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# COMPARATIVE STUDIES OF ORPHANS AND NON-ORPHANS IN UGANDA


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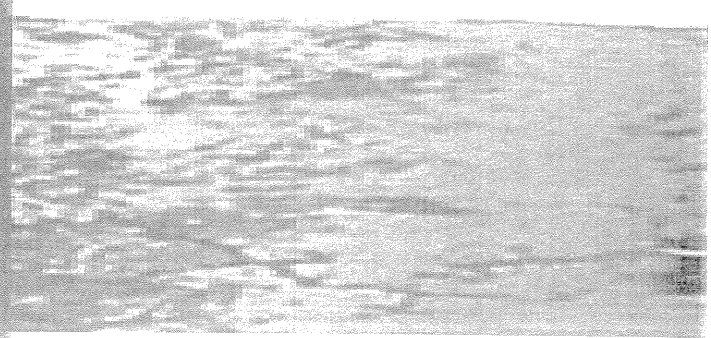

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*To the orphans of Uganda-*

*To their future, and, thus, to the future of Uganda*

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# ACKNOWLEDGEMENTS

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Finally, we wish to convey a heartfelt thank you to the many officials, agencies, and organizations with whom we collaborated in conducting these studies. Most of all, we thank the caregivers and children, especially the orphans themselves, who participated in the studies by sharing their experiences, views, and hopes for the future.

# INTRODUCTION

Kris Heggenhougen
Center for International Health and Development

There are now in Uganda more than two million orphans, i.e. children under 18 years old who have lost one or both of their parents. Roughly one in every five children is an orphan and one in every four households in the country is caring for at least one orphan. As a follow-up to a *Situation Analysis of Orphans in Uganda* in 2002, this monograph presents six studies carried out by Ugandan researchers in 2003 and 2004 on different aspects of the orphan crisis about which the Situation Analysis found inadequate data. Five studies focused on the following: the comparative psycho-social situation of orphans relative to other children (two studies), the legal issues (such as property grabbing and abuse) which they face, suspected differential care-giving practices, and whether orphans face greater risk for sexually transmitted diseases (including HIV/AIDS). The sixth study conducted a comparative evaluation of an orphan support and intervention effort to determine its impact and to test a particular evaluation approach. The results of these studies have already contributed to the preparatory discussions and formulation of the Uganda National Policy on Orphans as well as to the Uganda National Strategic Program Plan of Interventions for Orphans which were produced in 2004.

The crisis situation of orphans in Uganda is a challenge of tremendous proportion, one which is experienced in numerous countries throughout sub-Saharan Africa (and to a lesser extent elsewhere). This challenge is stretching the capabilities of the extended family/kinship system, which, in Africa, has always been there to care for children of deceased relatives. Indeed, fosterage has always been a fact of African life, even, in some cases, when parents were alive. While the extended family has always stepped in, and is doing so now, as we can witness in Uganda and elsewhere, the numbers are now so large, and rising, that unless households and communities caring for orphans get assistance, they will not be able to cope. The current extended family and kinship caretaking system will likely collapse, with dire consequences for the orphan children themselves, for their households and communities and for the future development and political stability of countries which, without outside help, are themselves unable to provide the necessary support.

In many instances the signs of collapse are already visible, with the destitution of children who are taken care of by a poor grandmother, and also with the growing phenomenon of second-generation orphans who are left when that grandmother dies. What do the children do then? Who will be there to care for them? Increasingly, we see child-headed households—households in which children, sometimes as young as ten years old, take care of other children—their siblings.

The publication *Children on the Brink 2004* (UNAIDS, UNICEF, USAID, 2004:3) pointed out that in Asia and sub-Saharan Africa there are now more than 130 million orphans (as a result of all causes) —87.6 million in Asia and 43.4 million in sub-Saharan Africa. The total population of Asia is more than five times that of sub-Saharan Africa and a proportionate number of orphans would be 17 million in Sub-Saharan Africa. But orphans number close to 44 million in sub-Saharan Africa and are estimated to increase significantly in the next decade. The proportion of orphans in sub-Saharan Africa is greater than in any other region in the world.

A significant proportion of the orphans in Uganda and elsewhere in Africa have lost their parents because of AIDS. Those dying from AIDS are primarily young adults, precisely those with young children. Thus, not only are their children orphaned but their own parents, who are still alive and who had counted on their own children caring for them in old age, are also destitute. This situation is compounded when these grandparents (mostly grandmothers), many of whom are extremely poor, and also frail, need to take care of numerous grandchildren. They may want to do so—but are they able?

Parents of approximately 13 million orphans in sub-Saharan Africa have died of AIDS; war, civil strife, accidents and other diseases have caused the deaths of the other 30 million. But the number of orphans due to AIDS alone is expected to triple to around 40 million by the end of the decade. Thus, the proportion of orphans due to AIDS will grow from around 30-35% of all orphans in 2002 to more than 68% of all orphans by the year 2010.

If the present trend of reducing and maintaining a relatively low prevalence rate continues, the situation in Uganda will be different than in the rest of sub-Saharan Africa. Why? Because Uganda has become recognized as a "success story" in terms of dealing with the AIDS epidemic. From a prevalence rate of around 20% in the early 1990s, UNAIDS and others declared Uganda's prevalence rate to be 5% in 2002--a four-fold reduction. While the 5% prevalence rate has been

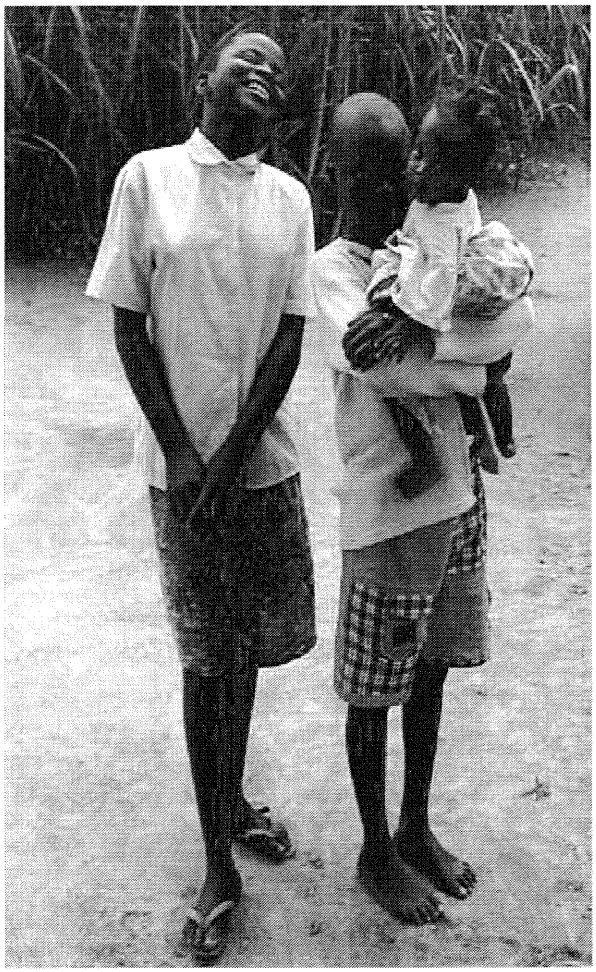
challenged by some, there is no disagreement on the fact that it has dropped significantly. An ongoing special prevalence survey will establish once and for all the exact current prevalence rate. But whether it is 5% or slightly higher, the number of new orphans due to AIDS will not drop immediately. This is because of the lag time between HIV infection and the ultimate death due to AIDS. One can think of the process in three waves: The wave of an increasing number of HIV positive young adults, the wave of AIDS deaths, and the wave of orphans—one after the other. Thus it will take some time for the number and proportion of orphans, relative to the overall number of children in Uganda, to decline. The number of orphans in Uganda will likely remain at around two million for many years. But unlike the situation of other sub-Saharan African countries, orphans due to AIDS in Uganda in 2010 is estimated to be less than 40% of all orphans, whereas they will constitute close to 70% of all orphans in many other sub-Saharan African countries.

Although interventions against HIV-AIDS in Uganda were initiated long before anything was being done in most other African countries, accounting for the drop in prevalence, and testifying to the seriousness with which different sectors of Ugandan society met the challenge of the epidemic, the orphan situation will remain a crisis in Uganda as well as in other countries for some time. But just as Ugandans mounted a concerted effort to prevent the epidemic from overwhelming the country, so also, are Ugandans now joining together to ensure the physical, educational and psycho-social well-being of orphans, and the households and the communities in which they live. Ugandans recognize that "our children are our future," and are rallying to safeguard the future of Ugandan society itself.

This awareness and commitment are evident at the highest level, for example by the fact that First Lady Janet Museveni opened the workshop in February, 2002 which launched the *Situation Analysis of Orphans in Uganda*, for which she had written a very personal and powerful Foreword. They are of course evident through the daily efforts of Ugandan community-based organizations, faith-based organizations, local and national non-governmental agencies and governmental agencies, as well as the millions of households throughout the country. The international donor community is also engaged; many interventions are collaborative and supported by both Ugandans and international agencies—bilateral and unilateral. This collaboration was also the case with the preparation of the *Situation Analysis of Orphans in Uganda*, supported by the efforts of the Ministry of Gender, Labour and Social Development; the Institutes of Social Research and of Public Health at Makerere University; UNICEF; USAID,

which provided the bulk of the funding; as well as numerous caretakers, orphans and other individuals and organizations throughout the country. Similarly, the preparation of the National Policy and the National Strategic Program Plan of Intervention on Orphans was a collaborative effort between the Government of Uganda, UNICEF, USAID and others, with these efforts being led and controlled by Uganda.

This monograph, and the research which it represents, is also a collaborative effort. In the final analysis, however, it represents the work of six Ugandan research teams. The research was funded by USAID, through its Applied Research on Child Health (ARCH) initiative support to the Center for International Health and Development (CIHD) at the Boston University School of Public Health (BUSPH). It was a privilege for a number of us at the Center for International Health and Development and the Department of International Health at the BUSPH to be able to be involved in a supportive role.



This supportive capacity building collaboration included three workshops. The first was a Proposal Writing Workshop held in Jinja, Uganda, conducted by facilitators from both Uganda and from Boston University. Nine research groups that had submitted preliminary research proposals for funding came together for a week to gain greater understanding of research methods and analysis, and successfully wrote a research proposal. From the nine proposals received, six were selected for funding, and through continued collaboration further refinement of the six research protocols was carried out, with ethical review and clearance provided both through Boston University and in Uganda. The second workshop, conducted by Dr. Joseph Tham, data analyst expert, and Ugandan colleagues after the teams had carried out their field research, involved using the researchers' field data to

review appropriate data analysis techniques and presentations. The final, Writing Workshop, was held in Entebbe, Uganda and led by Professor Lucy Honig, Writing Specialist in the Department of International Health, BUSPH, during which members of the research teams presented drafts of final reports, gave feed-back on each other's monograph chapters, and worked on manuscripts for journal publication. A number of colleagues from Boston University also had the opportunity to accompany the teams when they were carrying out field work and to discuss this process with them. I was privileged to participate in most of these events.

The following are a few brief observations relative to the findings of the six studies presented in this monograph:

The study on **legal issues in protecting the rights of orphans** carried out in **Iganga and Kampala districts** found that in terms of protecting children's rights there were gaps in the law, but even when the law was specific, there were problems with enforcing the law and in accessing the legal system, including poor general knowledge of laws that apply to children's issues. In accessing legal protection, the study showed that the situation is much worse for orphans than for non-orphans, and double orphans (both parents having died) and paternal orphans (the father having died) tend to fare worse than other children when it comes to accessing legal protection. Perhaps even more importantly, the study also began to reveal the extensive degree to which orphans suffer bodily (and sexual) assault and property theft. Their situation is dire, in terms of both the rights abuses they suffer and of the inadequacy of legal assistance they achieve. Of those who were able to access the system, the outcomes were worse for certain kinds of orphans. The study also showed that a much greater proportion of orphans than non-orphans faced abuses of property rights and physical and sexual rights. There seem also to be differences in legal outcomes associated with the gender of the caregiver. Cases associated with male caregivers were much more likely to have been completed or to be ongoing than cases of children with female caregivers. The educational level of the (male and female) caregivers also seemed to influence the outcome of these cases—higher education, better outcome. The study recommended policy, law and institutional reforms, with special emphasis on the application and enforcement of existing laws. Further, the authors suggested establishing community- or parish-based orphan support centers and also that relevant laws should be simplified, compiled and written in the local languages, and distributed to such local centers.

The comparative **study on risky sexual behavior among adolescents** carried out in **Tororo District** in Eastern Uganda showed that orphaned girls were more vulnerable to early sexual debut and to sexual abuse than their male counterparts and non-orphans (especially the non-orphan girls). Many of the orphaned girls were either lured into having sex, or began having sex for material gain. While the consequences of poverty seemed to contribute significantly to risky sexual behavior for all adolescents, this study indicated that orphaned adolescent girls are especially at risk. It is important to note that this study (as well as the others) shows that not one, but rather a constellation of factors contribute to risky sexual behavior, and thus the researchers who conducted the study recommend that a "holistic intervention package to increase household incomes, safe sex practices and access to information, would minimize risky adolescent sexual behavior."

The community-based **psycho-social study** carried out in **Masaka District** indicated that psychosocial problems were higher among orphans than non-orphans and the findings also appeared to show a difference between orphans due to AIDS and orphans left by parent(s) dying from other causes. Like the study in Rakai District (see below), this study found a higher number of orphans than non-orphans had been abused. Of note was also the finding that orphans' psycho-social problems were particularly severe immediately after their parent(s)' death and seemed to diminish over time. Note should be taken that psycho-social support for a child may be particularly needed during the period of time when the parent(s) is dying and during the first months and year of being orphaned. Both studies recommended, among other things, that teachers and other key people in the communities should receive training in providing psycho-social counseling and that such support should be provided to both orphans and other vulnerable children as well as to caregivers. Caregivers too should receive training on how better to preserve and improve the psycho-social health of the children in their care.

The school-based **psycho-social study carried out in Rakai District**, where AIDS was first identified in Uganda, and the district most ravished by the epidemic, found no significant psycho-social difference between orphans and non-orphans relative to most indicators, but did find that "both categories of children had high levels of emotional and behavioral problems." Both of these findings are important and show that all children in the district, whether orphans or not, have a higher proportion of emotional problems than the national average. This may very well be due to widespread trauma to entire families and communities, so that most children in Rakai

District must feel when so many young adults around them are dying. Driving through Rakai one sees children and old people, but seldom young adults. The implication of this research is that all children in Rakai are vulnerable and possibly need psycho-social support. The study did find, however, that a significantly greater number of orphans than non-orphans reported having experienced sexual abuse, and the social functioning of orphans within the family unit was much worse than that of the non-orphans. There seems to be a difference in how orphans and non-orphans are treated and in the protection they receive within their households. Any psychosocial interventions need to pay attention to these indications.

The study ("Is discrimination against presumed AIDS orphans real?") investigating the **possibility of differential intra- and inter-household preventive care and treatment seeking patterns** for orphans compared to non-orphans, carried out in **Mukono District**, did not find broad (and statistically significant) evidence of discrimination against orphans. This is certainly an important and positive finding. However, while most of the differences did not turn out to be statistically significant, there were some indications that orphans, whose parents are presumed to have died from AIDS, were not treated as well as other orphans or non-orphans. For example, more of the AIDS-related orphans ate only one meal a day compared to the other children, and they also had a lower immunization rate than the other children. The study also found that a larger proportion of non-orphans, compared to all orphans, were taken for treatment when they had fever. While we might celebrate the fact that most differences appear not to be statistically significant, the study did uncover signs of differences which could show up more clearly in a larger study. Since anecdotal evidence and qualitative research findings point to discrimination between non-orphans and orphans (especial orphans whose parents have died from AIDS), and since this study showed some discrimination, there is clearly a need both for another, larger, study and for intervention initiatives to be mindful of the possibility of discrimination.

Many have questioned whether, and to what degree, interventions make a difference in the lives of orphans and their households, and thus **a comparative program evaluation study** was carried out in **Luwero District** to determine if differences could be detected among orphans and non-orphans in sub-counties which had, and had not, received support (in this case by the NGO Association Francois Xavier Bagnoud). This study looked at the differences between the two sub-counties, and the differences between the orphans and non-orphans in each sub-county. It also compared the two sub-counties in terms of the level and the degree of difference between orphans and non-orphans. Looking at school lunches it was found that more than twice the

proportions of orphans in the intervention sub-county compared with the control sub-country had access to school lunch. Especially interesting was that since the NGO supported schools in general a much larger proportion of non-orphans in the intervention sub-county also had access to school lunch than non-orphans in the control sub-county. There were similar findings for children's possession of a bed and a blanket. The study clearly showed that the NGO intervention had helped close the gap between orphans and non-orphans but, equally important, that it seemed to benefit all of the children in the intervention communities.

# CHAPTER 1: LEGAL ISSUES IN PROTECTING THE RIGHTS OF ORPHANS IN UGANDA

Flavia Nabugere Munaaba,[1] Matovu I.D. Vero[1]

[1] Women and Law in East Africa

## INTRODUCTION

AK, 12, was abused, subjected to hard labour, cheated, and evicted from his late father's house. He reported to the police but was not assisted. The police demanded a letter from the Local Council (LC) or the Probation and Social Welfare Office (PSWO). The area LC was biased so AK went to the PSWO. The PSWO in turn called AK's uncle and aunts. These accused AK of taking marijuana. The decision of the PSWO was an order directing him to go home to his relatives and behave himself. Subsequently, AK was abandoned in a small, isolated house formerly belonging to his late grandmother. There he lived alone and was his own caregiver. He presented himself to our research team for interviews but was rejected for ethical reasons because he had no accompanying adult to consent to his interview. He stood his ground and insisted that his story be heard. The schoolteacher where this orphan was found supported this request and requested that we listen to the boy's story. In the end, we did hear his story and document it.

AK is one of 2.35 million children in Uganda who have lost a mother, a father or both parents (Hunter and Williamson, 2000). Available literature indicates that many such children suffer a wide range of violations of their rights, yet access to legal remedies in the legal system is problematic (Nabugere-Nemaha, 2001; Wakhweya et al., 2002; Chain-Linked Masaka Initiative, 2001). This is so despite the existence of international, national and customary laws designed to protect children.[1] These laws confer a wide range of rights on children, while setting standards and granting authority to both formal and alternative institutions[2] to enforce the protection of those rights.

## STUDY AIMS AND OBJECTIVES

The research aim of this study was to investigate the challenges in Uganda's legal system in protecting the legal rights of children. Specifically, it investigated the challenges involved in protecting the rights of orphans in Uganda. The focus was on property rights and the right to be

[1] Specific examples of international laws are the Convention on the Rights of Children (CRC) and Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). At the regional level, the laws include the African Charter on Human and People's Rights and the African Charter on the Rights of the Child. In Uganda, national laws include the Constitution, the Children Act, the Penal code Act, the Succession Act as amended in1972, the Administrator General's Act, the Marriage Act, including the customary marriage decree, the NCC Act, the Land Act, the Civil Procedure Code, the Law of Contract, and the Local Council Statute. In addition, there are local customary norms that regulate the lives of children depending on ethnic and or tribal orientation.

[2] Formal institutions include the courts of law, the police, the prison, the office of the Administrator General, and land tribunals. Alternative institutions include the Local council courts, the Probation and social welfare office, NGOs such the Legal Aid Clinic, Hope After Rape, ANPCAN and other Civil Society organizations.

free from physical abuse, including sexual abuse. Its working hypothesis was: *orphans are more at risk of lacking effective legal redress and institutional support as compared to non-orphans when their property rights and their right to be free from physical and sexual abuse are violated.* Essentially, orphans are in need of legal protection but a search for remedies in the legal system is problematic for various reasons.

The study was designed to establish the extent to which orphans and their caregivers are among Ugandans who seek remedies from the legal system when their property rights and bodily integrity are violated. We also investigated the relevancy, adequacy and effectiveness of existing laws to the situation of children in the context of HIV/AIDS epidemic. In addition, the study examined the extent to which existing institutions for the protection of children's rights are accessible and appropriate as a means of protecting the rights of orphans.

## METHODOLOGY

The study followed an exploratory, descriptive and comparative design and was basically qualitative. Data were collected from a review of relevant documents and from interviews with study participants in Kampala and Iganga districts. These districts were purposively selected because they were among the six districts of Uganda with the largest number of orphans. They were also selected to provide an urban–rural (Kampala-Iganga) dichotomy.

The documents reviewed included institutional records, registers, legal texts, legislation, and case files. Participants included 42 key informants, 48 participants in focus group discussions (FGDs) and 137 primary respondents. The key informants included officials from government institutions and law enforcement agencies, civil society organizations (including NGOs), religious organizations and local councils as well as school nurses. Teachers, surviving fathers, surviving mothers and heads of households (12 of each) were the FGD participants.

Primary respondents included children (orphans and non-orphans) and their caregivers who had reported cases in the formal and alternative institutions of law enforcement. They were identified from formal institutions such as the Administrator General's office, alternative institutions such as the PSWO and schools. Sixty-nine children participated (fifty-seven orphans and twelve non-orphans) along with sixty-eight caregivers (one child did not have a caregiver but was still permitted to participate). All primary participants joined the study following an informed consent process.

For this study, we combined qualitative and quantitative research methods. Qualitative data collection was pursued through in-depth interviews with key informants, focus group discussions and direct observations. For primary respondents, we used questionnaires for orphans and caregivers that covered a broad range of questions and issues, including open-ended questions. Following data collection, we sorted, coded and analyzed the qualitative data using content analysis of recurrent themes, while quantitative data were analyzed using a statistical software package.

## STUDY FINDINGS

A total of 68 caregivers and 69 children were interviewed for the study. In Table 1, we provide demographic information for both groups. It shows that nearly two-thirds of caregivers (66.2%) were women. About one-half (49.2%) were aged 36-52 years; another 40% were aged 19-35 years. Only one caregiver was over 70 years of age. The educational level of the caregivers was

quite low; roughly one-half had never attended school or only attend through primary school (17.5% and 33.3%, respectively). Just over 11% had received vocational or graduate education.

Among the child respondents, girls made up over one-half (60%). The largest age group was the 13-15 year group, which comprised close to one-half (44%) of the total; nearly one-third (30.9%) were aged 10-12 years, while the rest (25%) were 16-17 years old. Three-fourths were either double orphans (41%) or paternal orphans (33.3%); only 8.7% were maternal orphans. Twelve children, or 17.4%, were non-orphans. The figures also show that 40% of the children were living with a natural parent – 27% with their mother and 13% with their father. Another 13% resided with a stepmother. One in seven children lived with a grandparent (14.2%), while an older sibling cared for 5%. Just over one-third (34.9%) lived with someone who was not a parent, grandparent, or sibling, including aunts, uncles, and non-relatives.

**Table 1: Demographic information on primary respondents**

| **Caregiver Participants (Total N = 68)*** | | | **Child Participants (Total N = 69)*** | | |
|---|---|---|---|---|---|
| **Variables:** | Number | Percent** | **Variables:** | Number | Percent** |
| **Age (years)** | | | **Age (years)** | | |
| 19-35 | 26 | 40.0 | 10-12 | 21 | 30.9 |
| 36-52 | 32 | 49.2 | 13-15 | 30 | 44.1 |
| 53-69 | 6 | 9.3 | 16-17 | 17 | 25.0 |
| 70+ | 1 | 1.5 | Total | 68 | 100.0 |
| Total | 65 | 100.0 | | | |
| **Gender** | | | **Gender** | | |
| Male | 22 | 33.8 | Male | 27 | 39.7 |
| Female | 43 | 66.2 | Female | 41 | 60.3 |
| Total | 65 | 100.0 | Total | 68 | 100.0 |
| **Education Level** | | | **Orphan Status** | | |
| None | 11 | 17.5 | Double orphan | 28 | 40.6 |
| Primary | 21 | 33.3 | Paternal orphan | 23 | 33.3 |
| Secondary | 24 | 38.1 | Maternal orphan | 6 | 8.7 |
| Vocational | 5 | 7.9 | Non-orphan | 12 | 17.4 |
| Graduate | 2 | 3.2 | Total | 69 | 100.0 |
| Total | 63 | 100.0 | | | |
| **Relationship to Child** | | | | | |
| Stepmother | 6 | 13.0 | | | |
| Mother | 17 | 27.0 | | | |
| Father | 6 | 13.0 | | | |
| Grandmother | 5 | 7.9 | | | |
| Grandfather | 4 | 6.3 | | | |
| Sibling | 3 | 4.8 | | | |
| Other | 22 | 34.9 | | | |
| Total | 63 | 100.0 | | | |

* Differences in category totals and the total number of interviewees are due to missing values for some variables.

** Percentages are shown for the category total (excluding missing values).

## Violations of the rights of orphans

Information from this study revealed that children, both orphans and non-orphans, suffer a wide range of violations. The violations cited by our sample population included: neglect, physical abuse including murder, sexual abuse, incest, property grabbing, denial of food, hard labor, arrest, imprisonment on allegations of a criminal nature and psychological torture. For purposes of establishing trends of seeking legal remedies by orphans and their caregivers, these violations were grouped under two broad categories: violation of property rights and violation of bodily integrity through physical and sexual abuse. These were perceived as the most serious forms that are commonly reported.

## Violations of property rights

Some of the children interviewed in this study, especially orphans, were entitled to inherit a wide range of properties. The properties included land, houses, household property, commercial machinery, cattle, cars, bicycles, sewing machines and a power saw. However, many children had suffered "property grabbing" by family members, relatives, caregivers or outsiders. Some of the offending relatives reportedly were initial sympathizers but gradually dispossessed children and caregivers of their property. Where property consisted of houses, especially in trading centers or urban areas, relatives pretended to take care of the properties and either occupied them or put tenants there, but then became hostile when asked for assistance. In some cases, surviving fathers were reported to have deprived children of property inherited from spouses or other deceased relatives. One 20-year-old respondent in the study claimed that she had successfully challenged an attempt by her father to sell a house left to the children by a deceased mother. Respondents said that this deprivation of property had exposed them to a lot of stress.

## Violations of bodily integrity

The violation of bodily integrity was done through sexual abuse, including incest, constant beating, burning, and other forms of physical and psychological torture. Caregivers said that the beatings served to discipline difficult children, but such abuse appeared to have had consequences such as bodily injury and psychological trauma. Some cases were reported where sexual abuse

had led to HIV/AIDS. For instance, a report was made about a girl who was being sexually abused by her widowed father. Her elder sister, who had also suffered the sexual abuse, had already died of AIDS. This girl also feared that she might likewise be infected. There was also a reported case of murder. In this case, an uncle witnessed his orphaned niece with a man and suspected that she was having an affair with him. The girl was subsequently flogged by three uncles and locked in a house, where she was later found dead. The uncles were reported to the court at Iganga but were later released without a trial.

Deprived of property and physically abused, some orphans were driven from their homes onto the street. Other orphans lived in institutions that had rescued them from the streets.

## Reporting violations of children's rights

Ideally, the violations described above should be addressed in Uganda's formal and alternative institutions of law. The formal institutions covered in this study are the Courts of Law (including the Family and Children's Courts) and the Administrator General's Office. The alternative institutions include the Probation and Social Welfare Office and Local Council Courts.

More specifically, under Section 191 of the Succession Act, violations of property rights can be mitigated through an application for letters of administration from the Courts of Law. However, under Section 5 of the Administrator General's Act, any person other than a surviving spouse who applies for letters of administration must first secure a letter of "No Objection" from the Administrator General. If there is a conflict, the Administrator General can be requested to administer the estate of a deceased person. Where property is grabbed and misappropriated, criminal proceedings may be commenced against the offender under Section 11 of the Administrator General's Act.

Cases of physical abuse and sexual abuse are criminal in nature. Such cases should be reported to the police and investigated, and then are typically registered and prosecuted in a court of law by the Director of Public Prosecutions. The aim is to legally punish the offender. Other serious violations may be mediated in family and children's courts, which were established under the children's statute to take care of the legal needs of children.

In addition, mild instances of assault and less contentious inheritance cases may be reported to Local Council officials. Under Section 10 of the Children Act, each Local Council (through the Secretary for Children) has responsibility for the welfare of all children in its area. This encompasses mediating in situations where the rights of a child are infringed, including the right to the property of a deceased parent. Under the same law, the Probation Office is mandated to offer support in such situations.

Other avenues of reporting identified in this study include the land tribunals, schoolteachers and family members. Non-government organizations (NGOs) such as the Legal Aid Project of the Uganda Law Society, Legal Aid Clinic of the Law Development Center and the Federation of Women Layers (FIDA) can be approached to offer legal aid. Other institutions such as Hope after Rape may give support of one type or another when approached. Religious institutions, clan heads and other civil society organizations are among those institutions that may intervene to avert or mitigate violations of children's rights.

**Reporting trends**

The findings of this study suggest that many violations of children's rights occur, but not all incidents are reported. This was demonstrated during the mobilization phase of our research when many respondents identified with legal problems could not qualify to participate in the study because they had not formally reported their cases to an institution. This is not surprising in light of the findings of a survey of the criminal justice system in Uganda, which indicated that only 50% of all criminal cases are reported. Of the capital cases that are reported, defilement, which refers to sexual abuse of children, ranks the highest in terms of number of capital cases reported (Justice Law and Order Sector, 2002). Thus, there is clearly a major problem in the reporting of violations, though without additional household-based data, it is impossible to know the full extent of the numbers and types of violations that currently go unreported.

Among the children participating in this study, there were several striking findings regarding reported legal violations. One was the varying number of legal violations that had been reported on behalf of children with different orphan status. Although our total sample size was small, we nonetheless found a statistically significant difference in the number of violations that had been reported for different groups of children, with double orphans and paternal orphans having far more multiple reported violations than either maternal orphans or non-orphans. As is shown in Table 2, close to one-half of both double orphans (45%) and paternal orphans (55%) had experienced and reported more than one violation, while nearly 20% of double orphans had reported three violations. In contrast, only one maternal orphan (17%) and no non-orphans had reported more than one violation. This difference can also be seen in the mean number of violations reported for each group. Both double and paternal orphans had reported more than 1.5 violations, on average, compared to 1.2 for maternal orphans and 1.0 for non-orphans.

**Table 2: Number of reported legal violations by child status***

| | Child Status | | | | |
|---|---|---|---|---|---|
| **Number of Violations** | **Double Orphans** | **Maternal Orphans** | **Paternal Orphans** | **Non-Orphans** | **Total** |
| 1 | 15 (56%) | 5 (83%) | 10 (45%) | 12 (100%) | 42 |
| 2 | 7 (26%) | 1 (17%) | 11 (50%) | 0 (0%) | 19 |
| 3 | 5 (19%) | 0 (0%) | 1 (5%) | 0 (0%) | 6 |
| Total | 27 (100%) | 6 (100%) | 22 (100%) | 12 (100%) | 67 |
| Mean | 1.63 | 1.17 | 1.68 | 1.00 | 1.46 |
| P-value | 0.008** | | | | |

* Data are presented only for those children with complete information on the number of their violations.
** Statistically significant at the 1% level.

Although the numbers are small, and although it is possible that some children experienced more violations than were reported on their behalf, these findings suggest that double orphans and paternal orphans are more likely to suffer and to report multiple legal violations than maternal orphans or non-orphans. This perhaps reflects the fact that the children in the former groups have all lost their fathers and may not have an older male in their lives who can successfully step in to protect their property and other rights. Compared with other orphans, paternal orphans, though they may suffer a multitude of hardships, may be disproportionately protected in many formal ways due to the presence of their fathers.

Another strong trend that emerged was the variation in the types of legal issues encountered and reported by different groups of children. Table 3 presents the types of rights violations reported for children, by orphan status. It should be noted that because this table shows types, rather than numbers, of reported violations it is possible for the numbers (and percentages) shown in a given column to sum to more than the total for the group (in the fourth row of the table) because some children experienced more than one type of violation. The totals (far right column) indicate that 68% of the children had experienced one or more property rights violation; 10% had suffered sexual abuse; and 28% had been physically abused.

**Table 3: Type of legal violation by child status***

| Type of Violation | Child status | | | | |
|---|---|---|---|---|---|
| | **Double Orphans N=28** | **Maternal Orphans N=6** | **Paternal Orphans N=23** | **Non-Orphans N=12** | **Total N=69** |
| Physical Abuse | 10 (36%) | 1 (17%) | 3 (13%) | 5 (42%) | 19 (28%) |
| Sexual Abuse | 2 (7%) | 0 (0%) | 1 (4%) | 4 (33%) | 7 (10%) |
| Property rights | 19 (68%) | 5 (83%) | 20 (87%) | 3 (24%) | 47 (68%) |
| Total | 31 (111%) | 6 (100%) | 24 (104%) | 12 (100%) | 73 (106%) |
| P-value | 0.005** | | | | |

* Percentages for each group do not necessarily sum to 100% because some children had experienced more than one type of abuse. Some children also suffered more than one violation within an abuse category.
** Statistically significant at the 1% level.

The detailed figures by child status indicate a predominance of property-related rights violations among all the cases involving orphans. Among maternal and paternal orphans, fully 83% had suffered a property rights violation, while 68% of double orphans had reported this legal issue. This contrasts with only 24% of non-orphans who had encountered this type of legal problem. While striking, this finding is not surprising given that non-orphans would be unlikely to suffer property rights issues, unless they were involved in situations of grandparent inheritance or possibly divorce. Property grabbing, as discussed above, is a common experience of orphans in Uganda, just as in many countries in sub-Saharan Africa.

What is somewhat surprising is that a higher proportion of non-orphans reported sexual abuse than double orphans, who would seem most vulnerable to such abuse. We believe that this is an anomaly, perhaps due to the small number of our sample size, and does not reflect the true extent of sexual abuse among double orphans. This is fundamentally because children who are defiled may not themselves report cases. Instead, relatives or parents usually report a case after they learn that an offence has been committed. Double orphans frequently have fewer adults looking after their interests and safety, and are frequently more dependent on a male head of household (because their own mothers are not living). Among all the orphans, a higher percentage of the double orphans in our study had experienced both physical abuse and sexual abuse, which highlights the special vulnerability of children who have lost both their parents.

Although the Administrator General and the Courts are the most competent institutions to handle property violations and cases of physical and sexual abuse, most of the reports analyzed for this study did not, in fact, reach these institutions. To the contrary, most cases were reported to a

Local Council Court[3] or Probation and Social Welfare office (alternative legal institutions). Some cases were reported to the police, religious institutions, civil society organizations or school officials. This trend underscores the tendency to report cases to the wrong institutions.

In addition, although children were among or were the only beneficiaries in some cases, most case reports were made by adults on behalf of the children. These included relatives and friends, some of whom had no direct connection with the estate. On the other hand, children who made an effort to report cases on their own did not generally receive a favorable response. In fact, law enforcement officials could only vaguely recall the cases reported by children, suggesting that they did not give them particular priority.[4]

## Case Outcomes

Of the 69 reported cases examined for this study, more than one in three (26, or 38%) had been abandoned or withdrawn. Almost another one-third (22, or 32%) were still pending (9, or 13%) or had an unknown fate (13, 19%). Only 21 cases (30%) had been heard and completed. Of these, three quarters (16, 76%) had been decided in favor of the child, though only two in three cases (11 cases or 69%) had actually been enforced.

**Table 4: Case outcome and caregivers' characteristics***

| | **Case Outcomes** | | | |
|---|---|---|---|---|
| **Caregiver Characteristics** | **Abandoned or Terminated: Number (%)** | **Completed or Ongoing: Number (%)** | **Don't Know: Number (%)** | **Total: Number (%)** |
| **Gender:** | | | | |
| Male | 7 (33.3) | 12 (57.1) | 2 (9.5) | 21 (100) |
| Female | 19 (45.2) | 18 (42.9) | 5 (11.9) | 42 (100) |
| Total | 26 (41.3) | 30 (47.6) | 7 (11.1) | 63 (100) |
| P-value: 0.013** | | | | |
| **Level of Education:** | | | | |
| None/Primary | 17 (53.1) | 11 (34.4) | 4 (12.5) | 32 (100) |
| Secondary or Above | 9 (29.0) | 19 (61.3) | 3 (9.7) | 31 (100) |
| Total | 26 (41.3) | 30 (47.6) | 7 (11.1) | 63 (100) |
| P-value: 0.094 | | | | |
| **Relationship to Child:** | | | | |
| Mother | 9 (52.9) | 7 (41.2) | 1 (5.9) | 17 (100) |
| Father | 2 (33.3) | 3 (50.0) | 1 (16.7) | 6 (100) |
| Grandparent | 2 (22.2) | 5 (55.6) | 2 (22.2) | 9 (100) |
| Other | 13 (41.9) | 15 (48.4) | 3 (9.7) | 31 (100) |
| Total | 26 (41.3) | 30 (47.6) | 7 (11.1) | 63 (100) |
| P-value: 0.761 | | | | |

* Figures are presented only for those cases for which clear caregiver information was available.
** Statistically significant at the 5% level.

[3] Local Councils in Uganda are Local Government administrative units set up under the Local Government Act. The executive committees of the councils at village, parish and sub-county level have been designated as courts.

[4] In one case in this study, an orphan who reported a case of property grabbing to the police was not given a favorable response. Instead the authorities sided with the relatives who were abusing him.

Given the large number of cases with unknown status, it is impossible to draw major conclusions from these data. However, some trends are evident. First, it is clear that many cases are not pushed through the legal process to completion. Second, even among cases that are heard and completed, a significant proportion is either decided against the child or is not enforced (10 out of the 21 cases here). Third, very young children typically did not know that cases had been reported, although some children knew about the cases but not their outcome. It was not clear whether the children benefited from the decisions made in their favor in such cases.

In addition, some patterns are clear in the relationship between case outcomes and caregiver characteristics. Table 4 presents data for the 63 cases for which we were able to gather caregiver background information. They indicate that cases associated with male caregivers were far more likely to have been completed or to be ongoing compared with cases associated with female caregivers (57.1% v. 47.6%), and far less likely to have been abandoned or terminated (33.3% v. 45.2%). Despite the small number of cases involved, this gender difference is statistically significant, suggesting that female caregivers, and the children in their care, are at some disadvantage in seeing cases through to completion. Not surprisingly, caregivers with an educational level above primary school also had a much higher proportion of cases that had been completed or were pending compared to less well-educated caregivers (61.3% v. 34.4%), though this difference was only borderline statistically significant. There was not a significant difference in case outcome by caregiver relationship to the child.

## THE CHALLENGE OF ENFORCING THE RIGHTS OF ORPHANS

Our findings reveal serious challenges in legally enforcing the rights of orphans. Here, we will discuss some of the major factors that play a part in this challenge, including gaps in the law, the challenge of accessing the legal system and problems with enforcement of the law. Most of this section is based on analysis of documents and information gained from Key Informants and the Focus Group Discussions, and supplemented from our survey results and other studies.

### Gaps in the Law

A review of legislation revealed that with the exception of the Constitution (1995) and the Children Act and the Succession Act, Uganda's existing laws have no special provisions for orphans. Likewise, the provisions in the Penal Code that address physical abuse, sexual abuse and other assaults apply to children generally.

Laws governing succession do not compel a parent to will property to his or her children. Provisions in the Succession Act that provide surviving children of a parent who dies intestate (without making a will) 75% of his/her property have no guidelines to assist underage beneficiaries to manage their share of the property. Instead, this responsibility is given to adults. This gap exposes children to the risk of being deprived of their share of inherited property.

Some provisions of the law are exclusionary and put orphans at a distinct disadvantage. For instance, Order 29 of the Civil Procedure Rules requires minors to file claims through an adult termed the 'next friend'. Unfortunately, this "friend" could be a caregiver or relative who is the person abusing the child, or else closely associated with the abuser. In criminal cases, children who are sexually or physically abused are treated as witnesses only. Complainants are adults who pursue cases on behalf of children. However, studies on defilement indicate high rates of withdrawal of cases, often because caregivers accept monetary compensation or other settlements

outside the legal system (Nabugere-Munaaba, 2001; Chain-Linked, 2001). Likewise, some adults who pursue inheritance claims for children do so for their own benefit.

The law of evidence requires corroboration for the un-sworn evidence of young children. This means that children making independent claims may be suspect and at risk of being taken far less seriously than a testifying adult, even if that adult is the one abusing the children. This is a chronic problem in the legal systems of many countries, but it is particularly worrisome in a country where so many orphans and other vulnerable children are subject to abuse.

Further analysis indicates that most laws were made on the assumption that when one parent dies, another parent remains to look after the interests of surviving orphans. However, in reality, many Ugandan orphans are double orphans, or have a very ill surviving parent. Broader reports indicate that large numbers of double orphans are becoming increasingly common in most countries with an advanced HIV/AIDS epidemic (Hunter and Williamson, 2000).[5]

## Challenges in accessing the legal system

Economically, children have no resources of their own and must depend on adults. In Uganda, as in most countries, children live in families in which their interests are (or should be) taken care of by adults. The pursuit of legal claims therefore depends on the decisions of caregivers, which thus exposes orphans to abuse by adults purporting to care about their interests. In this study, some heads of households and caregivers claimed that orphans were irresponsible, with rebellious tendencies, revealing a tendency not to take them or their rights very seriously.

There are a number of other major issues that orphans and their caregivers face in accessing the legal system. These include lack of knowledge about the law and appropriate legal institutions, technical and cost-related issues, and special vulnerabilities due to gender and age.

## Knowledge of the law and institutions that enforce the rights of orphans

Our surveys found that children and caregivers have little or no knowledge of individual laws. For instance, 77.1% children and 83.3% of the caregivers in the primary sample did not know about any laws. Those who knew something about specific legal protections did not know about all the laws that apply to children. These comprised 1.4% and 6.1% of children and caregivers, respectively. The rest of the children and the caregivers only had a rather vague idea about legal protections, being able to mention certain entitlements under the law(s) that they knew.

Our surveys also highlighted how little caregivers and children knew about institutions that handle legal cases involving children and the functions of particular institutions. For instance, 49% of the caregivers knew that the Local Council is an institution where one may report cases. Many children (37.7%) said that they knew they could report a case to their family. Knowledge of the formal courts and the Administrator General stood at 4.5% and 0% for caregivers and at 2.9% and 2.9% by children. Table 5 sets out percentages on knowledge of institutions.

[5] This report was written on HIV/AIDS orphans in 23 countries, including Botswana, Brazil, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo, Cote D' Ivoire, Democratic Republic of Congo, Ethiopia, Guiana, Haiti, Kenya, Lesotho, Malawi, Rwanda, South Africa, Thailand, Tanzania, Uganda, Zambia and Zimbabwe.

**Table 5: Knowledge of institutions by caregivers and children***

| Knowledge of Institutions | Caregivers | Children |
|---|---|---|
| Family | 15.2% | 37.7% |
| Courts | 4.5 % | 2.9% |
| Police | 37.9 % | 24.6 % |
| Local Councils | 49.0 % | 24.6 % |
| Probation offices | 22.7 % | 14.5 % |
| Administrator General | 0.0 % | 2.9 % |
| Non-government organizations | 1.5 % | 1.4 % |
| Religious organizations | 0.0 % | 1.4 % |
| Other | 0.0 % | 17.4 % |

*Totals are greater than 100% due to multiple answers.

Lack of knowledge about laws and legal institutions constrain the ability of caregivers to take legal action when the rights of children under their care are violated. These findings also suggest that caregivers are more likely to report cases of physical abuse and property violation to a Local Council, though such cases should be reported to the police or to the Administrator General, respectively. Children's poor understanding of the law also suggests that they are more likely to report cases of property violation and even abuse to their own family members. Yet the family is the site of cultural values and interests that might, in many circumstances, condone the violation of children's rights. Though our study did not address this issue, these findings underscore the unfortunate tendency for many cases that involve children to fail to reach the formal legal system.

**Technical and cost-related issues**

Law is couched in technical terms and its application follows complex procedures. This makes it difficult for laypersons to interpret and use laws and other legal protections without assistance. For orphans and their caregivers, help from a lawyer is costly. Although there are institutions offering legal aid, these providers are few and typically located in urban centers far from rural residents. In addition, Uganda's laws are written in English, which is a foreign language for many Ugandans. These technical and language barriers make the law and legal institutions largely inaccessible for the majority of Ugandans who have little or no formal education.

For those who do actively seek to report a case, the costs are significant. Most primary respondents (even those with knowledge of legal institutions) cited distance and a lack of funds to travel to the institutions as obstacles to the pursuit of legal remedies. For instance, the office of the Administrator General is situated in Kampala. Although the Chief Administrative Officer in each district of Uganda is known as the representative of the Administrator General, the two officers we interviewed were not very aware of their duties regarding children protection. They initially referred us to the Probation Officer, for instance, when we approached them.

Some respondents who had reported a case to the Local Council and were referred to the police or a Probation Officer did not have the resources to pay the required travel expenses. Those who were able to travel often found that they were required to pay institutional fees. For instance, some caregivers who went to the Probation and Social Welfare Office said that they were asked to pay Uganda Shillings 30,000 (US $17), which they could not afford. In cases of physical or sexual abuse, caregivers often lacked the Uganda Shillings 10,000 (US $6) examination fee.

The results of other studies on the justice system also suggest a tendency for support staff in institutions of law enforcement to demand unofficial payments for facilitating the process of registration or case handling. An institution such as the Administrator General's Office was susceptible to such weaknesses where people weary of waiting in long queues might be forced to make extra payments (Gender and Access to Justice Strategy for the Judiciary, 2003).

## Vulnerability due to gender and age

The age and gender of orphans and of caregivers, including surviving parents, has an influence on the capacity to successfully pursue cases in the legal system. Very young children, for instance, cannot fully comprehend what goes on around them. Some children who had reported an issue to an institution such as the Local Council or the Administrator General explained that they had not followed up on the matter. Many did not know the outcome of the cases that they had reported.

Although caregivers in the age group 19–52 years were the majority among our primary sample, there is much evidence that the elderly, particularly grandparents, are caring for many orphans. In an earlier study, for example, on orphans (Ministry of Labour and Social Development, 1993:20), it was found that 22% of heads of households with orphans were above 60 years of age. Similar findings are discussed in the recent *Situation Analysis of Orphans in Uganda* (Wakhweya et al., 2002). It is likely that physical weakness, in addition to poverty, makes it especially difficult for many elderly caregivers to pursue legal remedies in cases of children's rights' violations.

We discussed above our finding that caregiver gender is related to case outcome, specifically the tendency for more cases brought by a female caregiver to be abandoned or terminated. The majority of caregivers involved in our study were female (66%), so the problem of abandoned and terminated cases is probably a major one in Uganda. Because women disproportionately experience barriers such as poverty, illiteracy, and lack of decision-making power, they undoubtedly find it harder to report legitimate cases than do men. The children who depend on them are thereby doubly disadvantaged when their rights are abused.

## Gaps in the enforcement of the law

There are numerous problems in the actual enforcement of the law. Perhaps most importantly, legal institutions that are charged with protecting rights often lack the capacity to enforce decisions. For example, it became clear in our interviews that although Local Council officials may attempt to reconcile inheritance disputes, they lack the power to carry out the physical distribution of property.

Officials in civil society organizations and schools as well as local councilors who receive reports on violations from local informants and children often lack the capacity to enact practical solutions. For instance, a report of sexual abuse has to be accompanied by a medical report, yet officials with whom we spoke did not have the resources to obtain such a report. In cases where the caregiver is the offender, the child(ren) should be removed from the home. However, due to a lack of resources or a home in which to place the child, such cases are typically not pursued. Another form of inadequate capacity is lack of personnel. For instance, at the time of our interviews, the Administrator General in Kampala had only 6 lawyers, each with a heavy workload. At the same time, the district-level representatives of the Administrator General (the Chief Administrative Officers) lacked the training to adequately fulfill their roles and therefore tended to neglect them, leaving all matters concerning orphans to the Probation Officers.

In Iganga, the Probation Office is located at the district level. The officers handle a wide range of social issues, including children's issues, but they tend to focus on criminal offences rather than civil matters. Children pursuing civil claims such as inheritance or those who desire to give evidence in criminal trials arising from sexual or physical abuse or property grabbing thus tend to be inadequately supported. Where a claim of sexual abuse involves an accused young boy and a girl, the Probation Officer assists the offender, not the victim, because the Probation office has a mandate to assist children accused of criminal offences. Assisting both children in such cases is clearly a conflict of interest. In interviews, Probation Officers in Iganga and Kampala claimed that their lack of adequate support made it difficult for them to follow up on cases and to know whether decisions were enforced in practice.

Officials in the institutions that do enforce the law are not particularly sensitive to orphans or their particular issues. In court, for example, officials are often unaware of the orphan status of children, which may remain unknown well into the trial. This is largely due to a lack of clarity in the status of children in official documents. We found that records at the courts and police stations did not indicate the status of children, for example. Likewise one has to search files at the office of the Administrator General in order to identify children below 18 years. The officials in the Administrator General's office only had vague recollections of previous cases involving orphans, suggesting they are not especially aware of such cases.

Assistance could help caregivers with their cases, but there is very little practical help available. The services offered by support institutions, such as religious organizations and civil society organizations, are limited in scope. Most of these organizations are mainly concerned with shelter, clothing, education and health services. Most of the officials we interviewed had little knowledge of the laws governing children. The institutions did not have the resources or capacity to attend to the legal problems faced by some of the children they were supporting in other ways.

The combination of gaps in the law, issues of accessing the law and problems with enforcement mean that the legal system is, in general, ineffective and unsatisfactory when it comes to protecting the rights of orphans. We thus turn to suggestions for interventions that have the potential to improve the ability of Ugandan society to protect these rights.

## PROPOSED INTERVENTIONS

This study has identified areas of vulnerability for orphans and their caregivers resulting from a variety of factors, including: gaps in the law, problems with enforcement of the law, and difficulties in accessing the legal system, including poor general knowledge of laws that apply to children's issues and of institutions where violations of children's (particularly orphans) rights may be reported; a need for caregivers to pursue legal redress even when they themselves are the abusers of children's rights; lack of technical and institutional support; and high costs. In this section we suggest a number of interventions to improve the legal situation of orphans. They are focused on regulatory changes and community-based initiatives.

### Reforms in the regulatory framework

One change that would help address the particular vulnerabilities of orphans and their caregivers would be a new policy that specifically addressed issues faced by orphans. Such a policy would help ensure that the legal concerns of orphans are specifically taken into account in the legitimate pursuit of rights protection. This policy should:

a. Set guidelines for review of other policies in order to better understand the legal needs of orphans;
b. Recognize the problem of abuse by caregivers and suggest ways that children can seek legal redress themselves in such cases;
c. Articulate a plan to improve knowledge of the law and its enforcement among the population at large, including orphans, caregivers and officers in legal institutions;
d. Propose strategies for the reform of specific laws and for filling gaps in its administration.

We also recommend a number of specific law-related reforms. One is operationalizing Article 34 of Uganda's Constitution, which would result in new laws to address existing gaps. Existing laws should also be reviewed to allow special provisions for orphans. For instance, the Succession Act should be amended to ensure the protection of property rights for children, to empower older children to act on their own behalf and to facilitate the enforcement of claims by children, particularly orphans, with respect to property grabbing and other violations.

In addition, an initiative should be undertaken to compile and simplify laws that apply to orphans and to translate them into local languages. Tools should also be prepared to disseminate guidelines for use of the simplified laws by the communities and institutions.

In terms of institutional reforms, we recommend the following changes that have the potential to improve access to justice for orphans and their caregivers:

a. Decentralization of the office of the Administrator General to the rest of the country, so that services can be expanded in districts that are currently underserved;
b. Increasing the staff of Probation Offices, so that they are better equipped to respond to child rights violations at the village level;
c. Creation of a weekly "Children and Women's day," in the courts to ensure special attention on legal issues facing orphans and their caregivers;
d. Design of orphan-responsive procedures and record keeping methods, in order to enhance sensitivity of the legal system to children's rights issues.

## Community-based initiatives

We recommend that an orphan support center be established with a clear mandate and the means to offer material, moral, social and legal support to orphans and their caregivers. The center should have outreach offices with child monitors posted at every sub county. This center should serve as an emergency mechanism through which children suffering abuse can be identified and rescued. It should have the capacity to supplement support activities with sensitization programs and advocacy campaigns. Such programs should include a focus on reviewing formal laws to identify those that require reform to better address the problems faced by orphans.

The orphan center should spearhead the development and implementation of legal literacy programs for orphans, caregivers and officials in support institutions, such as Local Councils, Land Tribunals and Civil Society Organizations. They should also advocate for the integration of legal education in the school curriculum at all levels from the lowest level to the highest.

In addition, there should be a system of legal service providers that operate at the sub-county level in all districts in order to bring support close to the population in greatest need.

To implement these recommendations, much effective collaboration will be required. Officials in the Ministry of Gender, Labour and Social Development will need to work closely with officials in the Justice Agencies that offer legal services as well as in Civil Society Organizations that offer support, training institutions such as law schools and police training schools and other relevant institutions. While difficult, such collaboration should better strengthen Uganda's legal system and its ability to effectively address the problem of rights abuses.

## Indicators for Monitoring and Evaluation

This study has suggested a number of interventions to improve the legal situation of orphans. In order to measure results of the proposed interventions, indicators for monitoring and evaluation that measure knowledge of the law and institutions, awareness and observance of children's rights in the household and the community, effectiveness of social and legal mechanisms and institutions, and reform initiatives are suggested. They are set out in Table 6 below.

**Table 6: Matrix for interventions to improve access to legal remedies for orphans and their caregivers**

| Issues | Strategic intervention | Monitoring Indicators |
|---|---|---|
| 1. Vulnerability | i) Make a policy on orphans<br>ii) Establish an orphan support centre | Policy documents<br>Activities and programs of the centre |
| 2. Knowledge gaps<br>a) Lack of awareness of the rights or orphans<br>b) Knowledge of the law<br>c) Lack of knowledge of institutions of law enforcement | i) Sensitization programs<br>ii) Legal literacy programs | Number of sensitization workshops<br>Legal literacy tools and programs |
| 3. Complicated and alien laws | Programs to simplify and dissemination the law | Booklets of translated laws published |
| 4. Access to institutions | i) Bring institutions closer to the users<br>ii) Programs to make institutions user friendly | Number of HH with legal problems enabled to access the Law. |
| 5. Effective of legal remedies | Enforcement of legal remedies | Number of cases completed and enforced |
| 6. Law reform | Audit of the law and advocacy programs. | New law on children |

## CONCLUSION

The study on legal issues in protecting the rights of orphans in Uganda has exposed the serious human rights abuses that are perpetuated against orphans by relatives, including adults, who purport to protect them. The study has highlighted the barriers in the legal system that constrains access to legal remedies for orphans and their caregivers. More particularly, it has exposed the gaps in the law and knowledge gaps in relation to the law and the institutions of law enforcement among orphans, caregivers and some officials in institutions that deal with children's issues. These need to be addressed through reforms and other relevant strategic interventions.

The study has shown how the legal system is blind to the situation of children with major cases. This needs to be addressed through training of officials and other strategies aimed at making the legal system more user-friendly.

Markedly absent is a strong system of social or legal support within the communities. State institutions that exist are fraught with inefficiency, while the activities of civil society organizations are limited in scope and coverage.

# CHAPTER 2: A COMPARATIVE STUDY OF RISKY SEXUAL BEHAVIOR AMONG ORPHANS AND NON-OPRHAN ADOLESCENTS IN TORORO DISTRICT

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## INTRODUCTION

In Uganda most of the people infected with HIV are within the reproductive age group of 15 to 49 years. Fifty percent of HIV/AIDS cases are among the 10-24 year age group hence they are especially important and of national concern, because Uganda has predominantly youthful age structure. In Uganda the number of orphans rose from 1,392,960 in the early 1990's to 1.65 million by the end of 1999 (UBOS, 2001). The current number of orphans is estimated to be more than 2 million, or about 20% of all children (though not all of these are due to AIDS), and several studies indicate that the number of orphans due to AIDS will increase significantly by 2010.

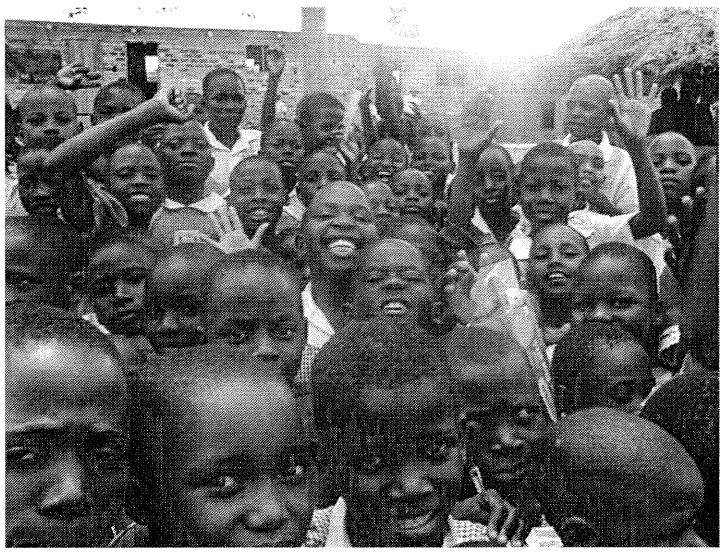
Although several studies have been conducted in Uganda on adolescents' reproductive health, sexual behavior and fertility intentions, none have attempted to make a critical comparison between orphan and non-orphan adolescents. This study examined the sexual behavior of orphan and non-orphan adolescents aged 10-<18 years in Tororo District in Eastern Uganda. It compared the sexual behavioral patterns among orphan and non-orphan adolescents, including the associated factors for risky sexual behavior.

The study used a comparative cross-sectional design involving orphan and non-orphan adolescents in rural households, and used qualitative and quantitative methods of data collection. These methods included focus group discussions, key informant interviews and household interviews with orphan adolescents, non-orphan adolescents and their caregivers.

The study established that there was earlier sexual debut among female adolescent orphans compared to the female non orphans, more female orphans were either lured or had first sexual intercourse for material gain an indication that female adolescent orphans are more vulnerable to risky sexual behavior. There was low use of condoms among both orphan and non-orphan adolescents. The young and middle aged adolescents complained about the size of the condoms in the market hence they found it difficult to use. Poverty in the households contributed significantly to risky sexual behavior. It is recommended that a holistic intervention package to increase household incomes, safe sex practices and access to information would minimize risky sexual conduct among adolescents and in their community.

## BACKGROUND

By the end of 2000 it was estimated that 13 million children world wide under the age of 15 had lost one or both parents due to AIDS (Hunter and Williamson, 2000). By 2010 it is estimated that 106 million children under 15 will have lost one or both parents with 25 million of this group being orphaned due to AIDS. In 2001, 12% of Sub-Saharan African children were orphans, having risen from 2.8% in 1990. This is almost double the proportion of orphans in Asia (6.5%) and more than double that found in Latin America (5%). Much of this difference can be attributed to AIDS. In the three regions 9.5 million orphans had lost both parents of whom at least 3.8 million had lost both due to AIDS. While the total number of orphans from all causes are expected to decrease in Latin America and in Asia (though those due to AIDS in Asia are likely to increase) by 2010, the number in Sub Saharan Africa is expected to increase dramatically due to AIDS (UNAIDS, UNICEF, USAID, 2002).



In Uganda the number of orphans rose from 1,392,960 in the early 1990s to 1.65 million by the end of 1999 (UBOS, 2001). Currently, orphans constitute 20% of the children population and are projected by Hunter and Williamson (2000) to reach 2,088,467 by 2010. It is estimated that 29% of all the children under the age of 15 in Uganda will be orphaned by that year. The magnitude of projected orphanhood is staggering and requires interventions to alleviate the immense burden Uganda and the extended families, within which the majority of the orphans are absorbed, will bear.

In Uganda most of the people infected with HIV are within the reproductive age group of 15 to 49 years. Fifty percent of HIV cases worldwide are among the 10-24 year age group. The key factors to adolescent vulnerability to sexually transmitted infections include lack of correct information on sexual and reproductive health, peer pressure to experiment with sexual intercourse, sex with more than one partner, unprotected sex, lack of parental guidance and socio-economic hardships at the household level. These factors result in the higher incidences of unwanted/early pregnancies and STIs among adolescents. Several cultural and environmental factors such as slum conditions and internally displaced people's camps also place young people especially adolescents, at increased risk of HIV infection (MOH, 2002). Many adolescents are vulnerable to HIV because of the above-mentioned factors as well as lack of preventive services. Marginalized young people are particularly at risk if they are excluded from health services or use illicit drugs.

Girls are much more vulnerable to HIV infection than boys due to earlier sexual debut (and sex with older men) and poverty. The female genital tract makes girls and women biologically more

susceptible to HIV infection than their male counterparts (Brookman 1990, Weiss et al, 1996, UNAIDS/PANOS, 2001). It is 5 to 10 times easier for an infected male to pass HIV to a woman than the other way round. In Uganda HIV prevalence among adolescent girls aged 15 to 19 years is four times higher than among boys of the same age group (MOH, 2001).

Recent studies (i.e. Jackson et al, cited in UNAIDS June 2001) conclude that high quality Voluntary Counseling and Testing is an effective strategy for reducing HIV risky sexual behavior among adults, little is known about its impact on youth and in particular on 10-19 years old adolescents. Studies in Zambia and Uganda indicate that their interest in VCT may not be immediately translated into actual demand. Sexual behavior and attitudes have been crucial especially in explaining how quickly the epidemic spreads particularly among 15-24 year old male adolescents who have more sexual partners than any other group (UNAIDS/PANOS, 2001).

Although several studies have been conducted in Uganda on adolescent reproductive health, sexual behavior and fertility intentions of adolescents (GOU/UNFPA, 2001; MOGLSD/PEARL, 2002; AYA, 2002; MFPED/POPSEC, 2003) none of them has attempted to make a critical comparison between orphan and non-orphan female and male adolescents. Therefore we conducted a comparative cross sectional study to examine and compare the sexual behavior of male and female orphan and non-orphan adolescents in Tororo District.

## RESEARCH QUESTIONS

1. What is the difference in sexual behavioral patterns between adolescent male and female orphan and non-orphan adolescents?
2. What is it about being a male/female adolescent orphan that would make them more vulnerable to risky sexual behavior compared to their non-orphan peers?
3. What access to STD treatments and HIV counseling, care and support do the male and female orphan and non-orphan adolescents have? (Physical, economic, social and behavioral access)
4. What interventions from the perspective of this cohort would be key, most appropriate, and timely and have the greatest potential to succeed?

## GENERAL OBJECTIVE

The general objective of the study was to examine the sexual behavior of adolescent orphans vis-à-vis non-orphans aged 10-<18 years in Tororo District and make recommendations for interventions that focus on adolescent orphans in particular and adolescents in general.

## SPECIFIC OBJECTIVES

1. Establish the sexual behavioral patterns among male and female orphan and non-orphan adolescents.
2. Identify factors that contribute to the risky sexual behaviors of sexually active male and female orphan and non-orphan adolescents.
3. Assess knowledge and practice of sexual and reproductive health among male and female orphan and non-orphan adolescents.
4. Make recommendations for appropriate interventions that seek to improve the health of male and female orphan and non-orphan adolescents.

## METHODOLOGY

### Area of Study

The study was conducted in Tororo District, Uganda in the sub-counties of Kirewa in West Budama County, and Merikit in Tororo County. Two parishes were randomly selected for the study in each of the sub-counties. These were Senda and Soni parishes in Kirewa Sub-county, and Merikit and Maliri in Merikit Sub-county.

### Sampling Procedure

The researchers visited households in the selected villages in the company of local council officials and asked if there was an orphan living in the household. Households with adolescent orphans were then listed. A corresponding household in the same neighborhood with a non-orphan adolescent living in it was also listed from where the non-orphan respondents were drawn. In households where there were more than one eligible orphan or non-orphan the eldest was interviewed. The caregiver who provided the day-to-day care for the adolescent was selected for the interview. Before the interview was conducted, the translated consent form was read to the would-be respondent. On agreeing to participate in the study the caregiver signed the consent form for himself/herself and the adolescent under his/her care. Similarly, the assent form was read to the adolescent. The interviews proceeded upon mutual agreement.

### Data Collection Techniques

The study used a comparative cross sectional design involving orphan and non-orphan adolescents in rural households, using qualitative and quantitative methods of data collection. Interviews using semi-structured questionnaires were conducted with: 216 adolescent orphans; 216 adolescent non-orphans; 216 caregivers from orphan households and 216 caregivers from non-orphan households. 18 key informant interviews were held with resource persons at community, sub-county, district and national levels. In addition 7 focus group discussions were held with purposively selected groups. A literature review was carried out.

### Caregiver and Adolescent Interviews

Pre-tested semi-structured questionnaires were administered to adolescents aged 10-<18 years and to their caregiver in the same household. The caregiver signed a consent form to allow the adolescent under his/her care to participate in the study. An assent form was read to the adolescent to obtain his/her consent to participate in the interview. The questionnaires collected information on the socio-demographic characteristics of the respondents, sexual behavior and practices, risky factors, condom use and knowledge of STIs.

### Key Informant Interviews

The research team interviewed 18 key informants at the community, sub-county, district and national levels using a key informant interview guide. The interviews elicited information on adolescent sexual and reproductive health problems, risky behaviors, condom use, sexual health services and programs available, and STI prevalence among others.

### Focus Group Discussions

Using a guide of themes, 7 focus group discussions were conducted with purposively selected groups to explore in-depth opinions and perceptions on pertinent adolescent sexuality issues: sexual behavior, knowledge of sexual health, availability of sexual health services, and STDs and HIV/AIDS prevalence among adolescents. Each group consisted of 6 to 12 participants. The participants for each group were selected in consultations with the local leaders. The participants were invited at least one or two days in advance and the general purpose of the discussions explained. The researchers ensured that the participants in the focus group discussions were more or less of the same age group, and of the same gender to ensure free discussion. The focus group discussions were moderated and recorded by the investigators. The following groups were selected for the discussions.

- Adolescent male orphans
- Adolescent female orphans
- Adolescent male non-orphans
- Adolescent female non-orphans
- Caregivers of orphans
- Caregivers of non-orphans
- Teachers from schools being attended by in-school orphans and non-orphans

## LIMITATIONS OF THE STUDY

It was difficult to access married female adolescents, as community members were reluctant to identify them due to fear of the defilement law that prohibits under-aged girls from getting married. It is common for non-school going female adolescents get married by 15 years of age. This was true for both orphan and non-orphan non school going female adolescents. It therefore took longer than anticipated to reach the required sample number. Market days and funerals disrupted fieldwork.

## RESEARCH FINDINGS

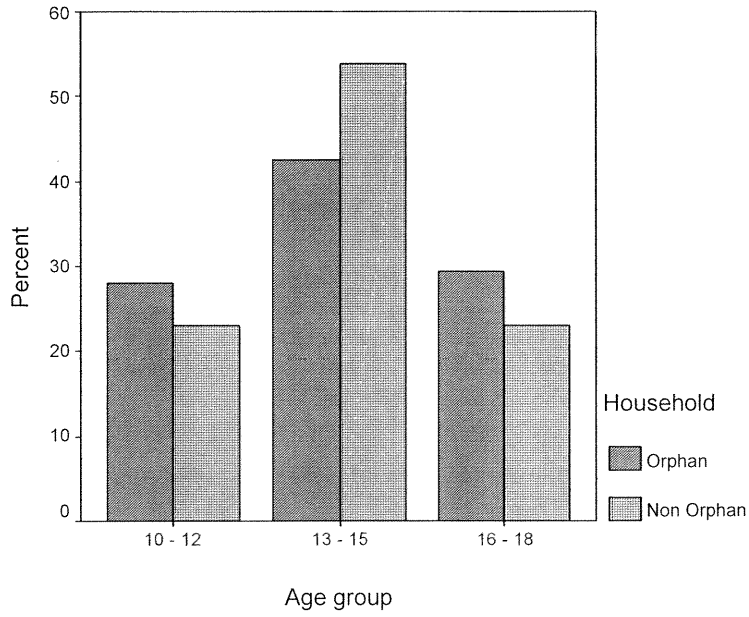
## Quantitative

### Characteristics of Respondents

### Sex Composition

The sex composition of the respondents, male orphans to male non-orphans; and female orphans to female non-orphans were approximately 1:1.

**Chart 1: Age distribution of adolescents**




The age distribution graph above indicates there were more respondents in the age group 13 – 15 years. The age group 10-12 and 16-<18, displayed a similar distribution pattern. The number of orphans and non-orphans interviewed in the age groups 10-12 and 16-<18 were more or less the same.

**Ever Had Sexual Intercourse**

Sixty three percent of the male orphans compared to 68.3% of the male non-orphans had had sex by the time of the study. In contrast, 47.6% of the female adolescent orphans compared to 44.2% of female adolescent non-orphans had indulged in sexual intercourse.

**Age at First Sexual Intercourse**

Thirty six percent of the orphaned male adolescents said they had their first sexual intercourse by the age of 12 years or less compared to 67.4% of the male non-orphan adolescents. More female-orphaned adolescents (51.4%) compared to female non-orphan adolescents (36.8%) reportedly had their first sexual encounter by the age of 12 or less.

**First Sexual Partner**

Most of the adolescents interviewed reported to have been initiated into sex by either a boy or girlfriend, with no significant variations across the different categories--male adolescent orphans (82.3%), female adolescent orphans (78%), male non-orphans (76.1%), and female non-orphans (78%). Others mentioned, in insignificant proportions, include cousins, playmates and neighbors.

**Comparison of age of respondent with that of sexual partner**

Slightly more male non-orphan adolescents (56.3%) than male-orphan adolescents (51.6%) had their first sexual encounter with a much older partner. On the other hand more female-orphaned adolescents (12%) had their first sexual intercourse with a much older partner compared to 8% of the female non-orphan adolescents.

**Circumstances of first sexual encounter**

The respondents were asked the circumstances that led to their first sexual intercourse. Twenty two percent of the female-orphan adolescents compared to 14% of the female non-orphan adolescents engaged in sex for the first time for material gain. 34.8% of the female-orphan adolescents were lured into sex compared to 20.9% of the female non-orphans. 2.2% of female-orphan adolescents versus 14% of the female non-orphans said they had their first sexual encounter to satisfy their physiological need/desire.

**Condom use during first sexual encounter**

Eighteen percent of the orphan male adolescents compared to 8.5% of the male non-orphan adolescents had used a condom during first sexual intercourse. Among the females 26% of the orphan female adolescents compared to 34% of the female non-orphan adolescents had used a condom during first sexual encounter.

**Major reasons for non-use of condoms**

Overall, the most important reason given for non-use of condoms during first sexual intercourse by all the different categories of adolescents was that they did not know about condoms. The reasons advanced for non-usage of condoms by male-orphan adolescents in order of importance were: did not know about them (45.1%), encounter was not planned for (7.8%), and trusted partner (5.9%). The female orphans attributed non-use of condoms to: did not know about them (62.2%) non-availability (8.1%), and don't like it/reduces pleasure (8.1%). Among the male non-orphans non-usage was ascribed to: did not know about them (38.5%), condom non-availability (12.3%) and could not afford one (4.6%). The reasons advanced by the female non-orphans were: did not know about them (54.5%), non-availability (6.1%), and reduces pleasure (6.1%).

## Qualitative Findings

Data in this sub-section was derived from focus group discussions (with male and female orphan and non-orphan adolescents, caregivers of male and female orphan and non-orphan adolescents, teachers in schools attended by the adolescents) and key informant interviews (with senior men and women teachers, probation and welfare officers, adolescent sexual health program coordinators among others).

**Sexual Health Problems Faced**

The most commonly mentioned sexual problems were STIs, especially HIV/AIDS, syphilis and gonorrhea, defilement, early marriages, and unwanted and early pregnancies. The others were rape, abortion and post abortion complications and maternal deaths during birth.

*"These young girls don't have the capacity of holding babies as they are still young and their bodies have not yet developed"* (KI Program Coordinator, Merikit and Molo Sub-counties).

**Category of Adolescents Most Affected**

Generally, it was noted that adolescent girls are more vulnerable to risky sexual behavior compared to the males. However, participants in the focus group discussions reported that adolescent orphan girls are much more affected by sexual health problems such as unwanted and early pregnancies than the non-orphan adolescent girls. On the other hand, most key informants were of the view that there is no significant difference in the degree of vulnerability to sexual health problems between orphan and non-orphan adolescents. Paternal orphans living with their mothers were said to be more vulnerable than maternal orphans. The situation becomes compounded with double orphanage. Lack of money and other resources was also mentioned as leading to increased vulnerability to sexual health problems among adolescents. Male adolescents from well off families have a tendency to procure sex and have multiple sexual partners so they are more exposed to risky sexual behaviors.

**Factors responsible for Risky Sexual Behavior among Adolescents**

Poverty was a cross cutting issue in exacerbating vulnerability of female adolescent orphans and non-orphan adolescents. Male adolescent orphans and non-orphans are sometimes lured into sex by much older women some of whom have lost their husbands due to HIV/AIDS. The girls on the other hand are lured by the material benefits they may get from the moneyed males including petty traders, retail shopkeepers and boda boda ("taxi") cyclists. Participants in the focus group discussions emphasized the role of poverty/lack of income in exposing adolescent girls (as well as boys) to risky sexual behavior.

Orphaned adolescents, particularly females, are more easily tempted to indulge in risky sexual behavior due to the needy situations in which they live. The caregivers cannot afford to provide for their basic needs like food, clothing, school requirements and sanitary pads. Generally, it also emerged that adolescents have desire many things beyond their means; things that they don't absolutely need for survival.

*"For a meal of posho and beans worth two hundred shillings ($0.10) a girl can get pregnant. You find a girl going to a shop ten times a day, The girls have a high desire for good things they cannot afford.* " (FGD with teachers, Kirewa sub-county)

Drug and other substance abuse featured in the discussions as one of the factors that contribute to risky sexual behavior among adolescents, more especially for out of school male adolescents. It is common to find adolescents taking alcohol at the numerous trading centers in the villages. Peer influence and sexual experimentation among adolescents are other factors that contribute to adolescent involvement in risky sexual behavior. This was reported to be more rampant among non-orphan male adolescents.

*"There is also competition among the adolescents themselves. In order to fit in the group, you have to do what others do, like having girl friends."* (FGD non-orphan boys Merikit Sub-county)

"*The orphans are sometimes forced into sex to satisfy their unmet needs: food, clothing, shelter among others. Adolescence is itself a problem to this group. They have no self- control to resist sexual urge. At times peer influence reigns high and is the controlling factor whether to have or*

*not to have sex. They like being in groups, learning and testing new ideas."* (KI Program Coordinator, Molo and Merikit sub-counties).

*"The boys tell us that at their age their libido is high and their sexual urge can only be satisfied by having sex with a female. Since the girls are not assertive enough to resist sexual advances, they are led into it like sheep." (FGD Teachers, Kirewa sub-county).*

Social functions, like discos, funeral rites, video shows, and games and sports days were also mentioned in all focus group discussions and in some key informant interviews as factors responsible for risky sexual behavior among adolescents. It was reported that such occasions act as locations for adolescents to engage in risky behaviors.

*"Discos are always here on Wednesdays and Saturdays. There is utter negligence by parents on these days and during any other functions. Children are left to roam around without control. They often adventure into sex." (KI Senior Male Teacher, Merikit sub-county).*

*"These young people watch very dirty video shows (blue movies) and when they come back, they usually act it out"* (KI Senior Male Teacher, Merikit Subcounty).

*"Last funeral rites provide another forum for risky sexual behavior. It brings people of different age groups together. You find young adolescents overindulging in alcohol that leads to having unprotected sex even with strangers"* (FGD Teachers Kirewa subcounty).

*"Events such as sports, football matches and music and drama competitions usually go on up to late in the evening. Some adolescents use such occasions as an opportunity to meet and have unbridled sex"* (KI Community Resource Person - Kirewa subcounty).

Cultural beliefs were also reported to promote risky sexual behavior among adolescents. It encourages early marriages and subsequently early motherhood. The prevailing poverty compels parents to marry off their adolescent daughters early so as to benefit from the customary bride price. The male adolescents are prompted to marry early to exert their adulthood and independence. Yes, at the same time, talking about sex to biological children is still a taboo. This undermines parental counseling and guidance on reproductive health issues.

Other factors mentioned to be responsible for risky sexual behaviors among adolescents were: the tendency for adult men to believe that young girls are HIV negative, and thus they seek out very young girls for sex; domestic violence leading to separation and divorce, and overcrowded accommodation exposing young people to early practical knowledge of sex.

**Sexual Health Information Available to Adolescents**

The most commonly mentioned available sexual health information by the key informants and focus group discussion participants were on HIV/AIDS and other STIs, promiscuity and dangers of early sex, abstinence, condom use, and dangers of early marriage, The others include family planning, blood testing for HIV, counseling, good moral behavior, career guidance, substance abuse, menstruation, faithfulness and indecent assault.

**Sources of Sexual Health Information in the Communities**

The major sources of sexual health information in the communities were said to be teachers, and radios especially FM stations such as Rock Mambo; The AIDS Support Organization (TASO);

and the Program for Enhancing Adolescent Reproductive Life (PEARL). Straight Talk magazines distributed to schools, religious leaders, friends/peers and parents were also important sources of sexual information. Health workers at nearby health facilities provide sexual health information to the adolescents when they go for treatment for various STD related ailments. Other sources of sexual health information mentioned include Plan International, Local Councils, Family Planning Association of Uganda, district departments, the Mifumi project and other NGOs. The Mifumi project is a local NGO working in the district focusing on domestic violence and primary health care.

Sexual and Reproductive Health Services/Programs Available to the Different Categories of Adolescents

**Voluntary Counseling and Testing (VCT)**

Key informants and participants in the focus group discussions pointed out that VCT was provided in Tororo and Busolwe hospitals within Tororo District. TASO was mentioned as a major provider of VCT for its clients. Other sources of VCT mentioned were in Mbale town (in the neighboring district) and Kampala, the capitol city some 200 kilometers away

The Key informants and participants in focus group discussions were aware of what is involved in VCT: counseling, informed decision-making, blood testing for HIV/AIDS, and receiving results. The need for confidentiality was emphasized for effective expansion of VCT.

Some adolescents are not willing to go for VCT, reportedly because:

- They have never had any sexual intercourse so they see no reason to go for blood test.
- They think they are safe because they believe they haven't had sex with an infected person
- The most convenient VCT service point is far away in Tororo town.
- They lack money to pay for investigation fees and transport to and from service points.
- Of fear of stigma, they fear that if found HIV positive, their friends will come to know of it and ostracize them.
- Of public opinion, since "it is generally assumed," that who ever goes for testing is HIV positive.
- Some of the health workers in some service points do not keep information about their clients confidential.

**Awareness of Ways of Ensuring Proper Use of Condoms**

The focus group discussions with adolescents revealed that more male adolescents compared to the female were aware of ways of ensuring proper use of condoms. The following were frequently mentioned after a probe:

- Checking for any damages after tearing it open.
- Holding the tip while putting it on to avoid air entering it.
- Dressing it to the pubic hair.
- Using one condom for every round of sexual intercourse.

Focus group discussions with caregivers and male adolescents noted that the current condoms in the market are too large to be used by early and middle aged adolescents for prevention of STIs and contraception. This age group is therefore exposed to risky sexual behavior and not protected by the condom component of the "abstinence, being faithful and condom use" (ABC) strategy being promoted in Uganda for the containment of HIV infection.

**Constraints in Utilizing Sexual Health Services/Programs**

Stigma was reported to be a major constraint in utilizing sexual health services/programs by adolescents. The adolescents were unable to utilize services within their localities freely because their relatives utilize the same services and confidentiality could not be assured. Another constraint was lack of fare to access health service points.

Health service providers cannot reach adolescents with relevant information because of lack of transport facilities. Video equipment and other educational materials cannot be easily moved to the villages for sensitization on adolescent sexual and reproductive health issues.

"*We have a video here at the head office to pass information to the adolescents but it has not been used because it is bulky and there is no transport to take it to the villages. Worse still, there is neither electricity nor generators in the villages to run it.*" (KI District Official, Tororo District)

Many adolescents are not aware of the existence of sexual health services in their areas. This was partly attributed to lack of active peer educators in the villages to sensitize the adolescents, as well as inadequate funding and disbursement. Although PEARL was reported by key informants to be operating in Tororo District, the adolescents in focus group discussions were not aware of the program. Even the services offered by TASO (the most prominent national NGO concerned with AIDS) were not clearly understood by the adolescents.

Widespread poverty in the villages was reported to be a major constraint to utilizing sexual health services by adolescents. Some of the services are not free and the adolescents lack the money to pay for them. Even where the services are offered freely the adolescents may lack means of transport to access them.

## DISCUSSION OF RESULTS

The results of the Uganda Demographic and Health Survey (UDHS) 2001/2001 indicate that the age of first sex among girls has risen from 16.1 years in 1995 to 16.7 in 2000/2001. For boys the UDHS puts the increase to be even greater: from 17.5 years in 1995 to 18.8 years in 2000/2001. The results of our study suggest that adolescents start sex even at an earlier age. Our findings indicate that by the age of 15, 92.3% of the female orphan adolescents compared to 91.7% of the female non-orphan adolescents had already had sexual intercourse. By this age 86.9% of the male orphans and 95.6% male non-orphans had had sex. The results further reveal that the bulk of the adolescents indulge in sex by the age of 12 or less. By that age more of the female orphans (66.7%) had had sex compared to the female non-orphans (50.8%). Programs should therefore be designed to empower caregivers to give guidance, counseling on sexual health starting at early ages as the study findings indicate that sexual activity starts as early as 8 years.

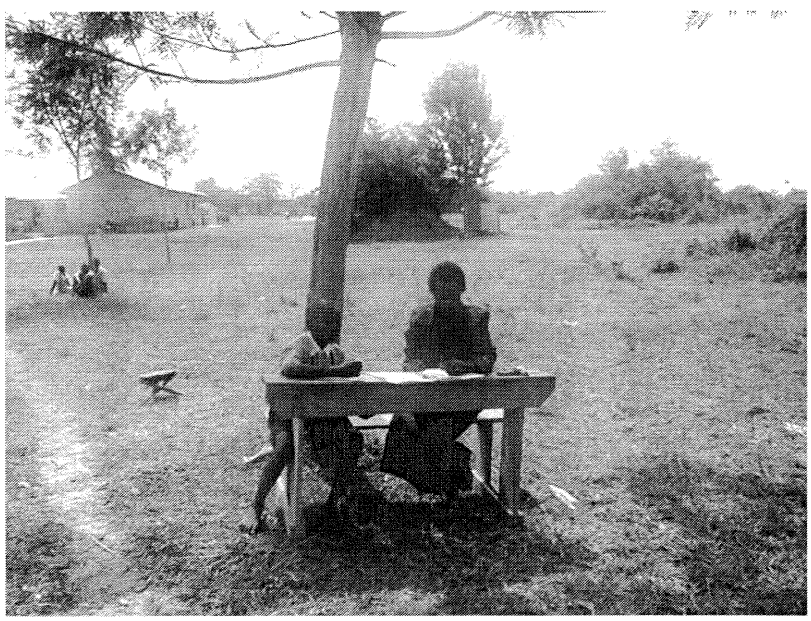
It is important to note that the results of the study show that more female orphans were either led into sex for material gain or lured into it through other ways compared to the female non-orphans.

The main reason for this may be because of the numerous unmet needs of the orphans, especially of the females. And adult males take advantage of this situation by sexually exploiting them. This calls for programs that can empower orphan households to provide adolescents with at least with the very basic necessities of life.

While young females are often considered more vulnerable than boys the results of our study reveal that young males are also at risk of STDs and HIV. According to the qualitative findings, much older women, some of whom have lost their husbands due to HIV/AIDS sometimes lure male adolescent orphans and non-orphans into sex. The household survey results also show that more male orphans had their first sexual intercourse with much older partners compared to the non-orphan male adolescents. The Situation Analysis of Orphans in Uganda 2002 indicate that there are increasing instances of child rape, both of boys and girls, though it is predominantly the girls who are taken advantage of by older men who think that the young girls are HIV negative.

It is a widely held perception that when today's adolescents do become sexually active, they are likely to have fewer partners and are much more likely to use condoms than the adolescents who were sexually active in the early 1990s. In the UDHS 2001/2002 it was found that condom use among unmarried females had risen from "negligible" in 1995 to 24% in 2000/2001. The results of our comparative study support this finding and show that 26% of the orphan female adolescents compared to 34% of the female non-orphan adolescents had used a condom during their first sexual encounter.

Despite the improvement in condom use among adolescents compared to the situation in the 1990s, this rate is still low among both orphan and non-orphan adolescents. Both young and middle-aged adolescents complained about the size of the condoms available in the market; they found it difficult to use the size available. Twice as many male orphans compared to male non-orphans used condoms during their first sexual intercourse. This could be due to being aware that their parent(s) died of AIDS. Condom distribution and social marketing are mainly carried out in urban centers and have not been aggressively carried out in rural areas. This could be due to issues related to its procurement, distribution, social marketing and poverty.



The study results show that a significant percentage of the orphans were living with widowed mothers, grandparents and other relatives such as aunts and uncles. The majority of the non-orphans were, as expected, living with both mother and father. Previous studies indicate that orphans are most likely to be cared for by either a surviving mother or a grandparent. The Situation Analysis of Orphans in Uganda (2002) found that grandparents cared for a third (33%) of the orphans in 326 households visited. An earlier study, in 1993, conducted by the Ministry of

Gender, Labour and Social Development, found that 9% of orphan households were headed by grandparents and faced a lot of difficulties in looking after the orphans.

It is of great importance to recognize the role friends and siblings play in assuaging the sexual health concerns of adolescents. In our survey a considerable percentage of both orphan and non-orphan adolescents reported that they discuss their problems with brothers, sisters and friends. The Situation Analysis of Orphans in Uganda (2002) established that orphans separated from their siblings have greater psychosocial needs than other orphans. This calls for the need to develop a cadre of peer guidance counselors at community level.

It was alarming that a significant percentage of both orphans and non-orphans did not seek any assistance/treatment the last time they experienced a sexual health problem. This has serious sexual and reproductive health implication for the community and the adolescents themselves. According to the National Policy on young people and HIV/AIDS, inadequate and inaccessible health services, facilities and limited supplies to promptly diagnose and manage STDs and HIV/AIDS have compounded the spread of HIV.

Stigmatization of HIV/AIDS clients, though not quantified, played a major role in influencing adolescents whether or not they were willing to go for VCT. A UNICEF workshop report (2000) indicates that even children of HIV/AIDS infected persons suffer stigma that usually leads to widespread discrimination. According to the report, children who live under such conditions are psychologically tortured to the extent that they withdraw from utilizing social services such as going to school and using health services.

According to the UDHS 2001/2002, a key indication of sexual behavior change is fewer teenage pregnancies: the percentage of girls aged 15-19 who are pregnant or have ever delivered fell from 43% in 1995 to 31% in 2000/2001. In our study, only 3.6% of the orphan adolescents compared to 2.4% of the non-orphan adolescents reported that they had ever been pregnant or made some body pregnant. These low responses do not necessarily give a true picture since they can be explained by the fact that most of those who had been made pregnant were already married and inaccessible to the interviewers (in fear of the defilement law). But the caregivers knew about early pregnancies and marriage among adolescents.

Out of school adolescents (and school dropouts) have limited access to accurate information on HIV/AIDS: transmission, prevention, voluntary counseling and testing etc. that is more readily available to the in-school adolescents. Many of the out of school adolescents spend their time after working in their fields in bars, thus exposing themselves to risky sexual behavior. They cannot access sexual health information from newspapers because of low literacy levels and high cost of the papers. Therefore, while it is important to integrate sexual health education into the school curriculum, there is also a need for outreach programs for out of school adolescents and their caregivers. For example, periodic community based audiovisual programs should be initiated. The current interventions, such as AYA and PEARL programs, are not universally available. And even where they are available they provide irregular and some times inadequate information.

According to the health sector strategic plan 2000/01 – 2004/05 midterm review report 2003, HIV infection prevalence rates from antenatal sentinel sites that had been declining over the last decade are now seen to be stabilizing. The overall antenatal prevalence rate in 2001 was 6.5% compared with 6.1% in 2000. According to the plan, however, knowledge on preventive practices has risen from 85% to 90% in its 1st and 2nd HSSP year respectively. The results of our study support this finding. According to the study, there was universal knowledge of both HIV

transmission and STI preventive measures among orphan and non-orphan adolescents, yet this knowledge is not necessarily reflected in practice.

Poverty in the households contributed significantly to risky sexual behavior. Most Ugandan youth live in poverty stricken conditions and most are in rural areas. The majority are unemployed or under-employed. The situation is worse for girls, who, because of economic hardships, are pushed into early marriages and materially induced sex in search of basic needs for themselves and/or their families. Poverty robs people of the knowledge and means to protect them such as basic education. Illiteracy is particularly high amongst females of 15 years and above who, because of economic hardships and social beliefs, are usually pushed out of school in preference for educating the boys. No wonder they become vulnerable since they lack the basic knowledge on prevention options and lack marketable skills for any gainful employment. Poverty should therefore be addressed in all sexual health interventions. Poverty alleviation programs should put special emphasis on vulnerable groups such as orphans, and train them on livelihood skills.

## Policy Implications

Sexual health education should be integrated into the school curriculum and outreach programs for out of school adolescents and caregivers should be established using audiovisual aids for effective communication of sexual health issues.

The law of defilement should be amended to protect all adolescents, male or female, against sexual abuse by peers or adults. As it is now, it discriminates against the boy child. If a boy of less than 18 years is found to have had sex with a girl of the same age the boy is prosecuted for defilement and the girl is left free.

Programs should be designed to empower caregivers to give guidance and counseling on sexual health, starting at the age eight, as the study findings indicate that sexual activity starts early.

Poverty is a major contributing factor leading to risky sexual behavior and should be addressed in all sexual health interventions. Poverty alleviation programs should put special emphasis on vulnerable groups such as orphans and train them in livelihood skills.

## Recommendations for Social Interventions and Programs

An intervention package is proposed consisting of adolescent-friendly community based "Sexual Health Clinics" at local health centers, "Sexual Health Awareness and Education Clubs" in schools and communities, "Skills development for adolescents" to raise household incomes and initial relief for affected households. The activities involved should be:

- Sensitization of adolescent orphans and non-orphans in schools and communities
- Provision of community adolescent sensitive sexual health services.
- Improvement and scaling up of existing adolescent health services and programs for example PEARL and AYA.
- Reform of the law of defilement to correct existing discrimination against the male adolescents.
- Skills development for orphans in the fields of tailoring, carpentry, brick making and laying, masonry welding and fabrication among others.
- Short term relief: food, clothes, beddings, shelter and scholastic materials.

## Methods of Selection of Beneficiaries

- Involvement of community members in listing and ranking households so as to be able to choose the neediest.
- Adolescents could be mobilized to form groups and elect leaders (existing ones could be supported and strengthened).
- Village and parish management committees should be constituted to continuously monitor and evaluate interventions.
- Sub-county monitoring, evaluation and verification officer should be selected and trained to provide technical guidance to the village and parish management committees.

## Indicators for Monitoring and Evaluation

- Improvement in quality of health indicators
- Number of peer educators trained in sexual health issues
- Number of educators actively in the field
- Number of orphans empowered with livelihood skills
- Number of artisans trained
- Number of tool kits given out upon graduation.
- Percentage of trained orphans employed.
- Number of households with improved household incomes.
- Number of orphans receiving sexual health information
- Number of orphans actively using safe sex practices
- Percentage of sexually active orphans regularly using condoms.
- Percentage of adolescents reducing alcohol and substance abuse
- Percentage of sexually active adolescents with one sexual partner
- Occupational and Environmental Medicine Program Percentage of adolescents who have never had STI
- Percentage of adolescents aware of condoms as a way of preventing STI
- Percentage of adolescents seeking health services

# CHAPTER 3: PSYCHOSOCIAL NEEDS ASSESSMENT OF ORPHANS AND NON-ORPHANS IN UGANDA: A CASE STUDY IN MASAKA DISTRICT

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Uganda has around 2 million orphans with presumed AIDS orphans forming the highest percentage. Research suggests that orphans due to AIDS may be experiencing many psychosocial problems, but little is known about the prevailing types and magnitude of these problems and the interventions that could address them. This implies that the mental health of orphans could be seriously affected leading to serious consequences for these children and Ugandan society. The main objective of this study was to identify the psychosocial problems of orphans and non-orphans, establish the psychosocial support offered to them, and based on the available support recommend appropriate psychosocial interventions.

A matched case control cross-sectional design was used with 203 orphans, 196 non-orphans, 390 caregivers, 75 teachers, 13 key informants and children in 8 focus group discussions participating in the study. Our findings show that prevalence and seriousness of psychosocial problems (negative emotion, stigma, depression and behavioral problems) was higher among orphans than non-orphans. On prevalence, orphans due to AIDS and orphans due to non-AIDS differed significantly on depression, negative emotion and stigma. On seriousness of problems, orphans due to AIDS and orphans due to non-AIDS cause did not significantly differ in levels of depression, stigma and negative emotion but did differ in hyperactivity. Length of time since the death of parent(s) predicted psychosocial problems among orphans. Qualitative results confirmed the existence of physical, sexual and emotional abuse and of behavioral problems among orphans. Some individuals and groups gave psychosocial support, though some of the support was neither appropriate nor sufficient.

Recommendations include: creating awareness and advocacy for children and caregivers, creating community action, implementing training programs in psychosocial skills, and setting up income generating activities for caregivers. Education, improved legislation, and imparting parenting skills to reduce child abuse and neglect are also suggested. In addition, we recommend group and cognitive behavioral therapy, offering vocational training, co-ordination of stakeholders, development of monitoring and evaluation indicators, offering ARVs to caregivers and children who are HIV/AIDS positive, and making "psychosocial skills" a course in training institutions.

## INTRODUCTION

Child psychosocial needs are a neglected issue in most countries of Sub-Saharan Africa. The death of a parent is a traumatic experience that has a serious impact on the child's psychological and social well being. The term "psychosocial" underlines the dynamic relationship between psychological and social experience where the effects of each are continually influencing the other. 'Psycho' in this study refers to depressive, emotional, and behavioral problems. 'Social' refers to a person's external relationships and to the influence of the social environment on

his/her wellbeing, including stigma, physical and sexual abuse, and poor household and caregiver characteristics (Barton and Mutiti, 1998). HIV/AIDS is one of the world's deadliest pandemics. The total cumulative number of AIDS deaths world-wide was estimated at 21.8 million in 2000. Of these, 17.5 million were adults, of whom 9 million were women, and 4.3 million were children under the age of 15 years (UNAIDS, 2000). It has been estimated that 71% of people with AIDS live in Africa (Reuters, 2000).

In Uganda, the number of AIDS cases continues to be underreported. In December 2002, the cumulative number of reported AIDS cases was 60,974 cases for both children and adults. As the number of AIDS cases increase, so will the number of orphans in Uganda. There are no accurate figures showing the number and type of orphans in Uganda (Wakweya et al., 2002). The number of orphans appears to have nearly doubled since 1991 and the current number of orphans is estimated to be more than 2 million (Wakweya et al., 2002). It is further reported that the ever increasing number of orphans in Uganda as a result of the HIV/AIDS epidemic has created stressful situations on the extended families and thus call for innovative programmers to meet their physical and psychosocial needs (Kakama, 1997).

The current numbers of children and orphans in Masaka, the district of this study, is not exactly known. However, in 1991, Masaka had 473,989 children aged 0 to 17 years, of whom 70,806 were orphans who had lost one or both parents (MFPED, 1991). The Uganda Women's Efforts to Save Orphans (UWESO) quotes the current population of Masaka as 1,130,000 (http://www.uweso.com/branches_masaka.htm, accessed 20/01/03). UNICEF (1991) put the population of Masaka District at 831,300, with 423,963 children, of whom 102,542 were orphans. UWESO (http://www.uweso.com/branches_masaka.htm) puts the current total number of orphans in Masaka at 200,000.

The neglect of the psychosocial needs of children appears to persist even when there is a large number of children affected by HIV/AIDS. Research conducted in Uganda and elsewhere suggest that orphans may suffer more serious psychosocial problems than other children (Descilo, 2000; Levine, 1995; Makame and Grantham-Mcgregor, 2002; Ngambi, 2001; Wolff and Fessaha, 1998). These problems, including physical, educational, emotional, behavioral and social setbacks, begin when the parents are diagnosed with HIV/AIDS (Ankrah, 1993). Children who have experienced the death of parents report psychiatric disorders, including depression and anxiety, displays of grief, distress dysphasia, and other emotional and behavioral difficulties (Dowdney, 2000). Alcohol and drug use have also been reported among orphans (Degenhardt, Lynskey, Coffy and Patton, 2002). Psychological problems are not always obvious and many

adults in charge of orphans are not able to identify their problems or to be particularly concerned about them (Sengendo and Nambi, 1997).

Methodologically, there have been limited studies comparing orphans and non-orphans, and very few studies have employed a matched case control design. Most of the research has been conducted outside Uganda and provide limited information on psychosocial problems in orphans. Little is known about the prevailing types and magnitude of these psychosocial problems in Uganda and the appropriate interventions that could address them. Available studies do not address psychosocial intervention for orphans.

In terms of policies for children in general, the Ministry of Gender, Labour and Social Development recommended rights, and delineated obligations, of children in Uganda. Some community-based interventions have been introduced to counter the increased psychosocial problems of orphans and a few communities have come up with projects to reduce them. These projects (such as Munno Mukabi, Friends of Children, Nsambya Home Care, etc.) support orphans in a variety of ways such as by providing food, meeting funeral expenses, sensitization, education and awareness campaigns, and giving moral, spiritual and economic support.

Interventions by NGOs and other agencies are in place, including the AIDS Support Organization (TASO) project and the Uganda Social Research and Education Centre, where orphans receive education, feeding and clothing support (Kaggwa, Banage, Mugisa, Kakande, and Wawala, 1998). People with AIDS Family Support Association, Orphans Foundation (Drop, Ali, Andiandu, and Olea, 1998), World Vision and UNICEF are other organizations helping orphans by providing social, psychological and material support. Some of the NGOs have school based interventions. These interventions were not evidence-based and their appropriateness is not clear. There is a need to develop an evidence-based policy and plan of intervention for orphans in Uganda which will direct and coordinate all efforts aimed at helping orphans and other vulnerable groups. Lack of research data and appropriate psychosocial interventions imply that the psychosocial health of a large number of orphans is being seriously affected and is leading to serious consequences for these children and the future of Ugandan society (Sigel, Perry, Rossini, and Quiet, 2003).

In view of the above, this study was designed and implemented to investigate the psychosocial problems and interventions among orphans and non-orphans. Here, we present our results comparing orphans and non-orphans on the prevalence and seriousness of psychosocial problems in a matched case-control and cross-sectional design. Aware of the (limited) number and quality of the existing psychosocial support, we recommend appropriate psychosocial interventions for children.

## OBJECTIVES

### The broad aim of the study

To identify psychosocial needs of orphans with the aim of suggesting psychosocial interventions that could be used to improve their psychosocial health.

#### Specific objectives of the study

1. To identify the psychosocial problems in orphans and non-orphans.
2. To compare orphans and non-orphans on the prevalence and seriousness of psychosocial problems.

3. To compare orphans due to AIDS and those due to non-AIDS causes on the prevalence and seriousness of psychosocial problems.
4. To establish current psychosocial support to orphans and recommend the types of appropriate psychosocial interventions needed for orphans.

**Study Hypotheses**

1. Orphans compared to non-orphans exhibit higher prevalence of psychosocial problems.
2. Orphans compared to non-orphans exhibit more serious psychosocial problems.
3. Orphans due to AIDS compared to orphans due to non-AIDS causes exhibit higher prevalence of psychosocial problems.
4. Orphans due to AIDS compared to orphans due to non-AIDS causes exhibit more serious psychosocial problems.

## METHODOLOGY

### Study design

We used a matched case-control, cross-sectional comparative design, in which each orphan child was matched to a non-orphan child using pre-determined criteria. The household was the focus of the study. Masaka District was purposively selected because it has a large number of orphans (Wakweya et al., 2002).

### Study population

Our study population was comprised of children aged 7-17 years (orphans and non-orphans), caregivers of children in each household, teachers of orphans and non-orphans, and Key Informants, e.g., NGO personnel and Local Council officials (LCs).

### Sample

*Selection of Children:*
A two stage sampling procedure was used in which we first randomly selected thirty villages from each of two sub-counties and then randomly selected 7 households with orphans from each village. The two sub-counties were purposively selected because of their high number of AIDS cases. One eligible orphan from each selected household was randomly selected to be included in the study. For the comparative component of the study (matched case-control), one non-orphan was identified from a non-orphan household in the same village, and from a household that met the following criteria: (i) one of the children in the non-orphan household was at most $\pm$ 2 years in age as the orphan child and (ii) the non-orphan household was of the same socio-economic status as the orphan household and approximately the same household size. Although the desired total sample was 420 children, 399 useable questionnaires were obtained, for a 95% return rate.

*Selection of caregivers:*
One person from each household doing most of the care-giving of children was purposively included in the study. A total of 420 caregivers were expected, but 390 useable questionnaires were obtained (a 92.9% return rate).

*Selection of teachers:*
For each child who was in school, his/her class teacher was to be purposively selected and interviewed. However, in implementation, a total of 75 teachers rated 169 pupils.

*Selection of key informants:*
Fifteen key informants were selected using purposive sampling and included: 4 LC personnel (2 Vice Chairpersons from each sub-county who are in charge of children); 2 LC 3 chairmen (1 from each sub-county), 1 representative from the National Council for Children; 1 representative from the Ministry of Labour, Gender and Social Development); and 6 NGO personnel. A traditional healer also participated and provided input on the services healers give to children.

**Measurements**

The main outcome variable in this study was children's psychosocial problems. These were measured using a number of quantitative indicators:

- Child depression. The Children Depression Inventory (CDI) by Kovacs (1992) was used to assess depression (see Kovacs, 2004). This is a diagnostic tool developed to measure the severity of depression in children of school going age and adolescents (7-17 years).
- Behavioral problems of children. Here, the Conners Parent Rating Scale (CPRS-48) of 1989 was used (Conners, 2004). It was developed to identify behavioral problems for ages 3-17 and is used for clinical assessment and routine screening of children in schools, clinics and residential treatment centers.
- Emotional problems. Baguma (1997) developed self-report measures to assess emotions in people with HIV/AIDS with help from Weiner (1993). These were adapted to this study to measure emotional reactions including self blame, regret and shame.
- Social problems (AIDS related stigma). A scale developed by Baguma (1997) was used to measure stigma.

*Main independent measures:*
The main independent measures in this study was type of orphan (presumed orphaned by AIDS or non-AIDS) and orphan status (maternal, paternal, double orphan or non-orphan).

*Other independent measures:*
These included: demographic data, physical status of the child (assessed by a structured interview schedule administered to the children), demographic data of the caregiver, household characteristics (assessed by a structured interview schedule administered to the caregivers), existing psychosocial support to orphans, and suggestions for improvement (assessed by a structured interview administered to caregivers and teachers). Teachers were requested to rate children who were then followed-up in school, and were rated using the CPRS-48 (Conners, 2004).

**Qualitative Techniques**

These involved the use of unstructured interviews (with open-ended questions), focus group discussions, stories, drawings and dreams/wishes about the future. These techniques provided rich back-up data to augment and enrich the quantitative findings.

*Children:*
Eight focus group discussions (FGDs) were conducted with children who did not participate in the survey (4 from each sub-county). These encompassed 2 female and 2 male FGDs, each with children aged 15-17 years (1 with orphans and 1 with non-orphans). Children were asked to draw pictures appropriate for two 2 occasions, one when they felt particularly happy and the other when

they felt particularly unhappy and to tell stories about the pictures. They also wrote about their dreams and aspirations for the future. This process was thought to be therapeutic as well as informative. An observation checklist to assess child abuse and neglect was also used.

*Caregivers, Teachers and Key Informants:*
Unstructured interviews were held with these groups in order to obtain information on the policy concerns, existing psychosocial support, psychosocial problems observed in children, and recommendations for psychosocial interventions.

**Data Analysis**

Quantitative data were analyzed using univariate and multivariate analytical techniques. Qualitative data, including children's drawings, were assessed using content analysis. This follows the guidelines of analyzing ambiguous pictures as advanced by Rorschach (1921), Di Leo (1973) and Pfeffer (2003). Analysis of stories involved qualitative judgment of the content of the stories based on the themes of the study, such as presence of depression, emotional, social and behavioral problems. Children's dreams and aspirations for the future were also analyzed qualitatively.

## RESEARCH FINDINGS

### Quantitative results

### Background characteristics of the caregivers

The results revealed that 4.9% were adolescent caregivers, 25.7% were aged above 50 years and the rest were between 25 and 50 years. 71.3% were female and were mainly from the Ganda ethnicity (62.1%); 71.0% were Catholic; and 24.4% were widows who had not remarried.

Regarding educational level, 56.4% of caregivers had no formal education or had not completed primary school, while 23.3% had completed primary school. The remaining caregivers completed higher education. Most of the caregivers were peasant farmers (90.5%) and had at least 2 children (<18 years) (53.1%); most resided in their own accommodation (91.5%). The majority had a household size of 6-10 people aged over 18 years (54.9%) and lived in temporary structures (54.4%).

The main source of water was unprotected wells (60.3%). The majority of households had no electricity (97.7%), used firewood for cooking (97.7%), and had poor sanitation, with 71% having no or inadequate toilet facilities and 74.1 % using covered pit latrines. 92.6% reported inadequate bedding. Malaria was the main health complaint reported (33.8%).

### Background characteristics of the teachers

Most of the teachers were young, between 20-34 years of age (69.9%), implying they may not have a mature attitude and the time to cater for orphans' needs at school. The majority were female (53.3%) with 5 years of teaching experience (45%). The rest had less teaching experience. Most had no training in psychosocial skills.

### Background characteristics of the key informants

The 6 LCs from Masaka were between the ages of 37-72. Five were male and 1 female, and all had completed primary school to tertiary levels. Their occupations were: LC 1 Deputy Chair and

farmer, LC 2 Chair and farmer, sub-county chief (2), LC 3 Chair (2). The 3 NGO personnel were aged 30-40 years; 2 were female and 1 was male. All were tertiary level graduates and were psychosocial workers except one who was a manager.

The three personnel from the three NGOs in Kampala were aged 35-38 years (two female and one male) and all had completed tertiary level education. One male traditional healer, aged 45 years who had completed primary education, was also interviewed on how he handled children with psychosocial problems.

**Background characteristics of children and child status**

There was no significant relationship between sex and child status at the 5% level. There was a significant relationship between age and child status, with the older the child, the more s/he was likely to be an orphan. There was also a significant relationship between educational status and child status. More double orphans compared to other orphans and non-orphans were not in school ($X^2 = 15.93$, df = 7, p = 0.00). Parental cause of death and child status are related, with a higher percentage of parents of double orphans having died of AIDS ($X^2=20.85$, df = 3, p = 0.00). There was a significant relationship between relationship to the caregiver and child status. Most of the paternal orphans were staying with their mothers, whereas maternal orphans tended to live with their grandmothers (not with their fathers) and double orphans with grandmothers and other relatives including aunts, uncles, siblings and other caregivers ($X^2 =224.02$, df = 21, p = 0.00).

**Physical abuse and child status**

There was a significant relationship between child status and the number reporting burns and scalds. The group reporting the highest percentage of scalds and burns was paternal orphans, followed by maternal orphans, double orphans and non-orphans ($X^2 = 11.99$, df = 3, p = 0.01). The relationship between child status and the number reporting fractures was also significant, with double orphans having the highest percentage of fractures; maternal orphans were next, followed by paternal orphans and non-orphans ($X^2 = 13.05$, df = 3, p = 0.00). There was a significant relationship between battering and child status; the highest percentage of reported battering was among double orphans, followed by maternal orphans, non-orphans and paternal orphans ($X^2 = 13.05$, df = 3, p = 0.00).

**Emotional abuse and child status**

Children were asked to indicate whether they talked with their caregivers, played or joked with them, whether the caregivers solved their problems and whether the caregivers allowed them to play with other children. There was no significant comparative difference between orphans and non-orphans.

**Sexual abuse and child status**

The study results indicated no significant relationship (at the 5% level) between being approached for sex, the type of person who approached, and whether a sexual encounter took place and child status. However, at the 10% significance level, the results were revealing: maternal orphans, followed by paternal orphans, compared to the other type of orphans and non-orphans, were more likely to engage in sex when approached ($X^2 =0.66$, df = 3, p = 0.09).

**Sharing household work and child status**

Although orphans tended to do more work than non-orphans, the results were not statistically significant.

**Physical health and health seeking behavior and child status**

A higher percentage of the paternal orphans compared to the other children reported having been sick within the last 30 days, though the difference was not statistically significant. The common sicknesses reported were malaria, diarrhea and cough.

There was a significant relationship between the place of medical treatment and child status. The majority of the double orphans were treated at home, followed by maternal orphans and non-orphans. The smallest number of children to be treated at home were paternal orphans, but paternal orphans were also more likely to visit a traditional healer compared to other children ($X^2$ = 33.9, df = 18, p = 0.01). There was a significant relationship between child status and who gave the medical assistance. There was no significant relationship between other indicators of physical health and health seeking behavior and child status.

**Hypotheses**

**Table 1: Prevalence of behavioral problems among children**

| Ratings by caregivers | | |
|---|---|---|
| Variable | Non-orphan (n=189) | Orphan (n=201) |
| Less than 50 | 160 (84.7)[a] | 167 (83.1) |
| 50+ | 29 (15.3) | 34 (16.9) |
| Ratings by teachers | | |
| Variable | Non-orphan (n=85) | Orphan (n=83) |
| Less than 50 | 74 (87.1) | 70 (84.3) |
| 50+ | 11 (12.9) | 13 (15.7) |

a = the number in brackets indicates percentages

**Hypothesis one: Orphans compared to non-orphans exhibit a higher prevalence of psychosocial problems.**

(i) Prevalence of emotional problems among children

1. There was no significant relationship between child status and self blame at home, school, and regret at home.
2. There was a significant relationship between regret at school and child status. The majority of paternal orphans compared to other children had regrets ($X^2$ = 11.89, df = 6, p = 0.05) mainly because of poor performance at school. Poor performance could have been due to lack of basic educational requirements.
3. There was a significant relationship between child status and regretting the death of parents. The majority of double orphans regretted the death of parents more compared to other orphans ($X^2$ = 22.89, df = 3, p = 0.00).
4. There was no significant relationship between feelings of shame at home and child status. However, there was a significant relationship between reason for feelings of shame at

home and child status. Lack of basics and unfair accusations were the main reasons for feelings of shame for paternal orphans ($X^2 = 23.03$, df = 12, p = 0.03).

5. The relationship between child status and feelings of shame at school was not significant.

(ii) Prevalence of behavioral problems among children as rated by caregivers and teachers

Ratings by caregivers showed that more orphans (16.9%) scored above the cut off point of 50 compared to non-orphans (15.3%). This distribution was not significant ($X^2 = 0.18$, df =1, p =0.67). Ratings by teachers showed that more orphans (15.7%) scored above the cut off point of 50 compared to non-orphans (12.9%), though the difference was not significant ($X^2 = 0.25$, df =1, p =0.61).

(iii) Prevalence of depression among children

The results concerning the total CDI scores were not significant. However, the CDI has sub-scales that indicate where children need intervention. These are children that score above a T-score of 50. The children were compared on the sub-scales. Male children who were aged 13-17 years (4.7%) were found to be associated with higher scores for anhedonia (inability to feel happiness). In the same age category, female children (4.3%) were also found to have higher anhedonia, though the difference was not significant. In the male and female category, at least 75% of the cases above the cut off-point were orphans ($X^2 = 5.33$, df = 1, p = 0.02). However, these numbers are very small and thus not conclusive.

(iv) Prevalence of stigma among children

There was a significant relationship between stigma and child status. A high percentage of the double orphans (22.5%) were in the high stigma category, followed by paternal orphans (18.9%), then maternal paternal orphans (12.8%). Only 6.2% of the non-orphans scored in the high stigma category ($X^2 = 19.16$, df = 6, p = 0.00).

**Hypothesis 2: Orphans compared to non-orphans exhibit more serious psychosocial problems in Uganda**

(i) Seriousness of emotional problems among children

There was no significant relationship between child status and self blame. There was a significant relationship between child status and regret, however. Orphans scored higher on regret than non-orphans (F = 3.31, p = 0.02). There was a significant relationship between child status and shame. Orphans scored higher on shame than non-orphans (F = 3.60, p = 0.01). There was no significant relationship between child status and total emotion score.

The least significant difference (LSD) tests showed that for overall emotion scores, paternal orphans differed from non-orphans. For regret, paternal orphans and maternal orphans differed significantly; for blame, groups did not differ significantly. For shame, non-orphans differed from paternal and maternal orphans, while double orphans differed from maternal orphans.

(ii) Seriousness of stigmatization among children

The results showed that child status significantly influenced stigmatization. The double orphans were the most stigmatized followed by paternal and then maternal orphans (F = 13.04, p = 0.00). The LSD test was run to find out the means that differed significantly from each other. The

results showed that paternal orphans differed significantly from non-orphans, while double orphans differed significantly from non-orphans and maternal orphans at the 5% level.

(iii) Seriousness of depression among children.

The results showed that children did not significantly differ on sub-scales of conduct problems, learning problems, psychosomatic problems, impulsivity, anxiety and CPRS total scores. However, orphans scored significantly higher than non-orphans on hyperactivity ($t = 2.14$, $df = 388$, $p = 0.03$).

**Hypothesis 3: Orphans due to AIDS compared to orphans due to non-AIDS exhibit higher prevalence of psychosocial problems in Uganda**

(i) Prevalence of depression among orphans due to AIDS and orphans due to non-AIDS.

Overall scores on CDI showed no significant group differences. The groups were then compared on the different sub-scales of the CDI.

(ii) Prevalence of emotional problems among orphans due to AIDS and orphans due to non-AIDS

The two types of orphans did not significantly differ on the emotions of shame, self blame, regret and total emotion score. However, surprisingly, a higher prevalence (26.7%) of orphans due to non-AIDS compared to orphans due to AIDS (9.6%) more often felt regret at school ($X^2 = 6.66$, $df = 2$, $p = 0.04$), reportedly because of poor performance and lack of teachers.

(iii) Prevalence of stigma among orphans due to AIDS and orphans due to non-AIDS

The results showed that more orphans due to AIDS were likely to be stigmatized more often by peers at school than orphans due to non-AIDS ($X^2 = 9.90$, $df = 3$, $p = 0.02$). Orphans due to AIDS were likely to be stigmatized more often compared to orphans due to non-AIDS by adults at home ($X^2 = 9.18$, $df = 3$, $p = 0.03$), by teachers at school ($X^2 = 9.99$, $df = 3$, $p = 0.02$), and were more likely than other orphans to be referred to as "orphan" by caregivers ($X^2 = 7.88$, $df = 3$, $p = 0.05$).

**Hypothesis 4: Orphans due to AIDS compared to orphans due to non-AIDS exhibit more serious psychosocial problems in Uganda**

(i) Seriousness of depression among orphans due to AIDS and orphans due to non-AIDS

Orphans due to AIDS did not significantly vary from orphans due to non-AIDS on CDI sub-scales and on total CDI scores.

(ii) Seriousness of behavioral problems among orphans due to AIDS and orphans due to non-AIDS

The results showed that orphans due to AIDS did not significantly vary from orphans due to non-AIDS on CPRS-48 sub-scales and on total CPRS total scores, except on one sub-scale of hyperactivity. Orphans due to non-AIDS were rated more hyperactive than AIDS orphans ($t = 2.14$, $df = 387.61$, $p = 0.03$).

(iii) Seriousness of emotional problems among orphans due to AIDS and orphans due to non-AIDS

The results showed that the orphans due to AIDS and orphans due to non-AIDS did not significantly vary on the seriousness of their emotions. The emotions included regret, self blame, and shame.

(iv) Seriousness of stigmatization among orphans due to AIDS and orphans due to non-AIDS

The two groups did not significantly differ on stigmatization ($t = 1.00$, $df = 75.7$. $p = 0.32$).

**Multivariate analysis**

The results showed that total depression score, negative mood and anhedonia were predicted by length of time since death of parent(s) ($t = 2.93$, $p = 0.01$; $t = 2.09$, $p = 0.04$; $t = 3.04$, $p = 0.00$). Variables of interpersonal problems, ineffectiveness, negative self esteem, regret, stigma and self blame had no significant predictors. Total emotion score and shame were predicted by length of time since the death of parent(s) ($t = 2.38$, $p = 0.02$; $t = 3.00$, $p = 0.00$. Emotional factors of regret, stigma and self blame also had no significant predictors.

**Availability of psychosocial support to children reported by caregivers**

Different players offered different types of psychosocial support. These included teachers, friends, relatives, well-wishers, caregivers, religious institutions, NGOs and LC personnel. The support given was in the form of basic needs, education, medical care, income generating activities and counseling. However, the majority of the children did not receive any psychosocial support and, for those who did, much of the support was thought to be inappropriate.

**QUALITATIVE FINDINGS**

**Psychosocial problems of orphans compared to non-orphans**

Among the emotional and social problems noticed among orphans compared to non-orphans, being ridiculed as orphans by caregivers, teachers, community members and peers, sexual harassment, poverty and mistreatment by step mothers were highly reported. At school, the orphans reported other children refer to them as "World Vision". When the NGO gives them T. shirts, other children tell them, *babajunye,*" meaning "*they have rescued you*". Non-orphans were noted for being unfriendly to orphans, emotionally disturbed by their parents' alcoholism and their fathers' womanizing and they also suffered from poverty.

There was a consensus by all children about mistreatment by stepmothers. It is mostly the orphans who have lost their own mothers who suffer this mistreatment. In homes where there are orphans and non-orphans, the orphans are not given blankets but rather bark-cloth (*embugo*) or sleep on dry banana leaves (*bisanja*), or put grass in sacks to use as mattresses.

On sexual harassment, it was reported that some fathers harass their daughters for sex, especially if the daughters are a bit grown up and the father never remarried after the wife died. Some girls may give in for sex but others decide to run away from home. Other caregivers take advantage of orphans while assisting them with school fees and use them for sex. Teachers are also known to sexually harass female pupils.

**Findings from children's pictures and their stories (when they felt particularly happy)**

The pictures and stories by orphans and non-orphans on when they felt particularly happy did not significantly vary. Most depicted happiness in school, with children holding books while going to school. Further happiness was portrayed in dressing up, with more orphan girls than others reporting they were particularly happy when they received a dress from a relative sister or mother. This was preceded by pictures of children smartly dressed. Others included mother giving advice to daughter and the child sleeping in a comfortable bed.

**Findings from children's pictures and their stories (when they felt particularly unhappy)**

There were few differences in the pictures and stories by orphans and non-orphans about when they felt particularly unhappy. The majority depicted being ridiculed that they were orphans, lacking school fees and scholastic materials, death of parents, being beaten by step mothers and suffering from malaria due to being exposed to mosquitoes since they slept without bedding. On lack of school fees, one picture was of a girl holding a hoe and unable to go to school. On ridiculing, they reported *"Ekigambo ekyo 'mulekwa' kitukwasa nnyo enaku,"* meaning *"that word 'orphan' makes us feel so sad"* (Female FGD, Kyanamukaaka). Stories by non-orphans, too, were about a lack of school fees and scholastic materials, and about the death of the parents of their friends. An exceptionally emotional picture was of a house drawn by an orphan boy who explained that he did not have a house because his parents left him with nothing. He is being chased by an uncle with whom he stays. He wants to build his own house but lacks the money.

**Orphans' pictures on: "the person I love" and "the person I hate"**

The persons loved most were those paying their school fees, i.e. World Vision and Lutheran World Federation, as well as mothers, grandmothers, and a few fathers and uncles. Others were those who provided food and clothing and mothers and grandmothers were highly reported.

The persons hated most were those not contributing anything to the family, such as grandfathers, paternal uncles and brothers. They were further pointed out for grabbing property after the death of parents. Others hated were alcoholics, prostitutes/womanizers and step mothers who scored on mistreating them and only loving their own children. Generally, most pictures and stories revealed reduced attachment of children to family members with indicators of anxiety, insecurity and resistance. Emotional and social problems were highly exhibited in children.

**Findings from children's dreams/wishes (desegregated by gender)**

Orphan girls (11%) and non-orphan girls (9%) wanted to be nurses while orphan boys (10%) and non-orphan boys (8%) wanted to become doctors. Orphan girls scored higher (20%) than other categories for the teaching profession followed by non-orphan boys (18%), non-orphan girls (15 %) and orphan boys (12%). Neither orphan girls nor orphan boys reported they wanted to marry and have a family, but the non-orphans did. The orphan girls and boys wished to gain enough education while the non-orphans did not report on it. More non-orphans than orphans wanted to have land and grow crops. More non-orphan girls did not have future dreams (46%), followed by orphan boys (42%), orphan girls (39%) and non orphan boys (29%). Generally, the results showed there were no big differences between orphans and non-orphans in the way they perceived the future. It is notable that a large number of all children are pessimistic about life and

have no dreams for the future. This may imply that there is a prevalence of anhedonia (loss of interest in life) among both orphans and non-orphans, possibly due to poverty. The results concur with the quantitative results on anhedonia in the children's depression inventory.

**Psychosocial support provided to orphans and non-orphans**

Key Informants observed that there was a lack of emotional support provided to children at the local, sub-county and district levels. However, the emotional support reported by orphans on counseling provided by friends who are fellow orphans was extremely touching. If they are depressed, particularly after the caregivers have mistreated them, orphans said that they can talk to these orphan friends, who counsel them. Grandmothers, too, provide some emotional support by comforting orphans. However, some children noted they did not receive any real emotional support from anyone. *''No one comforted us when our father died and mother died earlier. The relatives of our mother started tossing us around saying "it's your father who killed our daughter. He brought the disease AIDS that killed our daughter"* (Female FGD, Kyanamukaaka).

Children under World Vision support expressed hope for the future, perhaps because they were sure of gaining an education up to senior four or beyond, unlike those without support from NGOs. Non-orphans observed that orphans are more advantaged than they are and that their parents' support is inadequate.

The majority of the teachers noted there were no special school programs for orphans and the needy non-orphans. Orphan boys commented that Universal Primary Education (UPE) does not provide scholastic materials, food and uniforms, hence their failure to meet school requirements and frequent dropping out of school.

Behavioral support received by children was mainly from senior teachers as well as from local council officials. Inappropriateness of psychosocial support provided to children as reported by children and Key Informants included: delays in receiving support, caregivers' greed and diverting orphan support to non-orphans, and orphans' lack of immediate health care, clothing and bedding. Further findings showed lack of direct contact of talking to children about their emotional problems and follow up. As much as children appreciated the support provided by NGOs, they reported very few cases when they have been visited and talked to about what they go through in life. In addition, NGO support does not extend to caregivers, who also experience significant hardships and emotional problems.

We also noted that identification of the psychosocial needs of orphans handled by the NGOs is not systematic. There are no specific criteria in identifying, assessing, prioritizing and working out solutions for orphans' needs. The monitoring and evaluation indicators presented by most of the NGOs are not clear or uniform. Each actor providing interventions uses its own indicators. Some are performance indicators and others are presented in the form of problems. Although some relevant assistance is provided through national programmes for children by government, it appears that no NGO has extended psychosocial support to non-orphans.

**Reported recommendations by study respondents to improve child welfare**

The major recommendations included provision of counseling skills to caregivers and teachers and sensitizing communities about children's social and emotional problems. In the behavioral area, enforcement of laws and strengthening responsible structures to counteract child abuse was the major response. Participants also suggested training of psychosocial counselors.

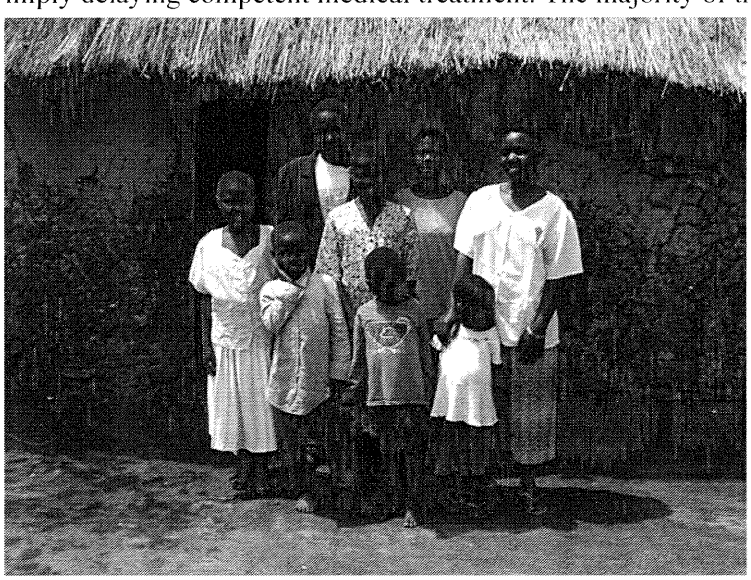
## DISCUSSION AND INTERPRETATION OF FINDINGS

The finding that some caregivers are adolescents suggests limited psychosocial skills to assist the children under their care. The poor socioeconomic status (SES) of the majority of caregivers also means limited resources to cater for children's needs. This finding supports that of Otieno Nyambedha, Simiyu Wandibba and Aagaard-Hansen (2001) who found that caregivers were typically from a poor SES background, e.g., without safe water and sanitation (see also Waterson, 2003). The majority of the teachers were youths with limited psychosocial skills. This has serious implications for the care of their pupils, especially orphans.

Orphans were older than non-orphans (due to the allowance of ±2 years difference allowed in matching). This implies that the majority of the orphans will soon mature and take on different roles while not enjoying adequate mental health. More double orphans were not in school, mainly because they lack the necessary educational requirements (Foster, 2002a). Many orphans watched their parents die of AIDS, supporting Mulama (2003) who reports that out of 34 million orphans in Africa, 11 million are AIDS orphans, a number that will rise to 25 million by 2010. Orphans due to AIDS are likely to suffer stigmatization, discrimination and prostitution, which are likely to adversely affect their psychosocial and physical health.

The majority of the orphans lived with surviving parents, grandmothers, aunts and other relatives. Most of these caregivers are poor and cannot adequately provide for the needs of the children, as is clear from the already over-stretched extended families (Hobbs, 2003; Otieno Nyambedha, Simiyu Wandibba and Aagaard-Hansen, 2001). More orphans than non-orphans report physical abuse, including burns, fractures and battering, with double orphans, especially, but also maternal orphans experiencing the worst of these abuses. The study indicates no significant differences between orphans and non-orphans regarding physical health, although other researchers have found poorer physical health, such as stunting, among orphans (Hobbs 2003).

The finding that the majority of paternal orphans were being taken to traditional healers may imply delaying competent medical treatment. The majority of the children were receiving medical help from caregivers, suggesting a difference (discrimination) in the way orphans and non orphans are cared for medically (Otieno Nyambedha, Simiyu Wandibba and Aagaard-Hansen (2001).



Regarding prevalence of psychosocial problems, the majority of paternal orphans (55%) and many non-orphans (44%) felt regret at school due to poor performance and lack of teachers, which may result in other emotional problems such as reduced self esteem and social (interpersonal) problems. This shows that a high percentage of non-orphans could also be experiencing poor emotional life. Interventions, therefore, should not focus on orphans only, but rather should reach all needy children.

More orphans compared to non-orphans scored in the high stigma category. Stigma works in such a way as to increase discrimination, abuse, neglect and exploitation, including sexual exploitation, with one result being that children take to the streets (Foster, 2002a). Stigmatization also may have a negative impact on school performance.

On behavioral problems, it is not clear why non-AIDS orphans were rated more hyperactive, but perhaps despite the cause, orphanhood may adversely affect a child's behavior. This is in line with Foster (2002a), who found orphans were more likely to act up and be psychopathic.

The finding that psychosocial support by caretakers, NGOs and other organizations was insufficient and even inappropriate is not surprising given that study caregivers were mainly from a poor socioeconomic background. Their ability to provide basic needs was limited, even more so their capacity to deal effectively with psychological problems (Otieno Nyabendha et al., 2001).

The qualitative results from children's interviews, discussions, pictures, and stories clearly indicate the prevalence and seriousness of psychosocial problems among orphans and non-orphans. Orphans were abused physically, socially, emotionally, and sexually. Notable among these, and quite highly reported, were orphans being ridiculed and referred to as 'orphans' which is not only stigmatizing but is also a form of trauma that may cause significant damage to the orphans. The lack of social protection for the girl orphans is also a serious problem (Carter, 2001), since sexual harassment adversely affects them emotionally, socially and physically, leading to a continued cycle of HIV/AIDS among children. This concurs with the findings on the 'Sugar Daddy' phenomenon in Sub-Saharan Africa (Plan International, 1996).

Lack of school fees and scholastic materials may also impact children's psychosocial well being unless interventions are put in place. The drawings and stories about when children felt particularly happy, the people they love most and future dreams about studying are all indicative of the value children attach to education. Happiness to them is being in school. It is noteworthy the degree to which non-orphans connected 'persons hated' with prostitution/womanizing, drunkenness, property grabbing and mistreatment by step mothers. On the other hand, the non–orphans' observation that orphans benefit a lot from NGOs, while other needy children do not, should affect how NGOs target their beneficiaries.

## POLICY IMPLICATIONS

1. The Ministry of Education and Sports as a line ministry in child welfare has a role to play in addressing psychosocial needs. Teachers contribute significantly to the up-bringing of children, so psychosocial counseling skills need to be integrated in their training, school curriculum and refresher courses.
2. Most NGOs working on child welfare mainly provide social support; little is provided on psychological support. This imbalance might be corrected if all NGOs dealing in child welfare were required to integrate psychosocial interventions within their programs.
3. The study has revealed the prevalence of emotional problems in all children, though particularly among orphans, hence the importance of considering the psychological needs of children in the national programs of child welfare. It is the responsibility of the Ministry of Gender, Labour and Social Development (MOGLSD) to ensure childcare and protection of children rights in Uganda by calling for the integration of psychosocial programs into the National Action Plan for Children.

## RECOMMENDED SOCIAL INTERVENTIONS

We recommend the following:

- Creating awareness among children through school peer pressure groups and equipping teachers with psychosocial counseling skills.
- Forming community pressure groups composed of parents/guardians, religious leaders and youth through the existing local women and youth associations, and equipping them with psychosocial skills. Community efforts have already been found to work in Zimbabwe (Foster, 2002ab).
- Sensitizing the local councils on child rights and equipping them with psychosocial counseling skills.
- Providing training (in collaboration with stakeholders) in child counseling, particularly in handling specific problems of children such as negative effects, hyperactivity, interpersonal problems, anhedonia and negative self-esteem.
- Implementing economic empowerment programmes that include training in income generating activities for small businesses for caregivers to reduce poverty.
- Increasing advocacy for caregivers so the wider community understands their problems.
- Expanding education, improved legislation and supervision of structures to watch for and prevent child abuse and neglect and imparting parenting skills to caregivers.
- Reducing emotional problems through the use of interpersonal therapy groups. Bolton et al. (2003), Lacey (2004), and Landmann (2004) have already tested these technologies and found them to work in some parts of Uganda.
- Expanding cognitive behavioral therapy for children, which can work for hyperactivity as well as depression.
- Instituting counseling centers at sub-county level (offering vocational training as well).
- Identifying psychosocial needs of children at the family level by sensitizing all members about how to identify needs and work out solutions for them.
- Working out a uniform approach with psychosocial actors to care for children, including monitoring and evaluation indicators.
- Prolonging the life of caregivers through AIDS treatment programs (Dabis and Ehounou Ekpini, 2002; Hobbs, 2002). The government's effort to offer ARVs to patients with HIV/AIDS is therefore highly recommended.
- Developing psychosocial skills training programs in Ugandan training institutions.

## INDICATORS FOR MONITORING AND EVALUATION

A sample of children will be followed to monitor psychosocial problem levels over 2 years using the Kovacs Children depression inventory, Conner's rating scale and qualitative measures. Indicators will reflect on:

- The number of children in the cohort sample presenting with depression as assessed by the Children depression inventory should have reduced by 50% by the end of one year.
- The number of teachers, children, parents, community leaders and religious leaders in the 2 sub-counties attaining 50% knowledge about children's psychosocial problems by the end of 1 year, as measured by the KAP monitoring tool designed by the research team.
- The number of teachers, children, LC2 Vice Chairpersons and community pressure groups in the 2 Sub-counties trained in implementing child and family counseling by the end of 2 years.

- Acceptance of government and other key stakeholders to establish counseling centers at Sub-county levels.
- The number of children reporting sexual abuse to the local authorities and trained counselors every 3 months.
- The number of children reporting being ridiculed, mistreated by step mothers, property grabbing by relatives, increased poverty, etc every 3 months.

## SUGGESTIONS FOR FUTURE RESEARCH

Caregivers have the burden of dealing with the psychosocial problems of orphans. Further research should investigate psychosocial problems of care-giving and coping strategies of care-giving. This research has indicated that orphans suffer more psychosocial problems compared to non-orphans, so there is a need to study the psychological coping mechanism among orphans, handling of orphans by traditional healers, assessment of children in orphanages and child headed households, and assessment of problems of caregiving. Since the study concentrated on one district, it is important to expand the research to other districts of Uganda. Methodologically, we recommend that subsequent research employs a longitudinal approach with cohort designs (Foster, 2002a).

## CONCLUSION

Findings of the study suggest that orphans compared to non-orphans are experiencing psychosocial problems. Program designers can use these findings to develop psychosocial programs for early detection and improvement of the psychosocial well being of orphans and other vulnerable children (OVC). The information from this study is also useful for those who want to train psychosocial helpers. Interventions should pay particular attention to characteristics of orphans including their age, length of time since death of parent(s) and type of orphan.

## ASSESSING THE LONG TERM SUSTAINABILITY OF SOCIAL INTERVENTIONS

The Institute of Psychology, Makerere University, is already collaborating with children's NGOs such as Christian Children Fund, World Vision and Ashinaga Uganda. Collaboration has also started with the Ministry of Gender, Labour and Social Development. It is hoped that this collaboration will ensure the long term sustainability and effectiveness of psycho-social interventions for orphans and other vulnerable children.

# CHAPTER 4: THE EMOTIONAL AND BEHAVIORAL PROBLEMS OF ORPHANS AS SEEN IN RAKAI DISTRICT, UGANDA

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Various studies have consistently shown orphans to have high rates of emotional and behavioral problems (Worden, 1996; Dunn, et al, 1991; Minde and Musisi, 1983; van Eedewegh et al, 1982; Gregory, 1965; Arthur, 1964). In Uganda there is very limited literature on the psychopathologic problems faced by orphaned children (Dunn et al, 1991; Minde and Musisi, 1982). Minde and Musisi (1982) reported on psychological problems in Ugandan children whose early attachment systems were disrupted due to a variety of causes including parental death, separation or divorce. However, in Uganda, no study has described the specific psychological disorders suffered by orphans and as such no specific treatments have been attempted.

The UNAIDS Statement of 2000 reported that there are over 1.7 million children orphaned by HIV/AIDS in Uganda. Others have given estimates of 1.1 to 2.35 million children being orphaned by HIV/AIDS and other causes in Uganda, a country of 24 million people (Wakhweya et al., 2002; Monitor Newspaper, July, 1999). Rakai District in Southern Uganda was the first district in the country to report cases of HIV/AIDS and it has borne the brunt of the AIDS epidemic. As a result, Rakai District has the worst orphan problem in the country (Dunn et al, 1991; Monitor Newspaper, July 1999).

In a recent study of HIV infected adolescents, Musisi and Kinyanda (2002) reported high rates of psychological and behavioral disorders in this subgroup of children, 97% of whom were orphaned. The *Situation Analysis of Orphans in Uganda,* carried out by the ARCH project of Ugandan and US colleagues (Wakhweya et al., 2002), reported a number of psychosocial problems faced by HIV/AIDS orphans. This analysis called for information on specific psychological, emotional, and social disorders encountered by these orphans as well as possible intervention strategies.

## OBJECTIVE

This study aimed to define the specific emotional and behavioral disorders suffered by orphans in Rakai District, Uganda, in order to suggest appropriate interventions.

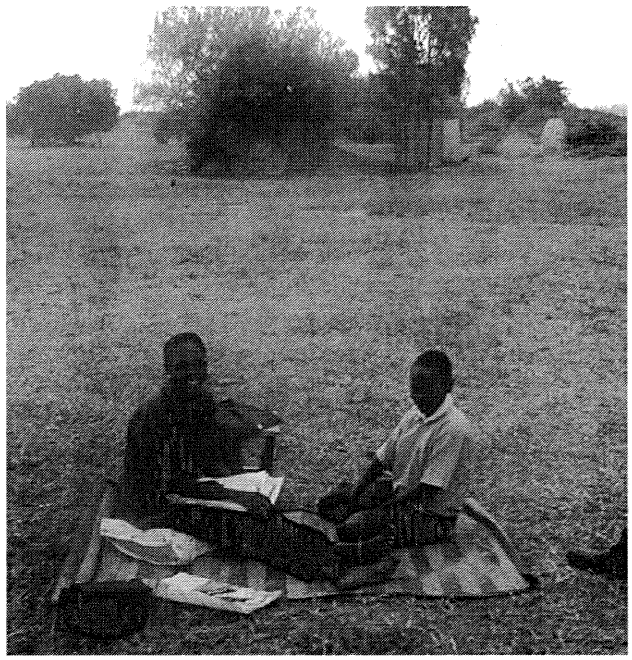
## METHODS

The study employed a cross-sectional comparative analytical approach using an unmatched case-control design. Both quantitative and qualitative data were collected to compare a randomly selected sample of 210 orphans to a group of 210 non-orphans on a number of parameters. Their caretakers were also studied. A standardized pre-tested questionnaire was used, composed of socio-demographic variables, orphan-hood status (father/mother/both parents dead), age at death of parents, current caretaker, financial support and school performance. The Rutter's Teacher

Administered Children's Behavior Questionnaire (Rutter, 1967), and a Modified Self-Report Measure for Social Adjustment (Cooper and Osborn, 1982) were also administered to all the children. Lastly a standardized psychiatric diagnostic interview was carried out on all the children scoring 9 and above on Rutter's Scale, using the WHO-ICD-10 symptom checklist for specific mental and conduct disorders (WHO, 1992) and the WHO SRQ – 25 sub-scale for psychosis (WHO, 1994). The caretakers' questionnaire consisted of demographic characteristics and the SRQ-25 questionnaire. Qualitatively, in-depth interviews were held with key informants including head teachers, health workers, community leaders and district officers from the Ministries of Health and Education, and focus group discussions were held with teachers, orphans, non-orphans and caretakers. Quantitative data were analyzed using the EPI–INFO and SPSS computer packages and qualitative data were analyzed using the thematic approach to identify general trends.

## RESULTS

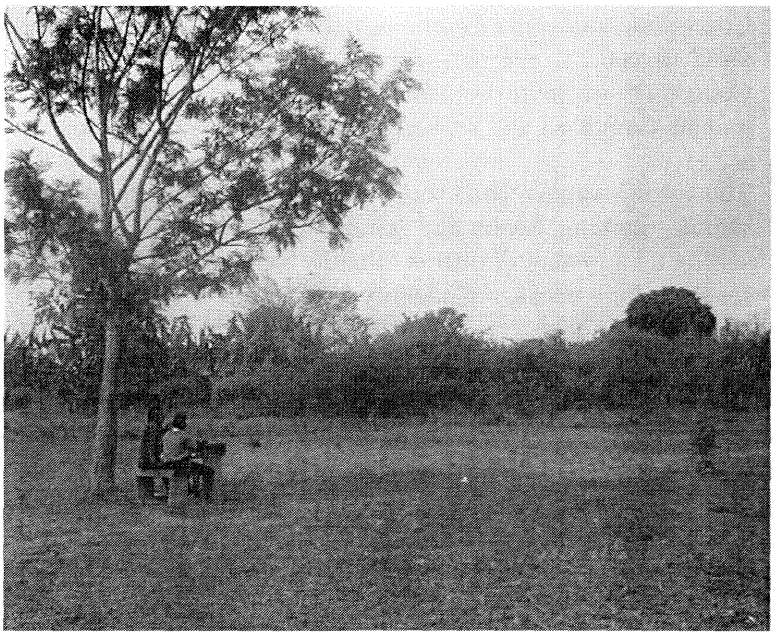
The orphans were mostly paternal (49.7%), then double (31.0%) and least maternal (18.8%). The causes of death of the parents were AIDS / presumed AIDS (41.9%), non-AIDS illness (17.5%), accidents (6.2%) and undetermined causes (34.4%). More orphans compared to non-orphans were older and in upper (≥ primary 5) classes, (51.5% and 38.8% respectively, p = 0.02). There were more elderly caretakers (≥ 60 years) for the orphans than for non-orphans (16.0%, and 4.0% respectively, p = 0.03) and more were females (75% and 57.1% respectively, p = 0.00). More of the orphans' caregivers were widowed compared to those for the non-orphans (44.3%, and 4.6%, respectively, p<0.00), with the latter being mostly married or cohabiting (39.7% and 79.6% respectively, p = 0.00). Significantly more orphans' caregivers compared to those for non-orphans had no formal education at all (18.3%, and 8.8% respectively, p = 0.04) .The majority of caregivers in both categories were employed as peasant farmers (71.2% and 65.5% respectively, p = 0.90). Both categories of children (orphans and non-orphans) had high levels of emotional and behavioral problems (Rutter score > 9; 45.1% and 36.5% respectively) but with no statistically significant differences (p = 0.10). These problems were associated with poor academic performance in both groups of children. Neither of the 2 groups had significantly more major psychiatric disorders and no major physical illnesses. The reported psychiatric disorders for the orphans and non-orphans were depression (6.9% and 2.0% respectively, p = 0.43); anxiety (16.7% and 12.2% respectively, p = 0.50); somatisation (16.7% and16.3% respectively, p = 0.96) and alcohol abuse (6.9% and 2.0% respectively, p = 0.43). Significantly more orphan children compared to the non-orphans reported finding "life unfair and difficult" (28.2% and 17.2% respectively, p = 0.03) and indeed more reported suicidal wishes (8.3% and 5.1% respectively p = 0.30). Lastly, significantly more orphans reported past sexual abuse (rape) compared to non-orphans (23.8% and 7.7% respectively, p = 0.05). The children's social functioning in the family unit rated significantly worse amongst the orphans compared to the non-orphans (p = 0.05).



Qualitatively, orphans were described as "needy, sensitive, delicate, isolative with low confidence and low self-esteem" and as often "lacking love, protection, identity, security, play, schooling, food and shelter." They often lived in big families with stretched resources, poverty, stigma and frequent relocation from relative to relative. This was in the context of no or inadequate organized community resources and no school based / initiated psychosocial counseling.

On the other hand orphans were quite resilient in facing their problems. Their academic functioning was on a par with the non-orphans and many played a competitive sport at school and they also took up leadership positions.

## DISCUSSION



A large number of both orphans and non-orphans had high levels of psychological distress as depicted by their Rutter scores. This may be related to the high level of poverty found in rural Rakai, with most families (>70%) being peasants. However more orphans lived with poor, elderly, and widowed female caretakers and they faced more social deprivation as well as abuse. These findings are in keeping with established literature (Wakhweya et al., 2002). Our school–going orphans were physically healthy, did not have HIV infection, and did not suffer major psychiatric disorders. This is in contrast with earlier findings of Musisi and Kinyanda (2002), who found high rates of major psychiatric disorders in the subgroup of orphans who were HIV infected. This suggests that orphans should be divided into two categories: those who are HIV infected and those who are not, with implications for differential intervention strategies, i.e. with the former needing medical and psychiatric intervention (e.g. anti-retroviral drugs, ARVs; physical treatments and psychotropic medications) in addition to psychosocial interventions, and the latter needing only psychosocial interventions both at school and in their families.

## Conclusions

Our school going orphans exhibited more common emotional and behavioral problems compared to the non-orphans, but no major psychiatric disorders. This was in keeping with established literature (Worden, 1996; van Eerdewegh et al, 1982; Minde and Musisi, 1982; Arthur and Kemme, 1964; Gregory, 1965). Orphans reported more dissatisfaction with life and were more likely to be (sexually) abused. They were described as being more often emotionally needy, isolative, materially deprived, and more likely to be exploited / abused /neglected. They lived in situations of poverty, big families and hardship. There were no adequate community or school programs to address their needs.

## RECOMMENDATIONS

There is a need to establish a National Orphan Policy that will make provisions for the establishment of a National Orphan Registry, to legally define the guardian or caregiver of every child and to spell out his/her responsibilities towards the child. This Orphan Policy should make provisions for the legal protection of the child, their schooling, health care and for protection of their rights. The policy should provide for the setting up of a National Child Protection Agency to address the security needs of vulnerable children including orphans and those in 'trouble or danger'. It should have branches in all the administrative areas of Uganda.

Counseling and Child Psychology should be taught to teachers, health care providers and parents/ child caretakers. All schools with large numbers of orphans should have a Child Guidance Counselor to help not only the orphans and other vulnerable children but also their parents/caregivers and the teachers in dealing with the children.

The specific orphan child support services should provide for the orphans' needs in terms of food, shelter, clothing, health and scholastic materials. There is also a need to strengthen families by setting up a system of district "Family Services" so that the orphans can have families to relate to for their daily needs, self-identity and cultural orientation.

## INDICATORS FOR MONITORING AND EVALUATION OF PROPOSED INTERVENTIONS

These need to be established at 5 levels: central government, local government, schools, families and the orphan child as follows:

1. Central Government Intervention: Orphan Registry; Orphan Policy; Child Protection Agency; courses in child care and counseling for teachers, health care providers and parents.

*Indicators:* An established Orphan Policy and Registry; a functioning Child Protection Agency; number of counselors trained; number of specific intervention programs set up.

2. Local Government Intervention: Child support services; LC I Secretary for Orphans and other Vulnerable Children (OVC) in severely affected districts; food security; vocational skills training; micro-credit schemes.

*Indicators*: Secretary for OVC established; number of child support services; number of new food gardens and granaries; number of credit schemes set up; number of OVC helped; number of OVC trained in vocational skills.

3. Schools Intervention: Child and Guidance counselors; Parent Teacher Associations (PTA); school report cards.

*Indicators*: Number of counselors trained; number of active PTAs set up; number (and percent) of good report cards received.

4. Family-level Intervention: Income generating activities; use of child's Health Care Card; family counseling sessions.

*Indicators*: Number and types of income generating activities set up; number of families attending counseling sessions and number of sessions attended; families with orphans accessing micro-credit assistance.

5. Orphan Child Intervention: Food, family shelter, clothing, scholastic materials, and psychological health support.

*Indicators:* 24 hour food recalls; nature and number of family shelters; number of inspections of childrens' wardrobes; number of inspections of children's scholastic materials; number of teacher-administered sessions using psychological assessment instrument (Rutter's).

# CHAPTER 5: IS DISCRIMINATION OF PRESUMED AIDS ORPHANS REAL?

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*"... You find that when a child falls sick in a home, the mother or father will act very fast on his own child and take him to the doctor but when the AIDS orphan falls sick... these are the ones you hear that they first gave herbs and tablets but the non-orphans are taken immediately. The orphans are also taken to clinics but not so often."*

*(FGD of Nakabago Local Council Leaders in Mukono town)*

The preceding citation from the Focus Group Discussion (FGD) of Nakabago Local Council Leaders echoes a PANOS (1996) report, which asserted that many children in Uganda die of malaria, minor infections or other preventable diseases because caregivers often assumed that when an orphan became ill, it was due to AIDS, and so care was not sought. Sub-Saharan Africa has borne the brunt of the AIDS pandemic, with countries facing serious difficulties. Many families can barely fend for themselves (Potkum, 2001). Orphans face special problems in accessing food and health care, including treatment of malaria, acute respiratory infections (ARIs) and diarrhea (FHI Publications, 2003; Mattes, 2003; Case et al., 2003).

According to numerous studies: "Orphans are more likely than non-orphans to suffer from poor nutrition, lack access to basic health care, miss school, and face psychological and emotional difficulties" (FHI Publications, 2003:1). Some caregivers believe that any illness is the first sign of AIDS and may be less likely to seek treatment and full immunization for orphans than for non-orphans. In some parts of Kenya, HIV/AIDS orphans were reportedly denied admission to public schools (Sheree, 2003). Such discrimination was attributed to an acute lack of awareness about the disease among the general population, though the key underlying factor could be lack of a policy on AIDS orphans (or orphans in general) as in the case of Kenya (Kagwe, 2004). Sadly, many sub-Saharan African countries still lack a policy in place to deal comprehensively with the situation of children orphaned by AIDS (Hobbs, 2003).

## THE CASE OF UGANDA

In Uganda, close to 20% of all children are now estimated to be orphans (Wakhweya et al., 2002), supporting earlier estimates (Hunter and Williamson, 2000) that there would soon be a staggering 2.35 million-orphans nationwide. Led by the Ministry of Gender, Labor and Social Development (MOGLSD), the Ugandan government initiated a national policy process for orphans and other vulnerable children (OVC) in order to systematically address the ever-increasing issues relating to OVC. The policy is *inter-alia* intended to improve the provision of care and services for OVC by targeting children with the greatest needs.

The draft policy document expressed concerns about resource distribution and the well being of orphans when compared to non-orphans within households where children live. It also expressed concern about the high level of poverty, which "makes it very difficult for households to extend

care and support to an increasing number of dependents, including orphans and other vulnerable children" (MOGLSD, 2003). Under such circumstances, discrimination of presumed AIDS orphans could be expected. Thus it is within this context that policy makers should consider preventing or mitigating any possible discrimination of orphans, whether or not they are presumed to be infected or affected by HIV/AIDS.

## METHODS

In 2003-04 we conducted a study entitled "Differential Preventive Care and Treatment Seeking Patterns for Presumed AIDS Orphans, Non-AIDS Orphans and Non-orphans" in Mukono District. The study's main objective was to look for patterns of differential caregiver behavior. We looked at various care-giving behaviors – current nutritional status, immunization, management of childhood illnesses and other preventive health care practices – between presumed AIDS orphans, non-AIDS orphans and non-orphans. Presumed AIDS orphan status was based on a close family member stating that the parent died of AIDS. Non-AIDS orphans are those children whose parent(s) died of a known cause other than AIDS, including homicide and drowning.

The study population included caregivers in households with at least one orphan and one non-orphan in the age bracket of 7 years or younger (down to 3 months only[6]), provided the caregivers gave a written informed consent to the interviewer. The rationale for this selection criterion was that the research team was interested in examining possible intra-household bias. We therefore needed an orphan and a non-orphan in the same household. A household was defined as a group of people who made common decisions and who lived together and/or cooked meals together.

We adopted a descriptive exploratory design, employing quantitative and qualitative approaches of data collection. The study compared caregivers' preventive health care provision and health seeking behavior patterns within orphan households. It adopted a purposive sampling procedure. In order to equally represent all 4 wards and all villages that constitute Mukono town, the study team allotted varying weights to all four wards not only to effectively represent "wealthy" enclaves of the town but also not to over represent the highly densely populated villages in the sample (see Table 1).

**Table 1: Proportion of households selected per ward in Mukono Town Council**

| Ward | # of villages | HHs | Population | | Total | Projected proportion of households selected | Actual number/ proportion of households selected |
|---|---|---|---|---|---|---|---|
| | | | Male | Female | | | |
| Ggulu | 11 | 3,682 | 6,799 | 7,011 | 13,810 | 31% | 80/31% |
| Namumira Anthony | 12 | 3,429 | 6,564 | 7,138 | 13,702 | 29% | 75/29% |
| Nsuube Kauga | 9 | 2,401 | 5,295 | 5,308 | 10,603 | 20% | 52/20% |
| Ntawo | 9 | 2,414 | 4,737 | 5,090 | 9,827 | 20% | 51/20% |
| **Totals** | 40 | 11,926 | 23,395 | 24,547 | 47,942 | 100% | 258/100% |

[6] We used 7 years down to 3 months because technically children younger than 3 months are not susceptible to our tracer conditions (malaria, ARI and diarrhea) since that age still largely relies on mothers antibodies.

Four selection questions were asked of an adult (or the head of household) to determine whether the household could be included in the study (see Table 2).

## DATA COLLECTION METHODS

Quantitative data were collected using a household questionnaire that was administered to caregivers. Data included household-level information; current nutritional status of and preventive care treatment for all children aged 7 years and younger; and treatment-seeking by caregivers for recently ill children in this age group. Qualitative data were gathered through semi-structured key informant interviews with district, town council, NGO and local council officials. In addition, six focus group discussions (FGDs), which brought altogether 37 participants with a balanced representation between different profiles and backgrounds of caregivers, were conducted. In addition, three case narratives were held with caregivers.

**Table 2: Selection questions, with selection based on a "yes" response to all questions**

| No. | Question | Response | | |
|---|---|---|---|---|
| | | Yes | No | Don't Know |
| 1. | Are there any children in this household aged 7 years or below? | √ | X | X |
| 2. | Have any of these children lost one or both of their parents? | √ | X | X |
| 3. | Do any of these children aged 7 years or younger have both of their parents? | √ | X | X |
| 4. | Have any of the children below the age of 7 years been ill in the last one month? | √ | X | X |

## DATA ANALYSIS

The focus of the data analysis for the quantitative data was on finding statistically significant differences in caregiver treatment of presumed AIDS orphans, presumed non-AIDS orphans and non-orphans. In addition, match-ups within homes were done to see if we could observe any significant differences. However, due to a relatively small sample this was limited to care seeking for fever/malaria symptoms only. All qualitative data interviews were analyzed using content analysis, identifying and organizing themes and patterns in the data, while keeping in mind the conceptual framework.

## RESULTS

The study team would like to state from the outset that the results are mixed. While we did not find consistent evidence of widespread bias, our findings suggest that there may be significant discrimination in some types of caregiver treatment of AIDS orphans, and bias towards all orphans in other areas. Perceptions abound from qualitative data, such as the view expressed by one of the FGD participants cited at the beginning of this chapter, that discrimination does exist. Overall, our qualitative data suggest that some caregivers who attempt to test orphans for their serological status have an ulterior motive of discriminating against AIDS orphans. However, some informants believe that testing orphans for HIV does not necessarily have a discriminative consequence, as suggested by a 40 year old female local leader: "Another thing is that if those two children are tested for HIV, I don't think a relative can leave the AIDS orphan belonging to his brother and then take the non-AIDS one, whom you don't even know."

Stepmothers in polygamous marriages were commonly mentioned as culprits in discriminating against orphans; indeed, participants in all FGDs mentioned that stepchildren are vulnerable to discrimination. As stated in one females' FGD: "the stepmothers have a tendency of discriminating and favoring among children under their care."

### BACKGROUND CHARACTERISTICS

The household survey included a total of 258 caregivers. About 70% of the caregivers were female, while the remainder (30%) was male. Almost 57% of the caregivers were not the heads of households, while 43% doubled as main caregivers and heads of households. About 43% of the households were in the lower income echelon, 40% were in the medium income echelon, while 17% were in the upper income echelon. These income echelons were based on a judgment made by the principal researchers with guidance from local field guides. The biggest proportion (44%) of caregivers was monogamously married but a relatively large proportion (36.1%) was widowed or divorced/separated (see Table 3).

**Table 3: Caregivers' demographic information**

| Characteristic | Frequency | Percentage (%) |
|---|---|---|
| Totals | 258 | 100 |
| ***Marital Status*** | | |
| Married-monogamous | 113 | 43.8 |
| Widow/widower, not married | 57 | 22.1 |
| Separated/Divorced, not married | 36 | 14.0 |
| Married-polygamous | 24 | 9.3 |
| Widow/widower, remarried | 14 | 5.4 |
| Co-habiting | 7 | 2.7 |
| Separated/Divorced, married | 5 | 5.4 |
| Never married | 2 | 0.8 |
| ***Education Level*** | | |
| None (Never attended school) | 25 | 9.7 |
| Attended some primary school, did not complete | 94 | 36.4 |
| Completed primary school | 53 | 20.5 |
| Attended some secondary school, did not complete | 66 | 25.6 |
| Completed secondary school | 17 | 6.6 |
| Attended tertiary institution, but did not complete | 1 | 0.4 |
| Completed vocational/tertiary school | 2 | 0.8 |
| ***Number of people per household*** | | |
| 3-4 people | 30 | 11.3 |
| 5-6 people | 61 | 23.8 |
| 7-8 people | 62 | 24.2 |
| 9+ people | 103 | 39.9 |
| Missing | 2 | 0.8 |

Table 3 also shows that a fairly large proportion (57%) of the caregivers had either completed primary level education or had attended primary level education but did not complete it. Almost 10% had never attended any school at all.

The total number of children in the sampled households was 1,325. Of these, 623 (47%) were male and 702 (53%) were female. Of the boys, 285 (46%) were orphans and 338 (54%) were non-orphans. The girls were nearly evenly divided between orphans and non-orphans (348 and 354). The majority (65%) of households had 7 or more people per household. Our main study questions related to those children in the household who were aged 7 years and below. This population numbered 798, very closely split between girls (403) and boys (395). As shown in Table 4, one-half the children were non-orphans (399), while just over one-fourth (208) were presumed AIDS orphans and slightly less than one-fourth (182) were presumed non-AIDS orphans. A slight majority of the children were attending school (55.9%). In terms of relationship to caregiver, close to one-half of the children (42%) were being cared for by a grandparent; one third by a natural parent (34%); and nearly one-fifth by an aunt or uncle.

**Table 4: Demographic information on child participants**

| Characteristic | Frequency | Percentage (%) |
|---|---|---|
| Total | 798 | 100 |
| ***Gender*** | | |
| Male | 395 | 49.5 |
| Female | 403 | 50.5 |
| ***Orphan status*** | | |
| Non-orphan | 399 | 50.0 |
| Presumed AIDS orphan | 208 | 26.1 |
| Presumed non-AIDS orphan | 182 | 22.8 |
| Missing values | 9 | 1.1 |
| ***School attendance*** | | |
| Attending school | 446 | 55.9 |
| Not attending school | 352 | 44.1 |
| ***Relationship to caregiver*** | | |
| Own child | 251 | 31.5 |
| Grandchild | 352 | 44.1 |
| Niece/nephew | 125 | 15.7 |
| Other blood relative | 32 | 4.0 |
| Other | 25 | 3.1 |
| Missing values | 13 | 1.6 |

**Nutritional status outcomes**

It has been shown elsewhere that AIDS orphans run greater risks of being malnourished and stunted (UNAIDS, cited in Macan-Markar, 2000). Anthropometrics measurements were taken for all children aged 7 years down to three months. When a child's weight-for-height is below –2 Standard Deviations (SD) from the median of the reference population, the child is considered wasted, which means significantly below normal in terms of current nutritional status, suggesting that the child has been provided inadequate food intake. Severe wasting refers to children whose weight-for-height falls below –3 SD of the reference median.

Our results (Table 5) indicate that a slightly larger proportion (5.8%) of non-orphans was wasted compared to presumed AIDS orphans (4.3%), though the difference is statistically insignificant. The same pattern is observed in the severely wasted category, though almost no child was severely wasted. This suggests that orphan status does not determine the food intake that a caregiver provides.

**Table 5: Nutritional status of children, by orphan status**

| Orphan status | Weight for height Z scores N = 625 | | | Weight for height Z scores N = 625 | | |
|---|---|---|---|---|---|---|
| | Above –2 St Dev | Below –2 St Dev | Total | Above –3 St Dev | Below –3 St Dev | Total |
| Presumed Non-AIDS Orphans | N = 18<br>100%<br>3.0% | 0<br>0<br>0 | N = 18*<br>100%<br>2.9% | N = 18<br>100%<br>2.9% | 0<br>0<br>0 | N = 18*<br>100%<br>2.9% |
| Presumed AIDS Orphans | N = 201<br>95.7%<br>33.9% | N = 9<br>4.3%<br>28.1% | N = 210<br>100%<br>33.6% | N = 208<br>99.0%<br>33.7% | N = 2<br>1.0%<br>25% | N = 210<br>100%<br>33.6% |
| Non-orphans | N = 374<br>94.2%<br>63.1% | N = 23<br>5.8%<br>71.9% | N = 397<br>100%<br>63.5% | N = 391<br>98.5%<br>63.4% | N = 6<br>1.5%<br>75% | N = 397<br>100%<br>63.5% |
| Total | N = 593<br>94.9%<br>100% | N = 32<br>5.1%<br>100% | N = 625<br>100%<br>100% | N = 617<br>98.7%<br>100% | N = 8<br>1.3%<br>100% | N = 625<br>100%<br>100% |
| **P-value** | **p = 0.440** | | | **p = 0.748** | | |

**Number of meals eaten by children**

Previous research has shown that the amount of food consumed can drop by 40% or more in certain households that are affected by AIDS (Hobbs, 2003). We asked caregivers to tell us the number of meals each child aged 7 years or below had eaten the previous day (24 hours). The results are illustrated in Table 6. They show that, overall, there is not a statistically detectable difference in the number of meals eaten by the different groups of children (p=0.113) and that a similar proportion of AIDS orphans (61%), non-AIDS orphans (63%) and non-orphans (62%) had eaten two meals in the previous day. However, a much higher percentage of AIDS orphans had one meal compared to non-AIDS orphans and non-orphans (13% compared to 7% and 9.6%, respectively). In fact, when the data are regrouped to explicitly compare the differences between presumed AIDS orphans and the other children, the difference in percentages of the two groups that had one meal (compared with more than one meal) was very close to statistically significant (p=0.085). This provides some evidence of relatively more malnourishment among AIDS orphans compared to both of the other groups of children. In addition, a higher percentage of non-orphans had had 4 meals compared with both groups of orphans.

**Table 6: Number of meals eaten by children, according to orphan status**

| Orphan status | | Number of meals eaten in previous day N = 786 | | | | Total |
|---|---|---|---|---|---|---|
| | 1 meal | 2 meals | 3 meals | 4 meals | Other | |
| Presumed Non-AIDS Orphans | N = 13<br>7.0%<br>16.7% | N = 114<br>62.6%<br>23.5% | N = 43<br>23.6%<br>25.6% | N = 4<br>2.2%<br>16.7% | N = 8<br>4.4%<br>25.8% | N = 182<br>100%<br>23.2% |
| Presumed AIDS Orphans | N = 27<br>13.0%<br>34.6% | N = 126<br>60.6%<br>26.0% | N = 48<br>23.1%<br>28.6% | N = 5<br>2.4%<br>20.8% | N = 2<br>1.0%<br>6.5% | N = 208<br>100%<br>26.5% |
| Non-orphans | N = 38<br>9.6%<br>48.7% | N = 245<br>61.9%<br>50.5% | N = 77<br>19.4%<br>45.8% | N = 15<br>3.8%<br>62.5% | N = 21<br>5.3%<br>67.7% | N = 396<br>100%<br>50.4% |
| **Total** | N = 78<br>9.9%<br>100% | N = 485<br>61.7%<br>100% | N = 168<br>21.4%<br>100% | N = 24<br>3.1%<br>100% | N = 31<br>3.9%<br>100% | N = 786<br>100%<br>100% |
| **P-value** | **p = 0.113** | | | | | |

Again and again, caregivers expressed strong concern about households facing food shortages. Inadequate food is a problem that affects many families, though it may be exacerbated for orphaned children, as asserted in a womens' FGD: "All situations are difficult regarding care and support of the AIDS orphans' and non-AIDS orphans' needs. The need to get them clothing, food and all other necessities is difficult. In addition, there is unexpected expenditure because these orphans were not on the family budget."

**Immunization outcomes**

Evidence regarding non-immunization of orphans abounds in several studies (Mast et al., 2002; Foster, 1998). Evidence suggests that many orphans are not receiving full immunization. Our study explored the general immunization status and availability of immunization records for each child aged 7 years and below.

The results (Table 7) show that non-orphans are more likely to be fully immunized than both groups of orphans (p=0.008). The presumed non-AIDS orphans (63.1%) and non-orphans (64.9%) were fully immunized at about the same rate whereas a lower percentage (55%) of the presumed AIDS orphans was fully immunized. This difference is statistically significant, suggesting a systemic bias against immunizing AIDS orphans.[7] Some key informants also mentioned a tendency to think that because orphans are HIV+, it is a waste to immunize them. However, a higher percent (31.1%) of caregivers answered "I don't know" regarding orphans' immunization status, so it is also possible that there is no real difference between the three groups regarding full immunization.

[7] In addition, when we re-grouped the data into a 2 x 2 table with presumed AIDS orphans versus the other children (presumed non-AIDS orphans and non-orphans together), the difference was borderline statistically significant (p=0.072).

**Table 7: Immunization status, by orphan status**

| Child status | Immunisation status of child N = 778 | | | | Total | P-value |
|---|---|---|---|---|---|---|
| | Yes, completed | Yes, not completed | Never immunized | Don't know | | |
| Presumed Non-AIDS Orphans | N = 113<br>63.1%<br>23.5% | N = 19<br>10.6%<br>19% | N = 7<br>3.9%<br>26.9% | N = 40<br>22.3%<br>23.4% | N = 179<br>100.0%<br>23% | |
| Presumed AIDS Orphans | N = 115<br>55.0%<br>23.9% | N = 23<br>11.0%<br>23% | N = 6<br>2.9%<br>23.1% | N = 65<br>31.1%<br>38.0% | N = 209<br>100.0%<br>26.9% | p = 0.008 |
| Non-Orphans | N = 253<br>64.9%<br>52.6% | N = 58<br>14.9%<br>58% | N = 13<br>3.3%<br>50.0% | N = 66<br>16.9%<br>38.6% | N = 390<br>100.0%<br>50.1% | |
| **Total** | N = 481<br>61.8%<br>100% | N = 100<br>12.9%<br>100% | N = 26<br>3.3%<br>100% | N = 171<br>22.0%<br>100% | N = 778<br>100.0%<br>100% | |

A focus group of community health workers expressed the view that caregivers do not discriminate against presumed AIDS orphans in terms of immunization: "Yes, they are all immunized without discrimination. It is like the time they were giving Vitamin A to children. Most homes were welcoming health workers and telling them to give Vitamin A to all the children." Though these FG participants were not asked whether orphans were included in the term "children," we presume that they were.

**Table 8: Availability of immunization cards (IC), by orphan status**

| Child Status | Child has an immunization card N = 575 | | | Total |
|---|---|---|---|---|
| | Yes | No | Don't Know | |
| Presumed Non-AIDS Orphans | N = 39<br>30.0%<br>14.8% | N = 88<br>67.7%<br>29.9% | N = 3<br>2.3%<br>17.6% | N = 130<br>100%<br>22.6% |
| Presumed AIDS Orphans | N = 64<br>45.7%<br>24.2% | N = 68<br>48.6%<br>23.1% | N = 8<br>5.7%<br>47.1% | N = 140<br>100%<br>24.3% |
| Non-orphans | N = 161<br>52.8%<br>61% | N = 138<br>45.2%<br>46.9% | N = 6<br>2.0%<br>35.3% | N = 305<br>100%<br>53.0% |
| Total | N = 264<br>45.9%<br>100% | N = 294<br>51.1%<br>100% | N = 17<br>3.0%<br>100% | N = 575<br>100%<br>100% |
| **P-value** | p = 0.000 | | | |

Misconceptions and or false beliefs were frequently blamed for low immunization coverage. A key informant observed: "Some people tell others that when their children get immunized, they will fall sick…that whites have brought bad medicine to destroy us…."

Caregivers were asked if each of the children in the household aged 7 years or below had an immunization card (IC). The results (Table 8) show that orphans were less likely to have ICs compared to non-orphans (p=000). Here, the difference between the presumed AIDS orphans (45.7%) and non-orphans (55.8%) was less than between the non-AIDS orphans (30%) and the non-orphans (55.8%). When orphans as a group are compared with non-orphans, the difference is also statistically significant (p=0.000).

**Bed net use for orphans and non-orphans**

Insecticide treated nets (ITNs) have emerged in recent years in Uganda as a promising tool to protect against malaria. Results from multi-center randomized, controlled field trials in the Gambia, Ghana, Kenya and Burkina Faso suggest that mortality is reduced by at least 20% if children sleep under nets regularly treated with insecticides (Okello-Ogojo, 2001).

Our study explored the question of differential access to mosquito nets, with the results provided in Table 9. They indicate that bed net use varied from between 61% to 71% for the three groups of children, but without a statistically significant difference in these rates (p=0.422). Our qualitative data results also suggest that orphans are not treated differentially when it comes to bed nets, but that general poverty coupled with large family sizes and high prices for bed nets undermine use of bed nets in most households. A treated bed net (at the time of data collection for this study) was priced at US $6 to $20, which is high in Uganda, where annual per capita income is about US $300. In such circumstances, bed nets may not be a priority, as implied by a key informant: "These problems are quite many. Food, clothing and others are making orphan care difficult. ... I have 30 children here [in this home] and the food, clothes, bedding and other things are no longer enough, unlike before when I had only a few [children]...."

We also explored the issue of preventing malaria among presumed AIDS orphans in particular. We asked FG participants to imagine that recently a young couple had died of a disease suspected to be AIDS, leaving a 2-year old baby. With no relatives to look after the child, the participants, according to the scenario, had agreed to take care of the child. Then FG participants were asked what they would do to prevent that child from getting malaria. All six groups unanimously mentioned giving the child a bed net (among several suggestions). "At this moment, you first think about a mosquito net for such a child...even clearing the home surroundings such that mosquitoes don't breed from there...even filling holes [in the compound] so that those mosquitoes don't breed in them" (FG, Community Health Workers (CORPS), Seeta).

**Table 9: Current use of bed nets, by orphan status**

| Child Status | Child is currently using a mosquito bed net N = 347 | | Total | P-value |
|---|---|---|---|---|
| | Yes | No | | |
| Presumed Non-AIDS Orphans | N = 39<br>60.9%<br>16.7% | N = 25<br>39.1%<br>22.1% | N = 64<br>100%<br>18.4% | |
| Presumed AIDS Orphans | N = 54<br>71.1%<br>23.1% | N = 22<br>28.9%<br>19.5% | N = 76<br>100%<br>21.9% | **0.422** |
| Non-orphans | N = 141<br>68.1%<br>60.3% | N = 66<br>31.9%<br>58.4% | N = 207<br>100%<br>59.7% | |
| **Total** | N = 234<br>67.4%<br>100% | N = 113<br>32.6%<br>100% | N = 347<br>100%<br>100% | |

Overall, most focus group participants perceived poverty as an overriding factor intertwined with many other factors. A participant in a widows' FG asserted: "Some have bought mosquito nets, others have not because of lack of enough money [and] having big families with about eight to ten children who cannot all be catered for. " Similarly a member of a community health workers' FG stated: "People are sleeping in rented houses; you find a family of 8 sleeping in one room. This bed is for the adults; the other one is for children, so how do you put nets in such a place? ... Even if a net were to be sold at 2,000 [Uganda Shillings, equal to about US $1], children are sleeping on the floor. Another thing is that, even a bed net... needs money. If you are unable to buy a bed, then how do you buy a bed net?"

### HEALTH CARE SEEKING BEHAVIOR PATTERNS

Earlier studies (Nangendo, 1993) suggest that discrimination is clear in inadequate health-seeking behavior for children presumed to be HIV positive. We asked caregivers about actions that were taken during recent episodes of child illness for children aged 7 years or below. Almost 56% of children in this age bracket had suffered from at least one episode of fever and/or a malaria episode, cough (*okukolora*) or difficult breathing (*okukalubilirwa mu kusa*) plus diarrhea (*ekidukano*). The results for those who had fever are shown in Table 10.

The results show that a smaller percentage of both groups of orphans was taken for treatment when they had fever compared to non-orphans, though this difference was not statistically significant. However, when we pooled the responses for all the orphans and analyzed their data in comparison with data for the non-orphans, the differences were statistically significant (p=0.039). This finding suggests that orphans as a group – regardless of presumed AIDS status – are less likely to be taken for treatment compared to non-orphans when they fall sick with fever.

**Table 10: Health care seeking for fever, by orphan status**

| Orphan Status | Child was taken for treatment of fever N = 500 | | Total |
|---|---|---|---|
| | Yes | No | |
| Presumed Non-AIDS Orphans | N = 54<br>50.5%<br>19.2% | N = 53<br>49.5%<br>24.2% | N = 107<br>100%<br>21.4% |
| Presumed AIDS Orphans | N = 70<br>52.2%<br>24.9% | N = 64<br>47.8%<br>29.2% | N = 134<br>100%<br>26.8% |
| Non-Orphans | N = 157<br>60.6%<br>55.59 | N = 102<br>39.4%<br>46.6% | N = 259<br>100%<br>51.8% |
| **Total** | N = 281<br>56.2%<br>100% | N = 219<br>43.8%<br>100% | N = 500<br>100%<br>100% |
| **P-value** | **p = 0.114** | | |

**Appropriate health care-seeking behavior**

Appropriate care-seeking in this context means a caregiver seeking treatment from a health facility manned by a qualified health worker; prompt care-seeking, on the other hand, means seeking treatment within 24 hours after recognizing the signs and symptoms of an ailment. When asked about the seriousness of each episode of recent illness among the young children in the household, a majority (63.5%) of caregivers reported that the recent illness had been serious. This conforms to our qualitative data results, in which one FGD participant stated: "... you come with a very sick child to the health center but they tell you to line up. Even if the child is almost dying, they will still not [pay attention]...." For each case of recent illness, caregivers were asked whether the child was taken for treatment after the caregiver noticed that the child was sick. Our results show that fewer caregivers sought treatment for orphans compared to non-orphans (as discussed above). The reasons for this are not obviously related to possible HIV+ status, though it is unlikely that caregivers would state this reason even if it was, in fact, a factor in their treatment-seeking behavior. The findings from our survey are shown below in Table 11.

**Table 11: Reasons for not consulting a trained health worker when child is ill**

| Reason | Orphan status (N= 144) | | |
|---|---|---|---|
| | Orphans | Non-orphans | All children |
| 1. It was expensive | 47.2% | 45.7% | 46.9% |
| 2. Thought illness was not serious | 16.7% | 18.1% | 17.2% |
| 3. Preferred traditional healer | 20.1% | 18.1% | 19.0% |
| 4. Already knew what to do | 15.3% | 15.7% | 15.4% |
| 5. Others | 0.7% | 2.4% | 1.5% |
| **Total** | 100% | 100% | 100% |

The frequent reference to the expense of treatment as a reason for failing to seek treatment for children ill with a fever correspond to our qualitative data findings. Due to poverty, some caregivers may be compelled to delay seeking treatment. As one district official observed: "You find that these children have been sick for more than a day, some two days, others a week and

when you ask the parents/caregivers what they were doing they give you the excuse [reason] that they were still looking for money; either money for transport or money for upkeep in the health facility." The average cost of a round-trip for Mukono town periphery locales ranges between Uganda Shillings 3,000 to 6,000 (US $1.5 to $3.0) using a *bodaboda* (taxi motorbike). This expense could be prohibitive for some families, despite the official's use of the word "excuse." Coupled with this access problem is the perceived poor quality of health care.

### PERCEIVED POOR QUALITY OF HEALTH CARE

Whereas there was a general feeling expressed in all FGDs that government health services have improved in recent years, concerns abound regarding frequent drug stock-outs, negative staff attitudes and long waiting times. In particular, patient neglect and irregular availability of staff at clinics seem to undermine appropriate care-seeking. In one FG, participants lamented: "Most government health centers, if you go there after 2:00 or 3:00 p.m., it is rare to find the health workers, especially doctors, there...." This criticism appears relevant for the welfare of children given that they are the ones so frequently in need for rapid treatment.

Private clinics are generally perceived to offer better and more efficient services. Private practitioners, especially pediatricians, were applauded for providing relatively higher quality services, though their charges were viewed as prohibitively high, as illustrated in focus group discussions: "For you to be admitted in such a [clinic], it is a lot of money. You first pay 10,000 shillings (US $5) before admission and the caregiver has to bring a mattress, a blanket and other things because without them, you can't be admitted...."

Qualitative data show that presumed AIDS orphans may be taken to private clinics at the same rate as non-AIDS orphans. The view voiced was that as long as the caregiver had the money to pay at a private clinic, then treatment seeking for a presumed AIDS orphan would be similar to that for a non-orphan. We asked caregivers to imagine visiting a friend who had her own children and was also looking after a six-month old orphan whose parents had recently died of AIDS. The situation was that both the biological child and the orphan had a cough accompanied by short, rapid, or difficult breathing. In response, participants in all six FGDs unanimously recommended taking both the non-orphan and the presumed AIDS orphan to a clinic. It is, of course, uncertain whether the members of this FG would actually do so in this situation.

However, during another FGD session, one participant asserted: "Yes, this orphan should be taken for treatment because he is still alive and even if he is going to die tomorrow, you have to take him for treatment. Even God will not be happy with you if you ignored an innocent child like that one." Some caregivers felt that denying treatment for a presumed AIDS orphan could amount to exposing the non-orphan to infection from their peer orphan. A local leader participating in a FG asserted: "... if you take your own child to the hospital alone and he is treated, the orphan who is not treated will still spread the cough to the other child so it is better to take him as well to the clinic." Caregivers generally felt that even if they cannot afford to take such children to clinics, at least they would self-medicate the children themselves.

### Self-medicating regardless of serological status

Repeatedly caregivers mentioned self-medication with herbal medicine as a first action. Aloe Vera (*ekigagi*), *muluruza* and *bombo, kwinini-plant* and numerous other herbs plus steaming with mixed multiple herbal concoctions were common therapies for malaria, diarrhea and cough or difficult breathing. Many caregivers commonly use tepid sponging, though apparently they mistook it for treatment instead of helping to reduce the child's fever. Self-medication was also

used for some presumed AIDS orphans, especially those presenting with chronic symptoms - these were dubbed *nandwadde* (a derogatory term meaning always sick). Their ailments are managed using a special local herbal therapy known as *kadomola*. It is believed that the *kadomola* could "treat" pediatric AIDS symptoms, and other common childhood illnesses as well as adult AIDS. Most importantly, all children, regardless of orphan status, could access the *kadomola*, which also suggests that there is less discrimination when it comes to basic home-based treatment, only that the price (between 3,000 and 20,000 Uganda Shillings, or US $1.50 to $10) could be prohibitive for some families.

Using combined regimens of herbal and western pharmaceuticals was also common. The most commonly used antimalarial drug was chloroquine. Nearly all FG participants recommended using chloroquine only, which suggests that caregivers were unaware of the anti-malarial drug policy: "Now the first line is Sulphadoxine pyremethamine (SP, commonly known as Fansidar) plus Chloroquine given in combination" (MOH, 2002).

## DISCUSSION AND INTERPRETATION OF RESULTS

The results of our study are mixed. Though they showed no strong, consistent pattern of bias against AIDS orphans, our findings suggest that there may be discrimination in some types of caregiver treatment toward AIDS orphans, as well as bias in other areas against all orphans. Our results are somewhat similar to those of a South Africa study, which found that instances of deliberate discrimination were rare (Mattes, 2003). Since a large proportion of children in our sample were single orphans, especially paternal orphans, a large number were being cared for by a surviving mother, which may have reduced discriminatory treatment (Hamilton's rule posits that "...caring is greater the closer the genetic ties" (Case et al., 2003)). Our results tend to support those of Ntozi and Nakayiwa (1999) and of Ntozi and Zirimenya (1999), who reported a high percentage of orphans being cared for by a surviving mother.

The qualitative results revealed a tendency to attribute discrimination to stepmothers, who were clearly believed to be the most likely culprits to discriminate (against their stepchildren). The quantitative results, however, are not conclusive on this point because of the small number of stepmothers (only 9.3% of mothers were in polygamous marriages and caring for stepchildren).

Our results also highlight caregivers' constraints in providing basic needs for children, not surprising since most participants were divorced or widowed mothers or grandmothers in lower income brackets. This supports Otieno et al. (2001), who reported that grandmothers generally wish to adequately support grandchildren, but are hampered by monetary and other constraints.

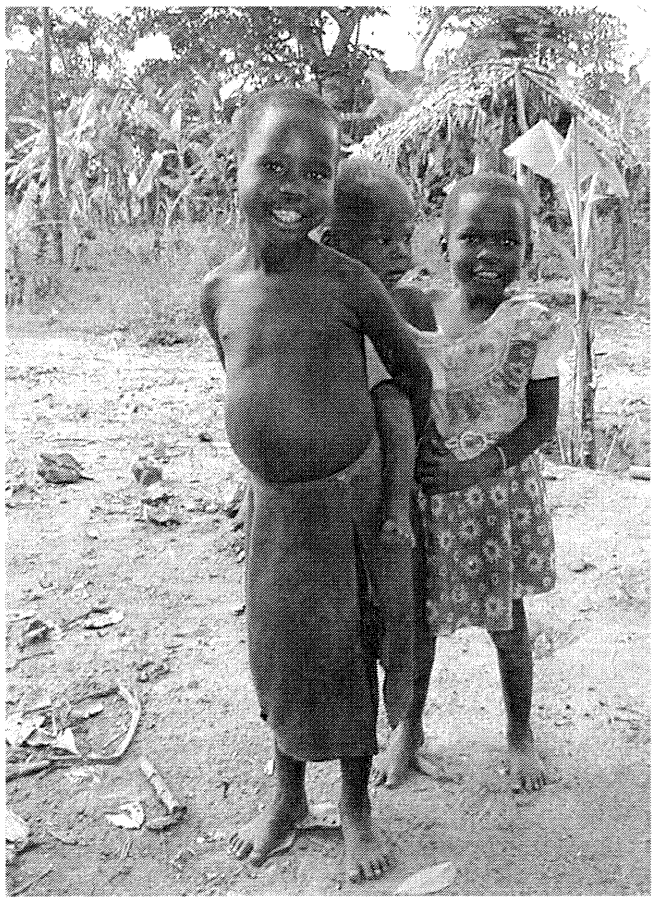
The study revealed caregivers' desire to test some orphans for their serological status. For instance, as one NGO official remarked: "If the guardian with an orphan finds out that the orphan is HIV positive, sometimes they tend to neglect any sickness, saying that after all the orphan is suffering from HIV/AIDS. That is why we discourage the testing of orphans and young children for HIV." This has strategic policy implications too, especially since "The policy guidelines for HIV testing indicate that testing is only permissible to people aged 18 years [and above]" (Kavuma, 2003). In these circumstances, one cannot rule out the possibility that caregivers intend to discriminate against AIDS orphans.

The finding that presumed AIDS orphans may be disproportionately malnourished (as measured by percent that eat only one meal per day) has critical implications for child hunger and malnutrition. Although providing sufficient food is not an uncommon problem in many Ugandan households, ensuring that all children receive adequate food intake should be a national priority

and thus our findings have implications for any policy directed at anti-poverty, basic needs, and child welfare.

Our results suggesting an apparent systematic bias against immunizing presumed AIDS orphans is also extremely significant and policy-relevant. More research is needed to clarify why this particular bias exists and whether caregivers are aware that individuals with symptomatic HIV infection can receive all the EPI vaccines except BCG and yellow fever vaccines (UBOS, 2000/2001). BCG and yellow fever are live attenuated vaccines, unlike the other vaccines in the EPI program, so when a child with full-blown AIDS receives these live vaccines, their health status may deteriorate further.

Similarly, our finding that presumed AIDS orphans and presumed non-AIDS orphans as a group are not taken as frequently to a clinic or to see a health care worker as are non-orphans suggests systematic differential treatment of orphans and non-orphans. This has clear implications for meeting the basic health needs of a large group of Ugandan children, with a role for interventions that target orphans to ensure more rapid and appropriate treatment-seeking activities by caregivers.



The generally low use of ITNs in Mukono town revealed by our study is cause for concern, but not surprising. Previous research suggests that use of bed nets is generally low in Uganda although Mukono District was reported as one of the two districts with the highest (26%) use of nets in the country (Okello-Ogojo, 2001). Low net use implies high vulnerability of orphans and non-orphans to malaria attacks. This becomes even more important in a context when most caregivers are unable to seek appropriate care for malaria victims.

Our finding that some caregivers gave orphans the anti-AIDS *"kadomola"* therapy is interesting because this particular medicine was very expensive. It tends to confirm earlier findings (Ntozi and Nakayiwa, 1999) of common recourse to traditional healers, who are frequently sought when modern medicine fails. In this study, however, our results suggest that herbal medicine is used as a first action treatment, which may explain the apparent delay in seeking appropriate treatment (as defined in this study). The results show that caregivers tend to practice self-medication irrespective of orphan status and the serological status of the patient, implying that orphaned and non-orphaned children were equally vulnerable to inappropriate treatment.

## CONCLUSIONS AND LESSONS

Overall, this study has found mixed differences in treatment-seeking practices among caregivers for presumed AIDS orphans, presumed non-AIDS Orphans and non-orphans in Mukono, thus suggesting that the findings from the PANOS (1996) report do not apply consistently throughout Uganda. One lesson from this is that it is improper to generalize findings carried out in one setting to other settings. Each setting has its own characteristics. For instance, while this study's results suggest that, overall, presumed AIDS orphans have roughly the same number of meals per day as non-orphans, Ayieko's (1998) study conducted in Kenya reported relatives hiding food from orphans. Although true for the study sites, this practice can not be generalized to all of Kenya, let alone elsewhere. The same comment holds for the PANOS report, which inspired this study. The PANOS report reported the results of a study in Rakai District and cannot be generalized to Uganda as a whole.

By and large, it appears that poverty, perceived poor quality of health care, and the cost of care-seeking and treatment affect presumed AIDS orphans and non-orphans fairly equally. In many respects, caregivers in orphan households do all they can to support orphans under their care. The lesson seems to be that children in orphan households, whether or not they are orphaned, become vulnerable, especially due to poverty. In this study, however, the family came out as a resilient entity, which provides better prospects for orphan support than we had anticipated. However, these families need to be supported to sustainably address orphans' needs in the medium and long-term period. The relatively high level of malnutrition, low ITN use, and unawareness of vaccination status and IC cards are clearly issues of great concern. They need to be pragmatically addressed, for instance, through health education programs.

Finally the research team believes that sample size was also a factor in the findings. Had the sample population been larger, the results might have been able to reveal significant intra-household discrimination. This perception is based on the fact that many p-values were close to a significant value of 0.05, in such areas as number of meals eaten ($p=0.113$) and health care-seeking ($p=0.114$), for instance.

## FUTURE DIRECTION AND POLICY IMPLICATIONS

We would like to make the following policy recommendations:

1. The architects of the policy for orphans and vulnerable children (OVC) should consider explicitly prohibiting discrimination related to HIV status, both within and outside the household (FHI, 2003). It should also provide guidelines and support for caregivers who wish to test children for serological status.

2. Orphan care requires additional income for households. Micro-enterprise loans targeted at urban and rural orphan households should be encouraged as one way of economically empowering caregivers. The purpose is to enable caregivers in poor orphan households to purchase food, ITNs, and travel to health units to immunize orphans and non-orphans.

3. We encourage community-based approaches that target caregivers in orphan households, especially as regards appropriate care, immunizations, vitamin A supplementation, etc. This should also involve awareness campaigns that encourage caregivers to find out orphans' immunization status and follow up with their records (such as ICs, birth certificates).

4. It is critical that there be systematic registration of orphans by local authorities in villages, health units, town councils and districts. Our team spent a lot of time looking for orphan homes, and a reliable registration list would facilitate fact-finding of this nature in the future.

5. Home management of illness fever/malaria is a critical issue. Our results did show that a substantial number of caregivers treated their children at home and did not seem to be aware of the MOH's new policy concerning home management of fever/malaria. The research team thus recommends that health authorities rigorously implement the MOH's new policy on malaria management at the community level.

6. Training caregivers and community health workers is a critical task. Training caregivers of AIDS orphans (and all orphans in general) could help reduce bias against AIDS orphans. Training community health workers is important because they need to work together with caregivers to maximize welfare with regard to orphans' immunization status, nutrition, bed-net use, treatment seeking; and not the least, testing orphans for their serological statuses.

7. Mechanisms for monitoring the impact of the above suggestions such as income generation activities, community approaches, vital registrations and home management of malaria must be put in place so that they ultimately benefit the orphans.

# CHAPTER 6: NGOs BRIDGING THE GAP: AFXB SUPPORT TO THE EDUCATION OF ORPHANS IN LUWERO DISTRICT, UGANDA

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This paper is based on research carried out in Luwero District, Uganda, to assess the impact of Association Francois Xavier Bagnoud (AFXB) interventions on orphans in an AFXB supported sub-county compared to non-orphans in the same sub-county, and to orphans and non-orphans in a non-AFXB supported sub-county. This research addresses the larger question of the impact of interventions implemented by NGOs.

## BACKGROUND

The number of orphans worldwide is on the increase, estimated to hit 40 million in 23 developing countries by 2010 (Hunter and Williamson, 2000). In Uganda, it is estimated that more than 2 million children are orphans (Hunter and Williamson, 2000), constituting about 20% of all children in the country (Wakhweya et al., 2002). Orphanhood has primarily been caused by civil wars and HIV/AIDS. Most of the orphans live and are cared for within their communities (Children Statute, 1996). The majority of orphans are under the care of female-headed families, the caregiver usually being a grandmother or mother (Hunter, 1990; Bicego et al., 2003). As the number of orphans increases, meeting their needs presents a major challenge to governments, communities and households. Studies have shown that orphans are more likely than non-orphans to drop out of school or have most of their educational requirements and needs remaining unmet (Kamali et al., 1996; Urassa et al., 1997; International HIV/AIDS Alliance, 2003). Many NGOs, both international and local, have set up programs to provide aid for orphans, including educational assistance. Despite the many years of such NGO support, there is still lack of common understanding about the actual contribution of NGO support to closing the gap between orphans and non-orphans. This chapter discusses the contribution of NGO support to the education of orphans in Luwero District, Central Uganda, taking the example of the support provided by the Association Francois Xavier Bagnoud (AFXB).

Luwero District has an estimated 16,575 orphans (Dunn et al., 1991). This figure is based on national census results of 1991 and the number of orphans has almost certainly increased since then. AFXB is an NGO based in Switzerland that has been operating in Luwero District since 1991. Its current program covers the sub-counties[8] of Semuto, Makulubita and Kasangombe. The primary goal of AFXB is to assist local people in developing community-based solutions to problems faced by orphans, and to assist them in acquiring capabilities to adequately meet the basic needs of orphans. The program also seeks to test the appropriateness of community-based

[8] In Uganda, a sub-county is a geographical jurisdiction that constitutes a Local Government level with an elected council as established by the Local Governments Act 1997. There are more than 30 such sub-counties in Luwero district, each with a total population of between 25,000 to 70,000 people.

approaches in solving the problems of orphans and other vulnerable children and use the experiences gained to replicate it in other areas.

The main program activities of AFXB include: support for primary education for orphans and other vulnerable children; providing assistance to individual guardians to undertake income generating projects or activities (IGAs) through which they generate resources to meet basic needs of orphans and other children; sensitization of communities about HIV/AIDS prevention and how people can live positively with it; protection of orphans' rights, including property rights; and HIV/AIDS care and treatment. The program's intervention strategy consists of a community-based approach, which emphasizes involving guardians and the entire community to participate in the program and to facilitate formation of community based structures in the form of committees to help in the implementation of the project. The strategy used in educational support is to negotiate for free education of orphans in schools in exchange for in-kind assistance to such schools.[9] AFXB's support is targeted at the most needy households selected following set criteria that reflect poverty and vulnerability levels.

AFXB's support must also be seen in the context of other interventions such as government educational and poverty alleviation programs that have been implemented. Since 1997, the government of Uganda has implemented the Universal Primary Education (UPE) program, in which four children per family are entitled to free primary education.[10] UPE, however, covers only tuition fees. Other school requirements, such as scholastic materials, uniforms, lunch and medical care, remain parental responsibilities. Thus a substantial cost of primary schooling still falls on parents and guardians. Other government programs include poverty eradication schemes, such as the *"entandikwa"* (vernacular for "start-up capital") credit scheme, which unfortunately hardly reach, or benefit, most people at the grassroots due to design and implementation problems.

## PROBLEM STATEMENT

Despite the many years of NGO support in Uganda, there remains a lack of common understanding about the strategies and methods of intervention that best work in supporting orphans and vulnerable children. There is also little understanding of the actual impact of NGO

[9] AFXB support to schools consists of building classrooms, construction of water sources, latrines, or provision of building materials. It may also provide food materials, depending on the requests made by the respective schools.

[10] In practice, all children in government-aided primary schools ended up benefiting from UPE due to the difficulty in enforcing the 'four children' limit.

assistance on the lives of the supported children and whether it has closed the welfare gap between orphans and non-orphans.

AFXB has been supporting orphans through its programs in 3 sub-counties for a number of years, though the impact of these programs on orphans is unknown. Internal monitoring by AFXB staff and external program reviews (AFXB, 1999) indicate positive results, but also point to certain deficiencies in program effectiveness. For instance, they revealed that many orphans had not been reached by school sponsorship support and income generating activities. There were also differences in meeting orphans' needs within households that had received support through these projects. No comparisons have been made between the recipients of support and the non-recipient households. In sum, the degree to which the interventions had translated into better satisfaction of orphans' needs for education was poorly understood.

This study therefore sought to fill these information gaps and to generate additional information about support services for orphans.

## AIMS AND OBJECTIVES

The major aim of this study was to assess the impact of AFXB interventions on orphans in an AFXB supported sub-county compared to non-orphans in the same sub-county, and orphans and non-orphans in a non-AFXB supported sub-county. With respect to education, the specific objective was to compare key educational outcomes and access to educational requirements between orphans in the two sub-counties and between orphans and non-orphans within the two sub-counties and to assess the magnitude of the difference.

The study was guided by the following research questions:

(1) Are the needs of orphans in an AFXB supported sub-county better provided for than those of orphans in another similar locality where there is no similar intervention?

(2) Do marked differences continue to exist between orphans and non-orphans in the AFXB and non-AFXB supported areas?

(3) Is the difference in terms of meeting needs between orphans and non-orphans in the AFXB supported sub-county smaller than the difference between orphans and non-orphans in the non-supported sub-county?

## STUDY DESIGN AND METHODOLOGY

### Study Design

A cross-sectional unmatched case-control study design was adopted, with one sub-county where the AFXB orphan program had been operating serving as the main study group while another sub-county of similar characteristics but without any intervention was used as the control group.

Three main strands of comparisons were used:

(1) Between orphans in the AFXB supported sub-county and orphans in the control sub-county (denoted by letter A in the diagram below).

(2) Between orphans and non-orphans (from non-orphan households) in each of the two sub-counties (denoted by letter B in the diagram below).

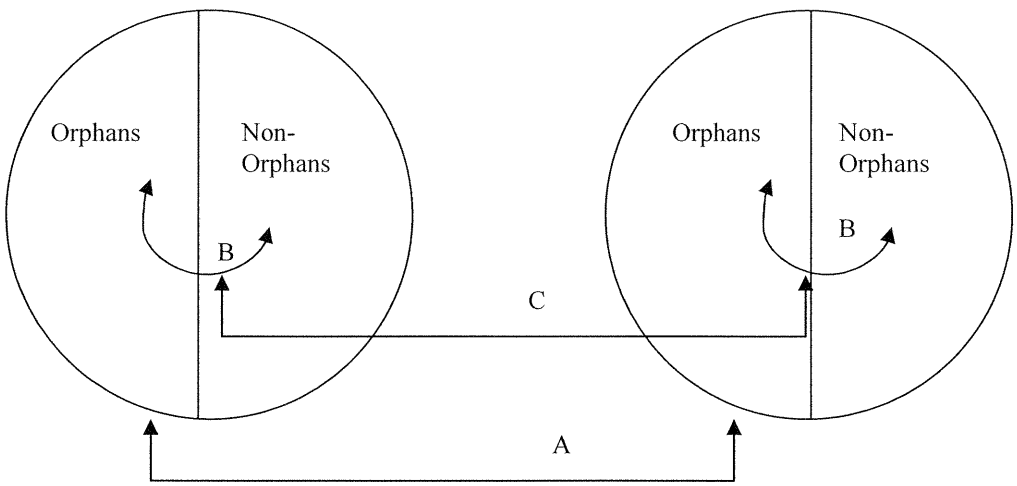
(3) Between the differences in orphans and non-orphans (from non-orphan households) in the two sub-counties (difference of the two differences in (i) and (ii) above) (denoted by letter C in the diagram).

**Study Areas**

The study was carried out in the sub-counties of Makulubita and Kamira in Luwero District. Makulubita served as the study sub-county where AFXB had supported orphans since 1996. Kamira sub-county was selected for control purposes because it had no similar intervention from an NGO or any other institution. It was also selected on the basis of possessing comparable characteristics to those of Makulubita, such as orphan prevalence, HIV/AIDS prevalence, resource base, demography, geographical location, and political history.

**Figure 1: Graphic Presentation of the Three Strands of Comparison**

NGO Supported Sub-county Control Sub-county




**Sampling and Data Collection**

Structured interviews were conducted with a statistically calculated sample of at least 98 orphans, 98 non-orphans (of school–age, 6-17 years of age), and a corresponding number of their caregivers/heads of households, randomly selected from a list of eligible households in 30 village clusters in the two sub-counties. Non-orphans were selected from non-orphan households. Specific children to be included in the sample were chosen using a random selection procedure from each selected household.

Focus group discussions were conducted with selected orphan caregivers and parents. Key-informant interviews were carried out with staff of AFXB, Luwero District Probation and Welfare Department, the Ministry of Gender, Labour and Social Development and the National Council for Children.

Data collection instruments were translated into the local language (Luganda) and back translated to English. The EpiInfo software was used for data entry, after which data was analyzed using SPSS.

## STUDY RESULTS

### Socio-demographic Characteristics of the Study Sample

*Children in the Sample*

Table 1 below shows the characteristics of the children (orphans and non-orphans) in the sample.

**Table 1: Descriptive Information on Children in the Study**

| | *Study sub-county* | | *Control sub-county* | |
|---|---|---|---|---|
| | Orphan Number (%) | Non-orphan Number (%) | Orphan Number (%) | Non-orphan Number (%) |
| ***Total number:*** | 120 (100) | 98 (100) | 102 (100) | 98 (100) |
| Male | 61 (50.8) | 46 (45.5) | 54 (52.9) | 52 (54.7) |
| Female | 59 (49.2) | 55 (54.5) | 48 (47.1) | 43 (45.3) |
| ***Age:*** | | | | |
| 6-9 years | 17 (14.2) | 44 (43.5) | 27 (26.5) | 31 (31.6) |
| 10-13 years | 64 (53.3) | 45 (44.6) | 53 (51.9) | 47 (48.0) |
| 14-17 years | 39 (32.5) | 12 (11.9) | 22 (21.6) | 20 (20.4) |
| ***Type of orphan:*** | | | | |
| Paternal | 64 (53.3) | N/a | 60 (58.8) | N/a |
| Maternal | 12 (10.0) | N/a | 15 (14.7) | N/a |
| Double | 44 (36.7) | N/a | 27 (26.5) | N/a |
| ***Relationship to caregiver:*** | | | | |
| Biological mother | 39 (32.5) | 69 (70.4) | 35 (34.3) | 74 (75.5) |
| Biological father | 1 (0.8) | 11 (11.2) | 7 (6.9) | 15 (15.3) |
| Grandparent | 45 (37.5) | 6 (6.1) | 36 (35.3) | 6 (6.12) |
| Sibling | 1 (0.8) | 1 (1.0) | 2 (2.0) | 0 (0.00) |
| Other blood relative | 23 (19.2) | 3 (3.0) | 18 (17.6) | 1 (1.02) |
| Others | 11 (9.2) | 8 (8.2) | 4 (3.9) | 2 (2.04) |
| ***Schooling:*** | | | | |
| In school | 114 (95.0) | 96 (98.0) | 93 (91.2) | 95 (96.8) |
| Not in school | 6 (5.0) | 2 (2.0) | 9 (8.8) | 3 (3.2) |

As indicated in Table 1, there were slightly more male children in the sample than females. Among the orphans, the majority were paternal orphans, followed by double orphans. However, the differences in the distribution of type of orphans by sub-county were not statistically significant. A majority of the children were in school, likely due to the impact of the UPE program.

*Caregivers in the Sample*

Table 2 provides information on the characteristics of the caregivers that participated in the study. As can be observed, the majority of caregivers looking after children, both orphans and non-orphans, were females, constituting more than four fifths of all the caregivers. Most of the

caregivers were in the 25-44 year old age range. While close to half of the caregivers of orphans and non-orphans were in monogamous marital relationships, more than one quarter was widowed. More than half of the caregivers had attended some primary school, but had not completed this level of education. The majority of caregivers were peasant cultivators, and were Baganda.

**Table 2: Characteristics of Caregivers in the Study**

| Characteristics | *Study Sub-county* Number (%) | *Control Sub-county* Number (%) |
|---|---|---|
| ***Total number:*** | 212 (100) | 206 (100) |
| Male | 31 (14.6) | 38 (18.4) |
| Female | 181 (85.4) | 168 (81.6) |
| ***Age:*** | | |
| <18 | 0 (0.0) | 1 (0.5) |
| 18-54 | 169 (79.7) | 167 (81.1) |
| 55+ | 42 (19.8) | 38 (18.4) |
| ***Marital Status:*** | | |
| Married, monogamous | 97 (45.8) | 101 (49.0) |
| Married, polygamous | 18 (8.5) | 18 (8.7) |
| Never married | 2 (0.9) | 1 (0.5) |
| Cohabiting | 1 (0.5) | 0 (0.0) |
| Separated/divorced, not remarried | 20 (9.4) | 21 (10.2) |
| Separated/divorced, remarried | 8 (3.8) | 7 (3.4) |
| Widow/widower, not remarried | 59 (27.8) | 55 (26.7) |
| Widow/widower, remarried | 7 (3.3) | 3 (1.5) |
| ***Education level:*** | | |
| None (never attended school) | 22 (10.4) | 59 (28.6) |
| Some primary, did not complete | 123 (58.0) | 106 (51.5) |
| Completed primary school | 35 (16.5) | 26 (18.6) |
| Some secondary, did not complete | 25 (11.8) | 11 (5.3) |
| Completed secondary school | 4 (1.9) | 3 (1.5) |
| Some tertiary education, did not complete | 1 (0.5) | 0 (0.0) |
| Completed tertiary education | 1 (0.5) | 1 (0.5) |
| Completed university, first degree | 1 (0.5) | 0 (0.0) |
| ***Main Occupation:*** | | |
| Peasant farmer-cultivator | 167 (78.8) | 156 (75.7) |
| Peasant farmer-cattle keeper | 15 (7.1) | 7 (3.4) |
| Petty trader | 8 (3.8) | 13 (6.3) |
| Salaried worker | 2 (0.9) | 3 (1.5) |
| Self employed | 4 (1.9) | 0 (0.0) |
| Casual laborer | 0 (0.0) | 2 (1.0) |
| Student | 0 (0.0) | 1 (0.5) |
| Full-time housewife | 12 (5.7) | 19 (9.2) |
| Unemployed | 1 (0.5) | 1 (0.5) |
| Retired | 3 (1.4) | 4 (1.9) |

The figures in Table 3 show that orphans participating in the study were more likely to be cared for by grandparents, siblings and other relatives while non-orphans were more likely to be with their biological parents. This difference was found to be statistically significant.

*Households in the Sample*

One third of the households (37.5%) were female-headed. Only one (0.2%) of the sample households was child-headed. Almost one-fifth of the heads of household were elderly, aged 60 and above. These three categories represent a vulnerable category of households that require support in the care of orphans. More than 80% of the households had at least 2 adults in the household. Almost half of the households had 4-6 children in the home. This study found a total of 1,781 children in the 418 households surveyed. Of all the children in these households, there were more boys (51.5%) than girls. The mean age of the children was 8.8 years.

**Table 3: Relationship of Caregiver to Child by Child Status**

| Child Status | *Relationship* Number (%) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Biological Mother | Biological Father | Grand-parent | Sibling | Other Blood Relative | Other | Total | P-value |
| Orphans | 74 (33.3) | 8 (3.6) | 81 (36.5) | 3 (1.4) | 41 (18.5) | 15 (6.8) | 222 (100) | 0.000* |
| Non-orphans | 143 (72.9) | 26 (13.3) | 12 (6.1) | 1 (0.5) | 4 (2.0) | 10 (5.1) | 196 (100) | |

* = statistically significant at the 5% level; ** = statistically significant at the 1% level;
Ns = not statistically significant at the 5% level

**School Enrollment of Orphans and Non-orphans**

AFXB supports selected schools with in-kind support, such as building materials, on the understanding that a given number of orphans enrolled in that school will not pay school charges or for lunches. School enrollment was therefore one of the key variables investigated in this study.

Overall, the enrollment of all children of school-age (6-17 years) was found to be high (95.2%). This is undoubtedly a result of the UPE program described above, which is designed to allow pupils to access "free" primary education. "Free" here means that the government pays for the tuition fees, which were previously paid by parents/caregivers. However, our study did reveal differences in enrollment between orphans and non-orphans, as well as those between the supported and the non-supported sub-counties, as shown below in Table 4.

**Table 4: School Enrolment among Orphans and Non-Orphans, by Sub-county**

| Sub-county | Child Status | School Enrollment | | P–value |
|---|---|---|---|---|
| | | Number in School (%) | Number out of School (%) | |
| Study | Orphan (N=120) | 114 (95.0) | 6 (5.0) | 0.26 (Ns) |
| Control | Orphan (N=102) | 93 (91.2) | 9 (8.8) | |
| | | | | |
| Study | Orphan (N=120) | 114 (95.0) | 6 (5.0) | 0.23 (Ns) |
| | Non-orphan (N=98) | 96 (98.0) | 2 (2.0) | |
| Control | Orphan (N=102) | 93 (91.2) | 9 (8.8) | 0.09 (Ns) |
| | Non-orphan (N=98) | 95 (96.8) | 3 (3.2) | |

* = statistically significant at the 5% level; ** = statistically significant at the 1% level;
Ns = not statistically significant at the 5% level

As Table 4 indicates, a higher percentage of orphans were enrolled in school in the study sub-country, where AFXB had been assisting households and schools, though this difference is not statistically significant. In addition, a higher proportion of non-orphans were enrolled in school in both sub-counties. Although these differences are not statistically significant at the 5% level, the difference is far greater (and borderline statistically significant) in the control sub-county (96.8% and 91.2%, respectively, among non-orphans and orphans) than in the study sub-county (98.0% and 95.0%), suggesting that AFXB assistance in the latter has perhaps played a role in closing the school enrollment gap between orphans and non-orphans compared to the control sub-county.

However, the fact that orphans' school enrollment in both sub-counties is lower than that for non-orphans points to the difficulties that orphans in both sub-counties continue to confront in attending school, despite the UPE program and assistance from NGOs. This is especially understandable when we bear in mind that in most cases NGOs will be unable to alter the basic conditions in homes or the attitudes of family and community members towards orphans.

**Table 5: Government and Parents' Responsibility in Financing Primary Education**

| Government Responsibility | Parents' Responsibility (As assigned by UPE) | Parents' Responsibility (Actual situation in schools) | Range of Charges Per Child per School Term (in Ug. Shs) | Equivalent in US $ |
|---|---|---|---|---|
| Tuition | Lunch for pupils | Lunch for pupils (monetised) | 1,500-3,000 | 0.8-1.5 |
| Building classrooms | School uniform | School uniform | 5,000-12,000 | 2.5-6.0 |
| Text books | Exercise books, pens, pencils | Exercise books, pens, pencils | 400-2000 | 0.2-1.0 |
| Paying teacher's salaries | Labour to work on school construction activities | Labour to work on school construction activities | Non-monetary | - |
| | | Paying or contributing to paying some teachers' salaries/allowances | 1,000-1,500 | 0.5-0.8 |
| | | Building fund charges | 2,000-3,000 | 1.0-1.5 |
| | | Church fee | 200-500 | 0.1-0.25 |
| | | Feeding teachers | 150 | 0.07 |
| | | Charges for security (paying guards/askaris) | 150-300 | 0.07-0.15 |
| | | Charges for borehole maintenance | 200 | 0.1 |
| | | Paying the school cook | 500 | 0.25 |
| | | Rehabilitation and other emergency development | 500-2000 | 0.25-1.0 |

On average, in addition to what is covered by UPE, each child is required to pay between 4,000 to 6,000 shillings,[11] excluding costs for uniform and other scholastic materials. Qualitative data indicated that these costs were considered too high for some parents. Inability to pay school dues was found to be the main reason for non-school attendance among those children who had dropped out of school.

We can conclude that in both the study and control sub-counties, school enrollment was high due to UPE program. However, NGO support seems to have improved enrollment of orphans even further and bridged the gap between orphans and non-orphans. In addition, the fact that AFXB support was given to the school as a whole had other positive gains; it contributed to the development of the community as a whole by improving school infrastructure. The benefits were therefore not limited to the individual children supported.

Our qualitative data results show the biggest constraint in the education of children, especially orphans, comes at the secondary level. From the focus group discussions, the most challenging

[11] The average household income per month in Uganda is about US $300 (shillings 600,000), but is much lower in rural areas.

criticism to the AFXB strategy concerned the way that support is mainly restricted to the primary level, even though that level is less costly than post-primary education. AFXB was found to be supporting only a few children in post-primary institutions, those that excelled in Primary Leaving Examinations. As a consequence, most children reported dropping out of school after primary seven due to an inability to pay for secondary school fees. School drop-outs may not be reflected in the data obtained by this study since those who do so after the age of 14 usually do not remain in their communities, but go to look for employment opportunities in towns.

Whereas it was expected that IGAs would help caregivers to meet secondary school dues, very few beneficiaries were found to have realized this goal.

**Possession of School Uniform**

Under Uganda's primary education system, parents have the responsibility of providing children with a school uniform. AFXB did not directly provide uniforms to supported children, orphan households that received support for IGAs were expected to use the proceeds from the projects to provide uniforms and other scholastic materials for school-going children. Non-supported children were supposed to have uniforms provided by their parents. Table 6 shows our findings on possession of school uniform between the groups of children in the two sub-counties.

**Table 6: Possession of School Uniform, by Orphan Status and Sub-county**

| Sub-county | Orphan Status | Possession of a School Uniform | | |
|---|---|---|---|---|
| | | Yes Number (%) | No Number (%) | P-value |
| Case | Orphan (N=120) | 88 (73.3) | 32 (26.7) | 0.00** |
| Control | Orphan (N=102) | 56 (54.8) | 46 (45.2) | |
| | | | | |
| Case | Orphan (N=120) | 88 (73.3) | 32 (26.7) | 0.11 Ns |
| | Non-orphan (N=98) | 62 (63.6) | 36 (36.4) | |
| Control | Orphan (N=102) | 56 (54.8) | 46 (45.2) | 0.05* |
| | Non-orphan (N=98) | 67 (68.5) | 31 (31.5) | |

* = statistically significant at the 5% level; ** = statistically significant at the 1% level;
Ns = not statistically significant at the 5% level

The figures above show that assisted orphans were more likely to have a school uniform than orphans who were living in the control sub-county (73.3% v. 54.8%), a difference that is statistically significant. In addition, in the case sub-county, a higher proportion of orphans than non-orphans had a school uniform, though this difference was not statistically significant, in contrast to the control sub-county, where there was a statistically significant difference in favor of non-orphans. These differences are precisely what would be predicted with effective AFXB assistance, as we would expect to see a difference between the two groups of orphans as well as a reduction in the gap between orphans and non-orphans in the case sub-country, while the continued gap between orphans and non-orphans in the control sub-county suggests the lack of targeted assistance. We found that close monitoring by AFXB staff played an important role in ensuring that caregivers followed through and bought uniforms for orphans.

These findings also point to the success of the AFXB strategy of supporting IGAs. The most commonly provided income-generating projects were cows and bulls that were given to individual orphan households. However, other beneficiaries opted for projects like poultry, crop

growing, piggery, and, in a few instances, direct financial support for small-scale retail businesses. A number of IGA beneficiaries, mostly those who received cows and bulls indicated that they had realized significant financial gains. Many caregivers were able to meet the educational needs of orphans as well as provide other basic necessities. However, close monitoring was essential to ensure that IGA recipients (caregivers) did not sell off or divert the benefits to other uses. At the same time, some caregivers admitted that IGAs such as cow/bull-raising was rather tedious and unexpectedly expensive. For instance, they claimed that it took a long time for a cow to produce milk and start giving yields. In the meantime, the cow would require significant inputs in terms of veterinary care, grazing and shelter. Such demands appeared to be too high for many elderly and sickly caregivers. Secondly, since most of the cows were of an indigenous local breed, milk yields were minimal. Therefore, some caregivers who had received a cow/bull as a project reported that they had not realized any gains at all but had instead suffered many inconveniences. Of the households that had received IGA support, only 56.6% reported that the IGA support had yielded some benefits.

## Lunch during School Days

Effective children's attendance of school requires that they obtain adequate food in-take. The responsibility of providing meals to children at school falls on parents/caregivers under the existing primary education system. The practice in the schools covered by this study was to ask parents/caregivers to pay between 1,500-3,000 shillings (approx US$ 0.8-1.5) per child per term for lunch (maize porridge). Children whose caregivers did not pay this charge were not provided with a lunch and went hungry. The AFXB-supported children were entitled to have lunch at school as per the agreement between AFXB and the schools. The table below compares access to lunch between orphans and non-orphans in the two sub-counties.

**Table 7: Access to Lunch during School Days, by Orphan Status and Sub-county**

| Sub-county | Orphan Status | Access to Lunch | | |
|---|---|---|---|---|
| | | Yes Number (%) | No Number (%) | P-value |
| Case | Orphan (N=120) | 92 (76.3) | 28 (23.7) | 0.00** |
| Control | Orphan (N=102) | 33 (32.3) | 69 (67.7) | |
| | | | | |
| Case | Orphan (N=120) | 92 (76.3) | 28 (23.7) | 0.04* |
| | Non-orphan (N=98) | 63 (64.6) | 35 (35.4) | |
| Control | Orphan (N=102) | 33 (32.3) | 69 (67.7) | 0.13 Ns |
| | Non-orphan (N=98) | 42 (42.4) | 56 (57.6) | |

* = statistically significant at the 5% level; ** = statistically significant at the 1% level;
Ns = not statistically significant at the 5% level

The results in Table 7 are somewhat similar to those for possession of a school uniform (Table 5), though they indicate an improved situation (that is statistically significant) for orphans in the case sub-county relative to both the orphans in the unassisted sub-county as well as the non-orphans in the same (case) sub-county. Meanwhile, access to a school lunch was far lower in both groups of children in the unassisted sub-county. This result suggests that the AFXB program not only closed the gap between orphans and non-orphans in the case sub-county but perhaps made the former even better-off than the latter.

## CONCLUSION

This evaluation of the AFXB program in Luwero provides evidence that a small-scale NGO intervention can effectively address some of the most pressing needs of Ugandan orphans. The AFXB case specifically demonstrates that support can be directed to the neediest orphans and their households, while at the same time contributing to broader community development.

The AFXB intervention further underlines the importance of close monitoring to ensure that programs are implemented as planned and that benefits go to the identified beneficiaries. Close monitoring seems to have been important in raising the general consciousness of the local communities about keeping children in school and fulfilling the expectations from the NGO that was supporting them.

The fact that the enrollment of orphans in school remained below that of non-orphans in both the supported and the non-supported sub-county highlights the possibility that other complex factors can affect orphans' enrollment and continuation in school, as has been shown by other studies (Kamali et al., 1996). These factors may include poverty and the need to work or earn cash, domestic responsibilities, psychological distress, stigma and discrimination at school, lack of adult support, ill health and malnutrition, as well as poor-quality education as documented by the International HIV/AIDS Alliance (2003).

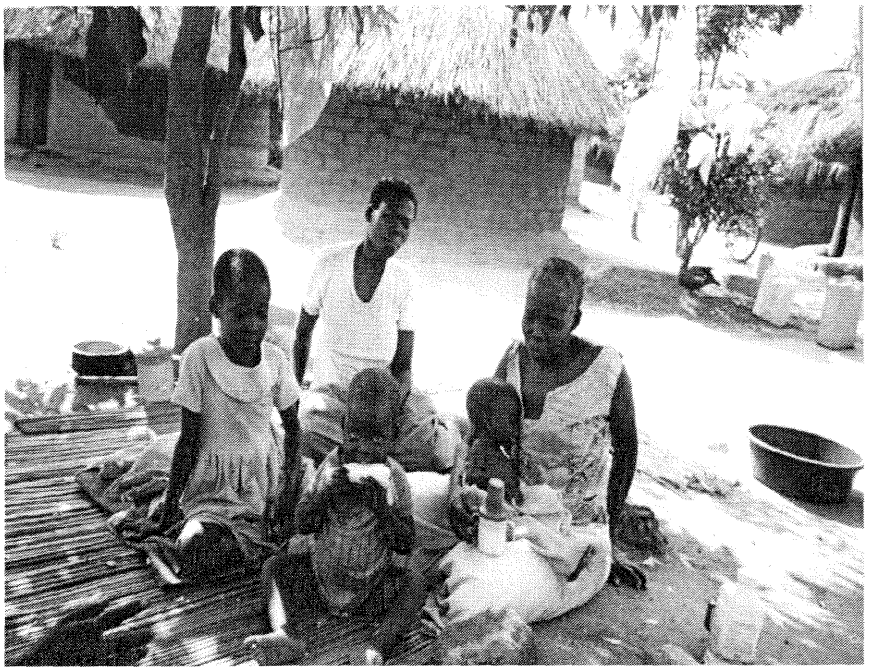
Our findings suggest that in critical areas such as access to a school lunch and possession of a school uniform, NGO assistance can have the result of not only improving the position of orphans vis-à-vis unassisted orphans, but also vis-à-vis non-orphans living in the same community. Perhaps ironically, this may have the effect of creating a class of orphans who are actually better off than other children – a big concern of NGO providers and local leaders alike. Other analysts (i.e., Fleshman, 2001) have pointed out this dilemma, and it is clear that such scenarios have the potential to breed tension, ill feelings and hatred among children.

One real issue of concern is the lack of a clear system for graduating children from support. In the case of AFXB, the only mechanism for beneficiary children to graduate from AFXB support is when they complete primary seven. The phasing out of beneficiaries was complicated by the fact that most are known to remain vulnerable and incapable of caring for orphans without external support.

AFXB program staff were also concerned about sustainability, despite having implemented measures such as close cooperation with local leaders. Despite these efforts, it was clear that local governments tend to see orphan support as an NGO responsibility, rather than a true community duty.

Based on the findings of this study, a number of policy issues can be identified. Perhaps the most significant is the policy challenge of how to have a clear social impact without creating long-term dependency. In addition, there is the challenge of devising mechanisms for up-scaling current small-scale interventions (such as those provided by AFXB) that are able to have an effective impact. Such expansion of assistance is critical since Uganda's traditional system of expanded-family support is not able to adequately meet the needs of all the country's needy children.

## RECOMMENDATIONS



Our study findings underscore the need for interventions that improve children's access to post-primary education, especially orphans. More alternative education opportunities, which can be accessed by children, including orphans, from poor families are also required. These might include vocational skills training, which could be designed in innovative and cost-effective ways – including community-based apprenticeships. These would be especially practical given that most orphans are paternal, with fathers who have frequently died of AIDS and whose mothers may not survive long, and thus need skills that can enable them to earn a living on their own. One option would be to provide skills/vocational training during primary education.

There is also a need to address other factors that constrain orphans' enrollment and continuation in school, apart from school dues and materials. Creating a favorable, non-discriminatory environment both in orphan households and in schools should be an integral part of efforts to support orphan's education. Interventions that integrate psychosocial support into schools could play a key role in nurturing such environments.

Where external support is given, the role of caregivers in adequately and specifically addressing the needs of orphans must be emphasized and enforced by local leaders. In fact, it is critical that community interventions be formulated and implemented in close collaboration with local structures such as local councils, community-based organizations, schools and a broad range of local leaders to ensure sustainability and a sense of community "ownership".

Finally, whereas targeting of the neediest must continue to ensure that support reaches those orphans whose needs are greatest; the AFXB case demonstrates the benefits of interventions that contribute to the development of the wider community. Other NGO and government programs should ideally follow this example and experiment with other approaches that combine reaching the worst off individuals with improving the welfare of broader communities.

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