental guidance	28.392	2	0.000
Love and affection	25.654	2	0.000
Opportunity to play	7.023	2	0.030
Acceptance	47.348	2	0.000
Confidentiality	15.526	2	0.000
Appreciation	17.372	2	0.000
Encouragement	18.957	2	0.000
Spiritual nourishment	6.767	2	0.031

4.5.2. Psycho-Social Needs Of OVC By Caregivers

The psycho-social needs of OVC identified by caregivers were: isolation (44.4%), lack of leisure activities (37.8%), lack of friends (30%) and stigma (18.9%)

(Table 4.26)

Table 4.26 Psycho-social needs of OVC by caregivers

Psycho-social need	Caregivers	
	N	%
Social isolation	40	44.4
Lack of friends	27	30.0
Mistreatment by others	18	20.0
Lack of leisure activities	34	37.8
Stigmatised	17	18.9

4.5.3 Frequency Of Visitors To The OVC

The most frequent visitors to OVC were relatives (41.1%) while the least frequent visitors were Faith Based Organisation groups (54.4%) and volunteers (56.7%). However, medical personnel did not visit at all (Table 4.27)

Table 4.27 Frequency of Visitors to the OVC

Visitors	Daily		Weekly		Monthly		Never	
	N	%	N	%	N	%	N	%
Relatives	37	41.1	23	25.6	26	28.9	4	4.4
Friends	20	22.2	42	46.7	16	17.8	12	13.3
Neighbours	23	25.6	32	35.6	21	23.3	14	15.6
Religious groups	0	0.0	0	0.0	41	45.6	49	54.4
Medical personnel	0	0.0	0	0.0	0	0.0	90	100.0
Volunteers	18	20.0	10	11.1	11	12.2	51	56.7

4.5.4. Visitors To OVC

Sixty one point one percent (61.1%) of the respondents had visitors who used to visit the OVC but no longer did. The largest group that had stopped visiting were church members (72.7%) (Figure 4.16).



Figure 4.16: Number of visitors who stopped visiting the OVC

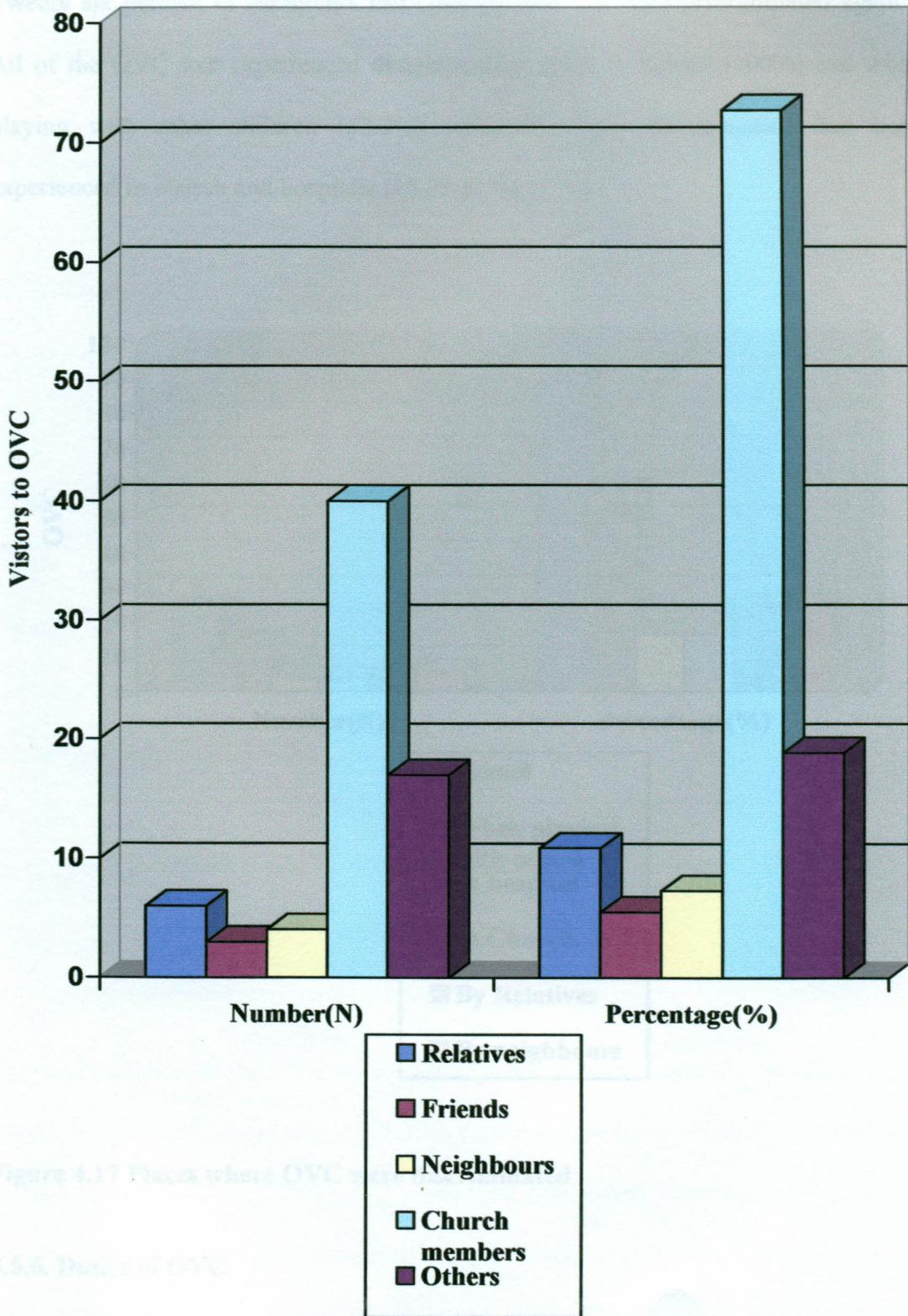


Figure 4.16 Visitors who stopped visiting the OVC

4.5.5. Discrimination Against OVC

Twenty six percent of caregivers had children who had been discriminated against. All of the OVC had experienced discrimination while in school (100%) and when playing with other children (58.3%) while the least discrimination had been experienced in church and hospitals (16.7%) (Fig.4.17).

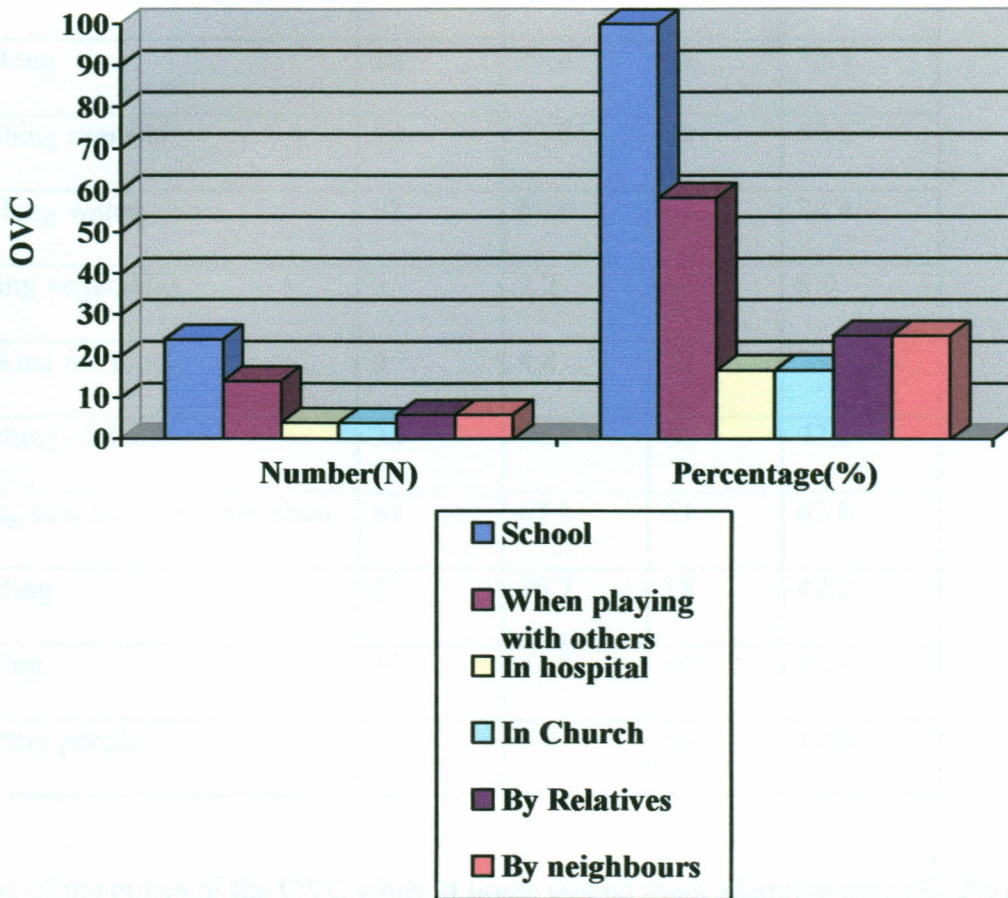


Figure 4.17 Places where OVC were discriminated

4.5.6. Duties of OVC

Sixty eight point nine (68.9%) of the boys and 74.4% girls fetched water. However, girls performed most of the duties, which also included: cooking (73%), washing

utensils (75.6%) and washing clothes (73.3%). They were also involved in taking care of other siblings (48.9%) and looking for food for the family (33.3%) (Table 4.28)

Table 4.28 Duties of OVC

Activity	Boys		Girls	
	N	%	N	%
Taking care of siblings	27	30.0	44	48.9
Cooking	16	17.8	66	73.3
Washing utensils	30	33.3	68	75.6
Fetching water	62	68.9	67	74.4
Selling vegetables	2	2.2	8	8.9
Looking for food	4	4.4	30	33.3
Washing clothes	33	36.7	66	73.3
Being sent to the market/shop	61	67.8	61	67.8
Reading	33	36.7	38	42.2
Playing	37	41.1	44	48.9
Visiting people	8	8.9	16	17.8

Some of the duties of the OVC while at home denied them adequate time (82.2%) and energy for academic assignments (63.3%). Consequently these resulted in lack of time to revise school work (77.8%). The study also established from the caregivers that 43.3% of OVC worked in order to earn income for the family while 56.7% did not (Fig 4.18).

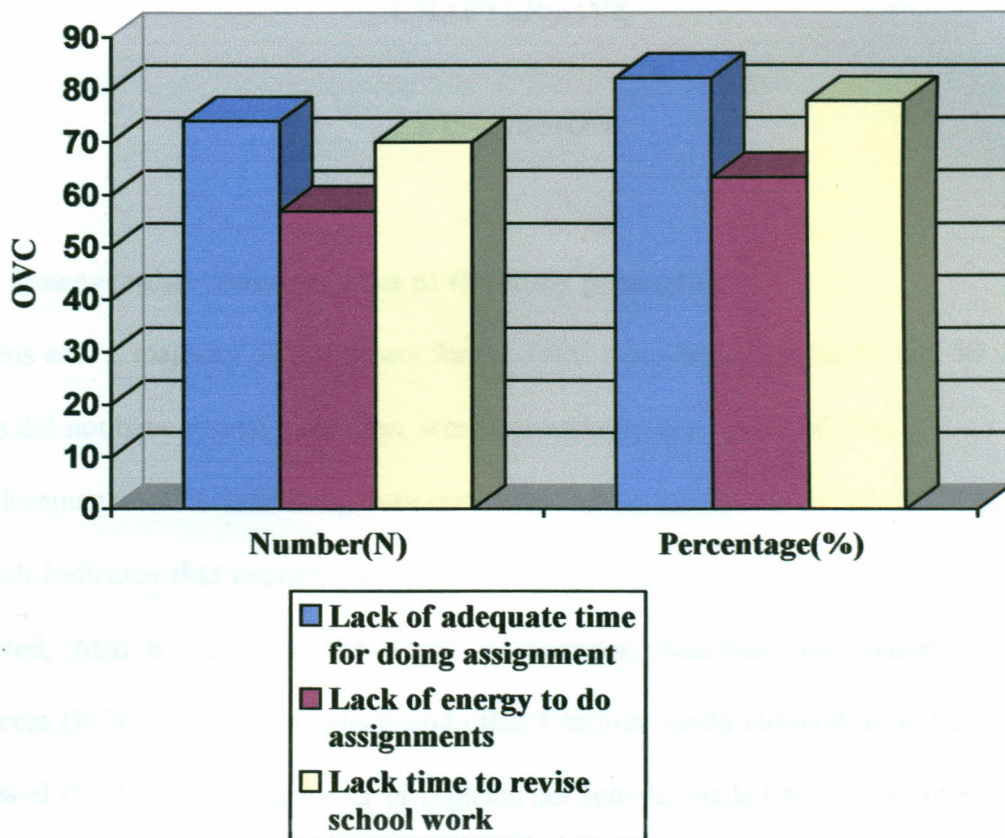


Figure 4.18 Effects of household duties on OVC

CHAPTER FIVE

DISCUSSION

5.1. Demographic characteristics of the study population

In this study, majority of caregivers for the OVC were females aged 41 and 50 years, who did not have formal education, were unemployed and widowed. The predominance of female caregivers compares well with reports by UNAIDS (2006), which indicates that orphans are more likely to live in households that are female-headed. Also a report on the Rapid Assessment, Analysis and Action Planning Process (ROK, 2004) for Orphans and other Children made vulnerable by HIV/AIDS showed that the average number of orphans per female headed household in Kenya is 2.1 compared to 1.8 orphans in the male-headed house-holds. These findings may also be due to the fact that majority of the population in Mwingi District are females (ROK, 2002-2008). The demographic results suggest that women have been left with the burden of caring for orphans while males aged 41-50 years have migrated to towns in search of employment. The results of this study showed that majority of the OVC had lost both parents (50%). Among other reasons, the death of both parents could have been as a result of the HIV/AIDS pandemic. These findings are in agreement with the Kenya Demographic Health Survey which established that approximately 11% of all children under 15years were orphans. Nationally 2% of these children have lost both parents, 9% have lost their fathers and 4% mothers (KDHS, 2003).

5.2. Educational Needs and Constraints of the OVC

This study revealed that despite the Free Primary Education (FPE) introduced by the Government of Kenya in 2003, where an additional one million children enrolled in primary school, 15% of the OVC within Central Division of Mwingi District did not attend school. The reasons given by the caregivers for non school attendance of OVC were lack of school uniforms (62.5%), lack of school levies (43.8%), looking after siblings (37.5%) and working in order to earn income to feed the family (37.5%).

The male OVC in this study did not attend school due to lack of school uniform (63.6%), working in order to earn income to feed the family (63.6%) and looking after other siblings. Among the female OVC the main reasons for non-school attendance were lack of school uniform (63.6%), working in order to earn income for the families (33.3%), looking after other siblings (33.3%) and taking care of sick parents (3.3%).

There was a significant difference between school attendance between girls and boys ($\chi^2 = 11.203$ $df=3$ $p = 0.01$) (Table 4.8).

These findings are in agreement with those of Mandela (2004), who reported that despite the introduction of free primary education by the Kenyan government in 2003, many orphans and other vulnerable children in Kisa Location of Butere-Mumias District Kenya did not attend school because their families lacked funds to meet school levies and to purchase school necessities such as school uniforms and books. A UNAIDS report (2002a), expressed fears that up to 47% of AIDS orphans drop out of school within 12 months of parent's death in sub-Saharan Africa. According to the KDHS (2003), school drop out rates in primary schools were 5.4%. Of all the children, 92% of those with both parents were in school, while only 88% double orphans were in school. A study carried out in Tanzania, noted that school attendance

for children whose parents were alive and lived with at least one of them was 71%, but in the case of double orphans, it was only 52% (UNAID 2004)

The current study revealed that most of the OVC from households with more than seven children did not attend school as they took care of other siblings. These findings concur with Bunyi (2000), who reported that orphans failed to attend school because they had to take care of their younger brothers and sisters and to undertake household duties. This was especially common among orphans from large families. In addition, the current study showed that all those OVC who did not attend school were under the care of unemployed caregivers. The number of siblings in the household and the occupation of caregivers influenced school attendance among the OVC. Caregivers who had no formal education and those with primary level education may have assumed that education was not very important for the OVC since they were not educated themselves. Ainsworth *et al.* (2002) in their study found that in house holds with an adult death, children participating in house work rose from 51% to 59%.

The results further established that the majority of those OVC who attended school encountered challenges. The main constraint reported was lack of school uniforms. This suggests that despite the government providing free education, guardians and parents have the obligation of availing uniforms. However, the results revealed that caregivers were unable to provide the uniforms. The results of this study suggest that scaling up of assistance to schools by the government and other agencies operating within Central Division of Mwingi District is necessary if OVC are to remain in school without interruptions.

Results from this study indicated that the OVC mostly fetched water and were sent to the shops. However, girls performed most of the activities, which also included cooking, washing utensils and washing clothes. The girls were also involved in taking care of other siblings and looking for food for the family. The results of this study are in agreement with the findings of Mandela (2004) in a study carried out at Kisa Location, Butere District where a large number of orphans especially girls were forced to perform household activities that were otherwise carried out by parents. Some of these activities denied OVC adequate time and energy to do academic assignments and to revise school work. In this study, 57.1 % of the OVC had to work to earn income for family upkeep. This denied them the opportunity to attend school. Saoke and Mutemi (1995) noted that even if orphans were not discriminated against where they were fostered due to death of their parents, they were made to work in the house holds and in farms. This denied them ample sleep and food.

5.3. Health needs and constraints of the Ovc

From the results obtained in this study, majority of the OVC rarely or occasionally fell sick. The most common sickness was malaria. This suggests that the OVC were exposed to conditions that made them vulnerable to malaria infections. These results could imply lack of health education among the community members on malaria control measures. Saoke and Mutemi Roslyn (1994) concur with this implication. There is need to provide health education to children and caregivers to avoid malaria infection.

In this study, there was good health seeking behaviour as most of the OVC (91%) reported that they sought medical treatments whenever they fell sick. Majority of

them were taken to hospital by their grandparents (27%) or their mothers (30%). These results suggest that the health needs of OVC are provided by caregivers and that there is need to empower them.

The main reasons cited by those who did not receive medical attention included lack of drugs in hospitals, lack of money for purchasing drugs and overcrowding in hospitals. The loss of one or both parents denied the OVC access to medical care. This is in contravention to the right to medical care as stipulated in the United Nations Convention on the Rights of Children, the African Charter on the rights and welfare of children, and the Kenyan children's Act (2001). Non orphaned children have a possibility of seeking medical care from private services. More often than not, OVC come from low income families where the deceased parents rarely leave behind a medical cover scheme. These findings compare well with the findings of Saoke and Mutemi (1994) who noted that children who fell sick were at risk of not receiving medical attention since they did not have money to pay in the dispensaries or for private consultations. Where a prescription was available in the dispensaries or hospitals, medicine was unavailable and had to be bought from private pharmacies and orphans did not seem to afford it.

An analysis of frequency of medical check among the OVC revealed that most caregivers did not take OVC for any check up regardless of their medical status. This may be due to lack of money, commitment and ignorance of caregivers. The findings further revealed that female caregivers, those who lacked formal education, the unemployed and caregivers with large number of children under their care were less likely to take OVC for medical check up. These results suggest that education, a

source of income and the number of dependants greatly influenced health seeking behaviour for the OVC by caregivers. These results compare with a quantitative study carried out in Masaka Uganda (Brouwer, 2000) in which caretakers of OVC expressed difficulties visiting health services or clinics regularly. They cited lack of money for transport, their own illness, lack of time, or hesitation about the usefulness of regular visits.

In investigating the medical care needs of OVC, majority of them lacked medical check up, adequate nutrition and drugs. However, the highest percentage of them who met medical care need among the OVC was home based care while sick. This could be due to the fact that care givers could not afford the cost-sharing fees required for surgery in hospitals. A study conducted in the district of Morogoro, Tanzania, which was sponsored by a religious institution in household's own premises, found that people do not visit health facilities in the district, particularly in government hospitals, with a preference in household's own premises. This is due to the fact that people do not have a ready cashed out as a result, where a family member worsened, when a person is ill, he will as far as possible, be cared for at home. There was a direct relationship between adequate nutrition and income. In this study, OVC whose care givers were unemployed had difficulties in obtaining a balanced diet. These results compare with the finding of a needs assessment report in Mbeya municipality Tanzania (URTZ, 2002) where children were found to be frequently afflicted with various infections due to general lack of food and a balanced diet.

5.4. Physical needs and constraints of the OVC

The most pressing physical needs among the OVC were food and clothing. This implies that in the marginal area of Central division of Mwingi district, the loss of a parent translates to lack of basic needs with the exception of shelter which quite often than not exists before the demise of the parent(s). These results suggest that there is need for social support in the provision of the basic needs in this area in order to reduce the vulnerability of OVC.

Nutritional status and health outcomes among orphaned and vulnerable children are influenced by equitable access to food. Evidence that food security is threatened among orphaned families is building in rural and urban settings. In a rural house hold survey in Kenya, it was established that the death of a prim-aged male household head was associated with a reduction in household's crop production by 47 to 68%. Female adult mortality also contributed to this decline, particularly in grain crops. These findings also concur with a study carried out in Rwanda, where a family's diet worsened when a father was ill as well as after his death; the same occurred with mother's illness and death though with less severity (Donavan, *et. al.* 2003). Without adequate diet, FAO reports that poor farmers are dying before they can transfer agricultural knowledge and skills to their children. Among households headed by orphans in Kenya, only a small fraction (7%) had work force for agricultural production (FAO, 2002), suggesting that OVC accessibility to food is threatened. The situation is worse for the OVC who are infected with HIV since inadequacy of these physical needs particularly food and clothing compromises their health status. According to Bijlsma (2000) children infected with HIV/AIDS need to be provided with a variety of food and nutritional supplements to improve their immune status.

In this study, all the physical needs (shelter, clothing and food) were moderately met. It was also noted that most of the OVC shared beddings. The inadequacy in meeting basic needs among the OVC is likely to have a negative impact on the holistic development of these children. Soake and Mutemi (1996) observed that clothing is one of the basic needs that children must have to ensure good health for adequate growth and development. Clothing covers nakedness, promotes cultural values, identifies sex of the child and protects the body from adverse weather conditions.

The factors of the issue

In this study, the OVC who had unmet physical needs were those under caregivers who were unemployed and those with more than seven children in the household. This implies that in providing any assistance to OVC these variables must be taken into consideration. Lack of employment denied the caregivers reasonable income to meet the physical needs of the OVC under their care.

Source of Physical and Personal Care

The main providers of physical needs were relatives, mothers and grandparents. These results suggest that communal support may be the correct approach to sustained management of physical needs of OVC.

The results of the study

5.5. Psycho-social needs of the OVC

From the results of this study, the most pressing psychosocial needs of the OVC were parental guidance, love and affection (Table 4.24). The emotional loss suffered by death of a parent is great. In most cases, caregivers of OVC have no knowledge on the need for guidance and mainly focus their efforts on physical needs at the expense of the psychological well being of the children. Clive (2000) reported that many OVC watch as their parents are devastated by HIV and AIDS, leaving them to face societal

stigma. The OVC suffer anxiety and insecurity concerning their future. The fragile environment in which OVC live suggests that these children need proper emotional support as well as unconditional love and affection. These findings compare favourably with Mandela (2004), who reported that many orphans in Kisa location of Butere District, Kenya missed their parents and kept remembering the love, affection and protection their parents provided before their death.

The findings of this study further showed that some of the OVC had suffered discrimination in school while playing with other children. According to Foster (2002), stigma and discrimination intensify violation of these children's rights and in particular their access to education, social services, community and familial support. Many orphaned children experience anger, guilt and fear for their future. This can lead to post-traumatic stress, syndrome, alcohol and drug abuse, aggression and even suicide. These results agree with those of Boler and Carroll (2003), who reported that orphans were discriminated against in schools and by other children because they lacked adequate uniform and learning materials.

The results of this study showed that the OVC with the most pressing needs of parental guidance, love and affection were those who had lost their mothers or both parents. Mothers enjoy closeness with their children as compared to fathers. Therefore the death of the mother denies children the close affection.

CHAPTER SIX

CONCLUSIONS AND RECOMENDATIONS

6.1. Conclusions

From the results of this study the following conclusions can be made:

1. The needs of orphaned and vulnerable children within Central Division of Mwingi District were education, food, medical care and psychosocial care.

2. Fifteen percent of the OVC within the Central Division of Mwingi District do not attend school. The main reasons for non school attendance by the OVC were lack of school uniforms, taking care of other siblings and working to earn income to take care of family needs.

2. The majority of the sampled OVC (72.2%) do not receive medical services due to lack of money, lack of drugs, and overcrowding in hospitals. The most affected were those under the care of female and unemployed caregivers.

3. The main providers of the physical needs for the OVC were relatives, mothers and grandparents. The pressing physical needs of the OVC were food and clothing. The most affected were those OVC under the care of unemployed caregivers and those with a large number of children in the household.

4. The most pressing psychosocial need of the OVC was parental guidance, love and affection. The children most affected were those who had either lost their mother or both parents.

5. The constraints in the provision of needs of the OVC in Central division of Mwingi district were lack of money and the high number of siblings under the caregivers.

Based on the findings of this study, the following recommendations can be made:

- i. There is need for increased efforts by all stakeholders to ensure that the identified needs are met adequately.
- ii. These results suggest that there is need to ensure community care for other siblings at school.
- iii. There is need for increased efforts to mitigate the financial needs that provision is needed within the Central Division of Mwingi District.
- iv. There is need for more programs to specifically address the constraints experienced in the provision of needs of OVC within the central Division of Mwingi District.
- v. There is need for increased community support may be the correct approach to address the financial and physical needs of the OVC.

6.3 Suggestions for Further Research

- i. This study was conducted in only one Division in Central division of Mwingi District. There is therefore need to replicate this study in other divisions in Kenya.
- ii. A comparative study between rural and urban areas should be carried out to determine whether there are differences in the needs of the OVC.
- iii. There is need for more studies to determine the particular needs of children living with HIV/AIDS.

6.2. Recommendations

Based on the findings of the study, the following recommendations can be made:

- i. There is need for concerted efforts by all stakeholders to ensure that all the identified needs are met adequately.
- ii. These results suggest that there is need to provide OVC with school uniforms, ensure community care for other siblings and a secure means of sustaining OVC in school.
- iii. There is need for a multi-sectoral response to mitigate the factors influencing provision of needs of OVC within the central Division of Mwingi District.
- iv. There is need to initiate programs to specifically address the constraints experienced in the provision of needs of OVC within the central Division of Mwingi District.
- v. These results suggest that communal support may be the correct approach to sustained management of the physical needs of the OVC.

6.3. Suggestions for Future Research

- i. This study was conducted in only one Division in Central division of Mwingi District. There is therefore need to replicate this study in other districts in Kenya.
- ii. A comparative study between rural and urban areas should be carried out to determine if there are differences in the needs of the OVC.
- iii. There is need for a study to determine the particular needs of children living with HIV/AIDS.

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It is important to understand the needs of orphans and other children affected by HIV and AIDS in Africa. This is because they are the most vulnerable group in the population. They are often left behind when their parents die of AIDS. They may not have anyone to take care of them. They may not have enough to eat. They may not have a place to live. They may not have access to education. They may not have access to health care. They may not have access to social services. They may not have access to legal services. They may not have access to financial services. They may not have access to information services. They may not have access to recreational services. They may not have access to cultural services. They may not have access to religious services. They may not have access to spiritual services. They may not have access to emotional services. They may not have access to psychological services. They may not have access to social services. They may not have access to legal services. They may not have access to financial services. They may not have access to information services. They may not have access to recreational services. They may not have access to cultural services. They may not have access to religious services. They may not have access to spiritual services. They may not have access to emotional services. They may not have access to psychological services.

Section A: Demographic and Personal Details

1. Name

Age	
-----	--

2. Sex

Have lost both parents	
Have lost father	
Have lost Mother	

3. How long have you been an orphan?

1 year	
2 years	
3 years	
4 years	
5 years	
6 years	
7 years	
8 years	
9 years	
10 years	
11 years	
12 years	
13 years	
14 years	
15 years	
16 years	
17 years	
18 years	
19 years	
20 years	
21 years	
22 years	
23 years	
24 years	
25 years	
26 years	
27 years	
28 years	
29 years	
30 years	
31 years	
32 years	
33 years	
34 years	
35 years	
36 years	
37 years	
38 years	
39 years	
40 years	
41 years	
42 years	
43 years	
44 years	
45 years	
46 years	
47 years	
48 years	
49 years	
50 years	

APPENDIX

APPENDIX 1: QUESTIONNAIRE FOR ORPHANS

Hello, my name is Patricia Mwendu from Kenyatta University. I am a Public Health student carrying out a survey on the care given to OVC in Mwingi District. Your answers will remain confidential and I will not take down your name or address so that no one will know you gave me these answers. There are no correct answers and each of your answers will depend on your views and your situation.

Section A: Demographic characteristics

1. Gender

Male	
Female	

2. Your age

6-10 years	
11 - 15 years	
16 - 18 years	

3. Type of Orphan

Have lost both parents	
Have lost Father	
Have lost Mother	

4. For how long have you been an orphan?

Less than 1 year	
1-3 years	

Yes	
No	

6. If yes, how many are you?

Brothers	
Sisters	
Total	

7. With whom do you reside at home?

Mother	
Father	
Grand parent	
Other relatives	
Guardian	
Others (specify)	

Section B: Education Needs

8. Do you go to school?

Yes	
No	

9. If yes, how regular?

Very regular	
Regular	
Occasionally	
Rarely	

10. What class are you?

Class 1-3	
Class 4-5	
Class 6-8	

Lack of school fees	
Lack of books and stationery	
Lack of school uniform	
I take care of my sick parent	
Look after other siblings	
Work in order to earn income to feed the family	
The person I leave with removed me from school to perform other household chores	
Others (specify)	

11. If you don't go to school, what is the reason(s)? Tick the ones that apply to you

12. If you go to school, do you have books and stationery for use in school?

Yes	
No	

13. If yes, how adequate are the books and stationery?

Very adequate	
Adequate	
Average	
Inadequate	

Very inadequate	
-----------------	--

14. Who buys your books and uniforms?

Mother	
Father	
Grand parent(s)	
Other relatives	
Church	
NGOs	
Others (specify)	

15. Do your brothers and sisters go to school?

Yes	
No	

16. How do you rate their school attendance?

Very regular	
Regular	
Average	
Irregular	
Very irregular	

Section C: Health Needs

17. How often do you get sick?

Very often	
Often	
Average	
Rarely	

Very rarely	
-------------	--

18. What kind of illness do you often suffer from?

Diarrhoea	
Stomach-ache	
Coughing	
Malaria	
TB	
Scabies	
STDs	
Others (specify)	

19. Do you go to hospital when you are sick?

Yes	
No	

20. If you go to hospital, who takes you to hospital?

Mother	
Father	
Grandparent(s)	
Sibling (brother or sister)	
Relative	
Church member(s)	
Guardian	
NGO	

21. Do you get medical services at the hospital?

Yes	
No	

22. How effective are the services in terms of treatment

Very effective	
Effective	
Average	
Ineffective	
Very ineffective	

23. If you don't get medical services (treated), what is the reason?

Lack of money	
Overcrowding in hospital	
Lack of enough drugs in the hospital	

24. If no, where do you go to when you are sick?

Buy drugs from the chemist	
Go to a herbalist	
I prayed for	
Do nothing	
Others (specify)	

25. What are some of your pressing medical needs?

	Very pressing	Pressing	Average pressing	Least pressing	Not pressing at all
Drugs					
Medical check-up					
Care at home when sick					
Vitamin supplement					
Proper nutrition					
Others (specify)					

25. How adequate are these pressing medical needs met?

	Very adequate	Adequate	Average	Inadequate	Very inadequate
Drugs					
Medical check-up					
Care at home when sick					
Vitamin supplement					
Proper nutrition					
Others (specify)					

Section D: Physical Needs

27. What are some of your pressing physical needs?

Food	
Clothing	
Shelter (housing)	
Others (specify)	

28. How adequate are these physical needs being met?

	Very adequate	Adequate	Average	Inadequate	Very inadequate
Food					
Clothing					
Shelter (housing)					
Others (specify)					

29. Who meets these needs?

	Food	Clothing	Shelter (housing)	Others (specify)
Self				
Mother				
Father				
Grandparent(s)				
Relative(s)				
Guardian				
Church member(s)				
NGOs				

Government				
Others (specify)				

Section E: Psycho-social Needs

30. What are your pressing psycho-social needs?

Protection from exploitation	
Parental guidance	
Love and affection	
Opportunity to play	
Acceptance	
Confidentiality	
Appreciation	
Encouragement	
Spiritual nourishment	
Others (specify)	

31. How often are these needs met?

	Very often	Often	Occasionally	Seldom	Never
Protection from exploitation					
Parental guidance					
Love and affection					
Opportunity to play					
Acceptance					
Confidentiality					
Appreciation					
Encouragement					
Spiritual nourishment					
Others (specify)					

32. Who meets these needs?

	No body	Mother	Father	Grand parent	Relative	Guardian	Church	NGO	Government	Others specify
Protection from exploitation										
Parental guidance										
Love and affection										
Opportunity to play										
Acceptance										
Confidentiality										
Appreciation										
Encouragement										
Spiritual nourishment										
Others (specify)										

33. Do you share your problem with anyone?

Yes	
No	

34. If yes, with whom do you share your problem?

Mother	
Father	
Brother	
Sister	
Grandparent	
Relative	
Guardian	
Friend	
Church member	
Teacher	
Others(specify)	

Section F: General Information

25. Do you get support from anywhere?

Yes	
No	

26. What support do you receive?

Food	
Clothing	
Shelter	
School fees	
School uniform	
Books and stationery	
Counselling	
Protection from abuse and exploitation	

Others (specify)	
------------------	--

27. Name the source of support

	Relatives	NGO	Government	Well wishers	Church	Friends	Others (specify)
Food							
Clothing							
Shelter							
School fees							
School uniform							
Books and stationery							
Counselling							
Protection from abuse and exploitation							
Others (specify)							

28. Are you satisfied with the support you get?

Yes	
No	

29. Are you involved in any income generating activity?

Yes	
No	

30. If yes, what kind of activity?

Working for someone as house help	
Looking after animal for pay	
Selling items in the market centre e.g. vegetables, groundnuts	
Doing manual work for pay e.g. working in a shamba	
Doing odd jobs	
Others (specify)	

32. When do you carry out these activities?

Others (specify)	
------------------	--

32. When do you carry out these activities?

Throughout the day	
In the evening after school	
Over the weekends	
During school holidays	
When demand calls	
Others (specify)	

33. Do you like doing these activities?

Yes	
No	
I have to	

APPENDIX 2: QUESTIONNAIRE FOR CAREGIVERS

Hello, my name is Patricia Mwendu from Kenyatta University. I am a Public Health student carrying out a survey on the care given to OVC in Mwingi District. Your answers will remain confidential and I will not take down your name or address so that no one will know you gave me these answers. There are no correct answers and each of your answers will depend on your views and your situation.

Section A: Demographic Characteristics

1. Gender

Male	
Female	

2. Your age

Below 20 Years	
20-30 Years	
31-40 Years	
41-50 Years	
50 Years and Above	

3. Level of education

Non-literate	
Primary level	
Secondary level	
Tertiary level e.g. college, university	

4. Marital Status

Single	
Married	

Divorced	
Widowed	

5. Occupation

Unemployed	
Self-employed	
Casual labourer	
Civil servant	
Private organisation/company	
Others (specify)	

6. Religious Affiliation

Catholic	
Protestant	
Muslim	
Others	

7. How many children live in your household?

1-2	
3-4	
5-6	
7-8	
Over 8	

8. Among the children, do you have orphans? 01 Yes () 02 No ()

9. If yes, how many orphans do you care for under the following age groups?

	Under 5 years	6-10 years	11-15 years	Over 15 years
1-2				

3-4				
5-6				
7-8				
Over 8				

10. Are you related to the orphans? 01 Yes () 02 No ()

11. If you are related to the orphans under your care, state how you are related to them

Mother	
Father	
Aunt	
Uncle	
Cousin	
Brother/Sister	
Grandparent	
Nephew	
Others (specify)	

Section B: Nutritional Assessment

12. Do you have enough food to give the orphans?

Yes	
No	

13. What are some of the food the orphans took yesterday for breakfast, lunch and dinner?

	Food
Breakfast	
Lunch	

Dinner	
--------	--

14. Are you the one who provide all the food to the orphans?

Yes	
No	

15. If yes, do you face problems in getting the food?

Yes	
No	

16. What problems do you encounter?

Section C: Bedding and Clothing

17.

	Yes	No
Do the orphans under your care have bedding?		
Do your orphans have bedding?		
Do they have blankets?		
Do they have night gowns/ sleeping cloths?		
Do they have bed sheets?		
Are there any of your orphans with health problems that is worsened by cold weather		
Have you improved on the sleeping arrangement to avert adverse health		

outcomes for the above orphans?		
Do they share bedding?		
How many orphans share a sleeping mat/mattress/bed?		
Do they share rooms?		

Section D: Health Needs Assessment

18. Do you take the orphans for regular medical examination?

Yes	
No	

19. How often are the orphans examined?

3 Months	
Every 6 months	
Once a year	
Very irregularly	

20. What are some of the problems the orphans face in terms of the following?

Lack of medicine	
Lack of medical facilities e.g. clinics	
Lack of medical personnel	
Distance to the nearest health facility is far	
Others (specify)	

Section E: Psycho-social Needs

21. What are some of the social problems the orphans Face?

Social isolation	
Lack of friends	

Lack of leisure activities	
Mistreatment by others	
Stigmatised	

22. How often do visitors come to visit?

Visitors	Daily	weekly	Monthly	Never
Relatives				
Friends				
Neighbours				
Religious groups				
Medical personnel				
Volunteers				
Others (specify)				

23. Who visited you in the last one week?

Visitors	
Relatives	
Friends	
Neighbours	
Religious groups	
Medical personnel	
Volunteers	
Others (specify)	

24. Are there people who used to visit you but who no longer comet? 01 Yes () 02

No ()

25. If yes, who are they?

Relatives	
Friends	
Neighbours	
Church members	
Medical personnel	
Others (specify)	

26. Have the children ever been discriminated against? 01 Yes () 02 No ()

27. If yes, where?

In school	
When playing with others	
In hospital	
In church	
By relatives	
By neighbours	
Others (specify)	

Section F: Education Needs

28. Do all the orphans under your care go to school?

Yes	
No	

29. If no how many don't go to school?

Number that go to school	
Number don't go to school	

30. If there are those who don't go to school what are the reasons why they don't go?

Lack of school fees	
Lack of books and stationery	
Lack of school uniform	
I take care of my sick parent	
Look after other siblings	
Work in order to earn income to feed the family	
The person I leave with removed me from school to perform other household chores	
Others (specify)	

31. For those who go to school, do you experience any problem in educating them?

Yes	
No	

32. If yes, identify the problems?

Lack of fees	
Lack of Uniform	
Lack of Writing materials e.g. pens, books	
Others (specify)	

Section G: General Information

33. What are some of the activities the children engage in while at home?

Activity	Boys	Girls
Taking care of siblings		
Cooking		
Washing utensils		
Fetching water		
Selling vegetables		

Fetching water		
Selling vegetables		
Looking for food		
Washing clothes		
Being sent to the market/shop		
Reading		
Playing		
Visiting people		
Others (specify)		

34. How do these activities interfere with their school/academic work?

Lack of adequate time for doing assignment	
Lack of energy to do assignments	
Lack time to revise school work	

35. Are there any children in the household who work to earn income for the family?

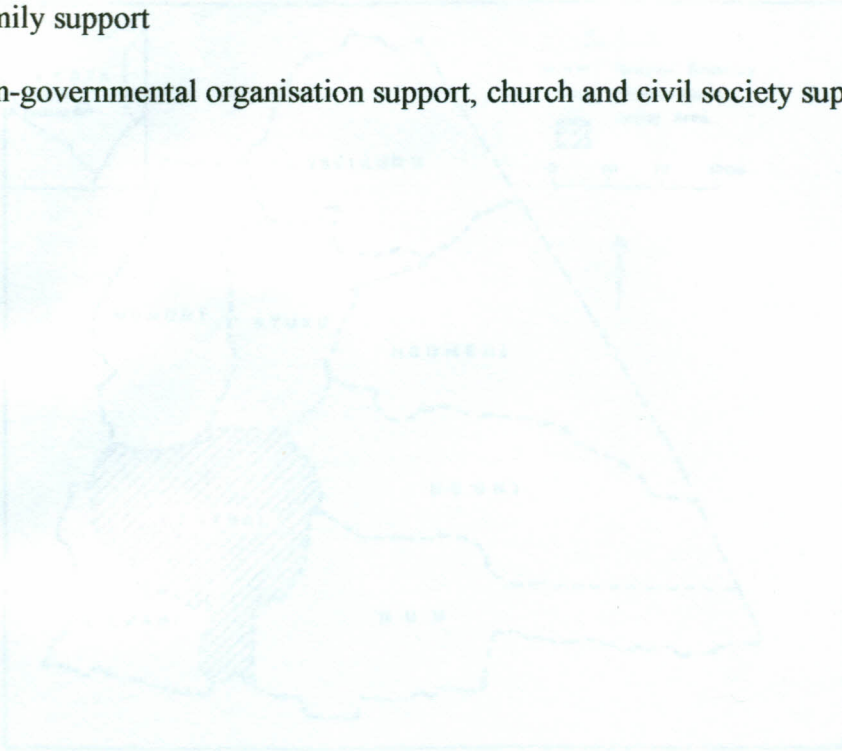
01 Yes () 02 No ()

36. If yes, what kind of work?

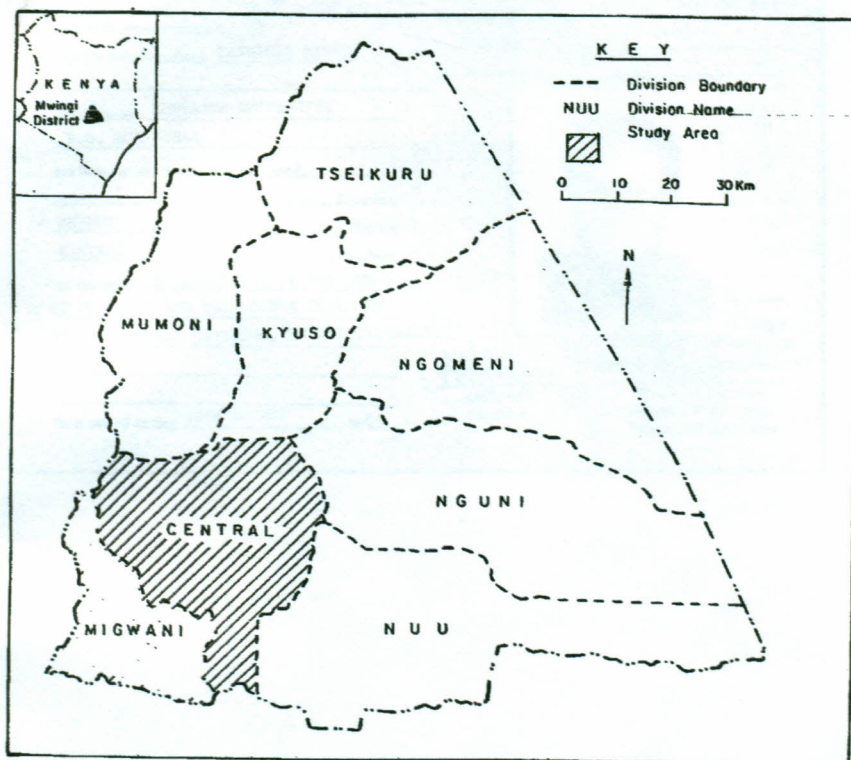
Child's position by birth	Gender	Age	Type of work

Interview Schedule

1. Health
2. Educational
3. Nutritional
4. Psychosocial needs
5. Family support
6. Non-governmental organisation support, church and civil society support



APPENDIX 3 : MAP OF MWINGI DISTRICT



APPENDIX 4 RESEACH AUTHORIZATION

APPENDIX 4 RESEARCH AUTHORIZATION

Page 2

This is to certify that: **Prof. Dr. M. Mwalimu PATRICIA MWEMBE**

of (Address) **KENYATTA UNIVERSITY**
P. O. BOX 43844

has been permitted to conduct research in _____
 Location **Dharam**
MURANGI
 District **Dharam**
EASTERN Province

on the topic **AN ASSESSMENT OF THE NEEDS OF ORPHANED AND VULNERABLE CHILDREN OF ORPHANED AND VULNERABLE CHILDREN**

VICTORIA CENTRAL DIVISION, MURANGI DISTRICT.


for a period ending **30TH AUGUST** . **2006**

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Research Permit No. **MOEST 13/004/35C 437**

Date of issue **25 - 08 - 2005**

Fee received **SHS 500**



Mwalimu Patricia Mwendu
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 Applicant's Signature
 FOR
 Permanent Secretary
 Ministry of Education,
 Science and Technology