CHALLENGES AND STRATEGIES FOR COPING WITH THE ORPHAN PROBLEM AT FAMILY LEVEL: A CASE STUDY OF CAREGIVERS IN BUSHENYI DISTRICT.

BY

AHIMBISIBWE WAMANYA

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DECLARATION

I, **Ahimbisibwe Wamanya** declare that this dissertation is original; it has not been published or submitted for any other degree to any university or institution of higher learning before.

Signed _____ Date_____

AHIMBISIBWE WAMANYA

This dissertation has been submitted with the approval of the Supervisor below:

Signed _____ Date _____

DR. NARATHIUS ASINGWIRE

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ACRONYMS

ADF	Allied Democratic Front
AIDS	Acquired Immune Deficiency Syndrome
FAO	Food and Agricultural Organization of the United Nations
GOU	Government of Uganda
HIV	Human Immuno-Deficiency Virus
ICOBI	Integrated Community Based Initiatives
ILO	International Labour Organisation
MOGLSD	Ministry of Gender, Labour and Social Development
MS	Microsoft
NGO	Non-Governmental Organisation
NRA	National Resistance Army
NSPPI	National Strategic Programme Plan of Interventions
OVC	Orphans and other Vulnerable Children
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UNAIDS	United Nations Joint Programme of AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UPE	Universal Primary Education
USAID	United States Agency for International Development

OPERATIONAL DEFINITION OF CONCEPTS

Orphan	A child below eighteen years of age who has lost one or both parents.
Vulnerable Children	Children who are not necessarily orphaned but are living in conditions of profound destitution and vulnerability.
Caretaker	A person, regardless of age, who has the primary responsibility for providing care to a child in a home.
Family	A group of people bound by kinship, which provides for the rearing of children and meeting other mutual needs of its members.
Extended family:	Individuals who by birth, marriage, or declared commitment share deep personal connections and are mutually entitled to receive and obligated to provide mutual support of various kinds to the extent possible, especially in times of need.
Coping	The ability to successfully preserve an acceptable livelihood in the context of challenging problems and difficulties.
Household	One or more persons who usually live and eat together, whether or not they are related by blood, marriage or adoption; and the individuals recognize each other as members of the same household.
Shelter	The general living conditions for individuals in a household, including physical structures (houses) as well as space, bedding and clothing.
Foster Care	A practice in which children are reared by people other than their biological parents.
Healthcare	All activities aimed at addressing the individual's physical and social needs.
Psychosocial Support	A form of care given to enhance the mental, social, spiritual, and emotional well being of an individual.

ABSTRACT

This study was undertaken to assess the challenges faced by families in caring for the rising number of orphans and coping strategies they use to mitigate the challenges. Using a combination of quantitative and qualitative techniques, the study was conducted among rural caretakers in Bushenyi district. Findings from the study were gathered through semi-structured interviews with 50 caretakers and 52 orphans as well as in-depth interviews with nine community leaders including eight local council leaders and the District Probation and Welfare Officer.

The findings revealed that even in the face of severe socio-economic challenges, there is continued willingness by families to absorb orphans. In fact, some caretakers, particularly grandparents derive satisfaction from offering the care. However, in spite of this willingness, the study found out that orphan care in families is fraught with several challenges whose scale and complexity often exceed the capacity of the families to effectively mitigate. Consequently, most of the needs of orphans are either partially addressed or not addressed at all.

To compound the challenges, majority of caretakers were elderly grandparents and surviving mothers, all depending on subsistence income. Although they were able to provide a secure environment for children, they were to a large extent unable to meet the orphans' psychological, social and basic needs. With little resources at their disposal, caretakers' efforts were devoted to meeting the basic survival needs of the orphans while ignoring investment in initiatives like skills building that ensure long term survival and sustainability.

From the study findings, it can be concluded that while the generosity, commitment and endurance of the families to keep orphans within their traditional family systems even in the face of the most challenging situations was acknowledged, families were realistically not coping with the orphan problem. Findings indicate a reminiscence of a potentially volatile situation with families at the verge of giving way.

Without external assistance, families can at the very best guarantee immediate survival for the children but cannot prepare them to be competitive in future. With the family still regarded as the most prominent current and future source of support for orphans, the study recommends that everything possible should be done to improve its economic capacity to be able to appropriately address the needs of orphans. Initiatives that strengthen the family's capability to earn income, such as those that improve agricultural productivity, linking households to markets for their produce and support for micro-enterprises were highly recommended.

CHAPTER ONE: INTRODUCTION

1.1 Background to the Study

Over the last three decades, the world has witnessed unprecedented upheavals manifesting through civil conflicts, epidemics and natural calamities of varying intensity and scale. As a result, many lives have been lost and maimed, leaving behind thousands of helpless dependants. Children in particular, have become susceptible to social and economic hardships due to loss of parents, illness in the home, displacement and often involuntary neglect. At the end of 2003, there were an estimated 143 million orphans in the world (UNAIDS, 2004). A major contributing factor to these figures is considered to be HIV and AIDS, without which the global number would be declining. In Sub-Saharan Africa, AIDS is said to have increased the number of children orphaned from all causes from 30.9 million in 1990 to 48.3 million by the end of 2005 (UNICEF, 2006).

Uganda has been prone to wars, civil unrest and disasters including road accidents, drought and famine. Uganda has also been severely affected by the HIV and AIDS epidemic, which has exceeded, in terms of cumulative deaths, morbidity and social disintegration, any major war or epidemic in its history. These calamities have together claimed thousands of people, most of them dying in their prime productive ages. Since its recognition in the early 1980's, AIDS alone has killed over 800,000 people and over 940,000 others are estimated to be infected (GOU - Ministry of Health, 2006). In the context of a country with high fertility, high adult mortality translates into a high orphan burden. In 2002, the number of orphans in Uganda was 1.8 million, representing 11.5% of all children in the country (GOU-UBOS, 2002). In 2006, there were an estimated 2.3 million orphans in Uganda, representing 14.8% of all children in the country (GOU - National Household Survey, 2006). This implies that the number of orphans had increased by 3.3% over the four years.

The government of Uganda has responded to the orphan problem by creating a conducive legal and policy framework to enhance protection and care for orphans and other vulnerable children. The Constitution of the Republic of Uganda (1995) and the Children's Statute (1996) are the major legal frameworks in this regard. There are several other legislations including the National Council for Children Statute (1996), the National Youth Council Act (2003), the Local Government Act (1997) and the Succession Act (1964), which explicitly address protection and welfare of children including orphans. The government's Poverty Eradication Action Plan (PEAP) also provides a planning framework for activities that impact on the welfare of children. In line with the PEAP, there are several government sectoral policies such as the Universal Primary Education (UPE), National Health Policy, the Uganda National Program of Action for Children (UNPAC) and the National Council for Children (NCC) that directly address the welfare of children including orphans.

The role of government in direct care and support for orphans in Uganda can be described as nascent and evolving. The Ministry of Gender, Labour and Social Development (MOGLSD) is the official government body charged with providing oversight to the welfare of children including orphans. Subsequent to a nationwide situational analysis of orphans and other vulnerable children in 2002, the MOGLSD developed the National Orphans and other Vulnerable Children (OVC) Policy and the National Strategic Program Plan of Interventions for Orphans and Other Vulnerable Children (NSPPI), both of which provide an intervention framework for both government and non-governmental organizations. However, implementation of the NSPPI has lagged behind. Like elsewhere in Africa, Uganda government's involvement in provision of social welfare services has been hampered by lack of resources and structural adjustment programs that have emphasized direct productive investment and consequently reduction in social spending (Abebe and Aase, 2007).

NGOs and faith based organizations are playing a big role in providing care for orphans and supporting families using a variety of approaches. However, although the scope of needs and challenges faced by orphans is really wide, not many of the NGOs and FBOs undertake interventions in more than one area. Consequently, their services remain largely limited in scope. As noted by Abebe and Aase (2007), NGOs operate with different principles, have limited outreach capacities, are partial, cost-ineffective and do not reach the poorest of the poor.

Ugandan communities have responded to the problem by maintaining orphans and other disadvantaged children with relatives through the extended family networks. Family based care for orphans remains the most dominant approach to addressing the orphan problem in Uganda. Currently one in four Ugandan households fosters at least one orphan, by providing shelter, health care, nutrition, education and other needs (Wakhweya, Kateregga, Konde-Lule , Mukyala, Sabin, Williams and Heggenhougen, 2002). Other studies in Uganda (UBOS/Macro International Inc. 2006; GOU-UBOS 2006) indicate that there is relatively a small number of children living on their own or on the streets. This implies that majority of orphans are still receiving care from their extended families. The Uganda Orphans and other Vulnerable Children Policy (2004) recognizes this community-based approach and emphasizes that the traditional family system, as the basic unit for the growth and development of children, should remain the first line of care for orphans.

The laudable efforts and the un-weathering commitment of families to absorb and care for orphans notwithstanding, there is increasing recognition that many families are weighed down by poverty and consequently the care provided may fall short of expectations. Various studies on orphan care in families (Abebe and Aase, 2007; Kamya and Poindexter, 2009; Mathambo and Gibbs, 2009; MOGLD, 2003), reveal that despite its prominence, the extended family system, without external support cannot provide optimum care to the rising number of orphans.

Eighty eight percent of Ugandans live in rural areas (UBOS 2006), implying that majority of the orphans in Uganda live in rural families.

At the same time, 91% of rural households in Uganda are chronically poor (Uganda Poverty Status Report, 2003). This implies that the bulk of orphans are cared for in families which are seriously impoverished, and the increasing numbers and complexity of orphans' needs are imposing a hefty burden on the already fragile family networks.
This burden in turn affects the quality of care offered to orphans as evidenced by the growing number of orphans not enrolling or completing school, engaging in child labour or living situations where they have limited access to services, emotional care and social protection.

1.2 Statement of the Problem

This study focused on challenges and coping strategies by families in Uganda faced with the orphan problem. Like elsewhere in the world, there have always been orphans in Uganda and the extended families have always incorporated orphans into their own social networks. However, as a result of increased adult mortality due to HIV and AIDS related illnesses, wars and other calamities, the number of orphans has dramatically increased while the capability to generate resources needed for their care has been simultaneously suppressed through loss of the most economically productive adults. Consequently, the capacity of the extended families to absorb orphans has increasingly become overstretched.

The key national policy documents on orphans and other vulnerable children in Uganda provide that ideal orphan care is realized if the child is able to access the key basic needs namely, adequate food and nutrition, education, healthcare, shelter and protection, as well as psychosocial support and love (National OVC Policy 2004; NSSPI 2004).

The policies further indicate that the family remains the prime line of care and support for orphans and that other options should be considered only when there is evidence of total failure or lack of a viable family system.

Accordingly orphans are being absorbed in families already weighed down by poverty, large sizes, social disintegration, loss of productive members and ill health due to HIV infection and age induced chronic conditions. In this context, and given the limited government programs available to directly support orphans, it is of interest to know the challenges that families providing basic care to the rising number of orphans are faced with and the strategies they apply to cope with the problem.

1.3 Study Objectives

1.3.1 General Objective:

The study sought to contribute to the national efforts in strengthening capacity of families to effectively provide care for orphans and other vulnerable children.

1.3.2 Specific Objectives:

The specific objectives of the study were to:

i. Explore the nature of care and support given to orphans in the selected families.
ii. Assess the challenges faced by families in providing care and support to orphans.
iii. Assess the strategies adopted by families to address the challenges associated with orphan care.
iv. Make suggestions for improved orphan care at family level.

1.4 Scope of the Study

This study specifically focused on orphaned children and their caretakers. It assessed the nature of care offered by families to orphans, challenges they face in offering this care and the strategies they adopt to cope with the challenges. The study covered all orphans regardless of the cause of orphanhood. Though there is universally considered merit in distinguishing between the different causes of orphanhood to allow for a better understanding of circumstances, vulnerability and need, this was never deemed useful given the objectives of the study. Similarly, although it was recognized that there were other vulnerable children whose needs and living conditions were in many ways similar and sometimes worse than those faced by some of the orphaned children, cost and time considerations could not permit inclusion of this category of children in the study.

In consideration of the sensitivity of the subject, only orphans aged 13 years and above were enrolled in the study. This choice was made on the understanding that younger children could have difficulty in discussing issues of their late parents and may feel traumatized when engaged in such discussions. Also it is recognized that the orphan problem is widespread affecting all communities in Uganda. However, the study was limited to Bushenyi District in the sub-county of Bugongi due to financial and time considerations.

1.5 Significance of the Study

Given the institutional weaknesses and financial limitations within the Ugandan public sector and the erratic nature of the private sector responses, it is conceivable that families will continue to play a dominant role in providing care and support for orphans and other vulnerable children. However, with the rampant and deepening poverty in communities, increasing number of orphans in need of care, large family sizes and high adult mortality, it is unclear how extended families will continue to successfully play this role.

Therefore, it is important that the challenges faced and strategies used by families in responding to this problem are assessed, understood and documented. This would provide a basis for possible development of appropriate community based orphan care models that would go a long way in strengthening the national response to the orphan problem.

Findings from this study will give insight into the dynamics of orphan care at family level and provide valuable programming input into the public and private sector interventions aimed at uplifting the welfare of orphans and other children in general. The study will also provide valuable information for policy makers and programmers seeking to build the capacity of families and caretakers to provide appropriate care for orphans.

Findings from the study will also assist current Orphans and other Vulnerable Children (OVC) programs in refining and improving their interventions, strategies, and priorities based on the empirical data.

The study further contributes towards increasing the body knowledge and literature on orphans in the Ugandan setting and aims at giving rise to additional and new areas of research into the area of care for orphans and other vulnerable children in Uganda and elsewhere.

1.6 Organisation of the Dissertation

This dissertation is presented in five chapters:

Chapter One presents the background to the study with insights into the context of the orphan situation in Uganda, current interventions and gaps. In addition, this chapter includes the statement of the problem that forms the hub of the study, followed by key objectives and scope of the study. Lastly the significance of the study is presented.

Chapter Two includes literature review, with an analysis of the current literature gathered from various studies on orphan care at family level done in Uganda and elsewhere. The review was done along five core elements of orphan care including food, education, health, shelter and psychosocial support. Gaps in the reviewed literature were assessed to provide a perceptual understanding of the value that this study would add to the existing knowledge. A Conceptual Framework for the study is presented to glean out the main variables of the study and show how they relate to define the study problem.

Chapter Three presents the methodology used in gathering data including the research design and area of the study, approaches used in selecting respondents, as well as methods of data collection and processing.
Also included are measures taken to ensure that the data meet the minimum quality standards and that the study takes cognizance of the national and international ethical considerations.

Chapter Four includes a discussion of the main findings of the study, presented along the four thematic areas, namely: nature of care provided to orphans, challenges faced in offering the care, strategies for coping with the challenges and the perspectives of caretakers on the impact of orphan care on their families.

Chapter Five presents the main conclusions and recommendations drawn from the study findings.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This Chapter presents related literature on orphan care at family level, drawn from studies on orphan care in Uganda and other parts of Africa, mainly the Eastern and Central African regions. It begins with a contextual overview of the care and support for orphans in Uganda, followed by the reviewed literature which is presented according to the three broad themes of the study, namely, care and support available to orphans, challenges families face in offering the care and support and the strategies they use to address the challenges. Under each theme, literature covers five elements of orphan care, namely; food and nutrition, shelter and protection, education, healthcare, and psychosocial support. These elements were the main orphan care constructs assessed in the study as described in the Conceptual Framework.

2.2 Context of Care and Support to Orphans in Uganda

An orphan in Uganda is any child below the age of eighteen years who has lost one or both parents (Wakhweya et al., 2002). This definition, though widely adopted, is fraught with limitations especially in the context of resource constrained environments in which many orphans live. For instance, the use of chronological age ignores many young persons above eighteen years whose parents are deceased and they are bereft of any family or external support. As noted by Chirwa (2002), the definition implies that by merely attaining the age of eighteen years, one automatically transitions from orphanhood to non-orphanhood and consequently ceases to be an orphan. In reality, his/her plight may not be any different from those below that age that live with him/her in a similar environment. In the situational analysis of vulnerable children in Uganda, Kalibala and Elson (2009) indeed found out that use of age as a criterion in providing assistance for education was penalizing teenagers who started school late by excluding them from continued education support once they turned eighteen years old.

Like elsewhere in the world, Uganda has had orphans even before the escalation of disasters, wars and the HIV and AIDS epidemic. Traditionally, the orphans were absorbed within the extended families that bore the responsibility to care for them. The term orphan then had little meaning as one's brothers and sisters were considered to be fathers and mothers of one's children in the real traditional African cultures (Jackson, 2002, Chirwa, 2002). Ntozi and Mikiza-Gapere (1995) further assert that provided an uncle or aunt lived, and was willing to care for the child, the child was not considered an orphan. Meintjes and Giese cited in Abebe (2009) also note that the term 'orphan' is only applicable to a child who has no parent and no substitute caregiver. According to them labeling of a child in this way is not only stigmatizing of the child, but a direct insult to those participants in the social network providing care and support to the child.

The most predominant form of extended family in Uganda is that based on kinship including frontline relatives such as paternal uncles and aunts, as well as paternal and maternal grandparents. These frontline relatives are traditionally responsible for assuming the care of orphans upon the death of parents. Ordinarily, one member of the extended family network assumes the primary caregiver role and others may periodically contribute resources. Similar to other African societies (Abebe and Aase 2007; Mathambo and Gibbs 2009; Nyamukapa and Gregson, 2004), the preference and willingness of families to take in orphans in Uganda and the quality of care they receive thereafter is influenced by emotional imperatives, most significant of which is the bond that existed between the deceased and adopting parents. Orphans will willingly move, integrate fast and feel more secure in adopting families when they know that these family members, particularly the parents, had a good past social relationship with their deceased parents.

Like elsewhere in Africa, the traditional system of childcare in Uganda has transformed in response to major social changes resulting from growing poverty, socio-economic transformation, urbanisation and the increasing number of orphans, all of which seem to weaken the social ties and the traditional philosophy of mutual obligation. However, it remains the only viable mechanism for responding to the orphan problem and partly explains why most orphans are still being cared for by their extended families. Studies on orphan care (Oleke, Blystad, Rekdal and Moland 2007; Subbarao and Coury 2004) further attest to the predominance and appropriateness of the family as the best model for orphan care in Uganda. They contend that keeping orphans in their homes and village environments ensures that they remain loved and protected within their homes, grow up in their cultural and traditional environments, and maintain oversight to their property.

Despite its prominence as the most viable mechanism of orphan care, the family has begun to show signs of distress. For instance when pressed hard, some families have begun to offer differential care and often discrimination in regard to allocation of resources between orphans and other children. In a study on experiences of orphan care in Northern Uganda, Oleke et al (2007) found many instances where orphans were neither wanted, cared for, nor loved by their caretakers. The study indicated that the inadequate and discriminatory care for orphans was mostly manifested through orphans' relatively heavy workloads, inadequate feeding, dress, shelter and limited rest compared to other children in the same households. Ntozi and Mukiza-Gapere (1995) similarly noted that despite the existence of the extended family system, some orphans were stunted and malnourished because they could not cope with orphanhood. They concluded that most orphans were deprived of education, parental care, nutrition, shelter, clothing and the legal protection of their parents' property.

In general, the orphan care and support context in Uganda can be described as one where there is still a strong felt cultural and mutual obligation by the extended families to care for children of their dead relatives.

This is recognized by the government as a strong and enduring resource to build upon and hence the family based approach to care is strongly emphasized in the national policy frameworks. However, insurmountable challenges arising mainly out of growing poverty, the rising number of children needing care and the extensive socio-economic restructuring have begun to take a heavy toll on the commitment and ability of the families to willingly accept and ably provide the care that orphans need.

2.3 Nature of Care and Support Offered to Orphans

Child care is considered to be effective if it enables children to develop physically and mentally in a healthy manner, have access to adequate nutrition, housing, medical care, education, and are brought up in a spirit of tolerance, peace and universal brotherhood (Uganda Constitution, 1995; National OVC Policy 2004). These five provisions are part of the ten core interventions in support of orphans as stipulated in the NSSPI. Literature on nature of care and support provided to orphans is accordingly reviewed along these five elements.

2.3.1 Food and Nutrition

Adequate nutrition is universally recognised as the foundation for proper physical and mental development, especially for children (UBOS/Macro International Inc. 2006). Lack of adequate food resources, especially for children has dire long term consequences on their physical and mental growth. Alderman, Behrman and Hoddinott (2004) posit that malnourished children score poorly on tests of cognitive function and have poor psychomotor development. They tend to have lower activity levels, interact less with their environment and fail to acquire skills at normal rates. Inadequate food also directly impacts on the productive capacity of the adults and ultimately their sustained capacity to care for orphans.

The ability to provide adequate food and nutrition is considered to be the primary element of care by many Ugandan families and is often a major source of stress if parents are not able to adequately meet this need. In a study on the stresses and strengths of HIV-affected Ugandan grandmothers, Kamya and Poindexter (2009) found that the major concern of the caretakers was how to raise income to buy food for their grandchildren. The caretakers overwhelmingly reported that they feel happy when they see their grandchildren alive and they have food for them.

Nutrition and health reports in Uganda indicate that although the country is well endowed with adequate food supplies, a large proportion of children are malnourished. Thirty percent of the children under five years are stunted, six percent are wasted and sixteen percent are underweight. Similarly, forty nine percent of women in child bearing age are anaemic (UBOS/Macro International Inc. 2006). Other studies carried out in Central Uganda (Kikafunda, Walker and Tumwiine 1998) found out that twenty two percent of the children surveyed were in poor health after clinical examination, four percent being classified as suffering from kwashiorkor and six percent with marasmus. They note that key among the risk factors for malnutrition were low socioeconomic status of the family, poor education of the mother, consumption of food of low energy density and small meals.

In the context of the overall poor nutritional status of children in Uganda, it can be expected that families caring for orphans are particularly in more vulnerable situations. Ntozi and Mukiza-Gapere, (1995); Wakhweya, et al. (2002) have all documented that food shortage in households caring for orphans has reached worrying levels, where households were unable to provide the full range of meals and in adequate amounts for children. Similarly, in their study on the nutrition status of orphans in South Western Uganda, Kikafunda and Namusoke (2006) found very high prevalence of malnutrition manifesting through underweight among orphans compared to non-orphans. They noted that it was rare for the orphans, particularly those under the care of the elderly to get four meals in a day and instead it was normal for caretakers to provide a common meal for lunch and supper.

Mangoma, Chimbari, Dhlombo, (2008) similarly indicate the inadequacy of food in orphan caretaker households, particularly those headed by widows and grandparents in Zimbabwe. In majority of these households, meals were usually limited to two per day instead of the normal four. However, these findings on malnutrition of orphans compared to non-orphans and the inability of the widowed and elderly caretakers to provide optimum orphan care contradict those from those of Neckermann and Muller (2005) which indicated that there are no differences in the prevalence of malnutrition between orphaned and non-orphaned children. They further contend that children who were looked after by the grandmothers were less likely to be stunted.

Nutritional status is directly linked to household food security. The International Fund for Agricultural Development (IFAD) cited in Tumushabe and De Waal (2003) describes household food security as the capacity of households to procure a stable and sustainable basket of food. Households are said to be food secure when food availability, equal access, stability of supplies and quality of food are in balance with each other. However, in many caretaker families food supply and availability are not guaranteed due to loss of adult and productive labour as well as the consequent social and structural transformation. In a study on the impact of HIV and AIDS on families, Topouzis (1994) indicated that loss of adult labour, particularly among households affected by HIV and AIDS had led to a deterioration of the quality of household diet and consequently malnutrition. She established that dietary diversity was found to become very limited mainly due to the inability of households to grow a wide variety of food crops. She noted that declining agricultural productivity often forced households to modify the family diet and limit the household diet to one or two staple foods, often of poor nutritional value. The result was that diets became excessively monotonous and insufficiently varied to provide the full range of nutrients required.

2.3.2 Education

Provision of education remains one of the most pressing priorities for Ugandan households. Studies undertaken among orphan caretaker households (Wakhweya et al, 2002; Kamya and Poindexter, 2009) indicate that education is one of the three primary priorities of orphan caretaker households and orphans themselves.

From these studies, suggestions from caregivers on how they could be assisted to care for orphans had the following responses: provide education-related support, provision of credit, food and clothing. Education is considered the most fundamental need as it lays the basic foundation for most of the social and economic indicators. It is considered to be the main engine for human capital development and hence a key derivative of higher incomes and economic growth (GOU- UBOS 2006). Oxfam, cited by Wakhweya et al (2002) notes that education is associated with more choices and opportunities, especially for women, better family health and nutrition, lower maternal and child morbidity, lower birth rates and with a greater sense of security, morals, and ethics among children. Salaam (2005) further asserts that attaining basic education and the resulting employable skills constitute an important part of preventing the spread of HIV/AIDS and breaking the cycle of poverty. He argues that education has positive impacts, particularly for orphans because not only are they enabled to have a higher income but also that the educated are less likely to contract HIV, and tend to have children later in life.

In 1996, the government of Uganda introduced the Universal Primary Education (UPE), an initiative that is a hallmark to Uganda's poverty eradication agenda. Orphans are among the disadvantaged children that were accorded the highest priority in enrolment under UPE. This has in the short run increased opportunities for orphans to attend school with almost similar percentages of orphans and non-orphans attending school (UBOS/Macro International Inc. 2006; Wakhweya et al., 2002).

In the recent ssituational analysis of vulnerable children in Uganda, Kalibala and Elson (2009) further indicated that more orphaned children aged 6 to12 years were enrolled in school compared to their non-orphaned counterparts. However, the apparent good enrolment levels in lower ages may be dampened by high attrition rates as the age of the orphans and level of education increase. This is clearly demonstrated by Kalibala and Elson (2009) who noted that in the age group 13 to 17 years old, orphaned children were less likely to be attending school. Some of the reasons highlighted in the report for this skewed trend are that that support for younger children to remain in school in the immediate aftermath of parental death may be followed by subsequent difficulties as the child grows up and the family faces up to financial realities, or the fostering family shows preference to keeping their own biological children in school. It is likely that more orphans may drop out of school at upper primary and secondary levels, since the opportunity cost of attending school will increase. For instance, they may be withdrawn to provide farm labour, engage in income generating activities to support the family or to care for the ill parents. A study on experiences of orphan care in Northern Uganda (Oleke et al, 2007) noted that orphans were burdened with domestic work to the extent that their schooling was affected. Responses from the teachers covered by the study indicate that albeit their good enrolment rates, orphans tended to report late to school, to perform poorly and to drop out of school more than other pupils.

2.3.3 Health Care

Health care for orphans is considered within the broad ambit of child health in Uganda. Child health indicators in Uganda continue to be poor compared to other African countries. UBOS/Macro International Inc. (2006) indicate modest improvements in child health between 2001 and 2005 as measured by the rates in infant mortality, child mortality and under five mortality which declined from 89 to 75; 76 to 67; and 158 to 137 per 1000 live births respectively. Despite these improvements, mortality rates remain unacceptably high.

In the same survey, thirty eight percent of Ugandan children under five years of age were found to be stunted (too short for their age), 6% were wasted (too thin for their height) while sixteen percent were underweight. In the context of the generally poor health conditions for children in Uganda, the situation of orphans can be expected to be particularly bad. For example, the situational analysis of orphans in Uganda, Wakhweya et al.(2002) found that 75% of the orphan caretakers reported that at least one child in the household was ill at the time of the interview or had been ill during the previous month. In over 90% of the cases, the ill child was an orphan occupant of the household. Preventable diseases, mainly malaria, fever, respiratory tract infections and diarrhea continue to haunt children especially in rural and peri-urban areas. UBOS/Macro International Inc. (2006) noted that these diseases remain the major cause of illness, especially among children.

Perhaps due to limited resources, healthcare in orphan caretaker families, particularly those in rural areas is exclusively perceived to be curative and is only considered when children fall ill. Preventive aspects of care such as safe water, sanitation and hygiene may not be prioritized as essential needs. Kalibala and Elson (2009) note that sanitation supplies including soap, toiletries and sanitary towels for girls were found to be lacking in most orphan households. In their study of orphans and their needs in Zimbabwe, Mangoma, Chimbari and Dhlombo (2008) similarly found acute lack of sanitation supplies particularly for girls. Poor access to such supplies especially for girls was noted to be a high risk factor rendering girls potentially vulnerable to exploitation. It was also noted to potentially cause low esteem, social dysfunction and loss of interest in education.

Mainly as a result of financial difficulties facing most orphan caretaker families, healthcare for orphans is predominantly sought from public facilities. However, it is widely acknowledged that the reliability and quality of services offered at these facilities rarely meets expectations.

From interviews with caretakers in the recent situational analysis of vulnerable children in Uganda, Kalibala and Elson (2009) note that government medical facilities are often under-staffed and rural facilities often experience delayed deliveries of drugs. This was noted to disproportionately impact orphans and other vulnerable children since they are unable to afford the fees or pay for medications from private clinics and pharmacies where they are often referred.

Even in the worst circumstances, caretakers have struggled to maintain equity and fairness in regard to the way they access health care to orphans and non-orphans under their care. In their study on intra-household healthcare dynamics between orphans and non-orphans in Uganda, Muhangi, Muhwezi and Mugumya (2009) noted that there were no major significant differences in healthcare dynamics, particularly in morbidity and health seeking behaviour between orphans and non-orphans. In a related study, Neckermann and Muller (2005) also found that although orphans were reportedly more prone to morbidity than non-orphans, there were no differences in reported treatment seeking behavior. Hence the two studies seem to suggest that against all odds, the extended family system is still doing its best to care for orphans in most possible equitable manner.

2.3.4 Shelter

In Uganda shelter is defined as a building or group of buildings in which a household lives (GOU-UBOS 2006). In the context of care and support for orphans, shelter goes beyond mere buildings and includes the capacity of families to love, rear and protect children and buffer them from negative effects (Alliance, 2003). Families attain the capacity if they have sufficient material and social resources to care for children, the motivation to ensure that children are nurtured and protected, and are part of a community of people who provide one another with mutual assistance (Haour-Knipe, 2008). Therefore, it can be deduced from these revelations that the quality of shelter has a direct correlation with the level of resources.

Looked at from the perspective of buildings, the housing situation in Uganda has improved over the last decade. The percentage of Ugandans living in detached dwelling units rose from 56% in 2003 to 61% in 2006 (GOU-UBOS, 2006). However, the apparent generally good picture conceals the actual dynamics and welfare of the individuals living in the households. GOU-UBOS (2002) found out that less than half of the households took sugar daily, or had a separate blanket for every child less than eighteen years. Similarly, GOU-UBOS (2006) further established that more than half of the households in Uganda had only one room for sleeping with the average per capita room occupancy ranging between three to four. Such conditions expose affected individuals, particularly children to the risk of contracting and spreading communicable diseases such as malaria and cough. In addition, GOU-UBOS (2006) further notes that thirty eight percent of Ugandans reside in grass-thatched houses. Houses constructed with mud and wooden poles were equally substantial, accounting for 42% of the households in Uganda. This type of houses requires constant maintenance including replacement of grass when roofs leak and resurfacing of walls with mud. Consequently become expensive in the end, as they are difficult to maintain especially to orphans and widows.

In seriously constrained families, which unfortunately care for majority of orphans, the housing situation can be seriously worrying. In their study on orphan care in Ethiopia, Abebe and Aase (2007) found situations where families were in extreme forms of impoverishment, with thatched roofs leaking, children sleeping on mattresses made of dried grass and with no blanket to cover them at night. According to UBOS/Macro International Inc. (2006), basic material needs of a child in a home are considered met if he/she has a pair of shoes, two sets of clothes, and a blanket in addition to a bed, mattress and bed sheets. However, very few Ugandan families are in position to provide the full range of these material needs. Only twenty eight percent of Ugandan households were providing the full range of these material needs (UBOS/Macro International Inc. 2006).

Only thirty seven percent of the children had shoes, and seventy four percent had two sets of clothes. In the recent situational analysis of vulnerable children in Uganda, Kalibala and Elson (2009) note that shelter, including the basic material needs for children is still a big problem. According to the study, children who had been orphaned were statistically less likely than children who were not orphaned to have the goods prescribed in UBOS/Macro International Inc. (2006) as key indicators of adequate shelter. However, it was interesting to note that although these differences in access occur, the margin is narrow, attesting to the efforts of the caretaker families to equitably meet the basic needs of children under their care. For instance, the study shows that twenty nine percent of orphans had shoes compared to thirty four percent non-orphans. Similarly, fifty three percent of orphans had two sets of clothes compared to fifty nine percent non orphans. With regard to accessing blankets, there no significant difference between orphans and non-orphans.

2.3.5 Psychosocial Support

The need for psychosocial care for orphans and their caretakers is a widely recognized problem. In one study carried out in rural Uganda, Atwiine, Cantor-Graae and Bajunirwe (2005) found high levels of psychological distress were in children who had been orphaned by AIDS. Anxiety, depression and anger were found to be more common among orphans than other children. Twelve percent of AIDS orphans in the study affirmed that they wished they were dead. Family Health International (2001) further notes that without proper psychosocial support mechanisms, orphans often spend most of their time and energy trying to create some source of order and security for themselves out of unpredictable situations and in struggling with their own identity problems. The long-term consequences for children who experience profound loss, grief, hopelessness, fear and anxiety, without assistance, can include psychosomatic disorders, chronic depression, low self-esteem, low levels of life skills, learning disabilities, and disturbed social behaviour.

Psychosocial care for caretakers is also an acknowledged need. Alliance (2003) posits that grandparents, children looking after their younger children and caregivers looking after many children often find it difficult to cope. They often blame themselves for not being able to do enough, even though they must also deal with their own grief and sadness. They indicate that as many caretakers struggle to meet their children's needs – food, clothes, health care , schooling and giving them love and attention – in conditions of financial hardship and with no practical, medical or social support, they suffer psychosocial effects . Mukoyogo and Williams (1996) further note that the health of older caregivers deteriorates as a result of the physical, emotional and economic stress of assisting orphaned children. Similarly, some guardians have expressed dismay about having to restart families late in their lives, with the attendant loss of freedom and the anxiety about meeting the financial and emotional needs of children (Hunter and Williamson, 2000). When left unaddressed, such psychological problems can have an effect on the care that caregivers offer to the orphans.

A family is considered to be the best source of psychosocial care especially for children since it is the only place where they can obtain solace and also freely express their feelings (Mangoma, Chimbari, Dhlombo 2008). Despite these realities, little if anything is done to address psychosocial care at household level, largely because caretakers lack skills to diagnose and appropriately address these needs. However, some caretakers also deliberately ignore orphans' psychosocial needs as mechanism of coping, especially in situations where they feel helpless. In a study on orphan caregivers in rural Uganda, Kamya and Poindexter (2009) encountered situations where caretakers had given up on the emotional needs of the orphans under their care. Similar situations where caretakers and orphans do nothing about their emotional stress have been documented elsewhere (Mangoma, Chimbari, Dhlombo 2008). Ideally the role of the community should be prominent in these situations, reaching out to orphans and their caretakers and building upon their inner strengths to help them move on.

However, as noted by Kalibala and Elson (2009), documented little support available from the community.

In general the foregoing literature indicates that orphan caretakers are endeavoring to do the best they can to meet the basic needs of children under their care. In the context of their limited resources, the provisions in many ways remain modest and in some cases fall short of expectations. In some situations, they are totally ill-prepared to address some of the needs such as psychosocial care. Even if material needs of children were adequately met, evidence shows that children may not function properly and appropriately interact with their environment if their psychosocial needs remain unmet. Similarly, caretakers tormented by psychological feelings of loss and ineptness may not be in position to provide the level of care desired, given that in the long run their resilience fizzles under stress and ultimately quality of care declines.

2.4 Challenges Faced by Orphan Care Families

This sub-section addresses the practical challenges that caretaker families contend with in providing care and support to orphans. Literature is also presented according to the constructs of orphan care addressed by the study, namely food and nutrition, education, healthcare, shelter and psychosocial support.

2.4.1 Food and Nutrition

In rural households, the key ingredients to the stable availability of food include family labour, land, and in times of famine, resources to purchase food (Bahiigwa and Ellis, 2001). In most rural households in Uganda, families depend on food locally produced in their gardens where family members including children provide the labour. However land shortage is becoming a prominent scenario especially in rural areas where families have too little land to meet their own agricultural needs (Adoko and Levin, 2005). Ntozi and Mukiza-Gapere (1995) further note that while in the past land was abundant and families could use it to produce enough food for any given

size of household, today, there is a critical shortage of land in most areas of Uganda raising serious limitations on food production at the household level.

Besides land shortage, some studies (Topouzis 1994; De Waal and Tumushabe 2003) indicate that high adult mortality due to HIV and AIDS has also severely affected agricultural labor patterns of households. They further note that loss of adult breadwinners results in loss of agricultural skills and experience and breaks the chain of knowledge transfer and labour sharing between generations. Many traditional agrarian societies rely on women to produce food, particularly in Africa, where eighty percent of subsistence farmers are women. Not only do women provide labour but they also possess cross-generational experience and skills to maintain food security in families. For example, as noted by Salaam (2005), during times of famine these women know which grains, roots, tubers and berries can be eaten when there are no crops. The women also teach their children how to farm and survive off the land. Therefore, the increasing adult mortality especially for women dampens the opportunities to transfer these skills to their children. Without agricultural skills and experience, orphans left behind will be technically deficient in food production even when land is available. Labour shortage as a result of adult mortality translates into limited acreage cultivated. This is adduced by FAO (2003) which notes that the impact of HIV and AIDS on affected rural subsistence communities has been the decreased average area cultivated due to labor constraints. Therefore, even where agricultural activities are sustained, barely enough is produced to guarantee food supply in quantities and variety required to sustain families.

As poverty bites, sale of crops, traditionally meant to be the main source of food is an emerging practice in many orphan families, especially in rural areas where opportunities for earning income are limited. In a study on the socio-economic impact of HIV/AIDS on rural families in Uganda, Topouzis (1994) established that widows were forced to sell part of the food they grow in order to maintain basic levels of hygiene and tend to their children's medical needs. Selling food crops to buy soap, matches and drugs was

found to be very common, particularly in Tororo district. While this may be viewed as a strategy for addressing immediate pressing needs, the long term consequences are dire as this eventually may lead to malnutrition and poor growth and development of children in the household.

2.4.2 Shelter

Children, including orphans are part and parcel of the household and their welfare is inextricably linked to that of the household and their caretakers. The capacity of households to provide for children depends on their ability to maintain or earn income and to stabilise livelihoods. In Uganda, as in many other parts of Africa, physical space for children was never regarded as a big issue provided they were able to meet the basic physical needs, particularly adequate food and health. In the context of widespread poverty, many caretaker households can barely address the physical needs of the children under their care. Meagre resources have to be spread across numerous needs ultimately creating no impact. Wakhweya et al., (2002) found out that many children sleep on the bare ground or on mats. Blankets, bed sheets or other forms of body cover were a rarity.

Family size also tends to compromise that quality of care in many of the African extended families. The orphans are added to an already fragile situation. For instance Wakhweya et al (2002) noted that on average 6.8 people lived in a typical family with orphans of whom 4.3 were children, compared to 4.9 people in an average non-orphan family of whom 2.7 are children. Monasch and Boerma (2004) further note that orphans are more likely than non-orphans to live in large, female-headed households where more people are dependent on fewer income earners. Therefore, it is clear that addition of orphans to such households increases the dependency ratio and further stretches the welfare needs of that household. This has a lot of implications on the household capacity to provide the needed shelter and the basic necessities such as clothing bedding and sanitation.

In households headed by widows, the growing phenomenon of property grabbing further compounds their economic hardships and elevates their inability to meet basic needs. UBOS/Macro International Inc. (2006) indicated that fourty eight percent of the widowed women reported that their late husbands' possessions went to someone other than themselves. This presents challenges to caretaker families who may have nothing to begin from. In order to mitigate this vice, household members are encouraged to write succession wills and memory books to offer guidance on estate management. However, in Uganda, will-making is generally regarded as an ominous practice and has not gathered momentum. For instance, UBOS/Macro International Inc. (2006) found that only twenty eight percent of orphan caretakers in Uganda had made any succession arrangements in form of wills, or memory books. This further deepens the vulnerability of the bonafide beneficiaries. As noted by Kezaala and Bataringaya (1998), a written will does not necessarily prevent unscrupulous persons from taking advantage of orphans, but absence of a will to document ownership of property and guide its transfer only serves to weaken the bonafide survivors' claims. Alliance (2003) further asserts that when parents do not make a will, children can lose their inheritance (money, land, property and livestock), especially when they do not have any legal rights, title deeds or access to legal support. There is often no support to enable children to claim their rights. Grandparents and widows, in particular, may lack the resources or capacity to pursue a legal case on behalf of the children under their care. Denial of access to property for orphans can take different dimensions. While relatives of the dead parent, usually men, are the most cited culprits there is also another dimension where property is grabbed by the new spouses of the surviving parent if he/she remarries. In their study of the of the problems and wishes of orphans in Zimbabwe, Mangoma, Chimbari and Dhlomo (2008) established that orphans who had lost one parent lost their inheritance to stepparents if the remaining parent remarried. In such cases the stepparents usually take full control of all assets and property, and when the remaining parent dies, these stepparents automatically grab the inheritance.

Besides physical assets left by deceased parents, orphans also often get dispossessed of basic items such as clothes, shoes, books and other scholastic materials that may be provided outside the family, mainly from formal institutions such as NGOs. Kalibala and Elson (2009) note that the support targeted at orphans and vulnerable children at the household level does not always reach them. For instance the support provided to orphans to support initiation of income generating activities (IGAs) is often withheld or sold off by caregivers. Assistance such as books and clothing may also be distributed among other children who are not orphaned but also facing vulnerability. In such cases the orphans suffer double loss, their parents and the assistance that would have improved their livelihood. This signals the need for a more holistic approach in addressing the needs of orphans in poverty affected households. As lucidly pointed out by Abebe and Aase (2007), programs need to shift focus towards strengthening families to build their resilience rather than implementing programs that target individual orphans.

Within some caretaker homes, orphans have to endure different and often difficult situations. Studies have documented situations where orphans are treated harshly, they are sexually abused often by the caretakers themselves, face overt and covert discrimination and are given roles that do not match their age and cognitive capacity (Oleke et al., 2005; Kalibala and Elson 2009, Abebe and Aase, 2007). Smart (2003) further noted that within extended families, some orphans tell of being expected to work harder than other children in the family and of being the last to get food or school fees.

2.4.3 Education

The Universal Primary Education Program (UPE) in Uganda is heralded for its exponential increase in access to primary education especially for vulnerable children. However, the program is not entirely free of cost. While government waived tuition fees, parents/guardians continue to provide all other essential costs such as uniform, feeding, books, and fees for infrastructure development.

In aggregate terms, these costs are high and remain unaffordable to many parents and guardians. Various studies in Uganda and elsewhere (Alliance 2003, Neckermann and Muller 2005, Mangoma, Chimbari and Dhlombo, 2008), all contend that many orphan caretaker households are unable to pay for schools fees and materials. Subbarao and Coury (2004) also posit that financial hardship is a key factor to the orphan disadvantage in school enrolment and could be eliminated through sectoral policies that minimise or totally abolish school fees and uniforms. GOU-UBOS (2006) also indicates that costs such as uniforms, boarding fees, stationery, lunch and transport were found to be prohibitive and a major cause of primary school dropout. In her assessment of the poverty trends in Uganda, McGee (2002) noted that use of school enrolment as an indicator of UPE success falls short of the fact that supply of education may not necessarily create its demand. She asserts that the requirement that households meet costs such as uniform, books, meals, part of school construction, registration for examinations at primary seven, all continue to dampen the enrolment and school completion rates.

Besides cost limitations, in families which are struggling to meet basic needs, education may be perceived to be secondary to food, shelter, clothing and medical care. This may translate into preferential treatment amongst children as families strive to balance needs with resources and to optimize long term returns. Alliance (2003) points out issues of equity in access to education especially in poverty stricken households. They aver that in families with scarce resources, boys are usually given preference educationally over girls and biological children over orphans. In other instances, older children often drop out of school early to help pay for the education of their younger siblings, and many more drop out to earn money to support themselves and their families.

2.4.4 Health

Access to good health care remains a challenge in many rural areas due to lack of money to pay travel costs and the lack of the needed services at the health units, which combine to substantially increase the opportunity cost of

seeking health care. Alliance (2003) notes that sometimes, because of lack of money, families delay taking a child for health care until the child is seriously ill. Delays in seeking treatment for some diseases such as pneumonia or malaria can be fatal. Healthcare for orphans becomes particularly more challenging if they are HIV-positive. Neckermann and Muller (2005) indicate that orphaned children were sick more often than non-orphaned children. They attributed the higher morbidity among orphans to HIV infection. Alliance (2003) indicates that although children with HIV often have the same infections as children without, the former's ailments are more frequent, severe and persistent. HIV infected children may also have special needs, such as prompt and frequent medical treatment as well as good nutrition, all of which may be out of reach for caretakers especially the elderly and those financially challenged. Failure to address these needs serves to heighten anxiety and stress among the caretakers. As Alliance (2003) notes, even with improved access to anti-retroviral therapy, caregivers, especially grandparents and older siblings may lack sufficient awareness about the availability of services or the skills to monitor adherence to treatment.

On the other hand, health care for orphans carries stigma which increases caretaker reluctance to access health services especially of the orphan is suspected to be HIV positive. For instance, Alliance (2003) indicates that caretakers may avoid using health services because of concerns over confidentiality or that somebody might discover their own or their child's HIV status. Consequently caretakers tend to rely on self medication with drugs procured from local drug shops or in some instances use of traditional medicine. In both situations, the health of the child could be seriously endangered if the illness is severe. In extreme cases, sick children do not receive adequate care and attention because caretakers feel it a waste of time and resources to care for them, especially if HIV infection is suspected (Kalibala and Elson 2009). In their study of orphan caretakers in Uganda (Kamya and Poindexter 2009) noted situations where caretakers were exhibited overwhelming anxiety whenever their HIV-infected orphans fell sick.

They held strong beliefs that the children would die soon and tried to withhold this “fact” from the children. In effect, this heightened their stress and restlessness.

The challenges with healthcare are compounded by the apparent limitations within the public health facilities. In principle public health facilities exist to meet the needs of all people, but primarily the poor who cannot access private services. With no resources available, and with no guaranteed access to government health services, healthcare for orphans remains in jeopardy and will continue to be a daunting challenge to caretakers.

2.4.5 Psychosocial Support

Provision of psychosocial support at household level is a key challenge to caretakers and it fraught with complex issues. First, unlike physical needs such as food, clothing or medical care, it is difficult to diagnose even at personal level. Therefore, as noted by Alliance (2003), at household level, psychosocial symptoms for orphans are less likely to be recognized and acknowledged and they are more likely to be isolated with their problems, without easy access to anyone who can help them find solutions or relief. Even when the needs are identified, there is a dearth of skills both in households and whole communities to address them. As noted by Smart (2003), such skills are either totally lacking or where they exist they have been found to be inappropriate.

Poor access to psychosocial support similarly affects caretakers. Studies have indicated that burn-out is common among caretakers arising out of everyday stresses and anxieties that are not addressed. These gradually undermine the carer’s mental and physical health, so that eventually care giving and personal relationships suffer (Alliance, 2003).

Children with HIV who are aware of their status have unique psychological and emotional needs, and require special and targeted help to come to terms with HIV and live positively, manage illness, deal with stigma and

discrimination and prepare for the future (Alliance, 2003). This ideally requires special skills to ensure that support is given in a manner that does not separate them from other children. With such skills largely lacking at household level, children are in most instances left to deal with emotional issues on their own. This ultimately impacts negatively on their ability to cope and to effectively play out as integral members of the caretaker households.

Balancing the need to demonstrate love to the orphans and to inevitably take corrective action when they slip off the acceptable behavioral path is another complex challenge for caretakers. Studies have indicated various instances where orphans have become hard to manage (Nyangoma, Chimbari and Dhlombo, 2008; Ntozi and Mukiza-Gapere 1995) Some had refused to work, others refused to go to school, while others decided to run away from their caretakers to seek employment in urban areas. Very often caretakers are at a loss as to the most appropriate approaches to use in addressing disciplinary issues for orphans. For instance in a study in rural Kenya, Horizon (2004) noted that the concern for the future of the children often pushes caregivers into extreme ends, on one hand being too soft due to fear that children may feel depressed and run away, and on the other, punishing children excessively when they make mistakes.

In general, the literature reveals that most of the challenges faced by orphan caretakers derive from their inability to access adequate resources to meet the immediate and long term needs of children under their care. In Uganda, like in other Sub-Saharan countries, the absence of viable social support systems, particularly at community level, implies that the family will continue to play a critical role in orphan care, albeit with uphill challenges. Therefore, understanding the dynamics of orphan care at this level of society is of critical importance in shaping the current and future interventions in orphan care.

2.5 Coping Strategies

High adult mortality alters the socio-economic stability of many individuals and households. Consequently, they adopt various coping strategies to enhance their capacity to sustain livelihood. Drimie (2002) notes that several factors will determine a household's ability to cope, including access to resources, household size and composition, access to resources of the extended family, and the ability of the community to provide support. UNAIDS (1999) cited in Drimie (2002), asserts that in the face of increased challenges, the most immediate household coping strategies primarily aim to improving food security, raise and supplement income to maintain household expenditure patterns and to alleviate the loss of labour.

This sub-section presents literature on strategies adopted by caretakers to mitigate challenges associated with provision of care and support to orphans. Strategies are also presented according to the five elements of care, namely, food and nutrition, education, healthcare, shelter and psychosocial support.

2.5.1 Food and Nutrition

In order to cope with food shortages, households react by reducing food intake, for instance by cutting the number of meals per day, which in the long term may lead to chronic malnutrition. Wakhweya et al (2002) noted that a significant portion of orphan households were not able to provide the three meals required in a day. Topouzis (1994) further noted that in Kabarole, the number of meals was in some cases reduced from three to two and in Tororo and in Gulu from two to one. Young widows reported regularly skipping meals (especially lunch) thereby jeopardizing their health and their ability to take care of their families. Cutting meals in effect allows families enough food just to survive and remain alive. However, it does not guarantee the required nutrition for normal growth in case of children or optimum physical and mental functioning for adults.

In families headed by elderly caretakers, children must assume greater roles in farming in a bid to sustain food security. Topouzis (1994) noted that older children aged ten years and above worked longer hours to assist single parents and their contribution to agricultural activities increased significantly. Children who lost both parents and were living with relatives were more likely to work longer hours than children who had only lost one parent and remained in the nuclear home. De Waal and Tumushabe (2003) further note that as food insecurity mounts, families resort to labour provided by children (implying they either have to combine school and work or drop out altogether) as the families struggle to maintain their traditional cropping patterns. However, Topouzis (2003) notes that in the contemporary situation, child labour may not ensure long term food security for households, because children may not live with their original families when they eventually grow, and more importantly, they may not have had sufficient exposure to farm work to gain the skills and experience to sustain the farming patterns. She asserts that the death of one or both parents deprives the family of the necessary knowledge, experience or skills to run the household farm. The surviving parent or children may not have the skills and experience required to sustain certain crops or animals. The net effect is that affected families gradually but steadily descend into vulnerability since their traditional sources of food and income cannot be sustained.

De Waal and Tumushabe (2003) indicate that in pursuit of rationalising the remaining labour for agricultural production, some families switch to growing crops that need less labour, often at the expense of labour intensive but highly nutritious crops. Rendering further credence to this finding, Topouzis (1994) found out that widows in Kabarole gave up growing tomatoes, a major cash crop, which they previously grew jointly with their husbands due to lack of money for fungicides. In Tororo district, rice and millet, which are labour-intensive, were also often abandoned in favour of maize and cassava which require less labour. All studies note that alterations in food composition can compromise dietary quality even when the quantity of food produced may remain stable.

2.5.2 Shelter

One common coping strategy adopted by the families is sharing whatever facilities and resources are available across all the children in the household, regardless of whether they are biological or not. In their study on orphan care in Ethiopia, Abebe and Aase (2007) found that caretakers were keen at being unbiased in as they offered care and emphasized the importance of being fair when buying clothes for or feeding children in the household. Similarly, a study of intra-household differences in health seeking behaviour for orphans and non-orphans in Uganda found no differences in the way orphans and non orphans were cared for at household level (Muhwezi, Muhangi and Mugumya, 2009).

In order to balance the burden of care across different members of the extended family, families where both parents have passed away are reconfigured and children distributed among different households. This practice has been part of the African culture even before the escalation of the orphan problem. As noted by Mathambo and Gibbs (2009), children have always purposively migrated between a fixed set of relatives for a number of reasons ranging from strengthening relationships, facilitating access to better educational facilities, offering companionship to childless couples or grandparents, instilling discipline in a difficult child or to alleviate pressure on a household facing economic difficulties. However, while this practice passes as normal African practice and as a viable survival strategy, studies have found out that children confront uphill challenges in receiving families and social and psychological costs of adjustment have been high. For instance, they get removed from their acquaintances and long known circles of friendship and solace, they often get resented in poor households that take them out of obligation and sometimes get allocated more household work due to lack of political or social power in the new settings. In other instances, children brought up in urban areas often find it hard to adjust to rural life and vice versa (Abebe, Aase, 2007; Mathambo, Gibbs, 2009; Nyambedha, Wandibba, Aagaard-Hansen, 2003).

Shelter is closely linked to household income and consequently many other strategies adopted to address shelter relate to efforts made by families to raise income. Micro enterprising such as selling charcoal, brewing local alcohol, handicrafts, and grocery selling are common prominent strategies adopted as a means of generating income (Rugalema, 1998, Sauerborn et al, 1996). Women, especially surviving parents of orphans also engage in wage labour as a means of earning income (Wakhweya et al, 2002). In some cases, household members, including children migrate to urban areas in search of employment.

With support from local and international organizations, many families engage in various forms of income-generating activities (IGAs) to elevate their levels of income. However, in most instances these IGAs have been designed along external stereotypes and hence reflect very little originality or relevance to local circumstances. For instance, ideas for IGAs are often applied to many communities without proper market or skills assessments. Therefore, in many cases the effort expended on these IGAs is quite out of proportion to the financial returns. Ultimately, IGAs as a strategy for empowering households to meet the needs of orphans has generated mixed results. For instance, in their review of HIV and AIDS community based care interventions, Asingwirie and Muhangi (1998) found that although IGAs were effective in leveraging local resources and keeping foster families together, most agricultural projects were not worthwhile as the returns on labour were found to be too low.

Seeking assistance from external sources is also a dominant strategy used by families to plug the holes in delivery of care and support to orphans. The most popular response in this regard is from NGOs and to some extent faith-based organizations. NGOs have largely responded to the plight of orphans by providing information, vocational training, basic education, medical care and micro-credit services. However, as Mukasa, 2004 (cited in MOGLSD, 2004) notes, these interventions remain limited in scope, coverage, impact, comprehensiveness and coordination.

Mangoma, Chimbari and Dhlombo (2008) further note that as a result of poor coordination, NGO services overlap and duplication of services is often apparent. They further indicate that NGO services do not achieve much impact as they often operate with little and inflexible resources. The ultimate impact is that NGO services do not achieve optimum reach and coverage.

Transfer payments, usually in form of money and physical goods from employed relatives is also a common form of external support that assists some extended families to provide care for orphans. Kalibala and Elson (2009) note that in many households caring for orphans, some relatives living and working in the cities and abroad do send remittances to the caregivers, which were reported to have made a difference in that they improved the care provided to the vulnerable children. However, it is acknowledged that the proportion of families with opportunities of accessing transfer earnings still remains paltry currently accounting for only five percent of all households in Uganda (UBOS 2006). Kalibala and Elson (ibid) also note that the money sent is often not adequate and often it intended to cover only education and not the other needs of the vulnerable children.

With limited external support, it is apparent that households are struggling to shoulder the burden of care for orphans using the paltry resources at their disposal. For example, a Wakhweya et al. (2002), indicated that eighty four percent of orphan households in Uganda were not receiving any form of assistance from government, community or other external agency, even though the vast majority of these households were living in poverty. Similarly, UBOS/Macro International Inc. (2006) further found out that as many as nine in ten orphans in Uganda lived in households that had not received any type of external support. With numerous demands placed on them, and as the crisis deepens, some households resort to liquidation of savings or selling off assets to raise funds for immediate survival needs. As noted by Salaam (2005), some of these strategies may yield short term solutions but also serious long term implications.

For instance, the consequences of depleting family assets are difficult to reverse because future household capacity to generate income and reinstate the property becomes seriously undermined, leading to perpetual destitution of the household.

2.5.3 Education

With limited resources, parents and caretakers usually strive to keep children in schools where fees are lower or where there are no fees at all. However, it is recognized that in many instances, such opportunities where there are no fees are rare. With the help of government and civil society organizations, caretakers have lobbied schools to drop charges for orphans or to accept part payment of school fees. For instance, in a situational analysis of orphans and vulnerable children in Zambia (1999), it was noted that one method of dealing with the shortage of funds to pay for school fees was to lobby schools to waive school fees for orphans. This was seen to work in one district, where waiver of fees increased enrollment dramatically (Government of Zambia, 1999). However, the flip side of this initiative as noted in the same report was that where children were allowed to attend school without paying fees, the parents who are paying felt undermined, and it placed the viability of the school in jeopardy. It was also seen to have potential for creating disharmony and tension in communities and setting people apart from one another.

Combining school and work especially for older children is another prominent strategy used by orphan caretaker families to meet the costs of education. Older children, especially boys engage in various activities in order to earn income to pay fees and also to sustain livelihoods of the families. However, some of these activities are often inappropriate for their age. In their study on problems and wishes of orphans in Zimbabwe, Mangoma, Chimbari and Dhlomo (2008) note that some orphans, particularly the older ones, were involved in income-generating activities like selling of vegetables, fruits, and pan cakes.

Others were involved in making mats out of reeds and grass for sale locally while others bought and sold fish heads and belly flaps from a local fish factory.

Faced with limited resources, parents and caretakers often exercise gender segregation in regard to education, preferring to keep boys rather than girls in school, especially in higher classes. Oleke et al (2007) note that the propensity for female orphans to be removed from school was higher than that of boys. Girls, more than boys were more likely to be removed to provide care for ill parents or close relatives and to provide labour, particularly in agriculture. A study on improving access to secondary education in Kenya similarly revealed that being male increases the probability of secondary education participation (Ngware, Onsomu, Muthaka, Manda, 2006). According to the study, intuitively, parents value the education of male children more than that of females based on the cultural perception that the expected future returns from educating female children are less for boys as it is perceived that female children will be married and, therefore, join the marital household. However, in their study on extended family's and women's role in orphan education in Zimbabwe, Nyamukapa and Gregson (2005) show contradictory findings where more orphaned girls than boys had completed primary education.

Given the costs associated with formal basic education and the unpredictable returns, many parents, caretakers and orphans tend to prefer vocational training to formal education. Consequently, vocational education pursued through informal community schools and apprenticeship mechanisms has evolved as a prominent mechanism for orphan education. These schools condense the formal government curricula into shorter durations (six months to one year), and because they are usually supported by NGOs, do not charge fees or require their pupils to wear uniforms (Government of Zambia, 1999). The teachers are usually community volunteers although it is also recognized that they are unreliable and have high attrition rates compared to paid teachers.

2.5.4 Healthcare

For many orphan caretakers, access to medical care is strenuous as they have no disposable income to pay bills. Therefore, their main source of health care is the public health facility that is within proximal distance.
Some studies (Hailu and Gezahegne, 2002) indicate that families also seek financial assistance from relatives and friends to meet their healthcare needs. The support from relatives is critically important to procure private healthcare services in common situations when public health facilities fail.

Pressed by the high cost of seeking medical care, many poor households postpone seeking health care and resort to self-treatment or visit a traditional healer. Wakhweya et al (2002) found out that 15% of the orphans reported that they were not receiving medical care citing caretakers' failure to find the money to seek care. It is only after the health condition worsens that they are forced to visit a formal health facility at the last hour.

2.2.5 Psychosocial Support

Current literature on this dimension of care and support for orphans seems to highlight the need for psychosocial support for orphans and their caretakers, much more than the strategies to address the problem. Therefore, strategies for coping with stress and emotional needs remain scanty and in most cases in form of generic recommendations.

Mangoma, Chimbari and Dhlombo (2008) highlight the role of the church and community based organizations as critical to addressing the psychosocial needs of orphans and their caretakers. Similarly, in their study on the stresses and strengths of HIV-affected Ugandan grandmothers, Kamya and Poindexter (2009) noted that spirituality was a key mechanism caretakers used in mitigating stress. In the study, more than seventy percent of the respondents referred to spirituality as a key source of their strength and resilience. In his study on social adjustment of orphaned grandchildren and the perceived care giving stresses in Kenya,

Odhiambo-Oburu (2004) noted that poor access to instrumental support in form of economic transfers was the most significant cause of stress for caring grandmothers. He contends that stress was heightened by failure to meet basic needs. Consequently, he observed that capacity building programs and instrumental support should be extended to these caretakers, which would in the long run make fostering grandmothers to be able to overcome economic handicaps that predispose them to experience elevated levels of stress. In a related study, Muthoni Kimemia (2006) indicated that emotional and instrumental support were significant strategies for coping with stress among caregivers. She notes that as caregivers struggle to provide the care recipients with medication, dietary requirements and at the same time meet their own needs as well as those of other family members, instrumental support is vital for survival. Muthoni Kimemia (2006) further points out hope as an important strategy for coping with psychosocial and emotional challenges among caretakers. She points out that in light of the increasing burden for care, it important that caregivers maintain a sense of optimism and don't give up. In many instances, orphan caregivers have approached their roles with incredible optimism and some are actually motivated to do it. For instance, in their study on orphan care in Ethiopia, Abebe and Aase (2007) found that despite the challenges faced, grandparents expressed satisfaction they had from being care providers and some emphasized spiritual reasons for doing it. Kamya and Poindexter (2009) similarly found the same optimism in Uganda where caretakers described the love between them and their grandchildren and the joy of being able to meet the grandchildren's needs as a source of their own strengthen and satisfaction. They argued that orphans were mirror images and a constant reminder of their (grandparents') deceased children.

The foregoing literature on coping strategies highlights a situation where against all odds, caretakers are trying to nurture and raise their children. Despite the hardships, many have approached the challenge with optimism, some viewing it through the lens of spirituality. They have consequently demonstrated hope, wisdom, and generosity.

However, one may hesitate to say that they are coping, as some of the strategies remain short lived while others are in fact inimical to the long term survival and growth of both caretakers and their children. In general the literature shows attempts by the caretakers not to succumb, rather than those to subdue the crisis.

2.6 Gaps in Available Literature

Despite the long history of adult mortality and orphanhood in Uganda, orphan care approaches and interventions are just evolving. The problem of orphans has gained significant attention of late consequent to the HIV and AIDS epidemic. A number of studies carried out on the orphan problem in Uganda Hunter & Williamson (2000); Wakhweya et al, (2002); UNICEF (2002); GOU-UBOS (2002), UBOS/Macro International Inc. (2006) aimed at establishing the size of the orphan problem by estimating the actual population of orphans in Uganda. There is paucity of literature on orphan care dynamics at family level, including challenges and strategies for coping. Therefore, although the reviewed literature offers invaluable insights into the challenges faced by families and the coping strategies adopted in response to the challenges of orphan care, most of it relates to studies done in the early 2000 and late 1990s. Even where data is recent, the actual challenges and strategies of caring for orphans are not addressed, especially at household level.

Most of the studies address the impact of death of adult breadwinners in the broad sense, looking at loss of income to households, distorted patterns of production, increased dependency ratios and the overall burden on the economy. Therefore, there is need to understand orphan care approaches at a micro level and to re-assess the challenges and coping strategies as society and social systems evolve.

Much of the literature reviewed relates to studies conducted in urban and per-urban settings. Rural settings, especially in the Ugandan context present unique realities, and the challenges and mechanisms in these areas differ greatly from those in urban areas.

Also although these studies highlight the inherent challenges that families are facing as they grapple with the growing orphan problem, they largely present perspectives from Southern and Central Africa. In order to provide country specific challenges and coping strategies within Ugandan families, it behooves us to undertake a related study, and expand the scope to include all orphans regardless of the cause of oprhanhood.

With regard to food and nutrition, the reviewed literature provides some useful insights into the food and nutrition dynamics in households caring for orphans. However, there are not many strategies pointed out that families use to cope with food and nutrition challenges. Only use of child labour to support domestic food production and reducing the number of meals eaten in a day are mentioned. In rural areas where food production is the responsibility of the entire family, with children providing the bulk of the labour, use of children in food production may not be unique to families caring for orphans. Similarly, food shortage seems to be an emerging issue affecting all families regardless of whether they host orphans or not.
It is imperative that more information is gathered to widen knowledge on how families caring for orphans cope with food shortages resulting from death of adult breadwinners as well as expanded family sizes.

Available literature on education of orphans is largely centered on the challenges faced by orphan caretaker households as they strive to access basic education to their children. The literature also highlights some of short and long term implications of failing to attain basic education on the children and families as a whole. However, there is no mention of the strategies that households are using to circumvent the problem. Studies (UBOS/Macro International Inc. 2006; Wakhweya et al 2002) indicate that despite the deepening challenges faced by families in caring for orphans, access to basic education remains equal among orphans and non-orphans. Given that most of the orphans are absorbed in households already financially constrained, hence raising both the direct and opportunity cost of sending the orphans to school, it is interest to know how families caring for orphans

are managing to keep their children in school, amidst high costs within an education system ostensibly meant to be free.

Available literature on shelter and housing conditions in Uganda is of general nature, pointing to a generally deplorable situation especially in rural and peri-urban areas. In this context, it is interesting to understand the unique challenges of households caring for orphans and how they address these challenges.

There is vast literature attesting to the growing need for psychosocial support for both orphans and caretakers (Alliance, 2003; Chirwa, 2002; Mathambo and Gibbs, 2009; Nyambedha, Wandibba, Aagaard-Hansen, 2003). However, there is a dearth of literature on effective strategies that orphan care households and orphans alike have taken to overcome these challenges.

Many of the studies that address the psychosocial element of orphan care focus on profiling this rather neglected piece of the overall orphan care and end by making recommendations on what should be ideally done. It would be interesting to know whether some of the recommended actions are actually applied in household settings and their effectiveness.

2.7 Conceptual Framework

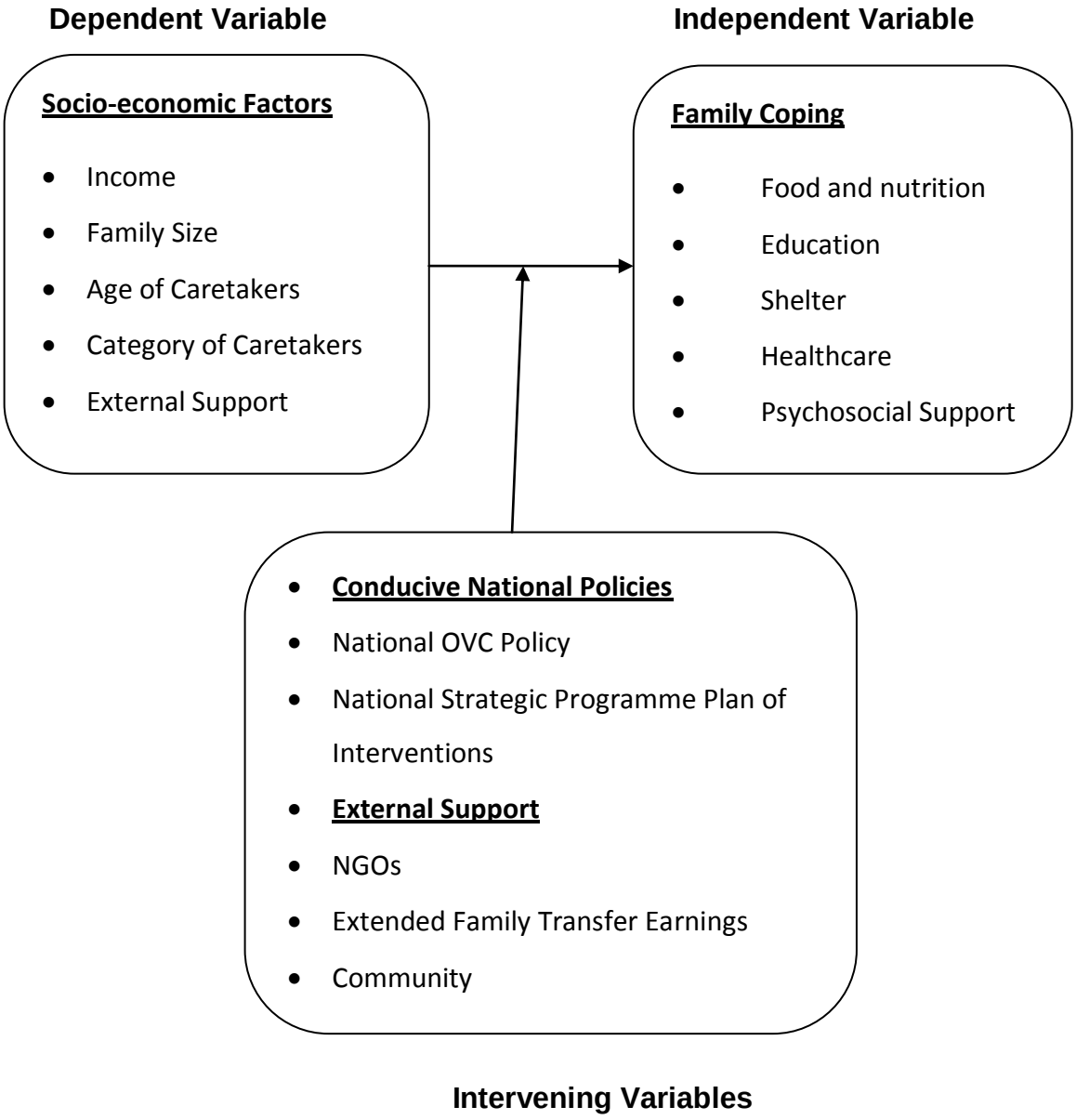
The study sought to assess how families already weakened by poverty, high fertility and aging caretakers are able to absorb and respond to the needs of orphans. Therefore the independent variable is the socio-economic status of households. From the literature, key factors that influence household capacity to provide orphan care include family size, income, age and category of caretakers and access to external support (Chirwa, 2002, Drimie, 2002, Mangoma, Chimbari Dhlombo, 2008, Muthoni Kememi, 2006, Nyamukapa, Gegson 2005). These factors formed the main constructs for the independent variable.

Other key factors presented in literature but not considered for the study included the shifts in demographic and labour patterns and structural changes in society that have weakened the traditional sense of social cohesion and mutual obligation among families.

The dependent variable is the families' coping with the orphan problem. The NSSPI (2004) outlines ten core services that constitute an ideal package of care for orphans. These include: socio-economic security, food security and nutrition, care and support, mitigation of the impact of conflict, education, psychosocial support, health, child protection, legal support and strengthening capacity and resource mobilization. Of these, those that are ideally delivered at family level are food and nutrition, education, psychosocial support, health care and child protection. Furthermore, the latter five services are considered the basic definitive package for orphan care (Uganda Constitution, 1995; National OVC Policy 2004, Drimie 2002). Based on the foregoing literature, the five core services were considered to form the constructs of the dependent variable. A family is deemed to be coping if it provides these services to orphans to a satisfactory level.

The study sought to establish the interface between these two variables, particularly to establish how families, already faced with social and economic challenges are able to offer effective care for orphans. Figure 1 shows a diagrammatic representation of the link between the variables in the study.

Figure 1: Conceptual Framework.



Adapted from literature (UNICEF, 1993; Uganda Constitution, 1995; NSPPI, 2004, National OVC Policy 2004, Drimie 2002, Chirwa, 2002, Drimie, 2002, Mangoma, Chimbari Dhlombo, 2008, Muthoni Kememi, 2006, Nyamukapa, Gegson 2005).

CHAPTER THREE: METHODOLOGY

3.1 Research Design

A cross sectional research design was employed in undertaking this study that sought to assess challenges faced by orphan caretaker families and their coping strategies. The cross-sectional analysis was intended to bring out relationships between and among variables at one point in time.

3.2 Study Area

The study was conducted in Bushenyi District, which was purposively selected considering that it is among the Ugandan districts worst hit by the HIV and AIDS epidemic, with prevalence estimated at 5.9% (GOU- HIV Sero-Behavioural Survey 2004-2005). It is also within the region of Uganda with the poorest child health indicators, shown by high levels of child stunting, wasting and underweight (GOU- UDHS, 2006). These indicators reflect serious inadequacies in child care. The district has also been affected by wars, the most recent being the Allied Democratic Front (ADF) rebellion. Although there are no data to show the orphan burden in the district, anecdotal evidence shows a picture similar to the rest of the country where at least one in three households have an orphan. Lastly, the district was selected because the researcher was conversant with the local language of the district and hence it was not necessary to hire interpreters to translate the tools. This made it possible for the researcher to maintain quality assurance over the data collection process, besides easing the costs. There are thirty sub-counties in Bushenyi District. Using the lottery method, Bugongi sub-county in Sheema County was randomly selected for the study.

3.3 Study Population

The study population consisted of both orphans aged thirteen to seventeen years as well as adult men and women who had the primary responsibility for providing care to the orphans that were enrolled in the study. The study targeted orphans irrespective of the cause of their orphanhood.

They provided information on the type and quality of care they receive, the challenges they face as orphans and what they were doing to cope with the challenges.

Caretakers provided information regarding the various forms of care they provide, the challenges they face, strategies they use to overcome the challenges and their personal perceptions on the quality and effectiveness of the care they offer to orphans. Local council officials with responsibilities linked to childcare were also included. They helped to provide information on community initiatives currently being undertaken in regard to care and protection of orphans. The District Probation Officer for Bushenyi District was also interviewed to gain insight into the policy environment in regard to orphan care in the district.

3.4 Sample Size and Selection

Bugongi sub-county is constituted by four parishes of Karera, Rugarama, Isingiro and Kyamurari. Using the lottery method, two parishes of Karera and Kyamurari were randomly selected for the study. The two parishes have a total of thirty one (31) villages, fifteen (15) in Kyamurari and sixteen (16) in Karera which formed the sampling frame. From each parish five (5) villages (approximately 30% of the total) were randomly selected using a lottery method to give a total of ten villages in the two selected parishes. In each village (LC1) a list of households with orphans was generated with the assistance of the Local Council leaders. A total of 500 households were listed in the ten villages. From the 500 households listed, 50 (10%) were selected for inclusion in the study. This sample was determined on the basis of the resources available to the researcher. Also given that the study was not purely quantitative and that the selected study villages shared similar socio-economic characteristics, a sample of fifty (50) households representing 10% of the total eligible households was deemed to be sufficiently representative and inferable.

In each village, the list of the households with orphans formed the sampling frame from which the five households were randomly selected. Systematic random sampling was used to select the households in which to conduct interviews. First, a sampling interval used in each village was derived by dividing the total number of registered households caring for orphans by the desired sample size of five (5). Therefore, the sampling interval varied, in tandem with the number of families caring for orphans in each village. After determining the sampling interval, one household from which to begin sampling was randomly selected from the entire sampling frame in each village. Subsequently, households were selected according to the sampling interval generated for each village.

At household level, caretakers with the primary responsibility for the care and support of the orphans in that household were interviewed. In situations where it was felt that the responsibility was equally co-shared, caretakers were offered the opportunity to decide who among them would be interviewed. Eligible orphans for the study were those aged thirteen years and above. Children below this age were considered too young to provide the desired information and to withstand the likely emotional feelings that could be aroused by the interviews. In each household, the target number of orphans to be interviewed was two (2). In households which had more than two eligible orphans, those to be interviewed were selected using a random sampling technique, but special attention was paid to ensuring gender equity.

The study covered a total of fifty households selected from a total of 500 households with orphans in the two parishes. As shown in Table 1, fifty caretakers and fifty two orphans were interviewed. Eight Local Council Chairpersons and one Probation and Welfare Officer were also interviewed. Five of the eight Local Council Chairpersons were drawn from Karera Parish while three were from Kyamurari. Two Local Council Chairpersons in Kyamurari were not accessible as they were not in the area at the time of the interview. Of the eight Local Council leaders, two were female, one from each of the two parishes.

Table 1: Distribution of Respondents

Respondents	Caretakers (N=50)		Orphans (N=52)		Community Leaders
	n	%	n	%	
Kyamurari	21	42	16	31	3
Karera	29	58	36	69	5
Total	**50**	**100**	**52**	**100**	**8**

3.5 Methods of Data Collection

Both quantitative and qualitative techniques were used to collect data for the study.

3.5.1 Quantitative Techniques

Semi-structured questionnaires with both pre-coded and open-ended questions were used to collect quantitative data from caretakers and orphans (Appendix I and II). Pre-coded aspects of the questionnaires focused on variables such as age of respondents, household size, level of educational attainment, income as well as relationships between caretakers and orphans.

The open-ended questions helped the researcher to get a deeper understanding of the problem of orphans in the study area, and in particular, to discern the challenges families face in providing care to orphans and the strategies they have adopted to cope with these challenges. They also provided insight into the conditions orphans live in, the problems they face in caretaker families and the strategies they use to mitigate these problems.

3.5.2 Qualitative Techniques

Qualitative data was collected from selected key informants using interviews guides, one for the local leaders and another for the District Probation and Welfare Officer (Appendix III and IV).

These interviews helped to capture community leaders' perspectives on the orphan problem and how families are coping with the burden. In addition, in the course of collecting primary data, particularly during interviews with caretakers and orphans, direct observation was also used as a complementary method. It assisted the researcher in collecting anecdotal and other information on aspects such as the household economy, living conditions, health and welfare of the orphans which could otherwise not be captured through formal interviews.

Secondary data was also corrected from various documents that were deemed relevant to the study, such as current national orphan policies and programs as well as reports from surveys and special studies related to orphan care in Uganda and other countries. Findings from these sources were used to corroborate some of the primary study findings.

Data from all these sources were triangulated to make generalizations and eventual conclusions on the challenges and coping strategies with respect to orphan care at family level.

3.6 Data Processing and Analysis

Qualitative data were generated from open-ended questions. The researcher checked all the filled questionnaires for completeness and accuracy. In line with the objectives of the study, responses from open ended questions, were grouped into similar or related categories to generate themes each of which was given a unique label. Subsequently, data codes were assigned to each identified variable under the themes. This helped reduce and attach meaning to qualitative data in line with the study objectives. The data was then exported into the Statistical Package for Social Scientist (SPSS) for final cleaning and eventual analysis.

With regard to quantitative data, a data entry template was developed, which included validation rules that helped to reduce possible data entry errors. Validation rules included limiting entry options according to the categories provided in the questionnaire.

For instance if a questionnaire had skips, these were also implemented in the data entry template. Data was then entered into the computer using Epidata software. Data was analyzed using SPSS and Microsoft s Excel. In SPSS, data was first imported from the Epidata to SPSS and analysed to generate frequency distribution tables and cross tabulations of key identified variables. Graphs were then generated using Ms Excel and then exported to Ms Word. Key phrases or statements on emerging issues and verbatim quotes have been integrated into the report to augment results.

3.7 Quality Control

Data collection staff was carefully trained for three days to ensure that they internalize the study rationale, objectives and were conversant with the tools before they were dispatched for data collection. During the training, the study objectives and methodology were clearly explained and interviewing techniques comprehensively demonstrated. The data collection team was familiar with Runyankole (the local language of the study area), hence, tools were maintained in English for straightforward translation during interviews. However, all questions and their translated versions were reviewed and cross checked before the data collectors were dispatched to the field. Responses were recorded as given and translated in English verbatim in order to maintain the content and spontaneity.

At the end of each day, a meeting was held between the data collectors and the principal researcher to review the filled questionnaires as well as the documented responses. This helped to ensure consistency and accuracy of the findings. The principal researcher also made follow up visits to sites where data collectors were deployed to ensure that they were interviewing the right people.

3.8 Ethical Considerations

Throughout the whole study, the researcher paid keen attention to ensure that the study was conducted in line with the basic ethical considerations for research studies involving human subjects. Foremost, consent had to be sought from all individuals involved in the study. Even after they were enrolled, respondents were given latitude to withdraw from the study at any time if they felt that their integrity and confidentiality were compromised.

Confidentiality was strictly observed and efforts were made to ensure that individual responses remain anonymous. All participants were voluntarily enrolled into the study and no form of enticement was used for this purpose. Interviews were undertaken in an informal manner, not to raise curiosity within the community and anxiety among participating families. Questions in the study tools focused on the subject and as much as possible, nothing outside the scope of the study was discussed.

CHAPTER FOUR: FINDINGS AND INTERPRETATIONS

4.1 Introduction

This Chapter presents the findings of the study along the study objectives indicated in Chapter One. The study had three objectives, namely; to explore the nature of care and support given to orphans, assessing the challenges faced by families in providing care and support to orphans, and to assess the strategies adopted by families to address the challenges associated with orphan care. The findings are presented along these objectives and analyzed along the core care elements provided by caretakers, namely; food, shelter, education, health and psychosocial support.

4.2 Profile of the Caretakers

As indicated in Table 2, forty six percent of caretakers were old people, most of whom were over fifty years of age. Cross-tabulation of age and marital status revealed that fifty six percent of those above sixty years were widowed of whom forty four percent were female and twelve percent male. Majority of the caretakers were peasants and depended on sale of crops and livestock as the main source of income.

It was not possible to establish a fair estimate of the average annual or monthly incomes of the households as caretakers did not have data nor could they discern what they earned. However, anecdotal reports, guess estimates from caretakers and observations by the researcher indicated that annual incomes could not exceed 200,000/= a year.

Table 2: Profile of Respondents

Respondent Characteristic	Caretakers (N=50)		Orphans (N=52)	
	n	%	n	%
Sex				
Male	18	36	23	44
Female	32	64	29	56
Total	50	100	52	100
Education Level				
None	22	44		
Primary	22	44	40	77
Secondary/Tertiary	6	12	12	23
Total	50	100	52	100
Age of Respondent				
13-14	-	-	30	58
15-17			22	42
18-30	6	12	-	-
31-40	10	20		-
41-50	11	22	-	-
51-60	6	12	-	-
61+	17	34	-	-
Total	30	100	52	100
Marital Status				
Single	3	6		
Married	17	34		
Separated	1	2		
Widowed	29	58		
Total	50	100		
Source of Income				
Self Employment	5	10		
Salary/Wage	7	14		
Crops/Livestock	37	74		
Other	1	2		
Total	50	100		
Relationship of Caretaker to Orphan				
Mother	17	34		
Father	1	2		
Grandparent	23	46		
Brother/Sister	3	6		
Uncle/Aunt	6	12		
Total	50	100		

Table 2 shows that fifty eight percent of the orphans that participated in the study were aged thirteen to fourteen years. In terms of relationship to caretakers, thirty six percent of the orphans were living with one of their

living parents, mostly mothers (thirty four percent) and only two percent living with their surviving father. This is consistent with findings from other studies on orphans in Uganda which showed that maternal orphans, those whose mother had died but whose father is still living were less common than paternal orphans (UBOS/Macro International Inc., 2006; Wakhweya et al., 2002).

All the orphans living with a surviving parent were kept together in one household. In all the families headed by single parents, there were no instances where orphans were living elsewhere. Grandparents provided the bulk of the care for orphans with twenty four percent being grandmothers and twenty two percent grandfathers. Only sixteen percent of the caretakers were uncles, aunts, brothers and sisters of the orphans under their care. The predominance of the grandparents as orphan caretakers is consistent with findings from other studies in Uganda (Kamya and Poindexter 2009; Oleke et al. 2007) as well as other parts of Africa (Chirwa, 2002; Mangoma, Chimbari, Dhlombo, 2008; Nyambedha, Wandibba and Aagaard-Hansen, 2003). Analysis of the age of caretakers who were caring for their brothers revealed that they were all above twenty years of age. Therefore, interestingly there were no child caretakers, and neither were there any orphans living with caretakers to whom there was no blood relationship. This implies that the cultural role of the extended family in absorbing children of deceased relatives could still be strong in the study area.

The age and social-economic pattern of caretaker households revealed by the study has considerable implications on the capacity and quality of care provided to orphans in these households. With the majority of caretakers being aged, less educated and depending on subsistence income, it is legitimate to expect that care for orphans is fraught with considerable challenges. For instance, many grandparents felt inadequate as quite often they were not able to respond to the essential needs of children under their care, such as food, clothing and education.

Findings from other studies on orphan care (Subbarao and Coury 2004; Oleke et al 2007) similarly indicate that although grandparents may provide a secure and loving environment, they find it difficult to respond to children's essential needs due to the strong material constraints they face.

4.3 Nature of Care Provided to Orphans

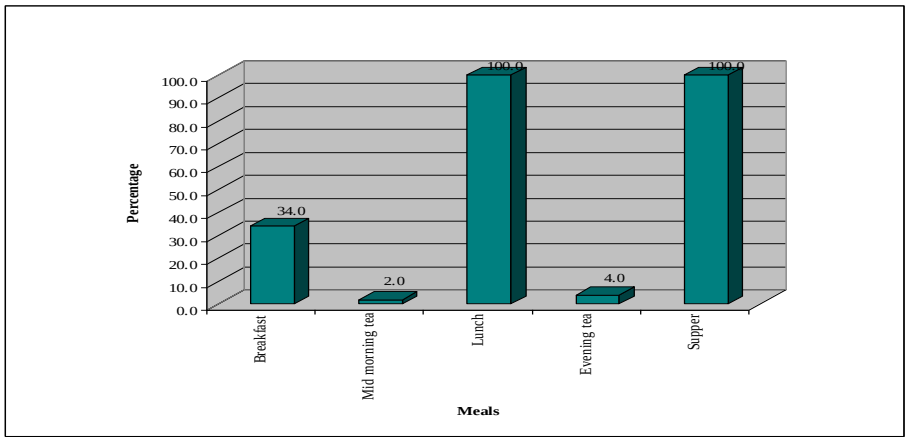
This objective aimed to establish the nature of care that orphans receive from the caretakers. Seventy eight percent of the caretaker households covered by the study were providing care to two or more orphans, all of whom were living in the same household. The mean number of orphans per household was three, with a minimum of one and a maximum of six orphans. Most households were providing care to a large number of orphans below ten years of age. Albeit with substantial constraints, orphan caretaker households made impressive attempts to provide almost all the required care considered essential for the survival and growth of a child. These include food, shelter, protection, education, health care and psychosocial support.

4.3.1 Food and Nutrition

Good nutrition is a key factor in human development, particularly for children. Children need sufficient quantities of proteins in order to grow, recover from illness and to guarantee proper cognitive growth. This study found that predominantly households survive on food locally produced in the gardens which strengthens their ability to address the orphan problem. They purchase food from the market only in times of famine. Children, including orphans engage in household food production by contributing labour to grow and tend food crops. Matooke, beans and vegetables were the most common foods eaten in the households covered by the study. Cereals and grains had become rare due to shortage of land. The frequency of meals was found to be below the internationally recommended level for children.

The recommended standard is that children should have at least four to six meals per day, depending on the energy density of the local foods and the amounts consumed at each feeding (WHO, 2005). Figure 2 below shows that very few households were able to provide the minimum four meals recommended in a day. Only thirty four percent of the households provided breakfast, served with porridge, milk and sometimes food left over from the previous supper. Mid morning and evening meals were rare, only provided in two and four percent of the households, respectively.

Figure 2: Meals provided by orphan caretaker families



Given that the local foods consumed, mainly matooke and vegetables, were of low energy density, it is implied that children were operating below their optimum daily calorie needs. Failure to provide the minimum recommended meals was closely correlated with the age of caretakers. For instance, breakfast was provided in only two of the seventeen households headed by caretakers above sixty years of age. No evening meals were provided by any caretaker in this age bracket. Similarly, only two of the eleven caretakers above forty years of age provided breakfast while only one caretaker in this age bracket offered evening tea. Failure of orphan caretaker households to provide the meals nutritionally recommended per day seems to be a consistent and growing problem. Wakhweya et al (2002) point out similar findings where sixty seven percent of orphan caretaker households were unable to provide three meals required in a day.

Other studies in Uganda (Kamya and Poindexter, 2009; Kikafunda and Namusoke 2006) and from other parts of Sub-Sharan Africa (Mangoma, Chimbari, and Dhlombo, 2008; Nyamukapa and Gregson, 2004) all attest to the inability of orphan caretakers to provide the required number of meals and the diversity of foods that are ideal for children to thrive.

There was no comparative analysis of the nutrition and feeding patterns of other families without orphans. However, interviews with local leaders and informal discussions with residents in the study area revealed that food and nutrition was a general problem in homes. They asserted that provision of the required three meals in a day was not a mundane practice in many households and hence the failure could not be wholly attributable to the orphan problem. However, in a situation where food and nutrition indicators are generally bad, orphan caretaker households, particularly those headed by the elderly can rationally be expected to be worse off.

4.3.2 Shelter

In terms of shelter, majority of the orphans covered by the study were staying with their caretakers in their households. This guaranteed them reasonable security and protection. The families were able to provide love, sense of belonging and social connections which are key ingredients in orphan care. The study did not find any cases of children living on their own without any adult caretakers or situations where children had slipped off the traditional safety nets to the streets. All households covered by the study had detached houses. Most of the houses were semi-permanent, constructed with mud and poles. In some homes, houses were in a state of dilapidation, with leaking roofs and cracked walls. This heightened anxiety among the affected caretakers about their ability to sustain the care they were offering to the children. In all the households covered by the study, the average number of sleeping rooms were two, but a significant number of homes had one bedroom. In such homes, parents were sharing bedrooms with their children, which raised serious concerns on their privacy and that of their children especially those in adolescent ages.

As shown in Table 3, caretakers generally expressed dissatisfaction with the quality of shelter they were providing to orphans with seventy six percent of the mothers, the lone father and eighty seven percent of the grandparents reporting that they were not addressing shelter for children as adequately as they would have wished.

Table 3: Caretaker perception on quality of shelter offered to orphans

Category of caretaker (N=50)	Satisfied		Not Satisfied		Total	
	N	%	n	%	n	%
Mother	4	24	13	76	17	100
Father	0	0	1	100	1	100
Grandparents	3	13	20	87	23	100
Brother	1	33	2	67	3	100
Uncle/Aunt	5	75	1	25	6	100

The major concern was on beddings, particularly blankets, bed sheets and mattresses. Caretakers were further asked whether they were able to provide separate bedding for their orphans. Table 4 below indicates that only twenty four percent of the caretakers were in position to provide separate bedding for the orphans under their care.

Table 4: Bedding status for orphans in the caretaker families

Availability of separate bedding for orphan?	**Caretakers (n)**	**Percent**
Yes	12	24
No	38	76
Total	**50**	**100**

Ability to provide separate bedding was cross-tabulated with the category of caretakers. Table 5 shows that predominantly, sharing of beddings was found to occur among children under the care of their mothers, with ninety

four percent of them unable to provide separate beddings for their children. Similarly seventy percent of the grandparents were unable to provide separate beddings.

Table 5: Bedding status of orphans by category of caretakers

Category of Caretaker (N=50)	Able to provide separate bedding for orphans under your care?					
	YES		NO		Total	
	n	%	n	%	n	%
Mother	1	6	16	94	17	100
Grandparent	7	30	16	70	23	100
Other	4	40	6	60	10	100

When further analysed in terms of the number of children in the households, it was found that of the caretakers who were able to provide separate bedding for their children, sixty six percent had one to four children under their care. The number of providers who were able to offer separate bedding declined further as the number of children cared for increased. This implies that the quality of shelter provided to children is closely linked with the number of children living within the caretaker household. Interestingly, in households caring for orphans who were not their biological children, there were no reports of differential or preferential treatment with regard to household provisions such as beddings. Orphans and biological children were all sharing the beddings that were available. In a study on the politics of orphan care at household level, Abebe and Aase (2007) similarly found out that caretakers were doing all they could to maintain equity and fairness in distributing resources among children under their care.

Level of income and external support, notably cash transfers and other in-kind support from relatives were also found to have great influence on the ability and ultimately satisfaction of the caretakers with the quality of shelter they offered to orphans.

For instance, all the uncles, aunts and brothers who expressed satisfaction with the quality of shelter they provide were either engaged in business or employed and earning regular salaries. Similarly, nineteen percent of the mothers and fourteen percent of the grandparents who reported that they were satisfied with the shelter offered to orphans were receiving external assistance from relatives. The importance of external assistance in enabling families to care for orphans has been documented in other studies (Kalibala and Elson, 2009; Muthoni Kimemia, 2006; Odhiambo-Oburu, 2004). Drawing from data presented in other household surveys in Uganda, lack of separate beddings for children appears to be a general problem within orphan and non-orphan households alike. For instance, the National Household Survey (2005/2006) indicates that only 35% of households in Uganda had children having a separate blanket. Therefore, while orphans may exert additional pressure, it is acknowledged that orphans get absorbed into households already constrained and hence the poor conditions pertaining in affected households may not be discretely attributable to orphan care.

4.3.3 Education

Education was considered to be the most essential form of care provided to orphans and caretakers believed it was the only way they would guarantee the future of their children. Many caretakers who were illiterate believed that they were poor because they did not go to school. From interviews with caretakers and orphans, it was evident that while they faced challenges in various areas, their main concern remained focused on how to raise income to defray costs of education. Besides promising a bright future, they intimated that keeping children in school also helped them to keep away from exploitation and abuse and also to form networks of social interaction that are essential for future growth and development. Therefore, within the limits of the resources available, caretakers have attempted to keep orphans in school.

"I have to pay school fees first. That is my vision of giving them a better future. I have suspended everything else. I have sold all the goats and they are now finished", Widow.

Table 6 shows that all the orphans covered by the study were enrolled in school, with fourty (seventy seven percent) in primary and twelve (twenty three percent) in secondary level. Cross-tabulation of sex and access to education revealed no major variation between sexes in terms of access to education. Of the fourty orphans attending primary education, twenty three (fifty seven percent) were males while seventeen (fourty three percent) were females. A similar pattern is maintained at secondary level. Of the twelve orphans accessing secondary education, seven (fifty eight percent) were girls and five (fourty two percent) were boys. Good school enrollment for orphans, especially in lower levels of formal education has been consistently documented in studies on orphans in Uganda (Kalibala and Elson, 2009; Wakhweya et al., 2002). It is a reflection of caretaker resolve and attempts to guarantee better future for their children but it could also be a reflection of the frantic efforts made by families to preserve the level of care received by children immediately after the death of parents, which later fizzles out as realities of limited resources unfold.

Table 6: Education enrollment of orphans by sex

Orphan (N=52)	Education Level				Total	
	Primary (n)	%	Secondary (n)	%	n	%
Male	23	44	5	10	28	54
Female	17	33	7	13	24	46
Total	40	77	12	23	52	100

Most of the orphans were pursuing primary education through public day schools which were relatively cheaper and required less material inputs.

In addition, day schools were preferred as they allow opportunities for children to contribute labour to deal with a host of domestic chores. This was essential given that children provided much of the labour to grow food. Although this could be considered an effective strategy for maintaining orphans in school, while simultaneously meeting their feeding needs, it was noted that in some households, labour for agriculture and other domestic work was not equitably distributed among all children. Orphans were more likely to meet more of the labour requirements of the households than non-orphans.

> ***"The orphan was put in a nearby school so that he can come home early after school to help with family chores. Mine are studying from far and come home late. They cannot do chores at home. He has to come home early and help in family work", Female Caretaker (Aunt).***

The inequitable distribution of domestic work has also been documented elsewhere, especially in families that are financially constrained. Oleke et al. (2007) found many instances where orphans were segregated in caretaker households, being required to do much more work than other children, Similarly, Mangoma, Chimbari and Dhlomo (2008) encountered similar revelations in their study of problems and wishes of orphans in Zimbabwe. They note that children reported that they were beaten, forced to work for longer hours after school, and were assigned numerous errands, while children of the caregivers living in the same household were not treated the same way.

4.3.4 Health Care

Seventy eight percent of caretakers reported good health for orphans under their care. Only six percent and sixteen percent of the caretakers reported that their children were sickly and sick, on and off, respectively. Table 7 shows that unlike in education where orphans were predominantly sent to government schools, majority of the caretakers sought medical care for their children from private clinics when they fell sick.

The major reason given was that government health units were prone to drug stock-outs and hence making it difficult to get the prescribed treatment.

Table 7: Sources of Healthcare for Orphans

What do you do to treat your children when they fall sick?	**n**	**%**
Buy medicine from drug shop	2	4
Buy medicine from traditional healer	1	2
Take the child to a private clinic	26	52
Take child to public hospital	19	38
Other	2	4
Total	50	100

Caretakers reported that they had established relationships with the private health care providers, which enabled them to receive treatment for their children on credit. This enabled them to get quality health care at reasonable and affordable terms. This health care seeking pattern was consistent with findings from the Uganda National Household Survey (2005/2006) which noted that forty five percent of Ugandans sought medical care from clinics. The survey similarly noted that health providers in private clinics were perceived to act professionally while others offered services on credit.

Source of health care for orphans was cross-tabulated with the profile of caregivers. Table 8 shows that private clinics again emerged as the main source of health care for orphans. Interestingly, grandparents sought health care for orphans from private clinics more than biological mothers of the orphans. Other caregivers, notably uncles, aunts, brothers and sisters predominantly seek health care from private clinics.

Table 8: Source of healthcare for orphans by category of caretakers

Caregiver (N=50)	Buy Medicine		Use herbal medicine		Private Clinic		Public health unit		Others		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
Mother	1	6	1	6	7	41	8	47	0	0	17	100
Grandparent	1	5	0	0	13	55	8	36	1	4	23	100
Other	0	0	0	0	7	70	3	30	0	0	10	100

While income and number of children under care may be a factor in the latter case, for the case of mothers and grandparents, the desire to access quality services was a major driver influencing them to seek care from private providers. Given that majority of them were peasants and depending on subsistence income, procurement of health services for orphans in private clinics was an indicator of the burden they carry in providing care.

To many caretakers, health was perceived exclusively in the context of absence of disease. Therefore as long as orphans under their care were not sick, they were regarded to be in good health. However, interviews with orphans revealed that there were other essential elements of health care that caretakers do not provide. For instance essential commodities required to meet basic hygiene such as clothing, soap, vaseline and sanitary pads for girls were repeatedly reported as main constraints to preservation of a minimum standard of health. Although most of the orphans reported that they had learned to live comfortably with what their caretakers can afford, failure to provide essential commodities, especially for girls put them in a situation of potential vulnerability.

Other studies (Kalibala and Elson, 2009; Mangoma, Chimbari and Dhlombo, 2008) similarly found out that basic sanitation was seriously in lacking and was an often ignored component of healthcare within orphan caretaker households. Girls, in particular could succumb to scrupulous men who could promise to address their immediate needs. Alternatively, children stood a risk of being forced into child labour to be able to raise money to meet these needs.

4.3.5 Psychosocial Support

Emotional care of children, especially in the era of rising orphanhood due to increased adult mortality has increasingly been acknowledged as an important, but often ignored component in the orphan care landscape. Any child's social and emotional development is compromised if parents or caretakers fail to identify stress and social dysfunction, and give adequate guidance, care and love. However, emotional distress is less tangible than the material needs and hence difficult to identify especially in situations of many pressing and competing needs. Table 9 shows the prevalence of psychosocial and emotional problems among orphans. Stress, often manifesting through loss of interest in age-appropriate play and withdrawal was found to occur very often among thirty nine percent of orphans. Thirty seven percent and nineteen percent of orphans respectively very often suffered feelings of uncertainty about their future and discrimination by peers at school and at home. However, despite the prevalence of discrimination, both at home and school, it was interesting to note that it was the least commonly felt psychosocial problem, reported to occur only sometimes and rarely among twenty three percent and fourty eight percent of the orphans, respectively.

Table 9: Prevalence of psychosocial problems among orphans

Experience (N=52)	Stress		Uncertainty		Discrimination	
	n	%	n	%	n	%
Very Often	20	39	19	37	10	19
Often	9	17	9	17	5	10
Sometimes	14	27	8	15	12	23
Rarely	9	17	16	31	25	48
Total	52	100	52	100	52	100

Atwiine, Cantor-Graae and Bajunirwe (2005) similarly found immense psychosocial needs among orphans in a related study in Uganda. Some caretakers reported that most of the psychosocial problems of orphans originate from issues such as lack as of material provisions which, quite often the caretakers are not in position to offer.

These reported predictors of psychosocial distress among orphans were cross-tabulated with the category of caretakers with whom orphans lived. Stress and uncertainty about the future were the most common psychosocial problems faced by orphans under the care of all caregivers except aunts. Feelings of uncertainty and pessimism about the future were more prominent among orphans under the care of mothers and grandparents, particularly grandmothers. It was surprising to find that orphans under the care of their surviving mothers were prone to psychosocial problems when in fact they are supposed to be living in an environment of optimum care and love. These psychosocial problems mainly stem from the failure of the mothers to provide the basic physical needs, hence implying that in order to provide effective care for orphans, basic, physical and psychological needs must be in balance. This finding is consistent with that of Oleke et al (2007) where in a study on orphan care in Northern Uganda they found in the context of severe impoverishment, it was not possible to find a consistent and predictable profile of orphan vulnerability.

They assert that it is possible to encounter orphans well and lovingly cared for by other members of the extended family, or those deprived or even abused by their maternal kin.

Asked as to what they do address the psychosocial needs of orphans, seventy two percent of the caretakers reported that they offer counseling and support to encourage the children cope with their problems. However, further analysis of the individual responses revealed that caretakers respond in a variety of ways, ranging from providing one-one psychological support, soothing and sometimes giving false promises, to outright rebuking. In other instances, caretakers reported that they pray, or sometimes slip into denial and imagine that no such things are happening with their children.

> ***"I persuade them and promise to buy them nice things such as shoes and new clothes. Then you see them resuming their normal life", Grandmother.***

> ***"I sympathize with them and also often cry with them. Sometimes I bark at them to stop worrying and nagging. When you bark at a kid, he/she stops and forgets everything", Grandfather.***

Orphans too, were not doing anything to address the psychosocial problems that they confront. Asked as to what they do when they feel stressed, uncertain or discriminated both at home and school, majority reported that they just keep quiet. This is by no means a solution to their problems. It is a clear indication that orphans have no viable support system through which they can address their emotional needs.

In general, within the limits of their meager resources, families caring for orphans were found to have done an excellent job in addressing the basic care needs of orphans, including food, shelter, basic education, health and social protection. Although some of the needs may be partially met or not met at all, the efforts thus far should be commended. The absence of children living on their own or with non-biological relatives in the study area attested to this incredible effort.

4.4 Challenges Faced by Families in Caring for Orphans

This section presents findings from the study with regard to the challenges that families are facing in providing care to orphans. The challenges are discussed and presented along the five core elements of care that families provide as described in the previous section. These include food/nutrition, housing/accommodation, education, psychosocial support and health care.

4.4.1 Food and Nutrition

With regard to food and nutrition, the study found out that families were to a large extent able to meet their own feeding requirements with locally produced food such as motooke, beans and vegetables.

However, due to high population density in the study area, land shortage was acute and had begun to impact negatively of the household capacity to produce adequate food. Families faced with shortage of land rented pieces of land on which to grow seasonal crops such as millet, beans and sweet potatoes. Besides carrying a prohibitive cost, renting of land was reported to limit household initiatives to diversify the crops and consequently led to limited dietary diversity. For instance, grains and cereals such as millet, peas, groundnuts, soybeans, and root crops such as cassava and sweet potatoes are no longer extensively grown in the study area due to acute land shortage. This is consistent with other previous studies (Ntozi and Mkiza-Gapere 1995; Tapouzis, 1994) which indicate serious impacts of land shortage on the amount and diversity of food crops produced in families caring for orphans. Without foods that can be stored for future use such as grains and cereals, household capacity to guarantee food security was found to be negatively affected and the vulnerability to vagaries of weather and the consequent episodes of famine very high.

During interviews, caretakers indicated that they were unable to provide the different types of food that children often demand. These mainly included foods that are not locally produced and have to be procured from the market such as rice, bread, posho and meat. Depending on the economic conditions in a household, such foods were only provided during festive seasons.

To the caretakers, failure to provide these foods, especially on festive days like Christmas was a common source of stress and parents or caretakers often perceived themselves as having failed to sustain the welfare of the households.

> ***"They need good feeding. They almost have no food. They don't even know how soda tastes; yet they talk about it so much. They always ask for posho, which I can't afford. When they eat lunch, I fail to get what to cook for them for supper. Should I steal? Even where should I steal from?" Grandfather.***

It was interesting to note, however, that although caretakers were finding difficulties in meeting the feeding and dietary needs of their children including orphans, this challenge could not be mainly attributable to caring for orphans. For instance, when asked as to what impact care for orphans had on the welfare of the households, only eighteen percent of the caretakers reported that food has reduced. Caretakers, especially widows who were looking after their own children said they were facing problems as a result of the death of their husbands who used to provide the food required by the children. Caretakers caring for orphans that are not their biological children similarly attributed lack of food in sufficient quantities and varieties to inadequate income. The implication is that even without orphans families were already too overstretched to adequately meet their own food requirements.

4.4.2 Shelter

In terms of shelter, findings from the study indicate that accommodation was perhaps the most problematic need for caretakers to address. Only twenty four percent of the caretakers were able to provide basic bedding and dressing to orphans. In a normal situation, basic bedding for a child would at a minimum constitute of a bed, blanket, soft mattress and bed sheets (UBOS/Macro International Inc., 2006). Responses from caretakers, orphans and the researcher's own observation revealed that the quality of shelter for children in households covered by the study was wanting, and in some households appalling.

In one in four of the households covered, children were sleeping on the floor, with mattresses made of synthetic sacks and filled with grass.

> ***"They don't have beddings to speak about. I make mats and spread them on the floor for them to sleep on. I cover them with my dress and in the morning when I find they have not urinated on it, I put it on. Coldness causes them constant fever. I have nothing to do. The little money I get I spend it on school fees", Widow.***

Seventy six percent of the children covered by the study were sharing beddings. While this may be commended as an approach to manage within the little resources available, it could also have serious implications for the health of the children as the risk of communicable diseases afflicting the entire household could be heightened.

> ***"They share accommodation. They sleep in twos. I cut the blanket into two pieces and gave a piece to two children and another piece to the other two. They don't have mattresses and they don't have beds. They have a sack filled with grass and that is what they use as a mattress", Grandmother.***

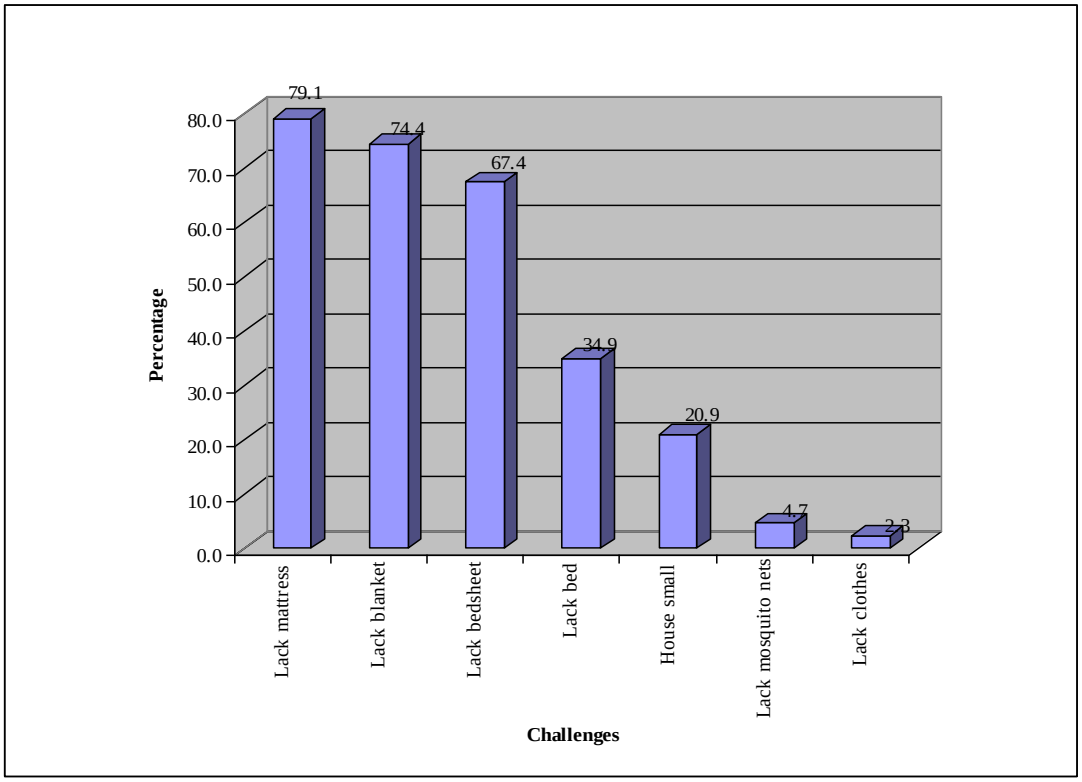
Some caretakers reported that even as they shared the beddings, available blankets or sheets were not enough to cover all the children and that it was common for fights to break out during the night as they struggled for the lone blanket or bed sheet.

> ***"When it comes to night time, they start fighting for the blanket. They start fighting each other that one has slept badly and taken the whole blanket", Widow.***

Figure 3 presents a summary of the main challenges associated with shelter, from the perspective of the caretakers. Failure to provide beddings featured as the most pressing problem. Inability to provide basic bedding for children was reported to be another major source of stress for caretakers, particularly in instances where they saw their children shivering in the cold without blankets or sometimes caretakers themselves having to share beds with their grown up children.

In some households, caretakers had given up, arguing that as long as children got what to eat, they would lie anywhere and sleep.

Figure 3: Challenges faced by orphan caretakers in providing shelter



Further analysis of the accommodation challenges was done on the basis of the type of caretakers. Table 10 shows that lack of mattresses featured prominently among all households regardless of the type of caretaker. Surviving mothers and grandparents also faced uphill challenges in regard to provision of bed sheets and blankets, although these were reported as challenges by only less than fourty five percent of other care takers.

Another significant challenge was inadequate space (house too small), reported in twenty four percent, eleven percent and fourty three percent of the mothers, grandparents and other caretakers, respectively. Interestingly despite the prevalence of malaria in the study area, lack of mosquito nets was not reported as a major challenge. Observations during household interviews indeed revealed that bed nets were rare.

Similarly, although many caretakers lamented that children were sleeping on the floor, lack of beds was not prioritized as a major challenge.

Table 10: Challenges of shelter for orphans by category of caretakers (multiple responses)

Challenge	Percent of caretakers facing the challenge		
	Mother	Grandparent	Other
Lack Mattress	82	79	71
Lack bed sheets	71	74	43
Lack blankets	77	84	43
Lack of beds	29	42	27
Lack of mosquito net	6	5	0
Lack of clothes	0	5	0
House very small	24	11	43

These living arrangements are a true reflection of the rupturing nature of the family as a result of poverty and increasing number of orphans in need of care. However, they are not unique to Uganda and in fact were a mirror image of what Abebe and Aase (2007) observed among orphan care households in Ethiopia. It is a clear indication that the challenge of absorbing an ever increasing number of orphans in homes already weakened by poverty and disease may surpass the material ability of many households regardless of their willingness or desire to help.

4.4.3 Education

With regard to education for the orphans, the main challenge was how to raise money to pay school fees and other scholastic materials required by the schools. All public primary schools were receiving government support through the Universal Primary Education (UPE) policy. Ostensibly, education provided through public schools was meant to be free under the UPE program, but parents purchase uniform, scholastic materials and provide lunch to pupils. In addition, schools also required parents to contribute towards things like teachers' welfare, internal examinations and school maintenance. All these translated into a substantial hindrance to accessing education. This was verified in the recent situational analysis of vulnerable children in which Kalibala and Elson (2009: 72) note:

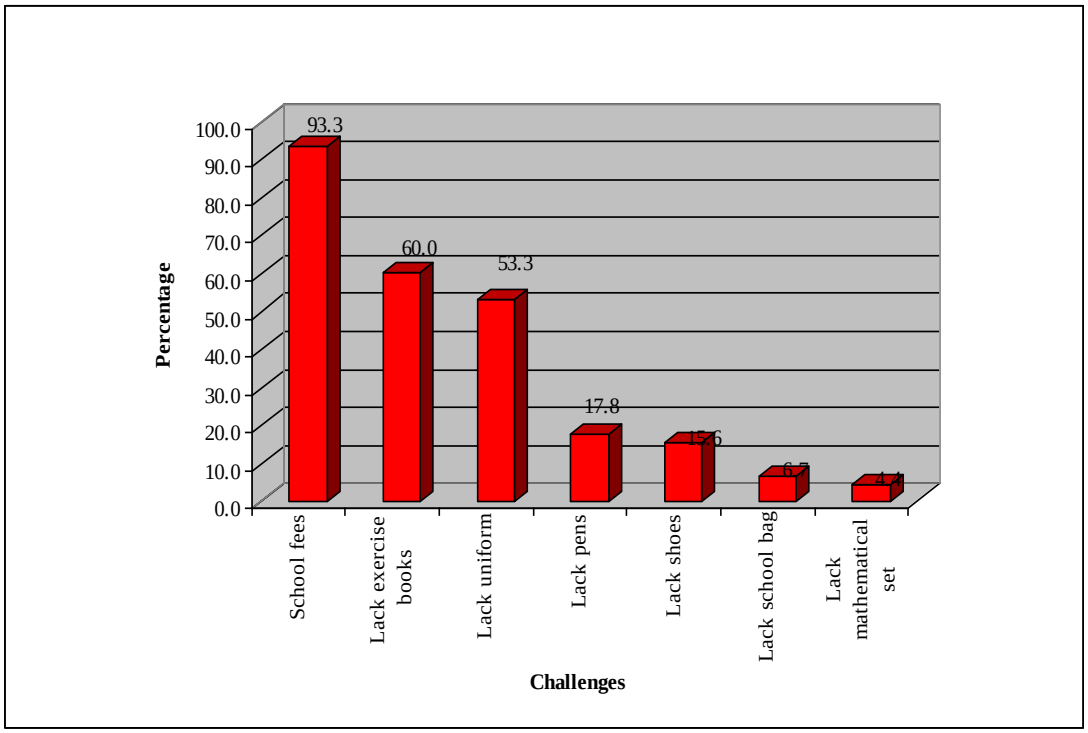
> ***Some respondents (district education officials) mentioned inadequate funding and delays in receiving school and UPE budgets from the government which drove teachers to find resources from families, many of whom could not afford them (and consequently the children dropped out of school). Indeed, the household survey showed that orphaned children had a higher rate of school drop-out than non-orphaned children.***

As indicated in Figure 4, school fees and scholastic materials were reported to constitute the most uphill challenges for the caretakers.

> ***"Quite often she doesn't attend school. Paying school fees is a big problem. Even on her report, they write that she is always absent", Grandmother.***

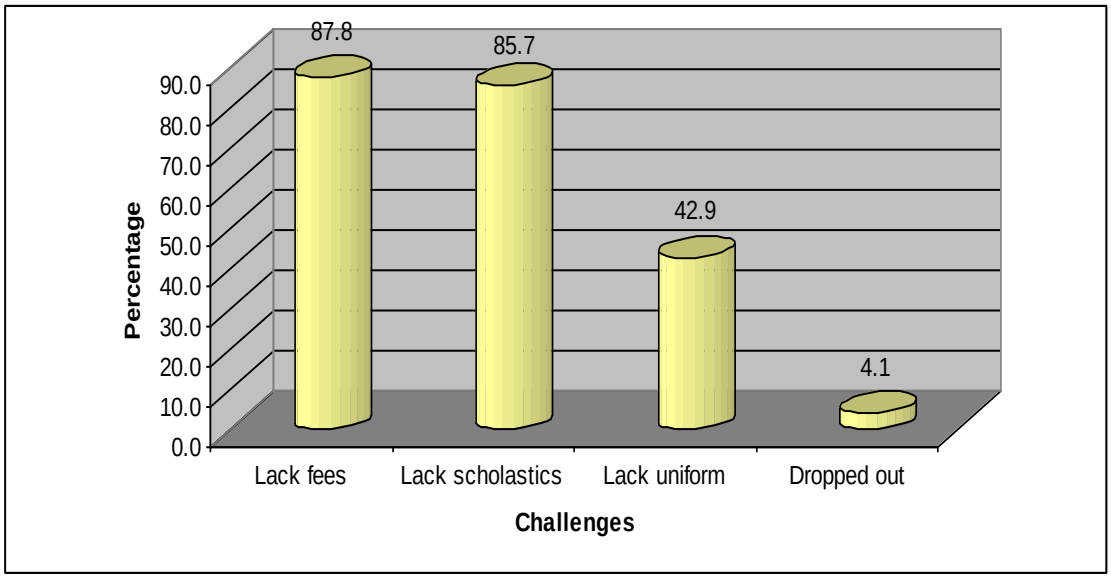
The school fees paid varied greatly between private and public schools, with the latter being the most expensive.

Figure 4: Challenges faced by caretakers in educating orphans



Interviews with orphans revealed the same pattern of challenges, with school fees, uniforms and scholastic materials emerging as the greatest challenges. Figure 5 similarly shows that school fees and scholastic materials were the main challenges affecting orphans' access to education.

Figure 5: Challenges faced by orphans in accessing education



Cross-tabulation of these challenges across different variables such as age, household headship and level of education of caretakers revealed the same pattern, with school fees and scholastic materials emerging as the most fundamental challenges faced in accessing education to orphans. As shown in Table 11, the burden of school fees was universally felt across other caretakers including uncles, brothers, and aunts who were able to provide reasonable quality of shelter for the orphans.

Table 11: Challenges of educating orphans by category of caretakers (multiple responses)

Challenge	Percent of caretakers faced with the challenge		
	Mother	Grandparent	Other
School Fees	94	95	100
Uniform	65	50	38
Shoes	35	5	0
Exercise Books	47	75	50
Pens	12	20	25
School Bag	6	5	13
Mathematical Set	6	6	0

It was further noted that challenges were reported in accordance with the caretakers' perceived level of their significance to the education of the orphan. For instance, although only five percent of the grandparents reported lack of shoes as a challenge, the reality on the ground was that majority of the orphans under their care were going to school without shoes. In this case, shoes were not considered a major hindrance to the education of the orphan. Similarly, although lack of exercise books was felt among forty seven percent of mothers as a challenge, not all the children under the care of the other fifty three percent had all the books they needed. The implication was that in a situation of extreme scarcity of resources, caretakers prioritized the very basic needs such as school fees and uniform that constituted the core necessities for a child to be at school. Others such as shoes, school bags and mathematical sets were felt but not regarded as essential needs.

Due to difficulties in raising school fees and scholastic materials, children attended school irregularly as they were often sent away, and others had to combine school with work to raise the required money to pay fees. Those who combined work with school were prominently aged fifteen to seventeen, with more boys than girls involved. Combining school with work among orphans has been documented in other studies (Abebe and Aase 2007; Mangoma, Chimbari and Dhlombo 2008; Oleke et al. 2005) in which it was generally found to have serious consequences on the academic performance of the orphans. In this study, combing school with work was also found to be associated with irregular school attendance and had potential to cause of low esteem among children as it aroused feelings of loss and hopelessness. The long term implication could be that the affected children could lose interest in education altogether and drop out of school.

> ***"What I do, I go and ferry sand for people in order to get money to pay school fees. Every term they chase me out of school because of uniform. Some of the friends I started school with are now in secondary level. I am still in primary level and it stresses me a lot", Adolescent Orphan.***

The study also revealed orphans were attending school at very late ages. For instance, while the official cut off age for primary education in Uganda was 13 years, it was found out that a significant number of the orphans covered by the study were not in the right grades compared to their age. Table 12 shows that fifty six percent of the children aged fifteen to seventeen years were still attending primary schools. In the lower age bracket (thirteen to fourteen years), ninety three percent were in primary education, when officially they are expected to be in secondary schools.

Table 12: Age and level of education for orphans

Age of Orphan (N=52)	Primary		Secondary		Total	
	n	%	n	%	n	%
13-14	28	93	2	7	30	100
15-17	12	55	10	45	22	100

Attending primary school at late ages was found to have a close association with the type of caretakers that the orphan lived with. As shown in Table 13, of the twelve orphans attending primary schools at the age of fifteen and above, four were under the care of widows. Three of the children were under the care of their brothers, while two were being looked after by grandmothers.

Table 13: Orphans attending primary education late by caretaker category

Relationship of orphan to caretaker	n	Percent
Mother	4	33
Grandmother	2	17
Grandfather	1	8
Brother	3	26
Sister	1	8
Uncle	1	8
Total	12	100

Level of income available to the households and consequent vulnerability of the caretakers had influence on the quality and consistency of support that orphans received for their education. For children living in severely constrained families, the propensity for the caretakers to engage them in non-school related activities such as generating income for themselves and the family as well as providing care for the caretakers was high. This had long term implications on their ability to concentrate on their studies. In addition these children were being stigmatized by their younger counterparts at school, which had deleterious affects their interest and commitment to continue with formal education.

4.4.4 Healthcare

Challenges in regard to healthcare for orphans were directly linked to the apparent lack of quality health services in the study area. All the parishes covered by the study had Health Centre II facilities within an average of 4 kilometers. However, as noted from the study, good geographical distance is not in itself sufficient to guarantee access to quality health care. The quality of services in these health centres was inadequate, characterised by chronic drug stock outs and irregular attendance or total lack of health workers.

Even when providers were there, caretakers and orphans reported that they were handed prescriptions and told that drugs were not available and had to be purchased from the private pharmacies. With no disposable income, caretakers have to raise money to pay for health care from selling crops, working for others, borrowing or even liquidating assets. The study revealed that quite a time, orphans and their caretakers were reluctant to seek medical care from these facilities in the knowledge that they would not find the required treatment at the health units.

> ***Sometimes when I fall sick, I remain here because of lack of money. When I go to Karera health unit, there are no drugs", Orphan.***

Poor services in the public health facilities implied that caretakers had to seek health care from private providers at a cost. Private clinics were found to be the major source of health care for many households with forty one percent mothers, fifty five percent grandparents and seventy percent other caretakers seeking care from these sources. In extreme cases where caretakers were unable to foot the bill for health care, they would resign and just look on. In such circumstances, it was only willing volunteers from the community or immediate neighbours that could intervene to save the orphan. This was often the case where the children were reported to be falling sick on and off.

> ***"I don't sleep. The girl cries the whole night. I think she has AIDS which killed her parents and I am so worried. Nothing can help me", Grandfather.***

In general, the study findings show that healthcare for orphans remains a big challenge, mainly because of poor health services in public health centres. Just like UPE, the government decentralized health services to parish level to improve access. This is goal will be realized if quality issues in service delivery are fixed. Fortunately, and perhaps due to the age of orphans covered by the study, not many of them fall ill frequently, which is a relief to caretakers.

However, in light of the inadequate services available it is realistic imagine that caretakers with orphans in young ages who need intensive health care are facing big challenges.

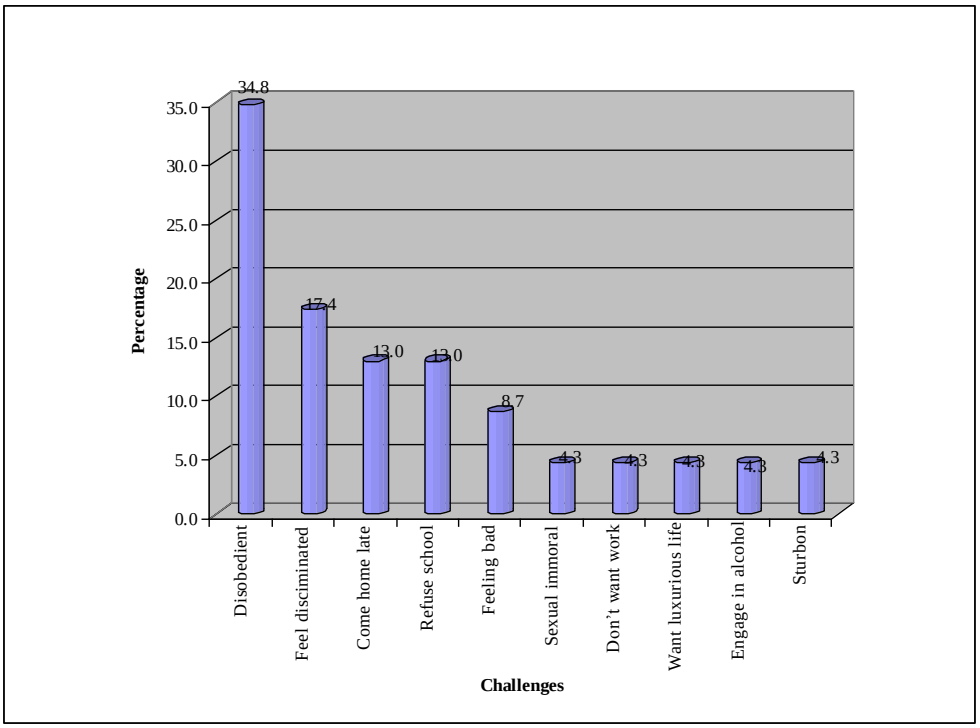
4.4.5 Psychosocial Support

With regard to psychosocial and emotional care, it was generally acknowledged that caretakers lacked the skills and knowledge to diagnose and effectively address psychosocial needs of the orphans under their care. Instead, they considered emotional and psychosocial care within the broader realm of care that orphans received. This may have profound impact on the future of the children since the nature of response to the psychosocial needs of these orphans may have far-reaching impact on their social and emotional development.

Caretakers reported great challenges associated with up-bringing of the children. In households where orphans were under the care of other relatives not their biological parents, efforts were made to ensure that they are brought up in the same way as caretakers' own children. However, it was reported that some of the orphans presented with various challenging behavioral problems.

Figure 6 presents the most common behavioral problems of orphans as reported by caretakers. Disobedience was the most common challenge.

Figure 6: Behavioural challenges of orphans



When cross-tabulated with the category of caretakers, it was found that disobedience was more common among orphans under the care of surviving mothers than any other caretakers. Disobedience was reported as a challenge by fifty five percent of the mothers, twenty five percent of the grandparents and no other caretakers. Although such behaviour could be exhibited by any other children including own biological children, caretakers often linked it with the children's orphan status. Behavioural challenges were similarly reported in a study on orphans in Zimbabwe (Managoma, Chimbari and Dhlombo, 2008) where orphans exhibited various forms of dysfunctional behavior including outright refusal to work, drug and alcohol abuse and running away from caretakers to vend merchandise on the streets in urban areas. Caretakers in this study reported that they were often at a loss as to how to effectively address cases of misconduct without being perceived to be oppressive by the orphans.

In addition, some caretakers, particularly grandparents reported challenges regarding care of orphans whose fathers or mothers they did not know.

In such cases, these were children brought under their care following the death of their sons and daughters previously working and living away from home. Such caretakers were at a loss as to what to do with the children when they eventually grow up. Within the Banyankole culture, children, especially boys are not allowed to inherit property from their maternal grandparents. Therefore, within this context, caretakers were concerned that the affected orphans would grow up to become landless, and without any base on which to establish their own heritage.

Caretakers revealed that they too had major psychosocial problems resulting from the burden of caring for the orphans in the context of very limited resources. These problems were particularly heightened whenever parents/caretakers failed to provide the necessities required by the children under their care.

> ***"I am old, I cannot dig. Sometimes I also cry with them when they cry because I cannot meet their needs. The food has reduced and we eat what we get. I have sold all my sheep to pay school fees" Grandmother.***

The findings indicate that both caretakers and their orphans faced immense psychosocial needs that went unaddressed. The major stressors stemmed from poverty and the resulting failure to have basic needs met. This could in part explain the increasing prevalence of dysfunctional social and behavioural attributes that orphans exhibit. Caretakers could think it was misconduct when actually orphans could be unconsciously demonstrating grief and distaste of the hopeless situation they lived in. Nyamukapa and Gregson (2004) encountered similar situations in Zimbabwe where orphans were dissatisfied with their living arrangements and left home to live on the streets or in orphanages. In the absence of social support systems at community level, caretakers were similarly bereft of any psychosocial support and despite the challenges they had, they strived to overtly demonstrate a sense of stability to give orphans hope and optimism. However, their long term mental health remains could be in jeopardy, and so is their long term ability to sustain the quality of care offered to orphans.

4.5 Strategies Households use to cope with Orphan Care Challenges

Faced by the inevitable need to provide care to orphans in a context of inadequate resources, caretakers came up with various strategies to cope with the challenges. In some instances, orphans themselves had also adopted their own coping strategies. Following is the discussion of these coping strategies, assessed along the five core elements of child care, namely food, housing, education, health and psychosocial care/protection.

4.5.1 Food and Nutrition

A couple of strategies were applied by orphan caretaker households in order to address their food and nutrition needs. In order to cope with increased family sizes or to accommodate loss of adult labour, children were found to have assumed greater roles in food production. The need for children to provide agricultural labour was widely reported by caretakers as one of the primary reasons why children were kept in public schools near their homes, despite their reservations on the quality of education offered in these schools. In a traditional African family setting, children constitute a strong source of labour for agriculture. Therefore, unless children are withdrawn from school or overworked, deploying them to grow and harvest food may not be perceived as an infringement on their rights. In a way this may also be considered to be a legitimate coping strategy, in that children are supported to acquire agricultural experience and skills which in the long term would guarantee food security for the households. However, interviews with some caretakers indicated that there were instances where children were indeed overworked.

> ***"I just make the children dig. Even on Sundays children have to dig, also when they come early from school on week-days, they don't rest. They have to dig so that we get what to eat", Widow.***

Overworking of children was confirmed by local leaders as a prevalent practice. It was noted that children are over-worked against their will in a bid to raise the extra resources needed for the welfare of the household.

"The caretakers have no money, and they make the orphans overwork especially over the week-end. They are made to dig from morning to evening. Orphans come and report to me" Local Council Chairman.

While deployment of children to do domestic work is acceptable, caretakers need to consider the age and scope of responsibilities given to children as in some situations, children could be overworked and/or exploited. Giving children tasks that are not consistent with their age has serious implications on their physical and mental growth.

Pressed by the need to survive with dwindling resources, caretakers also opted to alter the dietary composition of meals. They provided only locally grown and essential foods and excluded from the normal domestic menus foods that required cash expenses such as sugar, meat, rice, bread, posho and soda. Although endeared and commonly requested by children, such foods were only availed subject to availability of excess income in the household and sometimes on festive days.

In general, the strategies used by families covered by the study to cope with the rising need for food did not vary greatly from those documented in other previous studies (De Waaland Tumushabe, 2003; Topouzis, 1994; Wakhweya et al 2002). Families were coping fairly well mainly because most of the food required to support them was obtained from their own gardens. However, the limited access of most families to animal foods, especially milk and meat could in the long run increase the risk of deficiency in essential nutrients such as iron, iodine and vitamin A. In addition, dependency on foods with low energy density implies that children operate below their average daily energy requirements. Therefore, severe malnutrition could be imminent in future, especially in the context where overall nutrition indicators in the district are poor.

4.5.2 Shelter

Interviews with caretakers revealed that poor housing/accommodation was the biggest and most stressful challenge. In order to raise income to meet some of the basic needs, some families were engaged in small scale micro-enterprises and sale of labor to other well off families. This was mainly in form of digging and doing other forms of domestic work for a wage. Sale of casual labour was the main strategy through which families generated some income. Women, particularly widows were more involved in casual labour than men.

Other families resorted to borrowing from micro-finance institutions although this was done as last resort. Caretakers reported that they had painful experiences with these institutions due to the high interest rates they charge and the strict manner in which repayment was enforced. Some of the affected households had lost assets to these institutions. Local leaders also reaffirmed that borrowing from micro-finance institutions had become painful and appeared to be pushing caretakers more into impoverishment than it improved their well being. Some of the leaders had actually discouraged caretakers, especially widows from borrowing from these institutions.

> ***"Please note this. For me I don't support widows getting loans because they will fail to pay and their little land will be taken. I cannot sign for a widow to get a loan. I have seen some people losing their land because of loans so I don't recommend it", LC Chairman.***

Sale of property to meet immediate basic needs was also a prominent practice, reported in forty three percent of the caretakers. In many of the households, this referred to the assets left behind by the parent(s) of the orphan and included household commodities like radios, chairs, bicycles, food crops and in extreme cases land.

> ***"The land was divided into two parts. One part was sold to buy iron sheets to roof the house which their father left incomplete. Because land reduced, food also reduced. Now we don't have anywhere to grow crops. We now rent land to grow millet", Uncle.***

Liquidation of assets, especially land was noted to push families into deeper vulnerability and has long-term implications on the future survival of the orphans. Given the reality that many of the orphans might not go far in terms of formal education, chances of obtaining gainful employment could be very few. Therefore the possibility of re-establishing these assets remains rather murky and the risk of destitution and delinquency for children could be high.

Some of the families received modest input from external sources particularly other relatives. Support from the community, religious leaders, NGOs or government was minimal, only mentioned by three respondents. The limited access of orphan care families to external support was similarly reported by UBOS/Macro International Inc. (2006), in which nine in ten orphans surveyed lived in households that did not receive any external support. Kalibala and Elson (2009) similarly noted that external assistance to households caring for orphans was limited, and even when available targeted to a few needs. However, despite its limited reach and scope, external support was found to significantly change the outlook of orphan care in families that accessed it. Indeed, such households reported that they were satisfied with the care they were providing to the orphans.

> ***"I am satisfied. She is in a scheme of ICOBI (NGO). When she falls sick, they treat her free of charge", Widow.***

Similarly, unlike others which did not, families that were accessing external support did not feel the burden of care. For instance, when asked on what impact care of orphans has had on the welfare of the household, one grandmother receiving support from relatives remarked:

> ***"None, Things are there because my sons in Kampala send everything", Grandmother***

There were also desperate situations where caretakers had resigned completely as they could not balance their limited resources across various needs.

> ***"You see this house leaks (it is grass-thatched) . I want to get the children out of school so that I can save money to build another house. I don't sleep, I think a lot" Widow.***

Similarly orphans also expressed feelings of helplessness especially when it came to physical needs such as clothing.

> ***"I use my grandmother's sheet as a blanket because I have no alternative. Sometimes I wash my clothes without soap. For cleaning my teeth, I use sticks. When I am in my periods, I use clothes. It is all suffering. I have no money of my own. What can I do?" Adolescent Orphan.***

Deeper analysis of the strategies initiated to raise income showed that they were adhoc, and could only meet immediate needs. For instance, liquidation of assets could only help to sort out an immediate problem but could not guarantee consistent streams of income for the future. All families were aware of this problem and expressed the need for support in starting or restoring activities that generate income on a sustained basis. Cattle and goat rearing were top on the list of the needed support, followed by retail trade.

4.5.3 Education

The study established that in the context of limited resources, caretakers were exercising preferential treatment when it came to the type of schools where children went. It was interesting to note that of the caretakers caring for non-biological orphans, only twenty two percent were maintaining these orphans in the same schools as their own biological children. The rest were taking their own children in private schools which were presumed to offer better standards of education while orphans were maintained in public schools. There was a strong belief in the quality of education offered in private schools.

Caretakers who were parents of orphans, especially widows indicated that they would have preferred to send their children to private schools, but they were unable.

During in-depth interviews with local leaders, segregation in allocation of resources, particularly in regard to the type of schools where children go was pointed out as a serious and prevalent practice among caretaker households, especially where caretakers are not parents of the orphans. Local leaders reported that segregation is a major cause of stress for orphans and in some cases it leads to school dropout.

> ***"Orphans feel stress (enaku) when their guardians take their own children to good schools, buy them good clothes. When these orphans see other children in such schools when for them they are in UPE village schools, they feel neglected and not loved. Such stress makes them leave school and go to look for jobs", Local Council Chairman.***

Preferential treatment may have implications on the full integration of orphans in families if they continue to feel that they are second class members of the family. They may also be frustrated if they perform poorly in public schools compared to their counterparts in private schools. The resultant anger and loss of morale may result in eventual school dropout.

Ironically, caretakers who were sending orphans to public schools reported that they were satisfied with the education they provide to the orphans even though they take their own children in different schools. It could be argued that caretakers expressed satisfaction on grounds that they were at least able to provide some form of education to the orphans. On the other hand, it could be a reflection of the preferential choices individuals make when it comes to allocating scarce resources between biological and non-biological children. This finding is consistent with those from studies in other parts of Africa.

For instance in a study in rural Ethiopia, Abebe and Aase (2007) noted that though care providing families claimed that they made no distinction between their own biological children and orphans under their care, orphans mentioned different layers of bias they face in regard to schooling, health care and leisure.

Besides keeping orphans in public schools that are comparatively cheaper, households have come up with several other initiatives to assist them cope with the challenges of providing education to the orphans under their care. For instance many caretakers reported that they had established relationship with the administration officials in schools where they take their children to allow them pay school fees in installments and in some cases late. This was the only major strategy used by the majority of caretakers. However, they acknowledged that though it has helped, they have had to endure anxiety associated with the failure to default on the deadlines agreed with the school administration.

Orphans themselves reported that they had various initiatives adopted to ease the burden associated with the cost of education. Some of the adolescent orphans reported that they engaged in activities that raise income which is used to defray some school expenses and also contributed towards family welfare. Activities undertaken include catching and selling of mud fish, burning and selling charcoal, selling pan cakes and sweet bananas on market days, selling water, digging for money, as well as working on construction sites.

> ***"I dig for money at school. I wake up at 5.00 a.m. every morning and dig for the owner of the school where I am studying. In turn, he pays school fees for me", Adolescent Orphan.***

Although the efforts made by orphans to ward off pressure on caretakers were acknowledged, some of the activities they engaged in were found to be inappropriate for the children at this age. For instance, catching of mud fish in thick and soggy swamps is a risky undertaking which exposes the child to the risk of drowning or being hurt by aquatic reptiles.

Children under the care of poverty stricken and elderly headed households were particularly found to be vulnerable. They were frequently forced to leave school in order to engage in productive activities to raise income for sustaining the households.

There was no information available in households covered by the study to verify the performance of children who combine school with work. However, common experience has shown that provision of casual labor often interferes with school performance and it can be expected that such orphans could have performance problems. In a study on HIV/AIDS and education in Uganda, Hyde, et al (2002) cited in UNICEF/UNAIDS (2006) confirmed that school performance for orphans had deteriorated partly because of the need to engage in income generating activities, and partly because of anxiety.

Other coping strategies adopted by orphans include using their scholastic materials sparingly by writing in all the lines in the book and ensuring that all pages remain intact. They had also learned to live within the available means and do without some of the needs such as school bags, shoes and in some cases uniform.

4.5.4 Health Care

With most of the health care sought from private providers, caretakers had established relationships with private providers to receive treatment on credit. Ultimately health bills had to be paid and it remained a major challenge in the care of orphans. In poor families, especially those headed by elderly grandparents, healthcare for orphans was reported to be a major problem drawing down the resources that could otherwise have been devoted to other needs.

> ***"Their health care has made me poor. When I sell a bunch of matooke to do something for myself, they fall down sick and I have to take them for treatment. Their treatment has particularly made me poor", Grandfather.***

Faced with these challenges, some caretakers resorted to seeking formal or modern health care only when the illness was perceived to be grave.

"If the child gets fever, I use herbs (Ekiyondo) to treat it and that reduces on the money that I would spend on treatment. If the fever gets severe, that is when I take them to Kabwohe health centre for treatment and that is very expensive", Grandmother.

Wakhweya et al. (2002) similarly noted that without access to ready cash, many caretakers postponed seeking health care and preferred to self treat or visit a traditional healer, and it was only when the health situation became desperate enough that they were forced to visit a formal health facility at the eleventh hour.

In almost all the families covered by the study, caretakers reported that traditional forms of care, usually use of herbal medicine was the first line of treatment used when children fall sick.

"When I take my children to the health unit, health workers prescribe drugs for me to buy and then I fail to get money. I leave them until they get cured. Sometimes I start by giving them traditional herbs before going to health units", Widow.

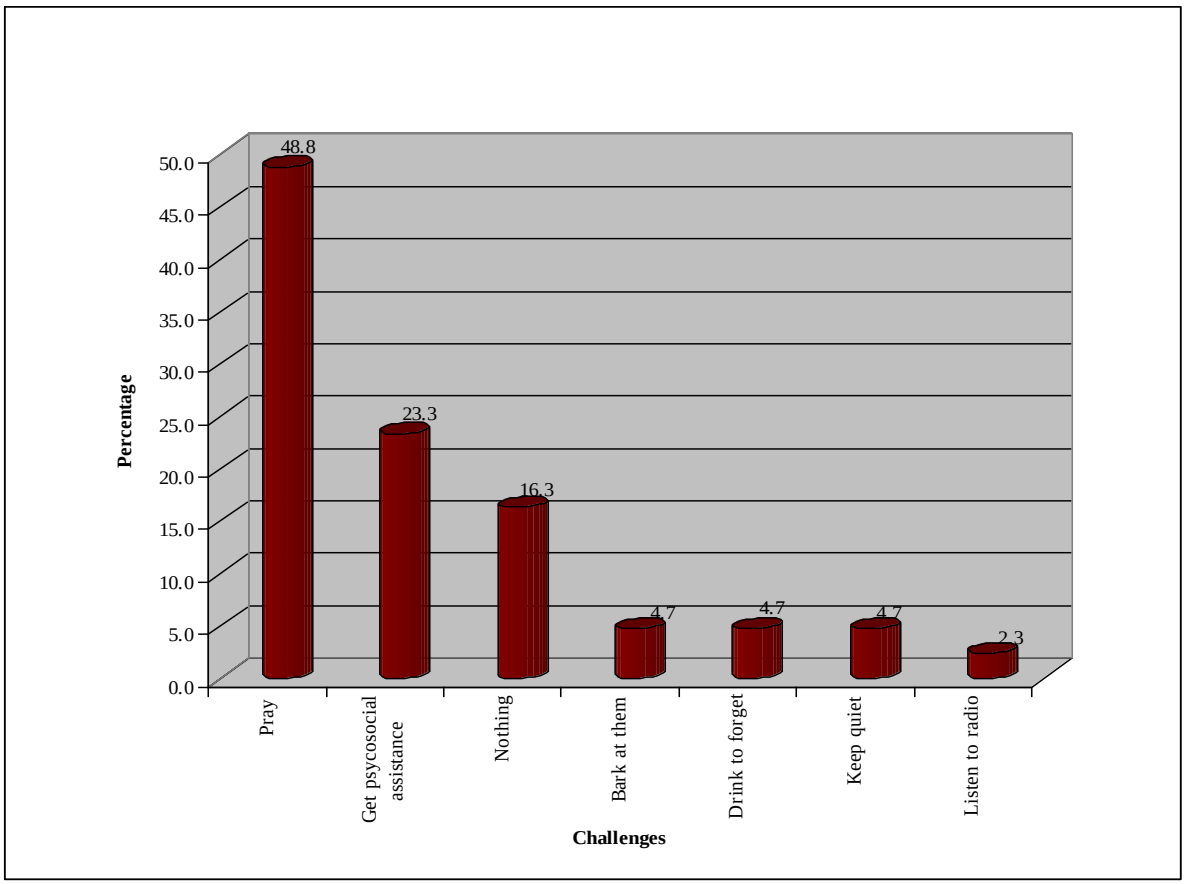
4.5.5 Psychosocial Support

The study revealed that psychosocial support was a critical need but due to lack of skills to appropriately diagnose and respond to it, it was largely neglected. It was evident from the study that while caretakers were expected to be the main source of psychosocial support for orphans, they also have needs for emotional support to address challenges of providing care for orphans in a context of limited resources. Asked as to what they do when they feel inadequate and challenged, majority of care takers indicated that they do nothing. Caretakers who had a strong spiritual orientation turned to prayer and singing as a way of dealing with stressful situations.

"When I feel stressed, I just go to my bedroom and pray. I like singing, so I sing church songs and that is how I forget my problems", Widow.

Figure 7 shows that prayer was the most prominent strategy used in responding to emotional stress among caretakers. Worth noting also is that a significant portion of caretakers (16%) were doing nothing when faced with emotional challenges, while others resort to other potentially calamitous strategies such as drinking, barking at children or simply keeping quiet. This could be a reflection of poor access or lack of awareness about psychosocial services in the study area. The ultimate impact could be that caretakers could get burned out which could have severe long term implications on the welfare of the orphans under their care. Further analysis of this finding indicated that more women than men resorted to prayer as a mechanism for addressing stress. On the other hand, more men than women were seeking psychosocial assistance. The sources of psychosocial assistance were mainly informal, and included peers, friends and close relatives. None of the caretakers interviewed indicated that they sought psychosocial care from formal organizations.

Figure 7: Strategies adopted by caretakers to address psychosocial problems



The strategies adopted by caretakers to cope psychosocial problems were cross-tabulated with the age and category of caretakers. Table 14 below shows that prayer was the most common strategy adopted by widows and grandparents. Twenty nine percent of the widows and a similar number of other caretakers did nothing to address the psychosocial challenges resulting from the care of orphans. Another fourteen percent of the other caretakers just kept quiet, implying that they also did nothing when they felt psychologically distressed. Failure to seek psychosocial care has implications on the mental and social health of the caretakers and may ultimately impact on the care they offer to orphans. For instance, barking at them when they express needs could be one of the effects.

Table 14: Strategies to address psychosocial problems of orphans by category of caretakers

Strategy to address psychosocial problem	**Percentage of caretakers using the strategy**		
	Mother	**Grandparent**	**Other**
Nothing	29	5	29
Pray	57	54	14
Barking at them	7	5	0
Seek care from friends	14	27	27
Drinking	0	5	14
Listening to radio	7	0	0
Keeping quiet	0	5	14

Seeking care from friends also came out prominently as one of the strategies. However, this was found to take various forms including informal discussions, sharing of experiences and seeking solutions to pressing problems.

While this was helpful in an environment where there are no formal counseling services, some of the challenges that need professional care could have remained unaddressed.

In terms of age of caretakers, Table 15 shows that those who do nothing to address their psychosocial needs were prominently below thirty years of age and within the age range between fourty one to fifty years. Prayer was more commonly used among old people, aged thirty years and above. These are mostly widows and grandparents. Interestingly, the number of individuals who reported that they do not do anything to address psychosocial needs was the same as those who reported that they seek care from friends. This implies that they do not regard informal consultation and experience sharing as a form of care. Barking at children emerged out significantly among old people, above fifty years of age. This could be a manifestation of the felt burden at these fragile ages and a symptom of despair when the resources and energy available to the caretakers fail to address the needs of orphans under their care.

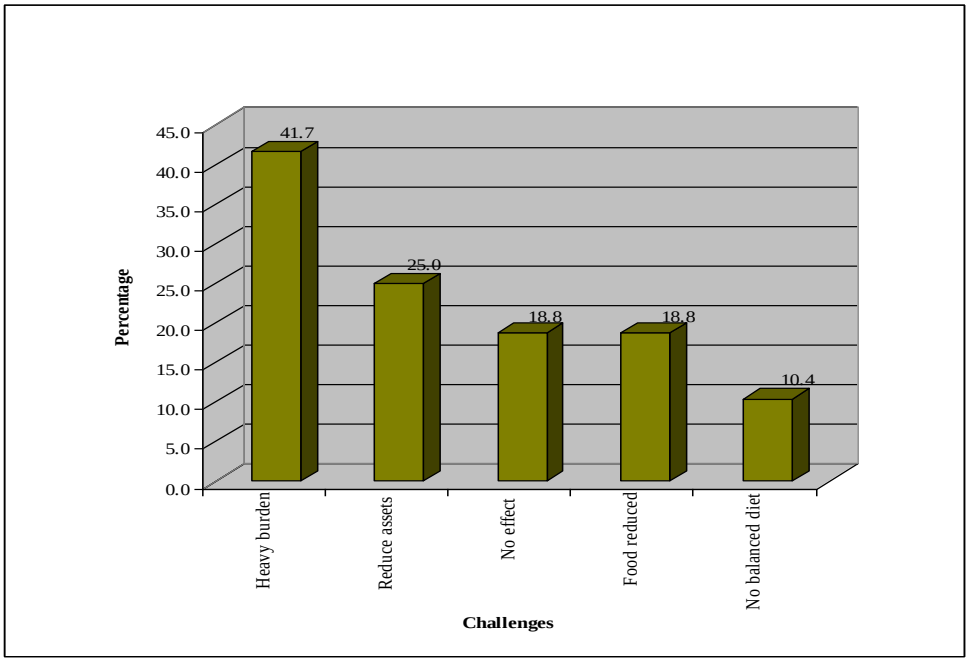
Table 15: Strategies to address psychosocial problems of orphans by age of caretakers

Strategy	Percentage of caretakers by age group adopting the strategy				
	>30	30-40	41-50	51-60	61+
Nothing	40	13	33	0	6
Pray	20	75	44	25	53
Barking at orphans	0	0	0	25	6
Seek care from friends	40	13	11	25	29
Drinking	0	5	14	25	6
Listening to radio	0	13	11	0	0
Keeping Quiet	0	13	11	0	0

4.6 Impact of Orphan Care on Households

Notwithstanding the laudable attempts made by families to absorb and keep orphans together, it was apparent from the study that households are hard pressed to provide care. This was partly witnessed by the inadequacy of care that orphans received. Some caretakers appeared to be already overstretched and told stories on how provision of care and support to orphans had affected their capacity to provide for their own children and reduced welfare for their homes. Households generally acknowledged that provision of care to orphans was a substantial burden. Some of the caretakers reported that they had to make substantial personal sacrifices in order to provide care for the orphans. Figure 8 shows that regardless of the age, sex or marital status of the caretaker, there was a general acknowledgement that caring for orphans constituted a great burden to the households.

Figure 8: Impact of orphan care on families



Families were enduring a substantial burden manifested through reduced assets, altered dietary intake and general reduction in food for consumption.

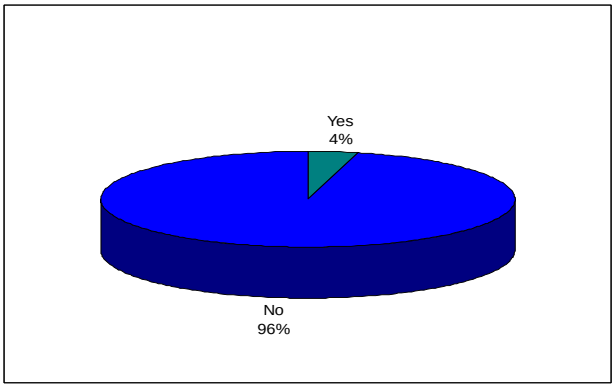
When further analysed by category of caretaker, Table 16 shows that regardless of their category and relationship to the orphans all caretakers were affected by the burden of care. Widowed mothers were found to be more prone to asset depletion and reduction in food than their counterpart caretakers. The burden of care was most felt by grandparents, with seventy four percent of them reporting that they felt overstretched. Notably, other caretakers, including aunts, uncles, sisters and brothers also felt a significant burden in terms of reduced household assets and inability to afford balanced diets for their families. This implied that addition of orphans to their households had altered their dietary composition and exerted pressure on their own household assets.

Table 16: Impact of orphan care by category of caretaker

Impact of orphan care (N=50)	**Mother (n=17)**		**Grandparent (n=23)**		**Other (n=10)**	
	n	%	n	%	n	%
Reduced household assets	7	40	3	13	3	30
Heavy Burden on household	3	20	17	74	4	40
No effect	0	0	0	0	0	0
Food has reduced	7	40	3	13	2	20
Cannot have balanced diet	0	0	0	0	1	10
Total	17	100	23	100	10	100

Findings from the study indicate that families are, within the limits of their income, struggling impressively to provide the basic needs for orphans under their care. It should be noted, however, that they are doing this amidst great difficulty. Some of the needs, particularly accommodation and education were not adequately met. Indeed majority of the caretakers reported that they were not satisfied with the quality of care they were providing. As shown in Figure 9, orphans indicated that the care they were receiving was not adequate as they frequently lacked essential health, education and household goods.

Figure 9: Adequacy of care offered



CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

Findings from the study show that amidst difficulty, families have remained resilient to the pressure imposed on them by the need to provide care to orphans. This is evidenced by their zeal to continue providing care to the orphans. All the caretakers covered by the study indicated that they would continue offering care to their orphans for as long as they could, since the orphans had nowhere else to go. Interestingly, however, most of them expressed reluctance to take on more orphans, citing old age and economic constraints. This dichotomy of caretaker opinions highlighted the need to reconsider the concept of coping capacity when it comes to orphan care. Coping capacity needs to be considered in economic and social perspectives. From these perspectives, it can then be concluded that in terms of economic capacity, that is, the ability of families to provide the material needs to ensure and sustain the welfare of orphans, families were overstretched to the limit and were surely not coping. However, in terms of social capacity – the willingness of families to keep orphans under the ambit of their social, cultural, family and heritage networks, there was unlimited room and commitment. Therefore like other studies have confirmed (Abebe and Aase March 2007), economic hardship does not necessarily diminish the social obligation of families for sharing the non-material resources of care and solace, nor does it damage the deeply embedded emotional exchanges with which poor people cope through crises. Social capacity still remains an essential ingredient in orphan care and justifies the preference of community care to residential care.

In terms of coping with the orphan burden, two types of families emerged; those that were at the rupturing stage, characteristically poverty ridden, headed by widows and elderly grandparents, and living marginally.

The second category, albeit very few in number, were those with elevated levels of income, either from existing assets or transfer incomes from relatives working elsewhere. These families were found to feel less burdened and the orphans under their care were better facilitated compared to their counterparts in the rupturing families. Unfortunately, the majority of the orphans covered by this study lived within rupturing families. With the majority of orphan caretaker households reaching the rupturing stage, it is rational to conclude that the absorptive capacity of extended families in Uganda is at its maximum and that families will give way giving rise to an increasing number of homeless and destitute children. This is confirmed by the nature and quality of care that orphans currently receive within caretaker households and the revelation by most caretakers that they are not in position to absorb more orphans.

5.2 Conclusions

The Children's Statute (1996) bestows upon the family and community the primary responsibility for orphan care. This study found out that despite the escalating socio-economic challenges and structural transformation, the family remains the strongest and most prominent unit of care for orphans. The study did not find any children living on their own and neither were there orphans living with caretakers with whom they had no blood relationship. This attests to the strength and resilience of the extended family and its continued prominence within the overall orphan response in Uganda. In the foreseeable future, families will remain the major asset to be drawn upon in handling the challenges associated with orphan care.

Grandparents provided the bulk of the care for orphans, with twenty four percent of them being grandmothers and twenty two percent grandfathers. Thirty four percent of the orphans lived with their surviving mothers, majority of whom were widowed. This implied that the greatest burden of care was born by people who were already weakened by age and widowhood and even those able to work had limited opportunities for earning extra income. Hence, meeting the needs of children remained an uphill task.

Family size stood out as one of the limitations encumbering parents and guardians to provide adequate care for orphans. Household size overstretched the little resources available for food, clothing, bedding and education. Consequently, many of the orphans' needs were either partially or not at all addressed. This manifested through children attending schools at late ages, sleeping in severely constrained conditions, seeking health care only when illness threatened life and not being able to get the desired foods. With limited resources available, caretakers were exclusively pre-occupied with fending for resources to meet immediate survival needs, particularly food, shelter and health. Little was done towards investment in human capital in terms of accessing orphaned children to quality education and vocational training. Therefore, based on the study findings, it is rational to conclude that the capacity of families to guarantee the future of the orphans remained questionable. When the orphans fail to get appropriate and quality education, they will most likely suffer permanent low productivity and will not be competitive. Experience in Uganda has already indicated that children with minimal education or employable skills can be live in profound vulnerability and are found doing work such as shining shoes, bartending, vending food, and most often in the case of girls, becoming domestic workers. Many observers believe that the desperation of these young children makes more susceptible to abuse and exploitation. Ultimately, there is a risk that Uganda will be faced with a big mass of unskilled low income earners who will be poverty transmitters to the next generation since their children also stand high chances of falling into this poverty trap.

Psychosocial care for both orphans and their caretakers was largely an ignored and one of the most lacking services in the study area. Due to lack of skills and the preoccupation with survival needs, there was little time to either diagnose or address psychosocial problems of orphans and caretakers. The long term impact is that children may grow up with low esteem, depression and in extreme cases psychosomatic disorders.

Similarly, the quality and motivation of caretakers to care for orphans will deteriorate and may in extreme cases translate into various forms of child abuse.

Caretakers and orphans had initiated several strategies to address their needs, particularly raising income to meet extra needs. However, the study findings indicate that these strategies remained haphazard and responsive to the immediate, rather than the long-term needs and survival of the orphans. For instance, engaging young children in fishing was found to be potentially hazardous while generation of income through sale of labour was also likely to expose children to various forms of exploitation. Similarly, strategies like combining work with education, or seeking health care only when the illness threatened life were all noted to be inimical to the proper social and emotional growth of children.

Level of income and the structural composition of the household are key elements in the household's ability to provide appropriate care for orphans. Households which received external facilitation, with a strong asset base as well as those with fewer children were found to cope very well in terms of meeting orphan needs. Conversely, families without external assistance were only struggling to meet immediate survival needs of the orphans and their households, but were still far away in adopting sustainable coping strategies that would guarantee a future for the orphans for whom they provide care. Therefore, looked at from the lens of the actual meaning of coping[1], it can be concluded that extended families, unless provided with various forms of external support, are not coping with the orphan burden. Most of the families visited lived in dire hardship and they exhibited incredible resilience as they struggled to bring up their children. While these efforts are credited, it is unrealistic given the circumstances, to say that families are coping. Families are merely exhibiting endurance and refusing to openly succumb to despair. Without external support, and as the orphan problem continues to grow, this will inevitably happen.

[1] Webster Definition – "to face or encounter and to find necessary expedients to overcome problems and difficulties.

5.2 Recommendations

Deriving from the findings and conclusions of the study, the researcher makes the foregoing recommendations. They may be of utility in influencing policy and programming geared to addressing the escalating orphan problem in Uganda. In particular, they could inform programming for family and community based orphan care.

The study revealed that despite the challenges being encountered, families are still committed and will remain the main focal units of care for orphans. Therefore, it is recommended that efforts be made by both government, civil society organizations and the private sector to shore up the capacities of individual families to cope with the growing orphan problem, and in particular, assisting them to live well above subsistence level. Valuable inputs into this strategy include support with micro-credit schemes especially targeting women and strengthening services that protect children's and widows' inheritance. While assisting families to cope with the orphan problem, priority should be given to building on existing activities and traditions rather than introducing new activities and concepts that have little chance of being sustained. The overall strategy should be geared to strengthening family resilience to orphanhood by building assets that generate wealth in order to lift families out of poverty.

From the study, it was evident that in the wake of diminishing and inadequate resources to meet total needs of orphans, efforts are devoted to meeting the immediate at the expense of long term survival needs of orphans. Therefore, it is recommended that efforts be made be made to build capacity of families to expand their focus beyond immediate survival needs of orphans and invest in human capital, particularly formal and vocational education. With limited chances available for orphans to get far along the formal education ladder, there is urgent need to improve accessibility to vocational training opportunities to enable them acquire skills that enhance their productivity and ability to look after themselves in future.

This will require shifting emphasis and preference from formal qualifications to practical on-job skills. Most of the orphans who drop out of school will most likely remain within the rural areas, so community-based vocational schools would offer excellent opportunities for them.

Immediate efforts need to be expended to improve food and nutrition at household level. Improving children's health and nutrition, and the ability of households to meet those needs is a complex issue and requires action by several sectors including health services, schools, agricultural extension services, microfinance institutions, political and traditional leadership, as well as by households and communities. Therefore programmes and organisations need to complement each other's efforts to meet the nutritional needs of orphans and vulnerable children effectively.

It was evident from the study that orphans are absorbed in families already weakened by poverty and other forms of vulnerability. It was interesting to note that apart from education, individuals caring for orphans who are not their biological children made every effort to equitably distribute available resources across all children. In this context, it is recommended that any assistance provided for orphans in such households should address the needs of the entire household, and in particular other children living with the orphans who are equally destitute. This is crucial for ensuring sustained love and harmony among the children in families caring for orphans. In addition, this could serve as a motivation for more families to absorb orphans.

The study revealed that both orphans and their caretakers were prone to bouts of stress and various forms depression mainly arising from unmet needs. However, there were no viable strategies in place to address this need, both within the families and the immediate community. Therefore, special interventions are needed to address the psychosocial needs of the orphans and their caretakers. This necessitates building skills among the caretakers to identify and address psychosocial needs of the orphans, increasing access to probation and community development services and building bodies of community resource persons and volunteers to whom

orphans and caretakers can turn for assistance when in distress. This will assist in recognizing early what children are going through and helping them understand what is going on around them in ways that offer opportunities for them to ask questions and understand.

Prayer was found to be a prominent strategy of addressing spiritual and emotional needs, particularly among biological mothers of orphans. As psychosocial problems continue to rise with increasing social and economic challenges, the role of spiritual leaders will continue to rise in prominence. It is therefore imperative that strengthen the capacity of these change agents to be able to provide appropriate care and effective support. Religious organizations such as Inter-religious Council of Uganda, Catholic Relief Services and other faith-based organizations should scale up training of religious and spiritual leaders at community level in skills that enable them to offer accurate and appropriate care.

The rise in the number of orphans is directly linked to high adult mortality. In Uganda, AIDS is the single, most prominent cause of adult mortality and subsequently orphans in Uganda. Therefore there is need to intensify HIV prevention messages and to deliver them in contexts that portray the risk of leaving children orphaned and vulnerable. Similarly, access to AIDS care and treatment services should be further improved to enable adults infected live longer and productive lives so that they can be able to provide for their children. In addition, programs that encourage responsible behavior, such as driving carefully, obeying high way codes need to be strengthened. At all costs, mitigation of conflicts and wars needs to be given priority. This will not only prolong the onset of orphanhood, but also ensure adequate care for children already orphaned.

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Appendix I

Confidential

CHALLENGES AND STRATEGIES FOR COPING WITH THE ORPHAN PROBLEM IN UGANDA

INTERVEIW SCHEDULE FOR CARETAKERS

To be administered to caretaker with primary responsibility over the orphans in the household

Introduction:

Good morning/Evening/Afternoon Sir/Madam

My name is Ahimbisibwe Wamanya, a student of Makerere University. I am doing a study on the challenges and strategies for coping with the orphan problem in Uganda. The study is being undertaken among orphan caretakers and the children under their care from selected households in Bushenyi district. It is in this regard that your have been selected to provide information, which can serve several purposes, especially guiding policy makers in designing programs for improving orphan care at household level.

With your permission, I would like to ask you some questions. If you feel any question is making you uncomfortable, you do not need to answer it. Your answers to these questions will be kept strictly confidential. Your name will not appear on the questionnaire and even in the report.

(Ask respondent for any comments, clarifications or questions before starting the interview).

Parish _____

Village _____

Date of the Interview _____

Start Time _____ End Time _____

Results of the Interview:

a. Completed on first visit
b. Completed on second visit
c. Incomplete (Specify reasons)

1.0 Household Profile

Request the respondent that in order to analyse family challenges surrounding orphan care, and the strategies families are using to cope with the problem, it is important to get details of each of the family members. Request him/her to provide you with the following information beginning with him/herself:

Initials of Household Member	**Relationship of caretaker to orphan**	Sex	Age (years)	Marital Status	Education Level	No. of children in household	No. of biological children	Source of Income
	Mother----------1 Father----------2 Grandparent-----3 Brother/Sister----4 Uncle/Aunt-------5 Other(specify)---6	F---1 M---2		Single----------1 Married--------2 Separated ---3 Widow --------4 Widower -----5	None-----1 Primary--2 Sec.------3 Tertiary--4 Univ------5			Trade/Self Employed--1 Salary/Wage----------2 Sale Crops/Livestock -3 Other (Specify)---------4

2.0 General Household Information

1. How many orphans are under your care in this household?

1. One
2. Two
3. Three
4. Four
5. Five
6. above five

2. How many orphans under your care live outside this household?

1. One
2. Two
3. Three
4. Four
5. Five
6. Above five

3. Of the orphans under your care, how many are not your biological children?

1. One
2. Two
3. Three
4. Four
5. Five and above
6. None **(skip questions12, 13, 14)**

4. What prompted you to offer care for the orphans that are not your biological children?

_____

_____

3.0 Nature of care and support offered to orphans

5. What type of care do you provide to orphans under your care? **(Multiple answers expected)**

	Tick
1. Education	
2. Health care	
3. Shelter	
4. Food and nutrition	
5. Psychosocial support	
6. Protection	
7. Other, specify	

6. On average, how long have you cared for each of the orphans?

_____

_____

7. How long do you anticipate continuing to offer this care to the orphans?

_____

_____

3.1 EDUCATION

8. How many orphans under your care are currently enrolled in school?

1. One
2. Two
3. Three
4. Four and above
5. None **(for those not in school probe why)**

9. What type of school and levels of education are they enrolled in?

	Primary	**Secondary**	**Number of children**
1. Private Day School			
2. Private Boarding School			
3. Public Day School			
4. Pubic Boarding School			
5. Vocational School/institution			

10. Who is paying school fees and other scholastic materials for those orphans?

1. Myself (caretaker)
2. Other relative (s)
3. NGO/FBO
4. Government
5. Orphan himself
6. Other (specify)

11. (If caretaker is the one paying) on average how much money do you pay per term in school fees and scholastic materials for these orphaned children?

_____

_____

12. How many of your own children are currently enrolled in school? (***Don't ask of respondent answered none in Q3)***

1. All of them (ask number)
2. Three
3. Two
4. One
5. None

(for those not in school probe why)

13. On average how much money do you pay per term in school fees and scholastic materials for your own biological children? (Don't ask if respondent answered none in Q3)

_____

_____

14. Are your own children attending the same schools with the orphans under your care? (If no, probe for reasons why). (Don't ask if respondents answered none in Q3)

_____

_____

15. Are you satisfied with the education you provide to the orphans under your care? ***(Probe for reasons)***

_____

_____

3.2 MEDICAL/HEALTH CARE

16. How would you describe the health status of the orphans under your care? (probe for reasons)

1. Sickly
2. Sick on and off
3. Rarely sick
4. Perfect health
5. Other, specify

17. What do you do when orphans under your care fall sick?

1. Buy drugs from a drug shop
2. Buy herbal medicine from a traditional healer
3. Take them to a private clinic/hospital
4. Take them to a public hospital
5. Nothing **(probe how the children get treated)**
6. Other, specify

18. Are you satisfied with the health care you provide to the orphans under your care? (Probe for reasons)

_____

_____

_____

19. On average how much money do you spend on health care of the orphans under your care in a year?

_____

_____

3.3 NUTRITION/FEEDING

20. What meals do your children (including orphans) eat in a day? **(Multiple answers expected)**

	Tick
1. Breakfast	
2. Mid morning tea	
3. Lunch	
4. Evening tea	
5. Supper	

21. What are the main sources of food used to feed the family? **(Multiple answers expected)**

	Tick
1. Locally grown	
2. Caretaker buys	
3. Donations	
4. Provide labour for food in the community	
5. Children work and buy food	
6. Other, specify	

3.4 SHELTER

22. How many people regularly live in this household?

_____

_____

23. Does each of the children under your care have separate beddings (bed, mattress, bed sheets, blanket)? **(Observe the housing situation and record)**

_____

_____

24. How satisfied are you with the quality of accommodation for children in your household?

_____

_____

3.5 PSYCHSOCIAL CARE

25. Do the orphans under your care;

	No	Yes	**If yes, how often?**
Look withdrawn (okwegunga) and lose interest in interacting with others			1. Very often 2. Often 3. Sometimes 4. Rarely
Exhibit strange behavior			1. Very often 2. Often 3. Sometimes 4. Rarely
Perform poorly at school			1. Very often 2. Often 3. Sometimes 4. Rarely

	No	Yes	**If yes, how often?**
Ask questions about the cause of death of their parents			1. Very often 2. Often 3. Sometimes 4. Rarely
Appear worried about the future			1. Very often 2. Often 3. Sometimes 4. Rarely
Report being stigmatized at school and at home			1. Very often 2. Often 3. Sometimes 4. Rarely

26. What do you do when you notice such situations?

_____

_____

27. What kind of support is being given to these orphans? **(Multiple answers expected)**

	Tick
1. Food	
2. School fees	
3. Medical care	
4. Bedding	
5. Shelter	
6. Social protection	
7. None	
8. Other (specify)	

4.0 CHALLENGES OF ORPHAN CARE

28. In you opinion, is the care and support being provided to the orphans in your household adequate? (Probe your reasons)

_____

_____

_____

29. What other form of support or assistance would you have liked to provide to these orphans? **(Probe for reasons why not provided)**

_____

_____

30. What particular challenges do you face in providing care and support to orphans with regard to:

Aspect	**Challenges**	**Rank challenges in order of importance**
Education		
Food and nutrition(feeding)		
Housing		
Behavior of children(upbringing)		
Health care		

31. On what items do you mainly spend money (cash or payment)? ***(Multiple answers expected)***

	(Rank in order of importance from the perspective of the respondent)
1. Food	
2. School fees	
3. Medical care	
4. Entertainment (drinking, smoking, parties)	
5. Other domestic necessities(salt, soap, fuel, e.t.c.)	
6. Other, specify	

32. On average, how much money do you spend on these items per year?

	(Amount)
1. Food	
2. School fees	
3. Medical care	
4. Other domestic necessities (salt, soap, fuel, e.t.c.)	
5. Other, specify	

33. On average, how much money do you earn per month?

1. 50,000/= to 100,000/=
2. 100,000/= to 200,000/=
3. 200,000/= to 300,000/=
4. 300,000/= to 400,000/=
5. Over 500,000/=

34. How has the care and support you offer to these orphans affected your household? **(Probe for impact on the family welfare)**

_____

_____

35. Would you be able to provide care for any additional orphan(s) if such a need arose?

	Tick	***Reasons***
Yes		
No		

5.0 COPING STRATEGIES

36. How have you managed to ensure that the orphans under your care stay in school?

_____

_____

37. How have you managed to ensure that there is food for the people in your household?

38. How have you managed to offer accommodation to the orphans under your care?

_____

39. How have you managed to ensure that the o0rphans under your care receive health care?

_____

_____

_____

40. What do you do to cope with your own psychological needs resulting from orphan care?

_____

_____

_____

41. How do you manage to raise extra income to meet the demands placed on your family?

_____

_____

_____

6.0 External Assistance Received.

42. How has your community helped you to provide care and support to orphan(s) under your care?

1. Contribute food in times of scarcity
2. Contribute money in times of difficulty
3. Counseling and encouragement
4. Social protection of the children
5. Nothing
6. Other, specify

43. What particular kind of people in your community have assisted you to provide care to orphan(s) and how?

	(How assisted)
1. Community Leaders	
2.Religious leaders	
3.Other relatives	
4. Other (specify)	

44. Have you received any assistance from any organization?

Yes	Name of organization	Assistance received
No		

7.0 Suggestions and Recommendations

45. In your own opinion, what do you think needs to be done to assist families to provide better care for orphans?

Appendix II

Confidential

CHALLENGES AND STRATEGIES FOR COPING WITH THE ORPHAN PROBLEM IN UGANDA

INTERVEIW SCHEDULE FOR ORPHANS

To be administered to: orphans aged 13-17 years

Introduction:

Good morning/Evening/Afternoon

My name is Ahimbisibwe Wamanya, a student of Makerere University. I am doing a study on the challenges and strategies for coping with the orphan problem in Uganda. The study is being undertaken among orphan caretakers and the children under their care from selected households in Bushenyi district. It is in this regard that your have been selected to provide information, which can serve several purposes specially guiding policy makers in designing programs for improving orphan care at household level.

With your permission, I would like to ask you some question. If you feel any question is making you uncomfortable, you do not need to answer it. Your answers to these questions will be kept strictly confidential. Your name will not appear on the questionnaire and even in the report.

(Ask respondent for any comments, clarifications or questions before starting the interview).

Parish _____

Village _____

Date of the Interview _____

Start Time _____ End Time _____

Results of the Interview:

a. Completed on first visit
b. Completed on second visit
c. Incomplete (Specify reasons)

1.0 BACKGROUND CHARACTERISTICS OF THE CHILD

Initials of Child	**Relationship to Household**	**Sex**	Age **(completed years)**	**Education Level**
	Mother----------1 Father----------2 Grandfather---------3 Grandmother-------4 Brother----------5 Sister----------6 Uncle----------7 Aunt----------8 None----------9 Other(specify)----10	F----1 M---2		None--------1 Primary-----2 Sec.---------3 Tertiary-----4 University---5

1. Do you have any bothers or sisters living with you in this household?

Yes, How many?	**No, where are they living?**
1. One 2. Two 3. Three 4. Four 5. Five and above	

2.0 CARE RECEIVED BY ORPHANS

2. What kind of care do you currently receive from your caretaker?

(Multiple answers expected)

	Tick
1. Education	
2. Healthcare	
3. Shelter	
4. Food and Nutrition	
5. Psychological Support	
6. Protection	
7. Others, specify	

3. Apart from your caretaker, where else do you get assistance?

(Multiple answers expected)

	(Assistance received)
1. Other Relatives	
2. Community	
3. Religious Leaders	
4. NGO/CBO	
5. Other (Specify)	

4. What particular challenges do you face with regard to the following care that you receive?

Aspect	**Challenges**	**Rank Challenges in order of importance**
Education		
Food and Nutrition (Feeding)		
Housing		
Health Care		

5. What are you doing to address these needs?

Aspect	**Challenges**	**Rank Challenges in order of importance**
Education		
Food and Nutrition (Feeding)		
Housing		
Health care		

6. How often do you experience the following?

Stress	1. Very often 2. Often 3. Sometimes 4. Rarely
Sense of hopelessness	1. Very often 2. Often 3. Sometimes 4. Rarely
Uncertainty abut the future	1. Very often 2. Often 3. Sometimes 4. Rarely
Discrimination and mistreatment by others	1. Very often 2. Often 3. Sometimes 4. Rarely
Hatred for everything around you	1. Very often 2. Often 3. Sometimes 4. Rarely
Questioning why you are in the situation you are	1. Very often 2. Often 3. Sometimes 4. Rarely

7. What do you do when you experience such situations?

Stress	
Sense of hopelessness	
Uncertainty abut the future	
Discrimination and mistreatment by others	
Hatred for everything around you	
Questioning why you are in the situation you are in	

8. In your opinion, is the care and support you receive in your household adequate? If No, probe what needs to be improved?

_____

_____

_____

9. In your own opinion, what do you think needs to be done to improve the care for orphans?

_____

_____

_____

THANK YOU SO MUCH FOR YOUR TIME AND IDEAS

APPENDIX III

Confidential

CHALLENGES AND STRATEGIES FOR COPING WITH THE ORPHAN PROBLEM IN UGANDA

IN-DEPTH INTERVIEW GUIDE FOR COMMUNITY LEADERS

To be administered to LCI Chairman or Vice Chairman

Introduction:

Good Morning/Evening/Afternoon Sir/Madam,

My name is Ahimbisibwe Wamanya, a student of Makerere University. I am doing a study on the challenges and strategies for coping with the orphan problem in Uganda. The study is being undertaken among orphan caretakers and the children under their care from selected households in Bushenyi district. It is in this regard that your have been selected to provide information, which can serve several purposes specially guiding policy makers in designing programs for improving orphan care at household level.

With your permission, I would like to ask you some question. If you feel any question is making you uncomfortable, you do not need to answer it. Your answers to these questions will be kept strictly confidential. Your name will not appear on the questionnaire and even in the report.

(Ask respondent for any comments, clarifications or questions before starting the interview).

Date of the Interview _____

Time of the Interview: Start Time _____End Time _____

Result of the Interview:

a. Completed on first visit
b. Completed on second visit
c. Incomplete (specify reasons)

1. What role do you play in this community?
2. How does you role relate to care and protection of orphans?
3. What major problems do orphans face in this community?
4. What are the main challenges faced by orphan caretakers in this Community?
5. What strategies are caretakers using to manager the orphan problem?
6. What are you doing to assist orphan caretakers improve the quality of care and support offered to orphans in this community?
7. What challenges do you face as a leader in regard to orphan care in your community?
8. In your opinion, do you think caretakers are coping with the orphan problem?
9. In what ways, if any, has the community assisted caretakers to offer care and support for orphans?
10. Are there any external organizations that have assisted orphans and their families in your community? If yes, which ones and what assistance have they offered?
11. In your opinion, what needs to be done to improve care and support for orphans in this community?

THANK YOU VERY MUCH FOR YOUR IDEAS AND TIME

APPENDIX IV

Confidential

CHALLENGES AND STRATEGIES FOR COPING WITH THE ORPHAN PROBLEM IN UGANDA

IN-DEPTH INTERVIEW GUIDE FOR DISTRICT LEADERS

To be administered to the District Probation Officer

Introduction

Good Morning/Evening/Afternoon Sir/Madam,

My name is Ahimbisibwe Wamanya, a student of Makerere University. I am doing a study on the challenges and strategies for coping with the orphan problem in Uganda. The study is being undertaken among orphan caretakers and the children under their care from selected households in Bushenyi district. It is in this regard that your have been selected to provide information, which can serve several purposes specially guiding policy makers in designing programs for improving orphan care at household level.

With your permission, I would like to ask you some question. If you feel any question is making you uncomfortable, you do not need to answer it. Your answers to these questions will be kept strictly confidential. Your name will not appear on the questionnaire and even in the report.

(Ask respondent for any comments, clarifications or questions before starting the interview).

Date of the Interview _____

Time of the Interview: Start Time _____End Time _____

Result of the Interview:

a. Completed on first visit
b. Completed on second visit
c. Incomplete (Specify reasons)

1. What is the orphan situation in this District?
2. What care and support services are available to orphans in this district?
3. What are the main problems faced by families that offer care and support to orphans?
4. What strategies are families using to meet the needs of orphans under their care?
5. In your opinion, to what extent do your think families are coping with the orphans' problem?
6. What is the district doing to operationalise the National Policy on Orphans and Other Vulnerable Children?
7. What local policies, by-laws and initiatives exist to improve care and support for orphans in this district?
8. What gaps remain un-addressed with regard to care and support for orphans in this district?
9. What suggestions/recommendations do you give to improve the quality of care and support for orphans in this district?

THANK YOU VERY MUCH FOR YOUR IDEAS AND TIME